



Mike DeWine, Governor
Lori Criss, Director

OHIO DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES
OFFICE OF PREVENTION SERVICES
STRATEGIC PLAN 2021-2024

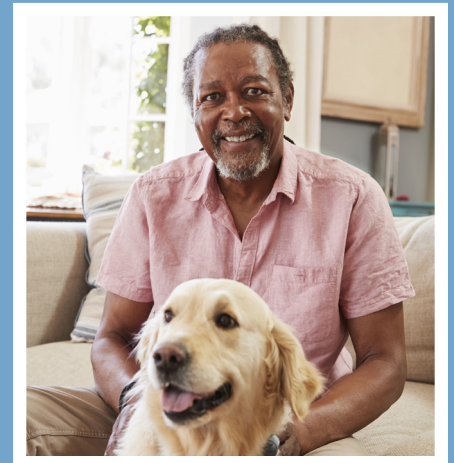


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Message from OhioMHAS Director Lori Criss

I am pleased to present the Strategic Plan for the Office of Prevention Services (OPS) within the Ohio Department of Mental Health and Addiction Services (OhioMHAS). Our Office of Prevention Services plays an essential role in carrying out our vision of ending suffering from mental illness, substance use disorders, and problem gambling for Ohioans of all ages, their families, and communities.

The OPS staff, led by Deputy Director Bobbie Boyer, is dedicated to building a workforce capable of sustaining community-based prevention strategies and growing the use of practices based on the science of prevention. In this strategic plan, they establish a roadmap for providing expansive, yet flexible infrastructure and support that has the capacity to sustain the future of effective prevention services in Ohio. Their work and planning complements the vision and goals outlined in our OhioMHAS 2021-2024 Strategic Plan.

This plan will be crucial as the Office of Prevention Services continues to provide exemplary support to local communities in their work to reduce risk and implement strategies that promote mental, emotional and behavioral health. I look forward to all the amazing work that will be accomplished, and am confident that this effort will have a lasting impact for years to come.

Sincerely,
Lori Criss, MSW, LSW
Director, Ohio Department of Mental Health & Addiction Services



Message from Deputy Director Bobbie Boyer

The COVID-19 pandemic, although challenging for all, offered an opportunity to highlight the role and value of prevention for building and sustaining good health. It also underscored the need to communicate clearly about the science that guides prevention and its effective strategies. The first section of this plan is devoted to helping the reader understand the evidence-based approaches that are foundational to prevention practices. Services are defined, and evidence-based strategies are described for delivering those services that foster mental, emotional, and behavioral health.

The last section indicates how the goals and objectives within the plan relate to other statewide plans. This alignment illustrates the collaboration that occurs on multiple levels with the support and leadership of Governor Mike DeWine and OhioMHAS Director Lori Criss. The priority placed on prevention is unprecedented and encourages all Ohioans to dream big as we envision a state in which all ages benefit from prevention approaches that promote mental, emotional, and behavioral health.

The Office of Prevention Services Strategic Plan is organized around these five priorities:

OPS Priority #1

Promote the alignment and leveraging of resources and priorities at the federal, state, and local levels.

OPS Priority #2

Support systems change efforts and implementation through community-based process.

OPS Priority #3

Enhance multi-sector efforts across the continuum of care to support Ohio's children, adults, and families.

OPS Priority #4

Advance the use of prevention science for substance use prevention and mental, emotional, and behavioral (MEB) health promotion.

OPS Priority #5

Grow and support Ohio's Prevention workforce, including those new to the field, current and emerging leaders.

I believe that the development of this plan will be viewed as a critical step toward an infrastructure that is capable of supporting local communities and organizations in their efforts to build protective capacity and to mitigate risk across the state. We look forward to partnering with you ***to advance innovative, high-quality prevention services across the lifespan for all Ohioans.***

Sincerely,

Bobbie J Boyer, LISW-S, LICDC-CS, OCPC

Deputy Director, Office of Prevention Services, OhioMHAS

Introduction

The Office of Prevention Services (OPS) is dedicated to building a workforce that is capable of sustaining community-based prevention strategies and growing the use of evidence-based practices rooted in the science of prevention. This Strategic Plan establishes a road map for providing expansive, strong infrastructure and support that has the capacity to sustain the future of effective prevention in Ohio. The goals and objectives identified in the OPS Strategic Plan align with the OhioMHAS Strategic Plan, the Recovery Ohio Plan, the Governor’s Office of Children’s Initiatives Strategic Plan, and the Suicide Prevention Plan for Ohio.

The Science of Prevention

The public health model provides the foundation for prevention and includes a focus on improving the well-being of populations. Public health describes a multi-disciplinary approach that engages the entire community. This model is applied in the Office of Prevention Services to reduce risk and increase protective factors that are likely to impact mental, emotional, and behavioral (MEB) health disorders. In 2020-21, the pandemic provided an opportunity to learn more about public health strategies and how each person plays a role in protecting communities from the spread of the virus. The same is true for preventing mental, emotional, and behavioral health disorders. Prevention professionals guide the development and implementation of collaborative partnerships and plans for policy, programs and services that target individuals, families, organizations, and communities. However, the opportunity is open and broad for all to play a role in prevention efforts.

Office of Prevention Services Vision

All Ohioans promoting healthy, safe, and resilient communities

There are three important reports that ground the work of prevention and public health. The 1994 Institute of Medicine (IOM) report entitled Reducing Risks for Mental Disorders: Frontiers for Preventive Intervention Research provided the basis for understanding prevention science by reviewing the existing research base and pointing toward the future of prevention. The second report is The National Academies of Sciences, Engineering, and Medicine: Preventing Mental, Emotional, and Behavioral Disorders Among Young People Progress and Possibilities, 2009. This work built on the 1994 report and documented an increasing number of mental, emotional, and behavioral problems in young people that were in fact preventable. The focus of this report was on the individual and family level of interventions. Most recently, the National Academies of Sciences, Engineering, and Medicine 2019 report was titled: Fostering Healthy Mental, Emotional, and Behavioral Development in Children and Youth: A National Agenda (2019). This third report articulated that healthy Mental, Emotional and Behavioral (MEB) development is shaped by experiences and circumstances that cross generations within families and affect entire communities. <https://www.nap.edu/catalog/25201/fostering-healthy-mental-emotional-and-behavioral-development-in-children-and-youth>

“The term ‘mental, emotional, and behavioral disorders’ encompasses both disorders diagnosable using Diagnostic and Statistical Manual of Mental Disorders (DSM-V) criteria and the problem behaviors associated with them, such as violence, aggression, and antisocial behavior. Many mental, emotional, and behavioral disorders of youth exist on a continuum. The term encompasses mental illness and substance abuse, while including a somewhat broader range of concerns associated with problem behaviors and conditions in youth. Prevention strategies are designed to decrease risk factors and increase protective factors at individual, family, organization, and community levels. Not only do these risks impact multiple issues, the protective factors also mitigate many kinds of issues.

The Science of Prevention has driven the development of a field of study and a credentialed profession supporting evidence-based services for all ages and communities. In the state of Ohio, there are four prevention credentials managed by the Ohio Chemical Dependency Professionals (OCDP) Board. The OCDP board defines prevention services as “a comprehensive, multi-system set of individual and environmental approaches that maximize physical health, promote safety and preclude the onset of behavioral health disorders.” Other professions include a scope of practice in prevention, including social work and certified health education specialists. The work of prevention is guided by science and led by certified and licensed professionals. However, it is a field that works best with the involvement of citizens from diverse sectors and walks of life. Community coalitions are the best example of where those broad-based community partners come together to accomplish the work of prevention.

Drawing from the IOM 2019 report, MEB development is known today to be a product of complex neurobiological processes that interact with characteristics of the physical and social environment, beginning before conception and continuing through and beyond adolescence. Healthy MEB development is shaped by experiences and circumstances that cross generations within families and affect entire communities. In effect, children’s social and physical environments literally shape their brains and consequently, the behaviors and emotions they learn. The work of prevention begins with promoting healthy MEB development. In this context educational strategies are used to develop skills-based positive attributes, such as self-regulation, self-efficacy (belief in their abilities), goal setting, and positive relationships. Many protective factors such as relationship skills, conflict management, and positive problem-solving can be taught to children, family members, teachers, and other caregivers.

Focusing promotion and prevention efforts on children and their parents or other caregivers increases the likelihood that mental health problems in children will be addressed early, before they can evolve into full-blown mental illnesses, including substance abuse. However, MEB promotion and prevention efforts need to be provided across the lifespan so that we are impacting the broader intersections of relationships across generations, within organizations and communities.

Office of Prevention Services Mission

To advance innovative, high-quality prevention services across the lifespan for all Ohioans

The IOM 2019 report focused on the interrelationship between the larger social systems and lifespan impacts over time. Risk factors, such as poverty and community violence, require approaches designed to impact those social determinants of health. Advancing equity and inclusion is at the core of OPS and the work of the prevention field. Communities need to identify the structural drivers of inequity, like racism and income inequality that can make good health unattainable. Utilizing Ohio’s Executive response: A Plan of Action to Advance Equity, National CLASS Standards and other equity frameworks, OPS works to address the challenges to achieve health equity through advocacy, multi-sector engagement and community change.

