INTRODUCTION

The Muskingum Area Board (hereafter referred to as the "Board") is responsible for the distribution of funds in the community for the provision of mental health, substance use disorder, and prevention services. The Board receives funds from a combination of Federal, State, and Local sources and takes its fiduciary responsibility to these funding sources very seriously. In an effort to utilize resources to best advance the mission and values of the organization, the Board recently determined that the process by which allocations are made should be amended to verify that the funded partners in the community direct resources in the most equitable manner possible, realizing also that efficiency and effectiveness are important aspects to consider.

There are many wonderful organizations in the community that are doing excellent work in meeting the needs of target populations. However, an organization should not continue to receive funds from the Board simply because it received funds in the prior year. The Board has an ongoing responsibility to use the resources at its disposal to maximize the impact of expenditures by verifying that high quality work continues and that new innovative efforts are given an opportunity to compete for support. On this basis, the Board will be phasing in a new process that all organizations that wish to receive funds from the Board will be required to follow. The process is designed to be fair to all organizations requesting investment by the Board, and it hinges on the ability of the funded organization to communicate clearly what allocated resources will be used for and to demonstrate success in achieving the stated goals.

Four distinct values are relevant to the allocation decisions made by the Board. They are Efficiency, Effectiveness, Equality and Equity, defined as follows:

1. Efficiency: A maximally efficient outcome is one that provides the highest ratio of output over input in a system. Efficiency does not consider the distribution of outcomes across recipients, but only the return on investment that is generated.
2. Effectiveness: A maximally effective outcome is one that maximizes benefit to the recipient of the resources or services in question so as to bring about the greatest gain for the chosen recipient. When we consider effectiveness, we seek to obtain the best possible best-case outcome.
3. Equality: An equal distribution is one that maximizes the degree of similarity of either input or outcome for all recipients of goods or services.
4. Equity: A maximally equitable distribution of goods or services is that which minimizes harm to the least advantaged potential target of support so as to bring about the least harm to the least advantaged potential recipients. When we consider equity, we seek to obtain the best possible worst-case outcome.

All of these values are important, but the order in which they are considered will greatly impact the fairness of any particular allocation decision. For instance, efficiency might be satisfied maximally by serving individuals with the simplest needs. Effectiveness would clearly be best served by working with individuals who have the fewest challenges. Equality would have to be defined either in terms of the level of resources committed across individuals or programs, or in terms of the outcomes produced, but it might be impossible to guarantee equality across disparate groups. Equity, which seems the closest match to 'fairness', is likely to require that we

pay greatest attention to the neediest recipients, which could result in reductions in all three of the remaining four values.

The process that is outlined below is based on a deep understanding of the role of the Board and the organizations which it funds. As a public provider of service that is designed as a safety net provider, it is imperative that highest priority be placed on the concept of equity, to ensure that those with the most serious and imminent needs are provided the greatest support. In choosing to place highest priority on the value of equity, it is important to recognize that the Board will not completely ignore the other relevant values. Efficiency and effectiveness will still play significant roles in its allocation decisions. For instance, it might be possible that a particular service could be provided that would generate true profit, such that by offering that service to individuals who produce a positive revenue stream to the agency that is fungible, increased resources would then be available to serve other individuals who would otherwise have no access to services. If such a scenario were available, then by choosing to be very efficient in the use of resources, and by leveraging those resources, a provider could actually do more good for individuals who are least advantaged. Likewise with regard to effectiveness, there could be times when choosing an effective option also works to the advantage of equity. When we aim to increase the equity of our allocation decisions, we must take into account the likelihood of producing positive and measurable results. Our goal is to make decisions that are calculated to maximize the benefit to the least advantaged, and we cannot know if we are doing that unless we make judgments about the probable effectiveness of any particular program.

In summary, the Board believes that the concept of equity should play heavily in prioritization decisions and that the values of efficiency and effectiveness should be applied in a supportive role of our efforts to be fair. There is one important caveat that should be made clear. In an environment where demand outpaces supply and the result of failing to fund a particular program is likely to result in serious and imminent needs going unmet, it is possible that all available resources could be shifted to critical response programs in the name of maximizing equity. Part of the Board's mission, however, is to provide a continuum of services including the support of prevention programs. If prevention services were asked to compete against emergency mental health supports in an environment of limited resources, the prevention programs would almost invariably lose in an equity-based competition, and the Board's commitment to providing an array of services would go unsatisfied. On this basis, in the first year of implementation of the new allocation system, available funds will be split into two distinct competitive pools. 78% of available funds will be allocated to treatment programs (including support and housing services) and 21% of available funds will be allocated to prevention services. The remaining 1% of funding will be allocated for non-competitive Community Collaboration grants that will be made on a first-come first-served basis. This division of resources is based on historical spending patterns and may be adjusted in future years as the Board re-evaluates the impact of its funding choices. Reassessment of the allocation of funding to each source will be based on multiple factors. For instance, if excess funds exist in one category, they will be re-allocated to categories that experience shortages. If it is determined, based on loss of revenue or an increased community need, that a significant risk of a failure to meet tier two and tier three treatment needs as defined below exists, then funds may be shifted away from prevention services. All of these decisions will be calculated to best support the mission, values, and strategic goals of the Board.

