Ohio Department of Mental Health and Addiction Services (OhioMHAS)
2023-2025 Community Assessment and Plan (CAP) Template:

ASSESSMENT

Overview

This is the first of three sections in the Community Assessment and Plan (CAP) Template. The Assessment section of the CAP Template informs the priorities in the Community Plan and is designed to be completed by ADAMH Boards and returned to OhioMHAS every three years.

All standardized indicators referred to in this template align with existing state agency plans or initiatives, including:

- OhioMHAS 2021-2024 Strategic Plan Pathway to Impact
- SAMHSA block grant
- Ohio Department of Health and Ohio Department of Aging plans (2020-2022 State Health Improvement Plan and 2020-2022 Strategic Action Plan on Aging)
- Ohio Children's Behavioral Health Prevention Network
- Ohio Department of Medicaid quality measures for managed care plans (HEDIS and other metrics)
- Integrated care measures, such as Certified Community Behavioral Health Clinics Quality Measures

OhioMHAS recommends that Boards conduct a community strengths and needs assessment every three years. OhioMHAS encourages Boards to use quantitative and qualitative data collection methods and to partner with other organizations, such as local health departments, hospitals, county Family and Children First Councils, and community coalitions to conduct the assessment. This assessment will be utilized to highlight gaps in the continuum of care and identify the community's behavioral health needs that the CAP Plan will then be used to address.

As part of the community assessment process, Boards should also be considering any capital funding that may also be needed. Boards will use the CAP Assessment process to identify any capital funding that will be needed to assist in meeting the community's identified behavioral health needs. Any capital funding needs identified in the CAP Assessment will then be included in a capital planning process that will commence in January 2023 and will be due to OhioMHAS by August 2023.

Template

Board name	Richland County Mental Health and Recovery Services Board
Date	

Key

▲	Pre-populated data provided by OhioMHAS
✱	Question that all Boards are required to answer
Optional	Question that Boards may choose to answer, but are not required to answer

Mental health and addiction needs

What is the prevalence of behavioral health conditions in your community, what are the most significant unmet needs and which groups are most affected?

▲**County profile(s): Mental health and addiction challenges.** Data for this question is provided by OhioMHAS and does not require any activity by Boards. Refer to the pre-populated county profile data tables provided by OhioMHAS which include the following data for the most recently available year for each county in the Board area, indicating if the county's prevalence is higher than, similar to, or lower than Ohio overall:

- Prevalence of serious mental illness (estimated number and percent from NSDUH)
- Prevalence of serious psychological distress (estimated number and percent from NSDUH)
- Prevalence of substance use disorders (estimated number and percent from NSDUH)
- Youth suicide deaths (number and rate from ODH Vital Statistics)
- Adult suicide deaths (number and rate from ODH Vital Statistics)
- Unintentional drug overdose deaths (number and rate from ODH Vital Statistics)
- Heavy drinking (BRFSS county-level pooled-year data from ODH)
- Binge drinking (BRFSS county-level pooled-year data from ODH)
- Poor mental health days (BRFSS county-level pooled-year data from ODH; our CHR)
- Physical inactivity (BRFSS county-level pooled-year data from ODH)

✱**Mental health and addiction challenges.** Based on the assessment findings, identify the level of need in your community for addressing the outcomes listed below. The purpose of this question is to identify outcomes that need improvement and to inform the selection of priorities in the Community Plan. Rate each challenge as major, moderate or minimal. Then, select the top three challenges for each age group.

	Major challenge	Moderate challenge	Minimal challenge	Top 3 challenges
Children, youth and families				**Select 3**
Mental, emotional and behavioral health conditions in children and youth (overall)		X		
Youth depression		X		
Youth alcohol use			X	
Youth marijuana use			X	
Youth other illicit drug use			X	
Youth suicide deaths			X	
Children in out-of-home placements due to parental SUD		X		X
Chronic absenteeism among K-12 students[1]		X		
Suspensions and expulsions among K-12 students		X		
Adverse childhood experiences (ACEs)	X			X
Other child/youth outcome, specify: Crisis Management	X			X
Other child/youth outcome, specify:				
Adults				**Select 3**
Mental health and substance use disorder conditions among adults (overall)		X		
Adult serious mental illness		X		X
Adult depression			X	
Adult substance use disorder		X		
Adult heavy drinking		X		
Adult illicit drug use		X		
Adult suicide deaths	X			X
Drug overdose deaths	X			X
Problem gambling			X	
Other adult outcome, specify:				
Other adult outcome, specify:				

✱Disparities. Based on the assessment findings, which of the following groups are experiencing the worst outcomes in your community for the mental health and addiction challenges listed in 1b? Include all groups with higher prevalence than the Board area overall for the conditions listed in 1a and 1b.

- X People with low incomes or low educational attainment
- ☐ People with a disability
- ☐ Residents of rural areas
- ☐ Residents of Appalachian areas
- X Black residents
- ☐ Hispanic residents
- X White residents
- ☐ Other racial/ethnic group, (specify: ___________)
- ☐ Older adults (ages 65+)
- ☐ Veterans
- X Men
- ☐ Women
- X LGBTQ+
- ☐ Immigrants, refugees or English language learners
- ☐ Pregnant women
- ☐ Parents with dependent children
- X People who use injection drugs (IDUs)
- ☐ People involved in the criminal justice system
- ☐ Other, specify: ___________

Optional: Disparities narrative. Describe the context for disparities in unmet needs in your community, such as general demographic characteristics, data limitations, trends, etc. [open ended]

Richland County in the past 2 years has encountered a significant increase in the rate of suicides and has an Overdose death rate that has consistently ben higher than the State average for the past 5 years. We are seeing a large impact in overdose deaths, primarily for fentanyl and/or injectables in the white, male 25-44 population. Suicides have also been disproportionately high among white males 25-54 but most of the individuals were also working.

Among youth (under the age of 18), we are seeing overall difficulties in self-regulation during crise and in interactions to traumatic situations, much of which has been exacerbated by COVID restrictions and constant change. Of susceptibility have been individuals who feel more marginalized especially those identifying as transgender. Suicidal ideations and self-harming behaviors have resulted in short and moderate term out of home placements. Due to the individual situations, this also may result in increased use of single occupancy rooms, limiting the available beds in residential services. We will be submitting a Capital Requests for match funding for developments of a 12 unit Youth Crisis Stabilization Unit. We are currently determining a potential location and hope to start this process in SFY 2023, but it may be as late as SFY 2025 depending on the location.

Historically Richland County has done well with service access from the black and brown communities with services percentages matching or exceeding County demographics. However, we, as with most of the country to see a disproportionate number of black residents that are diagnosed with more severe mental illnesses. Some of this may be due to a lack of early access to services, allowing symptoms to increase in intensity before interacting with the behavioral health system.

Richland County is currently in the process of expanding our Permanent Supportive Housing options for individuals with a severe mental illness. We have submitted for a Capital Match fund and will be build an apartment building with 12 1-bedroom apartments. This will then free up an 8 1-bedroom unit to be converted to Transitional Housing for adults 18-65+ that are stepping down from hospital or another higher intensity stay (i.e. Service Enriched Housing, Adult Care Facility, etc.) Length of stay will be limited to 18 months and staff will be available on-site to provide limited assistance to adjust to independent living. A second Capital grant will be sought for the cost to convert the facility to Transitional Living in SFY 2024.

Optional: Additional assessment findings. Describe any notable trends, qualitative findings or other assessment results regarding mental health and addiction outcomes that are relevant to your plan. [open ended]

A Point of clarification, the demographic data provided by the state was inaccurate. I am provided the data that is available on Census.Gov that is dated July 1, 2021.

Population 125,195: Female 61,220 48.9% and Male: 63,975 51.1%

American Indian and Alaskan Native:	250
Asian, Pacific Islander:	1,252
Black:	11,894
White:	108,795
Hispanic:	2,754
Other:	250

Median Household Income: $49,186

Highschool Education or equivalent or higher over the age of 25 total is 87.5%

The accuracy of other data points was difficult to verify due to the lack of available diagnostic and symptomatic data for the whole county in the data provided through OHMAS Datamart system. Internal data tracking is limited to contract agencies and other cooperative agencies but does not represent the county as a whole.

Mental health and addiction service gaps

★What are the biggest service gaps and access challenges for behavioral health in your community and which groups are most affected?

