What Focus Groups on the Recovery Oriented System of Care (ROSC) Reveal of Service Gaps in Wood County

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Executive Summary

The Wood County ADAMHS Board solicited focus group feedback on the Recovery Oriented System of Care (ROSC). The qualitative data from the focus groups would supplement existing quantitative data needed for strategic planning. A quantitative survey on the ROSC was conducted by the Ohio Department of Mental Health and Addiction Services in January, 2016. Qualitative data, designed to supplement the state survey, was obtained through a series of focus group meetings in July and August, 2016.

Dr. Ivoska conducted a series of focus group and one-on-one meetings with a wide variety of groups in Wood County. Meetings were held with persons recovering from mental health issues, from persons recovering from addiction, from families of persons recovering from mental health issues, from families of persons recovering from addiction, from the providers of ADAMHS Board funded services, from police officers, chiefs of police and fire, and from police officers who are Crisis Intervention Coordinators in Wood County.

The quantitative survey suggested gaps in service in several areas and those gaps were confirmed by the focus groups. The quantitative survey suggested gaps such as 'no services where I live,' 'lack of transportation,' 'no interim services while on waiting list,' 'uncoordinated follow up,' 'no peer helpers,' 'no interest in client feedback,' and 'no strategies to reduce stigma.'

Four reoccurring themes, or patterns of responses emerged from the focus groups. These themes were:

1. A need for greater awareness and understanding of mental health and addiction issues experienced by Wood County residents, and a greater awareness of the resources available in Wood County.
2. A need for communication and sharing between everyone involved, including ADAMHS Board members, police and fire personnel, families, individual, and providers.
3. A need for greater clarity of the pathway when experiencing a mental health or addiction issue or crisis. The need for clarity came from individuals and families in the form of a 'flowchart' or 'road map' and from police and fire in the form of a written protocol.
4. A need for new and improved services, including
    a. Crisis Stabilization Unit
    b. In-patient, short-term detox residential treatment for 16-19 year olds
    c. Low income 'recovery housing' or other sober living environments
    d. Continuation of mental health services in schools
    e. Continuation of Crisis Intervention Training
    f. Stronger referrals and coordination of services from criminal justice
    g. Help for the working poor
    h. More psychiatrists and clinicians
    i. Review of the Connections Center physical and administrative structure.

Sources of data

Focus groups and one-on-one meetings were held to gather qualitative data regarding perceptions of the Wood County ADAMHS Board's Recovery Oriented System of Care (ROSC). The focus groups included: 1. Wood County residents in recovery and dealing with mental illness, 2. Wood County residents in recovery and dealing with addiction, 3. Family members of those Wood County residents dealing with a mental illness, 4. Family members of those Wood County residents dealing with heroin addiction, 5. Members of law enforcement and judicial services in Wood County, and 6. Representatives of the provider agencies funded by the ADAMHS Board. More specifically, the focus groups and meetings included:

1. Persons recovering from Mental Illness: 24 members at the Connections Center in BG.
2. Persons recovering from Addiction: Members of Team Recovery.
3. Family members of those recovering from:
    a. Mental illness: seven family members at a focus group held at NAMI.
    b. Addiction: four families at a Solace group meeting held at A Renewed Mind
4. Law Enforcement and Judicial Services: meetings including:
    a. Focus group at a Chiefs of Police meeting (all police chiefs, the prosecuting attorney, and juvenile division representatives) in Wood County were present
    b. Focus group with three CIT coordinators, including police officers and sheriff deputy
    c. One-on-one interview with North Baltimore Police Chief
    d. Telephone conversation with Chief Sanderson of the BG fire department
5. Providers: 8 representatives from the following agencies:
    a. Wood County Educational Service Center
    b. Family Services of Wood County
    c. Zepf Center
    d. Children's Resource Center
    e. Behavioral Connections
    f. NAMI
    g. The Link

Other than the Chiefs of Police focus group, the attendees were assured that their contributions would remain confidential, their identities anonymous, and that the information would be presented in the aggregate. The groups were assured that there were no 'right or wrong' answers, but we wanted their opinions or experiences with the ROSC in Wood County.

Other than the Chiefs of Police focus group, Dr. Bill Ivoska led the discussion, while a note taker kept record of comments made.

