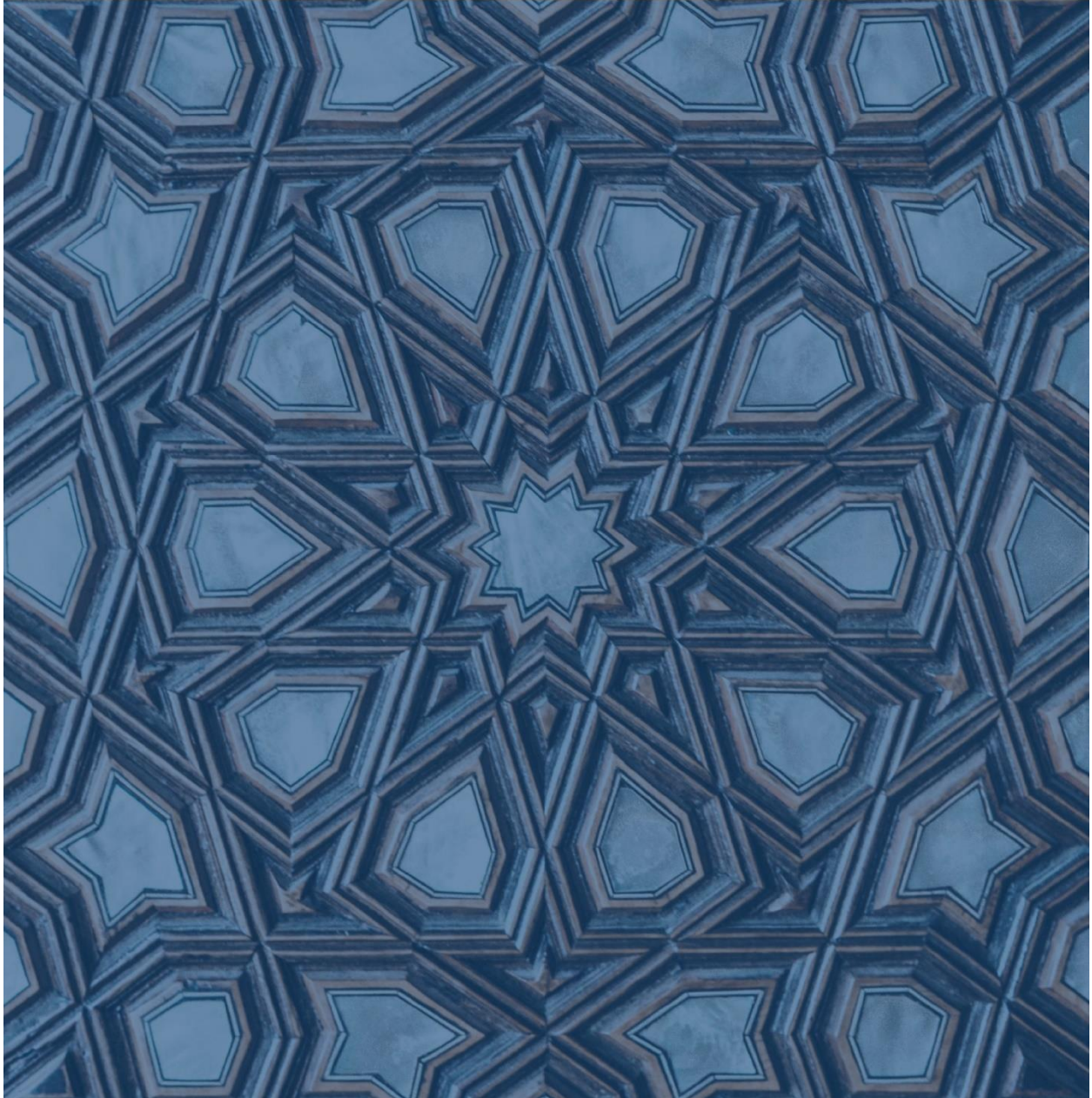




Community Needs Assessment ★ 2020



Contents

1. Introduction and Methods	4
Assessing Needs Beyond the ADAMH Network.....	4
An Inclusive Approach.....	4
Data Considerations.....	7
2. System Needs and Unmet Needs	9
Behavioral Health System of care	9
Behavioral Health Service Needs and Unmet Needs Across the System of Care.....	10
Prevention.....	11
Family Supports	13
Housing Services	15
Recovery Supports	17
Treatment Services	19
Crisis Services.....	21
Prioritizing Unmet Needs.....	23
Populations Reporting Significantly Higher Unmet Needs	24
3. Community Experience	26
Client Satisfaction with Services in the Broader Community	26
Client Satisfaction Related to Specific Populations	26
Client Barriers to Services.....	27
Practical Barriers	28
Barriers Rooted in Social Determinants of Health	29
Lack of Culturally Relevant Services.....	31
Barriers Related to Specific Populations.....	33
4. Social Service Provider Experience.....	37
Social Service Provider Experience and Satisfaction with ADAMH.....	37
Barriers Social Service Providers Face	39
Organizational Quality	39
Funding Bureaucracy	40
5. System Strengths and Opportunities	42
Positioned to Bring About Systematic Change	42
Making Quality and Impactful Services Accessible.....	43
Range of Services and Commitment of Providers In Our Community.....	43

6.	Broader Behavioral Health Trends in Franklin County.....	45
	Behavioral Health Outcomes	45
	Partnership and Strategies to Address Social Determinants of Health	48
	The Need to Inspire Hope	50
	Building a Community of Support.....	50
	Unique Behavioral Health Trends by Population Groups	50
7.	Key Takeaways	53
8.	Strategic Considerations.....	54
9.	Conclusion And Strengths, Weaknesses, Opportunities and Threats Analysis.....	58
	Appendix A: Social Service Provider Survey Respondents	62
	Appendix B: Comparison of Community Member Survey Respondents and Franklin County	66
	Appendix C: Data Description for Service Category Profiles	70
	Appendix D: Supporting Figures and Tables for Behavioral Health Trends in Franklin County	72
	Appendix E. Acknowledgements.....	76
	Works Cited	81

1. Introduction and Methods

The mission of the Alcohol, Drug and Mental Health (ADAMH) Board of Franklin County is to improve the well-being of our community by reducing the incidence of mental health problems and eliminating the abuse of alcohol and other drugs in Franklin County. ADAMH is a levy-funded agency that plans, funds, and evaluates behavioral healthcare services in our community.

