SEIU District 1199 WV/KY/OH
State of Ohio Chapter
Agency Professional Committee Meeting Minutes

ODMHAS Recovery Services
September 19, 2023

Laurie Spolaruch,
Todd Viars, LRO 3
John Sexten
Geoff Davies
Amanda Fletcher, RiCI
Stacey Adams, NCI
Michael Dray, CCI
Wes Bowling, SCI

1. **14 day referrals to be seen within 3 days, as a "crisis" situation.**
Explanation: there have been changes made to the timeframe that some Recovery Services referrals have to be completed. Some of the Supervisors are now dictating that some of the referrals designated as 14-day referrals have to be seen within 3-days due to the Supervisors deeming them a "crisis" situation.
*Some of the CPCs' licenses do NOT cover crisis assessment/intervention (at least I don't believe they do) in their scope of practice.
*The CPC's required to meet with these inmates who are in "crisis" have not received any specialized or general training for this.
Is this a new expectation?

What are we looking for? – It came from JS. What is it and what does it mean? Some isn't are saying ats a crisis switch so do within 3 days.
How is it deemed a crisis? LCDC are nervous about crossing into MH at all. Clear boundary between MH and RS. Licensed SW can cross. But Chem Dep cannot and not familiar.
LCDC 3 and 2 cannot deal with MH. Only OAD issues. LCDC 3 cant diagnose certain.
Came from a regional someone. Creating discomfort.
Mics MH to the extent could create slippery slope to MH. Not all our members are equal. LCDC can do crisis but only as relates to substance not MH.
Constant watch was deemed a crisis so wanted 3 days. On constant watch he's MH.

Clarification and demarcation of roles and repsonsbilites. If making changes then cool but needs to be in writing protocol and communicated cleary and also more staff.

JOHN: 6-8 weeks working on referral protocol. It breaks it all down. 3 vs 14 day. That will be released. Delay is electronic healthcare record screens are accurate.
What inst. Are doing it? We've not instructed anyone to change it yet or supervisors to bump anything.
Email them to John? Yes.

Rule 4757-15-01 Scope of Practice of license counselors. Clinical counseling methods and procures, assessing and analyzing crisi, treatment planning. Etc. LPC or LPCC. Rule for SW include the same thing. -6-03 scope for LCDC same language. Substance use counselling.

Diff between substance abuse counseling and MH counseling.
Internal Protocol will lay out the timeframes and what falls into a referral. We do not do MH counselling. That would need.
We will put it out to supervisors and managers and front line staff. Supervisor should review with employees. Questions that supervisor cannot be answered are escalated.

Stacey: someone in TPU overdosed related to mental health situation. Is that us or them? Who covers that?

Licensed can do crisis but only related to chemical dependency and substance abuse. Its diff for LDCD to respond to a MH crisis and figure out what and relevant to them. Its been drilled into us we are substance abuse special. The protocol blurs those lines.

John: the protocol not released yet.
Geoff: yes, but those regionals are putting it out already and wrong.
Ask the questioned the
Can we do a more central orientation, to avoid multiple supervisors giving potential different ideas of what it is?
John: guys do you think we should communicate policies centrally like that?
Stacey: no because very institution is a little different. But this
Wes: its potential mixed message. I'm told cant do crisis intervention before. What I see here is a mixed message. We're asked o go do these things but also told we cant.
MH sends referral to RS and they're worried about getting it in the timeframes. Window that they have to respond to the referral.
JS: I hear you saying as a helping professional you want to hear everyone in all situations but your counterparts saying just substance abuse.
No, everyone being asked to do more, but we have less. There needs to be precise clarification where DRC is asking us to do thing. It would be your job to let DRC know what message can be sent so I don't step forward in a way I've gone outside scope of my license.
Its not anything about union or that its safety of our jobs and what we're being asked to do
JS: this for me is about having the boundaries. If its outside your scope of license or duties, that's where you say I'm not permitted to do that.
AF: I recognize you do best to protect our lcienses but im worried that the info we were given is supervisor will look at referral regardless 3 or 14 and determine is a crisis or not and then pass to CPC to deal with it. If we're trying to protect against lawsuit, but it actually opens us up because we're going from 14 day to 3 day to crisis response which makes it sound emergent. Raises the stakes. It protect the supervisor, but exposes the CPC who doesn't have time when they have IOP.
JS: We included CPCs when we put it together. But the language of crisis intervention is not include in the protocol.
Amanda: did they express concern about the workload it might create?

