

***HANCOCK COUNTY BOARD OF ALCOHOL, DRUG  
ADDICTION & MENTAL HEALTH SERVICES***

**Mission: “To improve our community by reducing the incidence of mental health problems and eliminating the abuse of alcohol and other drugs in Hancock County through a locally administered, publicly funded system.”**

***FY 2007 – 2009 Strategic Plan***

*Over the next three years, the extent that our local system can raise the quality of life for those who need Board funded services is one measure by which we will have truly transformed.*



## Introduction

*“A fundamental question remains: If the purpose of the behavioral health system is not to help people on their path of personal recovery, what is it for?”<sup>1</sup>*

### **SHARED VALUES OF RESILIENCY & RECOVERY**

**Hope &  
Spirituality  
Competencies  
Empowerment  
Basic Needs & Safety  
Effective Clinical Care  
Medications & Doctors  
Supportive Connections  
Meaningful Involvement**

There is a national call to transform public treatment systems to become more Recovery and Resiliency oriented. In *Transforming Mental Health Care in America, Federal Action Agenda: First Steps*, Recovery is cited as the single most important goal for transforming mental health service delivery systems.

Within this growing momentum around Resiliency & Recovery (R&R), the Hancock County Board of Alcohol, Drug Addiction & Mental Health Services (ADAMHS) dedicated its strategic planning process to generate strategies that will answer this single question: ***How can our system become more resiliency and recovery oriented?***

When customers are asked what they need to recover, they report they need a sense of belonging, a decent place to live, friends, access to medications and effective care, and an adequate income. These desires are universal. ADAMHS believes that the **Shared Values** of R&R (see inset) are applicable to all of us, including customers of both mental health and substance abuse treatment services as well as to children and families.

While ADAMHS has been making investments consistent with R&R for several years (including growth of evidence-based practices, the establishment of a consumer run drop-in center, and resources supporting the vitality of a variety of consumer and family support groups), the shared values are the organizing principles that will be the engine that drives deep and permanent change in the delivery of behavioral health care.

Through this Strategic Plan, ADAMHS maps out its role within this transformation process and summarizes how we worked with customers<sup>2</sup> and stakeholders to generate answers to the transformation question. These answers are articulated through a set of six strategic priorities and three transformational goals (listed in Figure 1). The priorities are the objectives that will guide our actions and set our direction and include the incorporation of continuing initiatives that support R&R. The transformational goals allow us to periodically check our destination: that we are, in fact, staying on course.

<sup>1</sup> Jacobson, N. & Curtis, L.C. (2000). Recovery as Policy and Practice: How States Are Implementing the Concept. *Psychosocial Rehabilitation Journal*. 23:4, 333-341. 2000.

<sup>2</sup> Throughout this document, the term “customers” refers to individuals who use ADAMHS funded services, their families and loved ones.

**Figure #1: Strategic Priorities and Transformational Goals**

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**Strategic Priorities- Direction**

1. Increase customer voice
2. Strengthen engagement
3. Make system of care changes consistent with R&R
4. Adapt ADAMHS roles to R&R shared values
5. Targeted wellness promotion including selective prevention efforts
6. Focus partnerships with criminal and juvenile justice, physical health education, and child welfare

**Transformational Goals- Destination**

1. ADAMHS allocations will achieve a greater balance of funding across the eight shared values of R&R
  2. ADAMHS will continue to lead a culture shift based on the shared values to gain full participation of customers within work, school, and community settings
  3. The quality of life of customers will be raised using measures consistent with the shared values (with an emphasis on employment and school success) and monitored through a continuous quality improvement process.
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The Plan includes these sections:

1. Resiliency & Recovery as **THE** Transformation Tool to Address Quality of Life
2. The Planning Process
3. Resiliency and Recovery Defined
4. The Shared Values of Resiliency and Recovery
5. Transforming ADAMHS Core Functions
6. Strategies to Support Transformation Goals

**Attachments**

1. Strategic Planning Participants
2. Board Adopted Models
3. A Comparison of Recovery's application to Mental Illness and Addictions
4. Comparison of Recovery, Resiliency, and the Medical Model
5. Suggested Strategies to Fulfill our Priorities

# **1. Resiliency & Recovery as *THE* Transformation Tool**

*“Having a source of support so that, in the dark times, we can have a window or door open to let in even the smallest ray of light that can help us feel a sense of hope and empowerment to carry on.” – Local family member definition of resiliency*

The President’s New Freedom Commission states: “Care must focus on increasing customer’s ability to successfully cope with life’s challenges, on facilitating recovery, and on building resilience, not just on managing symptoms”.

It is clear from this statement that resiliency and recovery (R&R) provide a unique avenue to addressing “life’s challenges.” But what are these challenges?

The intersection of poverty and persistent addictions or mental illnesses presents challenges that can impact one’s ability to successfully cope. Co-occurring mental illness and addictions create even more vulnerabilities that can compromise one’s quality of life.

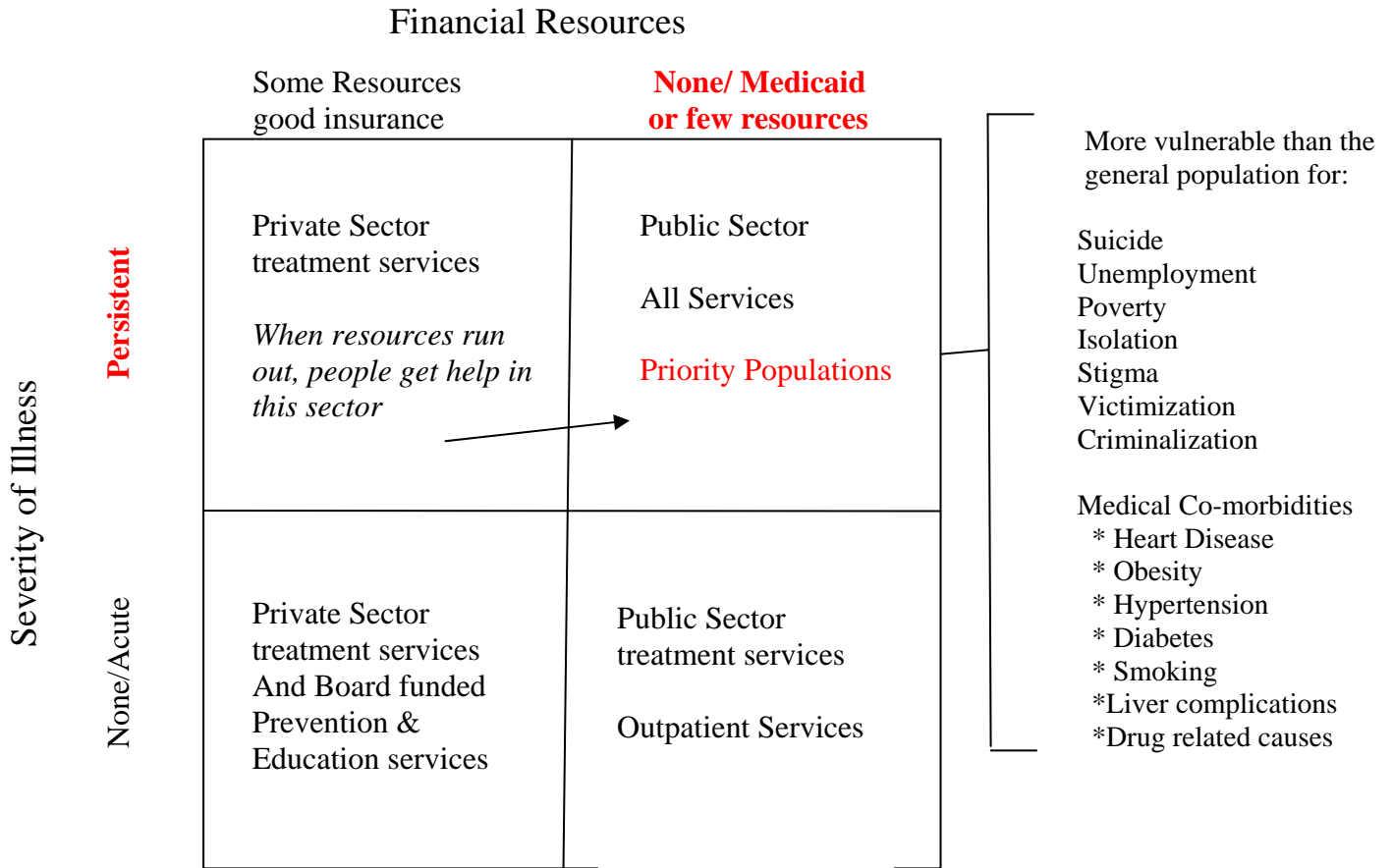
When compared to the general population, people who are poor and with persistent addictions or mental illnesses are more likely to:

- Be stigmatized
- Be victimized
- Suffer or die from a variety of co-morbid health conditions like heart disease, hypertension, diabetes, liver complications, and drug related causes.
- Die from suicide
- Be unemployed
- Be isolated
- Be homeless and hungry
- Be imprisoned
- Smoke and be overweight

Figure 2 summarizes the link between poverty, persistent conditions and the vulnerabilities that adversely affect one’s quality of life.

What R&R offer is a shared values base that is hopeful and empowering and addresses life’s challenges in a way symptom reduction alone can not. From the ADAMHS perspective, the call to transform systems using R&R as the major tools of change is a call to address quality of life issues. Over the next three years, *the extent that our local system can raise the quality of life for those who need Board funded services is one measure by which we will have truly transformed.*

Figure 2: Poverty, Persistent Conditions, Vulnerabilities



## 2. The Planning Process

The planning process adopted by ADAMHS began in January (2006) with an orientation for the members on the concepts of Resiliency and Recovery. In addition, the Board reviewed its statutory responsibilities related to funding, planning and evaluating as well as past planning assumptions and the status of the expiring FY '04 - FY '06 Strategic Plan. In addition, two focus groups were held with adult customers of mental health and substance abuse treatment services to gather further information on their perspectives of recovery and hear their experiences within the current system. All of this information was summarized as strengths and areas of growth regarding our system's readiness to transform:

<u>Strengths</u>	<u>Areas of Growth</u>
<ol style="list-style-type: none"> <li>1. Committed and caring providers</li> <li>2. Strong and involved Chief Clinical Officer (Dr. Basu)</li> <li>3. An array of housing services</li> <li>4. Access to medications and doctors</li> <li>5. Growth in funding of evidence-based services</li> <li>6. Successful grant applications</li> <li>7. Increased focus on the issue of engagement</li> <li>8. Allocation to form and foster a Drop In Center</li> <li>9. Allocations to support area support groups</li> <li>10. Implementation of Supported Employment</li> <li>11. Active Prevention Education efforts that build assets and address stigma</li> <li>12. Well connected collaborator at local and state levels</li> </ol>	<ol style="list-style-type: none"> <li>1. Limited funding to support expansion initiatives</li> <li>2. Limited growth in memberships of consumer and family member organization</li> <li>3. Turnover in leadership positions at both agencies</li> <li>4. Difficulties in hiring certain degreed positions</li> <li>5. Little use of data related to Quality of Life Issues</li> <li>6. Lack of clarity on ADAMHS and the system's role in leveraging some of the shard values (e.g., Hope, Spirituality, Empowerment)</li> <li>7. Stronger fight against stigma and for Parity.</li> <li>8. Only 1 FTE dedicated to Supported Employment</li> <li>9. No formal Peer Support programming at ADAMHS or Agency levels</li> <li>10. Underserved populations are the elderly and adolescents needing substance abuse treatment</li> </ol>

After the ADAMHS orientation session, the Board commissioned parallel planning committees, one with a focus on Resiliency and one with a focus on Recovery. Staff recruited content experts in each of these areas who acted as facilitators for the Planning Committees. Thelma Rist (Ohio Advocates for Mental Health) and Lisa Oswald (Adult Recovery Network) facilitated the Recovery Committee and Terri Garner (Ohio Federation for Children's Mental Health) and Rick Sheppler (Center for Innovative Practices) facilitated the Resiliency Committee. These experts spent over 16 hours in one month with a diverse group of some fifty customers, professionals, and ADAMHS members (customers of mental health or substance abuse services and family members made up over 40% of participants on each committee). Each Committee met for two hours once a week during the month of January. Committee participants are identified in **Attachment #1**.

### 3. Resiliency and Recovery Defined

As part of the planning process, the Recovery Facilitators conducted two focus groups with customers and asked what Recovery means to them. Here is a sampling of answers they provided:

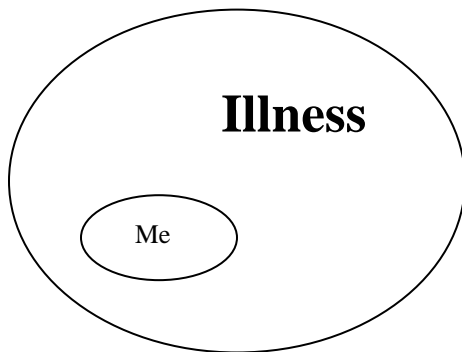
- "Recovery is a change in your life with increased friends"
- "To be recognized as a person, not a diagnosis"
- "Realistic hope"
- "To go about the business of everyday life"
- "To do what I want & not worry about mental illness"

When defining recovery, it is often contrasted with the traditional model (sometimes called the medical model). This contrast often centers on the traditional systems reliance on medications and clinical services and the role of the customer as a patient whose negative symptoms need to be addressed. In recovery oriented systems there is

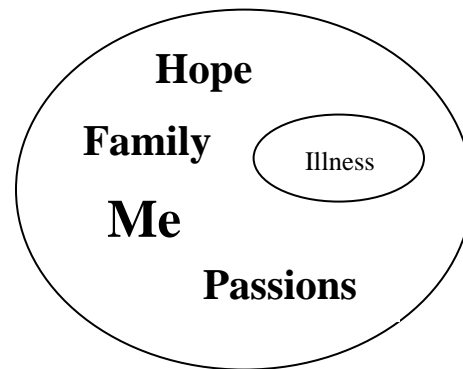
an emphasis on helping individuals to move beyond diagnostic labels. Often individuals internalize these labels, accepting them as their primary identity and experiencing unnecessary and detrimental self-stigma, low self esteem, and self-limitations.

Contrasted with R&R's emphasis on empowerment and hope, two pictures emerge that differ in how the customer experiences each system:

**Medical Model emphasis on symptom relief**



**Recovery / Resiliency's emphasis on hope**



In short, treatment efforts that are hopeful and empowering should be viewed as one of many critical tools that can support recovery. While customers may own their recovery process, boards, agencies, and the community can facilitate the journey.

