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

ASSESSMENT

Overview

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

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

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

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

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

Template

Board name	Mental Health and Recovery for Licking and Knox Counties
Date	

Key

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

Mental health and addiction needs

Sources

In developing the CAP, MHR has incorporated the following local assessments in addition to the secondary information provided by OhioMHAS and available from other state and federal sources. Below is a representation of local planning processes the board engaged in to meet its statutory CAP requirement. Some titled documents have been labeled (MHRLK CAP Assessment #) and submitted to OhioMHAS as addendums via email. Other are available on the organization's website.

- MHR SFY23 SFY25 Strategic Plan & Development Process (MHRLK CAP Assessment 1)
- Licking County Family & Children First Council SFY23 – SFY25 Shared Plan Development Process (MHRLK CAP Assessment 5 & 6)
- The Knox County HRSA RCORP Opioid Response Program Implementation and Psychostimulant Grants Data Collection and Outcome Management & the HRSA RCORP BH Grant Development Process (MHRLK CAP Assessment 7 – 10)
- Knox Public Health & the Knox Health Planning Partnership – SFY23 – SFY25 Community Health Assessment & Community Health Improvement Plan (MHRLK CAP Assessment 2). MHR chairs the CHIP Behavioral Health Work Group. The full CHA and CHIP may be viewed at https://www.knoxhealth.com
- Licking County Health Department (LCHD) Drug Overdose Prevention Coalition & Overdose Fatality Review Board (MHRLK CAP Assessment 3 & 4). The LCHD CHIP may be found at https://lickingcohelath.org LCHD is currently working on its SFY23 – SFY25 CHIP. The MHR Executive Director is the chair of the Behavioral Health Work Group.
- Knox RCORP Behavioral Health Disparities Impact Statement (MHRLK CAP Assessment 11)
- Knox County Family and Children First Council Shared Plan for SFY2023 – 2025 (MHRLK CAP Assessment 12)
- Licking County Job and Family Services – Children Services Division 2019 - 2021 Summary Performance Reports (MHRLK CAP Assessment 13)
- OHYES! Report for Licking County – 2020-2021 may be found at https://ohyes.ohio.gov

Information from these community processes and coalitions plus other sources was used to complete the CAP community assessment. Coalitions include a very wide representation of the community with members across service sectors, businesses, the criminal justice system, law enforcement, education, health care, and people with lived and shared experiences. Evidence of MHR participation including coalition meeting minutes, surveys, and outcome reports has been submitted as a separate addendum to OhioMHAS in a series of emails. In addition, MHR circulated the actually CAP survey to appropriately 50 community members with 16 returned responses.

Other sources of information were collected outcome results from various OhioMHAS sponsored grants and funding opportunities including ATP, CTP, SFSC, Emergency COVID funding, hospital diversion funding, legislative withdrawal management and crisis stabilization funding, and SOR. Additional information for crisis services was taken from the CAP Legislative Report submitted in October 2022 and the Ohio BH Crisis Services Data Collection Report (October 2021). Patterns of service utilization for multi-system youth served by wrap-around family teams in both counties was analyzed as were trends identified by multi-system adult teams, QRT teams, and special docket court treatment teams. Information was also used from MHR SFY21 – SFY22 Performance Targets and Outcomes Measures provider annual reports.

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

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

OhioMHAS Provided County Population Data

Prevalence Measure	Knox County	Licking County	State
Prevalence of serious mental illness (estimated number and percent from NSDUH)	7.83%	7.38%	6.6%
Prevalence of serious psychological distress (estimated number and percent from NSDUH)	27.18%	27.18%	23.84
Prevalence of substance use disorders (estimated number and percent from NSDUH)	7.14%	7.14%	7.52%

Prevalence Measure	Knox County	Licking County	State
Youth suicide deaths (number and rate from ODH Vital Statistics)	2	1	99
Adult suicide deaths (number and rate from ODH Vital Statistics)	14.9 (per 100,000)	16.3 (per 100,000)	15.1 (per 100,000)
Unintentional drug overdose deaths (number and rate from ODH Vital Statistics)	<10	23.8 (per 100,000)	35.4 (per 100,000)
Heavy drinking (BRFSS county-level pooled-year data from ODH)	5.3%	6.8%	6.5%
Binge drinking (BRFSS county-level pooled-year data from ODH)	17.2%	17.6%	17.3%
Poor mental health days (BRFSS county-level pooled-year data from ODH; our CHR)	13.5%	15.8%	14.7%
Physical inactivity (BRFSS county-level pooled-year data from ODH	27.9%	28%	26.7%

SOR 2.0 Grant Disparities Narrative

In additional to the comparison data provided by OhioMHAS, MHR used information collected to develop a disparities narrative and plan for the SOR 2.0 grant submission in its CAP community assessment. Information included in the statement has been collected from the same sources during the same time period as provided by OhioMHAS for the CAP. That ranges from 2016 – 2022.

