2026-2028 Community Assessment and Plan

Mental Health & Recovery Board of Wayne & Holmes Counties

Serving Wayne & Holmes Counties

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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		
Youth other illicit drug use		X		
Youth suicide deaths	X			X
Children in out-of-home placements due to parental SUD	X			X
Chronic absenteeism among K-12 students			X	
Suspensions and expulsions among K-12 students			X	
Adverse childhood experiences (ACEs)		X		
Other child/youth outcome, specify: No response.				
Other child/youth outcome, specify: No response.				
Adults				
Mental health and substance use disorder conditions among adults (overall)	X			X
Adult serious mental illness	X			X
Adult depression		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: No response.				
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
- White residents
- Youth (ages 17 and under)
- Transition-aged adults (ages 18-24)
- Men
- Parents with dependent children

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			X
Mental health treatment services		X		
Substance use disorder treatment services		X		
Medication-assisted treatment		X		
Crisis services	X			
Recovery supports	X			X
Criminal justice			X	
Mental health workforce (mental health professional shortage areas)	X			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			X
Lack of school-based health services, youth			X	
Uninsured children			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		
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		
Lack of follow-up after hospitalization for mental illness challenges, adults	X			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			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: No response.				
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
- Residents of rural areas
- Hispanic residents
- Youth (ages 17 and under)
- Transition-aged adults (ages 18-24)
- Immigrants, refugees, or English language learners

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		
Low educational attainment		X		
Violence, crime, trauma, and abuse		X		
Stigma, racism, ableism, and other forms of discrimination	X			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			X
Other, specify: No response.				
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		
Lack of physical activity			X	
Lack of fruit and vegetable consumption			X	
Food insecurity		X		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
- Residents of rural areas
- Transition-aged adults (ages 18-24)

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
- Availability of specific resources or assets
- Creativity and innovation

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.).

- *"WHMHRB not only fiscally supports but plays in active role in local prevention programming. Examples are Suicide Prevention Coalition, Partnership for Drug Free Wayne and Holmes Counties. WHMHRB understands the enormous value of robust prevention programming and prioritizes supporting partner agencies in the delivery of such programs."*

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	7
Mental health treatment	12
Substance use disorder treatment	3
Medication-assisted treatment	3
Crisis services	1
Recovery supports	8
Criminal justice	4

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	5
Mental health treatment	3
Substance use disorder treatment	2
Medication-assisted treatment	2
Crisis services	1
Recovery supports	5
Criminal justice	4

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	3,500
Mental health treatment	5,500
Substance use disorder treatment	2,500
Medication-assisted treatment	180
Crisis services	1,295
Recovery supports	5,000
Criminal justice	500
Required Special Populations	**Estimated Number of Individuals Served in CY 2024**
Pregnant women with SUD	18
Parents with SUD with dependent children	300
Youth	3,182

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.

- *"Wayne and Holmes Counties, located in northeast Ohio, are predominantly rural regions with distinct demographic and socioeconomic characteristics that contribute to disparities in health and human services. Wayne County has a population of approximately 115,000, while Holmes County is home to around 45,000 residents. Holmes County is notable for its large Amish population, which comprises nearly half of its residents and presents unique cultural and logistical considerations in service delivery. Unmet Needs: Both counties face significant unmet needs in behavioral health, substance use treatment, and crisis response. Youth mental health concerns are rising, with increased reports of anxiety, depression, and suicidal ideation. Access to timely care remains a challenge, particularly for individuals with co-occurring disorders, pregnant women with substance use issues, and families impacted by trauma. In Holmes County, cultural norms and limited engagement with traditional healthcare systems contribute to underreporting and underutilization of services. In Wayne County, stigma and transportation barriers further limit access, especially in outlying areas. Service Gaps: Service gaps are pronounced across both counties, particularly in intensive outpatient programs, residential treatment, and mobile crisis services. Waitlists for mental health and addiction services are common, and the shortage of licensed providers exacerbates delays. Holmes County has fewer service providers overall, and its rural geography makes centralized care difficult to access. Wayne County, while more developed, still struggles with coordination across agencies. Fiscal concerns and constraints further contribute to service gaps. Social Determinants of Health: Economic instability, limited transportation, and housing insecurity are key drivers of health disparities in both counties. Wayne County has pockets of poverty and food insecurity, with 70% of adults classified as overweight or obese — a reflection of limited access to nutritious food and wellness resources. Holmes County's rural infrastructure presents additional barriers, including geographic isolation and limited public transit. Educational attainment varies widely, and individuals with lower levels of education face*

compounding challenges in employment, healthcare access, and financial stability. The aging population in both counties also faces mobility limitations and insufficient geriatric care, contributing to increased isolation and unmet health needs. Data Limitations and Trends: Data collection across agencies is inconsistent, with limited interoperability and real-time access. Holmes County's unique cultural landscape further complicates data gathering, as many Amish residents do not participate in traditional surveys or electronic health records. In Wayne County, fiscal and administrative fragmentation makes it difficult to assess spending patterns and service utilization. Trends indicate rising substance use, particularly opioids and methamphetamines, and increased demand for youth mental health services. These patterns underscore the need for improved infrastructure, culturally responsive care, and cross-sector collaboration to address disparities and build a more equitable system."

