2026-2028 Community Assessment and Plan

Trumbull County Mental Health & Recovery Board

Serving Trumbull County

July 2026

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Department of Behavioral Health

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Background and Statutory Requirements

Based on the requirements of Ohio Revised Code (ORC) 340.03, the community Alcohol, Drug Addiction, and Mental Health (ADAMH) Boards are to evaluate strengths and challenges and set priorities for addiction services, mental health services, and recovery supports in cooperation with other local and regional planning and funding bodies. The ADAMH Boards shall include treatment and prevention services when setting priorities for addiction services and mental health services. This is known as the Community Assessment and Plan (CAP) process. The CAP process is on a three-year cycle, and this plan covers calendar years 2026-2028.

The ADAMH Board CAP is a tool to assess community behavioral health needs, to identify local behavioral health priorities, and to support alignment with federal and state behavioral health priorities of each of Ohio's fifty community ADAMH Boards. The CAP process has been designed to support policy development, strategic direction, strategic funding allocation decisions, data collection and data sharing, and strategic alignment at both the state and community level. The CAP process balances standardization and flexibility as the ADAMH Boards identify unmet needs, service gaps, and prioritize community strategies to address the behavioral health needs in their communities. The CAP process is also designed to support increased levels of collaboration between ADAMH Boards and community partners, such as local health departments, local tax-exempt hospitals, county Family and Children First Councils (FCFCs), and various other systems and partners.

In part one, the Assessment section, ADAMH Boards use data and other information to complete a community assessment that identifies mental health and addiction needs, service gaps, community strengths, environmental factors that contribute to unmet needs, and priority populations that are experiencing the worst outcomes in their communities.

In part two, the Plan section, ADAMH Boards complete a plan that identifies local priorities across the continuum of care to address unmet needs and close service gaps. The Plan also identifies priority populations for service delivery and plans for future outpatient needs of those currently receiving inpatient treatment at state and private psychiatric hospitals. Each identified priority is matched with SMART objectives and outcomes, which will be evaluated across the span of the three-year plan.

In part three, the Legislative Requirements section, ADAMH Boards complete information regarding the provision of crisis services. The use of this section may vary from cycle-to-cycle and is reserved to complete and/or submit statutorily required information.

Part One: Assessment

A. Assessing Behavioral Health Needs and Associated Disparities.

Mental health and addiction challenges. ADAMH Boards were asked to identify the level of need in their Board area for addressing the outcomes listed below in Table 1A.1. ADAMH Boards rated each challenge as 'major', 'moderate', or 'minimal'. Then, ADAMH Boards selected the top three challenges for children, youth, and families and for adults. Note, order/rank does not matter. Table 1A.1 below outlines this information.

Table 1A.1: Assessing Behavioral Health Challenges

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

	Major challenge	Moderate challenge	Minimal challenge	Top 3 challenges selected
Adults, continued				
Adult problem gambling		X		
Other adult outcome, specify: *"Homelessness."*		X		
Other adult outcome, specify: No response.				

Disparities. ADAMH Boards were asked to include all groups that experience the worst outcomes and/or higher prevalence than the overall Board area for the conditions listed in Table 1A.1 above.

- People with low incomes or low educational attainment
- People with a disability
- Residents of rural areas
- Black residents
- Parents with dependent children
- People involved in the criminal justice system

B. Assessing Behavioral Health Service Gaps and Associated Disparities.

Service gaps and access challenges. ADAMH Boards were asked to identify the level of challenge experienced in their Board area related to prevention, treatment, and recovery services access. ADAMH Boards rated each challenge as 'major', 'moderate', or 'minimal'. Then, ADAMH Boards selected the top three challenges related to the overall service gaps in continuum of care, access for children, youth, and families, and access for adults. Note, order/rank does not matter. Table 1B.1 below outlines this information.

Table 1B.1: Assessing Behavioral Health Service Gaps

	Major challenge	Moderate challenge	Minimal challenge	Top 3 challenges selected
Overall service gaps in continuum of care				
Prevention services, programs, and policies		X		
Mental health treatment services		X		X
Substance use disorder treatment services		X		
Medication-assisted treatment			X	
Crisis services	X			X
Recovery supports		X		
Criminal justice	X			X
Mental health workforce (mental health professional shortage areas)	X			
Substance use disorder treatment workforce	X			
Other service gap, specify: No response.				
Other service gap, specify: No response.				
Other service gap, specify: No response.				
Access for children, youth, and families				
Unmet need for mental health treatment, youth		X		X
Unmet need for substance-use/addiction treatment, youth	X			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, youth		X		
Uninsured children		X		X