Prevention Services

Prevention services are the planned sequence of culturally relevant, evidenced-based strategies, which are designed to reduce the likelihood of or delay the onset of mental, emotional, and behavioral disorders. Services can be direct or indirect.

- **Direct Services:** Interactive prevention interventions that require personal contact with small groups to influence individual-level change (i.e. classroom-based program, parenting program, community training, etc.).
- **Indirect Services:** Population-based prevention interventions that require sharing resources and collaborating to contribute to community-level change (i.e. compliance checks, media campaigns,

advocacy, etc.).

The term primary prevention is reserved for interventions designed to reduce the occurrence of new cases of MEB health disorders (IOM, 2009). Two criteria define primary prevention efforts:

- First, prevention strategies must be intentionally designed to reduce risk or promote health before the onset of a disorder.
- Second, strategies must be population-focused and targeted either to a universal population or to subgroups with known vulnerabilities (selective and indicated populations) (IOM, 2009).

Primary prevention should include a variety of strategies that prioritize populations with different levels of risk. Specifically, prevention strategies can be classified using the Institute of Medicine Model of Universal, Selective, and Indicated, which classifies preventive interventions by priority population.

Universal prevention refers to approaches designed for an entire population without regard to individual risk factors. Selective prevention is when strategies are targeted to one or more subgroups of a population determined to be at risk of MEB problems. Indicated prevention is when interventions are aimed at individuals showing signs and symptoms of MEB problems.

Early intervention is an integral part of the continuum of prevention services. These interventions happen after serious risk factors have already been discovered or early in disease progression soon after diagnosis. The goal is to halt or slow the progress of disease in its earliest stages. Early interventions are implemented through a comprehensive developmental approach that is collaborative, culturally sensitive, and geared towards skill development and/or increasing protective factors. These primary prevention services provided prior to a clinical assessment are usually included in the indicated category, and most often use education and problem identification and referral strategies.

Mental, Emotional and Behavioral Health Promotion encourages the development of protective factors and healthy behaviors that can help prevent the onset of a diagnosable mental disorder and reduce risk factors that can lead to the development of a mental disorder. Health promotion interventions are universal efforts to enhance an individual's ability to achieve developmentally appropriate tasks and a positive sense of self-esteem, mastery, well-being, social inclusion, and to strengthen their ability to cope with adversity (IOM, 2009). The integration of skills-based positive attributes, such as self-regulation, self-efficacy, goal setting and positive relationships are specifically named in the IOM 2019 document (IOM, 2019).

Evidence-based Strategies

There is a wide spectrum of tools available for delivering prevention services and fostering MEB health. It is important to match the appropriate tools to the need if population-level adverse MEB outcomes are to be reduced. The Center for Substance Abuse Prevention's (SAMHSA/CSAP) six prevention strategies are best implemented based on the results of using a planning process such as the Strategic Prevention Framework. This process begins with the assessment of needs, resources, and readiness, conducted as part of the community-based planning process. This planning ensures that prevention interventions will target individual, family, organization, and community risk/protective factors that reduce MEB health disorders. All six strategies in appropriate proportions are needed as part of a comprehensive prevention approach.

Communities receive the greatest benefit when a comprehensive public health approach is used that combines all six strategies in the appropriate balance to address the needs of universal, selective, and indicated populations in their own unique community (IOM 2009, p.64).

Community-Based Process: This strategy focuses on enhancing the ability of an organization or community to provide prevention services through planning, training, interagency collaboration, coalition building

and/or networking. Community-based process activities are essential to effectively implementing other strategies. Planning and meeting must result in the selection of either a prevention education or environmental strategy to allow for the return on investment of the community's resources invested in the coalition building, capacity building and planning processes.

Prevention Education: This strategy focuses on the delivery of services to target audiences with the intent of increasing knowledge and skills as well as influencing attitude and/or behavior. It involves two-way communication and is distinguished from information dissemination by the fact that interaction between educator/facilitator and participants is the basis of the activities. Activities influence critical life skills and social/emotional learning including decision-making, refusal skills, critical analysis and systematic judgment abilities.

Environmental: This strategy is designed to establish or change standards or policies that will reduce the incidence and prevalence of behavioral health problems in a population. This is accomplished through media, messaging, policy and enforcement activities conducted at multiple levels in the social-ecological model (considers the complex interplay between individual, relationship, community, and societal factors).

Alternatives: This strategy focuses on providing opportunities for positive behavior support as a means of reducing risk taking behavior and reinforcing protective factors. Alternative programs include a wide range of social, cultural and community service/volunteer activities. These activities must be conducted as a part of a larger comprehensive prevention effort and are best when paired with opportunities to build attachment and bonding to families, schools, communities, and peers. Otherwise, they are merely a fun activity that cannot be distinguished from healthy participation in community life.

Information Dissemination: This strategy focuses on building awareness of mental, emotional and behavioral health and the impact on individuals, families and communities, as well as the dissemination of information about prevention services. It is characterized by one-way communication from source to audience.

Problem Identification and Referral: This strategy focuses on providing individuals who are exhibiting high risk behaviors that may need a brief intervention or screening. If there is no change in behavior, then referral to a behavioral health or other assessment may be warranted.

For related information on evidence-based frameworks and theories that influence and guide the work of prevention, please see **Appendix A, Theoretical Foundations**.

OhioMHAS Vision

The Ohio Department of Mental Health and Addiction Services exists to provide statewide leadership of a high-quality mental health and addiction prevention, treatment and recovery system that is effective and valued by all Ohioans.

OhioMHAS Mission

OhioMHAS strives to end suffering from mental illness, substance use disorders, and problem gambling for Ohioans of all ages, their families, and communities.

Office of Prevention Services

Vision

All Ohioans promoting healthy, safe and resilient communities



Mission

Advance innovative, high-quality prevention services across the lifespan for all Ohioans



Guiding Principles

These principles were developed by the prevention team as key indicators for applying the OhioMHAS values as outlined in the department’s strategic plan.

Contribute and Collaborate	Serve Compassionately
<ul style="list-style-type: none"> • Promote cross-systems collaboration • Cultivate innovative partnerships • Increase coordination and cooperation • Understand the entire continuum of care • Serve as subject matter experts • Contribute to policy development 	<ul style="list-style-type: none"> • Be responsive to stakeholders • Foster openness and inclusion • Seek cultural humility • Value collaborator’s view • Promote person first language • Be authentic and dependable
Deliver Quality	Be Accountable
<ul style="list-style-type: none"> • Promote evidence-informed strategies • Develop Communities of Practice • Build a certified workforce • Invest in promising practices • Advance systems improvement • Deliver excellent customer service 	<ul style="list-style-type: none"> • Make data driven decisions • Ensure timely reporting • Establish relationships first • Reinforce efficiency • Communicate accurately • Strive for measurable outcomes

Theory of Change and Prevention Priority Areas

A Theory of Change is a comprehensive description that illustrates how and why a desired change is expected to happen. It maps out what has been described as the “missing middle” between what a program or change initiative does (its activities or interventions) and how these lead to desired goals being achieved. It does this by first identifying the desired long-term goals and then works back from these to identify all the conditions (outcomes) that must be in place (and how these related to one another causally) for the goals to occur.

The Office of Prevention Services Strategic plan is organized around these prevention priority areas derived from its Theory of Change that can be found in **Appendix B**.

Prevention Priority Area #1

Promote the alignment and leveraging of resources and priorities at the federal, state, and local levels.

Prevention Priority Area #2

Support systems change efforts and implementation through community-based process.

Prevention Priority Area #3

Enhance multi-sector efforts across the continuum of care to support Ohio’s children, adults, and families.

Prevention Priority Area #4

Advance the use of prevention science for substance use prevention and mental, emotional, and behavioral (MEB) health promotion.

Prevention Priority Area #5

Grow and Support Ohio’s Prevention workforce, including those new to the field, current and emerging leaders.

Prevention Priority Area #1
Promote the alignment and leveraging of resources and priorities at the federal, state, and local levels.

Goals

- 1. Increase opportunities for investments and funding mechanisms that will sustain high-quality and effective prevention services across domains in local communities for all age groups and populations.**

Objectives

- Seek funding sources that match prevention needs of target populations and priorities.
- Facilitate collaborative funding strategies with partners and initiatives that will multiply available resources and opportunities.
- Advocate for prevention infrastructure (comprehensive approaches and systems for developing policy, programs, and practices) needs as a priority investment of resources.

Prevention Priority Area #2
Support systems change efforts and implementation through community-based process.