As a funder, ADAMH invests in a network of 33 providers to make behavioral health care available to those who need support. Investments are made in prevention, family supports, housing services, recovery supports, treatment services and crisis services. While services and investments focus on those who are under-insured or uninsured, 24/7 crisis services through ADAMH's network are available to everyone in the community. Whenever an individual is in crisis, ADAMH's provider network is available.

In the role of planning and evaluation, ADAMH is responsible for coordinating the ongoing assessment of community needs for mental health and addiction services and supports across Franklin County's system of care. The process of monitoring community behavioral health data ensures that the provider community offers the best quality services and responds to evolving community needs by expanding services whenever necessary.

Assessing Needs Beyond the ADAMH Network

In 2020, ADAMH initiated a comprehensive community needs assessment to illuminate the behavioral health system strengths and opportunities and quantify the met and unmet service needs. The Community Needs Assessment goes beyond ADAMH's current network and investments and explores the behavioral health needs of the entire community. Additionally, this Community Needs Assessment investigates a wide range of factors impacting behavioral health (i.e., social determinants of health, cultural bias, etc.). Though these factors may be outside of the scope of ADAMH's resources to address, ADAMH believes being informed will help them be stronger leaders. Understanding the current state of the larger system will guide support and advocacy for the well-being of Franklin County.

The results of the 2020 Franklin County Community Needs Assessment will guide the strategic priorities for 2022–2026 of the ADAMH Board of Trustees and staff.

An Inclusive Approach

Beginning in July 2020, ADAMH partnered with Measurement Resources Company (MRC) to complete an inclusive, comprehensive study representative of all voices throughout Franklin County. Data collection strategies were carefully designed to capture a wide range of experiences within and outside of the ADAMH network with strategies for drawing out specific experiences. The data summarized in this report came from the following sources:

1. ADAMH Internal Data

Consumer satisfaction survey data and the 2020 Levy Fact Book were reviewed to provide an overview of the ADAMH-funded system landscape.

