

***HAMILTON COUNTY***  
***ALCOHOL AND DRUG ADDICTIONS SERVICES BOARD***



**COMMUNITY PLAN**  
**FOR THE PROVISION OF ALCOHOL**  
**AND OTHER DRUG SERVICES**  
**SFY 2006 – 2007**

Submitted to:  
OHIO DEPARTMENT OF ALCOHOL AND DRUG ADDICTION SERVICES  
March 31, 2005

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***HAMILTON COUNTY ALCOHOL AND DRUG ADDICTION SERVICES BOARD***

**MISSION STATEMENT**

The Hamilton County Alcohol and Drug Addiction Services Board uses public funds to plan and monitor alcohol, other drug and gambling treatment, prevention and education services for the citizens of Hamilton County.

**VISION STATEMENT**

No individual should suffer from the impact of substance abuse and addiction.

## SECTION I: CURRENT CIRCUMSTANCES

### Legislative Context

The Hamilton County Alcohol and Drug Addiction Services Board (Board) 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 and other 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 (SFY) 2006 – 2007 (July 1, 2005 through June 30, 2006).

The Community Plan and Federal Level Drivers: Government Performance and Results Act (GPRA), the Substance Abuse Prevention and Treatment (SAPT) Block Grant and Performance Partnership Grants (PPG's)

*The Government Performance and Results Act (GPRA) of 1993* (Public Law 103-62) mandates performance-based management by federal agencies. The legislation focuses on outcomes in monitoring the effectiveness of federal programs and federal agency progress toward achieving national goals. The law places increased emphasis on collecting, reporting and reviewing data to hold an agency accountable for achieving results with public funds.

Performance Partnership Grants (PPG's) is the Substance Abuse and Mental Health Services Administration (SAMHSA) response to GPRA. While not yet finalized, PPG's move the Substance Abuse Prevention and Treatment (SAPT) Block Grant from a compliance-oriented document to an incentive-driven planning process that emphasizes continuous quality improvement. Included in the proposed performance partnership grants are a set of treatment and prevention outcomes that states/counties are required to report. ODADAS and the Board has aligned its investor targets with the proposed PPG outcomes.

State Level Driver: H.B. 317

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

1. Assessing service needs and evaluating the need for programs;
2. Setting priorities;
3. Developing operational plans in cooperation with other local and regional planning and funding bodies;
4. Reviewing and evaluating substance abuse programs;
5. Promoting, arranging and implementing working agreements with public and private social agencies;
6. Assuring effective services that are of high quality

## H.B. 484

Section 340.15 of the Ohio Revised Code requires Boards 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 to parents, guardians and caregivers of children involved in the child welfare system.

## Performance Ohio

Performance Ohio, still in its formative stage, is an Executive Branch initiative to tie State Department's goals, objectives and measures identified in their respective state plans to the Governor's priorities. ODADAS has recently undertaken a strategic mapping process to align its priorities with the Governor's priorities in order to respond to and communicate the Performance Ohio initiative to counties.

## Environmental Context

This section will provide relevant information about the HCADAS Board area. It will include major achievements of the Board since the previous Community Plan (Plan) SFY 2004-2005 including units of service, number of clients served, recent trends such as changes in services and populations.

Hamilton County (County) is situated in the extreme southwestern corner of the State of Ohio and covers an area of 407.4 square miles. Within the County are 37 municipalities, including 21 cities, 16 villages, and 12 townships. Hamilton County, the third most populous in the State, had a year 2000 Census of 845,303 (Source: [www.hamilton-co.org/about.asp](http://www.hamilton-co.org/about.asp)). A report of economic indicators reveals the urban core area has experienced a population decline over the past thirty years due in part to the flow of population to suburban areas and surrounding counties. A continuation of this decline is projected over the next thirty years (Source: Ohio Department of Development).

Major achievements from the previous Plan (SFY 2004-2005) include:

- Issuance of contracts to local non-profit organizations for provision of treatment, education and prevention services totaling over \$18 million,
- Adopted and implemented Special Populations Task Force services proposal for LEP Hispanic clients. Hired a bilingual/bicultural Hispanic clinician at the Recovery Health Access Center (RHAC) and initiated discussion with neighboring county boards regarding collaboration on the LEP Hispanic initiative.
- Approved funding to hire two full-time ADAS service coordinators; one for Substance Abuse and Mental Illness (SAMI), and one for Post-Treatment Follow-Up services

- Published a *Sourcebook on Alcohol and Other Drug Abuse Trends in Hamilton County* – a 50 page reference on local data intended for use by social services planners and researchers,
- Submitted thirteen grant proposals (3 developed and submitted solely by HCADAS and 10 developed collaboratively with HCADAS providers and stakeholders). Non-HCADAS organization involvement in grant proposal writing included: University of Cincinnati (U.C.) Departments of Psychology, Psychiatry and Criminal Justice; U.C. Hospital Neonatal Program; Hamilton County (H.C.) Probation; H.C. Community Mental Health Board; Southwest Ohio Parole, River City Corrections; Cincinnati Children’s Hospital Medical Center (CCHMC); Ohio Citizen Advocates; Bienestar/Santa Maria Social Services;
- Developed and approved a two-year Strategic Plan with mechanisms for tracking objectives and related action steps,
- Analyzed first full year of treatment outcome data, published revised complete outcomes data collection guidelines and trained providers on outcomes data collection,
- Coordinated planning and execution of multiple National Alcohol and Drug Addiction Recovery Month events with local and national publicity,
- Revised and printed new ADAS Services Brochure,
- Participated as a lead organizer/planner in the successful launch of a Southwest Ohio Prevention Training and Preceptor Program,
- Organized an ADAS Prevention Planning Committee and developed a county evidence-based prevention services framework,
- Participated in multiple community planning and/or coordinating activities or committees including but not limited to: All-Hazards Behavioral Health Planning; Cincinnati Public Schools Drug-Free Advisory Committee; Behavioral Health Focus Group; Homeless Management Information System leadership committee; 25 Cities Initiative; SAMI Initiative; Multi-county System; IMPACT Project; Off The Streets Planning Project, Juvenile Justice Planning Project,
- Continued to meet the Behavioral health (BH) reporting requirements of 70% or more of file submission,
- Converted provider’s existing UFMS files to the HIPAA Procedure Coding and created and submitted HIPAA 837P claim files for most provider agencies through CMHC,
- Decreased time for reconciliation of SFY 04 accounts through improved financial and CMHC communication,
- Reduced impact of claims processing on resources of ODADAS Pass-Thru providers through development of new Board process,
- Created a Medicaid Manual for agencies interested in Medicaid contracting only,
- Worked with providers to reduce open and inactive cases (past year and past 30 days) in CMHC. Implemented reports that allow monitoring of entry dates for client registration, claims and discharges, and provides a summation of minimum data set information,
- Improved accuracy of expenditures authorization for the IMPACT Program by developing an in-house computer software program for managing services,

- Simplified data entry for providers by combining ADAS Outcomes and BH discharge information using the same database and definitions. The revision insures that all ADAS clients will be measured at intake and discharge from SFY 2005 forward,
- Provided data analysis and consultation for a Drug and Poison Center research grant on enhanced prevention services in Cincinnati and Toledo.

