Mental Health & Recovery Board
of Clark, Greene & Madison Counties

Providing help, healing, and hope.

Chairman Hackett, Vice-Chair Huffman, Ranking Member Thomas, and members of the Finance Subcommittee on Health and Medicaid, good morning.

My name is Greta Mayer, and I am the Chief Executive Officer of the Mental Health & Recovery Board of Clark, Greene & Madison Counties, informally known as MHRB. Thank you for the opportunity to testify today, and for your interest in investing in issues related to mental health and addiction. Your investment to build capacity in local prevention and crisis intervention services will address two of these critical issues: overdose and suicide.

Ohio in Crisis

Like other areas, our Board region has been profoundly affected by the opioid epidemic. In 2016, Clark, Greene, and Madison Counties experienced 106 unintentional overdose deaths. In 2017, that number rose to 170 unintentional overdose deaths. Increasing crisis capacity and recovery support is needed to mitigate the underlying trauma and lack of social connection which is exacerbating the addiction epidemic in our communities.

As a result, our local agencies have seen an increased need for grief support, caregiving support, addiction support for families, and financial and emotional support for grandparents raising their grandchildren. Local first responders are drained from the trauma they experience daily. Other community partners such as Children's Services and our Family and Children First councils are left with increased numbers of children who are significantly impacted, and many placed in foster care. The criminal justice system is adversely affected. Unfortunately, the magnitude of these situations requires solutions that are reactive. But today, there is an opportunity to proactively reach children who now are at greater risk for developing their own mental health and addiction problems. We can do this by using proven prevention strategies **that we know work**. For instance, Botvin LifeSkills, an evidence-based prevention curriculum for substance use delivered in schools yields an 87% reduction in tobacco use, 60% reduction in alcohol use, and 75% reduction in marijuana use of teens. Locally, we already have received promising results about the effectiveness of this curriculum for our specific population of youth. While some local school districts initially were reticent to introduce these programs, relationship and capacity building on the local level has allowed us to expand Botvin programming, increase capacity, and instill resilience in our children. In Clark County alone, 13 new schools adopted the curriculum for this school year and next. This progress would not be possible without strong community partnerships that are able to pivot and quickly address local needs. Likewise, Greene County is growing early childhood strategies and building upon successful PAX Good Behavior Game® implementation. Madison County is also offering a menu of robust prevention strategies to schools and communities, most recently in youth led opportunities.

Our counties also are experiencing unprecedented levels of suicide. Ohio experienced a 36% increase in suicide between 1999 and 2016, without proportional changes in population size. 59 deaths in Clark, Greene, and Madison Counties were ruled as suicides in 2018 (with additional

cases pending)—and we know that these numbers are underreported. For the first time in history, first responders die more often by suicide than in the line of duty, and LGBTQ individuals also are at an increased risk of suicide compared to the general population. We have lost young people, middle-aged, and older adult residents in these special at-risk groups across Clark, Greene, and Madison Counties.

For everyone that dies by suicide, parents, children, siblings, uncles, aunts, grandparents, and friends are left with a lifelong battle to understand and cope with their devastating and incomprehensible loss. Each of those individuals has a 65% increased risk of attempting suicide themselves. Further, we know that the impact of suicide is not solely emotional; in some cases, it also is economic. In 2013, suicide accounted for 24 percent of medical and work-loss cost in the United States, amounting to 50.8 billion dollars.

Thoughts of suicide or suicide completion represent acute crisis, which oftentimes occur after an individual has experienced significant trauma. While there is a strong need for crisis care, we also must acknowledge that underlying trauma should be addressed with proper prevention, treatment, and recovery supports. These services can reduce the impact of trauma on repeated crisis episodes, and thus lower the risk of acute crises.

Recovery supports also can help people stay well. Our local Board has invested in supporting several strategies to uphold individuals in recovery, including: a drug-free workforce strategic plan and investment; peer recovery support training and infrastructure building; and expansion in recovery housing to address addiction and supportive housing projects for individuals with severe and persistent mental illness in all three counties.

Scale of the Problem

These are not just "mental health and addiction problems." They are issues that negatively impact the overall health of our state and its citizens. The Health Policy Institute of Ohio recently released its 2019 Health Value Dashboard, ranking Ohio 46th out of 50 states in health value. It also identified addiction as one of three explanations for Ohio's low ranking, citing it as a root problem of health challenges, including overdose deaths, unemployment, and incarceration. All three of our local jails are at or over capacity and staff are seeking additional resources to better manage high-risk individuals with mental illness and addiction.