2. Review of Publicly Available Community Data

More than 31 local studies (e.g., Franklin County Health Map 2019, 2018 Vocational Rehabilitation Comprehensive Statewide Needs Assessment, Ohio Department of Youth Services 2019 Annual Report, etc.), along with the American Community Survey (ACS) five-year population estimates were used to describe the current demographic and historical population level trends related to mental health and addiction. Secondary data collection began in September 2020.

3. System Expert Interviews

Twenty-five interviews were conducted with ADAMH system and stakeholder group experts to discuss the strengths and opportunities for the larger behavioral health system of care within Franklin County. Interviews took place in November and December of 2020. Experts were invited to participate in an interview based on their expertise in at least two of the following:

- The policy, partnerships and organizational practices of an ADAMH service line in Franklin County.
- The policy, partnerships and organizational practices of social services outside of ADAMH but that are related to social determinants of health in Franklin County.
- The needs of a specific ADAMH stakeholder or community group in Franklin County, including grassroots advocates and community leaders who were also members of underrepresented community groups speaking from the perspective of their own backgrounds (e.g., experts on recovery needs had lived experience with addiction, experts on needs of African Americans and immigrant men were also African Americans and African immigrants).

4. Focus Groups

Ten focus groups, including 51 community members, were conducted to better understand the experiences of traditionally underrepresented populations. Community champions were used to assist with participant recruitment and to assist in anticipating needs, such as interpreting services and access to Zoom. Focus groups took place in November and December of 2020. All focus group participants were offered a \$25 honorarium for their time. Focus groups were conducted with the following community groups:

- Justice-involved adults
- Adults receiving residential/group home services
- Youth, urban and suburban*
- LGBTQ+*
- Aging*
- Veterans/men who have experienced homelessness/received mental health services
- Asian community leaders and liaisons*
- First- and second-generation refugee immigrants, including High School students and recent graduates*
- African American and immigrant-African community advocates*
- Latino and Hispanic parents*

** Focus groups that included at least one community member who reported not having utilized ADAMH services.*

5. Social Service Provider Survey

Eighty unique organizations were represented in the provider survey with a total of 317 providers responding to the survey. The survey was open from October to December 2020. Providers gave insights on the system service quality and accessibility, barriers to behavioral health services, system strengths and weaknesses; and ADAMH's quality and effectiveness. The providers who responded to the survey represent the following systems:

- Criminal justice system
- Cultural and ethnic minority communities
- Faith-based communities
- First responders
- Homeless service community
- Individuals with lived experiences with mental health and addiction services
- LGBTQ+ services
- Medical and public community
- Older adult-serving community
- Other community supports
- Youth-serving community

See Appendix A for a full description of social service provider survey respondents.

6. Community Survey

The general community survey was administered with the goal of mirroring Franklin County broadly with respect to the distribution of age and race. Using a targeted snowball sampling strategy (i.e., word of mouth referrals and invitations to complete the survey) to reach Franklin County community members, more than 1,635 individuals responded to an online survey. The survey was open from October to December 2020. Surveys were available in English, French, Nepali, Somali, and Spanish and made available on paper when requested. To improve response rates, there were two drawings for a \$100 Amazon gift card. More than 73 community organizations actively participated in survey distribution to their networks. Using a sampling strategy for population age and race, the results of the survey are reflective of the community. Tables B1 and B2 in Appendix B demonstrates how the survey respondents reflect the age, race, and ethnicity of the community.

Survey responses provided estimates of system service demand and gap for the total population of Franklin County; perceptions of the quality of system services among those who have accessed behavioral health services; perceptions of barriers to services; and perceptions of what is working well and not working well in the system of behavioral health care.

Table 1 presents the demographic breakdown of the community survey sample to that of the Franklin County population. A full comparison of sample and Franklin County demographics can be found in Appendix B.

