



**Butler County
Mental Health & Addiction
Recovery Services Board**

**STRATEGIC PLAN
2016 - 2018**

Dr. Scott Rasmus
Executive Director
Fairfield, Ohio

Prepared by

**BROWN CONSULTING, LTD.
121 N. Erie Street
Toledo, Ohio 43604**

January 2016

TABLE OF CONTENTS

	<u>PAGE</u>
I. INTRODUCTION	1
II. METHODOLOGY	2
III. MISSION AND VISION.....	3
IV. STRATEGIC PLANNING ASSESSMENT	4
PREVALENCE DATA REVIEW	4
FOCUS GROUP, INTERVIEW AND SURVEY KEY STAKEHOLDER INPUT	10
RECOVERY-ORIENTED SYSTEM OF CARE SELF-ASSESSMENT (ROSC) RESULTS	23
OHIO BEHAVIORALHEALTH RE-DESIGN – MOVING FORWARD.....	27
SUMMARY AND RECOMMENDATIONS.....	31
V. MASTER STRATEGIC PLAN	34
LEADERSHIP.....	35
FINANCE.....	37
PROGRAMMING / SERVICE DELIVERY SYSTEM	39
QUALITY IMPROVEMENT / RESEARCH.....	42
INFORMATION TECHNOLOGY.....	44
ADVOCACY / PUBLIC RELATIONS	45
VI. ADDENDUM.....	47
A. Key Community Stakeholder Participant List.....	48

INTRODUCTION

The Butler County Mental Health and Addiction Recovery Services Board (BCM HARSB) is the statutory planning authority charged with responsibility for planning and implementing a system of mental health and addiction services within Butler County. In September 2016, the Butler County Mental Health and Addiction Recovery Services Board engaged the services of Brown Consulting, Ltd. to conduct a successful planning process culminating in a Three (3) Year Strategic Plan. The planning process includes an assessment component that results in the identification of initiatives and priorities to guide the completion of a three (3) Year Strategic Plan. The following objectives form the basis for the assessment phase of the planning process:

- Objective 1:** Review Strategic Plan to determine current status of plan. Complete an industry scan with respect to State / National Healthcare reform and impact on Board funding.
- Objective 2:** Inventory current addiction recovery and mental health system and review local data to determine trends and patterns in service utilization. Profile and trend Butler County utilization patterns.
- Objective 3:** Review the current capabilities and continuum of services within Butler County available to support priority target populations (i.e. service availability, access and gaps).
- Objective 4:** Identify the perception within local government, the professional community and consumers concerning current service delivery system capabilities and future needs.
- Objective 5:** Complete Assessment / Evaluation and provide planning recommendations prioritizing strategic needs within Butler County based on assessment.
- Objective 6:** Update Strategic Plan based on Assessment / Evaluation results.
- Objective 7:** Present updated Strategic Plan to include target service and structure priorities, resource requirements and budget.

METHODOLOGY

An interview / research method approach was employed by Brown Consulting, Ltd. to complete the Butler County Mental Health and Addiction Recovery Services Board three (3) year Strategic Plan assessment. In order to achieve the primary goal and objectives defined for the Strategic Plan, the following approach was utilized by Brown Consulting, Ltd.

PHASE I — PROJECT PLANNING

- Collaborate with Board Executive Director to ensure the addiction recovery concerns / needs of the BCMHARSB are embodied in the update Strategic Plan. Develop project schedule, identify stakeholder participants and confirm deliverables.

PHASE II - ASSESSMENT

- Complete industry scan to include a review of local and state addiction recovery planning documents meaningful to this project (i.e. political environment, state budget, healthcare reform).
- Complete review of current addiction utilization trends / patterns of service providers.
- Review BCMHARSB Service Delivery System resources / service capabilities and performances.
- Conduct interviews and facilitate focus groups with mainly addiction recovery stakeholders to gain subjective view and perception of services capabilities future needs within Butler County:
 - Butler County Mental Health and Addiction Recovery Services Board
 - Health / Helping Professionals
 - Criminal Justice
 - Local Government
 - Service Providers
 - Consumers
- Conclude on analysis. Articulate analysis to result in the identification of new or ongoing initiatives, priorities and resource requirements to guide the development of the service delivery system and update the Strategic Plan.

PHASE III — STRATEGIC PLAN REVISION

- Using the results of analysis, collaborate with Board leadership to revise / update Strategic Plan to identify:
 - Priorities (population / services, etc.)
 - Strategic Initiatives
 - Goals and Objectives
- Present updated Strategic Plan to Butler County Mental Health and Addiction Recovery Services Board Governing Body.

MISSION AND VISION

The BCMHARSB Board of Directors completed an update and approved the organization's Mission and Vision Statements during a Board Meeting in 2015 after the merger of the two boards. The BCMHARSB's new Mission and Vision Statements below articulate its current purpose, the nature of its "business" and moving forward, what the addiction and mental health services organization aspires.

Mission Statement

The mission of the Butler County Mental Health and Addiction Recovery Services Board, in partnership with the community, is to provide a comprehensive recovery oriented system of care and prevention. In addition, the Board will continue to improve the quality of life of Butler County citizens through the support of addiction and mental health recovery services.

Vision Statement

The vision of the Butler County Mental Health and Addiction Recovery Services Board is to ensure a system of care that is best practice based, financially stable and publicly funded. Butler County residents will be provided services and support that are preventative, impactful and measurable.

STRATEGIC PLANNING ASSESSMENT

PREVALENCE DATA REVIEW

The development and analysis of prevalence estimates and treatment needs provides a view of the estimated magnitude of mental health and co-occurring disorders in Butler County as a resource for the Butler County Mental Health and Addiction Recovery Services Board in strategic planning, decision-making and prioritization of resource allocation.

METHODOLOGY

National, state and Butler County population data from the 2010 U.S. Census was identified. Prevalence data was researched and obtained from sources including the National Institute of Mental Health, SAMHSA, the National Institute of Drug Abuse, and the U.S. Center for Disease Control. The data were applied to the national population and extrapolated to the local adult and youth populations to arrive at mental illness and substance use disorder prevalence estimates for Butler County residents.

Prevalence

Table 1

United States, State of Ohio, Butler County Population By Age (Estimated 2014)

	2014 Estimated	2014 Estimated	2014 Estimated
Age	US (%)	Ohio (%)	Butler Co. (%)
Under 18 years	73,655,978 (23.1%)	2,643,469 (22.8%)	90,920 (24.3%)
18 to 64 years	198,966,790 (62.4%)	7,153,599 (61.7%)	233,849 (62.5%)
65 years and over	46,234,272 (14.5%)	1,797,095 (15.5%)	49,389 (13.2%)
TOTALS	318,857,056 (100%)	11,594,163 (100%)	374,158 (100%)

2010 U.S. Census

Key Findings:

- Total estimated Butler County population in 2014 was 374,158 persons, compared to an actual population in 2010 of 368,130 persons. The estimated increase in the Butler

County population was 1.6% between 2010 and 2014. According to the Ohio Developmental Services Agency, Butler County is projected to grow by 3.4% between 2015 (378,370 persons) and 2020 (390,110 persons).

- Butler County has a smaller elderly population percentage (13.2%) as of 2014 when compared to the US (14.5%) and Ohio (15.5%). The 2014 Butler County population age 18 years and younger (24.3%) is slightly larger than the US (23.1%) and Ohio (22.8%).

Adult Mental Illness Prevalence

Prevalence rates of mental illness published by SAMHSA, NIMH, and NIDA, indicate that over 18% of the general adult population will experience some level of mental disorder on an annual basis. Updated population estimates from 2014 were applied to the prevalence percentage rates in Table 2 below.

Table 2

Adult Mental Illness Prevalence (Annual) – Butler County, 2014

Disorder	Prevalence (Annual)	Adults (Age 18 and older – 283,238 total pop.)
Any Mental Illness in US Adults	18.1%	67,724
Serious Mental Illness (SMI) in US Adults	4.1%	15,340
Anxiety Disorder	18.1%	67,724
Any Personality Disorder	9.1%	34,048
Major Depression	6.6%	24,694
PTSD	3.5%	13,095
Co-Occurring Disorder	3.4%	12,721
Panic Disorder	2.7%	10,102
Bi-Polar Disorder	2.6%	9,728
Borderline Personality	1.6%	5,987
Schizophrenia/Other Psychoses	1.1%	4,116

Source: National Institute of Mental Health, SAMHSA, (2010) & U.S. Census

Key Findings:

- It's projected that 18.1% of adults age 18 and over or 67,724 Butler County residents will experience any mental illness during any 12-month period of time, while it's projected that 4.1% or 15,340 Butler County adult residents will experience a serious mental illness during any 12-month period of time.
- The most prevalent sub-group disorder estimated in the general adult U.S. population are individuals that are projected to have an Anxiety Disorder at 18.1% during any twelve (12) month period of time. It is estimated that on average 67,724 persons 18 and older in Butler County will experience an Anxiety Disorder during any 12-month period.

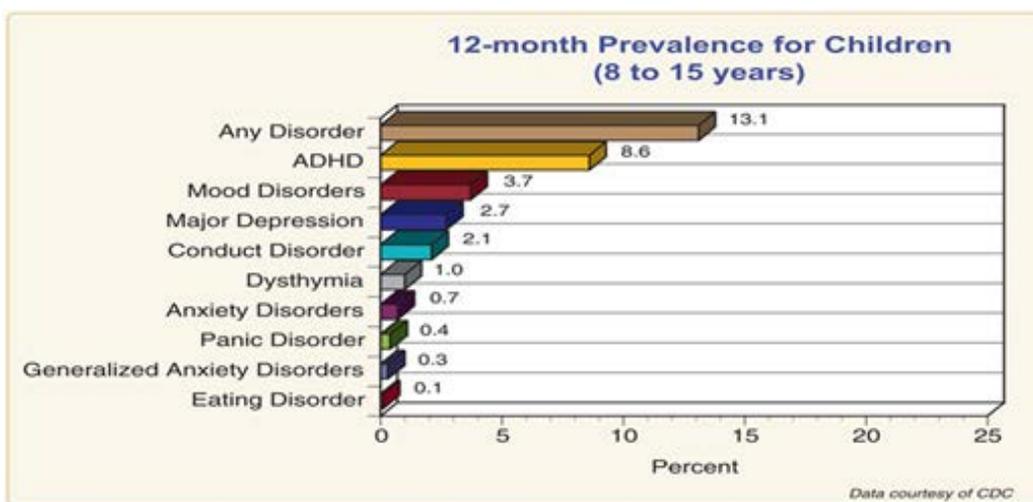
- Any type of Personality Disorder at 9.1% (34,048 Butler County adults) and Major Depression at 6.6% (24,694 Butler County adults) are the next 2 major sub-categories of mental illness that may impact adults during any 12-month period of time.
- According to SAMHSA, 3.4% (12,721 Butler County adults) are projected to experience a co-occurring disorder (mental illness and substance use disorder) during any 12-month period.