It will be going out when the templates and workflows are done. That's DRC.
Stacey: can supervisors stand up and help with the referrals?
JS: its for RS staff. Sorry other institutions not assisting but that is the role of a supervisor to manage and assist. If theyre not let me know.

Geoff: I'm going to ask that the protocol is shared with this committee for review before it goes out.
Todd: I will make a note fo your request. Also send to me in writing.
Alright.

When will the protocol come and meetings begin?

GEOFF: Email Laurie and ask them to sort it out first. Kill the regionals.

2. **CPC classifications explanation**
   Aim? Theres a lot of cross over AOD and LCDC are lower but they're doing equal work? Also issue with hiring into the positions

   SAMI focused (Sub Abuse and Mental Illness)
   MAT focused (Medication Assistance Therapy)
   Peer Support
   TPU rounds.
   If these are different jobs then that needs to be clear, not assignments.

   Todd: if you look at updated the JD is there.

   Yes, I was asking for updated according to the various roles. We believe a CPC is a CPC. So its all going to be the same PD but updated with additional duties that weren't there when.
   JDs will be sent out once done. With HR right now.
   We can certainly discuss at negotiations any modifications. Cant give you a firm deadline.
   We'll respond accordingly.

   After caucus: pick the battle. MAT will be going to medical, but peer support is big. 2 IOPs is 36 hours out of 40.
   Could Mat truly go to medical? Michael: Medication yes, but a certain time of therapy is required. What is the minimum?
   Providing so many different areas of support and therapy, you should have different classifications or level of CPC.
   Or make it a separate assignment within the CPC position. AODC look at pay rates and risk 3%
   You can get hired as a AODC and move up? No, you stay where you are unless you transfer. Theres no TC policy on it.

   If CPC doing IOP and Peer Support and Mat where is the carrot and money

   Whats most important to our members?

   OTP director oversees Peer Support as well.

3. **Policies/protocols for MAT** – OTP and how does it line up with current CPC job description? MAT is not CBT.
   We're not clear on clear lines. OTP. Its not working. Little to no communication on process. Institutions that have it - - Grafton, CRC, Lorain, ORW (DCI) are putting the therapy component onto the CPCs because they have to have treatment components.
   Outside organization should be doing it, not us?
   State was hiring MAT specific coordinators. How many are there?
   Mailing medicine and not treatment.

   Ciommuncation
   So, who is doing it where. What are the clear roles and responsibilities.
   Is there medication with no treatment – there's no treatment in the community

Mat is a n accompaniment

JS: indivuals prescribed and eligible, requirement by DEA that they participate in treatment. They're met with weekly until placed into one of our treatment programs.
What is the contractors role. Community Medical Services, contracted medical provider licensed by DEA and certified dot detrmine eleigiblity and then they dispense. Wther they give it depends on institutions. Can be delivered by nursing staff. Also othe delivery sites and they can be sent there and dispensed there by DRC medical staff

ask about education, AOD education does MAT is it covered by this AOD education!!!
RJS: RS staff, not just AOD, are trained onhow to screen theindicuals and then when doing the counseling theyre following the guidelines of the treatment groups.
There Mat positons? Filled not fiolled?
Four MAT coordinator positions who are at Lorain, Grafton CRC and ORW who are to screen the individuals. Since it is a CPC potion we have two filled and two vacant. Vacant are being fille din those roles.
What are they doing with the rest of there work?
JS: Some of those services are ?
Delivery sites?
DCI, Warren, and others, Lebanon, and PCI. FMC but only medical issues.
Are CPC involved int hat
Yes, for screening and assessing

Duties involved...AOD therapy VS AOD education. Are the clients supposed to be getting therapy? This is part of the "job description." I'm hearing 2-different explanations.

