2023-2025 Community Assessment and Plan

ADAMHS Board of Erie County

Ms. Diane Taylor – Executive Director

Background and Statutory Requirements

The new Community Assessment and Plan (CAP) process is designed to better support policy development, strategic direction, strategic funding allocation decisions, data collection and data sharing, and strategic alignment at both the state and community level. This planning process balances standardization and flexibility as the Alcohol, Drug Addiction, and Mental Health (ADAMH) Boards identify unmet needs, service gaps, and prioritize community strategies to address the behavioral health needs in their communities. Included in these changes is an increased focus on equity and the social determinants of health that are now imbedded in all community planning components.

Based on the requirements of Ohio Revised Code (ORC) 340.03, the community 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 boards shall include treatment and prevention services when setting priorities for addiction services and mental health services.

The Ohio Department of Mental Health and Addiction Services (OhioMHAS) has redesigned the CAP to support stronger alignment to the 2021-2024 OhioMHAS Strategic Plan, and 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. The new community planning model has at its foundation a data-driven structure that allows for local flexibility while also providing standardization in the assessment process, identification of disparities and potential outcomes.

Required Components of the CAP

Assessment – OhioMHAS encourages the ADAMH Boards to use both quantitative and qualitative data collection methods and to partner with other organizations, such as local health departments, tax-exempt hospitals, county FCFCs, community stakeholders, and individuals served to conduct the assessment. During the assessment process, ADAMH Boards are requested to use data and other information to identify mental health and addiction needs, service gaps, community strengths, environmental factors that contributes to unmet needs, and priority populations that are experiencing the worst outcomes in their communities (disparities)

Plan – ADAMH Boards develop a plan that identifies local priorities across the behavioral health continuum of care that addressed unmet needs and closed 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.

Legislative Requirements – This new section of the CAP is reserved to complete and/or submit statutorily required information. The use of this section may vary from plan-to-plan.

Continuum of Care Service Inventory – ADAMH Boards are required to identify how ORC-required continuum of care services (340.033 and 340.032 Mid-Biennial Review) are provided in the community. This information is to be completed via an external Excel spreadsheet.

Contents

CAP Plan Highlights – Continuum of Care Priorities and Age Groups of Focus

The CAP Plan priorities section is organized across the behavioral health continuum of care and two special populations. Each of the Plan continuum of care priority areas will be defined on the following pages. The information in this CAP Plan will also include the Board's chosen strategy identified to address each priority, the population of focus, identification of potential populations experiencing disparities, the chosen outcome indicator to measure progress ongoing, and the target the Board is expecting to reach in the coming years.

For each identified strategy, the Board was requested to identify the age groups that are the focus for each identified CAP Plan strategy. These age groups include Children (ages 0-12), Adolescents (ages 13-17), Transition-Aged Youth (ages 14-25), Adults (ages 18-64), and Older Adults (ages 65+). The table below is an overview of which ages are the focus of each priority across the continuum of care.

Continuum of Care Priorities	**Children** (ages 0-12)	**Adolescents** (ages 13-17)	**Transition-Aged Youth** (ages 14-25)	**Adults** (ages 18-64)	**Older Adults** (ages 65+)
Prevention	●	●			
Mental Health Treatment	●	●			
Substance Use Disorder Treatment				●	●
Medication-Assisted Treatment				●	
Crisis Services	●	●	●	●	●
Harm Reduction		●	●	●	●
Recovery Supports		●		●	●
Pregnant Women with Substance Use Disorder		●		●	
Parents with Substance Use Disorder with Dependent Children	●	●			

CAP Plan Highlights – Continuum of Care Priorities

→ ***Prevention***: *Prevention services are a planned sequence of culturally relevant, evidenced-based strategies, which are designed to reduce the likelihood of or delay the onset of mental, emotional, and behavioral disorders. **

- **Strategy:** Increase capacity for youth and families to engage in community, behavior, health, wellness, and safety planning. Currently, Erie County does not have a suicide prevention program. The Board will partner with Huron County to identify a suicide prevention programming provider.
- **Age Group(s) Strategy Trying to Reach:** Children (ages 0-12), Adolescents (ages 13-17)
- **Priority Populations and Groups Experiencing Disparities:** Residents of Rural Areas, Black Residents, Older Adults (ages 65+)
- **Outcome Indicator(s):** Percentage or number of children that are considered high risk for suicide
- **Baseline:** Establish baseline
- **Target:** Decrease baseline by 25% by 2025

→ ***Mental Health Treatment***: *Any care, treatment, service, or procedure to maintain, diagnose, or treat an individual's condition or mental health.*

