2026-2028 Community Assessment and Plan

Fairfield County ADAMH Board
Serving Fairfield County

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Department of Behavioral Health

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Background and Statutory Requirements

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

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

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

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

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

Part One: Assessment

A. Assessing Behavioral Health Needs and Associated Disparities.

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

Table 1A.1: Assessing Behavioral Health Challenges

	Major challenge	Moderate challenge	Minimal challenge	Top 3 challenges selected
Children, youth, and families				
Mental, emotional, and behavioral health conditions in children and youth (overall)	X			X
Youth depression		X		
Youth alcohol use		X		
Youth marijuana use	X			X
Youth other illicit drug use		X		
Youth suicide deaths		X		
Children in out-of-home placements due to parental SUD			X	
Chronic absenteeism among K-12 students		X		
Suspensions and expulsions among K-12 students			X	
Adverse childhood experiences (ACEs)		X		
Other child/youth outcome, specify: *"Youth vaping."*	X			X
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		
Adult depression		X		
Adult substance use disorder		X		
Adult heavy drinking	X			
Adult illicit drug use	X			X
Adult suicide deaths	X			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
- Youth (ages 17 and under)

B. Assessing Behavioral Health Service Gaps and Associated Disparities.

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

Table 1B.1: Assessing Behavioral Health Service Gaps

	Major challenge	Moderate challenge	Minimal challenge	Top 3 challenges selected
Overall service gaps in continuum of care				
Prevention services, programs, and policies		X		
Mental health treatment services	X			X
Substance use disorder treatment services			X	
Medication-assisted treatment			X	
Crisis services		X		
Recovery supports		X		
Criminal justice			X	
Mental health workforce (mental health professional shortage areas)	X			X
Substance use disorder treatment workforce			X	
Other service gap, specify: *"Housing."*	X			X
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		
Lack of well-child visits			X	
Lack of child screenings: Depression and developmental			X	
Lack of child screenings: Developmental			X	
Lack of child screenings: Anxiety			X	
Lack of follow-up care for children prescribed psychotropic medications			X	
Lack of school-based health services, youth			X	
Uninsured children			X	

	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: *"Youth crisis services."*	X			X
Other child/youth access challenge, specify: *"Workforce (mental health, youth)."*	X			X
Other child/youth access challenge, specify: No response.				
Access for adults				
Unmet need for mental health treatment, adults	X			X
Unmet need for outpatient medication-assisted treatment, adults			X	
Unmet need for non-MAT substance-use/addiction treatment, adults			X	
Low SUD treatment retention, adults	X			X
Lack of follow-up after hospitalization for mental illness challenges, adults	X			X
Lack of follow-up after ED visit for mental health, adults	X			
Lack of follow-up after ED visit for substance use, adults	X			
Unmet service need for criminal justice-involved adults			X	
Unmet service need for uninsured adults			X	
Unmet need for specific diagnostic categories, adults, specify: No response.				
Other adult access challenge, specify: *"Transportation."*	X			
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
- Youth (ages 17 and under)
- Older adults (ages 65+)

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		
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			X
Attitudes about seeking help	X			X
Family disruptions (divorce, incarceration, parent deceased, child removed from home, etc.)		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
- Older adults (ages 65+)

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.).

- *"We facilitate and/or participate in several community coalitions. We have a staff attend the County's Healthcare Coalition meeting, which is held quarterly. One staff member is on the Executive Committee for the County's Housing Coalition. These meetings are held monthly. We co-facilitate/co-chair the County's Suicide Prevention Coalition and that meeting is held every other month. Additionally, our Prevention Coordinator chairs the Fairfield County PART Coalition (prevention, advocacy, recovery supports, and treatment). This meeting is held monthly and numerous ADAMH staff attend and represent the subcommittees. in 2026, we will have a staff attending the Transportation Coalition."*

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	5
Mental health treatment	17
Substance use disorder treatment	17
Medication-assisted treatment	5
Crisis services	3
Recovery supports	15
Criminal justice	2

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	4
Mental health treatment	7
Substance use disorder treatment	5
Medication-assisted treatment	5
Crisis services	3
Recovery supports	13
Criminal justice	1

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	30,495
Mental health treatment	1,328
Substance use disorder treatment	751
Medication-assisted treatment	144
Crisis services	499
Recovery supports	614
Criminal justice	435
Required Special Populations	**Estimated Number of Individuals Served in CY 2024**
Pregnant women with SUD	103
Parents with SUD with dependent children	66
Youth	224

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.

