MONTGOMERY COUNTY

MONTGOMERY COUNTY
Alcohol & Drug
Abuse Task Force

Report to Improve Alcohol & Other Drug Abuse & Addiction Services

IN MONTGOMERY COUNTY

FAMILY AND CHILDREN FIRST COUNCIL
MONTGOMERY COUNTY

Dear Community Member,

The Montgomery County Alcohol and Drug Abuse Task Force (referred to as the "AOD Task Force") is pleased to present this ***Report to Improve Alcohol and Other Drug Abuse and Addiction Services in Montgomery County, Ohio.*** This document is the culmination of work performed over the last two years by numerous dedicated individuals representing a comprehensive cross-section of the community.

Alcohol and other drug (AOD) abuse and addiction impact tens of thousands of individuals in Montgomery County every year. Addiction is a very complex brain disease in which the individual becomes mentally obsessed with drugs and alcohol, despite negative consequences such as family disintegration, loss of employment, failure in school, domestic violence, and child abuse among others. Legal ramifications and criminal justice involvement commonly occur as a result. The impact to individuals, children, families, and entire communities is often devastating. Consequently, AOD abuse and addiction is **EVERYONE'S** problem as it infringes on every niche of every community.

Scientific advances over the last 30 years have defined AOD dependence as a chronic relapsing disease with psychological and physiological characteristics. Despite this fact, many continue to believe that addiction is a personal choice and evidence of moral weakness. Stereotypes and stigmas play significant roles in diminishing our community's ability to respond to this issue; thus, the consequences to individuals, families, and communities are exacerbated.

For these very reasons, the approach taken by the Montgomery County AOD Task Force to address this issue has included members from nearly every sector of our community. Over 150 community members and stakeholders participated in these efforts, including representatives from social services, treatment and prevention, housing and homelessness, behavioral and physical healthcare, policy makers, criminal justice, community members, and individuals currently in recovery.

Through the Task Force process, we have learned the following about AOD abuse and addiction in Montgomery County:

- An estimated 42,390 people aged 12 and older needed services for AOD abuse and addiction in 2008 (*National Survey on Drug Use and Health: National Findings)*. In the local public system, only 5,106 (12%) of those individuals received assessment services (*CrisisCare, FY 2008*); only 3,035 (7%) individuals made it to their first treatment appointment; and only 1,032 (2%) completed all of their treatment sessions (*ADAMHS Board, FY 2008*). While others received treatment services through the private system, those cannot be calculated due to a lack of data integration between the public and private systems.
- The impact of AOD abuse and addiction is felt across the entire landscape of Montgomery County. A geographic review of drug-related arrest rates, emergency room rates, and mortality

rates indicate that the devastation caused by AOD abuse and addiction is evident in every segment of every urban, suburban, and rural neighborhood in our community.

- Montgomery County's criminal justice population is overwhelmingly filled with individuals struggling with AOD abuse and dependency issues. In fact, as many as 50% of the daily jail population are currently booked with drug charges or have had prior bookings involving drugs. Another 68% of individuals in the Court of Common Pleas system are alcohol and/or drug related. And the entire community pays for this; in 2009, criminal justice accounted for 71% of the County's General Revenue Fund spending.

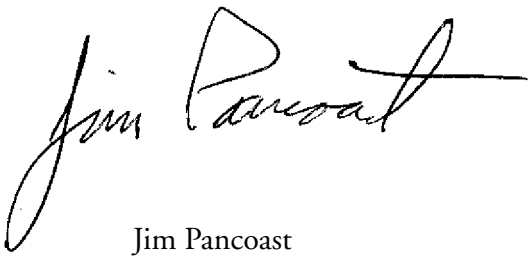
The Task Force developed recommendations to address gaps in services, systemic barriers, and to improve our overall AOD systems and services. As outlined in this report, these recommendations are contingent upon five key principles:

- The **INFRASTRUCTURE** necessary for Montgomery County to provide quality AOD services requires an increased capacity to work collaboratively across and between systems and services.
- **PREVENTION** services are critical to thwarting the detrimental effects of AOD abuse and addiction and are vital in building resilient and productive Montgomery County residents.
- High-quality **TREATMENT** services that meet each individual's unique needs and circumstances should be available and accessible to all individuals struggling with addiction.
- **LINKAGES**, or transition services between prevention, assessment, treatment, and aftercare, should exist along an unbroken continuum so that individuals do not have the opportunity to fall through the cracks.
- The capability to **SHARE DATA** across systems currently exists and implementation of those data sharing mechanisms would enhance overall service provision and client care.

The efforts of the AOD Task Force have been substantial thus far and the development of this report is its culminating product; however, our work is just beginning. Now is the time to cease talking about the community's problems and begin implementing tangible and realistic community solutions. We urge you to read this report and consider how you play a role. Please join us as we take these first steps towards improving the community's ability to respond to this vitally important issue.

Sincerely,

Dan Foley
Montgomery County Commissioner



Jim Pancoast
President, Premier Health Partners

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* *This document has been produced in both a summary and a full version. The summary version does not contain the appendices. For a copy of the full version of the report, or to access any of the individual appendices, please contact the Montgomery County Office of Family and Children First at (937) 225-4695.*

TASK FORCE ROSTER

Dan Foley
Montgomery County Commissioner,
Task Force Co-Chair,
Data Sharing Subcommittee Co-Chair

Jim Pancoast
Premier Health Partners, President
Task Force Co-Chair

David Ames
Consumer,
ADAMHS Board for Montgomery County

Bryan Bucklew
Greater Dayton Area Hospital Association

Honorable Anthony Capizzi
Montgomery County Juvenile Court,
Repeat Offenders Subcommittee Co-Chair

James Dare
Montgomery County Court of Common Pleas

Debra Downing
Montgomery County Department of Job
and Family Services

Allen H. Elijah
United Way of the Greater Dayton Area

Deron Emmons
Deaf Community Resource Center, Inc.

Russel Falck
Wright State University/Center for
Interventions, Treatment, and Addictions
Research, Prevention Subcommittee Co-Chair

Deborah Feldman
Montgomery County

Janet Grant
CareSource,
Data Sharing Subcommittee Co-Chair

James Gross
Public Health—
Dayton & Montgomery County

Major Mark Hess
City of Dayton Police Department

Gregory Hopkins
Community Health Centers
of Greater Dayton

Honorable Katherine Huffman
Montgomery County Court of Common Pleas,
Repeat Offenders Subcommittee Co-Chair

Tanisha Jumper
United Way of the Greater Dayton Area
(on behalf of Allen H. Elijah)

Tom Kelley
Montgomery County Office of Family
and Children First (OFCF)

Vickie Killian
Killian Counseling and Consulting,
Bridging the Gaps Subcommittee Co-Chair

James Knowles
Montgomery County Veterans
Service Commission

Honorable Peggy Lehner
State Representative

Connie Lucas-Melson
Family and Children First Council

Sue McGatha
Samaritan Behavioral Health, Inc.

Charlotte McGuire
Montgomery County Juvenile Court/
Reclaiming Futures,
Prevention Subcommittee Co-Chair

Sheriff Phil Plummer
Montgomery County Sheriff's Office

André Roldan
Dayton Public Schools
(on behalf of Rebecca Lowry)

Norm Schneiderman, MD
Miami Valley Hospital

Leigh Sempeles
St. Vincent de Paul

Eric Shafer
Montgomery County Juvenile Court

Hassan Shakir
Leaders for Equality and Action in Dayton

Joe Spitler
Montgomery County Criminal Justice Council, Detox Subcommittee Co-Chair

Margy Stevens
Montgomery County Educational Service Center

John Strahm
Eastway Corporation

Joe Szoke
ADAMHS Board for Montgomery County

Doug Teller, MD
Kettering Medical Center Network, Detox Subcommittee Co-Chair

Andrea White
South Suburban Alcohol and Other Drug Abuse Prevention Coalition

Rev. Carlton Williams
Mount Olive Baptist Church, Wright State University/Substance Abuse Resources and Disability Issues

Jim Wilson
Parity, Inc.

Joel Zeugner
Dayton Municipal Courts
(on behalf of Jacquelyn Jackson)

STAFF:

Sandy Barnum
OFCF, Task Force Staff

Debra Downing
Montgomery County Department of Job and Family Services, Data Sharing Subcommittee Staff

Andrea Hoff
OFCF, Task Force Staff, Detox Subcommittee Staff

Jayne Jones-Smith
ADAMHS Board for Montgomery County, Task Force Staff, Repeat Offenders Subcommittee Staff

Tom Kelley
OFCF, Detox Subcommittee Staff

Diane Luteran
OFCF, Bridging the Gaps Subcommittee Staff

Geraldine Pegues
OFCF, Bridging the Gaps Subcommittee Staff

Joyce Probst MacAlpine
OFCF, Repeat Offenders Subcommittee Staff

Catherine Rauch
OFCF, Prevention Subcommittee Staff

William Roberts
Public Health—Dayton & Montgomery County/Center for Alcoholism and Drug Addiction Services, Prevention Subcommittee Staff

Kathleen Shanahan
OFCF, Bridging the Gaps Subcommittee Staff

Robert L. Stoughton
OFCF, University of Dayton Fitz Center, Data Sharing Subcommittee Staff

Numerous other dedicated individuals participated in the work of the Task Force in a variety of different capacities. See Appendix A for a matrix of all participants and the role(s) they played in the Montgomery County AOD Task Force process.

EXECUTIVE SUMMARY

Individuals impacted by alcohol and other drug (AOD) abuse and addiction can be found in every neighborhood of every community in Montgomery County. AOD abuse and addiction does not discriminate against any race, gender, or socio-economic background. Furthermore, the level by which people are impacted by abuse and addiction varies significantly; some individuals are in the early stages of abuse while others have struggled with the disease of addiction for many years. Given the extreme variations, it is understandable that there are no easy solutions to this community issue.

In recognition of the turmoil that AOD abuse and addiction have on our community, the Montgomery County Board of County Commissioners established the **Montgomery County Alcohol and Drug Abuse Task Force** in May of 2008. The Task Force is chaired by Montgomery County Commissioner Dan Foley and President of Premier Health Partners, Jim Pancoast, and includes many key community stakeholders.

The Task Force combined their efforts with members from virtually every sector of our community. Nearly 150 community members and stakeholders participated in these efforts, including representatives from social services, treatment and prevention, housing and homelessness, behavioral and physical healthcare, public administrators, policy makers, criminal justice, community members, and individuals currently in recovery. These professionals represent a broad spectrum of disciplines that join the battle against AOD abuse and addiction every day with their clients; everyone has a role to play in the continuum of AOD services. This inclusive group of dedicated and knowledgeable professionals, community members, and key stakeholders was charged with assessing the public and private AOD systems and identifying recommended paths for change using a cross-systems approach. This report is the culmination of the work they performed over approximately two years.

The continuum of AOD services is widespread and incorporates research and knowledge that has accumulated over the last several decades. Acknowledging that effective community solutions had to be holistic, the Task Force incorporated the entire spectrum into their work: prevention, intervention (or assessment), treatment, aftercare, and enforcement and compliance efforts. This process also considered different populations—from the young to the elderly, and including special populations such as homeless individuals and individuals with disabilities and co-occurring disorders.

To support the work of the Task Force, the County engaged the University of Dayton's Business Research Group and Wright State University's Center for Interventions, Treatment, and Addictions Research to collect critical data and analyze the community's needs with respect to alcohol and other drug abuse and addiction. Three critical reports on community trends and data were created as a result: *The Montgomery County Substance Abuse Needs Assessment: Phase One, The Montgomery County Substance Abuse Needs Assessment: Phase Two,* and *The Inmates Who Use Jail Services Extensively Study*. Information extrapolated from these reports was utilized by the AOD Task Force for decision-making purposes.

The Task Force members participated in a SWOT analysis in order to assess the Strengths, Weaknesses, Opportunities, and Threats of the alcohol and drug abuse/addiction services and systems in Montgomery County as a whole. The responses provided during this process were used to determine a set of strategic goals, objectives, and proposed initiatives for the future improvement of AOD services in Montgomery County. From this work, five goal areas were established and a subcommittee was assigned to each area:

- Bridging the Gaps Subcommittee—Bridge the gaps across assessment, treatment, and aftercare/recovery services
- Data Sharing Subcommittee—Improve the processes for the collection and sharing of data on individuals and populations
- Detox Subcommittee—Improve Montgomery County's capacity to provide detox services
- Prevention Subcommittee—Develop a comprehensive, coordinated, county-wide prevention and community education system
- Repeat Offenders Subcommittee—Strengthen intervention and resources for repeat criminal justice offenders

Each subcommittee consisted of members from the AOD Task Force as well as other key community leaders and service providers who were given the charge of developing a set of recommendations related to their respective goal area. All subcommittees completed a written report describing their findings and recommendations.

The subcommittees devised a combined total of 83 recommendations. Many of these recommendations were duplicated across subcommittees; therefore, to increase functionality, it was necessary to transform the broader set of recommendations into a smaller amount of merged recommendations. This consolidation process reduced the total 83 subcommittee recommendations into 32 Task Force recommendations that will be used to guide Montgomery County once the implementation of the recommendations has begun.

A variety of themes surfaced out of the subcommittee recommendations, which ultimately resulted in the following five key principles that served as the driving force for the remainder of the AOD Task Force work:

- The **INFRASTRUCTURE** necessary for Montgomery County to provide quality AOD services requires an increased capacity to work collaboratively across and between systems and services.
- **PREVENTION** services are critical to thwarting the detrimental effects of AOD abuse and addiction and are vital in building resilient and productive Montgomery County residents.
- High-quality **TREATMENT** services that meet each individual's unique needs and circumstances should be available and accessible to all individuals struggling with addiction.

- **LINKAGES**, or transition services between prevention, assessment, treatment, and aftercare, should exist along an unbroken continuum so that individuals do not have the opportunity to fall through the cracks.
- The capability to **SHARE DATA** across systems currently exists and implementation of those data sharing mechanisms would enhance overall service provision and client care.

A series of focus groups were conducted in order to obtain the perspective of individuals currently in treatment and recovery. These focus groups painted a picture of the individuals' lives and the tribulations they've endured as a result of their addictions. Each group was asked to review a portion of the Task Force's recommendations applicable to their particular cohort. This information provided some valuable "lessons learned" that will be utilized as the Task Force moves into the implementation phase.

The Task Force then engaged in an extensive dialogue to identify priorities for Montgomery County. There was consensus from the group that the recommendations related to infrastructure, capacity building, partnerships/collaborations, and staffing the implementation of the Task Force recommendations took center stage.

The AOD Task Force will begin the process of implementing the recommendations through the release of the report to the Montgomery County Board of County Commissioners. The Board of County Commissioners will then establish an AOD Implementation Advisory Team to support the collaborative cross-systems approach of the recommendations and assist with strategic input and influence. This Team will schedule briefings with key influencers from various systems in order to discuss alignment of the recommendations within the individual systems and seek endorsement. In addition, an AOD Work Group consisting of high-level managers will be necessary to guide the internal changes and a variety of ad hoc committees will be required for those recommendations that require specificity.

Staff time dedicated to supporting and coordinating the implementation of the recommendations will be dedicated by the Montgomery County Office of Family and Children First and will be requested from the ADAMHS Board and the Greater Dayton Area Hospital Association. These staff will facilitate and provide administrative support, research and planning, community education, program support, and oversight for the ongoing reporting of activities and accomplishments. It is anticipated that this framework will lead to increased collaborative decision-making within the AOD network of systems.

The AOD Task Force has achieved significant milestones for fostering community collaboration in Montgomery County. The process of pulling together a broad cross section of our community to address AOD issues has resulted in some early achievements for Montgomery County. These accomplishments represent the first step among many in our battle against alcohol and other drug abuse and addiction. But our work is just beginning.

Taking action to improve Montgomery County's AOD services will require many changes. In order to implement the Task Force reccommendations, financial resources—both new dollars and a reallocation of current dollars—will be necessary as will targeted state advocacy efforts, and the right human capital. Even more important will be the community's willingness to be accepting of new concepts and methodologies.

The work and recommendations of the Task Force reinforce the critical need for the community to work as a comprehensive unit. Divisions within and between community sectors will continue to burden Montgomery County citizens if barriers are not consciously eliminated. Our capacity to provide better AOD services relies on our ability to identify community solutions on a large scale and as an entire community. Please join us as we take these first steps towards improving the AOD services and systems in Montgomery County.



INTRODUCTION

Individuals impacted by alcohol and other drug (AOD) abuse and addiction can be found in every neighborhood of every community in Montgomery County. AOD abuse and addiction does not discriminate against any race, gender, or socio-economic background. Furthermore, the level by which people are impacted by abuse and addiction varies significantly; some individuals are in the early stages of abuse while others have struggled with the disease of addiction for many years. Given the extreme variations, it's understandable that there are no easy solutions to lessening the impact of abuse and addiction to individuals or to our community.

Alcohol and other drug addiction is progressive and can be fatal if untreated, but it is preventable. Addiction is a very complex and chronic brain disease with an unknown single cause that slowly invades people's lives, takes over through mental obsession and compulsion, and results in an onslaught of negative consequences. Despite these consequences, the addicted person continues the destructive behavior. To individuals not affected by addiction, this scenario appears nonsensical and an indicator of moral failing—people must be too weak or unethical to discontinue these behaviors. But scientific advances over the last 30 years have taught us there are genetic and biological factors that predispose an individual to addiction. Despite this fact, stigmas and stereotypes prevail, prohibiting communities from making the social, systemic, and policy changes necessary to overcome this problematic community issue.

The social acceptability of alcohol (as a legal substance) and marijuana (in some cultures more so than others) further hinders our efforts in combating abuse and addiction issues. Despite the painstaking and diligent efforts of service providers, the devastation is still felt by thousands of Montgomery County citizens every day. And the negative consequences of AOD abuse and addiction are not felt just by the abuser; friends, family members, and entire communities are impacted.

MONTGOMERY COUNTY FAMILY AND CHILDREN FIRST COUNCIL

The Montgomery County Family and Children First Council (FCFC) has identified substance abuse and addiction as a priority issue for Montgomery County. FCFC's mission is to foster interdependent solutions among public and private community partners to achieve the vision for the health and well-being of families, children, and adults. Their work is organized around six deliberately-chosen outcome areas which serve as attributes of a thriving and healthy community:

- Economic Self-Sufficiency
- Healthy People
- Young People Succeeding
- Positive Living for Special Populations
- Safe Neighborhoods/Supportive and Engaged Neighborhoods
- Stable Families

Each outcome area is driven by an Outcome Team which consists of a select group of action-oriented professionals charged with advancing initiatives in their respective areas by engaging in community planning processes. In recognition of the turmoil that AOD abuse and addiction have on our community, the Positive Living for Special Populations (PLSP)[1] Outcome Team identified substance abuse as a priority issue soon after the Outcome Team was established. This initial identification was the impetus for the creation of the Montgomery County Alcohol and Drug Abuse Task Force (referred to as the AOD Task Force throughout the remainder of this report).

The PLSP Outcome Team determined that the abuse of alcohol and other drugs is the **prevailing root cause** of many of our community's problems, impacting all six of the Montgomery County Family and Children First Council's outcome areas. Noting the limited availability of treatment, the PLSP Outcome Team urged that people who require treatment should be able to access it without a lengthy wait. They also concluded that Montgomery County needs prevention, early intervention, and a coordinated approach in our community to impact this problem.

WHAT ARE THE COSTS OF SUBSTANCE ABUSE TO OUR COMMUNITY?

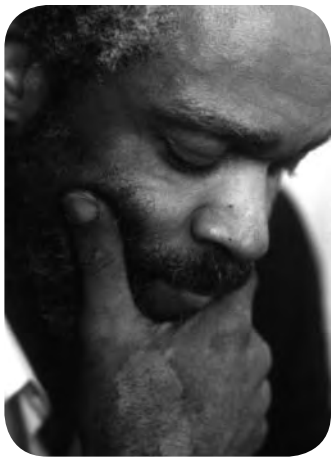
Closing the door at the front end by preventing people from needing AOD services to begin with, or intervening early when problems begin, avoids much bigger bills down the road. The costs of waiting until alcohol and other drugs have wrecked lives include:

- Juvenile justice and adult corrections
- Child abuse/neglect, spousal/partner abuse, elder abuse
- School failure, dropouts, lack of self-sufficiency
- Poverty and unemployment
- Blighted and unsafe neighborhoods

To demonstrate that substance abuse is the root cause of so many of our community's problems, the PLSP Outcome Team identified examples of the impact of substance abuse for each of the FCFC outcome areas. These impacts include the following:

1 "Special populations" encompass people of all ages and a variety of conditions, including alcohol and other drug abusers, persons with mental disabilities, persons who are frail and elderly, and others who cannot perform basic life functions without assistance.

