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

Q1      Board Name

Trumbull County Mental Health & Recovery Board     ⌄

Q2      Executive Director

Ms. April Caraway

**Mental Health and Addiction Challenges** - Based on the assessment findings, identify the level of need in your community for addressing the outcomes listed below.

Q3      **Children, Youth and Families**: Please consider each challenge listed regarding the need for your children, youth, and families. Choose Major Challenge, Moderate Challenge, or Minimal Challenge for each of the challenges listed below.

| | Minimal Challenge | Moderate Challenge | Major Challenge |
|---|:---:|:---:|:---:|
| Mental, emotional and behavioral health conditions in children and youth (overall) | ○ | ○ | ◉ |
| Youth depression | ○ | ◉ | ○ |
| Youth alcohol use | ○ | ◉ | ○ |
| Youth marijuana use | ○ | ◉ | ○ |
| Youth other illicit drug use | ○ | ◉ | ○ |
| Youth suicide deaths | ○ | ◉ | ○ |
| Children in out-of-home placements due to parental SUD | ○ | ◉ | ○ |
| Chronic absenteeism among K-12 students | ○ | ◉ | ○ |
| Suspensions and expulsions among K-12 students | ◉ | ○ | ○ |
| Adverse childhood experiences (ACEs) | ○ | ○ | ◉ |
| Other child/youth outcome (specify): | Suicidal ideation | | |
| Other child/youth outcome (specify): | | | |

Q4     **Children, Youth and Families**: Please consider each challenge listed regarding the need for your children, youth, and families. Choose Major Challenge, Moderate Challenge, or Minimal Challenge for each of the challenges listed below.

| | Minimal Challenge | Moderate Challenge | Major Challenge |
|---|:---:|:---:|:---:|
| Suicidal ideation | ○ | ○ | ◉ |

Q5     Please select the **Top Three** challenges for <u>Children, Youth, and Families</u> in your Board area.

☑ Mental, emotional and behavioral health conditions in children and youth (overall)
☐ Youth depression
☐ Youth alcohol use
☐ Youth marijuana use
☐ Youth other illicit drug use
☐ Youth suicide deaths

☐ Children in out-of-home placements due to parental SUD
☐ Chronic absenteeism among K-12 students
☐ Suspensions and expulsions among K-12 students
☑ Adverse childhood experiences (ACEs)
☑ Suicidal ideation

**Mental Health and Addiction Challenges** - Based on the assessment findings, identify the level of need in your community for addressing the outcomes listed below.

Q6     **Adults**: Please consider each challenge listed regarding the need for your adult population. Choose Major Challenge, Moderate Challenge, or Minimal Challenge for each of the challenges listed below.

| | Minimal Challenge | Moderate Challenge | Major Challenge |
|---|:---:|:---:|:---:|
| Mental health and substance use disorder conditions among adults (overall) | ○ | ◉ | ○ |
| Adult serious mental illness | ○ | ◉ | ○ |
| Adult depression | ◉ | ○ | ○ |
| Adult substance use disorder | ○ | ◉ | ○ |
| Adult heavy drinking | ○ | ◉ | ○ |
| Adult illicit drug use | ○ | ◉ | ○ |
| Adult suicide deaths | ○ | ○ | ◉ |
| Drug overdose deaths | ○ | ○ | ◉ |
| Problem gambling | ◉ | ○ | ○ |

Other adult outcome, specify: | MH and SUD conditions among adults (overall) |

Other adult outcome, specify: | |

**Q7    Adults**: Please consider each challenge listed regarding the need for your adult population. Choose Major Challenge, Moderate Challenge, or Minimal Challenge for each of the challenges listed below.

| | Minimal Challenge | Moderate Challenge | Major Challenge |
|---|:---:|:---:|:---:|
| MH and SUD conditions among adults (overall) | ○ | ● | ○ |

**Q8    Please select the Top Three challenges for <u>Adults</u> in your Board area.**

☐ Adult serious mental illness
☐ Adult depression
☐ Adult substance use disorder
☐ Adult heavy drinking
☐ Adult illicit drug use

☑ Adult suicide deaths
☑ Drug overdose deaths
☐ Problem gambling
☑ MH and SUD conditions among adults (overall)

<u>Disparities</u> - Based on the assessment findings, consider which special population groups are experiencing the worst outcomes in your community for the <u>mental health and addiction challenges</u> identified in the previous question.

There will be an opportunity to identify how any special populations will be served in the Plan.

**Q9    ✱Disparities.** Based on the assessment findings, which of the following groups are experiencing the worst service gaps and access challenges in your community? 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
☑ 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

**Q10    Optional Disparities Narrative (Not a requirement)** - Describe the context for disparities in unmet needs in your community, such as general demographic characteristics, data limitations, trends, etc.

**Q11    Additional Assessment Findings (Not a requirement)** - Describe any notable trends, qualitative findings or other assessment results regarding mental health and addiction outcomes that are relevant to your plan.

> We distributed a modified version of the CAP assessment instrument to contract agencies, seeking their views on disparities, challenges, service gaps, priority populations, and social determinants of health. Findings from this survey of providers are incorporated throughout this document. More qualitative insights into community needs are derived from conversational exchanges at meetings of the Trumbull County Suicide Prevention Coalition, Alliance for Substance Abuse Prevention (ASAP), and other problem-focused community coalitions.

# Mental health and addiction service gaps and access challenges

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

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 major challenges for each age group.

Q12      <u>**Overall service Gaps in continuum of care**</u>:

| | Minimal Challenge | Moderate Challenge | Major Challenge |
|---|:---:|:---:|:---:|
| Prevention services, programs and policies | ○ | ◉ | ○ |
| Mental health treatment services | ○ | ◉ | ○ |
| Substance use disorder treatment services | ○ | ◉ | ○ |
| Medication assisted treatment | ○ | ◉ | ○ |
| Crisis services | ○ | ○ | ◉ |
| Harm reduction services | ○ | ◉ | ○ |
| Recovery supports | ○ | ◉ | ○ |
| Mental health workforce (mental health professional shortage areas) | ○ | ○ | ◉ |
| Substance use disorder treatment workforce | ○ | ○ | ◉ |
| Other service gap, specify: | | | |
| Other service gap, specify: | | | |
| Other service gap, specify: | | | |

Q14      Please select the **Top Three** <u>service gaps in continuum of care</u> in your Board area.