- *"In 2024 we conducted a community needs assessment. The assessment indicated gaps in services for youth and older adults."*

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

- *"In 2024 we conducted a community needs assessment. The assessment indicated gaps in services for youth and older adults."*

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.fairfieldhealth.org/pdf/Fairfield-CHA-Report-2025.pdf"*

Part Two: Plan

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

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

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

Table 2A.1: Continuum of Care – Prevention

Prevention Priority Strategy			
Priority Strategy	*"Implement, evidence-based, school-based prevention programs within Fairfield County Schools."*		
Age Group(s)	• Children (ages 0-12) • Adolescents (ages 13-17)		
Priority Population(s) and Group(s) Experiencing Disparities	• Youth (ages 17 and under)		
Capital Funding Needs	No		
SMART Objective for Prevention Priority Strategy			
Outcome Indicator	*"Average percentage of students who identified an increase in knowledge."*		
Data Source	*"Provider outcome reports."*		
Baseline Year	2025	**Target Year**	2026
Baseline Data Value	70	**Target Data Value**	75

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

Mental Health Treatment Priority Strategy			
Priority Strategy	*"Enhance and strengthen the mental health treatment workforce by providing clinician training - this strategy focuses on building clinician capacity through targeted, accessible and sustainable training initiatives that support both early career and experienced mental health professionals."*		
Age Group(s)	• Children (ages 0-12) • Adolescents (ages 13-17) • Older adults (ages 65+)		
Priority Population(s) and Group(s) Experiencing Disparities	• Youth (ages 17 and under) • Older adults (ages 65+)		
Capital Funding Needs	No		
SMART Objective for Mental Health Treatment Priority Strategy			
Outcome Indicator	*"Average percentage of professionals who identified an increase in knowledge."*		
Data Source	*"Pre/post surveys and evaluations."*		
Baseline Year	2026	**Target Year**	2028
Baseline Data Value	0	**Target Data Value**	70

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

SUD Treatment Priority Strategy			
Priority Strategy	*"Partner with the local recovery community to develop, implement, operationalize a recovery community organization in Fairfield County."*		
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	• People with low incomes or low educational attainment • People with a disability • Residents of rural areas • Pregnant women with SUD • Parents with SUD with dependent children • People who use injection drugs (IDUs)		
Capital Funding Needs	No		
SMART Objective for SUD Treatment Priority Strategy			
Outcome Indicator	*"Number of Recovery Community Organization participant/member surveys."*		
Data Source	*"Participant surveys/provider outcome reports."*		
Baseline Year	2026	**Target Year**	2028
Baseline Data Value	0	**Target Data Value**	70

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

MAT Priority Strategy			
Priority Strategy	*"Continue with current MAT program in the Fairfield County Jail. Enhance case management and peer support services to ensure that consumers are following up with outpatient care upon release from jail."*		
Age Group(s)	• Adults (ages 18-64)		
Priority Population(s) and Group(s) Experiencing Disparities	• 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 that follow-up with outpatient care upon release from jail."*		
Data Source	*"Provider outcome reports."*		
Baseline Year	2024	**Target Year**	2026
Baseline Data Value	11	**Target Data Value**	50