Child / Adolescent Mental Illness Prevalence

Prevalence rates for mental illness in youth published by the National Institute of Mental Health and the Centers for Disease Control indicates an estimated 13.1% of 8 to 15 years of age, may experience a mental disorder during any 12-month period of time. The Centers for Disease Control demonstrates 12-month mental disorder prevalence estimates for children ages 8 to 15 years in Table 3. These data show that over 13% of children / adolescents ages 8 to 15 years may have had a diagnosable mental disorder within the previous year. The authors were not able to locate reliable Butler County population data for this specific age range (8 – 15 years) in US census data. The authors decided to use 2014 Ohio Development Services Agency data for youth age 10 to 14 years and apply the CDC prevalence data in the attempt to best determine Butler County youth mental disorder prevalence in Table 4. *Use discretion when applying the population estimates of mental disorder prevalence to the Butler County children and adolescents totals.

Table 3

12-month Prevalence for Children (8 to 15 Years) – United States, 2014



Source: Centers for Disease Control, 2015

Key Findings:

- The Centers for Disease Control estimates that 13.1% of all children in the United States age 8 to 15 years old will experience any type of mental disorder in any given 12-month period.
- The CDC also estimates that 8.6% of youth age 8 to 15 years old in the US will experience ADHD during any 12-month period, followed by 3.7% with Mood Disorders and 2.7 with Major Depression.

Table 4

Children (8 to 15 Years) Mental Illness Prevalence (Annual) – Butler County, 2014

Disorder	Prevalence (Annual)	Children (Age 10 to 14 years) – 25,850 estimated pop.) ODSA
Any Mental Illness in Children	13.1%	3,386
ADHD	8.6%	2,223
Mood Disorder	3.7%	956
Major Depression	2.7%	698
Conduct Disorder	2.1%	543
Co-occurring MDE and a substance use disorder	1.4%	362
Dysthymia	1.0%	259
Anxiety Disorder	0.7%	181
Panic Disorder	0.4%	103
Generalized Anxiety Disorder	0.3%	78
Eating Disorder	0.1%	26

Source: National Institute of Mental Health, SAMHSA, Ohio Development Services Agency, 2010 U.S. Census

Key Findings:

- The estimated Butler County child and adolescent population (18 years and under) in the 2014 U.S. Census was 90,920 persons.
- According to Centers for Disease Control mental disorder prevalence estimates and Ohio Development Services Agency population estimates in 2014, of the 25,850 youth age 10 to 14 years in Butler County, 13.1% (3,386 persons) of those youth will experience any type of mental disorder during any 12-month period.
- Attention Deficit Hyperactive Disorders (ADHD) at 8.6% (2,223 persons age 10 to 14 years old) is the most prevalent mental disorder sub-group, followed by Mood Disorders at 3.7%, or 956 youth age 10 to 14 years.
- Based on NIMH, SAMHSA and ODSA estimates, co-occurring Mental Disorder prevalence was 1.4% of the population and is estimated to impact 362 youth ages 10 to 14 years in Butler County.

Table 5

Illicit Drug Use in the Past Month Among Individuals Aged 12 or Older in the US in 2013 – Estimated Number in Butler County Aged 10 and Older - 2013

Substance	Aged 12 or Older Number in the US – 2013*	Aged 12 or Older Percentage in the US – 2013*	Estimated Butler Co. Residents 2013 (**Aged 10 and older – 321,009 total pop.)
Any Illicit Drug Use	24,573,000	9.4%	30,175
Marijuana and Hashish	19,810,000	7.5%	24,076
Cocaine	1,549,000	0.6%	1,926
Inhalants	496,000	0.2%	642
Hallucinogens	1,333,000	0.5%	1,605
Heroin	289,000	0.1%	321
Nonmedical Use of Prescription-type Drugs	6,484,000	2.5%	8,025
Pain Relievers	4,521,000	1.7%	5,457

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey of Drug Use and Health (NSDUH), 2014, 2010 U.S. Census; Ohio Research Office – A State Affiliate of the US Census, 2013.

Note: 1) *Numbers and percentages do not sum to the illicit drug use estimate as individuals may have used more than one illicit drug. 2) **Butler Co. residents aged 10 and older estimates were used due to fact no recent breakdown of residents aged 12 and older was found / available for comparison purposes.

Key Findings:

- According to the SAMHSA Center for Behavioral Health Statistics and Quality, National Survey of Drug Use and Health (NSDUH) prevalence estimates for 2013, of the approximate 321,009 Butler County residents aged 10 and older, that 9.4% (30,175 persons) may have had “past month” use of any illicit drug.
- It is projected that 7.5% or 24,076 Butler County residents aged 10 years and older may have used marijuana or hashish in the previous month, that 2.5% (8,025 Butler County residents) are projected to have had “nonmedical” use of prescription-type drugs in the previous 30 days, and that 1.7% (5,457 Butler Co. residents) are estimated to have used pain relievers in the 30 days prior to the survey.

Table 6

**Current, Binge and Heavy Alcohol Use Among Individuals Aged 12 or Older in the US
in 2013 – Estimated Number in Butler County Aged 10 and Older - 2013**

Substance	Aged 12 or Older Number in the US – 2013	Aged 12 or Older Percentage in the US – 2013	Estimated Butler Co. Residents 2013 (**Aged 10 and older – 321,009 total pop.)
Current	136,900,000	52.2%	167,567
Binge	60,100,000	22.9%	73,511
Heavy Use	16,500,000	6.3%	20,224

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health (NSDUH), 2013; 2010 U.S. Census; Ohio Research Office – A State Affiliate of the US Census, 2013.

Note: **Butler Co. residents aged 10 and older estimates were used due to fact no recent breakdown of residents aged 12 and older was found / available for comparison purposes.

Key Findings:

- According to the SAMHSA Center for Behavioral Health Statistics and Quality, National Survey of Drug Use and Health (NSDUH) for 2013, 52.2% of the population 12 years and older were current users of alcohol during the 30 days prior to the completion of the survey. It's estimated that 167,567 (52.2%) of the Butler County residents aged 10 years and older were potentially current users of alcohol during the previous month.
- It is projected that those persons reporting past month use in the NSDUH Survey Report 2014, that 22.9% or 73,511 Butler County residents aged 10 years and older may be considered potentially "binge" use of alcohol in the previous month and that 6.3% (20,224 Butler County residents) are projected to have "heavy" use of alcohol in the last 30 days.

Table 7

Current, Binge and Heavy Alcohol Use Among Individuals Aged 12 to 17 Years Old in the US in 2013 – Estimated Number in Butler County Aged 10 to 19 Years Old - 2013

Substance	Aged 12 to 17 Years Old in the US – 2013	Aged 12 to 17 Years Old Percentage in the US – 2013	Estimated Butler Co. Residents 2015 (Aged 10 to 19 Years Old – 56,420 total pop.)
Current	2,900,000	11.6%	6,545
Binge	1,600,000	6.2%	3,498
Heavy Use	293,000	1.2%	667

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health (NSDUH), 2013; 2010 U.S. Census; Ohio Development Services Agency 2015.

Note: **Butler Co. residents aged 10 to 19 years old estimates were used due to fact no recent breakdown of residents aged 12 to 17 years old was found / available for comparison purposes.

Key Findings:

- According to the SAMHSA Center for Behavioral Health Statistics and Quality, National Survey of Drug Use and Health (NSDUH) for 2013, 11.6% of the population 12 to 17 years of age were current users of alcohol during the 30 days prior to the completion of the survey. It's projected that 37,237 (11.6%) of the Butler County residents aged 10 to 19 years old were potentially current users of alcohol during the previous month.
- It's also projected that 6.2% or 19,903 Butler County residents aged 10 to 19 years old may be considered potentially "binge" users of alcohol in the previous month and that 1.2% (3,852 Butler County residents 10 to 19 years old) are projected to be considered "heavy" users of alcohol in the last 30 days.

FOCUS GROUP, INTERVIEW AND SURVEY KEY STAKEHOLDER INPUT

During October and November 2015, BCMHARSB staff facilitated a series of seven (7) focus groups with eighty-six (86) participants, three (3) face-to-face interviews that included clients, family members, addictions and mental health administrators and providers, local court, law enforcement and government, social service representatives, BCMHARSB Board members and staff, and other key community stakeholders. The intent was to gain subjective input from the representative populations regarding their perceptions concerning the strengths, weaknesses, opportunities, threats, gaps, needs and priorities as they relate to the Butler County addictions and mental health service delivery system. Additionally, a Recovery-Oriented System of Care Self-Assessment (ROSC) was completed by fifty-six (56) community stakeholders and the results were summarized in this assessment component.

STAKEHOLDER INPUT RESULTS

The purpose for the series of focus groups and interviews was to identify and examine the addictions and mental health priorities and needs of Butler County residents. Detailed findings do not necessarily represent the expressed opinion of all participants, but provides supplemental information for the needs assessment phase of the Butler County Mental Health and Addiction Recovery Services Board's strategic planning process. Following is a summary of the key findings from the focus groups and interview participant's input regarding the completion of the Butler County Mental Health and Addiction Recovery Services Board's Strategic Plan 2016 - 2018.

Strengths

Focus group, interview and survey participants identified a wide range of strengths related to the Butler County Board and the addictions and mental health service delivery system. Several trends related to the strengths identified by stakeholders emerged included, but was not limited to:

1. The Butler County addictions and mental health service delivery system's continuum of care. Strong provider network of agencies.
2. Community awareness of addictions and mental health services.
3. Board's expansion of services into the Middletown area.
4. Good system collaboration and improved communication.
5. Community support for the system of care.
6. Prevention services and trauma informed care professionals.