Social and demographic factors: The MHR Licking-Knox service district is impacted by a variety of social determinants of health especially related to poverty and lower income. Knox County, (est. 62,897 pop.) has 10,378 (16.5%) enrolled in Medicaid and Licking County, (est. 180,401 pop.) with 27,781 (15.4%), enrolled. (2022-2023). In Knox County, 13.4% and 11.1% in Licking County face severe housing problems. At total of 12.5% people in Knox and 9.75% in Licking live in poverty, with 16.7% (Knox) and 12.4% (Licking) of children also living in poverty. (2021-2022). An estimated 21.9% of Knox residents (12,600) and 20.0% in Licking County (33,299) live at or below 150% of poverty. (U.S. Census Bureau: 2013-2017 American Community Survey 5-Year Estimates). (ODJFS, Ohio Labor Market Information, Ohio Unemployment Rates; June 2020 rate not seasonally adjusted) In SFY22, approximately 3.7 million dollars (local, state, and federal funding) was used to provide non-Medicaid treatment services to almost 3000 adults and nearly 290 children living often at or below 200% of the poverty level representing 33% of MHR's total expenditures. The group predominately contains working poor

families. This may include individuals not qualifying for expansion or unable to take advantage of other ACA benefit options, those excluded from using third-party policies due to restrictions related to court ordered addiction treatment, adults and families who could not afford the high deductibles and co-pays of policies purchased on the exchange, and families needing case management services and other supports for children not covered by insurance.

The United Way of Licking County Community Blueprint cited their first priority as focusing "on addressing addiction, child abuse and neglect, domestic violence, and mental health by increasing awareness and access of behavioral health resources." The Knox CHA reported 7% or 3,159 Knox County adults used medication not prescribed for them or taking more than prescribed to feel good, high, more active, and/or alter mood during the past 6 months increasing to 14% for those with incomes less than $25,000. About 31% of Americans in poverty say they have at some point been diagnosed with depression compared with 15.8% that are not in poverty. (2011 Gallup Healthways Well-Being Index). Economic hardship is the most common adverse childhood experience (ACE) reported nationally and in almost all states, followed by divorce or separation of a parent or guardian. (2014 Child Trends Research Brief). Nationally, it is estimated that one in four children experience economic hardship. The four most common ACE experiences among children ages birth through 17 in Ohio include: Economic Hardship (27%), divorce (15%), violence (13%), and alcohol (12%). Knox County CHA reported 13% of adults surveyed experienced 4 or more adverse childhood experiences (ACES). In the 2017-2018 OYES Report for Licking County Schools of the 2224 students surveyed 309 students reported 4 or more ACES (14%) with 1057 reporting at least one (47%). Untreated depression and anxiety increases the chance of risky behaviors such as drug or alcohol abuse or the self-medication of symptoms leading to potential addiction. The Anxiety and Depression Association of America estimates 20% of Americans with an anxiety or mood disorder such as depression have an alcohol or other substance use disorder, and 20% percent of those with an alcohol or substance use disorder also have an anxiety or mood disorder.

In Knox County, percentages of people served in the system of care from different racial/ethnic groups are representative of the general population. There is a slight disproportional increase in the percentage of some minority groups in Licking County receiving services and a decrease in the number of Caucasians engaged in care. Percentages have been rounded.

	Licking		Knox	
	% of the Total Population*	% Served in the Public System of Care**	% of the Total Population*	% Served in the Public System of Care**
African - American	4%	8%	1%	1.5%
Asian	2%	7%	.<1%	0%
Caucasian	91%	84%	97%	98%
Hispanic/Latino	3%	2%	1.6%	1.5%

*Ohio Census Bureau – Quick Facts

**MHR Contract Provider SFY21 BAP Application Data for Identified Demographic Groups Receiving Care per Total Number Served

Percentages of people served to date in SFY21 (984) by primary MHR contract SUD providers also suggest that this group is representative of the general population: African-American (3%), Caucasian (94%), Hispanic/Latino (2%), Native American (less than 1%), and other (less than 1%). By gender, 71% were male, 29% were female, and .3% were unknown. 66% qualified for Medicaid under 138% of poverty. (SFY21 GOSH Service Data). It is estimated that 4.3% of Licking and Knox Counties identifies with the LGBTQ+ community. These prevalence estimates are based on self-reporting from the approximate 4.3% of Ohioans identifying with this population (Williams Institute –UCLA).