The HCADAS provider network delivered 763,623 units of service in SFY 2004, an increase of almost 56% over the 488,624 units of service delivered by the same providers in the previous year. There were a total of 5,553 new adult admissions and 923 adolescent admissions registered in the CMHC system in SFY 2004. Adult admissions were down 11.6% and adolescent admissions were up 34% from SFY 2003.

Much of this drop in adult admissions may be attributable to the cessation of “orientation” groups by one large provider. In the past these groups triggered admissions, even though as many as one-half of the clients never returned for treatment. The increase in adolescent admissions was primarily the result of the inclusion of juvenile TASC admits which were not available for stats in previous reports.

The increase in units of service resulted from several factors including: individual counseling units of service more than tripled, group counseling units more than doubled, improved data collection processes, the addition of services, and some services were unbundled for billing purposes.

It is noteworthy that adults admitted for cocaine increased by 10%. There was an increased and ongoing inquiry for access to methadone treatment for opiate and heroin abuse despite the overall drop in admits. The heroin and opiate admissions reflect the capacity of the current system. These admissions would have been much higher if the system had the capacity to serve all clients seeking opiate treatment. There have also been steady inquiries for adolescent opiate addiction treatment.

An additional trend may be inferred from the fact that 34% of adults were “self-referrals”, up from 26% last year. Criminal Justice referrals dropped from 38% to 30% and the Department of Job and Family Services referrals fell from 24% to 17%. *HCADAS community outreach through Recovery Health Access Center (RHAC) may be increasing the numbers of self-referred clients in our system.* Referrals for adolescents originated primarily in the criminal justice system, as has been the case in previous years.

There is an absence, in Hamilton County, of increased methamphetamine abuse that was predicted for urban areas nationwide. In spite of significant law enforcement interdiction and meth-lab busts in neighboring counties, there has not been a significant increase in admits. Finally, we note the inability of the local public and private alcohol and other drug (AOD) treatment systems to meet the needs for detoxification services.

## Characteristics of Clients Receiving Services

The following excerpts of client profiles were taken from the Outcome Management Plan written and submitted by provider agencies.

- 1) “Jane is a 50 year old widowed African American female who has been crack cocaine dependent for 10 years. Jane is unemployed and estranged from her family. Jane was arrested for theft. She stole to support her drug habit”.
- 2) “Mary is a 31 year old single Caucasian mother of 7 minor children. Mary was arrested 6 months ago for solicitation. Mary solicited to maintain a 15-year heroin addiction. Mary completed the eighth grade, but is average in intelligence. Mary is motivated to obtain her GED”.
- 3) “The average patient is a single 32 year old African-American male. His drug of choice is crack/cocaine usually with alcohol as a secondary drug. He has had prior legal involvement. He is unemployed and in need of a stable living environment. The average female patient is of the same age group, race is fairly evenly split between Caucasian and African-American. Her drug of choice tends to be the same. She has usually suffered sexual abuse sometime in her life and is in treatment because her children are at risk – referred by the Department of Job and Family Services”.
- 4) “Shaquita is a 30 year old African-American female. She is a high school graduate but illiterate. She has a 10-year history of alcohol and crack dependence. She has a diagnosis of paranoid schizophrenia. She has a 6 month old daughter who is the result of a rape”.

Altogether during SFY 2004 HCADAS providers admitted 5,453 clients, their gender, ethnicity, IV drug use and/or HIV+ status may be seen in Appendix 1. The five core outcomes and complete outcomes data on a sample of 1,912 admitted clients – nearly triple last years’ number - can be found in Appendix 2. Treatment completion and client disposition at discharge is presented in Appendix 3, and Appendices 4 and 5 provide data on Special Populations and female clients who were pregnant at admission respectively.

## Evidence-Based Programs and Practices

Prevention Model Programs, Services and Institute of Medicine Target Audiences:

- Botvin’s LifeSkills – Universal
- Project Toward No Tobacco Use – Universal
- Reconnecting Youth – Indicated
- Second Step – Universal
- Strengthening Families Program (SFP) – Selected
- GED and Vocational Education – Selected
- Emergency Shelter for Homeless Persons – Indicated
- CSAP’s Six Prevention Strategies
- Adult and Youth Intervention – Selected
- HIV-AIDS and AOD Education – Universal
- AOD Teacher Training – Universal
- Mentoring and Asset-Building – Universal
- 24-Hour Crisis Intervention Care with Hotline – Indicated

#### Treatment Services:

- Cognitive Behavioral
- Motivational Enhancement Therapy
- Culturalogical Approaches
- Assessment for Abuse and Dependency with AOD Screening
- Integrated Dual-Diagnosis Treatment (IDDT)
- Family Systems Therapy with Children's Residential Care
- Adolescent, Women, Pregnant Women and Older Adult Specific Programs
- Medically-monitored Detoxification and Medical Somatics
- Matrix-Model
- GED and Vocational Education
- IOP and Residential
- Medication-Assisted Opiate Substitution Therapy
- 12-Step Recovery (AA/NA, etc.)
- Self-Help Programs (ALA-Teen, AL-ANON, etc.)
- Comprehensive Client-Centered Case-Management
- Adult and Juvenile Offender Re-entry
- Adult Drug Court
- Aftercare, Relapse Prevention and Post-Discharge Follow-up
- Cannabis Youth Treatment (CYT)
- TASC for Juveniles and Adults
- Stephanie Covington Recovery Program

#### Workforce Development

Key Informant interviews indicated work force development as a priority area for increased Board involvement. It was reported that providers are hard-pressed to find competent well-trained, qualified, licensed and credentialed staff and that the cost of recruiting staff has reached prohibitive levels. High case loads and low wages are thought to contribute to excessive turnover. In addition, older workers are retiring and fewer new entrants are replacing retirees contributing to a shrinking recruitment pool.

In view of an increased focus on workforce development and the new ODADAS project – the Ohio AOD Workforce Resource Center – HCADAS joined forces with regional players in the planning and development of a Southwest Ohio Prevention Education and Preceptor program designed to increase the number of well-trained prevention providers in our area.

During the first year of implementation the Prevention Education and Preceptor program involved the Butler County ADAS Board and several Butler and Hamilton County ADAS Board providers. A total of 24 enrollees started, and 20 completed, the program in its first year. A majority of the program graduates will apply and take the OCPS examination within a year of graduation.

## Capital Improvements

Insufficient transitional housing for homeless, post-treatment discharge and re-entry client populations present a major obstacle to an important system service outcome. Capital needs for construction and renovation have been identified by several providers in making application for funding to ODADAS in the past year.