	Major challenge	Moderate challenge	Minimal challenge	Top 3 challenges selected
Access for children, youth, and families, continued				
Unmet need for specific diagnostic categories, youth, specify: No response.				
Other child/youth access challenge, specify: No response.				
Other child/youth access challenge, specify: No response.				
Other child/youth access challenge, specify: No response.				
Access for adults				
Unmet need for mental health treatment, adults	X			X
Unmet need for outpatient medication-assisted treatment, adults			X	
Unmet need for non-MAT substance-use/addiction treatment, adults			X	
Low SUD treatment retention, adults	X			X
Lack of follow-up after hospitalization for mental illness challenges, adults	X			
Lack of follow-up after ED visit for mental health, adults	X			X
Lack of follow-up after ED visit for substance use, adults	X			
Unmet service need for criminal justice-involved adults	X			
Unmet service need for uninsured adults	X			
Unmet need for specific diagnostic categories, adults, specify: *"Autism."*		X		
Other adult access challenge, specify: No response.				
Other adult access challenge, specify: No response.				
Other adult access challenge, specify: No response.				

Disparities. ADAMH Boards were asked to include all groups that experience the worst service gaps and access challenges and/or higher prevalence than the overall Board area for the issues listed in Table 1B.1 above.

- People with low incomes or low educational attainment
- People with a disability
- Residents of rural areas
- Black residents
- Transition-aged adults (ages 18-24)
- Lesbian/Gay/Bisexual
- People involved in the criminal justice system

C. Social Determinants of Health.

Social determinants of health driving behavioral health challenges. ADAMH Boards were asked to describe the extent to which the following factors are driving mental health and addiction challenges in their Board area. ADAMH Boards rated each issue as 'major', 'moderate', or 'not a driver'. Then, ADAMH Boards selected the top three drivers for each category. Note, order/rank does not matter. Table 1C.1 below outlines this information.

Table 1C.1: Assessing Social Determinants of Health

	Major driver	Moderate driver	Not a driver or unknown	Top 3 drivers selected
Social and economic environment				
Poverty	X			X
Unemployment or low wages	X			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		
Attitudes about seeking help		X		
Family disruptions (divorce, incarceration, parent deceased, child removed from home, etc.)		X		
Other, specify: *"Housing instability."*		X		
Physical environment and health behaviors				
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		X
Lack of physical activity		X		
Lack of fruit and vegetable consumption		X		
Food insecurity		X		
Other physical environment, specify: No response.				
Other health behaviors, specify: No response.				

Disparities. ADAMH Boards were asked to include all groups that are most affected by these social determinants and/or higher prevalence than the overall Board area for the conditions listed in Table 1C.1 above.

- People with low incomes or low educational attainment
- People with a disability
- Residents of rural areas
- Black residents
- Transition-aged adults (ages 18-24)
- Older adults (ages 65+)
- Lesbian/Gay/Bisexual
- Parents with dependent children
- People involved in the criminal justice system

D. Strengths, Including Community Assets and Partnerships.

Community strengths Boards draw upon to address needs and gaps. ADAMH Boards were asked to select up to three strengths that are the most significant in their Board area:

- Collaboration and partnerships
- Engaged community members
- Other, specify: *"Large recovery community here."*

Local Prevention Coalitions. ADAMH Boards were asked to describe their Board area's collaboration with local Prevention Coalitions (i.e., suicide, substance use, problem gambling, etc.).

- *"The Trumbull County Mental Health & Recovery Board maintains a strong, collaborative partnership with the local prevention coalitions it hosts—specifically the Alliance for Substance Abuse Prevention (ASAP) Coalition and the Trumbull County Suicide Prevention Coalition. As the host agency, the Board provides dedicated staff support to manage, chair, and coordinate both coalitions, ensuring they have the organizational infrastructure needed to be effective. Through this collaboration, the Board: Offers strategic leadership by guiding coalition priorities, facilitating workgroups, and ensuring alignment with countywide behavioral health goals; Maintains partnerships with both contracted and noncontracted agencies that provide behavioral health services to Trumbull County residents; Provides administrative and operational support, including meeting coordination, data collection, reporting, fiscal management, and grant oversight; Promotes cross-collaboration between coalitions to address shared risk and protective factors—such as social isolation, trauma, and community connectedness—recognizing that substance use and suicide prevention often intersect; Strengthens community partnerships by connecting coalitions to local agencies, schools, healthcare partners, and grassroots organizations to expand prevention efforts and ensure broad community engagement; Advances evidence-based prevention strategies, supporting implementation of programs, public awareness campaigns, and community-level initiatives that improve health and safety across Trumbull County. Overall, the Board's collaboration ensures that each coalition operates with strong guidance, consistent support, and a unified focus on improving the well-being of Trumbull County residents."*

ADAMH Boards were then asked to indicate the extent to which their Board *currently* interacts with each potential identified community partner. Table 1D.1 below outlines this information. The four levels of collaboration were defined as…

- 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; compatible goals
- Collaboration: Signed MOU; long-term planning; integrated strategies; collective purpose; consensus is reached on all decisions; shared trust

Table 1D.1: Community Partnerships

Partner	No interaction at all	Networking	Cooper-ation	Coordin-ation	Collabor-ation	Entity Does Not Exist
Local prevention coalition(s) (suicide, substance use, problem gambling, 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			

Partner	No interaction at all	Networking	Cooper-ation	Coordin-ation	Collabor-ation	Entity Does Not Exist
State psychiatric hospitals				X		
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, specify: No response.						
Other, specify: No response.						