Goals

- 1. Increase the knowledge, skills and abilities of community coalition leaders to implement systemic changes that can mitigate a broad variety of risk factors and develop protective factors capable of impacting mental, emotional and behavioral disorders including substance use, suicide, and problem gambling.**

Objectives

- Ensure infrastructure needs are in place to provide professional development, leadership skill-building opportunities and development of communities of practice, including strong training and technical assistance for data driven strategic planning efforts in local communities.
- Support the development of local structures that bring together people and sectors (including healthcare) to enhance public and private partnerships and implement innovative solutions.

- 2. Increase the utilization of prevention expertise in community level planning practices for behavioral health and wellness.**

Objectives

- Reinforce opportunities for prevention professionals to participate in planning and coordination with local ADAMH Boards, departments of health, Children and Family First Councils, school districts, area hospitals and other community/county/state partners.
- Promote data driven, strategic planning processes using tools such as the Strategic Prevention Framework and the Collective Impact Model.
- Further the use of trauma-informed approaches that promote resiliency such as the Tool for Health & Resilience in Vulnerable Environments (THRIVE) and the Adverse Community Experiences and Resilience Framework, or ACE/R.

3. Multiply efforts toward health equity by addressing social determinants of health.

Objectives

- Build capacity for communities to address social determinants of health and collective impact across the continuum of care.
- Establish strategies for increasing coalition development and involvement from communities of color, LGBTQ+, peers, and recovery advocates.

4. Expand community-based prevention efforts toward reducing the suicide rate in Ohio.

Objectives

- Foster public and private partnerships that will accomplish the goals of the statewide suicide prevention plan, while aligning efforts and coordinating local, state, and federal resources.
- Develop knowledge, skills and abilities of local leadership that will help the work of suicide coalitions to align with the Centers for Disease Control and Prevention's (CDC's) strategies for preventing suicide and how to integrate the use of SAMHSA's Center for Substance Abuse Prevention (CSAP) strategies in their work.
- Develop strategies to increase faith community involvement in suicide prevention coalitions (Governor's Challenge).
- Integrate efforts to reduce access to lethal means, including safe storage of firearms (Governor's Challenge) and expansion of postvention strategies into local and statewide plans.
- Advance the utilization of the Zero Suicide framework to improve suicide care within health and behavioral health systems.

5. Strengthen youth-led programming efforts that involve young people in community change.

Objectives

- Sustain the Ohio Youth-Led Prevention Network's Youth Council and include their input in developing high quality, evidence informed youth-led programming across Ohio.
- Support local implementation and sustainability efforts of youth-led programming in Ohio communities
- Continue to advance the development of the Ohio Adult Allies partnership.

Prevention Priority Area #3

Enhance multi-sector efforts across the continuum of care to support Ohio's children, adults, and families.

Goals

1. Improve efficiency and better outcomes through cross-agency coordination and strategic alignment of best practice frameworks for MEB prevention.

Objectives

- Continue working with the Ohio Department of Health (ODH) and the Ohio Department of Education (ODE) to identify specific plans and resources that will support the expansion of the Ohio Healthy Youth Environment Survey (OHYES!) and the Youth Risk Behavior Surveillance System (YRBS) in Ohio schools.
- Sustain collaborative opportunities with ODE to improve prevention services and supports in schools, including before and after school programming.
- Participate in school safety partnership with ODE and the Department of Public Safety (DPS) that will implement Ohio's Safety and Violence Education Students (SAVE Students) Act and support other safety strategies.

- Engage the Ohio Department of Higher Education (ODHE) and other statewide partners in developing relationships with community-based organizations that support mental health promotion, prevention, treatment, and recovery support services for campus communities.
- Provide ongoing involvement, technical assistance and leadership support for RecoveryOhio and other statewide and local partnerships that support our mission.
- Uphold the partnership with the Ohio National Guard Counter Drug Task Force to support local drug prevention efforts.
- Continue problem gambling collaborative relationships with the Ohio Lottery Commission, Ohio Casino Control Commission, and other key leadership that supports problem gambling prevention, treatment, and recovery services.
- Engage ODH and DPS partners to explore new opportunities related to tobacco prevention and cessation, including the support of Tobacco 21, SYNAR, and vaping prevention strategies.
- Continue working with Prevention Action Alliance on marijuana prevention efforts to expand the reach and impact of educational resources and opportunities.
- Strengthen the Children of Incarcerated Parents partnership with Ohio University and ODRC with targeted expansion and investments.
- Facilitate the expansion of the Zero Suicide framework through the Ohio Children’s Hospital Association partnership and local community involvement.
- Support Urban Minority Alcoholism and Drug Abuse Outreach Programs (UMADAOP) that offer community led programming with a primary focus of providing culturally appropriate prevention, treatment, and outreach services to African American and Hispanic/Latino American communities in Ohio.
- Facilitate collaborative work that supports the Ohio CareLine with funding and technical assistance.
- Lead the development of partnerships and infrastructure that will support the new 988 number for suicide prevention and crisis calls as part of an improved crisis continuum.
- Support rural and Appalachian partnership development opportunities.

2. Develop early intervention frameworks and implementation resources that can be disseminated to primary care, education, community, and faith-based partners.

Objectives

- Promote the use of standardized universal screening tools for early identification and intervention.
- Continue to explore strategies for increased motivational enhancement and engagement trainings for the child welfare system.
- Develop a guide that describes the early intervention framework for youth and young adults ages 10-25
- Support training and technical assistance for implementing early intervention programs and services across the lifespan.
- Invest in early intervention service implementation opportunities.

3. Expand opportunities for stakeholder input in developing prevention services priorities.

Objectives

- Engage stakeholders in the Ohio Administrative Code (OAC) Rule update process.
- Develop and implement education and training on new OAC Rule and its application to Prevention professionals.
- Develop and implement education and training on new OAC Rule and its application for Prevention certified provider agencies and agencies interested in obtaining Prevention certification.

4. Disseminate models of prevention programs and practices across the lifespan that include senior citizens, families, youth, and college students.

Objectives

- Increase investments in older adult programming and coordinate efforts with Department of Aging to promote strategies statewide.
- Look for additional opportunities to share strategies that reach across the lifespan through multi-sector efforts.

5. Support the expansion of drug-free workplace programs focused on the health and wellness of Ohio's workers.

Objectives

- Continue partnering with the Bureau of Workers' Comp (BWC) to support educational and technical assistance opportunities.
- Partner with related stakeholders in supporting education and technical assistance for employers to support employees and their families.

6. Strengthen the prevention role of law enforcement in schools and communities.

Objectives

- Provide training opportunities through the school safety partnership.
- Encourage law enforcement inclusion with local assessment and planning efforts.
- Support and encourage first responder partnerships that expand the use of best practices in working with persons with substance use disorders and mental illness.
- Continue development of the Handle with Care network.
- Connect Ohio National Guard analysts and their work with law enforcement data with local prevention efforts and with the Ohio Substance Abuse Monitoring (OSAM) team.

Prevention Priority Area #4

Advance the use of prevention science for mental, emotional, and behavioral (MEB) health prevention and promotion.

Goals

1. Increase the use of evidence-based programs, policies, and practices through targeted investments of resources.

Objectives

- Explore the development and identification of resources to create a Center of Excellence that promotes evidence-informed prevention and supports community capacity-building efforts.
- Provide ongoing learning opportunities that support the understanding of prevention science and implementation of evidence-based frameworks, policies, programs, and practices.
- Invest in opportunities for training of trainers or master trainers that can help sustain evidence-based programming, (i.e., Creating Lasting Family Connections; Sources of Strength; Signs of Suicide, PAX GBG).
- Ensure trauma and culturally competent principles are embedded into all prevention efforts.
- Disseminate evidence-based approaches related to preventing mental, emotional, and behavioral health disorders and how to integrate skills-based positive attributes, such as self-regulation, self-efficacy, goal setting and positive relationships into promotion efforts.

2. Increase utilization of current data and outcome measures to make data-driven decisions around prevention needs and department priorities.

Objectives

- Participate in department Data Management Committee and development of shared indicators.
- Contribute policy change recommendations that will improve data collection from providers.
- Assist with developing data practices that could improve multi-system planning efforts for suicide prevention.
- Collaborate with Quality Planning and Research to determine how to improve the use of prevention data and outcome measures and collection systems (GFMS data and Performance Management process) that will result in improved demonstration of results.

3. Promote understanding and support for the vision/mission and organizational goals of the Office of Prevention Services.

Objectives

- Identify messages that will be communicated for both internal and external audiences.
- Create promotional materials and distribution methods for understanding the prevention continuum of services and best practices.

4. Increase opportunities for public education strategies with evidence to prevent overdoses, accidental poisonings, suicide, problem gambling and substance use disorders.

Objectives

- Ensure public education and campaigns are based on the public health model including an emphasis on positive messaging and strategies to decrease stigma.
- Promote safe medication disposal programs, safe storage of medications, including marijuana for medical use, and safe storage of firearms.
- Strengthen public knowledge and ability to promote wellness, recognize suicide risk, and take appropriate action for self and others (gatekeeper trainings).
- Present learning opportunities for understanding low risk drinking guidelines and connections between alcohol and MEB health problems.