## Financial Status

The overall trend in funding for AOD prevention and treatment services has taken a turn for a decline with federal budgets for Federal Fiscal Year (FFY 2006). The HCADAS Board is hopeful about the Governor's proposed biennial budget which included a 2.9% increase for SFY 2006 and an additional 2.9% increase for SFY 2007 for ODADAS.

The Governor's proposed budget increases to ODADAS may or may not be passed along to ADAMHS/ADAS Boards resulting in either flat funding or reductions in program funding at the local level. The Governor's budget also proposed a 20% cut to Local Government funds. This may also have an indirect effect on local services funding.

Increased emphasis on competitive federal government, regional and local, corporate and foundation grants, to maintain and/or fund services expansion has become critically important. HCADAS has facilitated a grants seeking committee of provider agencies and has enjoyed modest success in increasing the flow of additional dollars from these sources for service delivery within the system.

Locally, the Board receives approximately 1.5 million dollars from the Hamilton County Health and Hospital Levy (Drake) to implement the Adult Drug Court Treatment Program known as ADAPT. Talbert House manages and has provided services for the ADAPT Program. However, the County Administration has requested that these monies be bid for services resulting in an HCADAS RFP release in February of 2005.

The Health and Hospital Levy (University of Cincinnati/Children's Hospital) was renewed for five years starting in calendar year 2003. The Board receives 2.5 million through this levy in calendar year 2004 to provide indigent care services and additional Adult Drug Court treatment services. The funding was an increase of 41% over the previous allocation of 1.77 million dollars, however the Hamilton County Board of County Commissioners plan to cut that amount to \$1.4 million in calendar year 2005 due to other priorities. This loss will strain the local service system.

The Board spends a considerable amount of its resources on Medicaid clients. Yet the amount of HCADAS FFP payout has decreased both in total dollar amount spent and as a percent of the Board's total service budget over the past three years (approximately \$2.4M in 2002, \$1.9M in 2003 and \$1.6M in 2004). There were 22, 23 and 24 agencies receiving these dollars in 2002, 2003 and 2004 respectively.

<b>Fiscal Year</b>	<b>Total Services Spend (\$)</b>	<b>Medicaid Amount (\$)</b>	<b>% Medicaid Vs Services</b>	<b>Difference (\$)</b>	<b>% Increase or Decrease</b>
FY04	17,234,672.27	1,640,073.53	9.52%	-250,658.44	-13.20%
FY03	19,226,367.00	1,890,731.97	9.83%	-483,556.75	-20.37%
FY02	19,795,705.97	2,374,288.72	12.48%	-1,187,319.65	-33.34%

The Board manages out-of-county Medicaid clients in accordance with the guidelines and operating principles for residency determination as set forth by the State of Ohio. In regards to non-Medicaid out-of-county clients, the Hamilton County Prosecutor has informed the Board that it has no legal authority or obligation to cover the cost of treatment.

Portfolio of Providers

Table 1: Portfolio of Providers (Based on SFY 2004 Board Contracts)

LEVEL OF CARE	PROVIDER	PROGRAM (Provider Specific)	PROGRAM ADDRESS	MACSIS UPI
PREVENTION (Federal Definitions)				
Information Dissemination	Alcoholism Council (AC), Crossroads Center (CC), Central Community Health Board (CCHB), Drug and Poison Information Center (DPIC), Talbert House (TH), Urban Minority Alcohol and Drug Abuse Outreach Program (UMADAOP)	Recovery Health Access Center (AC), Community Hotline, Speakers Bureau (DPIC) ?  HIV Awareness & Outreach (UMADAOP) ?	2828 Vernon Place Cincinnati, OH 2900 Vernon Place Cincinnati, OH  4015 Cherry Street Cincinnati, OH	01267,01258, 10127, N/A, 01249, 01036
Education	Alcoholism Council, Crossroads Center, Central Community Health Board, Drug and Poison Information Center, GLAD House (GLAD), Talbert House, Urban Minority Alcohol and Drug Abuse Outreach Program, Mallory Center (MC), Wyoming Youth Service Bureau (WYSB)	Kids Connection, Life Skills, Parent Training, Adult Education and Evaluation Program (AEEP), (AC),  Compulsive Gambling , HIV AIDS Early Prevention and Intervention Program (EPIP), (CCHB),  Maintaining African American Traditions (MAAT), Responding to Every Adolescents Cry for Help (REACH), (DPIC),	2828 Vernon Place  3020 Vernon Place  2900 Vernon Place	01267,01285, 01270,01258, 10127,N/A, 01249,01036

LEVEL OF CARE	PROVIDER	PROGRAM (Provider Specific)	PROGRAM ADDRESS	MACSIS UPI
		<p>After School and Summer Program, Without Walls Program, GLAD Hands Club Strengthening Families Program, Second Step, LifeSkills (GLAD),</p> <p>Substance Abuse Awareness and Prevention Strategies (SAAPS), (MC)</p> <p>GED, Reconnecting Youth, Second Step, Project PASS, AOD Teacher Training (TH),</p> <p>Too Young to be High, Aiming High, Mentoring (UMADAOP)</p>	<p>4721 Reading Rd.</p> <p>3262 Beekman St.</p> <p>2600 Victory Parkway (and various public schools)</p> <p>4015 Cherry St.</p>	
Problem Identification and Referral	Alcoholism Council, Crossroads Center, DPIC, Talbert House, Urban Minority Alcohol and Drug Abuse Outreach Program	<p>Workplace Intervention Network (WIN), Employee Assistance Program (EAP), (AC) ?</p> <p>24-Hour Crisis Intervention (DPIC)</p> <p>Circle for Recovery (UMADAOP)</p>	<p>2828 Vernon Place</p> <p>2900 Vernon Place</p> <p>4015 Cherry</p>	01258,01249, 01036
Community-Based Process	Alcoholism Council, Crossroads Center, Central Community Health Board,	Westside Alliance, Community Education, Professional Training, (AC),	2828 Vernon Place	01267,01258, 10127, N/A, 01249,01036