Healthy People



- Prenatal exposure to substances often has life-long consequences including a host of physical and developmental problems resulting from babies being born at low birth weight, infant withdrawal from substances, and fetal alcohol spectrum disorders.
- Addicts are, in general, more physically unhealthy than individuals who do not abuse substances. Resulting health conditions include liver problems, hepatitis, and HIV/AIDS. In fact, AOD abuse behavior plays the largest role in the spread of HIV infection in the U.S.[2]
- As many as 20% of returning veterans are likely to have post traumatic stress disorder and/or have suffered a traumatic brain injury while deployed.[3] Many self-medicate with alcohol and/or other drugs rather than seeking treatment.

Young People Succeeding

- For students, alcohol and other drug use impacts school attendance and performance and increases dropout rates. It also instigates youth addiction, teenage pregnancy, and engagement in illegal activity.
- Approximately 26% of all alcohol consumed in Ohio is consumed by underage drinkers.[4]
- Almost half of patients admitted to a brain injury healthcare unit have substance abuse disorders; many are young people.[5]

Stable Families

- Children whose parents have abused alcohol or other drugs are 2.7 times more likely to be abused and 4.2 times more likely to be neglected.[6]
- 30 to 40% of all reported incest cases involve an alcoholic parent.[7]
- 40 to 80% of families that come to the attention the U.S. child welfare system each year live in families with alcohol and other drug problems.[8]

Economic Self-Sufficiency

- Substance abuse strains family finances, making it difficult to meet the basic needs of a family, threatens employment, affects health, increases family violence, increases divorce, and increases poverty.
- Use of alcohol and other drugs impact work accidents and worker productivity.
- Alcohol and other drug abusers use more sick days, are tardy three times more frequently, and are five times more likely to file workers' compensation claims.[9]

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2 National Institute on Drug Abuse, March 2005.
3 Rand Corporation, *One in Five Iraq and Afghanistan Veterans Suffer from PTSD or Major Depression,* news release, April 17, 2008.
4 Underage Drinking Toolkit, www.ebasedprevention.org/.../Underage%20Drinking%20Toolkit%20-%20PowerPoint%20Presentation%20for%20THM.ppt.
5 National Institute of Neurological Disorders and Stroke, http://www.ninds.nih.gov/disorders/tbi/detail_tbi.htm.
6 The National Center on Addiction and Substance Abuse, Columbia University, *Family Matters: Substance Abuse and the American Family,* March 2005.
7 Child Trends Data Bank, *Heavy Drinking Among Parents,* http://www.childtrendsdatabank.org/archivepgs/48.htm.
8 Child Welfare League of America, http://www.cwla.org/articles/cv0109sacm.htm.
9 U.S. Dept. of Health and Human Services, SAMHSA, *Integrating Substance Abuse Treatment and Vocational Services, Treatment Improvement Protocol (TIP) Series 38*, http://ncadi.samhsa.gov/govpubs/bkd381/38d.aspx.

Safe and Supportive Neighborhoods

- 85% of all U.S. inmates have some substance abuse involvement, including 65% who meet the medical criteria for substance abuse addiction. [10]
- Alcohol and other drugs are involved in 78% of violent crimes; 83% of property crimes; and 77% of public order, immigration or weapon offenses, and probation/parole violations.[11]
- Alcohol and other drug addiction and mental illness play a major role in extending homelessness for single adults.[12]
- Neighborhood impacts include crime and abandoned housing.

Positive Living for Special Populations

- Substance abuse affects approximately 17% of the elderly population aged 60 years and older. By 2020, the number of older adults with substance abuse problems is expected to double.[13]
- Estimates suggest that up to 7 million adults in this country have at least one co-occurring mental health and substance-related disorder.[14] Individuals with co-occurring disorders tend to be more symptomatic, have multiple health and social problems, and require more costly care.[15]
- Many individuals with physical and/or mental health conditions choose to self-medicate rather than seek treatment.

A COMPLEX COMMUNITY ISSUE REQUIRING COMMUNITY COLLABORATION

Due to its wide-ranging impacts, the PLSP Outcome Team concluded that the issue of substance abuse and addiction went beyond the scope of the PLSP Outcome Team and needed a higher-level focus. They urged that a collaborative approach be pursued to tackle a community problem that crosses systems and neighborhoods and affects all age groups.

PLSP Outcome Team Co-Champions, Amy Luttrell and Emmett Orr, met with the Co-Champions of the other FCFC Outcome Teams and with the Family and Children First Council. They obtained agreement that substance abuse was a common theme affecting all FCFC outcome areas. Additional dialogue on the effects of substance abuse on our community occurred at the April 2007 FCFC meeting.

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10 The National Center on Addiction and Substance Abuse, Columbia University, *Behind Bars II: Substance Abuse and America's Prison Population*, February, 2010. CASA noted that in the last 12 years since its first *Behind Bars* report was issued in 1998, there has been no progress in reducing the number of substance-involved inmates in prisons and jails, and only 11 percent receive any treatment. CASA calls for providing treatment to inmates with AOD programs and increased use of drug courts and prosecutorial drug treatment alternative programs.

11 Ibid.

12 Montgomery County, Ohio, *Homeless Solutions 10-Year Plan Executive Summary, A Blueprint for Ending Chronic Homelessness and Reducing Overall Homelessness in Dayton and Montgomery County, OH*, http://www.mcohio.org/services/fcfc/homeless_solutions.html.

13 Hazelden Foundation (2010). *Substance abuse among the elderly: A growing problem.* http://www.hazelden.org/web/public/ade60220.page. (para. 4).

14 U.S. Department of Health and Human Services (1999). *Mental Health: A Report of the Surgeon General.* Washington, DC.

15 National Clearinghouse for Alcohol and Drug Information (2003), *Co-occurring mental and substance abuse disorders: a guide for mental health planning + advisory councils*, http://download.ncadi.samhsa.gov/ken/pdf/NMH03-0146/NMH03-0146.pdf.

FCFC Substance Abuse Presentation and Discussion

Joe Szoke, Executive Director of the ADAMHS Board for Montgomery County, gave a presentation to the FCFC that illustrated the costs of untreated substance abuse and its effects on children, adults, and communities. He stated that an estimated 125,800 people in Montgomery County (23% of the County's population) need services from across the AOD and mental health continuum.[16] Participants at the meeting were informed of the low availability of treatment services in our community and the significant barriers that exist for individuals seeking treatment.

A general profile of adults and adolescents seen for treatment in Montgomery County was presented and included the following: 50% had legal involvement, 8% were identified as homeless, 80% of adult females who received non-medical community residential treatment services were unmarried with children, and 60% or more were male. The County Coroner reported that in the prior three years, 23% of non-traumatic deaths had occurred from drug overdoses. In addition, two-thirds of adult arrestees and more than one-half of juvenile arrestees tested positive for at least one illicit drug. According to the ADAMHS Board, only 3% of adults receiving AOD residential treatment who access the ADAMHS Board's (publicly-funded) system have private insurance or Medicaid to pay for their residential treatment.

Treatment Works - People Recover - Recovering People Go to Work and Pay Taxes

According to the Partnership for a Drug Free America, studies indicate that treatment services reduce alcohol and drug use by 40 to 60 percent.[17] The relapse rates for other chronic diseases are the same or higher than for an addiction disorder. People need to be taught to manage this illness like any other chronic illness.

Prevention and Education

The FCFC identified that prevention efforts need to begin as early as preschool and parent education is a critical component. While it was noted that prevention is the key to impeding the advancement of substance abuse, there are an inadequate number of successful prevention programs available and funding is extremely limited.

Furthermore, children are affected prenatally by alcohol and other drugs. According to the Montgomery County Coroner's Office, most premature infant deaths result from the substance abuse of mothers. Fetal Alcohol Spectrum Disorders (FASD) are 100% preventable if the pregnant

16 Based on the State and National prevalence rates for mental health, including those with co-occurring disorders of mental health and alcohol and other drug addictions.
17 http://www.drugfree.org/Intervention/WhereStart/13_Myths_About_Drug_Abuse.

mother does not drink during pregnancy. If a child is born with FASD, however, there is no cure and there is a lifetime of effects.[18]

The attendees at the FCFC meeting also discussed the following: the widespread accessibility of drugs throughout the community; changes in society that are creating new stressors; how drugs are more dangerous than in previous years; the need for alcohol and other drug prevention and treatment; the role of schools, neighborhoods, and aftercare groups; the stigma of public attitude toward substance abuse; and the need to set indicators to measure progress. The result of these discussions was the establishment of the Montgomery County Alcohol and Drug Abuse Task Force.

ESTABLISHMENT OF THE MONTGOMERY COUNTY ALCOHOL AND DRUG ABUSE TASK FORCE

The consensus from participants at the Montgomery County Family and Children First Council (FCFC) meeting was that alcohol and other drug abuse and addiction were significant issues for Montgomery County and needed a coordinated community approach.

As a result, on May 6, 2008 the Positive Living for Special Populations Outcome Team Co-Champions, Amy Luttrell and Emmett Orr, provided the Montgomery County Board of County Commissioners (BCC) with a review of how substance abuse is affecting all FCFC outcome areas. The BCC then passed Resolution No. 08-0834 (see Appendix B), establishing the Montgomery County Alcohol and Drug Abuse Task Force, with Montgomery County Commissioner Dan Foley and Jim Pancoast, President of Premier Health Partners, named as Co-Chairs.[19]

MONTGOMERY COUNTY ALCOHOL AND DRUG ABUSE TASK FORCE'S CHARGE FROM THE BOARD OF COUNTY COMMISSIONERS

To examine the community's alcohol and other drug abuse continuum of care, and to develop findings and recommendations to create an innovative and achievable set of strategies to improve and finance enhanced prevention and treatment services for vulnerable populations in Montgomery County.

18 In early 2008, the FCFC created the Montgomery County Fetal Alcohol Spectrum Disorders Task Force that endorsed the "Not a Single Drop" message. This message indicates that all pregnant women should abstain from drinking alcohol the entire nine months of their pregnancy in order to prevent the damaging effects to the fetus caused by prenatal exposure to alcohol. Support of the "Not a Single Drop" message was also a recommendation in *The Low Birth Weight Registry—Report to Montgomery County (OH) Family and Children First Council, February 2010*—another FCFC initiative. This report also indicates that the Miami Valley region is in need of expanded substance abuse treatment options for pregnant women and women with children in their care. It is important to note that Montgomery County used to have an AOD treatment facility for pregnant women called Born Free, a Miami Valley Hospital program. This facility was closed in 2007 due to lack of funding.

19 Montgomery County Board of County Commissioners, Resolution No. 08-0834, May 6, 2008, www.mcohio.org.

The PLSP Co-Champions also met with the AOD Task Force at its first meeting on May 12, 2008 to provide the newly formed Task Force with the above background information on the need for a collaborative community-wide approach to address alcohol and other drug abuse in Montgomery County and the wide-ranging impacts of these issues.

ALCOHOL AND OTHER DRUG TERMINOLOGY

It was important to ensure that the AOD Task Force members were all speaking a common language as they proceeded through the strategic process. Therefore, in July 2008, the Task Force heard a presentation from Jim Ryan, President of Ryan Training and Consultation. The focus of this presentation was to create a foundation of knowledge regarding the entire continuum of services for alcohol and other drug use, abuse, and dependency. The learning objectives centered on increasing the Task Force members' ability to understand the chemical dependency continuum; to explain prevention, intervention, treatment and aftercare/recovery; to identify services as prevention, intervention, treatment or aftercare/recovery; and to increase their capacity to appropriately utilize the continuum of services.

Alcohol and other drug use can be a potentially sensitive topic for many individuals. Cultural factors play a distinct role in an individual's belief and value systems regarding the use of substances; what may be acceptable in one culture may be completely unacceptable in another. As a legal substance, alcohol use is even more controversial, and solutions oftentimes become all the more ambiguous. Thus, the ability to understand the difference between use, abuse, and addiction, as agreed upon by the professionals in the AOD field, was a crucial step in ensuring the AOD Task Force moved forward productively and collectively.

USE, ABUSE, AND DEPENDENCY

According to the American Society of Addiction Medicine, the term *use* is defined as consuming or ingesting a substance in medically and socially appropriate levels. The term *medically appropriate* creates a distinction that clarifies the cultural ambiguity; regardless of a culture's or society's acceptability regarding the quantity and frequency of the consumption of a particular substance, the substance consumed can have no negative health consequences in order to remain in the *use* category. Furthermore, the term *socially appropriate* creates a distinction between legal substances—such

as alcohol and prescription medications[20]—and illegal substances. Therefore, the consumption of **any** illegal substance bypasses the *use* category and immediately falls under *abuse*.

Abuse is defined as a pattern of use that can result or has resulted in medical or social problems.[21] Therefore, any social consequence that occurs as a result of the consumption of a substance—such as driving under the influence or being too debilitated to meet an obligation—is considered abuse. *Addiction* or *dependency*, on the other hand, is a primary, chronic, neurobiological disease with genetic, psychological, and environmental factors influencing its development and manifestations.[22] It is characterized by behaviors that include one or more of the following: impaired control over use, compulsive use, continued use despite harm, and cravings. It is important to note that there are current arguments within the field as to when an individual crosses the threshold from abuse to addiction and that abuse is not always an indicator of addiction.

People are typically unaware they have a biological disposition to develop the disease of addiction; exploring an individual's family history can illuminate an individual's risk. Similar to heart disease, if there is a prominent family history, the individual may be at a higher risk. In this instance, abstinence is the best option.

There are preventative recommended amounts of alcohol consumption for individuals who choose to drink. Studies show that men who consume no more than two servings of alcohol per day and women who consume no more than one serving per day have a lesser chance of contracting the disease of addiction.[23] In addition, not all substances are equally addictive in nature; some substances have stronger capacities to instigate chemical reactions in the brain. For example, methamphetamine, nicotine, and cocaine are more addictive in nature, whereas alcohol and marijuana take longer to produce addictive behavior.

Similar to other diseases, such as diabetes and hypertension, a person's chances of contracting the disease of addiction is impacted by a combination of both biological factors and behavior.

B + C = D
(Biology + Choices = Disease)

20 It is important to note that prescription medications are only considered "legal" when consumed in the quantity and frequency prescribed by a physician.
21 American Society of Addiction Medicine.
22 American Society of Addiction Medicine.
23 Gaziano et al. (1993). *Is alcohol good for your health?* New England Journal of Medicine, 329 (25), 1882-1883.

Consider this scenario: if an individual chooses to eat hamburgers and french fries every night for dinner, does that mean they have heart disease? Certainly not—but their choice to eat unhealthily will surely increase their risk of getting heart disease and their unique biology will also be a factor. This is very similar to an individual choosing to drink alcohol. Individuals who consume alcohol in an unhealthy quantity and frequency increase their chances of becoming addicted. It is also important to note that ANYONE can become addicted; this disease does not discriminate against any race, gender, or socio-economic status.

CONTINUUM OF CARE

The continuum of AOD services is exemplified in the acronym "PITA":

The following section provides more information about each point of this continuum.

Prevention

According to the Ohio Department of Alcohol and Drug Addiction Services (ODADAS), prevention is defined as follows:

> 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. It is a proactive, multifaceted, multi-community sector process involving a continuum of culturally appropriate 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 planned sequence of activities that, through the practice and application of evidence-based 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.

A variety of social factors are involved in an individual's choice to drink or use drugs. For example, teenagers face daily emotional challenges and pressure from peers. Therefore, assisting people with handling life struggles is a critical component of prevention. Providing referrals to appropriate services is also vital.

The intended audience for prevention services is *anyone who does not already have the disease of addiction*. More specifically, this general population can be broken down into three service categories that target unique populations:

- **Universal Prevention—**Targets everyone regardless of risk
- **Selected Prevention**—Targets "at risk" individuals or groups, such as the children of alcoholics
- **Indicated Prevention**—Targets individuals identified as experiencing problematic behaviors with alcohol and/or other drugs

The Center for Substance Abuse Prevention[24] has identified six prevention strategies to address the three target populations:

- **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. It also includes the dissemination of information about prevention 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/or 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, attitudes, and/or behaviors. It 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

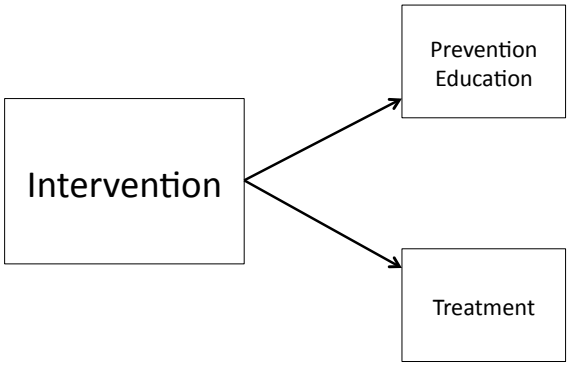
24 The Center for Substance Abuse Prevention is a division of the Substance Abuse and Mental Health Service Administration of the federal government.

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 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.

Intervention

Intervention is the point of access for all services within the alcohol and other drug continuum and focuses on preventing the progression of the problem.[25] The target audience for intervention services is *anyone*. This service is analogous to when an individual goes to their dentist to get their annual check-up; this is an intervention. If a problem is identified, the individual is referred for more services, such as filling a cavity or having a root canal. If no problems are identified, the individual is provided with prevention education—such as information about brushing and flossing—and sent on their way until the next check-up. Understandably, people do not necessarily need an annual behavioral health "check up"; however, conceptually it is similar. Intervention for AOD services includes an assessment that determines the path of services to follow. The individual either needs education to prevent future problems or they need treatment services.



The correct usage of the intervention terminology is demonstrated as intervention as a screening and assessment process. This is not to be confused with intervention as an activity, which is what most people see in the popular media—people being confronted by their family and friends because of their obvious problem with alcohol and/or other drugs. In these scenarios, the concerned group of family members and friends are attempting to "intervene" with them. This is not the proper definition of intervention within the AOD field.

Montgomery County has a centralized system for AOD assessments. CrisisCare, a division of Samaritan Behavioral Health, Inc., is the county-wide crisis and assessment service for people with mental health and/or AOD needs. Individuals entering the public treatment system must be referred by CrisisCare in order to access treatment services in the public system.

25 Ohio Department of Alcohol and Drug Addiction Services.

Treatment

Treatment is a structured process of activities designed to minimize or arrest the harmful effects of alcohol and/or other drug addiction thereby improving the individual's physical, psychological, and social level of functioning.[26] The audience for treatment is *anyone who has the disease of addiction*.

The core functions of treatment services include: screening, intake, orientation, assessment, treatment planning, counseling, case management, crisis intervention, client education, referral, report and record keeping, and consultation with other professionals. In addition, levels of care include:

- **Detoxification**—occurs before treatment is administered
- **Pre-treatment**—occurs before the addiction status
- **Outpatient**—participants live at home and engage in services
- **Residential**—participants live in a facility to receive services

Treatment providers face many challenges and many individuals do not necessarily get the services they need due to the financial cost. This is particularly true for those needing residential services, which are by far the costliest. In addition, the public's perception is that treatment does not work. Therefore, the public is often unwilling to financially support public AOD treatment services. Contrary to this belief, treatment centers on average have a fairly high success rate. In fact, high-quality treatment services equate to success rates that are higher than some chronic medical conditions, including diabetes and some forms of heart disease.[27] [28] However, when a patient with heart disease is periodically re-hospitalized for complications caused by their unhealthy lifestyle, the public does not see it as the hospital's failure. Yet, when drug addicts or alcoholics relapse, the blame is often placed on the treatment service.

The fact remains that addiction is a chronic relapsing disease and oftentimes individuals have to reach a certain place in their lives before treatment will work for them. The public does not see the success rate because individuals do not vocalize their past history for fear of stigmatization. This creates misperceptions within the general public regarding the success rate of treatment services.

Aftercare/Recovery Support

Aftercare and recovery support are defined as processes of change through which an individual achieves abstinence and improved health, wellness, and quality of life;[29] this is a vital service for relapse prevention. The targeted audience for aftercare and recovery is *anyone with the disease of addiction attempting to maintain sobriety*.

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26 Ohio Department of Alcohol and Drug Addiction Services.
27 Ohio Association of County Behavioral Health Authorities, *Behavioral health: Developing a better understanding.* 3I(8).
28 http://alcoholism.about.com/cs/relapse/a/blcaron030804.htm.
29 Substance Abuse and Mental Health Services Administration.