Prevention Priority Area #5

Grow and support Ohio's Prevention workforce, including those new to the field, current and emerging leaders.

Goals

1. Grow the number of credentialed prevention professionals that include a priority on geographic and culturally diverse populations.

Objectives

- Partner with credentialing boards to develop strategies for engagement and recruitment of prevention professionals.
- Support advocacy efforts that highlight the value and expertise that prevention professionals contribute to community-based processes.
- Participate in department workforce development partnerships and strategies.
- Support the development of college course work that includes content needed for credentialing of prevention professionals, including preventing mental, emotional, and behavioral health disorders.

2. Improve workforce competencies through training in evidence-based and promising practices.

Objectives

- Continue investment in professional development opportunities, training, technical assistance and coaching to support comprehensive prevention programs, policies, and practices.
- Support a sustained infrastructure investment for workforce strategies such as those facilitated by Prevention Action Alliance (SPCA), Prevention First (OCAM), Ohio University (Ohio Adult Allies), ADAPAO (Prevention Fellowships) and Problem Gambling Network of Ohio (PG conference and prevention and clinical professional development).

3. Increase the number of organizations that are providing quality prevention services.

Objectives

- Update OAC Rules that govern certification of prevention organizations to align with current best practices and needs of the field.
- Develop engagement strategies for mental health providers to obtain certification.

4. Increase the number of licensed practitioners holding the Problem Gambling endorsement and those able to provide quality treatment interventions.

Objectives

- Continue investment in professional development opportunities and supervision for problem gambling practitioners.

State Partners in Suicide Prevention



ALWAYS READY, ALWAYS THERE



Appendices

Appendix A: Theoretical Foundations

Appendix B: Theory of Change

Appendix C: Office of Prevention Services Guidance Document

Appendix D: Prevalence of Behavioral Health Issues in Ohio

Appendix E: Alignment to Other State Plans



Appendix A

Theoretical Foundations

Public Health Model

The focus of [public health](#) is about promoting healthy behaviors that have the capacity to improve individual and community health. Some examples include promotion of hand washing and breastfeeding, providing vaccinations, and distributing condoms to prevent the spread of sexually transmitted diseases. The public health model seeks change in individual behavior, but also creates understanding of how the environmental context impacts encouraging or precipitating behaviors. Using a disease prevention analogy, the public health model approaches an issue by understanding the interrelationship between the host (person) the agent or vector (substance) and the environment (place, situation, circumstances, relationships).

Fundamental to the public health approach is the issue of [risk and protection](#). Research and practice have identified risk and protective factors that affect the vulnerability of children to mental emotional and behavioral (MEB) health problems. Also fundamental to the public health approach is that mental health is everyone's concern. Responsibility for promotion and prevention programs is shared across multiple systems, including but not limited to schools, primary health care, behavioral health, juvenile justice, and child welfare. There are many contexts and environments that influence an individual's beliefs and behaviors. They include the broad society, the community to which an individual belongs, their family, and individual characteristics.

In 1992, Doctors David Hawkins and Richard Catalano developed the [Risk and Protective Factor Theory](#) as a [foundational approach](#) to determine the causes and solutions to substance use and other behaviors. This theory is seen as a foundational concept to assist in the design, selection, and implementation of prevention strategies and programs.

Social Development Strategy

The [Social Development Strategy](#) was built on Catalano and Hawkins work and organizes the research on protective factors into a framework that can buffer from risks and promote positive youth development. Protective factors that buffer young people from exposure to risks are simply communicated. The goal is to develop [healthy beliefs and clear standards](#) for all children and youth. This process begins with bonding or attachment and commitment to families, schools, communities and peers. Young people need to have opportunities for meaningful involvement with families, schools and communities; in order to be successful, they need social, emotional and cognitive skills and they need recognition for their efforts and participation. Individual characteristics, such as a positive social orientation, high intelligence and resilient temperament can help protect against risk.

Resiliency Theory

[Resiliency theory](#) was developed by Emmy Werner and is one of the earliest research studies related to prevention. The study focused on identifying the strengths and assets of youth that can buffer against negative behavior. Although surrounded by "risk factors," the cohort showing the most resiliency was identified as those who had access to "protective factors." The decades-long study showed that, although an instinctive capacity for resiliency helps, it is never too late to develop protective factors to bounce back from adversity.

MEB Health Promotion and Prevention

Over several decades, research led by the National Academies of Sciences, Engineering, and Medicine (the National Academies) focusing on the improvement of mental emotional and behavioral development,

health promotion and prevention activities. In the first two reports released, *Reducing Risks for Mental Disorders* (1994) and *Preventing Mental, Emotional, and Behavioral Disorders Among Children and Youth* (2009), the focus was on prevention and were widely adopted to advance MEB outcomes in young people. As prevention science continued to advance, it became evident that although an individual focus is important, it is equally important to focus on achieving population-level outcomes. The most recent report [Fostering Healthy Mental, Emotional, and Behavioral Development in Children and Youth: A National Agenda](#) notes that despite the development of programs that are effective in supporting healthy MEB development in individuals and groups of children and youth, successful population-based efforts need to be expanded. These can broadly counter adverse environments and experiences that threaten healthy MEB development for so many of the nation's young people.

Evidence-Based Frameworks and Model's for Prevention

Ohio communities that want to develop the necessary conditions for preventing MEB and intervening early, must engage in an authentic, collaborative, community-based process. The following evidence-based models/frameworks guide this work.

[The Social-Ecological Model](#) considers the complex interplay between individual, relationship, community, and societal factors. It allows us to understand the range of factors that put people at risk for MEB and the protective factors needed to prevent MEB. It is necessary then to provide evidence-based prevention across multiple levels (Individual, Relationship, Community, Societal). Research and experience have shown that prevention must begin with an understanding of these complex behavioral health problems within their complex environmental contexts; only then can communities establish and implement effective plans to address MEB's.

[The Strategic Prevention Framework \(SPF\)](#) is a data-driven, strategic planning process developed by the Substance Abuse and Mental Health Services Administration (SAMHSA) for preventing substance misuse and abuse. Ohio has expanded the utilization of the SPF to address MEB's across Ohio's prevention continuum. The process includes steps in assessment, capacity, planning, implementation, and evaluation, guided by the principles of sustainability and cultural competency.

[The Collective Impact \(CI\)](#) approach recognizes that complex social and environmental issues, like the opioid crisis, cannot be solved by one sector alone. Instead, CI promotes multi-sector collaboration characterized by a common agenda, progress measures, continuous communication, and mutually reinforcing activities. This collaborative work is facilitated and supported by a backbone organization in the community. Collective Impact was first introduced in 2011 by John Kania and Mark Kramer as a framework – a vehicle for change. The premise was that no one person or entity can solve the increasingly complex social problems facing communities. Part of Collective Impact is understanding that the role of the backbone organization is not only to help lead the initiative, but also to facilitate the work and act as a system integrator. The ever-changing environment of wicked problems, such as the opioid crisis, requires communities to work together in order to develop and implement innovative solutions.

[Prevention Institute's Tool for Health & Resilience in Vulnerable Environments \(THRIVE\)](#) enables communities to determine how to improve health and safety and promote health equity. It is a framework for understanding how structural drivers, such as racism, play out at the community level related to the social-cultural, physical/built, and economic/educational environments. These community-level indicators are the social determinants of health. In addition to being a framework, THRIVE is also a tool for engaging community members and practitioners in assessing the status of community determinants, prioritizing them, and taking action to change them in order to improve health, safety, and health equity. A complementary framework and tool for this work is the [Adverse Community Experiences and Resilience Framework \(ACE|R\)](#). The ACE|R framework helps communities understand the relationship between

community trauma and violence and social determinants of health. It outlines specific strategies to address and prevent community trauma—and foster resilience—using techniques from those living in affected areas.

[The Youth Empowerment Conceptual Framework \(YECF\)](#) is one of the key frameworks that informs the work of youth-led programs in Ohio. The YECF Youth empowerment specifically develops sociopolitical awareness in young people, enhancing their skills to be community change agents (Zimmerman, 2000). Youth empowerment facilitates young people in constructing meaningful community change, with the goal of enhancing the wellbeing of all individuals. A youth empowerment approach utilizes young people as resources rather than a “collection of problems” in establishing community change (Holden, 2004). By emphasizing collective participation and contribution, young people gain skills and competencies that cultivate their own positive development, while also promoting the healthy development of others.

By combining a data-driven, strategic planning process (SPF, YECF) with an emphasis on working collectively across the continuum of care (the Collective Impact Model), communities are working to prevent MEB’s and addressing social determinants of health in their communities by utilizing a trauma-informed approach that reduces trauma and promotes resiliency (the Tool for Health & Resilience in Vulnerable Environments, or THRIVE, and the Adverse Community Experiences and Resilience Framework, or ACE|R).