HRSA RCORP Behavioral Health Disparities Impact Statement
As the project lead, MHR, on behalf of the Knox Opioid Response and Recovery (KORR) Consortium, recently completed a disparities assessment and plan for the HRSA RCORP grants. (MHRLK CAP Assessment 11). The KORR Consortium will place their focus on several subpopulations and the disparities that keep them from accessing care. This work is incorporated in the CAP plan priorities and has been generalized for both counties. The subpopulations include adults with co-occurring addition and mental illness, adults with addiction involved in the criminal justice system, and pregnant women with addiction.

Additional Findings
Below are additional findings used as part of the CAP community assessment and in developing the plan.

Prevalence rates from the National Survey on Drug Use and Health (NSDUH) In 2020, NSDUH changed methods used in collecting data and information including the introduction of DSM IV and shift to web based interviewing while experiencing a disruption in collection during the pandemic. SAMHSA suggests care when attempting to 'disentangle' the effects on 2020 estimates due to real changes in the population (e.g. impact of COVID – 19) and revised research methods. Prevalence rates for 2019 are included as comparison.

SUD Prevalence

Measure	Rural County		Midwest Region		United States		Data Source(s)
Prevalence or incidence of SUD in the target rural population, by type:*	**2019**	***2020***	**2019**	***2020***	**2019**	***2020***	**National Survey on Drug Use and Health (NSDUH) 2019, 2020**
Alcohol (heavy consumption)	5.8%	*8.2%*	7.1%	*8.5%*	6.3%	*7.0%*	
Psychostimulants			.				
Methamphetamine	1.0%	*.3%*	.8%	*.9%*	.8%	*1.0%*	
Prescription CNS Stimulants (misuse)	2.2%	*.6%*	3.9%	*3.8%*	3.9%	*4.0%*	
Opioids	3.0%	*.7%*	4.0%	*3.2%*	3.8%	*3.6%*	

Measure	Rural County		Midwest Region		United States		Data Source(s)
Other substances—please specify Marijuana	12.3%	*7.5%*	18.6%	*19.9%*	18.0%	*18.7%*	

MH Prevalence

Measure	Rural County		Midwest Region		United States		Data Source(s)
Prevalence or incidence of MH in the target rural population, by occurrence	**2019**	***2020***	**2019**	***2020***	**2019**	***2020***	**National Survey on Drug Use and Health (NSDUH) 2019, 2020**
Any Mental Illness	16.7%	*15.2%*	22.1%	*22.8%*	20.6%	*21.0%*	
Serious Mental Illness	5.2%	*4.3%*	5.6%	*6.6%*	5.2%	*5.6%*	
Co-occurring with any mental illness	N/A	*2.5%*	N/A	*7.5%*	N/A	*6.7%*	
Co-occurring with serious mental illness	N/A	*.2%*	N/A	*3.1%*	N/A	*2.2%*	

Other Significant Prevalence Measures

Measure: National prevalence or incidence of suicide by occurrence of usage type							Data Source
	Serious Thoughts		Plans		Attempts		**National Survey on Drug Use and Health (NSDUH) 2019, 2020**
	2019	***2020***	**2019**	***2020***	**2019**	***2020***	
Alcohol	5.3%	*5.2%*	1.6%	*1.3%*	.6%	*.5%*	
Psychostimulants							
Methamphetamine	21.3%	*19.6%*	7.4%	*8.8%*	3.2%	*4.7%*	
Other Stimulants	17.3%	*17.2%*	6.5$	*4.3%*	2.7%	*2.5%*	
Opioids	15.3%	*17.7%*	6.0%	*6.1%*	2.5%	*3.1%*	
Heroin	21.4%	*N/A*	10.6%	*N/A*	4.1%	*N/A*	
Marijuana	11%	*11.1%*	3.5%	*3.4%*	1.5%	*1.4%*	

Trends

There is agreement by coalitions and community assessment sources of the specific unmet needs and health disparities experienced by those with behavioral health care issues. This is reflected in collaborative planning, developing collective strategies, and shared resources in addressing the needs of the population.