Procedures for the meetings: Families and Individuals

Meetings with families and individuals (dealing with mental illness and addiction) began with a statement about confidentiality: that the information would be anonymous – no names would be associated with any comments; that the comments would be confidential and only shared only with the ADAMHS staff and Board, and that comments would be presented in the aggregate, as themes or patterns of responses across focus groups.

Following the assurance of confidentiality, a clarification of a Recovery Oriented System of Care was explained. The definitions of a ROSC were taken from state's 'Recovery is Beautiful' publications. The information read to the group included the following:

"*Ohio's mental health and addiction system is moving from one that focuses on acute care to one that focuses on recovery management to help individuals not only get well, but to stay well.*
Ohio's ROSC will promote good mental health/substance abuse support through:

1. *prevention and wellness programs*
2. *provide crisis intervention*
3. *treatment services*
4. *recovery supports in the community*

We know for a fact that Treatment Works and People Recover. However, we also know that in order to have treatment work and people recover, it is insufficient to have only prevention and wellness programs, crisis intervention and clinical treatment but we also need recovery supports in the community such as:

1. *housing,*
2. *peer supports,*
3. *employment supports*
4. *transportation*

A fundamental principle of a Recovery-Oriented System of Care, is that

1. *Clients are key. Services are when and where the client needs them. Clients are the designer, driver and manager of their own care."*

Questions asked

With the preceding introduction in mind, the meeting with families and individuals dealing with mental health or addition issues began and proceeded with the questions that follow. The meeting with the Police Chiefs, CIT coordinators, and Providers had different questions. The order of the questions was not consistent between meetings, allowing for each meeting to take its own conversational course.

With the ideal vision of a Recovery Oriented System of Care in mind, let's talk about the ROSC in Wood County. Keeping the ROSC in mind,

1. Are services available when and where you need them?
    a. Do we have enough service? Professional clinicians, doctors, providers? Peer supports? Community centers?
    b. Access: transportation, detox centers, medications, outpatient support ability to pay, enough practitioners/providers, benefit specialists for coverage.
    c. Timeliness. Can you get into services in a timely manner?
    d. Community attitudes:
        i. Sober living communities
    e. Employer support. Do employers provide and support addiction services?
    f. Recovery follow-up services: do you feel retention efforts are made for you?

2. Are services responsive for you? Do you and your family feel fully involved:
    a. Do you feel you have the ability to design, drive and manage your total care?
    b. Integrated between your clinician, family doctor, probation officer, and employer
    c. Do you see community education designed to reduce stigma; reduce discrimination, and provide education on mental illness and addiction.
    d. What is the role of judicial system? Is it supportive?
    e. Crisis first responders? Your experience and how could it have been improved?

f. What gets in the way of service?

3. Is the client key? (Trauma Informed Care)
    a. Do you feel safe?
    b. Respected?
    c. Treated with kindness and warmth
    d. Empowered (voice and choice) or dependent upon agency choices
    e. Unconditionally accepted

4. Are services effective?

5. Where are the gaps in service in Wood County? What functions in the community do we need?
    a. Are there enough psychiatrists? Psychiatric nurse practitioners, clinicians?
    b. A crisis center
    c. Long term housing for patients
    d. Education for families?
    e. CIT training for first responders?
    f. Prevention education

Service Providers and Law Enforcement

For the meeting with Service Providers, the following question were asked:

1. What or where are the gaps in behavioral health care services in Wood County? Where do we have gaps in the 5 principles of a "Recovery Oriented" system, as per the handout?
    a. Focus on clients and families
    b. Promoting healthy , safe, and drug-free communities
    c. Ensuring access to care
    d. Prioritizing accountable and outcome-driven financing
    e. Locally managing systems of care
2. The ADAMHS Board has limited financial resources (~$10 million annual budget) and unlimited concerns. Prioritize where their resources should go.
3. What is the relationship between your agency and the ADAMHS Board? Are they meeting your needs?

For the Chiefs of Police meeting, it was shared that the ADAMHS Board wanted the Chief's input for the Board's upcoming 3 year strategic planning meeting. A single question was asked, "What are your concerns regarding mental health and addiction issues in the county that you want the Board to consider in their strategic plan?"