Individuals often differentiate *recovery support* as the medical service an individual receives after treatment and *aftercare* as the ongoing support an addict needs to prevent relapse. The most common of these services include 12-step programs such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA). Twelve-step programs offer a set of guiding principles for recovery from addiction, compulsion, or other behavioral problems. As summarized by the American Psychological Association, the process involves the following:

- Admitting that one cannot control one's addiction or compulsion;
- Recognizing a greater power that can give strength;
- Examining past errors with the help of a sponsor (experienced member);
- Making amends for these errors;
- Learning to live a new life with a new code of behavior; and
- Helping others who suffer from the same addictions or compulsions.

The 12-step concept originated from Alcoholics Anonymous. Noting the widespread use of the program and the benefits in assisting people to maintain sobriety, the 12-steps have been adapted to many other addictive behaviors. The original 12-steps from Alcoholics Anonymous are as follows:

THE TWELVE STEPS OF ALCOHOLICS ANONYMOUS[30]

1. We admitted we were powerless over alcohol—that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God, as we understood Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God, as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.

30 http://www.12step.org/references/versions-of-the-12-steps.html.

Through the 12-step process, individuals are provided a sponsor—a recovering addict or alcoholic who leads the new individual, by example, through the 12-step process. This individual acts as a mentor and friend to the individual entering the 12-step program. Alcoholics Anonymous defines a sponsor as "an alcoholic who has made some progress in the recovery program who shares that experience on a continuous, individual basis with another who is attempting to attain or maintain sobriety through AA."[31] Other 12-step-related programs include Al-Anon and Alateen. Al-Anon serves relatives and friends of alcoholics who share their experience, strength, and hope in order to solve their common problems. The only requirement for membership is that a relative or friend is experiencing alcoholism. Alateen is specifically organized for young people, typically teenagers, whose lives have been affected by someone else's drinking or other drug use. Other aftercare/recovery services include re-entry support, recovery management, and empowerment.

Enforcement and Compliance Efforts

While not a part of this continuum, it is important to include enforcement and compliance efforts in the discussion of AOD abuse and addiction. *Enforcement efforts* include those processes that enforce the laws that decrease the access and availability of illegal substances and *compliance efforts* include those processes that promote adherence to those laws. Enforcement and compliance efforts were included in the AOD Task Force process.

EVIDENCE-BASED PRACTICES

The importance of utilizing evidence-based practices in the provision of AOD services cannot be understated. According to the Ohio Department of Alcohol and Drug Addiction Services (ODADAS), consumer outcomes can be improved when AOD programs are culturally relevant and incorporate the lessons learned through science into their service delivery and continuous quality improvement strategies. Methods and strategies based on research and scientifically proven practices have been identified as producing more successful results. Moreover, service providers are being mandated more often by funding organizations to incorporate evidence-based practices into their provision of services than in the past.

31 http://12-steps-recovery.com/resources/sponsors/.

MONTGOMERY COUNTY AOD SERVICES AND SYSTEMS INVENTORY

An inventory of the AOD services and systems in Montgomery County was reviewed with the AOD Task Force in September 2008. This inventory focused on the public sector and select private providers. Although Wright State University is located outside of Montgomery County, they were included in the inventory because of their significant contributions to the AOD field and because they serve Montgomery County residents. Information was presented as aggregate data to generate thoughts and discussion. This inventory was not intended to include every single resource but to be the impetus for discussion regarding potential gaps in services.

The AOD system includes individual and small group private providers (which were impossible to account for in their entirety) as well as hospitals, law enforcement, community-based organizations, faith-based organizations, other non-profit organizations, schools (including colleges and universities), ADAMHS Board-funded providers, and other governmental entities. Many of the organizations delivering AOD services provide one or more of the following services: assessment, aftercare, research, prevention, treatment, enforcement, and compliance.

PUBLICLY FUNDED SERVICES

Local providers of AOD services receive funding from the Alcohol, Drug Addiction, and Mental Health Services (ADAMHS) Board for Montgomery County by a direct allocation of funds and/or by "pass through" funds from the Ohio Department of Alcohol and Drug Addiction Services (ODADAS). Although there is no local control over which providers receive the "pass through" funding, ADAMHS is required to monitor those contracts.

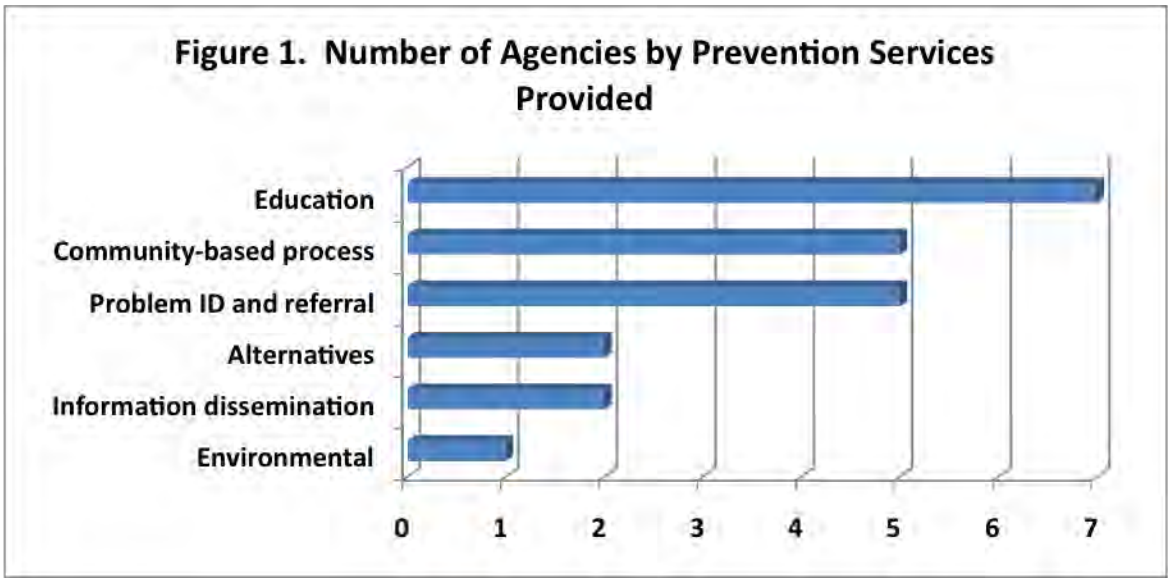
In 2008, ADAMHS monitored the services of 18 different organizations (see Table 1). Of these 18 organizations, eight delivered assessment and/or treatment services, eight delivered prevention services, and two delivered both prevention and treatment services. These services comprised 32 different programs: 16 prevention and 16 treatment.

Table 1. Montgomery County AOD Services

Organization—Program	Type of Services*
City of Kettering—Parks and Recreation	Prevention
Daybreak—Prevention Millenium	Prevention
Family Service Association—Deaflink	Prevention
Project Impact of Dayton including STAND and Youth Mentoring	Prevention
Training on Prevention Services (TOPS)	Prevention
Unified Health Solutions—Project Empower	Prevention
Urban Minority Alcoholism and Drug Addiction Outreach Program (UMADAOP) including Circle of Recovery, Elder Care, and Teen Institute	Prevention
Wright State University's School of Professional Psychology –PECE-PACT Program	Prevention
ATS Behavioral Health	Treatment
DayMont Behavioral Health Care including the Sojourner Program	Treatment
Eastway Corporation including Webster Street Academy	Treatment
Miami Valley Hospital—Turning Point	Treatment
Nova House including Women's Treatment Program	Treatment
Project C.U.R.E. including Project W.I.L.L. and HIV/AIDS Intervention Services	Treatment
RCI/Women's Recovery	Treatment
Samaritan Behavioral Health—CrisisCare	Treatment
Public Health–Dayton & Montgomery County—Center for Alcoholism & Drug Addiction Services (CADAS) and HIV Prevention Services	Both
Wright State University—Consumer Advocacy Model (CAM)	Both

*Treatment = assessment and/or treatment

Figure 1 below illustrates how many agencies identified as prevention providers in Table 1 delivered each type of service.



Education is the most frequently utilized prevention service by agencies receiving public funds. Community-based process and problem identification and referral are two other strategies frequently utilized in Montgomery County. Less frequently used strategies include alternatives, information dissemination (through billboards, printed materials, media spots, etc.), and environmental strategies.

The following assessment and/or treatment services were delivered to Montgomery County residents in state fiscal year 2007 by the 10 agencies identified in Table 1 as treatment providers:

Table 2. Numbers Served by Service Category

Service	No. of Agencies	No. of Unduplicated Individuals
Case management	9	6,102
Group counseling	9	3,331
Individual counseling	9	3,609
Lab urinalysis	8	1,571
Medical somatic	5	886
Urine dip screen	4	1,157
Assessment	3	4,924
Residential treatment, Non-medical	3	736
Crisis intervention	1	49
Intensive outpatient	1	166
Methadone administration	1	660
Residential treatment, Medical	1	62

While case management was utilized to serve the most people needing AOD treatment services, this number may actually represent very little time spent with an AOD client. In fact, one study identified that the majority of individuals (60%) received an hour or less of this service.[32] Group counseling and individual counseling are also utilized for many individuals. These and other community-based services are utilized more than all residential services, perhaps due to limitations in insurance coverage or other funding.

Also in the public sector, CrisisCare, a division of Samaritan Behavioral Health, Inc., is the county-wide, centralized, crisis and assessment service for people with mental health or drug and alcohol needs. Individuals must have a referral from CrisisCare in order to access treatment services in the public sector. For more information on the centralization of assessment services in Montgomery County, see appendix C.

EDUCATIONAL INSTITUTIONS

Schools are another source of prevention services. All 16 K-12 public school districts, the regional career technology center, and 24 charter schools in Montgomery County were surveyed in the Fall of 2008 about the AOD prevention and education services they provided. Responses were received from staff in 14 (82.4%) school districts and two (8.3%) charter schools. The results indicate:

- All (100%) respondents incorporate a "no use" message into student policies and procedures, such as the student handbook.
- D.A.R.E. is offered in more than half (57%) of the responding school districts.[33]
- Three-quarters (75%) of the responding school districts participate in AOD awareness programs other than D.A.R.E.
- Just over half (56%) of the respondents reported using an evidence-based AOD prevention curriculum.
- Less than half (43%) of local school districts employ a Safe and Drug Free Schools Coordinator.

Survey responses also indicated that 14 of the school districts received funding through Safe & Drug Free Schools and Communities (SDFSC), referred to as Title IV. This funding is a part of the No Child Left Behind legislation to support programs that prevent violence in and around schools and/or prevent the illegal use of alcohol, tobacco, and other drugs (ATOD). School districts have discretion over the use of their SDFSC allocation—they may choose to spend it on violence prevention, ATOD prevention, or a combination of the two. However they choose to use this funding, programming must meet principles of effectiveness developed by the U.S. Department of Education. (Note: President Obama's fiscal year 2010 budget eliminates the Safe & Drug Free Schools and Communities grants to states which were funded at $294.8 million in FY 2009.

32 Rapp, R. (2009). *Final Report from the Inmates who Use Jail Services Extensively Study*, Wright State University Center for Interventions, Treatment, and Addictions Research.

33 The Drug Abuse Resistance Education program, commonly known as D.A.R.E., is delivered by law enforcement officers in K-12 schools.

Instead, he proposes adding $100 million to the National Programs portion of SDFSC for competitive grants to state educational agencies.)

AOD prevention among student populations is not limited to the K-12 educational system. A 2008 survey conducted on behalf of the Task Force found that Sinclair Community College, Wright State University, and the University of Dayton delivered 16 prevention programs to their students. Most (88%) of these prevention services involved education and nearly half (44%) included problem identification and referral.

In addition, these institutions of higher education provided seven treatment programs and one aftercare program. The treatment programs included screening, assessment, outpatient treatment recovery support, medication management, case management, crisis services, and Integrated Dual Diagnosis Treatment (IDDT).

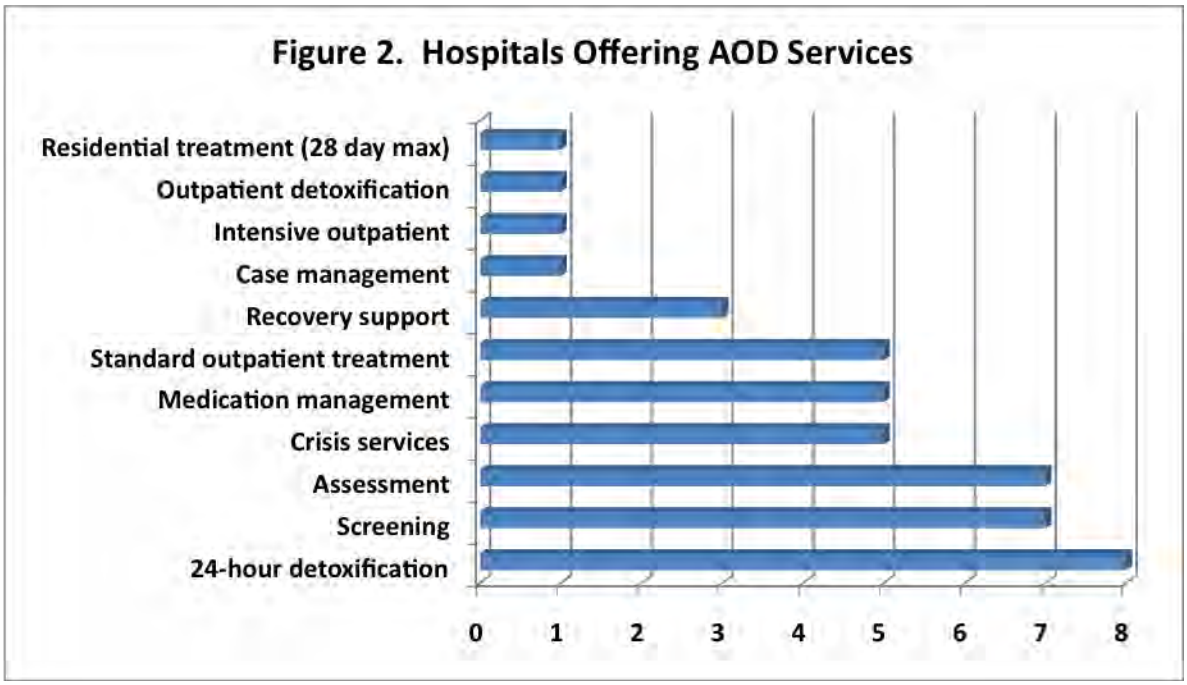
Finally, research about alcohol and other drugs is conducted by local universities. Wright State University is involved in five different research services:

- Ohio Substance Abuse Monitoring (OSAM) Network
- Dayton Area Drug Survey (DADS)
- State Epidemiological Outcomes Workgroup
- Wright Health Study
- Reducing Barriers to Drug Abuse Treatment Services

Wright State also provides consultation and evaluation services through its Center for Interventions, Treatment, and Addictions Research (CITAR). The University of Dayton does the same through the Business Research Group.

HOSPITALS

Figure 2 illustrates how many of the 12 hospitals and medical centers in Montgomery County deliver AOD treatment services, by service modality.



In addition, two hospitals provide prevention education and one provides aftercare services.

NON-PROFIT ORGANIZATIONS

Other non-profit organizations not funded through the ADAMHS Board include Addictions Resource Center, South Community Behavioral Health Care, Spirit of Peace Community Development Corporation, and Southern Ohio Rehabilitation and Treatment Services (Volunteers of America, Ohio River Valley affiliate). One of these organizations is involved in prevention (specifically, enforcement efforts and indicated prevention); the others are treatment providers.

Community-based groups and faith-based organizations are other entities involved in the fight to prevent AOD abuse and addiction as well as support those in recovery. The South Suburban Teen Alcohol and Other Drug Abuse Prevention Coalition focuses on education, alternatives, and environmental prevention services while the Dayton Area Prevention Alliance offers a network for AOD prevention professionals to enhance their awareness of community resources. The Northwest Dayton Weed and Seed Program is coordinated through the Spirit of Peace Community Development Corporation and focuses on AOD enforcement (weed) and other prevention activities (seed).

A myriad of places of worship and other faith-based organizations provide residents with aftercare services, primarily 12-step programs—the most common aftercare service in Montgomery County. In Montgomery County, there are 189 AA programs in 72 locations, 39 NA programs in 24 locations, 20 Al-Anon programs in 16 locations, and one Alateen program.

GOVERNMENTAL ORGANIZATIONS

Some governmental organizations are involved in services to prevent and treat AOD abuse and addiction. Montgomery County Court of Common Pleas offers more than one program to address drug and alcohol abuse. The Secure Transitional Offender Program (STOP) is a 40-45 day indicated prevention program focusing on educational activities serving up to 42 male residents. In addition, the Adult Probation Department runs a Chemical Offenders Program that offers intensive outpatient drug and alcohol intervention to chemically dependent offenders three days a week. A client can be sanctioned to complete the Chemical Offender Program directly by the court or by the Probation Department as a violation of probation for usage of an illegal substance or for the abuse of alcohol.

The MonDay Community Based Correctional Facility delivers a chemical dependency treatment program and refers residents who successfully complete the program for aftercare services in the community. The Juvenile Court's Reclaiming Futures program focuses on helping teens with alcohol or other drug-related criminal charges to turn their lives around through interventions with youth and their families. East Dayton Weed and Seed is coordinated through the Sunrise Center and concentrates on AOD enforcement (weed) and prevention (seed).

Of the 31 law enforcement agencies in Montgomery County[34], 25 supplied information about their enforcement, compliance, and prevention activities in response to a survey conducted by the AOD Task Force in 2008. Seven of these agencies delivered educational programs, including D.A.R.E. Enforcement activities by category included permit holder checks (19 agencies), under-age sales programs (15), undercover narcotics investigations (20), DUI checkpoints (14), and narcotics trained sniffing dogs (7). Other enforcement and compliance activities included:

- DUI saturation patrols
- Montgomery County OVI (Operating Vehicle Intoxicated) Task Force
- Ohio Department of Public Safety High Visibility Traffic Enforcement

34 Includes Ohio State Highway Patrol and law enforcement departments from the Dayton Airport, Five Rivers MetroParks, Sinclair Community College, and the University of Dayton.

- Highway drug interdiction using K-9 officers
- Drug eradication conducted by organized crime unit
- Narcotics sweeps with K-9's at high schools and middle schools
- Traffic grants from the Governor's office for the enforcement of alcohol-related driving offenses
- Open container law violations and possession/use of narcotics on school property and adjacent streets
- Collaboration with neighboring jurisdictions

PRIVATE PROVIDERS

Also not funded by the ADAMHS Board are private providers such as social workers, counselors, psychiatrists, and psychologists who have a specialty in substance abuse and addiction. During the August 2008 inventory conducted by the AOD Task Force, almost 200 private providers were identified in Montgomery County. Services provided by these professionals include both mental health and AOD services.

CERTIFIED/LICENSED PROVIDERS

In addition to the local private providers, there were over 300 AOD professionals in Montgomery County in 2008. Data on these providers is available from the Ohio Chemical Dependency Professionals Board (OCDPB), the administrative entity responsible for the oversight of AOD certifications and licensures in the state of Ohio. There are two prevention professional certifications and four levels of treatment licensure:

- Ohio Certified Prevention Specialist I (OCPS I)
- Ohio Certified Prevention Specialist II (OCPS II)
- Chemical Dependency Counselor Assistant (CDCA)
- Licensed Chemical Dependency Counselor II (LCDC II)
- Licensed Chemical Dependency Counselor III (LCDC III)
- Licensed Independent Chemical Dependency Counselor (LICDC)

According to OCDPB, there were 17 certified AOD prevention professionals and 293 licensed treatment professionals in 2008. Of the 293 licensed treatment providers, 223 provided services in Montgomery County. These services are provided in a variety of venues, the largest of which is through the public system funded by the ADAMHS Board. Other sectors include corrections, faith-based, government, hospitals, non-profits, private sector, secondary schools, and universities.

DRUG-FREE WORKPLACE PROVIDERS

Clearly, most of the AOD services identified are intended to make our neighborhoods and schools safer places to live and learn. Places of employment are also environments in which considerable time is spent by many Montgomery County citizens. Therefore, it is important to ensure workplace safety and health in all types of organizations. According to the U.S. Department of Labor, a comprehensive drug-free workplace program includes five components:

- Drug-free workplace policy
- Supervisor training
- Employee education
- Employee assistance
- Drug testing

ODADAS identified eight such workplaces in Montgomery County in 2008:

- AmCare, Inc./Doctor's Urgent Care Office
- Dayton Area Chamber of Commerce
- Good Samaritan Hospital
- JM & DM, Inc.
- Kettering Worker's Care—Dayton and Huber Health Center
- Lowex, Inc.
- The Ohio Intervention Center
- Wright State Physicians—Consumer Advocacy Model

A summary of all Montgomery County services, by service category is illustrated in Table 3.