- **Strategy:** Enhanced evidenced-based treatment for children that have been expelled or suspended from local schools.
- **Age Group(s) Strategy Trying to Reach:** Children (ages 0-12), Adolescents (ages 13-17)
- **Priority Populations and Groups Experiencing Disparities:** People with a Disability, Residents of Rural Areas, Black Residents
- **Outcome Indicator(s):** Percentage of K- 12 Children that have been expelled from school or suspended
- **Baseline:** 41%
- **Target:** 5% decrease by 2024

**All definitions of the BH Continuum of Care are from Ohio Revised Code (ORC) and Ohio Administrative Code (OAC)*

CAP Plan Highlights – Continuum of Care Priorities Cont.

→ ***Substance Use Disorder Treatment***: *Any care, treatment, or service to treat an individual's misuse, dependence, and addiction to alcohol and/or legal or illegal drugs.*

- **Strategy:** Increase the number of individuals receiving ASAM-appropriate treatment services by tracking intake vs completion rate and providing feedback to providers. Staff will provide evidence-based services.
- **Age Group(s) Strategy Trying to Reach:** Adults (ages 18-64), Older Adults (ages 65+)
- **Priority Populations and Groups Experiencing Disparities:** People with Low Incomes or Low Educational Attainment, Residents of Rural Areas, Black Residents, Older Adults (65+)
- **Outcome Indicator(s):** Substance Use Disorder Treatment Retention Rates
- **Baseline:** 2021 baseline of noncompliance - 21%
- **Target:** 10% increase in individuals successfully completing SUD treatment by 2025

→ ***Medication-Assisted Treatment***: *Alcohol or drug addiction services that are accompanied by medication that has been approved by the USDA for the treatment of substance use disorder, prevention of relapse of substance use disorder, or both.*

- **Strategy:** Track appropriate referrals to MAT services
- **Age Group(s) Strategy Trying to Reach:** Adults (ages 18-64)
- **Priority Populations and Groups Experiencing Disparities:** People with Low Incomes or Low Educational Attainment, People with a Disability, Residents of Rural Areas, Black Residents, White Residents, Older Adults (ages 65+), Veterans, Men, Women, People Involved in the Criminal Justice System
- **Outcome Indicator(s):** Number of MAT referrals to providers that serve Erie County residents
- **Baseline:** 2021 clients served in MAT programming - 125
- **Target:** Streamline referral process and increase cross service collaboration by 2024; Increase the number of referrals to MAT services by 10% by 2025

CAP Plan Highlights – Continuum of Care Priorities Cont.

→ ***Crisis Services***: *Any service that is available at short notice to assist an individual to resolve a behavioral health crisis or support an individual while it is happening.*

- **Strategy:** Update the Local Crisis Continuum by working with our Regional providers. Assess the crisis system and identify gaps in services.
- **Age Group(s) Strategy Trying to Reach:** Children (ages 0-12), Adolescents (ages 13-17). Transition-Aged Youth (14-25), Adults (ages 18-64), Older Adults (ages 65+)
- **Priority Populations and Groups Experiencing Disparities:** People with Low Incomes or Low Educational Attainment, People with a Disability, Residents of Rural Areas, Black Residents, White Residents, Older Adults (ages 65+), Veterans, Men, Women, LGBTQ+
- **Outcome Indicator(s):** Identification of Gaps in services and work with Regional partners to fill gaps via the creation of a crisis services infrastructure plan.
- **Baseline:** Lack of crisis continuum. Erie County does not have Mobile Outreach or Residential Crisis support.
- **Target:** Increase participation in Regional collaboration to create a crisis services infrastructure plan to fill gaps by 2025
- **Next Steps and Strategies to Improve Crisis Continuum:** Identify gaps in Crisis services and develop a crisis group to begin addressing the issues.

→ ***Harm Reduction***: *A set of practical strategies and ideas aimed at reducing negative consequences associated with drug use.*

- **Strategy:** Reduce overdose death by increasing access to overdose prevention information and harm reduction protocols
- **Age Group(s) Strategy Trying to Reach:** Adolescents (ages 13-17), Transition-Aged Youth (ages 14-25), Adults (ages 18-64), Older Adults (ages 65+)
- **Priority Populations and Groups Experiencing Disparities:** People with Low Incomes or Low Educational Attainment, Residents of Rural Areas, Black Residents, Older Adults (ages 65+), Veterans, Men, Women
- **Outcome Indicator(s):** The number and location of material distributed; Overdose by city; and Unintentional overdose death rate via ODH
- **Baseline:** 2021 overdose rate - 305
- **Target:** Increase by 10% the number of resources distributed and distribution location by 2025; 5% reduction in overdoses and overdose deaths

CAP Plan Highlights – Continuum of Care Priorities Cont.

