Hamilton County Mental Health & Recovery Services Board

Strategic Plan 2017

HAMILTON COUNTY
Mental Health &
Recovery Services Board

Preface

Hamilton County Mental Health and Recovery Services Board's Role

Hamilton County Mental Health and Recovery Services Board (MHRSB) provides leadership in public behavioral health care as the authority charged under ORC §340 with planning, funding, managing, and evaluating behavioral health care in Hamilton County. MHRSB is statutorily prohibited from providing direct care to clients and instead contracts with numerous non-profit agencies to provide direct care in a community based (non-hospital) setting.

STAKEHOLDERS

- Taxpayers
- Clients and their Families
- Board Members
- Behavoral Health Providers
- Elected Officials

PARTNERS

- Adult Protective System
- Children's Protective System
- Court Systems
- Hamiton County
- Hamilton County Heroin Coalition
- Law Enforcement/Corrections
- School Systems

Purpose of Strategic Plan

MHRSB has prepared this strategic plan to assess and adjust its direction in response to local and state political developments, changing demographics and service needs, behavioral health care challenges at the local, state, and national levels, economic conditions, and potential changes to national healthcare policies.

The strategic plan guides MHRSB in setting new priorities, focusing resources, aligning system-wide goals, and identifying intended results. The strategic plan will guide MHRSB future direction, define the actions needed to make progress, and describe measures to determine success.

The results of this strategic plan will be used for the purpose of targeting resource allocation among service providers.

Planning Process

The strategic planning process addresses the state of the current behavioral health system in Hamilton County as well as expectations for the future. To accomplish this, the strategic plan results from an evaluation of our operating landscape, a needs assessment of Hamilton County's demographic, national prevalence and other trend data, and the combined expertise and input of our behavioral health stakeholders and partners as well as MHRSB managers.

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HAMILTON COUNTY MENTAL HEALTH AND RECOVERY SERVICES BOARD SYSTEM OF CARE

OUR MISSION

is to develop and manage a continuum of mental health, addiction, and prevention services that have a positive impact on the community and are accessible, results oriented, and responsive to individual and family needs.

State and Federal Revenue
Ohio Department of Mental Health and Addiction Services

Local Revenue
Mental Health Levy
Family Services and Treatment Levy
Indigent Care Levy

22% | **78%**

HAMILTON COUNTY
Mental Health & Recovery Services Board

Planning, Funding, Managing and Evaluating Behavioral Health Care in Hamilton County

MHRSB Network of Contract Providers
37 Non-profit agencies
who deliver non-hospital behavioral health services
— crisis care, outpatient, residential, and housing —
to Hamilton County residents

Client/Receipients of Care
On an annual basis, over 26,000 Hamilton County residents receive care from an MHRSB contract provider based on a sliding fee scale

Executive Summary of Strengths and Challenges

The Hamilton County Mental Health and Recovery Services Board (MHRSB) provides leadership in public behavioral health care as the authority charged under ORC § 340 with planning, funding, managing, and evaluating behavioral health services provided by a network of nonprofit, community-based organizations (providers) in Hamilton County. Providers deliver prescribed treatment, prevention, and supportive services that form a continuum of care that promotes recovery and helps residents lead healthy and productive lives.

MHRSB has become a leader in the state in the provision of high quality cost effective services and supports for clients. This leadership has been built upon strengths in creating successful collaborations and partnerships, strategic investment in system resources, data driven planning, and strong system management.

STRENGTHS: MHRSB engages in several collaborative efforts with community partners (e.g., adult protective system, children's protective system, court systems, Heroin Coalition, law enforcement/corrections agencies, hospitals, school systems and various Hamilton County departments) to ensure that clients receive person-centered care that is managed across partners for cost efficiency and treatment effectiveness. Hamilton County MHRSB has also formed an association with the two other large urban boards in the state (Cuyahoga County and Franklin County) as together these three counties are responsible for the treatment of nearly 30% of Ohio behavioral health clients. The counties have formed a Council of Governments to work with OhioMHAS as well as state legislatures to develop legislation and policies that best serve the largest number of clients.

Recovery from mental illness and/or addiction requires more than just treatment. Therefore, MHRSB invests in critical supportive services that assist clients in maintaining stable living arrangements, preparing for employment, and living independent lives. These investments have been strengthened over the last levy period, as MHRSB was able to reallocate financial resources made available by Medicaid expansion.

MHRSB continually collects and analyzes data from many sources to guide in decision making, setting and prioritizing goals, and evaluating progress. By focusing on data, MHRSB is able to make informed decisions regarding system planning, resource allocation, client benefit management, and staff management. In addition, MHRSB offers an incentive payment to providers to collect and submit outcomes data. Use of this data ensures that clients are receiving the best, most efficacious treatments available. To build upon its strength in data informed decisions, MHRSB has invested in a new comprehensive data management system designed to provide comprehensive data management of all business transactions between MHRSB and contract providers.

MHRSB managers have an average of 18 years' experience at MHRSB, and an average of 25 years in public service. The breadth and depth of this experience has empowered the MHRSB with the flexibility and adaptability to respond proactively to shifting needs and changing financial environments while maintaining consistent levels of client care. In addition, line employees at MHRSB are exceptionally well qualified to manage provider

Executive Summary of Strengths and Challenges

networks to ensure maximum efficiency and maximum client outcomes. With an average of 12 years at the MHRSB, employees apply extensive knowledge in their respective fields to maintain MHRSB's low administrative costs and constructive relationships with treatment providers.

MHRSB's strengths in the above areas position us well to meet the challenges evidenced during the planning process. Completion of the planning process requires in-depth knowledge of the relevant political, economic, behavioral health, and technological environments as well as a complete understanding of demographic trends, service needs, and service capacity within Hamilton County. Thus, MHRSB has prepared both an environmental scan and a comprehensive needs assessment.

CHALLENGES: The environmental landscape for community behavioral health in Ohio shifted dramatically during the last levy cycle reflecting several major policy changes at the state and federal levels. The most significant changes involved Medicaid "elevation" and implementation of the Affordable Care Act (ACA), which included Medicaid expansion. Responding to these changes required restructuring of MHRSB internal operations and provider contracts, which resulted in a significant reduction of MHRSB staff, and redirection of funds made available through Medicaid expansion to supportive services vital to client recovery (e.g., housing, job readiness, peer support, successful transitions, etc.).

Entering the next 5 year planning cycle, major policy changes are again expected to significantly affect publicly funded behavioral health care in Ohio. At the national level, potential repeal of the ACA and reduced Medicaid funding is expected to exclude from Medicaid coverage a significant portion of the population with behavioral health issues. This could potentially add a considerable number of clients to the Hamilton County behavioral health system at a time when funding from OhioMHAS continues to be unstable and a larger portion of the total revenues budgeted by MHRSB are derived from local tax levies. For calendar year 2017, 64.7% of MHRSB revenue was generated by three local levies.

Changes occurring in the behavioral health field are triggering shifts in MHRSB service patterns requiring careful prioritization of contract allocations. Among the most significant of these challenges is the rapid increase in opioid (Heroin) addiction. Treatment for opioid addiction increased 360% between 2010 and 2015. This is of critical concern as opioid addiction significantly contributes to community and family problems such as crime, disease, and children's services issues.

Additionally the behavioral health field is experiencing a shortage of qualified workers. The shortage of workers is severe and is exacerbated by insufficient reimbursement rates and increasing numbers of individuals and families requiring mental health or addiction services. Finally, as in other healthcare fields, information technology drives efficient operations and effective decision-making. Therefore, investment in information technology must be included when prioritizing and allocating resources.

Executive Summary of Strengths and Challenges

Because MHRSB primarily serves the indigent population, related demographic trends signal increasing service needs as the population able to pay for those services decreases. An increasing number of individuals and families are living in poverty in Hamilton County (a 9% increase in approximately 10 years) with additional information evidencing a 57% increase in the number of Hamilton County residents receiving publicly funded mental health services. Demographic trends also indicate that a larger number of those with greater resources are migrating out of Hamilton County, while those migrating into the county reflect lesser means. Additionally Hamilton County has experienced the fourth highest birth rate in the state (13.6%) combined with the second highest rate of low birth weight babies (9.6%) and the highest rate of births to unwed mothers (52.2%).

A comparison of Hamilton County to the state of Ohio and other large urban counties indicates that Hamilton County's service system engages a larger percentage of individuals with the most serious and costly forms of mental illness (48.11%) than either the state (28.4%) or the two other urban counties (Franklin 38.1% and Cuyahoga 36.4%). However, the Hamilton County service system lags the state and Franklin County in reaching mentally ill individuals not considered to be severely mentally ill (SMI) by state criteria.

Hamilton County outperforms its two larger counterparts in its penetration rate for individuals age 18 to 24 with an AOD service need, though it lags the state as a whole. For individuals aged 25 and above Hamilton County outperforms Cuyahoga County in service provision for this category, but does not perform as effectively as Franklin County or the state as a whole in the percentage of those served relative to those estimated to have need.

The needs assessment survey includes three separate survey efforts (Providers, Informed Community, and Consumers [clients]). The summary tables on the following page illustrate the most critical issues derived from the survey results. As detailed in these tables, the Hamilton County system is challenged with the acquisition and retention of psychiatrists and physicians who provide medication assisted treatment, issues related to inadequacies with insurance coverage, housing, and the necessary supports that serve to assist individuals in successfully maintaining their independence within the community, as well as access to hospitalization and crisis residential services during more severe periods of illness.

In response to the environmental scan and the needs assessment, MHRSB identified 13 strategic goals (divided into service goals and stewardship goals) that reflect MHRSB's commitment to build on current strengths while advancing its mission to develop and manage a continuum of mental health, addiction, and prevention services that have a positive impact on the community, are accessible, results oriented, and responsive to individual and family needs.

Executive Summary of Strengths and Challenges

Mental Health Treatment Barriers

1 Shortage of Psychiatrists			
Rankings:	Provider 1	Informed Community 1	Client 3
2 Inadequate Insurance Coverage			
Rankings:	Provider 5	Informed Community 3	Client 1
3 Shortage of Other* Mental Healthcare Providers			
Rankings:	Provider 3	Informed Community 7	Client 4
3 Inadequate Transportation to Services 3			
Rankings:	Provider 2	Informed Community 6	Client 6
3 Cost of Medication			
Rankings:	Provider 7	Informed Community 5	Client 2

* other than psychiatrists

Mental Health Treatment Insufficiencies

1 Crisis Residential			
Rankings:	Provider 1	Informed Community 1	Client 1
2 Psychiatric Medication Management			
Rankings:	Provider 2	Informed Community 2	Client 2
3 Hospitalization			
Rankings:	Provider 3	Informed Community 4	Client 4

Mental Health Support Service Insufficiencies

1 Supported Housing			
Rankings:	Provider 1	Informed Community 1	Client 2
2 Housing			
Rankings:	Provider 2	Informed Community 3	Client 1
3 Independent Living Supports			
Rankings:	Provider 4	Informed Community 2	Client 3

Alcohol and/or Other Drug Treatment Barriers

1 Inadequate Insurance Coverage			
Rankings:	Provider 2	Informed Community 1	Client 1
2 Shortage of MAT Providers			
Rankings:	Provider 2	Informed Community 4	Client 4
3 Stigma |			
Rankings:	Provider 5	Informed Community 3	Client 3

MHRSB Strategic Goals: Introduction

Strategic Goals are a blueprint for MHRSB as it addresses individual and community service needs in the context of an evolving behavioral healthcare environment. These goals reflect MHRSB's commitment to build on current strengths while advancing its mission to develop and manage a continuum of mental health, addiction, and prevention services that have a positive impact on the community, are accessible, results oriented, and responsive to individual and family needs. To this end, MHRSB has identified 13 mission-critical goals that are divided into Service Goals and Stewardship Goals as follows:

Service Goals

- Provide a system of care with a wide array of Evidence Based Treatment Services that ensures a high quality of care for Hamilton County residents and promotes recovery and a favorable quality of life
- Reduce the impact of opiate addiction on individuals and the community
- Promote prevention and education efforts that reduce the impact of mental illness and addiction in the community
- Expand recovery supports
- Ensure individuals with behavioral health needs are treated in an environment that best meets their needs
- Support the development and retention of a professional workforce adequate to meet the needs of the community
- Enhance opportunities to integrate behavioral health and primary health care

Stewardship Goals

- Maximize efficiency and effectiveness of the Hamilton County behavioral health system
- Ensure financial viability of the HCMHRSB and its service delivery system through efficient, accountable, and responsible financial management
- Maintain system-wide procedures that achieve compliance with all legal obligations and reporting requirements
- Organize board staff and other resources in a manner consistent with established priorities and available resources, and monitor organization at all levels for effectiveness and efficiency
- Advocate to local community, and state and national elected officials to provide increased support for community-based services
- Prepare for changing community needs and changing financial environments while maintaining consistent levels of care

Objectives and performance measures are outlined for each of these goals. Given the broad range and complexity of MHRSB's programs, these goal statements are not an inventory of all objectives MHRSB will pursue or all actions that it will undertake. Instead, these goals present priority objectives reflecting important changes and outcomes that MHRSB hopes to achieve, and key performance measures that will be used to track and evaluate progress toward meeting the goals.

MHRSB Strategic Service Goals

SERVICE GOAL 1	OBJECTIVE	PERFORMANCE MEASURES
Provide a System of Care with a wide array of Evidence Based Treatment Services that ensures a high quality of care for Hamilton County residents and promotes recovery and a favorable quality of life	**Promote agency use of Evidence Based Practices**	Monitor agency use of EBPs using reporting mechanisms such as MHRSB Community Plan and agency data entered in Ohio MHAS Grants Funding Management System (GFMS)
	Identify unmet service needs	Use established reporting methods from providers and stakeholders (i.e. monthly MHAP report) to identify needs and plan to address
	Build capacity to meet the behavioral health needs of individuals and families	Realize an increase in the number of clients served
	Increase open access to needed services for individuals and families	Realize an increase in the number of agencies offering open access
	Ensure clients achieve maximum benefit from their insurance plans	Use established reporting methods from providers and stakeholders (i.e. monthly MHAP report) to identify needs and plan to address
	Ensure contracted provider agencies administer and submit Ohio Scales measures for Mental Health Clients	Meet target of 65% for agency purchase of service for adult clients and for child/youth clients exhibiting improvement in overall symptom distress and/or quality of life measures over the course of treatment
	Ensure contracted provider angencies administer and submit the Brief Addictions Monitor (BAM) for Alcohol and Other Drug Services Clients	Meet target of 60% for agency purchase of service for clients exhibiting improvement through a reduction in their use of substance(s) during their episode of care

MHRSB Strategic Service Goals

SERVICE GOAL 2	OBJECTIVE	PERFORMANCE MEASURES
Reduce the impact of opiate addiction on individuals and the community	**Increase utilization of Medication Assisted Treatment (MAT) in AOD system**	Collect and analyze data on the total number of clients receiving MAT
	Identify and remove barriers impacting the treatment for individuals with an opiate addiction	Collect and analyze data on total number of agencies providing evidence based programming
	Collaborate with system partners and community organizations such as HCHC	Maintain active participation with HCHC

SERVICE GOAL 3	OBJECTIVE	PERFORMANCE MEASURES
Promote prevention and education efforts that reduce the impact of mental illness and addiction in the community	**Increase the number of individuals receiving prevention and education services**	Collect and analyze data on total number of individuals served on an annual basis
	Increase prevention and education services that are evidence based	Collect and analyze data on total number of agencies providing evidence based programming
	Promote data driven prevention/education interventions	Monitor agency performance using MHRSB prevention outcomes and Ohio MHAS Grants Funding Management System data (GFMS)

SERVICE GOAL 4	OBJECTIVE	PERFORMANCE MEASURES
Expand recovery supports	**Support agency development of expanded recovery supports (e.g., transportation, housing and vocational services)**	Secure additional funding specific to recovery supports

MHRSB Strategic Service Goals

SERVICE GOAL 5	OBJECTIVE	PERFORMANCE MEASURES
Ensure individuals with behavioral health needs are treated in an environment that best meets their needs	**Increase number of consumers diverted from incarceration**	Realize an increase in client access to specialty dockets and increase the use of Crisis Intervention Treatment (CIT) programming for local law enforcement.
	Address needs of consumers upon re-entry to the community	Increase the use of recovery supports such as housing, vocational training and peer support as evidenced by contracting for such supports
	Maintain level of care screening/review through MHAP	Continue preparation and evaluation of monthly MHAP reports

SERVICE GOAL 6	OBJECTIVE	PERFORMANCE MEASURES
Support the development and retention of a professional workforce adequate to meet the needs of the community	**Strengthen relationships with local universities and colleges to attract individuals to the behavioral health field**	Collaborate with local universities and providers
	Support agency efforts to recruit and retain workers	Continue review of agency funding opportunities
	Improve staff skills and cultural competency	Provide ongoing training opportunities to support agency staff

SERVICE GOAL 7	OBJECTIVE	PERFORMANCE MEASURES
Enhance opportunities to integrate behavioral health and primary healthcare	**Solidify partnerships in the healthcare community that focus on integrated care**	Realize an increase the number of clients identified under Keys to Health and increase the number of agencies with access to data alerts from local hospitals via Healthbridge

MHRSB Strategic Stewardship Goals

STEWARDSHIP GOAL 1	OBJECTIVE	PERFORMANCE MEASURES
Maximize efficiency and effectiveness of the HC BH system	**Evaluate funding decisions continually using a combination of business, health, outcome, and financial stability criteria**	Monitor programs, services and/or providers to ensure they meet business, health and/or outcome criteria and support the financial stability of the MHRSB
	Evaluate system contracts and procedures to maximize the use of existing resources	Review and evaluate the strengths and resources of providers
	Maintain effective mechanisms for optimum communication and collaboration with stakeholders, partners, and public	Conduct and participate in regular meetings with BH coalitions. Foster ongoing communication and discussion with providers and community groups (e.g., NAMI, HCHC). Provide written action items for board meetings. Maintain a public comments section in board meetings. Maintain MHRSB website and social media sites (Facebook and LinkedIn).

STEWARDSHIP GOAL 2	OBJECTIVE	PERFORMANCE MEASURES
Ensure financial viability of the HCMHRSB and its service delivery system through efficient, accountable, and responsible financial management	**Maintain financial stability of HC BH system**	Align annual budget available resources with identified needs
	Develop a 5-year financial forecast based upon projected system needs and resources	Develop and continually update a five-year levy plan
	Continue and expand outcomes-based funding	Continue and expand provider outcomes-based incentive program
	Conduct annual financial audit	Complete Annual Financial Statement audit resulting in unqualified opinion with no findings
	Convert cost reimbursement contracts to purchase-of-service situations to enhance data gathering related to the number of clients served, service provision, and outcomes	Realize a 70% conversion rate to purchase-of-service

MHRSB Strategic Stewardship Goals

STEWARDSHIP GOAL 3	OBJECTIVE	PERFORMANCE MEASURES
Maintain system-wide procedures that achieve compliance with all legal obligations and reporting requirements	**Monitor compliance and submit local and state behavioral health reports**	Realize acceptance status by OMHAS of Community Plan

STEWARDSHIP GOAL 4	OBJECTIVE	PERFORMANCE MEASURES
Organize Board staff and other resources in a manner consistent with established priorities and available resources while also monitoring organization at all levels for effectiveness and efficiency	**Evaluate MHRSB workforce with regard to changing needs and financial means**	Convene weekly meetings with executive staff and have departmental staff meetings and all-staff meetings as needed to analyze and communicate needs and resources
	Evaluate MHRSB computer hardware and software capabilities with regard to MHRSB needs and financial means	Meet with appropriate VPs to analyze needs and resources
	Evaluate MHRSB office facility and building systems with regard to operational needs and financial means	Meet with appropriate VPs to analyze needs and resources

MHRSB Strategic Stewardship Goals

STEWARDSHIP GOAL 5	OBJECTIVE	PERFORMANCE MEASURES
Advocate to local community, and state and national elected officials to provide increased support for community-based services	**Articulate the need for local resources and demonstrate that all resources are used efficiently and effectively**	Demonstrate increased support efforts to pass levies that fund MHRSB services (e.g., MH, HHIC, FST)
	Secure support for funding formulas that are linked to the number of clients served, clients' level of illness, and ability to pay	Demonstrate increased support efforts toward equitable funding for board services
	Secure support for legislation that allows community systems the freedom to design high quality systems that best meet the needs of clients within the community	Demonstrate increased support efforts to pass legislation that will reform and update ORC 340 and ORC 5122
	Articulate the need for increased psychiatric hospital capacity	Realize an increase in the total number of available psychiatric beds in the region

STEWARDSHIP GOAL 6	OBJECTIVE	PERFORMANCE MEASURES
Prepare for changing community needs and changing financial environments while maintaining consistent levels of client care	**Monitor state and federal regulations and legislation**	Review federal, state, and county budget forecasts that pertain to HC BH system
	Monitor economic conditions and forecasts that may affect Hamilton County BH system	Attend legislative events and develop understanding of potential pertinent legislation. Review changes to ORC and relevant publications (OMHAS directives, BH news, etc.)
	Ensure that funded services continue to fulfill consumer needs and deliver a measurable health impact	Analyze pertinent departmental and system reports
	Monitor availability of effective and affordable technologies that best support changing BH system needs	Analyze efficient and effective system-wide data management tool
	Monitor state progress toward BH redesign	Review state directives and attend forums

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Environmental Scan— Introduction | Political Landscape

INTRODUCTION

Political developments over the term of the last mental health levy period, changing demographics and service needs, challenges in the behavioral field, economic conditions, and potential changes to national healthcare policies will affect significant aspects of MHRSB operations over the next five years.

During the past levy period, we restructured our internal organization and provider contracts to align with policies of the then new state administration. In 2012, the Ohio Department of Job and Family Services assumed full responsibility for Medicaid-eligible behavioral health consumers. This resulted in a retraction of state funding to HCMHRSB and an overhaul of HCMHRSB financing and contracting strategies. This overhaul included a significant reduction of MHRSB staff, moving to a calendar fiscal year, selectively choosing the services we fund and the contractors who provide them, and redirecting funds made available through Medicaid expansion to services important to consumer recovery (e.g., housing, job readiness, peer support, successful transitions, etc.). Nevertheless, entering the next 5 year planning cycle, we are once again faced with potentially sweeping changes to our system of care.

Political developments over the term of the last mental health levy period, changing demographics and service needs, challenges in the behavioral field, economic conditions, and potential changes to national healthcare policies will affect significant aspects of MHRSB operations over the next five years.

POLITICAL LANDSCAPE

Recent and upcoming political actions may become the future drivers of MHRSB funding and policy direction. During the five-year levy cycle, a new Ohio Governor will be elected possibly affecting MHRSB state funding, and driving program/service direction. In addition, the recent national election could affect accomplished MHRSB funding and program transformations as well as compel changes in other operating strategies.

Behaviorial Health Redesign: The Ohio Office of Medicaid is in the process of making significant changes to the behavioral health system in Ohio. This initiative is commonly referred to as Behavioral Health (BH) Redesign and will among other changes, require utilization of a complex coding and rate structure that will affect clients and families, behavioral health providers, and will affect local Boards' planning, funding, monitoring, and evaluating of community services. HCMHRSB anticipates its service system will invest a significant amount of human and financial resources to develop and coordinate the processes necessary to implement the complex changes contemplated.

Medicaid Elevation: In 2013, responsibility for Medicaid clients was transferred to the Ohio Department of Jobs and Family Services (ODJFS). As a result, the relationship between MHRSB and network providers who offer Medicaid-reimbursable services has undergone a major shift, as MHRSB no longer contracts with agencies providing services only to individuals with Medicaid coverage. Nevertheless, there remain a high percentage of individuals whose behavioral health services are managed by both the MHRSB and Medicaid, resulting in difficulty maintaining continuity of care for these clients.

Environmental Scan — Political Landscape

Medicaid Expansion: Possible national changes to Medicaid could result in a prolonged period of funding and policy ambiguity for MHRSB. States anticipate that the funding mechanism that distributes federal funds to states for Medicaid will be changed to a finite block grant in order to limit the amount of Medicaid spending. States would then have increased flexibility in administration and reimbursement of the limited funding. In addition, recent Medicaid expansion (that provided coverage for an expanded population in Ohio) could be retracted. This would potentially add a considerable number of clients to the Hamilton County behavioral health system, which could significantly increase MHRSB expenses.

The federal Affordable Care Act, with coverage that includes essential mental health services, could be repealed or drastically altered, restricting access to mental health care for those without private coverage.

The Affordable Care Act: The federal Affordable Care Act, with coverage that includes essential mental health services, could be repealed or drastically altered, restricting access to mental health care for those without private coverage. Ohio's Governor supports a "thoughtful strategy" to repeal and replace the Affordable Care Act because the administration anticipates "serious consequences" of repealing the law without a replacement. Ohio is among the areas that would be hardest hit potentially losing $3.5 billion in federal funding in 2019. In addition, the people helped the most by the ACA are the ones most likely to suffer from poor mental health and addiction. It is estimated that nearly 30% of those who received coverage through Medicaid expansion have a mental disorder or substance addiction. That compares to 20% of the overall population who experienced a diagnosable mental health or substance abuse disorder in the past year. Furthermore, the increasing number of diverse healthcare plans with differing benefits (e.g. access to medications) will challenge consumers and families in meeting their expectations from multiple public payer systems.

Changes to Ohio Revised Code (ORC): With recent changes in Ohio Revised Code §340, OHMHAS has reserved the right to disapprove local behavioral health budgets (i.e., withhold funds) when the state and federal fund allocations do not meet OHMHAS criteria. This approach is somewhat troubling to Hamilton County and the other large urban boards, as these boards have been leading the way in developing and implementing innovative and cost effective services and programs as well as determining and prioritizing needs within their respective counties.

Advocacy: Hamilton County MHRSB together with the two other large urban boards (Cuyahoga County and Franklin County) has a critical role in shaping the future of behavioral healthcare throughout the state. Together these counties are responsible for the treatment of nearly 30% of the clients in Ohio. Therefore, the Hamilton County MHRSB has combined resources with the Boards in Franklin and Cuyahoga counties to engage the services of a state lobbyist to represent the interests of the three large urban boards before the state legislature. The three counties have created a Council of Governments (COG) to work with OHMHAS as well as state legislatures to create legislation and policies that best serve the largest number of clients. Efforts focus on advocating for funding formulas that are linked to the number of clients served, clients' level of illness, and ability to pay as well as legislation that allows community systems the freedom to design high quality systems that best meet the needs of clients within the community.

Environmental Scan — Economic Landscape | Behavioral Health Landscape

ECONOMIC LANDSCAPE

Sustained economic stressors continue to influence MHRSB strategies. In general, state funding to local governments decreased by 57% between 2010 and 2015. During the current five-year levy period, behavioral health funding to MHRSB from OHMHAS has declined $1.2 million. Future revenue from OHMHAS could decline further as the Ohio Governor has warned that future budgets will be tighter. The Director of OHMHAS anticipates cutting $41 million over two years even if the OHMHAS budget receives 100 percent funding of last year's funding. Stating that the priority is to keep state mental hospitals open implies that cuts may have to be made in funds for community services.

To maintain an adequate level of care, the MHRSB service system relies more heavily on the support of Hamilton County voters. Of the total revenues budgeted by the HCMHRSB for calendar year 2017, 64.7% are derived from three local levies: the Mental Health Levy, the Health Hospitalization & Indigent Care Levy, and the Family Services and Treatment Levy. Due to changes in State law, these levies have experienced a significant decrease due to the phase-out of Tangible Personal Property (TPP) Tax. In 2008, the Mental Health Levy reported Tangible Personal Property tax receipts of $5.6 million. Those revenues were phased-out during the subsequent eight years with the final receipt of $333 thousand received in calendar year 2016. Likewise, changes occurring within the Family Services and Treatment Levy have resulted in a 20% decrease when comparing the prior and current levy periods. Future community support for these levies is uncertain due to the recent announcements about economic uncertainty in Ohio. Failure to pass the levies or a reduction in the levy amounts would negatively affect available services for residents with mental health or addiction needs.

To maintain an adequate level of care, the MHRSB service system relies heavily on the support of Hamilton County voters.

BEHAVIORAL HEALTH LANDSCAPE

Demographic changes to the Hamilton County population and changing service needs will continue to drive MHRSB planning and resource allocation as available behavioral health resources must be aligned with need.

Heroin Addiction: The scope and urgency of the heroin epidemic has become a leading driver in MHRSB's addiction service planning and allocation of resources. Heroin addiction has become so prevalent that service needs outpace available monetary, human, and capital resources. This is likely to continue well into the future as a successful long-term approach to this problem has yet to be evidenced.

Hamilton County has invested resources in multiple initiatives and projects aimed at reducing the impact of opiate and heroin addiction in our county. One such initiative, the Hamilton County Heroin Coalition (HCHC) was formed by the Hamilton County Board of County Commissioners to coordinate communication and help focus the efforts of various county agencies in abating the opiate epidemic. Specific goals of the HCHC include fostering collaboration and collectively advocating strategies for addressing treatment, prevention, harm reduction, and supply reduction. MHRSB also funds several successful "quick response teams" designed to persuade overdose survivors to enter into treatment.

Environmental Scan — Behavioral Health Landscape

15,000,000

An estimated 15 million young people in the nation can currently be diagnosed with a mental health disorder and many more are at risk.

At the same time that Hamilton County initiated several active and practical efforts to best meet the needs of our residents, Ohio passed legislation mandating specific services that all counties must make available in a "Continuum of Care" for opiate and heroin addiction. While MHRSB already had these services in place, many smaller and more rural counties cannot meet this mandate. For example, detox is an expensive service not covered by Medicaid, and there are not enough available physicians to meet the need for medication-assisted treatment. Thus, even with service mandates and the extensive resources available in Hamilton County, the need remains greater than available capacity.

Workforce Shortage: Recruitment and retention of qualified and competent professional staff has become increasingly competitive. Provider agencies continue to experience increasing costs and increasing difficulty in recruiting and retaining qualified professional staff. Reasons for this difficulty stem from behavioral health professionals being more concentrated in affluent areas, low wages and benefits combined with heavy caseloads, stigma associated with working with the behavioral health population, and a lack of professionals entering the field.

Increased Children, youth, and families at risk: An estimated 15 million young people in the nation can currently be diagnosed with a mental health disorder and many more are at risk of developing a disorder due to various risk factors. Furthermore, it is estimated that only about 7 percent of these youth receive appropriate help from mental health professionals. Since January 2015, MHRSB has seen a 73.5% increase in the number of families served through the FAIR (Family Access to Integrated Recovery) program, which provides behavioral health services for children and families who have an open case with HCJFS (currently HCJFS has 1,900 children in their care). The FAIR census in October 2016 equaled 3,353 clients, and continues to climb, causing concerns about ability to maintain service levels.

Psychiatric Inpatient Capacity: Access to inpatient care has reached a crisis state over the past 24 months. Reduced funding at the county level makes it more difficult to keep persons in the community for treatment. State operated inpatient facilities are operating at near capacity on a daily basis. Summit hospital, which services Hamilton County, recently experienced similar issues related to capacity. Local hospitals with psychiatric beds are commonly full. Recently one of the largest capacity hospitals significantly cut the number of available beds. The lack of hospital capacity strains local resources as boards must spend more resources on crisis services and related services in courts and jails.

Poverty: While the most recent U.S. Census estimates show modest growth in population within Hamilton County, demographic shifts in the population are increasing the number of those most in need of services provided through public funds. There is a trend in migration patterns that has resulted in a net out-migration from Hamilton County to adjacent suburban counties with in-migrations reflecting households with lesser incomes. Additionally, as in many areas, income disparities appear to have widened in Hamilton County, which evidenced

Environmental Scan — Behavioral Health Landscape

an increase in the poverty rate of 11.8 percent in 2000 to a rate of 18.4 percent in 2014. Not inconsistent with other urban cores, the city of Cincinnati itself witnessed a more dramatic change during this same period from 21.9 percent to 30.9 percent.

Homelessness: According to the Substance Abuse and Mental Health Services Administration, 20 to 25% of the homeless population in the United States suffers from some form of severe mental illness. This population can be particularly challenging to serve for many reasons including the transiency associated with homelessness. Homeless counts in Hamilton County exhibited a downward trend from 2006 (9,448 individuals) through 2010 (6,965 individuals) at which point a significant increase was experienced (2011 = 7,838) and have remained relatively stable to this point.

Trauma: Ninety percent (90%) of clients in public behavioral healthcare have experienced trauma (e.g., domestic or neighborhood violence, military involvement, overdose, family stress, etc.). To ensure the best possible health outcomes for these individuals, evidence-based "trauma informed care" must be incorporated into treatment. Significant training has already occurred in the MHRSB system but additional ongoing and expanded training is necessary.

Integration of Increased Numbers of Ex-Offenders Entering the Community: The U.S. Department of Justice (DOJ) reports that more than half of inmates are diagnosed with a mental health disorder; in addition, many prisoners are incarcerated for nonviolent drug crimes that are the result of substance addiction. These prisoners are ultimately released, and their mental health issues and unaddressed addiction can increase their risk of reoffending and make it difficult to reenter society as a productive, nonthreatening citizen. Individuals who have been incarcerated are generally less educated, have fewer job skills, have poor family support systems, and likely have a mental illness or substance use disorder. Thus, community reintegration requires coordination of several services such as vocational and job readiness training, treatment for mental illness or addiction, and housing assistance.

Diversion from Jails and Prisons: Many communities including Hamilton County have initiated diversion programs as a cost effective alternative to expensive incarceration. Diversion programs are designed to prevent future criminal behavior, and provide the benefit of community improvement through community service. There are also benefits to victims such as financial restitution and apology and benefits to the offender of avoiding a criminal conviction record. For example, 81% of youth and 83% of adults referred to diversion complete the program resulting in 81% (victim of youth offender) and 93% (victim of adult offender) of victims receiving restitution, and over 19,000 hours of community service.

Recovery Support: As we get better at treating mental illness, "recovery" support becomes an integral part of client care and reduces the likelihood of relapse. Stable housing, peer support, job readiness, etc. enhance community life for clients and conserve other limited behavioral health resources. Peer support helps clients retain hope and remain in recovery;

90%

Ninety percent (90%) of clients in public behavioral healthcare have experienced trauma (e.g., domestic or neighborhood violence, military involvement, overdose, family stress, etc.).

Environmental Scan — Technology Landscape

The economic costs of mental illness are enormous. In addition to health and social service costs, there are the additional costs of lost employment, reduced productivity, impact on families and caregivers, levels of crime and public safety, and premature mortality.

housing support reduces the need for institutionalization or out-of-home placements and reduces overall costs. Employment and education are both an outcome, and a core component of, recovery. With support, individuals can work in competitive jobs or increase their education, which provides the means for them to increase their earnings over time. Increased income enables people to improve their living situations, reducing exposure to violence and other stressors that may adversely affect behavioral health and recovery. This is particularly important because being unemployed is associated with increased rates of mental health issues and substance use.

Stigma and Prevention: The economic costs of mental illness are enormous. In addition to health and social service costs, there are the additional costs of lost employment, reduced productivity, impact on families and caregivers, levels of crime and public safety, and premature mortality. There are other hard to measure costs such as the negative impact of stigma and discrimination or lost opportunity costs to individuals and families. Educating the community about consumer needs and the diseases of mental illness and addiction will help to decrease stigma. Resources must be allocated to address prevention and reduction of stigma to remove barriers to treatment and eventually decrease the number of citizens requiring treatment. Resources must be focused on identifying and addressing multiple related risk and protective factors.

Increased Acuity of Youth: The youth population is becoming increasingly more challenging to treat. Youth present with challenges that are more complex and severe than in the past. Complicating this matter is the fact that several local residential facilities have recently closed, causing high need/high risk youth with residential treatment needs to receive treatment at facilities outside of Hamilton County. Furthermore, care for these youth must be coordinated with families, which is a service not covered by Medicaid.

Engaging transition aged youth is vital to the community to prevent youth who have reached emancipation from disengaging in successful treatment only to end up in jail, in a hospital or dead. To this end, MHRSB has continued to fund and expand the Journey to Successful Living program that was initially funded by a six-year SAMHSA grant.

TECHNOLOGY LANDSCAPE

Innovations: It has become increasingly important for the MHRSB to invest in and prepare for new technologies in the behavioral health field. Technology such as Electronic Health Records, telemedicine, electronic patient reporting, genetic testing, patients apps, and similar advances are already being used in the medical field. MHRSB must follow the use and effectiveness of new technological developments that could be adaptable for use in the behavioral health field; and be prepared to invest in and utilize those applications that can be used to improve the behavioral health system in Hamilton County.

Data Needs: Reliable and accessible data is a pre-requisite for efficient and effective planning, funding, and evaluating – the essential components of MHRSB operations. Data drives every

Environmental Scan — Technology Landscape

Strengths

- Collaborations
- Investment in System Resources
- Data Driven Planning
- Strong System Leadership

Weaknesses

- Workforce Shortage
- Lack of Access to Medicaid Data
- Access to Inpatient Hospitalization
- Reduced MHRSB Staffing

Opportunities

- BH Redesign
- New Collaborations
- Health Integration
- Decreasing Stigma
- Recovery Supports

Threats

- BH Redesign
- Potential Changes to ACA
- Health Integration
- 65% of Funding From Local Levies
- Managed Care

day decisions as well as strategic actions. MHRSB decisions and actions regarding system planning, finances, client demographics, client benefit management, claims, outcomes, and staff management are all influenced by the data we have. Therefore, it is vital that MHRSB is able to generate and access data that is timely and reliable. MHRSB must continue to utilize and invest in the best data resources available to optimize the behavioral health system in Hamilton County.

Shared Healthcare and Recovery Enterprise System (SHARES): The SHARES data management system is designed to provide comprehensive data management of all business transactions between the participating boards (Hamilton, Franklin, and Cuyahoga counties) and their contract providers. Full implementation now allows service providers to enroll and manage client information, submit service claims, and register outcomes data obtained through the required Ohio Scales system. Additionally, the outcomes module provides valuable client-level clinical reports for providers' use in treatment planning and client management.

Client Outcomes: HCMHRSB initiated an outcomes effort in late 2001 to collect client progress data at regular intervals, this practice was later mandated by the state for all counties. Although the Ohio mandate for participation was lifted in 2007, HCMHRSB, along with a number of other boards in the state, have continued to use and enhance the system to ensure that clients are receiving the best, most efficacious treatments available. The MHRSB offers an incentive payment to providers to collect and submit outcomes data.

References:

30, December. 2017. "Obamacare Repeal May Cost States Billions." Accounting Today. Accessed January 29. http://www.accountingtoday.com/opinion/obamacare-repeal-may-cost-states-billions.

"2017-2018 Governors' Races: Where Power Is Most and Least Likely to Flip." 2017. Accessed January 15. http://www.governing.com/topics/elections/gov-2017-2018-governors-races-predictions.html.

ann.lynsen. 2014. "Prevention of Substance Abuse and Mental Illness." Text. June 20. https://www.samhsa.gov/prevention.