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

Crisis Services Priority Strategy			
Priority Strategy	*"Strengthen the behavioral health crisis continuum by enhancing mobile crisis services in Fairfield County and continue to operate a clinically effective, recovery-oriented crisis stabilization unit (Starlight Center) to provide person-centered care and appropriate diversion from emergency departments and jails."*		
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	• People with low incomes or low educational attainment • People with a disability • Residents of rural areas • Older adults (ages 65+)		
Capital Funding Needs	No		
SMART Objective for Crisis Services Priority Strategy			
Outcome Indicator	*"Number of individuals served by mobile crisis or Starlight Center averted."*		
Data Source	*"Provider outcome reports."*		
Baseline Year	2025	**Target Year**	2027
Baseline Data Value	66	**Target Data Value**	70

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

Recovery Supports Priority Strategy			
Priority Strategy	*"Complete the construction of, and implement, a permanent supportive housing project (Venture Place) to improve housing stability, reduce system utilization and enhance quality of life for individuals diagnosed with serious mental illness or co-occurring behavioral health disorders."*		
Age Group(s)	• Adults (ages 18-64)		
Priority Population(s) and Group(s) Experiencing Disparities	• People with low incomes or low educational attainment • People with a disability		
Capital Funding Needs	No		
SMART Objective for Recovery Supports Priority Strategy			
Outcome Indicator	*"Percentage of individuals remaining in stable housing."*		
Data Source	*"Provider outcome reports."*		
Baseline Year	2026	**Target Year**	2028
Baseline Data Value	0	**Target Data Value**	85

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

Criminal Justice Priority Strategy			
Priority Strategy	*"Identify and engage with incarcerated individuals (Fairfield County Jail) with mental health and substance use disorders early and provide evidence-based treatment and recovery support services during incarceration."*		
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	• People with low incomes or low educational attainment • People with a disability • People involved in the criminal justice system		
Capital Funding Needs	No		
SMART Objective for Criminal Justice Priority Strategy			
Outcome Indicator	*"Number of individuals who followed up with outpatient appointments upon release (within one month)."*		
Data Source	*"Provider outcome reports."*		
Baseline Year	2026	**Target Year**	2028
Baseline Data Value	0	**Target Data Value**	70

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

Pregnant Women with SUD Priority Strategy			
Priority Strategy	*"Implement Plans of Safe Care training to treatment providers, social service providers, primary care providers, etc. in the community. Continue to fund and provide support for a MOMS program and service coordination for pregnant women with substance use disorder through the perinatal cluster."*		
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 moms misusing drugs at the time of birth."*		
Data Source	*"Fairfield Medical Center."*		
Baseline Year	2024	**Target Year**	2027
Baseline Data Value	11	**Target Data Value**	5

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

Parents with SUD with Dependent Children Priority Strategy			
Priority Strategy	*"Provide evidence-based parenting programs with an emphasis on reducing barriers to participation, such as offering childcare support and transportation."*		
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	*"Number of parents with SUD served."*		
Data Source	*"Provider outcome reports."*		
Baseline Year	2026	**Target Year**	2028
Baseline Data Value	0	**Target Data Value**	30

Table 2A.10: Required Special Population – Youth

Youth Priority Strategy			
Priority Strategy	*"Develop and implement a youth drop-in center with a focus on low-barrier engagement, early intervention and integrated support services to increase access to mental health and SUD support services, including treatment, for youth in the community."*		
Priority Population(s) and Group(s) Experiencing Disparities	• Youth (ages 17 and under) • Transition-aged adults (ages 18-24)		
Capital Funding Needs	Yes		
SMART Objective for Youth Priority Strategy			
Outcome Indicator	*"Number of youth visits within the first six months of opening."*		
Data Source	*"Provider outcome reports."*		
Baseline Year	2027	**Target Year**	2028
Baseline Data Value	0	**Target Data Value**	50