☐ Prevention services, programs and policies
☐ Mental health treatment services
☐ Substance use disorder treatment services
☐ Medication assisted treatment
☑ Crisis services

☐ Harm reduction services
☐ Recovery supports
☑ Mental health workforce (mental health professional shortage areas)
☑ Substance use disorder treatment workforce

Q15      Access for children, youth and families

| | Minimal Challenge | Moderate Challenge | Major Challenge |
|---|:---:|:---:|:---:|
| Unmet need for mental health treatment, youth | ○ | ○ | ◉ |
| Unmet need for major depressive disorder, youth | ○ | ◉ | ○ |
| Lack of well-child visits | ○ | ◉ | ○ |
| Lack of child screenings: Depression and developmental | ○ | ◉ | ○ |
| Lack of child screenings: Developmental | ○ | ◉ | ○ |
| Lack of child screenings: Anxiety | ○ | ◉ | ○ |
| Lack of follow-up care for children prescribed psychotropic medications) | ○ | ○ | ◉ |
| Lack of school-based health services | ○ | ◉ | ○ |
| Uninsured children | ◉ | ○ | ○ |
| Other child/youth access challenge, specify: | Lack of child screening depression and anxiety | | |
| Other child/youth access challenge, specify: | Access to SUD treatment | | |
| Other child/youth access challenge, specify: | | | |

Q16 **Access for children, youth and families**

| | Minimal Challenge | Moderate Challenge | Major Challenge |
|---|---|---|---|
| Lack of child screening depression and anxiety | O | O | ◉ |
| Access to SUD treatment | O | O | ◉ |

Q17 Please select the **Top Three** gaps to <u>Access for children, youth, and families</u> in your Board area.

☑ Unmet need for mental health treatment, youth

☐ Unmet need for major depressive disorder, youth
☐ Lack of well-child visits
☐ Lack of child screenings: Depression and developmental
☐ Lack of child screenings: Developmental
☐ Lack of child screenings: Anxiety

☑ Lack of follow-up care for children prescribed psychotropic medications)

☐ Lack of school-based health services
☐ Uninsured children
☐ Lack of child screening depression and anxiety
☑ Access to SUD treatment

Q18 Access for adults

| | Minimal Challenge | Moderate Challenge | Major Challenge |
|---|---|---|---|
| Unmet need for mental health treatment, adults | O | ◉ | O |
| Unmet need for major depressive disorder, adults | ◉ | O | O |
| Unmet need for outpatient medication-assisted treatment | O | ◉ | O |
| Low SUD treatment retention | O | O | ◉ |
| Lack of follow-up after hospitalization for mental illness challenges | O | O | ◉ |
| Lack of follow-up after ED visit for mental health | O | O | ◉ |
| Lack of follow-up after ED visit for substance use | O | O | ◉ |
| Uninsured adults | ◉ | O | O |
| Other adult access challenge, specify: | Partial hospitalization and intensive outpatient programs | | |
| Other adult access challenge, specify: | | | |
| Other adult access challenge, specify: | | | |

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**Q19**     <u>**Access for adults**</u>

|  | Minimal Challenge | Moderate Challenge | Major Challenge |
|---|:---:|:---:|:---:|
| Partial hospitalization and intensive outpatient programs | ○ | ◉ | ○ |
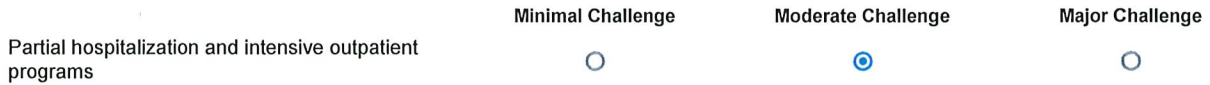
**Q20**     Please select the **Top Three** gaps for Access<u> for adults</u> in your Board area.

- ☐ Unmet need for mental health treatment, adults
- ☐ Unmet need for major depressive disorder, adults
- ☐ Unmet need for outpatient medication-assisted treatment
- ☑ Low SUD treatment retention
- ☑ Lack of follow-up after hospitalization for mental illness challenges

- ☐ Lack of follow-up after ED visit for mental health
- ☑ Lack of follow-up after ED visit for substance use
- ☐ Uninsured adults
- ☐ Partial hospitalization and intensive outpatient programs

**Q21**     ✱**Disparities**. Based on the assessment findings, which of the following groups are experiencing the worst <u>service gaps and access challenges</u> in your community? 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
- ☑ 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

**Q22**     **Optional: Disparities narrative**. Describe the context for disparities in service gaps in your community, such as general demographic characteristics, data limitations, trends, etc.

[ ]

**Q23**     **Optional: Additional assessment findings.** Describe any notable trends, qualitative findings or other assessment results regarding service gaps that are relevant to your plan.

[ ]

## 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?

**✱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. Rate each issue as major, moderate or not a driver. Then, select the top three major drivers for each category.

**Q24    Social and economic environment**

| | Not a driver or unknown | Moderate Driver | Major Driver |
|---|:---:|:---:|:---:|
| Poverty | ○ | ○ | ◉ |
| Unemployment or low wages | ○ | ○ | ◉ |
| Low educational attainment | ○ | ◉ | ○ |
| Violence, crime, trauma and abuse | ○ | ○ | ◉ |
| Stigma, racism, ableism and other forms of discrimination | ○ | ◉ | ○ |
| Social isolation | ○ | ◉ | ○ |
| Social norms about alcohol and other drug use | ○ | ◉ | ○ |
| Attitudes about seeking help | ○ | ◉ | ○ |
| Family disruptions (divorce, incarceration, parent deceased, child removed from home, etc.) | ○ | ○ | ◉ |
| Other, specify: | | | |

**Q26    Please select the Top Three** <u>Social and economic environment</u> determinants in your Board area.

- ☑ Poverty
- ☐ Unemployment or low wages
- ☑ Low educational attainment
- ☐ Violence, crime, trauma and abuse
- ☐ Stigma, racism, ableism and other forms of discrimination
- ☐ Social isolation
- ☐ Social norms about alcohol and other drug use
- ☐ Attitudes about seeking help
- ☑ Family disruptions (divorce, incarceration, parent deceased, child removed from home, etc.)