Service gaps and access challenges. Based on the assessment findings, identify the level of challenge experienced in your community related to prevention, treatment and recovery service access and quality. The purpose of this question is to identify access issues that need improvement and to inform the selection of priorities in the Plan section of the CAP template. Rate each challenge as major, moderate or minimal. Then, select the top three challenges for each age group.

	Major challenge	Moderate challenge	Minimal challenge	Top 3 challenges
Overall service gaps in continuum of care				**Select 3**
Prevention services, programs and policies			X	
Mental health treatment services			X	
Substance use disorder treatment services			X	
Crisis services		X		X
Harm reduction services			X	
Recovery supports			X	
Mental health workforce (mental health professional shortage areas)	X			X
Substance use disorder treatment workforce	X			
Other service gap, specify: Medication specific Mental Health services provision	X			X
Other service gap, specify:				
Other service gap, specify:				
Access for children, youth and families				**Select 3**
Unmet need for mental health treatment, youth	X			X
Unmet need for major depressive disorder, youth		X		
Lack of well-child visits			X	
Lack of child screenings: Depression and developmental		X		
Lack of child screenings: Developmental			X	
Lack of child screenings: Anxiety		X		
Lack of follow-up care for children prescribed psychotropic medications)		X		
Lack of school-based health services		X		X
Uninsured children			X	
Other child/youth access challenge, specify: Overnight Crisis care options	X			X
Other child/youth access challenge, specify:				
Other child/youth access challenge, specify:				

Access for adults				Select 3
Unmet need for mental health treatment, adults		X		
Unmet need for major depressive disorder, adults			X	
Unmet need for outpatient medication-assisted treatment	X			X
Low SUD treatment retention		X		
Lack of follow-up after hospitalization for mental illness challenges		X		
Lack of follow-up after ED visit for mental health		X		
Lack of follow-up after ED visit for substance use		X		
Uninsured adults		X		
Other adult access challenge, specify: Community Based Crisis Response		X		X
Other adult access challenge, specify: Housing options for individuals with Severe and persistent mental illness		X		X
Other adult access challenge, specify:				

✱Disparities. Based on the assessment findings, which of the following groups are experiencing the worst service gaps and access challenges in your community? Include all groups with higher prevalence than the Board area overall for the issues listed in 2a.

- ☐ People with low incomes or low educational attainment
- X People with a disability
- ☐ Residents of rural areas
- ☐ Residents of Appalachian areas
- ☐ Black residents
- ☐ Hispanic residents
- ☐ White residents
- ☐ Other racial/ethnic group, (specify:_____)
- ☐ Older adults (ages 65+)
- ☐ Veterans
- ☐ Men
- ☐ Women
- ☐ LGBTQ+
- ☐ Immigrants, refugees or English language learners
- ☐ Pregnant women
- ☐ Parents with dependent children
- ☐ People who use injection drugs (IDUs)
- ☐ People involved in the criminal justice system
- ☐ Other, specify: ____________

Optional: Disparities narrative. Describe the context for disparities in service gaps in your community, such as general demographic characteristics, data limitations, trends, etc. [open ended]

Any service gaps indicated to do not disproportionately impact any one service population. Richland County needs more Psychiatric accessibility, this is across the Board, Access to service providers is immediate, but access to psychiatrist once through the Diagnostic Assessment process, can be up to several months.

Staffing shortages in both Mental health and Addiction services will also impact the entire community not just specific demographics. We are in a unique position where we can fund innovative programming to fill gaps, we simply lack the qualified staff to provide the services.

Although Richland County has a fairly thorough crisis response program for adults and youth, we endeavor to expand to make sure community-based options are expanded and to fill a gap of overnight crisis accommodations for youth, similar to what is available for adults. Again, however, this gap does not overly impact a single demographic more than another.

Social determinants of health

What are the social determinants of health (i.e., environmental factors or community conditions) that contribute to your community's behavioral health conditions and unmet need?

▲**County profile(s): Social determinants of health.** Data for this question is provided by OhioMHAS and does not require any activity by Boards. Refer to the pre-populated county profile data tables provided by OhioMHAS which include the following data for the most recently available year for each county in the Board area, indicating if the county's prevalence is higher than, similar to, or lower than Ohio overall:

i. Child poverty
ii. Adult poverty
iii. Median wages
iv. Unemployment rate
v. High school graduation rate (by school district)
vi. Some college (population educational attainment)
vii. Affordable housing
viii. Severe housing cost burden
ix. Residential segregation- Black/white
x. Broadband access
xi. No vehicle
xii. Violent crime
xiii. Food insecurity
xiv. Child physical activity
xv. Adult physical activity
xvi. Primary care physicians (ratio of primary care physicians to population)

✱Social determinants of health driving behavioral health challenges. Based on the assessment findings, describe the extent to which the following factors are driving mental health and addiction challenges in your community. The purpose of this question is to identify community conditions that need to be addressed in partnership with other systems and to inform the selection of priorities in the Plan section of the CAP Template. Rate each issue as major, moderate or not a driver. Then, select the top three drivers for each category.

	Major driver	Moderate driver	Not a driver or unknown	Top 3 driver
Social and economic environment				**Select 3**
Poverty		X		
Unemployment or low wages		X		
Low educational attainment			X	
Violence, crime, trauma and abuse	X			X
Stigma, racism, ableism and other forms of discrimination		X		
Social isolation	X			
Social norms about alcohol and other drug use	X			X
Attitudes about seeking help		X		
Family disruptions (divorce, incarceration, parent deceased, child removed from home, etc.)	X			X
Other, specify:				
Physical environment and health behaviors				**Select 3**
Lack of affordable or quality housing		X		X
Lack of transportation		X		X
Lack of broadband access			X	
Lack of access to healthy food			X	
Other physical environment, specify:				
Lack of physical activity			X	X
Lack of fruit and vegetable consumption			X	
Food insecurity		X		
Other health behaviors, specify:				

✱Disparities. Based on the assessment findings, which of the following groups are most affected by these social determinants in your community? Include all groups with higher prevalence than the Board area overall for the conditions listed in 3a and 3b.

- X People with low incomes or low educational attainment
- ☐ People with a disability
- ☐ Residents of rural areas
- ☐ Residents of Appalachian areas
- X Black residents
- X Hispanic residents
- ☐ White residents
- X Other racial/ethnic group (specify)
- X Older adults (ages 65+)
- ☐ Veterans
- ☐ Men
- ☐ Women
- ☐ LGBTQ+
- ☐ Immigrants, refugees or English language learners
- ☐ Pregnant women
- X Parents of children/youth
- X People who use injection drugs (IDUs)
- X People involved in the criminal justice system
- ☐ Other, specify: ____________

Strengths, including community assets and partnerships

✱Identify community strengths your Board will draw upon to address needs and gaps. Select up to three strengths that are the most significant in your community:

- X Collaboration and partnerships
- ☐ Engaged community members
- X Availability of specific resources or assets
- ☐ Economic vitality
- X Creativity and innovation
- ☐ Natural resources and greenspace
- ☐ Colleges or universities
- ☐ Faith-based communities
- ☐ Social support and positive social norms
- ☐ Other, specify: ____________
- ☐ Other, specify: ____________
- ☐ Other, specify: ____________

✱Indicate the strength of your Board's collaboration with community partners: Review the descriptions of different levels of collaboration and then indicate the extent to which your board **currently** interacts with each potential identified community partner.

Definitions for five levels of collaboration:[2]

- **Networking:** Aware of organization; little communication
- **Cooperation:** Provide information to each other; formal communication; regular updates on projects of mutual interest
- **Coordination:** Share ideas; defined roles; some shared decision making; common tasks and compatible goals
- **Collaboration:** Signed MOU; long-term planning; integrated strategies and collective purpose; consensus is reached on all decisions; shared trust

Partner	No interaction at all	Networking	Cooperation	Coordination	Collaboration	Entity Does Not Exist
Local prevention coalition(s) (suicide, tobacco, Drug Free Community, etc.)					X	
Local health district(s)				X		
Local tax-exempt hospital			X			
Local school district(s)				X		
Educational service center(s)				X		
Law enforcement				X		
Criminal justice system/courts					X	
Child protective services (PCSA)				X		
Family and Children Services Council(s)					X	
Private psychiatric hospitals			X			
State psychiatric hospitals					X	

Partner	No interaction at all	Networking	Cooperation	Coordination	Collaboration	Entity Does Not Exist
People with lived experience/ people in recovery					X	
UMADAOP					X	
Area Agency on Aging			X			
Housing (such as the Housing continuum of care (COC) entity or public housing authority)					X	
Transportation (such as the regional planning commission or transit authority)				X		
Job training and economic development (such as OhioMeansJobs center(s) or chamber of commerce)				X		
Food access (such as food bank(s) or farmer's markets)		X				
Other: ________						
Other: ________						

★Indicate the relationship the Board has with community providers

Identify the number of providers in the Board area across the continuum of care.