Following is a comprehensive list of the strengths identified by BCMHARSB key stakeholders:

- Cross System Collaboration between organizations including access and resources
- Five Drug Free Community Coalitions in the county with the Oxford Coalition being a sustaining Coalition
- Interest in school based prevention
- Crisis 844-4 Crisis Number
- Opiate Task Force meetings and creation of strategic plan for this group
- Roosevelt location in Hamilton, OH for provider Modern Psychology (Dr. Moss)
- BC Mobile Crisis Team

- St. Aloysius and Talbert House supports mental health and alcohol and drug treatment services in local school system
- Envision Partnerships provides prevention services
- Beckett Springs Hospital in support of individuals with Mental Illness (MI) and Alcohol and Other Drug (AOD) problems
- Beckett Springs Hospital recent expansion of their beds from 48 to 72
- The offering of education to community mental health professionals & families
- Diversity of services in the community
- Diversity of the BCMHARS Governing Board
- SAMI court programming
- Board expansion of services to the Middletown area
- Expertise of the Board's staff
- Public nature of the BCMHARS Board meetings
- In "Your Own Voice" program
- Board's support of NAMI
- Board supports non-traditional programming
- Good system collaboration including courts and judicial system
- Better system communication in general
- Local Leadership
- Board contract providers work well and support jail staff
- Recognition/appreciation that one doesn't happen with another (Dual Diagnosis) - Before (when the MH and AOD Boards were separated), it seemed like the left hand didn't know what the right hand was doing. Now we have better communication between the MH and AOD system
- Better utilization of county resources (financial) and staff
- Mental Health levy has strengths and demonstrates community support for Mental Health
- Community Awareness of Mental Health/AOD Services
- Combined professional experience
- Education by BCMHARS Staff at community events & NAMI Volunteers participation in the *In Our Own Voice* program
- Community support of levies
- Joint Leadership
- Strong Provider Network
- Excellent Agencies
- Continuum of Care – Crisis to Step Down AOD/MI
- Board is User Friendly
- Communication between providers
- Collaborations between providers
- Collaborations with Children's Services and Criminal Justice System
- Committed Governing Board (attendance)
- Resource Rich (MH & AOD)
- County Trauma Informed Care
- Board Members have attended community events – with elected officials
- Elected officials seem educated and tied in with MH/AOD issues
- C3 – MH/AOD Group

- The Board and community mental health and addictions system is the safety net for the county
- Qualified professionals are running mental health/substance use programs and services
- Crisis Hotline
- Ability for anyone in the county to consult with Board staff about mental illness and substance use issues & treatment
- Board provided service guides and waiting list information that are published
- County's five prevention coalitions (Drug Free Communities)
- Well trained mental health and substance use professionals
- Expanded mental health services to our elderly
- Trauma Informed care trained professionals

Weaknesses

Focus groups and interview participants identified a wide range of weaknesses related to the BCMHARSB service delivery system. Several trends related to the weaknesses identified by community stakeholders emerged included, but were not limited to:

1. Limited community knowledge and understanding regarding the BCMHARSB system of care and services.
2. Community education on addictions and mental health.
3. Addictions detoxification and sober living capacity.
4. Limited funding for addictions and mental health services in general. No levy support for addiction services.
5. County residents understanding regarding what levy funds generated provide in the community.
6. Psychiatric services capacity.
7. Waiting time for services.

Following is a comprehensive list of the weaknesses identified by BCMHARSB key community stakeholders:

- Lack of talk about substance misuse including the sharing of experiences about it
- 211 & 4Crisis line are not better integrated
- Opiate Task force has a strategic plan but hasn't taken action
- Lack of single point of entry in Butler County into the ADAS treatment system
- Detox services
- Sober Living Facilities
- Lack of safe housing options
- Waiting time for assessment & treatment
- Better care coordination is needed
- Haven't utilized Casey's Law fully
- Need more ADAS counseling services
- Fear of implementing plans

- Need services that go to the client's setting
- Silos in ADA & MH service via funding and billing
- Lack of funding in general
- Lack of education and awareness of mental health and addiction issues including suicide warning signs,
- DD/autism, violence (including domestic violence), and psychotropic medications
- Aftercare for students wanting to commit suicide
- Groups in the community mental health & addiction systems that are non-identifying/confidential safe places for students and their families
- The need for speakers to address youth needs (e.g., transitional youth skills) from a MH/ADA perspective
- Beckett Springs Hospital's expansion indicates there is great need for MI and AOD treatment options
- Heroin epidemic
- MI and AOD is "out of sight and out of mind" for most people
- Violence with MI and AOD
- Education about MI and AOD including what they are and how it affects people
- Education about substance use disorders
- Education about provider programming and treatment resources
- Board's website need to be updated and revised to be more user-friendly
- School Administrators are not trained about mental illness and substance use disorders
- NAMI needs to be more involved in local CIT
- Board's support for school district related to mental health
- Stigma of mental illness is strong especially in the school system
- Education in the faith community especially for pastors and clergy
- More social recreational services for our county youth
- NAMI not being used more comprehensively
- Transportation and recreational opportunities for those with mental illness
- Vocational services are limited and more ongoing job coaching is needed
- More drop in centers for youth needed in our county
- Community awareness about the frequency and breadth of mental health, mental illness, and addiction issues
- BC residents don't understand what our MH levies purchase and do
- What our community mental health providers do
- Care coordination services
- Education about mental illness
- Lack of awareness and education about Heroin and the Heroin epidemic
- Not in my neighborhood perspective about mental health and addiction problems
- Lack of support for addiction services
- No levy support for AOD
- Fact that Board geographic location in Fairfield at the southern-most border of county is not conducive to collaboration with other Butler County Government organizations and agencies
- New Board should/could have started with fresh members with out history
- Lack of staff flexibility and recognition of differing professional roles that staff fulfill
- Levy itself – confusing (there are 2 separate levies) – does not include substance abuse
- Website needs improvement

- The way funds are allocated –Have a look with review how agencies are funding by MHARS
- Not enough funding, housing, services, doctors, transportation
- Waiting Lists are too long
- Education of a bewildered public
- Dual Diagnosis services
- Restrictions related to having two different funding streams (MH and AOD)
- Lack of resources/capacity to impact the heroin epidemic
- Government relationship
- Education of signs and symptoms of AOD and MI
- Lack of funding for providers in general
- Lack of Funding for Working Poor
- SED Funding
- Lack of Funding for Parent Education and Support Groups
- Psychiatry time
- Licensed qualified staff/employment pool
- Reimbursement rate for psychiatrists
- Medicaid Rate low and not going up
- Inability to get Medicaid as secondary
- Client Transportation
- Silos & capping of rates for long term recovery
- Electronic Medical Record systems need to speak to each other better
- Funding for non-traditional mental health services
- Lack of awareness to residents of mental health and substance abuse programming
- Lack of communication of the importance of local levies vs. other issues in the county
- Transportation for clients
- Waiting list for substance abuse rehabilitation
- St. Aloysius leaving Oxford, OH as the only community mental health provider
- Need for centralized assessment setting
- More school based treatment
- Psychiatric shortage
- Lots of mental health professional turnover especially in school based settings
- Lost evidenced-based practices
- Not enough emphasis on mental health prevention
- The need for continued PR on the new crisis hotline number to reduce stigma and promote conversations about mental illness

Opportunities

Focus group and interview participants identified a range of opportunities related to the BCMHARSB service delivery system. On review, several trends related to the opportunities identified by stakeholders emerged including, but not limited to:

1. Increase community education opportunities on addictions, mental health and dual disorders. Utilize / promote collaboration with local business groups, etc.
2. Develop and implement more addictions and mental health evidence-based “best practice” models.
3. Develop and implement a Peer Recovery Community model.
4. Utilize media to educate the community regarding addiction and mental health topics, improve community knowledge of the BCMHARSB system of care.
5. Enhance faith-based and other non-traditional partnerships and service activities.

Following is a comprehensive list of the opportunities identified by BCMHARSB key stakeholders:

- Run more Town Hall meetings
- Just take baby steps to implement existing task force plan
- Pay for small projects and efforts to implement plans
- Education doesn't take a lot of money
- Work through the fear of implementation & have faith
- Just do the plan and don't over think it!
- Use a peer recovery community to support volunteering and low cost
- Use local volunteers and grass roots efforts more
- Implement “Somewhere Dark Program”
- Implement a Peer Recovery Community model like in Colerain & Lucas Counties
- Use mobile unit for triage, support, & advocacy
- Utilize more seized law enforcement dollars from drug busts
- Edgewood Schools mental health professionals are committed to volunteer in support of local community needs
- Butler County NAMI to have more of a presence at the school
- Utilize local high school football games to promote PR and education about mental illness and addictions
- Rural vs. City local opportunities
- Having a Mental Health/Addiction Services provider in the Trenton, OH area even if part-time.
- To educate, re-educate, and inform about MI and AOD especially due to the transient nature of Butler County residents
- Be proactive vs. reactive with our PR and messaging
- Hook up with organizations with like interests by reaching out to a broader audience with our PR efforts including hospitals, schools, etc.

- Butler County to take the lead to collaborate and include all stakeholders in the area/region including those community partners in Hamilton, Warren, Montgomery, and Preble counties especially along the I-75 corridor to address MI and AOD
- Build a model community concept (e.g., Caring Community Collaboration) to help bring awareness, education, prevention, and treatment to reduce the impact of MI in our area
- Seek out more MI/AOD best practices
- Seek out corporate sponsors to help support and address MI and AOD problems
- We always need to keep in mind where we are at with our goals and where we are going with them
- Use Metropolitan statistics and data to support our messaging and PR efforts
- More school system in services about mental illness and substance use disorders
- In services for pastors and clergy
- Increase collaboration with local FCFC including residents with DD
- Using Board funds to educate about dual diagnosis (MI/AOD)
- Getting local businesses involved with mental health and substance use prevention, education, and treatment
- Expand relationships between the jail, agencies, and courts
- Better intake process to identify jail inmates with mental illness and addiction issues
- Better system to track clients treatment histories and status to support treatment planning especially for jail inmates
- To address how many pregnant inmates have substance use problems
- Better discharge planning and after care coordination for those with mental illness
- With Medicaid expansion – Money “left on table” which is currently not utilized
- Take a good look at how 2 previous Boards (MH and ADAS) can work unified together. Look at strengths so 2 Boards can use their gifts and resources complimentary
- Have opportunity to change the face of both MH and AOD issues in county – seen as exponential not as additive
- Education about street drugs for the community – Film Operation Street Smart training so it can be used to educate others that were unable to attend the event
- New levy that can be used to fund AOD treatment and services
- Partnership concerns
- Public events to disseminate information
- More stories about agencies addressing MH and Addiction issues in individuals
- Putting a real face on MH and AOD issues in the media
- Journal News media involvement
- Outreach – serve special populations
- Faith Based organization involvement
- Medicaid Elevation/Expansion
- Expand Medicaid service to other non-covered service areas
- Getting Medical Care – Managed Care – savvy with MH Care
- AOD Levy

- Education of community about AOD
- Non-traditional services using community players (churches, clergy, hospitals)
- Programs that have positive outcomes – MST – course system, positive outcomes
- Reach out to diversity partners to educate on cultural diversity on MH/AOD
- County wide faith communities partnership
- Influx of refugees with trauma (w/out SSN) ways to help individuals
- Behavioral Health redesign
- Education efforts promoting interaction with local businesses
- One on one interactions with local business Human Resources departments
- Speaking opportunities including those through local Chambers of Commerce
- More agencies with flexible working hours (after 5 pm and weekend hours)
- Better mental services to the Hispanic population
- Have more culturally aware counselors
- Expand opportunities for basic health and wellness education especially special issues such parenting, mental health and addiction issues, and cutting by family members
- Expand Mental Health First Aid training
- Be more collaborative with community partners like the faith communities in the county
- Conversations about how mental health fits in to peoples overall well being
- Identify the benefits of the upcoming behavioral health redesign of Medicaid that the state is currently doing.