**Q27    Physical environment and health behaviors**

| | Not a driver or unknown | Moderate Driver | Major Driver |
|---|:---:|:---:|:---:|
| Lack of affordable or quality housing | ○ | ○ | ◉ |
| Lack of transportation | ○ | ○ | ◉ |
| Lack of broadband access | ○ | ◉ | ○ |
| Lack of access to healthy food | ○ | ◉ | ○ |
| Lack of physical activity | ○ | ◉ | ○ |
| Lack of fruit and vegetable consumption | ○ | ◉ | ○ |
| Food insecurity | ○ | ◉ | ○ |
| Other physical environment, specify: | | | |
| Other health behaviors, specify: | | | |

Q29     Please select the **Top Three** <u>Physical environment and health behaviors</u> determinants for your Board area.

☑ Lack of affordable or quality housing          ☐ Lack of physical activity
☑ Lack of transportation                          ☐ Lack of fruit and vegetable consumption
☐ Lack of broadband access                        ☑ Food insecurity
☐ Lack of access to healthy food

Q30     ✱**Disparities**. Based on the assessment findings, which of the following groups are most affected by these <u>social determinants</u> in your community? Choose **all** that apply.

☑ People with low incomes or low educational attainment      ☐ Men
☑ People with a disability                                    ☐ Women
☑ Residents of rural areas                                    ☑ LGBTQ+
☐ Residents of Appalachian areas                              ☐ Immigrants
☑ Black residents                                             ☐ refugees or English language learners
☐ Hispanic residents                                          ☐ People who use injection drugs (IDUs)
☐ White residents                                             ☑ People involved in the criminal justice system
☑ Older adults (ages 65+)                                     ☐ General community program
☐ Veterans                                                    ☐ Other

Q31     **Optional: Disparities narrative**. Describe the context for disparities in social determinants of health in your community, such as general demographic characteristics, data limitations, trends, etc.

The University of Wisconsin's Population Health Institute in collaboration with the Robert Wood Johnson Foundation maintains a system of county rankings in each state on key public health indicators. According to their website (www.countyhealthrankings.org), the County Health Rankings "show the rank of the health of nearly every county in the nation and illustrate that much of what affects health occurs outside of the doctor's office. The Rankings help counties understand what influences how healthy residents are and how long they will live. The Rankings look at a variety of measures that affect health such as the rate of people dying before age 75, high school graduation rates, unemployment, access to healthy foods, air and water quality, income, and rates of smoking, obesity and teen births. Based on data for each county, the Rankings are unique in their ability to measure the overall health of each county in all 50 states on the many factors that influence health, and they have been used to garner support among government agencies, healthcare providers, community organizations, business leaders, policymakers, and the public for local health improvement initiatives." In 2016 Trumbull County ranked 65th out of 88 Ohio counties on health outcomes, a composite measure combining life expectancy/premature death, low birth weight, and poor physical and mental health. In 2020 we fell to 71st and in 2022 to 72nd. In 2016 we ranked 72nd on health factors, another composite measure that includes health behaviors (e.g., smoking, obesity, teen birth rate) clinical care (e.g., number of primary care physicians, dentists, uninsured persons), social and economic factors (e.g., education, unemployment, child poverty, violent crime), and physical environment (e.g., air quality, healthy food, drinking water safety). We fell to 75th in 2020 and 80th in 2022.

Q32     **Optional: Additional assessment findings**. Describe any notable trends, qualitative findings or other assessment results regarding social determinants of health that are relevant to your plan.

## Strengths, including community assets and partnerships

**Q33** **✱Identify community strengths your Board will draw upon to address needs and gaps.** Select the **three strengths** that are the most significant in your community:

- ☑ Collaboration and partnerships
- ☐ Engaged community members
- ☑ Availability of specific resources or assets
- ☐ Economic vitality
- ☐ Creativity and innovation
- ☐ Natural resources and greenspace

- ☐ Colleges or universities
- ☑ Faith-based communities
- ☐ Social support and positive social norms
- ☐ Other 1
- ☐ Other 2
- ☐ Other 3

✱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 four levels of collaboration:
**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

**Q34** Partners

| | No interaction at all | Networking | Cooperation | Coordination | Collaboration | Entity does not exist |
|---|---|---|---|---|---|---|
| Local prevention coalition(s) (suicide, tobacco, Drug Free Community, etc.) | ○ | ○ | ○ | ○ | ● | ○ |
| Local health district(s) | ○ | ○ | ○ | ○ | ● | ○ |
| Local tax-exempt hospital | ○ | ○ | ○ | ● | ○ | ○ |
| Local school district(s) | ○ | ○ | ○ | ● | ○ | ○ |
| Educational service center(s) | ○ | ○ | ● | ○ | ○ | ○ |
| Law enforcement | ○ | ○ | ● | ○ | ○ | ○ |
| Criminal justice system/courts | ○ | ○ | ○ | ○ | ● | ○ |
| Child protective services (PCSA) | ○ | ○ | ○ | ● | ○ | ○ |
| Family and Children Services Council(s) | ○ | ○ | ○ | ○ | ● | ○ |
| Private psychiatric hospitals | ○ | ○ | ○ | ● | ○ | ○ |
| State psychiatric hospitals | ○ | ○ | ○ | ● | ○ | ○ |
| People with lived experience/ people in recovery | ○ | ○ | ○ | ● | ○ | ○ |
| UMADAOP | ○ | ○ | ● | ○ | ○ | ○ |
| Area Agency on Aging | ○ | ○ | ● | ○ | ○ | ○ |
| Housing (such as the Housing continuum of care (COC) entity or public housing authority) | ○ | ○ | ○ | ○ | ● | ○ |
| Transportation (such as the regional planning commission or transit authority) | ○ | ● | ○ | ○ | ○ | ○ |
| Job training and economic development (such as OhioMeansJobs center(s) or chamber of commerce) | ○ | ○ | ○ | ● | ○ | ○ |
| Food access (such as food bank(s) or farmer's markets) | ○ | ● | ○ | ○ | ○ | ○ |
| Other: | | | | | | |
| Other: | | | | | | |

Indicate the relationship the Board has with community behavioral health providers.