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

- *"Mental Health and Addiction Outcomes: Mental health remains a top concern in both counties. In Wayne County, data show a sharp increase in suicide ideation, self-harm, and suicide attempts among youth ages 10–24. Excessive alcohol use is reported at 21%, exceeding the state average of 19%. Holmes County, while more rural and less densely populated, faces similar challenges with access to behavioral health services. Wayne County has high rates of opioid and methamphetamine use, with OneEighty and other providers noting steady demand for addiction treatment. Co-occurring disorders are prevalent, and pregnant women and parents with substance use disorders have been identified as priority populations due to elevated risk and limited service availability. Service Gaps: Wayne County continues to experience gaps in crisis response, intensive outpatient services, and residential treatment. Waitlists are common, and rural geography limits access for residents outside service hubs like Wooster. Holmes County faces even greater challenges due to its rural landscape, with fewer providers and limited infrastructure for behavioral health care. Workforce shortages, particularly in licensed clinical roles, strain both counties' systems. Fiscal oversight issues in Wayne County have also impacted service delivery, with programming often operating without timely or accurate financial data. Coordination across agencies remains inconsistent, and real-time data sharing is limited. Social Determinants of Health: Economic instability, housing insecurity, and limited transportation are key drivers of poor health outcomes in both counties. In Wayne County, 70% of adults fall into the overweight or obese category, reflecting broader concerns around nutrition and access to healthy food. Educational attainment varies widely, and individuals with lower levels of education face compounding barriers to employment, healthcare, and wellness. Holmes County's rural nature presents additional challenges, including geographic isolation, limited public transit, and fewer community-based supports. The aging population in both counties also faces mobility limitations and insufficient geriatric care. Qualitative Insights: Community feedback emphasizes the need for trauma-informed care, culturally responsive services, and streamlined referral pathways. Stakeholders report frustration over fragmented systems and administrative burdens that detract from direct care. These insights underscore the urgency of investing in infrastructure, workforce development, and cross-sector partnerships to build a more responsive and equitable system."*

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).

- *"https://www.wayne-health.org/"*
- *"https://www.holmeshealth.org/"*

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	*"Given limited fiscal resources and the absence of formal prevention programming from our predominant mental health provider, we propose a targeted prevention strategy that leverages existing crisis response infrastructure to build a sustainable, upstream model. Specifically, we will require that all individuals who engage in crisis services-whether through adult mobile crisis, MRSS (Mobile Response and Stabilization Services) for youth, QRT (Quick Response Team) outreach and calls to the 24-hour SUD Treatment Navigator, be connected to a structured prevention pathway post-crisis. This includes psychoeducation, peer support, family engagement, and community health referrals. While this approach is reactive in origin, it embeds prevention as a required follow-up, creating a bridge between crisis stabilization and long-term wellness. This strategy also integrates DEC (Drug Endangered Child Alliance) Preventative Services to disrupt generational cycles of trauma, substance use, and mental health challenges. DEC programming will focus on family systems, early intervention, and culturally responsive outreach, particularly for youth and parents impacted by substance use. We will partner with Anazao, Catholic Charities, schools, juvenile courts, and community organizations to deliver trauma-informed workshops, peer mentoring, and parent education using evidence-based models."*
Age Group(s)	• Children (ages 0-12) • Adolescents (ages 13-17) • Transition-aged adults (ages 18-24) • Adults (ages 18-64)
Priority Population(s) and Group(s) Experiencing Disparities	• 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 • Youth (ages 17 and under) • Transition-aged adults (ages 18-24) • Older adults (ages 65+) • Veterans • Men • Women • Lesbian/Gay/Bisexual • Immigrants, refugees, or English language learners

	• Pregnant women with SUD • Parents with SUD with dependent children • People who use injection drugs (IDUs) • People involved in the criminal justice system		
Capital Funding Needs	No		
SMART Objective for Prevention Priority Strategy			
Outcome Indicator	*"Percentage of individuals engaged in crisis services who are successfully connected to a prevention service within 30 days."*		
Data Source	*"Crisis service logs, referral records, prevention program enrollment data."*		
Baseline Year	2025	**Target Year**	2026
Baseline Data Value	45	**Target Data Value**	60

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

Mental Health Treatment Priority Strategy	
Priority Strategy	*"Expand mobile and telehealth-based mental health treatment services across Wayne and Holmes Counties, with a specific focus on reaching underserved populations such as Amish and Mennonite communities. Recognizing the cultural and geographic barriers to traditional clinic-based care, this strategy will prioritize bringing treatment directly to individuals through mobile units, home-based visits, and secure telehealth platforms. Anazao's Access Team and the Viola Startzman Clinic serve as exemplary models of flexible, community-centered care. Building on their success, we will promote cross-agency collaboration to ensure that each provider's strengths are leveraged, whether in trauma-informed care, culturally competent outreach, or crisis stabilization. The strategy will also include training for providers on culturally responsive engagement with Plain communities and other populations that may be reluctant to seek traditional mental health services. To maximize impact within fiscal constraints, we will: 1) Expand mobile outreach routes using existing staff and vehicles 2) Promote telehealth access through community hubs (e.g., libraries, schools, churches) 3) Coordinate referrals and care plans across agencies to reduce duplication and improve continuity 4) Explore shared staffing models and grant funding to support sustainability."*
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 • People with a disability • Residents of rural areas • Residents of Appalachian areas • Black residents • Hispanic residents • White residents • Youth (ages 17 and under) • Transition-aged adults (ages 18-24) • Older adults (ages 65+) • Veterans • Men • Women • Lesbian/Gay/Bisexual • Immigrants, refugees, or English language learners