Threats

Focus group and interview participants identified a range of threats related to the BCMHARSB service delivery system. Several trends related to the threats identified by community stakeholders included, but were not limited to:

1. Funding, funding, funding. Federal and state funding losses.
2. Behavioral health “re-design” process underway in Ohio.
3. Impact of heroin epidemic, increased resident drug abuse, increasing death rate from overdose and suicides.
4. Separate treatment funding streams (Addictions and Mental Health).
5. Competition between local addiction and mental health service providers for available funds.
6. Not passing levies.

Following is a comprehensive list of the threats identified by BCMHARSB key stakeholders:

- Separate treatment & funding streams for residents with MI/AOD issues

- Funding limitations
- Many MD's not comfortable prescribing medications for those addicted
- Fear and failure to take action
- Funding
- Lack of Education
- Increased Stigma
- Not recognizing the reality of the prevalence of Mental illness, addictions, and violence in schools
- Don't be redundant with our PR message but keep it dynamic to meet ongoing changing needs of our county
- Community safety
- Transient nature of the county
- Lack of community members committed to a comprehensive behavioral health treatment message and model
- Funding to support services
- Increasing county population growth
- More residents using drugs/substances inappropriately than ever
- Increasing death rate for overdoses and suicides
- Loss local jobs and industrial base
- Child care
- Lack of Regional Collaborative presence in our SW Ohio Region
- Transportation for employment
- Not treating the whole person for those with mental illness
- Inappropriate aftercare/release treatment for jail inmates
- Awareness and education about mental illness and addiction issues in jails
- People becoming institutionalized in jails to treat their mental illness
- Not enough treatment and residential services for the homeless
- Neither past ADAS & MH Board willing to give up their identities
- Egos – a perception in the community of no unification
- Location – Fairfield – Isolated
- Funding- Federal and State \$ drying up
- Change Name of this analysis to SWOC (Challenge not Threat)
- Money
- Community disengagement
- Competition for services (silos)
- Insurance Gaps
- Psychiatrist shortage
- Behavioral Health Redesign (loss of revenues) and service
- Specifics –billing per provider? Specifics around codes, nursing staff
- Workforce, impact of BH redesign
- Planning of MH/AOD is in the hands of the Department of Medicaid
- Losing status at the state level
- Levies (AOD & MH) Why do levies with Health Exchanges? Message
- Cautious of regulations – BH challenges - provider increase QI cost - burden to the system
- BH redesign significant threat to system

- Heroin problem and ripple effects like trauma on youth
- People serviced not in commercial health care system – population is distinctly different than what private professionals are used to dealing with
- BVR impossible system to work with
- Funding
- Heroin epidemic over shadows other mental health issues
- Businesses not feeling they have a role in employee mental health promotion
- Exceeding treatment capacity to address Heroin epidemic
- Loss of levies
- Programs like The Incredible Years for preschoolers are losing funding

Service Delivery System Gaps

Focus group and interview participants identified a range of perceived gaps related to the BCMHARSB service delivery system. On review, several trends related to the service delivery system gaps identified by community stakeholders included, but were not limited to:

1. Access to services. Waiting lists for services, especially addictions treatment.
2. Detoxification services. Currently only drug detox at the jail and no alcohol detoxification locally.
3. Psychiatric services capacity, especially for children / youth.
4. Community education and prevention services.
5. Marketing. Limited public education and relations capacity.
6. Collaboration within the county as well as with other counties, businesses, etc.
7. Transportation services.
8. Coordination with criminal justice services

Following is a comprehensive list of the service delivery system gaps identified by BCMHARSB key stakeholders:

- Little peer support services used and coordinated
- Addiction Services for patients in Hospital ER's especially for children
- Not using substance use crisis more fully to promote client education
- Use more social media to promote more education
- Play therapy
- MH/ADA Services in the Trenton, OH – Edgewood Schools Area
- Early Childhood Education & Prevention
- Rape Education & Supports
- Education related to mental health and addictions
- Lack of qualified mental health and addiction professionals to address non-Medicaid services & programming needs

- The need for more education efforts to reduce AOD stigma
- Education to inform county residents and business leaders
- Comprehensive marketing approach inclusive of local chamber of commerce (e.g. 5 chamber newsletter article on MH in the workplace)
- Collaboration with like missioned organizations (e.g., healthcare)
- Message and PR efforts targeting MI to address the 10 million visitors to the new Liberty Center Mall
- Good local statistics and data collection to support Butler County ongoing needs assessment
- Addressing county population growth
- Ongoing collaborative efforts with other counties
- Having good MI/AOD forecasting in support of future needs, programs, and services via trend analyses projecting 5 to 10 years in the future
- Identification of the significant MI/AOD trends in other counties
- Connecting with more local businesses and chambers more so (e.g., Human Resources Depts.)
- Transportation in general
- Better integration of agency services especially mental health and addictions
- More collaboration between agencies
- Transportation especially for young mothers
- Better hospital discharge planning for our clients/residents including case management and coordination
- Lack of communication between mental health professionals at agencies and with clients and their families
- Mental health providers don't communicate well with each other
- Lack of psychiatrists to support hospital like Fort Hamilton Hospital
- More community involvement beyond the Board and its provider system to education about mental illness and substance abuse
- Use more state of the art technology in mental health such as texting by crisis hotline workers
- Crisis Hotline staff should be trained by NAMI
- Reporting of jail inmate health data
- Better systemic collaborative treatment planning with community partners
- Awareness and education about mental illness especially in the jail
- Addressing inmates with special needs in the jail
- Jail becoming hospitals to treat the mentally ill and it becoming like home to these county residents.
- Access to services- still waiting lists (addiction)
- Community member doesn't know purpose and mission of Board – no public relations – need to cultivate growth here i.e. education (inform community members of Board work, function, what they do and don't do)

- Justice system
- Coordination with Law Enforcement
- Jail Services
- Lack of space/capacity
- Treatment Gaps
- Service Delivery Gaps
- Detox availability (right now it's the jail) - Medical Detox (Benzo)
- Alcohol detox has no services
- Lack of understanding of DD clients and families
- Prevention
- Not enough trauma informed services
- Lack of knowledge of school systems and where to refer kids
- Lack of MI/DD and MI/DD/AOD services – very vulnerable population
- Housing (continuum of care)
- Psych assessment for children on the spectrum
- Don't know diagnosis for DD and how to treat with psychopharmacology – can't find any training
- DD system training in Behavioral Health and Mental Illness
- Seniors and providers to provide Medicare services. Can't afford Medicare copay.
- Dementia – issues with seniors and appropriate screenings – education of caregivers and supports for caregivers
- School MH services but getting parents to complete documentation needed by Providers
- Spanish speaking providers (cost of translation services not reimbursed)
- Funding to see clients after release or before release from jail
- Funding for early childhood
- Play therapy (be aware of all provider services – especially providers with specialized services and programs)
- Providers going into schools
- Cuts to other social service providers
- Transportation
- BVR participation in the MH/AOD system
- Lack of psychiatrists for adults and kids
- Lack of mental health certified providers
- Board reimbursement for telemedicine med-some non-Medicaid
- Services in general for youth pre-school on up (without family support system)
- Being diagnosed younger and younger with school-based Mental Health/AOD services
- Appropriate rehabilitation of residents who have criminal backgrounds with mental illness and substance use issues so they can more easily find employment
- Education about mental illness and substance use issues as well as treatment resources in the community.
- Difficulty for residents to get into the drug and alcohol treatment system

- Better communications between providers and treatment professionals
- Children psychiatrists
- Transportation especially for young mothers
- Central point of mental health access
- Better community education about mental health resources
- Work with community partners to better the system approach to treatment including comprehensive community wide collaboration.

RECOVERY-ORIENTED SYSTEM OF CARE SELF-ASSESSMENT RESULTS

The BCMHARSB facilitated the completion of an extensive 87-question ROSC Self-Assessment during the fall of 2015 in support of its Strategic Planning process. A total of fifty-six (56) responses were received and reviewed for input into the BCMHARSB Strategic Plan update. Many of the questions asked required a response on a 5-point Likert Scale: (1) Strongly Disagree (2) Disagree (3) Neutral (4) Agree (5) Strongly Agree as well as a “Don’t Know” option (D/K). Review highlights of the survey results include the following:

Areas of system strength according to the Butler County ROSC Self-assessment survey results included:

- Service providers do not use threats or bribes or other forms of coercion to influence the person’s behavior or choices;
- Progress toward goals (as defined by the person in recovery) is regularly monitored;
- Age appropriate services are offered to children, adolescents, young adults, and seniors;
- Intake and engagement strategies use evidenced-based practices (e.g., motivational interviewing, contingency management and cognitive behavioral techniques);
- Staff uses recovery language (e.g., hope, high expectations, respect) in everyday conversations;
- Provide low-intensity care for those who would not benefit from high-intensity treatment at that time (e.g., outpatient vs. residential); and
- Intake and engagement strategies use evidenced-based practices (e.g., motivational interviewing, contingency management and cognitive behavioral techniques).

Areas of system that may need attention in planning according to the Butler County ROSC Self-assessment survey results included:

- Most services are provided in a person’s natural environment (e.g., home, community, workplace);
- Barriers (e.g., childcare, transportation) are addressed for participants;

- Individuals have timely access to the services and supports that are most helpful for them;
- Co-occurring behavioral and physical health are addressed in integrated ways, including assertive referral to and coordination with primary care providers, with an aim to address co-occurring issues through integrated rather than consecutive care;
- A no-wrong-door policy exists in the community for children, adolescents, and adults to engage individuals at whatever point they enter the system and determine the most appropriate type and level of care at that time;
- Interim services are available for people on waiting lists and/or who are not ready to commit to treatment;
- Assertive linkages exist during transitions using peer-based recovery support staff and volunteers through levels of care;
- Cities, township ordinances are receptive to sober lifestyle communities (e.g., housing, self-help groups, consumer advocacy groups);
- Strategies to decrease stigma are conveyed to all partners and are consistently implemented in communities;
- Young adults as adolescent peer support specialists are active in the community;
- Primary care and behavioral health follow-ups are integrated and coordinated; and
- Communities are proactively addressing emerging issues.