1. Catalyst Life Services
2. Family Life Counseling and Psychiatric Services
3. Mansfield UMADAOP
4. Community Action for Capable Youth
5. National Alliance on Mental Illness
6. Third Street Family Health Services
7. Healing Hearts Counseling Center
8. Community Alternative Center
9. Abraxas Ohio
10. Foundations for Living
11. Hope 419
12. Encompass Counseling
13. 33 Forever
14. Project One
15. Starfish Project
16. Appleseed Counseling Center
17. OhioHealth Mansfield
18. Silver Lining Group
19. Akron Children's Hospital
20. Nationwide Children's Hospital
21. Brightview Mansfield Addiction Treatment Center
22. Mansfield Comprehensive Treatment Center
23. Talbot Health Services
24. Village Network
25. ASI Community Wellness
26. Spiro Health
27. New Directions
28. Life Steps
29. Heritage Counseling Center
30. New Day Counseling Services

Identify the number of providers the Board is partnering with by evidence of a formal memorandum of understanding (MOU) or other formal agreement.

1. Catalyst Life Services -Full Contract
2. Family Life Counseling and Psychiatric Services -Full Contract
3. Mansfield UMADAOP -Full Contract
4. Community Action for Capable Youth -Full Contract
5. National Alliance on Mental Illness -Full Contract
6. Third Street Family Health Services -Affiliate Agency with MOU
7. Healing Hearts Counseling Center -Affiliate Agency with MOU
8. Community Alternative Center -Affiliate Agency with MOU
9. Abraxas Ohio -Affiliate Agency with MOU
10. Foundations for Living -Affiliate Agency
11. Hope 419 -Affiliate Agency
12. Encompass Counseling -Affiliate Agency
13. Project One -Partner Organization with MOU
14. Starfish Project -Partner Organization with MOU
15. 33 Forever -Partner Organization
16. Appleseed Counseling Center -Special Service MOU
17. OhioHealth Mansfield -Special Service Agreements

Additional information

Optional: Link to other community assessments. Insert link(s) to any local or regional community assessments that are relevant to your Board, such as your Recovery Oriented Systems of Care (ROSC) Assessment, a local health department Community Health Assessment (CHA) or hospital Community Health Needs Assessment (CHNA).

richland_county_sfy_21-22_community_plan.pdf (richlandmentalhealth.com)

Strategic Plan | Mental Health & Recovery Services Board (richlandmentalhealth.com)

richland_county_final_2016_health_assessment_4-14-17_1-1.pdf (richlandhealth.org)

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[1] This is a high priority in the education sector and is an Ohio Department of Medicaid quality measure. Some, but not all, chronic absenteeism may be due to student or parent behavioral health issues. The data source does not indicate the underlying reason.

[2] Modified from Frey, B. B., Lohmeier, J.Hl, Lee, S.W., and Tollefson, N. (2006). Measuring collaboration among grant partners. American Journal of Evaluation, 27, 3, 383-392.)

Ohio Department of Mental Health and Addiction Services (OhioMHAS)
2023-2025 Community Assessment and Plan (CAP) Template:
LEGISLATIVE REQUIREMENTS

Overview

This new section of the CAP is reserved to complete and/or submit other statutorily required information. The use of this section may vary from cycle-to-cycle, but it will be implemented to streamline non-OhioMHAS data collection requirements and limit other additional reporting processes and tools when and where possible.

In the SFY 2022-2023 Biennium Budget (HB 49), the Ohio General Assembly allocated funds to establish Regional Crisis Stabilization Centers and the use of Crisis Flex and Infrastructure funds throughout Ohio. As required by the legislation (HB 49 Sections 337.50 & 757.20), OhioMHAS is requesting ADAMH Boards to use the CAP to complete and submit the required information regarding the use of the state General Revenue Funds (GRF) for these purposes. ADAMH Boards may need to work in collaboration with regional partners and providers to secure the information requested.

THIS REPORT IS INTENDED TO CAPTURE THE FULL CONTINUUM IN YOUR BOARD AREA REGARLESS OF PAYOR SOURCE OR FUNDING.

Crisis Services Continuum Report for: *(Board Area)* **Richland County**

Date of Report Submission:____________________

Contact Person at the Board (Name/email):Joseph Trolian/jtrolian@rcmhb.org

1. **Describe the Board's Crisis Planning Committee/Task Force**:

The Richland County Mental Health and Recovery Services Board does not have a specific Crisis Planning Committee/Task Force. Crisis planning is a much larger issue and is a part of many discussions taking place at other established committee meetings. The following committees provide continual feedback regarding the currently established crisis system and provide input regarding gaps in the systems and ideas for enhancements. The Board has an established Planning and Education subcommittee and Strategic Planning Committee. We have a quarterly Executive Director and Clinical Leaders meeting, a monthly Trauma Informed, Resilience and Recovery Oriented Community of Care (TIRROCC)Advisory Committee. A Crisis Intervention Team Training Advisory Committee, A Domestic Violence and Sexual Abuse Committee, a Homeless Coalition. A suicide Prevention Coalition, A Specialty Docket Advisory Committee, an Opiate Review Board, and a Community Corrections Board. We also have a Wellness Committees with 8 of 9 school systems that occur on an as needed basis. The needs and performance of the Crisis

Continuum is a regular topic at each of these meetings. These committees include partners from most social service departments, agencies, law enforcement and corrections, elected officials, educators, medical professionals, community members and individuals with lived experiences and their families. Forming a free-standing committee to do crisis planning and evaluation would be redundant and would limit the amount of feedback that we are currently receiving regarding the crisis system.

2. **Describe the Board's current crisis continuum of care in the following table.** *(Please complete this information on the provided spreadsheet and send the original completed spreadsheet to)*

Please note: The crisis services identified below reflect the common terms created/used during the recent crisis landscape work overseen by OhioMHAS. Please see Page 7 for a crosswalk of these services and the current/official Licensure and Certification certified classifications for these services outlined in Ohio Revised Code and Ohio Administrative Code.

Crisis Continuum	Service offered in your board area (Yes/No)	Model Used(s) (ex. CAHOOTS, MRSS) as applicable	Provider(s)	Provider Address (Street, City, State, County)	Do you collaborate/contract with providers in another county to provide crisis services?	
					Financially (Yes/No)	Accepts Referrals for your county Board (Yes/No)
Crisis call centers	Yes	Hotline	Catalyst Life Services	741 Scholl Road Mansfield, Oh., Richland		
Crisis call Center	Yes	Warmline	Catalyst Life Services	87 East First Street, Suite U, Mansfield, Oh., Richland		
Crisis call Center	Yes	Warmline	Mansfield UMADAOP	283 Grandview Avenue, Mansfield, Oh. Richland		
Mobile crisis teams	Yes	W/ Law enforcement	Catalyst Life Services	741 Scholl Road Mansfield, Oh., Richland		
Mobile crisis teams	Yes	MRSS	Family Life Counseling and Psychiatric Services	151 Marion Avenue, Mansfield, Oh., Richland		
Crisis residential services	Yes		Catalyst Life Services	741 Scholl Road Mansfield, Oh., Richland		
23-hour Crisis Observation	No					
Crisis Stabilization Center	Yes		Catalyst Life Services	741 Scholl Road		