Appendix B Theory of Change

OhioMHAS Office of Prevention Services Theory of Change

In Order To

Promote alignment and leveraging of resources

Support community-based systems change efforts

Strengthen multi-sector efforts across the continuum

Advance the use of prevention science

Grow and support Ohio's prevention workforce

OPS will engage partners at the federal, state, and community level

SAMHSA/NASADAD, NPN, Ohio's Cabinet-level Agencies, Recovery Ohio, ADAMH Boards, Prevention Providers, Grantees, Contractors, Coalitions and Task Forces, Institutions of Higher Education, Local Education Agencies, Boards of Health, Family and Children First Councils, Hospitals, Associations

Using these culturally relevant and sustainable strategies

Workforce development

Cross system partnerships

Training, technical assistance & coaching

Information and resources

Leadership development

Peer exchange and networking

To develop conditions for Ohio's local communities

Engage in collaborative community-based process

Develop comprehensive data-driven plans

Implement evidence-based interventions

Evaluate progress and report outcomes

That create population level change

Decrease substance use/misuse

Reduce suicide rates

Diminish problem gambling

Increase Resiliency

Improve MEB health

Promote healthy family functioning

Which will lead to

Healthy, Safe and Resilient Communities

Appendix C

Guidance Document

OhioMHAS Prevention Services Guidance Document Office of Prevention Services March 2021

Prevention in Ohio is grounded in the public health model, which focuses on improving the well-being of populations. Public health draws on a science base that is multi-disciplinary and engages the entire community through the social-ecological model. Prevention aims to reduce underlying risk factors that increase the likelihood of mental, emotional and behavioral (MEB) health disorders and simultaneously to promote protective factors that decrease MEB health disorders. MEB health disorders include but are not limited to substance use disorders, mental illness, suicide, problem gambling, etc.

This document demonstrates the continuum of prevention-based services for MEB health disorders and contains definitions and explanations of how the six prevention strategies can be used to support comprehensive prevention efforts. Ohio's prevention system is fortunate to have several funding sources to provide prevention services; however, it is imperative to match the selection of services with the appropriate funding source to obtain the desired outcome for the population you are serving. This document provides guidance for funding, including what funding source can be utilized for each service, and takes into consideration the requirements of different funding sources.

I. Definitions

Prevention

Prevention promotes the health and safety of individuals and communities. It focuses on reducing the likelihood of, delaying the onset of, or slowing the progression of or decreasing the severity of MEB health disorders.

Prevention services are a planned sequence of culturally appropriate, science-driven strategies intended to facilitate attitude and behavior change for individuals and communities. They can be direct or indirect.

- **Direct Services:** Interactive prevention interventions that require personal contact with small groups to influence individual-level change (i.e. classroom-based program, parenting program, community training, etc.).
- **Indirect Services:** Population-based prevention interventions that require sharing resources and collaborating to contribute to community-level change (i.e.: compliance checks, media campaigns, advocacy, etc.).

The term **primary prevention** is reserved for interventions designed to reduce the occurrence of new cases of MEB health disorders (IOM, 2009). Two criteria define primary prevention efforts:

- First, prevention strategies must be intentionally designed to reduce risk or promote health before the onset of a disorder.
- Second, strategies must be population-focused and targeted either to a universal population or to sub-groups with known vulnerabilities (selective and indicated populations) (IOM, 2009).

Primary prevention should include a variety of strategies that prioritize populations with different levels of risk. Specifically, prevention strategies can be classified using the Institute of Medicine Model of Universal, Selective, and Indicated, which classifies preventive interventions by priority population. The definitions for these population levels of risk are:

- **Universal:** "Targeted to the public or a whole population group that has not been identified on the basis

of individual risk. The intervention is desirable for everyone in that group” (IOM, 2009 p. xxix).

- Selective:** “Targeted to individuals or to a subgroup of the population whose risk of developing mental, emotional or behavioral disorders is significantly higher than average. The risk may be imminent, or it may be a lifetime risk. Risk groups may be identified based on biological, psychological, or social risk factors that are known to be associated with the onset of a disorder. Those risk factors may be at the individual level for non-behavioral characteristics (e.g., biological characteristics such as low birth weight), at the family level (e.g., children with a family history of substance abuse but who do not have any history of use), or at the community/population level (e.g., schools or neighborhoods in high-poverty areas)” (IOM, 2009 p. xxviii).
- Indicated:** “Targeted to high-risk individuals who are identified as having minimal but detectable signs or symptoms that foreshadow mental, emotional, or behavioral disorder, as well as biological markers that indicate a predisposition in a person for such a disorder but who does not meet diagnostic criteria at the time of the intervention” (IOM, 2009 p. xxvi).

These primary prevention interventions are fundable by any OhioMHAS prevention funding stream.

Early Intervention

Early intervention is an integral part of the continuum of prevention services that include early services and supports after serious risk factors have been identified. These interventions are implemented in order to halt or slow the impact of those risks and indicators of MEB health disorders in the earliest stages. Early interventions are implemented through a comprehensive developmental approach that is collaborative, culturally sensitive, and geared towards skill development and/or increasing protective factors. **These primary prevention services provided prior to assessment are usually included in the Indicated intervention category, and most often are Education, Problem Identification and Referral strategies, including screening.**

The only **OhioMHAS prevention funding streams that can fund early intervention services are Problem Gambling, targeted General Revenue Funds (State GRF), Early Childhood Mental Health (ECMH), and if applicable the Mental Health Block Grant.** These services can also be funded by local levy funds and other funds from foundations, or other public or private organizations, etc. While early intervention and those interventions implemented to slow the progression or decrease the severity of a MEB health disorder are allowable prevention services, the Substance Abuse Prevention (SAPT) Block Grant primary prevention funding cannot be used on these services.

Recovery Support

Recovery support or relapse prevention focuses on helping people manage complicated, long-term health problems such as diabetes, substance use disorders, mental health disorders, etc. The goal is to prevent further physical deterioration and maximize quality of life. Ohio’s definition of recovery is, “the personal process of change in which Ohio residents strive to improve their health and wellness, resiliency, and reach their full potential through self-directed actions.”

Activities or interventions that are implemented to assist individuals with maintaining their recovery of an MEB health disorder are not classified as prevention services. These services are identified as recovery support or services that support individuals’ abilities to live productive lives in the community. Therefore, recovery services are not considered prevention services and cannot be funded by any OhioMHAS prevention funding stream, without exception.

Therefore, **primary prevention** services exclude clinical assessment, treatment, recovery support services, relapse prevention, case management (individualized assistance and advocacy to ensure that needed services are offered and procured) or medication services of any type. It also excludes working with only one

individual at a time except in instances when a prevention professional must use the Problem Identification & Referral Strategy to screen and refer an individual enrolled in a direct prevention service that is identified as possibly needing or being able to benefit from services that exceed the scope of prevention.

Health Promotion

Health promotion interventions are universal efforts to enhance an individuals' ability to achieve developmentally appropriate tasks (developmental competence) and a positive sense of self-esteem, mastery, well-being, social inclusion, and to strengthen their ability to cope with adversity (IOM, 2009 p.66). These services can be provided across the entire continuum of care. Most of these services can be funded by local levy funds, state funds and other funds such as foundations, civil organizations, etc. *Limited services in this category that meet the primary prevention definition may be funded under SAMHSA's Substance Abuse Prevention and Treatment Block Grant (SAPT BG).*

Harm Reduction

Harm reduction is a set of ideas and interventions that reduce the harms associated with both drug use and ineffective drug policies. Harm reduction stands in stark contrast to a punitive approach to problematic drug use—it is based on acknowledging the dignity and humanity of people who use drugs and bringing them into a community of care in order to minimize negative consequences, promoting optimal health and social inclusion. These activities reduce the harms of use such as health issues, overdose, etc., and are not considered primary prevention. As a result, they cannot be paid for with prevention dollars from the SAPT BG funds. Training for such interventions, activities would fall under the community-based process strategy since community members are receiving training and this would be an allowable primary prevention service. Purchasing Naloxone, needle exchange and implementing other types of harm reduction intervention is not allowable. Harm reduction activities are sometimes necessary throughout the continuum of care and can be paid for with other funding.

Equity and Inclusion

Advancing equity and inclusion is at the core of OPS and the work of the prevention field. Communities need to identify how the structural drivers of inequity, like racism and income inequality (Social Determinants of Health), impact communities and make good health unattainable. Primary Prevention is a key strategy for eliminating inequities. Utilizing Ohio's Executive response: A Plan of Action to Advance Equity, National CLASS Standards and other equity frameworks, OPS is intentional in all efforts to address the challenges faced by communities to achieve health equity through advocacy, multi-sector engagement and community change.