CAAO and CCAO. 2013. "Fact Sheet: Funding the Provision of Services to Ohio's Citizens - The Partnership Between State and Local Governments." County Auditors Association of Ohio and County Commissioners Association of Ohio.

"Children's Mental Health." 2017. Http://www.apa.org. Accessed January 29. http://www.apa.org/pi/families/children-mental-health.aspx.

"Diversion Programs: An Overview." 2017. Accessed January 29. https://www.ncjrs.gov/html/ojjdp/9909-3/div.html.

Galewitz, Phil. 2016. "Millions Could Lose Medicaid Coverage Under Trump Plan." Kaiser Health News. November 10. http://khn.org/news/millions-could-lose-medicaid-coverage-under-trump-plan/.

Hoge, Ph.D., M., J. Morris, M.S.W., G. Stuart, Ph.D., A.P.R.N., L. Huey, M.D., S. Bergeson, M.B.A., M. Flaherty, Ph.D., O. Morgan, M.A., et al. 2009. "An Action Plan for Behavioral Health Workforce Development." Psychiatric Services 60 (7): 883–87. doi:http://dx.doi.org.proxy1.nku.edu/10.1176/ps.2009.60.7.883.

"Horizon Health. Leaders in Clinical Excellence." 2014. Horizon Health. April 4. http://www.horizonhealth.com/us/.

"Obamacare Repeal Jeopardizes Mental Health, Addiction Coverage." 2017. USA TODAY. Accessed January 15. http://www.usatoday.com/story/news/politics/2017/01/08/obamacare-repeal-jeopardizes-mental-health-addiction-coverage/96199628/.

"Offender Reentry: Correctional Statistics, Reintegration into the Community, and Recidivism - RL34287.pdf." 2017. Accessed January 29. https://fas.org/sgp/crs/misc/RL34287.pdf.

"Ohioans Would Be Affected in Many Ways by State Budget Belt-Tightening | The Columbus Dispatch." 2017. Accessed January 15. http://www.dispatch.com/content/stories/local/2017/01/08/ohioans-would-be-affected-by-belt-tightening.html.

"Report: Repeal of Health-Care Law Will Affect Those Treating Drug Addiction, Mental Illness." 2017. The Columbus Dispatch. Accessed January 15. http://www.dispatch.com/content/stories/local/2017/01/11/ohioans-may-lose-care-if-health-law-scrapped.html.

"Tax Revenues Miss Again, Kasich Says Ohio on Verge of Recession." 2017. The Columbus Dispatch. Accessed January 15. http://www.dispatch.com/content/stories/local/2016/12/06/Kasich_warns_of_recession_as_state_tax_take_remains_depressed.html.

"The Effects of Incarceration on Mental Health." 2013. GoodTherapy.org Therapy Blog. March 15. http://www.goodtherapy.org/blog/prison-incarceration-effects-mental-health-0315137.

"The State of Mental Health in America." 2017. Mental Health America. Accessed January 29. http://www.mentalhealthamerica.net/issues/state-mental-health-america.

US Department of Health and Human Services, US Department of Education, and US Department of Justice. 2000. Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda. Publications and Reports of the Surgeon General. Washington (DC): US Department of Health and Human Services. http://www.ncbi.nlm.nih.gov/books/NBK44233/.

"Where GOP Governors Stand on 'Repeal and Replace.'" 2017. Accessed January 15. http://www.governing.com/topics/health-human-services/gov-republican-governors-obamacare-repeal.html.

A Changing Landscape — Key Demographics

Alcohol, Drug Addiction and Mental Health Service (ADAMHS) Boards are statutorily responsible for the planning, funding, and evaluation of behavioral health services within their local jurisdictions. These responsibilities require an in-depth understanding of the communities served in order to ensure the best use of the limited resources available to meet the significant needs of those impacted by mental illness and/or addiction.

Achieving an understanding of the population, and changes to that population over time, is a necessary first step in any planning effort.

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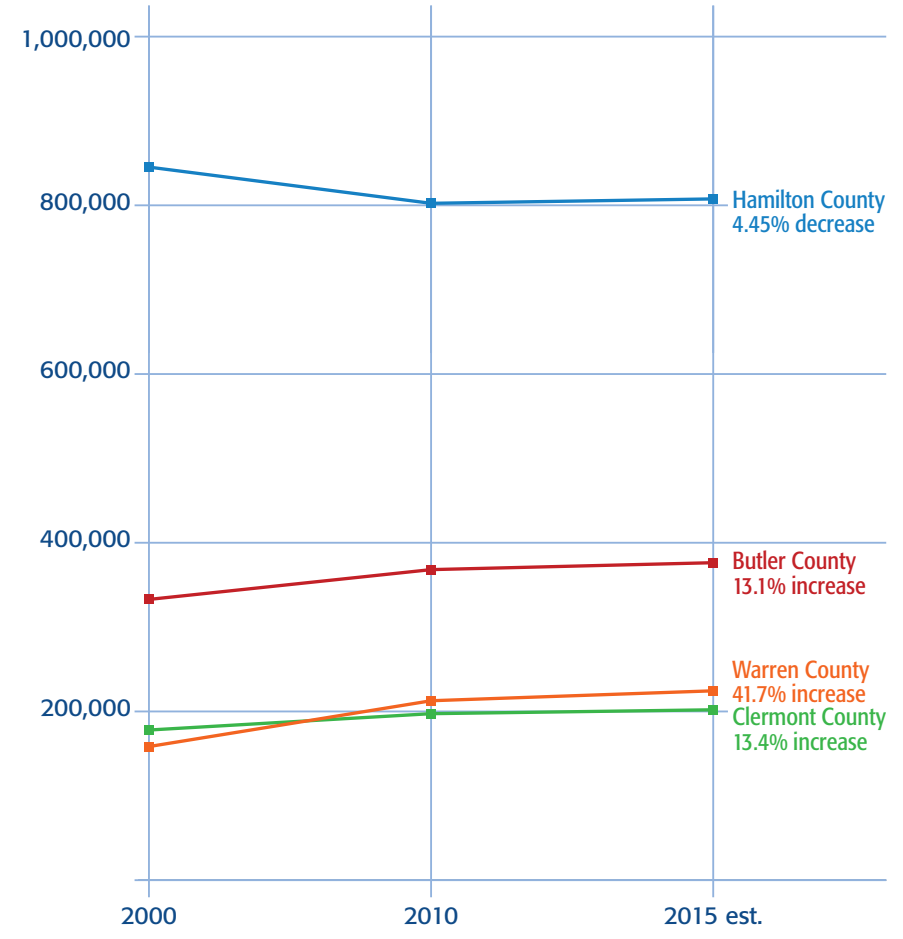
Hamilton County is the third most populace county in the state of Ohio with 807,598 residents according to 2015 population estimates. While the state of Ohio has exhibited modest, though consistent, growth since 2000, Hamilton County exhibited a decrease in population between the 2000 decennial census and the 2010 decennial census. This decrease appears to have reversed with a modest annualized rate of growth of 0.12 percent since the 2010 decennial census finding.

This recent growth makes Hamilton County one of only 29 counties (33%) in the state of Ohio that exhibited growth in population during this period. Hamilton County's adjacent Ohio neighbors have exhibited significantly higher rates of growth during this same period with Warren County exhibiting an annualized growth increase of 1.03 percent, Clermont County exhibiting an annualized growth increase of 0.44 percent, and Butler County exhibiting an annualized growth increase of 0.42 percent. Population changes among Hamilton County's peer, urban counties is mixed.

A Changing Landscape — Key Demographics

Ohio Population Change: 2000–2015

Hamilton, Butler, Warren, and Clermont Counties Population Change: 2000–2015

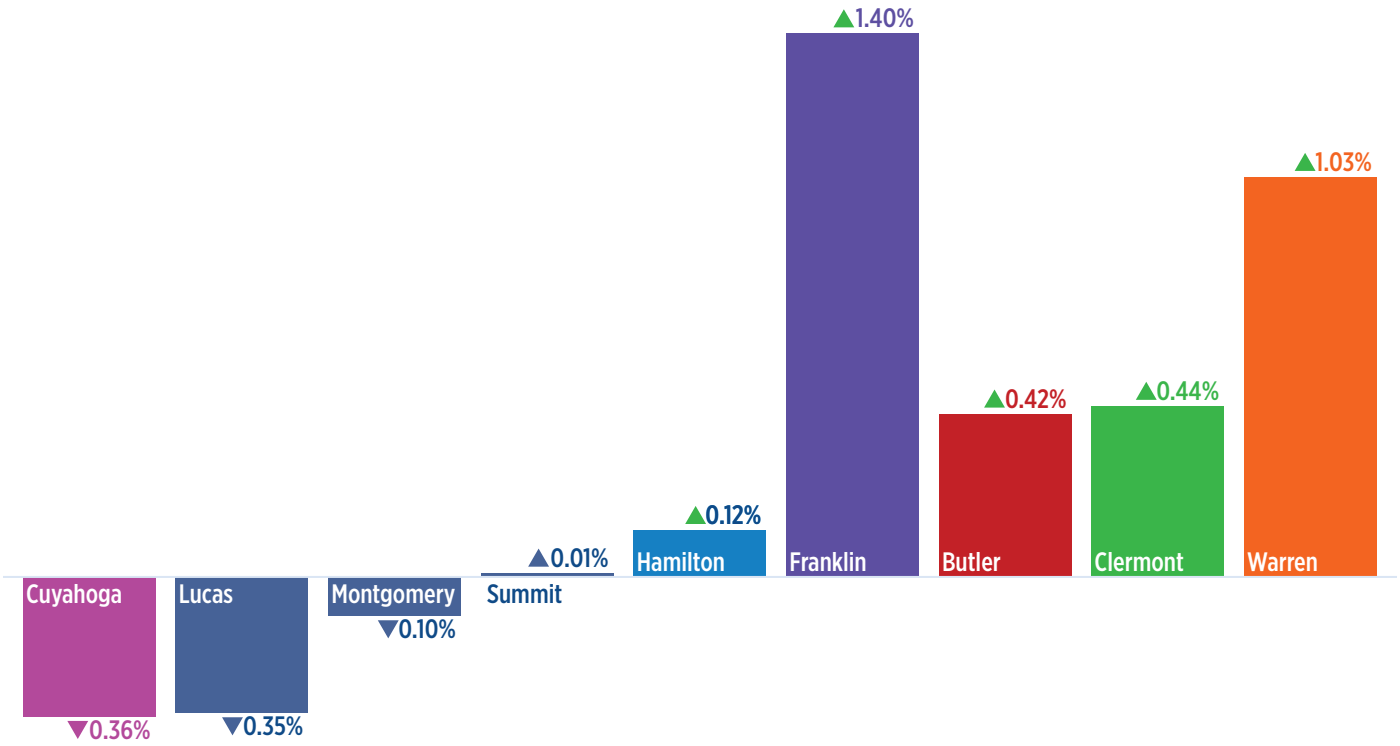


While the state of Ohio has exhibited modest, though consistent, growth since 2000, Hamilton County exhibited a decrease in population between the 2000 and the 2010 decennial censuses. This decrease appears to have reversed with a modest annualized rate of growth of 0.12 % since the 2010 decennial census finding.

A Changing Landscape — Key Demographics

While Franklin County exhibited the highest level of positive population change at an annualized growth rate of 1.40% and Summit remained virtually unchanged (0.01%), the remaining three urban counties exhibited varying levels of population reductions (Cuyahoga -0.36%; Lucas -0.35; Montgomery -0.10%).

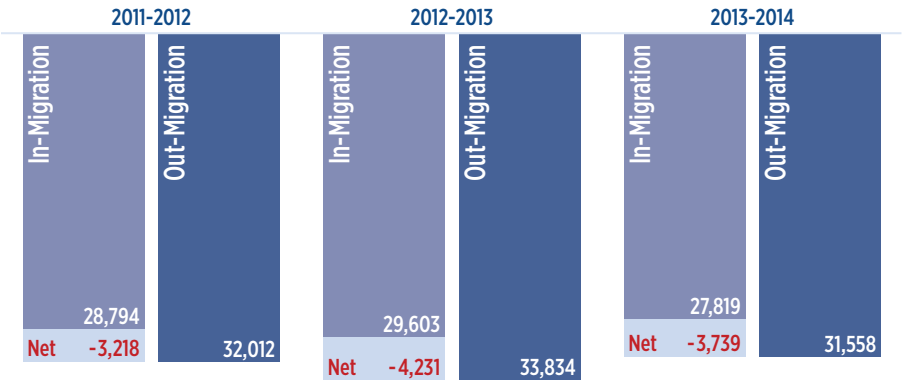
Hamilton, Butler, Warren, and Clermont Counties Population Change: 2000–2015



While increases in population often necessarily result in an increase in need for the number of individuals requiring treatment for mental illness, the established correlation between socioeconomic status (SES) and rates of mental illness call for a more in-depth analysis of the population and its demographic changes with time. In other words, an increase in population may not necessarily increase the level of need if the change is modest in size and demographic features of those resulting in the increase, particularly SES, are more favorable. Similarly, a decrease in population does not necessarily result in fewer individuals experiencing need if shifting demographics result in a greater number of those sub-populations that experience higher levels of mental illness. The following chart reflects the most recent changes observed in Hamilton County.

A Changing Landscape — Key Demographics

Total Individual Movement by Year: 2011–2014



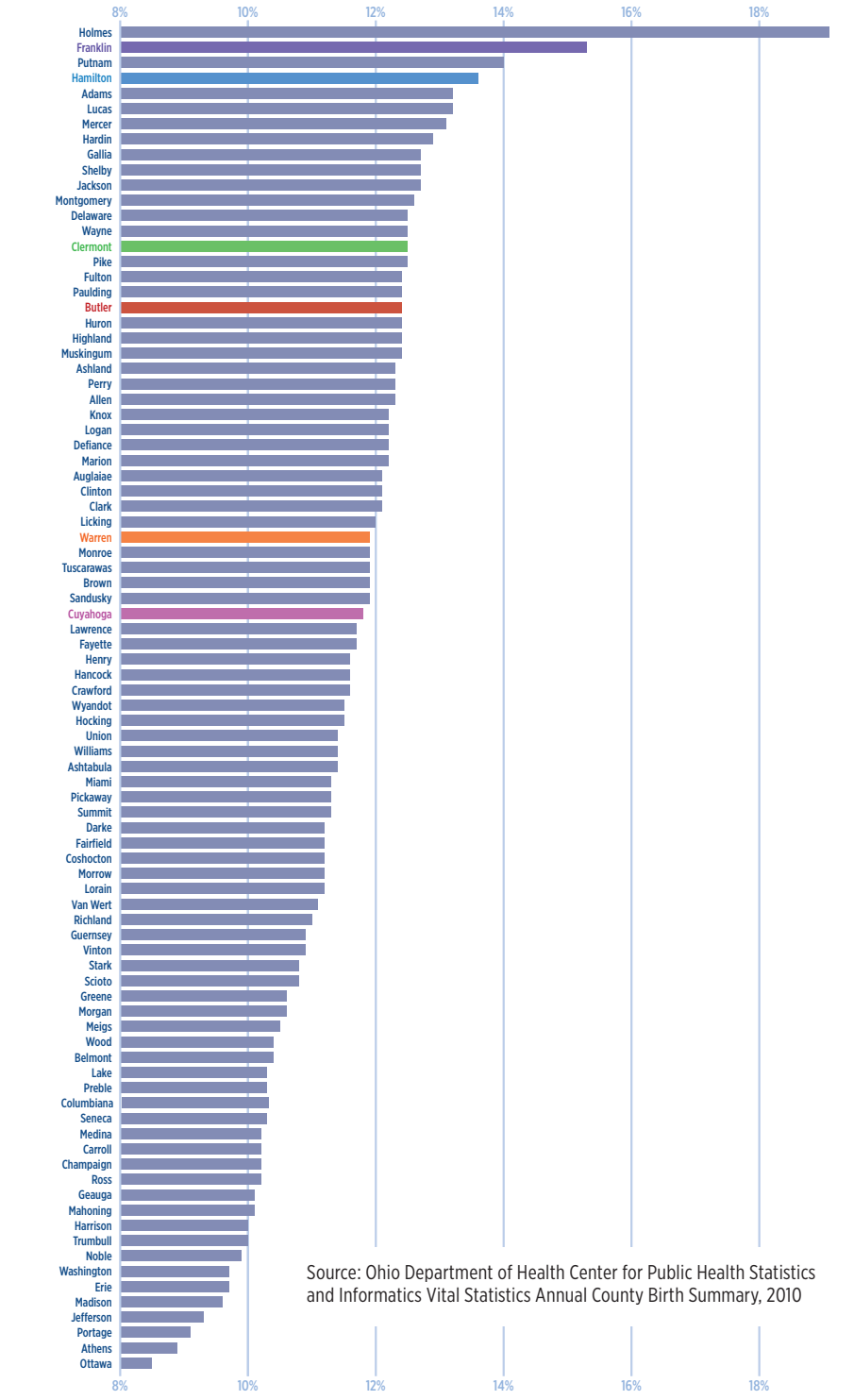
As illustrated in the bar chart above, changing migration patterns in Hamilton County reflect a pattern of migration characterized by the out-migration of those with greater levels of personal resource than those migrating into the county. Additionally, with net out-migrations greater than in-migration, and overall population increases observed over the same period, overall population increases would appear to be attributable to new births. Hamilton County has the fourth highest birth rate of all Ohio counties, with a rate of 13.6%, and is among the top ten counties in rates of births to unwed mothers and for low birth weight babies, factors that can significantly add to stress and financial challenge.

A Changing Landscape — Key Demographics

Hamilton County has the fourth highest birthrate of all Ohio Counties and is among the top ten counties in rates of births to unwed mothers and for low birth wieght babies.

10,876 Births // Rate 13.6

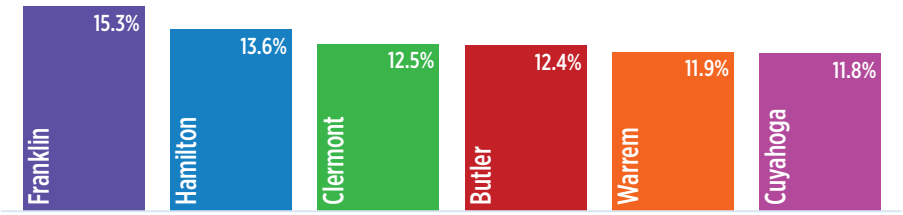
Birth Rates by County: 2010



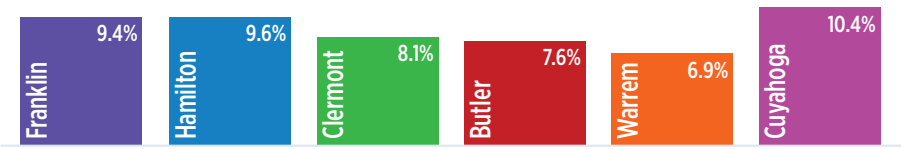
Source: Ohio Department of Health Center for Public Health Statistics and Informatics Vital Statistics Annual County Birth Summary, 2010

A Changing Landscape — Key Demographics

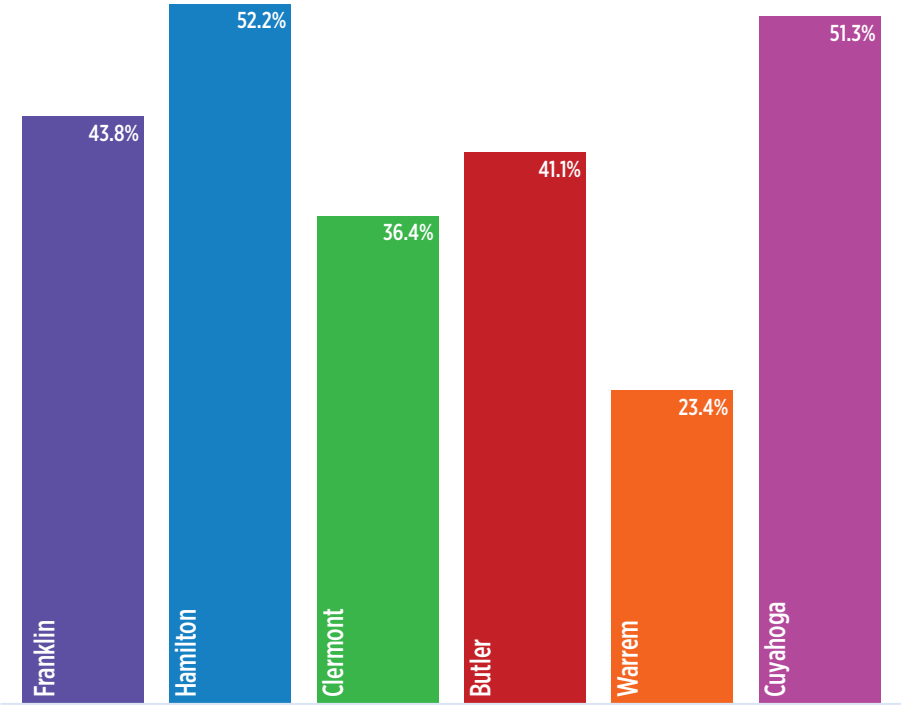
Urban and Adjacent County Birth Rates: 2010



Urban and Adjacent County Low Birth Weight Rates: 2010



Urban and Adjacent County Unwed Birth Rates: 2010



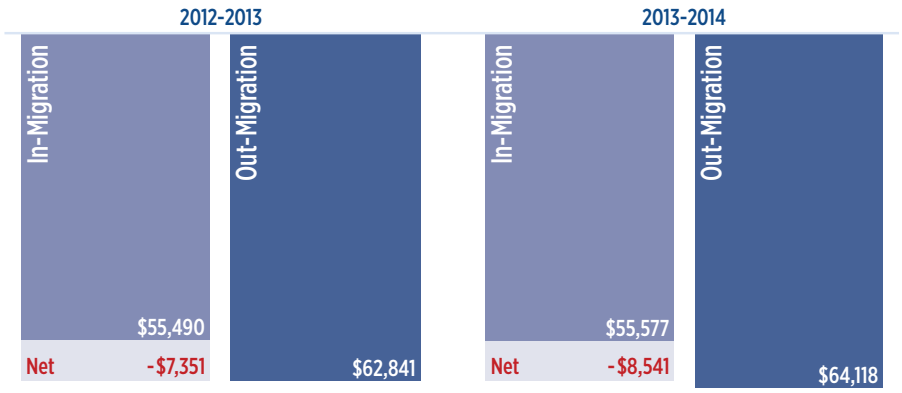
Source: Ohio Department of Health Center for Public Health Statistics and Informatics Vital Statistics Annual County Birth Summary, 2010

A Changing Landscape — Key Demographics

Further analysis of population change relative to the financial status of families is made possible through the use of available Federal tax return information.

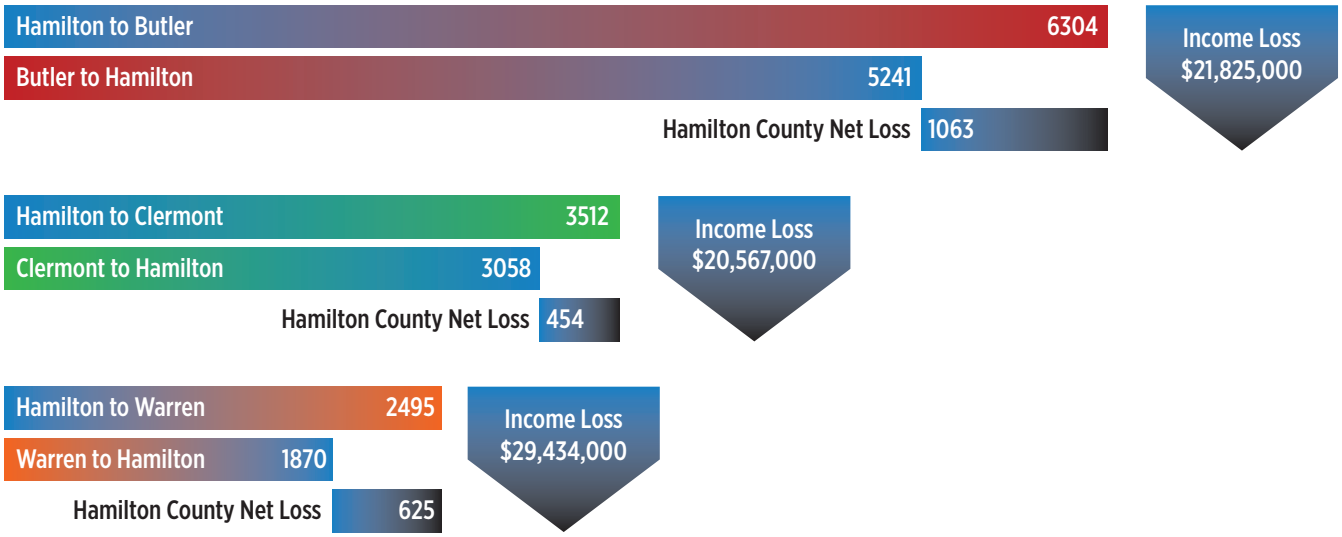
Adjusted Gross Income by Year: 2012–2014

2011-2012 Not Available

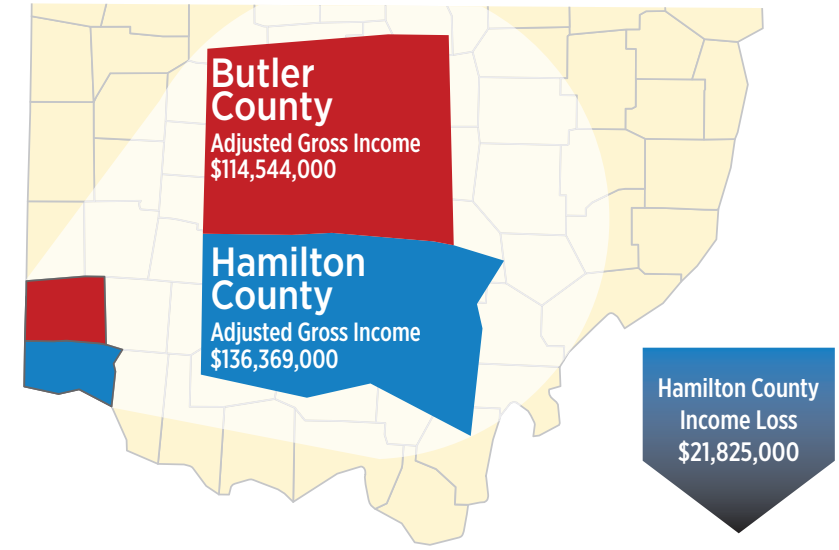


As reflected in the above bar chart, this information evidences a pattern wherein those with greater resources are choosing to migrate to other areas outside of Hamilton County, while those migrating into the county reflect lesser means. In many cases (48%) those individuals leaving Hamilton County are migrating to areas outside of the tri-state. However, for those moving to or from an adjacent Ohio county, it is possible to assess the income differences, as illustrated through the following graphics.

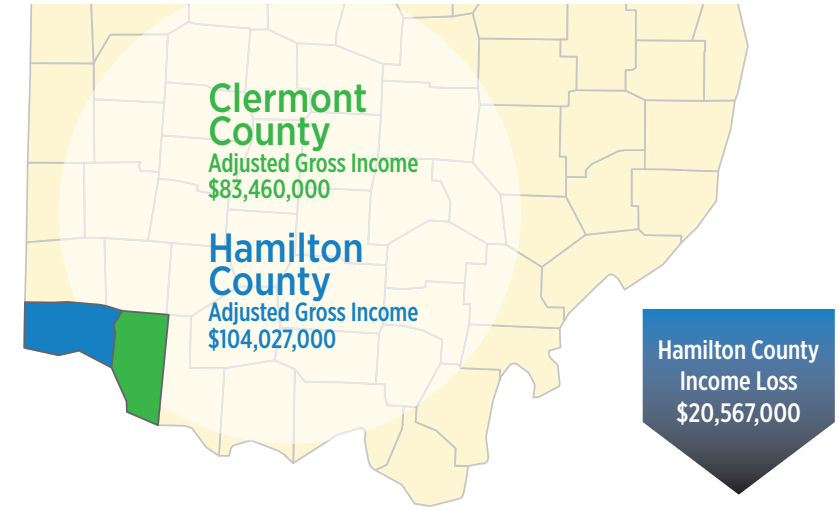
Directional Population Change — Hamilton County with Butler, Clermont, and Warren Counties: 2013–2014



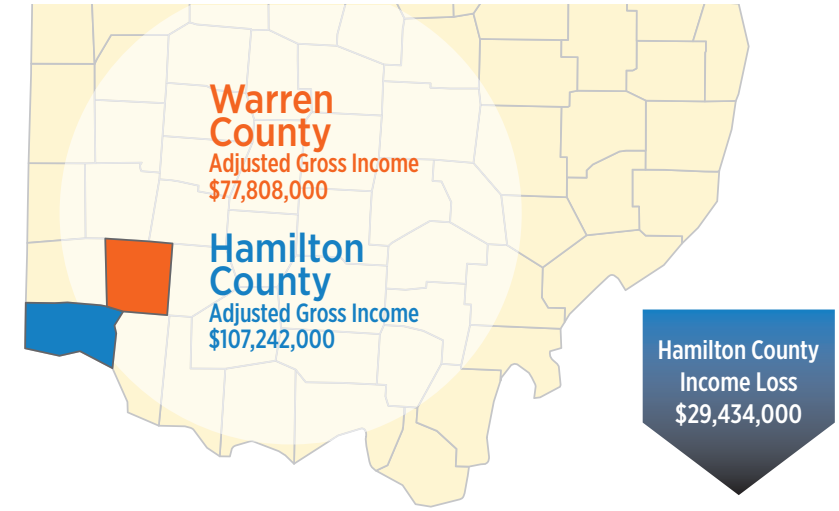
Hamilton County Directional Population Change with Butler County 2013-14



Hamilton County Directional Population Change with Clermont County 2013-14



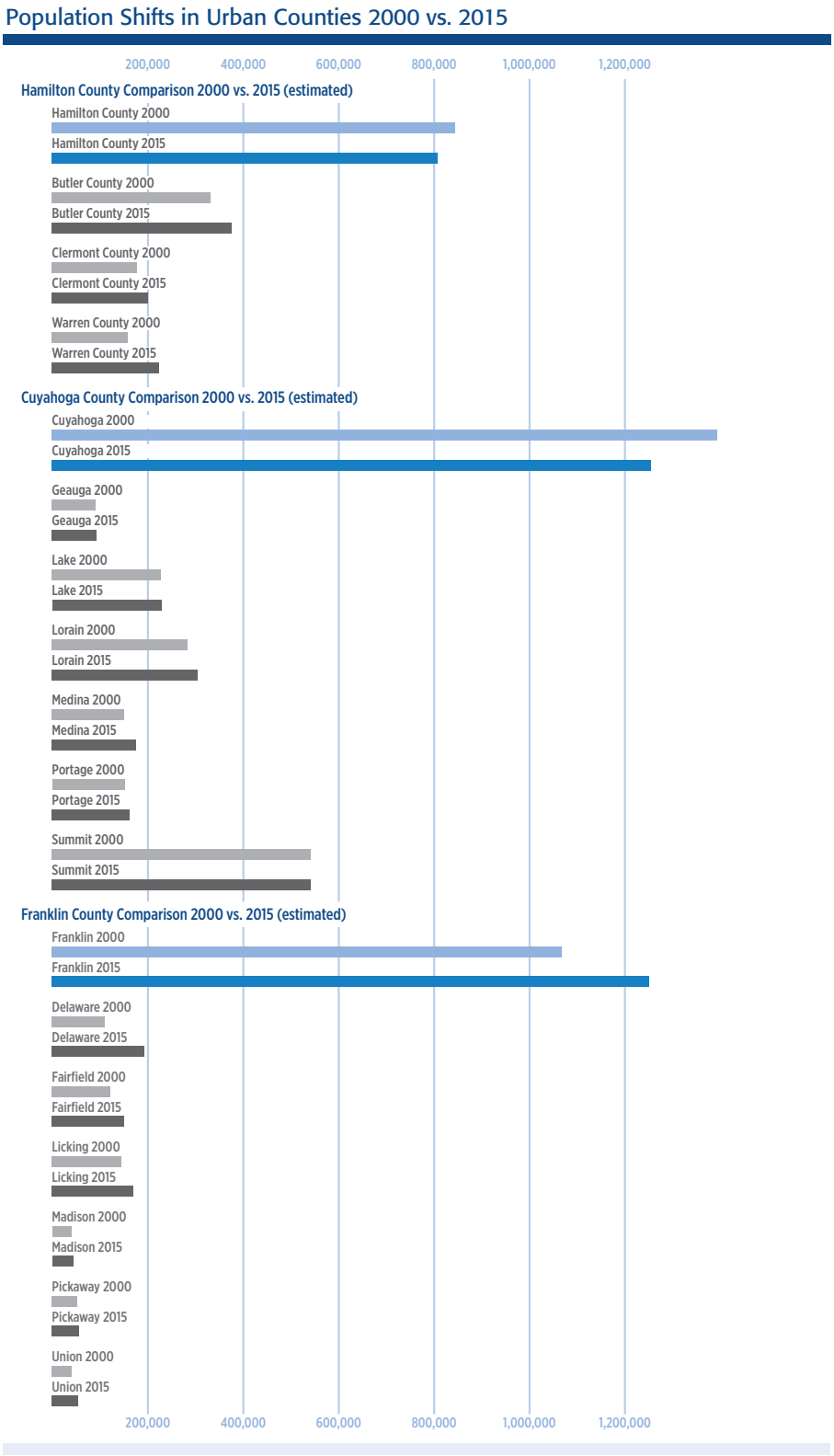
Hamilton County Directional Population Change with Warren County 2013-14



The change in residents between Hamilton and Butler counties for the period 2013 - 2014 is a net loss of 1,063 residents to Hamilton County with an accompanying decrease of $21,825,000 in income. For the same period, the net loss in Hamilton County residents to Clermont County was 454 individuals with an associated loss of $20,567,000 in income. The loss of residents to Warren County was 625 but came with the highest loss in income with a difference of $29,434,000.

A Changing Landscape — Key Demographics

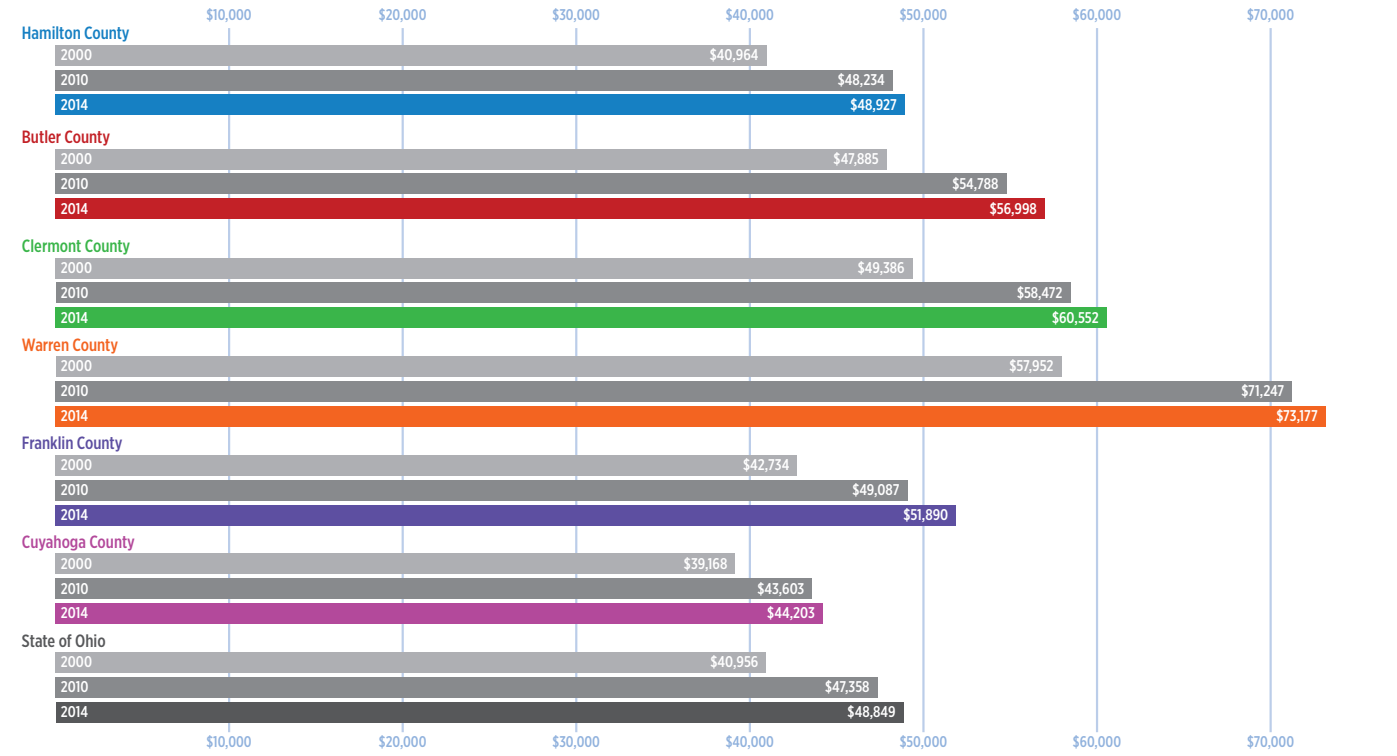
Similar shifts in population demographics have been witnessed for all three of Ohio's most populace counties with surrounding counties experiencing growth rates that exceed that of the urban counties for which they are adjacent.



A Changing Landscape — Key Demographics

Measures of wealth within a particular population are not only valuable as a planning consideration given the positive correlation between that factor and mental illness, but also because ADAMH boards must ensure that those who are mentally ill and lack the necessary resources to obtain care through private insurance are able to attain those services through the public system that exists for that purpose. Hamilton County, similar to other large urban counties, adjacent counties, and the state as a whole, has seen median household income increases since 2000. While Hamilton County closely mimics the state of Ohio on this measure, it lags significantly its three adjacent Ohio counties while falling between its two largest urban counterparts.

