



**Alcohol and
Drug
Addiction
Services Board**

OF LORAIN COUNTY

**COMMUNITY PLAN
*FOR SFY 2010-2011***

Submitted on:
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INTRODUCTION

The Alcohol and Drug Addiction Services Board of Lorain County (ADAS) is a special purpose governmental agency charged with planning, evaluating, coordinating, funding and contracting for the delivery of publicly-financed alcohol and drug addiction education, prevention and treatment services for the benefit of the residents of Lorain County, pursuant to the Ohio Revised Code (Title 3 – chapter 40).

ADAS is governed by an 18 member volunteer board, all of whom are Lorain County residents appointed by the Lorain County Commissioners or the Director of the Ohio Department of Alcohol and Drug Addiction Services.

The Ohio Department of Alcohol and Drug Addiction Services' (ODADAS) Planning Committee of the Governor's Shareholders Group produced a final report June 17, 2003 that continues to provide guidance to the development of the community plans. The report identified seven priority issues related to community planning which have been expanded upon to address the Alcohol and other Drug (AoD) and mental health system community plan in counties throughout Ohio:

1. The community plan should be a living, useful document with widespread applicability and awareness. The Community Plan should be viewed as a management tool for the Board. In this regard the Plan is best used for marketing, resource development, service identification and delivery and evaluation.
2. Service planning needs to be purposefully connected with other related planning processes in the community. The plan should address shared community priorities where possible. It should promote solution for priorities established by other entities within the service area.
3. The Planning Committee believed that it was important to identify "best practices" of community planning and share these practices with all counties.
4. It is important to identify tangible benefits for local communities that come from doing quality planning.
5. There must be a better connection between local community plans and Departmental funding priorities and decisions. This allows local planners to support Departments' initiatives and allow the Departments to promote local initiatives. An improved connection between state and local planning places the field in a position to better advocate for and develop the system. Community Plans and Department priorities should jointly be the basis for the development of state plans.
6. Identify and eliminate activities that are non-productive to the planning process.
7. Recognize that local political process and activity influences community planning.

The Governor's Shareholders Group Planning Committee also identified key reasons for engaging in quality planning. These included:

1. Improve the financial position of local behavioral health systems by attracting support from other areas that have a vested interest in assuring that a healthy

- alcohol and other drug and mental health system exists in the county.
2. Improve the ability of other systems to meet their needs and objectives.
 3. A basis for marketing efforts that is needed to attract participation and support (investment) from other systems including the business community.
 4. The Community Plan should be product oriented – its operationalization should result in concrete results based upon identified priorities. This should be a *community product* related to shared community priorities.

In summary, the Community Plan for SFY 2010-2011 places an emphasis in clarity of outcomes and results within a planning process. The plan results in the ADAS Board's focus on Board Investor Targets (outcomes) that are consistent with and contribute to Department Investor Targets (outcomes) and verification of achieved' results.

MISSION STATEMENT

“The mission of the Alcohol and Drug Addiction Services Board of Lorain County is to evaluate program quality and continuity of care, as well as, plan, coordinate, fund and contract for services to prevent, educate and treat alcoholism and other drug addiction that will result in the well-being of Lorain County residents. The Board will assess programs and provide feedback to ensure that all services are of high quality, efficient and effective in recovery and prevention.”

VISION & VALUE STATEMENTS

We believe through our contract provider- and collaborative-partnerships (locally, statewide and nationally), consumers can move towards abstinence with positive life-style changes.

We believe that as stewards of public funds for alcohol, tobacco and other drug prevention, intervention and treatment services, our system needs to continually refine and learn from the behaviors and activities of our consumers and their families – as affected by the disease of alcoholism and other drug addiction.

We believe that a full continuum of care, including prevention, intervention and treatment is only the beginning of the foundation of recovery from the disease of alcoholism and other drug addiction.

SECTION I: CURRENT CIRCUMSTANCES/ “AS-IS” STATE

I. Legal Context of the Community Plan

The Alcohol and Drug Addiction Services Board of Lorain County is required by Ohio law to prepare and submit to the Ohio Department of Alcohol and Drug Addiction Services (ODADAS) a plan for the provision of alcohol, drug addiction services in its service area. The plan, which constitutes the Board’s application for funds, is prepared in accordance with procedures and guidelines established by ODADAS. This plan covers state fiscal years (SFY2010 – 2011 (July 1, 2009 through June 30, 2011)).

The requirements for the community plan are broadly described in state statute. In addition, federal requirements that are attached to state block grant dollars regarding allocations and priority populations also influence community planning.

Ohio Revised Code (ORC) 340.03 and 340.033 – Board Responsibilities

Section 340.03(A) of the Ohio Revised Code (ORC) stipulates the Board’s responsibilities as the planning agency for mental health services. Among the responsibilities of the Board described in the legislation are as follows:

- 1) Identify community mental health needs;
- 2) Identify services the Board intends to make available including crisis intervention services;
- 3) Promote, arrange, and implement working agreements with social agencies, both public and private, and with judicial agencies;
- 4) Review and evaluate the quality, effectiveness, and efficiency of services; and
- 5) Recruit and promote local financial support for mental health programs from private and public sources.

Section 340.033(A) of the Ohio Revised Code (ORC) stipulates the Board’s responsibilities as the planning agency for alcohol and other drug addiction services. Among the responsibilities of the Board described in the legislation are as follows:

- 1) Assess service needs and evaluating the need for programs;
- 2) Set priorities;
- 3) Develop operational plans in cooperation with other local and regional planning and development bodies;
- 4) Review and evaluating substance abuse programs;
- 5) Promote, arrange and implement working agreements with public and private social agencies and with judicial agencies; and
- 6) Assure effective services that are of high quality.

ORC Section 340.033(H) (H.B. 484)

Section 340.033(H) of the ORC requires ADAS Board to consult with county commissioners in setting priorities and developing plans for services for Public Children Services Agency

(PCSA) service recipients referred for alcohol and other drug treatment. The plan must identify monies the Board and County Commissioners have available to fund the services jointly. The legislation prioritizes services, as outlined in Section 340.15 of the ORC, to parents, guardians and care givers of children involved in the child welfare system.

HIV Early Intervention Services

Eleven Board areas receive State General Revenue Funds (GRF) for the provision of HIV Early Intervention Services. Boards that receive these funds are required to develop an HIV Early Intervention Investor Target and include: Butler ADAS, Eastern Miami Valley ADAMHS, Cuyahoga ADAS, Franklin ADAMHS, Hamilton ADAMHS, **Lorain ADAS**, Lucas ADAMHS, Mahoning ADAS, Montgomery ADAMHS, Summit ADAMHS and Stark ADAMHS Boards.

Federal Substance Abuse Prevention and Treatment (SAPT) Block Grant

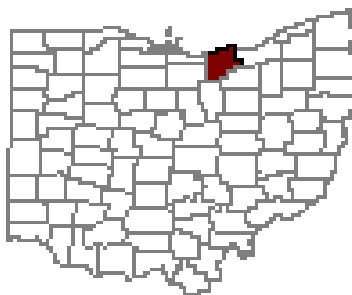
The federal Substance Abuse Prevention and Treatment (SAPT) Block Grant requires prioritization of services to several groups of recipients. These include: pregnant women, women, injecting drug users, clients and staff at risk of tuberculosis, and early intervention for individuals with or at risk for HIV disease. The Block Grant requires a minimum of twenty (20) percent of federal funds be used for prevention services to reduce the risk of alcohol and other drug abuse for individuals who do not require treatment for substance abuse.

II. Environmental Context for the Community Plan

A. Board Area and Clients Served

Board Area

The ADAS Board of Lorain County serves the county Lorain, Ohio. Lorain County is the ninth largest county in Ohio and covers approximately a 492 square mile area for its approximately 301,993 residents. There are approximately 577 persons per square mile in the county which is part of the Cleveland-Elyria-Mentor Metropolitan Statistical Area. Relevant statistics are identified:



- 17.6% of Lorain County residents were living below the federal poverty level in 2006 with the highest concentrations in the cities of Elyria and Lorain;
- *20.8% persons below age 18 (children) are identified as living in a household below the poverty level;*
- In January, 2009, the county experienced a 8.9% unemployment rate where the state average was 9.7 % (unadjusted);
- Lorain County has experienced a 445 percent growth in the number of increased foreclosure filings in the past 10 years;

- A Media Release from the Ohio State Highway Patrol indicates that Lorain County had the second highest number of DUI stops state-wide in 2006!

Lorain County is located in the northeast portion of Ohio bordering on Lake Erie. Major attractions in Lorain County include 21 miles of Lake Erie shoreline, various state/metropolitan parks and cultural events, which proudly spotlight the county's diverse ethnic and multi-cultural residents. Lorain County is westerly-connected to Cuyahoga County – Ohio's largest county. Two of its major interstates (80/90) are often considered the "drug pipeline" connecting Detroit and Chicago to New York cities – that travel directly between Lorain and Elyria cities. Lorain County is comprised of 14 major cities and includes many smaller cities, townships and villages – it is a mix of urban and rural communities. We have inherited urban sprawl migration from Cuyahoga County (Cleveland) in our fringe communities, while having urban poverty centers in our core. South Lorain (a Lorain city neighborhood) has a large population of Hispanic Americans, many of whom are in monolingual households. In contrast, the Southern fringes of Lorain County are largely rural, with some volume of working farms. 68% of the population resides in the urban areas, while 32% resides in rural areas of the county. There are no tribal areas or populations targeted in Lorain County. The largest cities are: Lorain, Elyria, North Ridgeville and Avon Lake. The county seat is located in Elyria. There is one 2-year public college, one private college and one joint vocational school in the county. The public college has undertaken aggressive partnerships, which allows for Lorain County residents to obtain four-year (and masters) degrees in a number of categories.

Public transportation provides service primarily between the two largest communities (Lorain, and Elyria), and west into Cleveland, thus transportation has been an issue for many in fringe communities. Further complicating this issue is the large number of those in publicly funded alcohol and drug treatment services that have lost driving privileges due to their substance abuse. Lorain County remains the ninth most populous county in Ohio. Lorain County ranks among the top 10 counties in Ohio prioritized by the Ohio State Highway Patrol for Impaired Driving Enforcement Activities. The 2006 census estimates profile general demographic characteristics and identify the following for Lorain County: total population, 301,937; Gender: 49.1% male, 50.9% female; Median Age: 37.7 years; approximately 14.36% of Lorain County residents are minority (including significant African American (7.2%) and Hispanic (primarily Puerto-Rican) (7.4%) populations). Of the population 5 years and older, 8.1% primarily speak language other than English (including Spanish, Other Indo-European, Asian and Pacific Island languages). Twenty seven percent (27%) of these reported that they did not speak English "very well". The median household income is \$47,913. Approximately 12.4% (36,742) residents are 65 years and older and 24.3% (73,384) of the residents is under 18 years of age. Of those 25 years and older, 17.2% (31,888) attained either less than 9th grade (4.1%) or 9th – 12th grade, no diploma (13.1%). 82.2% of people 25 years and over had at least graduated from high school and 15% hold a bachelor's degree or higher. Among people 16 to 19 years old, 27% were dropouts; they were not enrolled in school and had not graduated from high school. The primary industry is manufacturing (24.2%) followed next by educational, health and social services (19.3%).

We continue to emphasize partnerships, leveraging and acquisition of resources appropriate to our outcome findings. We continue to look towards regional and national opportunities in terms of trainings, funding and other technical assistance towards the ultimate goals of client success. The details of our initiatives include: Ohio’s State Access and Retention – State Implementation – with Lorain County Alcohol and Drug Abuse Services, Inc. (LCADA) , Great Lakes Addiction Technology Transfer (workforce, training and manualization), active partnership with the Network for Improvement of Addiction Treatment (NIATx), grants acquisition – Drug Free Communities and Support (Office of National Drug Control Policy) (ADAS Board – 5 year award) and technical assistance in our community to acquire two Substance Abuse and Mental Health Services Administration (SAMHSA) – Pregnant and Postpartum Women residential substance abuse treatment (LCADA - 3 year award) and HIV/AIDS Outreach and substance abuse treatment capacity expansion (Lorain UMADAOP – 5-year award). We were also a finalist with the Robert Wood Johnson Foundation – Advancing Recovery Initiative. Locally, our investor targets are shared with venues that include the Lorain County Children and Families Council and our local Community Foundation. The Board’s recently completed Continuous Quality Improvement Report (2008) included components of Waiting List, Clinical/Prevention Reviews, Outcomes, Satisfaction Data, Grievances and Major Unusual Incidents, Workforce Development, Utilization Review. Details of these accomplishments are further embedded in key components of this plan.

Client Characteristics (Clients Served)

Annually, the ADAS Board completes utilization review data as part of its’ continuous quality improvement plan. Inclusive of this is waiting list and utilization data. 2008 CQI findings are below:

Substance Abuse Treatment and Recovery Support Services

Utilizing State Fiscal Year 2008, an identification of clients in receipt of alcohol and other drug addiction treatment was gathered from claims, behavioral health (BH) and DataMart sources. Information includes client demographic data (at assessment), detox services analysis, prevention and treatment investments.

Demographic Data at Assessment:

FY 08	Race	Number	Percentage
	Asian	2	0.12%
	Black/African American	310	18.60%
	Native American	11	0.66%
	White	1287	77.20%
	Unknown	40	2.40%
	Multi-Racial	17	1.02%
	Total	1667	100.00%

FY 08	Ethnicity	Number	Percentage
	Puerto Rican	133	7.98%
	Mexican	22	1.32%
	Other Hispanic	10	0.60%
	Not Hispanic or Latino	1499	89.92%
	Cuban	1	0.06%
	Multi-Ethnic	2	0.12%
	Total	1667	100.00%

Using the Behavioral Health Module, 2008 some statistical items:

89% of these clients are over the age 18 (between the ages of 18-64). 61% of the clients are male, 39% of the clients are female. 40.37% have been reported as high school graduate.

As part of the Board's annual CQI report, services, procedures and costs are compiled. The details for SFY 2008 are identified in the table below:

SFY 2008 Detail of Services/Procedures/and Cost

Service	UPI	UCI	Units	Measure	to Total	AVG	Billed	% Billed	Paid	Medicaid
Assessment	31	1,712	3,418.20	hour	2%	2.00	420,365.74	7%	285,349.27	118,943.17
Laboratory Urinalysis	14	40	266	per screen	0%	6.65	13,995.25	0%	10,084.16	9,923.92
Individual Counseling	26	1,094	15,738.00	15 min	9%	14.39	384,253.92	7%	338,236.69	176,535.72
Group Counseling	23	1,149	104,121.00	15 min	62%	90.62	947,252.57	16%	531,002.02	211,267.97
Case Management	27	1,813	3,775.80	hour	2%	2.08	318,169.45	5%	298,039.08	143,421.27
Crisis Intervention	6	44	39.1	hour	0%	0.89	7,915.66	0%	4,286.92	2,291.67
Acute Hospitalization	2	3	7		0%	2.33	3398.5	0%	0	0
Subacute Detoxification	3	57	301	day	0%	5.28	117,569.08	2%	116,584.38	0
Ambulatory Detox					0%			0%		
Intensive Outpatient	13	862	20,964.30	day	12%	24.32	2,855,388.84	49%	1,393,425.61	568,454.76
Medical Somatic	7	44	170.1	hour	0%	3.87	30,675.07	1%	29,204.46	17,544.53
BH Non-Med, Non-Acute	1	20	1379	day	1%	68.95	75,637.85	1%	0	0
Methadone Administration	1	13	3,323.00	dose	2%	255.62	21,298.28	0%	20,617.16	20,617.16
Other AOD Services	1	15	764.1		0%	50.94	45,846.00	1%	42,672.00	0
Family Counseling	3	5	71	15 min	0%	14.20	933.89	0%	469.79	0
Child Care	1	61	3,340.70	hour	2%	54.77	47,538.33	1%	47,527.07	0
Med. Comm Treatment Room & Board	5	234	10,034.10	day	6%	42.88	403,998.01	7%	349,933.19	0
Transportation	1	1	13	month	0%	13.00	94,503.50	2%	87,234.00	0
Urine Dip Screen				per screen	0%			0%		
Non-Med Comm Treatment	2	4	220	day	0%	55.00	29,765.69	1%	0	0
Undefined	2	2	63		0%	31.50	5,040.00	0%	0	0
BH Non-Med Comm Treat.	2	2	75	day	0%	37.50	7,499.25	0%	0	0
Totals			Mixed Units	Mixed Units	100%		5,831,044.88	100%	3,554,665.80	1,269,000.17

Detoxification Services

The ADAS Board continues its contract for non-medical sub-acute Detoxification with Stella Maris representing 56 adults receiving this service in 2008. These clients received an average of 5.12 detox days for a total cost of \$116,584 for an average cost per client of \$2,082 for this level of care. Similarly from 2007, 100% of the detox clients presented

with Opioid dependence.

Most clients (54 of the 56) received only 1 episode of detox in the year. Most of these clients (76.79%) received only 1 episode of detox in the past 4 years. During the year, most of the clients received other treatment services in the ADAS Board's network; of these 4 clients also were induced with the medication Suboxone. Overall, these 56 clients received \$295,444 in treatment services, for an average cost per client of \$5,267. Of particular note is the (mode) age of the clients between 2007 to 2008 which indicates a younger age group of clients needing detoxification this year:

Mode Age:	<u>2007</u>	<u>2008</u>
Female	35	26
Male	42	30

Other Treatment Services

Utilizing State Fiscal Year 2009 information the Board's investment in treatment is program based. Within these programs are brief descriptions of the customers (clients) for this category:

Pretreatment programming primarily serves clients from all agencies that have completed assessment and are awaiting level of care placement. There are currently seven pre-treatment groups. Two of these groups are designated for symptomatic clients. Current capacity is around 140 (men and women) – a majority of these clients are awaiting residential or intensive outpatient treatment.

Adult Outpatient programming primarily serves men (there is a women's program – see below) includes intensive (IOP) and low-intensive outpatient programming; Programs include treatment, family groups and aftercare in Lorain and Elyria. Assessments are provided at the agency as well as in Lorain and Elyria Municipal Court settings. IOP programming is offered 1-5 times a week between 12 weeks to 6 months. Low Intensity is mainly group format offered 3 hours a week for 4-6 weeks. Vocational case management and drug screens are integral components of this level of care.

Women's Intensive Outpatient programming' capacity approximates 36 slots; an additional evening IOP group has been recently added.

Residential (men and women) currently has capacity for 16 beds at separate facilities (men/women); the Men's residential facility includes an Intensive Outpatient with supportive housing component. At the close of State Fiscal Year, 2008, the one of the Board's treatment providers (Compass House) ceased its operation. This agency was a primary provider of men's residential treatment and one of two providers for women's residential treatment and outpatient programs for adults. Upon the culmination of the State Fiscal Year 2009, the Board contracted with Lorain County Alcohol and Drug Abuse Services for expansion of men's residential treatment. This transition has balanced the availability of residential beds for adult men and women –each at 16 bed capacity. Men's Residential programming targets approximately 30 days residential, an additional 5-6 months of intensive outpatient followed by aftercare services. Women's Residential programming approximates 90-120 days for residential and an additional 30-60 days in intensive outpatient followed by aftercare/relapse programming. Childcare is a core component. The Women's residential component has been enhanced by a recent 3 year SAMHSA Treatment Capacity Expansion program - Pregnant and Postpartum Women initiative.

Suboxone with counseling is offered across our system for Opioid addicted adults. This has been integrated targeting retention in treatment (residential, outpatient). Current indigent capacity for this program is for 9 persons annually; clients are generally on Suboxone for a period of 2 years. The medication component is \$270/month per customer for those participating.

Sub-acute Detoxification programming exists with a provider 25 miles out of Lorain County. Current annual funding capacity is to offer this level of care to approximately 56 adults (average length of stay is 6-7 days for Opioid addicts). There does not exist any other level of detoxification in our county.

Adolescent Outpatient programming includes IOP and low-intensity services. Annual capacity approximates 126 adolescents per year. IOP is offered at various sites (including Juvenile Facilities (Pathways and Stepping Stones) and in Wellington – southern part of Lorain County; transportation is a key component of the adolescent program. IOP runs approximately 12-24 weeks followed by step down to outpatient which can range for an additional 8-16 weeks. Family counseling (including in-home family therapy) is offered at least monthly. Eligible families also participate in Strengthening Families programming. Low intensity programming is group and individual based for approximately 12-15 weeks.

Adolescent Residential treatment exists with a provider 45 miles out of Lorain County. Current annual funding capacity is to offer this level of care to approximately 8 adolescents. Priority is given to indigent adolescents with a referral care plan post residential treatment.

Family and Juvenile Drug Courts

We continue to be fortunate to have both a Family and a Juvenile Drug Court. Through a Memorandum of Understanding between the ADAS Board and the Court of Domestic Relations, we are able to provide the treatment linkages to both courts. Both courts are overseen by the Judge Debra Boros and the partnership enhancement from Lorain County Children’s Services supports the Family Drug Court. Additional funding that includes Medicaid, HB 484 and other treatment funding (including an additional amount from the court for juvenile drug court treatment) helps to leverage the state grant for these projects.