LEVEL OF CARE	PROVIDER	PROGRAM (Provider Specific)	PROGRAM ADDRESS	MACSIS UPI
	Coalition for A Drug-Free Greater Cincinnati (CDFGC) Drug and Poison Information Center, Talbert House, Urban Minority Alcohol and Drug Abuse Outreach Program	Professional Training, (TH), Coalition Building (UMADAOP), (CDFGC)	2600 Victory Parkway 4015 Cherry	
Environmental	Alcoholism Council, Crossroads Center, Central Community Health Board, Drug and Poison Information Center, Talbert House, Urban Minority Alcohol and Drug Abuse Outreach Program, Drop Inn Center (DIC)	Shelterhouse, (DIC)	217 West 12 <sup>th</sup> St.	01267,01258, 10127,N/A, 01249,01036
Alternatives	Alcoholism Council, Drop Inn Center, GLAD House, Mallory Center, Urban Minority Alcohol and Drug Abuse Outreach Program  Wyoming Youth Service Bureau	Teen Institute, TREND, (AC) Emergency Shelter (DIC), Giving Life A Dream Mentoring Program, (GLAD) Shock Field Trips, (MC) Aiming High After School, Black Family Day, Mentoring Project, (UMADAOP) Mentoring Teens, (WYSB)	2828 Vernon Place 217 W. 12 <sup>th</sup> St. 4721 Reading Rd.  3262 Beekman St. 4015 Cherry St.  800 Oak Avenue Wyoming, OH	01267, 01036
OUTREACH	Alcoholism Council, Crossroads Center, Central Community Health Board, Talbert House, Drug and Poison Information Center	RHAC, (AC) NOMAD, (DPIC)	2828 Vernon Place  2900 Vernon Place	01267,01258, 10127,01249
CONSULTATION AND EARLY INTERVENTION (Level 0.5)				
OUTPATIENT (Level 1)				
Outpatient	Alcoholism Council, Crossroads Center,	Alcohol Safety Action Program (ASAP), LEP, Post- discharge follow-up (AC)	2828 Vernon Place 3009 Burnet Ave.	01267,01258, 01258,10127,

LEVEL OF CARE	PROVIDER	PROGRAM (Provider Specific)	PROGRAM ADDRESS	MACSIS UPI
	Center for Chemical Addictions Treatment, (CCAT) Central Community Health Board, First Step Home, (FSH), Prospect House, (PH) Talbert House, Treatment Alternatives for Safer Communities (TASC)	Alcohol Safety Action Program (ASAP), LEP, Post- discharge follow-up (AC), Home-Based Treatment, Cognitive Behavioral and Motivational Enhancement, IDDT, CYT, (CC), (FSH), Methadone (CCHB), Black Support Group, Gamblers Group, (PH), Women's Aftercare Relapse Prevention/Intervention, (FSH) Adult & Youth Re-entry (TASC)	2828 Vernon Place  3009 Burnet Ave. 3020 Vernon Place  628 Hawthorne Ave. 2203 Fulton Ave.  911 Sycamore St.	02996,06901, 01249,
Intensive Outpatient/Day Treatment	Center for Chemical Addictions Treatment, Central Community Health Board, Crossroads Center Talbert House TASC	Older Adult (OASIS), Relapse Program, (CCAT)  Adult and Youth Reentry, (CC), (TASC), (TH),  Adult Drug Court, Adult, Alternatives, Passages (TH)	830 Ezzard Charles Drive    3009 Burnet Ave.	01285,06868, 10127,06901, 01249
COMMUNITY RESIDENTIAL (Level 2)				
Non-Medical	Center for Chemical Addictions Treatment, Crossroads Center, First Step Home,	Community Residential, (CCAT, FSH), (PH), Stephanie Covington Program, (FSH)	830 E. Charles Dr. 2203 Fulton Ave. 3009 Burnet Ave. 2600 Victory	01258, 01285, 02996, 01290, 01249

LEVEL OF CARE	PROVIDER	PROGRAM (Provider Specific)	PROGRAM ADDRESS	MACSIS UPI
	Prospect House, (PH), Talbert House	Matrix Model, (CCAT), Adult Males, Alternatives, Passages, The Brodge, (TH), Chaney Allen Project, (CC), Pregnant & Parenting Women's Residential, (CC, FSH), Life After Bars, After Nam, Focus, Gambler's Group, (PH), SAMI, (CC, TH), ADAPT-Women, ADAPT-Men, (TH)	Pkwy.  628 Hawthorne Ave.	
Medical				
SUBACUTE (Level 3)				
Ambulatory	Center for Chemical Addictions Treatment		830 Ezzard Charles Drive	01285
23-Hour Observation Bed	Center for Chemical Addictions Treatment		(same)	01285
Sub acute Detoxification	Center for Chemical Addictions Treatment		(same)	01285,
ACUTE HOSPITAL DETOXIFICATION (Level 4)				
Acute Detoxification				

## Section II: CAPACITY DEVELOPMENT

### Capacity Development Targets

The Board's Capacity Development Targets for SFY 2006 – 2007 are all taken from the Department's Capacity Development Targets and are listed below without prioritization:

*1). A highly effective workforce for the AOD system.*

The HCADAS provider system seeks to maintain a highly effective workforce. The Board provides funds for system-wide training of agency staff. However, provider agencies report continuing difficulty attracting and retaining a sufficient number of qualified staff. In addition, through use of Key Informant Interviews, it was reported that agencies continue to see a high turnover rate that results in the loss of agency productivity, low morale, and disruption of continuity of care for clients. The Board is aware of the ODADAS "Workforce Development Initiative" and supports the effort.

At the local level, the Board maintains ongoing discussions with agency directors regarding the Board's role in assisting agencies to attract and maintain qualified staff. During SFY 2004-2005 the Board also allocated dollars to a regional, multiple county prevention education and preceptor program for expansion and development of the prevention workforce.

*2). Reduce stigma.*

For the past two years the Board has facilitated a planning committee that engages funded providers, persons in recovery, non-funded AOD service providers, and stakeholders in the implementation of local events for National Alcohol and Drug Addiction Recovery Month (NADARM). Local, state and national publicity aimed at eliminating stigma associated with the disease of addiction, the importance of seeking help and treatment, and the success and benefits of treatment is the driving force for NADARM events.

The Board and the local provider prevention and treatment community also participate in the White House's Office of National Drug Control Policy (ONDCP) "25 Cities Initiative" and the Partnership for a Drug-Free America's (PDFA) Pilot Media Campaign. The 25 Cities Initiative is a planning process to address concerns for professionals and community representatives in those cities that are acutely affected and ravaged by AOD traffic and abuse. The PDFA media campaign also is designed to reduce stigma and recruit those affected by AOD addiction to seek help. The Board has assigned staff members working with each group.

*3). Increase the use of "evidence-based" policies, practice, strategies and programs in the AOD system.*

The Board, through the strategic planning process has identified a need for and implemented internal and external Continuous Quality Improvement (CQI) Management Committees. These committees are charged with selecting and managing the piloting of additional evidence-based programs, policies, strategies and practice across the system.

The internal committee is staffed by the Board staff and the external committee is staffed by Board staff and funded agency staff.

*4). Increase diversity of revenue sources to support Ohio's alcohol and other drug system.*

A grants seeking committee comprised of funded-agency representatives and a Board staff facilitator have met for the past two years. Multiple collaborative proposals have been developed and submitted to federal agencies, and national and local foundations for program development or expansion. In addition, the committee has networked with non-system professional providers, educators, evaluators and others in proposal development processes. This effort has met with modest success but continues to function in a very aggressive manner.