Ohio Revised Code 340.011 (A) stipulates that Boards are statutorily charged with, "establishing a unified system of treatment for mentally ill persons and persons with addictions" and with "foster[ing] the development of comprehensive community mental health services, **based on recognized local needs**…". Locally, we take these responsibilities very seriously—as do our colleagues across the state. For these reasons, I echo Ms. Walter's comments regarding earmarks. To meet our statutory responsibilities and provide the strongest, most cost-effective systems of care, Boards must have flexible and sustainable funding rather than earmarked or restrictive dollars.

Local investment

Despite the dramatic state funding cuts in fiscal year 2010, our Board continues to invest our local levy dollars in prevention. In fiscal year 2019, 44% of MHRB-funded prevention services were funded by local levy dollars. We invested these funds for two reasons. First, we know that there will never be enough treatment dollars available to address the growing demand for services. Second, we know that universal prevention yields a strong return on investment. According to the National Institute on Drug Abuse, substance abuse costs the United States more than $600 billion dollars annually – but every dollar invested in addiction treatment programs saves between $4 and $7 by reducing crime, criminal justice-related costs, and theft. After accounting for health costs, savings outweigh costs by a 12 to 1 ratio.

By investing local dollars, our Board area has greatly expanded its prevention efforts through partnerships with local coalitions, schools, Family and Children First Councils, and Children's Services. These investments not only have increased access to prevention in schools, they also contributed to building a viable workforce that is equipped to deliver prevention services. Although our Board continues to invest in prevention, our modest amount of local and state funding to support evidence-based, effective strategies is not enough to address the growing need.

We applaud your willingness to consider investing in mental health and substance use crisis intervention, prevention, and long-term recovery support. But I would be remiss not to state that while this support is appreciated, more is needed. In fiscal year 2019, our Board funded 63% of treatment, prevention, and supportive services through local levy dollars. Funding our local continuum of care at this current rate is unsustainable. At this rate, the system would collapse in 6.7 years.

It is possible to make progress; to reduce deaths by overdose and suicide and to build healthier, stronger communities. It also is necessary. While offering hope to those in active addiction and help to those who are seeking treatment, we must also provide healing to those left behind to safeguard against further damage through prevention education.

As you consider House Bill 166, please be assured that Ms. Walter, Mr. Osiecki, Mr. DeCamp, me, and our fellow colleagues would be happy to serve as resources for you not only today, but every day. We stand ready to assist you with information on local and state mental health and addiction services.

Again, thank you for the opportunity to speak with you this morning, and for your service to Ohio. I welcome any questions you may have.

SUICIDE

in Clark, Greene & Madison Counties

As a state, we failed to proactively address opiate addiction and are now spending millions of dollars to address the epidemic. Suicide impacts Ohioans of all ages, and the problem will continue to grow if we do not change our approach.

On average, 187 youth die by suicide every year in Ohio. For each child that dies, parents, siblings, uncles, aunts, grandparents, and friends are left with a lifelong battle to understand and cope with the devastating and incomprehensible loss.

Further, the impact is not solely emotional; in some cases, it also is economic. In 2013, suicide accounted for 24 percent of medical and work-loss costs, amounting to 50.8 billion dollars[1].

2018 Confirmed Suicides

30	4	22
Clark	Madison	Greene

STATEWIDE:

2nd

leading cause of death in youth & young adults ages 10-24[2]

36% ↑

in suicides between 1999 and 2016[3]

LET'S PREVENT IT BY:

1. **Expanding ORC 5122. 04 to allow for children who may be suicidal to receive a crisis risk assessment, even if parents are not available to provide consent.**
2. **Authorizing coroners to provide consistent and timely reporting of suicide data to county ADA/MH Boards.**
3. **Funding suicide prevention, intervention, and postvention in a manner that reflects the scope of the problem.**

1. National Institute of Mental Health (2018). Cost of Suicide Deaths, data courtesy of CDC [Figure 6]. Retrieved from https://www.nimh.nih.gov/health/statistics/suicide.shtml
2. National Institute of Mental Health (2018). Leading Cause of Death in the United States 2016, data courtesy of CDC [Table 1]. Retrieved from https://www.nimh.nih.gov/health/statistics/suicide.shtml
3. Ohio Suicide Prevention Foundation (2018). About. Retrieved from http://www.ohiospf.org/content.php?pageurl=about