Common trends across all sources of assessment incorporated into the CAP plan include:

- Residents face barriers finding easy and timely access to behavioral health care leading to unmet need. Barriers include a lack of necessary workforce,

transportation, geographical distance, cost, stigma, and confusion in accessing available services.

- Unserved or underserved people experiencing multiple health disparities keep them from engaging in care and achieving greater health and wellness. Consequences of untreated mental illness and addiction include poor health and risk of disease, homelessness, boarding in emergency departments, and arrest leading to incarceration and involvement in the criminal justice system. There is also a high incidence of unintentional overdose deaths especially in Licking County. Complex needs require coordinated care management and access to resources and supports.
- The MHR service district has a high rate of estimated death of despair (death by suicide, drug poisoning, and alcohol abuse) at 41.94 (Knox) and 49.7 (Licking) deaths per 100,000 people. https://www.winmeasures.org Health disparities cause deaths of despair and are fueled by easy access to lethal means, along with a lack of social connection and economic and spiritual fulfillment. Local assessment indicate people are experiencing mental health symptoms more frequently. Unidentified trauma including ACEs negatively affect a person's health and wellness. Residents would benefit from family supports and universal evidenced based prevention strategies to strengthen resilience and promote protective factors. Public awareness would also decrease stigma.
- Both counties would benefit from more school-based interventions to mitigate risk factors associated with addiction and mental illness by promoting protective factors and greater resiliency in students.
- Both counties have taken custody of a significant number of children due to their parents' addiction many of whom are not involved in care. This family disruption causes significant trauma for all involved and tremendous cost to the counties.
- Housing challenges including lack of affordable and safe housing and homelessness is a contributing condition to health disparities and barriers faced by residents including those seeking or using behavioral health care services.

In preparing the CAP, MHR sought the participation of different groups to provide information, review, and suggestions. These groups included the MHR Provider Executive Directors, the MHR Program/SUD Committee, the Knox HRSA RCORP Knox Opioid Response and Recovery (KORR) Consortium, the Licking County Health Department Drug Overdose Prevention Coalition, and representatives from Knox Public Health – Knox Health Planning Partnership and the Licking County Family and Children First Council. Both county health departments identified that the community assessment findings and the resulting plan aligned with their CHAs and CHIPs.

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

	Major challenge	Moderate challenge	Minimal challenge	Top 3 challenges
Children, youth and families				**Select 3**
Mental, emotional and behavioral health conditions in children and youth (overall)	X			**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[1]			X	
Suspensions and expulsions among K-12 students			X	
Adverse childhood experiences (ACEs)	X			**X**
Adults				**Select 3**
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		
Drug overdose deaths	X			**X**
Problem gambling			X	

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

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

d. **Optional: Disparities narrative.** Describe the context for disparities in unmet needs in your community, such as general demographic characteristics, data limitations, trends, etc. **See pages 1 - 8**

e. **Optional: Additional assessment findings.** Describe any notable trends, qualitative findings or other assessment results regarding mental health and addiction outcomes that are relevant to your plan. **See pages 1 – 8.**

Mental health and addiction service gaps

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

	Major challenge	Moderate challenge	Minimal challenge	Top 3 challenges
Overall service gaps in continuum of care				**Select 3**
Prevention services, programs and policies		X		
Mental health treatment services	X			
Substance use disorder treatment services	X			**X**
Crisis services	X			**X**
Harm reduction services	X			
Recovery supports		X		
Mental health workforce (mental health professional shortage areas)	X			**X**
Substance use disorder treatment workforce	X			**X**
Access for children, youth and families				**Select 3**
Unmet need for mental health treatment, youth	X			**X**
Unmet need for major depressive disorder, youth	X			**X**
Lack of well-child visits			X	
Lack of child screenings: Depression and developmental		X		
Lack of child screenings: Developmental			X	
Lack of child screenings: Anxiety		X		
Lack of follow-up care for children prescribed psychotropic medications)		X		
Lack of school-based health services	X			**X**
Uninsured children			X	
Access for adults				**Select 3**
Unmet need for mental health treatment, adults	X			**X**
Unmet need for major depressive disorder, adults		X		
Unmet need for outpatient medication-assisted treatment		X		
Low SUD treatment retention	X			**X**
Lack of follow-up after hospitalization for mental illness challenges	X			
Lack of follow-up after ED visit for mental health	X			**X**
Lack of follow-up after ED visit for substance use	X			
Uninsured adults	X			

