Ohio's Mental Illness/Developmental Disabilities Coordinating Center of Excellence

Summary of Ohio:

- 7th largest state – population 11,353,140
- 34th largest state geographically
- 7 of top 10 metro areas in the country are in Ohio
- 8 medical schools

Summary of Ohio: The State Picture

Funding: SFY 2010 and 2011

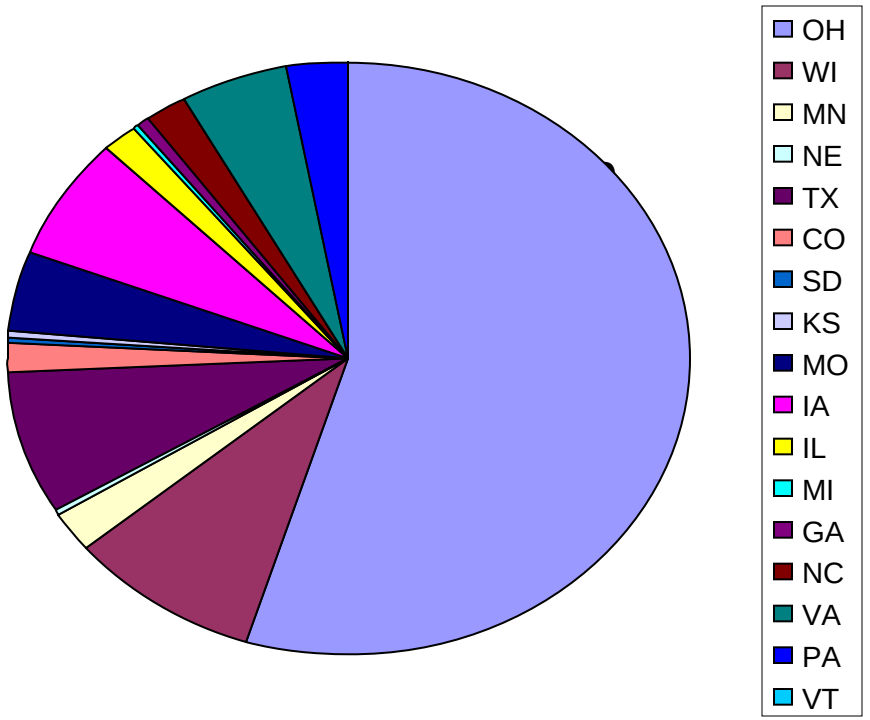
	ODMH	ODODD
State GRF	$900m	$635m
% diff from 08-09	-17.33%	-9.14%
Local	$330m	$900m

For 2012 – 2013 we're all holding our breath

Summary of Ohio: Local Picture

- Strong Home Rule State
- Services funded, administered and provided on the local level
- Over half of all locally raised dollars in the nation are raised in Ohio.

Local Spending in DD



Summary of Ohio: Local Picture

- Mental Health and Drug/Alcohol services administered through Combined Local Alcohol/Drug And Mental Health (ADAMH) Boards

- Many of these boards are regional, covering two to three counties, making local partnerships difficult

Incidence

- Approximately 34.7% of individuals with developmental disabilities served in the community have dual diagnoses*