Table 3. Montgomery County AOD Services by Service Category

Type of Organization	No. of Programs Inventoried in this Report		
	Prevention (Including Enforcement)	**Treatment** (Including Assessment)	**Other**
ADAMHS funded (includes ODADAS "pass through" funding)	16	16	--
K-12 School districts	*14 or more	--	--
Colleges / Universities	16	7	1 Aftercare; 7 Research
Community-based	3	--	--
Faith-based	1	--	**Aftercare
Hospitals	2	8	3 Recovery Support
Other Non-profits	2	1	--
Governmental: law enforcement	*25 or more	--	--
Governmental: courts, jail/prisons	3	2	--
Governmental: community	1	--	--
Total	**at least 83**	**34**	**at least 11**

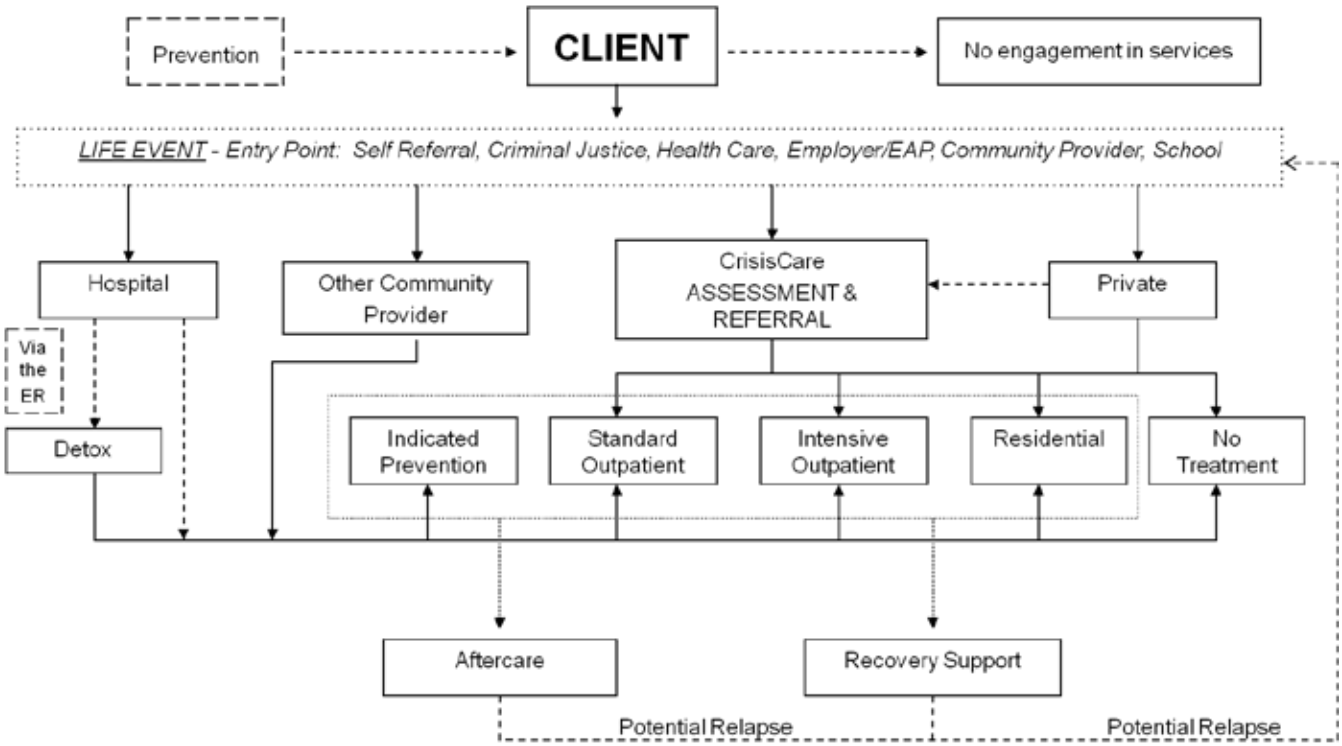
*Survey responses were less than 100% of the total in Montgomery County.
**Exact figures not available.

As evident by the preceding section, there are a multitude of providers offering a variety of AOD services in Montgomery County. While glaring gaps in services along the continuum were not identified through this inventory process, it became evident to the AOD Task Force that far too often these services are being delivered in isolation without a coordinated approach or effort. The intention of the AOD Task Force is to break down barriers between systems and move the community towards implementing collaborative solutions.

ACCESSING AOD SERVICES IN MONTGOMERY COUNTY

Rarely does a person choose to seek treatment for no apparent reason. That decision is typically due to a significant life event that occurs as a result of the person's addictive behavior (e.g., getting fired from a job, having a spouse leave them, having a brush with the law, etc.). Regardless of the reason an individual chooses to seek treatment, there are multiple entry points into the AOD system for services. Figure 3 illustrates the various paths individuals may take to access the AOD system when needing treatment services.

Figure 3. AOD Point of Access Flow Chart



According to ODADAS, there were more than 87,000 referrals made to Ohio AOD treatment services in state fiscal year 2007. This is compared to the 10,480 referrals that were made to Montgomery County AOD treatment services. Montgomery County referrals to AOD services were approximately 12% of all referrals in the state while the population of Montgomery County is approximately 4.65% of the state population, indicating a disproportionately high number of AOD referrals for Montgomery County.[35] During that time, Montgomery County residents were more likely than residents of the rest of the state to be referred for AOD treatment services by mental health providers and community providers while being less likely to make a self-referral or to be referred by an AOD provider as indicated in Table 4.

35 American Community Survey, 2008 (One Year Estimates).

Table 4. Percentage of Montgomery County AOD Referrals Compared to Ohio AOD Referrals

	State of Ohio		Montgomery County	
Referral Source	**No. of Referrals**	**% of Total**	**No. of Referrals**	**% of Total**
Criminal justice	39,368	45.8%	4,576	43.7%
Self-referral	23,880	27.2%	2,476	23.6%
Health care provider	8,984	10.2%	1,152	11.0%
Other AOD provider	5,221	5.9%	363	3.5%
Other community provider	5,116	5.8%	1,256	12.0%
Mental health provider	3,253	3.7%	505	4.8%
Dual provider	760	0.9%	122	1.2%
School	742	0.8%	24	0.2%
Employer or EAP	479	0.5%	6	0.1%
Totals	87,803	100.0%	10,480	100.0%

As we begin to look at these numbers, it is important to remember that these services are not unduplicated. Rather, these numbers represent the number of admissions, which means a single individual could have entered treatment more than once within FY 2007. This is important to note considering the chronic, relapsing nature of addiction; individuals often participate in several treatment episodes in their attempt to attain and maintain sobriety. Also, the referral numbers are only inclusive of those providers in the public system, and therefore, do not include individuals who obtained treatment services from a private organization or individual.

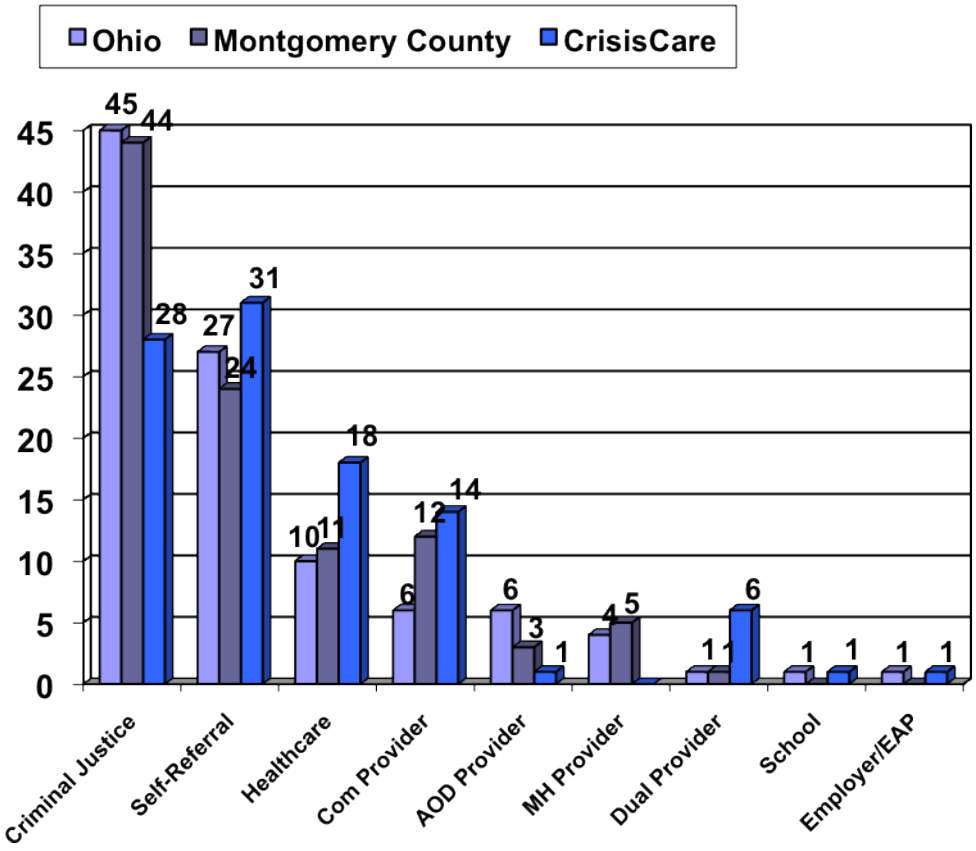
Of the 10,480 referrals made to treatment services, CrisisCare received a total of 5,537 referrals in 2007 from the following organizations:[36]

- Self-referral 31%
- Criminal Justice 19%
- Health Care Providers 18%
- Other Community Referrals 14%
- Juvenile Courts 9%
- Dual Providers 6%
- Schools 1%
- Other AOD providers 1%
- Employers 1%

36 Ruth Addison, Director of CrisisCare, presentation to the AOD Task Force on November 3, 2008.

Figure 4 depicts a comparison of the State of Ohio, Montgomery County, and CrisisCare regarding the percentage of referrals made to treatment services.

Figure 4. Comparison of Referral Sources for AOD Treatment, in Percentages, 2007



In September and October 2008, representatives from hospitals, other non-profit providers, ADAMHS-funded agencies, and private providers presented information about accessing AOD treatment services from their individual perspective. The following information provides a summary of that discussion.

HOSPITALS

Many individuals with AOD issues enter the hospital system via the Emergency Departments, either in need of detoxification or with one or more medical diagnoses in addition to their substance abuse and addiction. This provides an opportunity for the hospital to assist these individuals in accessing and becoming engaged in treatment services. Detoxification services (hereafter "detox") are available in every hospital in Montgomery County as a byproduct of providing emergency room services. Dr. Doug Teller, from Kettering Medical Center Network, noted that one in five people (20%) involved in emergency medical cases has an AOD-related health concern. The Task Force identified

that Emergency Departments frequently turn people away when they need detox services; this is a concern they agreed to address during the Task Force implementation process.[37]

It was noted by the hospital representatives that hospital workers typically do not have access to critical information, nor the capacity to provide extensive services, necessary to properly serve this population. For example, appropriate treatment services require access to the patient's treatment history; hospitals typically do not have access to this type of information. In addition, working with "extenders" is necessary—the individual's family, friends, employer, and faith community—in order for individuals to attain and maintain sobriety. Hospital systems are not always designed to fulfill this service.

Recently, Kettering Medical Center received an SBIRT (Screening, Brief Intervention, and Referral to Treatment) grant from the Substance Abuse Mental Health Services Administration. SBIRT involves screening individuals with, or at-risk for, substance use-related problems. Screening determines the severity of substance use and identifies the appropriate level of intervention. The system provides brief interventions within the community setting and motivates and refers those identified as needing more extensive services to a specialist setting for assessment, diagnosis, and appropriate treatment.[38] In Dr. Teller's role, the intent is to educate residents with the hope that they will implement this knowledge in their future practices. Educating physicians on the different AOD systems available for client referrals (including proper screening and AOD assessment) is ultimately important if physicians are to perform this role.

The Dayton Veterans Affairs (VA) Medical Center facility is the third oldest in the United States. All 72 VA centers in the U.S. provide AOD services. The VA manages four hospitals in Ohio—Chillicothe, Columbus, Cincinnati, and Dayton—including four additional clinics in Dayton, Indiana, Lima, and Springfield. Currently, all veterans are assessed for alcohol and other substance abuse. The local VA has five different services in their Substance Abuse Treatment Program (SATP). For dual diagnosis cases, they have an eight-week program with 20 beds. Outpatient treatment services are provided for 12-26 weeks.

The VA has a care model of change that is dependent upon engaging the consumer based on their individual needs. They have AOD and Suicide Coordinators to assist patients immediately; there is no wait period for these services. Additionally, a 12-week Saturday group is available to provide education to those interested in learning about substance abuse-related issues. The ongoing struggle is motivating patients who are still unsure if they want to address their substance issues. Therefore, the VA provides AOD education regardless of where the patient is with this decision.

The VA is federally mandated to track veterans participating in any AOD service. They follow the veterans for 30-60 days to monitor the veterans' access of needed services. VA staff conduct home

37 A Detox Subcommittee was later formed by the AOD Task Force to address this issue, as well as other detox-related issues.
38 http://sbirt.samhsa.gov/about.htm.

visits for 30 days and follow-up phone calls for 30 additional days. Educational groups are available for family members, including children; however, treatment-specific services are primarily for the veterans.

The Dayton VA currently has two beds devoted to ambulatory detox. This program is monitored by three staff and averages two patients per week. Detox services are provided for 7-12 days depending on the physician. This is provided at a reduced cost compared to intensive detox services. The VA maintains a continuum of care from detox to treatment so there is no interruption of services for the patient.

A dialogue is needed to educate the medical community on services offered to veterans through the Dayton VA. The majority of the veterans end up at hospital emergency rooms without knowledge of the services they can receive at the VA. It would be advantageous to have a facilitated transfer from the hospital to the VA without creating a delay in services.[39] Sometimes this can be facilitated with the use of a VA triage nurse who will work to ensure this is expedited. Police officers can also transport veterans to the VA.

ADAMHS-FUNDED AGENCIES

CrisisCare of Samaritan Behavioral Health, Inc. is the county's central intake system for diagnostic mental health and AOD assessments. The admission process starts with clients calling to make an appointment. They are scheduled for their intake appointment within seven (7) calendar days. Walk-in appointments are available Monday through Friday. Priority populations, which include pregnant females, individuals within the child protective system, IV drug users, and individuals referred through drug courts (among others), are mandated by law to receive services within 48-72 hours. CrisisCare therapists also go into the community to school systems, hospitals, Juvenile Court, the County Jail, Montgomery County Department of Job & Family Services–Children Services Division, County probation departments, and the Samaritan Homeless Clinic.

ODADAS and the Ohio Department of Mental Health have developed a standardized diagnostic instrument which is required for agencies to obtain and maintain certifications. During the evaluation process, issues are determined and appropriate interventions are applied. The length of the assessment is two-to-three hours and assists with determining the appropriate level of care needed.

39 This later became a recommendation from the Detox Subcommittee.

Steps within the assessment process include the following:

- Intake/registration
- Medical clearance by nursing staff
- Therapist/psychiatric evaluation (if deemed clinically appropriate)
- Level of care determination—a service level is recommended, a referral goes to the provider agencies, and an appointment is scheduled

PRIVATE PROVIDERS

While the public system is available for people without private insurance, private providers deliver services to those who do have insurance coverage. However, many people do not understand their insurance policy or know what AOD services are covered. Employees can consult their employer's human resources department, but many don't for fear of being stigmatized. Employees often don't want their employers to know they are struggling with alcohol or other drug issues because they are scared of being reprimanded or terminated.

Private insurance is not without limitations. Clients are prohibited from obtaining services that are not in-network. Residential AOD services are no longer covered by most insurance policies. Typically, insurance policies will only cover 6-12 outpatient sessions; this is counterproductive for individuals diagnosed with an addictive disorder because AOD addiction is a chronic disease that requires ongoing services. Moreover, deductibles are a barrier for those looking for private services and many private insurance providers do not cover AOD services at all.

Some people go directly to CrisisCare by pretending they don't have insurance to receive services for free. Many private practices are now refusing to accept insurance and are forcing individuals to pay out of pocket. The Task Force identified the benefits of the private and public agencies working together to overcome these barriers.

DATA COLLECTION

In order to move forward in an educated and productive manner, the AOD Task Force knew they had to secure the most up-to-date, accurate, and local data regarding AOD issues in Montgomery County. They would be remiss in moving forward haphazardly by using faulty or outdated data or assuming that state or national data pertain to our local community.

Therefore, in order to obtain critical information on community trends and data, the services of local researchers were secured to support this effort. By utilizing data-driven methodologies, these contracted services resulted in three individual reports:

- The Montgomery County Substance Abuse Needs Assessment: Phase One
- The Montgomery County Substance Abuse Needs Assessment: Phase Two
- The Inmates Who Use Jail Services Extensively Study

Information extrapolated from these reports was utilized by the AOD Task Force for decision-making purposes. The history and results of these studies are summarized below.

The Montgomery County Substance Abuse Needs Assessment Reports

Led by Dr. Richard Stock, the University of Dayton's Business Research Group was responsible for conducting a community-wide needs assessment through the use of data collection, key informant surveys, social indicators, and case studies. This study was ultimately divided into two reports:

1. **Phase One**—Compiles data from external sources and presents it in a usable format that paints a picture of the impact of alcohol and other drugs on Montgomery County. See Appendix D for the full report.
2. **Phase Two**—Consists of information extrapolated from a series of interviews conducted with "front line" workers—those professionals who are confronted by the impact of alcohol and other drugs daily. See Appendix E for the full report.

MONTGOMERY COUNTY SUBSTANCE ABUSE NEEDS ASSESSMENT REPORT: PHASE ONE

The ***Phase One Report*** traces the geographic and socioeconomic patterns of substance abuse in Montgomery County over the last decade. The focus is quantitative and utilizes a framework suggested by W.E. McAuliffe et al.[40] The framework suggests that "treatment need" can be measured for a local area using archival data where "treatment need" is defined as "requiring professional help or care to recover from an alcohol or controlled drug use disorder." Certain outcomes are used as proxies for treatment need because they help define the extent of those needing treatment. The measures used in the report are:

1. Drug and alcohol-related mortality rates
2. Drug and alcohol-related emergency room treated and released discharges
3. Drug-related offenses (possession and sales) and alcohol-defined offenses for adults and juveniles

In addition, the outcome-based measures are supplemented by additional survey and school-based data that provide additional insight and comparatively place Montgomery County's issues in a national perspective. This information was presented to the Task Force in two segments: 1) Adults and 2) Juveniles. Significant findings are listed below in no particular order and are specific to Montgomery County:

Adult Drug-Related Data:

- Arrests for drug trafficking are highly concentrated by zip code; 45406 has almost double the number of drug trafficking arrests compared to the next two highest zip codes.
- Arrests for possession of drugs are also highly concentrated by zip code centering mostly in the urban communities of Dayton.
- Arrests for manufacturing drugs are infrequent and occur across a broad spectrum of zip codes across Montgomery County.
- There have been substantial changes in the pattern of all AOD-related arrests over the last seven years demonstrating a considerable "urban sprawl" effect—a clear distinction of movement from the urban core outwards and into the suburban communities.
- The City of Dayton has seen a significant increase in narcotic offenses over the last seven years.
- Opioid abuse has a distinct pattern relative to cocaine abuse with a higher incidence on the east side of the city than on the west side and a more dispersed pattern with respect to overall incidence.
- Emergency room (ER) visits illustrate a picture of abuse/dependency consequences not captured through local law enforcement. Cocaine-related ER visits are visible over a wide range of zip codes throughout Montgomery County.

40 William E. McAuliffe, Ryan Woodworth, Caroline (Hui) Zhang, Ryan P. Dunn, *Identifying substance abuse treatment gaps in substate areas*, Journal of Substance Abuse Treatment, 23 (2002), 199– 208.

- All drug-related ER visits provide a visible indication of how widely spread drug-related health issues are across Montgomery County.
- Drug-related deaths are primarily centered in the urban core of Dayton suggesting that the affected suburban communities have not yet experienced this ultimate consequence of abuse and dependency. This may suggest that these communities are in an optimal position for highly targeted prevention or intervention efforts.