Board relationships with community behavioral health providers. ADAMH Boards were asked to identify the number of providers across the behavioral health continuum of care that the Board is aware of within their Board area. Table 1D.2 below outlines this information.

Table 1D.2: Community Behavioral Health Providers

Continuum of Care	Estimated Number of Community Providers
Prevention	13
Mental health treatment	30
Substance use disorder treatment	14
Medication-assisted treatment	7
Crisis services	4
Recovery supports	15
Criminal justice	7

Of those providers, ADAMH Boards were then asked to identify the number their Board is partnering with by evidence of a formal memorandum of understanding (MOU) or other formal agreement. Table 1D.3 below outlines this information.

Table 1D.3: Community Behavioral Health Providers with a Formal MOU or Other Formal Agreement

Continuum of Care	Estimated Number of Community Providers with a Formal MOU or Other Formal Agreement
Prevention	13
Mental health treatment	10
Substance use disorder treatment	7
Medication-assisted treatment	2
Crisis services	3
Recovery supports	12
Criminal justice	5

E. Estimated Number of Individuals Served.

Number served in each area of the behavioral health continuum, as well as special populations, through Board contracts/funding. ADAMH Boards were asked to report the number of individuals served across all funded Board programs, not just those prioritized strategies identified in the Plan section below. Table 1E.1 below outlines this information.

Table 1E.1: Estimated Number of Individuals Served in CY 2024

Continuum of Care	Estimated Number of Individuals Served in CY 2024
Prevention	10,000
Mental health treatment	1,471
Substance use disorder treatment	1,390
Medication-assisted treatment	211
Crisis services	263
Recovery supports	893
Criminal justice	222
Required Special Populations	**Estimated Number of Individuals Served in CY 2024**
Pregnant women with SUD	100
Parents with SUD with dependent children	800
Youth	85

F. Additional Context for Community Assessment.

Optional: Disparities narrative. ADAMH Boards were given the opportunity to describe the context for disparities in their Board area, such as general demographic characteristics, data limitations, trends, etc. If ADAMH Boards chose to complete this optional question, it was suggested that Boards describe the context regarding disparities in unmet needs, service gaps, and/or social determinants of health in their Board area.

- No response.

Optional: Additional assessment findings. ADAMH Boards were given the opportunity to describe any notable trends, qualitative findings, or other assessment results that are relevant to their Plan below. If ADAMH Boards chose to complete this optional question, it was suggested that Boards describe findings regarding mental health and addiction outcomes, service gaps, and/or social determinants of health that are relevant to the Plan below

- No response.

Optional: Additional Information. ADAMH Boards were given the opportunity to insert weblink(s) to any online local or regional community assessments that are relevant to their Board, such as their Recovery Oriented Systems of Care (ROSC) Assessment, a local health department Community Health Assessment (CHA), or hospital Community Health Needs Assessment (CHNA).

- *"chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://youngstownohio.gov/sites/default/files/forms/MTCHP_2025_CHA_FINAL%20.pdf"*

Part Two: Plan

A. Continuum of Care Priority Strategies, Including SMART Objectives for Each Priority Strategy.

The findings from the Assessment section above were used to guide the selection of priority strategies below. ADAMH Boards were required to identify ten priority strategies: seven that are specific to each aspect of the continuum of care (i.e., prevention, mental health treatment, substance use disorder [SUD] treatment, Medication-Assisted Treatment [MAT], crisis services, recovery supports, and criminal justice) and three that are specific to the required special populations (i.e., pregnant women with SUD, parents with SUD with dependent children, and youth).

For each of these priority strategies, ADAMH Boards were required to identify the targeted age group(s), priority population(s), outcome indicator(s), and if there will be capital funding needs. Then, using the outcome indicator(s) identified for each priority strategy, ADAMH Boards developed a SMART objective for each of the strategies. Tables 2A.1 through 2A.10 below outlines this information by continuum of care and required special populations.