Median Household Income — Hamilton, Butler, Clermont, Warren, Franklin, Cuyahoga Counties and Ohio: 2000, 2010, 2014

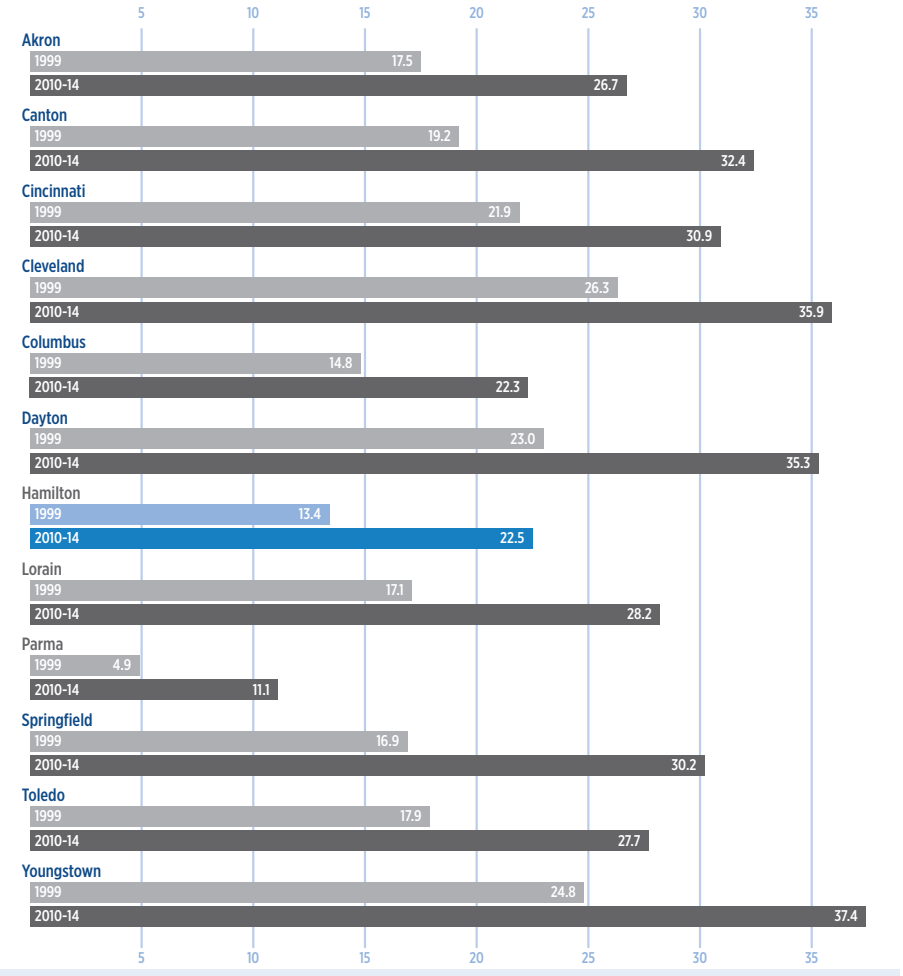


A Changing Landscape — Key Demographics

Similar shifts in population demographics have been witnessed for all three of Ohio's most populace counties with surrounding counties experiencing growth rates that exceed that of the urban counties for which they are adjacent.

Also, similar to other more populace counties with large urban centers, Hamilton County has witnessed a significant increase in the number of individuals who live in poverty.

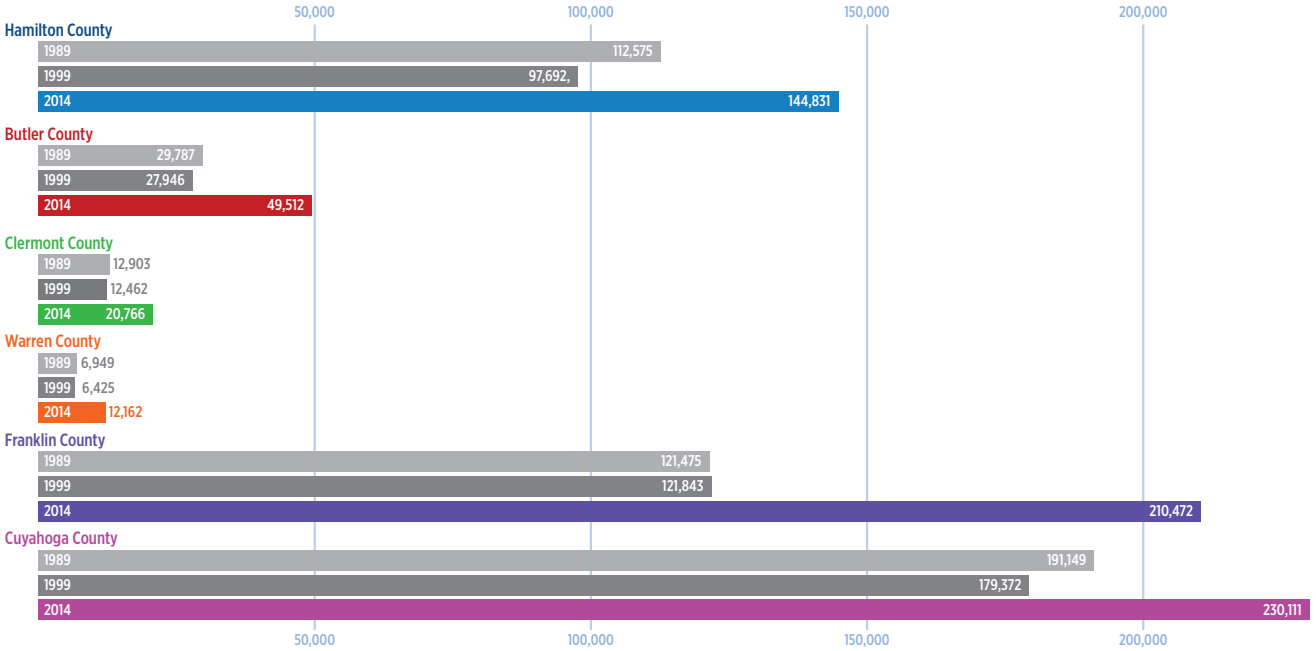
Changes in Poverty Rates in Ohio's 12 Largest Cities: 1999 to 2014



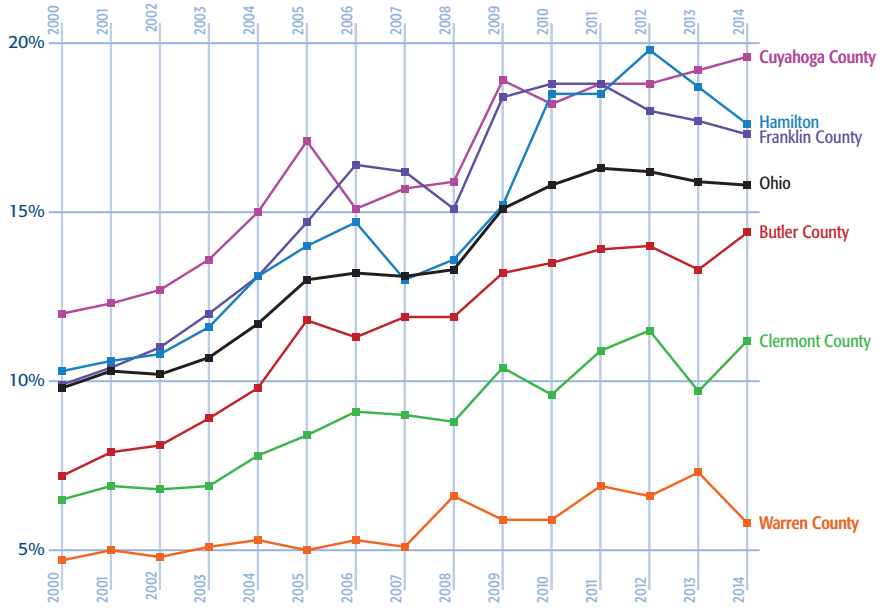
Source: U.S. Census Bureau
Note: Metropolitan area central cities are indicated with blue bars.

A Changing Landscape — Key Demographics

Number of Poor Persons by County — 1989, 1999, 2010-14



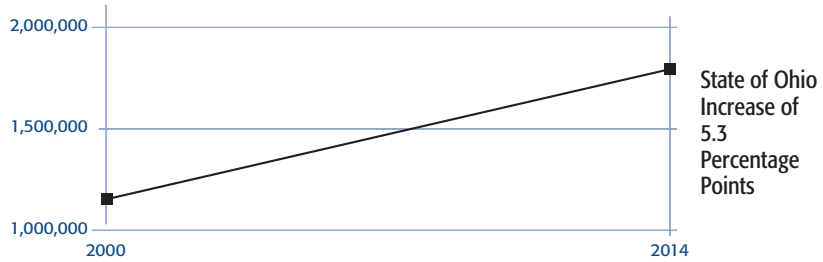
Percentage of Poor by Select Counties and Nationally: 1989–2014



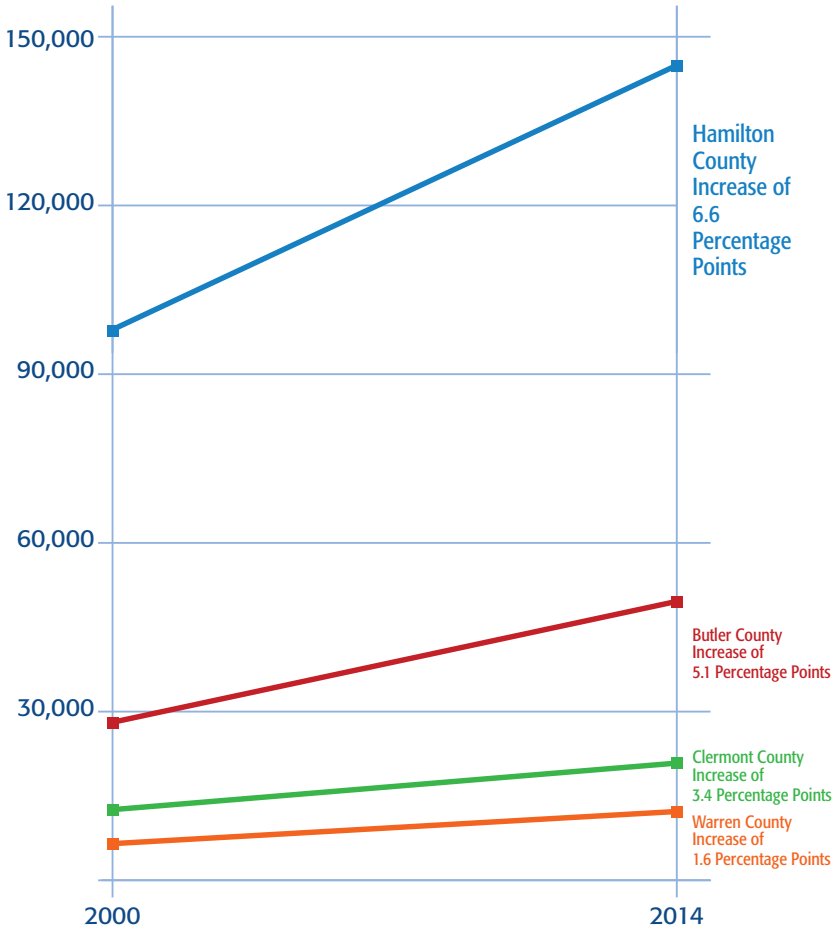
A Changing Landscape — Key Demographics

Looking at the change in poverty over the period 2000 to 2014 overall, Hamilton County has experienced a more significant increase (6.6 percentage points) than it's contiguous counties and the state of Ohio (5.3).

State of Ohio Poverty Change: 2000–2014

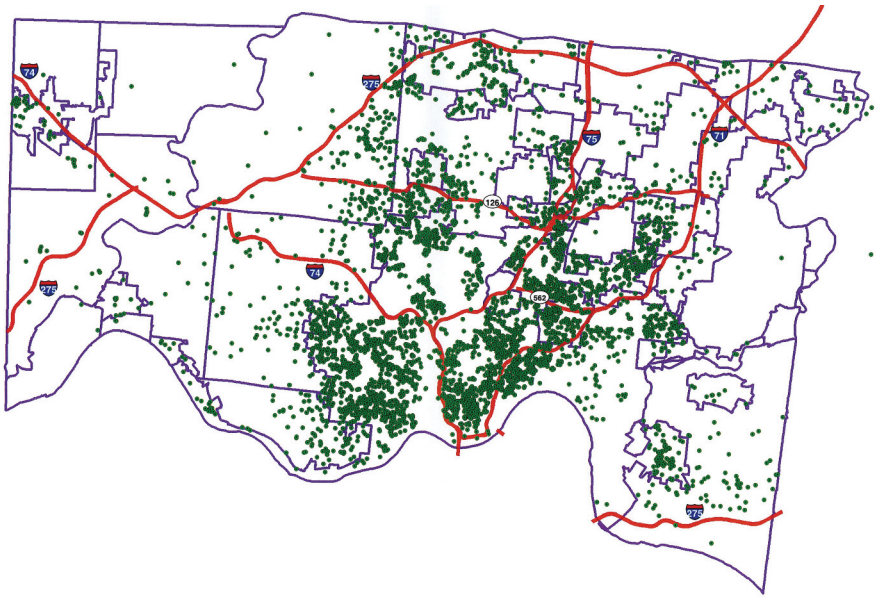


Hamilton, Butler, Warren, and Clermont Counties Population Change: 2000–2014

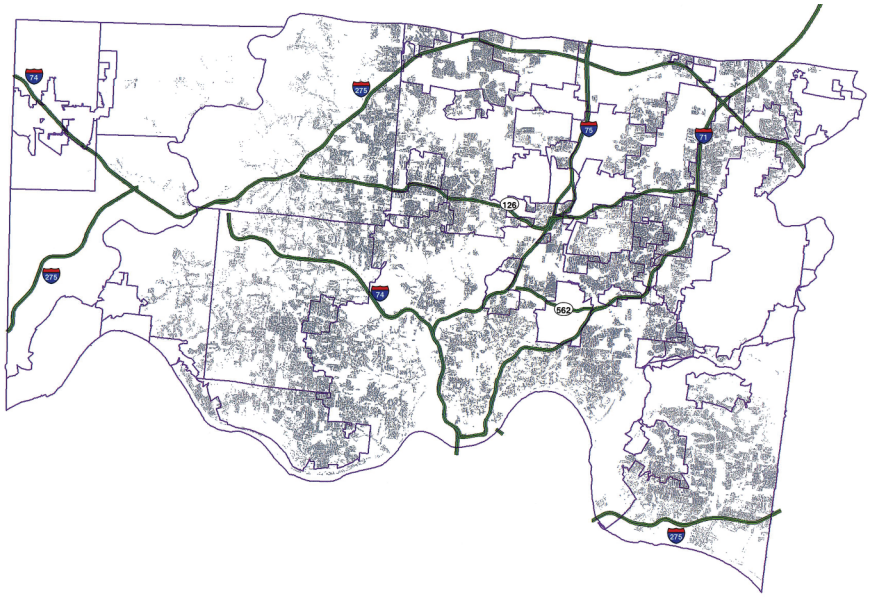


The Hamilton County Service System

The dispersion of clients receiving services through Hamilton County's publicly funded service system is broad and generally consistent with the population as a whole.



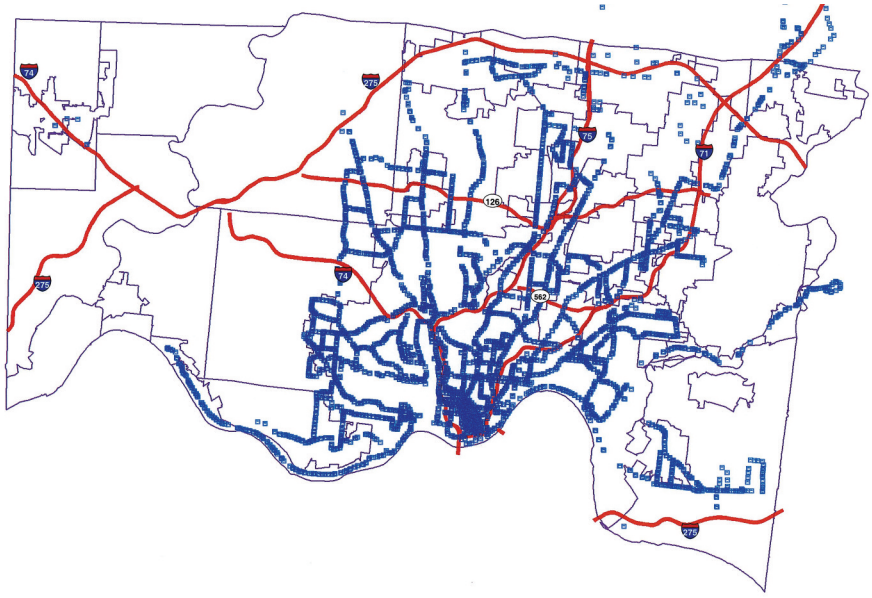
The map below provides detail on all residential housing units located in Hamilton County, regardless of type, allowing comparisons to be drawn between client residential locations and residential locations in general. For instance, lesser levels of client penetration observed in the western and north-western areas of the county are consistent with the significantly reduced residential unit penetration witnessed in these areas.



The Hamilton County Service System

Cincinnati metro bus service is quite comprehensive in its service routes through the more densely populated areas of Cincinnati and Hamilton County. There is a noted reduction, and in some cases, absence of service in more suburban areas outside of the county's urban core.

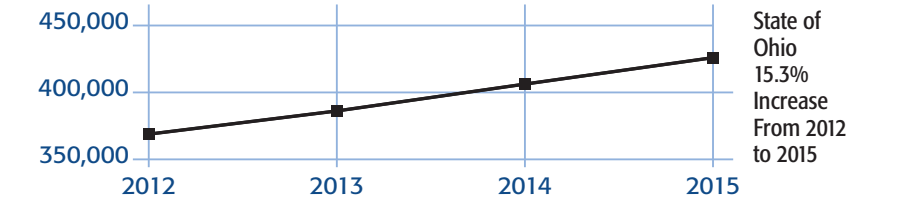
The following map details metro bus stop locations throughout Hamilton County. As many clients in the public system are reliant upon public transportation to access services, and as Cincinnati's metro bus service serves as that source of transportation, locations convenient to both agencies and residential units is important.



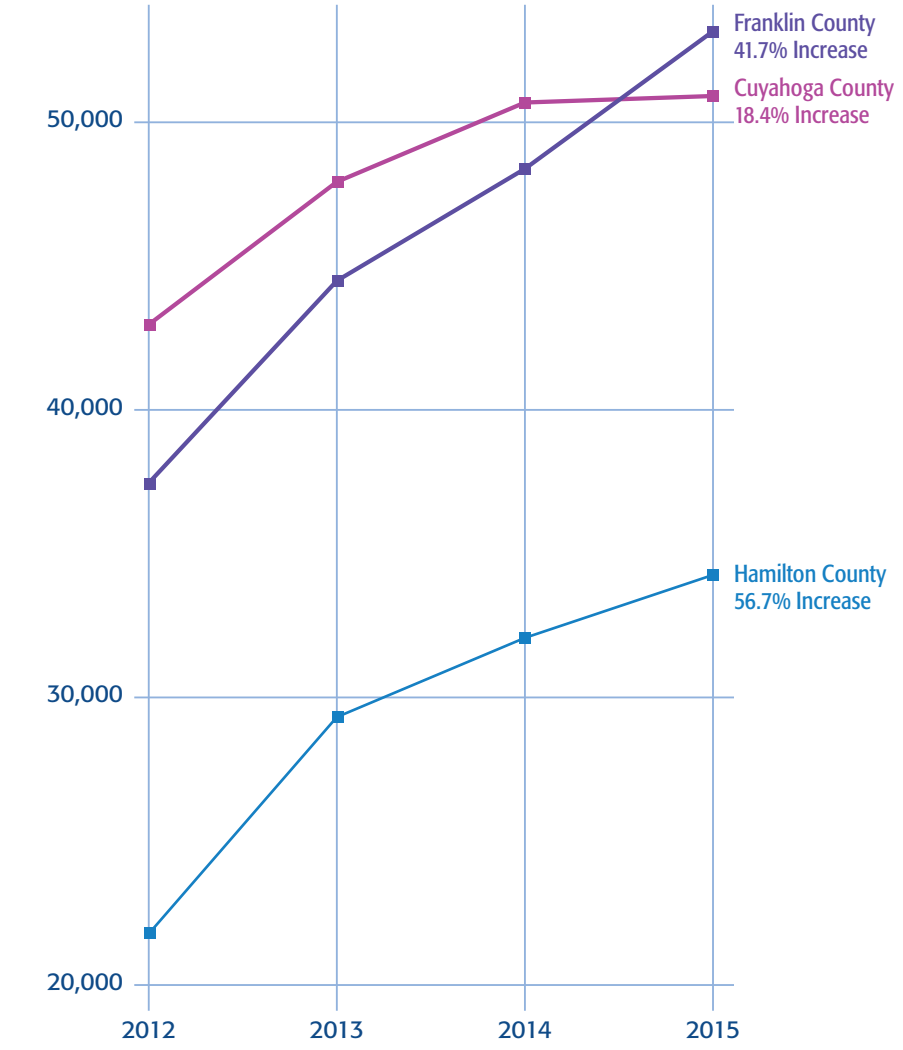
An examination of the overall number of clients served in Hamilton County through publicly-funded behavioral health services reveals a significant increase over the past several years. These increases may largely be attributable to changes in access to care that have occurred as the result of federal and state changes in health coverage access (i.e., Affordable Care Act, Medicaid Expansion). Beginning with SFY 2013 the State of Ohio assumed responsibility for administering the Medicaid program for individuals with behavioral health conditions, a responsibility that ADAMH boards held prior to that time. And effective January 2014 the state introduced the expansion of Medicaid increasing the number of individuals eligible at that time. A review of client counts for the period 2012 through 2015 reflects a significant increase in those receiving mental health services through public funding (as per OH-MHAS Multi-Agency Community Services Information System).

The Hamilton County Service System

Ohio Medicaid and Non-Medicaid Mental Health Client Counts: 2012-2015



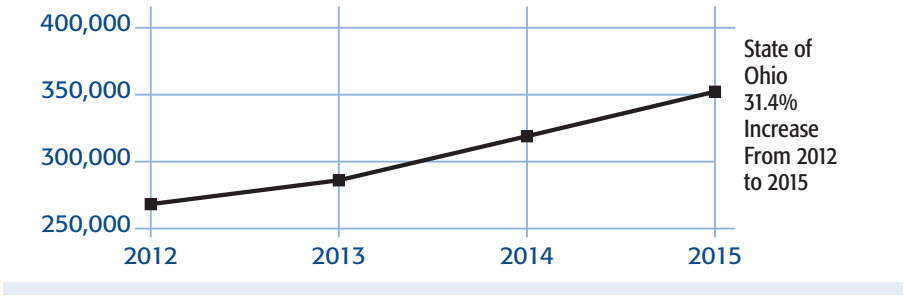
Urban County Medicaid and Non-Medicaid Mental Health Client Counts: 2012-2015



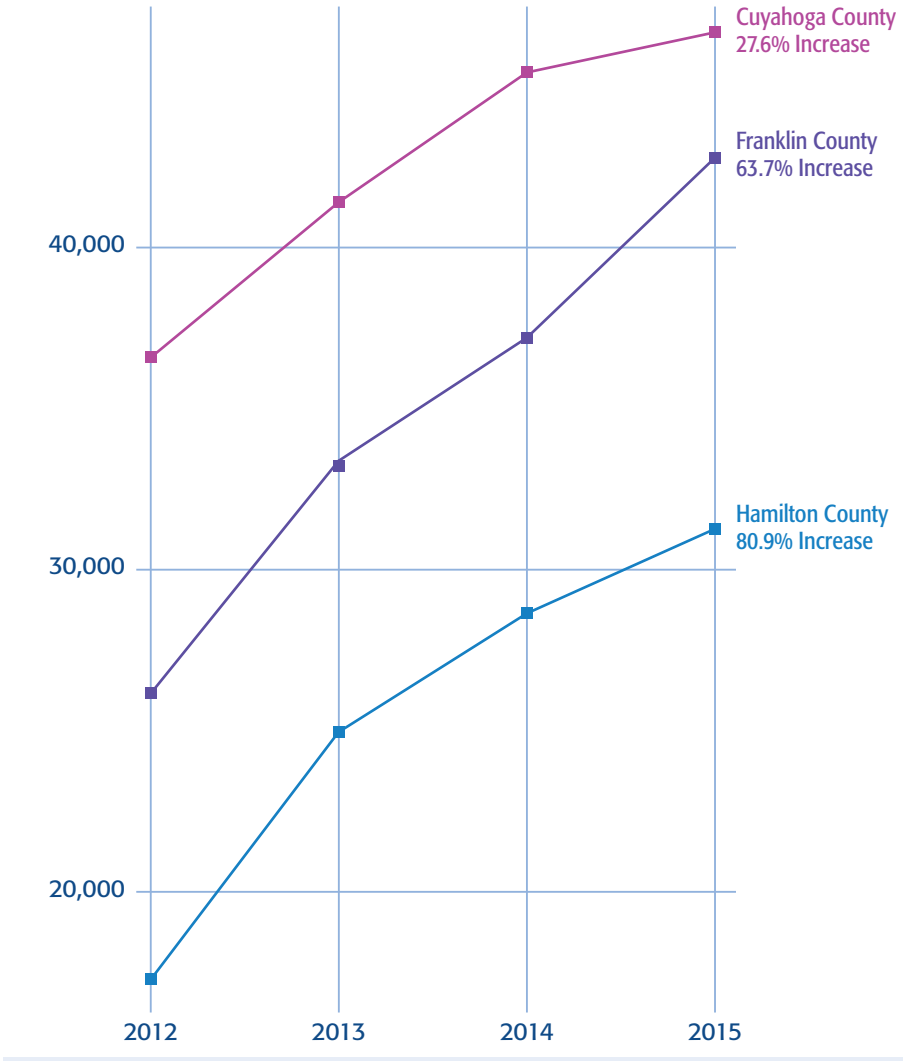
The Hamilton County Service System

MACSIS counts specific to those whose services are funded through Medicaid reflect even more significant increases.

Ohio Medicaid Mental Health Client Counts: 2012-2015



Urban County Medicaid Mental Health Client Counts: 2012-2015

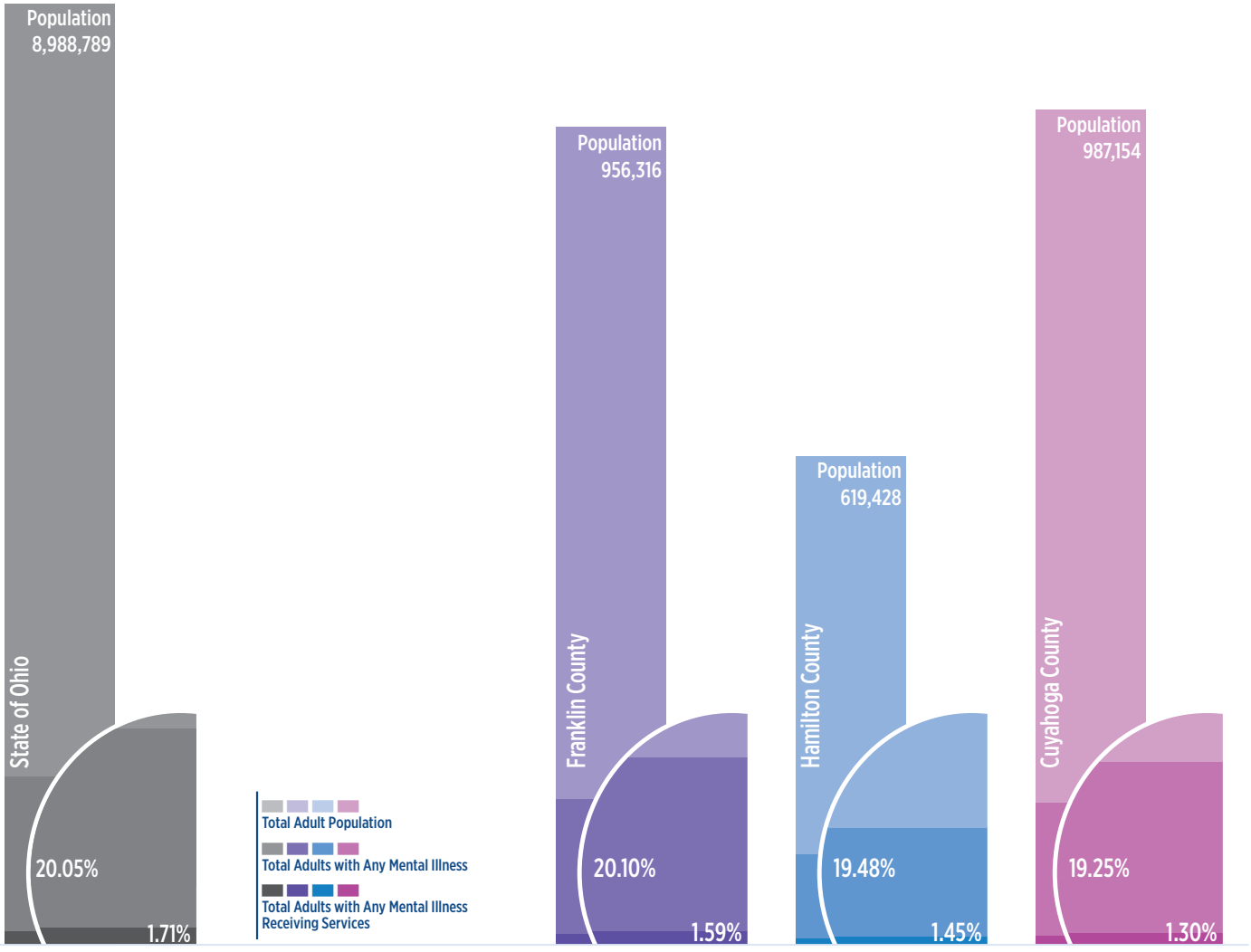


The Hamilton County Service System

Based upon (SAMHSA) prevalence estimates of all mentally ill adults, Hamilton County exhibits a slightly more modest occurrence than the state overall and Franklin County.

The Hamilton County system reaches 7.42 percent of those estimated to have some level of mental illness and 1.45 percent of the population overall. Ohio overall exhibits a rate of 8.55 percent for those estimated to have some level of mental illness and 1.71 percent of the population overall. For Franklin County the rates are 7.91 percent of those estimated to have some level of mental illness and 1.59 percent of the population overall. Cuyahoga's penetration rate is less with 6.77 percent for those estimated to have some level of mental illness receiving service and 1.30 percent of the population overall being served.

Ohio and Major Ohio Urban County Adults with Any Mental Illness Relative to the Population

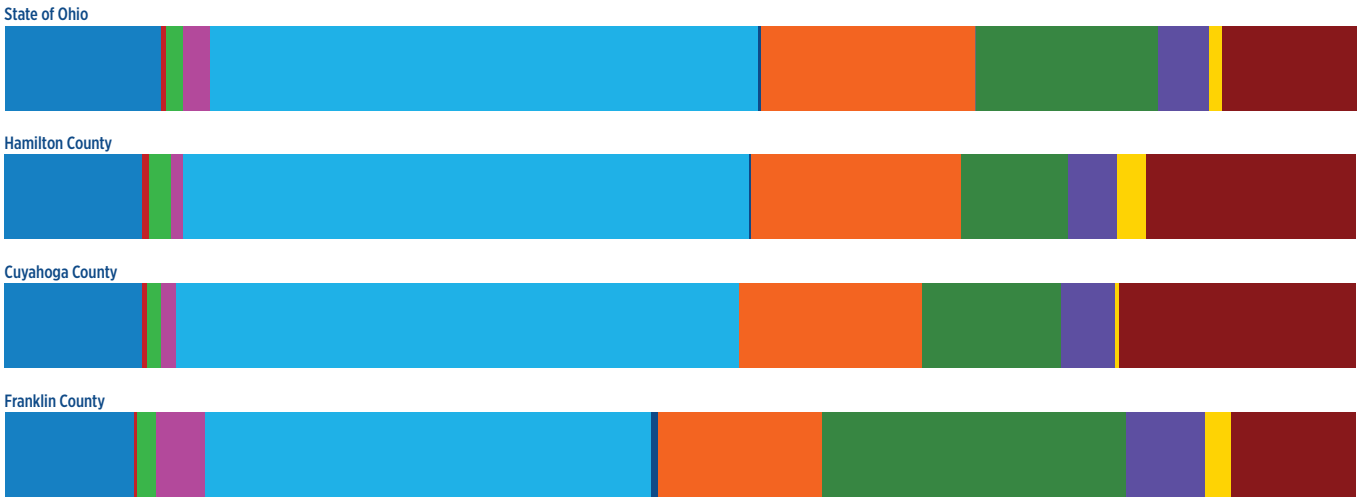


Data Sources: U.S. Census Population Estimates for 2015
Substance Abuse and Mental Health Services Administration (SAMHSA)
Ohio Department of Mental Health and Addiction Services (Ohio MHAS)

The Hamilton County Service System

An examination of adult individuals receiving publicly-funded mental health services relative to state and other urban counties indicates that as a percentage of those served, Hamilton County service recipients reflect greater representation than the state overall in two significant categories: those diagnosed with major affective disorders and those diagnosed with some form of schizophrenia.

Public System Adult Service Recipients by Primay Diagnosis



	Ohio	Hamilton	Cuyahoga	Franklin
Adjustment Problem	11.7%	10.2%	10.1%	9.6%
Childhood Disorder	0.3%	0.4%	0.5%	0.2%
Conduct Disorder	1.3%	1.7%	1.1%	1.4%
Drug/Alcohol	1.9%	1.0%	1.1%	3.6%

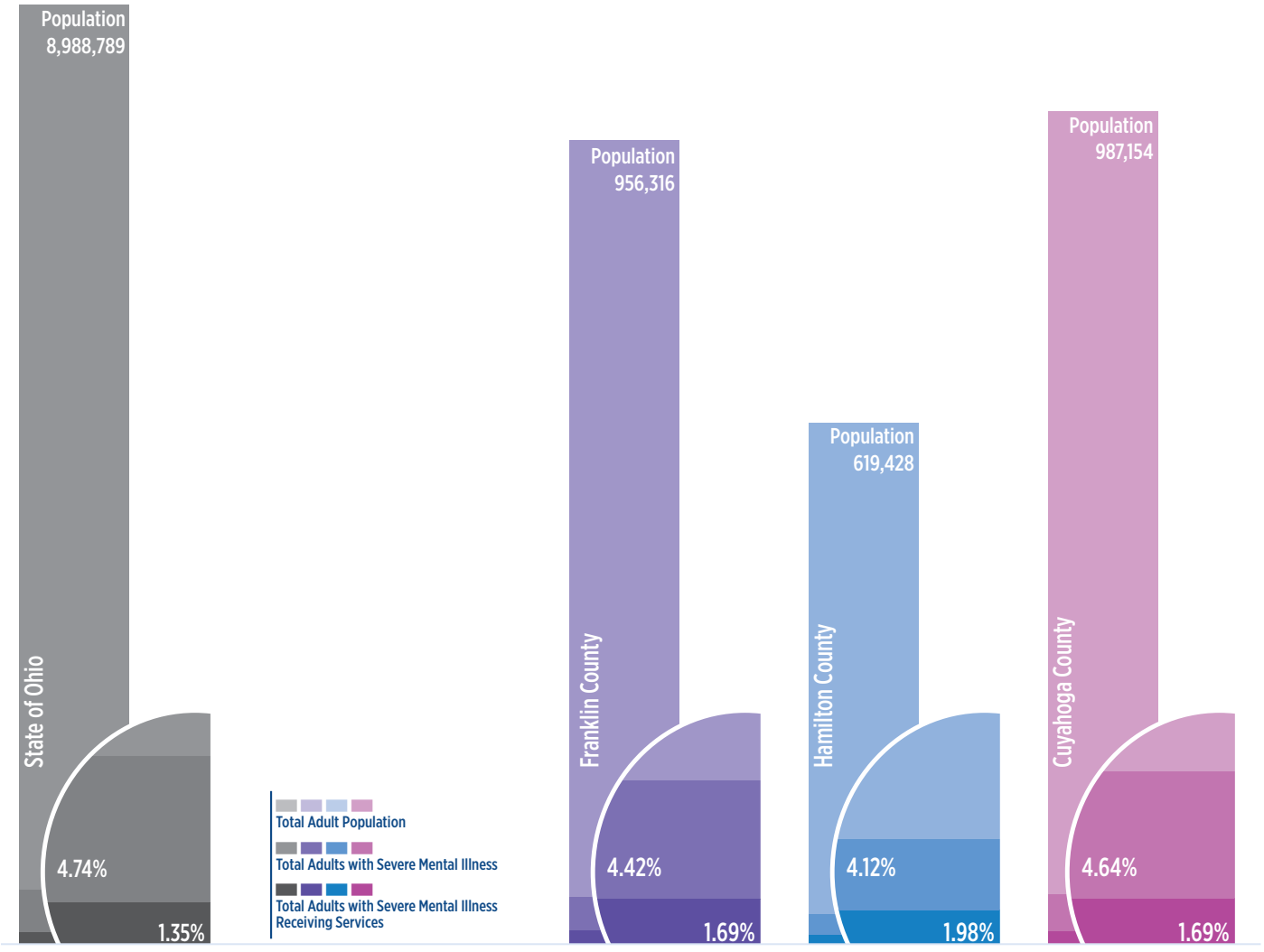
	Ohio	Hamilton	Cuyahoga	Franklin
Major Affective	40.6%	41.8%	41.6%	33.2%
Mental Retardation	0.2%	0.2%	0.1%	0.5%
Non-Psychotic	15.9%	15.6%	13.4%	12.0%
Organic Psychosis	0.0%	0.0%	0.1%	0.0%

	Ohio	Hamilton	Cuyahoga	Franklin
Other	13.4%	7.9%	10.2%	22.6%
Other Psychoses	3.8%	3.7%	3.9%	5.8%
Personality Disorder	1.0%	2.2%	0.5%	1.9%
Schizophrenia	9.9%	15.4%	17.4%	9.2%

The Hamilton County Service System

Further examination of differences between areas related to adults diagnosed with severe mental illness indicate that while Hamilton County is estimated to have slightly fewer cases proportionally than the state overall, as well as the other two most populace counties In Ohio, the Hamilton County system has managed to serve a greater percentage (48.11%) of that population than any of the other three entities utilized for comparison (Ohio: 28.43%; Franklin County: 38.17%; Cuyahoga County: 36.41%).