The planning process included a discussion of Recovery's application to those living with a substance abuse disorder. Alcoholics Anonymous (AA) and other 12-step programs were the first to recognize that the traditional concepts of medical recovery were not sufficient to address how people healed from these disorders. They taught that sobriety was more than abstinence from addictive substances – that it entailed completely replacing old ways with new ways, giving up an old life and learning how to create a healthy and fulfilling life. With this approach, the concept of recovery was expanded to encompass many non-medical aspects of healing: the social, cognitive, interpersonal and even spiritual elements of an individual's life. Similarly, symptom remission or illness management alone is inadequate to define recovery from psychiatric disorders.

In addition, the congruence of resiliency and recovery were explored. Resiliency is a concept that initially emerged from studies of youth and families and was used to describe those individuals who seem to not only survive in difficult situations but also seem to constructively rebound from adversity. Essentially, resiliency is a personal characteristic that combines individual traits and learned skills; recovery is a process of positive growth, healing, and building meaningful and productive lives. A recovery and resiliency oriented system identifies and builds upon assets and strengths to support achieving a sense of mastery and regaining a meaningful sense of membership in the

community. Learning and developing resilience skills (e.g. problem solving, coping skills, nurturing positive attitudes) can be viewed **as an essential aspect of one's recovery journey.**

Each of the groups were then charged with adopting definitions of Resiliency and Recovery. As a context to this exercise, the Committees reviewed ADAMHS's existing Board adopted Models (revised as **Attachment #2**). This is different than the Board's Mission statement which describes the line of business the ADAMHS is in. The Board Models articulate the values that we strive to incorporate within our system of care and guides program delivery and clinical services and include:

<u>AREA</u>	<u>MODEL</u>
Prevention & Education	Life-Style Risk Reduction Model (AoD) Developmental Assets Model
System of Care Models	Wraparound for Youth & Recovery for Adults
Clinical Models	StageWise Treatment approaches

In reviewing ADAMHS's adopted models the Recovery Planning Committee revised the current Recovery language and, because the statement was silent on Resiliency, that planning committee developed a definition: These definitions incorporated in the revised statement are:

***Resiliency** is the innate capacity to successfully meet life's challenges with a sense of self-determination, mastery and hope. **Recovery** refers to a point in someone's illness in which the illness is no longer the first and foremost part of his or her life, no longer the essence of all his or her existence. It is the belief that all people can have full lives through the management of their addiction and mental illness through hope, support, sobriety, and effective treatment.*

As a step toward understanding ADAMHS's duties in the transformation process, the committees also drafted a statement on the Board's role in supporting resiliency and recovery.

*The role of the local system of care is to facilitate and nurture resiliency and recovery through empowerment, supportive relationships and environments, education and access to effective services that are responsive to the needs of all.*

Finally, the Resiliency Committee discussed the importance of family empowerment. Often when families need public treatment services, they are in a state of crisis and dealing with a new diagnosis of a loved one. When exploring the definition and values within resiliency, the Committee identified ways that families can assume an empowering role in advocating for their family's needs. While suggestions came from the Resiliency Committee, they are equally applicable to the adult customers. These include:

### Family/Customer Roles in R&R\*

1. Promote your own family's health and build resiliency capital (increase assets and natural supports).
2. Learn as much as you can about your child's disorder/issue. Educate yourself on what resources are available to you and use them when needed.
3. Know when to ask for help, and ask for it. Ask for what you need. Identify what you want.
4. Get involved in your child's treatment. Be an advocate for your family.
5. Take responsibility for improving your quality of life.
6. Provide a safe and nurturing sanctuary for all family members.
7. Reach out to others in need, you are a valuable and powerful resource to others.

*\*When a family cannot do one or more of these by themselves, we believe it is the public system's role to empower families.*

## **4. The Shared Values of Resiliency and Recovery**

The planning process with ADAMHS and the committees explored the similarities, differences of R&R across different customer populations (these are summarized in Attachments #3 and #4). There are important distinctions between Recovery as it applies to the field of mental health and substance abuse. For example, one difference centers around the issues of power and powerlessness. One of the primary elements of 12-step recovery is to admit powerlessness and turn one's self and life over to the power and direction of a trusted "other" or Higher Power. In mental health recovery, the focus tends to be more on empowerment and self-determination, helping individuals to find their own voice. This is based on the belief that individuals need to reclaim their own power as one of the first steps of a recovery process.

Also, in 12-step programs, members are encouraged to label themselves as their addiction (e.g., "I am an alcoholic). In recovery-oriented mental health care, individuals are encouraged to NOT identify themselves or be identified by others as their diagnosis ("I am a schizophrenic"). A person may "have" a disorder such as schizophrenia or depression, but there is more to the person than this – it is not their sole defining characteristic.

While noting these distinctions, the planning committees believe that what the concepts of R&R have in common with respect to a shared values base should be the focus of transformation. The Committees concluded *that Resiliency and Recovery are holistic in their scope and should be viewed as universal in their application. Recovery*

from addiction and mental illness means learning to live a full and healthy life. Lessons learned from both Committees in the exploration of R&R include:

1. R&R values are universal and apply to all of us. We all seek supportive and caring connections. We all need hope and meaning in our lives.
2. Recovery is traditionally thought of as an “adult” process because an illness has already happened (e.g., schizophrenia) and Resiliency is typically applied only to youth. The integration of R&R, however, is not exclusively age specific. From a family systems perspective, adults need resiliency as much as youth and, given each family’s unique traditions and cultures, a parent’s recovery affects their children’s resiliency.
3. There is an important non-linear aspect to R&R -- “two steps forward, one step back” that recognizes the process is not easy and that people need the presence of supportive others and hopeful, caring environments to positively impact their quality of life.
4. Resiliency has traditionally been applied to prevention/education programming but transforming will occur to the extent that the shared values base is applied to treatment programs as well (e.g., balanced assessments, using hope to strengthen engagement and guide treatment, emphasis on school success for youth and meaningful involvement for adults).
5. Recovery’s application to prevention and education can focus on selected and targeted efforts to raise community acceptance, reduce stigma, expand the use of Advance Directives, and build competencies around illness management and recovery.

Many different sources exist that identify either the value-base of Resiliency OR the values inherent in Recovery. For example, the Substance Abuse Mental Health Services Administration’s National Consensus statement on Mental Health Recovery identifies ten components of Recovery (Hope, Self-Direction, Individualized, Empowerment, Holistic, Non-Linear, Strength-based, Peer Support, Respect, Responsibility). Friedman<sup>3</sup> cites five major components of Resiliency (hope and optimism, competencies, connection to individuals and intuitions, a sense of contribution, high expectations). Our strategic planning process led us to focus on the shared values base that these two concepts have to fuel transformation for children, families, and adults that need treatment in the public system regardless of the reasons why.

Hope & Spirituality

Quality of Life Issues

Community Acceptance/ Stigma

Empowerment

Advocacy

Self-help

Self-determination

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<sup>3</sup> Friedman R. (2003). All Ohio Institute on Community Psychiatry. System of Care and Evidence-based Practices. Creating Bridges, Cleveland, Ohio.