Table 2A.1: Continuum of Care – Prevention

Prevention Priority Strategy			
Priority Strategy	*"Universal school-based suicide prevention programs."*		
Age Group(s)	• Children (ages 0-12) • Adolescents (ages 13-17)		
Priority Population(s) and Group(s) Experiencing Disparities	• Residents of rural areas • Black residents • Lesbian/Gay/Bisexual		
Capital Funding Needs	No		
SMART Objective for Prevention Priority Strategy			
Outcome Indicator	*"Percentage of Trumbull County 6th, 8th, and 10th graders reporting thoughts of suicide."*		
Data Source	*"Trumbull County Pride Survey data."*		
Baseline Year	2021	**Target Year**	2026
Baseline Data Value	37	**Target Data Value**	10

Table 2A.2: Continuum of Care – Mental Health Treatment

Mental Health Treatment Priority Strategy			
Priority Strategy	*"Support and promote Coleman Access Center."*		
Age Group(s)	• Adults (ages 18-64) • Older adults (ages 65+)		
Priority Population(s) and Group(s) Experiencing Disparities	• People with low incomes or low educational attainment • People with a disability • Residents of rural areas • Black residents • Older adults (ages 65+) • Veterans • Lesbian/Gay/Bisexual • People involved in the criminal justice system		
Capital Funding Needs	No		
SMART Objective for Mental Health Treatment Priority Strategy			
Outcome Indicator	*"Number of deaths by suicide."*		
Data Source	*"Trumbull County Coroner's Office."*		
Baseline Year	2021	**Target Year**	2028
Baseline Data Value	16	**Target Data Value**	5

Table 2A.3: Continuum of Care – Substance Use Disorder (SUD) Treatment

SUD Treatment Priority Strategy			
Priority Strategy	*"Expand capacity for treatment at Meridian HealthCare's Warren location."*		
Age Group(s)	• Adults (ages 18-64) • Older adults (ages 65+) • People with low incomes or low educational attainment		
Priority Population(s) and Group(s) Experiencing Disparities	• Pregnant women with SUD • Parents with SUD with dependent children • People who use injection drugs (IDUs) • People involved in the criminal justice system		
Capital Funding Needs	Yes		
SMART Objective for SUD Treatment Priority Strategy			
Outcome Indicator	*"Percentage of project completion."*		
Data Source	*"Meridian HealthCare."*		
Baseline Year	2025	**Target Year**	2028
Baseline Data Value	0	**Target Data Value**	100

Table 2A.4: Continuum of Care – Medication-Assisted Treatment (MAT)

MAT Priority Strategy			
Priority Strategy	*"Support and grow MAT program in the Trumbull County jail."*		
Age Group(s)	• Adults (ages 18-64)		
Priority Population(s) and Group(s) Experiencing Disparities	• People with low incomes or low educational attainment • People who use injection drugs (IDUs) • People involved in the criminal justice system		
Capital Funding Needs	No		
SMART Objective for MAT Priority Strategy			
Outcome Indicator	*"Number of inmates receiving Brixadi injection."*		
Data Source	*"Meridian HealthCare."*		
Baseline Year	2025	**Target Year**	2028
Baseline Data Value	10	**Target Data Value**	35

Table 2A.5: Continuum of Care – Crisis Services

Crisis Services Priority Strategy			
Priority Strategy	*"Build services at the TCMHRB BH Crisis Center."*		
Age Group(s)	• Children (ages 0-12) • Adolescents (ages 13-17) • Transition-aged adults (ages 18-24) • Adults (ages 18-64) • Older adults (ages 65+)		
Priority Population(s) and Group(s) Experiencing Disparities	• People with low incomes or low educational attainment • Residents of rural areas • Black residents • Other: *"Adults with SPMI."*		
Capital Funding Needs	No		
SMART Objective for Crisis Services Priority Strategy			
Outcome Indicator	*"Number of screens completed at the Behavioral Health Crisis Center."*		
Data Source	*"Coleman Professional Services."*		
Baseline Year	2025	**Target Year**	2028
Baseline Data Value	0	**Target Data Value**	1,000

Table 2A.6: Continuum of Care – Recovery Supports

Recovery Supports Priority Strategy			
Priority Strategy	*"Support and expand quality recovery housing."*		
Age Group(s)	• Adults (ages 18-64)		
Priority Population(s) and Group(s) Experiencing Disparities	• People with low incomes or low educational attainment • People who use injection drugs (IDUs) • People involved in the criminal justice system		
Capital Funding Needs	No		
SMART Objective for Recovery Supports Priority Strategy			
Outcome Indicator	*"Percent of recovery house residents who report no illicit drug use in past 30 days."*		
Data Source	*"Ohio Recovery Housing (ORH) Outcomes Tool."*		
Baseline Year	2022	**Target Year**	2028
Baseline Data Value	76	**Target Data Value**	90