What help is coming?
We are activel y recruiting and working to fill those.
When does the something change?
Laurie: we cant tell you when things are going to change. Or what duties are going to be shifted to make sure people can get done what they need to get done. We're still looking at incentives. Nobody here has the singular authroty to make change happen.

Right but you control the operational side asking our members to do these various hings. What are you doing operational aspect?

JS: we have told are staff if don't have the staff don't provide the services. We're not soying do three and our treatment groups, we're paring it donw to what is essebntial.

Amanda: have you reahce dout to line sytaff to see if that's what happening or just suoperviors?
JS: I do when I go to the prisons. I lso rely on the data we collect. I know there are less treatment activies. IOP, TC. Interbention, because eof the fewer numbers of staff.

Amanda: Taken on Peer Support, MAT, your comfortable saying there have been some IOPS and BIP that have been foregone.
JS: yes not provided because of the vacancies.
AF: at hat point do you hit the brakes in providing additional things?
JS: We do it routinely, here are multiple things we've been asked to do that we have not done. We don't advertise that.
AF: but we still have clinicians doing 2 IOPS AND 2-3 additional assignments – MAT, Narcan, TPU rounds, Referrals.

JS:
JS: If ACPC is doing two IOPs, 10 hours treatment, 2 hours ancillary, then prep and documentation. Face time is 22 hours a week. The yes there is documentation. Im not saying.
WB: starting Point, education group. Is it taking place of MAT?
JS: no, it's the old 39 group who self report use. We're engaging those people. 25-33% of them go on to be in treatment.
WB: people can volunteers for the group.

GD: Duties involved...AOD therapy VS AOD education. Are the clients supposed to be getting therapy? This is part of the "job description." I'm hearing 2-different explanations.

Michael: what if there is not a spot for an inmate, he wants the treatment. Treatment modalities are rejecting them. You have bill wants to get into treatment but we don't want him because he has to do XYZ before he can.
Inmate Refers to recovery coaches and go to some meetings and then when IOP opens up we put them in. Thye don't go straight tin. Or inmate in TPU for too long no groups so we pu them in a BIP first.
MeicaheL: With Mat when you have an divual with active addiction that eprosn needs a lot from them. It requires a lot of time an deffort. It seem sth eommucnation isn't well distributed. When the story isn't told from the chain of command we fill it with dialogue to fill the gaps of why and what we're doing. We might be missing the mark. Mat need ssome fine tuning.
JS: don't disagree that communication is paramount is helping clients understand. We deal with indicual who jsyt wan tto get the substance. So we try to communicate as much as we can. We meet routinely with the OTP group, DRC, medical, etc where we try to reifine and improve things we find.

Michael: I admire that but I see it as a Medical, MH and Recovery services collaboration. [But there's not the joining up happening over top of it]. But the CPC sees it and take sin ot but not with enough info and support and streamlining. Meanwhile other factors are happening, alcohol and TPU.
GD: what can be done or what needs to be addressed to be able to give that joining up?
JS: that s what we routinely try to do. Try to work with other areas, that what the meeting tis morning.

Stacey: right but there are areas when nothing is taken off the plate. Regional said do it or find another job. Its not particular to one area.

Thing I'm not clear on:
Induction sites: CMS Screen them at Lorain, Grafton CRC and ORW who are to screen the individuals.
CPCS do a portion of screening that can happen at any institution.
Delivery sites: DCI, Warren, Lebanon, and PCI, FMC (but only medical issues). SCI
GET WRITTEN policy, who is doing what? Giving naltrexone, vivtrol etc.

WB: Michael is saying there's a guy doing all the right things to get back in. But then ive got another guy with a release date sooner who says he's cured, I've got to put him in group ahead of this other guy.
JS: not have circumstances. Guidance is talk with you supervisor about putting him in group – why put them in group if he's cured?
If youre in starting point can he get naltrexone? No.
Its not formal treatment, its AOD Education. So if only doing AOD education what can you do? None.