Q36    Identify the number of providers across the BH continuum of care that the Board is aware of within its area:

| | |
|---|---|
| Prevention | 6 |
| Mental Health Treatment | 29 |
| Substance Use Disorder Treatment | 23 |
| Medication-Assisted Treatment | 12 |
| Crisis Services | 7 |
| Harm Reduction | 3 |
| Recovery Supports | 29 |

Q37    Of those providers, identify the number the Board is partnering with by evidence of a formal memorandum of understanding (MOU) or other formal agreement:

| | |
|---|---|
| Prevention | 5 |
| Mental Health Treatment | 8 |
| Substance Use Disorder Treatment | 10 |
| Medication-Assisted Treatment | 2 |
| Crisis Services | 5 |
| Harm Reduction | 2 |
| Recovery Supports | 23 |

## Additional information

Q38    **Optional: Link to other community assessments.** Insert link(s) to any local or regional community assessments that are relevant to your Board, such as a local health department Community Health Assessment (CHA) or hospital Community Health Needs Assessment (CHNA).

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http://www.tcchd.org/PDFS/Trumbull%20County%20Community%20Health%20Improvement%20Plan.pdf http://www.tcchd.org
/PDFS/2019%20Community%20Health%20Assessment%20Final.pdf The 2022 Mahoning-Trumbull Community Health Improvement
Plan (see below) identifies three priorities: mental health and substance use, community conditions with an
emphasis on community safety, and access to care. The TCMHRB will be heavily involved in the implementation of
strategies under the first priority. Community Health Needs Assessment (CHNA) Mahoning and Trumbull Counties
Priorities (June 2022) 1. Mental Health and Substance Use Rationale: • Mental Health ranked #1 priority in
community voting, both counties • Mental health ranked #1 in stakeholder prioritization voting • Across community
conversations, mental health identified as a concern and area of need • Almost 40% of Community Health Opinion
Survey respondents reported either they or a member of their household experienced feeling down or sad for more
than 2 weeks in the past 6 months • National indicators of mental health, particularly youth mental health, suggest
mental health may have been declining in past two years • Substance use ranked as 5th overall priority in community
voting, but #2 among Trumbull County respondents • Natural alignment of substance use and mental health because of
overlapping root causes, comorbidities, and integration of service providers 2. Community Conditions, with an
emphasis on community safety Rationale: • Community Conditions ranked as #4 among respondents who identify as
Black/African American or Hispanic/Latino in community voting • Recognition by stakeholder group of how community
conditions (housing, transportation, economic opportunity) drive health outcomes and may be root cause of many
health disparities • Children under 5 face the highest rates of poverty at 34.6% in Mahoning and 36.2% in Trumbull;
this is a higher percentage than in the state and peer counties • Community Safety ranked at #2 priority in
community voting overall, and #1 among Black/African American respondents • Community Safety ranked #2 in
stakeholder [prioritization voting • Community Safety raised as a major concern in community conversations,
highlighting recent increase in crimes, particularly homicides; unsafe conditions for LGBTQ+ community members is a
barrier to services and mental health 3. Access to Care Rationale: • Access to Care ranked as #3 in community
voting and #2 among respondents who identified as Hispanic/Latino • Access to Care ranked #3 in stakeholder
prioritization voting • Community conversations highlighted access to care as an area of concern and source of
inequities; limited availability of appointments, transportation, cost of care, and lack of adequate care for
LGBTQ+ community members were cited as major barriers • Community Health Opinion Survey respondents who reported an
income below $50,000 experienced more problems seeking care in the past year than higher-income respondents
```

## 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.

Q39    Please describe how your Community Plan applies to the area served by your Board:

- ◉ Our Board serves one county
- ○ Our Board serves more than one county, and our Plan covers all counties together

## ✱Priorities

Use the findings from the Assessment section of the CAP Template 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) and two priorities specific to the required priority populations (pregnant women with SUD and parents with SUD with dependent children). One of the seven continuum of care priorities must be targeted toward the youth population. You may also choose to identify collective impact priorities to address the social determinants of health.

## Continuum of Care – Prevention

Q40    **Strategy** – Briefly indicate the service, program or policy change you will implement.  (Continuum of Care-Prevention)