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

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

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

B. Multi-System Youth.

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

- The following describes any needed child services resulting from a finalized dispute resolution with a county FCFC(s) [340.03(A)(1)(c)].
  - *"This does not apply. We have not had any."*
- 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.
  - *"We have a contract in place with Fairfield County Family and Children First Council for the Council to provide service coordination and services to assist families when their children are experiencing multiple problems, involved in multiple systems. The goal is to provide intervention as close to home as possible. Referrals and coordination occur with the use of a wrap-around model. A monthly meeting with appropriate stakeholders takes place to discuss, staff, and coordinate care. FCFC uses high-fidelity wrap-around model. The ADAMH staff participate in the MSY cluster meetings as well as several community behavioral health providers."*
- 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.
  - *"We have a contract in place with Fairfield County Family and Children First Council for the Council to provide service coordination and services to assist families when their children are experiencing multiple problems, including out-of-home placements and services to prevent out-of-home placements. The MSY "pooled fund" is used to assist families with the burdensome cost of placement outside the home. The Board also provides funding for Intensive Home-Based Services (IHBT) through the Council. FCFC refers and coordinates cases with the IHBT team. This is an intervention used to reduce out-of-home placements. The Council also provides several parenting education curriculums to the community and has a relationship with the courts and JFS to take referrals."*

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.
  - *"The ADAMH Board staff and local treatment provider participate in monthly meetings with the regional state hospital. We provide additional financial support to the treatment provider for them to be able to do assertive outreach and engagement with individuals in the state and/or private hospitals. The agency no longer has a designated liaison due to difficulty staffing the position. Since we do not have an inpatient unit in our County, we also provide episodic care contracts for indigent patients of private psychiatric hospitals outside of our community. In attempt to improve discharge planning, we have added language to our episodic care contracts that outline the Board's requirements for discharge planning or the hospital will risk non-payment."*
- 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 private psychiatric hospital(s)
  - Other: *"Uninsured or underinsured ("straight" Medicaid or Medicare) patients in need of financial assistance."*
- ADAMH Boards were then asked to explain how the Board is attempting to address those challenges.
  - *"Fairfield County does not have a local inpatient psychiatric unit and our residents typically receive inpatient care at private psychiatric hospitals in Franklin County. We have developed episodic care contracts with these hospitals and have added language about discharge planning expectations to these contracts. We have requested meetings with hospitals when there are issues, and they are typically very responsive. We host a "high-risk" meeting each month and invite all community partners and service providers. We provide a*

large amount of funding to the crisis continuum of care in our community which includes funding for partners to do some assertive outreach and engagement with individuals with frequent hospitalizations. We are able to utilize local funding to support inpatient hospitalizations for individuals who are underinsured or uninsured."

D. Optional: SMART Objectives for Groups Experiencing Disparities.

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

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

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

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

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

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

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

F. Optional: Data Collection and Progress Report Plan.

ADAMH Boards were given the opportunity to describe their plans to evaluate progress on the SMART objectives described above. The Ohio Department of Behavioral Health (DBH) encouraged Boards to develop a plan that includes data sources, data collection methods, partners involved in evaluation, a data collection timeline, and a plan for sharing and using evaluation results.

- *"We collect quarterly program outcomes from all of our network of care providers. These outcomes are evaluated regularly by ADAMH staff. We also contract with Ascend who provides us with digital tools to help us to plan and monitor for the behavioral health services in our community."*

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.

- *"In the process of being updated."*

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).

- *"https://www.fairfieldhealth.org/pdf/Fairfield-CHA-Report-2025.pdf"*

Part Three: Legislative Requirements

A. Crisis Planning Committee/Task Force.

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

- *"The Fairfield County ADAMH Board staff facilitate a "Crisis System of Care" meeting monthly. This meeting is made up of staff across ADAMH's network of care crisis programs within the community. The purpose of the meeting is to collaborate and discuss any issues, barriers and/or needs across the crisis continuum of care in the county. Beginning January 2026, this group will host a monthly "stakeholder" group where we will complete a SWOT analysis that will be used to inform the decision-making and strategic planning for crisis services in the future."*

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		No	No	No
SUD Crisis Residential	X			
Other: No additional crisis services reported.				