State and Major Ohio Urban County Adults with Severe Mental Illness (SMI) Relative to the Population

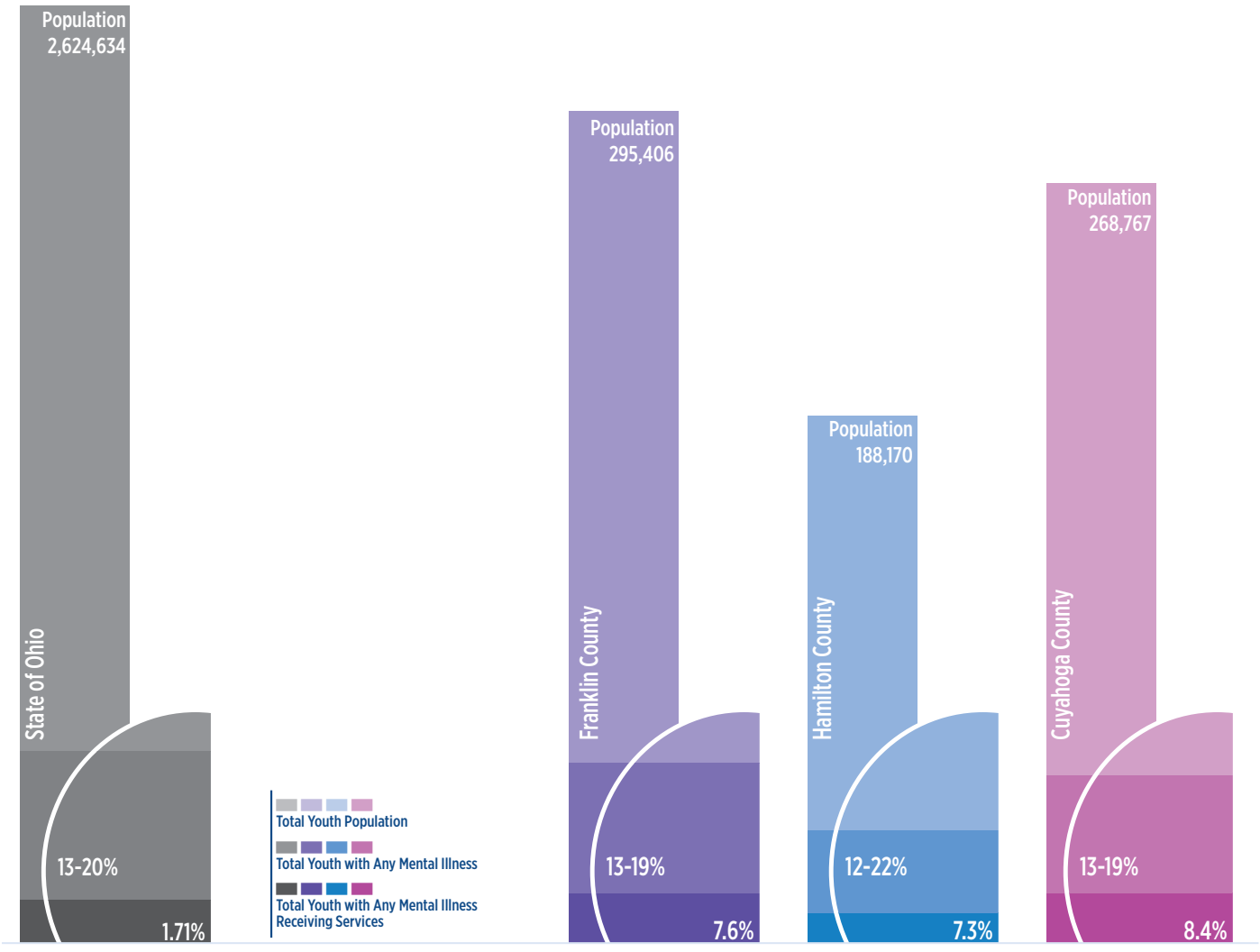


Data Sources: U.S. Census Population Estimates for 2015
Substance Abuse and Mental Health Services Administration (SAMHSA)
Ohio Department of Mental Health and Addiction Services (Ohio MHAS)

The Hamilton County Service System

Findings related to children and youth are more mixed. While Hamilton County does exhibit a penetration rate (44.29% of estimated MI population; 7.3% overall population) that exceeds overall state findings (34.72% of estimated MI population; 5.7% overall population), it trails Ohio's two other major urban counties (Franklin: 46.52% of estimated MI population; 7.6% overall population; Cuyahoga: 50.63% of estimated MI population; 8.4% overall population).

Ohio and Major Ohio Urban County Children/Youth with Any Mental Illness Relative to the Population



The Hamilton County Service System

The following bar chart illustrates the contrasts for child/youth service recipients between Hamilton County and other major urban Ohio counties as well as the state overall.

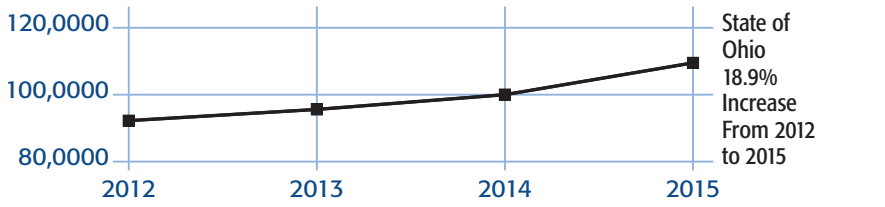
Public System Child/Youth Service Recipients by Primay Diagnosis

	Ohio	Hamilton	Cuyahoga	Franklin
Adjustment Problem	22.9%	23.6%	17.8%	18.5%
Childhood Disorder	10.1%	10.6%	9.3%	9.4%
Conduct Disorder	10.0%	7.2%	13.4%	13.2%
Drug/Alcohol	0.2%	0.1%	0.2%	0.3%
Major Affective	12.2%	11.1%	11.3%	12.2%
Mental Retardation	0.1%	0.1%	0.0%	0.1%
Non-Psychotic	32.5%	39.7%	35.7%	27.7%
Organic Psychosis	0.0%	0.0%	0.1%	0.0%
Other	8.6%	5.3%	10.8%	12.2%
Other Psychoses	3.2%	1.8%	1.3%	6.2%
Personality Disorder	0.1%	0.2%	0.1%	0.1%
Schizophrenia	0.2%	0.3%	0.1%	0.1%

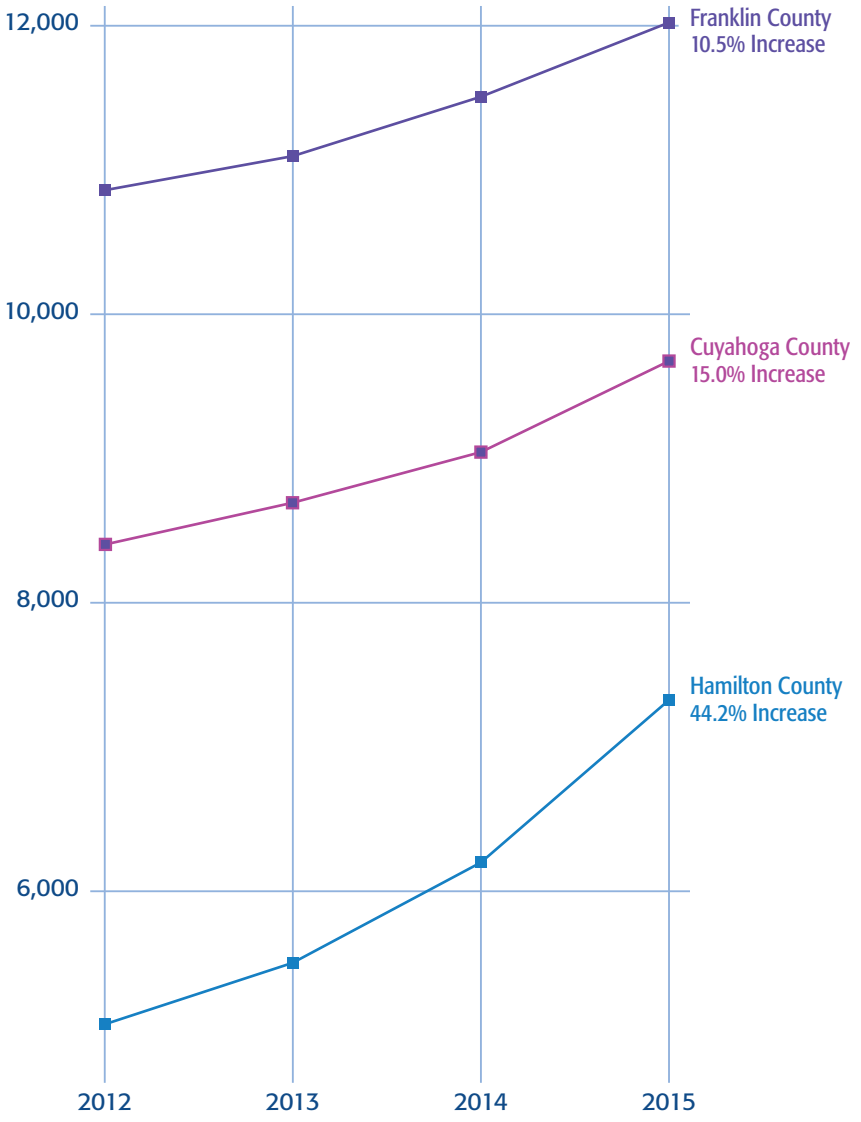
The Hamilton County Service System

Similar to the significant increases in the number of publicly funded mental health clients seen over the past several years those individuals receiving services for substance use disorders have shown even more dramatic increases. This is especially true for clients receiving their services through Medicaid funding. While statewide publicly funded mental health clients increased 15.3 percent from FY 2012 through FY 2015, AOD clients increased by 18.9 percent during that period.

Ohio Medicaid and Non-Medicaid AOD Client Counts: 2012-2015

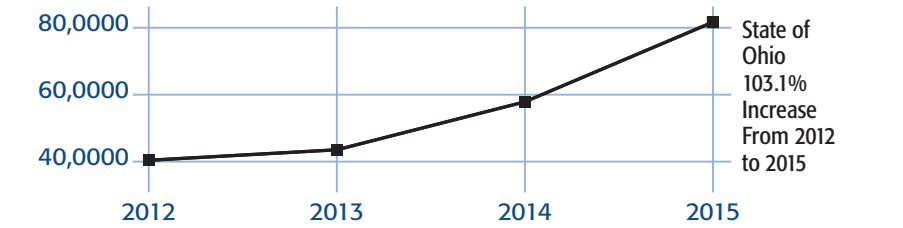


Urban County Medicaid and Non-Medicaid AOD Client Counts: 2012-2015

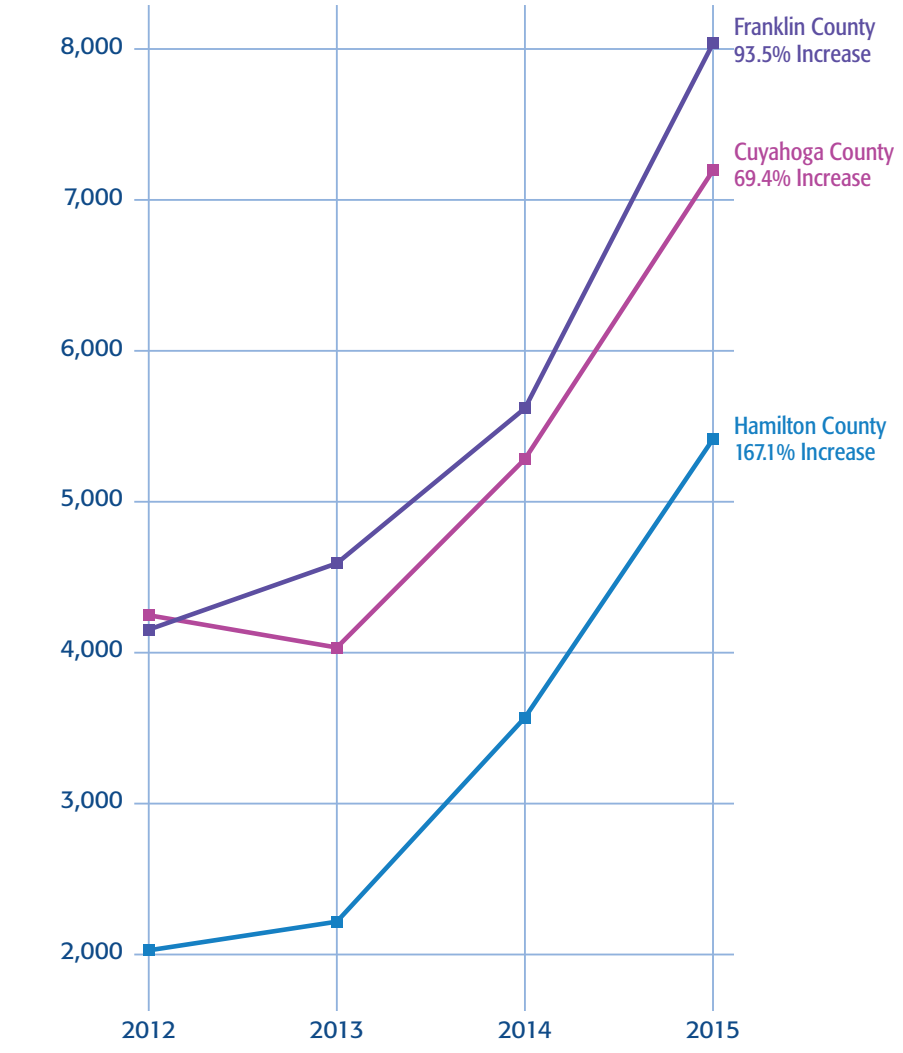


The Hamilton County Service System

Ohio Medicaid AOD Client Counts: 2012-2015



Urban County Medicaid AOD Client Counts: 2012-2015

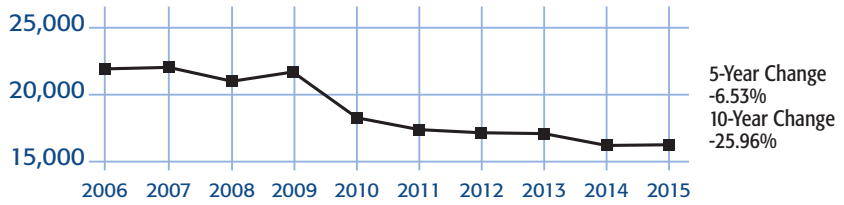


These increases appear largely driven by factors related to the state's Medicaid program as those receiving services through that funding mechanism increased 103%, from just over 40,000 clients during fiscal year 2012 to over 80,000 clients during fiscal year 2015. In Hamilton County this change was even more significant with an observed increase of 167 percent. Hamilton County's increase far surpassed that of its two peer urban boards, Franklin and Cuyahoga, which realized gains of 94 percent and 69 percent, respectively.

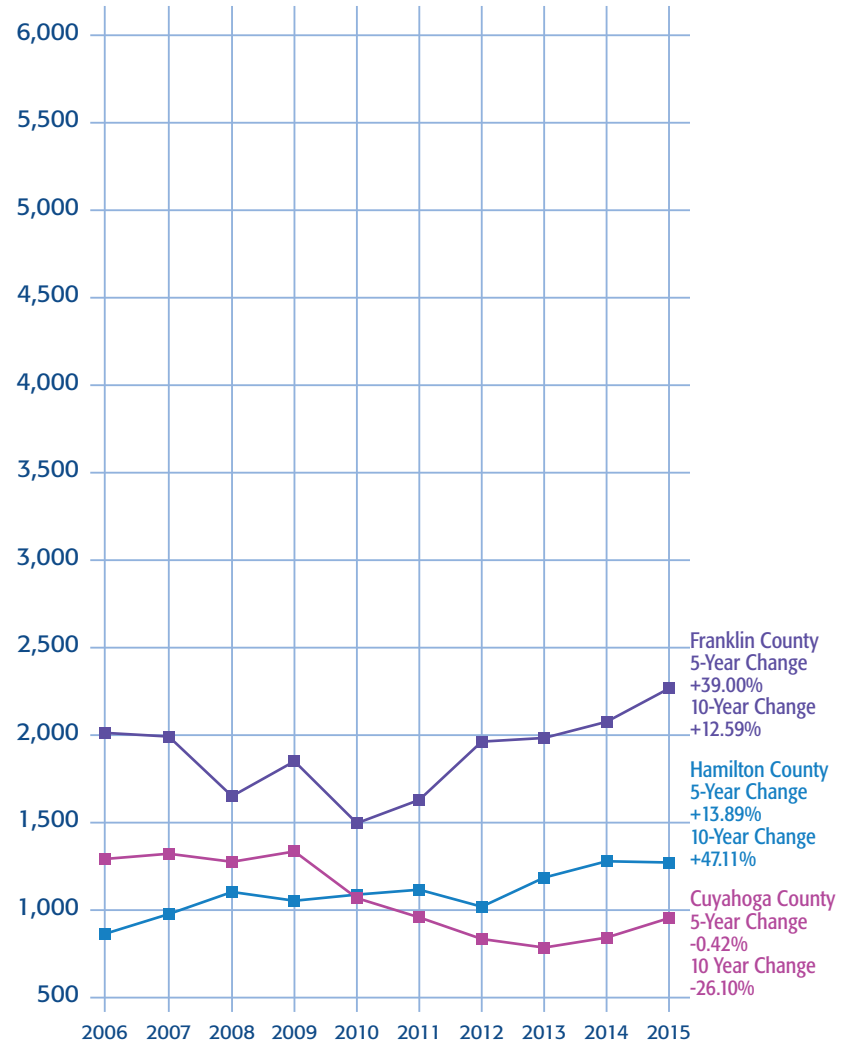
The Hamilton County Service System

A close examination of the changes by substance type also assist in defining the driving force to this increase in individuals requiring service for an AOD addiction. The graphs that follow depict the changes in client counts by substance type, as identified through diagnostic categories, for both state and major urban counties, for the four major substance categories most frequently seen in the public treatment system.

48 Ohio Client Diagnosis Counts — Alcohol

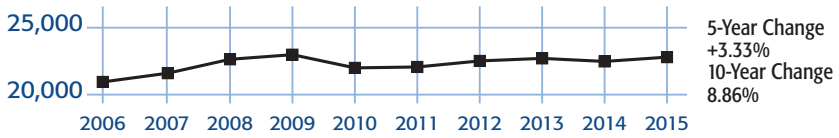


County Client Diagnosis Counts — Alcohol

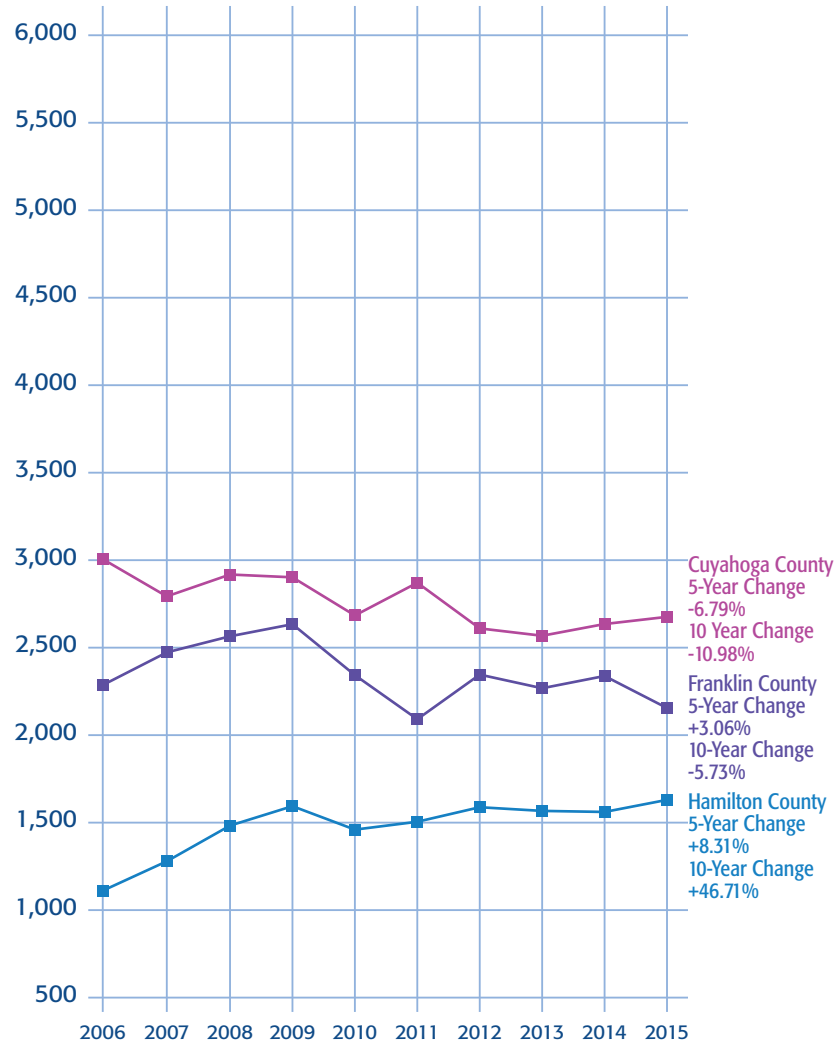


The Hamilton County Service System

Ohio Client Diagnosis Counts — Cannabis

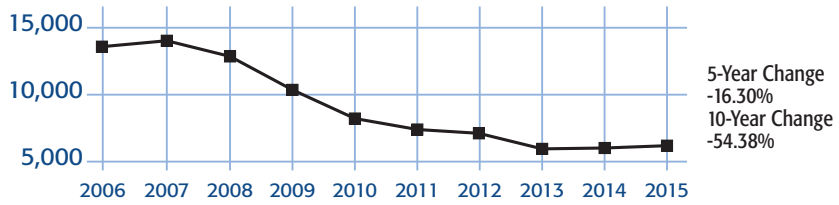


County Client Diagnosis Counts — Cannabis

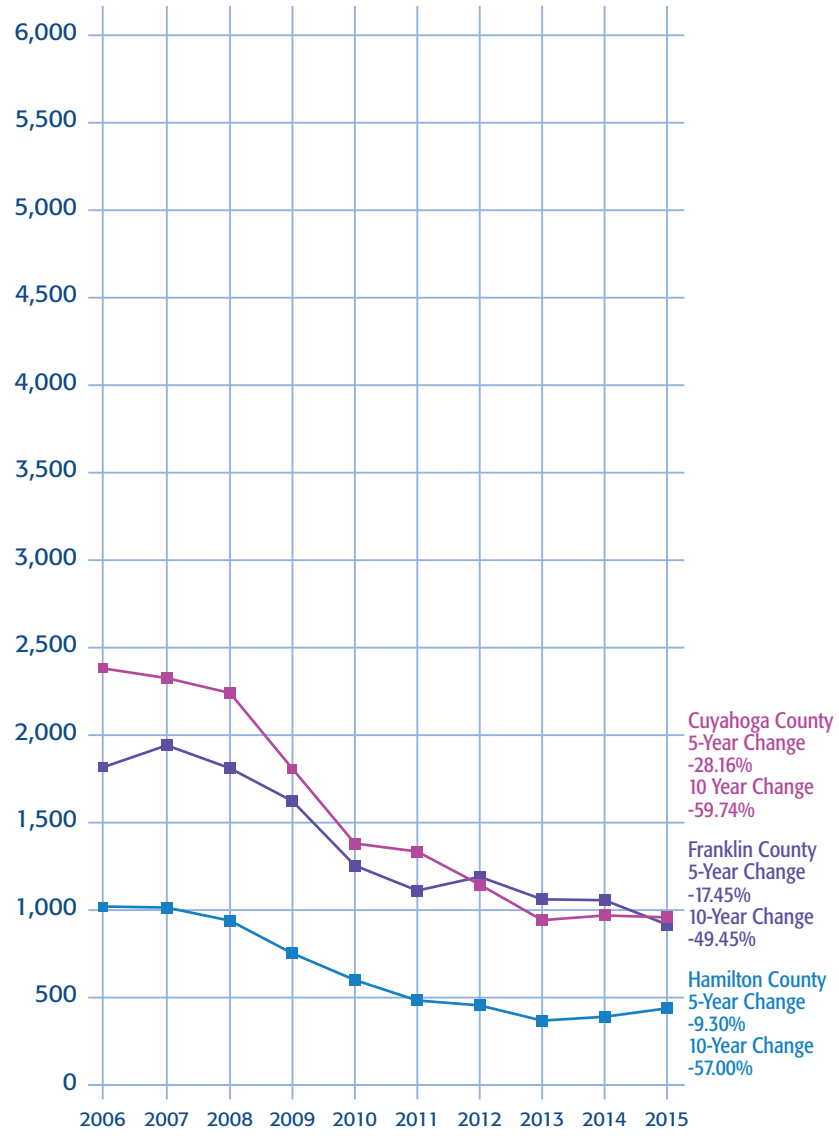


The Hamilton County Service System

Ohio Client Diagnosis Counts — Cocaine

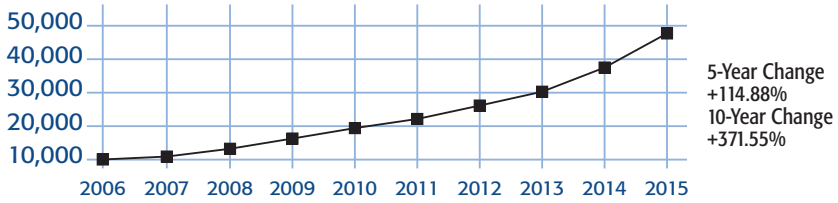


County Client Diagnosis Counts — Cocaine

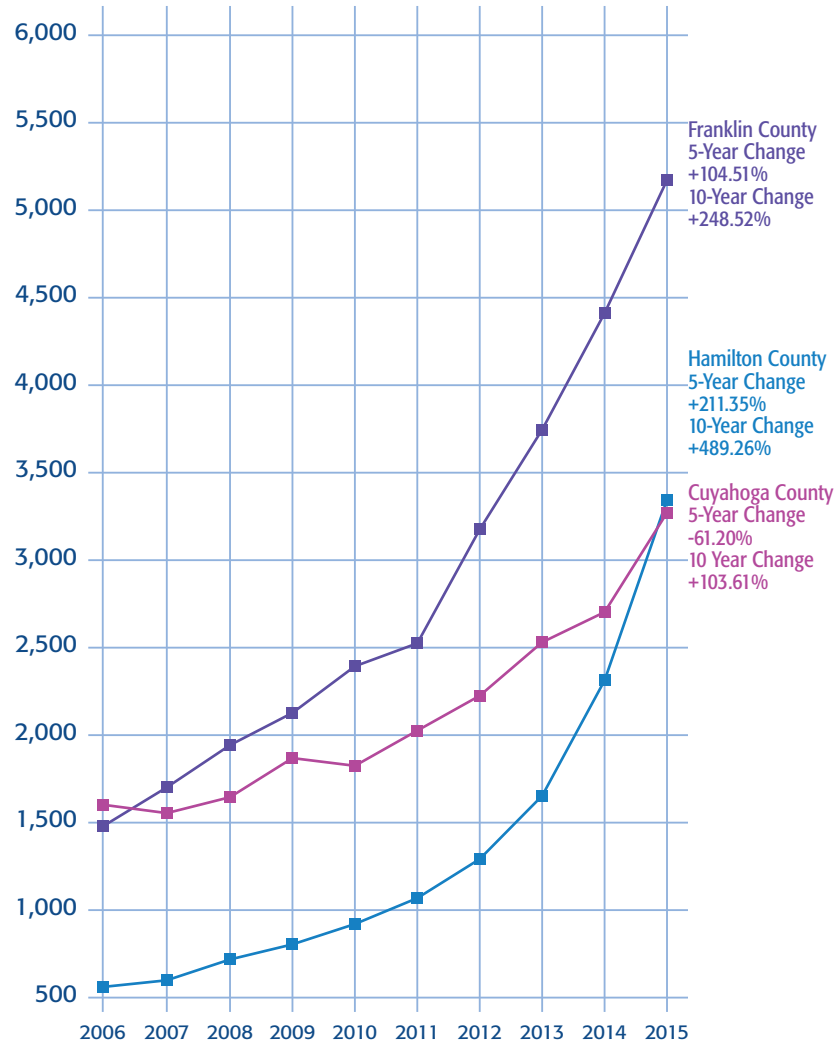


The Hamilton County Service System

48 Ohio Client Diagnosis Counts — Opiate



County Client Diagnosis Counts — Opiate

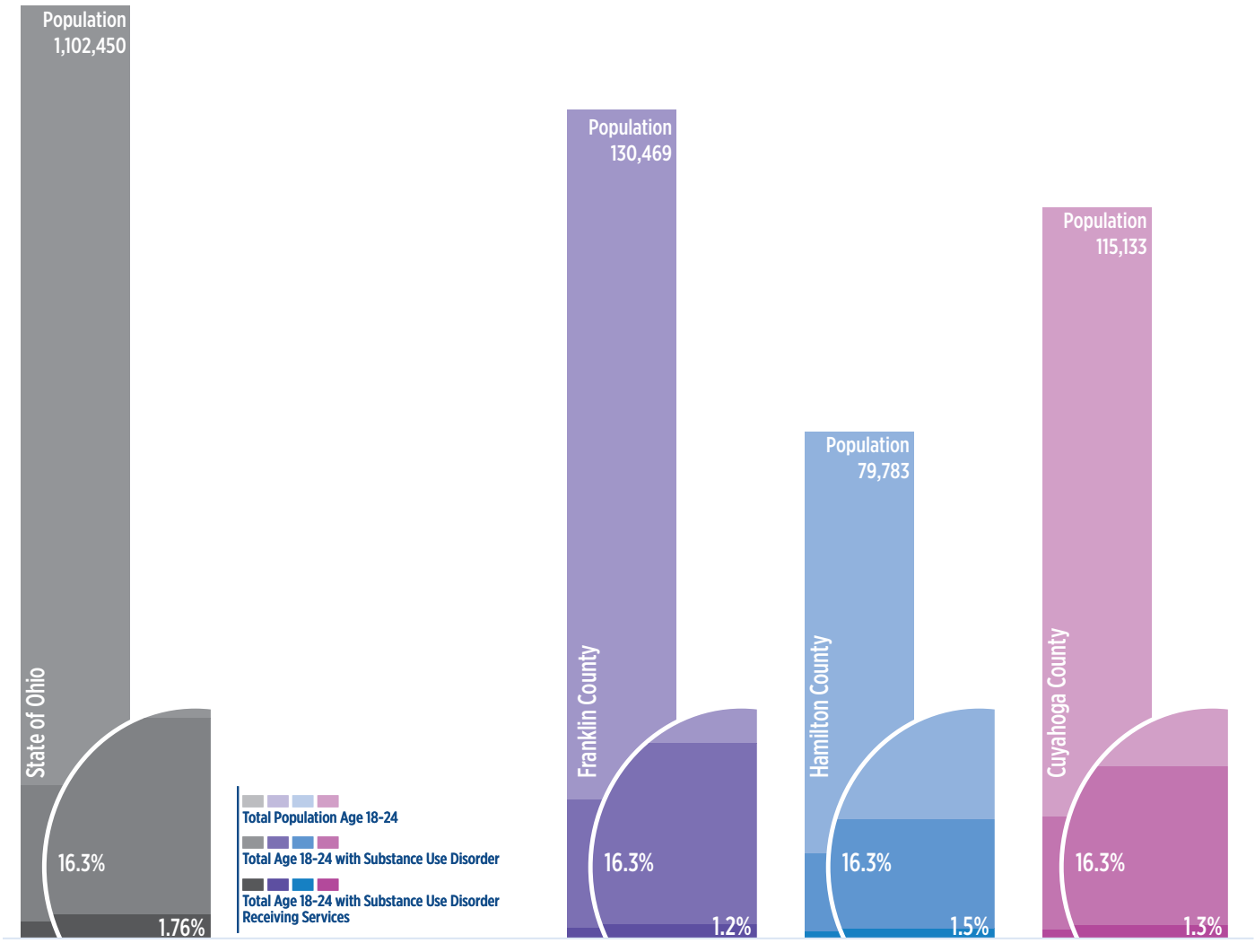


As evidenced through these charts, Hamilton County has witnessed significant increases in three of the four main substance categories: alcohol, cannabis, and opioids. A significant decrease in those receiving treatment for cocaine has been observed statewide (5-year change = -16.3%; 10-year change = -54.385). These decreases have also been observed at both the 5-year and 10-year periods for all three of Ohio's largest counties, however, Hamilton County has witnessed a reversal in this trend over the past three year period with an increase of 19 percent between FY 2013 and FY 2015. Certainly the most marked trend has been the exponential increase in the category of opioids with a statewide 10-year increase of 372 percent and a 5-year increase of 115 percent. The change has been even more profound for Hamilton County, relative to both the state as well as other major urban counties, with a 10-year increase of 489 percent and a 5-year increase of 211 percent.

The Hamilton County Service System

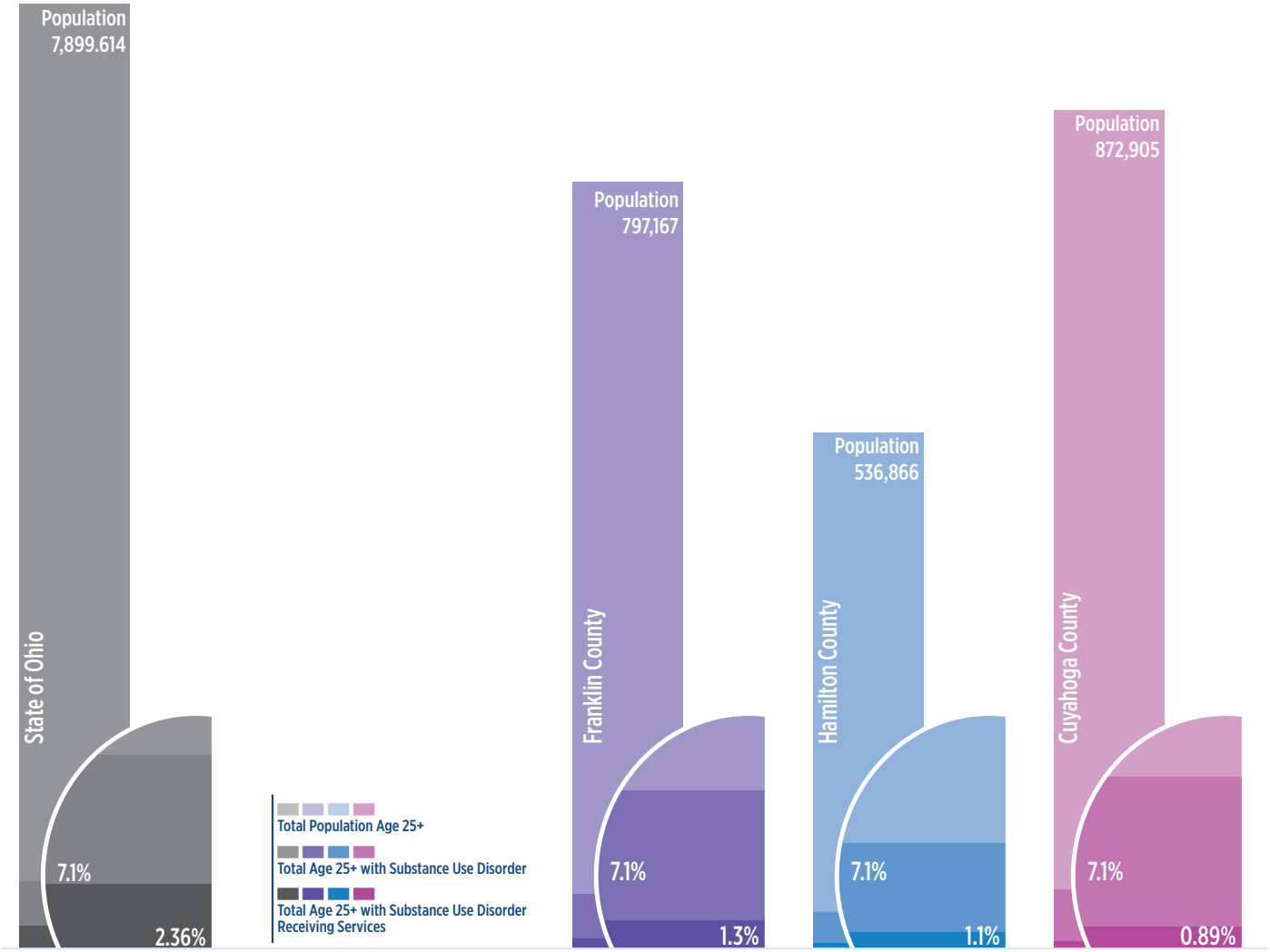
Penetration rates for AOD service are not dissimilar from those exhibited for mental health service with far more individuals evidencing service need than are accommodated annually. SAMHSA estimates substance use disorder rates for adults ages 18 to 25, and 26 plus of 16.3 percent and 7.1 percent (2014 estimate), respectively. Application of this data to statewide population estimates would indicate that while nearly 180,000 Ohioans between the ages of 18 and 25 experienced a substance use disorder (SUD) in 2015, only 19,452 (1.76%) received a service directed toward that need. Estimates for those Ohioans age 26 and older indicate SUD need for 560,873, while 186,695 (2.36%) actually received service. The disparities are greater for Ohio's largest urban areas with Hamilton County serving 1.5 percent of Ohioans between the ages of 18 and 25, and 1.1 percent of those 26 years of age and above.

Ohio and Major Ohio Urban County Adults (Age 18-24) with Substance Use Disorder Relative to the Population



The Hamilton County Service System

Ohio and Major Ohio Urban County Adults (Age 25+) with Substance Use Disorder Relative to the Population



Provider Survey

In late 2016 and early 2017, the Hamilton County MHRSB conducted a series of surveys to assist in determining service sufficiency and need for mental health assistance in Hamilton County. Incorporated in this effort were measures for alcohol and other drug addiction treatment service as well as prevention efforts related to both mental health and alcohol and other drug abuse/dependence.

Three separate surveys were conducted in support of this effort and were based upon three separate populations. The first population solicited for involvement consisted of providers of mental health and alcohol and other drug treatment and prevention services currently under contract with the MHRSB. The second population solicited for involvement consisted of the "informed community," comprised of those individuals involved in community organizations focused upon mental health issues. The third group surveyed consisted of those individuals currently receiving services for a mental illness.

The survey instruments were constructed to collect information related to both treatment (i.e., counseling, psychiatric medication management, partial hospitalization) as well as subsidiary services (i.e., supported housing, peer support, employment/vocational) and were directed toward mental health care and alcohol and other drug treatment, separately. Item selection was conducted through a review and consolidation of items discerned through an examination of survey instruments utilized in similar, previous efforts. Additionally, providers were asked a peripheral set of questions related to mental health and alcohol and other drug prevention services. Actual copies of the three instruments appear in the appendices.

All three surveys were conducted using an online application provided through Typform.com. This application allows respondent participation through the use of numerous electronic devices including personal computers, tablets, and smartphones, at and when convenient to the solicited respondent. Additionally, prospective respondents were given the opportunity to complete the survey in a paper-and-pencil format if they were more comfortable with that approach. All three surveys contained the same or similar questions to allow for comparison across the three populations.

Provider Survey

The Hamilton County MHRSB contracts with 30 separate entities providing behavioral health treatment and/or prevention services in Hamilton County. Contact was made with the executive staff of all 30 of these community providers requesting their support in the effort through completion of a brief online survey. Limits were not imposed upon the number of staff who could participate from any single agency as, in certain situations, different staff may have specific knowledge related to particular areas covered in the survey. This type of survey is referred to as a census survey as it does not involve sampling, instead seeking participation from all involved parties. Sixty-three agency staff representing 23 (77%) contract agencies responded to the survey. A copy of the actual survey can be found in the appendices.