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

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

b. **Optional: Disparities narrative.** Describe the context for disparities in service gaps in your community, such as general demographic characteristics, data limitations, trends, etc. **See pages 1 - 8**

c. **Optional: Additional assessment findings.** Describe any notable trends, qualitative findings or other assessment results regarding service gaps that are relevant to your plan. **See pages 1 - 8**

Social determinants of health

3. **What are the social determinants of health (i.e., environmental factors or community conditions) that contribute to your community's behavioral health conditions and unmet need?**
   a. ▲**County profile(s): Social determinants of health.** Data for this question is provided by OhioMHAS and does not require any activity by Boards. Refer to the pre-populated county profile data tables provided by OhioMHAS which include the following data for the most recently available year for each county in the Board area, indicating if the county's prevalence is higher than, similar to, or lower than Ohio overall:
      - Child poverty
      - Adult poverty
      - Median wages
      - Unemployment rate
      - High school graduation rate (by school district)

- Some college (population educational attainment)
- Affordable housing
- Severe housing cost burden
- Residential segregation- Black/white
- Broadband access
- No vehicle
- Violent crime
- Food insecurity
- Child physical activity
- Adult physical activity
- Primary care physicians (ratio of primary care physicians to population)

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

	Major driver	Moderate driver	Not a driver or unknown	Top 3 driver
Social and economic environment				**Select 3**
Poverty	X			**X**
Unemployment or low wages	X			
Low educational attainment	X			
Violence, crime, trauma and abuse	X			**X**
Stigma, racism, ableism and other forms of discrimination	X			**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			
Physical environment and health behaviors				**Select 3**
Lack of affordable or quality housing	X			**X**
Lack of transportation	X			**X**
Lack of broadband access		X		
Lack of access to healthy food		X		
Other physical environment, specify:				
Lack of physical activity			X	
Lack of fruit and vegetable consumption		X		
Food insecurity	X			**X**

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

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

d. **Optional: Disparities narrative.** Describe the context for disparities in social determinants of health in your community, such as general demographic characteristics, data limitations, trends, etc. **See pages 1 - 8**

e. **Optional: Additional assessment findings.** Describe any notable trends, qualitative findings or other assessment results regarding social determinants of health that are relevant to your plan. **See pages 1 - 8**
The following data sources may be useful for assessing social determinant factors:

- County Health Rankings: Health behaviors, social and economic factors, physical environment
- National Equity Atlas: Economic vitality, readiness, connectedness
- Online State Health Assessment: Social and economic environment, physical environment
- Ohio Department of Health, Health Improvement Zones
- Ohio Department of Health, Social Determinants of Health Dashboard (coming soon)

Strengths, including community assets and partnerships

4. ✱**Identify community strengths your Board will draw upon to address needs and gaps.** Select up to three strengths that are the most significant in your community:
   - ☐ **Collaboration and partnerships**
   - ☐ Engaged community members

- ☐ **Availability of specific resources or assets**
- ☐ Economic vitality
- ☐ **Creativity and innovation**
- ☐ Natural resources and greenspace
- ☐ Colleges or universities
- ☐ Faith-based communities
- ☐ Social support and positive social norms

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

Definitions for five levels of collaboration:[2]

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

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

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

6. ✱**Indicate the relationship the Board has with community providers**
   a. Identify the number of providers in the Board area across the continuum of care.
   b. Identify the number of providers the Board is partnering with by evidence of a formal memorandum of understanding (MOU) or other formal agreement.

Relationship with BH Providers	Number Known BH Providers in Community	Number with Formal MOU or Agreement with MHR
Prevention	5	5
Mental Health Treatment	16	8
Substance Use Disorder Treatment	18	7
Medication-Assisted Treatment	4	3
Crisis Services	1	1
Harm Reduction	3	2
Recovery Supports	9	8

Additional information

7. **Optional: Link to other community assessments.** Insert link(s) to any local or regional community assessments that are relevant to your Board, such as your Recovery Oriented Systems of Care (ROSC) Assessment, a local health department Community Health Assessment (CHA) or hospital Community Health Needs Assessment (CHNA). **See pages 1 – 8**

MHR recognizes the need to conduct a comprehensive assessment of behavioral health care needs for both counties. This has been identified in the board's strategic plan. MHR is currently negotiating with the Ohio State University College of Public Health and Illuminology to begin this process in spring 2023. Revisions will be made to the SFY23 – SFY25 Updates from the results of this assessment.

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

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