COMMITTEE DIDN'T FEEL CONCERN WAS RECOGNISED
WHAT AR ETHE PRODCUTVTY NUMBERS? Hours of each responsibility.

What are the actual hours associated with each role?
Last APC we gave them some figures. Community offers and perks.

Peer Support

4. Filling the Peer Recovery Supervisor roles
    a. So will there be more pstions and filling them?
    No, budget does not allow to increase.
    How to decrease the workload for those who need it to focus on this program?
    JS: Ive taken some notes, we'll talk and see what can be done.

    At NCI im doing the day to day and supervisor doing admissions and paperwork and Stats. Thinking going o go back to an IOP but my sueprvior said no way. We have waitlist.
    So the IOP doesn't happen?
    JS: that's the balance we have the managers look at for the essential operational activities.
    Is it an assigned duty or volunteers?
    JS: both. Manager look at skillset, willingness and attitude to see who is going to be a best fit.

5. Peer Support facilitating group – concerns.
    a. Stacey: it comes from Fij and Bacon, they cofaciliate IOP. Not set ip take donw.
    JS: no that's a clinician problem A peer shouldn't be listed as cofacilaitor. We have aPeer coming in and assiteing, first ive heard.

6. New item: What exactly Peer Supervisor role is supposed to do.

Doesn't take that much off the CPC plate on what we do at NCI. Still doing scheduling, dealing with issues because she won't be there, and having to make sure the paperwork is out for them to see their peer.

We seem to be doing this too.
In the last three months Stacey supervisor recovery coaches.
New role for supervisor – regional supervisors. Northern filled. SE now. SW will be someone at CCI. But they are supervising an hour a week and one hour quarterly. But the day to day operations falls on CPC. Nowhere does it does it say supervisor, which is what we're doing.
I'm meant to be doing IOP, but cant.

Why are we doing this? We can't be doing this program with 5 peer supporters minimum while doing our other work.
Supervisor has six prisons, how can they do that? Each isn't should have its own.
TC has a scheduling operations person. Peer Support could have the same idea.

MAT coordinators only four covering specific institutions working with those fiducials coming into the system from county.
CPCs around the state who may be doing the MAT work, that has been part of the work since it began.

For the Peer Support – the primary duties of the PS Supervisor is they ensure th programs following protocol san procedures. They ensured all trained individuals are doing supervision meetings, review documentation collected.
Assit with screening.
Include lintied travel to the sites. And support Peer Supprot Coordinators. Provide training.

Stacey: Can we get a copy of this. Because th protocol from 2022 doesn't mention the regional supervisor. It says the coordinator who cis the CPC does.
I have met our regional supervisor twice. She come sin half a day to do the supervision. My recovery coaches did 84 meetings. Everyone has badges. To go to dorms. Its reall yon me. We need an operation manager like TC. I though Supervisor would be taking over so I can go back to IOP, but I dint want to see this program fail.

- Who and where is the Peer Support in place/targeted
- Who are the assigned Peer Recovery Coordinators?
- Who are the Peer Support Supervisor over them?

What insts? – 18 insitutions where the rei sPeer USpport, and other come on board. Ide ais everywhere where possible. Not SOCF or ORW because security, CRC, TOCI
Loads we'rent taken off anyone to fill the role, we need more regional supervisors
Toledo? – No, level 4 so no.

NCI has 7 Peer Supports
CCI has 19 Peer Supports
BECI 7

We don't want this to fail, it's great but it is added responsibility.

WB: its getting overwhelming. Its agreat program, very important. You've only got tow people where at SCI.
Im hearing from othe r isnittuons, PS is a beats, its own program. Its rakin up to 60% of persona stime.
To make it work you have to invest like and IOP program, dedicate clcincical. Need to take a look at it. You ask us go over there and do that and we do, we know its good for people.
An assignment
JS: the PS Supervisor positions not filled. 2 Filled, one being filled, two the positions posted.
Stacey: one of the reasons I didn't apply for the regional supervisor is it seems to be so much.