Adult Alcohol-Related Data:

- Montgomery County has a slightly lower reported use of alcohol than the country as a whole and substantially lower reported use than other Ohio urban counties.
- Montgomery County has a slightly higher rate of heavy drinkers than the country as a whole and comparable rate of heavy drinkers than other Ohio urban counties.
- Montgomery County has a slightly lower rate of binge drinkers than the country as a whole or the other Ohio urban counties.
- Alcohol-related ER visits have a pattern similar to that for opioid abuse with a higher incidence on the east and northeast side of the city of Dayton than on the west side. The overall incidence of alcohol-related ER visits is similar to that of other drugs of abuse.
- Deaths attributed to alcohol show a pattern similar to alcohol-related ER incidences suggesting the long-term nature of the geographic pattern of alcohol abuse and dependence.
- Montgomery County has a higher alcohol-related mortality rate compared to other Ohio urban counties which is not explained by its high rates of poverty or its proportionally larger African American population.

Juvenile Drug-Related Data:

- There are substantial differences between juvenile arrests for drugs compared to adults with Miamisburg and Huber Heights being roughly equal to numbers seen in the inner city zip code with the highest number of arrests (45406).
- While cocaine use and possession are highly concentrated in minority zip codes there is some evidence of juvenile use across the suburban counties.
- A juvenile African American male is 22 times more likely to be involved with a Juvenile Court incident for cocaine use or possession than a juvenile white male.
- Juvenile marijuana use is highly spread across zip codes with the highest numbers found in Huber Heights and in the southwestern tier of the county.
- A juvenile African American male is 1.74 times more likely to be involved with a Juvenile Court incident for marijuana use or possession than a juvenile white male.
- The number of cases with drug-related symptoms showing up in the ER for 10 to 19 year olds is relatively small. In contrast to Juvenile Court cases which document extensive use in lower income minority neighborhoods (with the exception of Huber Heights), ER treat and release cases for drug-related symptoms have a higher number in moderate and upper income tracts. Minority adolescents do not present to the ER with drug-related symptoms as often as their non-minority counterparts.

- The incidence of juvenile cases for disorderly conduct while intoxicated is linked to both race and income; incidence is highest in white low-income urban areas and in rural areas.
- In contrast, juvenile offense data on driving under the influence indicates a different pattern. Low-income youth with no transportation are unlikely to come to the attention of authorities in this regard while lower-middle income youth (Miamisburg, Huber Heights, and parts of Kettering) with access to transportation are.
- Similar to Juvenile Court cases for disorderly conduct, lower-middle income juveniles (Huber Heights, Moraine, and Miamisburg) are towards the top in highest numbers of alcohol-related ER treat and release cases for 10 to 19 year olds, although these numbers are relatively small.

MONTGOMERY COUNTY SUBSTANCE ABUSE NEEDS ASSESSMENT REPORT: PHASE TWO

The ***Phase Two Report*** differed from its predecessor in that it assessed the gaps and barriers to service with respect to substance abuse and dependency in Montgomery County through a series of one-on-one interviews. The methodology employed was to ask knowledgeable people involved in the legal and treatment aspects of substance abuse in Montgomery County to discuss their perceptions of gaps in service, barriers to service, and how they would prioritize finding solutions to the gaps they identify. Where services were being provided, information was sought on outcomes associated with that service. This report attempts to accurately reflect what was learned in those conversations and in the course of analyzing data associated with those interviews. During the interviews, Dr. Stock asked for "proof," or quantitative measures, from individuals to verify that what they were saying was true.

Each of the observers interviewed had a view from their particular perch in the system. One way to think about gaps in service is to think in terms of what occurs at those points where intervention *might* occur and then differentiate between what services occur or do not occur at each of those possible points of intervention. This is, in fact, what observers do from their particular perch. Four points of intervention were examined:

1. At the point where a person seeks help from the public sector within the substance abuse service system
2. At the point where someone has been arrested for a crime
3. At the point where the public system attempts to mandate or encourage treatment either through the public or private system of care
4. At the point where a person leaves public sector treatment

The following summarizes the main points from those interviews.

Centralized Intake at CrisisCare

In determining gaps in the service system, one must evaluate services provided by CrisisCare. Data captured in the *Phase Two Report* speaks to the interviewees' feedback regarding the current status of this system.

Almost half of the population that initiates contact with CrisisCare does not make it to their scheduled appointment and is not identified as returning in the immediate future. This data excludes those appointments made at a satellite office (including the Montgomery County Jail and the Samaritan Homeless Clinic) and those individuals who are court-escorted to their appointment. There was not much variation between gender, race, geography, priority code, or abuse/dependency. However, certain groups have disproportionately higher missed/never show rates, including: African Americans, females (mostly related to childcare issues), young individuals (ages 18 to 20), crack cocaine users, homeless persons, inmates, those with part-time employment, those with higher arrest rates, those being discharged from a hospital, and those residing in certain geographies. Alternatively, a higher follow-through rate was correlated with mandatory referrals, such as treatment in lieu of conviction court programs.

Additionally, only 39% of those who initially call CrisisCare show up to their first appointment with the treatment provider. There are special populations in which central intake created more obstacles, such as with youth and the deaf population. Some interviewees indicated that a much more aggressive outreach strategy is necessary; clients should be actively sought out. Some felt there are reasons to reconsider, or redesign, the entire central intake system.

Driver Intervention Programs (DIPs)

Driver Intervention Programs, most often offered to DUI offenders, provide an opportunity to target potential clients and persuade them to seek further treatment opportunities. However, not all DIPs are the same—some provide clinical assessments (such as the Weekend Intervention Program at Wright State University) while others provide only the state-required screen. Comprehensive assessments are preferable because it differentiates between those who need formalized treatment services and those who do not; this method provides a more effective intervention.

Some interviewees felt that the courts do not take full advantage of DIPs and ignore the potential to influence behavior at this critical juncture. The Kettering Courts were singled out for praise in their use of information from DIPs. Furthermore, clients who are fully engaged in the DIP leave the program feeling motivated to change harmful behaviors. Those clients with private insurance often discover that their insurance does not cover ongoing treatment sessions and they are, therefore, left without any follow-up or continuing support.

Public Intoxication

Police and other interviewees have voiced their complete frustration about the lack of a detox center in Montgomery County. There were 11,818 arrests for public intoxication between 2006 and 2008. These individuals are no longer accepted at the County Jail, emergency rooms are only an option if they have a medical condition, and homeless shelters are inappropriate in most cases. If officers were to release these individuals back to their homes (or to a friend or family member's home), they could harm themselves or others. At this time, however, there simply is nowhere else to take them.

Private Insurance

Individuals with private insurance have a great deal of difficulty in obtaining the duration and frequency of treatment sessions they need. There has been a significant decline since 2003 in private health insurance's coverage of substance abuse treatment. Private insurance often does not pay for the appropriate number of treatment sessions that individuals need to attain sobriety. Some interviewees indicated that it's much easier for people without insurance to access treatment services because they have access to the public sector. Private providers have indicated a sense of guilt when they are forced to develop treatment plans for fewer sessions than what they know the person actually needs. Nonetheless, they must adhere to the number of sessions the insurers will cover and individuals end up incurring exorbitant out-of-pocket expenses. Consequently, the public sector increasingly has become the primary funding for substance abuse treatment.

Treatment

Interviewees expressed their concern regarding the lack of residential treatment options. These options are currently limited to what the reimbursement system will allow and *not* driven by what's in the best interest of the client.

Additionally, providers expressed their frustration over the excessive amount of paperwork they must complete indicating that 30 to 40 percent of their time is spent on paperwork. This takes time and dollars away from prevention and treatment services. There are a variety of views regarding the fundamental problem of paperwork—some blamed the federal and state governments. Reducing duplication between systems could ease some of the burden and produce substantial benefits from using these resources more efficiently.

Interviewees also noted that there were obstacles to conducting sound program evaluations. Consequently, providers measure whether or not their program is maintaining fidelity to evidence-based models and not whether their clients achieve outcome-based measures. Furthermore, collecting evaluation information is not a billable service placing the burden of time onto the providers.

Integration of treatment-in-lieu-of-conviction clients into group therapy has created difficulty for some providers. Many of these clients are at a pre-contemplative phase and integrating them with others who are further along in their recovery process creates challenging group dynamics.

Aftercare

Interviewees identified the critical aftercare, recovery, and support issues that need to be addressed particularly as they relate to employment, housing, and other self-sufficiency supports. Individuals who complete their treatment sessions leave feeling motivated and then are faced with the burdens of having no job or home.

There was also agreement among interviewees that aftercare programs are needed to supplement the formal treatment sessions. The literature supports the benefits of 12-step programs; it also says that programs are more successful when they are on-site. Most treatment programs accessing community support groups show significant evidence that support groups make a difference. However, there is an uneasy relationship between the courts and 12-step programs. Traditional aftercare services focus on getting linked to a mentor/sponsor and attending group sessions. Some observers noted that clients often report that the groups were "not very believable" and people were just "collecting their tickets"—this is the typical method by which mandated clients verify their attendance. A lack of 12-step program sponsors was another identified gap.

Opiates

Local police data, as well as data from the coroner's office, show a huge surge of heroin-related crimes from 2007 to 2008 across all sectors of the community. The true impact that opiates are having in our county is most easily captured by noting the dramatic increase in the number of opiate users accessing treatment services at Project CURE. Project CURE is a non-profit drug rehabilitation program that provides professional drug rehabilitative and support services and is Montgomery County's primary methadone administration clinic.

Despite efforts to make the process more efficient, the line of people awaiting services stretches out the door on a daily basis. The Director noted that "three to four years ago Project CURE was seeing between 350 and 400 clients a day; that number is now up to 700 a day."[41] He went on to note estimates from the Montgomery County ADAMHS Board that only 17% of opiate abusers

41 Virgil McDaniel, 2009, as quoted in *Montgomery County Substance Abuse Needs Assessment: Phase II*.

in the area are accessing services. Interviewees felt this was particularly true for adolescents and those with co-existing medical conditions. At this point, Project CURE and the Dayton Veterans Administration are the only methadone programs in Montgomery County.

Opiates account for 68% of individuals' "primary drug of choice" upon seeking treatment in Montgomery County.[42] Compared to the remainder of the state, including counties of comparable size and demographic, Montgomery County appears to be faring the worst. In fact, of the 88 counties in Ohio, Montgomery County ranks #1 in the average annual rate of unintentional prescription drug poisonings.[43] This data shows that between 2000 and 2007, Montgomery County experienced 532 deaths as a result of unintentional drug poisonings of this nature. This is almost three times more than the next highest ranked county and 2½ times higher than the State's rate.

The target population is very clearly discerned in the mortality data as well as data received on clients served at Project CURE. Age breakdown of the mortality data shows us that mortality rates for Montgomery County begin to increase at age 30 and peak between the ages of 40 and 54; this is almost identical to the client demographics served at Project CURE. Data for gender and race is also concurring, showing that by far, services sought for opioid addiction and opioid mortality rates are much higher for white males than any other population. In fact, during fiscal year 2009, 84% of the clients served by Project CURE were white.

Outcomes

Many observers believe current efforts to obtain outcome measures at a county-wide level have insufficient funding and may not represent the most logical approach to getting the outcome information required to judge program results. ADAMHS's current efforts to obtain outcome information resulted in 159 clients being interviewed out of the 1,818 who had given consent for follow-up. This sample suffers from profound biases that make the information obtained virtually useless and the size of the sample is simply too small to be useful to individual agencies. Observers suggest that there are alternative models of obtaining outcome information that should be explored. Various individual programs have had some success, which is expected considering the significant relationships that programs build with participants.

In the absence of good long-term outcome data, this report used units of services provided to alcohol and other drug clients assessed in FY 2007 who received at least one unit of service in one of five major procedure codes. The percent of clients in each procedure code was determined by the

42 Stock, R., *Montgomery County Substance Abuse Needs Assessment: Phase I*, 2009.
43 *Alarming Rise in Unintentional Drug/Medication Related Poisoning Deaths in Ohio*. Injury Prevention Program, Ohio Department of Health. 2009.

total number of units they received in the 365 days after they were first assessed. Given the positive relationship between time in treatment and success, such information can be of some use. The five major procedure codes examined were associated with the following number of total clients:

- Non-Medical Community Residential Treatment .....461 Clients
- Individual Counseling .....1,817 Clients
- Adult Group Counseling .....1,686 Clients
- Case Management Service.....3,390 Clients
- Methadone Administration.....240 Clients

Three quarters of clients (75.3%) who started non-medical community residential treatment stayed for at least the length of treatment that is typically reimbursed (28-31 days). A relatively small number of clients (12.1%) left in the first two weeks.

Only a quarter of the clients (26.3%) who had individual counseling had more than five hours of individual counseling. Slightly more than half (52.3%) had three or fewer hours.

Just over half (53%) of the adult clients, who had group counseling at least once, had more than 20 hours of group counseling. Just under a quarter of adult clients (23.4%) received 10 or fewer hours.

Of those clients receiving any case management, the majority (60%) received an hour or less. Only 9.9% received more than three hours of case management.

With respect to methadone administration, units of service were measured for the 365 days from when the client was first assessed. Doses are to be taken daily. Just over a quarter of clients (27.5%) had 281 or more doses in the 365 days after being first assessed. More than half (53.7%) of clients had 160 or fewer doses in the 365 days after being first assessed.

INMATES WHO USE JAIL SERVICES EXTENSIVELY STUDY

Montgomery County's criminal justice system is overwhelmingly filled with individuals struggling with AOD abuse and dependency issues. As many as 50% of the daily jail population are currently booked with drug charges or have had prior bookings involving drugs.[44] Another 68% of individuals in the Court of Common Pleas system are alcohol and/or drug related.[45] The County commits a large amount of resources to these individuals; in fact, in 2009, 71% of the County's General Revenue Fund was spent supporting our criminal justice system.[46] Regardless of this financial commitment, many individuals struggling with AOD abuse and addiction issues continue to be frequently arrested and incarcerated.

44 JusticeWeb Report for Montgomery County Jail, 2/10/10.
45 Montgomery County Court of Common Pleas, 2/10/10.
46 *2009 Budget in Brief.* Montgomery County Office of Management and Budget.

In acknowledgment of this, Wright State University's Center for Interventions, Treatment, and Addictions Research (CITAR) was chosen to study and gain a better understanding of the high prevalence of AOD abuse and addiction in incarcerated individuals in Montgomery County jails. This study attempted to identify the psychosocial characteristics, extent of alcohol and other drug problems, and service utilization of 100 inmates who were frequently incarcerated. Frequently incarcerated inmates were those with the most bookings in the Montgomery County detention facility with at least one drug charge. Recommendations on possible structural changes that might facilitate preventive and diversion strategies were extrapolated from this work. (See Appendix F for the full report.)

The total sample of 100 individuals had a total of 4,362 bookings—approximately 49 bookings per individual—at a total cost to the community of about $4 million. The following information was obtained through a record review:

- A large majority (85.4%) of bookings were misdemeanor charges including traffic violations; these individuals tended to exhibit more self-destructive behaviors than being destructive to others.
- Almost 60% of individuals were female.
- 55% of individuals were African American.

The study also attempted to identify and interview 50 of the top 100 individuals; the investigators were successful at completing 40 interviews. Inmate demographics included the following:

- The average age was 41.
- The majority of individuals (43%) were living at "someone else's place."
- 95% have never been married or were currently divorced or separated.
- Almost all (95%) did not have a valid driver's license and used public transportation as a result.
- Most (60%) were currently unemployed.
- 43% had completed at least the 11th or 12th grade.

With regard to alcohol and/or drug-dependency data among the 40 interviewed individuals, the following was discovered:

- Almost all individuals (94%) were dependent on at least one drug with almost half having more than one dependence.
- The majority (88%) were drug dependent on cocaine.
- One-half (50%) were addicted to alcohol.

Assessment and linkage information was available for 30 of the 40 interviewed individuals. These participants were assessed frequently (n=118), but rarely entered into formal treatment sessions (n=24) for a total linkage rate of 20.3%. Individuals (n=11) who had been assessed five or more times accounted for 74 of the assessments. Among 18 of the individuals who linked with treatment: four successfully completed their treatment sessions at some point in their lifetime, two had

completed residential, 11 never completed any program, and one was currently in treatment. As many as 11 individuals had never been in treatment and another 10 had been in treatment only once in their lifetime. This demonstrates significant costs to conduct assessments that do not pay off in terms of improvement with their dependency issues or criminal activity making recidivism an almost certainty for this population.

The data is shocking with regard to prostitution and its inevitable connection to AOD abuse and addiction. Forty of the 43 women in the top 100 listing had at least one prostitution-related arrest. These women averaged almost 44 bookings, most of them for prostitution-related offenses. Of these bookings, 17% also contained at least one drug-related charge. Together, women involved in prostitution spent 457 days in jail. Of these women, 22 were interviewed and presented with the same level of psychosocial problems as did the men in the study. Three points unique to the women included:

- 41% stated that having "bad friends" was their biggest influence in committing criminal activities.
- 21% attributed the cause of their criminal activities to family problems.
- 64% said they had been physically or sexually abused before the age of 16.

When asked why they were arrested so often, 36% stated that it was to support their drug use. This same amount of individuals (36%) also stated that in order to stop their criminal activity, they needed to stop using alcohol/drugs and seek treatment.

Lessons learned from this study indicate that this population will likely not be successful with the AOD service system as it exists today (with multiple referrals being made to treatment but with minimal follow-up being made). A new, more productive, approach will require an integrated method that addresses individuals' numerous challenges including substance abuse, mental health, employment, housing, etc. Other recommendations from this study included longer jail stays rather than many short stays which forces a minimal level of abstinence during their jail stay. This could also provide valuable time to spend on conducting psychosocial evaluations.

The researchers also recommended establishing a specialty residential prostitution program that includes a minimum of one month duration with most services being provided in-house (substance abuse, mental health, supportive services, etc.), and intensive follow-up services. A residential specialty program for males or the establishment of a coordinated cross-systems specialty services team to monitor their participation in all services will eliminate barriers for this population. Any future interventions or programs should be based on nationally recognized, evidence-based practices, and be multi-services in scope with a rigorous outcome evaluation plan.

OTHER STUDIES

In addition to the research conducted for the AOD Task Force purposes, other pre-existing studies were incorporated and utilized by the Task Force during their strategic planning process. Three of these studies played a specifically important role:

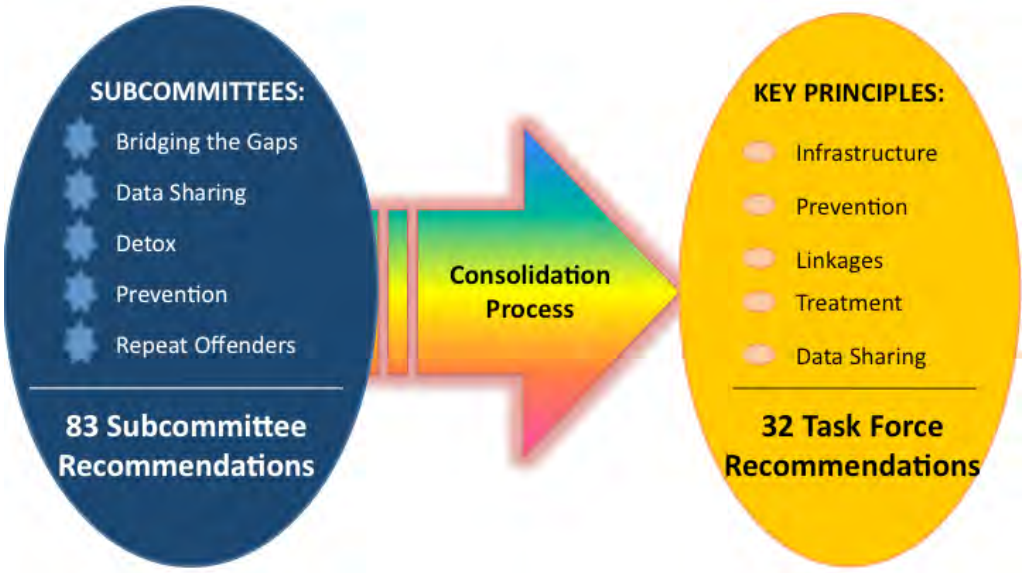
- **Reducing Barriers to Treatment Report—**Presented by Richard Rapp from Wright State University's CITAR, this study compared the current Samaritan CrisisCare services with motivational interviewing and strengths-based case management and reviewed waiting time to treatment entry, linkage with treatment, retention in treatment, and successful completion of treatment services. (See Appendix G for the full report).
- **Increasing Substance Abuse Treatment Compliance for Persons with Traumatic Brain Injury Study—**Presented by Dennis Moore from Wright State University's Consumer Advocacy Model (CAM), this study investigated reducing logistical barriers to attending treatment appointments, utilizing brief motivational interviewing to increase motivation for treatment, and financial incentives to participate in treatment. (See Appendix H for the presentation of this report).
- **Dayton Area Drug Survey Data (DADS)—**Presented by Russel Falck from Wright State University's CITAR, this survey has been conducted since 1990 with more than 150,000 young people participating. Students in grades 7-12 voluntarily respond anonymously to a self-report questionnaire in a classroom setting regarding their alcohol and other drug use as well as other risky behaviors in order to reveal trends in the data. (See Appendix I for the full report.)