Following are some key areas and documented results drawn from the review of the Butler County ROSC Self-assessment results:

- Over 55% of the respondents in the ROSC results sample were Board Members (13) and AOD and MH service providers. Other ROSC respondents included clients, family members, children's services and responses from the Butler County criminal justice system.
- Question: Service providers are trained regularly in recovery topics and resilience-based and trauma-informed assessments? Of the 50 responses to this question the average rating was **3.83** on a 5-point Likert Scale.
- Question: Service providers do not use threats or bribes or other forms of coercion to influence the person's behavior or choices? Of the 50 responses to this question the average rating was **4.38** on a 5-point Likert Scale.
- Question: Service providers offer specific services and programs for individuals with different cultures, life experiences, interests and specific needs? Of the 50 responses to this question the average rating was **3.62** on a 5-point Likert Scale.

- Question: People in recovery can choose (and change, if desired) the therapist, psychiatrist, physician, or other providers from whom they receive services? Of the 50 responses to this question the average rating was **3.74** on a 5-point Likert Scale.
- Question: Most services are provided in a person's natural environment (e.g., home, community, work place)? Of the 50 responses to this question the average rating was **3.24** on a 5-point Likert Scale.
- Question: Progress toward goals (as defined by the person in recovery) is regularly monitored? Of the 50 responses to this question the average rating was **3.98** on a 5-point Likert Scale.
- Question: Barriers (e.g., childcare, transportation) are addressed for participants? Of the 50 responses to this question the average rating was **3.02** on a 5-point Likert Scale.
- Question: Stage-appropriate services (e.g., detox before treatment, crisis services) are offered? Of the 50 responses to this question the average rating was **3.66** on a 5-point Likert Scale.
- Question: Age appropriate services are offered to children, adolescents, young adults, and seniors? Of the 50 responses to this question the average rating was **3.97** on a 5-point Likert Scale.
- Question: Individuals have timely access to the services and supports that are most helpful for them? Of the 44 responses to this question the average rating was **2.79** on a 5-point Likert Scale.
- Question: Co-occurring behavioral and physical health are addressed in integrated ways, including assertive referral to and coordination with primary care providers, with an aim to address co-occurring issues through integrated rather than consecutive care? Of the 44 responses to this question the average rating was **3.17** on a 5-point Likert Scale.
- Question: Cross training and referrals with child and adult protective services are in place? Of the 44 responses to this question the average rating was **3.59** on a 5-point Likert Scale.
- Question: A no-wrong-door policy exists in the community for children, adolescents, and adults to engage individuals at whatever point they enter the system and determine the most appropriate type and level of care at that time? Of the 44 responses to this question the average rating was **2.63** on a 5-point Likert Scale.

- Question: Interim services are available for people on waiting lists and/or who are not ready to commit to treatment? Of the 44 responses to this question the average rating was **2.90** on a 5-point Likert Scale.
- Question: Intake and engagement strategies use evidenced-based practices (e.g., motivational interviewing, contingency management and cognitive behavioral techniques)? Of the 44 responses to this question the average rating was **3.97** on a 5-point Likert Scale.
- Question: The community receives education about mental illness and addictions? Of the 44 responses to this question the average rating was **3.65** on a 5-point Likert Scale.
- Question: Peer leaders are developed and promoted to affect program development, evaluation and improvement? Of the 43 responses to this question the average rating was **2.96** on a 5-point Likert Scale.
- Question: Young adults as adolescent peer support specialists are active in the community? Of the 42 responses to this question the average rating was **2.68** on a 5-point Likert Scale.
- Question: Primary care and behavioral health follow-ups are integrated and coordinated? Of the 42 responses to this question the average rating was **3.10** on a 5-point Likert Scale.
- Question: Safe, sober, and fulfilling activities are offered in the community? Of the 42 responses to this question the average rating was **3.44** on a 5-point Likert Scale.
- Question: Communities are proactively addressing emerging issues? Of the 42 responses to this question the average rating was **2.78** on a 5-point Likert Scale.
- Question: Are there treatment services available in the community, including outpatient, residential, partial hospitalization and sub-acute detoxification? Of the 41 responses to this question **38 (93%) indicated yes.**
- Question: Are recovery supports available in the community including peer support, housing and transportation? Of the 41 responses to this question **25 (61%) indicated yes.**
- Question: Are there workforce programs and supports available to help individuals get back to work? Of the 41 responses to this question **28 (68%) indicated yes.**

OHIO BEHAVIORAL HEALTH RE-DESIGN - FORWARD PLANNING

With the implementation of Medicaid expansion and the continued roll out of Managed Care Medicaid in the State of Ohio, it is left to ponder – what is the future of behavioral health services? The final decision has yet to be determined, according to the Joint Medicaid Oversight Committee (JMOC) which includes the offices of Ohio Job and Family Services (ODJFS), Ohio Department of Mental Health and Addiction Services (OMHAS), Ohio Department of Medicaid (ODM), and the Office of Health Transformation (OHT). The JMOC has established a subcommittee of various stakeholders to address the future of behavioral health services in Ohio as it is affected by ACA implementation and the Mental Health Parity Law. Given that it is still a process in determination from the state work committees, what are the possibilities?

The one constant among the research and materials made public by OMHAS is – modernizing Medicaid behavioral health benefits will occur under the auspice of care coordination through managed care. Exactly how this will look has yet to be determined. Several states have created regional authority offices who oversee the managed care organization's services while others have determined which MCOs that meet rigorous quality measures are selected to oversee the care coordination of its Medicaid eligible population with behavioral health needs. Oregon is host to the nation's biggest experiment in Medicaid managed care. Unlike most states, which rely on Medicaid managed care plans, Oregon has enrolled 90 percent of its Medicaid population in newly formed Coordinated Care Organizations (CCOs). These CCOs are networks of local providers who care for a population of Medicaid members under a fixed global budget with an emphasis on care coordination, integrated care, wellness, and chronic disease management.

<http://www.oregon.gov/oha/ohpb/pages/health-reform/ccos.aspx>

One of the most recent documents released by the Office of Health Transformation is the Behavioral Health Redesign Timeline. Over the next three years, providers and service recipients can expect to experience significant changes as redesign to behavioral health services are made to the state's determination of eligibility, authorized providers, covered services, and payment amounts and methods. From this document, by July 2016 the following new services will be developed and implemented:

- The 1915(1) which will include peer support, supported employment, case and recovery management
- ACT and Youth and Family Evidence-based Practices, and
- Other services, such as labs, etc.

The National Correct Coding Initiative will be initiated with three other initiatives: requirement identification of the rendering provider, coordination of benefits for providers of dual eligible clients, and the discontinuation of health home payment methodology. By July 2017, Substance Use Disorder coding will be simplified and the NCCI effort will continue with ongoing training to providers and stakeholders.

<http://www.healthtransformation.ohio.gov/CurrentInitiatives/RebuildCommunityBehavioralHealthSystem.aspx>

Other initiatives of the re-design process include: disaggregate certain existing BH services (Community Psychiatric Supportive Treatment, Case Management and Health Home services) and provide for lower acuity service coordination and support services; Develop new services for people with high intensity needs under the Medicaid Rehabilitation Option including Assertive Community Treatment, Intensive Home Based Treatment, residential treatment for substance abuse; The addition of BH services to Managed Care Plan contracts, with specific requirements for MCPs to delegate components of care coordination to qualified Community Behavioral Health providers; and to design and implement new health care delivery payment systems to reward the value of services, not volume.

Regarding CPAT / Case Management services, by July 2018, the finalized CPST changes will have been determined and implementation will occur. Per the timeline, this has been identified as Targeted Case Management which CMS just recently proposed changes in early October 2015. Targeted Case Management (TCM) is primarily defined by CMS as a Medicaid State Plan Optional Behavioral Health Benefits - Rehabilitative Services and Targeted Case Management. TCM services are defined at 42 CFR 440.169 as "services furnished to assist individuals, eligible under the state plan in gaining access to needed medical, social, educational and other services." States may target the TCM benefit to specific beneficiary groups. Targeted beneficiary groups can be defined by disease or medical condition or by geographic regions, such as a county or a city within a state. Targeted populations, for example,

could be individuals with HIV/AIDS, tuberculosis, chronic physical or mental illness, or developmental disabilities.

<https://downloads.cms.gov/cmsgov/archiveddownloads/MedicaidGenInfo/downloads/CMS2237IFC.pdf>).

The proposed CMS changes to TCM billing could have tremendous effects on those states that have already implemented TCM, such as Colorado, Florida, Indiana and Massachusetts. The proposed CMS changes could primarily affect how case management services are billed and how claiming of administrative case management tasks are completed so that duplicate services by various agencies are not being provided, billed and/or reimbursed.

BH services provided under the Rehab Option rules will cause strict enforcement of the “golden thread of medical necessity.” Thus providers will need to ensure on stricter internal auditing measures that the golden thread of medical necessity is maintained from assessment to treatment planning to progress notes to discharge. As an example, TCM tasks are more strictly defined and may align to some of the various activities of CPST as defined in OAC 5129-22-17 (B). TCM will most likely be defined per population-based areas, possibly as SPMI, SED, polysubstance use, and those returning to communities from incarceration.

In 2019 and 2020, the value-based purchasing option for residential treatment for substance use disorders as well as examining and redefining residential treatment services for children/adolescents, specialized services in long-term care facilities and a review of waiver options will be the focus. All of which specific details have yet to be penned.

It is more than likely Ohio will follow suit with other states, such as Wisconsin, Minnesota, and Iowa to select a panel of service providers that will negotiate with the big 4 managed care plans (CareSource, Molina, Buckeye Health, United Health Care, and Paramount) in Ohio to provide the redesigned services. This could even set the stage for Ohio Medicaid to pare down from the big four to possibly 1 or 2 MCOs. Or Ohio could develop along the lines of redefined Medicaid Managed Care such as Oregon developed and implemented in 2012. Oregon developed Coordinated Care Organizations as a network of local providers who care for the Medicaid population under a fixed budget with emphasis on care coordination, integrated care, wellness and chronic disease management, which includes chronic mental illness and poly-substance use. Reimbursement is based on 17 various quality measures including substance abuse screenings, hospital readmissions, and primary care.