	• Pregnant women with SUD • Parents with SUD with dependent children • People who use injection drugs (IDUs) • People involved in the criminal justice system
Capital Funding Needs	No

SMART Objective for Mental Health Treatment Priority Strategy			
Outcome Indicator	*"Percentage of individuals from underserved populations who initiate mental health treatment through mobile or telehealth services within 14 days of referral."*		
Data Source	*"Referral and intake logs, community hub utilization records."*		
Baseline Year	2025	**Target Year**	2026
Baseline Data Value	30	**Target Data Value**	50

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

SUD Treatment Priority Strategy	
Priority Strategy	*"Strengthen and streamline substance use disorder (SUD) treatment access across Wayne and Holmes Counties by expanding mobile assessment capacity, improving care coordination, and building a consistent referral system for youth requiring higher levels of care (LOC) than can be provided locally. This strategy prioritizes prompt mobile assessments to eliminate the need for individuals to travel to provider offices for initial engagement. By deploying trained clinicians into homes, community settings, and hospitals, we will reduce delays and address persistent transportation barriers that often prevent timely treatment. This is especially critical for individuals detoxing at the WCH RAMP Program, who should be assessed on-site and transitioned directly to the appropriate level of care. The current practice of discharging individuals with instructions to follow up days later introduces unnecessary risk and must be replaced with a seamless, in-hospital transition protocol. For youth, we will establish a clear and consistent referral system to connect individuals to regional or statewide providers offering residential or intensive outpatient services. Coordination with juvenile courts, schools, MRSS teams, and family support networks will ensure timely identification and placement. A centralized referral protocol will be developed to reduce delays, improve continuity of care, and ensure that youth are not lost in the system due to geographic limitations. To remain fiscally responsible, we will: 1) Leverage existing provider networks and mobile teams Integrate mobile assessments and referral protocols into current workflows (e.g., QRT, Navigator calls, RAMP transitions) 2) Seek grant funding to support transportation and youth care coordination 3) Utilize shared staffing and telehealth platforms to expand reach without increasing overhead."*
Age Group(s)	• Adolescents (ages 13-17) • Transition-aged adults (ages 18-24) • Adults (ages 18-64)
Priority Population(s) and Group(s) Experiencing Disparities	• 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 • Youth (ages 17 and under) • Transition-aged adults (ages 18-24) • Older adults (ages 65+) • Veterans

	• Men • Women • Lesbian/Gay/Bisexual • Immigrants, refugees, or English language learners • Pregnant women with SUD • Parents with SUD with dependent children • People who use injection drugs (IDUs) • People involved in the criminal justice system
Capital Funding Needs	No

SMART Objective for SUD Treatment Priority Strategy			
Outcome Indicator	*"Percentage of individuals assessed through mobile outreach who are successfully connected to the appropriate level of care within 72 hours."*		
Data Source	*"Mobile assessment logs, referral tracking systems, intake records."*		
Baseline Year	2025	**Target Year**	2026
Baseline Data Value	55	**Target Data Value**	70

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

MAT Priority Strategy	
Priority Strategy	*"Expand access to low-barrier Medication-Assisted Treatment (MAT) across Wayne and Holmes Counties to ensure timely, equitable, and sustained engagement in opioid use disorder treatment. This strategy will focus on same-day induction, flexible scheduling, and mobile or telehealth delivery to meet individuals where they are, physically, emotionally, and logistically. MAT services will be embedded into existing community touchpoints, including QRT outreach, mobile crisis response, the 24-hour SUD Treatment Navigator, and post-crisis follow-up. Special emphasis will be placed on reducing stigma and increasing awareness of MAT. Providers will be encouraged to adopt trauma-informed, culturally responsive practices that support long-term recovery. A critical component of this strategy is the integration of mobile MAT assessments, moving away from models that require individuals to travel to provider offices. This approach addresses persistent transportation barriers and ensures that individuals can be assessed and inducted into treatment in homes, hospitals, or community-based settings. Additionally, individuals detoxing at the WCH RAMP Program will be assessed on-site by MAT providers such as OneEighty, allowing for direct transitions to the appropriate level of care without delay. This eliminates the current practice of discharging individuals with instructions to follow up days later, which introduces unnecessary risk and increases the likelihood of relapse or disengagement. To remain fiscally responsible, we will: 1) Leverage existing MAT providers and mobile teams Integrate MAT protocols into current workflows (e.g., QRT, Navigator calls, RAMP transitions) 2) Utilize telehealth platforms and shared staffing models to expand reach 3) Seek grant funding to support mobile induction and transportation for follow-up care."*
Age Group(s)	• 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 • People with a disability • Residents of rural areas • Residents of Appalachian areas • Black residents • Hispanic residents