The Recovery Oriented System of Care (ROSC) in Wood County

Four reoccurring themes emerged from the focus groups. The first themes suggested a need for greater awareness and understanding about mental health and addiction by citizens in Wood County. It was suggested that that people are unaware of the mental health and addiction services offered in the county and board members need updates from families, individuals, and providers. The second theme was that greater communication occur between ADAMHS Board funded agencies and the Board, and between ADAMHS Board funded agencies and other agencies in Wood County. Third was a clear request for clarity of protocols, or road map, regarding the sequence of events in the mental health journey. Law enforcement wanted specific protocols, particularly in times of crisis, while families seemed confused and frustrated. Finally, all groups asked for new or improvements in services.

Each of the four themes will be reviewed in greater detail.

1. Awareness and Understanding

Both the quantitative survey and the qualitative focus groups suggested a lack of understanding of mental illness and addiction and a lack of awareness of the services available in Wood County. People don't seem aware of the illness or the services until they experience or need them (personally or professionally). These two seemed related since a lack of understanding and awareness of the problem would lead to a lack of awareness of resources. At nearly every focus group meeting I heard the statements: "people don't understand mental illness/addiction'" and/or "we have great services in Wood County, but nobody is aware of them."

A. Families. Members stated that mental health appears to have a cloak of secrecy about it. Many first appealed to their friends for knowledge, but friends are unaware or biased (especially those without mental health or addiction experiences). Uninformed friends don't understand what a family is going through, and make comments such as 'you just need a hobby' (so you won't be so preoccupied with your family member). Or, 'just tell your kid/spouse to quit being so lazy.' Because of perceived societal bias, family members do not want to share their struggles with friends and instead become isolated. They felt that residents seem to support services because they are supposed to, not because they understand the illnesses.

Family members wanted more public awareness of mental health issues and services. NAMI classes and Solace meetings were reported as very helpful in providing needed education and support. All family members wished they had heard of NAMI prior to treatment. They praised the classes and the family-to-family support. The Behavioral Connections web site received praise. However, while family member assumed mental health information was 'out there,' they didn't know how to find it.

B. Clients in recovery. Member at the Connections Center believe the stigma against those struggling with mental illness has improved, but still problematic. Awareness of connections center is lacking by the public with few knowing where or what it is. They constantly hear community members' state: "what is that place. What goes on in there?" They are pleased that police officers in CIT training make visits. Members feel the general public believe mental health issues are a moral choice, not an illness. Members want to help educate County residents about mental health issues. They want the Connections Center to operate under ICCD standards and believe that type of independence will help change community attitudes.

   Members of Team Recovery believe there is a huge stigma against those struggling with addiction. They believe that the current opiate crisis, particularly concern for heroin, has helped reduce the stigma. However, they believe the general public still believe that addiction is a moral choice and not an illness.

   Team recovery members do not believe the public appreciates the challenge of the recovery process. They note the vulnerability of relapse after treatment, due to many factors, including their illness, the lack of life skills, and the predatory nature of heroin dealers. They noted how heroin dealers throw free heroin packets into the parking lot at Zepf, how they've found packets of heroin on their car windows, and how other recovery meeting places are targeted.

c. Law Enforcement. "NAMI? I never heard of NAMI until I became police chief," was stated by one local chief; a sentiment that evoked head nods from all the other chiefs. Other EMT and fire staff noted that they only hear about resources at levy time and believe that people aren't aware of services or how to access services. Even among law enforcement, they believe constant education is needed as new officers are added and new situations emerge.

d. Transportation. People are either unaware of free transportation, or it doesn't work effectively for them.
   i. Unaware: The issue of a lack of transportation remains a perceived problem in the county by those in recovery, by law enforcement, by providers and others. "This is the first I heard that we have transportation," was stated at the Police Chiefs meeting.
   ii. Not working: Transportation is for behavioral health treatment appointments and to get medications. These arrangements were reported as less than ideal for two reasons: first, too much advanced notice must be made to get a ride, and if the ride is late, people miss their appointments. Second, the need for transportation in other facets of the lives of those suffering from addiction and mental illness goes beyond appointments for treatment. Transportation is needed for groceries, for other agency visits, and for dialing living.

e. Service Providers. Believe that county wide education and information about ADAMHS funded providers is needed. Providers stated Wood County has great agencies, but no one knows about them. Need more generalized education about mental illness and addiction to reduce stigma, promote understanding and acceptance.

f. Parent and family education classes. The Wood County ESC, NAMI, and the CRC all offer classes for parents and/ or family members to learn techniques to improve family functioning. The need for such classes was endorsed by NAMI families, Solace families, and the providers. However, the enrollment is these classes, at all three locations, is very low. The low enrollment may be due to the lack of awareness of these classes, to the lack of advertising of these classes, or to the lack of interest in these classes prior to family crisis event.