<https://cco.health.oregon.gov/Pages/AboutUs.aspx>

Another redesign option on the table at the state level is the implementation of Peer Support Services. Several states have implemented such an option. For instance, the State of Minnesota adopted Certified Peer Support services with a limit of 300 hours of service per year per service recipient. The costs per unit are as follows:

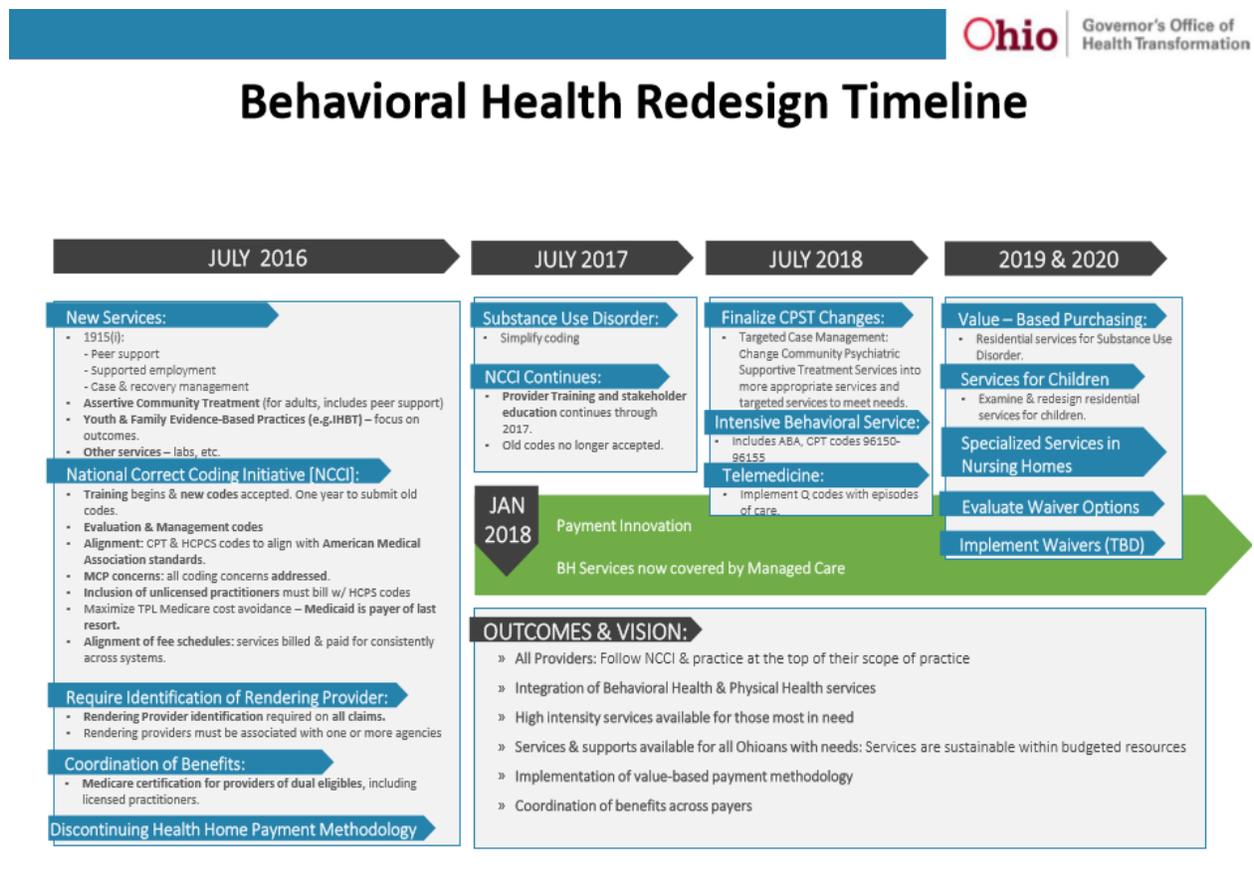
Procedure Code	Procedure Code Description	Rate
H0038	Self-Help/Peer Services	The lower of the submitted charge or \$11.38 per 15-minute unit
H0038-Modifier=U5	Self Help/Peer Services Specialist Level II	The lower of the submitted charge or \$13.01 per 15-minute unit
H0038-Modifier=HQ	Self Help/Peer Services in a Group Setting	In a group setting, the lower of the submitted charge or \$5.72 per 15-minute unit

http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&dDocName=dhs16_149185&RevisionSelectionMethod=LatestReleased

As can be seen on the following page, the Ohio Behavioral Health Redesign Timeline indicates the provision of behavioral health services in Ohio will be radically transformed over the next few years. By January 2018, all behavioral health services will be under a managed care option. Instead of the current system, most likely providers will need to clearly understand the operational and financial implications of these changes as they are implemented. As for CPST and AOD Case Management services, more specific criteria will be implemented as Targeted Case Management with Peer Support intertwined. Thus careful articulation of documentation of TCM services will need to occur as was shared by Mary Thornton in 2009 when the ODMH provided statewide trainings on medical necessity's golden thread. Even then the "writing was on the wall" that behavioral health services will be further re-designed.

In short, redesigned behavioral health services will be implemented over the next three years with additional hidden cost containments which hopefully are in the best interest of those being served.

Below is a brief overview of the BH Redesign Timeline released by the State of Ohio in October 2015.



SUMMARY AND RECOMMENDATIONS

The purpose of the Strategic Plan is to strengthen The BCMHARSB for future success in continually changing and increasingly demanding integrated behavioral healthcare and human services environments. The strategic planning process addresses the areas of “where we are” and “where we need to go.” In order to do so, the Strategic Plan results from a needs assessment of the Butler County demographic, prevalence and other trend data, and the

combined expertise and input of internal and external community stakeholders. The Strategic Plan recognizes and considers behavioral healthcare changes and challenges which are occurring at the local, state and national levels, revenue issues, and increasing demands for the BCMHARSB to do more with less while better demonstrating the effectiveness of its planning and service monitoring activities.

The BCMHARS Board has managed several significant changes during the last 12 months including the merger of the ADAS and MH Boards on July 1, 2015. During this transition, numerous integration processes have been facilitated to ensure the successful merger and the successful integration of addiction and mental health services planning and delivery in Butler County. As part of this integration process, the merged organization has initiated strategic planning to more effectively facilitate the merging of the boards and to integrate addictions services into the Board's forward planning process.

Implementation of this 3-year Strategic Plan will require the ongoing commitment and collaboration of BCMHARSB Board of Directors and leadership staff. In the current atmosphere, behavioral health organization like the Board are vulnerable to volatile regulatory changes requiring the continual re-examination and evaluation of strategic planning efforts to ensure that the organization responds to industry trends and the needs of its constituencies. This Strategic Plan is intended to be a living document that will be modified with the ever-changing environment and will be regularly reviewed and updated as needed by the Board of Directors and leadership staff. Portions of this plan may require modification based on availability of funding and capital.

Based on input from key community stakeholders and ROSC Survey results, the Butler County Mental Health and Addiction Recovery Services Board and the service delivery system have many identified strengths and opportunities to successfully move the organization and system forward. Key strengths identified included Butler County addictions and mental health service delivery system's continuum of care, a strong provider network of agencies, the community's awareness of addictions and mental health services, and the Board's expansion of services into the Middletown area, good system collaboration and improved communication, community support for the system of care, and prevention services and trauma informed care professionals.

Service delivery system needs / weaknesses identified by stakeholders included limited community knowledge and understanding regarding the BCMHARSB system of care and

services, community education on addictions and mental health, addictions detoxification and sober living capacity, limited funding for addictions and mental health services in general. No levy support for addiction services, psychiatric services capacity and waiting time for services.

The following Strategic Initiative Areas were identified to form the basis for the BCMHARSB's 3-year Strategic Plan. Strategic Initiatives are thrust areas that are necessary to move the organization forward. It's recommended that the Butler County Mental Health and Addiction Recovery Services Board utilize the assessment information contained in this report along with other planning and support documentation provided by BCMHARSB staff to identify strategies, goals and timeframes related to the following strategic initiative areas and are used to formulate the foundation for the Board's new three (3) year strategic plan:

STRATEGIC INITIATIVES

Leadership

Finance

Programming / Service Delivery System

Quality Improvement / Research

Information Technology

Advocacy / Public Relations

MASTER STRATEGIC PLAN



**Butler County
Mental Health & Addiction
Recovery Services Board**

2016 - 2018

LEADERSHIP

STRATEGIC GOAL: To enhance our identity as a collaborative center and a resource for excellence in the planning and delivery of behavioral health care services in Butler County while meeting identified community addiction and mental health needs.

#	Objectives / Actions	Lead	Year					
			Y1 Months		Y2 Months		Y3 Months	
			1-6	7-12	1-6	7-12	1-6	7-12
1.0	Ensure the provision of current knowledge to Board members regarding the changing focus, role and priorities of the BCMHARSB.							
1.1	Provide Board members with education and cross-training regarding addictions and mental health targeted population-based prevention and treatment / recovery models and services.	Executive Director and Board Staff		X	X	X	X	X
1.2	Conduct ongoing research on innovative integrated addictions and mental health Board models.	Executive Director and Board Staff	X	X	X	X	X	X
1.3	Provide information on state and federal-level changes in behavioral health, specifically providing information updates related to the Behavioral Health (BH) System Redesign process in Ohio.	Executive Director and Board Staff	X	X	X	X	X	X
1.4	Evaluate and implement recommendations to enhance ongoing Board education.	Board Chair and Executive Director		X		X		X
1.5	Complete Board self-evaluation at least annually or during times of high Board member turnover / transition. Use results to develop and implement a plan of action in response to recommendations for Board process improvement.	Board Chair and Executive Director		X		X		X
2.0	Establish and strengthen liaisons and collaborations with provider organizations, educational institutions and local business partners.							
2.1	Facilitate Board-to-Board interactions. Invite provider organization's Board members to BCMHARSB Board meetings.	Board Chair and Executive Director		X	X	X	X	X
2.2	Enhance relationships and establish collaborations with local higher educational institutions.	Executive Director and Board Staff	X	X	X	X	X	X
2.3	Establish collaborative leadership with community partners to provide public education on addictions and mental health issues. Consider the development and implementation of an integrated Community Education Plan with a special emphasis on addictions and specifically opioid addiction.	Executive Director and Board Staff			X	X	X	X
2.4	Consider the creation of a mental health and addictions Political Action Committee (PAC) related to levy activities, diversification, and involvement with businesses beyond the system providers.	Executive Director		X	X			