	• White residents • Youth (ages 17 and under) • Transition-aged adults (ages 18-24) • Older adults (ages 65+) • Veterans • Men • Women • Lesbian/Gay/Bisexual • Immigrants, refugees, or English language learners • Pregnant women with SUD • Parents with SUD with dependent children • People who use injection drugs (IDUs) • People involved in the criminal justice system
Capital Funding Needs	No

SMART Objective for MAT Priority Strategy			
Outcome Indicator	*"Percentage of individuals referred for MAT who initiate treatment within 72 hours."*		
Data Source	*"MAT provider intake logs, referral tracking systems, hospital discharge records."*		
Baseline Year	2025	**Target Year**	2026
Baseline Data Value	55	**Target Data Value**	75

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

Crisis Services Priority Strategy	
Priority Strategy	*"A critical enhancement to the crisis services continuum in Wayne and Holmes Counties is the development and implementation of specialized response protocols for individuals with dual diagnoses- particularly those experiencing psychosis triggered by substance use. Currently, these individuals are often treated solely for mental health symptoms, while the underlying substance use disorder remains unaddressed. This fragmented approach leads to repeated crises, poor outcomes, and missed opportunities for stabilization and recovery. Key Components of the Strategy: Integrated Screening and Assessment: All mobile crisis teams, MRSS responders, hospital staff, and QRT members will be trained to recognize signs of substance-induced mental health crisis and co-occurring disorders. Crisis assessments will be updated to include validated screening tools for both mental health and substance use, ensuring that dual diagnoses are identified in real time. Dual Diagnosis Response Protocols: Develop standardized workflows for responding to dual diagnosis presentations, including immediate linkage to both mental health and SUD services. Ensure that crisis stabilization plans include coordination with MAT providers, outpatient SUD programs, and peer recovery supports. Create shared care plans that follow the individual across systems, reducing duplication and improving continuity. Cross-Training and Workforce Development: Provide ongoing training for crisis responders, clinicians, and peer specialists on dual diagnosis best practices, trauma-informed care, and cultural responsiveness. Build capacity for dual diagnosis response within existing teams rather than creating siloed roles. Post-Crisis Engagement and Prevention: Every dual diagnosis crisis will trigger a prevention follow-up plan, including psychoeducation, peer support, and family engagement. Community health referrals will be used to address social determinants that contribute to repeated crises (e.g., housing, transportation, food insecurity)."*
Age Group(s)	• Children (ages 0-12) • Adolescents (ages 13-17) • 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 • Residents of Appalachian areas • Black residents • Hispanic residents • White residents • Youth (ages 17 and under) • Transition-aged adults (ages 18-24) • Older adults (ages 65+) • Veterans • Men • Women • Lesbian/Gay/Bisexual • Immigrants, refugees, or English language learners • Pregnant women with SUD • Parents with SUD with dependent children • People who use injection drugs (IDUs) • People involved in the criminal justice system
Capital Funding Needs	No

SMART Objective for Crisis Services Priority Strategy			
Outcome Indicator	*"Percentage of individuals identified with dual diagnosis during crisis response who receive integrated follow-up care within 7 days."*		
Data Source	*"Crisis response logs, referral tracking systems, provider follow-up records."*		
Baseline Year	2025	**Target Year**	2026
Baseline Data Value	40	**Target Data Value**	65

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

Recovery Supports Priority Strategy	
Priority Strategy	*"Community Health Worker Expansion: Partner with the Viola Startzman Clinic to expand its Community Health Worker (CHW) Program. CHWs will serve as trusted navigators embedded in recovery pathways, providing culturally responsive support, advocacy, and linkage to services - especially for individuals transitioning out of crisis, incarceration, or treatment. Youth Peer Recovery Programming: Collaborate with NAMI to expand youth peer support programs that offer mentorship, psychoeducation, and recovery-focused engagement in schools and community settings. Partnerships with O'Huddle and Goodwill will strengthen access to youth programming, leadership development, and life skills training. SUD and Mental Health Peer Support Integration: Increase the availability of certified peer supporters across SUD and mental health systems, embedding them into QRT outreach, MAT follow-up and mobile crisis teams. Peer support will be tailored to meet the needs of both youth and adults, with flexible scheduling and mobile delivery options. Family Engagement for Justice-Involved Populations: Develop targeted recovery supports for families impacted by incarceration, including parenting education, family reunification planning, and peer-led support groups. These services will be coordinated with reentry programs, probation offices, and local courts to ensure continuity and reduce recidivism. School-Based Liaisons: Establish school-based liaisons-which may include paraprofessionals or therapeutic behavioral support (TBS) staff, to serve as bridges between families and schools. These liaisons will support youth in recovery, facilitate communication with caregivers, and ensure that school environments are responsive to behavioral health needs. Transition Liaisons for Youth Returning Home: Create dedicated liaison*