				Mansfield, Oh., Richland		
Inpatient Crisis Psychiatric Services	Yes		OhioHealth Mansfield	335 Glessner Avenue, Mansfield, Oh., Richland		
Urgent care crisis services	Yes		Catalyst Life Services	741 Scholl Road Mansfield, Oh., Richland		
Withdrawal management	Yes	ASAM Level 3.7/3.2	Catalyst Life Services	707 Scholl Road, Mansfield, Oh., Richland		
Withdrawal management	Yes	Ambulatory	Mansfield UMADAOP	400 Bowman Street, Mansfield, Oh., Richland		
Withdrawal management	Yes	Ambulatory	Healing Hearts Counseling Center	680 Park Avenue West, Mansfield, Oh., Richland		
Withdrawal management	Yes	Ambulatory	Third Street Family Health Services	600 West Third Street, Mansfield, Oh., Richland		
SUD Crisis Residential	Yes	ASAM Level 3.7/3.2	Catalyst Life Services	707 Scholl Road, Mansfield, Oh., Richland		
Crisis Respite	No					
Other	Yes	Jail Based	Catalyst Life Services	73 East 2nd Street, Mansfield, Oh., Richland		
Other	Yes	Homeless Response Team	Catalyst Life Services	741 Scholl Road, Mansfield, Oh., Richland		
Other	Yes	Opiate Response Team	Catalyst Life Services	741 Scholl Road, Mansfield, Oh., Richland		
Other	Yes	Opiate Response Team	Family Life Counseling and Psychiatric Services	151 Marion Avenue, Mansfield,		

				Oh., Richland		
Other	Yes	Opiate Response Team	Healing Hearts Counseling Center	680 Parke Avenue West, Mansfield, Oh., Richland		
Other	Yes	Opiate Response Team	Third Street Family Health Services	600 West Third Street, Mansfield, Oh., Richland		
Other	Yes	School-Based Critical Incident Stress Management Team	Catalyst Life Services	741 Scholl Road, Mansfield, Oh., Richland		
Other	Yes	School-Based Critical Incident Stress Management Team	Family Life Counseling and Psychiatric Services	151 Marion Avenue, Mansfield, Oh., Richland		
Other	Yes	School-Based Critical Incident Stress Management Team	Appleseed Community Counseling Center	2233 Rock Lane, Ashland, Oh., Ashland County	Yes	Yes

3. **Based on the data available to your Board, enter the number of youths and adults served for each crisis service in the Board area for each fiscal year indicated. Select whether the number served was an increase, decrease, or the same compared to the previous year.**

Crisis Service	Source of Data	# Adults Served FY21	# Adults Served FY22	Change +/-	# Youths Served FY21	# Youths Served FY22	Change +/-
Crisis call centers	Agency Reports	5642	6327	+685	Not tracked separately	Not tracked separately	NA
Mobile crisis teams	Billing Info	50	56	6	Not tracked separately	Not tracked separately	NA
Crisis residential services	Agency Report	58	78	20	0	0	0
23-hour Crisis Observation	NA	NA	NA	NA	NA	NA	NA
Crisis Stabilization Center (short term LOS)		116	145	+29	0	0	0
Inpatient Crisis psychiatric services	Info not reported to the Board	NA	NA	NA	NA	NA	NA
Urgent care crisis services	Billing Info	Not operational	612	+612	0	38	+38
Withdrawal management	Agency Report	91	128	+37	0	0	0
SUD Crisis Residential	Agency Report	90	127	+37	0	0	0
Crisis Respite	NA	NA	NA	NA	NA	NA	NA
Other: Jail based Services, Homeless Services, Homeless Response Team, Opiate Response Team and School Based Teams	Agency Reports	200	392	+192	78	147	+69

4. **Describe how people in need of crisis services locate and access services in the Board area's crisis continuum of care.**

The easiest way to access crisis services in Richland County is to call 419-522-HELP (4357). This is a 24-hour crisis hotline. The hotline staff have access to CIT police officers, and Board registered Health Officers. Other numbers that can be called and can help access crisis care is 911 and 211. There is also the availability of a Behavioral Health Urgent Care through Catalyst Life Services. The Urgent Care is design to be an option while needs are at an "urgent" level,

they can address crisis as well. CIT officers are trained and aware of the multiple ways to access Health Officers in the field as well as when to utilize the Emergency Departments. Finally, we have two Emergency Departments through OhioHealth and Avita Health Systems. We have also established through Catalyst Life Services, Family Life Counseling and Appleseed Community Counseling, Wellness teams that have a regular presence in 7 of 9 public school systems. All staff are trained in Critical Incident and Stress Management and in how to manage School Based crisis.

5. **What gaps, based on the continuum in question 1 are currently present in the Board area?** **Describe the target population most impacted by this gap in terms of age, gender, race, geographic location, special population status, etc.**

Richland County has invested significant effort in assuring a complete crisis continuum of care. This system has ebbed and flowed over the decades to address new concerns and to reorganize based on changes to the system. However, with that said, there is always room for improvement. For adult crisis we have 12 Board registered Health Officers that are available for crisis intervention services on site at Catalyst Life Services, in secured locations, such as Emergency departments or jails or as a mobile crisis in tandem with law enforcement. Although the crisis response for adults is 24/7, some is based on an on-call system and based on the time of need, it may determine if the mobile crisis response is available or if crisis interventions will be limited to secure locations. Richland County is in the process of examining the crisis continuum to look at more efficient ways of doing business that will rely more heavily on immediate availability of staff as well as changes in funding structure. Ideally the varying types of intervention should be based of individual need versus staff availability. We would like for all types of crisis intervention to be available 24/7 with a timely response. Youth and Adolescent crisis response in Richland County tends to be a bit spotty. Due the number of agencies that work with youth and adolescents it is often confusing, who to reach out to in times of crisis. Many crisis calls are initiated from a school setting, so we have expanded the presence of specially trained wellness teams in most of the school systems to allow for easier access at times of crisis, but also to provide these staff the ability to apply pre-crisis efforts to diffuse situations prior to needing a crisis response. The wellness teams are active in 7 of 9 public schools and inroads are being made with the remaining two. We are also making efforts with charter and parochial schools as well. Richland County is also in need of a stabilization unit for adolescents that will allow for a protective environment for individuals who are too great of a risk to be at home but are not necessarily in need of a hospital level of care. The unit would also be a stepdown option for those adolescents that have been in a hospital level of care and need to be discharged but are still at risk if the go directly home. The Board is currently pursuing ownership of a building that can be retrofitted to establish a 12-bed stabilization unit for adolescents. The building is located adjacent to the Catalyst Life Services campus and will be operated by Catalyst. If this project does not move forward at the current location, other locations are being considered with the plan to have a unit established by the end of State Fiscal Year (SFY) 2025. Finally, Richland County has had an operational Crisis Hotline since 1986. The HELPline is operated by Catalyst Life Services and has operated as a crisis line, an information line, and a dispatch line for Health Officers. With the introduction of 988, we will be working with the agency to either pursue certification as a

regional lifeline, if that becomes an option or to establish the best way to work with 988 to make sure crisis assistance remains just one phone call away.

6. What opportunities and challenges does the Board area face in implementing Mobile Crisis Teams?

The biggest challenge to implementing Mobile Crisis Teams as a component of the overall crisis continuum in Richland County, comes down to staffing and funding. Because of the nature of crisis ebbs and flows, optimally, the usage of a "firehouse" model will be ideal. This model requires steady and consistent funding at times of high need as well as low. Staffing levels that are based on the highest potential need to be consistently in place even when crises are not occurring. Crisis services have traditionally been funded on a fee for service basis, with some accommodations or supplementary funding to cover the cost of non-billable services. Also, in Richland County, crisis care has been setup as various programs, (i.e., stabilization unit, hotline, warmline, urgent care, response teams, etc.) rather than as one cohesive continuum of care. A continuum will allow assigned staff with various disciplines to have multiple responsibilities which will lead to more efficient use of their time as well as keep clinicians from falling into a rut and increasing the rate of burnout. The Board will be working with Catalyst Life Services during SFY 2023 to explore a redesign option with a plan to implement changes at the start of SFY 2024.