Respondent Agency Size by Client Census

Seventy-three percent of the respondents were employed at agencies that serve over 1,000 clients.

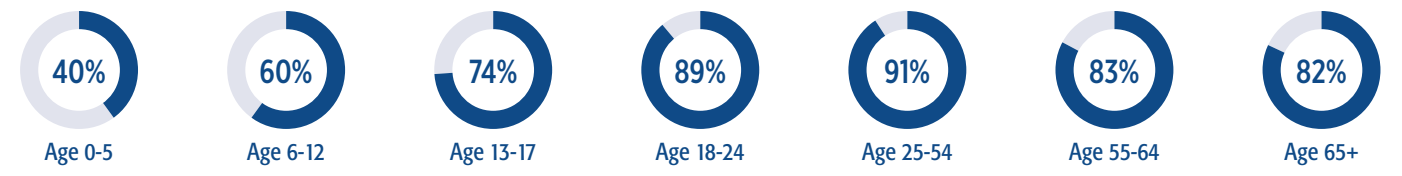
As expected, the majority of agency respondents held leadership positions within their respective agencies with just over half (51%) serving as the CEO/President/Executive Director or the Clinical Director.

Agency Respondents by Position Held Within Organization

Categories Listed for Other include:
- Director
- Program Coordinator
- Education and Prevention Specialist
- LSW Social Worker/Therapist
- Billing Manager/Software Engineer
- Finance Dept.
- Vocational Instructor/Quality Assurance Coordinator
- Program Director
- Director of Quality Management
- Financial/System Specialist
- QA Admin. Asst.
- Administrative Assistant
- Middle Manager
- Quality Improvement/ Housing Inspector
- Property Management Department Coordinator; Coordinator
- Housing Specialist

Represented agencies generally served a wide spectrum of clients as defined by age. Almost all (9 of 10) responding agencies served the general adult population. Only 40% of responding agencies served young children (ages 0 to 5).

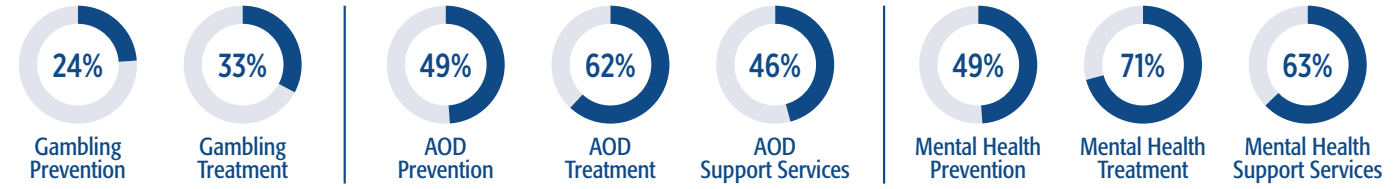
Respondent Agency Client Population by Age



Provider Survey

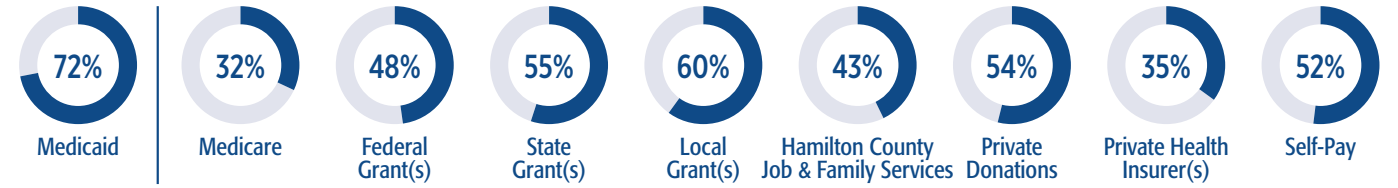
Agencies were also well-represented across the variety of condition types served with most agencies (71%) providing general mental health treatment. Sixty-two percent of respondents worked at agencies that provided alcohol and other drug treatment.

Service Type Provision by Respondent Agency



Agencies were also well-represented by a diverse base of funding sources with 72 percent of agencies reporting revenue through Medicaid, the largest payer of mental health services in the country.

Agency Revenue Sources Beyond MHRSB Funding



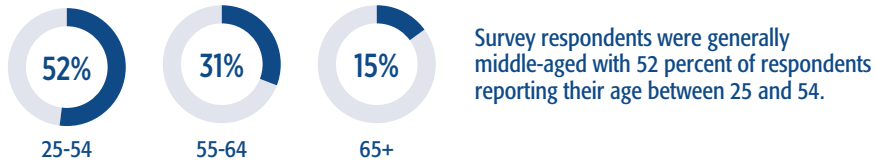
Informed Community Survey

Hamilton County has two very involved National Alliance on Mental Illness (NAMI) chapters; NAMI Southwest Ohio and NAMI Urban Greater Cincinnati Network on Mental Illness. These organizations are comprised of individuals with a strong interest in the needs of those with mental illness and many members are close family or friends to an individual with a mental illness. Often there is considerable overlap in roles with members themselves having experienced a mental illness and/or working as a professional in the area as is evidenced through the chart below depicting the varying roles/relationships of those who responded to the Informed Community Survey.

Community Survey Respondent Background

As these individuals serve as subject experts through their life experience, postcard solicitations were distributed to the two organizations seeking input from their members. This effort was similar to the Provider Survey in both measures and methods with the survey being made available through the same online application with paper copies being made available upon request. This effort was undertaken through the use of a convenience sample, not a probability sample. Solicitations were made to all members through their respective chapter and 230 individuals completed the survey.

Community Survey Respondent Age

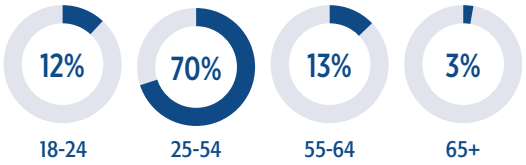


Survey respondents were generally middle-aged with 52 percent of respondents reporting their age between 25 and 54.

Consumer Survey

The third survey effort conducted as part of this initiative was that of a client/consumer survey. Agency leadership was contacted for their assistance in soliciting consumer involvement. In addition to posters with tear tabs providing the url for access to the survey, postcards were provided to agencies for distribution to clients during or following visits to the agency site. Paper copies of the survey were also made available to clients who preferred this mechanism for completing the survey. Similar to the Informed Community sample, this effort relied upon use of a convenience sample as opposed to use of a probability sample and, for that reason, may be subject to self-selection bias. A total of 203 consumers responded to the survey during the three-week period in which it was in the field.

Consumer Survey Respondent Age

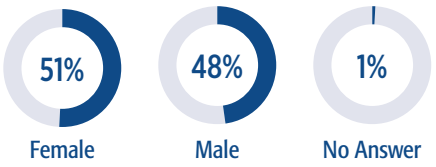


The majority of participating consumers were between the ages of 25 and 54. There were no respondents under the age of 18.

Consumer respondents were asked to share, using the U.S. census classification, the racial categories with which they identified. The following graph exhibits the findings. In some cases respondents identified with more than one category. State (MACSIS) data indicate approximately 51% of mental health clients served in Hamilton County during fiscal year 2015 self-reported as White/Caucasian while 42% reported as Black/African-American.

Consumer Respondents by Self-Identified Race

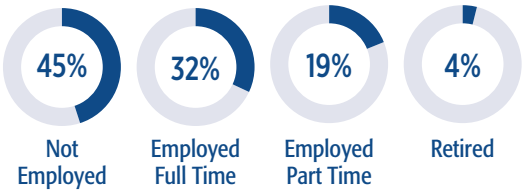
Consumer Respondent Gender



Gender of participating respondents was generally evenly split with 51% being female and 48% male. This is consistent with fiscal year 2015 MACSIS findings.

Consumer Survey

Consumer Respondent Employment Status



Respondents were also evenly split on employment status with 51 percent reporting full or part-time employment and 49 percent reporting they were unemployed or retired

Consumer Respondent Treatment Tenure

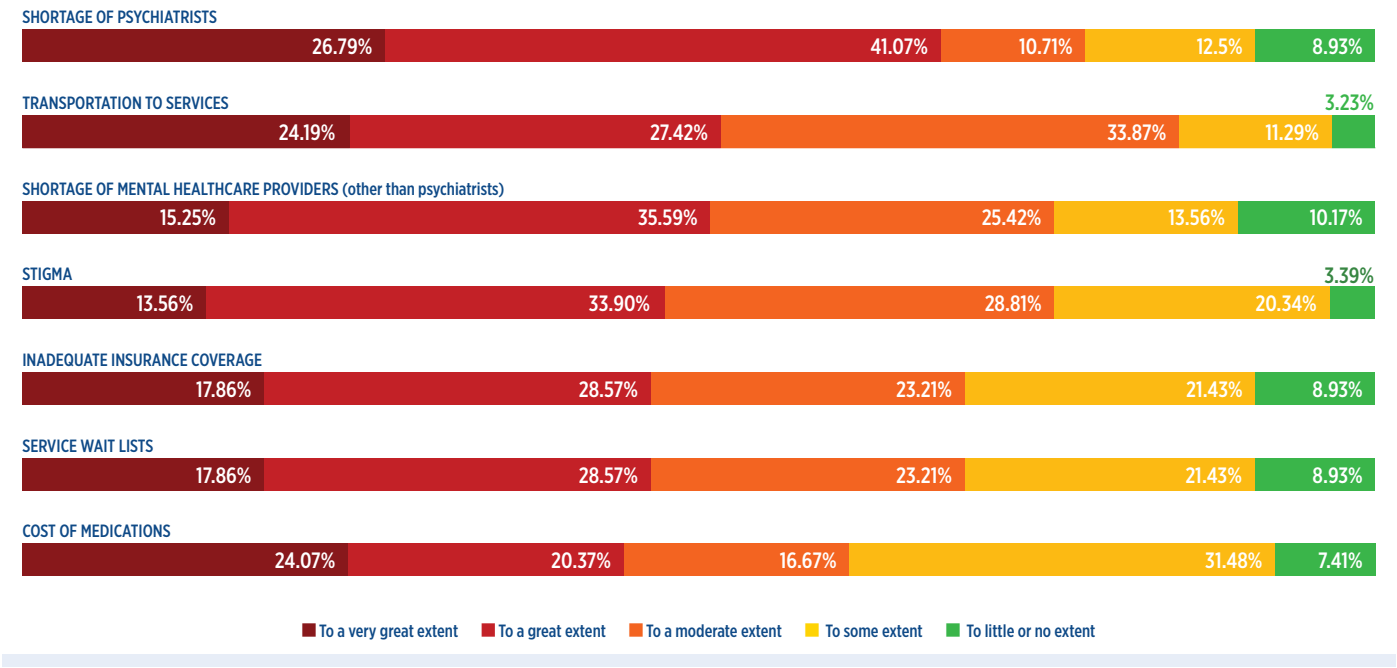
Treatment tenure varied considerably with the largest percentage of respondents reporting involvement in treatment for more than one year.

Perceived Barriers to Obtaining Mental Health Services

The first set of items contained in the surveys requested information regarding issues that may serve as barriers to an individual in attempting to obtain necessary mental health services. Seven commonly identified issues were specifically addressed as well as an option for respondents to narratively provide any additional issues that they felt served to impede an individual from obtaining services. An additional eighth item was incorporated in the consumer version of the survey related to issues of inconsistency, or "turnover," in mental health provider staff.

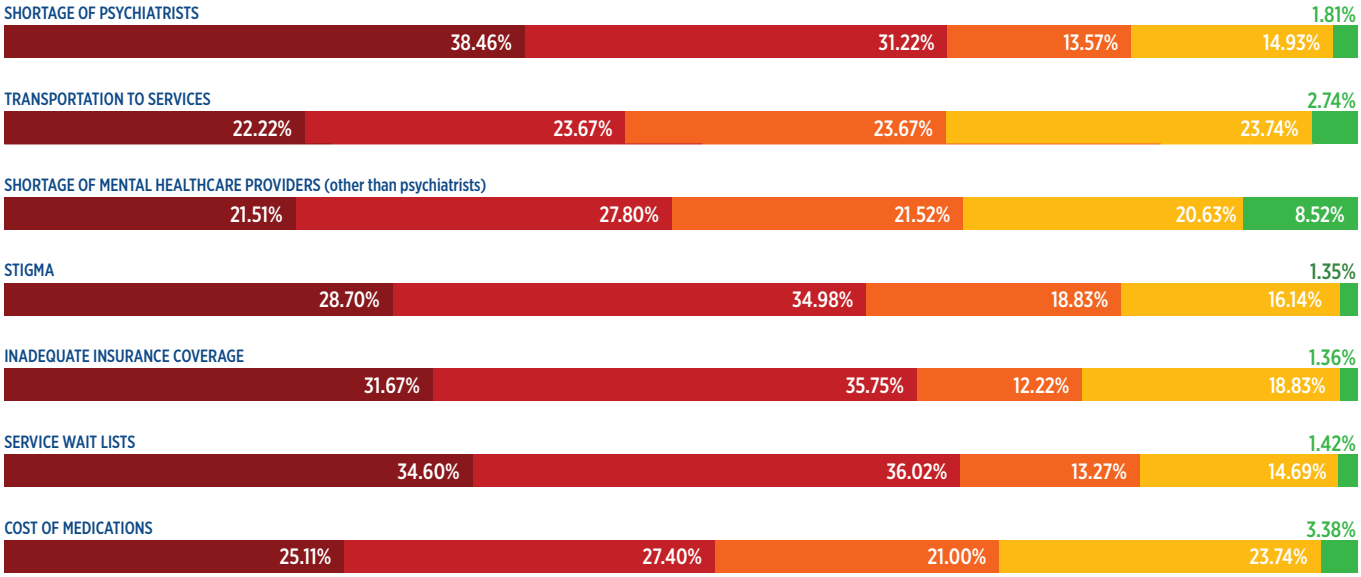
The graphs that follow detail the findings by the particular population surveyed.

Perceived Barriers to Obtaining Mental Health Services — Provider Perspective

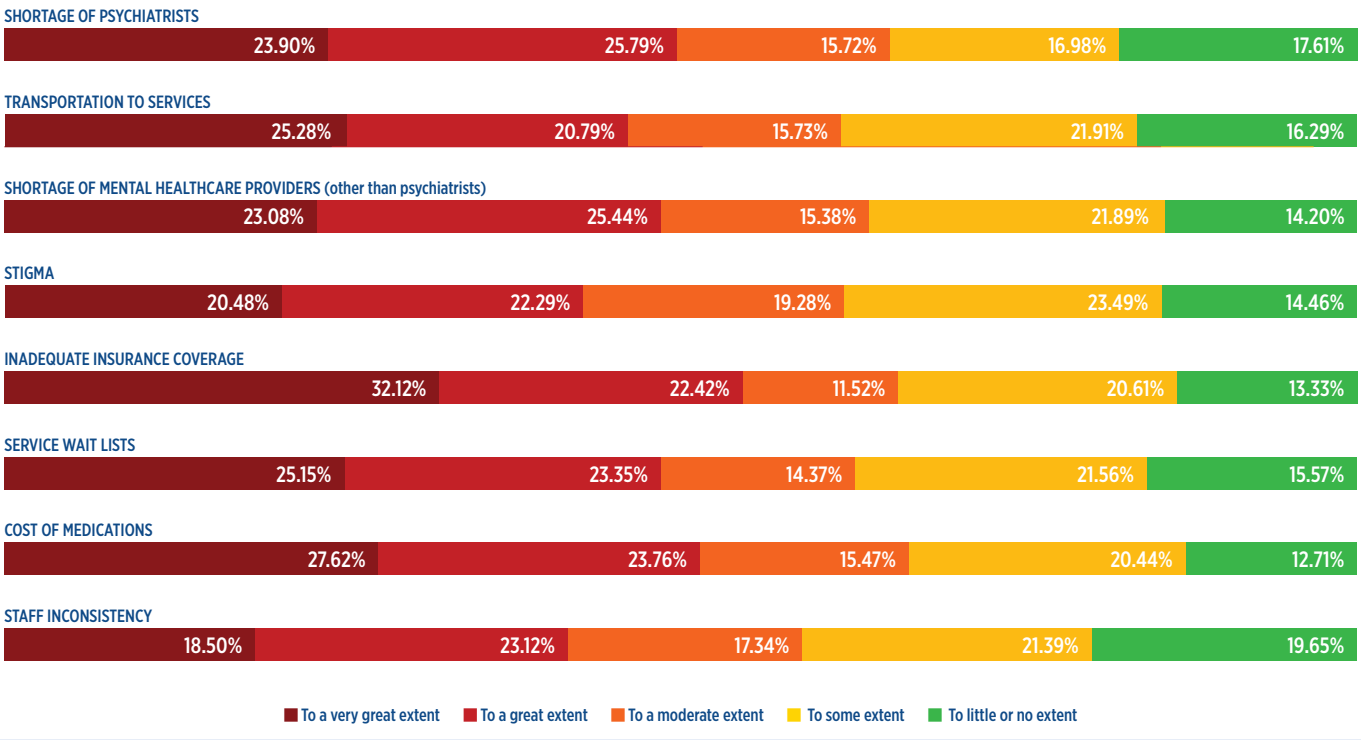


Perceived Barriers to Obtaining Mental Health Services

Perceived Barriers to Obtaining Mental Health Services — Community Perspective



Perceived Barriers to Obtaining Mental Health Services — Consumer Perspective



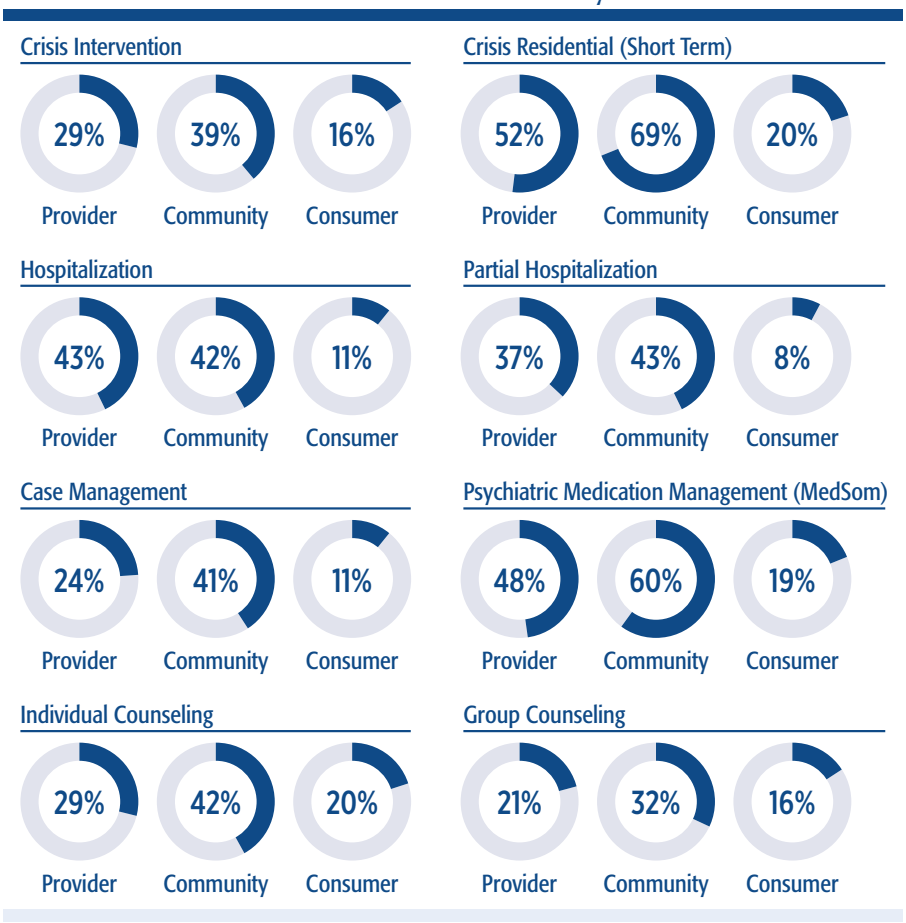
Perceived Barriers to Obtaining Mental Health Services

As evidenced in the graphs, there was general agreement among all three surveyed populations that a shortage of psychiatrists within the system is an impediment to care. More than two-thirds of provider and informed community respondents (67.86% and 69.68%, respectively) considered this shortage to be a barrier to a great or very great extent, while half of consumer respondents indicated similarly. This barrier was the most commonly cited issue for providers and informed community respondents, and the third most commonly cited for consumer respondents. Inadequate insurance coverage was the second most significant barrier when reviewed across the three respondent groups, but reflected greater disparity between groups with this issue being reported as the number one impediment by consumers, third for the informed community group, and fifth by providers. It may be worthwhile to note that the surveys were conducted following the 2016 presidential election in which the demise of the Affordable Care Act had been promised. This may have raised significant anxiety for those reliant upon the ACA for their insurance coverage as well as those who had gained coverage through the Medicaid expansion that occurred as a result of that act.

Sufficiency of Mental Health Treatment Services

The second set of questions addressed issues related to areas of insufficiency within the Hamilton County system of care. Specifically, respondents from all three population groups were asked "From the following list of mental health treatment services, please select those that are not sufficiently available in Hamilton County." Response categories were identical for all three groups. As illustrated in the following bar charts, there was considerable agreement among the varied groups as to the core areas requiring attention.

Insufficient Mental Health Treatment Service Availability



There also existed considerable agreement between providers and informed community respondents related to insufficiencies in hospitalization (43% and 42%, respectively) and to a slightly lesser extent around partial hospitalization (37% and 42%, respectively), though consumers were less inclined to identify this as an area of need.

Respondents were in complete agreement, based upon the services listed, that crisis residential service was the most significant area requiring attention. More than two-thirds of informed community respondents cited this as an area of service insufficiency and over half of providers agreed that service in this area is not sufficient. This was also reported to be the most significant issue for consumer respondents, tied with availability of individual counseling, though consumer respondents as a group were less-inclined across all categories to identify treatment service insufficiencies.

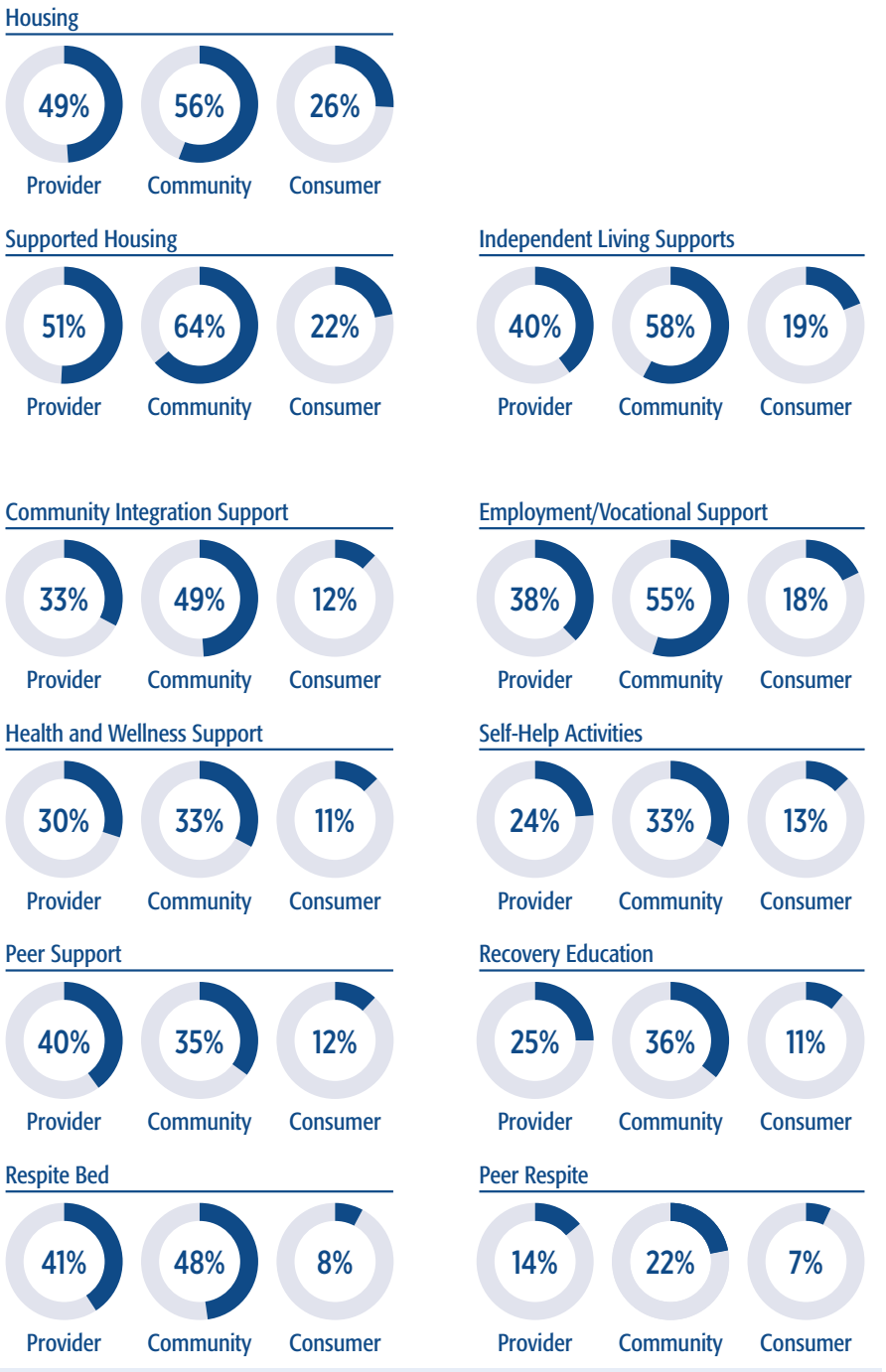
Consistent with the findings discerned from the section on barriers to mental health treatment, Psychiatric Medication Management (Med Som) service, a primary service provided by psychiatrists, was consistently selected by respondents as an area of insufficiency in Hamilton County's system. Sixty percent of informed community respondents identified this as an area requiring attention while nearly half (48%) of providers identified it as such.

Sufficiency of Mental Health Support Services

Housing needs are the most critical

For the purpose of the current examination of the Hamilton County system, services were necessarily segregated by type, with a special section addressing support services separately from the aforementioned treatment services. Similar to the section on treatment services, respondents were asked to indicate areas of insufficiency among eleven named support services. Examination of this data across the three respondent groups identified a very clear pattern of agreement revealing the most critical issue being the need for housing services. Insufficiencies in supported housing were selected as the most critical area by informed community respondents (64%) and provider respondents (51%), and as the second most pressing area for consumers (22%). Housing itself was identified as the most critical issue for consumers (26%) while this was the second most identified area for providers (49%) and the third most pressing area for informed community respondents (56%). Independent living supports, those services that assist individuals in maintaining their independent living status, was the third most significant area identified overall.

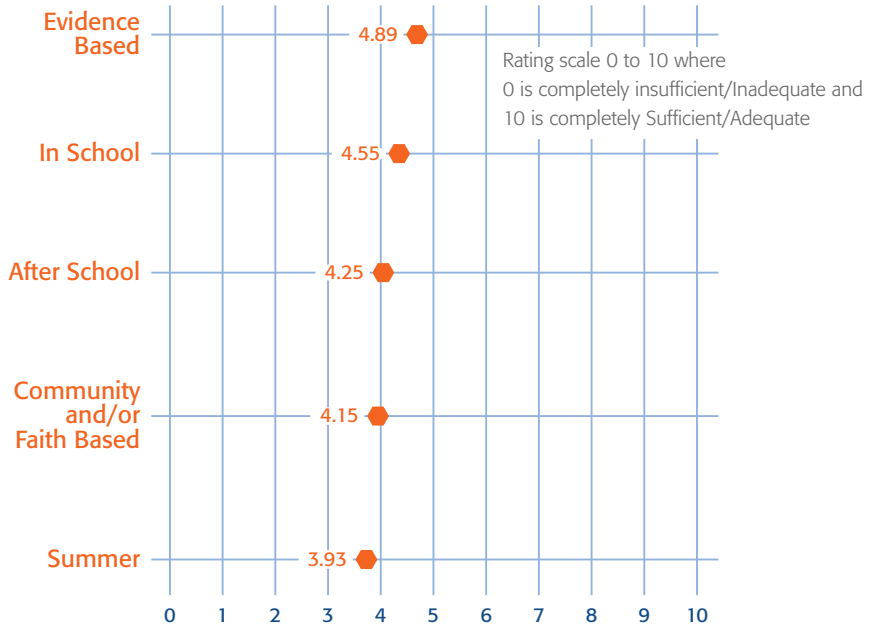
Insufficient Mental Health Support Service Availability



Sufficiency of Mental Health Prevention Services

An important function of Mental Health and Alcohol and Other Drug boards across the state is to ensure community efforts related to prevention. For this reason, the community of service providers in Hamilton County received an additional set of questions regarding this topic separately for mental health prevention and alcohol and other drug prevention. Providers were asked to report on the sufficiency of these efforts based upon common categories of service type with higher numeric ratings representing greater sufficiency.

Mental Health Prevention Programming Sufficiency/Adequacy

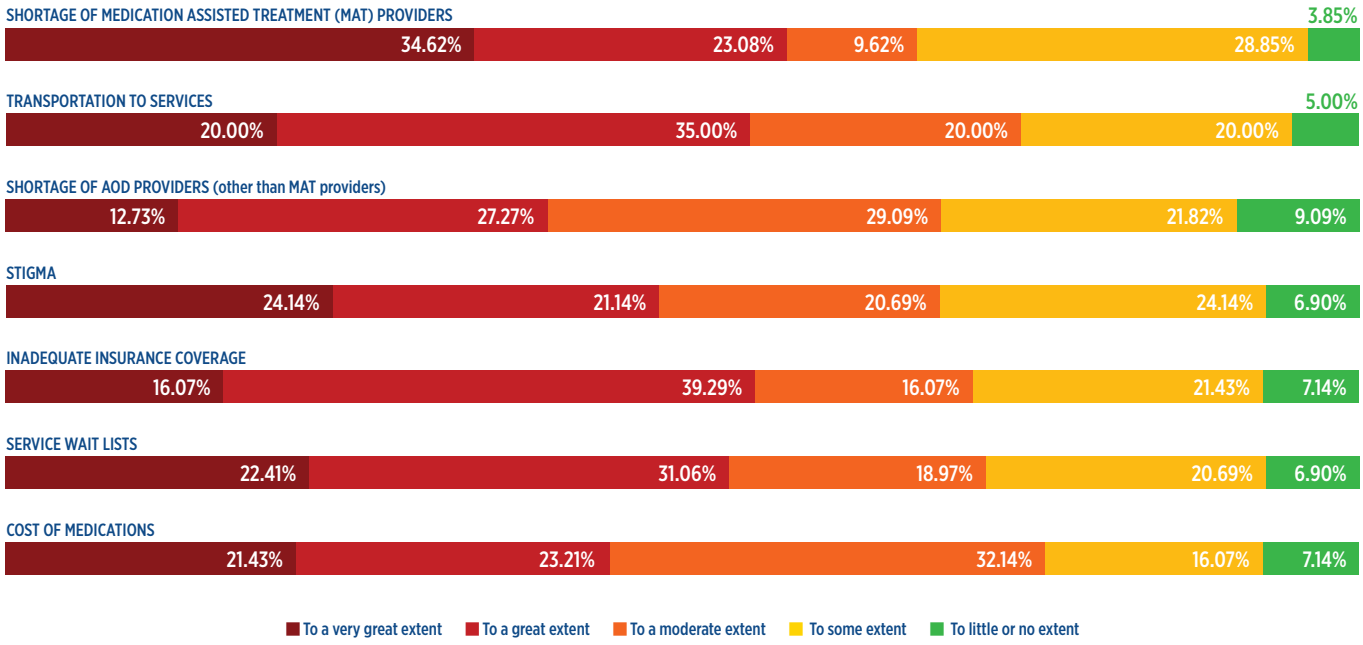


As illustrated in the above bar chart, and an important note, there was no prevention category that exceeded the midpoint (5) of the sufficiency scale, on average. The category reflecting the highest sufficiency rating was that of evidence-based mental health prevention programming which received an average rating of 4.89. The fact that this particular type of service received the highest rating among the options listed is likely a reflection of the increased attention that funding sources have given to the need for providers to utilize practices that have been shown to have a favorable impact through research efforts that rely upon valid methods and measures for establishing impact. The category least likely selected for sufficiency was that of Summer prevention programming, a likely reflection of the manner in which programs operate by capitalizing on access to children/youth through academic settings.

Perceived Barriers to Obtaining Alcohol and/or Other Drug Treatment Services

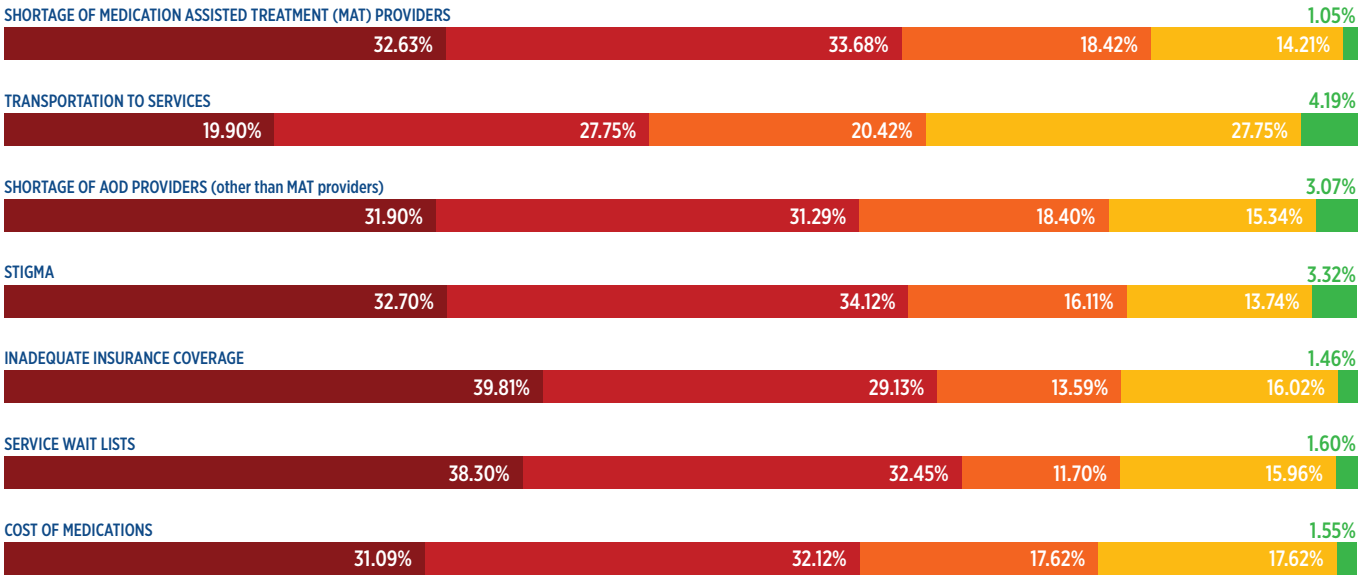
Toward the end of the survey all respondent groups were asked a series of questions related to barriers to obtaining services for alcohol and other drug addictions. This series of items was close in wording and format to those that appeared for this same purpose related to mental health services, with the exception of a replacement for the item inquiring about psychiatric service for one related to Medication Assisted Treatment providers (MAT). By Ohio statute MAT service can only be administered by a specially trained physician, or in some circumstances, by a non-physician medical professional working under the direction of a specially trained physician.

Perceived Barriers to Obtaining Alcohol and/or Other Drug (AOD) Treatment Services — Provider Perception

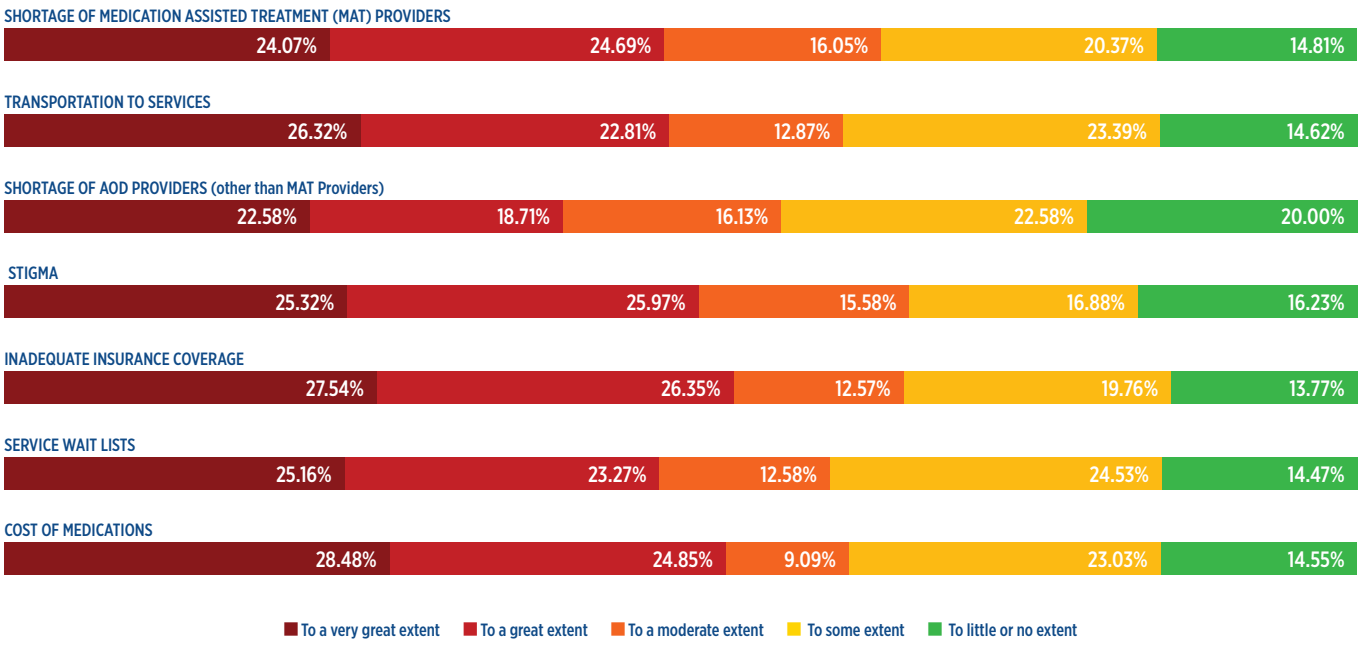


Perceived Barriers to Obtaining Alcohol and/or Other Drug Treatment Services

Perceived Barriers to Obtaining Alcohol and/or Other Drug (AOD) Treatment Services — Community Perception



Perceived Barriers to Obtaining Alcohol and/or Other Drug (AOD) Treatment Services — Consumer Perception



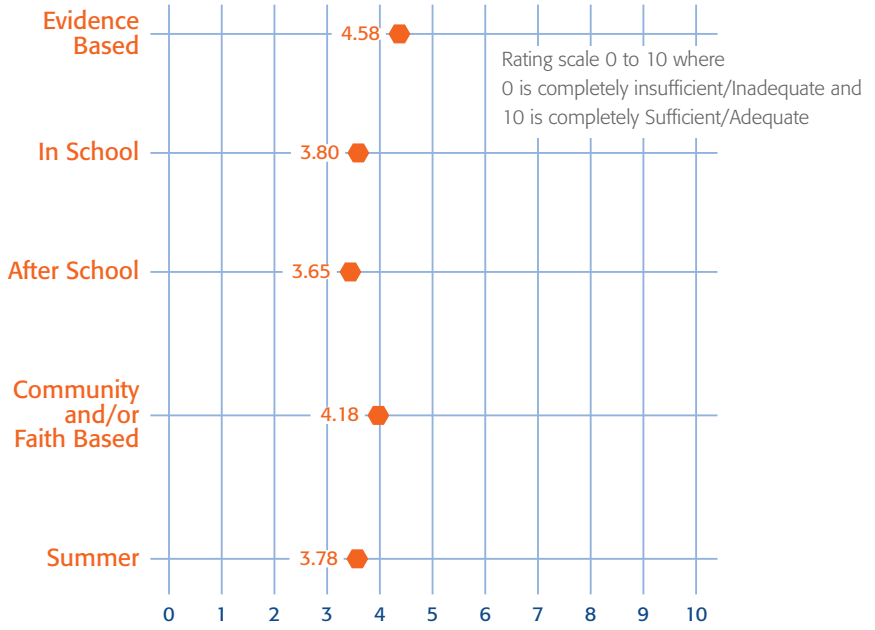
Sufficiency of Alcohol and Other Drug Prevention Services

As with mental health prevention programming sufficiency, the Provider survey contained a series of questions related to the sufficiency of AOD prevention programming within Hamilton County. Also similar to the findings related to mental health prevention sufficiency, none of the alcohol and other drug prevention service categories were rated, on average, at or above the scale mid-point.