	roles to support children transitioning from foster care or residential treatment back into their home environments. These liaisons will work closely with families, schools, and providers to stabilize the transition, reduce risk of re-entry, and promote recovery-oriented family functioning during this critical period. Employment and Stability Supports: Partner with Coleman Health Services to expand employment readiness and placement services for individuals in recovery. This includes job coaching, resume building, transportation assistance, and coordination with local employers committed to recovery-friendly hiring practices. To remain fiscally responsible, we will: 1) Leverage existing programs and community partnerships Integrate recovery supports into current workflows (e.g., Navigator calls, RAMP transitions, MAT follow-up) 2) Utilize shared staffing and community spaces to reduce overhead 3) Seek grant funding to support CHW expansion, youth programming, liaison roles, and employment supports."
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 • People with a disability • Residents of rural areas • Residents of Appalachian areas • Black residents • Hispanic residents • White residents • Youth (ages 17 and under) • Transition-aged adults (ages 18-24) • Older adults (ages 65+) • Veterans • Men • Women • Lesbian/Gay/Bisexual • Immigrants, refugees, or English language learners • Pregnant women with SUD • Parents with SUD with dependent children • People who use injection drugs (IDUs) • People involved in the criminal justice system
Capital Funding Needs	No

SMART Objective for Recovery Supports Priority Strategy			
Outcome Indicator	*"Percentage of individuals engaged in recovery support services who remain connected to at least one behavioral health or supportive service 90 days post-engagement."*		
Data Source	*"Recovery support logs, behavioral health provider records."*		
Baseline Year	2025	**Target Year**	2026
Baseline Data Value	50	**Target Data Value**	70

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

Criminal Justice Priority Strategy			
Priority Strategy	*"Expand access to low-barrier, injectable Medication-Assisted Treatment (MAT) for justice-involved individuals across Wayne and Holmes Counties, with a focus on rapid assessment and prompt initiation. This strategy will prioritize same-day or within-72-hour assessment following intake into jail, probation, or reentry programs, and transition away from oral MAT to long-acting injectables that support adherence and reduce diversion risk. Key components include: Rapid MAT Assessment and Initiation: Ensure individuals entering the criminal justice system are assessed for opioid use disorder within 72 hours of intake. Injectable MAT will be prioritized to reduce withdrawal symptoms, stabilize individuals, and prevent overdose. Transition from Oral to Injectable MAT: Shift protocols away from oral formulations toward long-acting injectables as the default option unless clinically contraindicated. This reduces the need for daily administration, minimizes diversion, and improves adherence. Contingency Management via Tablet-Based Incentives: Implement a contingency management program using the jail's existing tablet system. Individuals will earn commissary rewards for completing modules focused on: Overdose education; MAT engagement; Stigma reduction; and Peer recovery stories. This approach reinforces positive behavior, increases engagement with educational content, and supports motivation for treatment and recovery. Cross-System Coordination: Coordinate with jails, probation departments, courts, and reentry programs to embed MAT and contingency management into intake workflows. Ensure individuals receiving MAT while incarcerated are connected to community-based providers prior to release, with no gaps in medication or care. Stigma Reduction and Education: Provide training for corrections staff, probation officers, and judicial partners on the effectiveness of injectable MAT and contingency management. Peer recovery supporters and CHWs will be engaged to educate clients and support adherence. To remain fiscally responsible, we will: 1) Leverage existing MAT providers and mobile teams 2) Integrate MAT and contingency management into jail and reentry workflows 3) Utilize existing tablet infrastructure and shared staffing models 4) Seek grant funding to support injectable MAT access, tablet-based incentives, and care coordination."*		
Age Group(s)	• Transition-aged adults (ages 18-24) • Adults (ages 18-64) • Older adults (ages 65+)		
Priority Population(s) and Group(s) Experiencing Disparities	• Older adults (ages 65+) • People involved in the criminal justice system		
Capital Funding Needs	No		
SMART Objective for Criminal Justice Priority Strategy			
Outcome Indicator	*"Percentage of justice-involved individuals assessed for MAT within 72 hours of intake who initiate injectable MAT during incarceration."*		
Data Source	*"Jail intake records, MAT provider logs, contingency management tracking."*		
Baseline Year	2025	**Target Year**	2026
Baseline Data Value	35	**Target Data Value**	60

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

Pregnant Women with SUD Priority Strategy			
Priority Strategy	*"Strengthen and promote specialized treatment pathways for pregnant women with substance use disorders across Wayne and Holmes Counties, ensuring timely access to care, coordinated support, and sustained engagement throughout pregnancy and postpartum. OneEighty currently receives targeted funding to prioritize treatment for this population, and this strategy will focus on expanding visibility, improving referral pathways, and enhancing wraparound supports. Key Components: Priority Access to Treatment: Ensure pregnant women are fast-tracked into SUD treatment services at OneEighty and other providers, with same-day or next-day intake options. MAT, counseling, and case management will be tailored to meet the unique needs of pregnant clients, including coordination with OB/GYNs and prenatal care. Enhanced Outreach and Visibility: Develop a targeted outreach campaign to raise awareness of available services for pregnant women with SUD. Materials will be distributed through WIC offices, OB/GYN clinics, VSC, Pregnancy Care Center, Gabriel Project, hospitals, mobile crisis teams, and community health workers. Messaging will emphasize confidentiality, compassion, and the prioritization of care. Integrated Care Coordination: Establish cross-system coordination between SUD providers, prenatal care teams, child welfare, and community health workers to ensure seamless care. Shared care plans will be developed to support both maternal recovery and infant health outcomes. Family-Centered Supports: Offer parenting education, peer support, and recovery housing options that accommodate pregnant women and new mothers. Services will include transportation assistance, childcare coordination, and linkage to early childhood programs. Postpartum Engagement: Ensure continued support after delivery, including MAT maintenance, mental health care, and parenting support. CHWs and peer supporters will help maintain engagement and prevent relapse during the vulnerable postpartum period. To remain fiscally responsible, we will: 1) Leverage OneEighty's existing funding and infrastructure 2) Integrate outreach into current workflows (e.g., CHW visits, Navigator calls, hospital referrals) 3) Utilize shared staffing and community partnerships 4) Seek grant funding to support postpartum care and family stabilization."*		
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	*"Percentage of pregnant women with SUD referred to OneEighty who initiate treatment within 5 days of referral."*		
Data Source	*"Referral logs, OneEighty intake reports care coordination systems."*		
Baseline Year	2025	**Target Year**	2026
Baseline Data Value	50	**Target Data Value**	80