2. Communication and sharing

a. Law Enforcement/Criminal Justice. Both the police chiefs and the county prosecutor's office shared a need for communication with the ADAMHS Board. "We need to get to know each other and work through some of our common problems – transport, screening, etc." Both groups do not understand why they are not included in the decision making process with the ADAMHS Board. Both cited a liaison person who formerly brought people together and they believed that was helpful. Staff have changed and the new people are unaware of ADAMHS services, and flowcharts need updated. "Everyone is busy and no one wants another meeting, but we need to sit and talk so they can understand our issues."

The county prosecutor's office believes that prosecuting attorneys, defense attorneys and probation officers are unaware of the options available to them regarding ADAMHS services. New programs could be initiated, such as the 'swift and certain sanctions' program. This program would incentivize individuals to seek and use services and would help to coordinate the client's interactions between agencies. "We need to talk it through with the ADAMHS board."

In the past, Wood County had a criminal justice coordinator position (Laura Selders) who was contracted through FSNWO to act as a liaison between the criminal justice system and the ADAMHS Board services. This function is sorely missed and still needed. The flowchart that described how Board services interacted with criminal justice needs an update and communicated to new employees on both sides. More discussion of the gaps and barriers in the existing system was requested.

Some police and fire officials stated they took their concerns to Tom and Lorrie and things improved because of the discussion. Both police and fire officials stated things could be better, but still want a defined protocol, want groups to get together, and want to be part of the decision making process.

b. Recovering persons and families. Both clients and families felt that the ROSC seemed more like 'silos' than 'systems' of care. Frustrations centered on the lack of any one agency or person willing to explain how the interactions work between ADAMHS service providers and other county agencies. They did not feel a sense of collaboration between agencies and felt shuffled between agencies, never getting the complete services they need. For example, client problems, particularly for the working poor, may involve working with their clinical provider, with pharmacies, with insurance carriers, with the DMV, with child support, with Career Link, and with JFS. Another example was the challenge of moving from hospitalization to post hospital care and recovery: different services providers require different things (criminal records, hospital records, certain insurance coverages). Families expressed a need for a case worker or social worker to help them pull things together. Others felt the agencies need to get together so that clients felt they were in a fluid system rather than moving between silos.

While sitting with families, I witnessed families coaching families on methods to navigate the system. My request for input would get sidetrack after one family would

share their frustration and a different family would jump to the rescue, offering solutions. The conversation would turn into a sharing of solutions for common problems. Oftentimes, problems involved being unable to pay for services. Financing services while unemployed is a problem for persons struggling with mental health and addiction issues. Getting stuck with an unpayable bill causes persons and families to leave the mental health system.

c. Providers believe the ADAMHS board members need current updates about salient mental health issues as they relate to funding. Board members need to hear from agencies and from consumers and family members who have shown interest in collaborating to improve services. For example, both agencies and families struggle with budget issues for recovering persons.

Budget reviews and education about services is needed. For example, the opiate problem requires more resources which cannot be found by cutting existing resources. Providers felt they were already doing more with less. Providers are being asked to make cuts in existing services (which they feel are inadequate) in order to help pay for new services. Those agencies who bill clients have substantial 'write offs' where services were provided without remunerations from clients. The ADAMHS board requires a rejection of Medicare expansion programs before paying for services and this ADAMHS rule results in indigent clients. Clients drop and run from services because they receive invoices they cannot pay. Appears the clients that agencies are causing barriers. Must turn referrals away. CPSD's (support personnel) not covered by any type of insurance.

3. Clarity

a. Frustration and confusion are the initial emotions expressed by family members as they enter the ROSC in Wood County when experiencing a mental health crisis. Family members stated a need for a road map or flow chart, in Wood County, about actions they might take, about where this journey will go, about community resources and how to access them. Internet searches are too overwhelming and too generic.

Families report those struggling with mental health issues (adult children and spouses) do not share their treatment plans with them. This may be because the person struggling is in denial about his or her illness and/or because he blames the family. They frequently are adult children living at home who do not share treatment experience with family members. In response, those with adult children report struggling with parenting issues. They do not know how to act as parents and vacillate between empathy for their child's struggle, their own enabling behaviors, and the decision to become strict and allow their child to fail.