II. Prevention Strategies

This guidance is based on a model for how the Substance Abuse and Mental Health Services Administration/ Center for Substance Abuse Prevention's (SAMHSA/CSAP) six prevention strategies are to be implemented for the greatest impact in Ohio's communities. Strategies implemented are based on the result of the Strategic Prevention Framework which begins with assessment of needs, resources and readiness conducted as part of the community planning process. This ensures funded prevention interventions will address individual, family, organization, and community risk/protective factors to reduce MEB health disorders. All six strategies in appropriate proportions are needed as part of a comprehensive prevention approach. Communities receive the greatest benefit when a comprehensive public health approach is used that combines all six strategies in the appropriate balance to address the needs of universal, selective and indicated populations in their own unique community (IOM 2009, p.64).

The prevention strategies of community-based process, education and environmental are key prevention strategies, due to the intervention strength they contribute to influencing attitudes, behaviors, policy standards and impacting outcomes at the community and societal levels.

Community-Based Process

The community-based process (CBP) is essential to comprehensive prevention efforts. CBP acts as the foundation for the other five strategies. Without a CBP, none of the other CSAP strategies can be implemented, and if they are, they certainly will not be as effective. Strategies should be selected through a community-based process (e.g. a community coalition or a youth-led program), and not merely by one prevention professional or prevention agency. All other strategies are organized, planned, and implemented as a result of the collaboration during a community-based process. This strategy focuses on enhancing the ability of the organization or community to provide prevention services through planning, training, interagency collaboration, coalition building and/or networking. Community-based process activities are essential to effectively implement an environmental strategy. Planning and meeting must result in the selection of either a prevention education or environmental strategy to allow for the return on investment of the community's resources invested in the coalition building, capacity building and planning process.

Education

This strategy focuses on the delivery of services to target audiences with the intent of increasing knowledge and skills as well as influencing attitude and/or behavior. It involves two-way communication and is distinguished from information dissemination by the fact that interaction between educator/facilitator and participants is the basis of the activities. Activities influence critical life skills and social/emotional learning including decision-making, refusal skills, critical analysis and systematic judgment abilities.

Environmental

This strategy is designed to establish or change standards or policies that will reduce the incidence and prevalence of behavioral health problems in a population. This is accomplished through media, messaging, policy and enforcement activities conducted at multiple levels in the social-ecological model (considers the complex interplay between individual, relationship, community, and societal factors).

The following three strategies support the implementation of the above key strategies. These are implemented in conjunction with Community-Based Process, Education and Environmental strategies.

- **Alternatives:** This strategy focuses on providing opportunities for positive behavior support as a means of reducing risk taking behavior and reinforcing protective factors. Alternative programs include a wide range of social, cultural and community service/volunteer activities. These activities must be conducted as a part of a larger comprehensive prevention effort and are best when paired with opportunities to build attachment and bonding to families, schools, communities, and peers. Otherwise, they are merely a fun activity that cannot be distinguished from healthy participation in community life.
- **Information Dissemination:** This strategy focuses on building awareness of mental, emotional and behavioral health and the impact on individuals, families and communities, as well as the dissemination of information about prevention services. It is characterized by one-way communication from source to audience.
- **Problem Identification & Referral:** This strategy focuses on referring individuals who are currently involved in primary prevention services and who exhibit behavior that may indicate the need for a behavioral health assessment. This strategy does not include clinical assessment, treatment for behavioral health disorders. Although SBIRT (Screening Brief Intervention and Referral to Treatment) services could be included in this strategy, it cannot be funded by SAPT block grant prevention funds. The Problem Identification and Referral strategy is implemented when an individual enrolled in a direct service is identified as possibly needing or may benefit from services that exceed the scope of prevention.

III. Funding Ohio's Prevention Service System

OhioMHAS primarily supports the prevention service delivery system through allocations to the Alcohol

Drug and Mental Health Boards. A small amount of grant funds is used to support state-wide initiatives.

Prevention Certification

Agencies providing prevention services and strategies funded through OhioMHAS must be a certified prevention agency, unless exempted through administrative rule, and must be staffed by qualified, credentialed individuals as described in administrative rule (<http://codes.ohio.gov/oac/5122-29-20>). Workforce development expenses specifically related to evidence-based prevention approved by the Ohio Chemical Dependency Professionals Board for prevention registered clock hours are allowable under all funding sources. Allowable expenses include training that contributes to, and the application fee for, the Ohio Certified Prevention Assistant, Specialist, and Consultant credentials and renewals. OhioMHAS prevention funding cannot be used to support training and application expenses for credentials other than the three listed.

Billing Method

Community prevention efforts benefit all Ohioans through several programs at the local and state levels. A fee for unit of service billing method is not optimal for funding modern, public health approaches to community prevention, because the unit method is based on a treatment model of providing discrete services to individuals. OhioMHAS strongly recommends that communities explore other billing methods that facilitate the integration of OhioMHAS funded strategies with those funded by other federal, state and local entities into a comprehensive plan for collective community impact.

SAPT Block Grant and General Revenue Funding

All prevention interventions funded through Substance Abuse Prevention and Treatment (SAPT) Block Grant and State General Revenue Funds (GRF) must be in alignment with federal prevention National Outcome Measures, be based on data-driven decision-making, provide some level of evidence (according to SAMSHA's definitions <https://jjie.org/wp-content/uploads/2018/09/identifying-and-selecting-evidence-based-interventions-samhsa-2009.pdf> of prior effectiveness, and produce measurable outcomes reported annually.

Any activity that is not primary prevention or that is not specifically substance abuse prevention is not permitted to be funded with Substance Abuse Prevention and Treatment (SAPT) Block Grant prevention funding. (See 45 CFR 96.124 and 45 CFR 96.125.) Therefore, services such as Screening, Brief, Intervention & Referral to Treatment (SBIRT), testimonials by individuals in recovery, needle exchanges or other HIV prevention activities, food purchases that are not inherently part of an evidence-based program, case management, which includes continual individualized assistance and advocacy to ensure that needed services are offered and procured or any relapse prevention such as psycho-social education for individuals in recovery are not permitted to be funded with OhioMHAS SAPT Block Grant prevention funds.

Additionally, overdose prevention drugs such as Naloxone or projects related to overdose prevention such as Project DAWN are also not permitted to be funded with any OhioMHAS SAPT Block Grant prevention funds, without exception. These types of projects are medical interventions not behavioral health prevention interventions. Although, SAMHSA does allow for SAPT prevention funds to be utilized to support overdose prevention education, the redirection of primary prevention dollars from community resources to support this effort is unnecessary. The Ohio Department of Public Safety has already developed a local naloxone education assistance training for EMS, which is available free online, and the Ohio Department of Health provides overdose education and naloxone distribution programs in which training is provided by a trained opioid overdose prevention educator. These services can, however, be paid through General Revenue Funds (GRF), Problem Gambling funds, Local Levy funds, Foundation and Philanthropic funding and other funding directly allocated to these types of services.

All OhioMHAS funded prevention services must be in alignment with federal and state funding source priorities and produce measurable outcomes. Different funding sources have varied reporting requirements and restrictions for use of funds.



Appendix D

Prevalence of Behavioral Health Issues in Ohio

Substance Use

The National Survey on Drug Use and Health (NSDUH) (SAMHSA, 2019/2020) indicates there are 757,000 (7.7%) persons in Ohio with a Substance Use Disorder, and 353,000 (3.6%) of those reported illicit drug use in the past year. Fifty-two thousand (52,000) Ohioans aged 12 and older reported past year heroin use and 414,000 (4.5%) reported past year misuse of pain relievers. An estimated 88,000 Ohioans demonstrated past year pain reliever use disorder. The average prevalence of past-year opioid use disorder in Ohio was 1.45% of the population, or 142,000 people, which is higher than the national average. According to the 2017-2018 NSDUH over the past year 45,000 Ohioans 12 and older reported methamphetamine use, and 156,000 reported cocaine use. Five hundred and three thousand (503,000) Ohioans, or 5.1% of the population had a past-year alcohol use disorder.

In terms of substance use treatment, in a single-day count 66,296 Ohioans were enrolled in substance use treatment—an increase from 45,129 people in 2015. The number of individuals enrolled in substance use treatment in Ohio receiving Buprenorphine increased from 7,347 people in 2015 to 13,672 people in 2019. Survey estimates suggest that 271,000 (2.3%) Ohioans needed but did not receive treatment for illicit drugs.

Overdose Deaths

The Ohio Department of Health's (ODH, November 2020) published annual drug overdose report revealed that while the 2018 unintentional drug overdose death rate was the lowest since 2015, from 2018 to 2019, the overdose death rate increased by 6.4% to a rate of 36.4 deaths per 100,000 population, which is similar to the 2016 rate. Additionally, beginning in the second quarter of 2017, the number of unintentional overdose deaths began to decrease, and this trend continued into the first half of 2018. However, the number of deaths began to increase in the second half of 2018, and 2019 deaths saw steady increases each quarter. The number of fentanyl-related overdose deaths increased 12.3% from 2018 to 2019, and fentanyl was involved in 76.2% of unintentional overdose deaths. The number of fentanyl deaths involving carfentanil increased 577.3% from 75 deaths in 2018 to 508 deaths in 2019. The percentage of deaths related to psychostimulants (e.g. methamphetamine) increased. In 2019, 20.5% of unintentional overdose deaths involved psychostimulants.