Competencies/ Meaningful Involvement  
 Work/School  
 Volunteer

Supportive Connections  
 Peer/Natural Supports  
 Hobbies & Passions  
 Mentors

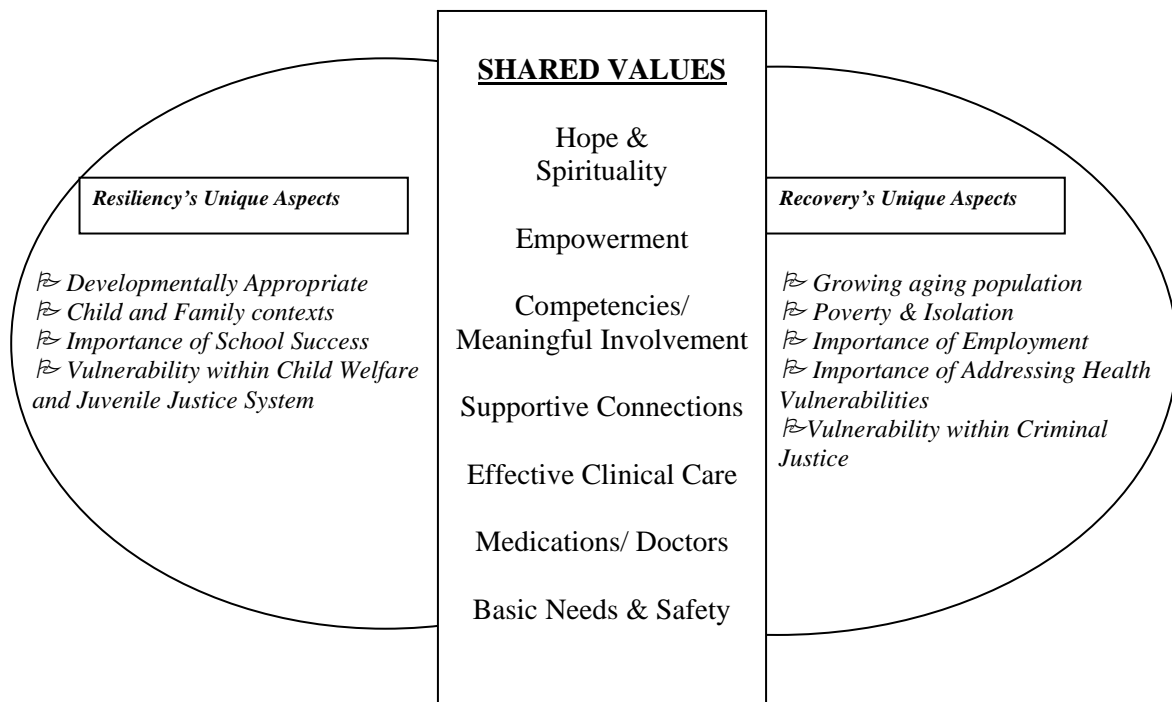
Medications/ Doctors  
 Holistic in approach (co-morbid health issues)  
 Good access  
 Illness education/medication side effects

Basic Needs & Safety  
 Housing  
 Finances  
 Crisis plans/Advance Directives

Effective Clinical Care  
 Evidence-based/ Strength-based services  
 Highly Individualized (Wellness Recovery and Action Planning and Wraparound)  
 Assertive outreach and engagement  
 Application of Stages of change to treatment cases  
 Cultural competency and awareness of cultural differences

While collectively these shared values create the context for transformation, Committee members often identified the critical link between hope and quality of life and how these can be the outcomes of successful integration of the other Shared values. It is hard to be hopeful when basic needs are not being met. It is difficult to impact quality of life when you are ill and can't access effective clinical care or doctors. If you don't feel empowered you won't feel hopeful. We incorporated the values within Resiliency and Recovery to a shared set of values that we summarized in Figure 3 and defined below:

Figure 3: Resiliency and Recovery's Shared Values



## 5. Strategic Priorities to Support Transformation

Much discussion occurred within each committee on how the local system can become more oriented to the shared values offered by resiliency and recovery. While no criteria were used to guide idea generation, the committee did discuss the need to propose strategies that would truly change the core functions of ADAMHS (Allocation, Planning, and Evaluating). By way of an example, a transformational goal affecting the Board's function of allocations would NOT be to simply fund additional services or programs. Rather, strategies that clarify the ADAMHS role in leveraging hope, empowerment, or spirituality would be transformational.

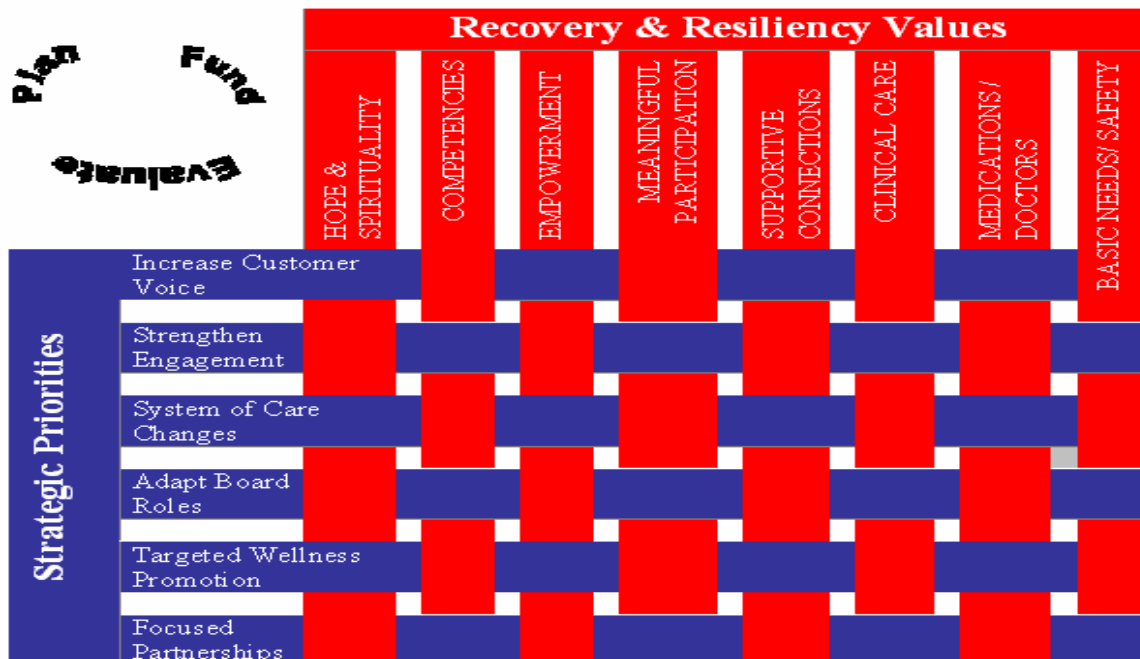
With this in mind, the Committees identified dozens of possible strategies. To identify common themes across each committee's work, several different ways of classifying and organizing the strategies generated were tried before the groups adopted a common framing. Each of the strategies supports one of these six priority areas:

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### Strategic Priorities

1. Increase customer voice
2. Strengthen engagement
3. Make system of care changes consistent with R&R
4. Adapt ADAMHS roles to R&R shared values
5. Targeted wellness promotion inclusive of indicated prevention efforts.
6. Focus partnerships with criminal and juvenile justice, physical healthcare, education, and child welfare

So that the Board stays focused on the relationship (and importance) of these strategies, its core functions, and the shared values, this illustration was developed:



Parallel to the Committees generation of these strategies, Board staff were reviewing transformational planning documents and strategic plans from other states and counties. In total, over 35 activities that support the six priority areas are listed in Attachment #5. Collectively these issues represent the system's "work-plan" over the next three years. For successful implementation of this plan, the ADAMHS will need to consider the following:

1. Data driven- ADAMHS Planning should be mindful of how it impacts the current burden level, especially at the agency level. To that end Board planning should prioritize the use of existing data provided through MACSIS/BH/Claims databases and must increasing rely on the sixteen Care Management Indicators of Quality services identified in the state's Medicaid Business Plan.
2. Progress must be measurable- For the remainder of this fiscal year, it is recommended that the ADAMHS continue defining the transformational goals so that as of July1st, baseline data using FY05-FY06 will be completed and the transformational goals will be verifiable.
3. Timing- There is a general chronology to the strategies that will need to be considered as ADAMHS begins implementation in Year 1. Areas dedicated to training and reviews of foundational documents (e.g., policies, mission statements), as well as formalizing how this plan will be implemented, reviewed and reported on should be a year one priorities.
4. Mutual synergy around the need to transform- As the local planning authority, the Board sets the direction for the behavioral health system for the entire community. Since the Board does not provide direct services, it must orchestrate multiple contracts into a system of care. Transformation will be successful to the extent that agency's embrace R&R, the need to transform, and advocate for their role in the transformation process. Similarly, our ways and patterns of relating to our customers must instill hope and our on-going work must reflect their sentiment ***"Nothing about us without us!"***

## **6. Positioning for Change: Three Transformational Goals**

We know our system of care is transforming around the principals of recovery and resiliency if it fundamentally changes the way we do business. The tools used by boards to orchestrate the system of care are its core functions of planning, funding, and evaluating. To explore further transformation related to the Boards functions, a R&R values assessment was completed that noted how each of the Boards functions were generally being implemented and how this may look differently within a R&R framing.

**VALUES ASSESSMENT: Impacting the Board's Functions with R&R Values**

	<b>Where we are now</b>	<b>Where we want to be in an R&amp;R framework</b>
PLANNING	ADAMHS exceeds minimum requirements of having customer representation on the Board of Directors and associated Board committees. Agency by-laws and practice are silent on the role of customers with agency governing boards and related committees. Customer input is primarily received via client complaints and grievances, satisfaction surveys or periodic focus groups.	ADAMHS and agency decision-making structures have multiple outlets for Customer voice. Customers don't have to be "invited" to give input periodically because their voice is ingrained within decision-making structures that impact all aspects of planning- funding, services, and supportive programs. A meaningful role for customers within the CQI process is developed and facilitated. Formal avenues for customer participation are many and include active customer and family advocacy and support groups, the hiring of customers and the use of peer helpers/mentors/specialists. Customers are assigned as an advocate or ombudsmen or client's rights officer.
FUNDING	ADAMHS funds are allocated to purchase services consistent with the ODMH/ODADAS billing taxonomy. An effort is made to have these services be evidence-based. An array of housing options for mental health clients exist as well as a Drop-in Center. Board funds are used for targeted staff development that supports ADAMHS priority services. Prevention/Education efforts are provided universally, and most of them are aimed at increasing assets and ATOD programs. Some financial support is provided to customer and family support groups. No formal peer-support positions are funded.	Allocations support effective clinical services as well as psychosocial rehabilitation programs and effective support programs (self-help and mentoring programs). Prevention/Education is both universal and targeted. Anti-stigma efforts and use of the Asset Model is prevalent. Targeted prevention efforts include relapse prevention and illness management strategies. Capacity across services is balanced (employment, adolescent alcohol, tobacco and drug treatment and housing). An effort is made to employ customers throughout the system. Customers are hired to run customer-run agencies and are sought naturally to fill vacancies in peer-support positions within ACT/IDDT and other programs.
MONITOR/ EVALUATE	Performance is largely defined and monitored around financial solvency, meeting reporting requirements, and fidelity to select programs. The system has some ability to track progress in symptom reduction or increased functioning on an aggregate basis. Collection of quality of life indicators is difficult and not used within a CQI format. The treatment process is monitored for client participation via signatures, continuity of care issues and about a dozen characteristics of treatment success as defined by family members.	Performance is defined as raising the quality of life of those in the system. Recovery and Resiliency measures are identified and adherence to them is monitored within a CQI process. Quality of Life indicators and Engagement indicators are developed with customers and monitored. The treatment process is highly individualized with strong engagement strategies provided by clinical staff as well as peers/mentors/advocates. The treatment process is monitored for fidelity to R&R principals and addresses crisis plans, advance directives, isolation, and meaningful participation in the community (work, school).

We believe that if we implement the six strategic priorities over the next three years that we will be transforming our system from one with an emphasis on effective clinical care to a system with an emphasis on positively impacting the quality of life for those who need our services, especially for those with persistent mental illness and addictions. Said differently, three years from now when reviewing the progress on this Strategic Plan, an indicator of success (by itself) should not be that we were able to expand services, but that we were able to orient the system's resources to improving the quality of life of customers in a measurable way.

To better assure that the Board is reaching this goal, three transformation goals were developed, one relating to each of the Board's core functions. Each of these goals will have baselines developed and will be measurable. Board status reports on subsequent reviews of this Plan's implementation will be measured against these three goals.

These transformational goals are:

<u>Board Function</u>	<u>Goal</u>	<u>Baseline Measurements</u>
1. Allocations	Board Allocations will achieve a greater balance of funding across the eight Shared Values	FY '05 Allocations will be categorized to identify services and supports consistent with the Shared Values
Planning	Customers will be Empowered	Hopefulness Scale in the Ohio Scales, customer participation on governing boards, planning initiatives, memberships in consumer and family support groups, satisfaction/CQRT data, growth of peer-support initiatives within the treatment system, growth in evidence-based practices.
Evaluating	The Quality of Life of Customers will be raised	Medicaid Business Plan indicators (increased employment, successful completion of treatment, community tenure), school success, youth will have more assets.

## Attachment # 1 Strategic Planning Participants

### Resiliency Sub-Committee

Terre Garner, Co-Facilitator  
Rick Shepler, Co-Facilitator

### Recovery Sub-Committee

Lisa Oswald, Co-Facilitator  
Thelma Rist, Co-Facilitator

Elizabeth Betts, Family Member  
Julie Betts, Family Member & ADAMHS Board  
Barbara Brahm, OSU Extension Office  
Mary Burget, Findlay High School  
Marty Cohen, Family Member  
Brenda Frankart, Liberty-Benton High School  
Tonnie Guagenti, Family Resource Centers  
Ada Hilton, Parent Advocate  
Diana Hoover, Hancock County Job & Family Services  
Peggy Lehman, Family First Council  
Paul Lilley, Hancock County ADAMHS Staff  
Rhonda Moor, CASA/GAL  
Robert Nichols, ADAMHS Board Member  
Cheryl Preston, Family Member  
Cara Reynolds, Family Resource Centers  
David Rinebolt, Hancock County ADAMHS Board  
Kay Sidle, Findlay City Schools  
Precia Stuby, Hancock County ADAMHS Staff  
Pat Sudlow, Findlay City Schools  
Carol Taylor, Family Resource Centers  
Rick Van Mooy, Hancock County Educational Service  
Center  
Cathy Weygandt, Family Member  
Amber Wolfrom, Hancock County Community  
Partnership