Recovery Support Services

In partnership with Great Lakes Addiction Technology Transfer Center, STAR-SI and the Access and Retention Initiative (LCAR), we have begun to embed recovery support (i.e. recovery checkups and recovery management) through our adult treatment system. Initial emphasis is to include recovery support to ready clients for treatment and prepare them for aftercare.

Substance Abuse Prevention Services

During State Fiscal Year 2008, Lorain County’s prevention providers submitted service units in the following mix of prevention strategies:

	Information		Community		Environmental	Problem ID & Referral	Alternatives	Total
	Dissemination	Education	Based					
Total Units	1,208.5	2,185.9	826.8	141.5	1,106.0	1,808.4	7,277.1	
% of Total units	17%	30%	11%	2%	15%	25%	100%	
<i>Provided by:</i>								
Big Brothers Big Sisters	262.5	144.1	-	-	721.1	333.3	1,461.0	
Catholic Charities	205.2	-	311.0	-	-	22.0	538.2	
LCADA	713.3	1,330.6	468.3	141.5	337.3	21.3	3,012.3	
Lorain UMADAOP	27.5	711.2	47.5	-	47.6	1,431.8	2,265.6	

Utilizing State Fiscal Year 2009 information submitted from prevention providers, the Board's investment in prevention are program based. Within these programs are brief descriptions of the customers (clients) for this category:

Mentoring Programs: 91% of youth served are from low income homes.; Most are living with just their mother, though an increasing number reside with a grandparent or in foster care; Nearly 75% are at high risk for substance abuse concerns and half have a parent with substance abuse problems; Nearly a third of them have a mental health diagnosis and increasingly those diagnoses are for severe emotional disturbances; The majority of our children, 64%, are racial minorities; about 15% have a parent incarcerated.

Community Collaboration: targets individuals who hold formal and informal leadership positions within their organization and/or community. Customers include: Professionals and lay leaders involved in promoting or conducting Jr. and/or Sr. High athletics – coaches, school personnel, athletic directors, booster clubs, health teachers, and community organizations hosting Jr. and/or Sr. High athletics; Formal and informal leaders working with parents and/or youths within schools, faith communities, criminal justice systems, social-service agencies, alcohol / drug prevention and treatment programs, civic groups/coalitions, and behavioral healthcare services Also included are: Youth: Grades 6, 8, 10 and 12; Community: Individuals who live in the cities, villages and townships that comprise Lorain County; Schools: Fourteen school districts comprised of city, suburban and rural schools; Parents & Caregivers: Individuals in Lorain County who have legal responsibility for children residing with them.

Drug-free Workplace (DFWP) trainings target both supervisory staff and employees. Most businesses conducting DFWP services are motivated by one or more of the following: Federal mandates to engage in DFWP services as a condition of directly or indirectly receiving federal dollars; Concerns for health and safety of their employees and business; and/or desire for premium discounts through the Ohio Bureau of Worker's Compensation.

Juvenile Diversion – Parent Component: This program primarily serves parents/guardians referred by the courts in lieu of their adolescent being formally charged with a first time legal charge. Other families are referred through LCADA's adolescent and prevention departments. While 25% of these parents have adolescents still in the experimental phase of use, at least 60% have adolescents whose use has progressed into a substance problem. Most of the parents fall into one or more of the following categories: parents with little or no knowledge regarding the nature and extent of their adolescent's involvement with substances; parents who believe that adolescent substance use is a normal developmental stage that ALL youth go through; and/or parents who believe that the adolescent's use is only a symptom of problems related to the other parent, peer group, school system, mental health issues. Approximately 50% of these parents represent single-parent households. An equal percentage admits to a history of parental substance abuse. While the reasons cited vary widely, the majority of the parents report insufficient time and/or emotional energy for adequate parental involvement / supervision. Although most parents are initially angry at being forced to participate in

the program, approximately 75% admit that their concerns regarding the adolescent extend beyond the incident that led to the adolescents' arrest. They report the adolescents' behaviors have increased familial / parental stress levels and negatively impacted younger siblings. Commonly reported adolescent issues include school truancy, difficulty with anger and impulse management, negative peer association, and/or increased adolescent rejection of parental values

Juvenile Diversion – Youth component: This program primarily serves adolescents referred by the courts in lieu of being formally charged with a first time legal offense related to alcohol / drug use. While some (25%) appear to have been engaged in early experimental use, many (60%) are harmfully involved with substances. Most of the adolescents, and many of their parents, believe that all adolescents engage in substance use and that such use is a relatively harmless rite of passage. Approximately 50% of these youth are from single-parent households and an equal number have a parent(s) with a history substance abuse.

Other Parenting Programs: Parenting Challenges - Although universal audiences are not excluded, this program specifically targets selective and indicated audiences. Common familial risk factors for the targeted parents include: history of familial substance abuse; limited social and familial support; acting-out behaviors by youth including substance use, illegal activities, and/or rejection of family / societal values; familial stress and disorganization; poor supervision and discipline of youth; unrealistic expectations of behavior for youth and/or Inadequate life skills and/or self-care skills. While some of these families could benefit from alcohol, drug or mental health services, outreach, education and support services are needed to empower them to take this step on their own behalf.

Strengthening Families (programs for families with children ages 10-13 and 14-17). These programs target parents/guardians of youths aged 10 through 17. Although open to all, most participants have been recruited from 12-step groups, addiction services, children's services, and from school suspension programs. Personnel in both the Juvenile and Adult criminal justice systems have recently made commitments to refer families into these programs. This program targets youths, aged 13 through 18, who are engaged in alcohol / drug treatment services, their siblings, and their parents. All of the treatment youths have either substance abuse or dependency problems. Eighty-five percent (85%) of the families have a history of parental substance abuse. All of the families have communication issues or conflictual relationships. Parents report the adolescents' behaviors have increased familial / parental stress levels and negatively impacted younger siblings. Most have been struggling with out-of-control teenagers for years with little or no knowledge and/or acceptance of their adolescent's usage. Many are emotionally and physically drained. Many of the adolescents report a history of physical and/or emotional abuse within the home. Ninety percent are living within single-family households. Although the reasons cited vary, most report living most of their lives outside of parental supervision.

Traditional and non-traditional athletic programs: In addition to the minority of Jr. & Sr. High School athletes using performance enhancing or body sculpting substances, a significant number are involved in the celebratory or consolatory use of alcohol and drugs following athletic events. These programs target Jr. and Sr. High School athletes with all Lorain County School Districts and all appropriate community-based athletic

organizations. The ATLAS (Athletes Training and Learning to Avoid Steroids) program targets male athletes, the ATHENA (Athletes Targeting Healthy Exercise and Nutrition Alternatives) program targets female athletes. Portions of the program also address school personnel, athletic directors, coaches and booster clubs.

Preschool aged: The Building Blocks program targets youth attending a publicly funded pre-school. The pre-school targets income challenged children, and children at risk of starting school at a disadvantage due to a spectrum of family challenges. Common situations include: Very young parents, usually in a single parent household; Heads of households who speak little or no English; Grandparents or other kinship care providers raising children due to parental alcohol /drug use and/or incarceration; Absent, incarcerated, and/or unidentified fathers; Poor school attendance due to parents' lack of organization skills and lack of value placed on education; Language-poor environments - children who are infrequently read to and are exposed to little verbal communication within the household; Domestic abuse, both verbal and physical, within the home. As a result of these factors, these youths often demonstrate a range of risk factors including: inadequate social skills particularly as relates to social problem-solving and communication, aggressiveness, a lack of emotional awareness, lack of school bonding, and a lack of self-control. Some children remain in the program beyond age 5 as the result of previously unidentified learning disabilities, or the need for completion of a behavioral Action Plan prior to beginning Kindergarten

School Aged: Lifeskills: Although primarily focused on serving selective and indicated audiences within alternative schools, these programs will be made available to other school systems and audiences upon request. The Lorain County Academy and Fairhome are alternative schools serving students who have been removed from mainstream school systems due to behavioral problems. Common issues among these students include: ADD/ADHD, ATOD use, association with acting out/ using peers, school failure, parental substance abuse, inadequate social / coping skills, aggressiveness, and legal entanglements. While housed in Oberlin, the Lorain County Academy serves students from all over the county. Fairhome School serves Lorain City residents.

Reconnecting Youth: targets the following youth: Single parent homes (80%); Two-parent homes with one of the parents being a step-father (5%); Biological father(s) in prison for drug trafficking (15%); Anger management issues (35%); High risk population (children of substance abusers) (65%); Bi-racial (10%); African American (75%); Hispanics (15%); 6-12th graders (100%); All are low income (100%); Some receive good grades in school (15%); Participants age ranges from 11-18 (100%); Males (85%); Females (15%)

Family Intervention: This program targets families who have a loved one that is harmfully involved with substances. A few of these families function quite well, albeit the disease has effectively blocked communication and intimacy. Most of the families experience emotional isolation (separated from others and from their own feelings); an obsessive tendency to deny their own needs while focusing on solving or denying the addict's problems; a sense of personal shame (there's something wrong with who I am); and a sense of physical or emotional abandonment. The stigma/shame connected to addiction often makes it appear more dangerous to acknowledge and seek help for the pain than to simply continue living with it. While all of the families seeking this service are initially focused on 'how do we get help for the addict?', they are helped to

understand that the primary goal is to increase personal and familial health regardless of the outcome of the intervention with the addict.

HIV Early Intervention programming primarily serves customers participating in treatment and prevention programs funded by the ADAS Board (selective and indicated audiences) and the professionals serving those individuals. The predominate risk factor for the indicated audiences is their alcohol and/or drug usage. Other audiences are served as the opportunity arises. Groups are drawn from sources including schools, faith communities, social-service agencies, and community-based youth groups.

During State Fiscal Year, 2009 the prevention system began its conversion of data format to the state Web Based Prevention System (WBPS). This will allow for the Board to clearly identify the characteristics of all prevention programs in terms of strategies and demographics for customers.

In fall, 2009, Lorain Urban Minority Alcoholism and Drug Abuse Outreach Program (UMADAOP) received a five-year grant from the Substance Abuse and Mental Health Services Administration (SAMHSA). The grant, Target Capacity Expansion for Substance Abuse Treatment and HIV/AIDS (outreach, testing and counseling).

B. Capacity to Provide Services

Access to Services

Although our treatment network offers a wide continuum of services including: assessments, outpatient services, intensive outpatient services, non-medical community residential services, and sub acute detoxification services (adult only); there is no single agency within the ADAS structure that offers this complete continuum independently. Thus, in many cases customers must move between providers in order to experience their prescribed levels of care.

Generally, women and adolescents are provided almost the same day treatment appointment. The converse is true for medically indigent adult males who are mostly un- or under-insured. This population may find an approximate 14-30 day wait for assessment and a possible additionally 25-30 day wait for level of care placement.

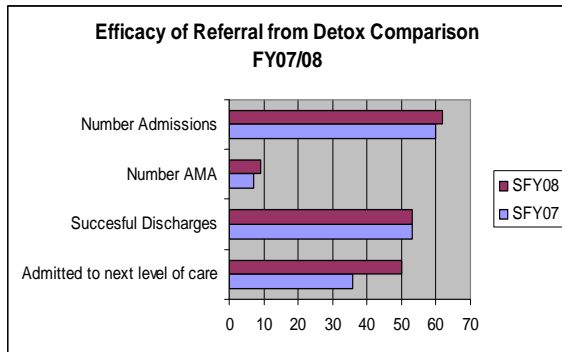
The Board continues with collaborative efforts to elevate client access and continuation rates across the network both in regards to **Treatment** and **Prevention**.

TREATMENT SERVICES:

Detoxification Services

Detoxification services are a critical piece of the treatment continuum. The most efficient and effective utilization of this resource involves seamless transition from successful detox to subsequent levels of care. Several years ago over 50% of clients dropped out before they could be admitted to their next level of care. Many of those relapsed only to seek additional detox services. The Board has addressed this attrition rate through enhanced communication and referral protocols between providers. The following charts represent comparisons of referral efficacy between SFY07 and SFY08. Results are

measured through outcomes reports and efficacy of referral data. Improvements have led to much more efficient utilization of detox as evidenced by an increase from 67.9% to 94.3% referral efficacy. In SFY07 17 clients who completed detox did not follow continuing care recommendations; During SFY08 only 3 successful detoxed clients failed to follow through with subsequent treatment. **This equates to a 39% increase (26.6 points) in efficacy of referral!**



Efficacy of Referral-Detox	SFY07	SFY08
# Admissions	60	62
# Discharged against medical advice (AMA)	7	9
Successful Discharges	53	53
Admitted to next level of care	36	50
	67.90%	94.30%

We do not have hospital-based detoxification in our county. We know that area hospitals are seeing an increase in detox referrals via the emergency rooms, primarily for alcohol – this is a service that is not Medicaid reimbursable and is usually uncompensated. Our local county jail and community based correctional facility indicate also that they receive inmates who are under the influence or in need of detox protocols upon incarceration. In order to address these findings, the ADAS Board has begun to fact-find and convene meetings with these ancillary partners to shore up the intersystem referral protocols necessary for detox clients.

Finally, we have seen a larger number of opiate-addicted young adults (males/females under age 30) presenting for both residential and detoxification services. This priority has placed a significant burden on the ability to provide alcohol detoxification in our system.

Men’s Non-Medical Residential

During 2008, the ADAS Board navigated through its intent to not renew the annual contract with Compass House for services. In late winter, the Board published a “Request for Information for Adult Non-Medical Residential Programming for Adult Males and/or Intensive Outpatient with Residential Support for Adult Males” for services to begin on July 1, 2008. One provider submitted which was funded by the Board which provided of up to sixteen (16) beds for adult men.

Emphasis at the year’s end was to prioritize the transfer of care services for adults (men and women) currently at Compass House. In order to assist in transition, the ADAS Board received funding support from the Community Foundation of Lorain County to

provide support for emergency services for transitional clients. Assistance from the Legal Action Center assisted the Board and the system in format and requirements to transfer client records.

Assessments

The system has increased its access for assessments primarily through placement partnerships with the Lorain and Elyria Municipal Courts – an assessor is on site at each court one day per week. This has reduced the average wait for all adult assessments (men and women) to an average of 10 days. Adolescents are able to access an assessment within 24 hours of their first contact.

Other Levels of Care

There still exist waiting lists for men and women’s treatment (residential and/or IOP); current snapshot indications are that approximately 150 adults are awaiting rehabilitative levels of care.

Adolescent Treatment

There is still portion of funding for adolescent residential treatment programming. Annually, the Board funds about 8 adolescents for this level of care. Our summer (’08) lessons learned found that there was a smaller number of referrals through our provider network due primarily to the building of a juvenile diversion program. In response, the ADAS Board worked with assessors from juvenile court and children’s services to allow a direct-referral process into non-medical residential treatment for identified adolescents.

Substance Abusing and Mentally Ill (SAMI)

Years ago, the ADAS Board and the Mental Health Board co-piloted a SAMI initiative. The continued reduced funding and lack of local levy in the ADAS’ system has not supported the continuation of this initiative. The mental health system does have a mentally ill, chemically abusing (MICA) residential program with limited capacity and other SAMI services offered through their funding streams.

Behavioral Health and Primary Health

We are continuing to focus our community discussions regarding behavioral health and primary health. The previously funded Recovery Healthcare Assistance initiative (ODADAS, 2007) allowed an opportunity to partner with the healthcare system. The removal of that funding stream from the state budget and the current economic status of our local hospitals and the Center for Health and Dentistry (Federally Qualified Health Center – look a-like) have not prioritized this integration. We continue our partnership with the “Affordable Healthcare for the Uninsured” (local initiative) and participate on another workgroup with Mental Health to look at methods to integrate behavioral health and primary health. We are also working on a focus to bring hospitals, jails, treatment providers to a discussion to ensure that detox protocols and referral processes are connected across systems.

Recovery Support Services

Through technical assistance from the Great Lakes Addiction Technology Transfer

Center (ATTC) as well as our inclusion in the ODADAS' STAR-SI component we are focused on recovery-oriented transformation in our system. LCAR partners have participated in the ATTC' sponsored "1st Midwest Recovery Management Symposium for Policy Makers" (Spring, 2007) and a similar summit "Transformation: Recovery Based Approach to Care" (Summer, 2008). We've submitted an Advancing Recovery Initiative to the Robert Wood Johnson Foundation to overlay recovery transformation throughout outreach, treatment and into aftercare. These continue to maintain our Board's commitment to embed recovery oriented process and services. Recently, we have completed a Recovery Oriented System readiness assessment. The results will be analyzed and prioritized for strategies for implementation. Through our LCAR initiative, recovery services have begun to be built into the pre-assessment and pre-treatment components to target access and retention at these levels. Lorain UMADAOP has recently received a five year SAMHSA Grant (HIV/AIDS Outreach and Substance Abuse Treatment Expansion). This grant includes recovery support services from outreach to treatment. ODADAS' Continuum of Care and Service Taxonomy now includes Recovery Support but it not generally reimbursable with current funding streams (including Medicaid). Our target is to develop a focus for local recovery oriented transformation within the access and retention initiatives from outreach to aftercare with regional and state partners.

PREVENTION SERVICES

Communities That Care – Lorain County

The ADAS Board continues its shared investment with the United Way of Greater Lorain County and Catholic Charities Community Services for the implementation of Communities That Care (CTC) – Lorain County. Initiated from a State Incentive Grant (ODADAS, 2003), this prevention planning process continues to link risk- and protective factors to adolescent problem behaviors via the implementation of evidence-based prevention practices programs and strategies. The CTC continues to provide mechanisms for schools, agencies, parent systems and other groups to convene.

Key initiatives from 2008 are highlighted:

Resource Assessment and Evaluation was completed to provide a comprehensive process of matching local programs to the elevated risk and protective factors and other priorities identified from the 2006 Youth Survey and the Data Workgroup (CTC) recommendations. Results indicate that 11 different nationally recognized research based prevention programs exist in Lorain County that address at least one priority risk factor and that 39 different prevention "home-grown" programs address at least one priority risk factor. (full report via www.lorainadadas.org Communities That Care tab). Recommendations from this workgroup are:

- a. Promote all tested and effective programs available in Lorain County with special emphasis on those underutilized
- b. Encourage fidelity scales when using tested and effective programs
- c. Encourage collection of outcome measures for home-grown programs
- d. Target communities and schools in a manner that ensures the largest impact from limited funding
- e. Develop system-wide prevention referral strategies ensuring clients get a continued mix of prevention services across the continuum of care.

In partnership with Lorain County Commissioners, Job and Family Services, Board of Mental Health, United Way and others, the Youth Pages (a backpack directory of services and resources for youth) was produced in 2008. Over 25,000 copies have been printed and over 15,000 were distributed through the local school districts. We are currently in the process of updating this booklet. The goal is to target distribution to 8th graders throughout Lorain County.

Strengthening Families programs continue via Lorain County Alcohol and Drug Abuse Services, Lorain UMADAOP, Catholic Charities Community Services – Lorain County. These are funded through a variety of sources: the ADAS Board, Lorain County Board of Mental Health, Children and Families Council (via the Children’s Trust Fund) and Lorain County Juvenile Court). Spanish adaptation programs occur through Lorain UMADAOP and Catholic Charities. Programs have been adapted to target families in the following age groups: 6-10, 10-14, 14-17. Two booster sessions were funded with low family participation numbers. Murray Ridge has adapted a program for families of older adolescents (16-21) who are also learning disabled.

ATLAS/ATHENA (Athletes Training & Learning to Avoid Steroids and Athletes Targeting Healthy Exercise and Nutrition Alternatives) programs were unsuccessfully implemented in 2008. This is primarily due to two reasons: one staff person available for training and minimal support for acceptance from local athletic systems. The ADAS Board and the provider (LCADA) brainstormed during the second half of 2008 to identify strategies for approaching both traditional and non-traditional athletic systems (and providing stipends) for implementation. Strategies for additional trainers have also been discussed. This program continues to receive notice from the Cleveland Indians (MLB local team) who hosted a training (Fall, 2008) to train an additional 14 facilitators.

Lorain County Children and Families Council

In Response to Ohio’s HB 289, the Children and Families Council established local indicators, priorities and monitors the county’s progress toward increasing child well-being in the county. The priorities shall focus on expectant parents and newborns thriving, infants and toddlers thriving, children being ready for school, children and youth succeeding in school, youth choosing healthy behaviors, and youth successfully transitioning into adulthood. Two of the Focus Areas and Intermediate Outcomes for Children and Youth Engage in Healthy Behaviors are:

- | <u>Focus Area</u> | <u>Intermediate Outcome</u> |
|-----------------------------------|--|
| 1. Strengthening Community Assets | To increase awareness by Lorain County families of community resources that support positive youth development through the formation of a community-based initiative led by Council partners that focuses on asset development in youth. |

2. Alcohol and Drug Use by Youth To reduce the prevalence of alcohol, cigarettes and marijuana lifetime use among youth in grades 6th-12th by an overall mean average score of 10% using evidence-based, county-wide education and prevention strategies.