*5). Increase the use of data within the AOD system to make informed decisions about planning and investment.*

The ability to capture data and process that data in determining need impacts the planning process for capacity development and expansion. HCADAS has worked tirelessly over the past few years in this area and the results are beginning to show fruition. HCADAS published the Sourcebook on Alcohol and Drug Abuse Trends in Hamilton County in late 2003. The first update to this sourcebook took place this past year in 2004. The sourcebook paints a picture of AOD abuse in Hamilton County, using data from the HCADAS information system and other available sources outside the system.

The sourcebook is intended as a resource for all professionals and community leaders involved in the development, planning, funding, provision, and/or evaluation of substance abuse prevention and/or treatment services. The document is also intended to be useful to all those in the community working to address the medical and behavioral health needs of the residents of Hamilton County. The sourcebook is not intended to provide an evaluation of the existing service systems in the county, but service gaps and potential areas of improvement are mentioned

Correct interpretation and management of data is fundamental to administrative planning processes. Improving communication processes for capturing, analyzing and using data can be facilitated through technology. HCADAS has nurtured and improved technical communications processes with providers through a refinement of the following mechanisms:

- Simplification of data-entry for providers by combining ADAS outcomes and BH discharge information using the same database and definitions. The revision ensures that all ADAS clients will be measured at intake and discharge from SFY 2005 forward,
- Conversion of provider's existing UFMS files to the HIPAA Procedure Coding and created and submitted HIPAA 837P claim files for most provider agencies through CMHC,
- Reducing impact of claims processing on resources of ODADAS Pass-Thru providers through the development of a new Board process,

- Provided a summation of minimum data-set information and implemented reports that allow monitoring of entry dates for client registration, discharges and claims, and worked with providers to reduce open and inactive cases (past year and past 30 days) in CMHC,
- Improved accuracy of expenditures authorization for the IMPACT Program by developing an in-house computer software application program for managing services,
- Development in-house of a similar database to be implemented beginning in SFY 2006 and used for the IDAT Program,
- Creation of a Medicaid Manual for agencies interested in Medicaid only contracts
- Investment in electronic clinical records software programs for faster service, reduction of error and elimination of fraud,

### Access to Services

The HCADAS provider system continues to fall short of adequate program access for all of those in need of our services within the county. This shortfall in access is particularly acute with respect to residential services for adolescents and services for opiate dependence. Many Hamilton County residents in need of adolescent residential or opiate treatment services may choose to seek out-of-county and out-of-state providers rather than placement on a waiting list.

With implementation of the Recovery Health Access Center (RHAC), HCADAS and providers planned a central intake operation with capabilities of providing assessments and appropriate level-of-care referrals to anyone seeking access to services for system provider and non-provider agencies. The Alcoholism Council of Cincinnati, a NCADD certified substance abuse treatment facility manages the RHAC project which provides 24-hour / 7-day telephone access, comprehensive assessment, information and referral, and transitional case management services for persons seeking access to services within the HCADAS funded provider system or referral to non-system agencies.

For the past two years the Board has examined access and retention while engaging in a strengthening treatment access and retention grants seeking process that involved submitting a proposal application to the Paths To Recovery Program funded by the Robert Wood Johnson Foundation and based at the Network for the Improvement of Addiction Treatment at the University of Wisconsin ([www.NIATx.net](http://www.NIATx.net)). The Board has given considerable attention to improving access via study of defined and observed barriers. In addition, we will continue to apply to the Paths to Recovery Program with the expectation of benefits to be learned thereto.

### **Section III: TREATMENT AND RECOVERY SERVICES**

#### Treatment Needs

The HCADAS Board's *Strategic Plan* identifies treatment need areas and a process – Continuous Quality Improvement (CQI) – for assessing and planning implementation of evidence-based programming to meet those treatment needs. For SFY 2006 – 2007 the HCADAS Board has identified treatment needs through a community-based, strategic planning process.

Through a variety of qualitative approaches including surveys, focus groups, and key informant interviews, the Board obtained expert opinions from provider representatives, consumers, social service, education, mental health, local government, criminal justice, community faith-based organizations, and community AOD treatment leadership in determining the future direction and priorities of addiction treatment services in Hamilton County.

During the summer of 2003 and 2004, the Board conducted a **survey** of the community leadership, including those who work in systems which are impacted by individuals and families with substance abuse related problems. Based on a roster of the previously established Needs Assessment and Strategic Plan Advisory Committee, a listing of respondents was compiled including members of local government, criminal justice, mental health, education, human services, and social service organizations. A total of one hundred thirty-nine (139) individuals were mailed a copy of the survey. The Board received twenty-two (22) completed surveys. Respondents were asked to provide information and opinions in the following areas:

1. Quality improvement/assurance
2. Needs assessment
3. Increasing service capacity, access and efficiency

Board staff conducted a series of **focus groups** consisting of consumers of treatment services from provider organizations. Participants were clients at a structured treatment program for women and a structured treatment program for adolescents. The structured focus groups were held at program sites and were 75 minutes in length. There were four participants in each of the two structured sessions. In addition, questions were asked of two randomly selected groups of three clients waiting for programs to begin at the ADAS Center. All participants were assured that their responses would remain confidential. Responses provided qualitative feedback based on the following discussion areas:

1. Likes and dislikes of services received
2. Identification of unmet needs, new programs needed, segments of the population not being served or under-served
3. Opinion on determination of service priorities
4. Opinion on the value and ultimate benefits to the community that should guide the Board's planning processes

Board staff conducted **interviews** with the executive directors and key staff of funded service providers. These sessions were held during the summer of 2003 and again in the fall of 2004. Participants in these interviews were asked to comment on the Board’s vision statement, existing strategic plan goals, and the SFY 2004 – 2005 Community Plan.

Findings obtained from these sources along with data collected on populations served by the funded provider system assisted the Board in clarifying priorities around treatment needs, service gaps and assessing on-going collaboration issues. The new HCADAS Board Community Plan incorporates elements issued and monitored by ODADAS.

Treatment Priorities and Investor Targets

<b>SERVICE NEED PRIORITY</b>		<b>INVESTOR TARGET</b>	<b>\$\$ ALLOCATED*</b>
<b>HIGH</b>	Adolescent AOD Tx	5% Tx completion increase by SFY '07	\$1, 631, 481.80
	Child Welfare Clients	5% Tx completion increase by SFY '07	\$667,790.21
	Criminal Justice Referrals	5% Decrease in legal involvement; 5% increase in abstinence, employment and stable housing by SFY '07	\$2,317,662.00
<b>MEDIUM</b>	Homeless Persons with AOD Problems	5% Increase in safely housed clients by SFY '07	\$31,960.92
	HIV Early Intervention	5% Increase in abstinence	
<b>LOW</b>	I-V Drug Users	5% Reduction in legal involvement by SFY '07	
	Older Adults	5% Increase in Tx completion by SFY '07	

\* These are not new dollars.

Adolescent treatment services are prioritized in the high category based upon a continuing large percent of adolescents who do not have access to residential care in the system. HCADAS also believes an increased emphasis should be placed on catching the adolescent alcohol abuser early in the cycle of abuse to shorten the long lag from chronic use to treatment for dependence. A significant number of these clients come from the child welfare and criminal justice systems.