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

Parents with SUD with Dependent Children Priority Strategy			
Priority Strategy	*"Integrate Drug Endangered Children (DEC) programming (Anazao & Catholic Charities) into the continuum of care for parents with substance use disorders (SUD) and dependent children across Wayne and Holmes Counties. This strategy will focus on engaging adult clients with children through trusted providers like OneEighty and the Viola Startzman Clinic, connecting families to DEC-specific clinical services, parent-child supports, and community health resources. The goal is to break intergenerational cycles of substance use, trauma, and system involvement by embedding recovery into the family unit. Key Components: DEC Referral Integration: Embed DEC screening and referral protocols into intake and treatment workflows at OneEighty and Viola Startzman. Clinicians and community health workers will be trained to identify families eligible for DEC services and initiate warm handoffs to parent-child programming. Parent and Child Clinical Services: Expand access to trauma-informed, family-centered clinical services that address both parental SUD and child wellbeing. Services will include parenting education, family therapy, developmental screenings, and linkage to early childhood supports. Community Health Supports: Coordinate with CHWs to provide wraparound supports such as transportation, housing, nutrition, and childcare. These services will be tailored to meet the needs of families impacted by substance use and will be delivered in culturally responsive, accessible formats. Cross-System Collaboration: Partner with child welfare, juvenile courts, schools, and early intervention programs to ensure families are identified early and supported consistently. Shared care plans will be developed to reduce duplication and improve continuity across systems. Breaking the Cycle Through Engagement: Use DEC programming as a bridge to long-term recovery by engaging parents not only in treatment but in rebuilding safe, stable home environments. Peer supporters and CHWs will provide ongoing coaching and advocacy to help families navigate recovery and parenting simultaneously. To remain fiscally responsible, we will: 1) Leverage existing DEC infrastructure and provider networks 2) Integrate DEC protocols into current workflows (e.g., Navigator calls, CHW visits, OneEighty intake) 3) Utilize shared staffing and community partnerships 4) Seek grant funding to support family-centered care coordination and DEC expansion."*		
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 with SUD and dependent children engaged in treatment who are connected to DEC-related services within 30 days of intake."*		
Data Source	*"Intake records, DEC referral logs, CHW tracking systems."*		
Baseline Year	2025	**Target Year**	2026
Baseline Data Value	40	**Target Data Value**	70

Table 2A.10: Required Special Population – Youth

Youth Priority Strategy			
Priority Strategy	*"Establish a youth-centered continuum of care across Wayne and Holmes Counties by launching a Youth Advisory Committee under the Partnership for a Drug-Free Wayne and Holmes Counties, expanding youth peer programming, and creating a dedicated referral pathway for youth with substance use disorders (SUD) who require higher levels of care (LOC). This strategy ensures that youth voices shape local prevention and treatment efforts, while also addressing critical service gaps in engagement, navigation, and access to appropriate treatment. Key Components: Youth Advisory Committee Formation: Create a standing Youth Advisory Committee composed of diverse youth representatives from both counties. The committee will provide input on program design, outreach strategies, and system gaps, ensuring that services are responsive to the lived experiences and needs of young people. Youth Peer Support Programming: Expand peer-led recovery and prevention programming for youth, including mentorship, school-based groups, and community engagement. Peer supporters will be trained to provide age-appropriate, trauma-informed support and will work alongside MRSS teams, schools, and youth-serving agencies. Dedicated Referral Pathway for Higher LOC: Develop a clear, county-wide referral system for youth with SUD who require residential or intensive outpatient treatment. This system will include: A centralized point of contact for families and providers; Assistance with placement coordination and transportation; and Follow-up support to ensure continuity of care. This approach replaces the current practice of simply instructing families to "call around," which often leads to delays, frustration, and disengagement. Cross-System Collaboration: Coordinate with schools, juvenile courts, MRSS teams, and family support networks to identify youth in need of higher LOC and ensure timely, supported referrals. Shared care plans and warm handoffs will be prioritized. To remain fiscally responsible, we will: 1) Leverage existing youth-serving programs and peer networks 2) Integrate referral protocols into current workflows (e.g., MRSS, school counselors, Navigator calls) 3) Utilize shared staffing and telehealth platforms 4) Seek grant funding to support youth peer training, transportation, and care coordination."*		
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	*"Number of actionable recommendations generated by the Youth Advisory Committee that are adopted or implemented by local prevention or treatment partners annually."*		
Data Source	*"Committee meeting minutes, implementation logs, Partnership documentation."*		
Baseline Year	2025	**Target Year**	2026
Baseline Data Value	2	**Target Data Value**	5