Community Coalition for a Drug Free Lorain County

The Community Coalition for a Drug Free Lorain County in partnership with the ADAS Board, Catholic Charities Services, Communities That Care – Lorain County, Elyria YWCA, Lorain County Prosecutor, Lorain County Tobacco Prevention Partnership, Lorain Urban Minority Alcoholism and Drug Abuse Outreach Program, and Safe Communities Coalition hosted a town hall meeting on underage drinking on 04/01/08. The event was in response to the U.S. Surgeon General’s “Call to Action to Prevent and Reduce Underage Drinking”. The town hall was then followed up by a public policy training (05/01/08). The ADAS Board’s professional training series then hosted a training topic “Environmental Strategies in Prevention” (05/16/08) to ready our movement using environmental strategies for community change.

The Board received a grant award from the “*Leadership to Keep Children Alcohol Free*” to partner with an additional town hall meeting. Additionally, the Board received a stipend from SAMHSA to participate with the schools in the annual *Reach Out Now* Teach-in targeted at 5th and 6th grade classrooms.

Drug Free Communities Grant

The ADAS Board has recently received a Drug Free Communities Grant to the Office of National Drug Control Policy on behalf of Lorain County. This five-year grant’s goals mirrors the goals of the ADAS Board and the Communities That Care – Lorain County initiative: 1) Expand and enhance local efforts to address the specific problems of alcohol, tobacco and marijuana use among youth and include local efforts targeted at the national growing trend of prescription drug and over the counter medication abuse. 2) Strengthen and mobilize collaboration that improves community efforts to promote and implement effective evidence based prevention strategies and 3) Reduce risk factors and promote protective factors that influence age of onset of use, substance use among youth, perceptions of risk or harm and perception of disapproval of used of alcohol, tobacco, marijuana and prescription and over-the-counter medication abuse. {The topic of prescription and over-the-counter medication abuse has been added into the grant as a result of an ADAS Board member’s project, which has been supported by the ADAS Board.} This grant began effective 10/01/08 to embed environmental (community) changes throughout Lorain County.

Parent Networks

Currently there are two parent networks in Lorain County that are affiliates of the regional Parent to Parent Network (P²PN) - Avon Lake and Amherst. The goal of P²PN is to help schools, organizations and communities throughout Northeast Ohio educate parents on critical issues impacting the health, safety and well-being of children and teens. This

network is a comprehensive information resource and support system for parents. Through P²PN communities and organizations give parents the knowledge to understand the risks facing today's youth and guide them toward healthier choices. The ADAS Board has locally participated with this network to bring a mother/son team into the county to raise the conversation about underage drinking based on their life experience (co-authored a book "From Binge To Blackout – A Mother and Son Struggle with Teen Drinking). The goal of the ADAS board's relationship is to support the existing networks in our county as well as provide assistance to additional communities to create these networks. A recent partnership initiative with the Lorain city School District has written in the creation of a P²PN for them (the HHS – Safe Schools Healthy Students Initiative has been recently submitted by this school district with a target of creating this network).

Workforce Development and Cultural Competence

State Workforce Development Initiatives

The ADAS Board has taken on a role in the overall Ohio Addictions/Prevention professional's workforce development initiative and two board staff participating in numerous initiatives. John Ellis has served as a member of the Ohio Treatment Workforce Development Task Force helped develop Ohio's Long-Term and Strategic Workforce Development Recommendations. Additionally he had been appointed to Ohio Chemical Dependency Professionals Board, and currently serves as Chairperson of the Education Committee. Elaine Georgas has been re-appointed to Ohio's Governors Council on Alcohol and Drug Addictions Services. {Workforce development is one of the Governors' priority arenas}. Additionally she has been named to the advisory Board of the Great Lakes ATTTC and is a member of their Ohio Caucus. Currently the caucus is offering Motivational Interviewing trainings as well as completing a state-level assessment to prioritize workforce training needs for the addiction treatment field.

Workforce and Technology Transfer

Technology Transfer is the transmission of information for the purpose of behavior change (Backer, 1991). Rather than simply providing training and "letting go," technology transfer is a process providing targeted information (training) and then following through with strategies of implementing the new knowledge or skill.

With this strategy in mind special core trainings were developed in SFY08 to address client access and retention issues. A list of trainings were offered including: *Client Retention* (07/07) presented by Dr. Joe Rosenfeld, GLATTC ; *Pre-Treatment Strategies* (08/07) presented by Serena Wadwha GLATTC; *Recovery Management* (09/07) presented by Mark Sanders GLATTC; *Engaging Mandated Clients* (10/07) presented by Randall Webber- Center for Excellence in Criminal Justice; *Assertive Case Management* (11/07) presented by John Ellis ADAS; *Improving Outcomes with Motivational Incentives* (12/08 co-presented by J. Ellis ADAS, Lonnetta Albright GLATTC. Attendees included contract treatment agencies as well as allied partners (Adult Parole, Mental Health, Adult Probation, CBCF, and Sheriffs Department). Additionally the Board (through LCAR) developed local resources to aid in the implementation of Evidence Based Practices: John Ellis- ADAS Board, was sponsored by GLATTC to

become a certified trainer of trainers (TOT) for Contingency Management (*1 in Ohio*); Deborah Broaddus- Nord Center, was sponsored by GLATTC, and certified as a trainer of trainers (TOT) of Motivational Interviewing Assessment: Supervisory Tools for Enhancing Proficiency- MIA-STEP (*1 of 2 in Ohio*).

The Board's annual professional training series has recently reformatted its program evaluation forms to include the following questions: "How realistic is it for this strategy to be implemented in your current practice?" "Would you be able to start using this approach in your practice today?" "Would you be able to start using this approach in your practice today?" "Would you be able to start using this approach in your practice today?" "How are you already using this, or how do you intend to begin using this strategy?" These responses will be compiled and embedded into our annual CQI process as part of our technology transfer approach.

As we work towards recovery-oriented transformation in our system, we are assessing the feasibility of integrating Recovery Coaches' in our workforce. Currently these are un-certified positions, thus are not currently bound to any standards of ethics. Preliminary planning in partnership with Great Lakes ATTC and the Ohio Chemical Dependency Professionals Credentialing Board (OCDP) is to navigate the rules for potentially a new certification that would hold merit for these coaches to assist the recovery initiatives in our communities.

Staff Recruitment and Retention

During SFY 2008 the ADAS Board continued its relationship with the School of Social Work at Cleveland State University and the Ohio Chemical Dependency Professionals Board. A local "faculty team" consisting of clinical leaders from LCADA, Compass House, ADAS Board, Stella Maris, and UMADAOP, designed, and is currently instructing **SWK 693 Theories and Procedures in Addiction Studies**. "Faculty stipends" have been collected and earmarked for tuition reimbursement as of June 30, 2008.

The Board has continued to promote intern opportunities. During SFY08 the Board supervised one (1) clinical intern from Youngstown State University (*via LCCC partnership*). The intern assisted with: Events (5K, Board dinner), training series implementation and reporting, quality improvement data gathering, and case management with Nord Suboxone Program. The Intern has since received her BSW, Chemical Dependency Counselor Assistant (CDCA), Social Work License (LSW) and been hired to work with chemical dependency populations at a Lorain County Entity.

A key issue in our community is the lower pay scales at some providers. This often inhibits staff remaining with an entity once they've attained their certification/counselor-accredited status as they become marketable. We are working with our provider to address staff retention as significant investments are made for recruitment and hiring. Additionally, one of our key findings are that staff vacancies often result in clients not attaining outcomes.

Additionally, there are only two Ohio Certified Prevention Specialists in our county both of whom are Executive Directors of certified prevention agencies (Big Brothers Big Sisters of Lorain County and Lorain Urban Minority Alcoholism and Drug Abuse Outreach Program). The remaining prevention staffs in our system are Registered Applicants. This appears to be a norm throughout Ohio. We are looking forward to potential revisions in the state’s certification process that may alleviate some of the structural burdens to allow more staff to move towards certification.

Professional training series

The goal of the Board’s professional training series is to elevate the clinical expertise of our professional system, create an atmosphere that fosters partnership and networking across our counties social service system, equip area professionals with effective clinical tools, keep abreast of changing standards and emerging practices, and to offer local opportunity for social service professionals to either maintain, or work towards, their clinical professionals.

- During SFY 2008 the ADAS Board provided or assisted with delivery of thirty three (33) events totaling 129.25 Hours to 1,097 attendees.
 - The Core Training Series consisted of ten (10) trainings totaling 30.00 Hours to 454 participants (*avg. 45.4/event*).
 - The Board Co-Sponsored twenty four (24) other trainings totaling 99.25 Hours with partners including: *Lorain County Health District, Community Coalition for a Drug Free Lorain County, Lorain County Anti-Hate Task Force, and Ohio Association of County Behavioral Health Authorities (OACBHA)* to 643 participants (*avg. 26.79/event*).
 - All trainings (*129.25 hours*) offered continuing education credit for chemical dependency counselors, social workers, and professional counselors.
 - Most trainings (*120.25 hours*) offered continuing education credit for prevention professionals.
 - Board trainings generated \$3397 in revenue (\$2261expenses) for a carry over amount of \$1136.

Core Training Series			
	# Hours	# Participants	Average/event
Average from 3 prior years	37.5	511 (N=1533)	43.8
SFY2008	30	454	45.4

Co- Sponsored Trainings			
	# Hours	# Participants	Average/event
Average from 3 prior years	53.08	267.6 (N=803)	21.13
SFY2008	99.25	643	26.79

The Board will maintain its provider status standing with the Ohio Chemical Dependency Professionals Board and the Ohio Counselor, Social Worker, Marriage-Family Therapist Board to continue providing certified continuing education units for the Lorain County workforce.

Cultural Competence

As our community is very diverse in terms of racial makeup, our board and providers continue to focus on ensuring that minority staff are hired at all levels and are represented on the management and board levels. As part of the Request for Information (bi-annual submission) providers indicate within their key people, the relevant staff that have cultural appropriateness to work with the clients/consumers of diverse background. The Board and providers all have Spanish-speaking staff within their front office and direct and support service staff available to assist with our large Spanish speaking community. We are planning to include the statewide initiative Deaf Off Drugs and Alcohol in our annual professional training series for 2010. This will educate our treatment community and be offered to our ancillary partners for referral into this services for the deaf community.

Our newly funded Drug Free Communities Initiative will offer cultural competency trainings regularly to all coalition partners as we embed environmental strategies throughout our county.

The Board continues to fund a Spanish-adaptation of the Strengthening Families Program with Lorain UMADAOP to assist with the mono-lingual parents of participating youth.

The Lorain UMADAOP- Circle for Recovery Program continues to accept ex-offenders from the adult parole authority. A recent topic of the joint board committee (between the ADAS Board and the Lorain County Board of Mental Health) is to prioritize focus on re-entry for ex-offenders with behavioral health needs as well as better coordinate the behavioral health care while incarcerated. The recent announcement to Reinstate Medicaid for Public Institution Recipients will help to eliminate barriers to (formerly) incarcerated individuals.

Capital Improvements

The ADAS Board has been gifted their administrative offices from its landlord. The downstairs unit sits vacant and lacks ADA compliance. It is a goal of the ADAS Board to begin renting this space to offset administrative costs. In order to move forward a capital improvement to add and ADA compliant restroom and wheelchair stair system is necessary.

LCADA has recently completed two capital projects for their residential facilities. Two additional projects have been identified: roof replacement and new HVAC units on the agency's Westpark building. Secondly, there is need to complete the third floor of the women's treatment facility for additional programming capacity.

As of the drafting of this plan, LCADA has recently been informed that the St. Joe's facility

– which houses the men’s residential program – is being vacated as of December 31, 2009. This will mean that LCADA will have to search again for an adequate rehabilitative setting with 16 residential beds for this program

Financial Status

a. Potential Reduction – Impact

The majority funding to the ADAS Board of Lorain County is provided through various allocations from Ohio Department of Alcohol and Drug Addiction Services (ODADAS).

The ADAS Board does not have a local levy to support our funding. Like most other boards in the state, we continue to see our general revenue fund (GRF - state monies) being earmarked towards Medicaid Match at the expense of our under- or un-insured medically indigent persons.

The closing of Compass House left a balance of \$110,250 that had been allocated by ODADAS through the gender specific fund (women). The ADAS Board requested this entire amount be re-designated to the other women’s treatment program (the Key) which also receives ODADAS gender specific funding – but this request was only 50% funded. This net loss of \$55,125 has reduced some programming.

Providers have been guided annually to adhere to their budgets. Most are more diligently focused but a few (in- and out-of-county Medicaid Providers) do not support the concept of “living within their means” for Medicaid billings. This can be remedied with the implementation of the fixed fee. We continue to see a growth of Medicaid billed services disproportionately to the non-Medicaid services. This places an additional burden to move more monies towards Medicaid match – away from non-Medicaid services. We know also that administrative claiming is available to other departments who bill Medicaid in Ohio. Currently this is not available for the behavioral health system – we continue to lose \$12 million (statewide) due to this missed opportunity.

We have been successful in leveraging our state funds where possible. One example is the Board’s receipt of a federal Drug Free Communities & Support initiative from the Office of National Drug Control Policy (five year initiative began in SFY 2008). This grant is a 1:1 match of which we are currently using state funds from ODADAS to support approximately \$70,000. Should this state fund not be available, we would also see a reduction in the federal grant portion – thus a double jeopardy situation. This initiative is also co-funded by the local United Way. As their donations may be potentially impacted, their level of funding may also be reduced to this initiative. Again, since the ONDCP grant is a 1:1 match, we would also lose federal support equitably.

Finally, as the state received federal block grant (Substance Abuse Prevention and Treatment (SAPT) Block Grant) funds are based on maintenance of effort, the GRF reductions that may be taken now will impact the SAPT in the upcoming years.

Not only does the ADAS Board receive state allocations for general purposes, a large proportion of other programs (i.e. flow through programs) also benefit from state funding – GRF. Other programs that are impacted (i.e. state funded – flow through) are: Drug

Court, Circle for Recovery, Youth-Led Prevention, Youth Mentoring, Women’s Set-aside Adolescent Capacity, HB 484 – which are all client-based funds. Therefore to address funding reductions, a scenario of a 10% reduction in these funds could potentially mean:

Fund	Impact Description	Impact Amount(s)
State GRF	Loss of federal funds to support leveraged Drug Free Communities Initiative	(\$7,000) in direct environmental community change strategies (prevention)
State GRF	<p>Loss of available funds for medically indigent clients in all treatment services.</p> <p>While there are direct allocations of state funding in Board invested programs, any reduction in funds is analyzed at the board level. This may mean a re-allocation of all available funds – therefore the impact is not often directed at a particular program or level of care at this time.</p> <p>As we have a cross-system of providers for our levels of care, any reductions at one program will also have impact to the referral level of care. Our waiting lists will increase; substance use will continue in the community.</p> <p>Greater proportion of remaining GRF to go towards Medicaid match, thus leaving less funding to non-Medicaid services.</p> <p>We know that our capacity is already limited. Further reducing the available of funds for programs has potential impact on our ancillary partners including:</p> <ul style="list-style-type: none"> a. higher number of emergency room visits b. reunification plans (JFS) will slow down c. probation/parole violations may increase d. institutional overcrowding (jails) may get worse e. monitoring strain, public safety needs may increase f. mental, physical health issues may 	<p>(\$81,459) – this amount is approximately the entire total of the Board’s investment in Sub-Acute Detox this could potentially eliminate this high end level of care (i.e. approximately 55 persons annually would not receive this level of care);This is also greater than the board’s total investment in the Suboxone initiative and could potentially eliminate this level of care (i.e. approximately 9 persons annually at the Suboxone agency plus a reduction in the successful outcomes of these clients in our other levels of care as we are using this as a retention tool Other potential impact could be in any number of the following:</p> <ul style="list-style-type: none"> * Outpatient – impact approximating 28 adults/14 adolescents * Men’s Residential – impact approximating 10 men * Women’s Residential – impact approximating 5 women

	<p>become exacerbated and finally</p> <ul style="list-style-type: none"> g. waiting lists will grow h. case management functions may be reduced to critical cares i. access and retention rates may decline j. clients, families suffer k. Federal SAPT Block Grant to Ohio will be reduced (maintenance of effort) two years from now directly targeted to current GRF reductions. 	
Drug Court	<p>This would impact the administration and treatment components of both the Family and Juvenile Drug Courts; this may impact the court's available options for sanctions and may need to place these offenders in higher level, higher cost programs.</p> <p>As a portion of this funding goes toward Medicaid Match, a reduced amount of this allocation will reduce the available treatment funding for non-Medicaid drug court recipients.</p>	(\$17,619) in availability to provide drug court services to 3 women (family drug court) and 2 juveniles (juvenile drug court)
Women's Set-aside	<p>In addition to reductions in program funding, this would cross-impact the Board's GRF allocation should this be reduced – we use a portion of this for Medicaid Match – so not only could this impact programming, we would then shift a higher need for Medicaid Match to our GRF at the expense of non-Medicaid services.</p>	(\$5,300) in availability to provide services to approximately 2 women in treatment; the Board's GRF available would also reduce by a proportion since some of this may be used for Medicaid match
H.B. 484	<p>In addition to reductions in program funding, this would cross-impact the Board's GRF allocation should this be reduced – we use a portion of this for Medicaid Match – so not only could this impact programming, we would then shift a higher need for Medicaid Match to our GRF; this may also impact the local reunification plans (JFS) for the affected parent/caregiver(s) who would not be able to access treatment.</p>	(\$10,367) in availability to provide services to approximately 4 parents/caregiver's in treatment; the Board's GRF available would also reduce by a proportion since some of this may be used for Medicaid match
Circle for Recovery	<p>Reductions in this program would proportionately impact adult parole</p>	(\$6,533) approximately 16 ex-offenders would not be

	authority probation roles as there may be a limited availability for cross-referrals.	able to access services, thus may impact their parole status.
Youth Mentoring	Reductions in his program would directly impact the ability for mentoring of minority teens.	(\$3,755) approximately 8 minority teens would not be provided mentoring

b. Contributing factors to service costs

Over the last several years, our providers have made technological enhancements for MACSIS and preparation for Web Based-Prevention. All agencies have absorbed costs related to purchase of new software (ClientMinder and E-Z Claim). While this fosters efficiency in the long run, there have been numerous iterations of MIS staff time in development and implementation (along with test and live sites for the software to ensure validation). While we have stabilized our informational technology workload this year, a primary provider who leads the county’s investment in ClientMinder is now searching for another software product. This will again burden the service costs for those providers should another transition occur with this software.

The ADAS Board’s staff have continued to focus on the impact of HB 496 which had eliminated (the prior) Chemical Dependency Counselor certification (CCDC’s). While the Board continued to publish notice of impact to providers, at least one staff in our system did not make the December, 2008 time limit to translate towards the Chemical Dependency Counselor Assistant (CDCA), thus placing a limit on their employability.

Through numerous years of using the Outcome Framework, we have found that we have a “graying” of clinical staff. This often leads to use of medical leave – which often directly results in clinical services not being available to clients.

Providers have mostly received flat-funded allocations (although 2009 forced ODADAS reductions to the provider level). In the meantime, providers continue to experience increase in the cost of transportation (fuel and repairs), increase in the cost of utilities (gas, electric, water), personnel costs associated with significant increases in the costs of health insurance, workers compensation and unemployment insurances, increased in the cost of food (related to both food costs and increase bed capacity at both adult residential facilities).

Finally, the lack of a fee schedule (statewide) has some providers losing reimbursement for Medicaid Services. There are providers who are billing at the ceiling when their costs exceed the Medicaid ceiling – the ADAS Board, having no local levy, does not have the ability to reimburse the non-Medicaid services above any ceiling per Uniform Customary Reimbursement (UCR) guidance. However, the ADAS Board continues to support the reimbursement for non-Medicaid services attributed for programs within their contract structure for Medicaid clients (like childcare, room and board, and transportation).

c. Cost Saving Measures and Operational Efficiencies

In order to address the staff turnover, the Board, in partnership with the Great Lakes Addiction Technology Transfer Center and Communities That Care, has re-aligned key training components to embed train-the-trainer models in our community. We have invested in the MIA-STEP (Motivational Interviewing Assistance – Supervisory Tools for Enhancing Proficiency) for our clinical teams and ancillary partners. Our investment in evidence based prevention, particularly Strengthening Families and ATLAS/ATHENA also include trainer models to assist in unplanned staff turnover to keep programs intact.

We have streamlined the Indigent Drivers Alcohol Treatment funding through the municipal courts to come through the ADAS Board. Providers who receive IDAT referrals identify the clients to the Board and bill a standard claim through the state billing system (MACSIS). As these claims are adjudicated, we are able to invoice the muni courts a validated claim for IDAT reimbursement. This process has streamlined agency billing mechanisms and tapped into the IDAT resources from the local courts.