Table 2A.7: Continuum of Care – Criminal Justice

Criminal Justice Priority Strategy			
Priority Strategy	*"Inmates are connected with post release resources."*		
Age Group(s)	• Adults (ages 18-64)		
Priority Population(s) and Group(s) Experiencing Disparities	• People with low incomes or low educational attainment • People who use injection drugs (IDUs) • People involved in the criminal justice system		
Capital Funding Needs	No		
SMART Objective for Criminal Justice Priority Strategy			
Outcome Indicator	*"Number of inmates connected with post release housing."*		
Data Source	*"Catholic Charities & Thrive Peer Support."*		
Baseline Year	2025	**Target Year**	2027
Baseline Data Value	9	**Target Data Value**	15

Table 2A.8: Required Special Population – Pregnant Women with SUD

Pregnant Women with SUD Priority Strategy			
Priority Strategy	*"Promote and support growth of inpatient programs for pregnant women."*		
Priority Population(s) and Group(s) Experiencing Disparities	• Pregnant women with SUD		
Capital Funding Needs	No		
SMART Objective for Pregnant Women with SUD Priority Strategy			
Outcome Indicator	*"Number of newborns in Trumbull County hospitalized for Neonatal Abstinence Syndrome."*		
Data Source	*"Ohio Department of Health."*		
Baseline Year	2020	**Target Year**	2028
Baseline Data Value	37	**Target Data Value**	32

Table 2A.9: Required Special Population – Parents with SUD with Dependent Children

Parents with SUD with Dependent Children Priority Strategy			
Priority Strategy	*"Continue collaboration with Children Services and Family Court to support the Trumbull County Family Dependency Treatment Court (FDTC)."*		
Priority Population(s) and Group(s) Experiencing Disparities	• Parents with SUD with dependent children		
Capital Funding Needs	No		
SMART Objective for Parents with SUD with Dependent Children Priority Strategy			
Outcome Indicator	*"Percentage of parents enrolled in FDTC who are reunified with their children."*		
Data Source	*"Trumbull County Family Court."*		
Baseline Year	2022	**Target Year**	2028
Baseline Data Value	22	**Target Data Value**	35

Table 2A.10: Required Special Population – Youth

Youth Priority Strategy			
Priority Strategy	*"Collaborate with Thrive Counseling and the Family Court to implement Behavioral Health services for youth detained in the juvenile justice center."*		
Priority Population(s) and Group(s) Experiencing Disparities	• Youth (ages 17 and under)		
Capital Funding Needs	No		
SMART Objective for Youth Priority Strategy			
Outcome Indicator	*"Percentage of youth who returned to the detention center within the calendar year."*		
Data Source	*"Trumbull County Family Court."*		
Baseline Year	2025	**Target Year**	2026
Baseline Data Value	20	**Target Data Value**	18

Optional. ADAMH Boards were given the opportunity to identify additional local priority strategies and SMART objectives separate and apart from the required priority areas. If ADAMH Boards chose to complete this optional question, this information was completed in the same manner as the priority strategies and SMART objectives outlined above. Tables 2A.11 below outline this additional information.

Table 2A.11: Optional – Additional Local Priority Strategy

Additional Local Priority Strategy			
Priority Strategy	No response.		
Age Group(s)			
Priority Population(s) and Group(s) Experiencing Disparities			
Capital Funding Needs			
SMART Objective for Additional Local Priority Strategy			
Outcome Indicator			
Data Source			
Baseline Year		**Target Year**	
Baseline Data Value		**Target Data Value**	

B. Multi-System Youth.

ADAMH Boards were asked to describe their relationship with county partners to address the needs of multi-system youth.

- The following describes any needed child services resulting from a finalized dispute resolution with a county FCFC(s) [340.03(A)(1)(c)].
  - *"There have been no such cases in recent years."*
- The following describes the ADAMH Board's collaboration with local partners (i.e., FCFCs, CMEs, other Child Serving Agencies) to serve high-need/multi-system youth.
  - *"TCMHRB has been actively involved in the implementation of OhioRISE over the past three years. TCMHRB has partnered closely with Cadence Care Network, the CME for Trumbull and Mahoning Counties, with the implementation of Care Coordination, Respite and Intensive Home-Based Treatment for high-need/multi-system youth. The TCMHRB Director of Youth Programs attends a monthly meeting with the CME Directors and the Trumbull County FCFC Director to review cases that are cross-involved with FCFC and the CME. The Director of Youth Programs also provides group coaching to FCFC Wraparound Facilitators who serve high-need/multi-system youth who do not qualify for OhioRISE (i.e. youth with private insurance). The TCMHRB is an active member of the Family Wraparound Oversight Committee who oversees funding through FCFC for high-need/multi-system youth."*
- The following describes the ADAMH Board's collaboration with county partners (i.e., FCFCs, CMEs, other Child Serving Agencies) to reduce out-of-home placements.
  - *"In addition to their partnership with the Cadence Care CME and the Trumbull County FCFC, the TCMHRB is actively involved in the Trumbull County Communities of Support Collaborative, which addresses system needs, barriers and gaps for multi-system youth, and works to reduce out-of-home placements. TCMHRB has*