Homeless persons with AOD involvement also are prioritized along with HIV early intervention due to the increased risks these populations face. Although a considerable number of I-V drug users continue to need access to services and are referred out of county, an expansion of these services cannot be realized without significant investment.

These priorities cover all of the ODADAS priority populations with the exception of women and pregnant women for whom considerable services are currently available within the system.

### **Section IV: PREVENTION SERVICES**

#### Prevention Needs

In 2003 HCADAS submitted a proposal to implement a Prevention planning process in the county. The proposal for the State Incentive Grant (SIG) was not funded. However, the planning process began in 2004. The first order of business in the planning process has been to take inventory of evidence-based programs and practices used by HCADAS funded prevention providers and invite non-funded Prevention providers to the table for discussion. In addition, HCADAS played a major leadership role in the planning and development of a Prevention education and preceptor program to expand a well-trained prevention workforce in southwest Ohio.

Many Prevention providers have contributed to the development of a Prevention services grid for Hamilton County. The service grid captures not only evidence-based programs and practices but links those programs and practices to communities and their age and culturally appropriate population targets through the use of the Institute of Medicine nomenclature. The effort seeks to develop a large coalition that identifies needs and gaps in services, provides greater clarity of focus and eliminates duplicity and repetition in achieving outcomes.

#### Prevention Priorities and Investor Targets

<b>SERVICE NEED PRIORITY</b>		<b>INVESTOR TARGET</b>	<b>\$\$ ALLOCATED*</b>
<b>HIGH</b>	Adolescent AOD Abuse	Decrease by 5% the percent of adolescents who self-report AOD use by SFY '07	
		Increase age of first AOD use by 10% for self-reporting youth by SFY '07	
		Increase by 5% the percent of adult family members involved with AOD education	
<b>MEDIUM</b>	Females of Child-bearing age	5% Decrease in new AOD self-report use by SFY '07	
	Individuals involved in the criminal justice system	5% reduction in new drug trafficking arrests	
<b>LOW</b>	I-V Drug users	5% reduction in the number of new cases	

\*These are not new dollars.

## Section V: COLLABORATION

The Board, in accordance with its long-term planning objectives, has demonstrated effective leadership in joining diverse partners and in facilitating enhanced community perceptions around the primary impact of alcohol and drug addiction and their solutions. The Board has initiated and maintained continuous involvement in multiple system models and planning endeavors aimed at 1) improving and expanding services, 2) increasing collaboration to improve efficiencies and generate new revenue sources. Highlights the Board's inter-system, state, local, and provider partnerships may be found in Appendix 6.

As a direct result of its long-term history of partnerships in Hamilton County, the Board has not experienced major challenges in involving others in the planning process, especially with respect to obtaining their cooperation to attend meetings and otherwise become actively involved in providing necessary input and achieving consensus about community alcohol and other drug needs, services and priorities.

A few examples of ways that coordination and collaboration have been successful for the Board are:

- Receipt of SAMHSA funding for implementation of a Family Treatment Drug Court,
- Submitted proposal for Knowledge Dissemination Conference on IDDT,
- Submitted proposal on recidivism reduction training for TASC case managers and Parole and Probation Officers,
- Networked with community Hispanic social service providers to implement an AOD treatment outreach program for limited English proficient Hispanics,
- Partnered with non-ADAS funded providers and the Butler County Alcoholism Council to implement a Prevention education and preceptor program,
- Worked with the Cincinnati Police Department's Asset Forfeiture financed Community Preventive Education Grants Program to ensure grant awards to effective community prevention programs,
- Partnered with the University of Cincinnati Department of Psychiatry, the Health Alliance, Bethesda Hospital and Christ Hospital in presenting a forum to medical college staff on AOD issues including prescription pain medication and addiction, the impaired professional, and screening, brief intervention and referral of AOD abusing patients,
- Began development of an external Continuous Quality Improvement Committee to set standards on client wait time, services evaluation, selection, piloting and implementation of evidence-based programs,
- Maintained a liaison with the Coalition for a Drug-Free Greater Cincinnati and the community and national leadership of the 25 cities Initiative and the Partnership for A Drug-Free America's new test pilot campaigns that are airing through the media in only two national markets including Cincinnati.

## Section VI: EVALUATION

Investor Target achievement will come as a result of careful planning, implementation of effective strategies and programs, and carefully tracking outcomes data through the new Continuous Quality Improvement process. Performance-based contracting criteria, monitoring standards and evaluation methods are set forth in annual contracts with provider agencies and communicated to the agencies during the annual contract hearing. Two CQI committees, an internal committee of HCADAS staff and an external committee consisting of HCADAS staff and provider representatives are charged with an ongoing evaluation task to ensure the realization of target achievement.

Verification of results achieved will be done largely through a qualitative and quantitative data comparison of starting and ending condition. Resource utilization may be one of several qualitative methodological criteria reviewed by the Board in evaluation of the Community Plan, and Investor Target achievement. Investor Target outcomes viewed as changes in conditions may be either qualitative or quantitative criteria as it reflects the providers' measurement intention(s).

That the public (including community and legislators) possesses a clear understanding of substance abuse and the benefits of prevention and treatment remains a central factor in determining whether the planned strategies actually strengthen the existing service system by meeting customer expectations. Obtaining input into the evaluation of the Community Plan involves the Board conducting various qualitative and quantitative measures, to be defined by the CQI Committees, as a Quality Management Plan (QMP). The QMP will include internal and external reviews of Board administration, operations and achievements. QMP will also include provider quality monitoring processes including reviews of outcome data and utilization of best-practice models of service delivery.

The CQI committees are in the process of modifying contract performance requirements to include reporting guidelines for waiting list monitoring, client grievance, client satisfaction, 90% capacity information and status of clinical protocol implementation. On a regular basis, information on grievances, waiting list management and 90% capacity is reviewed by the CQI committees. Results of provider reports on treatment satisfaction and prevention services participant satisfaction will be collected every few months.

When evaluations are judged less effective/efficient than anticipated, the Board will perform an internal review. The internal review is to be conducted at the Board level for the Community Plan and at the agency level for Investor Target achievement. Following any internal agency review, the Board staff will request the provider agency to submit a plan to resolve any discrepancies. A follow-up review and conference is scheduled to determine satisfactory completion of agreed upon actions.

The results and learning from the Community Plan will be communicated within the local Alcohol and other Drug system through publications such as the *Annual Report*, and

*Sourcebook.* CQI committee members will also receive routine reports that may be communicated to respective funded agency staff.

### WAIVERS

#### Inpatient-Hospital Rehabilitation Services

HOSPITAL	ODADAS UPID #	ALLOCATION

#### Generic Services

AGENCY	ODADAS UPID #	SERVICE	ALLOCATION

**SIGNATURE PAGE**

The undersigned is a duly authorized representative of the Hamilton County Alcohol and Drug Addiction Services Board and on behalf of the Board hereby acknowledges that the information contained in this application for funding, the Community Plan for SFY 2006 – 2007, is complete and accurate.