7. Current filled/unfilled all Rec Services Roles by institution

April

Staffing Totals		Vacancies	Vac. %	
Total State Funded Positions	250	65	26%	1 grant positions
Total Contract Positions	3	0	0%	
Total Private Positions	11	3	26%	
TOTAL OVERALL POSITIONS	**264**	**68**	**26%**	
Total OSC Staff Admin / RRSA	21	11		
Total Supervisor Positions	25	2		
Total TC Supervisors Postions	6	0		
Total MHA 3 Position	1	0		
Total CPC Positions	168	49		
Total AODC Positions	29	6		
Total Disability	5			

September

Staffing Totals		Vacancies
Total State Funded Positions	248	59
Total Contract Positions	3	2
Total Private Positions	13	6
TOTAL OVERALL POSITIONS	**264**	**67**
Total OSC Staff Admin / RRSA	18	11
Total Supervisor Positions	25	2
Total TC Supervisors Postions	6	0
Total MHA 3 Position	9	0
Total CPC Positions	165	49
Total AODC Positions	30	6
Total Disability	1	

Row Labels	Count of FILLED or VACANT
AOCI	**6**
FILLED	5
VACANT	1
BeCI	**6**
FILLED	4
VACANT	1
VACANT - SAMI- HOLD	1
CCI	**7**
FILLED	6
FILLED - SAMI	1
CCI	**1**
FILLED	1
CCI - TC	**5**
FILLED - TC	4
VACANT - TC	1
CRC	**5**
FILLED	5
CRC - MAT	**1**
VACANT - MAT	1
DCI	**7**
FILLED	5
FILLED - DIS	1
VACANT - SAMI - Hold	1
FMC	**2**
FILLED	2
GCI	**5**
FILLED	5
GCI	**1**
FILLED	1
GCI - TC	**6**
FILLED - TC	6
GCI-MAT	**1**
FILLED - MAT	1
LeCI	**9**
FILLED	4
VACANT	3
VACANT - HOLD	1

VACANT - SAMI HOLD	1
LoCI	**7**
FILLED	4
VACANT	3
LorCI	**8**
FILLED	7
FILLED - SAMI	1
LorCI	**1**
VACANT - MAT	1
MaCI	**6**
FILLED	5
VACANT	1
MaCI	**1**
VACANT	1
MaCI - TC	**6**
FILLED - TC	6
ManCI	**9**
FILLED	7
FILLED - SAMI	1
VACANT	1
MCI	**7**
FILLED	4
VACANT	3
NCI	**6**
FILLED	5
VACANT	1
NCI - TC	**6**
FILLED - TC	5
VACANT - TC	1
NeRC	**3**
FILLED	3
ORW	**7**
FILLED	4
VACANT	2
VACANT - SAMI - HOLD	1
ORW	**1**
FILLED	1
ORW - TC	**5**
FILLED - TC	4
VACANT - TC	1
ORW-MAT	**1**
VACANT - MAT	1

OSP	**4**
FILLED	4
PCI	**7**
FILLED	5
VACANT	2
PCI - TC	**6**
FILLED - TC	4
VACANT - TC	2
RCI	**3**
FILLED	2
VACANT	1
RCI	**4**
FILLED	3
VACANT	1
RiCI	**7**
FILLED	7
SCI	**6**
FILLED	4
VACANT	2
SOCF	**5**
FILLED	4
VACANT - SAMI	1
TCI	**7**
FILLED	4
VACANT	2
VACANT - SAMI	1
ToCI	**4**
FILLED	1
VACANT	3
WCI	**6**
FILLED	5
VACANT	1
Grand Total	**195**

8. Recruitment and Retention Supplements – current status. Review of vacant positions shows repeated reposting with none or unqualified applicants.
   Year long probation, pay, risk, security level

   LAURIE: We don't have the authority right now. DRC is bringing our CPCs. They're giving them a technical demotions into 43.11 positions. We're competing with DRC.
   We have things in process. We've not seen a proposal from you.