Barb Barlchlett-Butler  
Julie Betts, ADAMHS Board Member  
Dick Bibler, ADAMHS Board Member  
Carl Etta Capes, AA Community  
Marty Cohen, Family Member  
Tom Davis, Findlay City Board of Health  
Paul DeMoss, ADAMHS Board Member  
Barbara Dysinger, Century Health Board  
Judy Greiwe, ADAMHS Board Member  
Paul Hancock, ADAMHS Board Member  
Suzi Healy, Century Health Board member  
Becky Hickle, Depression Bi-Polar Support Alliance  
Kathy Hirschfeld, ADAMHS Board Member  
Greg Horne, Findlay Police Department  
Pamela Kasiorkiewicz, Century Health, Inc.  
Gina Lewis, NAMI Hancock County  
Paul Lilley, Hancock County ADAMHS Staff  
Lisa Markel, L&M Supportive Housing Services  
George Milligan, ADAMHS Board Member  
Leni Mueller, Agency on Aging  
Chris Nold, Focus on Friends  
Larry Nold, ADAMHS Board Member  
Tina Pine, Century Health, Inc.  
Marilyn Rule, Century Health, Inc.  
Lynn Snyder, ADAMHS Board Member  
Precia Stuby, Hancock County ADAMHS Staff

## Attachment #2

### Board Adopted Models

(developed Jan/2002, revised Feb/2003 and Feb/2006)

It is the ADAMHS Board's responsibility to orchestrate multiple contracts into a coordinated system of care. Within this system of care, "models" exist that identify important values around how programs should be conceived, how services should be delivered, how customers should be treated, and the role of direct care staff in providing care. The Board desires the development of a System-of-Care vision that is grounded in the most current knowledge about prevention and treatment and encompasses the fields of mental health and substance abuse. This Vision should be created in partnership with provider agencies and approved by the ADAMHS Board as it will provide a context and direction for how we want our local system to grow. We believe a sound Vision can help connect and weave the ADAMHS initiatives and agency programs into a coherent, coordinated system-of-care.

**For Prevention & Education of alcoholism/drugs**, the model adopted by the Community Partnership and provider agencies is the **Life Style Risk Reduction Model**. This model clarifies for people the disease of alcoholism. The model also articulates the various factors (biology, psychology, and social factors) that influence a person's use and the effect of that use. These factors, when combined with education on the frequency and quantity of alcohol/drug use teaches the difference between high and low risk choices. The model provides a no-use message to minors and a harm reduction message to those adults who choose to drink. For individuals addicted to illegal/non-prescriptive drugs, the goal is abstinence.

**For education around mental health**, the model adopted by the agencies is the **Asset Model**. This model articulates internal (eg., self respect) and external (parental monitoring) assets that children need to thrive. Research has shown the more assets a child has in his/her life, the greater the chances are that they will not make high risk choices around sexual activity, drug use, and school failure. In addition, education efforts are offered to the general public that are aimed at reducing stigma and increasing awareness of existing programs and how to access help.

**For the Child/family system**, the model adopted by the ADAMHS Board is the Resiliency Framework. **Resiliency** is the innate capacity to successfully meet life's challenges with a sense of self-determination, mastery and hope. In addition, the Board and the Family First Council have adopted the **Wraparound Model**. This model articulates a way to improve the lives of families who have complex and multiple needs. Wraparound is a philosophy of care and a process. Wraparound care always utilizes a planning process involving the child and family with a team of individuals that results in an individualized set of services and supports designed to help the family improve their situation. Services must not only be individualized but strength based and designed to

meet the needs of children to promote success, safety and permanence in home, school and community.

**For the Adult system**, the model adopted is the **Recovery Model**. Both mental illness and addiction can be treated within the philosophical framework of a disease and recovery model. **Recovery** refers to a point in someone's illness in which the illness is no longer the first and foremost part of his or her life, no longer the essence of all his or her existence. It is the belief that all people can have full lives through the management of their addiction and mental illness through hope, support, sobriety, and effective treatment.

The model to guide the delivery of **Clinical Treatment programs** is one that integrates approaches for both mental illness and substance abuse treatments, called the StageWise model. This model views both addictions and mental illness as persistent, progressive diseases where relapse and decompensation should be expected as part of the nature of the disease. The corresponding treatment approach developed to address the cyclical nature of these diseases includes four stages of treatment: Engagement, Persuasion, Active Treatment, and Relapse Prevention. *The model guides clinical programs to provide interventions that are diagnosis-specific, but also specific to the different phases of recovery and stage of change.* These stages should focus the treatment effort on “meeting the client where they are”.

All of these models have important principals that they share in common:

- Early Intervention- For prevention services, this means that the community is provided the educational opportunities and skills building needed across the lifespan of its residents so that adults and children make healthy, low risk choices and that families thrive because assets abound. For treatment services, this means the recovery and wraparound begins at the first point of contact.
- Client/family driven- the needs of the client/family dictate the services and programs offered. Plans are needs-driven rather than service-driven, although a plan may incorporate existing categorical services if appropriate to the needs of the customer. The initial plan should be a combination of existing or modified services, newly created services, informal supports, and community resources, and should include a plan for a step-down of formal services. When clients/families feel that treatment is relevant to their situation and they feel listened too, positive treatment outcomes occur. This is especially critical to children and adolescents in which they should be treated within the context of their family.
- Strength-based planning- from initial assessment to on-going treatment, care plans are individualized by identifying and leveraging the talents, skills, and family and support networks that clients have. When “internal” assets can be strengthened, adolescents do not make high risk choices and family cohesion is strengthened.

- Asset building- The healing of clients and families is viewed in the larger context of a thriving, healthy community whose assets (like mentoring) should be leveraged on behalf of the client.
- Evidence-based applications- Where programs and services have been proven effective, the system will align resources and allocations to develop the effective approaches.
- Community-based- Services and programs should be offered in the most natural and least restrictive settings possible and include the use of family, natural, and community supports.

In summary, all of the chosen models seek empowerment. For adults struggling with addictions, empowerment is found through sobriety. For adults and families struggling with a mental illness, empowerment is found through recovery. And for the entire community, empowerment is found through education in that knowledge is the power to live a healthy life.

*The role of the local system of care is to facilitate and nurture resiliency and recovery through empowerment, supportive relationships and environments, education and access to effective services that are responsive to the needs of all.*

### **Citations for selected models:**

#### Lifestyle Risk Reduction Citations

*Programs based on the Lifestyle Risk Reduction Model have been shown effective in reducing the quantity and frequency of alcohol use among people of all ages. These evaluations found that, after attendance at various PRI curriculum classes, a significant number of participants believed that they had real risk and were much more likely to make low-risk alcohol and drug choices (from PRI website).*

#### Assets Citations

*Assets have tremendous power to protect youth from many different harmful or unhealthy choices and the number of assets have an accumulative effect: that youth with the most assets are least likely to engage in four different patterns of high-risk behavior (Problem Alcohol Use, Violence Illicit Drug Use Sexual Activity) based on surveys of over 217,000 6th- to 12th-grade youth in 318 communities and 33 states during the 1999-2000 school year From Search Institute website)*

#### Wrap Around Citations

*Substance Abuse and Mental Health Services Administration (SAMHSA) best practice publication Burns BJ, Goldman SK (Eds.): Promising practices in wraparound for children with serious emotional disturbances and their families. Systems of Care: Promising Practices in Children's Mental Health, 1998 Series, Volume IV. Washington, D. C.: Center for Effective Collaboration and Practice - American Institute for Research, 1999. Multiple uncontrolled studies of case management using a wraparound approach were summarized in a recent monograph focusing on the wraparound process (Burns & Goldman, 1999). Overall, the reviewed studies, although using uncontrolled methods, offer emerging evidence of the potential effectiveness of case management using a wraparound process.*

#### StageWise Citations

Research has shown that an integrated approach using stagewise treatment reduces relapse, duplication of services and costs, and improves continuity of care Literature in both the addiction field and the mental health field has emphasized the concept of stages of change or stages of treatment, and demonstrated the value of stagewise treatment (Drake et al, 2001.)