7. What opportunities and challenges does the Board area face in implementing Crisis Stabilization Centers?

Richland County has a 13 bed Crisis Stabilization unit for adults that has been operating constantly since 1988. This unit grew from the original 7 beds to 13 in 2009. An issue that continues to be a challenge for the Stabilization Unit is the inconsistency in Medicaid funding. For every person who is admitted to the Stabilization Unit, there is a varying amount of needs. Services for a Stabilization Unit are billed as an "a la carte." Some days may be service heavy with Case Management, Individual Psychotherapy, Group Psychotherapy, Crisis Interventions, etc. other days, and individual may only be able to manage a short meeting with a nurse and then spends more time journaling or speaking to support staff or some other non-billable service. The cost to be on the unit for a 24-hour stay is consistent (space, meals, support staffing, building overhead, etc.) but the potential income for the agency for a stay is not. This requires a significant amount of supplemental funding for a Room and Board Rate through non-Medicaid funding. On the substance use disorder side, the ASAM Level 3 services, have eliminated this obstacle by funding a per diem for Withdrawal Management and Residential Care. Individuals in a Residential Level of Care (ASAM 3.5) receive a Per Diem ($213.70) each day. The agency can them provide the number of services need by the individuals without concerns of providing a calculated number of services to meet a particular financial benchmark. Mental Health Crisis Stabilization would run more efficiently with a similar level of care per diem approach. Richland County is currently finalizing the plans to implement a Youth Crisis Stabilization Unit. The Current barrier is the purchase of the building from the current owner. The company (Lumen) is currently under acquisition by another company (Brightspeed), so until that acquisition is over, Brightspeed will not continue with the sale of the Building to the Board and our Partner Richland County Developmental Disability. Once the hurdle is overcome, we will face the same challenge above, with finding the right amount of room and board to provide to offset the inconsistency of Crisis Stabilization billing.

8. **Crisis Continuum Funding Sources and Amounts.**

Total Crisis Continuum Funding: Identify the amount of funding that supports the crisis continuum		
Funding Source	**Amount SFY 22**	**Amount Planned in SFY 23**
Local Levy	**755656**	**745519**
Local Grants *(grants not funded via OhioMHAS)*	**0**	**0**
State GRF	**645141**	**721450**
OhioMHAS Funded Grants	**267926**	**326253**
Other Funding:	**0**	**0**

9. **Which Crisis Services are funded by the Board?** Include those services provided inside and outside of the Board area. Indicate all that apply. Please add funding amounts for each funding type utilized.

Crisis Service	**Local Levy**	**Local Grant Funds**	**State GRF**	**OhioMHAS funded Grants**	**Other Funding**	**Total**
Crisis call centers	223869	0	186071	149057	0	558997
Mobile crisis teams	10000	0	30000	0	0	40000
Crisis residential services	72840	0	109660	0	0	182500
23-hour Crisis Observation	0	0	0	0	0	0
Crisis Stabilization Center (short term LOS)	145681	0	219319	0	0	365000
Inpatient Crisis psychiatric services	0	0	0	0	0	0
Urgent care crisis services	60000	0	0	0	0	60000
Withdrawal management	10194	0	45000	54482	0	109676
SUD Crisis Residential	9444	0	45000	39482	0	93526
Crisis Respite	0	0	0	0	0	0
Other: Jail based Services, Homeless Response Team, Opiate Response Team and School Based Teams	213891	0	86400	83282	0	383523

10. **How were the Regional CRISIS STABILIZATION FUNDS used during this period?**

Crisis Stabilization Fund Utilization SFY22		
Funding Amount Allocated	**To Whom**	**For What**
150000	Catalyst Life Services	Regional use of Withdrawal Management Unit and Transportation
100000	Catalyst Life Services	Regional use of Crisis Stabilization Unit and Transportation

11. **What is the planned use of SFY 23 Regional CRISIS STABILIZATION FUNDS?**

Crisis Stabilization Fund Utilization Plan SFY23		
Funding Amount Allocated	**To Whom**	**For What**
70000	Catalyst Life Services	Regional use of Withdrawal Management Unit and Transportation (carryover from SFY 2022)
100000	Catalyst Life Services	Regional use of Crisis Stabilization Unit and Transportation

12. **How were the FLEX FUNDS used during this period?**

Crisis Flex Fund Utilization SFY22		
Funding Amount Allocated	**To Whom**	**For What**
81459	Catalyst Life Services	Room and Board for Crisis Stabilization Unit

13. **What is the planned use of SFY 23 FLEX FUNDS?**

Crisis Flex Fund Utilization Plan for SFY23		
Funding Amount Allocated	To Whom	For What
81459	Catalyst Life Services	Room and Board for Crisis Stabilization Unit

14. **How were the CRISIS INFRASTRUCTURE FUNDS used during this period?**

Crisis Infrastructure Fund Utilization SFY22		
Funding Amount Allocated	To Whom	For What
50000	Catalyst Life Services	Crisis Transportation and police security assistance

15. **What is the planned use of SFY 23 CRISIS INFRASTRUCTURE FUNDS?**

Crisis Infrastructure Fund Utilization Plan for SFY23		
Funding Amount Allocated	To Whom	For What
50000	Catalyst Life Services	Crisis Transportation and police security assistance

16. **Describe the Board's plan to enhance, expand, or continue to support the crisis continuum in your board area?** Include the goals identified in the Community Assessment Plan and capital plans to support expansion of the continuum. Also include plans to address Gaps identified in Question 5 above. Note what outcomes you are measuring to indicate success and to manage continuous quality improvement.

Richland County over the remainder of SFY 2023, will explore and construct a reworking of the Crisis Continuum with focus on moving from purchase of service to a firehouse model and looking at full continuum rather than several smaller individualize programs. It is anticipated that this approach will require an increase in overall allocations of 15% to 20%. The goal will be to implement a Pilot Crisis Continuum for SFY 2024. This innovative approach should increase availability of essential crisis services and the efficiency of how these services work together. We will continue to move forward with pursuing a Youth Crisis Stabilization Unit. We have already applied for a Capital Grant, which is currently on hold pending the purchase of desired building. Match funds are currently available through the Board Capital Reserve and preliminary drawings have already been obtained. Once the purchase of the building occurs, we estimate 9 to 12 months to bid the project, complete the renovations and implement programming. Richland County would like to place a full Wellness Team in each of the public schools, scaled based on the student body and offer teams to all charter and parochial schools, again, scaled based on the size of the student body. We will pursue a collaborative relationship with each school system regarding funding. During SFY 2024 we will look at the Child and Adolescent Crisis Continuum through a similar lens that was used to modernize the Adult Crisis Continuum. We anticipate more of a challenge because the child and adolescent crisis continuum involved multiple agencies for the school-based wellness teams, Catalyst Life Services for immediate community crisis response and staffing of the Youth Crisis Stabilization Unit and Family Life Counseling for Mobile Response Support Services (MRSS) provider for Richland County. We want to assure that any changes will focus on all entities collaborating constructively and providing the service the youth needs and not just what the agency offers. Finally, we want to look closely at our 24-hour Crisis Hotline and explore the possibility of this program becoming a Certified Lifeline and becoming part of 988 or, if it is determined that Certification is not a possibility, determine the best way to adapt the HELPline to provide crisis dispatch services and become a central contact for the crisis continuum on Richland County.

Current Term for survey	Definition- taken from Roadmap to the Ideal Crisis System	Dashboard Term	Licensure and Certification Rule (Current)
Crisis call centers	Call center or crisis line: A direct-service telephone line that is answered 24/7 by staff that has been trained to work with individuals in urgent and emergent crisis and can connect individuals to needed resources and help support problem solving and coping skills. Warmline or helpline: A direct service in which trained peers or volunteers provide support via telephone during specified hours of operation. These lines are used for non-emergent situations, such as loneliness, anxiety or need for support, that could potentially worsen to an emergency if not addressed.	24-Hour Crisis Hotline/Textline; Warm Lines	CBHC Certificate 5122-26 with following certified Services: BH Hotline 5122-29-08 Peer Support Services 5122-29-15
Mobile crisis teams	Mobile crisis services: Teams consisting of behavioral health specialists, usually professionals and peers, who can be deployed rapidly to meet an individual experiencing a crisis at their location in the community. These teams perform psychiatric assessments, de-escalate crises, determine next steps in an individual's treatment and connect the individual in crisis to needed services in the community. Mobile crisis workers may be deployed independently and/or work as co-responder teams with law enforcement, emergency medical services or other first responders	Mobile Crisis Team/ Children Mobile Response Stabilization	CBHC Certificate 5122-26 with following certified services: General Services 5122-29-03 Crisis Intervention 5122-29-10 Referral and Information 5122-29-22 SUD Case mgmt. 5122-29-13 Peer Support Svcs 5122-29-15 Community Psychiatric Supportive Tx 5122-29-17 Therapeutic behavioral svcs & Psychosocial Rehabilitation 5122-29-18 Youth Specific Mobile Response & Stabilization Service 51-29-14 (MRSS requires provider to also be certified in