What are you looking for? Come to me with onsite concrete it gives me something to take forward. Something concrete. We have more discretion because only CPCs.
Need facts and data for wages for example. Comparable.
DAS don't do it. for the comparable.

Anything ~~beyond pay we~~ would appreciate so we can take it with some concrete points and data. We know what happening with DRC and our staff. Any info we don't have or haven't asked. And we need that extra push. We don't want to wait until next year though.

Peer leaving for jobs in private sector. Get that info to share so we can do something, sooner than Feb march 2024.

TALK TO KRISTIE.

9. Supervisors looking at assignments and schedules of institution to make sure its equal and even sharing. And schedules best meet the needs. We're looking at how to spread the pain more evenly. – Progress report?
John: We have had supervisors look at schedule and assignments distribute work evenly as much as possible. Beyond that. I hear workload, but I hear more about vacancies and lack of staff. As I've said we try to make things as manageable a possible to mee the need of our clients.

JS: its ongoing and when things come to our attention and like someone coming on or leaving we aks th esupervior to look at that
Michael: do we have any say in that?
JS: sure, picking up kids etc, that has to be taken into account as a working together of the employees as a team.
Michael: Yes, you mentioned job satisfaction. Make sure schedule accommodates work life bakance.
Laurie: that's happening
Michael: Sure but there are places where it doesn't.
Laurie: balance between employee and operational need. I you cam eup with onne that meets th needs

There are a bunch of schedules. Four days, differ. While there may be more efficient way to do it and schedule we've got push back from superviors. Blanc eis there may be better schedules but the people doing the work like their four 10s. Five 8s might be better but we don't want to switch the schedules.

Michael: how can someone do that? Essentially any members can start that discussion under 43.10 alternative work schedules.

Amanda; workloads as distributed. Would you be comfortable putting this CPC with this workload, and the answer would be no. Some superviors aware some can't keep up which creates a lot of contention. When conversations about workload come up. Ethic or time/speed. When I talk about workload being too much, how the assignments are structured they should be comfortable plugging anyone in anywhere. Assignments/job clusters, should be equal.
JS: I agree in principle. But If there are some.

Explanation: In our Last APC in response to my question under Item 4 **Current vacancies by institution** you said:

> *Spolarich: we have brought it up. Put it forward. It is not a unilateral decision we make. It has to be vetted by DAS. In the process. There is only so much ability to push these issues. DD has brought it up. Its there it will be reviewed.*
> *I'm looking at different things we can do. Find out some other issues were having, we're losing staff. So I can present that to the executive team to get the okay to go to DAS to sit down with 1199 to discuss possibilities.*

What we do with our hospitals does not cover RS. 43.11 covers specific classification, RS not covered under that. We are where we are unfortunate, between contracts. That's the language we've used so far, for 1199. Unfortunately, we didn't have that. I can't tell you more than that. We are trying to get it.
We do not want to put something out there that might not happen. I do not want to put false hope out there.
Davies: What is the vison? Where is the hope?
Sexten: ask supervisor to look at case load for CPC to make sure equally distributed.
We are going to do task every supervisor to look at assignments and schedules of institution to make sure its equal and even sharing. And schedules best meet the needs.
We're looking at how to spread the pain more evenly.
We're bringing them in as best we can. This is not a RS alone issue. Everybody is short. The applicant pool is hallow. This is a statewide issue. More money isn't the solution. Job satisfaction is and can be. Its not deckchairs its balance.

~~10. NEW ITEM: Flex time~~

11. NEW ITEM: OHMAS to DRC transfers – preference/criteria. Section 4 "Job Related Questionnaire" on the job application no longer asks "if you are a recovery services employee working in an ohio correctional facility."

    Laurie: that's a DRC question. Why did they change it? they've never asked us. We didn't even know. We don't have anything like that on ours. Every app asks for previous employments.