Table 1. Comparison of Community Member Survey Respondents and Franklin County			
Demographic	Community Survey		Franklin County
	%		%
Age Range			
Under 20 (18 & 19)	4%		3%
20 to 34 years	21%		25%
35 to 44 years	30%		13%
45 to 64 years	37%		24%
65 years and up	8%		12%
What is your race?	% Survey Selection	% One Race Alone	
American Indian or Alaskan Native	2%	0.3%	0.2%
Asian	3%	2%	5%
Black or African American	24%	22%	23%
Native Hawaiian or Other Pacific Islander	0.3%	0.1%	<0.1%
White or Caucasian	74%	71%	66%
Another Race (please specify):	1%	1%	1%
Multiracial	4%	4%	4%
Are you of Hispanic, Latino, or Spanish origin?			
No, I am not of Hispanic, Latino, or Spanish origin.	95%		95%
Yes, I am of Hispanic, Latino, or Spanish origin.	5%		6%
What sex was originally listed on your birth certificate?			
Female	84%		48%
Male	16%		52%

Data Considerations

When using the community survey data to make generalizations of the population at large, it should be noted that a targeted snowball sampling methodology was utilized. Based on the importance and, often, largely differing perceptions of mental health by age and race, the sampling strategy prioritized a reflective representation by age and race. As a result, the community survey has an overrepresentation of females, families with children at home and individuals who are employed.

Because of the overrepresentation of some demographic groups in the sample as compared to the Franklin County population, the data team explored the use of survey weights (i.e., weighting survey responses by an individual's demographics to ensure alignment of the survey estimates to the Franklin County population) by comparing weighted survey estimates to unweighted survey estimates. The comparison was tested on 42 different survey items and the differences were negligible (i.e., the largest difference found was +3.6% in need of a specific

service for the weighted sample as compared to the unweighted sample). Because of the small differences in estimates and in an attempt to include as many survey responses as possible (i.e., the weighting approach would require limiting responses to individuals who completed all key demographic questions), the unweighted approach was taken.

Additionally, specific estimates of the number of people experiencing service needs and unmet needs in a specific year are unable to be calculated with the survey data. Survey participants were asked if either themselves or a family member needed a service at any point in time. To address this, the analysis focuses on relative rate of need and unmet need.

The voices of men, specifically Black men, and justice-involved youth are underrepresented in this sample. To address this, data were mined post hoc for anyone who identified as a man to discover unique themes. That specific analysis is included in this report. To capture the voice of justice-involved youth, ongoing community engagement strategies have been identified to strengthen the voice of this population.

Finally, the Community Needs Assessment data collection took place September through December of 2020, well into the COVID-19 pandemic. This is not a limitation so much as it is context. The perceptions of and need for behavioral health services during a pandemic are lived experiences in real time.

2. System Needs and Unmet Needs

Understanding the system needs and unmet needs can help ADAMH prioritize funding strategies to address the community's most pressing issues related to mental health and addiction recovery. The following sections quantifies the service needs and unmet needs across the system of care and identified specific populations who experience greater unmet needs.

Behavioral Health System of care

The system of care is represented in ADAMH's six service categories: prevention, family supports, housing services, recovery supports, treatment services, and crisis services. These categories are a framework for ADAMH to organize programs and funding strategies. This framework was used in this Community Needs Assessment so that ADAMH can align strategies to funding.



Prevention Services

Prevention Services include efforts to build awareness, knowledge and skills that will reduce incidence of mental illness and prevent addiction.

Family Supports

Family Supports are community-based services that assist and support family members and loved ones in their roles as caregivers.

Housing Services

Housing Services are a key to recovery for individuals with a mental illness or addiction. ADAMH supports and funds housing programs that include varying levels of treatment support along with a safe place to live.

Recovery Supports

Recovery Supports address many of the social determinants of health including employment, education, and engaging with supportive communities to help individuals build productive lives in recovery.

Treatment Services

Treatment Services provide mental health and addiction interventions including community-based, outpatient, and residential services.

Crisis Services

Crisis Services are those that help to stabilize individuals experiencing behavioral health crises.

Behavioral Health Service Needs and Unmet Needs Across the System of Care

Community Needs Assessment findings reveal an opportunity to improve the quality of services across the system. Additionally, there are unmet needs identified across the system of care, with specific members of our community experiencing higher unmet needs.¹ These data insights were gathered through multiple sources.

In the social service provider surveys, people were asked to rate (on a five-point scale with five being positive) the quality of services, cultural competency of staff, timeliness of services, and accessibility of services. In open-ended comments, providers gave additional explanations for low perceptions.

In the general population survey, community members were asked to identify service needs and unmet needs for themselves or family members over their lifetime. Additionally, community members ranked barriers to services and provided additional details in open-ended comments about what is working well and what is not working well in the system of behavioral health care. For more details about how quality, service needs, and barriers were assessed, please see Appendix C. The following section provides insights into the perceptions of behavioral health service quality and trends regarding the unmet needs for each part of the system of care.