			General Services 5122-29-03 SUD Case mgmt. 5122-29-13 Peer Support Svcs 5122-29-15 Community Psychiatric Supportive Tx 5122-29-17 Therapeutic behavioral svcs & Psychosocial Rehabilitation 5122-29-18
Crisis residential services	Residential crisis services: Provide a few days up to two weeks of 24-hour crisis intervention and monitoring for individuals in acute behavioral health crisis who cannot be served as outpatients but do not require inpatient psychiatric services. Services provided include 24-hour supervision, assessment and treatment of symptoms, individual and group therapeutic services, social services and referrals and handoffs to community resources. Different terms are used, such as crisis stabilization unit, crisis residential unit and crisis respite services, depending on the level of medical/nursing involvement and service intensity.	Short-Term Acute Residential Treatment	CBHC certificate 5122-26 with following certified services: General Services 5122-29-03 Peer Support Svcs 5122-29-15 Community Psychiatric Supportive Tx 5122-29-17 Therapeutic behavioral svcs & Psychosocial Rehabilitation 5122-29-18 SUD Specific (Adults) Residential, Withdrawal, and inpatient SUD 5122-29-09 (Youth) SUD qualified residential treatment program (QRTP) for youth 51-22-29-09.1 SUD Case mgmt. 5122-29-13

			MH Specific requires a Residential Class 1 License plus CBHC certificate (ADULT) Residential Class 1 license with (YOUTH) QRTP 5122-30-32
23-hour Crisis Observation	Extended (23-hour/48-hour) crisis observation: Provide up to 23 or 48 consecutive hours of direct and usually intensive supervised care in order to help individuals in acute crisis with either unclear or transient situations to have more thorough assessments and potentially resolve the crisis to avoid unnecessary hospitalization. Services provided include 24-hour observation and supervision, assessment and treatment of symptoms and referrals to appropriate community resources.	23-Hour Observation Level of Care	CBHC Certificate 5122-26 with following certified services: General Services 5122-29-03 Crisis Intervention 5122-29-10 Referral and Information 5122-29-12 Peer Support Svcs 5122-29-15 Community Psychiatric Supportive Tx 5122-29-17 Therapeutic behavioral svcs & Psychosocial Rehabilitation 5122-29-18 <u>SUD Specific</u> Residential, withdrawal, and inpatient SUD 5122-29-09 SUD Case Mgmt 5122-29-13
Crisis Stabilization Center	Crisis hub or crisis center: Also called crisis access centers or crisis resource centers. These centers are licensed and provide an array of 24/7 behavioral health crisis services in one location, including assessment, treatment, stabilization and referrals to appropriate	Crisis Stabilization Unit	Same as Crisis Residential Services requirements listed above If providing 23 obs crisis @ the

	community resources and follow-up care and often serve as a point of coordination for all the crisis services in the continuum for all age groups and populations.		CSU will need to include the guidelines for 23 hour crisis observation as listed above
Inpatient Crisis psychiatric services	Inpatient psychiatric care: inpatient hospital-based psychiatric treatment in general hospital or freestanding psychiatric hospital settings, designed for individuals whose acute exacerbation of psychiatric symptoms render them unable to cope safely in the community and are too severe to be managed at a lower level of care. Services provided include a secure setting, 24-hour medical and nursing management, 24-hour observation and supervision, intensive assessment and treatment of symptoms, both individual and group therapeutic services, social services and development of a plan to transition the individual back into the community	Level 1 Acute Care Psychiatric Inpatient	Private Psychiatric Hospital 5122-14 Youth or Adult (Youth) CBHC Certificate, deemed/national accreditation, Psychiatric Residential Treatment Facility (PRTF) PLUS Residential Class 1 License
Urgent care crisis services	Walk-in behavioral health urgent care services are conceptually equivalent to medical urgent care services. Behavioral health urgent care provides a valuable cost-effective alternative to ER utilization for behavioral health crises, just as medical urgent care provides similar value for diverting individuals with urgent but non-emergent medical needs. Behavioral health walk-in urgent care can provide easy access to a crisis response that does not initially require intensive or secure intervention. Individuals and families can access these services on their own, in convenient locations in the community or be directed to urgent care centers by the call center or crisis line (when that option is more appropriate than mobile crisis).	n/a	CBHC Certificate 5122-26 with following certified services: General Services 5122-29-03 Crisis Intervention 5122-29-10 Referral and Information 5122-29-12 Peer Support Svcs 5122-29-15
Withdrawal management	Withdrawal management, or medical detoxification safely manages the acute physical symptoms of withdrawal associated with stopping drug use. The goal of withdrawal management is to enable a person to stop taking the addictive substance as quickly and safely as possible.	Detoxification Services	CBHC Certificate with certified services Residential, withdrawal mgmt., and inpatient SUD 5122-29-09 (Youth) 5122-29-09.1 QRTP

			SUD Case Mgmt 5122-29-13 Ambulatory withdrawal mgmt. - outpatient or less than 23 hour obs. – CBHC Certificate 5122-26 with following certified services: General Services 5122-29-03
SUD Crisis Residential	**Adult SUD Residential Crisis Services** (ASAM Level 3 Withdrawal Management): ASAM 3.7: Medically Monitored**, ASAM 3.2: Socially supported**, Option to consider: Sobering Center **Adolescent SUD Residential Crisis Services** (ASAM Level 3 WDM): ASAM 3.7: Medically Monitored**, ASAM 3.2: Socially supported**	n/a	CBHC Certificate with certified services Residential, withdrawal mgmt., and inpatient SUD 5122-29-09 (Youth 5122-20-09.1) SUD Case Mgmt 5122-29-13 General Services 5122-29-03 (to cover dual disorder)
Crisis Respite	Respite services: Residential crisis services in a home-like environment. Some respite centers are peer-based with substantial peer support as the primary intervention.	Peer Respite Services; Children's Respite Services	Same as Crisis Residential Services, or Crisis Stabilization Unit or 23 Hour crisis observation requirements listed above depending upon length of stay
Other		Crisis Intervention Teams Peer Crisis Support/Peer Navigator	Peer Crisis Support/Peer Navigator CBHC certificate 5122-26 with certified services Peer Support Svcs 5122-29-15 General Services 5122-29-03

			Crisis Intervention 5122-29-10 Referral and Information 5122-29-12 <u>Crisis Intervention Team (CIT)</u> Same as Mobile Crisis Teams listed above

Ohio Department of Mental Health and Addiction Services (OhioMHAS)
2023-2025 Community Assessment and Plan (CAP) Template:
PLAN

Overview
This is the second of three sections in the Community Assessment and Plan (CAP) Template. The Plan section of the CAP Template will serve as the Board's 2023-2025 Community Plan and is designed to be completed by ADAMH Boards and returned to OhioMHAS every three years.

Template

Board name	Richland County Mental Health and Recovery Services Board
Date	January 17, 2022

Key

▲	Pre-populated data provided by OhioMHAS
✱	Question that all Boards are required to answer
Optional	Question that Boards may choose to answer, but are not required to answer

1. **✱Counties.** Please describe how your Community Plan applies to the area served by your Board:
   - **X** Our Board serves one county
   - ☐ Our Board serves more than one county, and our Plan covers all counties together
   - ☐ Our Board serves more than one county, and we have developed a separate Plan for each county. *Repeat each of the sections below for each county and indicate the county.*

2. **✱Priorities**

Use the findings from the Assessment section of the CAP to guide selection of a strategic set of priorities for your Community Plan. Briefly describe your community's priority strategies, priority populations and priority outcomes using the table below.

You will identify nine priorities total: Seven that are specific to each aspect of the continuum of care (prevention, mental health treatment, substance use disorder (SUD) treatment, Medication-Assisted Treatment (MAT), crisis services, harm reduction and recovery supports) in which one must be focused on youth, and two priorities specific to the required priority populations (pregnant women with SUD and parents with SUD with dependent children). You may also choose to identify collective impact priorities to address the social determinants of health (See table on Page 6). See the table below for additional instructions and an example.