also initiated a local MRSS Implementation Success Committee with Alta Behavioral Health (the Regional MRSS Provider), Coleman Health Services (contracted MRSS provider) and other community stakeholders to help with the transition to the regional model of MRSS. Finally, the Trumbull County MHRB received an Enhancing the System of Care Grant from ODBH and has added additional prevention, treatment and recovery supports for youth and families. Having access to a wide array of services will help to reduce the number of youth requiring out-of-home placements."

C. Hospital Services.

ADAMH Boards were asked to describe their relationship with local hospitals in terms of transition planning from inpatient care to any needed outpatient services.

- ADAMH Boards were asked to identify how future outpatient treatment/recovery needs are identified for private or state hospital patients who are transitioning back to the community.
  - *"There are bimonthly meetings held with local and state hospitals and area agencies to coordinate treatment for individuals who are returning to the community. The discussions are centered around the barriers the client is facing, how to overcome those barriers, resources that are available, and how to support each other."*
- ADAMH Boards were asked to identify what challenges, if any, are being experienced in this area. ADAMH Boards were allowed to select more than one challenge.
  - N/A
- ADAMH Boards were then asked to explain how the Board is attempting to address those challenges.
  - *"N/A."*

D. Optional: SMART Objectives for Groups Experiencing Disparities.

ADAMH Boards had the opportunity to develop additional SMART objectives using disaggregated data, if available, for priority populations and/or groups experiencing disparities. These additional SMART objectives would be used to monitor progress towards achieving equity. If ADAMH Boards chose to complete this optional question, this information was completed in the same manner as the SMART objectives outlined above. Tables 2D.1 below outline this additional information.

Table 2D.1: Optional – SMART Objective for Group Experiencing Disparities

Additional Group Experiencing Disparities			
Priority Population / Group Experiencing Disparities	No response.		
SMART Objective for Additional Group Experiencing Disparities			
Outcome Indicator			
Data Source			
Baseline Year		**Target Year**	
Baseline Data Value		**Target Data Value**	

E. Optional: Collective Impact to Address Social Determinates of Health.

As identified during the Assessment section above, ADAMH Boards had the opportunity to identify how they will be leading, convening, or significantly contributing to a community effort to address up to three social determinants of health that are driving behavioral health challenges in the community. If ADAMH Boards chose to complete this optional question, it was recommended that each Board seek to address the top ranked social determinants of health that they identified in the Assessment section above. ADAMH Boards then had the opportunity to identify up to three top community partners that will assist the Board in addressing each selected social determinant of health. Table 2E.1 below outlines this information.

Table 2E.1: Optional – Collective Impact to Address Social Determinates of Health

Collective Impact to Address Social Determinates of Health	Strategy	Key Partners	Priority Populations and Groups Experiencing Disparities	Outcome Indicator
Specify: No response.				
Specify: No response.				
Specify: No response				

F. Optional: Data Collection and Progress Report Plan.

ADAMH Boards were given the opportunity to describe their plans to evaluate progress on the SMART objectives described above. The Ohio Department of Behavioral Health (DBH) encouraged 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.

- No response.

G. Optional: Link to the Board's Strategic Plan.

ADAMH Boards were given the opportunity to provide weblink(s) to their Board's most recent strategic plan, impact report, or other documents that are relevant to the Plan.

- No response.

H. Optional: Link to Other Community Plans.

ADAMH Boards were given the opportunity to provide weblink(s) to any local or regional community improvement plans that are relevant to their Board, such as a local health department Community Health Improvement Plan (CHIP) or hospital Community Health Needs Assessment-Implementation Strategy (CHNA-IS).

- *"chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://youngstownohio.gov/sites/default/files/forms/MTCHP_2025_CHA_FINAL%20.pdf"*

Part Three: Legislative Requirements

A. Crisis Planning Committee/Task Force.

ADAMH Boards were asked to describe their Crisis Planning Committee/Task Force. If the ADAMH Board did not have one, the following describes the ADAMH Board's plan to implement a Crisis Planning Committee/Task Force.