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	*"Workforce Retention and Cross-Agency Collaboration – Support behavioral health workforce retention and system sustainability by promoting creative staffing solutions, shared resources, and structured collaboration across agencies. This strategy will reduce burnout, improve service continuity, and ensure that limited resources are used efficiently and strategically. Key Components: Pilot shared staffing models between agencies (e.g., rotating peer supporters, CHWs, or clinical specialists). Launch a workforce retention toolkit including mentorship programs, flexible scheduling options, and recognition strategies. Facilitate quarterly cross-agency collaboration meetings to align service delivery, reduce duplication, and share best practices. Promote joint initiatives that allow agencies to operate within their strengths while supporting system-wide goals."*		
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 • People with a disability • Residents of rural areas • Residents of Appalachian areas • Black residents • Hispanic residents • White residents • Youth (ages 17 and under) • Transition-aged adults (ages 18-24) • Older adults (ages 65+) • Veterans • Men • Women • Lesbian/Gay/Bisexual • Immigrants, refugees, or English language learners • Pregnant women with SUD • Parents with SUD with dependent children • People who use injection drugs (IDUs) • People involved in the criminal justice system		
Capital Funding Needs	No		
SMART Objective for Additional Local Priority Strategy			
Outcome Indicator	*"Percentage of behavioral health agencies participating in quarterly collaboration meetings that report improved staff retention or role satisfaction annually."*		
Data Source	*"Collaboration meeting logs, provider surveys, HR data."*		
Baseline Year	2025	**Target Year**	2026
Baseline Data Value	30	**Target Data Value**	60

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)].
  - *"No dispute resolution. Placement is an ongoing challenge- cost, lack of local or appropriate LOC placement options, lack of placement options that keep siblings together."*
- 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.
  - *"Tension between Ohio Rise and Local FCFC. Lacking resources."*
- 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.
  - *"Collaboration is strong however the solution is lacking."*

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.
  - *"When contacted, we engage in discharge planning."*
- 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.
  - Lack of communication/cooperation from state regional psychiatric hospital
  - Lack of access to state regional psychiatric hospital
- ADAMH Boards were then asked to explain how the Board is attempting to address those challenges.
  - *"Communication & outreach."*

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 through 2D.3 below outline this additional information.

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

First Group Experiencing Disparities			
Priority Population / Group Experiencing Disparities	• Youth (ages 17 and under)		
SMART Objective for First Group Experiencing Disparities			
Outcome Indicator	*"Number of actionable recommendations generated by the Youth Advisory Committee that are adopted or implemented by local partners annually."*		
Data Source	*"Youth Advisory Committee meeting minutes, Partnership documentation, implementation logs."*		
Baseline Year	2025	**Target Year**	2026
Baseline Data Value	2	**Target Data Value**	5

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

Second Group Experiencing Disparities			
Priority Population / Group Experiencing Disparities	• Transition-aged adults (ages 18-24)		
SMART Objective for Second Group Experiencing Disparities			
Outcome Indicator	*"Percentage of transition-aged adults assessed through mobile outreach who are successfully connected to the appropriate level of care within 72 hours."*		
Data Source	*"Mobile assessment team logs, referral tracking systems, intake records."*		
Baseline Year	2025	**Target Year**	2026
Baseline Data Value	50	**Target Data Value**	70

Table 2D.3: Optional – SMART Objective for Third Group Experiencing Disparities

Third Group Experiencing Disparities			
Priority Population / Group Experiencing Disparities	• Parents with dependent children		
SMART Objective for Third Group Experiencing Disparities			
Outcome Indicator	*"Percentage of parents with SUD and dependent children engaged in treatment who are connected to DEC-related services within 30 days of intake."*		
Data Source	*"Intake and treatment records from OneEighty and Viola Startzman Clinic, DEC referral and engagement logs, CHW tracking systems."*		
Baseline Year	2025	**Target Year**	2026
Baseline Data Value	40	**Target Data Value**	70

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: *"Community Health."*	*"Expansion of Community Health Program."*	*"Viola Startzman."*	• 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 • Youth (ages 17 and under) • Transition-aged adults (ages 18-24) • Older adults (ages 65+) • Veterans • Men • Women • Lesbian/Gay/Bisexual • Immigrants, refugees or English language learners • Pregnant women • Parents with dependent children • People who use injection drugs (IDUs) • People involved in the criminal justice system	*"Percentage increase in individuals engaged through community health outreach (e.g., CHWs, mobile teams, health hubs) who are successfully connected to behavioral health or supportive services within 30 days."*
Specify: *"Mentoring/Life skills."*	*"Mentoring/Life skills."*	*"O'Huddle & Goodwill."*	• Youth (ages 17 and under)	*"Percentage of youth enrolled in mentoring or life skills programs who demonstrate improvement in self-*

				efficacy, decision-making, or goal-setting within 90 days of engagement."
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.