THE STRATEGIC PROCESS

The AOD Task Force underwent a comprehensive strategic process that allowed for open dialogue about AOD abuse and addiction in Montgomery County. This process was the impetus for accomplishing the following milestones:

- the establishment of an agreed upon set of strategic goal areas,
- the formation of subcommittees,
- the acquisition of consumer feedback,
- the establishment of a set of 83 subcommittee recommendations,
- the development of five key principles, and
- the consolidation of all the recommendations into a set of 32 Task Force recommendations.

The following process diagram depicts the process that the AOD Task Force underwent in order to consolidate a total of 83 subcommittee recommendations to a merged set of 32 Task Force recommendations. This process is described in depth in the following pages of this report.



SWOT ANALYSIS

Acknowledging the enormity of their task, the AOD Task Force engaged David Ramey, President of Strategic Leadership Associates (SLA), to assist them in moving to the next phase of their work. Since AOD issues are so expansive, a narrower focus was required in order to shift from problem identification to solution development. Therefore, in May and June 2009, the Task Force members and local AOD service providers participated in a SWOT analysis in order to assess the Strengths, Weaknesses, Opportunities, and Threats of the alcohol and other drug abuse/addiction systems in Montgomery County as a whole. (See Appendix J for the complete transcription of the SWOT analysis and Appendix K for the SWOT analysis summary.)

The responses provided during this process were used to develop a set of strategic goals, objectives, and proposed initiatives for the future improvement of AOD services. A subcommittee was then established for each goal area and each subcommittee was given the responsibility of formulating recommendations for public policy, funding, and interventions corresponding to their particular goal area.

STRATEGIC GOAL AREAS CHOSEN AND FORMATION OF SUBCOMMITTEES

The AOD Task Force identified five essential goal areas that emerged from the SWOT analysis as indicated in Table 5.

Table 5. Strategic Goal Areas Chosen and Corresponding Subcommittees

GOAL AREA	SUBCOMMITTEE
Bridge the gaps across assessment, treatment, and aftercare/recovery services	Bridging the Gaps Subcommittee
Improve the processes for the collection and sharing of data on individuals and populations	Data Sharing Subcommittee
Improve Montgomery County's capacity to provide detox services	Detox Subcommittee
Develop a comprehensive, coordinated, county-wide prevention and community education system	Prevention Subcommittee
Strengthen intervention and resources for repeat criminal justice offenders	Repeat Offenders Subcommittee

The following provides a rationale as to why the individual goal areas were chosen by the AOD Task Force and the charge that was given to each of the subcommittees in developing solutions to the identified goal areas.

1. **Bridge the Gaps Across Assessment, Treatment, and Aftercare/Recovery Services—**Individuals struggling with addictions are burdened by the challenges of transitioning between services that lie along the AOD continuum. Prevention, assessment, treatment, and aftercare services need to be provided along a seamless continuum in order to avoid potential loss of client engagement. However, there are notable gaps between these services in the current service system and an unacceptable number of clients end up falling through the cracks.

   The subcommittee assigned to this goal area was referred to as the ***BRIDGING THE GAPS SUBCOMMITTEE.*** They were accountable for developing recommendations that focused

on engaging private providers and payers, universities, and the public system in creating effortless transitions across assessment, treatment, and aftercare/recovery support services with a common set of metrics to track client progress.

2. **Improve the Processes for the Collection and Sharing of Data on Individuals and Populations—**Recurring responses in the SWOT analysis demonstrated a lack of effective coordination among all major community players to share data, and a lack of data to assess the effectiveness of the AOD services and programs. While there appears to be agreement that the capability to share data across systems exists, those data sharing mechanisms are not currently being utilized. Implementation of such a system would enhance both service provision and overall client care.

   The subcommittee assigned to this goal area was referred to as the ***DATA SHARING SUBCOMMITTEE***. They were responsible for developing recommendations that would engage the assessing and treating organizations, as well as the Greater Dayton Area Hospital Association (GDAHA) and the universities, in improving the processes for the collection and sharing of data on individuals and populations that are involved in AOD services.

3. **Improve Montgomery County's Capacity to Provide Detox Services**—Multiple responses gathered during the SWOT process identified a sheer lack of services for individuals in need of detoxification from alcohol or other substances. This analysis also indicated that the county needs a standardized system of care with regard to detox services. Prior to the SWOT analysis, the lack of detox services was becoming abundantly apparent as a growing burden for both law enforcement and the hospitals. With no other options available, beds at both the County Jail and the hospital emergency rooms are being misused to provide detox services to this population. This broken system is equating to extensive lengths of stay at a hospital for these individuals at exorbitant costs to the community.

   The subcommittee assigned to this goal area was referred to as the ***DETOX SUBCOMMITTEE*** and was given the responsibility of developing recommendations that would engage the public system, hospitals, and the jails in creating a response system for providing detox services in the community by realigning current services.

4. **Develop a Comprehensive, Coordinated, County-Wide Prevention and Community Education System—**It behooves any community spending scarce fiscal resources on the effects of abuse and addiction to reduce the number of individuals needing those services. An even more worthy reason to invest in prevention is both moral and ethical—the considerable improvement in the quality of life of individuals, neighborhoods, and entire communities when the detrimental effects of AOD abuse and addiction are averted.

   The subcommittee assigned to this goal area was referred to as the ***PREVENTION SUBCOMMITTEE***. Based on the evidence-based practices of other communities, this subcommittee was charged with developing recommendations that centered on a comprehensive, coordinated, county-wide prevention and community education system that promotes the prevention of alcohol and other drug abuse and addiction by enhancing partnerships to educate, advocate, and support locally-based, community mobilization with shared efforts on state and federal funding, advocacy, training, and stigma reduction.

5. **Strengthen Intervention and Resources for Repeat Offenders—**The term "Repeat Offender" refers to a person who has been convicted of a crime more than once. Research shows that alcohol and other drug abuse treatment improves outcomes for alcohol and other drug abusing offenders and has beneficial effects for public health and safety. In addition, this population consumes a large amount of the community's AOD services and resources throughout their criminal career. Thus, it is in the best interest of any community to target and enhance AOD services to this population.

   The subcommittee assigned to this goal area was referred to as the ***REPEAT OFFENDERS SUBCOMMITTEE***. They were given the charge of developing recommendations that would engage the courts and the criminal justice system in strengthening interventions and resources for repeat criminal justice offenders.

Each subcommittee consisted of members from the AOD Task Force as well as other key community leaders and service providers necessary to complete their work. All subcommittee recommendations were required to meet the following criteria:

- Align with the strategic goals, objectives, and initiatives assigned to the subcommittee.
- Prioritize the effective use of existing resources and re-engineer current programs, processes, or partnerships.
- Attract dollars outside the County for services or needs within the County representing additional potential funding.

The subcommittees met between July 2009 and November 2009; during this time, the full AOD Task Force was on hiatus. All five subcommittees completed written reports that described their respective subcommittee process, the work they accomplished, and the findings and

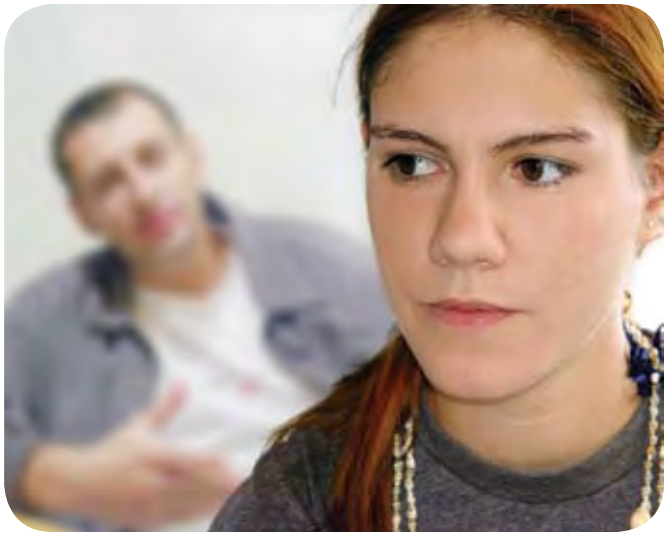
recommendations that concluded from their work. (See the corresponding appendix for the complete report of findings and recommendations from each of the subcommittees.)

- Bridging the Gaps Subcommittee, Appendix L
- Data Sharing Subcommittee, Appendix M
- Detox Subcommittee, Appendix N
- Prevention Subcommittee, Appendix O
- Repeat Offenders Subcommittee, Appendix P

CONSUMER FEEDBACK

As a part of the strategic process, the perspective of individuals currently in treatment and recovery was obtained through a series of focus groups. Five focus groups were conducted with people who have a history of abusing alcohol and/or other drugs. The groups were conducted by Diane Lawrence from Strategic Visioning, Inc. and included a total of 41 individuals from Nova House, Project CURE, Samaritan Homeless Clinic, Adult Drug Court, and Juvenile Drug Court. Valuable insights resulted from the information provided by the focus group participants.

The focus groups painted a picture of these individuals' lives and the tribulations they've endured as a result of their addictions. Their experiences varied greatly from individuals who were first-time offenders, to individuals who had been in and out of treatment more than a dozen times. Some were court mandated to treatment while others were there on their own volition. Most were addicted to multiple drugs and a few were dually diagnosed—suffering both mental health issues and substance addiction. Different individuals participated in different levels of programming, from standard outpatient to intensive residential; their responses justifiably differed as a result.



The focus group participants were especially thankful that Montgomery County was engaged in this type of initiative and acknowledged the tremendous need for it. They were also very willing to be both open and forthright. Focus group participants identified problems they had encountered as well as some of their positive experiences. The majority of them saw treatment services as a "life saver" but also wished the services could last longer to continue supporting them throughout their recovery.

Each group was asked to review a portion of the Task Force's recommendations applicable to the services provided to their particular cohort. Their general feedback regarding which of the recommendations they supported—or did not support—is indicated with an asterisk and notation next to the corresponding recommendation in the next section. When appropriate, additional commentary is also included even though it may have nothing to do with the participants' actual support—or lack of support—for that recommendation. These items are important to note because they can be utilized as valuable "lessons learned." See Appendix Q for the full Focus Groups Report.

SUBCOMMITTEE RECOMMENDATIONS

Prior to the start of the subcommittee process, the projected quantity of recommendations anticipated from each of the subcommittees was estimated at eight to ten. However, by the end of the process, the subcommittees had devised a combined total of 83 recommendations. It is evident that the complex nature of AOD issues equated to a much higher number of recommendations from each of the subcommittees. The complete set of recommendations from each of the subcommittees is listed below. See Appendix R for a two-page representation of the subcommittees' recommendations.

Bridging the Gaps Subcommittee Recommendations

1. Designate an entity for implementing the AOD Task Force recommendations.
2. Create a system that monitors the AOD system for effectiveness and efficiency.
3. Create flexibility in the AOD system to respond to emerging needs and new technology.
4. Establish a county-wide partnership of AOD providers so that client information can be easily shared.
5. CrisisCare should remain the front door for AOD assessments.
6. CrisisCare should schedule assessments 24 hours a day, seven days a week.
   **This recommendation was fully supported by focus group participants.*
7. CrisisCare should provide assessments within 24 business hours of referral.
   **This recommendation was fully supported by focus group participants.*
8. CrisisCare should immediately schedule appointments with a provider post-assessment.
   **This recommendation was fully supported by focus group participants.*
9. Develop new pre-treatment services at CrisisCare.
   **It is important to note that the Task Force did not come to consensus on this recommendation. Some were concerned that instituting pre-treatment services would create an additional barrier to accessing treatment services, particularly for the hardest-to-serve clients. This sentiment was echoed by the focus group participants, who stated that most people would continue using during their "pre-treatment" timeframe, miss their pre-treatment sessions, and lose their spot at the treatment facility as a result. More dialogue is necessary regarding this recommendation prior to considering it for implementation.*
10. Establish three-tiered case management services at CrisisCare.
11. Ensure respect and sensitivity in providing treatment services to people with disabilities.
12. Extend client's treatment under the provider's case manager for 12-18 months.

13. Train all treatment agencies on motivational interviewing.
14. Include day treatment at the frequency and intensity that the client needs.
    **This recommendation was fully supported by focus group participants.*
15. Pursue a waiver from ODADAS so that clients can receive services at the needed intensity, frequency, and duration.
16. Increase IDDT programs to serve consumers with dual diagnoses who are heavy users of AOD services.
17. Establish a real-time data-driven system with an electronic record capability for sharing data.
18. ADAMHS should establish a system for capturing client outcomes that measure the effectiveness of treatment.
19. Pilot the case management recommendation with funds currently allocated to AOD residential treatment.
20. ADAMHS should have an open proposal system for the allocation of AOD funds.
21. ADAMHS should explore providing financial incentives to providers who are producing positive outcomes.
22. Explore additional potential sources of funding for the AOD system.

Additional Focus Group Lessons Learned about Existing Service Gaps:
**Interestingly enough, focus group participants thought the wait between assessment and treatment is a way of weeding out people who are not serious about treatment. When participants were asked about their experience with scheduling appointments at CrisisCare, responses varied widely. Some had difficulty scheduling an appointment time for an assessment, others did not. In some cases, people were referred to CrisisCare by a caseworker. When a caseworker was involved, the process appeared to progress more quickly and with fewer problems.*

**Focus group participants identified a lack of transitional housing and the process to finding an opening difficult.*

**With regard to transitioning to aftercare services, residential focus group participants stated it would ease their transition out of inpatient services if they could attend NA and AA meetings while still in residential treatment. This would help them to establish an "aftercare home" as well as help them to learn the culture of the 12-step program. They also identified a lack of sponsors as a barrier to maintaining their sobriety.*

**In every adult focus group, someone expressed frustration about the people who are in treatment but do not appear to be serious about their sobriety. Because treatment facilities have limitations that create the wait for acceptance, they suggested putting a process in place to weed out these individuals.*

**The focus group participants identified problems with having access to therapists in some programs. Continual meeting cancellations and a lack of face-to-face time with a therapist resulted in a lack of*

adherence to treatment plans. In some cases this was simply the result of caseload. In other situations, it was a reflection of the program design.

**Finding a program for young people was identified as a challenge. Focus group participants expressed the struggle they had trying to find help for their children and grandchildren who were also involved with alcohol and/or other drugs.*

Data Sharing Subcommittee Recommendations

1. Open up JusticeWeb to agency and ADAMHS access.
2. Move to a more sophisticated electronic system for collecting/exchanging data.
3. Examine HealthLink Information Exchange (HIEx) as a potential backbone exchange for this new data sharing system and as a common Electronic Health Record.
4. Establish a data sharing system that is usable and actionable that allows for apples-to-apples comparisons—no matter who is inputting the data, no matter what agency.
5. Develop community dashboards as part of the data sharing solution.
6. ADAMHS should take the lead in prioritizing data sharing for their network of providers.
7. Establish a local oversight body for this system of AOD data sharing.
8. Encourage hospital and criminal justice entities to share relevant data systems.
9. Staff this effort to get it done right using existing resources or new resources.
10. Develop an automated AOD bed availability system through Greater Dayton Area Hospital Association's Surgenet system.
11. Ensure the data allows agencies to track where clients have accessed services.
12. Integrate with the Healthcare Safety Net Task Force as a potential funding mechanism.
13. Identify other potential funding sources (federal and state).

Detox Subcommittee Recommendations

1. Adopt consistent detox protocol across the systems.
2. Follow best practices for detox services established by the Substance Abuse and Mental Health Services Administration in the Treatment Improvement Protocol 45.
3. Train all non-medical staff in Clinical Institute Withdrawal Assessment for Alcohol (CIWA-A) and Clinical Institute Narcotics Assessment (CINA).
4. Transfer all eligible persons to the Dayton Veterans Administration for detox services.
5. Hospitals should consider implementing the ambulatory detox guidelines established by the Dayton Veterans Administration.
6. Conduct a media/marketing campaign to educate citizens on the proper use of Emergency Departments.
7. All hospitals should create a Medical Detox Team.
   **This recommendation was fully supported by focus group participants.*

8. ADAMHS should allow patients assessed by a Medical Detox Team to bypass CrisisCare for assessment.
9. Develop a Sobering Center for individuals in need of a safe place to detox.
10. Establish a Detox Triaging Hotline at CrisisCare.
11. Rehabilitation facilities should allow individuals to be admitted pre-detoxing.
12. Assign a CrisisCare assessor to the jails to assess individuals prior to release.
    **This recommendation was supported by focus group participants. Since jail time is a situation where a person is thinking about their addiction and their future, they felt that having a CrisisCare assessor at the jail may increase the possibility for individual attention beyond the actual assessment. They also indicated that having private interactions with the CrisisCare worker would equate to more helpful exchanges.*
13. Develop a data sharing system to provide hospitals with real-time bed availability.
14. ADAMHS should reinstitute the Fast Track Program.[47]
    **This recommendation was fully supported by focus group participants.*
15. Conduct a community campaign to attract more staff to Project CURE.
16. Develop a Team to provide oversight and leadership to advance the recommendations.
17. ADAMHS should align funding priorities with the recommendations.
18. ADAMHS should conduct a review of their providers to ensure they support the recommendations.

Additional Focus Group Lessons Learned about Detox:
**Specific to staff at the Montgomery County Jail, the focus group participants generally supported the idea of training jail staff about the specific needs of addicted persons and thought this would prevent future problems when dealing with this population. They stated that people who are detoxing are typically treated very poorly by jail staff.*

Prevention Subcommittee Recommendations

1. Adopt the ODADAS definition of prevention.
2. Include tobacco in prevention efforts.
3. Create a prevention collaborative with staff responsible for implementing the prevention recommendations.
4. Develop process and outcome measures for prevention and community education.
5. Advocate for policies that will reduce availability of/access to ATOD and enforce consequences for ATOD-related offenses.
6. Advocate for systems change for data-driven local/state decisions about prevention funding.
7. Increase total prevention funding.
8. Encourage the creation and continuation of community and neighborhood coalitions.
9. Create a comprehensive asset development system as the foundation of universal prevention.

47 The Fast Track program allowed Project CURE to honor prescriptions written by specifically-designated medical doctors for methadone administration, providing immediate access to services. In 2006, this program was eliminated as a reimbursable service by the ADAMHS Board for Montgomery County.

10. Promote the implementation of evidence-based practices.
11. Provide educational opportunities and encourage prevention certification.
12. Include grassroots and faith-based providers in community-wide planning and assist with building their capacity.
13. Conduct public education for community mobilization and to reduce stigma.
14. Engage local media in implementing culturally appropriate communication.
15. Promote the use of a unified consistent prevention message.
16. Create a "rapid response communication mechanism" to notify the public of drug-related public health problems.

Focus Group Lessons Learned about Prevention:
**The young people from the Juvenile Drug Court indicated they would have been less likely to misuse drugs or alcohol if there were recreation centers for the county's young people.*

**Juvenile Drug Court participants perceived that the majority of their friends abuse alcohol, marijuana, and/or other drugs stating there is significant pressure to take part. In fact, the pressure is so great that participants believed some of their peers lie about alcohol and other drug use to achieve status.*

**Many focus group participants stated that prevention needs to start with parents, specifically on teaching parents how to talk to their children about alcohol and other drugs.*

Repeat Offenders Subcommittee Recommendations

1. Expand Juvenile Drug Court by increasing the number of case managers.
   **Juvenile Drug Court focus group participants were not in support of this recommendation. It is important to note that these youth did not choose to participate in the program—they were forced to participate. In addition, they typified the conventionally naïve teenage view of life—that what they do today will not have long-term negative effects on their lives. This was demonstrated by the pride they exhibited in being able to circumvent rules of the Drug Court program by continuing to use drugs and alcohol without being detected. They also believed their juvenile status protects them from repercussions. This mentality seems to have led to a devalued perception of the opportunities afforded to them through Drug Court.*
2. Create a liaison position to link Drug Court and treatment providers.
3. Develop alternative financial approaches for juveniles in families that have healthcare insurance.
   **Focus group participants expressed a considerable level of difficulty accessing treatment services in the private system, indirectly supporting the need for developing alternative financial approaches for individuals with private insurance.*
4. Streamline the process to move youth from outpatient to residential treatment.
5. Develop an appeals process for treatment denial.
6. Develop intervention programs for families with members in both Juvenile and Adult Drug Courts.