Family members are not included in the treatment plan and therefore do not feel valued. Family members wanted therapists to be more sensitive and empathetic towards their struggle.

Examples of frustration and disrespect as shared by family members included: when an adult child is green carded, the family did not know where their child was taken, or when he would be returning. Privacy seemed overblown, especially when safety was an issue. When a spouse was admitted, the partner felt her input (facts and opinions) was unwanted and rejected and she did not feel part of the treatment team. The psychiatrist arrived late and left early. Another felt fear and frustration when his son returned home; fear since safety was an issue, and frustration over the housing shortage. Another shared the difficulty of getting a depressed family member in for assessment, only to be 'safety planned' and released. All family members complained of the waiting list to see a psychiatrist. In all cases, family felt powerless and unsure how to help. Follow-up by caseworkers seemed inconsistent with no follow-up for missed appointments.

Family members pleaded for something, even general information, to hold onto. Concerns vocalized by family members included a laundry list of FAQ's about such things as: "how often should my family member be going to treatment," "who should we call if…," "will I need to meet with others…," "might we be using prescriptions,…would you recommend NAMI or SOLACE group meetings…, would you recommend reading XYZ websites or articles." It seemed that family members understood that behavioral mental health needs to be individualized. However, they desperately wanted a roadmap that gave them a sense of understanding and participation in the treatment and recovery process

b. First Responders. Police and fire officials repeatedly stated we do not have a well-defined protocol to handle those desperately seeking assistance in a crisis situation involving alcohol or mental illness. Accommodations are being made with The Link and Behavioral Connections. Some police chiefs stated things are better due to recent procedural changes made. However, other chiefs were unaware.

For example, different interpretations were reported regarding the transport of a person in a mental health or addiction crisis. Some officers felt the relationship between Behavioral Connections and The Link, as it related to pre-screening, was satisfactory. Others felt that interns were still being used. Other felt that the officer had made a very trustworthy assessment and a pre-screen was not required to pink slip the individual. Other were frustrated with repeated safety plans and releases that typically resulted in another incident or arrest at a future date. Other officers preferred to follow ORC and pink slip themselves, bypassing The Link altogether.

4. Services

a. **Crisis Stabilization Unit**. Wood County police and fire officials all stated a need for a place to take individuals experiencing a mental health or substance abuse crisis where they need stabilization prior to hospitalization. The need occurs on a 24/7 basis and is immediate. Equally important is the need for follow-up mental health and alcohol abuse treatment services

Concerns were that BG hospital has no psych unit, so those brought for alcohol misuse are sobered up and released. NOPH needs patients stabilized before they will accept them. Mercy, Flower, and others are outside Wood County and require both transport and bed availability.

Both the Sheriff and the police chiefs stated their jails and holding cells are being misused as temporary mental health centers, without treatment.

There were inconsistencies between all focus groups on how persons are processed during a mental health crisis.

The BG Fire Chief stated, "When someone calls because their house is on fire, we don't say 'let me call you back while we look for a firetruck,' - they need help immediately."

Some officers felt The Link safety planned persons who they knew to be functioning alcoholics, inappropriately returning them to potential domestic violence or other problematic situations. Because of perceived uncertainty with The Link, they advocated for a Crisis Stabilization option.

b. **In-patient, short-term, detox residential treatment for 16-19 year olds**. Currently no safe, medicated, detox center exists for 16-19 year olds who are in crisis. Older teens do not belong at either the CRC or Devlac or Cygnet. They need in-house pharmacy services. Suggest a collaborative center with other NW Ohio counties.

c. **Low income 'recovery housing' with Life Skills training/coaching** or another sober living environment that is safe and secure and includes a reeducation component. Families and those in recovery shared housing related problems, such as:

i. Criminal background checks and income requirements disqualify too many from Devlac Hall (female) and Cygnet (Male). Families talked of their adult children living for months in hotel rooms. Some predicted that Wood County will see an influx of church sponsored half-way houses that do not provide treatment or supervision. Another concern was the belief that housing was only available if a client of the housing sponsoring agency.