C. Collaboration with 988 Call Center(s).

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

- *"The Fairfield County 2-1-1 Information and Referral agency is also our 988 call center. Prior to 988, 211 operated as the call center for our crisis line. Historically, the ADAMH Board has funded the call center so the transition to 988 was smooth for both us and them. We continue to provide funding to support the call center. The call center provides ADAMH with quarterly outcomes for both 988 calls and local crisis line calls. The ADAMH staff meet regularly to review and analyze data. This data is also compared to the data that is provided by other crisis programs such as the mobile crisis team and the outcomes collected from the Starlight Center, our crisis residential facility. Data review will be included as an agenda item in the newly formed "stakeholder" meeting."*

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.

- *"We no longer have an inpatient psychiatric unit local to our community. When residents need inpatient care, they often go to private hospitals in Columbus. All residents, of all demographics, are impacted by this gap in*

crisis services. The Board does have great relationships with many of the private hospitals, and we will do individualized episodic care contracts with the hospitals to ensure that the inpatient care needs of indigent residents are being met."

E. Crisis System Funding Sources and Amounts.

Table 3E.1: Total Crisis System Funding

Funding Source	Amount Planned in CY 2026	Amount Planned in CY 2027	Amount Planned in CY 2028
Local Levy	$1,391,386	$1,335,731	$1,282,302
Local Grants *(grants not funded via DBH)*	$0	$0	$0
State GRF	$274,806	$274,806	$274,806
5TZ0	$110,521	$110,521	$0
DBH Funded Grants (non-GRF)	$0	$0	$0
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.

- *"ADAMH will continue to identify and treat, through our contracts, those persons most in need of crisis behavioral health services at all levels of care. ADAMH staff will continue to work collaboratively with the agencies that are performing the crisis services to collect and analyze quarterly data; and monthly data for mobile crisis. Regarding the Starlight Center, ADAMH staff meet monthly with leadership team to review updates to a recent Performance Improvement Plan the agency was placed on to ensure that both the MH and SUD residential programs are meeting its goals and providing quality services. A survey was just distributed to community partners to help us better identify and understand the experiences that any partners may have had in making referrals to the center. This will be used to improve referrals and admissions processes. Regarding our mobile crisis team, 24/7 staffing has been a barrier for the agency operating mobile crisis services. ADAMH will continue to provide funding to support the services and meet regularly with leadership to discuss staffing barriers and problem-solve solutions."*

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.

- *"We collect a variety of measures across crisis programs. The mobile crisis program reports details for all their calls and we use that data to create data dashboards that are easy to analyze and compare month-to-month. Those measures include the percentage of calls that result in a mobile visit, the percentage of mobile visits that were responded to in 60 minutes or less and the percentage of calls that were followed up on within three days. All call data is logged, and we monitor trends in calls by the days of the week, times of the day and locations. Mobile call referral sources are also logged. Primary presenting problems, crisis types and dispositions as well as demographics of those in crisis are also tracked and monitored. Similarly, the crisis call center (988/211) provides us with the total number of calls with the breakdown of calls that came through to 988 versus the local crisis line.*

We also receive presenting problem and number of calls linked to resources and/or services. The leadership team also conducts quality assurance audits on calls, and we receive information on the average QA score for call audits on a quarterly basis. The Starlight Center reports outcome measures quarterly that includes demographics of those admitted into either the SUD or MH residential programs, the percentage of those referred to outpatient treatment, the percentage of those successfully discharged completing at least one outpatient appointment, and the information for all referrals to the Center. Additionally, due to low consensus, the Starlight Center leadership team collaborated with ADAMH staff to create a performance improvement plan (PIP). For the PIP, we are tracking the monthly consensus and outreach and marketing/education efforts done by the CSU staff. Additionally, they have developed a survey for community partners who are making referrals to the Center. The survey will help the Center staff and ADAMH staff to determine if there are barriers to making referrals as well as assist in identifying barriers to admissions and outpatient follow-up."