7. Ensure that Juvenile Drug Court and treatment providers work together to address treatment barriers.
   **Focus group participants identified transportation, housing, and employment as significant barriers to both their successful completion of treatment and maintaining their sobriety post-treatment.*
8. Engage offenders in treatment earlier in the criminal justice process.
9. CrisisCare should screen offenders while still in the jail following arrest.
   **This recommendation was fully supported by focus group participants.*
10. Provide a case manager in the jail to coordinate treatment options.
11. Develop a uniform system to identify offenders who would benefit from Drug Court.
12. Expand Adult Drug Court capacity to increase the number of participants served.
    **This recommendation was fully supported by focus group participants.*

13. Provide appropriate resources for success post-treatment.
    **This recommendation was fully supported by focus group participants, particularly those currently housed at a residential treatment facility. Many of them had no plan for housing or employment once they left the facility and were concerned this would compel them to relapse. They also felt these support services needed to be streamlined in order to improve accessibility to community supports.*
14. Promote greater family involvement, including Adult Drug Court.
    **This recommendation differed among focus group participants. Some participants believed family members should receive the necessary education so they could act as a support to them when they returned home. Other participants felt that forcing their families to be involved only burdened them further; some felt a strong sense of guilt and shame associated with their addictive behaviors. These comments were made with regard to family involvement in general, not just from Drug Court participants.*

Additional Focus Group Lessons Learned about Offenders:

**Adult Drug Court focus group participants saw little value in the requirement to attend NA and AA meetings because it is so easy to find ways around it. They indicated it would be more effective to conduct the NA and AA groups directly at the jail to verify their attendance in the 12-step programming as well as have individuals submit to a urine test while they are there.*

**Occasionally, there is some tension between people who are referred to treatment from the criminal justice system and those who self-refer. Clients who seek treatment on their own think people who come to treatment as a way of avoiding jail time are not as serious about recovery, but are "taking up space" that could be used by people who have not engaged in criminal behavior and are motivated to be in treatment.*

**While the Adult Drug Court program will keep a felony conviction off the record of program graduates, it is on the record while the individual moves through the program. The Adult Drug Court focus group participants felt it may be easier for them to find a job if their record remained clean while they were completing the program. They identified the stipulation that they would have to fulfill all program requirements in order for this to be a viable option.*

**One of the very few complaints people had about the Adult Drug Court program had to do with stringent regulations around regular urine testing when someone is unable to provide a specimen. The importance of needing to provide clean urine leads many to consume liquids so they are able to provide a specimen. However, when the individual is made to wait before providing the urine, there can be problems. This has led to people using the restroom prior to being called in for their appointment and then not being able to provide a specimen at their appointment. By Drug Court standards, this is considered "dropping a dirty sample" and the individual goes to jail.*

**Focus group participants felt that their medicinal needs are not considered while they are detained. Some stated they were forced to go off their medications while they were in jail and that this added to their instability.*

**Some of the focus group participants had experienced negative encounters with the local police. They felt they were treated unfairly and with disrespect as a result of the police officers' lack of understanding about addiction. However, others had interactions with officers that were compassionate and stated the interaction was the responsibility of both parties.*

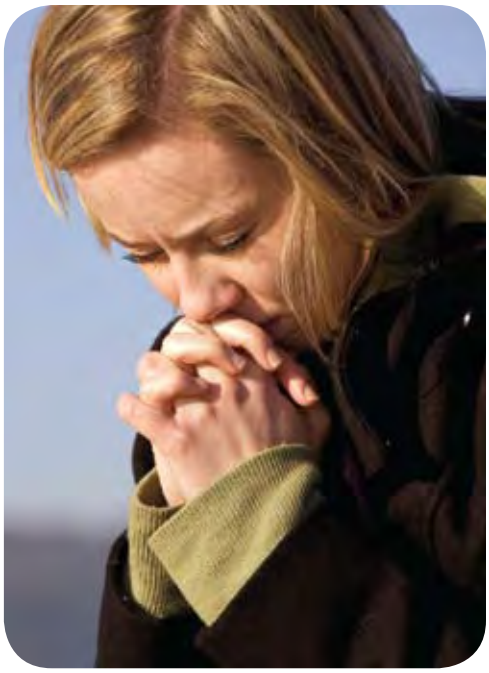
KEY PRINCIPLES

In December 2009, the AOD Task Force members and service providers were reconvened to hear presentations from the Co-Chairs of each of the subcommittees about their formulated recommendations. In review of the subcommittees' recommendations, a variety of themes began to surface, which ultimately resulted in the following five key principles that served as the driving force for the remainder of the AOD Task Force work.

- **The INFRASTRUCTURE necessary for Montgomery County to provide quality AOD services requires an increased capacity to work collaboratively across and between systems and services.**
  - Existing barriers—both acknowledged and covert—must be eliminated in order for the public system, private system, hospitals, schools, social service, law enforcement, and judicial systems to

work cooperatively towards combating AOD abuse and addiction in our community. Even unintentional barriers prohibit us from being as effective as we can be.

- Our local resources are not enough to meet the need here in Montgomery County. An increased ability to compete for dollars—both state and federal—is necessary to expand our current service capacity.
- "Treatment success" is not currently defined. Systematic program evaluations, through the utilization of outcome-based measures, are the only definitive way of knowing if our efforts are making a difference and to ensure we are making the wisest and most fruitful funding decisions.



- **PREVENTION services are critical to thwarting the detrimental effects of AOD abuse and addiction.**
  - Evidence-based prevention strategies have been proven to decrease youth participation in risky behaviors that lead to AOD abuse and addiction.
  - Although most people agree that prevention services are vital in building resilient and productive Montgomery County residents, prevention is often regarded as a "soft science" that can be done by anybody. However, research indicates that ineffective prevention strategies are not only a waste of time and money, but can also have an opposite and damaging effect.[48]
  - Existing prevention services in Montgomery County are currently being provided in isolation; a coordinated, county-wide approach would enhance and strengthen our community's ability to provide effective prevention services.

- **High-quality TREATMENT services that meet each individual's unique needs and circumstances should be available and accessible to individuals struggling with addiction.**
  - Scientific advances over the last 30 years have defined AOD dependence as a chronic relapsing disease. Recognizing addiction as a chronic, relapsing brain disorder helps to diminish the social costs associated with drug abuse and addiction.[49]
  - High-quality treatment services equate to success rates that are higher than some chronic medical conditions.[50] [51] Just as people with other chronic diseases must adjust their lifestyles and assume responsibility for managing their own care, so do those with addictions to drugs and alcohol. Thus, individuals struggling with addictions deserve to be treated with respect equal to that of individuals diagnosed with diabetes, asthma, and hypertension.

48 U.S. Department of Health and Human Services, National Institutes of Health, NIH Consensus Development Program, NIH News, October 15, 2004.
49 Leshner, Alan (October 1997). *Addiction is a brain disease, and it matters.* Science, Vol. 278 (5335), 45—47.
50 Ohio Association of County Behavioral Health Authorities, *Behavioral health: Developing a better understanding.* 3I(8).
51 http://alcoholism.about.com/cs/relapse/a/blcaron030804.htm.

- The ability to provide high quality treatment services relies on the providers' ability to utilize evidence-based practices, respond to individuals' unique needs and circumstances, and understand factors related to special populations such as individuals with disabilities and those who are dually diagnosed.

- **LINKAGES, or transition services between prevention, assessment, treatment, and aftercare, should exist along an unbroken continuum so that individuals do not have the opportunity to fall through the cracks.**
  - Individuals struggling with abuse and addictive behaviors are highly ambivalent. Their alcohol and other drug seeking behaviors make them unpredictable—they may want help one minute but not the next.
  - Service gaps (both between assessment and treatment as well as between treatment and aftercare) represent a highly vulnerable time in which an addicted person may choose to continue their destructive behavior.
  - Research has shown that decreasing wait times, filling gaps with support services (such as case management), and implementing incentives are associated with increased rates of treatment engagement.[52] [53]

- **The capability to SHARE DATA across systems currently exists and implementation of those data sharing mechanisms would enhance overall service provision and client care.**
  - Ineffective coordination among AOD service providers results in poor linkage rates, follow-up, and client engagement.
  - Montgomery County currently lacks accepted metrics that allow us to analyze our return on investment regarding the number of people served and success rates.
  - AOD providers could make more informed decisions regarding treatment plans if they had access to client treatment history, demographics, and rates of recidivism.

TASK FORCE RECOMMENDATIONS

There was consensus from the Task Force members that the broader set of 83 subcommittee recommendations needed to be transformed into a framework that would be conceptually viable, strategically sound, manageable, and functional. This decision moved the Task Force into their next phase—devising a merged set of recommendations that addresses Montgomery County's AOD issues through comprehensive and achievable strategies. These consolidated Task Force recommendations will be used to guide Montgomery County once the implementation of the recommendations has begun.

52 Rapp, R. C., Xu, J., Carr, C. A., Lane, D. T., Wang, J., Carlson, R. G. (2006). *Treatment barriers identified by substance abusers assessed at a centralized intake unit.* Journal of Substance Abuse Treatment, 30(3), 227 235.

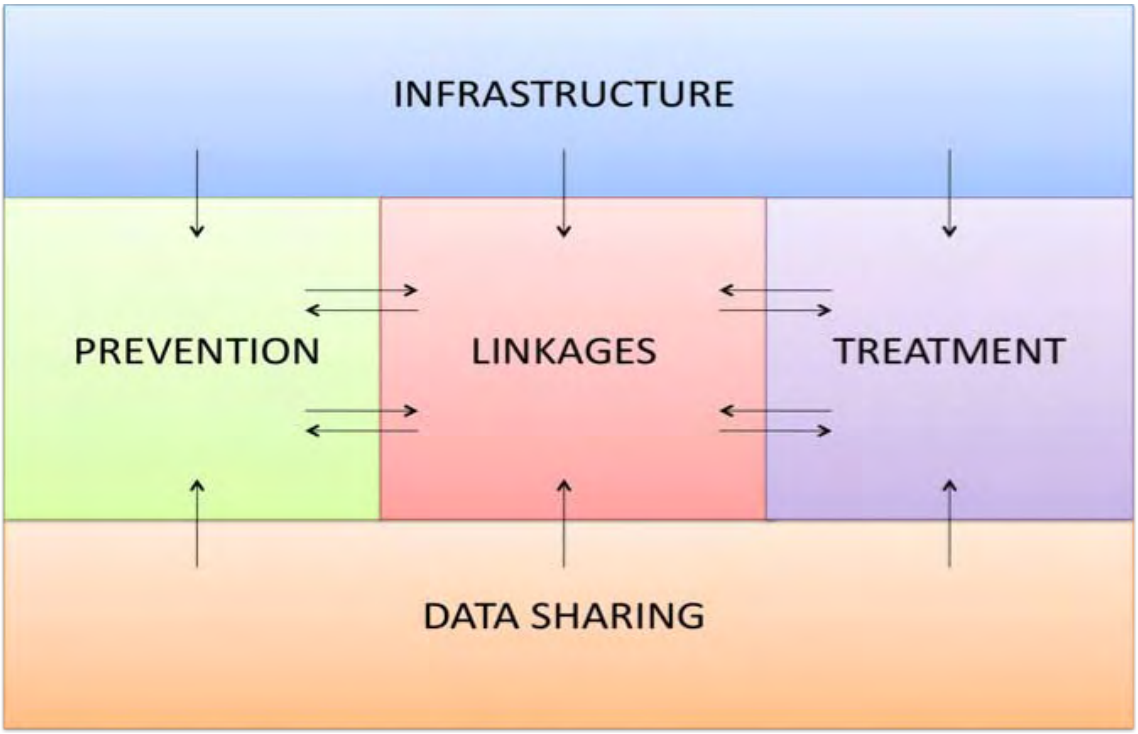
53 Corrigan, J. D., Bogner, J., Lamb-Hart, G., Heinemann, A., Moore, D. (2005). *Increasing substance abuse treatment compliance for persons with traumatic brain injury.* Psychology of Addictive Behaviors, 19(2), 131-139.

The consolidation process was accomplished in two ways:

- There were clearly some overlapping discussions that occurred independently by the different subcommittees. This was demonstrated by the commonalities found among their formulated recommendations and served to reinforce the necessity of those particular recommendations. During the consolidation process, similar recommendations were merged into single recommendations.
- Some recommendations, while different in their approach, make contributions towards accomplishing the same or similar outcomes. For example, there were many recommendations that focused on increasing overall funding for AOD services, but each recommendation accomplished this via different methods; these recommendations were combined during the merging process.

The framework chosen to consolidate the recommendations was based on the five key principles discussed in the preceding section. The recommendations were divided among a schematic that categorized the recommendations and put them into a much more usable format. Figure 5 depicts the schematic chosen and the interplay of the recommendations that are categorized into each of the various key principles. The Task Force identified that progress in all five sections is required to produce meaningful improvements to the AOD services in Montgomery County.

Figure 5. Schematic Chosen to Categorize the AOD Task Force Recommendations



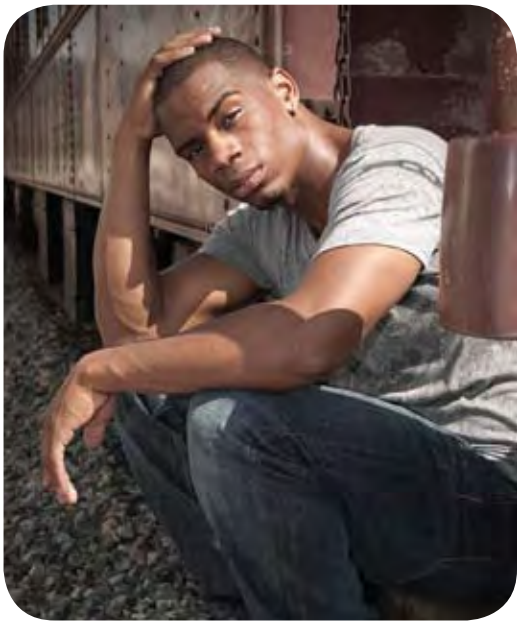
This process was successful at consolidating the total set of 83 subcommittee recommendations into 32 Task Force recommendations. It is important to note that none of the subcommittees' recommendations were eliminated during the consolidation process. The resulting Task Force recommendations are listed below. The corresponding subcommittee recommendation(s) are identified at the end of each recommendation for cross-referencing purposes. The following key should be used when cross-referencing:

BG = Bridging the Gaps Subcommittee
DS = Data Sharing Subcommittee
DX = Detox Subcommittee
P = Prevention Subcommittee
RO = Repeat Offenders Subcommittee

*NOTE: The full set of 83 subcommittee recommendations in Appendix R and the merged set of 32 Task Force recommendations in Appendix S are also color-coded for cross-referencing purposes.

Infrastructure/Capacity Building

- Establish and designate an entity responsible for providing oversight to the AOD Task Force recommendations with staff time devoted to implementation (BG 1; DS 7, 9; DX 16).
- Encourage the utilization of best practices in the establishment of system-wide protocol that is consistently monitored for effectiveness and efficiency, responds to emerging needs and technology, and focuses on the development of process and outcome measures (BG 2, 3, 18; DX 1, 2; P 4, 10).
- Establish county-wide partnerships/collaboratives for community planning—including grassroots and faith-based providers—to ensure that systems can share client information and work together to address client barriers (BG 4; RO 7; P 12).
- Increase funding that comes into the county by actively exploring non-local funding sources and capitalizing on existing local funding sources for services along the continuum (BG 22; DS 12, 13; P 7).
- Advocate for local/state funding decisions to be data-driven and restructure the ADAMHS funding system by aligning ADAMHS funding priorities with AOD Task Force recommendations, instituting an open proposal system, and providing incentives to providers who produce positive outcomes (BG 19, 20, 21; DX 17, 18; P 6).
- Expand the community's capacity to provide detox service by training all non-medical staff in



CIWA-A and CINA, establishing a Medical Detox Team and implementing ambulatory detox guidelines at the hospitals, developing community Sobering Centers and a Detox Triage Hotline at CrisisCare, conducting community campaigns to attract professional staff to Project CURE, and to educate the public on the proper use of ERs (DX 3, 4, 7, 9, 10, 15).

Prevention

- Create a prevention collaborative with staff responsible for implementing the prevention recommendations (P 3).
- Promote the use of a unified consistent prevention message that adopts the ODADAS definition of prevention and includes tobacco in prevention efforts (P 1, 2, 15).
- Advocate for policies that will reduce the availability of and access to ATOD and enforce consequences for ATOD-related offenses (P 5).
- Encourage the creation and continuation of community and neighborhood prevention coalitions (P 8).
- Create a comprehensive asset development system as the foundation of universal prevention (P 9).
- Provide educational opportunities and encourage prevention certification (P 11).
- Create a "rapid response communication mechanism" to notify the public of drug-related public health problems (P 16).
- Conduct public education for community mobilization and stigma reduction that involves engaging local media (P 13, 14).

Linkages

- CrisisCare should schedule assessments 24 hours per day/7 days per week, provide assessments within 24 business hours of referral, and immediately schedule appointments with a provider post-assessment (BG 5, 6, 7, 8).
- Develop new pre-treatment services at CrisisCare (BG 9).
- Expedite linkages both pre- and post-detox from hospitals by transferring all eligible persons to the Dayton VA for detox services, allowing patients assessed by a Medical Detox Team to obtain a bed-to-bed transfer, and reinstituting the Fast Track program at Project CURE (DX 4, 8, 14).
- Expand Adult Drug Courts' capacity to serve more people and engage criminal justice offenders early in the process by developing a uniform system to identify appropriate offenders for Drug Court, conducting CrisisCare assessments in the jail, and allowing individuals to enter rehabilitation facilities pre-detox (DX 11, 12; RO 8, 9, 11, 12).
- Promote linkage to treatment for criminal justice offenders by creating a liaison position to link Drug Court and treatment providers, providing a case manager in the jail to coordinate treatment options, and developing an appeals process for treatment denial (RO 2, 5, 10).
- Expand Juvenile Drug Courts' capacity to serve more people and promote access to services for juvenile criminal justice offenders by streamlining the process to move youth from outpatient to residential treatment and developing alternative financial approaches for juveniles in families that have healthcare insurance (RO 1, 3, 4).

- Promote post-treatment success by providing appropriate wrap-around services and promoting family involvement in Adult Drug Court (RO 13, 14).

Treatment

- Train all treatment agencies on motivational interviewing and working with people with disabilities (BG 11, 13).
- Establish 3-tiered case management services for up to 12-18 months (BG 10, 12).
- Include day treatment at the frequency, intensity, and duration that the client needs and pursue a waiver from ODADAS to make it reimbursable (BG 14, 15).
- Increase IDDT programs to serve consumers with dual diagnoses who are heavy users of AOD services (BG 16).
- Develop intervention programs for families with members in both Juvenile and Adult Drug Courts (RO 6).

Data Sharing

- Develop a sophisticated electronic system for collecting/exchanging data that incorporates community dashboards and is usable, actionable, allows for apples-to-apples comparisons, and ensures that the data allows agencies to track where clients have accessed services in real-time (BG 17; DS 2, 4, 5, 11).
- Examine HIEx as a potential backbone exchange for this new data sharing system and as a common Electronic Health Record (DS 3).
- Open up JusticeWeb to provider and ADAMHS access (DS 1).
- Develop an automated data sharing system, possibly through GDAHA's Surgenet system that provides hospitals with real-time treatment bed availability information (DS 10; DX 13).
- Encourage hospital and criminal justice entities to share relevant data systems (DS 8).
- Have ADAMHS take the lead in prioritizing data sharing for their network of providers (DS 6).

MONTGOMERY COUNTY PRIORITIES

In January and February 2010, the Task Force began an extensive dialogue to identify priorities for Montgomery County. Small and large group discussions were utilized to stimulate thoughtful and meaningful conversations in order to build consensus. Prioritizing the recommendations was an arduous task for a variety of reasons. There are far too many gaps in the current system to definitively determine which actions are more important than others. There were also challenges with funding (much of which is state mandated) and ease of implementation issues to consider.

However, there was consensus from the group that those recommendations related to infrastructure, capacity building, partnerships/collaborations, and staffing the implementation of the Task Force recommendations took center stage. In fact, the recommendation for an oversight

body to facilitate and manage the implementation of the recommendations was identified by most subcommittees. A summary of the priorities from each of the five key principle areas are outlined below.

Infrastructure:
The Task Force felt strongly that county-wide partnerships and collaboratives were the foundation for ensuring that the recommendations are implemented and that staff time had to be devoted to this effort in order to make it happen. Furthermore, AOD service providers are currently utilizing different paradigms and methodologies—some of which are more effective than others. The AOD Task Force believed that consistent protocols should be established and utilized across the various systems. These protocols should draw on best practices, respond to emerging needs and technology, and focus on the development of sound process and outcome measures.