Without low income recovery housing, stresses occur in existing systems.

ii. Jails become detox centers and short term behavioral health centers because housing is not available.
iii. Gamesmanship of rule bending to survive. Peer helpers, family members (and some providers) teach methods to beat the system in order to secure needed care. For example, coaching to present as suicidal at the E.R. when your real issue is a

need for detox. If persons present as suicidal, they get referred to a psych ward, a welcome place to detox. Police noted a similar manipulation to get arrested when the persons real issue was a housing need related to a mental health issue. Other manipulation included using ADAMHS funded transportation to Walmart for a prescription when a trip for groceries was really intended. Some addicts do not want Vivitrol until they see if the recovery transition will work out. If the recovery transition does not work, they chose to get high again by trying something else.

Need for Life Skills/mentoring component included in the housing

iv. "Getting sober is easy. Staying sober is hard." Members of Team Recovery had a single pressing need from the ADAMHS Board: a need for post treatment life skills/mentoring/coaching. "The shit hits the fan 6 months after treatment – that's when life gets real," was a sentiment expressed by all members. Treatment is a vacation – it is a time to be isolated, get sober, and re-think about choices. Life starts after treatment. They shared the challenges of transitioning back into life: challenges of dealing with stressors, paying bills, getting their kids back, trying to find employment, learning how to 'say no' to drugs and alcohol. They noted that the life skills they need are not available.

Members of Team Recovery want Life Coaches and claimed that were it not for their recovery family, they would have started using again. They noted many people who have returned to drugs because they had no help learning how to transition or survive in society on their own. There are no caseworkers to follow up on the post treatment transition period.

Those in recovery and the family member of those in recovery believe that more education about addiction needs to occur in the medical community. They believe doctors prescribe Suboxone too easily, trying to cure an addict with drugs. They do not receive a medication/treatment balance from physicians.

d. **Continuation of mental health services in schools**. Families appreciated that schools systems have trained staff who can identify and intervene with kids exhibiting distress, who are suicidal, who are addicted, etc. Two family members who lost children to suicide were previously unaware of school based programs and services.

Police officials were concerned about education on gateway drugs. Providers and others were proud of school based initiatives: programming (ESC), on-site prevention specialists (ESC), and on-site clinicians (CRC). Family members also shared their concern for catching problems while kids are young. Depression screening in schools was mentioned several times. Family members wished more schools would implement drug testing in schools. Perrysburg was praised for their commitment to drug testing and other schools were criticized for not testing. Family members believed that drug testing gave kids a reason to 'pass' on drugs and that a drug-adverse culture was more likely to evolve.

There was a consensus to **expand Mental Health First Aide training**. If in the schools, then include all staff: aides, bus drivers, maintenance staff, etc. Also need to

promote mental health first aid training within communities: churches, clubs, and organizations.

e. **Crisis Intervention Training (CIT)**. Since the manner in which police interact with citizens is being scrutinized in America today, it seems obvious that Wood County's CIT program is a model. CIT coordinators report transferable skills between CIT training, and other facets of their job, especially when interacting with challenging individuals. Law enforcement officers who received CIT training report it helped their ability to deescalate a mental health crisis, to understand that people don't 'chose to' have a mental health or addiction crisis, and to understand the underlying reasons for behaviors. They strongly encouraged that more officers receive the training (I heard that ~25% of Wood County officers (n=80) are CIT trained). Presently 12 officers are trained, per class, and classes are offered 2 times per year.

   The problem with CIT was incentivizing more officers to take the class. Officers may feel CIT is too 'soft' (similar to DARE) and would prefer other training options. With an increase in crisis oriented situations potentially increasing, we need to ensure all officers, EMT's and fire personnel receive the training.

f. **Strong referrals for treatment from criminal justice system**. Police officials noted that criminal activity are oftentimes alcohol or drug related where the criminal is trying to support his drug habit. They believe that typically these persons are viable, decent, contributing people who need treatment. Without treatment they return to the community after jail or prison and are still troublesome. As such, police officials favor treatment, even diversion for treatment. A drug court in Wood County was not perceived as a gap, but a program such as Swift and Certain Sanctions would be welcomed.

   Members of Team Recovery fully support either a drug court or a swift and certain sanctions program. They believe that addicts need and prefer to be held accountable. They desperately want help connecting services, such as jobs and family services, treatment, and other needed programs.