Caution must be exercised in the interpretation of the results and in the deployment of actions directed as the result of the finding.

This effort is comprehensive in that it utilizes multiple and varied sources of information to draw conclusions; additional sources of information may exist to further enrich the conclusions.

Alcohol and other Drug Prevention Programming Sufficiency/Adequacy



Evidence-based prevention programming was again rated the highest of the options that appeared in this series with an average sufficiency score of 4.58 out of 10. Summer prevention programming was rated lower for alcohol and other drug prevention (3.78) than was found for mental health prevention. While this effort has served to highlight many areas that would benefit from attention, it is important to note that the gravity of all areas should be considered in any planning effort. Needs assessments often serve to expose areas requiring attention, but resource limitations must commonly dictate the decisions made related to which areas receive the necessary focus and available resources. For example, the fact that the respondent groups identified insurance inadequacies as the highest rated issues for AOD treatment barriers with between 54 percent and 69 percent of respondents indicating this issue as being a barrier to “a very great extent” or “a great extent,” it should not discount the fact that the lowest ranked issue, that of a shortage of AOD providers (other than MAT providers) was rated as being a great or very great barrier to between 40 percent and 63 percent of respondents, dependent upon the group.

Appendix A — Service Provider Survey

The following survey will serve a vital role in the Hamilton County Mental Health & Recovery Services Board's planning efforts for the coming years. We appreciate your willingness to contribute to that effort through completion of this brief survey.

Following is a list of some possible barriers that may serve to prevent Hamilton County residents from obtaining the MENTAL HEALTH TREATMENT services they need. Based upon your experience, to what extent, if at all, do you believe each item serves as a barrier:

Answers choices:
- To little or no extent
- To some extent
- To a moderate extent
- To a great extent
- To a very great extent
- Not sure

To what extent, if at all, do you believe **INADEQUATE INSURANCE COVERAGE** serves as a barrier?

To what extent, if at all, do you believe **A SHORTAGE OF PSYCHIATRISTS** serves as a barrier?

To what extent, if at all, do you believe **A SHORTAGE OF MENTAL HEALTHCARE PROVIDERS** (other than psychiatrists) serves as a barrier?

To what extent, if at all, do you believe **STIGMA** serves as a barrier?

To what extent, if at all, do you believe **TRANSPORTATION TO SERVICES** serves as a barrier?

To what extent, if at all, do you believe **SERVICE WAIT LISTS** serves as a barrier?

To what extent, if at all, do you believe **COST OF MEDICATION(S)** serves as a barrier?

Please list any other barriers that you can think of that serve to prevent individuals from obtaining the MENTAL HEALTH TREATMENT service(s) they need.

_____

From the following list of mental health treatment services, please select those that are not sufficiently available in Hamilton County. (Choose as many as you like)

Individual Counseling
Group Counseling
Crisis Residential (short term)
Case Management
Psychiatric Medication Management (MedSom)
Hospitalization
Partial Hospitalization
Crisis Intervention
NONE - All of the above services are sufficiently available
Other (Specify)_____

Appendix A — Service Provider Survey

From the following list of mental health support services, please select those that are not sufficiently available in Hamilton County. (Choose as many as you like)

Employment/Vocational
Housing
Supported Housing
Respite Bed
Independent Living Supports
Community Integration Supports
Peer Support
Recovery Education
Health & Wellness Support
Peer Respite
Self-Help Activities
NONE - All of the above services are sufficiently available
Other (Specify)_____

Please list any other mental health service needs that are not currently being met in Hamilton County.

What do you believe are the most significant challenges in meeting the needs of individuals within Hamilton County that have a mental illness?

Rating scale: 0 to 10

0 is completely insufficient/inadequate

10 is completely sufficient/adequate.

The following items ask that you rate the sufficiency/adequacy of certain types of MENTAL HEALTH PREVENTION PROGRAMMING within Hamilton County.

How sufficient/adequate is
In-school prevention programming?

How sufficient/adequate is
After-school prevention programming?

How sufficient/adequate is
Summer prevention programming?

How sufficient/adequate is
Community and/or faith-based prevention programming?

How sufficient/adequate is
Evidence-based prevention programming?

Please list any other MENTAL HEALTH PREVENTION PROGRAMMING that you feel is not currently adequate/sufficient within Hamilton County.

Appendix A — Service Provider Survey

Following is a list of some possible barriers that may serve to prevent Hamilton County residents from obtaining the ALCOHOL AND/OR OTHER DRUG TREATMENT services they need. Based upon your experience, to what extent, if at all, do you believe each item serves as a barrier?

Answers choices:

- To little or no extent
- To some extent
- To a moderate extent
- To a great extent
- To a very great extent
- Not sure

To what extent, if at all, do you believe
INADEQUATE INSURANCE COVERAGE serves as a barrier?

To what extent, if at all, do you believe
A SHORTAGE OF MAT LICENSED/AUTHORIZED PRESCRIBERS serves as a barrier?

To what extent, if at all, do you believe
A SHORTAGE OF AOD PROVIDERS (other than MAT prescribers) serves as a barrier?

To what extent, if at all, do you believe
STIGMA serves as a barrier?

To what extent, if at all, do you believe
TRANSPORTATION TO SERVICES serves as a barrier?

To what extent, if at all, do you believe
SERVICE WAIT LISTS serves as a barrier?

To what extent, if at all, do you believe
COST OF MEDICATION(S) serves as a barrier?

Please list any other barriers that you can think of that serve to prevent individuals from obtaining the ALCOHOL AND/OR OTHER DRUG TREATMENT service(s) they need:

What do you believe are the most significant challenges in meeting the needs of individuals within Hamilton County that have a drug or alcohol problem?

The following items ask that you rate the sufficiency/adequacy of certain types of ALCOHOL OR OTHER DRUG PREVENTION PROGRAMMINGwithin Hamilton County.

Rating scale: 0 to 10

0 is completely insufficient/inadequate

10 is completely sufficient/adequate.

How sufficient/adequate is
In-school prevention programming?

How sufficient/adequate is
After-school prevention programming?

How sufficient/adequate is
Summer prevention programming?

How sufficient/adequate is
Evidence-based prevention programming?

How sufficient/adequate is
Community and/or faith-based prevention programming?

Please list any other ALCOHOL OR OTHER DRUG PREVENTION PROGRAMMING that you feel is not currently adequate/sufficient within Hamilton County.

Appendix A — Service Provider Survey

What ideas do you have for the Hamilton County Mental Health & Recovery Services Board that would enhance our Hamilton County system of care?

You're almost done! This last set of questions provides important information about you and your organization.

What is your role/title/position within your organization?

- Executive Director/President/CEO
- Vice President
- Clinical Director
- Medical Director
- Other

From the following list, please select those that currently contribute funding to support your organization. (Choose many as you like)

- Hamilton County MHRSB
- Medicaid
- Medicare
- Hamilton County Job and Family Services
- Private Health Insurer(s)
- Self-Pay
- Local Grant(s)
- State Grant(s)
- Federal Grant(s)
- Private Donations

Please select from the following list those services that your agency provides. (select all that apply)

- Mental Health Treatment
- Mental Health Prevention
- Mental Health Support Services
- Alcohol & Other Drug Treatment
- Alcohol & Other Drug Prevention
- Alcohol & Other Drug Support Services
- Gambling Treatment
- Gambling Prevention

Appendix A — Service Provider Survey

Please indicate the total number of clients served by your agency during the most recent year.

- 0 – 50
- 51 – 100
- 101 – 500
- 501 – 1000
- 1001 – 2000
- 2001 +

Please indicate which of the following age groups your agency serves (select all that apply).

- 0 – 5
- 6 – 12
- 13 – 17
- 18 - 24
- 25 – 54
- 55 – 64
- 65+

With which agency are you associated?

THANK YOU! Please press “Continue” and then “Submit” to ensure that we receive your survey responses. If you have any questions regarding this survey, please contact Erik Stewart at Eriks@hcmhrsb.org

Appendix B — Informed Community Survey

The following survey will serve a vital role in the Hamilton County Mental Health and Recovery Services Board's planning efforts for the coming years. Survey responses are not registered until you press "Submit" at the end of the survey. We appreciate your willingness to contribute to this effort through completion of this brief survey.

Answers choices:

- To little or no extent
- To some extent
- To a moderate extent
- To a great extent
- To a very great extent
- Not sure

Following is a list of some possible barriers that may serve to prevent Hamilton County residents from obtaining the MENTAL HEALTH TREATMENT services they need. Based upon your experience, to what extent, if at all, do you believe each item serves as a barrier?

To what extent, if at all, do you believe **INADEQUATE INSURANCE COVERAGE** serves as a barrier?

To what extent, if at all, do you believe **A SHORTAGE OF PSYCHIATRISTS** serves as a barrier?

To what extent, if at all, do you believe **COST OF MEDICATION(S)** serves as a barrier?

To what extent, if at all, do you believe **A SHORTAGE OF MENTAL HEALTHCARE PROVIDERS (other than psychiatrists)** serves as a barrier?

To what extent, if at all, do you believe **STIGMA** serves as a barrier?

To what extent, if at all, do you believe **TRANSPORTATION TO SERVICES** serves as a barrier?

To what extent, if at all, do you believe **SERVICE WAIT LISTS** serves as a barrier?

To what extent, if at all, do you believe **COST OF MEDICATION(S)** serves as a barrier?

Please list any other barriers that you can think of that serve to prevent individuals from obtaining the MENTAL HEALTH TREATMENT service(s) they need.

From the following list of mental health treatment services, please select those that are not sufficiently available in Hamilton County. Choose as many as you like.

- Individual Counseling
- Group Counseling
- Crisis Residential (short term)
- Case Management
- Psychiatric Medication Management (MedSom)
- Hospitalization
- Partial Hospitalization
- Crisis Intervention
- NONE - All of the above services are sufficiently available
- Other

Appendix B — Informed Community Survey

From the following list of mental health support services, please select those that are not sufficiently available in Hamilton County. Choose as many as you like.

- Employment/Vocational
- Housing
- Supported Housing
- Respite Bed
- Independent Living Supports
- Community Integration Supports
- Peer Support
- Recovery Education
- Health & Wellness Support
- Peer Respite
- Self-Help Activities
- NONE - All of the above services are sufficiently available
- Other

Please list any other mental health service needs that are not currently being met in Hamilton County.

What do you believe are the most significant challenges in meeting the needs of individuals within Hamilton County that have a mental illness?

As a group, individuals with mental illness are also more likely to experience a problem with alcohol or other drugs. For this reason, we are interested in your opinion on this topic. Following is a list of some possible barriers that may serve to prevent Hamilton County residents from obtaining the ALCOHOL AND/OR OTHER DRUG TREATMENT services they need.

Based upon your experience, to what extent, if at all, do you believe each item serves as a barrier?

Answers choices:

- To little or no extent
- To some extent
- To a moderate extent
- To a great extent
- To a very great extent
- Not sure

To what extent, if at all, do you believe **INADEQUATE INSURANCE COVERAGE** serves as a barrier?

To what extent, if at all, do you believe **A SHORTAGE OF MAT (MEDICATION-ASSISTED TREATMENT) LICENSED/AUTHORIZED PRESCRIBERS** serves as a barrier?

To what extent, if at all, do you believe **A SHORTAGE OF AOD PROVIDERS (other than MAT prescribers)** serves as a barrier?

To what extent, if at all, do you believe **STIGMA** serves as a barrier?

To what extent, if at all, do you believe **TRANSPORTATION TO SERVICES** serves as a barrier?

Appendix B — Informed Community Survey

Answers choices:

- To little or no extent
- To some extent
- To a moderate extent
- To a great extent
- To a very great extent
- Not sure

To what extent, if at all, do you believe **SERVICE WAIT LISTS** serves as a barrier?

To what extent, if at all, do you believe **COST OF MEDICATION(S)** serves as a barrier?

Please list any other barriers that you can think of that serve to prevent individuals from obtaining the ALCOHOL AND/OR OTHER DRUG TREATMENT service(s) they need.

What do you believe are the most significant challenges in meeting the needs of individuals within Hamilton County that have a drug or alcohol problem?

What ideas do you have for the Hamilton County Mental Health & Recovery Services Board that would enhance our Hamilton County system of care?

You're almost done! This last set of questions helps us understand more about the individuals responding to our survey. We value your privacy. This information is only used in an aggregate manner. No information will be collected or used that would identify a specific individual.

Select all that apply and choose as many as you like. Are you?

- An individual that has a mental illness
- A family member of an individual with a mental illness
- A friend of an individual with a mental illness
- A mental health professional who works with individuals with mental illness
- Other

Please indicate your approximate age.

- < 18
- 18 – 24
- 25 - 54
- 55 – 64
- 65+
- Prefer not to answer

THANK YOU! Please press “Continue” and then “Submit” to ensure that we receive your survey responses. If you have any questions regarding this survey, please contact Erik Stewart at Eriks@hcmhrsb.org

Appendix C — Consumer Survey

The following survey will serve a vital role in the Hamilton County Mental Health & Recovery Services Board's planning efforts for the coming years. We appreciate your willingness to contribute to this effort through completion of this brief survey.

Following is a list of some possible barriers that may serve to prevent Hamilton County residents from obtaining the MENTAL HEALTH TREATMENT services they need. Based upon your experience, to what extent, if at all, do you believe each item serves as a barrier:

To what extent, if at all, do you believe
INADEQUATE INSURANCE COVERAGE serves as a barrier?

To what extent, if at all, do you believe
A SHORTAGE OF PSYCHIATRISTS serves as a barrier?

To what extent, if at all, do you believe
A SHORTAGE OF MENTAL HEALTHCARE PROVIDERS (other than psychiatrists) serves as a barrier?

To what extent, if at all, do you believe
STIGMA serves as a barrier?

To what extent, if at all, do you believe
TRANSPORTATION TO SERVICES serves as a barrier?

To what extent, if at all, do you believe
SERVICE WAIT LISTS serves as a barrier?

To what extent, if at all, do you believe
COST OF MEDICATION(S) serves as a barrier?

To what extent, if at all, do you believe
INCONSISTENCY IN PROVIDER STAFF (SUCH AS FREQUENT CHANGES IN A CASE MANAGER) serves as a barrier?

Please list any other barriers that you can think of that serve to prevent individuals from obtaining the MENTAL HEALTH TREATMENT service(s) they need.

From the following list of mental health treatment services, please select those that are not sufficiently available in Hamilton County. Choose as many as you like.

Individual Counseling

Group Counseling

Crisis Residential (short term)

Case Management

Psychiatric Medication Management (MedSom)

Hospitalization

Partial Hospitalization

Crisis Intervention

NONE - All of the above services are sufficiently available

Other _____

Appendix C — Consumer Survey

From the following list of mental health support services, please select those that are not sufficiently available in Hamilton County. Choose as many as you like

- Employment/Vocational
- Housing
- Supported Housing
- Respite Bed
- Independent Living Supports
- Community Integration Supports
- Peer Support
- Recovery Education
- Health & Wellness Support
- Peer Respite
- Self-Help Activities
- NONE - All of the above services are sufficiently available
- Other _____

Please list any other mental health service needs that are not currently being met in Hamilton County.

What do you believe are the most significant challenges in meeting the needs of individuals within Hamilton County that have a mental illness?

Answers choices:

- To little or no extent
- To some extent
- To a moderate extent
- To a great extent
- To a very great extent
- Not sure

As a group, individuals with mental illness are also more likely to experience a problem with alcohol or other drugs. For this reason, we are interested in your opinion on this topic. Following is a list of some possible barriers that may serve to prevent Hamilton County residents from obtaining the ALCOHOL AND/OR OTHER DRUG TREATMENT services they need. Based upon your experience, to what extent, if at all, do you believe each item serves as a barrier.

To what extent, if at all, do you believe
INADEQUATE INSURANCE COVERAGE serves as a barrier?

To what extent, if at all, do you believe
A SHORTAGE OF MAT (MEDICATION-ASSISTED TREATMENT) LICENSED/AUTHORIZED PRESCRIBERS serves as a barrier?

To what extent, if at all, do you believe
A SHORTAGE OF AOD PROVIDERS (other than MAT prescribers) serves as a barrier?

To what extent, if at all, do you believe
STIGMA serves as a barrier?

To what extent, if at all, do you believe
TRANSPORTATION TO SERVICES serves as a barrier?

Appendix C — Consumer Survey

To what extent, if at all, do you believe **SERVICE WAIT LISTS** serves as a barrier?

To what extent, if at all, do you believe **COST OF MEDICATION(S)** serves as a barrier?

Answers choices:

- To little or no extent
- To some extent
- To a moderate extent
- To a great extent
- To a very great extent
- Not sure

Please list any other barriers that you can think of that serve to prevent individuals from obtaining the ALCOHOL AND/OR OTHER DRUG TREATMENT service(s) they need:

What do you believe are the most significant challenges in meeting the needs of individuals within Hamilton County that have a drug or alcohol problem?

What ideas do you have for the Hamilton County Mental Health & Recovery Services Board that would enhance our Hamilton County system of care?

You're almost done! This last set of questions helps us understand more about the individuals responding to our survey. We value your privacy. This information is only used in an aggregate manner. No information will be collected or used that would identify a specific individual.

How optimistic are you about your future?

- The future looks very bad
- The future looks bad
- The future looks both good and bad
- The future looks OK
- The future looks somewhat bright
- The future looks very bright

Please indicate your approximate age:

- < 18
- 18 – 24
- 25 - 54
- 55 – 64
- 65+
- Prefer not to answer

Appendix C — Consumer Survey

Please indicate, from the following US Census categories, the racial category or categories that you identify with. Choose as many as you like

- White
- Black or African American
- American Indian and Alaskan Native
- Asian
- Native Hawaiian and Other Pacific Islander
- Some Other Race
- Prefer Not to Answer

Please indicate, from the following US Census categories, your sex:

- Male
- Female
- Prefer Not to Answer

Please indicate your employment status:

- Employed full time
- Employed part time
- Not employed
- Retired

Approximately how long have you been involved in treatment for a mental health issue:

- Less than 1 month
- Between 1 month and 6 months
- Between 6 months and 1 year
- More than 1 year
- I'm not currently in treatment
- Prefer not to answer

THANK YOU!

Appendix D — Service Provider Survey: Participating Agencies

Agencies identifying themselves as respondents:
Addiction Services Council
Beech Acres Parenting Center
Camelot Community Care
Center for Addictions Treatment
Central Community Health Board
Central Clinic
Court Clinic
Excel Development Co.
First Step Home
Freestore Foodbank
Greater Cincinnati Behavioral Health
IKRON
Lighthouse Youth Services
Mental Health America of Northern Kentucky and Southwest Ohio
Pressley Ridge
PreventionFIRST
St. Aloysius Orphanage
St. Joseph Orphanage
Talbert House
Tender Mercies, Inc.
The Crossroads Center
The Salvation Army
UMADAOP

Appendix E — Prospective Respondent Postcard Solicitation: Informed Community

The Hamilton County Mental Health & Recovery Services Board is asking individuals with an understanding of the experience of mental illness within our community to participate in a brief survey. Results of this survey will be considered in service planning efforts in Hamilton County. The survey can be completed using most internet-connected devices including a computer, smart phone, or tablet by typing the following url address in your web browser:

https://hcmhrsb.typeform.com/to/iTP98w

You may request a paper copy of the survey along with a self-addressed, stamped, return envelope by contacting HCMHRSB at 513-946-8600.

Appendix F — Prospective Respondent Postcard Solicitation: Consumer

The Hamilton County Mental Health & Recovery Services Board is asking individuals involved in our service system to participate in a brief survey. Results of this survey will be considered in service planning efforts in Hamilton County. The survey can be completed using most internet-connected devices including a computer, smart phone, or tablet by typing the following url address in your web browser:

https://hcmhrsb.typeform.com/to/ssy24W

You may request a paper copy of the survey along with a self-addressed, stamped, return envelope by contacting HCMHRSB at 513-946-8600

Appendix G — Narrative Responses to Mental Health Treatment Service Barriers: Providers

Responses provided without alteration except for removal of individual and agency identifying information.

Narrative responses to the question
"Please list any other barriers that you can think of that serve to prevent individual from obtaining the MENTAL HEALTH TREATMENT service(s) they need"

Lack of integrated approach to health care, where behavioral health is part of physical health, where a person's primary health care provider includes screening for behavioral health issues regularly and manages these chronic diseases after specialist has been consulted.

Lack of family support

Limited inpatient bed availability to get stabilized.

poverty and the issues that come with it

Individuals don't often know what they need. In some circumstances they are hospitalized or treated for the immediate symptoms but don't get connected to long term treatment that will really be impactful. There is no dialogue about recovery and how to achieve recovery using all of the dimensions of wellness. Much of what is provided is just crisis stabilization- with no strong connection to treatment and recovery support.

lack of child care, transportation, lack of commitment at times

A history of negative experiences from mental health service providers.

lack of knowledge of resources

Cultural/racial/psychological barriers

lack of social/family support

Consistency of providers; Medicaid caps; utilization driven services that lead providers to close clients who may struggle to access services due their MH; the list of diagnoses that qualify for CPST in the adult system; disorganization of agencies; unfriendly front desk staff.

Undocumented individuals.

need many more Docs

Lack or outreach and education about available services.

CPS workers having the supervision necessary to assist with timely follow-up with a client in the community; skills to manage a difficult case; and the list of community resources to insure community integration.

Case managers that have case loads that are to large to manage adequately and that are not trained, paid and educated adequately.

Appendix G — Narrative Responses to Mental Health Treatment Service Barriers: Providers

Needing more case management assistance, access to group therapy services after 5:00 pm

One size fits all with the same providers in the loop. Our system needs to be inclusive in practice not word.

Childcare and lack of variable appointment times for people who are employed.

transportation

intake efficiency

The number of other environmental demands (food, shelter, clothing, school /work) on their time and money that may precedent to healthcare.

Culturally competent providers, lack of easy access if you are not apart of the JFS system or list as SMD.

Wait list, limited psychiatrist

Poverty

Understanding the necessity or availability of services. Inability to navigate the system.

education on the importance of mental health. Parity.

drugs and alcohol

Better chemical dependency counceling

Many mentally ill persons are without stable housing. It's hard to focus on mental health when you don't know where you are going to sleep. Homelessness and the associated stress greatly exasperates symptoms of mental illness.

Quality of service is the issue. Clients can get case management, but QUALITY case management is few and far between.

Not thinking they have a mental illness. Substance abuse. Lack of knowledge on how to get help. Not wanting help I.E. feeling safer on the streets than an apartment, not wanting to take medication, etc.

Lack of understanding of Mental Health services, lack of support in obtaining services, mentoring/peer support services for families in need of mental health services.

Appendix H — Narrative Responses to Mental Health Treatment Service Barriers: Informed Community

Responses provided without alteration except for removal of individual and agency identifying information.

Community respondent narrative responses to the question
"Please list any other barriers that you can think of that serve to prevent individuals from obtaining the MENTAL HEALTH TREATMENT service(s) they need.

Inadequate reimbursement by third party payers which causes providers to opt out of insurance networks.

Understanding of mental illness, or awareness of the problem

Long waits to be seen or connected with services, community mental health centers not accepting clients with only Mood Disorders, PCPs not longer willing to prescribed psych medications

Lack of psychiatrists

Rapid turnover in case managers in agencies

Self awareness of the issue and family involvement in getting care

Lack of family understanding

People do not know who they should contact for assistance.

The illness, itself. Often, members don't recognize the symptoms of their illness and those who love them can't force them to get help.

Fear

No room in hospitals. We need more long term facilities. Lack of funding

I believe the stigma, the lack of insurance or insurance coverage, the cost of both services and medication but the biggest barrier to potential patients is the lack of qualified psychiatrist and doctors.

Need for more quality providers.

Few options for intensive treatment at a place like Lindner.

Just finding a provider

long waiting lists for providers, insurance confusion (e.g., My Care Ohio), shortage of people answering phones and reliably calling back even if you have a place that can take you, My Care Ohio (Molina and

Aetna provider lists have virtually NO psychiatrists on them that take My Care Ohio, even though they say they do), lack of case managers, case managers who have huge case loads,

Appendix H — Narrative Responses to Mental Health Treatment Service Barriers: Informed Community

Fear of adverse side effects from medications.

i think that the requirement at some mental health centers that the person served must participate in a bundle of services in order to get psychiatry services is a barrier.

Continuity of care after an initial hospitalization.

Lack of knowledge on where and how to access services. Also, miseducation on what "mental health issues" look like.

Treatment is the key for individuals with mental illness. However, in order to help them stay on their meds and have a successful recovery, the family has to be involved as coaches and a support group. Therefore, families need to be trained how best to reach, coach and support their loved ones with mental illness. Families can be a barrier if they are not trained.

language barriers or cultural barriers.

Lack of parent follow through and consent to engage in services for their child

no transportation

The lack of MH services designed to go to patients' homes - esp. to administer injections. Large numbers of the SMD population just don't "show up" but we still expect this to change.

A step wise process outlining how caregivers can proceed when they want to assist getting services for their adult children. This outline would include the names and contact numbers of these services.

Cultural or language differences

Part of treatment involves diagnosis, and many people seeking services either resist (out of fear of being labeled) or come to see themselves as deficient and dependent on the system of care that should instead be empowering them to no longer need services.

When my son has been discharged from inpatient psych there is next to nothing in place in terms of a discharge plan.

I am often told that patients who are already connected with case management services are not eligible or there are lengthy wait lists to get in to see psychiatry. Many patients (especially those with Medicaid) are then limited to where they can get psychiatry-only services and are sometimes being served by two different agencies, further creating issue with lack of continuity in patient care.

Lack of insight into illness, side effects from medication

Lack of services, long waiting lists.

Appendix H — Narrative Responses to Mental Health Treatment Service Barriers: Informed Community

Too many people don't look at it as being a problem there isn't enough program to back it

Too many MH providers do not accept Medicaid

Too many clients per case manager.

Awareness of resources.

Not enough providers in your area that accept medicaid/medicare or your particular insurance

knowledge of available services

As indicated, I believe that the lack of mental health providers available is a significant barrier and I feel that in addition to that, some of the providers that are available are not knowledgeable enough to be the most help possible. In addition, case loads are probably too high for most case managers to be consistent and regular support to accomplish things with some clients which is truly crucial to seeing change and progress in the lives of clients.

Not knowing how to find resources, unless you know someone...

Ease of access

Patient ability to follow through with multiple steps before getting help such as medication, talk Therapy

The types of insurance accepted at each agency/provider.

lack of U.S. documentation

mental health providers, esp. pyschiatrists, not accepting any insurance

low reimbursement, esp. Medicaid and commercial insurance

Individuals who also are Intellectual or Developmentally Delayed

Lack of training and knowledge of PCP

proper dx; doctors prescribing medicines too quickly and easily vs trying alternative methods

Knowing how to access services, complicated systems that are difficult to navigate.

limited services following inpatient admission, poor follow up care, difficulty making appts when in need, not enough help for all the cases. Very poor follow up with families and support especially when loved one in an inpatient setting.

A Patient's willingness to get help.

Lack of knowledge and understanding of mental illnesses and how they effect a person's cognitive reasoning to make good decisions about their health and well being.

Appendix H — Narrative Responses to Mental Health Treatment Service Barriers: Informed Community

Stigma

Lack of knowledge of the mental system;how to get the services needed; facilities available for the needs; differences in treatment modalities, best practices for the specific diagnosis, differences in the various mental health providers can be very confusing. Psychiatrists listed with insurance but they tell you not on their lists / just charging regular fees. I assume that is insurance co who dont update their lists even when told of the situation. Few psychiatrists that prescribe Vivitrol.

Most psychiatrist dont do counciling therapy just meds, so now you have to have 2 mental health appointments for the month. Do those mental health providers talk monthly -probably not when their should be coordination of care. Been through this with 2 of my four children over a course of 14 years and it has been eye opening once you are confronted with having to deal with this.

Undocumented status, which prevents Medicaid or Board funding for services. Also, inability to engage parents of youth clients (i.e. lack of phone, unstable housing, incarceration, etc.)

Facilities not taking insurance and/or Obamacare members

Case management after initial contact is very poor to non existent. Affected individuals and their advocates need more guidance to locate the resources necessary for treatment and employment.

Just when a comfort level is achieved in managing an illness, rules are changed and the patient must start figuring out to navigate the maze all over again.

Time between an intake appointment at a community mental health agency and an actual scheduled psychiatric appointment. 2.) Fast turn over of providers at community mental health agencies. 3.) Many psychiatrists have retired in the past 1-2 years. 4.) GCB is no longer accepting patients without psychotic disorders for medication management. 5.) Primary care doctors are treating people that are outside of their scope of practice and often do not have adequate knowledge to treat mental health conditions. 6.) Co-occurring substance abuse. 7.) Lack of stable housing.

Mental health providers do not have the appropriate training to serve all populations. Also there is a lack of providers that take Medicaid.

Inability to get disability despite doctors statement and proof the person cannot work.

Qualified practioners.

Lack of diversity/ options in specialized supports; limited collaboration efforts across agencies to pool resources and treatment

Navigating the system. Who, what, where do I seek for good information. What info should I have with me?

Appendix H — Narrative Responses to Mental Health Treatment Service Barriers: Informed Community

Denial of need or feeling that one can control the illness.

Assistance for caregivers of the mentally ill. Training and respit care centers with evening and weekend hours so that the caregivers may obtain some relief from the stress of caring for the mentally ill.

Lack of insurance coverage for integrative therapies that are really helpful and have less/no side effects i.e. yoga therapy, acupuncture, reiki etc.

Family support, access (rural vs. city)

Individual beliefs that they do not need treatment.

I believe misunderstandings by family and friends as to the seriousness and "reality" of mental health issues is still a major barrier. Many are uninformed or misinformed so they lack the understanding that mental health issues are just as "real" as physical health issues. They are not a result of weakness or lack of self control. They must be taken seriously and treated with the appropriate combinations of medication and therapy (which, of course, vary by individual). I also think there's a lack of knowledge of the latest technology available to assist in medication selections (e.g. Assurex GeneSight test).

Access to the doctors is slow. Identifying the issue as a mental health issue to begin with slows the decision making. Doctors don't always agree to the resolution. Less severe cases are tossed in with the severe cases- should be a way to expedite less severe cases, while at the same time, immediately treat and make determinations for the severe cases? Those with mental illness are usually least able to afford the care, as they have not be able to keep a steady job....and have no insurance or weak insurance.

access to information about resources

Relationship building with individuals who are homeless or living alone

Lack of adequate insurance coverage for mental health

Poor access to other social services, such as housing, Adult protective services, Child protective services, Developmental disabilities services.

Limited psychologists

Not knowing where to go or how to go about finding a psychiatrist or therapist. What to do if you don't really like the therapist you have been "assisgned".

Addiction

Difficulty navigating the process. Not getting clear direction or instructions on intake.

The potential for congress and the government to trash Medicare in the near future is very disconcerting for me, as I rely on it for health care.

Appendix H — Narrative Responses to Mental Health Treatment Service Barriers: Informed Community

More talk therapy is needed v. strictly meds. It's difficult to find the "right" therapist for the specific issues one faces at times.

It seems that the bigger mental health agencies have difficulty retaining staff so clients frequently report not knowing who their mental health case manager is, or not having any contact with this person in many month.

recognizing signs of mental illness

needing services to be close to home

a severe lack in psychiatrist

No child care provided

The high turn-over rate for mental health case managers is a barrier. Many of my clients feel that it is difficult to have to continually explain their situations to new people; nor do they always feel comfortable disclosing their information with a stranger so often. Many clients give-up on the services altogether because of this.

Shortage of dual-diagnoses (MH & Substance abuse) providers!

The biggest issues I see are the lack of psychiatrists and the cost of seeing one. Many of the good psychiatrists/therapists are not on insurance panels. I Pay $215 per session to see my psychiatrist.

No mental health hospitals for severe cases.

inadequate social support

basic needs not met

lack of awareness

mistrust

older, whiter work force, MH providers not understanding and supporting MAT

Schedules are too busy for working people.

Shame, financial resources, lack of qualified personnel to help them, stigma in our culture regarding mental illness

Lack of psychiatrists who accept Medicare or no insurance at all. Inexperienced case managers and social workers. Premature hospital discharges and poor coordination of follow up.

Decreased hospital beds: shorter lengths of hospital stays; not enough crisis or step down residential beds; so many prior authorizations for meds.

Lack of awareness of the problem. Not understanding what mental health professionals do to help.

Appendix H — Narrative Responses to Mental Health Treatment Service Barriers: Informed Community

Services need to be provided on-site where concentrations of the highest risk populations are found - homeless shelters, for example. The community needs more beds for in-patient care and mental health hospitals; costs could be offset by the smaller number of mentally ill persons who are currently incarcerated instead of receiving the treatment they need.

No support from family or friends - either due to denial, lack thereof, or refusal to get involved.

Most people don't know about guardianship and the LAWS make it almost impossible to involuntarily commit someone who isn't rational/delusional but not suicidal or homicidal!! Our LAWS pose a barrier too!!

Lack of guardians for chronically ill people without family members to assist and support them.

The wait and insurance issues impact seeking services from a psychiatrist more so that from a mental health counselor and MSW, in my experience.

Many people with mental health problems are homeless and / or choose not to take medications and families are unable to convince them to take their medications. If there were more residential facilities to these persons, or perhaps a homeless shelter that housed only mental health persons, this might help.

Even if someone has insurance, reimbursement is low and many MH providers won't accept what insurance pays.

A great lack of individuals in education and medical field trained in recognizing and effectively referring individuals for treatment, coupled by lack of communication with support team (loved ones or family). Those with impaired mental health are not likely to communicate well with support team until mental health is being addressed.

Lack of awareness of services available to them.

No support from family or friends that the illness is real. People feeling so overwhelmed in the system that they just forgo treatment because they can't understand who treats what (psychiatrists for meds,

counselors for cognitive behavioral treatment, etc.) and overwhelmed by all the red tape that they encounter with insurance. Wait times with community (affordable services for those without coverage) are completely out of control.

hours of operation

Not enough money allocated for the services needed. Waste of money. Why must patients be transported to a probate court. The magistrates should get off their butts and come to the hospital's for court hearings. They fall asleep on the bench in the middle of hearings. The whole system is a travesty of Justice.

Lack of knowledge of the options services available

The fact that only the mentally ill can admit themselves for treatment UNLESS THEY ARE A HARM TO THEMSELVES OR OTHERS.

Appendix H — Narrative Responses to Health Treatment Service Barriers: Informed Community

In-home caretaking relies on unskilled family/friends.

Its a hugh problem when family members cant help their adult children because of the Hippa law – it has caused many deaths.

I believe the case managers case loads exceed the ability to meet their clients needs. Open clinic days may better serve your clients.

Lack of knowledge about available services and need for more programs to enable mentally ill patients to become the best they can be

Waiting lists and transportation are truthfully the largest barriers I have seen as a Social Worker.

people are homeless and thus don't have consistent addresses or phone numbers for providers to be able to follow up with them.

barriers exist when employers do not allow flexibility from work schedule to participate in doctor visits

difficulty obtaining services when they conflict with other concerns--employment, child care, other caregiving: lack of social support is one of the conditions coexisting with mental illness. Reluctance to admit (or ignorance of) a mental illness in individual and/or family. Finally, I can't help thinking that the broad term “mental illness” is more stigmatizing to those with disorders on the milder end of the spectrum (depression, anxiety) because of lumping them in with people suffering from more severe conditions (psychosis, post-traumatic stress disorder.) Another problem is the restrictions, of confidentiality, which keep therapists, family, and a low-functioning patient himself, from collaborating effectively. The factors in the boxes, above, are FAR higher barriers.

Case managers have to large of case loads, and only do minimal to help client.

Lack of support for educators to deal with mental illness in the classroom and how to best support their students.

lack of family support and education about mental health

lack of dual diagnosis services, turn over of community based staff, wait lists, lack of housing services

Too many other stressors to attend to, lack of child care

Limited funding for adult services

Not enough diversity of service providers.

Lack of finances. Social Security does not allow enough support to pay for basic needs and psychiatric care. To qualify for assistance we are in poverty. We can't win.

You pretty much touch all that I can think of. Definitely not enough providers or coverage.

Appendix H — Narrative Responses to Mental Health Treatment Service Barriers: Informed Community

Not enough beds for inpatient needs.

not knowing who to contact or how to contact services, more bulletins and posters need to be in communities. peer support in mental health centers, people that have been in the place of getting help for the first time that understand how stressful and fearful this can be. Follow up phone calls to clients with mental health issues to make sure they are taking medications and going to appointments when they need to be there. More mental health support groups especially for newly diagnosed people, that are held in mental health centers.

Trying to find the pathway to follow to get started.

Education and awareness about what constitutes mental illness. I normalized, ignored, and didn't realize that mental illness was the core cause of my loved ones struggle for 15 years until it was too late.

If I had known earlier I could have influenced him getting treatment.