```
Universal school-based suicide prevention programs
```

Q41    **Age group** – Indicate which age group(s) the strategy will be designed to reach (choose all that apply for Continuum of Care-Prevention)

- ☑ Children (ages 0-12)
- ☑ Adolescents (ages 13-17)
- ☐ Transition-aged youth (14-25)
- ☐ Adults (ages 18-64)
- ☐ Older adults (ages 65+)

Q42    **Priority populations and groups experiencing disparities** - Indicate which group(s) the strategy will be designed to reach (choose all that apply for Continuum of Care-Prevention).

- ☐ 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
- ☐ 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

Q43    **Outcome Indicators** – Identify **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 group(s) experiencing disparities.

See the standardized indicator spreadsheet for suggested outcome indicators.

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Percentage of Trumbull County 6th, 8th, and 10th graders reporting thoughts of suicide
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## Continuum of Care – Mental Health Treatment

Q44     **Strategy** – Briefly indicate the service, program or policy change you will implement.  (Continuum of Care-Mental Health Treatment)

Support and promote Coleman Access Center, 24/7 crisis center

Q45     **Age group** – Indicate which age group(s) the strategy will be designed to reach (choose all that apply for Continuum of Care-Mental Health Treatment)

☐ Children (ages 0-12)                          ☑ Adults (ages 18-64)
☐ Adolescents (ages 13-17)                      ☑ Older adults (ages 65+)
☐ Transition-aged youth (14-25)

Q46     **Priority populations and groups experiencing disparities** - Indicate which group(s) the strategy will be designed to reach (choose all that apply for Continuum of Care-Mental Health Treatment).

☑ People with low incomes or low educational attainment     ☐ Men
☑ People with a disability                                  ☐ Women
☑ Residents of rural areas                                  ☑ LGBTQ+
☐ Residents of Appalachian areas                            ☐ Immigrants
☑ Black residents                                           ☐ Refugees or English language learners
☐ Hispanic residents                                        ☐ People who use injection drugs (IDUs)
☐ White residents                                           ☑ People involved in the criminal justice system
☑ Older adults (ages 65+)                                   ☑ General community program
☑ Veterans                                                  ☐ Other

Q47     **Outcome Indicators** – Identify **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 group(s) experiencing disparities.

See the standardized indicator spreadsheet for suggested outcome indicators.

Deaths by suicide

## Continuum of Care – Substance Use Disorder Treatment

Q48     **Strategy** – Briefly indicate the service, program or policy change you will implement.  (Continuum of Care-Substance Use Disorder Treatment)

> Contract with OhioMHAS certified agencies to provide a culturally competent, full continuum of care for substance use disorder treatment for children and adolescents

Q49     **Age group** – Indicate which age group(s) the strategy will be designed to reach (choose all that apply for Continuum of Care-Substance Use Disorder Treatment)

- ☑ Children (ages 0-12)
- ☑ Adolescents (ages 13-17)
- ☐ Transition-aged youth (14-25)
- ☐ Adults (ages 18-64)
- ☐ Older adults (ages 65+)

Q50     **Priority populations and groups experiencing disparities** - Indicate which group(s) the strategy will be designed to reach (choose all that apply for Continuum of Care-Substance Use Disorder Treatment).

- ☑ 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
- ☐ 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

Please specify what "Other" priority populations the strategy is designed to reach.

> Youth involved in the juvenile justice system

Q51     **Outcome Indicators** – Identify **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 group(s) experiencing disparities.

See the standardized indicator spreadsheet for suggested outcome indicators.

> Percent of Trumbull County 6th, 8th, and 10th graders who report illicit substance use in the past year (includes marijuana)

## Continuum of Care – Medication Assisted Treatment (MAT)

**Q52**    **Strategy** – Briefly indicate the service, program or policy change you will implement.  (Continuum of Care-Medication Assisted Treatment)

> Support MAT in the County jail and in the community

**Q53**    **Age group** – Indicate which age group(s) the strategy will be designed to reach (choose all that apply for Continuum of Care-Medication Assisted Treatment)

- ☐ Children (ages 0-12)
- ☐ Adolescents (ages 13-17)
- ☐ Transition-aged youth (14-25)
- ☑ Adults (ages 18-64)
- ☐ Older adults (ages 65+)

**Q54**    **Priority populations and groups experiencing disparities** - Indicate which group(s) the strategy will be designed to reach (choose all that apply for Continuum of Care-Medication AssistedTreatment).

- ☑ 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
- ☐ 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

**Q55**    **Outcome Indicators** – Identify **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 group(s) experiencing disparities.

See the standardized indicator spreadsheet for suggested outcome indicators.

> Unintentional overdose deaths involving opiates

## Continuum of Care – Crisis Services

**Q56**    **Strategy** – Briefly indicate the service, program or policy change you will implement.  (Continuum of Care-Crisis Services)

> Support and promote Mobile Response and Stabilization Services (MRSS)

**Q57**    **Age group** – Indicate which age group(s) the strategy will be designed to reach (choose all that apply for Continuum of Care-Crisis Services)

- ☑ Children (ages 0-12)
- ☑ Adolescents (ages 13-17)
- ☑ Transition-aged youth (14-25)
- ☑ Adults (ages 18-64)
- ☑ Older adults (ages 65+)

**Q58**    **Priority populations and groups experiencing disparities** - Indicate which group(s) the strategy will be designed to reach (<u>choose all that apply</u> for Continuum of Care-Crisis Services).

- ☑ 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
- ☐ 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

Please specify what "Other" priority populations the strategy is designed to reach.

> Families experiencing a behavioral health crisis

**Q59**    **Outcome Indicators** – Identify <u>**ONE**</u> 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 group(s) experiencing disparities.

See the standardized indicator spreadsheet for suggested outcome indicators.

> The percentage of families served by MRSS who transition from the mobile response to ongoing stabilization services

**Q60**    Please identify the next steps and strategies to improve/enhance your crisis continuum. – Are there other strategies that will be continued other than the one identified above?

> We are looking to strengthen our MRSS program in the coming year. Due to workforce shortages, this program has not transitioned to a 24/7 service. Additionally, the Board has been working with our crisis provider and community stakeholders to develop a 24/7 Crisis Center for adults. Funding is still needed for this project. Our current crisis center operates from 8 am-4:30 pm. Since a plan for a 24/7 crisis center has not been finalized, we are working to extend the current crisis center hours in the meantime. Our community would also benefit from partial hospitalization programs (PHP) and mental health intensive outpatient programs (IOP). Our local psychiatric hospital previously discussed developing a PHP program, however, there has been no movement. The Board will continue to collaborate with the hospital for future PHP development. We are also looking to expand our re-entry program in the coming year to support not only those returning to the community, but also their families. Lastly, our county lacks programming for the LGBTQ+ community; we intend on building programming to support youth and adults.

## Continuum of Care – Harm Reduction

Q61    **Strategy** – Briefly indicate the service, program or policy change you will implement.  (Continuum of Care-Harm Reduction)

```
Ensure community-wide availability of Narcan
```

Q62    **Age group** – Indicate which age group(s) the strategy will be designed to reach (choose all that apply for Continuum of Care-Harm Reduction)

- ☐ Children (ages 0-12)
- ☐ Adolescents (ages 13-17)
- ☐ Transition-aged youth (14-25)
- ☑ Adults (ages 18-64)
- ☐ Older adults (ages 65+)

Q63    **Priority populations and groups experiencing disparities** - Indicate which group(s) the strategy will be designed to reach (<u>choose all that apply</u> for Continuum of Care-Harm Reduction)

- ☐ 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
- ☐ 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

Q64    **Outcome Indicators** – Identify <u>**ONE**</u> 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 group(s) experiencing disparities.

See the standardized indicator spreadsheet for suggested outcome indicators.