We continue our reciprocal relationship with the Summit ADM board for Independent Peer Review (IPR) annually. Both boards provide a staff person to complete the IPR based on the ODADAS’ guidelines.

The ADAS Board’s office space has been donated to the Board by its previous landlord. We have 2 years left on a “rent to own” scenario. Once this timeframe is up, the Board will be rent-free and able to lease the lower level at a reasonable cost. This will provide a reduction in board administrative costs.

Our system is implementing Paperwork Reduction initiatives as part of our Board’s review process for both treatment and prevention programs. In addition, Lorain County Alcohol and Drug Abuse Services (LCADA) is targeted the Paperwork and Administrative Reduction variance (submitted by the Ohio Alliance of Recovery Providers to ODADAS recently). The goal of these initiatives is to re-direct paperwork and administrative efficiencies towards increased productivity.

The Board’s investment in the local Integrated Services Partnership (ISP) allows for a team-centered family focused on adolescents who are involved in multiple systems.

Finally, Board and agency staff has become effective grant writers; our embedding of the outcome framework allows Board staff to be written into federal grants to assist in evaluation capacity. Our target investments have also been aligned with the Federal National Outcome Measures (NOMs).

Providers have noted the following cost savings and/or efficiencies: installing computer workstations at clinical sites for computer entry progress notes, collapsing all the food service for residential facilities to one location, installing an energy efficient HVAC unit for more energy savings, acquisition of a smaller mini-van to transport three or less clients to medical services, etc. (using a more efficient vehicle than the larger van).

d. Budgetary Planning Efforts

Due to the uncertain state budget, the Board has issued a 120-day notice to all contract providers. Should any reductions be allocated from the state, there may be impacts on provider contracts – particularly those funds that are directly to programs/populations. Administratively, the Board’s budget will be neutral. The Board will balance all allocations (and potential reductions) with the focus on quality care for consumers as a priority for maintenance. Therefore we will assess the outcomes not only of the program but most importantly the consumer outcomes.

We are working with the Ohio Association of County Behavioral Health Authorities and with the Lorain County Board of Mental Health on a budget platform which includes “do no harm” to behavioral health. During 2008-2009, ODADAS received three budget reductions while other sectors in the state were held harmless. Additionally, we are advocating with our legislators to ensure that both Medicaid and non-Medicaid consumers are able to access an adequate amount of AoD services in our county (and statewide).

An ongoing planning effort continues to educate local and state legislators about the disproportionate expenditures for treatment of alcohol and other drugs compared to the costs to society. Generally, states spend about \$.96 of every dollar to “shovel up” the wreckage in state programs and about \$.04 towards prevention and treatment of the problem. Only 1% of Ohio’s liquor revenues are distributed to the Ohio Department of Alcohol and Drug Addiction Services. Currently, states are reviewing the potential for alcohol tax increased in some cases to help pay for addiction treatment services. We will continue to share this information with our legislators for feasibility in our state.

We have secured a memorandum of understanding with the Elyria Municipal Court to access their local Indigent Drivers Alcohol Treatment fund for their offenders. The Lorain Municipal Court has regularly utilized the IDAT for payment of necessary treatment to their population. The IDAT continues to be a sporadic success in our other municipal courts. We will again target education and discussion with all municipal court judges regarding the most efficient manners to utilize these funds – pursuant to law.

The Board and providers review their expense and revenues monthly to assess production and variance both in terms of units and cost to minimize reconciliation issues or inability to meet goals. Providers are given opportunity to provide budget revisions as frequently as resources re-align. Bi-monthly, the Board’s Administrative Committee reviews the financial billing status of every program in its investment portfolio for variances and projections to year end. Emphasis on reviewing Medicaid (billings and match requirements) and HB 131/80 is a monthly priority for the Board’s financial department. However due to the current unlimited Medicaid program (i.e. entitlement) there are often providers outside the board system (or within the board system) who continue to bill Medicaid – which is an unplanned revenue. This uncertainty remains a fragile component any budgetary planning initiative.

Finally, the Board continues to monitor the most effective partners for leveraging of finite resources. Weekly scans of available grant sources as well as collaborative partner meetings continue to offer opportunities to our system.

Table 1 Portfolio of Providers

Appendix A, Table 1 lists the current Alcohol and Other Drug Services Providers in Lorain County. Inclusive of this list is the detail of evidence based programs throughout the continuum.

SECTION II: CAPACITY DEVELOPMENT

Access to Services

The Board's plan to address access issues is below:

Adolescent Services: Referral and Collaboration enhancements

The following processes were instituted (effective July 1, 2007) in efforts to most efficiently utilize the continuum of care available.

I. Improve timeliness of clinical recommendations being disseminated to court.

Process enhancement: To ensure prompt "turnaround" on recommendations relative to consumers referred by juvenile court, the assessing agency will forward to the court-client diagnosis, recommendations, and completed 42 Code of Federal Regulations (i.e. confidentiality disclosure) consent via fax. Copy of this correspondence will be maintained in the clinical record.

II. Remove duplicate assessments across Provider, Children's Services, and Court systems.

Process enhancement: To increase cross system communication;

- Upon an adolescent's arrival to an agency (LCADA, Nord, Psych & Psych) Intake Workers will inquire if youth has received an assessment at either Children's Services or Juvenile Court within last 90 days. If so, release will be signed immediately and assessment requested via fax. Provider will then complete only a streamlined assessment of using history.
- Juvenile Court and LCCS Chemical Dependency assessors will complete a brief standard letter indicating an AoD assessment was completed/date and give to the client. The client will be instructed to take this letter with them to the agency referred to.

III. Ensure efficient utilization of residential treatment services.

Process enhancement: Board extended referral authority for residential services (New Directions) to select staff and departments of Children Services and Juvenile courts so long as (a) ODADAS compliant assessment completed, and (b) Board funds available.

Adult Services: Referral and Collaboration enhancements

The following processes are being reviewed for implementation to most efficiently utilize the continuum of care available.

I. Transition to utilize the SOQIC forms for all assessments.

Process enhancement: To reduce administrative paperwork burden at assessment and provide a more holistic assessment.

II. Develop and refine protocols for all detox providers

Process enhancement: Determine most cost effective and efficient detox protocol. Review and assess the feasibility if implementing methadone and ambulatory detox, and Suboxone "taper" through the residential facilities.

III. Determine effective referral protocols from local hospital and criminal justice settings to treatment.

Process enhancement: To maintain “handoff” across systems.

Lorain County Access & Retention Collaborative (Lcar)

Every year more than 19 million Americans are in need of addiction treatment, but only 25% are able to access it. Of those who enter treatment, 50% drop out before completion. The Washington Circle- a multi-disciplinary group of providers, researchers, managed care representatives and public policy makers developed and pilot tested a core set of performance measures for addiction treatment services. Their research shows that **access to** and **retention in treatment** is the **greatest predictors of successful recovery**. As a local response to this global problem the Alcohol and Drug Addictions Services (ADAS) Board of Lorain County, has partnered with the Great Lakes ATTC in creation of a local multi system initiative aimed at increasing treatment access and retention for adult indigent men.

The goal of this initiative is to design and implement plans that:

1. Improve client access to and;
2. Improve client retention in Addictions treatment.

This is being accomplished through inclusion of 23 State and local partners and the establishment of the following structure:

- **Steering Committee-** Charged as decision making body for the change initiative.
- **Workforce Development-** Charged with developing training and implementation activities.
- **Evaluation and Replication-** Charged with evaluating interventions towards goals AND manualize process for other systems to replicate.

A systemic needs assessment was conducted to determine the impact of treatment “waiting lists,” to allied systems, gaps/strengths along the service continuum, and make recommendations for improvement.

To date, Lorain County has piloted several process improvements and evidence based initiatives all directed to client access and retention. Enhancements include:

- Enhanced interim levels of care
- On-site assessments at Muni Courts
- Contingency management
- Suboxone w/ counseling
- Motivational Interviewing
- Motivational Interviewing Assessment: Supervisory Tools for Enhanced Proficiency (MIA:STEP)
- Recovery Support

Summary of SFY 2008 LCAR Accomplishments:

During SFY 2008 LCAR focused training events on access and retention related topics, strategies, and evidence based practices during the 1st half of SFY08 (July-December). The

second half of the year either launched several pilot initiatives, or collected data for initiatives in place that addressed treatment access, retention or continuation.

Figure 1 reflects points on the treatment continuum where most bottlenecks/dropouts occur; **Figure 2** reflects piloted enhancements.

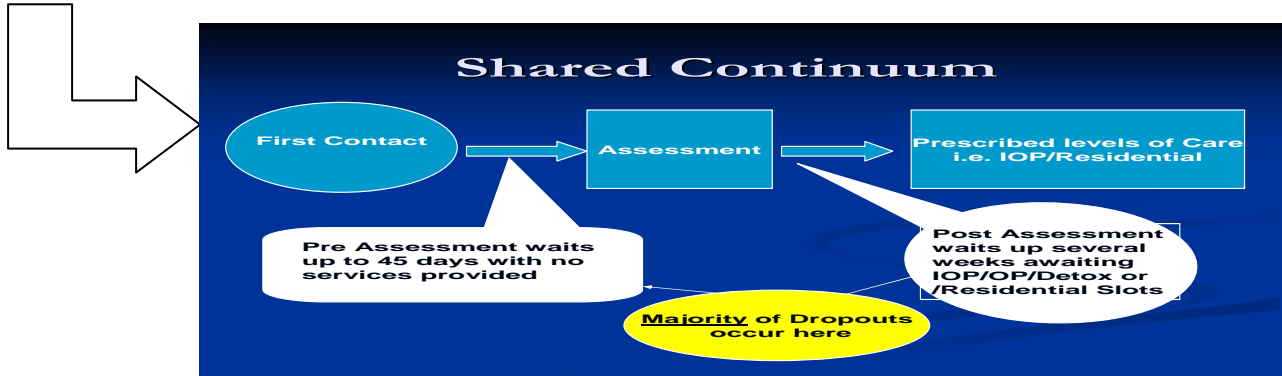
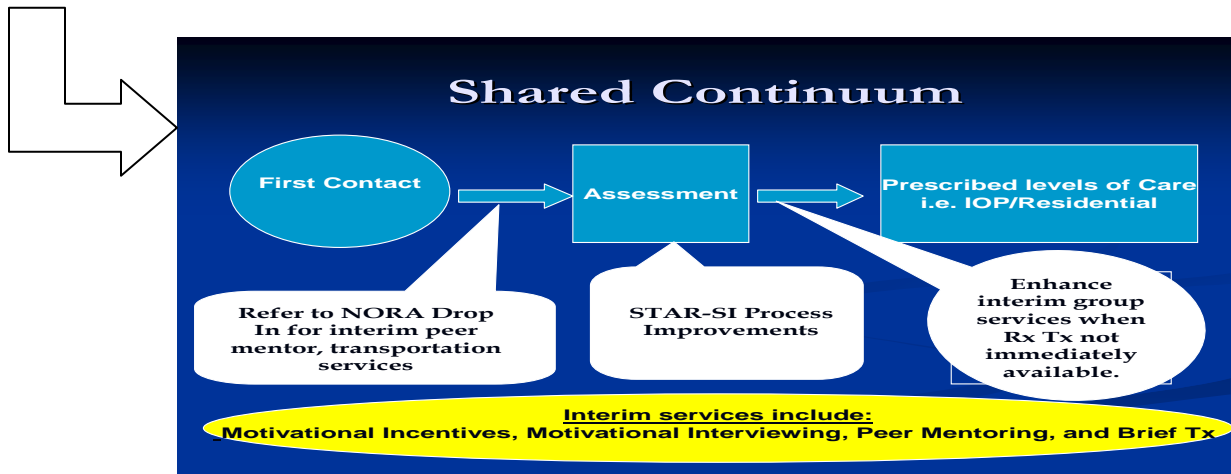


Figure 2



LCAR Interventions instituted or measured in SFY08 include:

- I. **Motivational Interviewing (MI):** MI shown to increase treatment attendance and retention (Carrol, 2006). LCAR began developing framework for implementing MI w/ fidelity in SFY09 through utility of Motivational Interviewing Assessment – Supervisory Tools for Enhancing Proficiency (MIA-STEP).
 - a. Offer county-wide Motivational interviewing Core training in July-August SFY09
 - b. Plan is to roll-out MI Sandwich January 2009 (this is a 20 minute Motivational Interviewing component both before and just after the assessment).

- II. Contingency Management : Contingency Management (also known as Motivational Incentives) is proven to increase treatment retention for a minimum investment (*Petry et al, 2000*)
 - a. Implemented to increase attendance/retention in interim services i.e., pre-treatment groups.
 - b. Special LCAR earmark from ADAS Board for Purchase of Incentives \$3000.
 - c. Between 1/1/08 and 6/30/08
 - i. 278 incentives awarded for consistent attendance.
 - ii. 66.7% attendance rate
- III. Recovery Management: Offers recovery support along a continuum, and beyond. Helps close gaps in the continuum.
 - a. Between 1/1/08 and 6/30/08
 - i. 10 Treatment clients have been assigned recovery coaches
 - ii. 74 clients referred to Northern Ohio Recovery Association (NORA)
 - iii. 41 referred by LCADA (6 received NORA services)
 - iv. 12 referred by Compass (12 received NORA services)
 - v. 9 referred by Adult Parole (9 accessed NORA Services)
 - vi. 12 self referred (12 accessed NORA Services)
 - b. In Total 39 Clients have received NORA Services
 - i. 36 Received Transportation
 - ii. 28 Received face to face services (groups)
- IV. Medication Assisted Treatment (Suboxone): Goal is to retain opiate addicted adults towards to completing treatment, getting stable housing, employment, and sober social supports. Once done medication will be discontinued.
 - a. During SFY08 73% (16 of 22) of clients follow through with all treatment recommendations.
 - b. Projected 40- received 166
- V. Strengthening Treatment Access and Retention- State Implementation (STAR-SI): ODADAS 3 year grant introducing NIATx process improvement methods to select treatment systems. The initiative will assist in building the state’s capacity to improve our service system at both the state and local levels. LCADA and Lorain ADAS Board were named as year two partners beginning October 2007. **STAR-SI Change initiatives include:**
 - a. Paperwork Reduction at Intake
 - i. Reduced Phone Screen paperwork from 12 pages to 3 pages.
 - b. Pilot same day (walk-in) assessments
 - i. February 2008 began assigning walk-in appointment windows for Elyria Court Clients
 - ii. Began conduct same-day on-site assessments at Elyria Muni Court
 - iii. Between 1/1/08 and 6/30/08;
 - I. 90 “same-day” assessments completed at Elyria Muni Court
 - II. 29 “walk- in” assessments at LCADA Elyria site
 - c. Enhancements to Pre-Treatment Services (combined STAR-SI/LCAR initiative)
 - i. Funds earmarked from ADAS Special LCAR allocation and STAR-SI \$
 - ii. Interim level of care between assessment and prescription level of care.
 - iii. Works with clients who may be symptomatic

- iv. 5 two hour Pretreatment groups offered at two sites. Includes Saturday Programming
- v. Between 1/1/08 and 6/30/08 – 131 Clients involved in Pretreatment services

LCAR Results: 1st Contact to Assessment Lag time in Calendar day averages

Baseline- 2nd Qtr FY08 (Pre-Test)

October 2007	- Avg wait 42.44 days
November 2007	- Avg wait 41.83 days
December 2007	- Avg wait 46.19 days

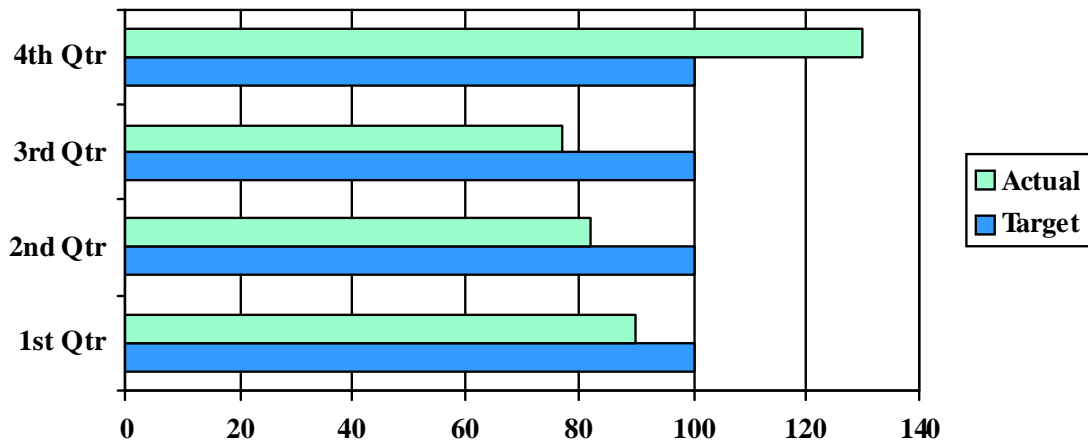
Post interventions- 3rd Qtr FY08 (Post Test)

January 2008	- Avg wait 37.17 days
February 2008	- Avg wait 35.60 days
March 2008	- Avg wait 22.15 days

Post Intervention- 4th Qtr FY08 (Post test)

April 2008	- Avg wait 10.89 days
May 2008	- Avg wait 17.78 days
June 2008	- Avg wait 24.18 days

Continuation rates assessment to treatment: This is a measure of Adult Males at LCADA’s Elyria location who followed through with post assessment treatment recommendations. LCADA surpassed continuation targets in the 4th Qtr of SFY08 after LCAR and STAR-SI interventions were implemented.



LCAR Lessons Learned

- Enhanced pretreatment services moved the “waiting list bubble” further down the continuum
- Confidentiality issues prove a barrier to coordinating pre assessment NORA services (releases must be signed first)

- NORA staffing patterns cannot accommodate volume for pre-assessment services.
- Staff turnover in key positions stalls LCAR change initiatives.
- Shorter wait list times not experienced by all populations. Walk- in assessments focused on Muni Court males. County probation, parole waiting list times did not change.
- Longer wait for suboxone than detox services.
- Insufficient case management services to accommodate suboxone coordination.
- System wide software transition delaying ability to track quality indicators.

Workforce Development and Cultural Competence

The following are the Board's Workforce Development and Cultural Competence Targets:

- a. Reduce local impact of Certified Chemical Dependency Counselor (CCDCI) elimination on December 23, 2008.
- b. Work with local colleges (including Lorain County Community College - LCCC) to develop and align addictions/prevention related coursework with the Ohio Chemical Dependency Professionals Board (OCDPB)
- c. Establish a process and methodology for utilizing CSU training stipend for tuition reimbursement.
- d. Promote internship opportunities within the ADAS Network for students seeking Associates Degree, Bachelor Degree (Youngstown State University, Cleveland State University (CSU), Case Western Reserve University (CWRU), and Masters Degree (CSU, CWRU).
- e. Enact policies that may offset burnout among treatment professionals.
- f. Localize efforts to reduce paperwork burdens among clinical staff.
- g. Include regular cultural competence topics on Boards' Professional Training Series Calendar.

A. Capacity Development Targets

A. *ODADAS Target: Reduce Stigma*

Lorain ADAS Board targets:

- a. Increase, maintain the Board's signature 5K Recovery Run Walk in conjunction with National Alcohol and Drug Addiction Recovery Month
- b. Continue to educate leaders in cities, county, statewide about the social and economic values of investing in substance abuse & addiction treatment and prevention.
- c. Continue to provide input and support to ODADAS and OACBHA's stigma reduction campaigns
- d. Become a member of Ohio Citizen Advocates and/or explore a regional OCA affiliate in Lorain County
- e. Maintain participation with the national Faces and Voices of Recovery (FAVOR) to disseminate stigma reduction messages
- f. Provide opportunities during Alcohol Awareness Month

B. *ODADAS Target: Addiction is recognized as a legitimate health care issue with an appropriate and necessary continuum of care that includes prevention/intervention and treatment and recovery services.*

Lorain ADAS Board targets:

- a. Include healthcare participation on the Lorain County Access and Retention Initiative
- b. Partner with Lorain County Medical Association to implement training regarding underage misuse of over the counter and prescription medications and disseminate toolkit to pediatricians, school counselors and parents to raise awareness.
- c. Work with OACBHA, ODADAS and ODJFS to allow Ohio to include Screening, Brief Intervention and Referral to Treatment as a Medicaid-reimbursable service.
- d. Continue the joint board committee (between ADAS and Mental Health) to determine effective integration of behavioral health and primary health for our constituents.
- e. Continue on local partnerships regarding the integration of behavioral healthcare and primary healthcare.

C. ODADAS Target: An accessible, effective, seamless prevention/ intervention, treatment and recovery services continuum from childhood through adult.