Hamilton County Alcohol and Drug Addiction Services Board

ADAS Board Name

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ADAS Board Executive Director

Date

Authorized ADAS Board Member

Date

## **APPENDICES**

**Appendix 1: Admissions and Demographics by Drug of Choice, SFY 2004**

<b>Drug of Choice</b>	<b>admits</b>	<b>% of total</b>	<b>% female</b>	<b>% male</b>	<b>% white</b>	<b>% black</b>	<b>Hispanic</b>	<b>injection history</b>	<b>HIV+</b>
Alcohol	2376	<b>43.6%</b>	29.3%	70.7%	61.1%	36.8%	21	34	47
Crack	1201	<b>22.0%</b>	47.4%	52.6%	33.2%	66.4%	4	27	30
Marijuana	913	<b>16.7%</b>	40.0%	60.0%	43.6%	55.5%	2	10	8
Heroin	377	<b>6.9%</b>	42.7%	57.3%	78.2%	21.2%	1	288	4
Other Opiates	290	<b>5.3%</b>	50.7%	49.3%	89.7%	9.7%	2	26	0
Cocaine (besides crack)	167	<b>3.1%</b>	45.5%	54.5%	60.5%	38.3%	0	25	4
None	40	<b>0.7%</b>	40.0%	60.0%	52.5%	45.0%	0	1	0
Other stimulants	33	<b>0.6%</b>	54.5%	45.5%	87.9%	9.1%	0	3	3
Other depressants	31	<b>0.6%</b>	64.5%	35.5%	87.1%	9.7%	1	2	0
Other	25	<b>0.5%</b>	36.0%	64.0%	44.0%	56.0%	0	2	0
<b>Grand Total</b>	<b>5453</b>	<b>100.0%</b>	<b>38.1%</b>	<b>61.9%</b>	<b>54.9%</b>	<b>43.8%</b>	<b>31</b>	<b>418</b>	<b>96</b>

## Appendix 2: Hamilton County ADAS SFY 2004 Treatment Outcomes

The Hamilton County ADAS Board, in collaboration with its treatment providers, tracks five core clinical outcomes, based on the outcomes areas under development nationally at the Center for Substance Abuse Treatment of the Substance Abuse and Mental Health Services Administration. A data set reflecting these outcomes is incorporated in CMHC (the ADAS MIS system, also used for billing and client demographics). Providers collect this data set on all clients at admission, and again at discharge. This year we have complete outcomes data on a sample of 1,912 individuals— nearly triple last year’s number. Below are highlights of the data.

- Treatment Completion: 37% of all treatment clients discharged in SFY 2004 had completed treatment. This is 3% more than last year.
- Frequency of Drug Use: There was a statistically significant decrease in frequency of use among clients in the sample of 1,912. The number of clients who reported daily use decreased from 664 at intake to 526 at discharge. Thirty-seven percent of clients in the sample reported no use at all at the time of discharge.
- Legal Involvement (arrests): Data collection for legal involvement has been revised to correct problems that made past data unusable. Unfortunately, the benefits of this improvement will not be seen until next year. We do know, however, that among Drug Court graduates, 12-month felony re-arrest rates have been 2% or less for three years in a row, and have been in the single digits since 2000.
- Living Situation (stable housing): From intake to discharge there was a 65% reduction in the number of clients who were homeless, and a 13% increase in the number living in their own home or apartment. (See chart for client counts.)
- Employment: There was a 36% increase from admission to discharge in the number of clients working full time, and a 24% decrease in the number of clients who were unemployed. (See chart for client counts.)

The following chart gives the numbers of clients in various situations, before and after treatment, out of a total sample of 1,912:

	Admission	Discharge	% Change
Living in own home or apartment	781	879	13
Homeless	230	81	65
Employed (full time)	357	484	36
Unemployed	865	657	24

### Appendix 3: Treatment Completion, SFY 2004

<b>Client Disposition at Discharge</b>	<b>count</b>	<b>%</b>
Goals Met, No Additional Services Needed *	1,233	36.9
Client Did Not Return to Treatment	713	21.4
Client Rejected Continuation of Treatment	472	14.1
Case Closed with Referral to AOD Treatment	338	10.1
Other	253	7.6
Needed Services Not Available	87	2.6
<i>missing data</i>	71	2.1
Case Closed with Referral to Mental Health Treatment	58	1.7
Client Moved	44	1.3
Case Closed with Referrals to Mental Health Treatment & AOD Treatment	31	0.9
Case Closed with Referral to AOD Aftercare	22	0.7
Case Closed with Referral to Mental Health Aftercare	8	0.2
Case Closed with Referrals to Mental Health & AOD Aftercare	5	0.1
Client Died	2	0.1
total	3,337	100.0

Thirty-seven point seven percent of clients reached at least aftercare. Note that this table includes only treatment clients, not clients who received assessment only (or were in service fewer than 8 days).

#### Appendix 4: Special Populations, SFY 2004

	“Yes”	
Alc/Othr Drug Abuse	4,478	96.9%
Probation/Parole	1,974	42.7%
COA/Other Drug Abuser	1,760	38.1%
School Dropout	1,578	34.1%
DUI/DWI	1,341	29.0%
Domestic Violence	1,036	22.4%
Phys Abuse Victim	825	17.8%
Sexual Abuse	771	16.7%
Forensic	669	14.5%
Visually Impaired	477	10.3%
Sev Ment Disabled	426	9.2%
Suicidal	407	8.8%
Ment Ill Ment Ret	378	8.2%
Physically Disabled	261	5.6%
Devel Disabled	170	3.7%
Hearing Impaired	141	3.1%
Other Group	97	2.1%
HIV/AIDS	92	2.0%
Speech Impaired	66	1.4%
Deaf	25	0.5%
Blind	17	0.4%

#### Appendix 5: Pregnant at Admission, SFY 2004

Drug of Choice	women		%
	admitted	pregnant	
Alcohol	696	17	2.4%
Crack	569	27	4.7%
Marijuana	365	10	2.7%
Heroin	161	7	4.3%
Other Opiates	147	6	4.1%
Cocaine (besides Crack)	76	3	3.9%
Other Drugs	63	0	0.0%
Grand Total	2077	70	3.4%