```
Number of unintentional overdose deaths involving opiates
```

## Continuum of Care – Recovery Supports

**Q65**  **Strategy** – Briefly indicate the service, program or policy change you will implement.  (Continuum of Care-Recovery Supports)

> Support and build quality recovery housing

**Q66**  **Age group** – Indicate which age group(s) the strategy will be designed to reach (choose all that apply for Continuum of Care-Recovery Supports)

- ☐ Children (ages 0-12)
- ☐ Adolescents (ages 13-17)
- ☐ Transition-aged youth (14-25)
- ☑ Adults (ages 18-64)
- ☐ Older adults (ages 65+)

**Q67**  **Priority populations and groups experiencing disparities** - Indicate which group(s) the strategy will be designed to reach (choose all that apply for Continuum of Care-Recovery Supports)

- ☑ 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
- ☐ 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

**Q68**  **Outcome Indicators** – Identify **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 group(s) experiencing disparities.

See the standardized indicator spreadsheet for suggested outcome indicators.

> Percent of board-contracted recovery house residents who report no illicit drug use in past 30 days

## Special Population – Pregnant Women with Substance Use Disorder

Q69    **Strategy** – Briefly indicate the service, program or policy change you will implement. (Special Population-Pregnant Women with Substance Use Disorder)

```
Promote and support Trumbull County's M.O.M.S. (Maternal Opiate Medical Supports) and Baby On Board programs
```

Q70    **Age group** – Indicate which age group(s) the strategy will be designed to reach (choose all that apply for Special Population-Pregnant Women with Substance Use Disorder)

- ☐ Children (ages 0-12)
- ☐ Adolescents (ages 13-17)
- ☐ Transition-aged youth (14-25)
- ☑ Adults (ages 18-64)
- ☐ Older adults (ages 65+)

Q71    **Priority populations and groups experiencing disparities** - Indicate which group(s) the strategy will be designed to reach (choose all that apply for Special Population-Pregnant Women with Substance Use Disorder)

- ☑ 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
- ☐ 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

Q72    **Outcome Indicators** – Identify **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 group(s) experiencing disparities.

See the standardized indicator spreadsheet for suggested outcome indicators.