Lorain ADAS Board Targets:

- a. Establish Alumni Association to assist with recovery coaching.
- b. Establish a systemic plan for tracking and ensuring “live-handoffs” at transitions in levels of care.
- c. Build Suboxone case management – this would allow for greater linkages between partners, increased consumer compliance to recommendations, and free up physician time sufficiently to increase client load.
- d. Explore use of suboxone for sub population of opiate addicted women who have high drop-out rates.
- e. Establish clinical referral procedures/protocols for individuals seeking multiple detox episodes- without referral efficacy. Clinical practices would include use of stages of change model and may require working with symptomatic individuals.
- f. Pilot Suboxone induction at residential level of care (in lieu of sub-acute detox)
- g. Incentivise discontinuation of Suboxone after obtaining clinical benchmarks *i.e. abstinence, housing, social supports, employment, fulfillment of legal obligations.*
- h. Establish protocols for alcohol-need detox.
- i. Analyze feasibility of transitioning to recovery management model of service delivery from outreach to aftercare
- j. Allow for participation in next level of care before discharge.
- k. Continue the joint board committee (between ADAS and MH) to build a feasible co-occurring continuum for constituents.
- l. Ensure that environmental prevention strategies exist in Lorain County.

D. ODADAS Target: A highly effective workforce for the AOD system.

Lorain ADAS Board Targets:

- a. Educate intake staffs on community resources.
- b. Focus on effective use of interns in our system
- c. Continuation of the Board’s Professional Training series (and maintenance of the Board’s provider status of CEU’s and RCH’s)
- d. ADAS Board staff to maintain representation on state workforce initiatives (Ohio Caucus – Great Lakes ATTC, Ohio Chemical Dependency Professionals Board)
- e. Continuation of ADAS Board/Cleveland State University partnership

- f. Continued focus of workforce development through LCAR and Drug Free Communities initiatives.
- g. Continued focus on train the trainer based evidence-based programs and practices
- h. Work with ODADAS to secure prevention credential for professional staff at agencies.

E. *ODADAS Target: Increase diversity of revenue sources to support Ohio's Alcohol and other drug system (e.g., apply for foundation and SAMHSA discretionary grants).*

Lorain ADAS Board Targets:

- a. Continue with resource acquisition initiatives (grant writing)
- b. Explore re-calibration of the services funding mix.
- c. Prorate Board funding for Suboxone medication.
- d. Explore in partnership with ODADAS a feasible reimbursement structure for recovery-oriented services before, during and after treatment
- e. Maintain ADAS Board' investment in Integrated Services Partnership.
- f. Continue partnering with local entities for leveraging of funds and inclusion of AoD in partner initiatives.
- g. Develop plans to grow Parent 2 Parent networks throughout Lorain County in turn will acquire further support of parent education.

F. *ODADAS Target: Increase the use of “evidenced-based” policies, practices, strategies and programs in the AOD system.*

Lorain ADAS Board Targets:

- a. Systemic training on Medication Assisted Therapies inclusive of volunteers, administrators, and Boards of Trustees.
- b. Embed Motivational Interviewing throughout treatment continuum.
- c. Embed Contingency Management throughout the treatment continuum
- d. Ensure that adolescent treatment services include A-CRA in their curriculum
- e. Ensure that all supervisors (treatment and prevention) are utilizing MIA-STEP
- f. Continued utilization of Outcome Framework stratagem
- g. Partner with other funders to enhance Strengthening Families Programs (inclusive of Booster Sessions) to be available throughout Lorain County
- h. Partner with school-based (and non-traditional) jr. and high-school athletic departments to implement ATLAS & ATHENA throughout their programs.
- i. Work with other co-funders (United Way, Mental Health, Children and Families Council, etc) to consistently fund and evaluate EBP's.

G. *ODADAS Target: Increase the use of data within the AOD system to make informed decisions about planning and investment.*

Lorain ADAS Board Targets:

- a. Determine systemic baseline and ongoing data measures for retention targeted at “Initiation” (defined by Robert Wood Johnson Foundation, Reclaiming Futures as “at least one service contact within 14 days of a full assessment”) and “Engagement” (defined by Robert Wood Johnson Foundation as “three successful service contacts within 30 days of a full assessment”).

- b. Disseminate results of STAR-SI Change initiatives to enable depth and spread of effective practices.
- c. Utilize Web-based Behavioral Health and Prevention Data for performance measurement and management
- d. Continuance of Board CQI process (inclusive of utilization management, utilization review)
- e. Utilize Ohio Association of County Behavioral Health Authorities (OACBHA) Care Management Reports
- f. Utilize county-wide youth survey data, archival data and qualitative data (AOD use, risk and protective factors) as basis for prevention investment.
- g. Continue use of Outcome Framework – semi-annual lessons learned for Board investments

SECTION III: PREVENTION SERVICES

Prevention Defined—Alcohol and Other Drug Specific

Alcohol and other drug prevention focuses on preventing the onset of AOD use, abuse and addiction. AOD prevention includes addressing problems associated with AOD use and abuse up to, but not including assessment and treatment for substance abuse and dependence. AOD prevention is a proactive multifaceted, multi-community sector process involving a continuum of culturally appropriate prevention services which empowers individuals, families and communities to meet the challenges of life events and transitions by creating and reinforcing conditions that impact physical, social, emotional, spiritual, and cognitive well-being and promote safe and healthy behaviors and lifestyles. AOD prevention is a comprehensive planned sequence of activities that, through the practice and application of evidence based prevention principles, policies, practices, strategies and programs, is intended to inform, educate, develop skills, alter risk behaviors, affect environmental factors and/or provide referrals to other services

The term Alcohol and Other Drugs (AOD) includes, but is not limited to the following drugs of abuse - alcohol, tobacco, illicit drugs, inhalants, prescription and over-the-counter medications.

Culturally appropriate means the service delivery systems respond to the needs of the community being served as defined by the community and demonstrated through needs assessment activities, capacity development efforts, policy, strategy and prevention practice implementation, program implementation, evaluation, quality improvement and sustainability activities.

Evidenced Based Prevention means the prevention policies, strategies, programs and practices are consistent with prevention principles found through research to be fundamental in the delivery of prevention services; the prevention policies, strategies, programs and practices have been identified through research to be effective; the service delivery system utilizes evaluation of its policies, strategies, programs and practices to determine effectiveness; and the service delivery system utilizes evaluation results to make appropriate adjustments to service delivery policies, strategies, programs and practices to improve outcomes.

Prevention Service Delivery Strategies Information Dissemination is an AOD prevention strategy that focuses on building awareness and knowledge of the nature and extent of alcohol and other drug use, abuse and addiction and the effects on individuals, families and communities, as well as the

dissemination of information about prevention, treatment and recovery support services, programs and resources. This strategy is characterized by one-way communication from source to audience, with limited contact between the two

Alternatives are AOD prevention strategies that focus on providing opportunities for positive behavior support as a means of reducing risk taking behavior, and reinforcing protective factors. Alternative programs include a wide range of social, recreational, cultural and community service/volunteer activities that appeal to youth and adults

Education is an AOD prevention strategy that focuses on the delivery of services to target audiences with the intent of affecting knowledge, attitude and/or behavior. Education involves two-way communication and is distinguished from information dissemination by the fact that interaction between educator/facilitator and participants is the basis of the activities. Activities affect critical life and social skills including decision making, refusal skills, critical analysis and systematic judgment abilities.

Community-Based Process is an AOD prevention strategy that focuses on enhancing the ability of the community to provide prevention services through organizing, training, planning, interagency collaboration, coalition building and/or networking.

Environmental prevention is an AOD prevention strategy that represents a broad range of activities geared toward modifying systems in order to mainstream prevention through policy and law. The environmental strategy establishes or changes written and unwritten community standards, codes and attitudes, thereby influencing incidence and prevalence of alcohol and other drug use/abuse in the general population.

Problem Identification and Referral is an AOD prevention strategy that refers to intervention oriented prevention services that primarily targets indicated populations to address the earliest indications of an AOD problem. Services by this strategy focus on preventing the progression of the problem. This strategy does not include clinical assessment and/or treatment for substance abuse and dependence.

Prevention Service Categories by Population Served: *Universal Prevention Services:*

Services target everyone regardless of level of risk before there is an indication of an AOD problem; *Selected Prevention Services:* Services target persons or groups that can be identified as "at risk" for developing an AOD problem; *Indicated Prevention Services:* Services target individuals identified as experiencing problem behavior related to alcohol and other drug use to prevent the progression of the problem. These services do not include clinical assessment and/or treatment for substance abuse and dependence

A. Prevention Needs

Process for Determining Prevention Needs

Ongoing assessment/ needs data is collected through a variety of ADAS Board committees, Board/Provider forums at all levels (executive, clinical/program, administrative). Additionally, board staff (and members) who participate with community partnerships to assist in the needs review for the Board including:

- The Family and Children's Council
- Safe Communities Coalition
- Drug Free Communities Coalition (ODADAS Flow through to Lorain UMADAOP)

- Drug Free Communities via The Lorain County *Communities That Care* © project – (State Incentive Grant – now transitioned to local investment)– ONDCP – new initiative
- Town Hall meetings and other public policy sessions (like the Poverty Simulation)
- Lorain County Prevention Connection
- Child Fatality Review Board
- Parent 2 Parent networks (other partnerships which are listed in the collaborative section of this plan)

Data is also gleaned from state and national resources and related to local experiences including: Ohio Substance Abuse Monitoring Network (OSAM), JoinTogether, Office of Juvenile Justice and Delinquency Prevention (OJJDP), Bureau of Justice, Monitoring the Future, Ohio Resource Network, and the Central Center for the Application of Prevention Technologies as applicable for localized prevention needs.

Additionally, through our Drug Free Communities Grant (ONDCP, effective 10/08), we have learned about the value of qualitative community assessment information. As such, the DFC initiative has allowed us to begin “listening sessions” throughout Lorain County about underage alcohol and other drug use, consequences of use and solutions. A host of listeners are currently contracted to complete these sessions between the months of April – June, 2009. Upon completion of these sessions, the findings with this will be partnered with the upcoming youth survey data to glean clear problem statements of need in our county focused toward environmental change. {More to follow through the update of this Community Plan as we progress through the listening sessions.}

Central to the prevention needs assessment for Lorain County is the youth survey on alcohol, tobacco and other drug use (lifetime and 30 day prevalence) along with risk and protective factors that are researched to affect ways that our community partners to promote positive youth development and to prevent youth problem behaviors including substance abuse, delinquency, teen pregnancy, dropping out of school and violence (and recently – depression). This system, developed by Dr. J. David Hawkins and Dr. Richard Catalano, is based on decades of research which identifies risk factors that predict youth problem behaviors and protective factors that buffer children from risk and help them succeed in life.

This youth survey was recently completed (fall, 2006) with over 10,000 students in grades 6, 8, 10 and 12th throughout Lorain County participating. (Complete survey results can be found on www.lorainadas.org/public.html) We will again complete this survey during fall, 2009. As such, the update of this plan may include additionally needs summary data.

Findings of the Needs Assessment

As reported in the previous community plan, past 30 day prevalence of ATOD use

During fall, 2006, the Lorain County *Communities That Care Student Survey*® was administered to students in fourteen (14) school districts in grades 6, 8, 10 and 12. A total of 10,523 students completed the survey. Comprehensive archival data from public statistics was also collected for Lorain County, which assisted in measuring risk factors and problem behaviors not covered by the survey. {These reports can be accessed via: www.lorainadas.org/public.html} The data was summarized in county-wide format for the Lorain County, compared to the 2003 survey results and

to national (Monitoring the Future) results. The following drug use, elevated risk factors and high protective factors were identified for Lorain County students:

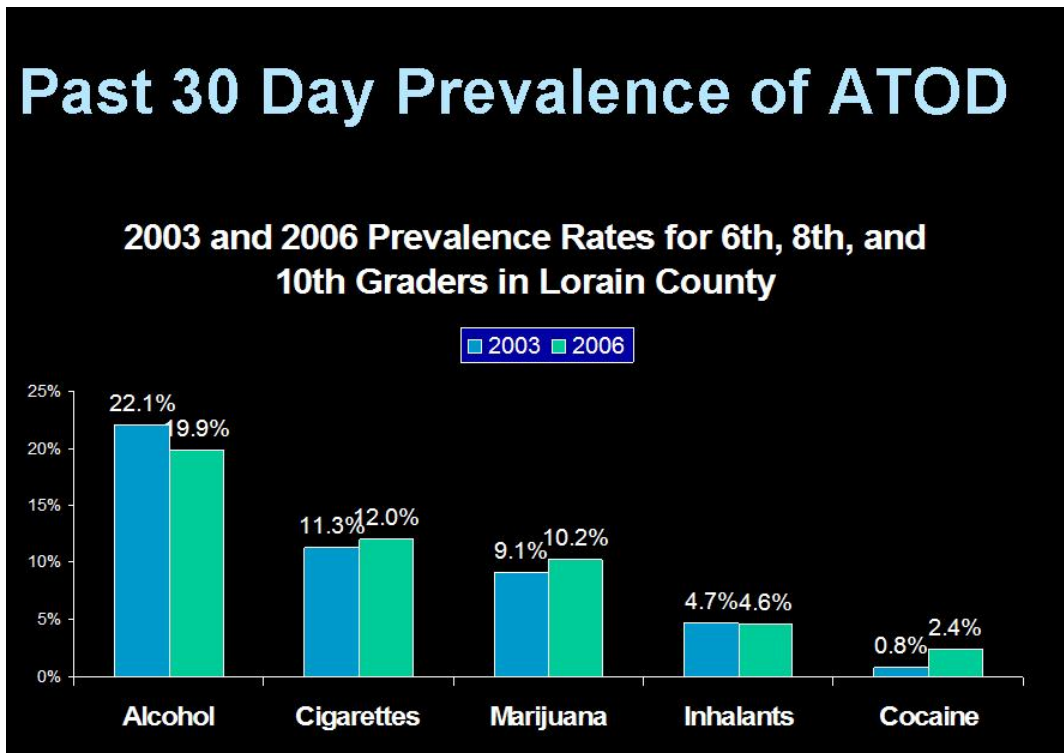
▪ **Patterns of Use:**

- Males more likely to use marijuana (especially in 10th grade) and cocaine (especially in 12th grade)
- African American youth have higher rates of use of marijuana & cocaine
- African American & Hispanic youth have higher rates of cigarette use in 6th/8th grades
- BUT in 12th grade, White students have a higher rate of smoking cigarettes, significant increase at 8th grade.

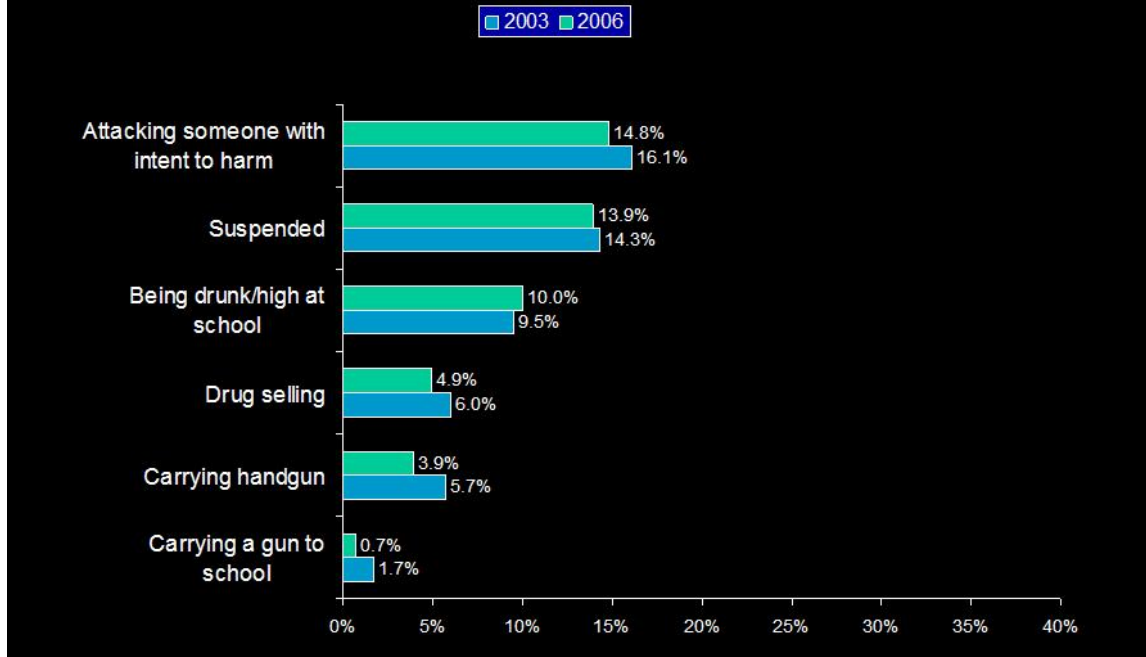
▪ **2003 to 2006 Differences:**

- Past 30 day use of alcohol decreased between 2003 and 2006.
- Antisocial behavior: attacking with intent to harm and selling drugs at school decreased between 2003 and 2006
- Reduction in friends' use of drugs
- Reduced delinquent behavior of friends
- Higher perceived risk of drug use

Key items are found in comparison between 2003-2006:



Anti-Social Behaviors



Targets/Goals

A. Problem Behaviors:

The following outcomes describe those changes expected by implementing evidence-based programming. The first column (2003 county) represents county-wide results obtained in the 2003 Youth Survey. This data serves as a baseline to which future results could be measured. (Note: the 2003 Youth Survey involved 6th, 8th and 10th grades; the 2006 Youth Survey added 12th grade. Therefore, 2006 county-wide results are not reported in this report for comparison.) The second column (2003 10th graders) represents those results particular to a specific grade which served as our focus for goal setting. The third column (Target 2006) represents the targeted percentage (goal) to be achieved by 2006. The fourth column (2006 10th) lists the actual percentage from the 2006 Youth Survey. The fifth column (Target 2009) serves as the new targeted percentage (goal) to be achieved by 2009.

The Community Board chose to *reduce* the majority of these problem behaviors (as measured by 10th graders) by 10 %.

1. To reduce substance abuse, as measured by 10th grade students reporting **30-day alcohol use** on the 2003 *Communities That Care® Youth Survey* (CTCYS), from 41 % in 2003 to 37 % by 2006.

2003 County	2003 10 th	Target 2006	Actual 2006	Target 2009
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23 %	41 %	37%	35.6%	32%
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2. To reduce substance abuse, as measured by 10th grade students reporting **30-day binge drinking** on the 2003 CTCYS, from 22.9 % in 2003 to 20 % by 2006.

2003 County	2003 10th	Target 2006	Actual 2006	Target 2009
12.7 %	22.9 %	20 %	21.1%	19%

3. To reduce substance abuse, as measured by 10th grade students reporting **30-day cigarette use** on the 2003 CTCYS, from 18.9 % in 2003 to 17 % by 2006.

2003 County	2003 10th	Target 2006	Actual 2006	Target 2009
11.7 %	18.9 %	17 %	19.5%	17%

4. To reduce substance abuse, as measured by 10th grade students reporting **30-day smokeless tobacco use** on the 2003 CTCYS, from 5.5 % in 2002 to 5 % by 2006.

2003 County	2003 10th	Target 2006	Actual 2006	Target 2009
3.5 %	5.5 %	5 %	6.7%	6%

5. To reduce substance abuse, as measured by 10th grade students reporting 30-day **marijuana** use on the 2003 CTCYS, from 19.8 % in 2003 to 17 % by 2006.

2003 County	2003 10th	Target 2006	Actual 2006	Target 2009
9.6 %	19.8 %	17 %	18.6%	17%

6. To reduce substance abuse, as measured by 10th students reporting **ecstasy use** on the 2003 CTCYS, from 1.6 % of 10th graders in 2003 to 1.4 % of 10th graders by 2006.

2003 County	2003 10th	Target 2006	Actual 2006	Target 2009
0.9 %	1.6 %	1.4 %	1.9%	1.6%

7. To reduce substance abuse, as measured by 10th grade students reporting **being drunk or high at school** on the 2003 CTCYS, from 20 % of 10th graders in 2003 to 18 % in 2006.

2003 County	2003 10th	Target 2006	Actual 2006	Target 2009
10 %	20 %	18 %	16%	14.5%

8. To reduce violence, as measured by 10th graders reporting **having attacked someone with intent to harm** on the 2003 CTCYS, from 19 % of 10th graders in 2002 to 17 % of 10th graders by 2006.

2003 County	2003 10 th	Target 2006	Actual 2006	Target 2009
16 %	19 %	17 %	15.6%	14.1%

9. To reduce delinquency, as measured by 10th graders reporting **having been arrested** on the 2003 CTCYS, from 9.7 % of 10th graders in 2002 to 8.5 % of 10th graders by 2006.

2003 County	2003 10 th	Target 2006	Actual 2006	Target 2009
7 %	9.7 %	8.5 %	9.7%	8.5%

10. To reduce delinquency, as measured by 10th graders reporting **having carried a gun** on the 2003 CTCYS, from 4.2 % of 10th graders in 2003 to 4.1 % of 10th graders by 2006.