→ ***Recovery Supports***: *Services that promote individual, program, and system-level approaches that foster health and resilience (including helping individuals with behavioral health needs to "be well," manage symptoms, and achieve and maintain abstinence).*

- **Strategy:** Increase the number of Recovery support opportunities for those suffering from a mental illness or co-occurring disorder.
- **Age Group(s) Strategy Trying to Reach:** Adolescents (ages 13-17), Adults (ages 18-64), Older Adults (ages 65+)
- **Priority Populations and Groups Experiencing Disparities:** People with a Disability, Residents of Rural Areas, Black Residents, White Residents, Older Adults (ages 65+), Veterans, Men, Women
- **Outcome Indicator(s):** Ensure 100% of Recovery housing meet standard. Ensure 100% of all housing funded by the board meets 90% of standards.
- **Baseline:** 2021 data – 82%
- **Target:** 100% Recovery housing 90% all other funded housing that meets current standards by 2025

CAP Plan Highlights - Special Populations

Due to the requirements of the federal Mental Health and Substance Abuse and Prevention Block Grants, the Board is required to ensure that services are available to two specific populations: Pregnant Women with Substance Use Disorder, and Parents with Substance Use Disorder with Dependent Children.

→ ***Pregnant Women with Substance Use Disorder:***

- **Strategy:** Develop a baseline data source
- **Age Group(s) Strategy Trying to Reach:** Adolescents (ages 13-17), Adults (ages 18-64)
- **Priority Populations and Groups Experiencing Disparities:** People with a Disability Residents of Rural Areas, Black Residents, White Residents, Veterans, Women
- **Outcome Indicator(s):** Establish baseline data of pregnant women living in Erie County that have a SUD diagnosis. Track the type of services and identify service gaps.
- **Baseline:** 12% used some type of drugs or alcohol
- **Target:** 10% by 2024

CAP Plan Highlights - Special Populations Cont.

→ ***Parents with Substance Use Disorder with Dependent Children:***

- **Strategy:** Enhance Recovery support for Parents with substance use disorder with dependent children. The county has a limited number of parenting and support services for this population.
- **Age Group(s) Strategy Trying to Reach:** Children (ages 0-12), Adolescents (ages 13-17)
- **Priority Populations and Groups Experiencing Disparities:** People with Low Incomes or Low Educational Attainment, Residents of Rural Areas, Black Residents, White Residents, Men, Women
- **Outcome Indicator(s):** Percentage of parents with unmet needs for Recovery support and parenting skills.
- **Baseline:** Of those that were pregnant 48% experience depression
- **Target:** Identify those in need of parental support by 2025

Optional: Collective Impact to Address Social Determinants of Health

→ ***Stigma, Racism, Ableism, and Other Forms of Discrimination:***

- **Community Partners:** Local health district(s), County Health Commissioner
- **Strategy:** Work in collaboration with the local health department to address, stigma, health-related issues, and outreach in the community
- **Priority Populations and Groups Experiencing Disparities:** People with Low Incomes or Low Educational Attainment, Residents of Rural Areas, Black Residents, White Residents, Older Adults (ages 65+), Men, Women, General Populations
- **Outcome Indicator:** Stigma, racism, ableism and other forms of discrimination
- **Baseline:** Baseline will be established
- **Target:** Increase by 10% the number of community partners working to reduce stigma by 2025

Optional: Collective Impact to Address Social Determinants of Health Cont.

→ ***Social Norms About Alcohol and Other Drug Use:***

- **Community Partners:** Local prevention coalition(s) (suicide, tobacco, Drug Free Community, etc.), Community foundation MH sub-committee, Behavioral Health Providers, and consumers
- **Strategy:** Establish a local suicide prevention coalition
- **Priority Populations and Groups Experiencing Disparities:** People with Low Incomes or Low Educational Attainment, Residents of Rural Areas, Black Residents, Men, Women, LGBTQ+
- **Outcome Indicator:** Number of services and supports provided to the community
- **Baseline:** Establish baseline
- **Target:** Increase the number of services and support by 10% by 2025

→ ***Family Disruptions (divorce, incarceration, parent deceased, child removed from the home, etc.):***