### Attachment #3

#### Comparison of Recovery's Application to Mental Illness and Addictions

<b>Focus On</b>	<b>Mental Illness</b>	<b>Addictions</b>
Recovery is ...	An ongoing journey or process	Both a phase in treatment and an individualized and lifelong process.
Recovery is enhanced by...	Mutually supportive relationships with family and friends, individualized person-centered care, access to medication, employment, and basic supports	Abstinence or reducing the negative consequences of addiction. Changing the environment in which the addiction occurs and changing social habits and relationships
The illness	Individuals are encouraged to NOT define themselves as their diagnosis, as a way to gain a feeling of power and control over one's life	Individuals encouraged to label themselves as their addiction ("I am an alcoholic")
Engagement	Anosognosia (impaired awareness of illness) is a major barrier to treatment engagement	Denial of illness is a major barrier to treatment engagement. While not true of most people who abuse drugs, public treatment clients are often court involved.
Power/Control	Empowerment and self-determination are used to help customers find their own voice.	Admit powerlessness and accept that there is a problem with alcohol/drugs and help is needed to overcome the addiction
Individual's role in Recovery is...	Learn about the illness and gain skills to manage and cope with symptoms	A commitment to working towards overcoming the addiction and preventing relapse
Relapse	Seen as part of the illness	Seen as part of the illness
The Goal of Recovery is ...	Hope and participating in community life	Rebuilding of life through abstinence to gain healthy relationships and meaningful activity

## Attachment #4

### Comparison of Recovery, Resiliency & the Medical Model

	<b>Medical Model</b>	<b>Recovery Model</b>	<b>Resiliency Model</b>
<i>Definition</i>	The medical model views disorders on a continuum from illness to health with a focus on treatment and cures.	Recovery is a deeply personal, unique process of changing one's skills and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness.	Resilience is an innate capacity that when facilitated and nurtured empowers children, youth, and families to successfully meet life's challenges with a sense of self-determination, mastery and hope.
<i>Origin</i>	Professionally driven model of care	Customer driven model of care. Grown out of lived experiences with mental illness	Developing those traits commonly found in resilient survivors: social competence; problem-solving; autonomy; and a sense of purpose and belief in a bright future.
<i>View of mental illness</i>	Lifelong, permanent condition from which people never fully recover but can be stabilized.	Lifelong condition where Recovery is the journey in which a persons tries to instill self-worth, hope, and meaning.	Emotional and behavioral disorders are not seen as permanent conditions. All youth and adults are born with innate resiliency.
<i>View of person with a mental illness</i>	Patient, client, consumer, etc.	A person in the process of over-coming the negative impact of a psychiatric disability despite its continued presence.	The belief that that everyone has innate resilience grounds practice in optimism and possibility, essential components in building motivation.
<i>Emphasis on</i>	Narrow focus on risk, deficit, and pathology to reduce symptoms and get the client/family well.	Self-determination through trusting and empowering relationships built around respect and hope.	Examination of the strengths youths, their families, their schools, and their communities have to promote healing and health.
<i>Type of treatments/ assistance</i>	Medications, evidence-based treatments, case management.	Self-help, illness management/ recovery skills. Gaining valued social roles through education and employment.	Family driven, child-centered programs based on the establishment of mutual relationships of care, respect, and trust between clients and professionals. Parents are the primary source of information on the child.
<i>How treatments/ assistance are directed</i>	Professionally determined in collaboration with the client through supportive, paid relationships.	Programs are viewed as a personal resource and a bridge to a hopeful future. Peer support and mutually supportive relationships enhance traditional services.	Communities and systems should foster caring relationships, high expectations, opportunities for meaningful participation and contribution.
<i>Goal of treatment/ Assistance</i>	Stabilization, maintenance, and increased level of functioning.	Hope and personhood through full participation in a community.	For youth with emotional disorders, systems and supports should be orchestrated to develop and nurture resiliency.

## ATTACHEMNT #5

### Suggested Strategies to Fulfill Our Priorities

#### 1. Increase Customer Voice

Suggested Strategies	<i>Shared Values*</i>	Verification / Implementation Issues
1. Develop customer empowerment guidelines that address how representation will be addressed across all levels of the system, including the provision of incentives for customer involvement.	<b><i>Empowerment, Meaningful Participation</i></b>	Such guidelines should be developed with customers and board/agency leadership and guidelines incorporated within board standards and contract language. Adherence to such guidelines can be one measure toward our transformational goal.
2. Increase membership to current support and advocacy groups. Explore developments of needed support groups (e.g., Dual Recovery Anonymous)	<b><i>Engagement, Supportive Connections, Hope</i></b>	Work with agencies to play an active role in the recruitment of family members. Growth in memberships of AMI, FOF, and DBSA, can be one measure toward our transformable goal baseline.
3. Increase number of opportunities where customer participation is sought in formal planning efforts.	<b><i>Empowerment, Meaningful Participation</i></b>	Identify formal planning efforts (e.g., Community Plans, Case conferences, Quality Improvement processes), and identify the extent of customer involvement.
4. Have customers train professionals about their experiences and needs.	<b><i>Competencies, Empowerment, Meaningful Participation</i></b>	Continue to use customers in CIT training and broaden their role in public relations, public education and training on R&R.
5. Identify and increase the number of customers acting in a governance role.	<b><i>Empowerment, Meaningful Participation</i></b>	Number of self-declared costumers on ADAMAHS and agency governing Boards.
6. Develop a more facilitative role with the AA community.	<b><i>Effective Clinical Care, Supportive Connections</i></b>	Develop and track needed array of 12-step programs.

***\*Note- the suggested strategies of the first three priority areas (Increase customer voice, Strengthen engagement, and System of care changes) directly advance the shared values of R&R and the format provided links the activity with the specific values being advanced.***

***The last three priorities have to do with Adapting ADAMHS roles, Strengthening the way we provide prevention and education services, and Focused relationships we will prioritize and these are formatted differently.***

## 2. Strengthen Engagement

Suggested Strategies	<i>Shared Values</i>	Verification/ Implementation Issues
1. Use Balanced/ Strength-based assessments with strong emphasis on strengths discovery.	<b>Hope &amp; Spirituality, Competencies, Effective Clinical Care</b>	Need to review evidence-based assessments, integrate with SOQIC.
2. Reach underserved populations (Elderly, ATOD adolescents, Sex offenders).	<b>Engagement, Effective Clinical Care</b>	Need to implement evidence-based approaches.
3. Use parent advocates, mentors and peer specialist and peer lead program offerings (Bridges, Family to Family, Hand-to-Hand, etc.).	<b>Empowerment, Supportive Connections, Meaningful Participation</b>	Clarify responsibility at various levels on recruitment and paying stipends for volunteers.
4. Accessible hours & services	<b>Engagement, Empowerment, Effective Clinical Care</b>	Work with agencies and customers to identify most convenient times. Care Management Indicator #12 Medicaid Business Plan.
5. Accept engagement as the responsibility of the system.	<b>Engagement</b>	Conduct a system-wide training on best practices with respect to engagement and outreach. Work with agencies to provide a range of outreach and engagement interventions.
6. Timely follow-up after a crisis.	<b>Engagement, Basic Needs and Safety</b>	Care management Indicator #11 in Medicaid Business Plan.
7. Provide assertive outreach through meeting customers where they are at and focusing on meeting their basic needs as an engagement strategy.	<b>Engagement, Basic Needs &amp; Safety</b>	Maslow's hierarchy is addressed via issues related to housing, safety, health care, and transportation.
8. Explore the use of the person-centered planning processes like Wellness Action and Recovery Planning	<b>Hope &amp; Spirituality, Competencies, Empowerment, Effective Clinical Care</b>	Clinicians work with customers collaboratively to develop a recovery management plan which focuses on hope and the interventions that will facilitate R&R and the resources that will support the R&R process.
9. Attention to spirituality and helping customers find meaning.	<b>Hope &amp; Spirituality,</b>	Evidence of training and supervision for staff around spirituality in treatment and support. Exploration of faith within strengths discovery and R&R planning.
10. Minimize use of coercive practices and approaches (e.g., involuntary treatment, guardianships, payeeships, conditional releases, commitments).	<b>Empowerment, Effective Clinical Care</b>	Every person under coercive mechanism knows the reason why and has a written plan on achieving self-management in their area of their life.