Continuum of care	Strategy	Age group	Priority populations and groups experiencing disparities	Outcome indicator
Instructions				
Identify a priority for each aspect of the continuum of care (each row below)	*Briefly indicate the service, program or policy change you will implement.*	*Indicate which age group(s) the strategy will be designed to reach (choose all that apply):* ☐ Children (ages 0-12) ☐ Adolescents (ages 13-17) ☐ Transition-aged youth (14-25) ☐ Adults (ages 18-64) ☐ Older adults (ages 65+) ***At least 1 strategy must be designed to reach youth (children, adolescents or transition-aged youth)***	*Indicate which group(s) the strategy will be designed to reach (choose all that apply):* ☐ People with low incomes or low educational attainment ☐ People with a disability ☐ Residents of rural areas ☐ Residents of Appalachian areas ☐ Black residents ☐ Hispanic residents ☐ White residents ☐ Other racial/ ethnic group (specify: ___)	*Select at least one measurable outcome indicator from the Community Plan Standardized Indicator list or provide your own indicator.* *All indicators must be measurable, specific and have a data source. All indicators must reflect outcomes that are relevant to the selected strategy and age group.* *If data are available, the indicator should be disaggregated for the selected priority population(s) and*

			☐ Older adults (ages 65+) ☐ Veterans ☐ Men ☐ Women ☐ LGBTQ+ ☐ Immigrants, refugees or English language learners ☐ People who use injection drugs (IDUs) ☐ People involved in the criminal justice system ☐ General community program ☐ Other, specify: ___________	*group(s) experiencing disparities.* *See the standardized indicator list for suggested outcome indicators.*
Example				
Prevention	*Universal school-based suicide awareness and education program in four school districts*	✓ *Adolescents (ages 13-17)* ✓ *Transition-aged youth (14-25)*	✓ *Residents of rural areas* ✓ *General community program*	*Youth suicide deaths. (Number of deaths due to suicide for youth, ages 8-17, per 100,000 population.)*
Prevention	School and Community Based Suicide awareness and education programs	☐ Junior High and High School (13 to 18) ☐ emphasis on businesses and other areas with age	☐ Junior Highs and Highschool students in all 9 school districts ☐ adults currently employed in the 25-54 age	☐ Completed suicides in Richland County

		groups 25 to 54.	range which is where we have seen the greatest spike in suicides.	
Mental health treatment	Increase timely access to Physician for Medication Evaluation and Managemen t.	☐ Children (ages 0-12) ☐ Adolescents (ages 13-17) ☐ Adults (ages 18-64) ☐ Older adults (ages 65+)	☐ People at or below 200% of Federal Poverty ☐ Hospital discharge w/in past 24 hours ☐ Criminal justice involved ☐ Youth with school disruptions	☐ Wait time between diagnostic assessment and first meeting with physician.
Substance use disorder treatment	Increase timely access to ASAM level 3 services regardless of county of resident	☐ Adults (ages 18-64)	☐ People who use injection drugs (IDUs) ☐ Individuals referred from Hospital Eds ☐ Criminal justice involved ☐ Adults from rural communities	☐ Time from referral to admission. ☐ Non-Richland County admissions.
Medication -Assisted Treatment (MAT)	Maintain capacity of MAT providers in Richland County and increase retention rates.	☐ Adults (ages 18-64) ☐ Older adults (ages 65+)	☐ People who use injection drugs (IDUs) ☐ People with Opiate Use Disorder	☐ Reported overdoses.

			☐ People at or below 200% of Federal Poverty ☐ Hospital discharge w/in past 24 hours ☐ Criminal justice involved	
Crisis services	Enhance and fill gaps in the Crisis Continuum for both adults and youth.	☐ Children (ages 0-12) ☐ Adolescents (ages 13-17) ☐ Adults (ages 18-64) ☐ Older adults (ages 65+)	☐ General Communit y	☐ Decrease response time for crisis intervention ☐ Increase Community based crisis responses
Harm reduction	Maintain availability of Narcan and Narcan training	☐ Adults (ages 18-64) ☐ Older adults (ages 65+)	☐ General Communit y	☐ Deaths from overdose.
Recovery supports	Continue the promotion and enhanceme nt of Crisis Hotline and Warmline with plans to integrate with 988 when the national lines is adequately operational.	☐ Children (ages 0-12) ☐ Adolescents (ages 13-17) ☐ Adults (ages 18-64) ☐ Older adults (ages 65+)	☐ General Communit y	☐ Number of calls fielded by Hotline, Warmline and 988 Regional Lifeline ☐ Media spots promoting Hotlines
Specify: ASAM Level 3 Access	Increase utilization of pregnant women in ASAM level 3.5 and 3.1	☐ Adults (ages 18-64)	☐ ***Required: Pregnant women with SUD*** ☐ People who use	☐ Number of drug free babies born from Veronica's House

	both pre and post delivery		injection drugs (IDUs)	
Specify: Access to full continuum of care for referrals from Richland County Children Services, Juvenile Court and Domestic Relations Court	Increase access to Substance Use Disorder services for parents who are referred from Children Services, Juvenile Court and Domestic Relations Court	☐ Adults (ages 18-64)	☐ ***Parents with SUD with dependent children***	☐ Time from Referral to first appointment from Children Services, Juvenile Court and Domestic Relations Court

3. **✱SMART objectives**

SMART objectives are specific, measurable, achievable, realistic and time-bound. Develop at least one SMART objective for each of the priorities in table 2.

Continuum of care	Outcome indicator	Data source	Baseline year	Baseline	Target year	Target
Instructions						
Identify a SMART objective for each priority that you selected	*Fill in the relevant outcome indicator from the priorities table above*	*Identify the data source for the outcome indicator*	*Indicate the year (or other time period) the baseline*	*Enter the baseline data value for the outcome indicator*	*Indicate the year (or other time period) that you will*	*Enter the data value for the outcome indicator that you aim to achieve, reflecting a*

			data was collecte d		set a target for to assess progres s	decrease in a negative outcome or an increase in a positive outcome
Example						
Prevention	*Youth suicide deaths. (Number of deaths due to suicide for youth, ages 8-17, per 100,000 population.)*	*ODH Vital Statistics, accessed through the Public Health Data Warehouse*	*2018*	*4.0*	*2025*	*3.0*
Prevention	Completed suicides in Richland County	As Reported by Richland Public Health and Richland County Coroner	Calendar Year 2022	□ Total 30 □ 18 & under = 1 □ 25-54= 54%	Calendar Year 2025	□ 15 or > □ 0 □ Less than 50%
Mental health treatment	Wait time between diagnostic assessment and first meeting with physician.	For Indigent populations, data is available through GOSH, for Medicaid and private insurance, the agency will need to track an report data until	SFY 2022	Average 45 days for adults and 60+ days from children and adolescents	SFY 2024	14 days for adults and 30 days for Children and adolescents

		such time as Boards gain access to countywide Medicaid data.				
Substance use disorder treatment	Time from referral to admission. The number of non-Richland County residents admitted	Will be reliant on Agency tracking and reporting For Indigent populations, data is available through GOSH, for Medicaid and private insurance, the agency will need to track an report data until such time as Boards gain access to countywide Medicaid data.	SFY 2022	Average 24 hours during the week and 24-72 hours on the weekends ASAM Level 3 Capacity of non-Richland County residents is 2%	SFY 2024	Average less than 12 hours when facility capacity is under 85% ASAM Level 3 Capacity of non-Richland County Residents 10%
Medication-Assisted Treatment (MAT)	Reported overdoses.	Mansfield Police Department through the Opiate	Calendar Year 2022	380 people overdosed in Richland County	Calendar Year 2025	300

		Review Board				
Crisis services	Response time for crisis interventio n The number of Communit y based crisis responses	Data from Agency and Data from 911 dispatch Will track using Pseudo client system in GOSH	SFY 2022	Average response time is 1 hour 5 communit y-based responses	SFY 2024	30 minutes 104 Community based responses
Harm reduction	Deaths from overdose	Mansfield Police Departme nt through the Opiate Review Board	Calend ar Year 2022	49	Calend ar Year 2025	35
Recovery supports	calls fielded by Hotline, Warmline and 988 Regional Lifeline Media spots promoting Hotlines	Activity Logs from Hotline and Warmline and report from Nord Center regarding 988 Contracte d spots per day per year for Radio and TV	SFY 2022	Hotline: 3592 Warmline 2735 988 NA 4320 radio spots 208 TV spots	SFY 2024	Hotline 4000 Warmline 3000 988*Integrat ed with hotline 8000 radio spots 400 TV spots
Strategy for pregnant women with SUD	Number of drug free babies born from Veronica's House	Agency generate d report	SFY 2022	2	SFY 2024	5

	ASAM Level 3.5/3.1					
Strategy for parents with SUD with dependent children	Time from Referral to first appointment from Children Services, Juvenile Court and Domestic Relations Court	Agency generated report	Calendar Year 2022	Average 14 days	Calendar Year 2025	Average Less than 7 days

4. **Optional: SMART objectives for priority populations and groups experiencing disparities**

To monitor progress toward achieving equity, you can develop SMART objectives using disaggregated data (if available for your community).