2003 County	2003 10 th	Target 2006	Actual 2006	Target 2009
4 %	4.2 %	4.1 %	4.8%	4.2%

11. To reduce delinquency, as measured by 10th graders reporting **having been suspended** on the 2003 CTCYS, from 13.3 % in 2003 to 13 % by 2006.

2003 County	2003 10 th	Target 2006	Actual 2006	Target
13.9 %	13.3 %	13 %	12.3%	11.1%

12. To reduce delinquency, as measured by 10th graders reporting **having sold drugs** on the 2003 CTCYS, from 10.9 % in 2003 to 10 % in 2006.

2003 County	2003 10 th	Target 2006	Actual 2006	Target 2009
5.2 %	10.9 %	10 %	8.9%	8%

14. To **reduce teen pregnancy** as measured by birthrate among juveniles ages less than 17, from the 2002 Ohio Center for Vital Health Statistics, from 17.5 % to 16 % by 2006.

2002 County	Target 2006	Actual 2006	Target 2009
17.5 %	16 %	18.5%*	16.7%

*we were unable to match exact data; therefore, we are using birthrate for juveniles 15-17 years.

B. Priority Risk Factors

The Community Board chose to *reduce* these risk factors by 5 % as measured by countywide results. (*The 2003 data for risk and protective factors on the charts below do not include 12th graders; the Data Workgroup is transitioning from this point forward to include 12th graders for countywide data; thus, comparisons can't be made between 2003 and 2006 for risk and protective factors; however, the numbers are included for documentation purposes.)

1. To reduce **Low Neighborhood Attachment and Community Disorganization**, as measured by students reporting *low neighborhood attachment* on the 2003 CTCYS, from scale score of 50 in 2003 to a scale score of 48 by 2006.

2003 County	Target 2006	Actual 2006	Target 2009
50	48	49	46

2. To reduce **Low Neighborhood Attachment and Community Disorganization**, as measured by students reporting *community disorganization* on the 2003 CTCYS, from scale score of 58 in 2003 to a scale score of 55 by 2006.

2003 County	Target 2006	Actual 2006	Target 2009
58	55	57	54

3. To reduce **Favorable Parental Attitudes**, as measured by students reporting *parental favorable attitudes toward antisocial behavior* on the 2003 CTCYS, from a scale score of 50 in 2003 to a scale score of 48 by 2006.

2003 County	Target 2006	Actual 2006	Target 2009
50	48	50	47

4. To reduce **Friends Who Engage in the Problem Behavior**, measured by students reporting *friends' delinquent behavior* on the 2003 CTCYS, from a scale score of 52 in 2003 to a scale score of 50 by 2006.

2003 County	Target 2006	Actual 2006	Target 2009
52	50	50	48

C. Protective Factor Outcomes

As measured by countywide results, the Community Board chose to *increase* the protective factors by 5% as measured by countywide results.

1. To increase **Community Bonding** as measured by students reporting *community rewards for prosocial involvement* on the 2003 CTCYS from a

scale score of 46 in 2003 to scale score of 53 by 2006.

2003 County	Target 2006	2006	Target 2009
46	53	48	50

2. To increase **School Bonding**, as measured by students reporting *school rewards for prosocial involvement* on the 2003 CTCYS from a scale score of 50 in 2003 to scale score of 53 by 2006.

2003 County	Target 2006	2006	Target 2009
50	53	51	53

3. To increase **Family Bonding** as measured by students reporting *family attachment* on the 2003 CTCYS from a scale score of 51 in 2003 to scale score of 54 by 2006.

2003 County	Target 2006	2006	Target 2009
51	54	52	54

4. To increase **Healthy Beliefs and Clear Standards** as measured by students reporting *religiosity* on the 2003 CTCYS from a scale score of 52 in 2003 to scale score of 54 by 2006.

2003 County	Target 2006	2006	Target 2009
52	54	47	49

5. To increase **Family Bonding** as measured by students reporting *family opportunities for prosocial involvement* on the 2003 CTCYS from a scale score of 52 in 2003 to scale score of 54 by 2006.

2003 County	Target 2006	2006	Target 2009
52	54	53	55

B. Alcohol and Other Drug Prevention Priorities

The Board considered materials from prior community plans, utilization and perception from prevention providers and the action plans from the county Communities That Cares Initiative (2003 and 2008). Additional criteria included trend and national data as well as funding directives.

Criteria Used to Determine Priorities

1. Cost Effectiveness of Board and partner investment
2. Use of Research-based or evidence based prevention programs
3. Responsive to community need (i.e address CTC target goals for problem behaviors,

- priority risk and protective factors)
4. Prevention programs that are provided within the framework of the National Institute on Drug Abuse Prevention Principles are more effective.
 5. Prevention programs that emphasize integrated partnerships will demonstrate better outcomes for their customers.
 6. Programs that address age, race, ethnicity, gender that are developmentally and culturally appropriate are most effective.
 7. Use of certified prevention staff
 8. ODADAS' priority initiatives: Fetal Alcohol Spectrum Disorder, Childhood/Underage Drinking, Youth-led Prevention, Evidence Based Practices, Stigma Reduction

Board Priorities

The Board's priorities for 2010-2011 are:

Prevention Need	Criteria for Prioritization	Need Rating (High, Medium, Low)
Age-appropriate prevention programming throughout Lorain County for youth and families	1, 2, 3, 4, 5, 6, 7, 8	High
Integrated community- and school-based prevention planning utilizing Strategic Prevention Framework	1, 2, 3, 4, 7, 8	Medium
Environmental prevention strategies throughout Lorain County	1, 3, 5, 6, 8	High

Implications to Other Systems

Our knowledge of the linkage between risk and protective factors to adolescent problem behaviors (substance abuse, delinquency, teen pregnancy, school drop out, violence, depression & anxiety) with the community, family, school and peer/individuals makes this a natural and required commitment from all sectors in our community. Clearly the linkage between certain risk factors and certain problem behaviors will have impact in specific systems. For example the risk factor “availability of drugs or firearms in the community” may have a direct impact in the juvenile justice system. Thus it is imperative that we continue to foster partnerships and raise community awareness of the importance of addressing these priorities in a holistic manner.

Our learning from the Drug Free Communities (ONDCP initiative), provides us with a greater ability to embed environmental change in our community. It is no longer just acceptable to create programs to address problems. The use of a community-focused strategy identifying problems, “but why?” and “but why here?” Statements will assist in framing our issues with clarity. Once we get through this phase, we will be more able to determine effective strategies along with short-, intermediate- and long-term objectives.

C. Prevention Investor Targets

During SFY 2009-2010, the ADAS Board continued to align its investor targets with the SAMHSA National Outcome Measures (NOMs). These targets naturally link to ODADAS Prevention Targets as identified below:

ODADAS Investor Target	ADAS Board Target	Implementer (Provider) Target Area(s)
Programs that increase the number of customers who avoid ATOD use and perceive non-use as the norm	Increase the number of customers under the age of 18 who avoid ATOD use.	Number of persons (unduplicated) reporting any alcohol, tobacco or other drug use in the past 30 days.
Programs that reduce the number of customers who misuse prescription and/or over-the-counter medications	Reduction in the number of customers who misuse prescription and/or over the counter medications.	Number of persons (unduplicated) reporting any prescription and/or over the counter medication use in the past 30 days.
Programs that increase the number of customers who perceive ATOD use as harmful	Increase the number of customers who perceive ATOD use as harmful.	Number of persons (unduplicated) reporting disapproval of peers using ATOD.
Programs that increase the number of customers who experience positive family management	Increase the number of customers who experience positive family management	Number of parents (unduplicated) reporting having talked to their child about ATODs during the past 12 months.
Programs that increase the number of initiatives that demonstrate an impact on community laws and norms	Demonstrate an increase of impact on community laws and norms relative to ATOD.	Demonstrated trend data from community indicators relative to ATOD, risk and protective factors.
Programs that increase the number of customers who demonstrate school bonding and educational commitment	Increase the number of customers who demonstrate school bonding.	Number of students with documented positive school improvement.
Use of Evidence-Based Practices	Continuance/increase in implementation of evidence-based programs	<i>Minimum Requirement:</i> Number of evidence-based programs implemented/established.
None Specified	Systemic Collaboration to prevent and reduce substance abuse by addressing risk factors and promoting protective factors.	<i>Minimum Requirement:</i> Delivery of an Evidence Based Strategic Prevention Framework (CTC) inclusive of needs assessment, resource assessments, capacity building, and evaluation.

SECTION IV: TREATMENT & RECOVERY SUPPORT SERVICES

A. Treatment and Recovery Support Needs

Process used to determine treatment and recovery support needs

While the ADAS Board has not completed a formal needs assessment since 1994, a variety of formats have been compiled to determine current treatment and recovery support needs. The most notable is the Organizational Assessment of the Lorain County Access and Retention Initiative (LCAR) completed in Spring 2007. This assessment was conducted and aggregated by the Great Lakes ATTC research assistants at UIC-Chicago. A semi-structured interview format was developed using the Access and Retention framework developed by NIATx and assessed the functioning of the Lorain County Treatment system across the five domains: outreach, referral to intake, intake through assessment, assessment through treatment, and cross-systems collaboration. Proposed questions were developed by Great Lakes ATTC and revised by LCAR's evaluation committee. 20 interviews with key informants were completed, five with treatment agency personnel, 15 with staff from referral partners in mental health, children services, criminal justice, and allied health services.

The second significant needs assessment was completed in conjunction with our application to the Robert Wood Johnson Advancing Recovery Initiative (fall, 2007). We conducted walk-through's at two treatment providers in the Lorain County system: Lorain County Alcohol and Drug Abuse Services, Inc. (LCADA) - provider of assessment, outpatient, intensive outpatient and Women's residential services & Compass House, Inc. - provider of assessment, outpatient, intensive outpatient, and residential services for Men and Women. Both agencies rely on ancillary partners for detox (Stella Maris Inc.) or medical/somatic/psychiatric (Nord Center) services. Evaluators received walk-through training and were instructed to each contact a treatment agency (anytime within a designated 36 hour period) and state they needed help with substance addiction issues. Both surveyors were given a script with diagnosis and life circumstances (304.00 IV Heroin user, and 303.90 court ordered multiple DUI offender), and instructed to follow the guidance of the agency they contacted. Out intent was to gain a clients eye view of initial calls, lags between contact and service and quality of encounter assessments, and efficacy of referrals. We utilized two (2) clinical staff from the MRDD system to portray treatment clients. To ensure their experiences were realistic the reviewers made initial calls (& subsequent if necessary), arrived at intakes and assessments, brought only what was suggested, and completed all paperwork. The "scripts" had embedded criterion leading to specific diagnosis, case management needs, and levels of care. It was through these clinical "nuances" that we could determine if appropriate referrals were being made as designed in policy. For instance, one individual portrayed an IV user of excess of 1 gram (10 bags or "bundle") of heroin per day, had unstable housing, no complicating medical conditions, and requested information on Suboxone. He made initial contact with LCADA. This scenario should have involved referrals to Suboxone case manager (Nord Center), completion of additional MAT forms, and coordination with residential services provider (Compass House). The efficacy of these front door referral processes and triggers were a target of the survey. We chose male social workers from the MRDD system for several reasons: a) They fit the NIATx suggested prototype of detail oriented and dedicated; b) are from outside of the addictions services continuum-thus, offer fresh

and objective perspective; c) are unknown to the lines staff who would be processing them; d) using other county professionals strengthens cross-system partnerships and; e) offers the MRDD system orientation to the addictions continuum..

Additionally, we conducted a State system walkthrough that consisted of reviewing rules and taxonomies with potential to complicate implementation of these strategies. The review was conducted in a regularly scheduled policy meeting among department chiefs and culminated in discussion with the ODADAS Director. Issues under discussion included: ever-growing documentation and reporting requirements impact time and funding available for direct service; lack of statewide physician training dedicated to linking Medication Assisted Treatment (MAT) certified physicians with treatment entities; clients must be enrolled in state billing system before many treatment engagement strategies can be funded

Most recently (spring, 2009), we completed a Recovery Oriented Care – Self Assessment. This assessment, modeled after Philadelphia’s ROSC initiative, was completed by 20 respondents from treatment, recovery, jail, probation and correctional facility staff. The purpose of this assessment was to provide a baseline for our community in terms of transitioning to a recovery oriented framework.

As a mandated member of the local Family and Children’s First Council, the ADAS Board participated in the HB 289 assessment and planning sessions of the council

Findings of the Needs Assessments

The primary emphasis on the needs assessments identified above focused on adults who abuse or are addicted to alcohol or other drugs – which is our largest population served.

The Organizational Assessment summary was a platform for prioritization of barriers. Salient points gleaned from this assessment and subsequent discussions were: a) linkages of treatment clients to other ancillary services could be improved; b) clients are too often expected to follow-up with prescribed referrals on their own; c) no-shows contribute to long waits between services; d) few resources or supports available to persons “between” levels of care. Identified barriers embedded in the County system include: a) historical Board funding not conducive to consultation, pre-treatment or interim levels of care; b) funding to agencies not across agencies/systems for clients served; c) delays in enrollment into the state billing system prevents prohibits identifying early engagement services; d) lack of interagency “handoff” policy, contract language, e) CQI systems to ensure assertive case management practices across a shared continuum; and f) traditional detox has fewer procedural delays than Suboxone with counseling. {We have also determined that the Ohio Chemical Dependency Professionals Board rules do not include certification/endorsement of recovery coaches.}

The most salient issues/points generating from the walkthroughs were: a) while direct face to face clinical encounters were professional, engaging, and high quality; points of contact processes preceding the assessments (1st contact- up to the assessment) were cumbersome and complicated; b) intake and referral processes lent to long periods of non-service; c) not all intake/first call staff was familiar with intersystem clinical protocols. *In summary we need to shore up (a) 1st call to assessment, (b) linkages and case management practices.* Several agency

level barriers may complicate the implementation of our selected EBP's: a) there still exists "anti-medication" culture in some entities, and community volunteers; b) Suboxone clients may require multiple levels of care across several providers; this requires the Rx physician to collaborate with multiple parties over an extended period of time; c) tracking requirements to gauge efficacy to already paperwork burdened staff; d) initial contact calls happen at all times of day/night - not all staff responding to calls is equal in familiarity with resources outside their own entity; e) engagement services require working with "using" or otherwise symptomatic individuals - resistance may come from some staff that has historically operated under abstinence-first beliefs.

The most salient observations made from the state walkthrough noted that some immediate barriers such reimbursement strategies can be addressed via changes in the contracting and services mix at the county board level (i.e. intermediate purchasing entity).

The most salient observations from the recovery oriented care – self assessment were that the respondents rated our community highest on the following: use of recover language by staff and that staff believe that people can recover and make their own treatment and life choices. The lowest rated components included: most services not proved in a persons' natural environment and people in recovery do not work along side agency staff on the development of new programs and services.

The findings from the Children and Families Council identified three key areas of focus: alcohol and drug use by youth, strengthening community assets and child abuse and neglect - all of which target prevention priorities. The ADAS Board is part of the council's Core Planning Committee which is beginning to address the service coordination mandate for CFC families and children.

The ADAS Board participates with Mental Health, Mental Retardation & Developmental Disabilities, Juvenile Court on the Integrated Services Partnership. There is ongoing dialogue and regarding the needs of adolescents in our community through this partnership.

The ADAS Board, in conjunction with the Lorain County Board of Mental Health regularly meets through the joint committee (represented by members of each board). The focus of this effort is to align priorities of both systems including services for persons with substance abuse and mental illness (SAMI).

B. Treatment and Recovery Support Priorities

The Board considered materials from prior community plans, utilization and perception from treatment providers and investment data (lessons' learned outcomes). Additional criteria included trend and national data as well as funding directives.

Criteria Used to Determine Priorities

1. Mandated Board functions pursuant to ORC 340.
2. If the anticipated cost of the proposed need may be realized by the Board and/or the Board and other funding sources without negatively impacting services for other priorities, the need is considered a priority.

3. Utilization and/or waiting lists. The service is considered a priority if the LCAR and the ADAS Board determines it will increase utilization (capacity) and reduce waiting lists.
4. Full continuum of care – offer services within ODADAS Service Taxonomy
5. Client characteristics locally identified as highest priorities include motivation for recovery, medically indigent, most at risk of relapse.
6. Mandated priority populations; mandated funding populations including: Pregnant Women, Women, Injecting Drug Users, clients referred by a public children services agency pursuant to HB 484 eligibility guidelines, Lorain County children, adolescents or their family members who are at risk for out-of home placement and are referred for services by the Integrated Services Partnership, Lorain County residents who are medically indigent, Adults who have completed detoxification programs.
7. Improved quality of outcomes – the best treatment is what engages a client through a stable recovery.

Board Priorities

The Board’s priorities for 2010-2011 are:

Treatment Need	Criteria for Prioritization	Need Rating (High, Medium, Low)
Evidence-based treatment programs	1,2,3,4,5,6,7	Medium
Localized detoxification needs for Lorain County residents	1,3,5,6	High
Waiting List management and reduction of waiting lists	3,4,5,6,7	High
Recovery-oriented focus	3,4,5,6,7	High
Board level outcomes (and ODADAS outcomes)	1,2,3,4,5,6,7	High
Support for residential programs (adults and adolescents); ancillary supports in place for residential components	1,2,3,4,5,6,7	Medium
Infrastructure (qualified staff, use of technology, systemic approach)	2,4,7	High

Implications to Other Systems

We are aware that substance abuse crosses many systemic boundaries (criminal justice, children’s services, school, etc). As such, the ADAS Board remains committed to ensuring that its investments are those that can be qualified and sustained by providers. Semi annual lessons learned meetings are held for treatment and prevention providers to gauge the providers’ ability to meet outcomes that are client focused.

As new ideas are spawned, the Board remains cognizant that creation of any new service or

program enhancement could reduce (or eliminate) existing programs without the infusion of new funding stream(s) or a critical re-focus on doing business more efficiently.

With the current funding scenario and potential additional budget reductions, we hope to at least maintain current services. We do know that waiting lists continue to grow disproportionately to treatment capacity; effective case management often targets only critical life areas and access and retention rates still need improving. These problems continue to be addressed with the Board’s leadership and the commitment from our providers.

C. Treatment and Recovery Support Investor Targets

During SFY 2009-2010, the ADAS Board continued to align its investor targets with the SAMHSA National Outcome Measures (NOMs). These targets naturally link to ODADAS Prevention Targets as identified below:

ODADAS Investor Target	ADAS Board Target	Implementer (Provider) Target Area(s)
Number of customers who are abstinent at the completion of the program.	Increase the number of customers who achieve and maintain abstinence	<i>Minimum Requirement:</i> Number of customers who show reduction in frequency of use at date of last service compared to date of first service.
Number of customers who are gainfully employed at the completion of the program.	Increase the number of customers who are gainfully employed at termination of services	<i>Minimum Requirement:</i> Number of customers who show increase in employment or school at date of last services compared to first service.
Number of customers who incur no new arrests at the completion of the program	Increase the number of customers who incur no new arrests.	<i>Minimum Requirement:</i> Number of customers who show reduction in number of arrests in past 30 days from date of first service to date of last service.
Number of customers who live in safe, stable, permanent housing at the completion of the program	Increase number of customers who achieve stability in life factors includes: <ul style="list-style-type: none"> • Regain custody of their children • Have no new findings of abuse/neglect • Have been assertively linked to resources that meet their needs • Who stabilize their finances • Who have stable housing • Who have improved their relationships • Who deliver drug free baby(ies) • Who have functional recovery support networks 	<i>Minimum Requirement:</i> Number of customers who show increase in stability in life factor(s) from date of first service to date of last service (identify each).

None Specified	Increase the number of youth who successfully transition back to their community (<i>Adolescent treatment</i>) includes: <ul style="list-style-type: none"> • Improve academic performance • Have functional positive peer supports • Have improved family relationships. 	<i>Minimum Requirements:</i> Number of customers who show improvement of in academic performance, have functional positive peer supports and/or improved family relationships - at date of last service compared to date of first service (identify each).
None Specified (NOM: Use of Evidence-Based Practices)	Continuance/increase in implementation of evidence-based programs	<i>Minimum Requirement:</i> Number of evidence-based programs implemented/established.
None Specified (NOM: Access/Capacity)	Number of persons needing service Number of persons receiving services	Number of persons served compared to # of persons requesting: <ul style="list-style-type: none"> a. <i>Assessment</i> b. <i>Primary treatment</i>
None Specified (NOM: Retention)	Continuation of services across shared continuum of care	Efficacy of interagency referral count
None Specified (NOM: Retention)	Unduplicated count of persons served.	Unduplicated Count of person(s) to be served.
None Specified (NOM: Retention)	Number of persons completing prescribed treatment continuum (versus transferred)	Number of persons and average length of stay from date of first service to date of last service by discharge: <ul style="list-style-type: none"> a. Completed b. Transferred c. Dropped Out d. Terminated e. Other

ORC 340.033(H) (HB 484)

In order to address the accountability related to H.B. 484, the following investor target is below:

ODADAS Investor Target	ADAS Board Target	Implementer (Provider) Target Area(s)
None specified	Increase number of customers who achieve stability in life factors includes: <ul style="list-style-type: none"> • Regain custody of their children • Have no new findings of abuse/neglect 	<i>Minimum Requirement:</i> Number of customers who show increase in stability in life factor(s) from date of first service to date of last service (identify each).