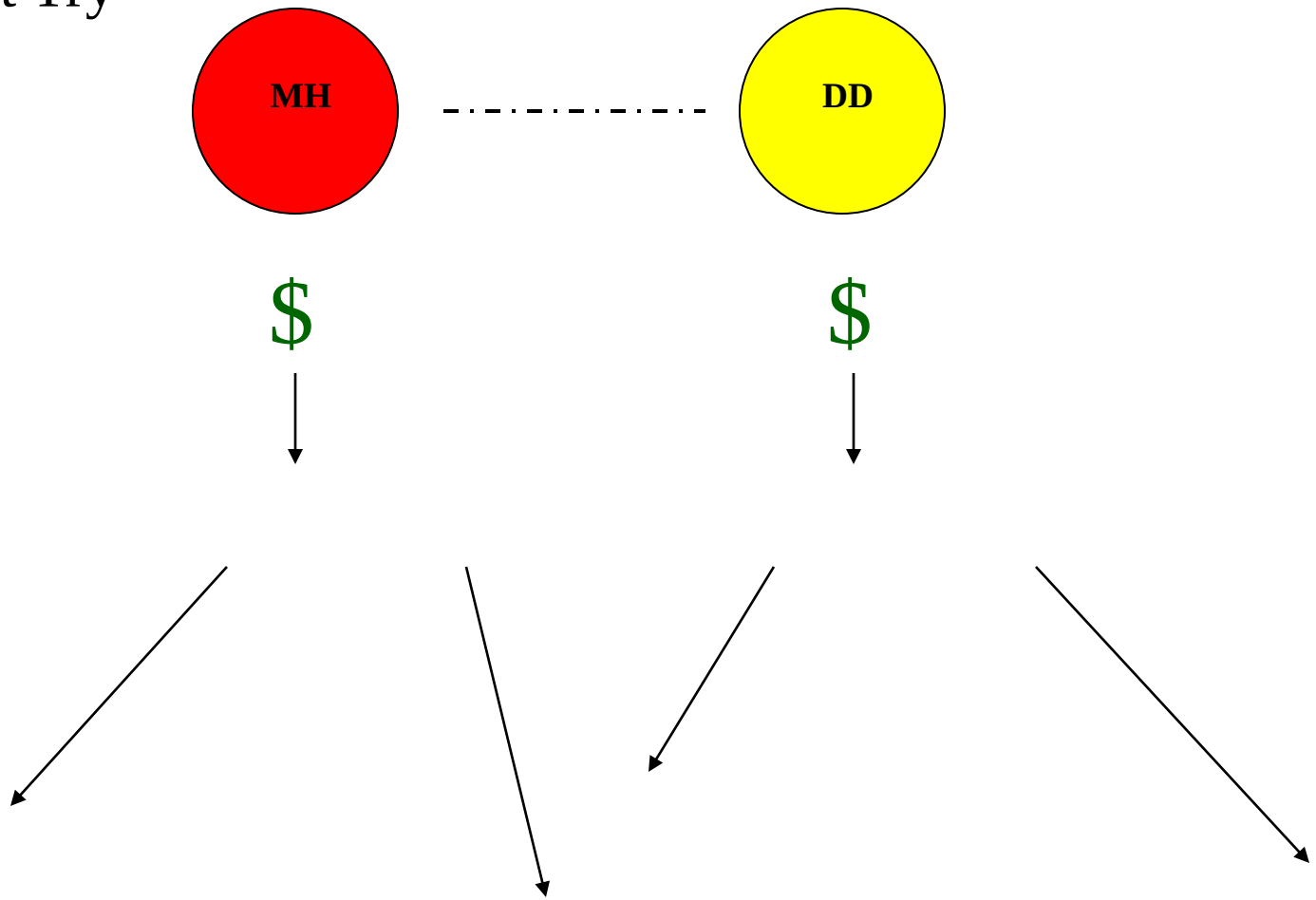
- Approximately 71% of individuals with DD in institutional settings have dual diagnoses.

*National Core Indicators, 2008-2009

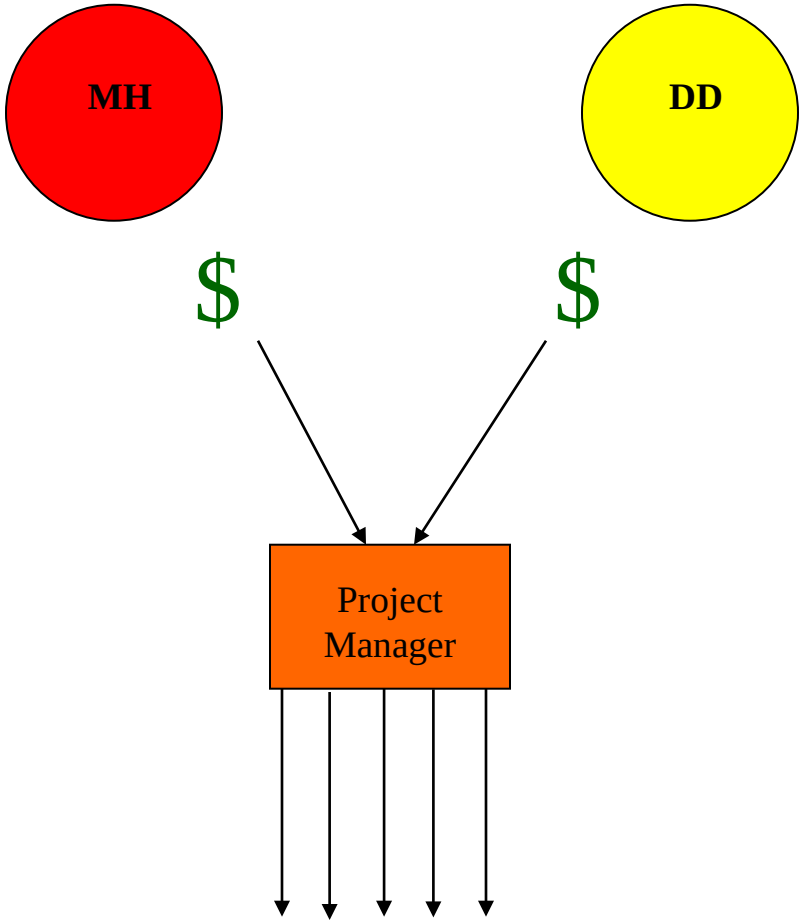
The official state
fossil of Ohio:

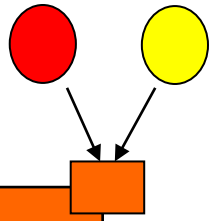
Trilobite Isotelus

First Try



What We Learned

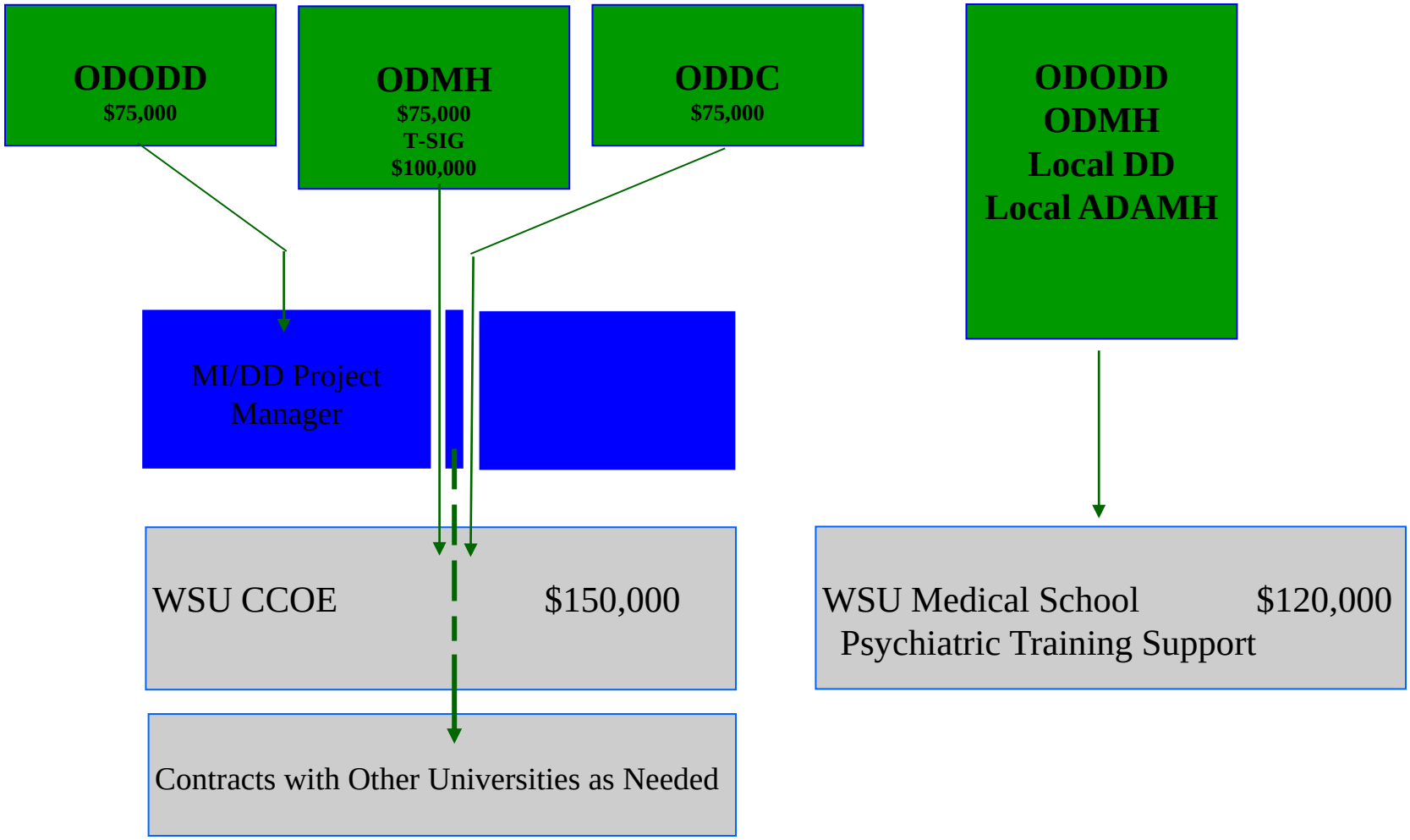




What We Wanted

- Operational Experience
- Mental Health Credentials
- Training and Educational Experience
- DD Experience
- Additional Potential for Synergy

Funding


ODODD
$75,000
ODMH
$75,000
T-SIG
$100,000
ODDC
$75,000
ODODD
ODMH
Local DD
Local ADAMH
MI/DD Project Manager
WSU CCOE
$150,000
WSU Medical School
Psychiatric Training Support
$120,000
Contracts with Other Universities as Needed

Our mission is to make life better for people who are diagnosed with mental illness and developmental disabilities. The MIDD CCOE

- **funds expert psychiatric diagnoses and assessments in several clinics around Ohio**
- **supports local/county trainings for professionals and paraprofessionals working with people with dual diagnoses**
- **encourages county mental health and developmental disabilities systems to talk to each other and train their staff to improve their work together**
- **helps colleges, universities and professional schools include dual diagnosis in their programs**

Diagnosis/Assessment

Oversight: Psychiatrist

- **Provide expert diagnostic assessments and med consults**
- **Coordinate CCOE-funded assessment clinicians**
- **Train psychiatry residents, develop dual specialization for the field**

Education

Oversight: Psychologist

- **Consultation for multi-disciplinary curricula and trainings**
- **Development of outcomes**
- **Collaboration with universities and schools to create dual diagnosis curricula**

Community Development

Oversight: DODD/ODMH Project Manager

- **Seed/Nurture County DDIT Teams**
- **Mini-Grants for County Trainings**
- **Larger Grants for Regional Trainings**
- **Infrastructure:**
  - **Listserv**
  - **Website**
  - **Resources**
  - **National conferences**

There is a continuum of dual diagnosis intensive treatment (DDIT) teams and other collaborations scattered across Ohio.

There is no set, defined structure for every team

- **Collaboration stronger where local relationships were already in place**
- **Planning emerged as a central focus (not actual service provision)**
- **Overall success is related to involvement/ investment of leadership**