- *"The Trumbull County Mental Health and Recovery Board's Crisis Planning Committee is multifaceted, in that we have several committees addressing crisis issues. We have a Behavioral Health Crisis Committee comprised of staff from Coleman Behavioral Health, Help Network of NE Ohio (our BH hotline), Compass Family Community Services, Alta Care Group, Travco Behavioral Health, Valley Health Services, Cadence Care Network, TCMHRB staff, Trumbull County Combined Health District, Warren City Health Department and the Trumbull County Emergency Management Agency. This committee developed the BH Crisis plan. For people in crisis due to homelessness and behavioral health issues, the housing collaborative meets every other Monday to link individuals and families with housing, behavioral health and other services. Representatives are from Coleman Behavioral Health, the Youngstown/Warren Urban League, Compass Family and Community Services, Adult Protective Services, Direction Home, Trumbull Metropolitan Housing Authority, Emmanual Community Care Center, Catholic Charities, Veteran's Affairs, PATH Outreach, Valley Health Services, Someplace Safe and the Trumbull County Mental Health and Recovery Board. The Mahoning Valley CISM Team is a collaboration of the Mahoning and Trumbull Counties Mental Health and Recovery Boards and provides a comprehensive, integrated, crisis intervention approach to manage critical incident stress after a traumatic event involving first responders in Mahoning and/or Trumbull Counties. The peer-driven is comprised of volunteers of first responders from law enforcement, fire, EMS, medical and mental health. The Coleman Access Center provides walk-in crisis services and Mobile Response and Stabilization Services Monday through Friday. Staff complete investigative reports for Probate Court, provide prescreening in the emergency room and Jail, complete outreaches in the community with police departments, arrange for psychiatric residential treatment, crisis stabilization, detox and treatment. They and Alta Behavioral Health provide MRSS 24/7 to families in need. Riverbend Center is a 12-bed, 24-hour Class 1 residential facility, owned by the TCMHRB, that provides transitional housing for people experiencing homelessness and behavioral health issues. Interventions include DA's, individual and group counseling, medication evaluation and monitoring, case management, residential/life skill services and structured therapeutic recreational activities. The TCMHRB utilizes the Broadway CSU, located in Mahoning County, as a stepdown for Trumbull County residents for Therapeutic Behavioral Services and Psychosocial Rehabilitation. Broadway CSU is a 15-bed, 24-hour, Class 1 residential facility that provides crisis stabilization in an intermediate level of care. Clients step down from inpatient psychiatric units or are diverted from inpatient psychiatric admission. Treatment interventions focus on stabilizing the current crisis and mobilizing resources so that the person can move to a less restrictive setting. Interventions include DAs, individual and group counseling, medication evaluation and monitoring, case management, residential/life skills, and structured therapeutic recreational activities. The TCMHRB holds monthly core provider meetings with contracted agencies to share information and discuss needs in our system so that we can avert many potential crises. Continuous Quality Improvement (CQI) team meetings facilitated by the TCMHRB occur twice per month to discuss clients on outpatient commitment, those who are in state or local mental health units, those who are in jail, forensic patients, those in an acute crisis, and high acuity clients who remain unengaged."*

B. Current and Planned Crisis System Components.

Table 3B.1: Current and Planned Crisis System Components

Crisis System Components	Service Currently Physically Offered in Geographic Board Area	New Service is Planned for CY 2026	New Service is Planned for CY 2027	New Service is Planned for CY 2028
Crisis Call Centers	X			
Mobile Crisis Services – Adult	X			
Mobile Crisis Services – Youth (non-MRSS)		No	No	No
Mobile Response and Stabilization Services (MRSS)	X			
Crisis Access Services	X			
Behavioral Health Urgent Care		No	Yes	No
Crisis Intervention with Observation		Yes	No	No
Crisis Residential Services		No	No	No
Inpatient Psychiatric Services	X			
Withdrawal Management	X			
SUD Crisis Residential	X			
Other: No additional crisis services reported.				

C. Collaboration with 988 Call Center(s).

ADAMH Boards were asked to describe how they collaborate with 988 call center(s), as well as how 988 data are used to support the ADAMH Board's crisis system.

- *"The TCMHRB works closely with Help Network of NE Ohio, the agency that provides 988, 211, and warm-line services for Trumbull, Columbiana, Ashtabula, and Mahoning Counties. We assist with collecting up to date information for their vast database of services available. Help Network, our BH hotline, provides monthly reports to the TCMHRB on calls received and help provided. We utilize this data to assist us in determining trends, needs and gaps in our system of care. We also use it in grant writing and identifying target populations for media campaigns. We include the data in speaking engagements and staff training of community agencies. The TCMHRB includes the 988 line in all marketing materials, on our website and in our overdose and suicide prevention programming. Help Network of NE Ohio also links people to residential withdrawal and inpatient SUD programs."*

D. Current Crisis System Gaps.

ADAMH Boards were asked to describe crisis system gaps currently present in the Board area, as well as the target population most impacted by this gap in terms of age, gender, race, geographic location, special population status, etc.