HIV Early Intervention

As the ADAS Board is one of eleven boards to receive the special allocation for HIV Early Intervention Services, the following investor target is below:

ODADAS Investor Target	ADAS Board Target	Implementer (Provider) Target Area(s)
None specified	Increase the number of customers who reduce the risk of contracting HIV/TB/Hepatitis.	Number of customers successfully completing provider HIV/TB Hepatitis program

SECTION V: COLLABORATION

Partnerships continue to be critical to the success of the ADAS Board's investments. National, regional, state and local partner relations continue to be developed and/or strengthened to leverage the Board's resources and ultimately enhance the capacity and service delivery system. Collaboration continues to be rated high on the Board's satisfaction surveys.

Nationally and regionally, our access and retention initiative is re-aligning its format towards a recovery-oriented transformation. Recovery oriented models such as the state of Connecticut and the cities of Philadelphia, PA and Detroit, MI have been recently brought to the attention of the ADAS Board. This work continues to be guided through consultation, training and technical assistance from the Great Lakes Addiction Technology Transfer Center (ATTC) to our community and is embedded in the LCAR initiative. As has been mentioned also, board staff participates on the Great Lakes ATTC Regional Advisory Board – Ohio Caucus.

Statewide, our continued relations with the Ohio Department of Alcohol and Drug Addiction Services (ODADAS) as a primary funder (and through the STAR-SI initiative) the board's investment strategies continually focused on the Substance Abuse and Mental Health Services Administration (SAMHSA) National Outcome Measures (NOMs). The 2008 investment continued the NOMs for client success the Board is implementing four additional NOMs targeted at Access/Capacity and Retention. ADAS Board staff remain active on various workgroups of the Ohio Association of County Behavioral Health Authorities (OACBHA – board trade association in Ohio) – particularly on the fiscal, clinical leaders, Medicaid, governance, futures and data workgroups. The Board and OACBHA shared a partnership for the provision of statewide trainings in 2008 focused on All-Hazards/Behavioral Health topics. OACBHA continues to bring one voice on behalf of community boards to legislators, governor and state departments. Finally, board staffs are represented on two statewide initiatives – Governor's Advisory Council on Alcohol and Drug Addiction and the Ohio Chemical Dependency Professionals Board. These appointments not only bring continued recognition to the ADAS Board but allow for the Board's projects to be shared at a state level.

Locally, many opportunities continue and new relationships have been solidified during 2008. Members of the Integrated Services Partnership (consisting of ADAS Board, Board of Mental Health, Juvenile Court, Children's Services and Board of Mental Retardation and Developmental Disabilities) participated in the Ohio Summit on Children towards a pilot initiative. ISP members also continue their research project "Predicting Delinquency for Maltreatment Children in Lorain County." The County Children and Family Council's (CFC) focus areas, long term commitment and intermediate outcomes include "strengthening community assets". Utilizing the Communities That Care (CTC) framework, emphasis on increasing protective factors and reducing risk factors along with adolescent drug use reduction are key components of Council's strategies. The CFC director has recently been added as a participant on the Board's prevention investment workgroup.

In 2008 specific collaboration efforts are noted:

- (a.) Focus on recovery through the annual 5K run/walk in celebration of National Recovery month, inclusive of obtaining proclamations (White House, State Senate, House of Representatives, County Commissioner and City of Lorain)
- (b.) Align recovery month events with the national Faces and Voices of Recovery – targeted at stigma reduction
- (c.) Partner with Coalition for a Drug Free Lorain County, Avon Lake Unites for Teens and the Leadership to Keep Children Alcohol Free for the implementation of two town hall meetings and public policy training focusing on underage drinking
- (d.) Partner with courts (and Erie/Ottawa Board) to secure Indigent Drivers’ Alcohol Treatment funding – particular to Elyria, Avon Lake and Vermilion Municipal courts.
- (e.) Participation in county administration “Wellness Fair” for the provision of substance abuse (treatment, prevention and services) to community
- (f.) Participation in United Way’s annual Day of Caring events
- (g.) Partner with county prosecutor’s initiative for Safe Schools Collaborative
- (h.) Participation regional “Social Policy” conversation at Cleveland State University
- (i.) Participation in Leadership Lorain County’s “Poverty Simulation”
- (j.) Received support from the Community Foundation of Greater Lorain County and provided technical assistance and funding support for transition of men’s residential treatment services
- (k.) Begin to align partnership with Oberlin College and Lorain County Community College towards college-age drinking initiatives
- (l.) Participation in northeast Ohio regional meetings focused on Medicaid Managed Care for behavioral health
- (m.) Co-participation (with Mental Health Board and Lorain County Health & Dentistry) forming the integrated behavioral health/primary health initiative
- (n.) Participation on county-wide Affordable Healthcare for the Uninsured initiative
- (o.) Participation on AIDS taskforce needs assessment and Lorain City Health Department’s strategic plan
- (p.) Invited for membership with Lorain County Homeless Summit Task Force
- (q.) Provision of national grant submissions: Advancing Recovery, Drug Free Communities, Criminal Justice Expansion
- (r.) Provide technical assistance on federal grants: Homeless Expansion, Pregnant and Postpartum Women Residential Treatment, HIV/AIDS Outreach and Treatment Expansion, Recovery Community Support, Lorain City, School and Mentoring Program
- (s.) Staff received trainer certification for Promoting Awareness of Motivational Incentives (aka Contingency Management) for use in access and retention initiatives (NIDA/SAMHSA Blending Initiative)
- (t.) Facilitated scholarship for an agency person to receive Motivational Interviewing Assessment – Supervision trainer certification for local system enhancements (NIDA/SAMHSA Blending Initiative)
- (u.) Partner with LCADA, Boys & Girls Club, Elyria YWCA, Lorain City Parks and Recreation, and Cleveland Indians for enhancements and promotion of

ATLAS/ATHENA program and inclusion of county youth in the Indians' Play Clinic

- (v.) Partner with Strengthening Families programs for booster session programming and assistance for adapted program through Murray Ridge for learning-disabled older teenagers (16-21) for program implementation.
- (w.) Lorain County Children Services (HB 484) – as a partner system, our relationship specifically with the Behavioral Health Assessment team of Lorain County Children Services continues to effectively identify and refer families whose children are at risk for abuse/neglect due to the addiction of the parent(s) and/or caregiver(s). We are able to streamline LCCS families into treatment services within and expedited manner in order to adhere to LCCS family guidelines. Additionally, the Board and providers are represented on the Community Advisory Network which is a quarterly process to address critical items in the LCCS Strategic Plan

We have used consumer perspective in our access and retention initiative through the “walk through” components of the needs assessment. While these perspectives are quasi consumer – we were able to get the view of our system. We know that more needs to be done for including Board involved customers in our planning process.

We have begun “listening sessions” as part of the community assessment for the Drug Free Communities initiative. Occurring between April – June, 2009 we expect to hear from youth, faith-based, parents, those in recovery, homeless individuals, neighbors and professionals about problems and solutions of underage alcohol, tobacco and other drug use. We know that these sessions will assist in insight to treatment programming enhancements as well.

Finally, as we move towards the goal of a recovery-oriented transformation, we will seek the advice from Ohio Citizen Advocates to assist in creating a platform for obtaining input for systemic improvement.

SECTION VI: EVALUATION

Evaluation Methods and Evaluation Collaboration

The Board has continued to utilize the Outcomes framework stratagem supported by ODADAS for its local treatment and prevention programs and services. All contract providers of the ADAS network establish performance targets for consumer success (based in measurable behavioral change) that contribute to the Board's Investor targets. Aggregate reports are submitted semi-annually regarding “actual” versus “projections” as consumers move throughout program continuums.

The ADAS Board continues the 2-year investment strategy. The Board and contract providers mutually agree upon key performance targets and strategies over a 24-month period for customer success. The concept of this investment is similar to the ODADAS Community Planning process. The Board and treatment providers agree upon components of performance targets (over 24 months)

using a consistent “data dictionary” for key terms (including early engagement, abstinence, non-traditional times). Milestone projections are estimated on a 6-, 12-, 18- and 24-month intervals. Core features that include: Essential Elements, comparative advantages, intensity/duration, delivery strategies, key people and intermediaries/collaborators and partners are included for each program/performance target. Budgets are submitted annually.

Provider have recently completed an update in February, 2009 that provides a “lessons learned” regarding significant, new and/or different outcomes achieved, trends experienced in the first year, utilization of outcome data to enhance performance and system improvements, and procedural/programmatic improvements planned in the second year.

Throughout the year, “results and lessons learned” meetings occur within the scope of monthly program directors meetings. The focus is on improving barriers to consumer care and involves all contract providers. Summaries from these meetings are discussed as a part of the Board Committee process. An annual outcomes meeting hosted by the Board for all contract agencies to ensure an opportunity to review a funding year, in whole, as it relates to the Outcomes Framework Model. Review forms have been developed to capture results versus initial Fiscal Year projections and generate discussion via the following questions:

1. Prior years Performance target statement (original)
2. Prior years Performance target result (replace proposed # with final actual #)
3. Did actual performance target # vary by > <20% of actual numbers? If yes, what was learned from this? What course corrections were incorporated last year to get closer to the performance targets?
4. What steps are proposed to get closer to next years performance targets?

Additionally *outcomes verification review* to ensure proper milestone verification strategies are implemented and documented inclusive of the annual record review process for all contract agencies. This practice will further solidify the integrity of the outcomes data received.

Barriers or other systemic issues pertaining to quality care that arise through this process will be identified and prioritized. These issues may need the necessity of longer time to see if the trends are continuing and/or random for specific programs/populations as identified. Those requiring additional action will be prioritized and placed as agenda items in future program directors meetings, executive director forums, and processed through the Board’s committees (Program and Administrative). Agency feedback will be solicited for staff discussions and meetings with the Board.

Quarterly, providers submit their CQI report and findings as a report to the ADAS Board. Annually the components of the Board’s CQI plan provides holistic evaluation and allow the Board to improve the quality of alcohol and drug addiction treatment and prevention services for Lorain County.

Priority for Evaluation of Effectiveness and/or Efficiency

The ADAS Board continues to focus on the following for priority:

- a. Those programs which “hand off” clients – ie. level of care changes – for efficacy of referral (particularly sub-acute detox and residential programs along with the Suboxone with counseling program)

- b. Those programs which address reduction waiting lists – both pre- and post-assessment
- c. Those programs that maintain access and retention as a goal – particularly pre-treatment and outpatient (including Intensive outpatient) services

Child & Adolescent Services

The ADAS Board does not modify its evaluation strategies for child & adolescent services.

**SECTION VII: OHIO DEPARTMENT OF ALCOHOL AND
DRUG ADDICTION SERVICES WAIVERS**

A. Waiver Request for Inpatient Hospital Rehabilitation Services

Funds disbursed by or through ODADAS may not be used to fund inpatient hospital rehabilitation services. Under circumstances where rehabilitation services cannot be adequately or cost-efficiently produced, either to the population at large such as rural settings, or to specific populations, such as those with special needs, a Board may request a waiver from this policy for the use of state funds.

Complete this form providing a brief explanation of services to be provided and a justification for this requested waiver. **Medicaid-eligible recipients receiving services from hospital-based programs are exempt from this waiver.**

A. HOSPITAL	ODADAS UPID #	ALLOCATION

The ADAS Board of Lorain County does not seek a Waiver for Inpatient Hospital Rehabilitation Services in this Community Plan

B. Request for Generic Services

Generic services such as hotlines, urgent crisis response, referral and information that are not part of a funded alcohol and other drug program may not be funded with ODADAS funds without a waiver from the Department. Each ADAMHS/ADAS Board requesting this waiver must complete this form and provide a brief explanation of the services to be provided

B.AGENCY	ODADAS UPID #	SERVICE	ALLOCATION

The ADAS Board of Lorain County does not seek a Request for Generic Services for this Community Plan.

SIGNATURE PAGE

Community Plan for the Provision of Alcohol, Drug Addiction and Mental Health Services
SFY 2010-2011

Each Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Board, Alcohol and Drug Addiction Services (ADAS) Board and Community Mental Health (CMH) Board is required by Ohio law to prepare and submit to the Ohio Department of Alcohol and Drug Addiction Services (ODADAS) and the Ohio Department of Mental Health (ODMH) a plan for the provision of alcohol drug addiction and mental health services in its area. The plan, which constitutes the Board's application for funds, is prepared in accordance with procedures and guidelines established by ODADAS and ODMH. The Community Plan is for State Fiscal Years (SFY) 2010 – 2011 (July 1, 2009 to June 30, 2010).

The undersigned is a duly authorized representative of the ADAMHS/ADAS/CMHS Board. The ADAMHS/ADAS Board hereby acknowledges that the information contained in this application for funding, the Community Plan for SFY 2010 - 2011, has been reviewed for comment and recommendations by the Board's Standing Committee on Alcohol and Drug Addiction Services, and is complete and accurate.

Alcohol and Drug Addiction Services Board of Lorain County

ADAS Board Name (Please print or type)

ADAS Board Executive Director

Date

Authorized ADAS Board Member

Date

[Signatures must be original or if not signed by designated individual, then documentation of authority to do so must be included (Board minutes, letter of authority, etc.).]

APPENDIX A:

Table 1: Portfolio of Alcohol and Drug Services Providers Instructions

Evidence-Based Programs Defined:

Alcohol and Other Drug Prevention

Alcohol and other drug prevention defines Evidenced Based Prevention to mean the prevention policies, strategies, programs and practices are consistent with prevention principles found through research to be fundamental in the delivery of prevention services; the prevention policies, strategies, programs and practices have been identified through research to be effective; the service delivery system utilizes evaluation of its policies, strategies, programs and practices to determine effectiveness; and the service delivery system utilizes evaluation results to make appropriate adjustments to service delivery policies, strategies, programs and practices to improve outcomes.

Alcohol and Other Drug Treatment

ODADAS and ODMH have engaged work groups to address definitions and use of promising, best and evidence-based practices. The diligent work of various groups and committees is in various stages of development, including documents in the form of recommendations to one or both Departments. To the extent that these efforts are a work in progress and recommendations may not have been acted upon as of this date, the Departments will use the following SAMHSA definition of EBPs for the purposes of these guidelines:

A program, policy strategy or practice that has met any of the following criteria: a) has appeared in a peer journal and has demonstrated effectiveness, b) is current on at least one federal government approved list of programs (e.g., SAMHSA's National Registry of Evidence-Based Programs, or NREPS), c) data demonstrates that the program, policy, strategy or practice is evidence based. That is, the implementing organization uses an outcomes system which is data driven and outcomes focused resulting in an ability to demonstrate program impact towards outcomes.

TABLE 1: PORTFOLIO OF ALCOHOL AND DRUG SERVICES PROVIDERS

Prevention Strategy and Level of Care	a. Provider Name	b. Program Name (Provider Specific)	c. Population Served	d. Prevention Level (Prevention only)	e. Evidence-Based Practice (EBP)	f. Number of sites	g. Located outside of Board area	h. Funding Source (Check the box if yes)		i. MACSIS UPI
								ODADAS	Medicaid Only	
PREVENTION										
Information Dissemination	a. Catholic Charities Community Svc – Lorain b. Big Brothers Big Sisters c. LCADA d. LCADA e. LCADA f. Lorain UMADAOP g. Lorain UMADAOP h. Lorain UMADAOP (flow-through)	a. Communities That Care/Drug Free Communities b. Big Brothers Big Sisters c. HIV Reducing the Risk d. Parenting for Prevention e. Project SOAR f. Youth Mentoring g. Parenting h. Aiming High for the Future	a. Government, Schools, Cities, Parents, Youth, Business, Faith Based, Media, Agencies b. boys, girls, adult mentors, schools c. adults in substance abuse treatment programs (@ risk for HIV due to addiction), community-based groups d. families who have loved one that is harmfully involved with substances, parents and guardians referred by the courts in lieu of their adolescent being formally charged with a first time legal charge, parents with a history of familial substance abuse, parents/guardians of youth ages 10-17 referred via children services, school suspensions programs, etc. e. Jr. & High School athletes, pre-school	a. Universal b. Selected c. Indicated d. Selected e. Selected, Indicated f. Selected g. Selected h. Universal	a. Communities That Care b. Big Brothers, Big Sisters of America c. HIV/AIDS Education in Drug Treatment, d. Strengthening Families (10-13 & 14-17), e. ATLAS/ATHENA, Strengthening Families (10-14, 13-17), Building Blocks, LifeSkills f. Reconnecting Youth, Rites of Passage, Lifeskills, Making the Peace g. Strengthening Families (10-14) including the Spanish adaptation h. Parent-To Parent, Anger Management, Too Good for Drugs,	a. 1 b. 1 c. 1 d. 1 e. 1 f. 1 g. 1 h. 1	a. <input checked="" type="checkbox"/> No b. <input checked="" type="checkbox"/> No c. <input checked="" type="checkbox"/> No d. <input checked="" type="checkbox"/> No e. <input checked="" type="checkbox"/> No f. <input checked="" type="checkbox"/> No g. <input checked="" type="checkbox"/> No h. <input checked="" type="checkbox"/> N	a. <input checked="" type="checkbox"/> Yes b. <input checked="" type="checkbox"/> Yes c. <input checked="" type="checkbox"/> Yes d. <input checked="" type="checkbox"/> Yes e. <input checked="" type="checkbox"/> Yes f. <input checked="" type="checkbox"/> Yes g. <input checked="" type="checkbox"/> Yes h. <input checked="" type="checkbox"/> Yes	a. <input checked="" type="checkbox"/> No b. <input checked="" type="checkbox"/> No c. <input checked="" type="checkbox"/> No d. <input checked="" type="checkbox"/> No e. <input checked="" type="checkbox"/> No f. <input checked="" type="checkbox"/> No g. <input checked="" type="checkbox"/> No h. <input checked="" type="checkbox"/> No	a. 10116 b. 8226 c. 1472 d. 1472 e. 1472 f. 1942 g. 1942 h. 1942

			children, adolescents referred from courts for first-time legal offense related to alcohol/drug use, youth (ages 10-17) and their parents f. Hispanic and African American adolescents (6 th 12 th graders) g. families of Hispanic and African American adolescents (ages 10-14) h. Hispanic and African American peer leaders (teens),							
Information Dissemination (continued)			h. (continued), parents of peer leaders, students in grades K-12, senior citizens							
Alternatives	a. Big Brothers Big Sisters b. LCADA c. Lorain UMADAOP d. Lorain UMADAOP e. Lorain UMADAOP (flow-through) f. Lorain UMADAOP (flow-through)	a. Big Brothers Big Sisters b. Project SOAR c. Youth Mentoring d. Parenting e. Project TAD f. Aiming High for the Future	a. boys, girls, adult mentors, schools b. Jr. & High School athletes, pre-school children, adolescents referred from courts for first-time legal offense related to alcohol/drug use, youth (ages 10-17) and their parents c. Hispanic and African American adolescents (6 th 12 th graders) d. families of Hispanic and African American adolescents (ages 10-14) e. preschoolers, K-2 nd graders, and their parents f. Hispanic and African American peer leaders (teens), parents of peer leaders, students in grades K-12, senior citizens	a. Selected b. Selected, Indicated c. Selected d. Selected e. Universal f. Universal	a. Big Brothers Big Sisters of America b. ATLAS/ATHENA, Strengthening Families (10-14, 13-17), Building Blocks, LifeSkills c. Reconnecting Youth, Rites of Passage, Lifeskills, Making the Peace d. Strengthening Families (10-14) e. Too Good for Drugs, New Kids, New Start (Ninitos Nuevos Pasos Nuevos), Parent-To-Parent f. Parent-To Parent, Anger Management, Too Good for Drugs	a. 1 b. 1 c. 1 d. 1 e. 1 f. 1	a. <input checked="" type="checkbox"/> No b. <input checked="" type="checkbox"/> No c. <input checked="" type="checkbox"/> No d. <input checked="" type="checkbox"/> No e. <input checked="" type="checkbox"/> No f. <input checked="" type="checkbox"/> No	a. <input checked="" type="checkbox"/> Yes b. <input checked="" type="checkbox"/> Yes c. <input checked="" type="checkbox"/> Yes d. <input checked="" type="checkbox"/> Yes e. <input checked="" type="checkbox"/> Yes f. <input checked="" type="checkbox"/> Yes	a. <input checked="" type="checkbox"/> No b. <input checked="" type="checkbox"/> No c. <input checked="" type="checkbox"/> No d. <input checked="" type="checkbox"/> No e. <input checked="" type="checkbox"/> No f. <input checked="" type="checkbox"/> No	a. 8226 b. 1472 c. 1942 d. 1942 e. 1942 f. 1942