Priority population or group experiencing disparities	Outcome indicator	Data source	Baseline year	Baseline	Target year	Target
Instructions						
Indicate the priority population or group experiencing disparities	*Fill in the relevant outcome indicator from the priorities table above*	*Identify the data source for the outcome indicator*	*Indicate the year (or other time period) the baseline data was collected*	*Enter the baseline data value for the outcome indicator*	*Indicate the year (or other time period) that you will set a target for to assess progress*	*Enter the data value for the outcome indicator that you aim to achieve, reflecting a decrease in or elimination of a disparity*

Example						
Males	*Youth suicide deaths among males. (Number of deaths due to suicide for males, ages 8-17, per 100,000 population.)*	*ODH Vital Statistics, accessed through the Public Health Data Warehouse*	*2018*	*6.0*	*2025*	*3.0*

Optional: Collective impact to address social determinants of health	Strategy	Key partners	Priority populations and groups experiencing disparities	Outcome indicator
Instructions				
Indicate the system (sector other than behavioral health or health care)	*Briefly indicate the service, program, campaign, policy change or initiative you will implement.*	*List the primary organizations involved in implementing this strategy*	*Indicate which group(s) the strategy will be designed to reach (choose all that apply):* ☐ People with low incomes or low educational attainment ☐ People with a disability ☐ Residents of rural areas ☐ Residents of Appalachian areas ☐ Black residents ☐ Hispanic residents ☐ White residents	*Select at least one measurable outcome indicator from the Community Plan Standardized Indicator list or provide your own indicator.* *All indicators must be measurable, specific and have a data source. All indicators must reflect*

			☐ Other racial/ ethnic group (specify: ___) ☐ Older adults (ages 65+) ☐ Veterans ☐ Men ☐ Women ☐ LGBTQ+ ☐ Immigrants, refugees or English language learners ☐ Pregnant women with SUD ☐ Parents with SUD with dependent children ☐ People who use injection drugs (IDUs) ☐ People involved in the criminal justice system ☐ General community program Other, specify: ___________	*outcomes that are relevant to the selected strategy.*
Examples				
Housing	*Buckeye County Affordable Housing Initiative (advocacy and planning)*	*Buckeye County Housing Alliance, Legal Aid, YWCA, Children's Hospital Medical-Legal Partnership, United Way*	✓ *People with low incomes or low educational attainment* ✓ *People with a disability*	*Affordable and available housing units (very low income). Number of affordable and available units per 100 renters with income below 50% of*

				Area Median Income (very low income)
K-12 schools	*Buckeye County Healthy Learners Collaborative (attendance interventions for chronically absent students and school-based health centers)*	*Educational service center, one large urban school district, chamber of commerce, corporate foundations, health systems*	✓ *Black students* ✓ *Hispanic students* ✓ *Students with a disability* ✓ *Economically disadvantaged students*	*Chronic absenteeism (K-12 students). Percent of students, grades K-12, who are chronically absent*
Expansion of Permanent Supportive Housing	During State Fiscal Year 2023, we will be constructing a new apartment complex with 12 x 1-bedroom units. Hope to complete construction by fall of SFY 2024.	Catalyst Life Services will manage this apartment complex, the Board will retain ownership and provide necessary capital upkeep. OHMAS providing a matching Capital Grant	Adults 18-65+ that have been diagnosed with a Severe Mental Illness	Maintain 85% occupancy.
Development of Transitional Housing	During State Fiscal Year 2024 convert a prior 8 unit permanent supportive housing facility to Transitional apartments with a length of stay not to exceed 18 months	Catalyst Life Services will manage this apartment complex. The Board will retain ownership and provide necessary capital upkeep along with fiscal subsidy to assist with the	Adults 18-65+ with Severe Mental Illness, Meet qualifications for Assertive Community Treatment (ACT), are transitioning from hospital or another higher level of institutional setting (i.e. Service Enriched Housing, Crisis Stabilization	Maintain 90% occupancy with 75% of residents accessing permanent supportive housing placement prior to 18 months.

		resident fee. OHMAS providing a matching Capital Grant	Unit, out of County ACF, etc.)	
Development of Adolescent Crisis Stabilization Unit	During the State Fiscal Year 2023 to 2025 establish a facility to develop a 12 bed Adolescent Crisis Stabilization Unit.	Catalyst Life Services will operate the facility and it will be owned by The Board. OHMAS providing a matching Capital Grant	12- <18 in need of acute stabilization that can be stabilized in less than 21 days. Extensions can be made on a case-by-case basis.	85% will return home within 21 days. 75% will not require placement of any kind within 30 days of completed stay and 60% will not require placement of any kind within 90 days of completed stay.

5. **Family and Children First Councils (FCFC)**

- Describe any child service needs resulting from finalized dispute resolution with county FCFC(s) [340.03(A)(1)(c)]

There have been no dispute resolutions filed through the Richland County Family and Children First Council.

- Describe your collaboration with the county FCFC(s) to serve high-need/multi-system youth

The Richland County Mental Health and Recovery Services Board is a standing and mandated member of the Richland County Family and Children First Council. In addition, the Executive Director is part of a three-year rotation to serve as the Chair of the Council. The Board also provides $70,000 annually to support both administration of the Council as well as to contribute to the pooled funding. Pooled funding provides support that may be needed for out of home placements, service grants and other assistance to the community that fall under the mission of the Council.

- Describe your collaboration with the county FCFC(s) to reduce of out-of-home placements (IFAST/MST)

The Council employs two staff that work directly with families in need, including those who receive assistance from Multi System Youth Funds, Family and Children Support Services Funds and those referred by teams for Wraparound services or need assessed for OhioRise. All efforts are made to prevent out of home placement. When placement is made, the Council will provide ongoing monitoring of the services being provided by the placement to assure that treatment plans are followed, progress is being made and that the youth returns home as soon as it is feasible.

6. **Hospital services.**
   - ☐ Boards are required to identify how future outpatient treatment/recovery needs are identified for private or state hospital patients who are transitioning back to the community.

The Board contracts with Catalyst Life Services to do Utilization Review with both the State Hospitals and OhioHealth. The purpose of the UR case manager is to assure timely and appropriate transition back to the community setting of the individual and teams choosing.

   - ☐ Boards are required to identify what challenges, if any, are being experienced in this area. Boards are provided with a dropdown list of potential challenges to choose from.

Difficulties in getting timely ongoing psychiatric care.

   - ☐ Boards are required to explain how the Board is attempting to address those challenges.

Currently the agency can access on a case-by-case basis bridge meds through the local FQHC. We will be working to formalize that process and, hopefully integrate this on a few days with the Urgent Care.

7. **Optional: Data collection and progress report plan.** Briefly describe plans to evaluate progress on the SMART objectives described above. OhioMHAS encourages Boards to develop a plan that includes data sources, data collection methods, partners involved in evaluation, a data collection timeline and a plan for sharing and using evaluation results.

Data collection for required outcomes listed above will be collected either quarterly or biannually with results being reviewed during the annual request for funding process and reported to the State by whatever means is determined by the State.

8. **Optional: Link to the Board's strategic plan.** Insert link(s) to your Board's most recent strategic plan, impact report or other documents that are relevant to your plan.

See other links

9. **Optional: Link to other community plans.** Insert link(s) to any local or regional community improvement plans that are relevant to your Board, such as a local health department Community Health Improvement Plan (CHIP) or hospital Community Health Needs Assessment- Implementation Strategy (CHNA-IS).