   Another reason for collaboration with criminal justice came from family members. They believed that criminal justice involvement may help bridge a gap in the coordination of service providers in Wood County. Family members are complimentary to the drug court in Lucas County and to the SEARCH program offered in Wood County through the Northwest community corrections center. Both were complimented because SEARCH provides life skills training and treatment; the drug court provides a coordination of service providers.

g. **Help for the working poor**. Transportation is an issue for many clients and transportation services are not known to those working with the clients. Insurance shortages are a problem for the working poor. The working poor with a $5,000 insurance deductible cannot afford mental health services. ADAMHS Board supplement are insufficient. Those working poor who are court ordered to receive

treatment typically have both financial and transportation issues that adversely affect their recovery/recidivism balance.

How do we make addicts employable again? Even if a person navigates through the perceived maze of service providers, and is moving through recovery, those with criminal records believe that they will remain unemployable. Questions were asked if the ADAMHS Board could take the lead in incentivizing local employers to hire recovering addicts.

h. **More Psychiatrists and clinicians**. The shortage of psychiatrists and clinicians was stated by every group, including the providers. The providers believed that new graduates gravitate to managed care organizations because of better pay and working conditions.

   The shortage of doctors poses threats for patients. For example, one person at A Renewed Mind, share his current fear. As a heroin addict, he finally got on Suboxone and had completed his treatment program. However, after treatment, he has been on a waiting list for Vivitrol and feared he will relapse before he received Vivitrol. The waiting list, he claimed, was because no doctors were available to see him, plus he had insurance issues.

i. **Connections Center needs revisited**. Concerns were expressed by the persons attending (members) for the physical environment and the administrative organization of the Connections Center. Overcrowding is a real problem as too many members use the center. Members stated that the center census could easily increase with increases in space, transportation, and funding.

   i. Physical environment. The Connections Center needs expansion. The physical space is insufficient for the membership size, the activity level, and staff/member/visitor interactions. No private space exists for case managers to meet with members. There is only one bathroom. Space limits programming to only one activity at a time, or only one crisis at a time (with most preferring to go outside for privacy). The space is small and crowded and thus too overwhelming (socially and psychologically) for many members.

      A space is currently available next door for expansion.

   ii. Administrative organization. Members believe that Harbor treats them as persons who are institutionalized, not persons in recovery. They cite the changes in their café, in name tags, and in petty cash as examples. They want the chance to operate their own center. Persons attending prefer to use the center as a learning experience for the life skills they need on the outside. They want to make their own decisions, handle finances, purchase food, plan meetings, etc. They prefer to be ‘members’ of this club, rather than people who are institutionalized (which is how they currently feel).

Current members want to be active as grass roots political action team members for increases in center funding, for mental health awareness and for levy campaigns. The want to work with grad students at BGSU.

iii. Transportation limitations. The Center members are primarily from BG. Those from around Wood County lack the transportation to get there. Staff average 90 minutes to take members home since van holds only 3 members per trip, which is also staff time away from the Center. There is no van driver. The van is not handicapped accessible. Previously, transportation was used for programming (trips to mall, recreation center, pools, exercise oriented activities, etc.), but this is no longer available. Parking is a problem for the few who have their own transportation as only 5 parking passes are available to members. This discourages new or younger members from attending.

Summary

Mental health care in Wood County, Ohio appears to be in a period of transition. The ADAMHS Board is presented with new challenges such as the opiate epidemic, the changes in Medicaid expansion, and the opportunity for new and innovative services. Those with leadership responsibility are in a unique position to affect positive change.

This report provided qualitative focus group input on the ROSC in Wood County. The results of the focus groups complemented the results reported in a statewide quantitative ROSC survey.

This report suggests a need listen more to those in recovery, to families, and to providers struggling to do more with less. We need to learn more about the unique challenges of those trying to recover from heroin and opiate addiction.

This report suggests those in recovery, the families supporting those in recovery, and the public officials at the front line of service, would benefit from increased collaboration between agencies. We need more systems and fewer silos. We need a place to ease the transitions. We need to let individuals and families solve their own problems by providing the tools they need.

Additional services were requested, including a crisis stabilization unit, an in-patient short-term detox residential treatment center for 16-19 year olds, low income recovery housing, the continuation of mental health services in schools, more crisis intervention training, stronger referrals from criminal justice, help for the working poor, more psychiatrists and clinicians, and expansion of the Connections Center.

The future of mental health care in Wood County seems bright. The ADAMHS board will be an exciting and rewarding place to continue making progress