### 3. System of Care Changes

Suggested Strategies	<i>Shared Values</i>	Verification/ Implementation Issues
1. Have peer support services integrated into the continuum of community care.	<b><i>Hope, Empowerment, Meaningful Participation, Effective Clinical Care</i></b>	Peer run programs and trainings and meaningful roles such as: peers advocates on ACT/IDDT teams, Supported Employment job coaches, hospital liaison, client grievances, peer engagement specialist.
2. Continue to foster a caring and hopeful culture across the system of care.	<b><i>Meaningful Participation, Hope</i></b>	Adoption of explicit R&R oriented philosophy and policies that articulates how customers and professionals will work together and how planning for and the delivery of care will be customer driven. Supervision practices that help workers develop and implement R&R oriented approaches
3. If funding allows, expand non-clinical services.	<b><i>Meaningful Participation, Hope &amp; Spirituality</i></b>	Recommendations include supported employment, transition services, and peer support services
4. Consider staging all customers not just ATOD. (e.g., Engagement, Persuasion, Active treatment, Relapse Prevention. MH = Unaware, Aware, Interdependent).	<b><i>Effective Clinical Care, Engagement</i></b>	Staging allows for and emphasis on engagement as well as matching interventions with the appropriate stage of treatment. Staging can also be used to develop highly individualized interventions.
5. Care should be highly individualized and attend to the roles assumed by the customer other than patient (e.g., parent, worker, tenant, student).	<b><i>Meaningful Participation, Hope, Effective Clinical Care, Engagement</i></b>	Plans should focus on strengths, and demonstrate creative approaches to meet individualized needs. Evidence that customers are encouraged to involve significant others and the role support groups play in strengthening R&R should be seen.
6. Non-crisis care should include pre-crisis planning for with multiple relapse histories.	<b><i>Engagement, Effective Clinical Care, Empowerment</i></b>	Advance directives and relapse prevention plans aid in skill development as well as symptom reduction.
7. If funding allows, expand evidence-based and practice-informed clinical services that are desired by customers, empowering and instill hope.	<b><i>Hope, Empowerment, Effective Clinical Care</i></b>	Recommendations include adolescent drug treatment, ATOD case management.

#### 4. Adapt Board Roles

Suggested Strategies	Verification/ Implementation Issues
1. Create a formal and systematic way to implement, periodically review and assess the implementation of this strategic plan.	A formal process should be developed that includes the use of customers and agency leaders to assist with the review and implementation
2. Adapt the Board's mission, vision, and by-laws with customers, to incorporate the R&R values and its application to prevention, education and treatment services.	This can be part of the work that is also addressed by the formal process to be created that was suggested above. May also include R&R oriented staff trainings, customer trainings, and board orientations.
3. Develop continuous learning on the shared values of R&R.	Train new Board members on R&R and develop Board/agency orientation tract. Map out a year in advance the education and training efforts that will be dedicated to R&R.
4. Adoption of Systems level CQI plan that articulates a set of systems level indicators that support R&R and seeks to eliminate barriers to R&R. Study of existing recovery measures at individual and systems levels.	Plan should include, the identification and tracking of quality of life issues, the monitoring of fidelity measures, and the integration with the Care Management indicators of Quality Services within the State's Medicaid Business Plan.
5. Conduct our oversight role in an accountable way by developing performance based contract standards and expected outcomes meaningful to customers and family members.	Evidence of explicit R&R language in mission, vision, and guiding principles documents. Recovery oriented outcomes evident in all contracts.
6. Provider contracts with the Board will be reviewed/ revised to promote R&R shared principles.	Inclusions may be how customer empowerment standards will be addressed and the negotiations around indicators/thresholds in the Board/agency level CQI plan.
7. Revise the quarterly audits and have them identify elements of R&R.	Monitor that documented treatment is individualized, leverages strengths, and is clearly linked to symptom reduction as well as "drivers of hope": An increase in assets (friends, family and faith and pro-social peers and activities) an enhanced skill set (increase in coping skills, abilities, talents), and educational success/ meaningful participation in the community.
8. Work with providers to have an agency-level CQI process that include customers, regularly seeks customer opinions and develops and collects information on R&R performance measures.	Persons in recovery will participate on CQI committees and evaluate data to ensure that members of diverse cultural groups are receiving effective treatment.

9. Work with providers to incorporate R&R self-assessments within their CQI process and as a staff training tool.	Review of current agency-level assessments and the Recovery Attitudes Survey.
10. Advocate within the larger community to have the basic needs of all families addressed (healthcare, education, food, housing) and to change policies and practices that work against recovery and resiliency (parity).	Continue advocacy efforts through the state association and BHG as well as local partnerships around housing and serving those in poverty.

### 5. Targeted Wellness Promotion

Suggested Strategies	Verification/ Implementation Issues
1. Train everyone on R&R shared values and their connection with effective treatment and a raised quality of life.	Build system competencies needed for R&R by dedicating resources to staff development, training, and educational opportunities for provider agencies, families and “gatekeepers” within the community.
2. Promote universal mental health and addiction education and public relations within a R&R framework through frequent and multiple outlets.	General education about illnesses/addictions, where to go for help, anti-stigma, connection between the shared values and successful recovery rates and the preventative power of assets.
3. Provide selective education and promotion efforts aimed at priority populations. Topical areas include advance directives, health promotion addressing co-morbid health issues, and illness management and recovery issues.	Persons in recovery will be able to access information regarding health promotion.
4. Incorporate customer voice within prevention, promotion and educational efforts.	Involve customers in public education and relations campaigns. Customer success is highlighted in public education and relations campaign.

## 6. Focused partnerships

Suggested Strategies	Verification / Implementation Issues
1. Articulate what the system's responsibility and role is in partnering with schools to help youth graduate.	Resources should be aligned to decrease truancy and help kids succeed in school and make a successful transition to adulthood. School systems should be encouraged and assisted with implementing SED and depression awareness curriculums, mental health screenings, staff development, and the implementation of best practices in social emotional learning and positive behavioral supports.
2. Partner with other child serving agencies, especially child welfare and juvenile justice.	Systems should be offered focused consultation and effective clinical care while working to reduce out-of-home placements of youth. A re-commitment to the wrap around process should be developed.
3. Sustain criminal justice collaboration	Track CIT and other CJ trainings. Maintain and grow co-occurring treatment in jail settings. Strengthen jail screening and diversion programs. Explore the development of specialized court dockets for handling mental health and substance abuse cases.
4. Integrate with physical health	Provide cross trainings with psychiatrist and medical doctors, including diagnosis of depression and alcoholism. Advocate for the availability of regular and low/no cost physical health screens and wellness services, ideally integrating such screens within physical health care. Implement Advance directives