Prevention:
Similar to the prioritized infrastructure recommendations, the Task Force also indicated that the establishment of a prevention collaborative—with staff responsible for implementing the prevention recommendations—was a high priority. The prevention collaborative would work in an oversight capacity county-wide; however, the Task Force also prioritized the creation and continuation of prevention coalitions to advance prevention efforts at the neighborhood level. All of this work should be accomplished through the creation of a comprehensive asset development system to be utilized as the foundation for universal prevention efforts. The asset development framework identifies those positive characteristics in youth that promote healthy decision-making and lead to resiliency.

Linkages:
Recommendations prioritized by the Task Force in this category were two-fold:

1. In order to engage clients more quickly, the referral and service process by CrisisCare should be highly accessible and should successfully transition individuals to treatment post-assessment. Specifically, CrisisCare should schedule assessments 24 hours per day/7 days per week, provide assessments within 24 business hours of referral, and immediately schedule appointments with a provider post-assessment. This revised structure does not allow individuals to become disengaged while they are moving through the process and will move our community closer to a "treatment on demand" system.

2. In order to promote services to the criminal justice population, the Task Force prioritized increasing Drug Court capacity for both adults and juveniles. At the adult level, this should be accomplished by engaging criminal justice offenders early in the process through the development of a uniform system that clearly distinguishes between those individuals who are, and are not, appropriate for Drug Court. In order to promote quicker access to treatment for this population, the Task Force felt that CrisisCare should conduct assessments directly in the jail and allow individuals to enter rehabilitation facilities pre-detox. For juveniles, promoting access to services for juvenile criminal justice offenders should be accomplished by streamlining the process to move youth from outpatient to residential treatment smoothly. They also felt strongly that alternative financial approaches needed to be developed for juveniles who come from families that have healthcare insurance.

Treatment:
Prioritized treatment recommendations demonstrate that treatment services should be conducive to the unique needs of individual clients. This includes the establishment of treatment sessions that are provided at the frequency, intensity, and duration that the client needs; this is not currently possible due to funding restrictions. Continued support is necessary for this vulnerable population; the Task Force felt that longer-term case management services should be offered for 12 to 18 months during that critical time when individuals are struggling daily with their sobriety. In addition, the Task Force identified that all treatment agencies should receive training on motivational interviewing, which is "a client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence."[54] Treatment providers should also be trained on understanding the unique circumstances of people with disabilities and identify treatment methodologies appropriate for specific populations.

Data Sharing:
The development of a sophisticated electronic system for collecting and exchanging data was the highest prioritized recommendation by the Task Force. This data exchange system should incorporate community dashboards, allow for usable comparisons, and ensure that it allows agencies to track where clients have accessed services in real time. Healthlink Information Exchange (HIEx)—a data exchange system through Wright State University's Center for Healthy Communities—should be examined for its ability to serve in this capacity. Furthermore, the Task Force felt that the ADAMHS Board should take the lead in prioritizing and requiring data sharing among their network of providers.

Understanding the priorities designated by the AOD Task Force provides guidance to the next phase of the process—implementation of the recommendations.

54 http://www.motivationalinterview.org/.

EARLY ACCOMPLISHMENTS: FIRST STEPS

The process of pulling together a broad cross section of our community to address AOD issues has resulted in some early achievements for Montgomery County. The following accomplishments have occurred at some point over the last two years and are directly attributable to the work of the AOD Task Force.

ENHANCED CLIENT ENGAGEMENT AT CRISISCARE

The Bridging the Gaps Subcommittee found that best practices indicate that a person's first time accessing the AOD system is an important opportunity for successful engagement and increased client motivation. Sometimes, that important opportunity presents itself when a person with AOD issues is in a hospital detox unit.

Early dialogue within the Bridging the Gaps Subcommittee quickly identified a gap: the connection between hospital detox services and the ability to schedule CrisisCare appointments after hours (when many of the persons needing the assessments present themselves at the hospital). This dialogue has already produced a change requested by the hospitals; CrisisCare has implemented scheduling assessments at hospitals 24 hours a day/7 days a week. (This is also a recommendation of the Bridging the Gaps Subcommittee—see Appendix L for more information.)

UNINTENTIONAL PRESCRIPTION DRUG OVERDOSES PROJECT

Local statistics regarding the impact of opiates present a very dismal view of Montgomery County (see Data Collection, page 47 of this report, for more information). These statistics, however, have been an eye opener to the community leaders serving on the AOD Task Force. It is with this in mind that a partnership was developed between Public Health—Dayton & Montgomery County, the Montgomery County Office of Family and Children First, and the Montgomery County Coroner's Office to address this issue. Funding was sought from and secured by the Ohio Department of Health to hire one full-time worker to coordinate a demonstration project to address

unintentional prescription drug poisonings. Upon being hired, this individual will be responsible for the achievement of 12 objectives that can be grouped into three broad categories:

1. The development of a Prescription Drug Poisoning Coalition to address the problem by reviewing relevant data and making recommendations to the Ohio Department of Health.
2. The development and implementation of a Prescription Poison Death Review process focusing on prescription drugs.
3. The facilitation and conduct of targeted Information, Training, and Educational opportunities to help address and prevent prescription drug overdoses.

Services are anticipated to start in early to mid 2010.

DATA SHARING ACCOMPLISHMENTS

Commissioner Dan Foley has briefed the Montgomery County Criminal Justice Council, which serves as the JusticeWeb Governance Board, regarding the recommendations of the Data Sharing Subcommittee. He said he would return in the future with a proposal regarding the utilization of JusticeWeb by various service providers. It should be noted that ADAMHS Board staff members, due to their role as members of a government entity, have the ability to utilize JusticeWeb under current guidelines established by the Criminal Justice Council.

During the discussions of the Data Sharing Subcommittee, there was consensus that the time lag between a CrisisCare referral and the provider agency receiving the assessment packet was unacceptably long because it was all done on paper and then sent by courier. While the long-term plan is to set up an electronic health record (EHR) exchange, the agencies wanted to do something now that would have an impact on the time lag. They have been working on a secure file transfer solution along with email notification between CrisisCare, the ADAMHS Board, and the provider. Currently, they have draft procedures and are in the testing phase of the project. By mid 2010 it is anticipated that the infrastructure and training will be complete and that the file transfer process for CrisisCare referrals will be implemented throughout the ADAMHS network of providers. This should have a major impact on reducing the lag time.

WHERE WE GO FROM HERE: NEXT STEPS

The completion of this report is the culmination of a two-year process examining the systemic needs of the AOD systems in Montgomery County and developing recommendations to make improvements. This report is a very productive step—but it is only the first step—and the implementation of the Task Force recommendations is the natural next step.

As has been noted, the AOD system is a complex network made up of many interdependent systems. Successful implementation of the Task Force recommendations will require commitments from each of these systems. Also essential will be ongoing influence by decision-makers to guide, enact, and support needed changes to achieve better community outcomes.

The AOD Task Force will begin the implementation process through the release of the report to the Montgomery County Board of County Commissioners. The Board of County Commissioners will then take several actions to move the implementation forward:

1. Establish an AOD Implementation Advisory Team to support the collaborative cross-systems approach of the recommendations, monitor activities, assess ongoing progress, and assist with strategic input and influence. This group will work in a liaison capacity to the Board of County Commissioners and the AOD systems and providers. Membership on this Team will consist of high-level individuals with the authority to enact policy and system change within their respective systems.

2. Review the report with the AOD Implementation Advisory Team and schedule briefings with key influencers from various systems. The purpose of these briefings will be to discuss the Task Force's work, present immediate successes and key recommendations, discuss alignment of the recommendations within the individual systems, seek specific system endorsement and commitment, and establish expectations that result in better community outcomes. These meetings will include:
    - Montgomery County Family and Children First Council
    - Montgomery County Human Services Levy Council
    - ADAMHS Board for Montgomery County
    - Montgomery County Criminal Justice Council
    - Montgomery County Court of Common Pleas
    - Montgomery County Juvenile Court
    - Greater Dayton Area Hospital Association and Hospital Networks
    - Montgomery County Homeless Solutions Policy Board
    - Prevention/Treatment Service Provider Community and Consumers

- Secondary and Post-Secondary Education
- Faith-Based Community
- Business/Employment/Workforce Community
- Others as Identified

3. Request a formal follow-up report from each group listed above within 60 days outlining their endorsement/commitment, what actions have already been taken, what immediate actions they will take, their short and long-term implementation plans, what assistance is needed, and any concerns.

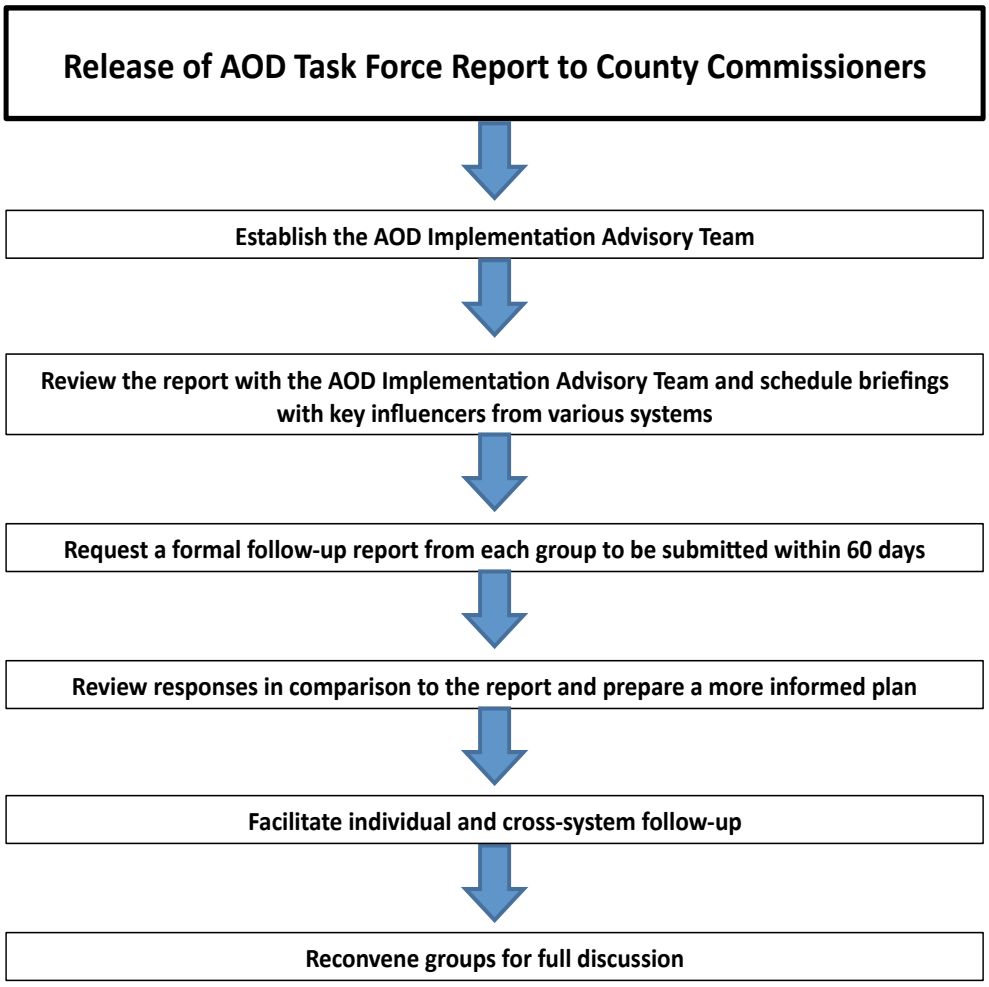
4. Instruct the Montgomery County Office of Family and Children First to review these responses in comparison to the report and work with the AOD Implementation Advisory Team to prepare a more informed implementation timeline, plan, and identified set of follow-up items.

5. Individual and cross-system follow-up will be facilitated as needed by the Montgomery County Commissioners, AOD Implementation Advisory Team, and Montgomery County Office of Family and Children First.

6. The Montgomery County Commissioners will then bring these groups together for a full discussion of the timeline, initial implementation plan, and any remaining outstanding items.

This recommended process is illustrated in Figure 6.

Figure 6. Process for Implementation of AOD Task Force Recommendations

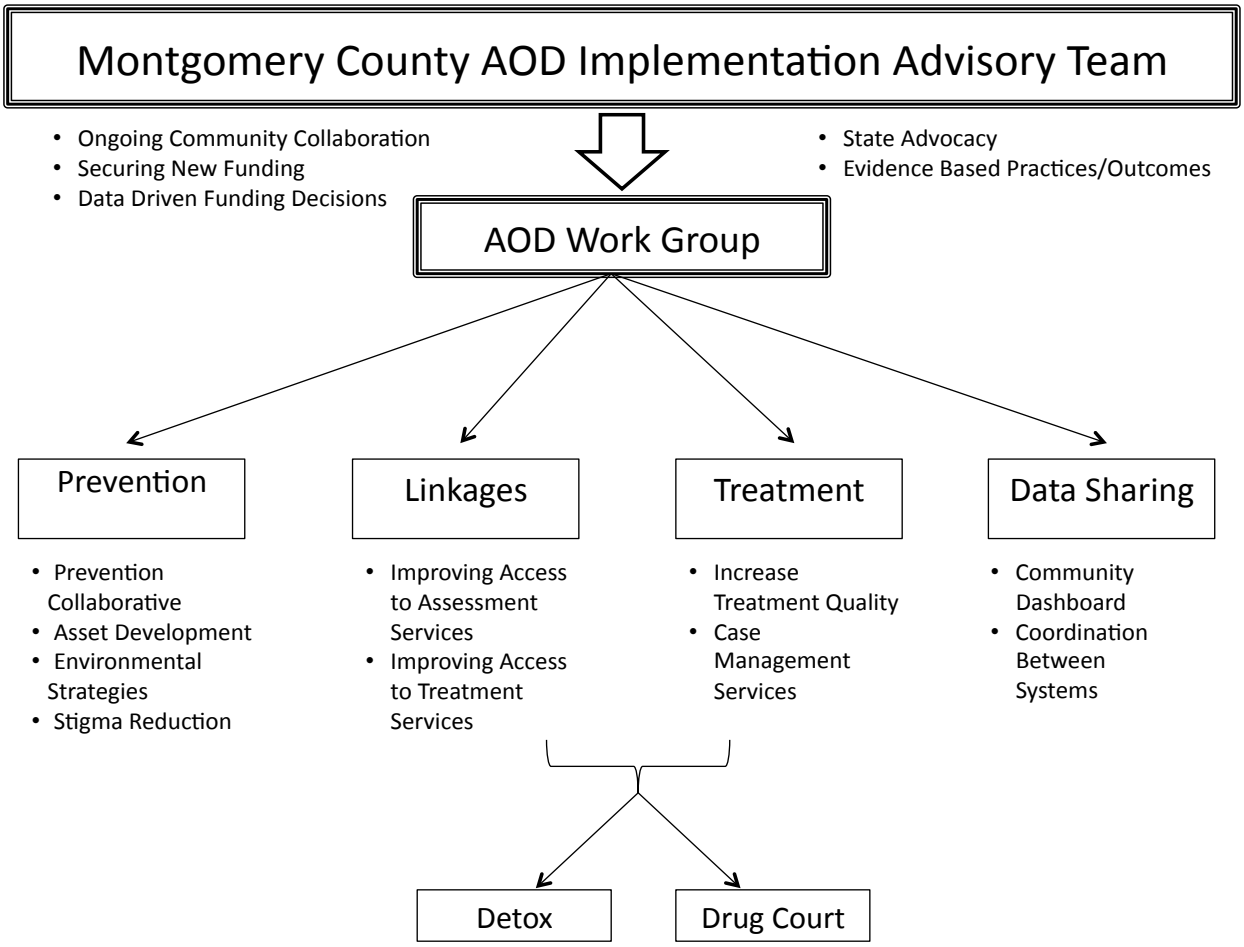


Staff time dedicated to supporting and coordinating the work of the AOD Implementation Advisory Team is necessary to ensure progress. The Montgomery County Office of Family and Children First will dedicate staff to support this work and staff will also be requested from the ADAMHS Board and the Greater Dayton Area Hospital Association. The Advisory Team staff will facilitate and provide administrative support, research and planning, community education, program support, and oversight for the ongoing reporting of activities and accomplishments.

Successful implementation of the Task Force recommendations will require individual system work, continued partnerships and collaborations. While the Advisory Team will establish strategies and actions to move the recommendations forward, an AOD Work Group consisting of high-level managers will also be necessary to guide the internal changes. A variety of ad hoc committees will be required for those recommendations or activities that require specificity. Periodic reports will be provided to the Montgomery

County Commissioners, AOD system partners, and others as needed. Figure 7 represents the suggested framework for implementation.

Figure 7. Framework for Implementation of AOD Task Force Recommendations



It is anticipated that this framework will lead to increased collaborative decision-making within the AOD network of systems. The AOD Task Force will reconvene one year after the release of their report to receive an update on progress, accomplishments, and outstanding items.

Many of the Task Force recommendations require the AOD system to seek and secure additional funding. Advancing and implementing the Task Force recommendations better position Montgomery County to compete for state and federal dollars; however, there must also be new and innovative ways for effective local funding decisions to be made that incorporate data-driven, outcome-based results. It will also require increased influence, collaboration, and partnership to identify lead agencies, and adherence to agreed-upon priorities and practices to apply for these funds and execute their use.

In addition, many of the Task Force recommendations will remain stagnant if state advocacy does not occur. This is particularly true when state waivers are necessary to implement currently unallowable or unreimbursable services. All affected systems will need to act in a consistent and unified manner and align themselves with advocacy groups in order to accomplish this work.

Along with any community plan should also be a plan to measure and evaluate the impact of the plan's implementation. While each recommendation may have its own set of metrics by which to evaluate its individual effectiveness, the following outcome measures should be tracked to determine how we are progressing as a community:

- Increased coordination by prevention providers
- Increased data sharing coordination
- Decreased wait time to access assessment services
- Decreased wait time to access treatment services
- Increased client engagement in treatment services
- Increased funding to support AOD services

The work and recommendations of the Task Force reinforce the critical need for the community to work as a comprehensive unit. Divisions within and between community sectors will continue to burden Montgomery County citizens if barriers are not consciously eliminated and the choice is not made to work together. Our capacity to provide better AOD services relies on our ability to identify community solutions on a large scale and as an entire community.

CONCLUSION: A CALL TO ACTION

The AOD Task Force has achieved significant milestones in fostering community collaboration in Montgomery County. While the AOD Task Force has been the conduit for that work, the willingness and cooperation by providers and community leaders across the various systems cannot be understated. The accomplishments that have already sprung from this work are the first step among many in our battle against alcohol and other drug abuse and addiction.

However, these accomplishments do not minimize the devastation still felt by thousands of Montgomery County citizens every day despite the painstaking and diligent efforts of service providers. Now is the time we must acknowledge that our current system often malfunctions; we simply cannot sit idly by and accept the human suffering and loss of life that occurs as a result.

Much is needed to make positive changes…
Financial resources—both new dollars and a reallocation of current dollars—will be necessary to implement the recommendations outlined in this report. Targeted state advocacy efforts, such as applying for and obtaining state waivers, will also be required if many of these recommendations are to be implemented in Montgomery County. Additionally, the right human capital, encompassing a vast array of knowledge along the AOD service continuum, will be a vital component. Even more important will be the community's willingness to be accepting of new concepts and methodologies. For many, this will require a significant paradigm shift and, understandably, that can be a difficult transition. In spite of these difficulties, change is necessary if we are to battle this community issue and introduce those affected by AOD abuse and addictions to a higher quality of life.

This work cannot be accomplished in isolation...
It will require the collective perseverance of each and every sector of the community to breathe life into the recommendations outlined in this report. Community partnerships are essential; only through cooperation and collaboration will we make the necessary strides to move our community forward. Every professional, community leader, service provider, and citizen is needed to participate in the process.

Our work is just beginning…
Now is the time that we cease talking about the community's problems and begin implementing tangible and realistic community solutions. We urge you to assess how alcohol and other drug abuse and addictions have impacted you, your life, your family, and your community. Determine how you can play a role in making a change. Please join us as we take these first steps towards improving the AOD services and systems in Montgomery County.

MONTGOMERY COUNTY
Alcohol & Drug
Abuse Task Force

FAMILY AND CHILDREN FIRST COUNCIL
MONTGOMERY COUNTY

MONTGOMERY
COUNTY
Ohio

451 West Third Street
P.O.Box 972
Dayton, Ohio, 45422-1317
www.mcohio.org

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