### Appendix 6: Collaborative Partnerships

<b>Intersystem Partnerships</b>	<b>Purpose of Involvement Improved Outcomes and/or Expanded Services</b>
Hamilton County Board of County Commissioners	Hamilton County Family and Children First Council Establish comprehensive, county-wide plan for service coordination, including pooled funding mechanisms through: <ol style="list-style-type: none"> <li>1 Executive Council</li> <li>2 Mid-level Managers</li> <li>3 Intersystem Training</li> <li>4 Service Coordination</li> <li>5 Children's First Advisory</li> <li>6 Early Start Advisory</li> <li>7 Financial Workgroup</li> </ol>
Joint Advisory Council (Department Of Job and Family Services)	Participate with local service providers (including HMOs and private sector) to address the county's Medicaid programs under welfare reform.
Law Enforcement/Judiciary	Corrections Planning Board Law Enforcement/Mental Health/Substance Abuse Committee TASC Advisory Committee
Juvenile Court, Public Defenders, ProKids, JFS, Providers	Implemented a Family Treatment Drug Court for parents/guardians at risk of losing custody of their dependent child/children due to their substance use. To date four individuals/families are receiving services through this voluntary program.
Drug Court	Responsible for representation and leadership; Hamilton County Commissioners, County Administrator, Counsel of the Prosecutor's Office, Chief Probation Officer, Director of Pre-Trial Services
Common Pleas Court	Drug Court Implementing Agency and member of Hamilton County Criminal Justice Coordinating Committee
Hamilton County Probation Department	Maintained contract to provide coordinated treatment for indigent persons convicted of DUI.

<b>Intersystem Partnerships</b>	<b>Purpose of Involvement Improved Outcomes and/or Expanded Services</b>
Hamilton County Mental Health Board & Council on Aging	Participate as a member of the Mental Health and Aging Coalition; Advisor to the ElderReach Project that specializes in planning to address substance abuse among older adults
Community Task Force	Coalition for a Drug-Free Greater Cincinnati County-wide Strategic Planning and Prevention Collaboration
Substance Abuse Management and Development Corporation	Management entity for state-owned property and development of transitional housing.
City of Cincinnati, Homeless Coalition, Health Foundation of Greater Cincinnati	Collaboration to submit Super Nofa: HUD/SAMHSA/HRSA/VA. Application to be submitted 4/03.
Hamilton County Department of Jobs and Family Services (JFS)	Continued the IMPACT program with Jobs and Family Services as a treatment model for provision of treatment services for persons in the child welfare system in accordance with H.B. 484 requirements.
Domestic Violence Coordinating Council	Serve as a member of Hamilton County Domestic Violence Coordinating Council.
Drugs Don't Work	Maintain a joint agreement with the Chamber of Commerce to provide consultation services for small businesses in Hamilton County.
Hamilton County Court of Common Pleas/Municipal Court	Leadership participation on the Hamilton County's Intermediate Sanctions for Women Policy Team.
Mental Health Board, Criminal Justice, 2 Provider Collaboratives, United Way, JFS, Schools	Substance Abuse/Mental Illness Initiative: Implementation of a pilot project for adults reentering the community after incarceration. Leadership team participation – responsible for coordination of services.
Partnership Team	In collaboration with JFS and the Mental Health Board, continued a partnership to implement an administrative services contract for centralized management information system. Released a new RFP in 2002 that included a reduction in services from the previous contract. JFS, MHB, and ADAS will assume additional responsibilities for care coordination and information system management.

<b>Intersystem Partnerships</b>	<b>Purpose of Involvement Improved Outcomes and/or Expanded Services</b>
JFS, Mental Health Board, MR/DD, Juvenile Court	Partnership for coordination of services to children involved with multiple systems. Includes pooled funding for services. Released an RFP and entered into a contract with a new managed care vendor. The partnership assumes additional oversight responsibilities with the new contract.
United Way of Greater Cincinnati	Joined the Health People Vision Council Leadership Team, the Behavioral Health Committee, and chair the Program Review and Funding Committee.
Junior League, Children’s Hospital, JFS, Cincinnati Public Schools, Juvenile Justice, Mental Health Board, Mr/DD, Health Foundation	Participate in the MindPeace Initiative to identify and quantify behavioral health care for children, assess gaps in services, provide advocacy, increase public awareness of the issues, provide education and training.
<b>Clients and Consumers</b>	The Board solicits advice and incorporates client surveys in the strategic planning process.
<b>Public Participation</b>	A public hearing is typically held to obtain information and public reaction to the Board’s draft of the strategic plan update.
Coalition for a Drug Free Greater Cincinnati	The ADAS system supports the endeavors of this community-based coalition, which has been effective in promoting the message of abstinence among the area’s high-risk children, adolescents, and families. The Board will continue to endorse funding proposals that support the efforts of the Coalition.
<b>Provider Partnerships</b>	<ol style="list-style-type: none"> <li>1) Revised adolescent residential treatment services to incorporate best-practice models.</li> <li>2) Implemented new day treatment program for clients referred from Juvenile Justice system.</li> <li>3) Facilitated an Adolescent Treatment Enhancement Committee.</li> <li>4) The Board funded a pilot project to improve access to the AOD system for any person seeking information and referral for education, prevention and treatment services. This coordinated system access project provides information, triage, assessment, referral, and transitional case management for persons waiting for placement into a treatment program.</li> <li>5) The Board operates a Prevention Provider Forum, which meets on a quarterly basis. The Forum serves as an open meeting for all providers interested in sharing information about critical issues and advocating recommendations regarding the planning and evaluation of prevention services throughout the county. Participation includes agency representatives involved in the Drug Free Workplace Programs, Drug-Free Community Coalitions, and the Safe and Drug Free Schools Projects.</li> </ol>
<b>State/Local Partnerships</b>	<b>Purpose of Involvement</b>

<b>Intersystem Partnerships</b>	<b>Purpose of Involvement Improved Outcomes and/or Expanded Services</b>
	<b>Collaboration to improve efficiencies and/or generate new revenue sources</b>
Ohio Association of County Behavioral Health Directors	Advocacy and representation of addiction, treatment and prevention service planning. Executive Committee Clinical Leadership Committee Finance Committee Kids Committee
<b>Provider Partnerships</b>	
Treatment and Prevention Providers	Implemented the Grant Coordination Committee to identify funding opportunities and coordinate the submission of grant applications.
<b>Inter-system Partnerships</b>	
City of Cincinnati, Homeless Coalition, Health Foundation of Greater Cincinnati, Providers	Collaboration to submit a proposal for the Super Nofa: HUD/SAMHSA/HRSA/VA. Application to be submitted 4/03. Proposal increases housing opportunities and services coordination for homeless persons residing in four of the city's shelters.
Mental Health Board, Criminal Justice, 2 Provider Collaboratives, United Way, JFS, Schools	Collaborated with the Hamilton County SAMI Leadership Team in submitting an application to the Robert Wood Johnson Foundation to expand services to meet the needs of persons with co-occurring psychiatric disorders (mental illness/AOD addictions).
Juvenile Court, Public Defenders, ProKids, JFS, Providers	Submitted and received funding through SAMHSA to implement a Family Treatment Drug Court.
Cincinnati Health District, Providers	Submitted an application for tobacco prevention programming. This application did not receive funding, however the collaborative continues to seek additional grant opportunities, and submitted an application in March 2003 prevention programming.