```
Number of newborns in Trumbull County hospitalized for neonatal abstinence syndrome
```

## Special Population – Parents with Substance Use Disorder with Dependent Children

**Q73**    **Strategy** – Briefly indicate the service, program or policy change you will implement. (Special Population-Parents with Substance Use Disorder with Dependent Children)

> Continue collaboration with Trumbull County Children Services and Trumbull County Family Court to support the Trumbull County Family Dependency Treatment Court (FDTC)

**Q74**    **Age group** – Indicate which age group(s) the strategy will be designed to reach (choose all that apply for Special Population-Parents with Substance Use Disorder with Dependent Children)

- ☐ Children (ages 0-12)
- ☐ Adolescents (ages 13-17)
- ☐ Transition-aged youth (14-25)
- ☑ Adults (ages 18-64)
- ☐ Older adults (ages 65+)

**Q75**    **Priority populations and groups experiencing disparities** - Indicate which group(s) the strategy will be designed to reach (choose all that apply for Special Population-Parents with Substance Use Disorder with Dependent Children)

- ☑ 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
- ☐ 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

**Q76**    **Outcome Indicators** – Identify **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 group(s) experiencing disparities.

See the standardized indicator spreadsheet for suggested outcome indicators.

> Number and percent of FDTC parents who are reunited with (i.e., regain custody of) their child(ren)

Identify SMART objectives for each of the seven continuum of care priority areas and two required special population areas.

<u>**Outcome Indicators**</u> (responses by topic in blue)
Prevention: Percentage of Trumbull County 6th, 8th, and 10th graders reporting thoughts of suicide
Mental Health Treatment: Deaths by suicide
Substance Use Disorder Treatment: Percent of Trumbull County 6th, 8th, and 10th graders who report illicit substance use in the past year (includes marijuana)

| | Prevention | Mental Health Treatment | SUD Treatment |
|---|---|---|---|
| Priority population | Residents of rural areas; Black residents; LGBTQ+; General community program | People with low incomes or low educational attainment; People with a disability; Residents of rural areas; Black residents; Older adults; Veterans; LGBTQ+; People involved in the criminal justice system; General community program | People with low incomes or low educational attainment; Residents of rural areas; Black residents; People who use injection drugs; Youth involved in the juvenile justice system |
| Data source | Trumbull County PRIDE survey data | | |
| Baseline Year | 2021-22 school year | | Trumbull County PRIDE data |
| Baseline | 6th: 37.2% 8th: 42.0 % 10th: 41.9% | Trumbull County Coroner's Office | 2021-22 school year |
| Target year | 2023-24 school year | CY 2021 | 6th: 10.7% 8th: 13.5% 10th: 28.8% |
| | -10.0% in each grade | 16 | 2023-24 school year |
| Target | | CY 2023 | -10% in each grade |
| | | -5.0% (<1) | |

(Continued) Identify SMART objectives for each of the seven continuum of care priority areas and two required special population areas.

**Outcome Indicators** (responses by topic in blue)
MAT: Unintentional overdose deaths involving opiates
Crisis Services:The percentage of families served by MRSS who transition from the mobile response to ongoing stabilization services
Harm Reduction:Number of unintentional overdose deaths involving opiates

| | MAT | Crisis Services | Harm Reduction |
|---|---|---|---|
| Priority population | People with low incomes or low educational attainment; People who use injection drugs; People involved in the criminal justice system | People with low incomes or low educational attainment; Residents of rural areas; Black residents; General community program; Families experiencing a behavioral health crisis | People who use injection drugs; People involved in the criminal justice system; General community program |
| Data source | Trumbull County Coroner's Office | MRSS data management system | Trumbull County Coroner's Office |
| Baseline Year | CY 2021 | SFY2023 | CY 2021 |
| Baseline | 90.0% | (in progress) | 90.0% |
| Target year | CY 2023 | SFY2024 | CY 2023 |
| Target | 80>0% (-10%) | 60% | 80>0% (-10%) |

(Continued) Identify SMART objectives for each of the seven continuum of care priority areas and two required special population areas.

**Outcome Indicators** (responses by topic in blue)
Recovery Supports: Percent of board-contracted recovery house residents who report no illicit drug use in past 30 days
Pregnant Women with Substance Use Disorder Priorities: Number of newborns in Trumbull County hospitalized for neonatal abstinence syndrome
Parents with Substance Use Disorder with Dependent Children: Number and percent of FDTC parents who are reunited with (i.e., regain custody of) their child(ren)

|  | Recovery Supports | Pregnant women with SUD | Parents with SUD and Dependent Children |
|---|---|---|---|
| Priority population | People with low incomes or low educational attainment; People who use injection drugs; People involved in the criminal justice system | People with low incomes or low educational attainment; Women; People who use injection drugs | People with low incomes or low educational attainment; Women; People who use injection drugs |
| Data source | Ohio Recovery Housing (ORH) Outcomes Tool | Ohio Department of Health | Trumbull County Family Court |
| Baseline Year | CY2022 | CY2020 | CY2022 |
| Baseline | 76.0% | 37 | 22.0% percent |
| Target year | CY2024 | CY2023 | CY2024 |
| Target | +9.0% (85.0%) | 30 (-18.9%) | 25.0% |

## Optional:Collective impact to address social determinants of health

As identified during the assessment process, please indicate how the Board will be leading a community effort to address up to three of the six (Q26 and Q29) social determinants of health "Major Drivers" that are driving mental health and addiction challenges in the community.

For the next three drop down questions, please select the Top Three Partners for your Board area collective impact to address social determinants of health.

Q131    Please select your Top Partner Choice using the drop down menu below

    --Click Here--                                                                          ∨

Q132    Please select your Top Partner Choice using the drop down menu below

    --Click Here--                                                                          ∨

Q133    Please select your Top Partner Choice using the drop down menu below

    --Click Here--                                                                          ∨

**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). Using the three drop down menus below select your Top Three priority populations and groups experiencing disparities.

Q146    Please select your Top priority populations and groups experiencing disparities using the drop down menu below

    --Click Here--                      ∨

Q147    Please select your Top priority populations and groups experiencing disparities using the drop down menu below

    --Click Here--                      ∨

Q148    Please select your Top priority populations and groups experiencing disparities using the drop down menu below

    --Click Here--                      ∨

# Other Community Plan Requirements - ORC 340.03(A)(1)(c) and Hospital Services

**Q173**  Describe any child service needs resulting from finalized dispute resolution with county FCFC(s) [340.03(A)(1)(c)]

We have had no such cases in the recent past.

**Q174**  Describe your collaboration with the county FCFC(s) to serve high-need/multi-system youth

TCMHRB collaborates very closely with FCFC to serve high-need/multi system youth. With the Board serving as the fiscal and administrative agent to the FCFC, there is ample opportunity for partnership and collaboration. The Board's Director of Youth Programs is an active member of the Wraparound Oversight Committee, the Wraparound Policies and Procedures Task Force, and the Multi-System Youth (MSY) Review Team. The Director of Youth Programs, who has an extensive history with the Wraparound Process, also provides group coaching to the Wraparound facilitators in Trumbull County, as well as consultation and technical assistance to other Family and Children First Councils around the state.

**Q175**  Describe your collaboration with the county FCFC(s) to reduce of out-of-home placements (IFAST/MST)

Trumbull County has a long history with the Wraparound Process, dating back to 1994. The Trumbull County FCFC delivers and promotes High Fidelity Wraparound, as their preferred method of Services Coordination. One of the main goals of the Wraparound Process is to keep kids in the least restrictive environment, preferably in a family setting in their own community. TCMHRB has been a key player in developing the Wraparound System of Care. While local pooled funds can be used to fund out-of-home placements, the policies state that out-of-home placement must be a last resort after other community-based options, such Intensive Home-Based Treatment (IFAST, MST, FFT), have been exhausted. The policy also states that residential placement is to be looked at as a short-term intervention, rather than a long-term solution; and funding (from local pooled funds) is limited to 180 days. TCMHRB staff, along with FCFC also sit on the BHJJ/MST Regional Collaborative, helping to oversee and promote Multi-Systemic Therapy. As a member of the MSY Review team, the Director of Youth Programs also reviews all local MSY applications and funding requests, to help ensure that residential placement requests are appropriate, that less-restrictive options have been explored, and that the team is actively working to return the youth to the community.

**Q176**  Identify how future outpatient treatment/recovery needs are identified for current inpatient private or state hospital individuals who are transitioning back to the community

Staff from outpatient providers, crisis units, and local and state hospitals meet twice per month for continuous quality improvement (CQI) meetings where discharge plans are reviewed. Agencies represented include Compass Family and Community Services, Coleman Health Services, Family and Community Services/Valley Counseling, MercyHealth St. Elizabeth Hospital, Trumbull Regional Medical Center, Forensic Psychiatric Center of NE Ohio, and the TCMHRB. Programs represented include Riverbend Treatment Center, Broadway Crisis Stabilization Unit, Horizon House intermediate residential facility, Assertive Community Treatment Team, jail liaisons, forensic monitor, persons on outpatient commitment through Probate Court, and the multi-system adult (MSA) program. Agencies and hospitals collaborate as patients are stepped down to the community. Previously, there was minimal communication between the state hospital and community providers regarding high risk cases and discharge plans. The state hospital and community providers have been holding discharge plan meetings to improve coordination of care. The state hospital has also started attending one out of the two monthly CQI meetings. There is limited collaboration and coordination at present with Generations Behavioral Health hospital, which is located in Trumbull County. Although invited, Generations does not attend CQI meetings and there is limited communication with community providers when their clients are admitted for inpatient treatment.

**Q177**  Identify what challenges, if any, are being experienced in this area (<u>choose all that apply</u>).

- ☐ Lack of Board capacity to staff a transition planning liaison
- ☐ Lack of communication/cooperation from state regional psychiatric hospital
- ☑ Lack of communication/cooperation from private psychiatric hospital(s)
- ☐ Lack of need for hospitalization, Lack of access to state regional psychiatric hospital
- ☑ Lack of access to private psychiatric hospital(s)
- ☐ N/A
- ☐ Other

**Q178**  Explain how the Board is attempting to address those challenges.

Challenges regarding the state hospital have improved by incorporating the state hospital during our CQI meetings and through discharge planning meetings. There has also been an increase in communication between the Board and social workers. The Board has reached out to Generations in the past to get them involved in CQI. Meeting invites and minutes are sent to Generations to encourage participation. When the Board is made aware of a Trumbull County admission, contact is made to assist with discharge, as needed. A new clinical director recently started and the Board will form a connection to encourage participation at CQI. The Board is not able to address the lack of psychiatric beds available for children and adolescents, although we frequently do single-case agreements with Belmont Pines Hospital, a child and adolescent facility which is also located in Trumbull County. When the Board is made aware of new inpatient programs, relationships are developed to collaborate on discharge planning and coordination in the community.

Q179 **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.

Q180 **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.

Q181 **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).