Community Mental health centers have dried up or been taken over by [name redacted], which is not much of a "mental Health" service place. They do brief treatment, hire poorly trained people, then overwhelm them with huge caseloads and no real clinical supervision. The old MH centers did quality work....like [name redacted] and [name redacted].... [name redacted] is now the last stronghold of decent care. Barriers also are no real good inpatient places..... [name redacted] is now a joke.

The side effects of medications.

The staff that work within mental health treatment organizations change jobs so frequently. Individuals with mental health issues have a difficult time forming an a connection to employees within agencies, because they are seldom working there more than one year.

coverage does not equal access, poor integration among community providers and hospitals, little to no after care, insufficient drug and alcohol coverage which is incredibly comorbid

Friendliness of staff at agencies.

Turnover of providers and case managers in community mental health.

The times services are offered by many providers - bankers hours

The misunderstanding of our legislative people in state of Ohio. We need to advocate on a big scale. Our people with mental health issues are NOT being taken care of very well.

Appendix I — Narrative Responses to Mental Health Treatment Service Barriers: Consumer

Responses provided without alteration except for removal of individual and agency identifying information.

Consumer respondent narrative responses to the question
"Please list any other barriers that you can think of that serve to prevent individuals from obtaining the MENTAL HEALTH TREATMENT service(s) they need."

MY Name is [redacted] an i dont haven insurence at all

Money

transportation issues, medicare, ssi, not employed

I can not think of any at this time

i need furniture

Homelessness

Need more help

more understanding

Not enough case managers.n

No return phone calls or follow thru from therapist

The high rate of client cancellations and No Show appointments is a barrier to them receiving consistent mental health services.

Misunderstanding in one's personal needs that they look forward of receiving.

Services are unknown to many people in need. Having insurance and income may prevent some people from being eligible for services.

self-want

Time

Long initial waiting for service when you go to your family doctor when you give a list of meds taking

stigma. embarrassed. denial.

There not enough funds for people whom does not have health insurance through the system.

people not doing what they are suppose to do.

Insurance

providers who do not understand my condition

Poorly trained staff, Budget limits and concern, Providers limited by billable hours versus completing services mental health population deserves.

Appendix I — Narrative Responses to Mental Health Treatment Service Barriers: Consumer

Schedules

because transportation

MISUSING MEDICATION

harsh illness

No availability of group homes. These can make it hard to find housing.

Family coming to groups, or friends

one on one help with resolving the needs and wants of a individual life and well being

getting people in for treatment

NOT LISTENING

Good, understanding psychiatrists is a huge problem. Wait lists for psychiatrists an issue.

Communication across county MH agencies also poor.

Being shamed, paying for services is really a big issue

Having the correct medication applied to their illness, listening. and taking in what the patient says about the medicine and or treatment plan.

-lack of income – transportation

lack of resources

Hiring people who have no idea what they are doing

I think an individual should be able to say around people that they are comfortable with. When inconsistency is in the environment situations such as frequent moves is a huge issue for one that has a mental health issue.

Not being able to talk to someone when they need to at hand and having someone that will listen without talk is judgement past.

lack of income

transportation

Old people

Not having communication with the doctors or nurses when needed involving your medication

Not enough money, health insurance that doesn't cover cost for it

Supervision of case management

Appendix I — Narrative Responses to Mental Health Treatment Service Barriers: Consumer

Waiting

Not enough treatment facility's or open “beds.”

Information

Return phone calls

Fear of judgement. Finding a provider that will take certain insurances, or if having none, that of free or sliding scale services.

Stigma

Forced treatment should increase

Appendix J — Narrative Responses to Other Insufficient Mental Health Treatment Services: Provider

Responses provided without alteration except for removal of individual and agency identifying information.

Narrative responses to the question
"Other insufficient mental health treatment services"

Housing,care management,nutrition,prevention,culturally competent/specific

Housing is healthcare and we need more housing stock in hamilton county

Appendix K — Narrative Responses to Other Insufficient Mental Health Treatment Services: Community

Responses provided without alteration except for removal of individual and agency identifying information.

Narrative responses to the question
"Other insufficient mental health treatment services"

Family counseling

Gender specific residential placement (non AoD) and residential placement for AoD for youth

Cross-cultural and diverse counseling/providers.

All are available but long wait lists and long processes before treatment actually starts

Substance abuse and mental health services together.

Transportation to services

treatment with other adults who have long term illness

Appendix L — Narrative Responses to Other Insufficient Mental Health Treatment Services: Consumer

Responses provided without alteration except for removal of individual and agency identifying information.

Narrative responses to the question
"Other insufficient mental health treatment services"

Help with my psychiatrist payment and help with my health insurance

Inconsistency between intake counselor and staff

no services needed for mental health

Finding them in your insurance plan

Appendix M — Narrative Responses to Other Insufficient Mental Health Treatment Services: Provider

Responses provided without alteration except for removal of individual and agency identifying information.

Narrative responses to the question
"Other insufficient mental health treatment services"

NO RESPONSES RECEIVED

Appendix N — Narrative Responses to Other Insufficient Mental Health Treatment Services: Community

Responses provided without alteration except for removal of individual and agency identifying information.

Narrative responses to the question
"Other insufficient mental health treatment services"

Family support and education

Not sure due to lack of knowledge

Again, services that BRING pts to these services

This is difficult for me to ascertain. We have good health insurance and our son has refused or not used these services.

treatment with other adults who have long term illness

Appendix O — Narrative Responses to Other Insufficient Mental Health Support Services: Consumer

Responses provided without alteration except for removal of individual and agency identifying information.

Narrative responses to the question
"Other insufficient mental health support services"

Part-time job with disability

Single parent support and teenager support programs and education

it's adequate

Appendix P — Narrative Responses Related to Other MH Services Needed in Hamilton County: Provider

Responses provided without alteration except for removal of individual and agency identifying information.

Narrative responses to the question
"Please list any other mental health service needs that are not currently being met in Hamilton County"

all of the above integrated with primary care

Absence of supportive services for Medicaid clients

Case management visits/continuity of care for clients incarcerated.

Specialized therapies like DBT. If they are available they are hard to find.

tokens for transporation

It's not MH, but detox options for adolescents, plus options other than CAT for adults.

Care for repeated compensators.

Financial education

Childcare

Programs for the transition between child to adult

co-occurring services

poverty needs not being met

Social /Recreational, parent support for children who experience mental illness.

Household items

Coordination between service providers and insuring providers on the same page as it pertains to mental health services for adults and families.

Appendix Q — Narrative Responses Related to Other MH Services Needed in Hamilton County: Community

Responses provided without alteration except for removal of individual and agency identifying information.

Narrative responses to the question
"Please list any other mental health service needs that are not currently being met in Hamilton County"

Addiction

Housing, housing, and more housing.

Inpatient addiction treatment

Alternative tx such as ECT

none that i can think of

Family therapy

It would be nice if there was some place person could just stop in and talk.

Hospital beds - huge shortages, people being discharged without adequate after care planning at all (particularly [redacted]). There's really NO adequate hospitalization treatment anymore. People are "stabilized" and thrown out on street before they are truly stabilized at all. And NO ONE gets into [redacted] anymore, which is a real shame. People need options where they can truly stabilize instead of going in and out of hospital every few weeks. I had someone over the summer that was at [redacted] and [redacted] 7 times in like 7 weeks, and the last time [redacted] let him out without even telling me, just gave him a bus pass, no meds, no food, no money, and kicked him out because they thought his problem was "behavioral". This guy had lived at [redacted] for 6 years: this is not "behavioral", it's psychiatric!

They suggested intensive sexual predator treatment - oh, good, where do we get that, for God's sake?

Specialized services for the aging individuals living with mental illness. The aging process is one that currently is not well addressed as individuals enter into their 60s and 70s. As the health care systems improve at keeping individuals living longer, services need to be designed to address their unique needs.

None that I can think of off the top of my head.

Specific supports for Grand-parents and other relatives caring for youth with mental health issues, especially trauma.

As stated above, families need to be trained on how to help their loved one.

psychiatric services for children and adolescents; respite care for children and adolescents; mentoring for children and adolescents.

See Item 8

Trauma informed trained therapists and Psychiatrists

Appendix Q — Narrative Responses Related to Other MH Services Needed in Hamilton County: Community

Home visits, routine, for those clients who begin to fail apptmts, usually d/t their symptoms

none that are not included above

Intermediate between short term hospitalization (PES) and long term hospitalization (Summit)

Mental health therapists really should be able to meet people as soon as they need services. Often, a several-week wait forces people to cope in other ways that are sometimes less than ideal.

A huge problem for us in that if you can find a provider there is a good chance they aren't taking insurance. It's my understanding that it is too much of a headache for them to deal with the hassles of insurance companies.

More substance abuse services

Family Support teams education facilities for the family or the patient

Simply, lack of knowledge about what to do, where to go.

Support for dual diagnosed

lack of inpatient and ongoing options

A bridge between crisis stage and being able to be seen by a provider.

group homes that are safe and well run

rapid access service, truly compassionate emergency psych services, low barrier housing

support & education for families when patient in an inpatient settings; support for families when patient discharges from facility and education regarding needs of loved one

not enough addiction services

Youth residential; intensive in-home services; youth ACT team.

longer recovery programs for addiction/mental health

Long term living arrangements after caretakers are no longer able to be caretakers, need to be found. More support for organizations like Plan SW Ohio is sorely needed.

LONG TERM HOSPITALIZATION. [redacted] IS NOT ACCEPTING NON FORENSIC PATIENTS. Though access to case management is available for many individuals the quality of the case management is severely compromised by the turn over of staff, high case loads, poor training (often times because agencies are so desperate to get case managers fully functioning and carrying a caseload that they don't adequately train them prior to sending them off on their own) limited availability of ACT and other specialized teams.

Appendix Q — Narrative Responses Related to Other MH Services Needed in Hamilton County: Community

help with young kids

Drug and Alcohol treatment, Inpatient Drug and Alcohol treatment.

Options for youth behavioral health supports; human trafficking; crisis stabilization (capacity)

Resources for families to gain greater knowledge about mental health challenges so they can recognize signs and symptoms - and help fellow family members or friends get treatment.

urgent appointments

Mental illness is a brain disease and would be great it we would stop looking at it differently than other brain diseases and other long term illness like diabetes, high blood pressure, etc. Medication has many side effects and needs to be a consideration when providing medication on a long term.

Perhaps funding for those who live with a mental health diagnosis to go/return to college and get a degree, the way veterans have it set up, would provide a great future benefit to society, locally and nationally.

We are fortunate to be able to afford our own needs which are NOT covered by insurance. I can only imagine how difficult it must be for those who are financially challenged on top of having mental health issues to find the services they need.

peds services

needs is being met but long process time before one can get actually treatment has a great impact to

once continuing the process to have treatment.

Services for dual diagnoses clients (MH & substance abuse) including medically assisted tx for heroin

Emergency housing

Youth residential - especially AOD.

Crisis help for families

Insufficient beds for inpatient needs.

Family/caregiver support groups and/or counseling

Hospitalization is inadequate as length of stay has come down to a matter of days for people who are severely ill and have been off medications for extended periods. People are being routinely discharged in unstable condition and unable to integrate into community treatment. Longer term treatment ends up being available only for those who become forensic patients after involvement with the criminal justice system.

Appendix Q — Narrative Responses Related to Other MH Services Needed in Hamilton County: Community

I answer the nami help line and i feel that there should be supervised housing more readily available. I get a lot of calls from concerned families that their loved one can't live with them, but they want them to be somewhere safe, someone looking over their shoulder, monitoring their meds, being a quasi-case manager.

Wonder if there are enough programs that address the social needs of people with mental illness.

homeless support

In-home caretaking - currently relies on unskilled family/friends.

Disconnect between patient seeing Psychologist (who knows the story) and Psychiatrist who just prescribes the drugs - lots lost in translation.

providing supports to seek, get and maintain adequate employment

Casework services in general but especially to those who don't qualify for Medicaid and can't afford private pay: it is my firm belief that insurance companies, especially those offering plans on the Marketplace, would save money by covering such services as a preventive measure. Comprehensive employment services for people with mental illness (services are underfunded and scattered at present.)

Would like to see more social workers working with clients than case managers. Social workers tend to have more time, will visit client and work with family. They seem to have more compassion and ability to step into situations, than case manager. Would like to see more mental health clinics or more staff, doctors, to support mentally ill patients. It is difficult for mentally ill patients to receive certain medications due to insurance issues, many times they are only given the traditional drugs, due to cost and insurance issues. Better housing accomodations for mentally ill to fit in community and neighborhood. Would like to have someone visit my mentally ill son, regularly, 2 or 3 times a week. Or take him out in community (peer). When family cannot help due to illness or family issues.

Transition programming from hospital to outpatient

Residential treatment for boys

Able to get meds for indigent in more places

I do not know of anything else.

Case coordination of services

Appendix Q — Narrative Responses Related to Other MH Services Needed in Hamilton County: Community

I think a focus should also be on teenagers that are aging out of the system. Teenagers could also really benefit from peer supports. Some system where clients adult and teen, where the clients can earn something while they are working toward mental health goals.

More community support, with help from groups such as NAMI, to provide for events and speakers. As aforementioned, psych wards should be numerous and allow each patient a separate room; there needs to be distinction between high-functioning and seriously impaired individuals [not always done at [redacted]].

outreach and prevention.....groups for families and children of mentally ill..... sliding scales and good therapy and medication follow-up.

affordable services for the employed.

art therapy

Appendix R — Narrative Responses Related to Other MH Services Needed in Hamilton County: Consumer

Responses provided without alteration except for removal of individual and agency identifying information.

Narrative responses to the question
"Please list any other mental health service needs that are not currently being met in Hamilton County"

that have the services that's needed

Free housing Sec,8HA C.M.H.A.

Everything has been met.

housing, insurance

Advocacy

help w/case managers for reintegration to the community

Things are better than they have been.

Psychiatrists that charge on a sliding scale based on income for individuals without insurance

My Doctor's payment...medicine/insurance...jobs

need more sober/residential housing programs to help addiction. and there isn't enough long-term outpatient mental health programs to make patients feel supported and helped

Encouragement to do better

Public and employer education

[redacted], [redacted] rehabilitation, case management, therapy

Organized trips in afternoons

Mental health retreats that are totally free of cost

Care Coordination/Role Model - a person whose job is to organize events in order to endure they are provided properly

providers who are knowledgeable about autistic adults

Eating disorder treatment, sex offender treatment, ADL/ IDL community supports

PLACE LIKE THE WELCOME CENTER FOR SOCIALIZATON

all thinkable service seems to be met

Group housing that is nice and has good settings.

I think Hamilton Co. does a great job with mental health services

Appendix R — Narrative Responses Related to Other MH Services Needed in Hamilton County: Consumer

employment assistance

Everybody understanding the basic needs of a individual and meeting the needs of that person on a person to person basis

getting a diagnosis for the doctor to help

case manager not helping find my apartment

out patient care

Education

It depends at what point of time it occurs

Not enough treatment facilities that people can afford

Beds for homeless, more transitional housing

I have very severe COPD and need better transportation and help getting into my apartment. I feel a lot of people won't be empathetic or sympathetic at all they simply tell me to go on my own and it is very difficult

Homeless outreach leading to placement

Not enough people for the patients here to be seen in a timely manner

More of a womens group to feel your not all alone

Programs to lower costs of medications. Free transportation to and from visits. After-hours centers. Doctor availability. Appointment availability.

In patient drug treatment

Appendix S — Narrative Responses Related to Significant Challenges in Meeting Needs of Those with Mental Illness: Provider

Responses provided without alteration except for removal of individual and agency identifying information.

Narrative responses to the question
"What do you believe are the most significant challenges in meeting the needs of individuals within Hamilton County that have a mental illness?"

stigma, knowledge of how to get help, transportation, waiting lists, housing for people with severe MI

stigma

Fragmented Medicaid services

Lack of inpatient beds, leading to more individuals who are unstable in the community and, in turn, become involved with the court system.

poverty

Care navigation, helping the community understand how to help people work toward recovery, building a stronger connection between prevention, early intervention, treatment, recovery and relapse prevention. Stigma- people still encounter stigma and the community doesn't see mental health as part of health.

Psychiatry and medication

The experience and feeling of being swallowed up by a system concerned only with bottom lines, checking boxes, and billing. The care is suffering under the weight of bean counters. Efficiency at the expense of care does not constitute efficiency; it constitutes poor care.

most mental health clients need long term care

provider training.Social/economic/political environment

Co-occurring issues, especially substance abuse. Difficulty finding psychiatrists. Some of the BH re-design plans could be very difficult barriers, and make no sense; example is the severe reduction in nursing reimbursement.

man power - clinicians

Getting clients connected and keeping them connected; staff turnover; rate of pay for providers.

Helping individuals come to their intake appointments to get started with treatment.

Getting the clients to come to groups.

Criminal background, dual diagnosis. Lack of inpatient SA Tx options

Appropriate services in the area of family involvment

doc access quickly

Appendix S — Narrative Responses Related to Significant Challenges in Meeting Needs of Those with Mental Illness: Provider

Lack of funding and ability to retain staff.

There are many case management concerns needed by individuals with mental illness that they have a hard time being met in a timely manner due to high caseloads

Coordination and collaboration

Lack of funding and providers

Staff retention; managing increasing costs with minimal revenue increases; co-occurring poverty; co-occurring substance abuse

Staff retention, managing risk, increasing operational costs, needed hospitalizations

Maintaining quality staff in the public MH system

providers with med som, transportation

Staffing at agencies, salary challenges. Psychiatry services

sufficient psych dr's and behavioral health NP's

urgent respite childcare to defuse a stressful household

understanding the relationship with addiction services and not supporting addiction services as the primary provider for co-occurring disorders

Access to treatment

daily living skills

insufficient access to care, poverty, lack of prevention services, trauma homelessness, poverty, jail overcrowding, access to quality services, the complexities when combined with opiate addiction, lack of child psychiatrists/prescribers, transportation, stigma

family support

face to face

Funding structures with rigid limitations that create gaps in service. Things people "can't" do...Homelessness. Many grants and services only cater to those who have been homeless for a really long time.

Getting them suitable housing and keeping them housed. Mental health symptoms and substance abuse impact are both minimized when clients have stable housing.

Great need and accessing care for individuals in need.

Appendix T — Narrative Responses Related to Significant Challenges in Meeting Needs of Those with Mental Illness: Informed Community

Responses provided without alteration except for removal of individual and agency identifying information.

Narrative responses to the question
"What do you believe are the most significant challenges in meeting the need of individuals within Hamilton County that have a mental Illness?"

wait list

The misconception that mental health issues are something people should be able to get over on their own, that it's a choice to be sick.

Service limits, lack of housing, poor treatment in group living

Helping individuals and families in crisis, meeting them where they are and create a

supportive, non-threatening network that will make getting help easier, less daugnting and more acceptable.

Availability. Help when people need it being available.

No beds available on a constant basis. No long term placement for those who can not function in the community

Being able to keep them on mediations, and in housing

The lack of quality psychiatrist.

fighting stigma and poverty; providing adequate psychiatry to those who have moderate mental illness; motivating people to hope; motivation to care about wellness

Adequate short and long term residential treatment facilities that are quality operations.

Finding care

Money to expand services

Breaking down individuals' resistance to getting evaluated.

Often are seen as a one group rather than looking a the needs of cluster groups to design services to address the needs.

Availability of qualified, multi-disciplined, insurance-covered (Medicaid, Medicare, MyOhioHealth) individual therapists. I don't qualify for services at the VA, but have been trying DESPERATELY to find a therapist who is trained and certified in EMDR that I can afford to see on a regular basis. I've been trying for at least 3 years to find someone that I don't have to pay out of pocket, to no avail!

Accessing appropriate levels of care and paying for it.

Finding proper care.

Appendix T — Narrative Responses Related to Significant Challenges in Meeting Needs of Those with Mental Illness: Informed Community

transportation; lack of insurance; lack of education.

The ability to find proper treatment to begin with. Finding care is difficult even for someone who's completely healthy; for someone with mental illness it feels nearly impossible and frustrating.

Transportation, Psychiatrist wait lists, providers that accept Medicaid, cost of medications

Medicaid funding

Pts' need more internet access, more in-home services, need to attach payee visits to med-som/CM visits

reimbursement rates

stigma and transportation

Social isolation, transportation, financial issues, housing issues

The system generally supports the "worried well," or those who are able to generally live independent lives. You need not go farther than the streets of downtown Cincinnati to discover severe mental illness among the homeless population. I have spent a great deal of time getting to know people in these conditions and witnessing active phases of the worst symptoms of mental illness. The system of care for these folks was simply never created on the community level following deinstitutionalization, and the biggest challenge is that there are simply few options today for folks who would have resided in an institution 50-75 years ago.

Insurance problems, lack of providers, lack of support outside of hospitals

Access to providers who are able to provide counseling, case management and psychiatry all under one roof.

Being able to afford adequate services, medication, finding the right type of medication that has the fewest side effects, being able to afford medication and counseling.

Lack of available resources

Adapting to the needs of the mentally ill and accepting the fact that it's a problem

Socioeconomic disparities

There is such a lack of housing for those with mental illness. Is also seems there is a lack of oversight for group homes.

Access to child psychiatrists.

insurance hassles or not having $ for therapy

availability of providers

Appendix T — Narrative Responses Related to Significant Challenges in Meeting Needs of Those with Mental Illness: Informed Community

money. Shame

Constant, progressive, and motivated staff to connect individuals to resources available.

Finding consistent help in a timely manner.

Compassionate Case Manager's ...underpaid Support for those that are decompensating and deemed not an immediate danger to self or others ...but are on the brink

Lack of clinically trained case management. All services are run through 2 agencies: [redacted] and [redacted].

Stigma, education, family support, community programs

Transportation is huge. For those that don't have support...someone to assist.

shrinking workforce. low reimbursement rates.

early/timely diagnosis

overcoming stigma, normalizing the mind/body connection, or clearly expanding the definition to include illness that is not extreme (as focused in the media)

STIGMA, complicated systems to access and long, long wait lists

understanding and education on what those needs are, how to access resources, how to advocate for loved one and how to afford medications and ongoing care

A patient's willingness to accept services.

Early diagnosis, access to Psychiatrists, counselors, and proper medications.

not enough psychiatrists and hospital beds and too much red tape re regulations on length of stay (insurance companies) andHiPAA re families having problems knowing what is going on.

lack knowledge of system

Above-listed barriers.

They cannot receive immediate care.

Gainful employment and socialization skills are challenges that must be addressed.

Long wait times to see a psychiatrist, [redacted] not accepting patients, guardians are not available for people who need them, limited supportive housing options, homelessness, lack of dual diagnosis residential treatment, and co-occurring substance abuse disorders.

When you to call for help there is nothing available

Drug and Alcohol treatment, not enough Med som providers.

Appendix T — Narrative Responses Related to Significant Challenges in Meeting Needs of Those with Mental Illness: Informed Community

Stigma

Funding for adequate numbers of well trained staff who have good support

engagement of the family and community in holistic treatment

Case workers/social workers or someone that can follow up with me and my progress.

Overcoming stigma from the community, access to services, understanding of insurance benefits and resources available

Improved community education as well as access to treatment and support services.

Initial Diagnosis is late; all things money.... paying $4,000 or more to stabalize a patient is outrageous for the services these places provide.

overuse of the emergency room when urgent appointments are not available

To have long term providers who build a relationship. Also, the stigma makes it hard to receive

treatment, so educating family practice physicians and have mental health physicians, social workers, counselors working in the family physicians offices.

Workforce shortages

Cost of therapy

Lack of support services

fixing the stigma & offering help with copays

Wrap around services d/t other needs when particularly dealing with MH symptoms that are episodic or long term.

Funding

Housing, residential services

When I was first seeking treatment, it was very hard to acknowledge I had any problems. Because of organizations like NAMI Southwest Ohio, I learned more about myself and others who live with a diagnosis, and became empowered.

Financial, limited crisis beds in hospitals or centers, stigma, drug follow up

finding available and affordable services.

non urgent access

being able to access all needed services in a timely manner

transportation/child care

Appendix T — Narrative Responses Related to Significant Challenges in Meeting Needs of Those with Mental Illness: Informed Community

Providing services for dual diagnosed individuals including those with opiate addiction (medically assisted tx), employment, housing.

lack of services

My daughter has irrational behavior sometimes and sees a psychiatrist and therapist. I can't seem to deal with her. What about relatives?

resources for individuals living in poverty,

connecting and promoting engagement in occupational activity, building safety

managing treating people with Dual dx

Not enough psychiatrists. Cost of meds. Lack of residential and hospital beds.

Denial and stigma

Financial, availability of qualified psychiatric and psychological resources

Continuity of care after hospital discharge. Patients not always stable enough and decompensate. Step down units, care centers that allow a 3-6 month timeframe for stabilization and then housing assistance would improve outcomes. Example UK Health System, Eastern State Hospital and Central [redacted] as an example. [redacted] helps with housing after rehab.

Costs and resources

Funding may be at the root - inadequate number of psychiatrists & psychologists, not enough in-patient beds for adults or children, waits as long as 6 months to see a pediatric provider.

Getting them the help they need, especially against their will. Also, housing line musing homes/assisted living - my mom was denied twice due to her bipolar disorder.

There needs to be a more integrated, comprehensive and individualized approach that responds to the acute care needs of persons at high risk for hospitalization or incarceration.

Initiating counseling and psychiatric care, education of citizens in general and family members.

Their willingness / ability to keep appointments and take medications.

Living safely somewhere with someone to watch over them.

The wide range of capacity for growth and the ability to respond to therapy and other programs makes it difficult to meet the needs of specific individuals. Some people need a lot of support and others need a minimal amount of support. Many agencies are limited in what they can offer to clients or patients with reference to time and types of therapies.

Appendix T — Narrative Responses Related to Significant Challenges in Meeting Needs of Those with Mental Illness: Informed Community

Adequate insurance coverage to successfully identify and develop a sustainable recovery plan that includes routine communication with recovery team (psychological, medical, nutrition, individual and loved one or family member)

Providing coordinated, longer term managed care outside of the hospital.

Treatment is too expensive and community level services are overwhelmed with patients.

Stigma of Mental health and cost of care

Money, long-term treatment beds, but mostly, nobody cares about these people except a few dedicated souls. [redacted] figured it out when a million plus was cut from their budget. The county does not care. [redacted] cut 40% of their beds!

Getting the individuals to accept that they need help and coordinating the treatment to their individual needs

MINIMAL run around for individual - e.g., do not give them lists of numbers to call for help, take them DIRECTLY to what they need....they do not have the capacity to deal with choices and need a hand to hold through the ordel.

In-home skilled care (for non-hospitalized patients). Just like hospice, this is an illness that requires skills not normally found in the average family member.

Guidance in where to get services. Adequate time in treatment or hospitalization to make some clear improvement.

Lack of psychiatrists and inability to pay for psychotherapy and medication management Lack of stable housing and lack of transportation.

Stigma of mentally ill patients is a huge challenge along with inadequate health insurance and not enough mental health professionals.

Many patients that I see are very poorly educated and have significant addiction issues. It makes it very easy for pts not to follow through on doing what it takes to get help.

building relationships with employers (possibly through HR groups) to increase employment of persons with mental illnes

Lack of resources

Appropriately treating those who have been “diagnosed” to jails and homeless shelters rather than warehousing them.

Appendix T — Narrative Responses Related to Significant Challenges in Meeting Needs of Those with Mental Illness: Informed Community

Police understanding and training with mentally ill, It seems once they get arrested, and our in justice system, you get no information and no communication. If it was not for NAMI giving me information on what to do in jail situation, we would have had no idea what, where or how my son was doing and were he was going. Community understanding of mental illness (stigma) More clinics in the areas, [redacted] is very busy, many times things change with socical workers to case managers. Client and family members have no idea of change, and our just given a case manager, I also think clients should have the right to ask for a different case manager/ social worker, if client and case manger/social workers do not connect with each other. The client should not have to feel fearful of doing this or demeaned. We also need more qualified mental health doctors, psychiatrist and psychologists.

Staffing, funding and structure.

Lack of EBT services or getting services all in one location

Agencies not working together to meet mental health needs of community

Education of what mental health is ; Stigma

Support in more areas in Cincinnati to get meds

Quality providers. Knowledge of and connection to services.

Not enough providers, services, support for the family to help the loved one.

Lavk of hospital beds and aftercare

Not enough services and difficult to navigate the services that are available.

Not enough people to help the people that need help, in every area, Psychiatrists, Therapists, Case Managers. The stigma of mental illness is still there, and people are still afraid to go get help.

Emergency services transitioning to release, and rejoining family or being helped to receive training to be placed in a job. If no longer able to work, more help is needed in navigating the maze of application to getting aid from various agencies, including county, state and federal.

IO

There aren't enough programs in Hamilton county that help to meet the needs of said individuals, nor are there enough case managers to help the number of individuals with mental illnesses in Hamilton county.

Landlords have a legal right to impose psychiatry on their tenants / children indefinitely. Also, bipolar disorder cannot be measured physically by brain scans, even though it supposedly is a chemical imbalance!

Care that is consistent and good, outreach, family support, training and hiring really well prepared staff and then taking care of them with supervision, decent pay, reasonable expectations and support.

Appendix T — Narrative Responses Related to Significant Challenges in Meeting Needs of Those with Mental Illness: Informed Community

getting the public to view mental illness as any other illness, such as cancer.

lack of providers who take medicaid forcing everyone to a community health clinic setting which can't see people

Good psychiatry

The gap in short term care for those who don't need hospitalization because they are not actively suicidal but current outpatient treatment isn't enough. This gap is stressing the system. Also there is a significant challenge of serving those with private insurance - high deductibles and/or high copays.

Appendix U — Narrative Responses Related to Significant Challenges in Meeting Needs of Those with Mental Illness: Consumer

Responses provided without alteration except for removal of individual and agency identifying information.

Narrative responses to the question
"What do you believe are the most significant challenges in meeting the needs of individuals within Hamilton County that have a mental illness?"

they help us get threw these challenges

Hilp ME

ttansportation and learning the most for the individuals needs

Housing Rapid Rehousing

The board.

treatment plans, crisis plans are not shared with all providers; lack of crisis response services an none driver, receiving medicine on time, housing, no money

The most significant challenges in meeting the needs of people with mental illness if being approved for services that are available to individuals in Hamilton County.

Homelessness, drug and alcohol addiction, pending criminal charges

Housing

knowing and understanding the person

People to care for the mentally ill, housing and support.

Doctor shortage and stigma

Abusive men with mental illness

There needs to be treatment inpatient for man/woman that will take active addict in still using and help them medically detox because as an addict i didn't want to go into treatment because no place would allow me in detoxing or help me detox.

That they can do better with a positive focus on changing times

Matching needs to support

Talking to other people about mental health issues

That my case manager [redacted] is the best case manager for me

finding the people who are in need of services

The way they judge you as in the assume your staying with someone despite you pay your half of the rent as in roommate

dealing with cops

Appendix U — Narrative Responses Related to Significant Challenges in Meeting Needs of Those with Mental Illness: Consumer

Having to speak in front of other.

Insurance

lack of providers who understand my condition

Transportation, poorly trained providers, high provider turn over, limited access to medical providers, severe limits to services individuals can receive.

Housing

they have to put up with diffrent illnesses

trying to stay out the hospital

BEING SOCIAL

unable to be seen dued to aggressiveness

Getting all the right care and services.

Metropolitan area with a great number of people that need help

Insurance

meeting their needs

Treating an individual as individual, not just assuming that their problems are the same as everyone elses

different material

lack of stable housing, lack of ins. Coverage

mental patients not seeking adequate help

lack of resources

housing for them - safe place for them for themselves and others

Identifying them

Lack of follow through (personal accountability). No job/means of support

At the beginning coming from [redacted] to [redacted] or whoever. There just seemed to be a lack of knowledge to the procedure for services

contacting a group of lots of people that are on the treatment case load

Getting around / money

client understanding what's going on

Appendix U — Narrative Responses Related to Significant Challenges in Meeting Needs of Those with Mental Illness: Consumer

Wait times, consistency amongst providers (my brother has been to 3 different psychiatrists, all differing diagnosis and medications). [redacted] told my brother his MH was not "severe enough" to warrant a psychiatrist, but he could receive CM and counseling??? Shortage of qualified, dedicated psychiatrists who actually listen, make eye contact, and take the time to understand the individual.

making the help available to everyone no matter the insurance or not

Housing/help getting help with employment

Waiting lists to some treatment centers

Getting them in adequate care most do not know where to go

Staff

Knowing where the individual is coming from

Consistent therspist

There are so many significant problems for mental health patents. Sometimes it's good to be around people they know. What ever comes easy for a person with a mental health disorder, I think that being around people that have mental health issues the person would feel more comfortable.

Having someone that a person that has a problem can really talk to

No

Communication

Money

getting them to the point of stability and keeping them there

Transportation

Helping people stay stable instead of being just clinical or cynical.

Getting people to seek out treatment; many more people are mentally ill than are seeking treatment.

Stigma

Not enough psychologists/psychiatrists for people who need help

Not enough long term hospitals. Not many homes.

Getting them to seek treatment

Diagnosis

More awareness, about mental illness. And learning to recognize mental illness.

Help centers for aid in finding doctors that are affordable and have openings.

Appendix U — Narrative Responses Related to Significant Challenges in Meeting Needs of Those with Mental Illness: Consumer

Availability to those with or without insurance, unknown resources to individuals lacking help, waiting lists.

Location of service

Chemical dependence

Support

Completing the goals you have set

Appendix V — Narrative Responses Related to Other Mental Health Prevention Programming that may be Inadequate: Provider

Responses provided without alteration except for removal of individual and agency identifying information.

Narrative responses to the question
"Please list any other MENTAL HEALTH PREVENTION PROGRAMMING that you feel is not currently adequate/sufficient within Hamilton County"

need to be starting at least at pre-school age to identify early social-emotional problems and therefore intervene earlier.

Many inner city schools have insufficient m h services

Don't know enough about what is going on in prevention programming- perhaps system partners need more communication in this regard.

mental health prevention program for the disabled

social/economic/political environmental supports

home-based services

AoD prevention in the schools is lacking

more volume in schools needed

Peer support services

Payee services, housing, transportation

Mental health provided in Hamilton County continues to lack substance, culturally competent providers and the client and their family is always blame as the reason for a lack of success.

two generational approaches, trauma informed training for professionals - school, child care, children's services

Early childhood mental health and parent peer support.

Appendix W — Narrative Responses Related to Barriers in Obtaining Necessary AOD Treatment Services: Provider

Responses provided without alteration except for removal of individual and agency identifying information.

Narrative responses to the question
"Please list any other barriers that you can think of that serve to prevent individual from obtaining the ALCOHOL AND/OR OTHER DRUG TREATMENT service(s) they need"

Not enough capacity in the system, due to underfunding. The infrastructure is there but operating funds have not kept pace with inflation or need.

again, behavioral health needs to be integrated into physical health - first touch points with individuals, to keep them healthy & well and to ID problems early. This requires a systems change as well as changing the associated stigma.

Limited access

knowing where to get help, having services available right away- including services for family and friends to support someone and prevent relapse after treatment

lack of knowledge of available resources

psychological,legal,cultural access

We only have one detox option, [redacted], and they can be very particular and will ban some people for life for not following rules while in the program.

The people that really want treatment for themselves.

how to maneuver the system

Not enough beds for detox patients

Childcare

having them in the evening hours

limited stay residential programs for opiate treatment.

Child care, knowing where to go, knowing what the options are

Those that use other drugs than heroin can not access treatment because all the focus is on heroin.

The alcoholic, marijuana user and crack user can forget about treatment.

Opportunities for stabilization while waiting for treatment

shortage of drug addictions programs

positive role models

Themselves, we need better early prevention and wrap around services for families prone to substance abuse.

Services are often wait listed with the current heroine outbreak.

Appendix X — Narrative Responses Related to Barriers in Obtaining Necessary AOD Treatment Services: Informed Community

Responses provided without alteration except for removal of individual and agency identifying information.

Narrative responses to the question
"Please list any other barriers that you can think of that serve to prevent individuals from obtaining the ALCOHOL AND/OR OTHER DRUG TREATMENT service(s) they need"

hours of service

Inpatient Rehab programs have long wait-lists. Some users are prepared to enter treatment on the day of their intake. A few weeks later they have begun using again and are either no longer interested or no longer reachable.

Homelessness

Don't know where to turn for resources.

Fear

Long wait times for treatment centers

Denial of the problem

Just the barriers listed.

immediate (and I mean immediate) access; regulatory environment for MAT; lack of residential/work options; lack of court support for diversion but MOSTLY lack of funding for drug addicts who have no source of income except what they steal

You covered it here. Poor access to providers who can help, inability to get into places like [redacted] House or other detox options, just "no's" from everyone in the SUD treatment community, even IF people want help.

Fear of being able to live without the self-medication.

Again, the needs of dually diagnosed individuals who are also senior citizens are often overlooked.

Providers tend to see these folks symptoms and think it is due to physical health issues when in reality it is due to hidden AOD issues

Lack of long-term detox/treatment beds.

Lack of facilities for the higher levels of care

Unlike with individuals living solely with mental illness, there seems to be increased stigma among community members that, when there is substance abuse involved, people "get themselves into that situation" without understanding or being empathic that attempts for self-medication, coping, symptom relief, etc. are also reasons as to why substance abuse disorders are often co-occurring.

knowledge of dual diagnosis treatment among providers

lack of transportation

Appendix X — Narrative Responses Related to Barriers in Obtaining Necessary AOD Treatment Services: Informed Community

baseline Social isolation, anxiety, lack of 12 Step types of visitors that can go to patient

Lack of knowledge about addiction

The treatment system responds slower than emerging trends, such as heroin. There simply isn't space or funding for people to receive appropriate services.

Not enough inpatient/residential treatment options available for patients of all insurance payers.

Need insurance to cover MAT.

Cost of treatment, cost of therapy

Education

Confusion regarding the most optimal treatment models

Collaboration of service providers?

Lack of knowledge about AA, NA, where to go, etc. Lack of knowledge about where to get treatment.

More communication needed.

holistic programming that is supporting mind, body spirit and open to returning when relapse occurs

People being unclear on the process; because even as a professional, I am a little unclear on the process at times

Transportation, support, finding a provider, insurance coverage...i see these every day!

not many services available for youth

insufficient in and outpatient services

the model that endorse moral choices instead of the disease model

family support and education

A lack of patient compliance.

Once again education and knowledge. Most individuals and families do not understand that self medicating with drugs and alcohol is a classic hallmark of mental illness.

need longer stays with more attention to the root problem

Appendix X — Narrative Responses Related to Barriers in Obtaining Necessary AOD Treatment Services: Informed Community

Again lack of knowledge of the system (families and patients)and how to maneuver through. Lack of inpatient for crisis/they have to meet certain criteria for them to keep and if patients 21 + they can walk out (change their mind)even though they are addicted to heroin, unless they voiced suicidal thoughts. Not much in way of support for families who are going through this except if patient is inpatient and they have family group sessions; except for AA which does not always fit the needs of the family . I feel like i am dealing with this "by the seat of my pants" I know very little how to work with this disease and how to approach my adult son and work with him to help him through this. Sometimes I wish I had someone I could call to run through conversations or situations going on...extremely stressful.