“My counselor... [was not listening] to my story or understanding what I was going through. [My counselor] recommended that I engage in activities (vacation, etc.) [to cope with stress] that were beyond my means (we're broke) and logistical ability (kids, school, work, etc.) to accomplish.”
—Adult Male Community Member

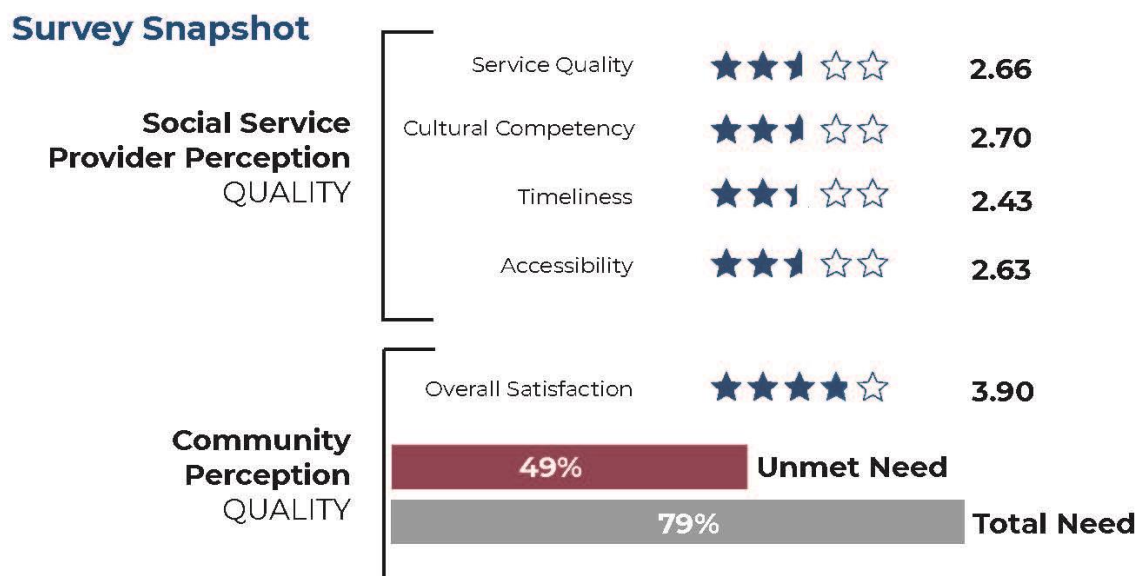
¹ Results of regression analysis, including further details about statistical significance is available upon request.

Prevention

From the social service providers' perspective, the service quality, cultural competency, timeliness and accessibility of prevention services in the community is low (Figure 1). In open-ended comments, social service providers articulated that the poor quality is driven by the general lack of awareness of services that are available, and the quality of communication. Some providers feel the sheer volume of information about available services is overwhelming, while others said they do not hear about or cannot find relevant information. Community members who participated in focus groups said that communications are not available in their first language and do not account for cultural stigma around mental health.