Education	<ul style="list-style-type: none"> a. Big Brothers Big Sisters b. LCADA c. LCADA d. LCADA e. LCADA f. Lorain UMADAOP g. Lorain UMADAOP h. Lorain UMADAOP (flow through) i. Lorain UMADAOP (flow through) j. Lorain UMADAOP (flow through) 	<ul style="list-style-type: none"> a. Big Brothers Big Sisters b. HIV Reducing the Risk c. Project FAST d. Parenting for Prevention e. Project SOAR f. Youth Mentoring g. Parenting h. Project TAD i. Aiming High for the Future j. Circle for Recovery 	<ul style="list-style-type: none"> a. boys, girls, adult mentors, schools b. adults in substance abuse treatment programs (@ risk for HIV due to addiction), community-based groups c. Youth (ages 13-18) engaged in AoD treatment services, their siblings and parents d. families who have loved one that is harmfully involved with substances, parents and guardians referred by the courts in lieu of their adolescent being formally charged with a first time legal charge, parents with a history of familial substance abuse, parents/guardians of youth ages 10-17 referred via children services, school suspensions programs, etc. e. Jr. & High School athletes, pre-school children, adolescents referred from courts for first-time legal offense related to alcohol/drug use, youth (ages 10-17) and their parents f. Hispanic and African American adolescents (6th 12th graders) g. families of Hispanic and African American adolescents (ages 10-14) h. preschoolers, K-2nd 	<ul style="list-style-type: none"> a. Selected b. Indicated c. Indicated d. Selected e. Selected, Indicated f. Selected g. Selected h. Universal i. Universal j. Indicated 	<ul style="list-style-type: none"> a. Big Brothers Big Sisters of America b. HIV/AIDS Education in Drug Treatment c. Strengthening Families Program (10-14) d. Strengthening Families (10-13 & 14-17), e. ATLAS/ATHENA, Strengthening Families (10-14, 13-17), Building Blocks, LifeSkills f. Reconnecting Youth, Rites of Passage, Lifeskills, Making the Peace g. Strengthening Families (10-14) including the Spanish adaptation h. Too Good for Drugs, New Kids, New Start (Ninitos Nuevos Pasos Nuevos), Parent-To-Parent i. Parent-To Parent, Anger Management, Too Good for Drugs j. none 	<ul style="list-style-type: none"> a. 1 b 1 c. 1 d. 1 e. 1 f. 1 g. 1 h. 1 i. 1 j. 1 	<ul style="list-style-type: none"> a. <input checked="" type="checkbox"/>No b. <input checked="" type="checkbox"/>No c. <input checked="" type="checkbox"/>No d. <input checked="" type="checkbox"/>No e. <input checked="" type="checkbox"/>No f. <input checked="" type="checkbox"/>No g. <input checked="" type="checkbox"/>No h. <input checked="" type="checkbox"/>No i. <input checked="" type="checkbox"/>No j. <input checked="" type="checkbox"/>No 	<ul style="list-style-type: none"> a. <input checked="" type="checkbox"/>Yes b. <input checked="" type="checkbox"/>Yes c. <input checked="" type="checkbox"/>Yes d. <input checked="" type="checkbox"/>Yes e. <input checked="" type="checkbox"/>Yes f. <input checked="" type="checkbox"/>Yes g. <input checked="" type="checkbox"/>Yes h. <input checked="" type="checkbox"/>Yes i. <input checked="" type="checkbox"/>Yes j. <input checked="" type="checkbox"/>Yes 	<ul style="list-style-type: none"> a. <input checked="" type="checkbox"/>No b. <input checked="" type="checkbox"/>No b. <input checked="" type="checkbox"/>No d. <input checked="" type="checkbox"/>No e. <input checked="" type="checkbox"/>No f. <input checked="" type="checkbox"/>No g. <input checked="" type="checkbox"/>No h. <input checked="" type="checkbox"/>No i. <input checked="" type="checkbox"/>No j. <input checked="" type="checkbox"/>No 	<ul style="list-style-type: none"> a. 10116 b. 8226 c. 1472 d. 1472 e. 1472 f. 1942 g. 1942 h. 1942 i. 1942 j. 1942
Education (continued)										

			<p>graders, and their parents</p> <p>i. Hispanic and African American peer leaders (teens), parents of peer leaders, students in grades K-12, senior citizens</p> <p>j. African American and Hispanic adult male ex-offenders referred from Adult Parole, Lorain Parole and Lorain County Courts</p>							
Community-Based Process	<p>a. Catholic Charities Comm Svc – Lorain</p> <p>b. LCADA</p> <p>c. LCADA</p> <p>d. LCADA</p> <p>e. LCADA</p> <p>f. LCADA</p> <p>g. Lorain UMADAOP</p> <p>h. Lorain UMADAOP</p> <p>i. Lorain UMADAOP (flow through)</p> <p>j. Lorain UMADAOP (flow through)</p>	<p>a. Communities That Care/Drug Free Communities</p> <p>b. HIV Reducing the Risk</p> <p>c. Project FAST</p> <p>d. Not In My Backyard</p> <p>e. Parenting for Prevention</p> <p>f. Project SOAR</p> <p>g. Youth Mentoring</p> <p>h. Parenting</p> <p>i. Project TAD</p> <p>j. Aiming High for the Future</p>	<p>a. Government, Schools, Cities, Parents, Youth, Business, Faith Based, Media, Agencies</p> <p>b. adults in substance abuse treatment programs (@ risk for HIV due to addiction), community-based groups</p> <p>c. Youth (ages 13-18) engaged in AoD treatment services, their siblings and parents</p> <p>d. Employers, School based athletic programs</p> <p>e. families who have loved one that is harmfully involved with substances, parents and guardians referred by the courts in lieu of their adolescent being formally charged with a first time legal charge, parents with a history of familial substance abuse, parents/guardians of youth ages 10-17 referred via children services, school suspensions</p>	<p>a. Universal</p> <p>b. Indicated</p> <p>c. Indicated</p> <p>d. Universal</p> <p>e. Selected</p> <p>f. Selected, Indicated</p> <p>g. Selected</p> <p>h. Selected</p> <p>i. Universal</p> <p>j. Universal</p>	<p>a. Communities That Care</p> <p>b. HIV/AIDS Education in Drug Treatment</p> <p>c. Strengthening Families Program (10-14)</p> <p>d. Drug Free Workplace, ATLAS/ATHENA</p> <p>e. Strengthening Families (10-13 & 14-17),</p> <p>f. ATLAS/ATHENA, Strengthening Families (10-14, 13-17), Building Blocks, LifeSkills</p> <p>g. Reconnecting Youth, Rites of Passage, Lifeskills, Making the Peace</p> <p>h. Strengthening Families (10-14) including the Spanish adaptation</p> <p>i. Too Good for Drugs, New Kids, New Start (Ninitos Nuevos Pasos)</p>	<p>a. 1</p> <p>b. 1</p> <p>c. 1</p> <p>d. 1</p> <p>e. 1</p> <p>f. 1</p> <p>g. 1</p> <p>h. 1</p> <p>i. 1</p> <p>j. 1</p>	<p>a. <input checked="" type="checkbox"/>No</p> <p>b. <input checked="" type="checkbox"/>No.</p> <p>c. <input checked="" type="checkbox"/>No.</p> <p>d. <input checked="" type="checkbox"/>No.</p> <p>e. <input checked="" type="checkbox"/>No.</p> <p>f. <input checked="" type="checkbox"/>No.</p> <p>g. <input checked="" type="checkbox"/>No.</p> <p>h. <input checked="" type="checkbox"/>No.</p> <p>i. <input checked="" type="checkbox"/>No.</p> <p>j. <input checked="" type="checkbox"/>No.</p>	<p>a. <input checked="" type="checkbox"/>Yes</p> <p>b. <input checked="" type="checkbox"/>Yes</p> <p>c. <input checked="" type="checkbox"/>Yes</p> <p>d. <input checked="" type="checkbox"/>Yes</p> <p>e. <input checked="" type="checkbox"/>Yes</p> <p>f. <input checked="" type="checkbox"/>Yes</p> <p>g. <input checked="" type="checkbox"/>Yes</p> <p>h. <input checked="" type="checkbox"/>Yes</p> <p>i. <input checked="" type="checkbox"/>Yes</p> <p>j. <input checked="" type="checkbox"/>Yes</p>	<p>a. <input checked="" type="checkbox"/>No</p> <p>b. <input checked="" type="checkbox"/>No</p> <p>c. <input checked="" type="checkbox"/>No</p> <p>d. <input checked="" type="checkbox"/>No</p> <p>e. <input checked="" type="checkbox"/>No</p> <p>f. <input checked="" type="checkbox"/>No</p> <p>g. <input checked="" type="checkbox"/>No</p> <p>h. <input checked="" type="checkbox"/>No</p> <p>i. <input checked="" type="checkbox"/>No</p> <p>j. <input checked="" type="checkbox"/>No</p>	<p>a. 10116</p> <p>b. 1472</p> <p>c. 1472</p> <p>d. 1472</p> <p>e. 1472</p> <p>f. 1472</p> <p>g. 1942</p> <p>h. 1942</p> <p>i. 1942</p> <p>j. 1942</p>

			<p>programs, etc.</p> <p>f. Jr. & High School athletes, pre-school children, adolescents referred from courts for first-time legal offense related to alcohol/drug use, youth (ages 10-17) and their parents</p> <p>g. Hispanic and African American adolescents (6th 12th graders)</p> <p>h. families of Hispanic and African American adolescents (ages 10-14)</p>		<p>Nuevos), Parent-To-Parent</p> <p>j. Parent-To Parent, Anger Management, Too Good for Drugs</p>					
Community Based (continued)			<p>i. preschoolers, K-2nd graders, and their parents</p> <p>j. Hispanic and African American peer leaders (teens), parents of peer leaders, students in grades K-12, senior citizens</p>							
Environmental	<p>a. Catholic Charities Comm Svc – Lorain</p> <p>b. LCADA</p> <p>c. Lorain UMADAOP (flow through)</p>	<p>a. Communities That Care/Drug Free Communities</p> <p>b. Not In My Backyard</p> <p>c. Drug Free Communities Coalition</p>	<p>a. Government, Schools, Cities, Parents, Youth, Business, Faith Based, Media, Agencies</p> <p>b. Employers, School based athletic programs</p> <p>c. Communities – emphasis on people of color</p>	<p>a. Universal</p> <p>b. Universal</p> <p>c. Universal</p>	<p>a. Communities That Care, Strategic Prevention Framework</p> <p>b. Drug Free Workplace, ATLAS/ATHENA</p> <p>c. Strategic Prevention Framework</p>	<p>a. 1</p> <p>b. 1</p> <p>c. 1</p>	<p>a. <input checked="" type="checkbox"/>No</p> <p>b. <input checked="" type="checkbox"/>No</p> <p>c. <input checked="" type="checkbox"/>No</p>	<p>a. <input checked="" type="checkbox"/>Yes</p> <p>b. <input checked="" type="checkbox"/>Yes</p> <p>c. <input checked="" type="checkbox"/>Yes</p>	<p>a. <input checked="" type="checkbox"/>No</p> <p>b. <input checked="" type="checkbox"/>No</p> <p>c. <input checked="" type="checkbox"/>No</p>	<p>s. 10116</p> <p>b. 1472</p> <p>c. 1942</p>
Problem Identification and Referral	<p>a. Big Brothers Big Sisters</p> <p>b. LCADA</p> <p>c. LCADA</p> <p>d. LCADA</p> <p>e. Lorain UMADAOP</p> <p>f. Lorain UMADAOP</p> <p>g. Lorain UMADAOP (flow through)</p> <p>h. Lorain UMADAOP (flow through)</p>	<p>a. Big Brothers Big Sisters</p> <p>b. HIV Reducing the Risk</p> <p>c. Project FAST</p> <p>d. Project SOAR</p> <p>e. Youth Mentoring</p> <p>f. Parenting</p> <p>g. Project TAD</p> <p>h. Aiming High for the</p>	<p>a. boys, girls, adult mentors, schools</p> <p>b. adults in substance abuse treatment programs (@ risk for HIV due to addiction), community-based groups</p> <p>c. Youth (ages 13-18) engaged in AoD treatment services, their siblings and</p>	<p>a. Selected</p> <p>b. Indicated</p> <p>c. Indicated</p> <p>d. Selected, Indicated</p> <p>e. Selected</p> <p>f. Selected</p> <p>g. Universal</p> <p>h. Universal</p> <p>i. Indicated</p>	<p>a. Big Brothers Big Sisters of America</p> <p>b. HIV/AIDS Education in Drug Treatment</p> <p>c. Strengthening Families Program (10-14)</p> <p>d. ATLAS/ATHENA, Strengthening Families</p>	<p>a. 1</p> <p>b. 1</p> <p>c. 1</p> <p>d. 1.</p> <p>e. 1</p> <p>f. 1</p> <p>g. 1</p> <p>h. 1</p> <p>i. 1</p>	<p>a. <input checked="" type="checkbox"/>No</p> <p>b. <input checked="" type="checkbox"/>No.</p> <p>c. <input checked="" type="checkbox"/>No.</p> <p>d. <input checked="" type="checkbox"/>No.</p> <p>e. <input checked="" type="checkbox"/>No.</p> <p>f. <input checked="" type="checkbox"/>No.</p> <p>g. <input checked="" type="checkbox"/>No.</p> <p>h. <input checked="" type="checkbox"/>No.</p> <p>i. <input checked="" type="checkbox"/>No.</p>	<p>a. <input checked="" type="checkbox"/>Yes</p> <p>b. <input checked="" type="checkbox"/>Yes</p> <p>c. <input checked="" type="checkbox"/>Yes</p> <p>d. <input checked="" type="checkbox"/>Yes</p> <p>e. <input checked="" type="checkbox"/>Yes</p> <p>f. <input checked="" type="checkbox"/>Yes</p> <p>g. <input checked="" type="checkbox"/>Yes</p> <p>h. <input checked="" type="checkbox"/>Yes</p> <p>i. <input checked="" type="checkbox"/>Yes</p>	<p>a. <input checked="" type="checkbox"/>No</p> <p>b. <input checked="" type="checkbox"/>No</p> <p>c. <input checked="" type="checkbox"/>No</p> <p>d. <input checked="" type="checkbox"/>No</p> <p>e. <input checked="" type="checkbox"/>No</p> <p>f. <input checked="" type="checkbox"/>No</p> <p>g. <input checked="" type="checkbox"/>No</p> <p>h. <input checked="" type="checkbox"/>No</p> <p>i. <input checked="" type="checkbox"/>No</p>	<p>a. 10116</p> <p>b. 1472</p> <p>c. 1472</p> <p>d. 1472</p> <p>e. 1942</p> <p>f. 1942</p> <p>g. 1942</p> <p>h. 1942</p> <p>i. 1942</p>

	i. Lorain UMADAOP (flow through)	Future i. Circle for Recovery	parents d. Jr. & High School athletes, pre-school children, adolescents referred from courts for first-time legal offense related to alcohol/drug use, youth (ages 10-17) and their parents e. Hispanic and African American adolescents (6 th 12 th graders) f. families of Hispanic and African American adolescents (ages 10-14) g. preschoolers, K-2 nd graders, and their parents h. Hispanic and African American peer leaders (teens), parents of peer leaders, students in grades K-12, senior citizens i. African American and Hispanic adult male ex-offenders referred from Adult Parole, Lorain Parole and Lorain County Courts		(10-14, 13-17), Building Blocks, LifeSkills e. Reconnecting Youth, Rites of Passage, Lifeskills, Making the Peace f. Strengthening Families (10-14) including the Spanish adaptation g. Too Good for Drugs, New Kids, New Start (Ninitos Nuevos Pasos Nuevos), Parent-To-Parent h Parent-To Parent, Anger Management, Too Good for Drugs I none					
***In addition to the local providers, during SFY 2008, Outpatient and Intensive Outpatient treatment services provided throughout the state to Lorain County Medicaid Recipients by thirty one (31) providers										
PRE-TREATMENT (Level 0.5)	a. LCADA	a. Pre-Treatment program	a. Assessed adults awaiting level of care placement (i.e. on waiting list)		a. Motivational Interviewing, Brief Solution Focused Treatment, Contingency	a. 2	a. <input checked="" type="checkbox"/> No	a. <input checked="" type="checkbox"/> No	a. <input checked="" type="checkbox"/> No	a. 1472

OUTPATIENT (Level 1)				Management, Motivational Enhancement Therapy					
Outpatient	a. Nord Center b. Psychiatric & Psychological Services c. LCADA	a. Suboxone program with counseling b. Outpatient program c. Low Intensity Treatment Services	a. adults with primary Opioid addiction b. adults and adolescents assessed for level of care c. Adults (primarily medically indigent men) and adolescents assessed for OP	a. Medication Assisted Treatment (MAT) b. unknown c. Motivational Interviewing Motivational Enhancement Therapy and Adolescent Community Reinforcement Approach - A-CRA (Adolescent)	a. 1 b. 1 c. 1	a. <input checked="" type="checkbox"/> No b. <input checked="" type="checkbox"/> No c. <input checked="" type="checkbox"/> No	a. <input checked="" type="checkbox"/> Yes b. <input checked="" type="checkbox"/> No c. <input checked="" type="checkbox"/> Yes	a. <input checked="" type="checkbox"/> No b. <input checked="" type="checkbox"/> Yes c. <input checked="" type="checkbox"/> No	a. 1047 b. 7116 c. 1472
Intensive Outpatient	a. Nord Center b. LCADA c. LCADA d. LCADA	a. Adolescent Outpatient – Juvenile Drug Court b. Intensive Outpatient Program (including aftercare) c. Women’s Intensive Outpatient Program (including aftercare) d. Adolescent Intensive Outpatient Program (including aftercare)	a. juveniles referred into Juvenile Drug Court b. Adults assessed for IOP (primarily medically indigent men) and men from residential program (step down) c. Women from residential program (step-down) as well as women assessed for IOP level of care and Family Drug Court participants d. Adolescents assessed for IOP level of care and adolescents from residential program (step down)	a. Motivational Interviewing b. Motivational Interviewing, Motivational Enhancement Therapy, Cognitive Behavioral Therapy, Recovery Management c. Motivational Interviewing, Motivational Enhancement Therapy, Cognitive Behavioral Therapy, Recovery Management d. Motivational Interviewing Motivational Enhancement Therapy and Adolescent Community Reinforcement Approach A-CRA	a. 1 b. 2 c. 1 d. 1	a. <input checked="" type="checkbox"/> No b. <input checked="" type="checkbox"/> No c. <input checked="" type="checkbox"/> No d. <input checked="" type="checkbox"/> No	a. <input checked="" type="checkbox"/> Yes b. <input checked="" type="checkbox"/> Yes c. <input checked="" type="checkbox"/> Yes d. <input checked="" type="checkbox"/> Yes	a. <input checked="" type="checkbox"/> No b. <input checked="" type="checkbox"/> No c. <input checked="" type="checkbox"/> No d. <input checked="" type="checkbox"/> No	a. 1047 b. 1472 c. 1472 d. 1472

Day Treatment	None					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
COMMUNITY RESIDENTIAL (Level 2)										
Non-Medical	a. New Directions b. LCADA c. LCADA	a. New Directions Residential program b. LCADA Men's Residential Program c. LCADA – the Key	a. adolescents – males/females referred via AOD assessment for level of care b. adult men assessed for level of care and step down from detox c. adult women assessed for level of care and step down from detox and Family Drug Court participants, including pregnant and postpartum women		a. Adolescent Community Reinforcement Approach (A-CRA), Cognitive Behavioral Therapy (CBT), Motivational Enhancement Therapy (MET) b. Motivational Interviewing, Motivational Enhancement Therapy, Cognitive Behavioral Therapy, Recovery Management c. Motivational Interviewing, Motivational Enhancement Therapy, Cognitive Behavioral Therapy, Recovery Management	a. 2 b. 1 c. 1	a. <input checked="" type="checkbox"/> Yes	a. <input checked="" type="checkbox"/> Yes	a. <input checked="" type="checkbox"/> No	a. 01119, 11180
Medical	None					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
SUBACUTE (Level 3)										
Ambulatory Detoxification	None					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
23 Hour Observation Bed	None					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Sub-Acute Detoxification	a. Stella Maris, Inc.	a. Stella Maris – Sub Acute Detox	a. Adults referred via AOD assessment for level of care		a. n/a	a. 1	a. <input checked="" type="checkbox"/> Yes	a. <input checked="" type="checkbox"/> Yes	a. <input checked="" type="checkbox"/> No	
ACUTE HOSPITAL DETOXIFICATION (Level 4)										
Acute Detoxification	None					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		