Using only AA as an option for recovery when program is completed.

Self delusion is a barrier. Individuals need to acknowledge that they are in need of treatment.

lack of dual diagnosis providers. treatment providers will not take on individuals they view as a "liability" because of co-occurring disorders. Mental health treatment providers and substance abuse treatment providers do not work together as a treatment team.

Not enough inpatient treatment options in the area.

Effective treatment strategies and time to implement them

engagement in treatment

integrative services more fully integrated into programs. Helps with cost, stress reduction, resilience which can help with ability to stay sober.

Again, the individual's belief that he/she does not need treatment - that use of alcohol, tobacco, and marijuana is not a problem

No experience with this.

Dual treatment centers are very much needed.

Not enough treatment facilities

options for heroin and meth addicts-going somewhere everyday does not help them in any way

Homelessness

I have tried to quit smoking tobacco for 10 years, with little help except advice and patch prescriptions from my PCP, and little success. If there was some sort of tobacco cessation clinic around, I think myself and many people would benefit from it.

They don't want the services...in spite of the need. However, if they DO desire the services, I don't know they are readily available and timing could be a huge issue with this sort of thing.

expertise of staff for co-occurring disorders

Appendix X — Narrative Responses Related to Barriers in Obtaining Necessary AOD Treatment Services: Informed Community

demanding IOP for all MAT...

Ham Co Drug Court policies of NOT allowing any use of medically assisted treatment is the BIGGEST barrier for those individuals. Incarceration, mandatory minimum sentences, and years of probation of non-violent, non-trafficking individuals for drug possession is inhumane and prevents individuals from actually getting drug treatment promoting a revolving door at HC Justice Center. Lack of dual diagnoses services (MH & substance use).

Lack of services/treatment available

lack of support and knowledge for MAT

Stigma

Availability of providers

Stigma about AOD treatment, and recognition of the damage these issues cause.

Education re when and how to seek treatment. Too often, it is only the court's intervention that initates treatment

Most treatment centers, unless court appointed, are voluntary and once people begin having cravings, they walk out and go back to using.

There is a limited number of residential treatment centers that are affordable to people who have no insurance.

Support team training - family or loved ones

Accepting they need help

not enough beds available for recovery services

Lack of inpatient treatment centers and halfway houses

Many of our healthcare providers are poorly educated about the dynamics of addiction. They most often tend to be more judgmental of people who struggle with addiction and have no appropriate understanding of how difficult is it to overcome addiction.

Detox and intensive outpatient services, particularly for uninsured persons

These conditions are often very serious and damaging before they are recognized: good community education about addictive diseases (including gambling) would help greatly! Also I fear that the success of self-help groups like AA is blinding the public to the crying need for ALL kinds of treatment. (Disclosure: I'm in recovery myself through a self-help group--but I'm not everybody.)

Not enough clinics and trained individuals, locations of meetings and so forth given to staff who work with clients

Appendix X — Narrative Responses Related to Barriers in Obtaining Necessary AOD Treatment Services: Informed Community

Mental health diagnosis and treatment when younger to help prevent substance abuse use.

Environment

Lack of child care, actively using and not having a place to engage in detox

Early intervention with children and prevention education in schools

Family , Personal reasons

Rehabs only want abusers who are dry. If able to go dry, why search for help. My step nephew died of his addiction because my brother could not get him healthcare It is cases of gross negligence. And it is not affordable for most families

Not enough places that are not self pay to help the individual. People don't have $45,000 for a 30 day stay in a treatment facility.

Peer support, lack of motivation on the clients part, fear of the unknown, and fear of being judged.

The individual can feel that it is not necessary, even when family or friends try to help. They may even be in denial, and will not accept the truth presented to them.

Public awareness and education regarding to co-occurring conditions. As a society, as churches, and as family members we know so little and therefore are unable to make the big difference we could be making.

There aren't enough alcohol/drug treatment programs readily available to said individuals in Hamilton county.

I cannot respond adequately because I did not abuse drugs or alcohol after my bipolar diagnosis in 1998.

Need to treat both the Mental Health issues and the substance abuse.....need special care and well prepared staff.....also TAKES TIME and brief services are not worth anything.

Providers that take insurance, and actual treatment centers that are not either several hours away or in another state. Also, there needs to be sufficient follow-up and day treatment programs.

Inpatient care is needed for dual diagnosed clients. Programs need to manage both and not turn people away because of either disorder being in a relapse.

Appendix Y— Narrative Responses Related to Barriers in Obtaining Necessary AOD Treatment Services: Consumer

Responses provided without alteration except for removal of individual and agency identifying information.

Narrative responses to the question
"Please list any other barriers that you can think of that serve to prevent individual from obtaining the ALCOHOL AND/OR OTHER DRUG TREATMENT service(s) they need"

they provide us with the right and helpful services that's needed for drug and alcohol services

Health

There is no barriers.

access; location;

no insurance, transportation issues, finance problems

I am unable to think of any at this time.

it a good thing

Insurance refusing to pay for medication

Communication

not enough treatment plans

Miss diag.

Abusive environment at home with mate

Their continuation uses of the product

Knowledge of available services

Drub treatment 2004 - Birmingham Alabama

Beds

To be able to understand that service is out there to help. And providers need to be open minded.

There are inside treatment programs but they are actually mills

stigma. Denial

Insurances

Insurance

Insurance

Experience, Knowledge, and honesty

Appendix Y— Narrative Responses Related to Barriers in Obtaining Necessary AOD Treatment Services: Consumer

Insurance

TRANPORTATION

AA MEETING

unavailable treatment medication

(be) quicker to let addicts in treatment, might save lives

Transportation

transportation services

criminal penalties

Seems as if drug treatment is easier to get if in legal trouble

Inside treatment among the groups thats already being instructed

my opinion is not giving up drugs or alcohol

more sponsors with sobriety

lack of knowledge

I don't use drugs, I enjoy them

Shamed, no money, no insurance

making the help available to everyone

Getting treatment for alcohol and drug treatment is key to helping people gt off the streets. It would lessen crime. Reaching homeless people/outreach programs

insurance to cover it

Locations

The treatment providers have no experience in this area themselves. A books education does nothing to help us

I think people of the above matter should be able to go to a place and live with positive people that are really working on recovery and not have to deal with the pressures of other current using addicts.

The need must be their first with the person who seeks help

Not enough places to detox, rehab is too expensive and can't afford it

Waiting to get into a place for help. Transportation. Having medical coverage.

Denial

Worrying about criminal proceedings after asking for help

Appendix Y— Narrative Responses Related to Barriers in Obtaining Necessary AOD Treatment Services: Consumer

Insurance. Not enough treatment places.

Information

More education

Wait lists, lack of doctors, lack of insurance, cost of low side effect medications or ones that may work better for someone than others.

Waiting list. People who are forced, and take up space.

Waiting lists, availability, educations towards addictions/alcoholism, “requirements” to get in certain facilities.

Location and knowing availability

Appendix Z — Narrative Responses Related to Significant Challenges in Meeting the Needs of Individuals with an AOD Problem: Provider

Responses provided without alteration except for removal of individual and agency identifying information.

Narrative responses to the question
"What do you believe are the most significant challenges in meeting the needs of individuals within Hamilton County that have a drug or alcohol problem?"

awareness of how and where to get help, transportation, stigma associated with substance use

available access for immediate admission; some of the challenges are a symptom of the disease- leaving treatment early, no show for appointments or admission- all attributed to "not thinking".

make it a priority to treat this disease like any other chronic disease - that means from a health insurance perspective, from a physical health perspective - one goes to the dr, who assesses the pt, who then refers to a specialist if needed, who then manages the chronic disease moving forward.

Improving access which must be same day

Providing intensive services to individuals who are not ready for treatment, which takes away services for those who may be more motivated. Need more engagement programming.

Addressing the heroin epidemic

the disease itself, willingness to engage in treatment, allow for relapse and then meet the person where they are, community perception and even the word "addict"

too many to serve at this time due to herion epidemic

lack of community education about mental illness, stress management, and coping skills; we glorify negative coping skills in our culture, so we have to actively and intentionally correct this with education

not enough treatment providers

economic/psychological/cultural/social human development determinants

means of communication to contact for services

The severity of the addiction, particularly opiate addiction. Also, a lack of detox facilities.

Transportation for treatment

Admitting to themselves they have a problem.

Lack of a coordinated response to the heroin epidemic

Treatment/inpatiant

access to MAT

Appendix Z — Narrative Responses Related to Significant Challenges in Meeting the Needs of Individuals with an AOD Problem: Provider

A great need for detox and long term residential and IOP services.

Wait lists for beds for detox program

Lack of funding

Having quick access to treatment, when people are ready to seek help

Need more MAT that is available when people are ready...however that is also difficult in regards to the careful assessment procedures that are required.

getting clients engaged in treatment, transportation to and from treatment

Providers that do not offer or follow 'best practices' offer limited help and create ‘repeat’ admissions

Inadequate funding, lack of licensed clinicians, increasing administrative complexity

Advertisement as to how to access services of agencies without marketing budget.

finding treatment

Public stigma and lack of understanding, poverty and lack of self sufficiency, lack of access to adult mental health.

homelessness, poverty, jail overcrowding, access to quality services, the complexities when combined with opiate addiction

Care coordination

inpatient progrm services

showing them their is life without drugs

The lack of families and social circles truly isolates a person's ability to quit or avoid chemical dependency.

Police are overwhelmed with heroine issues. Social workers don't know how to properly deal with users and drug dealers.

Treatment methods. Harm Reduction is a universally acclaimed method of treating substance abuse and it is not practiced nearly enough in our community.

People who do not want help or are not ready for help. Relapsing due to not being able to get away from situations that got them into substance abuse in the first place. They need more follow up.

Appendix AA — Narrative Responses Related to Significant Challenges in Meeting the Needs of Individuals with an AOD Problem: Community

Responses provided without alteration except for removal of individual and agency identifying information.

Narrative responses to the question
"What do you believe are the most significant challenges in meeting the needs of individuals within Hamilton County that have a drug or alcohol problem?"

wait list

Shortage of treatment services

Varying philosophies

Accessing services

People with no ins, hospitals not caring or sending them out the door when they are begging for help.

Sickness from getting off the drug/alcohol so they keep doing it to prevent sickness.

No beds available

The lack of funding and the lack of facilities to treat.

Lack of treatment on demand.

funding, culture change to believe it is an illness; changing the criminalization of drug use

Money to pay for the services.

To few providers and places to go, inordinate expense of methadone and suboxone treatments Encouraging people to ask for help early enough before the self-medication turns into addiction or worse.

Stigma

Lack of long-term detox/treatment beds, followed by consistent wrap-around services to help maintain sober/clean self-sufficiency.

Insurance and lack of residential facilities equipped to de-tox individuals. Not enough residential facilities to meet that level of care for youth.

Prognosis of individuals with substance abuse history is a big challenge, with individuals often not wanting help or relapsing. Stigma is a huge factor here anecdotally.

Access to treatment services, especially in areas that do not have sufficient access to public transportation and do not have much of a provider footprint (Harrison, cleves, etc.) a greater amount of individuals in need than what the county is able to serve; stigma with accepting help that's available

court assistance, such as drug court offers

lack of beds, lack of adequately supervised/trained staff

Appendix AA — Narrative Responses Related to Significant Challenges in Meeting the Needs of Individuals with an AOD Problem: Community

reimbursement rates

See previous response.

Resistance to heroin maintenance drugs like suboxone and lack of access to providers.

Not having enough treatment options.

cost of treatment and therapy

Education money and Facilities to treat them

Recognition of resources available.

See above

The drug/alcohol problem manifets from self medication. So treating the problem will help with dependence problems.

Access to care, cost

Treatment agencies “dump” clients from inpatient programming for various reasons (e.g. Not having 30 days of mess, having too severe of a medical condition). Clients are provided with no assistance to address these problems so that they can comeback and become discouraged and then are less likely to come back.

Difficulty in remaining sober while living in previous environment with triggers/temptation all around self awareness of patient, available providers, support

finding realistic and effective ways to combat heroin epidemic

ongoing support other than AA

keeping them involved in programs, educating families on how to support and encourage them, and support for families

A lack of patient compliance

money for services

paying for treatment/finding enough facilities to treat and providers. Support for families dealing with this horrible epidemic

Short recovery programs

Treatment is needed rather than jail time. Drug courts might offer alternatives to incarceration. Once an individual has a record, it diminishes opportunities for employment and self sufficiency.

Access to treatment at an appropriate level of care. Lack of dual diagnosis treatment beds. Waiting lists. Affordability. Limited secular options (not faith-based treatment). Lack of stable housing preventing engagement in IOP / PHP's

Appendix AA — Narrative Responses Related to Significant Challenges in Meeting the Needs of Individuals with an AOD Problem: Community

heroin addiction

Access to care.

Funding ANDknowledge of what workd

engagement in community and family change necessary to prepare the client for safe return from treatment.

Education of their specific situation

Cooperative education and therapy to encourage the addict to seek rehab and follow up.

Personal accountability and family background? Fear of “drug addict” stigma.

the increase of drugs and not enough caregivers.

Ongoing support post-rehab

alternative options for heroin and meth addicts

The lack of coordinated care that is available and affordable.

Immediate access to treatment. Incarceration instead of treatment.

The availability of alcohol and drugs in the area. For example, if we want to get serious about alcoholism, we should not be offering it at every restaurant, every corner store, etc.

Stigma

Financial and stigma

Getting them to participate and availability of services.

Prescribers

quick access to quality care

Not real world tx

See above comment.

Lack of any type of treatment

Buprenorphine availability - at hospitals, MH Agencies,

See above.

stigma, denial

There are not sufficient resources for the numbers afflicted

An inability to get people stable to continue treatment.

Not enough funding for people without insurance to obtain treatment.

Appendix AA — Narrative Responses Related to Significant Challenges in Meeting the Needs of Individuals with an AOD Problem: Community

Convincing the individual that he/she needs help.

Many People with drug and alcohol life styles are not able to stop using. Detox is painful and recovery is usually very slow. The combination of physical and mental discomfort and pain makes it very difficult for individuals to persevere.

Individuals accepting their drug or alcohol problem is not short-term, it is a life-long commitment, and preparing a recovery plan.

Compliance and willingness to seek treatment.

Available resources lack of communication outreach

Resources. The county is overwhelmed.

The caseload

The individual being able to identify they need help.

Not enough treatment programs, cost of treatment and lack of public knowledge about the illness of drug/alcohol addiction.

Need more inpatient drug and alcohol rehabs! Not just more but more importantly high-quality treatment centers. I have had to seek rehab treatment in 3 places OTHER THAN Cincinnati because of no excellent treatment centers or none at all. [redacted] is terrible! [redacted] is good for acute short- term help but insurance is a problem there - not many ins plans accepted and again it's not a proper 28, 30 days or longer facility

Lack of availability to treatment in general, especially medication assisted treatment.

Getting the patient to agree to treatment is the most significant challenge, followed by inability to provide immediate treatment due to waiting lists

Waiting lists and sometimes a bureaucratic system that is necessary for people to navigate. If the process to gain access to treatment were easier to understand, I believe more people would be inclined to seek help.

lack of services from detox, to inpatient, to intensive outpatient, to outpatient and then regular follow up. There needs to be a continuum of care and a gradual step down process

instant access to support by phone or internet to interrupt a temptation to resume use

Access and lack of resources

Recognition by people, families, and community that addictions are diseases and not voluntary choices. Lack of treatment resources and the ability to afford them (addiction treatment in all forms should also be covered by insurance companies.) More education about medication assisted treatment--and research into something like Vivitrol for alcoholics! General increase in the quality of community life, which for some people doesn't compete with the quality of a high.

Appendix AA — Narrative Responses Related to Significant Challenges in Meeting the Needs of Individuals with an AOD Problem: Community

Easy access to treatment

environment, housing, family support and education

Lack of insurance, limited access to MAT programs

The amount of families impacted by drugs and alcohol who do not seek services

Stigma, Denial

Not enough beds in facilities. Facilities not taking in addics who have active problems.

Access to services due to inadequate provider numbers for AoD services.

Cost

Need continued support after rehab sometimes long term

people wait until they are court ordered to get help, jails get overwhelmed with addicts instead of sending them for help, the clients go to jail,

The facilities that handle these patients are sometimes located on the fringes of cities, making the residents become critical of having these patients around. The idea of keeping these facilities closer to hospitals, and doctors offices may be a better idea.

Cost of treatment, and lack of case workers and programs

Stigma attached to “alcoholics” or “drug users” is similar to demonization under Prohibition or current War On Drugs. I propose treatment on demand.

Fear of legal repercussions when seeking help

medications, housing, easy access, transportation

Same as for mental illness.

lack of providers/clinics

Affordable inpatient care. For adolescents and adults in the middle class

Lack of treatment facilities for the heroin epidemic

Appendix BB — Narrative Responses Related to Significant Challenges in Meeting the Needs of Individuals with an AOD Problem: Consumer

Responses provided without alteration except for removal of individual and agency identifying information.

Narrative responses to the question
"What do you believe are the most significant challenges in meeting the needs of individuals within Hamilton County that have a drug or alcohol problem?"

it's a struggle but if you use your researches then it's possible to recover with the services they provide

the dispair of loneliness, hopeliness,desperateness most likely play so many sad roles to the effect.

getting off drugs some do and i don't

The help is there.

not enough treatment centers

health problems, homelessness, no finance status, not employed

staying clean

Wait lists for treatment, dealing with homeless population, dealing with the children affected by the disease

spotting the problem

complying

inadequate number of treatment facilities for women

Yes

lack of treatment, sheriff release jail too much, too quick

finding out What they ben thru and listen to them

Not enough rehabs

go to aa meetings

housing and mental counseling

encouragement to change for the better

Need more health programs for people that is having a problem with drug and alchol programs getting individuals to be willing to seek help

Drugs and alcohol itself, then the individual

They have to want it not just try. if you want it you have half the battle done

I wouldn't know cause I don't have that problem

insurance

Appendix BB — Narrative Responses Related to Significant Challenges in Meeting the Needs of Individuals with an AOD Problem: Consumer

Insurance

Instead of containing utilizing funds and people skils to help

Stigma

Cost of medications to decrease cravings, limited access to inpatient treatment

Peer support

must be met over and over and calls for patience

GOING TO A TREATMENT FACILITY WERE IN THIER NIEGHBORHOOD

NOT BEING ABLE AFFORD IT

Stop using

willing to deal with a problem even after the constant withdraw of some individuals

Awareness and drug laws

not quick enough

A large pool of clients with a lot of different problem sets

Getting to treatment

criminal pentalies

People not knowing about the programs or not seeking help

cost of program

ease of access to services

waiting lists

Identifying them

criminal penalties

I would guess more suboxone/methadone providers

Rehabbing

giving it up

more housing

knowing what a individual is able to grow from that will power or press to do better knowing life gets better

lack of knowledge

making the help available

Appendix BB — Narrative Responses Related to Significant Challenges in Meeting the Needs of Individuals with an AOD Problem: Consumer

Access to services, accommodations that are not desirable/equal to others. Judgment on the part of the community and even health care professionals.

Unless the person has insurance or gets in trouble they have a hard time getting help with their problems.

making the help available

not enough medicated detox facilities

waiting lists and costs of treatment

feeling the courage to get well

too few locations

Focusing on some of the good. Choosing battles. And not expecting so much out of us because it makes us feel like shit

Negative people in controlled environments. Clean people should have the choice to be with other clean people.

Yea

Communicating with the clients

Money

more detox programs

Shorter wait lists. Finding a Dr.

Getting the afflicted to seek out help.

Stigma, fear, lack of judgement-free places

Getting the people that want in a group setting

Waiting list. Not enough medically assisted detox. Cost.

Beds, insurance

The court system leading people to jail instead of treatment

Diagnosis

Once your clean maybe more rides to AA meetings. Or have an AA meeting at the treatment center for outpatients. More directions.

Removing fear of punishment.

Advertising more resources/educations the public as to what kind of help is available and how to receive it.

Consequences

Appendix CC — Narrative Responses Related to Significant Challenges in Meeting the Needs of Individuals with an AOD Problem: Provider

Responses provided without alteration except for removal of individual and agency identifying information.

Narrative responses to the question
"Please list any other ALCOHOL OR OTHER DRUG PREVENTION PROGRAMMING that you feel is not currently adequate/sufficient within Hamilton County"

accessible medically assisted drug treatment, both in patient and outpatient

needs to be part of everyday healthcare. it's not so much about where it is taking place (ie. afterschool or summer), but how is it part of our systems - it should be part of health education curriculum, it should be part of any well baby check-ups or adult annual physicals.

Inadequate training for teachers in this area

prevention services for the disabled

social/psychological/economic developmental supports

case management

See above comments about lacking detox options.

The use of AA and NA

need more school based services

Peer support services

"Wet housing" such as the [redacted]

90 day stay for Opiate users.

Culturally competent services for all of CPS; the number of Cincinnati schools served is to small. Most prevention services are taken to Norwood, Glendale and other safe suburban schools.

Support for families and children

in patients drug programs

Appendix DD — Provider Narrative Responses for Ideas to Enhance Care

Responses provided without alteration except for removal of individual and agency identifying information.

Narrative responses to the question
"What ideas do you have for the Hamilton County Mental Health & Recovery Services Board that would enhance our Hamilton County system of care?"

More outreach via media and community outreach

transitional housing accepting buprenorphine

integrate services with the hospital systems

Better funding for AOD

more prevention services for young children in preschools and early care programs

Provide training, or funding for training, in evidenced based practices.

Fund peer support and prevention initiatives

Increase communication and systems planning, Increase attention and focus on recovery and helping the community understand recovery and how to foster it, Increase attention to preventing early childhood traumas- perhaps not by doing the work but reinforcing community collaborations

more psychiatry

Reward excellence. Redirect agencies from bottom line thinking. Foster creativity and collaboration. Recognize and support people and agencies who are in this work for the right reasons. Avoid placating those who keep the system mired in the status quo. Imagine your family members as the ones who would have to receive the services you are supporting, and make that your standard of care.

Continue to advocate for more treatment dollars

need for more recovery housing

Now that a lot of effort is on heroin epidemic care need to be made that other drugs are not ignored

Continue to track outcome to see where progress are being made and where more work needs to be done

Training for providers

Focus on social/environmental/economic/political/community (rather than intrapsycic)determinants of human health

enhance the ease of contacting agencies by phone and also means of transportation

Appendix DD — Provider Narrative Responses for Ideas to Enhance Care

An integrated, electronic health record.

More prevention in the schools for AoD and for MH treatment. Community based prevention for children should be increased. Help children that do not have US documentation.

More treatment facilities.

better coordination of care for youth

Invest in longer term care.

To have more agencies that provide detox care

More collaborative inclusion. The same “favored” providers are included in decisions.

More funds for detox, residential treatment, and ancillary services (peer support, transportation, childcare). Also, higher rates of reimbursement for service so that licensed professionals can earn a living wage and others will be more likely to enter the field.

Need more family support programs.

Continue to communicate new ways to impact the entire array of needs of our clients; education-vocation, housing, transportation, etc. Keep open to ideas/suggestions

More ease of fee agreement process to access services, better sharing of information between board and agencies

This is an outstanding organization with staff that is really responsive to the providers.

The commissioners need to understand how this organization work to meet the needs of the community.

MH and AoD workforce training/development/retention. Trauma informed care and evidence based practice training. Prevention services, family oriented multi-generational approaches. collaboration across organizations.

I realize there is only so much funding for mental health services which in turn dictates the majority of funding goes to care of clients. This results in not enough funding for staff at most agencies. Mental health workers have large case loads which cuts down on time that can be devoted to their clients. This is a major complaint I hear from both care support workers and clients.

Care coordination

independent living programs coupled with drug support programs

keep embracing them too seek help

Appendix DD — Provider Narrative Responses for Ideas to Enhance Care

Improve case management agencies, some are either slow and ineffective, others have high turnover and are over worked.

I think we need more housing for those who are recovering. Yet, I think we need housing in which social workers give around the clock care.

Mandate system wide changes to treatment approaches incorporating Harm Reduction techniques.

Increase the permanent/transitional housing stock.

There is a high turnover in case managers. There needs to be something done about that. It could mean hiring more people even if it isn't for more money so people are not as stressed, lowering case loads, having more defined roles such as some people doing things like getting basic documents, one person taking people to the doctor, etc. Or it could mean just looking at what case managers are being asked to do and find alternative ways for some things to get done, such as create another agency, partner with another agency, etc. Also, clients may need to be held more accountable in some ways. If they are getting treatments or services maybe if they are able they should be required to do some volunteer work, etc. Or if they cannot live independently they need to take a class on how to live independently before they get put in another unit. I think there needs to be a lot more education on the front side rather than on the back. Also, hiring the right people for the jobs.

Concerted effort for full communication and collaboration of all service providers.

Appendix EE — Informed Community Narrative Responses for Ideas to Enhance Care

Responses provided without alteration except for removal of individual and agency identifying information.

Narrative responses to the question
"What ideas do you have for the Hamilton County Mental Health & Recovery Services Board that would enhance our Hamilton County system of care?"

add services

More collaboration with emergency assistance providers

A toolkit for those looking for treatment

Have clinics available to help people that are homeless, with no ins get the help they need so they can become productive members of the community some day and help others as they were once helped.

Allocate more funding (somehow). Pay workers more so the turnover rate is not so high.

More funding and day activities

We need more doctors.

More & better quality treatment facilities

I don't think it's your fault that the state budgets have dried up to the point you can't get anything done....

Workshops on "getting help" -- what's my first step to getting well?

A true centralized assessment center staffed by the most skilled clinicians to set the course of treatment rather than the current staffing of the systems at the agencies with the new grads.

MORE FUNDING TO PAY FOR MORE SERVICE/TREATMENT OPTIONS AND PROVIDERS.

County funded non profit facilities for youth and transition aged youth that can meet any level of care need. Partnerships with community agencies with incentives to establish programs that can meet all levels of care.

These surveys are extremely helpful in feeling heard. Also, ideally, it would be extremely helpful to have a centralized location with links to resources, how-tos on finding care, provider & organizational referrals, ABCs of insurance/medicaid/medicare, etc. Also, in the surveys, wouldn't it be helpful to ask for racial/ethnic demographic information?

invest in building capacity for family systems work with local providers including in-home and intensive in -home services, investing in resources to support agencies developing competencies to treat trauma, and improved funding for residential, crisis stabilization and supportive living for youth to increase the ability of programs to hire and retain more qualified staff.

Appendix EE — Informed Community Narrative Responses for Ideas to Enhance Care

First, better websites for all the agencies, [redacted]. Invest more money, engage more mentorships for CMs whose jobs are still untenable until caseloads get reduced. Exert political and public pressure on [redacted] to increase # psych beds. Use the media more to get out info to public re MH services here

fund prevention services

The community REALLY needs a facility to provide step down services after a crisis hospitalization or for a person who is chronically ill and unsafe but isn't able to be admitted at a hospital and doesn't yet need [redacted].

My feeling is that there still exists a huge chasm between substance treatment and mental health services. People bounce between the two, and I believe they could be better served by a more integrated system.

Push for single payer health care. Education of the public to reduce stigma. I've found NAMI, especially NAMI Ohio and the Treatment Advocacy Center to be good resources.

Looking at the cost that substance abuse and mental health costs the system, in particular inpatient hospitalizations (specifically with heroin use), comparing this to cost of providing adequate and available treatment and lobbying for money to get ahead of the problem instead of always just putting a band aid on it. My guess the medical issues alone from the heroin epidemic is way into the millions in single hospital systems. I think there needs to be a collaborative effort between all systems so that the biopsychosocial needs can be effectively met. For instance, many patients who are admitted to the hospital with issues as a result of their heroin use require medical treatment that substance abuse facilities cannot provide. Patients are often then left without substance abuse treatment until they have recovered medically and often by this time, they are out using again. The only way to treat this problem is to provide holisitic care for medical/mental health/substance abuse within one system that can communicate and collaborate to meet all of a patient's needs.

Better insurance coverage for therapy and medication

Water treatment facilities and more money an education

More psychiatrists, more providers that accept medicaid, more wraparound services for young adults/employment assistance and training

Increased funding

More information about programs, services, etc. to relevant community groups (e.g., schools, churches, etc.).

more providers that work nights & weekends to provide care for workers

Getting more information out, by whatever means: public service announcements; literature available at popular locations.

low cost ease of access

Appendix EE — Informed Community Narrative Responses for Ideas to Enhance Care

Increased harm reduction programming, not dropping clients from programming after a relapse---it's the time when they most need our support!!!

Some kind of transition program from hospital to community, especially if hospitalized for medical reasons but needing to start detox/MAT right away

Clearly more funding would help. Reaching out to those that work with these individuals would help.

More prevention dollars for youth and AoD issues. More prevention efforts with children 0-5 years of age. More focus on trauma issues.

Partnering more with Hamilton DD Services. And looking at what are other ways to leverage resources to better meet the needs of the community

Heroin czar for Hamilton County

I think offering more support and education to families who care or house their loved ones is so very important. Families need to understand the illness, know how to intervene, understand how to work w/insurance and multitude of costs. Families need support to then best support those they love most. This is not happening and it saddens me. I spent almost 40 dys watching my daughter in an inpatient setting and NO ONE would offer any information on how I can best serve her while inpatient and once she came home. Was so disappointed in the lack of support. My daughter readmitted within 3 wks inpatient.

Court ordered treatment

more centers for meds

Providing open sessions for those dealing with this to come and talk & providing educational sessions

More services for youth.

6 month program at minimal

More edubation

More longterm case managers who are adequately trained and compensated. It is my opinion that turnover is a result of low pay and poor support by the agencies who employ them.

Promote employee satisfaction of case managers. Create and market greater incentives for med students to engage in this community and specialize in psychiatry. Fund dual diagnosis programs, housing first models, and promote access to medications through enhancing availability and decreasing wait times.

more people to helop

More providers that focus on Harm Reduction, and training current providers in Harm Reduction tactics.

Good quality and knowledable staff and FUNDING

Appendix EE — Informed Community Narrative Responses for Ideas to Enhance Care

Engage in the systems approach and provide routine opportunities for interagency collaboration and specialized supports. Engage communities in recovery orientation model work to support change to the initial environment clients return to during and after treatment. Support training efforts by cost sharing

The lobby of [redacted] on [redacted] is a zoo that only serves to exacerbate serious illness. Reality television blasting an overly filled waiting room does nothing to help anyone, in fact, it contributes to a nightmarish setting.

add integrative modalities to all programs.

transportation assistance, outreach

Better education about reasons behind drug and alcohol abuse. Increased awareness of available services.

Improved communication, market the services to the public, public service announcements, regular Mental Health visits to Talk Radio; provide statistics to make the public more aware which in turn will improve communication of the services available.

working together, listening to those who struggle with mental illness and having them part of developing the care system. Many of the people who struggle with mental illness are very intelligent, are willing to talk about medication side effects, able to be a gift to our society and want to take part in their treatment plan.

One phone number to call in acquiring services

if the underlying issue of the drug and alcohol use is not fixed first then they will never recover Better understanding that the mental health symptoms a person may be experiencing are the very reason's patient may be unable to reach out for or maintain mental health treatment. Instead of closing their case, I believe an increase in wrap around services are needed to assist with keeping the patient engaged in mental health services.

Not familiar enough with the board to know what they are engaged with. I am on another county MHRS board.

Help for people trying to quit tobacco addiction, and perhaps a fresh advertising campaign to try to reduce the stigma associated with living with a mental health diagnosis.

Education to reduce stigma

prevention whenever possible. Family involvement and intervention whenever possible.

be more visible in the community, share what resources are already in place, and ideas for the future on how to bring about needed change

offer door to door pick up with child care

Appendix EE — Informed Community Narrative Responses for Ideas to Enhance Care

Please, please, please MANDATE that [redacted] in the [redacted] ALLOW medically assisted treatment for opiate abuse; MANDATE no more "therapeutic incarceration" (that's what [redacted] calls it!!) by [redacted] for individuals with non-violent, non-trafficking drug possession charges; MANDATE no more years of probation for these individuals (who can't use medically assisted tx per [redacted]) creating a revolving door for years(incarceration, release, relapse, probation violation, incarceration, on & on increasing the odds that the person will die. Advocate also for lessening the criteria for expunging felonies so that people can become employed!!

more services

[redacted] needs to be led by licensed therapist, not volunteers.

train and support MAT at every level of MH and AoD Tx

More connected system of care. Less middlemen ([redacted]) and more providers. Greater access to care. More residential and hospital based treatment. Telemedicine and other non-office based treatment options. Better training for lower level providers.

See previous response about [redacted] health care.

Add additional in-patient facilities, out-patient clinics, and satellite services in homeless shelters.

Education through advertisement, ads, speakers, something in the schools/curriculum for everyone!

easier/cheaper access to suboxone or methadone treatment

Recovery centers need to be closer to or within Hamilton County.

Support and make full use of those trained in Mental Health First Aid, [redacted], Prime For Life, all evidence based programs offered through non-profit organizations. Use evidence based prevention programs such as the one our group ([redacted]) offers free of charge to area schools - [redacted], addressing self-acceptance and self-esteem.

We need to find the funding to be able to help a person through the system (case manager) so that they receive excellent care without duplication of efforts. Also, it seems that the county is focusing on the heroin epidemic and forgetting those that need mental health help who do not do drugs. Disband this board and get people in charge who can think creatively. Why should psychiatrists have to leave their patients and come to [redacted] to wait around and testify? Who serves who? The Probate Court thinks the system revolves around them. No way! Other states know how to do this. Why can't we?

True parity in insurance coverage. Community mental health services that are readily accessible. Training of more mental health specialists.

More high quality care OTHER THAN [redacted]. The quality /level of care there hS really gone downhill over the past 2 years.

Appendix EE — Informed Community Narrative Responses for Ideas to Enhance Care

they need more recreational places for the metally ill to meet and have friends. That would help the depression !

More funding for treatment programs and professionals to staff them would be a great first step

We are in tremendous need of education across the community, from healthcare providers, to insurance companies and the citizens of the community.

Build relationships with employers so that they understand the similarities between physical and mental health disabilities and can be proactive in hiring in accordance with ADA

Improve and increase available resources.

Advocacy with insurance companies to provide coverage for mental health services. Advocacy with the residents of Hamilton County for more resources (why is it that the developmentally challenged have so much more money allotted to them per capita?) Enhancing case management services for people of all income levels. Close collaboration with private and not-for-profit agencies, as well as community resources including the Black Church, in helping people into appropriate treatment. EDUCATION (All I know about medication assisted treatment I learned from the Enquirer!) General community visibility (perhaps a fundraising walk or other benefit event.) Finally, NAMI is fighting the same enemy and seems a perfect partner.

Better training by police officers, more understanding of mental health issues. More clients, social workers

Prevention, earlier detection, education for schools and families and mental health screenings in schools.

increasing services on all levels

Collaboration between agencies to work together to reduce opioid use/abuse

More funds available for prevention and education

More places to get gov sponsored meds. More than the few available now. More practitioners accepting gov insurance.

More funding

Better funding for long term rehab care versus prison system

Improve awareness and accessibility to services.

after clients reach a point in their care, they could be responsible, by making pamphlets for others, greeting cards, phone calls, to help other people, when people are needed, they feel more motivated to get better, letting clients earn something for hard work in treatment could help

Appendix EE — Informed Community Narrative Responses for Ideas to Enhance Care

These patients need a lot of help, particularly if they have been hospitalized. Some need job training and job placement, others need help to make their way through the maze of government programs available to them.

Tell the stories. Stories reach people in a deep way and can be educational. Let's get real. Let's have the conversations we need to have in the public squares and in schools and ultimately around the dinner table.

Better funding for programs, and funding for facilities.

Respect creative ideas from high-functioning people in the community. I have seven years of college, but I still face significant challenges in life. As NAMI likes to say, "We are in this together until we win."

give more money and training to the workers.....reduce the big salary people at the top

Increase residential treatment and non-residential treatment centers.

Long term residential care for dual diagnosed

Expansion of treatment facilities for heroin recovery, Safety net for those who are not actively suicidal but who need short term intensive services, Expansion of financial help for families with private insurance who have very high deductibles

Appendix FF — Consumer Narrative Responses for Ideas to Enhance Care

Responses provided without alteration except for removal of individual and agency identifying information.

Narrative responses to the question
"What ideas do you have for the Hamilton County Mental Health & Recovery Services Board that would enhance our Hamilton County system of care?"

the services that are provided are good enough unless the carriers believe they need improvement

I Need it HELP me

better health education

keep fair housing drug free

You are doing everything necessary.

hire more people that's been through addictions and have been to school for canceling

to pay more attention to people in need

I do not have any ideas for the board at this time

doing the right thing

Programs that allow single fathers to bring their children

having a sit down

more services

try to understand everybody and help them out

To get more help with mental health issues and people to work in the field more.

More awareness to this group

community service programs that work with the court system to help recovering addicts get thru the legal system and finical obligations

continue you services and concepts for the better changes

More education of the general public. Education of employers who may be able to help at the onset of a problem.

Need more health services for the mentally illness

Some places (in) Hamilton County are rundown and the providers are rude and don't care about one's time and conversation.

more funding

more advertisement

Appendix FF — Consumer Narrative Responses for Ideas to Enhance Care

knowledgeable providers

Make craving medications more readily available

Greater Cmgmt

Great service already

more financial aid for some services

Ask more detailed opinions of addicts in recovery. It like one treatment fits a whole lot of addicts.

keep working program

Transportation

For me personally - some type of mentor program. A role model that I could spend some time here and there to learn to live life the right way to assure I am (or not) heading on the right path

activities, recreation

Giving transportation within a day

Put the resources out in the open more to know what (is) available to help the need of the clients

more one on one counseling

None. I think everything is done okay

Having simple lists available to clients w/ psychiatrists who are taking new patients, narrowed by specialty, location, and insurance accepted; more communication and collaboration between the county MH agencies. More support for family members of people w/ MI (support groups, classes on how to manage some of the challenges).

making sure everybody can afford it

less of a waiting list

Advertise

more providers

To actually listen to clients when they say theirs a problem with a counselor. We actually want help Home checkups for addicts or alcoholics, proper care and study of medication before giving it to a patient.

Different types of mental health groups

have people who really cares about people

Communication skills

Appendix FF — Consumer Narrative Responses for Ideas to Enhance Care

Lowering prices, more detox facilities, actual help from people who carr

get commissioners to OK more detox centers and transitional housing.

Try to listen not condemn. Be nice unless very other extremely warranted

Provide more treatment to drug users and the demand will fall. Spend less on enforcement and more on treatment.

More people to help

Income based clinics or treatment facilities.

Higher more people that actually care

More commercials, information saturation

More about recovery

More availability to care. And a group based AA meeting at center

More beds.

More funding

Increased access

Send clients to Prospect House

Housing