- *"The gaps in our crisis system are housing, staffing and transportation. Our crisis response team, at the Coleman Access Center, is not available 24/7. It currently operates during business hours and is not available weekends. This is directly due to staffing shortages. The population that is most impacted are those experiencing homelessness and adults with SPMI. Once fully staffed, we will have a true behavioral health urgent care with 24/7 accessible crisis services. Transportation is also a barrier for our residents. It creates challenges for individuals to continue their treatment. Public transportation is not available to all residents of the county, nor does it cover our largest city. Funding cuts to the WRTA bus routes have reduced an already small public bus route to only Route 422 that connects Trumbull and Mahoning Counties. Only people living on the bus line can access a ride to work, services, or recreation. Workforce shortages of drivers is also a barrier. All individuals are affected by the lack of transportation. We also have a shortage of affordable housing in the Mahoning Valley. Rent for a one-bedroom, dilapidated apartment is around $1000. Federal funding cuts from HUD will result in a loss of $700,000 in Shelter Plus Care Vouchers and nearly one hundred individuals and families may be displaced into homelessness due to these cuts in 2026. The Warren-Youngstown Urban League has a 28-bed shelter, and we just opened supportive housing for six female-head-of-household families and two single females at Sister Jean's Lighthouse located at our Trumbull County Behavioral Health Crisis Center. This was possible through 2.5 million in TCMHRB levy funds, $1,276,049 in DBH Capital Grant funds, 1.5 million in ARPA 1 funding from DBH, and funding from Community Development Block Grant for 3 years of staffing and a vehicle for the Warren/Trumbull Urban League to provide transportation for Sister Jean's Lighthouse. Every other week, however, we discuss more than sixty individuals and families who are in their cars, on the streets or in a shelter. This does not include the street-homeless who aren't engaged in services or those who are couch-surfing."*

E. Crisis System Funding Sources and Amounts.

Table 3E.1: Total Crisis System Funding

Funding Source	Amount Planned in CY 2026	Amount Planned in CY 2027	Amount Planned in CY 2028
Local Levy	$1,438,641	$1,463,641	$1,488,641
Local Grants *(grants not funded via DBH)*	$0	$0	$0
State GRF	$755,045	$755,045	$755,045
5TZ0	$307,747	$307,747	$307,747
DBH Funded Grants (non-GRF)	$233,000	$233,000	$233,000
Other Funding	$0	$0	$0

F. Plans to Enhance, Expand, or Continue to Support the Crisis System.

ADAMH Boards were asked to describe their plan to enhance, expand, or continue to support the crisis system. Boards were asked to include the goals identified above and capital funding plans to support expansion of the continuum, as well as plans to address any gaps identified above.

- *"We provide funding to and coordinate services at Help Network of Northeast Ohio, the 988 provider, and promote 988 in all Board marketing and that will continue. We also work closely with Coleman Health Services and Alta Care Group to ensure the success of MRSS. We meet monthly, promote MRSS on our website and social media and use the data we receive to identify gaps and promotional needs to ensure families are linked to MRSS and ongoing services. This will continue. We promote the 988 line through our website, social media, billboards, and other networks. The Trumbull County Mental Health and Recovery Board convenes monthly core provider meetings to review data, staffing, marketing, and to problem-solve any issues identified. We work closely with Coleman Health Services to develop new programs and expand crisis care. We will increase funding to fully staff the Coleman Access Center 24/7. We will continue funding for the TCMHRB Behavioral Crisis Center, utilize DBH indigent hospital funds to expand inpatient behavioral health care at the new Mercy Health Behavioral Health Hospital. We are supportive of expanding adult mobile response teams and will work with Coleman Behavioral Health to continue and expand that service."*

G. Crisis System Outcome Measures.

ADAMH Boards were asked to describe the outcome measures they are collecting to indicate success and manage continuous quality improvement.

- *"The Trumbull County Mental Health & Recovery Board (TCMHRB) collects outcome measures using multiple methods. As part of the funding application process, TCMHRB requires applicants to identify outcome indicators, baseline measurements, and performance targets for each program to be funded. Funded agencies submit quarterly performance updates, which are reviewed by Board staff to monitor progress, identify trends, and address performance concerns. To track total persons served, diagnostic and demographic information, the TCMHRB receives quarterly utilization and claims data through its claim processing system. This data allows the Board to monitor service reach and ensure programs align with identified community needs. Access to care and service barriers are further assessed through ongoing feedback gathered during monthly program and continuous quality improvement meetings with providers, community members, and individuals with lived experience. Information gathered through these forums helps identify challenges such as wait times, referral follow-through, and capacity issues, and informs strategies to improve access and service delivery."*