Leadership (Continued)

#	Objectives / Actions	Lead	Y1 Months		Year Y2 Months		Y3 Months	
			1-6	7-12	1-6	7-12	1-6	7-12
2.5	Develop strategic local business partnerships to fund levies.	Executive Director and CFO	X		X		X	
2.6	Evaluate and make recommendations to enhance new Board member orientation & implement recommendations	Board Chair and Executive Director			X	X	X	X
3.0	Develop and implement a detailed BCMHARSB Merger Operations Plan to support the successful integration of any outstanding internal addictions and mental health operations.							
3.1	Develop and implement detailed processes with time frames to integrate finance, IT, websites, QI, contracting, etc.	Executive Director and Board Staff	X	X	X	X	X	X
3.2	Ensure implementation of recommendations from the new Business Plan for Addiction Services.	Executive Director and Board Staff	X	X	X	X	X	X
4.0	Formally review progress on the BCMHARSB Strategic Plan at least annually.							
4.1	Facilitate the documented review of the BCMHARSB Strategic Plan. Update when indicated.	Board Chair and Executive Director		X		X		X
5.0	Promote and support professional staff development within the BCMHARSB service delivery system.							
5.1	Develop and implement a more comprehensive addictions training component within the service delivery system.	Executive Director and Board Staff	X		X		X	
5.2	Develop and implement a more comprehensive dual disorder training.	Executive Director and Board Staff	X		X		X	
6.0	Develop and implement a process / plan to assess levy feasibility for addiction services.							
6.1	Establish Ad-Hoc Board Committee to determine feasibility and time table for addictions levy option(s).	Board Chair and Executive Director	X		X		X	

FINANCE

STARTEGIC GOAL: Maintain financial viability of the BCMHARSB and the service delivery system through efficient and accountable financial management.

#	Objectives / Actions	Lead	Y1 Months		Year Y2 Months		Y3 Months	
			1-6	7-12	1-6	7-12	1-6	7-12
1.0	Seek and secure all funding sources available that are aligned with the BCMHARSB priorities.							
1.1	Research and pursue all potential grant & philanthropic foundation funding opportunities.	Executive Director and Board Staff	X	X	X	X	X	X
1.2	Track and keep documentation on any identified grant and foundation opportunities the Board considers.	Executive Director and Board Staff	X	X	X	X	X	X
1.3	Ensure full implementation and utilization of any grant/foundation funds issued to the Board specifically financial reporting and monitoring	Executive Director and Board Staff	X	X	X	X	X	X
1.4	Review current and any future funding sources for “flexible funding” possibilities	Executive Director and CFO	X	X	X	X	X	X
1.5	Ensure the full operational implementation and effectiveness of the GOSH billing system.	Executive Director and CFO	X	X	X	X	X	X
1.6	Research, review, and consider the application of performance based budgeting contracting models.	Executive Director and CFO		X				

Finance (Continued)

#	Objectives / Actions	Lead	Year					
			Y1 Months		Y2 Months		Y3 Months	
			1-6	7-12	1-6	7-12	1-6	7-12
2.0	Consider increased allocation of funds to meet local community needs and identified gaps in service.							
2.1	Review allocations between different types of programs / services as well as service & funding gaps in the system's continuum of care. Identify prioritized programs / services that the Board would support. (Specific programming, high health insurance deductibles and co-pays, etc.)	Executive Director and Board Staff		X	X	X	X	X
2.2	Ensure structured decision-making protocols for the funding allocation process.	Executive Director and Board Staff		X	X	X	X	X
3.0	Ensure timely information / understanding of possible impact(s) on the local system of care when decisions are made / implemented by the Office of Health Transformation's BH Re-design process.							
3.1	Monitor correspondence / information from the Office of Health Transformation and OACBHB for detail regarding projected changes in the Ohio BH model, impact of the Medicaid Managed Care option.	Executive Director and Board Staff	X	X	X	X	X	X
3.2	Formulate Board plan in response to potential increase in consumer requests for services under the Medicaid Managed Care option.	Executive Director and Board Staff	X	X	X	X	X	X

PROGRAMMING / SERVICE DELIVERY SYSTEM

STRATEGIC GOAL: Fund and maintain a high quality, cost effective addictions and mental health service delivery system which supports Prevention, Early Intervention, Treatment and Recovery.

#	Objectives / Actions	Lead	Year					
			Y1 Months		Y2 Months		Y3 Months	
			1-6	7-12	1-6	7-12	1-6	7-12
1.0	Establish opioid addiction intervention as a high priority in the Butler County addiction and mental health service delivery system.							
1.1	Research, develop and implement a comprehensive plan to address opioid addiction in Butler County.	Executive Director & Board Staff	X	X	X	X	X	X
1.2	Develop and utilize collaborative partnerships within the service delivery system to address the opioid addiction epidemic.	Executive Director and Board Staff	X	X	X	X	X	X
1.3	Develop and implement a Peer Recovery/Peer Mentoring model for mental health and addiction services	Board Staff		X	X			
1.4	Consider the feasibility of expanding acute and sub-acute detoxification services capacity for alcohol / drug addiction in Butler County.	Board Staff	X					
2.0	Assume leadership role in efforts to increase / improve system of care Pharmacological Management capacity and access.							
2.1	Facilitate the development of a formal plan to increase Pharmacological management capacity for adults and children in the mental health and addictions delivery system through collaborative efforts with relevant system providers.	Executive Director and Board Staff			X	X	X	X
2.2	Research and consider alternative options to increase psychiatry capacity through use of physician assistants, APRN's, general practitioners, contracting with vendors through outsourcing, etc.	Board Staff			X	X	X	X

Programming / Service Delivery System (Continued)

#	Objectives / Actions	Lead	Year					
			Y1 Months		Y2 Months		Y3 Months	
			1-6	7-12	1-6	7-12	1-6	7-12
3.0	Identify and encourage evidence-based models for treatment and prevention program services system-wide.							
3.1	Perform an overall assessment of all programming to identify and categorize programs as Evidenced-Based (EB), Modified Evidence-Based (MEB), or Non-Evidenced-Based (NEB)	Board Staff			X			
3.2	Evaluate the feasibility of requiring the implementation of EB models of addiction and mental health treatment and prevention services.	Board Staff				X	X	X
4.0	Research Butler County addictions and mental health service delivery services access.							
4.1	Develop and implement relevant client access targets for the community mental health and addictions system including time to assessment, treatment, and pharmacological management sessions.	Board Staff			X	X	X	X
4.2	Support and expand central access/ care coordination model for alcohol & other drug services	Board Staff	X	X	X	X	X	X
5.0	Complete a full analysis / review of the Crisis Intervention System including Mobile Crisis and Hotline Services.							
5.1	Complete a review / analysis Mobile Crisis and Hotline Services including mental health and alcohol & other drug services. Implement recommendations if feasible and cost effective.	Executive Director and Staff			X	X	X	X
5.2	Include consideration of Quick Response Team / First Responders program as well as training as part of the Business Plan for addictions.	Executive Director and Staff	X	X				
6.0	Complete a full analysis / review of the Butler County residential treatment capacity and effectiveness.							
6.1	Complete a review / analysis of mental health and alcohol & other drug residential treatment services for adults and implement recommendations if feasible and cost effective.	Executive Director and Staff			X	X		
6.2	Complete a review / analysis of mental health and alcohol & other drug residential treatment services for youth and implement recommendations if feasible and cost effective.	Executive Director and Staff			X	X		
7.0	Complete a review / inventory of housing capacity, utilization and effectiveness in meeting projected need.							
7.1	Review existing housing resources in the county for residents with mental health and alcohol & other drug diagnoses	Board Staff	X					
7.2	Develop a comprehensive housing plan to address mental health and recovery housing needs in the county including group homes, step down, transitional aged youth, & sober living facilities.	Board Staff		X	X			

Programming / Service Delivery System (Continued)

#	Objectives / Actions	Lead	Y1 Months		Year Y2 Months		Y3 Months	
			1-6	7-12	1-6	7-12	1-6	7-12
8.0	Research the feasibility of the creation of an “Alternative Sentencing Center” in Butler County.							
8.1	Review current alternative treatment center models (i.e. Clermont County) for applicability to Butler County, performance and cost effectiveness of the model(s). Implement if indicated and funded adequately.	Board Staff	X	X				
9.0	Consider increasing addiction services capacity.							
9.1	Complete Addiction Services outpatient capacity study and implement recommendations if indicated and cost-effective.	Board Staff	X	X				
9.2	Identify and secure additional revenue to fund increase in addiction services capacity (i.e. levy, grants, donations, addictions-specific state funding).	Board Staff	X	X	X	X	X	X
10.0	Evaluate Butler County addictions and mental health consumer transportation capabilities, gaps and needs.							
10.1	Complete addiction and mental health consumer transportation study and implement recommendations if indicated and cost-effective.	Board Staff					X	X
11.0	Evaluate need for continued consultation with the Ohio Coordinating Center of Excellence (CCOE) regarding dual diagnosis services.							
11.1	Follow-up with CCOE staff to consider moving forward with dual disorder (addictions, mental health and developmental disabilities) services model in Butler County.	Board Staff		X				
12.0	Evaluate Employment and Vocational services programming.							
12.1	Complete an evaluation of Employment / Vocational programming and based on recommendations create and implement plan for system improvements.	Board Staff				X		

QUALITY IMPROVEMENT / RESEARCH

GOAL: ENSURE A QUALITY IMPROVEMENT (QI) PHILOSOPHY THAT EMPLOYS DATA-INFORMED DECISION MAKING.