```
http://www.tcchd.org/PDFS/Trumbull%20County%20Community%20Health%20Improvement%20Plan.pdf http://www.tcchd.org
/PDFS/2019%20Community%20Health%20Assessment%20Final.pdf The 2022 Mahoning-Trumbull Community Health Improvement
Plan (see below) identifies three priorities: mental health and substance use, community conditions with an
emphasis on community safety, and access to care. The TCMHRB will be heavily involved in the implementation of
strategies under the first priority. Community Health Needs Assessment (CHNA) Mahoning and Trumbull Counties
Priorities (June 2022) 1. Mental Health and Substance Use Rationale: • Mental Health ranked #1 priority in
community voting, both counties • Mental health ranked #1 in stakeholder prioritization voting • Across community
conversations, mental health identified as a concern and area of need • Almost 40% of Community Health Opinion
Survey respondents reported either they or a member of their household experienced feeling down or sad for more
than 2 weeks in the past 6 months • National indicators of mental health, particularly youth mental health, suggest
mental health may have been declining in past two years • Substance use ranked as 5th overall priority in community
voting, but #2 among Trumbull County respondents • Natural alignment of substance use and mental health because of
overlapping root causes, comorbities, and integration of service providers 2. Community Conditions, with an
emphasis on community safety Rationale: • Community Conditions ranked as #4 among respondents who identify as
Black/African American or Hispanic/Latino in community voting • Recognition by stakeholder group of how community
conditions (housing, transportation, economic opportunity) drive health outcomes and may be root cause of many
health disparities • Children under 5 face the highest rates of poverty at 34.6% in Mahoning and 36.2% in Trumbull;
this is a higher percentage than in the state and peer counties • Community Safety ranked at #2 priority in
community voting overall, and #1 among Black/African American respondents • Community Safety ranked #2 in
stakeholder [prioritization voting • Community Safety raised as a major concern in community conversations,
highlighting recent increase in crimes, particularly homicides; unsafe conditions for LGBTQ+ community members is a
barrier to services and mental health 3. Access to Care Rationale: • Access to Care ranked as #3 in community
voting and #2 among respondents who identified as Hispanic/Latino • Access to Care ranked #3 in stakeholder
prioritization voting • Community conversations highlighted access to care as an area of concern and source of
inequities; limited availability of appointments, transportation, cost of care, and lack of adequate care for
LQBTQ+ community members were cited as major barriers • Community Health Opinion Survey respondents who reported an
income below $50,000 experienced more problems seeking care in the past year than higher-income respondents The
2022 Mahoning-Trumbull Community Health Improvement Plan identifies three priorities: mental health and substance
use, community conditions with an emphasis on community safety, and access to care. The TCMHRB will be heavily
involved in the implementation of strategies under the first priority.
```

SIGNATURE PAGE

# Community Assessment and Plan for the Provision of Mental Health and Addiction Services CY 2023-2025

Each Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Board, Alcohol and Drug Addiction Services (ADAS) Board and Community Mental Health Services (CMHS) Board is required by Ohio law to prepare and submit to the Ohio Mental Health and Addiction Services (OhioMHAS) department a community mental health and addiction services plan for its service area. The plan is prepared in accordance with guidelines established by OhioMHAS in consultation with Board representatives. A Community Plan approved in whole or in part by OhioMHAS is a necessary component in establishing Board eligibility to receive State and Federal funds and is in effect until OhioMHAS approves a subsequent Community Plan.
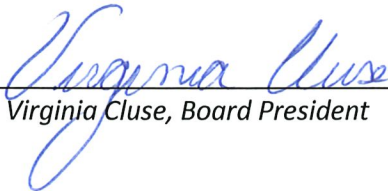
The undersigned are duly authorized representatives of the ADAMHS Board.

ADAMHS Board: Trumbull County Mental Health and Recovery Board

_____     1-17-2023
April J. Caraway, Executive Director      Date

_____     01-17-2023
Virginia Cluse, Board President          Date

Signatures must be original or if not signed by designated individual, then documentation of authority to do so must be included (Board minutes, letter of authority, etc.).