Formal teams meet regularly and have one or more levels of involvement (the administrator level and the direct service level, e.g.). They are likely to have shared funding, typically in one of the following ways:

- **Pooled funds**
- **Medicaid match agreements**
- **In-kind donations of staff time/services**
- **Grant partnerships**

Advantages for teams

- **Relieves some financial pressure**
- **Assists in maintaining tough cases in the community**
- **Improves service delivery for sub-acute cases**
- **Allows for more organized access to resources**
- **Better management of crises**

Challenges: Teams are still working to find...

- **Better resources for crisis/respite care (some counties are getting their local MH centers to become certified as provider agencies, thus allowing them to bill for respite for DD consumers)**
- **Easier access to brief hospitalization/sub hospital care**
- **More accessible outpatient psychiatry**
- **Psychotherapy and other mental health interventions**

- Better integration of treatment/service plans
- Housing, esp. for offender or sexually reactive population and transitional age youth
- Specialized treatment for sex offenders or sexually reactive constituents
- Valid, meaningful outcome measures
- Ongoing advanced training for staff, including video and web-based

- Outreach to areas in which collaboration does not yet occur
- Track emerging brain science and dual diagnosis modifications to standard mental health interventions (DBT, e.g.)
- Strengthen communication network for issues, innovative practices and scientific advances (listservs, websites, social networking)
- train MDs, RNs, therapists and social workers in dual diagnosis in graduate schools and universities
- Use technology to make consults, assessments and training available in remote or rural areas through telemedicine, videoconferencing and webcasts

Guiding principles for teams

- **Shared responsibility for clients**
- **Administrative buy-in and support at upper levels**
- **Strong relationships among system leaders AND among direct service staff**
- **Willingness to create new things**
- **Good training for staff**
- **Constant close communication, especially during crises or when expert help is needed**
- **Multi-disciplinary team membership, including AOD, law enforcement/court system, others**

The Magic Ingredient...