THE PROCESS

The Board recognizes that in addition to its own mission and values, much of the funding that becomes available for reallocation carries with it explicit expectations as to how the resources may be spent, and that a number of State and Federal level demands apply. These additional stipulations for how resources may be used constitute mandates. Mandates, however, come in three distinct types: a) Hard Mandates which stipulate exactly how and to what degree particular services must be provided, b) Soft Mandates which stipulate that a function of some specific type must be provided but which do not stipulate the manner or degree to which they must be done, and c) Contingent Mandates which only exist if certain funds are voluntarily accepted, but which do not apply if those funds are not accessed.

Based on the foregoing analysis, the Board has developed a prioritized evaluation of potential services to be offered in the community. In order to satisfy relevant mandates and to advance equity in our efforts, the Board has identified three tiers of funding for treatment, support, and housing, and two tiers of funding for prevention services in addition to a top tier regarding mandates. Programs and services that meet higher tier needs will receive priority over those that serve lower tier needs. The tiers of priority are as follows:

MANDATES

HARD AND SOFT MANDATES

The Board has an ethical, legal, and regulatory obligation to satisfy mandates. Therefore, programs and services that satisfy hard mandates will be given highest priority for funding along with those that make it possible to meet the minimum requirements of soft mandates.

TIER ONE TREATMENT, SUPPORTS, AND HOUSING

CRISIS SERVICES INVOLVING A RISK OF IMMINENT HARM

Highest priority will be given to funding programs and services that mitigate the risk of serious and imminent harm (including the need for emergency or urgent services due to danger to self/others, including inability of self-care due to behavioral healthcare issues and/or potential life-threatening symptoms resulting from withdrawal from substances and/or other safety issues). Services include assessment of risk, crisis/safety planning, and referral to appropriate levels of care to resolve any imminent harm.

TIER TWO TREATMENT, SUPPORTS, AND HOUSING

TREATMENT SERVICES INVOLVING HIGH BUT NON-IMMINENT HARM

Second priority will be given to court ordered NGRI/IST-U-CJ forensic care, monitoring, and treatment; services to persons of MHR priority populations with histories of community violence, treatment non-compliance, and/or criminal justice involvement; services to persons with co-occurring disorders and/or multiple hospitalizations and/or multiple detoxification stays; and services to youth (birth – 17) including those involved with multi-community system involvement and/or those in danger of out of home placement. This tier also addresses the needs

of individuals who are at risk of serious negative outcomes, but not imminent harm (including need for treatment or intervention to persons of MHR priority populations that provides structured recovery focused activities leading to stabilization of behavioral healthcare symptoms and/or other safety issues and/or increased functioning). All of the services in this tier include the use of consumer specific plans and must be medically necessary.

TIER THREE TREATMENT, SUPPORTS, AND HOUSING

RECOVERY SUPPORTS AND OTHER DETERMINANTS LEADING TO HEALTH

Third priority will be given to programs and services that mitigate the risk of potential negative outcomes in the long-term. This tier includes promotion of structured recovery supports and wellness activities leading to stabilization of behavioral healthcare symptoms, other safety issues, or increased functioning, or which provide activities that support the recovery process including the provision of basic needs. Programs that generally lead to improved determinants of health are included in this level such as resiliency-based interventions. These types of services typically include the use of a consumer specific plan but are not generally medically necessary and may target non-MHR priority populations.

TIER ONE PREVENTION

HIGH PRIORITY AND TARGETED/SELECTED POPULATIONS

Within the realm of prevention services, highest priority shall be given to programs or services that serve high-priority populations and that use identified EBP implementation to target individuals at risk for multiple problem behaviors. Included in this category are programs targeting the potential risk for negative outcomes for many participants in the intermediate to longer-term if services are not provided before more serious problems develop, early intervention programs delivered to young children and/or their parents, and programs delivered to at-risk adolescents before serious problems emerge. Negative outcomes these programs aim to prevent include child abuse and neglect, behavioral and social-emotional problems, school failure, alcohol and other drug abuse, teen pregnancy, delinquency, and violence. These interventions are not considered medically necessary and typically do not include the use of a consumer specific plan. The use of resiliency-based interventions is stressed including targeted and selected prevention strategies for ages 0 to 17, and universal strategies that target priority prevention populations involving ages 0 to 5 and 5 to 12.

TIER TWO PREVENTION

UNIVERSAL PREVENTION STRATEGIES

Second priority will be given to prevention programs or services that address potential risk for negative outcomes in the long-term for some participants. Negative outcomes these programs aim to prevent include alcohol and other drug use, violence, and sexual assault. These programs typically serve the general population of children or adolescents and their families, without regard to risk factors. They may also provide education and information to the general public with the goal to prevent problems before they arise (primary prevention). These programs do not

include a consumer specific plan and are not medically necessary. The use of resiliency-based interventions is stressed including science-based interventions (EBPs) that impact multiple problem behaviors and focus on population-based interventions.

As noted, 78% of funds will be allocated for treatment (including support and housing programs) and 21% will be allocated for prevention. This balance may shift in future years if the Board determines that a compelling excess or shortage of funds develops in one area or the other. Organizations requested funding will be asked to split their requests between treatment and prevention and to prepare separate applications for each.