#	Objectives / Actions	Lead	Year					
			Y1 Months		Y2 Months		Y3 Months	
			1-6	7-12	1-6	7-12	1-6	7-12
1.0	Develop an integrated Board system focused Quality Improvement Program							
1.1	Review former BCMHB, BCADAS, & other Board system focused QI plans.	Executive Director and Board Staff	X					
1.2	Implement new Board system focused QI plan.	Executive Director & Board Staff		X	X	X	X	X
1.3	Develop and Implement satisfaction survey process for the Board inclusive of Culture of Quality (COQ) requirements.	Board Staff		X		X		X
2.0	Develop an integrated Board focused QI Plan							
2.1	Review former BCMHB, BCADAS, & other Board focused QI plans.	Executive Director and Board Staff	X					
2.2	Implement new Board focused QI plan.	Executive Director & Board Staff		X	X	X	X	X
3.0	Review and update the BCMHARSB Outcomes Management System							
3.1	Integrate mental health and addictions outcome's management components.	Executive Director & Board Staff	X					

3.2	Create and implement an Outcomes Management System Plan.	Executive Director and Board Staff		X				
3.3	Ensure follow-up with the identification and development of system-wide outcome measures for addictions and mental health treatment and prevention.	Executive Director and Board Staff			X	X	X	X
3.4	Monitor ongoing validity, reliability and effectiveness of the system performance on the established outcome measures.	Executive Director & Board Staff			X	X	X	X
4.0	Develop an integrated Board Subsidy Audit Process							
4.1	Create and implement an integrated audit plan.	Executive Director , CFO, & Board Staff		X	X	X	X	X
4.2	Ensure audit plan includes financial consequences for non-compliance.	Executive Director, CFO, & Board Staff		X		X		X
5.0	Maintain process to identify and address the effectiveness of service delivery system programs and services.							
5.1	Identify, develop and implement addiction and mental health service program evaluation process with effectiveness measures for comparative analysis capability. Monitor and evaluate program provider corrective action plans.	Executive Director & Board Staff		X		X		X
5.2	Align, consolidate or eliminate poor performing Board supported provider programs based on assessed community needs, priorities, and available resources.	Executive Director & Board Staff		X	X	X	X	X
6.0	Ensure Culture of Quality re-certification.							
6.1	Board staff and other resources are assigned and accountable to ensure COQ recertification.	Board Staff)	X	X	X	X	X	X

INFORMATION TECHNOLOGY

GOAL: RESEARCH AND ADOPT CURRENT INFORMATION TECHNOLOGIES TO IMPROVE AND ENHANCE COLLABORATION AND COMMUNICATION TO BEST SERVE THE BCMHARSB, COMMUNITIES, CONSUMERS AND CLIENTS.

#	Objectives / Actions	Lead	Y1 Months		Year Y2 Months		Y3 Months	
			1-6	7-12	1-6	7-12	1-6	7-12
1.0	Ensure state-of-art information technology capability exists at the BCMHARSB.							
1.1	Prioritize the integration of the addictions and mental health IT systems. Ensure reliability and validity.	Executive Director and Board Staff	X	X	X	X	X	X
1.2	Ensure the development of a BCMHARSB Information Technology Plan.	Executive Director and Board Staff					X	
1.3	Identify and implement utilization of state-of-the-art social media and other IT technologies to improve communication, education and access for Board, providers, consumers and clients	Executive Director and Board Staff	X	X	X	X	X	X
1.4	Assess website content and complete an update of the BCMHARSB's website to include the integration of addictions and mental health components, to include portal access, education, and other Board-related business.	Executive Director and Board Staff	X	X	X	X	X	X
1.5	Research the feasibility of the BCMHARSB being completely electronic in all operations (Paperless).	Executive Director and Board Staff						X
1.6	Identify and utilize new technologies for community education / advocacy, communication and other BCMHARSB and Butler County needs.	Executive Director and Board Staff	X	X	X	X	X	X
1.7	Review and maintain HIPAA compliance related to PHI privacy, security and electronic transactions technology annually	Executive Director and Board Staff		X		X		X

ADVOCACY / PUBLIC RELATIONS

GOAL: ENSURE A KNOWLEDGABLE GENERAL PUBLIC, ELECTED OFFICIALS, AND OTHER STAKEHOLDERS ABOUT ADDICTIONS AND MENTAL HEALTH SERVICES THROUGH ADVOCACY AND PUBLIC EDUCATION ACTIVITIES.

#	Objectives / Actions	Lead	Y1 Months		Year Y2 Months		Y3 Months	
			1-6	7-12	1-6	7-12	1-6	7-12
1.0	Develop and implement a BCMHARSB Advocacy / Public Relations Plan.							
1.1	Identify specific public relations target areas, develop and implement an Advocacy / Public Relations Plan that includes strategies to better penetrate the Butler County market area and to enhance the BCMHARSB 'branding'.	Executive Director and Board Staff		X				
1.2	Implement Advocacy/Public Relations Plan	Executive Director & Board Staff			X	X	X	X
1.3	Establish a BCMHARSB Speaker's Bureau and publicize availability for public education	Executive Director & NAMI Director	X	X	X	X	X	X
1.4	Identify innovative ways to market the Board & educate public employing presentations & trainings promoting the use of counseling skills and abilities to local businesses	Executive Director & Board Staff	X	X	X	X	X	X
1.5	Compile a summary of ROSC Survey results and utilize in media campaign, levy promotion and public education opportunities.	Executive Director & Board Staff		X	X	X	X	X

Advocacy / Public Relations (Continued)

#	Objectives / Actions	Lead	Year					
			Y1 Months		Y2 Months		Y3 Months	
			1-6	7-12	1-6	7-12	1-6	7-12
2.0	Increase elected officials awareness and knowledge about addictions and mental health services.							
2.1	Enhance education of our county elected officials about mental and addiction issues	Executive Director and Board Staff	X	X	X	X	X	X
2.2	Develop annual events / presentations for elected officials on the BCMHARSB's addictions and mental health services system.	Executive Director and Board Staff		X		X		X
2.3	Identify key staff and Board members that will provide advocacy for addictions and mental health services at the local and state level(s).	Board, Executive Director and Board Staff	X	X	X	X	X	X
2.4	Develop and support addictions and mental health stigma reduction campaigns.	Board Staff	X	X	X	X	X	X
3.0	Expand existing advocacy / public education efforts regarding addictions and mental health.							
3.1	Establish local planning team to better understand and address the recommended changes / impact to the local addictions and mental health system by the BH Redesign Committee from the Office of Health Transformation. Prioritize advocacy efforts.	Board, Executive Director and Board Staff				X		
3.2	Partner with NAMI, OACBHA and other key partners to collaborative as a stigma reduction team.	Board Staff	X	X	X	X	X	X

ADDENDA

- **Key Community Stakeholder Participant List**

ADDENDUM A

KEY COMMUNITY STAKEHOLDER PARTICIPANT LIST

The following individuals provided input into Butler County Mental Health and Addiction Recovery Services Board's 2016 – 2018 Strategic Plan assessment phase through participation in one of the several focus groups, interviews or ROSC survey completion. Their contributions to the planning process were of significant help in gaining their subjective perception of the BCMHARSB's service delivery system capabilities, needs and direction for planning purposes.

Jennifer	Achterman	CFS
Captain Dennis	Adams	Butler County Jail
Michael	Albrecht	Fairfield City School District
Laura	Amiott	BCMHARS Board
Janae	Arno	Miami University Oxford
Sarah	Barnett	Butler County Educational Services Center
Katherine	Becker	Transitional Living, Inc.
Rhonda	Benson	NAMI Butler County
Sean	Blyth	St. Aloysius
Denise	Boyd	BCMHARS Board
Matt	Brashear	Community Behavioral Health
Steve	Cahill	Community Behavioral Health
Cindy	Carpenter	Butler County Commissioner
Jennifer	Carter	BCMHARS Board
Lauren	Costello	BCMHARS Board
Kenny	Craig	Greater Hamilton Chamber of Commerce
Angie	Creech	BCMHARS Board
Vivian	Crooks	BCMHARS Board
Eric	Cummins	St. Joseph Orphanage
Shavonte	Daren	Butler County SELF
	Deis-	
Patricia	Gleeson	BCMHARS Board
Barbara	Desmond	BCMHARS Board
Susan	Dodgson	NAMI Butler County
Megan	Eastman	Butler County Family and Children First Council
Ann	Elam	BCMHARS Board
Lindsey	Ervin	St. Aloysius
Kay	Farrar	City of Hamilton Health Dept.
Scott	Fourman	BCMHARS Board
Lisa	Frye	LifeSpan

Scott	Gehring	Sojourner Recovery Services
Julie	Gilbert	Butler County Children's Services
Bridgitte	Gray	Big Brothers Big Sisters
Chrystal	Green	Butler County Family and Children First Council
Chris	Hacker	BCMHARS Board
Ellen	Harvey	BCMHARS Board
Ben	Heroux	NAMI Butler County
Joe	Hinson	West Chester/Liberty Chamber Alliance
Tom	Huffman	Fort Hamilton Hospital
Dr. Theodore	Hunter	BCMHARS Board
Jolynn	Hurwitz	LifeSpan
Patricia	Irwin	BCMHARS Board
Brandy	Jones	Community Behavioral Health
Mary	Justice	NAMI Butler County
Cassandra	Kiesey	Assistant County Prosecutor
Deb	Kombere	Butler County Educational Services Center
Patrick	Kuhl	NAMI Butler County
Janalee	Lennartz	NAMI Butler County
Edward	Livesay	Mosaic Strategic Partners
Alyssa	Louagie	NAMI Butler County
Lauren	Marsh	Butler County Coalition
Lauren	Marsh	BCMHARS Board
Jennifer	Mason	Fort Hamilton Hospital
Wayne	Mays	BCMHARS Board
Kimberly	McKinney	Community Advocate
Brad	McMonigle	Talbert House
Jennifer	McMonigle	St. Aloysius
Dr. Cricket	Meehan	BCMHARS Board
Patrick	Moeller	City of Hamilton Mayor
Christy	Morris	Community Behavioral Health
Quinton E.	Moss	Modern Psychiatry and Wellness
Dennis G.	Murray	NAMI Butler County
Tim	Myers	Butler County Juvenile Court
Marianne	Niese	BCMHARS Board
Julie	Payton	BCMHARS Board
Leroy	Peyton	NAMI Butler County
Jackie	Phillips	Middletown City Health Department
Deanna	Proctor	Access Counseling Services, LLC
Patti	Quinn	BCMHARS Board
Debra	Rainer	Eve Center
Dr. Scott	Rasmus	BCMHARS Board

Amber	Reckner	BCMhARS Board
Kristin	Reed	St. Raphael
Gwen	Reynolds	NAMI Butler County
Marion	Rhodus	BCMhARS Board
Bruce	Ripley	Ripley Communications, LLC
Pam	Robinson	Transitional Living, Inc.
Judge Randy	Rodgers	Butler County Probate Court
Megan	Schultz	NAMI Butler County
Laura	Sheehan	Community Behavioral Health
Dorothy		
McIntosh	Shuemaker	Butler County Family and Children First Council
Rev. Gary	Smith	BCMhARS Board
Jenny	Souders	NAMI Butler County
Bill	Staler	LifeSpan
Debbie	Stanton	NAMI Butler County
Suzan	Stracke	NAMI Butler County
Kimball	Stricklin	Butler Behavioral Health Services, Inc.
Dave	Swigonski	BCMhARS Board
Lonnie	Tucker	BCMhARS Board
Christi	Valentini	Greater Hamilton Coalition