Mental Health

The National Survey on Drug Use and Health (NSDUH) (SAMHSA, 2019/2020) indicates there are 2,043,388 persons, or 17.4% of the population with Any Mental Illness in Ohio. Of those, 798,000 (6.8%) persons in Ohio are diagnosed with a Serious Mental Illness. Among youth aged 12-17 in Ohio, the annual average percentage with a Major Depressive Episode in the past year increased from 8.1% between 2004-2007 and 14.6% between 2016-2019. Of these youth, only 46.5% (or 59,000) received care for their depression between 2016-2019. Young adults follow this same trend. Among young adults aged 18-25 in Ohio, the annual average percentage with a Serious Mental Illness (SMI) in the past year increased from 3.9% between the years 2008-2010 to 9.5% between the years 2017-2019. Young adults also saw a significant increase in serious thoughts of suicide between these same time periods. For young adults the annual average percentage with serious thoughts of suicide in the past year increased from 7.2% between 2008-2010 to 13.3% between the years 2017-2019. Mental health service use among adults has increased in the past 10 years, with 48.4% or 989,000 of those in need receiving mental health services.

Estimated Prevalence of Major Depression among Adults Ages 19-64 Following COVID-19

The COVID-19 pandemic has had a significant impact on the mental health of Ohioans. One study, the Ohio Medicaid Assessment Survey (2020), found that the proportion of respondents who screened positive

for depression was between 14.2% and 17.5% in the weeks following the start of COVID-19 and dropped to between 10.3% and 15.3% in June through August 2020. By comparison, the estimated prevalence of major depression in the United States prior to the health crisis was 7.1%. In addition, 25.8% of respondents reported negative mental health or substance use effects and 28.1% of reported negative social effects due to the current COVID-19 health care crisis.

Suicide in Ohio

In Ohio, five people die by suicide every day, making it one of the leading causes of death across the state. In 2019, there were 1,809 suicides in Ohio, and the highest suicide rates were among adults 35-54 years old. The Ohio Department of Health (ODH) has multi-year evidence that suggests that over the past 12 years, Ohioans are at increasing risk of completing suicide. The rate of suicide among Ohioans has increased 42.66% between 2007 to 2019 (10.8 vs. 15.2 deaths per 100,000). Males are disproportionately more likely to die by suicide, and their rates are almost four times the rate of females. Youth suicides, those below the age of 24, rose 47% between 2007 and 2019. Suicides among youth aged 14 and below increased 300% during the same time-period. Access to lethal means remains a key feature of the suicide epidemic in Ohio, with 52% of all suicides being completed with firearms. While Ohio has seen increases in suicide in the past 12 years, efforts at reducing the availability of prescription opioids is making progress in reducing the number suicides completed because of drug overdose. Between 2010 and 2019, suicides by overdose has gone down by 51% for Ohioans.



Appendix E Alignment to Other State Plans

This chart indicates how the Office of Prevention Services Strategic Goals and Objectives align with other Ohio plans, including:

1. [Ohio's Executive Response: A Plan of Action to Advance Equity, August 2020](#)
2. [OhioMHAS Strategic Plan 2021-2024](#)
3. [RecoveryOhio Advisory Council Initial Report – March 2019](#)
4. [The Suicide Prevention Plan for Ohio 2020-2022](#)
5. [Ohio's Early Childhood Strategic Plan: Growing Ohio's Future – 2020-2022](#)
6. [Safety and Violence Education Students \(SAVE Students\) Act](#)

Prevention Priority Area #1:

Promote the alignment and leveraging of resources and priorities at the federal, state, and local levels.

Goal	Objectives	Plan
1. Increase opportunities for sustainable investments and funding mechanisms that will sustain high-quality and effective prevention services across domains in local communities for all age groups and populations.	a. Seek funding sources that match prevention needs of target populations and priorities. b. Facilitate collaborative funding strategies with partners and initiatives that will multiply available resources and opportunities. c. Advocate for prevention infrastructure (comprehensive approaches and systems for developing policy, programs, and practices) needs as a priority investment of resources.	RecoveryOhio



Prevention Focus Priority #2:

Support systems change efforts and implementation through community-based process

Goal	Objectives	Plan
<p>1. Increase the knowledge, skills and abilities of community coalition leaders to implement systemic changes that can mitigate a broad variety of risk factors and develop protective factors capable of impacting multiple issues; substance use disorder, mental, emotional and behavioral disorders, suicide, problem gambling, etc.</p>	<p>a. Ensure infrastructure needs are in place to provide professional development, leadership skill-building opportunities and development of communities of practice, including strong training and technical assistance for data driven strategic planning efforts in local communities.</p> <p>b. Support the development of local structures that bring together people and sectors (including healthcare) to enhance public and private partnerships and implement innovative solutions.</p>	<p>RecoveryOhio</p>
<p>2. Increase the utilization of prevention expertise in community level planning practices for behavioral health and wellness.</p>	<p>a. Reinforce opportunities for prevention professionals to participate in planning and coordination with local ADAMH Boards, departments of health, Children and Family First Councils, school districts, area hospitals and other community/county/state partners.</p> <p>b. Promote data driven, strategic planning processes using tools such as the Strategic Prevention Framework and the Collective Impact Model.</p> <p>c. Further the use of trauma-informed approaches that promote resiliency such as the Tool for Health & Resilience in Vulnerable Environments (THRIVE) and the Adverse Community Experiences and Resilience Framework, or ACE/R.</p>	<p>RecoveryOhio</p> <p>OhioMHAS</p>
<p>3. Multiply efforts toward health equity by addressing social determinants of health.</p>	<p>a. Build capacity for communities to address social determinants of health and collective impact across the continuum of care.</p> <p>b. Establish strategies for increasing coalition development and involvement from communities of color, LGBTQ+, peers, and recovery advocates.</p>	<p>OhioMHAS Advance Equity</p>

Goal	Objectives	Plan
<p>4. Expand community-based prevention efforts toward reducing the suicide rate in Ohio.</p>	<p>a. Foster public and private partnerships that will accomplish the goals of the statewide suicide prevention plan, while aligning efforts and coordinating local, state, and federal resources.</p> <p>b. Develop knowledge, skills and abilities of local leadership that will help the work of suicide coalitions to align with the Centers for Disease Control and Prevention’s (CDC’s) strategies for preventing suicide and how to integrate the use of SAMHSA’s CSAP strategies in their work.</p> <p>c. Develop strategies to increase faith community involvement in suicide prevention coalitions (Governor’s Challenge).</p> <p>d. Integrate efforts to reduce access to lethal means, including safe storage of firearms (Governor’s Challenge) and expansion of postvention strategies into local and statewide plans.</p> <p>e. Advance the utilization of the Zero Suicide framework to improve suicide care within health and behavioral health systems.</p>	<p>State Suicide Prevention</p> <p>RecoveryOhio</p> <p>RecoveryOhio State Suicide Prevention</p>
<p>5. Strengthen youth-led programming efforts that involve young people in community change.</p>	<p>a. Sustain the Ohio Youth-Led Prevention Network’s Youth Council and include their input in developing high quality, evidence informed youth-led programming across Ohio.</p> <p>b. Support local implementation and sustainability efforts of youth-led programming in Ohio communities.</p> <p>c. Continue to advance the development of the Ohio Adult Allies partnership.</p>	



Prevention Priority Area #3:

Enhance multi-sector efforts across the continuum of care to support Ohio’s children, adults, and families.