- **Community Partners:** Family and Children First Council(s), Executive Director and Family and Children First Executive Committee
- **Strategy:** Decrease the number of children in out-of-state placement due to the complexities of their behaviors. Work in collaboration to meet the needs of high-end children
- **Priority Populations and Groups Experiencing Disparities:** People with Low Incomes or Low Educational Attainment, Residents of Rural Areas, Black Residents, White Residents
- **Outcome Indicator:** Unmet mental health care needs. Percent of children with unmet mental health care needs
- **Baseline:** 2021 baseline - 48
- **Target:** Decrease the number of out-of-state placements by 10% by 2025

Optional: SMART Objectives for Priority Populations and Groups Experiencing Disparities

→ ***Residents of Rural Areas:***

- **Strategy:** Increase outreach to rural citizens
- **Outcome Indicator:** Percent of services provided to rural citizens
- **Baseline:** 9%
- **Target:** 1% by 2024

→ ***Black Residents:***

- **Strategy:** Increase outreach to black residents
- **Outcome Indicator:** Percentage of services provided to black residents
- **Baseline:** 9%
- **Target:** Establish target by 2024

→ ***Older Adults:***

- **Strategy:** Increase outreach to older adults
- **Outcome Indicator:** Percent of services provided to older adults
- **Baseline:** 9%
- **Target:** Establish target by 2024

CAP Plan Highlights - Other CAP Components

→ ***Family and Children First Councils:***

- **Service Needs Resulting from Finalized Dispute Resolution Process:** None noted
- **Collaboration with FCFC(s) to Serve High Need Youth:** The Board is a member of the county FCFC and the executive director is on the executive council. This has allowed the board to have strategic input into its planning process.
- **Collaboration with FCFC(s) to Reduce Out-of-Home Placements:** The board contributes funding for children that needs out-of-home placement. The board representative provides recommendations regarding alternatives to out-of-home placement.

→ ***Hospital Services:***

- **Identify How Outpatient Service Needs Are Identified for Current Inpatient Private or State Hospital Individuals Who Are Transitioning Back to the Community:** The board has a contract with a local Provider to monitor the transition back to the community and they submit a quarterly report.
- **Identify What Challenges, If Any, Are Being Experienced in This Area:** Lack of access to state regional psychiatric hospital
- **Explain How the Board is Attempting to Address Those Challenges:** The board meets with local and state hospitals to discuss the challenges of capacity.

→ ***Optional: Data Collection and Progress Report Plan:***

- Erie County is a new board we are in the process of developing strategies for data collection.

CAP Assessment Highlights

As part of the CAP Assessment process, the Board was required to consider certain elements when conducting the assessment. Those elements included identifying community strengths, identifying mental health and addiction challenges and gaps, identifying population potentially experiencing disparities, and how social determinants of health are impacting services throughout the board area. The Board was requested to take these this data and these elements into consideration when developing the CAP Plan.

→ ***Most Significant Strengths in Your Community:***

- Collaboration and Partnerships
- Engaged Community Members
- Faith-Based Communities

→ ***Mental Health and Addiction Challenges:***

Top 3 Challenges for Children Youth and Families

- Mental, Emotional, and Behavioral Health Conditions in Children and Youth (overall)
- Youth Depression
- Youth Marijuana Use

Top 3 Challenges for Adults

- Adult Serious Mental Illness
- Adult Depression
- Adult Substance Use Disorder

Populations Experiencing Disparities

- Residents of Rural Areas, Black Residents, Older Adults (ages 65+)

→ ***Mental Health and Addiction Service Gaps:***

Top 3 Service Gaps in the Continuum of Care

- Crisis Services
- Mental Health Workforce
- Substance Use Disorder Treatment Workforce

Top 3 Access Challenges for Children Youth and Families

- Unmet Need for Mental Health Treatment
- Unmet Need for Major Depressive Disorder
- Lack of Follow-Up Care for Children Prescribed Psychotropic Medications

Top 3 Challenges for Adults

- Unmet Need for Mental Health Treatment
- Unmet Need for Outpatient Medication-Assisted Treatment
- Low SUD Treatment Retention

Populations Experiencing Disparities

- Residents of Rural Areas, Black Residents, Older Adults (ages 65+), People Involved in the Criminal Justice System

→ ***Social Determinants of Health:***

Top 3 Social and Economic Conditions Driving Behavioral Health Challenges

- Stigma, Racism, Ableism, and Other Forms of Discrimination
- Social Norms About Alcohol and Other Drug Use
- Family Disruptions (divorce, incarceration, parent deceased, child removed from home, etc.)

Top 3 Physical Environment Conditions Driving Behavioral Health Challenges

- Lack of Affordable of Quality Housing
- Lack of Transportation
- Food Insecurity

Populations Experiencing Disparities

- People with Low Incomes of Low Educational Attainment, Residents of Rural Areas, Black Residents, Older Adults (ages 65+)