- *"To evaluate progress on the SMART objectives, the Board will implement a structured, multi-part evaluation plan that includes quantitative and qualitative data collection, cross-sector collaboration, and regular reporting cycles. Data Sources: Evaluation will rely on existing systems including crisis service logs, referral tracking systems, provider intake records, Youth Advisory Committee minutes, CHW and peer support logs, and agency HR surveys. These sources are already in use by partner agencies and will be standardized for consistency. Data Collection Methods: 1) Monthly extraction of service utilization and referral data from electronic records 2) Pre/post surveys for mentoring, life skills, and training programs 3) Quarterly provider surveys on workforce retention and satisfaction 4) Meeting documentation and implementation tracking for Youth Advisory Committee recommendations 5) Manual tracking for DEC-related service connections and MAT initiation timelines. Partners Involved: Evaluation will be coordinated by the Board in partnership with OneEighty, Viola Startzman Clinic, the Partnership for a Drug-Free Wayne & Holmes Counties, local schools, child welfare agencies, law enforcement, and behavioral health providers. Each partner will designate a data liaison to support collection and validation. Timeline: Monthly: Data extraction and review for service connection indicators. Quarterly: Collaboration meeting logs and provider surveys. Biannually: Youth Advisory Committee recommendation tracking. Annually: Comprehensive review of all SMART objectives and progress toward targets. Sharing and Use of Results: Evaluation findings will be shared through quarterly stakeholder meetings, annual community reports, and targeted presentations to funders and advisory groups. Data will be used to adjust programming, inform funding decisions, and identify gaps in service delivery. Disaggregated data will guide equity-focused improvements for youth, transition-aged adults, parents with dependent children, and rural residents."*

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.

- *"www.whmhrb.org"*

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).

- *"Previously linked."*

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.

- *"Meet bi-monthly- core group of community stakeholders."*

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		No	No	No
Behavioral Health Urgent Care		No	No	No
Crisis Intervention with Observation		No	No	No
Crisis Residential Services	X			
Inpatient Psychiatric Services		No	No	No
Withdrawal Management	X			
SUD Crisis Residential		No	No	No
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.

- *"Fragmented communication, working to improve. Prior to the beginning of October [2025] the communication was essentially non-existent; however intentional efforts are being made to improve and better collaborate."*

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.

- *"Services for Dual Dx Crisis Stabilization. The target population is individuals experiencing a mental health crisis. Wait times for Psych beds continue to be a critical concern. Funding for indigent clients is an additional concern."*

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	$375,193	$300,000	$250,000
Local Grants *(grants not funded via DBH)*	$0	$0	$0
State GRF	$949,765	$949,765	$949,765
5TZ0	$0	$0	$0
DBH Funded Grants (non-GRF)	$97,000	$97,000	$97,000
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.

- *"The Board will continue to gather data and analyze the information to better serve the communities. Specialized Crisis Response Protocol for Dual Diagnosis Clients: A critical enhancement to the crisis services continuum in Wayne and Holmes Counties is the development and implementation of specialized response protocols for individuals with dual diagnoses — particularly those experiencing psychosis triggered by substance use. Currently, these individuals are often treated solely for mental health symptoms, while the underlying substance use disorder remains unaddressed. This fragmented approach leads to repeated crises, poor outcomes, and missed opportunities for stabilization and recovery. Key Components of the Strategy: Integrated Screening and Assessment: All mobile crisis teams, MRSS responders, hospital staff, and QRT members will be trained to recognize signs of substance-induced psychosis and co-occurring disorders. Crisis assessments will be updated to include validated screening tools for both mental health and substance use, ensuring that dual diagnoses are identified in real time. Dual Diagnosis Response Protocols: Develop standardized workflows for responding to dual diagnosis presentations, including immediate linkage to both mental health and SUD services. Ensure that crisis stabilization plans include coordination with MAT providers, outpatient SUD programs, and peer recovery supports. Create shared care plans that follow the individual across systems, reducing duplication and improving continuity. Hospital-Based Coordination: Individuals presenting in emergency departments or detoxing at the WCH RAMP Program will be assessed for dual diagnosis and transitioned directly to integrated care. OneEighty and other providers with dual-capable teams will be engaged at the point of crisis, not days later, to reduce risk and improve engagement. Cross-Training and Workforce Development: Provide ongoing training for crisis responders, clinicians, and peer specialists on dual diagnosis best practices, trauma-informed care, and cultural responsiveness. Build capacity for dual diagnosis response*

within existing teams rather than creating siloed roles. Post-Crisis Engagement and Prevention: Every dual diagnosis crisis will trigger a prevention follow-up plan, including psychoeducation, peer support, and family engagement. Community health referrals will be used to address social determinants that contribute to repeated crises (e.g., housing, transportation, food insecurity).”

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.

- *“Outcome Indicators: Increased identification of dual diagnosis during crisis response. Increased number of individuals with dual diagnosis receiving integrated follow-up care. Reduced repeat crisis episodes among dual diagnosis clients. Increased direct transitions from hospital or detox to dual-capable treatment providers. Improved coordination across mental health and SUD systems.”*