Goal	Objectives	Plan
<p>1. Improve efficiency and better outcomes through cross-agency coordination and strategic alignment of best practice frameworks for MEB prevention.</p>	<p>a. Continue working with ODH and ODE to identify specific plans and resources that will support the expansion of OHYES! and YRBS in Ohio schools.</p> <p>b. Sustain collaborative opportunities with ODE to improve prevention services and supports in schools, including before and after school programming.</p> <p>c. Participate in school safety partnership with ODE and DPS that will implement SAVE Students Act and support other safety strategies.</p> <p>d. Engage ODHE and other statewide partners in developing relationships with community-based organizations that support mental health promotion, prevention, treatment, and recovery support services for campus communities.</p> <p>e. Provide ongoing involvement, technical assistance and leadership support for Recovery Ohio and other statewide and local partnerships that support our mission.</p> <p>f. Uphold the partnership with the Ohio National Guard Counter Drug Task Force to support local drug prevention efforts.</p> <p>g. Continue problem gambling collaborative relationships with the Ohio Lottery Commission, Ohio Casino Control Commission, and other key leadership that supports problem gambling prevention, treatment, and recovery services.</p> <p>h. Engage ODH and DPS partners to explore new opportunities related to tobacco prevention and cessation, including the support of Tobacco 21, SYNAR, and vaping prevention strategies.</p>	<p>RecoveryOhio Early Childhood</p> <p>RecoveryOhio Early Childhood</p> <p>SAVE Students Act</p> <p>RecoveryOhio</p> <p>RecoveryOhio</p> <p>RecoveryOhio</p> <p>RecoveryOhio</p> <p>RecoveryOhio</p>

Goal	Objectives	Plan
<p>1. Improve efficiency and better outcomes through cross-agency coordination and strategic alignment of best practice frameworks for MEB prevention.</p>	<p>i. Continue working with Prevention Action Alliance on marijuana prevention efforts to expand the reach and impact of educational resources and opportunities.</p> <p>j. Strengthen the Children of Incarcerated Parents partnership with Ohio University and ODRC with targeted expansion and investments.</p> <p>k. Facilitate the expansion of the Zero Suicide framework through the Ohio Children’s Hospital Association partnership and local community involvement.</p> <p>l. Support Urban Minority Alcoholism and Drug Abuse Outreach Programs (UMADAOP) that offer community led programming with a primary focus of providing culturally appropriate prevention, treatment, and outreach services to African American and Hispanic/Latino American communities in Ohio.</p> <p>m. Facilitate collaborative work that supports the Ohio CareLine with funding and technical assistance.</p> <p>n. Lead the development of partnerships and infrastructure that will support the new 988 number for suicide prevention and crisis calls as part of an improved crisis continuum.</p> <p>o. Support rural and Appalachian partnership development opportunities.</p>	<p>RecoveryOhio</p> <p>RecoveryOhio</p> <p>State Suicide Prevention</p>
<p>2. Develop early intervention frameworks and implementation resources that can be disseminated to primary care, education, community, and faith-based partners.</p>	<p>a. Promote the use of standardized universal screening tools for early identification and intervention.</p> <p>b. Continue to explore strategies for increased motivational enhancement and engagement trainings for the child welfare system.</p> <p>c. Develop a guide that describes the early intervention framework for youth and young adults ages 10-25.</p> <p>d. Support training and technical assistance for implementing early intervention programs and services across the lifespan.</p> <p>e. Invest in early intervention service implementation opportunities.</p>	<p>OhioMHAS RecoveryOhio</p> <p>OhioMHAS</p> <p>OhioMHAS</p> <p>OhioMHAS Recovery Ohio Early Childhood</p> <p>OhioMHAS</p>

Goal	Objectives	Plan
3. Expand opportunities for stakeholder input in developing prevention services priorities.	<ul style="list-style-type: none"> a. Engage stakeholders in the OAC Rule update process. b. Develop and implement education and training on new OAC Rule and its application to Prevention professionals. c. Develop and implement education and training on new OAC Rule and its application for Prevention certified provider agencies and agencies interested in obtaining Prevention certification. 	<p>OhioMHAS</p> <p>OhioMHAS</p> <p>OhioMHAS</p>
4. Disseminate models of prevention programs and practices across the lifespan that include senior citizens, families, youth, and college students.	<ul style="list-style-type: none"> a. Increase investments in older adult programming and coordinate efforts with Department of Aging to promote strategies statewide. b. Look for additional opportunities to share strategies that reach across the lifespan through multi-sector efforts. 	<p>RecoveryOhio</p> <p>RecoveryOhio</p>
5. Support the expansion of drug-free workplace programs and programs focused on the health and wellness of Ohio's workers.	<ul style="list-style-type: none"> a. Continue partnering with BWC to support educational and technical assistance opportunities. b. Partner with related stakeholders in supporting education and technical assistance for employers to support employees and their families. 	<p>RecoveryOhio</p> <p>RecoveryOhio</p>
6. Strengthen the prevention role of law enforcement in schools and communities.	<ul style="list-style-type: none"> a. Provide training opportunities through the school safety partnership. b. Encourage law enforcement inclusion with local assessment and planning efforts. c. Support and encourage first responder partnerships that expand the use of best practices. d. Continue development of the Handle with Care network. e. Connect Ohio National Guard analysts and their work with law enforcement data with local prevention efforts and with the OSAM team. 	<p>RecoveryOhio</p>

Prevention Priority Area #4:

Advance the use of prevention science for mental, emotional, and behavioral (MEB) health prevention and promotion

Goal	Objectives	Plan
<p>1. Increase the use of evidence-based programs, policies, and practices through targeted investments of resources.</p>	<p>a. Explore the development and identification of resources to create a Center of Excellence that promotes evidence-informed prevention and supports community capacity-building efforts.</p> <p>b. Provide ongoing learning opportunities that support the understanding of prevention science and implementation of evidence-based frameworks, policies, programs, and practices.</p> <p>c. Invest in opportunities for training of trainers or master trainers that can help sustain evidence-based programming, (i.e., Creating Lasting Family Connections; Sources of Strength; Signs of Suicide, PAX GBG).</p> <p>d. Ensure trauma and culturally competent principles are embedded into all prevention efforts.</p> <p>e. Disseminate evidence-based approaches related to preventing mental, emotional, and behavioral health disorders and how to integrate skills-based positive attributes, such as self-regulation, self-efficacy, goal setting and positive relationships into promotion efforts.</p>	<p>OhioMHAS</p> <p>OhioMHAS</p> <p>OhioMHAS</p> <p>OhioMHAS</p> <p>OhioMHAS</p>
<p>2. Increase utilization of current data and outcome measures to make data-driven decisions around prevention needs and department priorities.</p>	<p>a. Participate in department Data Management Committee and development of shared indicators.</p> <p>b. Contribute policy change recommendations that will improve data collection from providers.</p> <p>c. Assist with developing data practices that could improve multi-system planning efforts for suicide prevention.</p> <p>d. Collaborate with Quality Planning and Research to determine how to improve the use of prevention data and outcome measures and collection systems (GFMS data and Performance Management process) that will result in improved demonstration of results.</p>	<p>OhioMHAS</p> <p>OhioMHAS</p> <p>State Suicide Prevention</p> <p>OhioMHAS</p>
<p>3. Promote understanding and support for the vision/mission and organizational goals of the Office of Prevention Services.</p>	<p>a. Identify messages that will be communicated for both internal and external audiences.</p> <p>b. Create promotional materials and distribution methods for understanding the prevention continuum of services and best practices.</p>	

Goal	Objectives	Plan
<p>4. Increase opportunities for public education strategies with evidence to prevent overdoses, accidental poisonings, suicide, problem gambling and substance use disorders.</p>	<p>a. Ensure public education and campaigns are based on the public health model including an emphasis on positive messaging and strategies to decrease stigma.</p> <p>b. Promote safe medication disposal programs, safe storage of medications, including marijuana for medical use, and safe storage of firearms.</p> <p>c. Strengthen public knowledge and ability to promote wellness, recognize suicide risk, and take appropriate action for self and others (gatekeeper trainings).</p> <p>d. Present learning opportunities for understanding low risk drinking guidelines and connections between alcohol and MEB health problems.</p>	<p>RecoveryOhio</p> <p>RecoveryOhio</p> <p>RecoveryOhio State Suicide Prevention</p> <p>RecoveryOhio</p>



Prevention Priority Area #5:

Grow and Support Ohio’s Prevention workforce, including those new to the field, current and emerging leaders.

Goal	Objectives	Plan
1. Grow the number of credentialed prevention professionals that include a priority on geographic and culturally diverse populations.	<ul style="list-style-type: none"> a. Partner with credentialing boards to develop strategies for engagement and recruitment of prevention professionals. b. Support advocacy efforts that highlight the value and expertise that prevention professionals contribute to community-based processes. c. Participate in department workforce development partnerships and strategies. d. Support the development of college course work that includes content needed for credentialing of prevention professionals, including preventing mental, emotional, and behavioral health disorders. 	<p>OhioMHAS Advance Equity</p> <p>OhioMHAS</p> <p>OhioMHAS Early Childhood</p> <p>OhioMHAS Early Childhood</p>
2. Improve workforce competencies through training in evidence-based and promising practices.	<ul style="list-style-type: none"> a. Continue investment in professional development opportunities, training, technical assistance and coaching to support comprehensive prevention programs, policies, and practices. b. Support a sustained infrastructure investment for workforce strategies such as those facilitated by Prevention Action Alliance (SPCA), Prevention First (OCAM), OU (Ohio Adult Allies), ADAPAO (Prevention Fellowships) and Problem Gambling Network of Ohio (PG conference and prevention and clinical professional development). 	<p>OhioMHAS</p> <p>OhioMHAS</p>
3. Increase the number of organizations that are providing quality prevention services.	<ul style="list-style-type: none"> a. Update OAC Rules that govern certification of prevention organizations to align with current best practices and needs of the field. b. Develop engagement strategies for mental health providers to obtain certification. 	
4. Increase the number of licensed practitioners holding the Problem Gambling endorsement and those able to provide quality treatment interventions.	<ul style="list-style-type: none"> a. Continue investment in professional development opportunities and supervision for problem gambling practitioners. 	