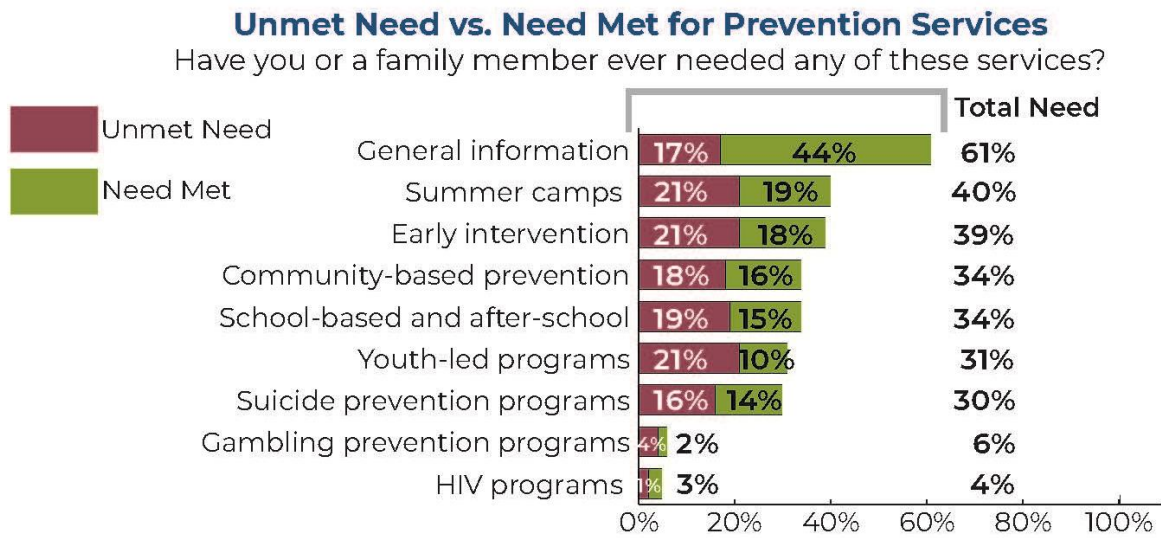
Figure 1 also conveys that community members who have received prevention services in Franklin County have more neutral perceptions of the quality of services. In terms of accessibility, 79% of the survey population needed at least one prevention service for themselves or a family member at some point in their lives. Of those, 49% were unable to receive the prevention service they needed.

Figure 1. Prevention Quality Snapshot



Overall, more than 60% of Franklin County residents surveyed indicated needing general information about behavioral health prevention services (Figure 2). More than one in five survey respondents indicated needing prevention programs for youth, and early intervention. These findings may reflect the overrepresentation of families—more specifically, women with children under 18 living at home—who responded to this survey.

Figure 2. Prevention Needs and Unmet Needs

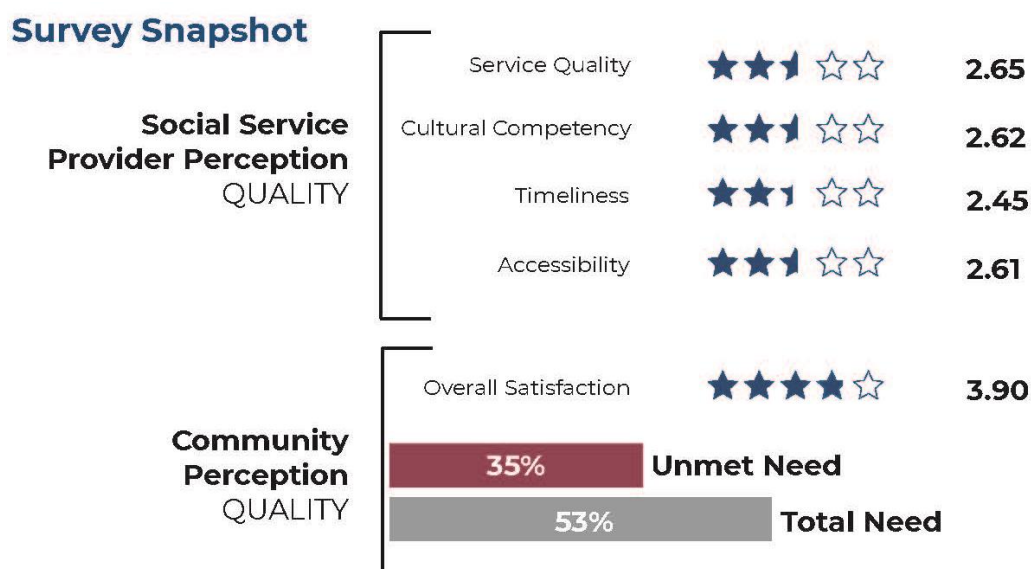


Family Supports

From the perspective of social service providers, the service quality, cultural competency, timeliness and accessibility of family supports in the community is low (Figure 3). Providers reported that the complexity of navigating the qualifications for family supports, the lack of services that are available, and the ability of services to meet the needs of family units are reasons for low ratings related to the quality of family supports. Additionally, focus group participants and system experts agreed that family supports lack a holistic approach to serving families. From the community needs assessment results, a more family unit-oriented approach to behavioral health would include services that do not just address the individual, but address the needs of the entire family—eliminating the need for individual family members to travel to different locations for services. This was especially true for minority families, but would improve the quality of outcomes for all families.

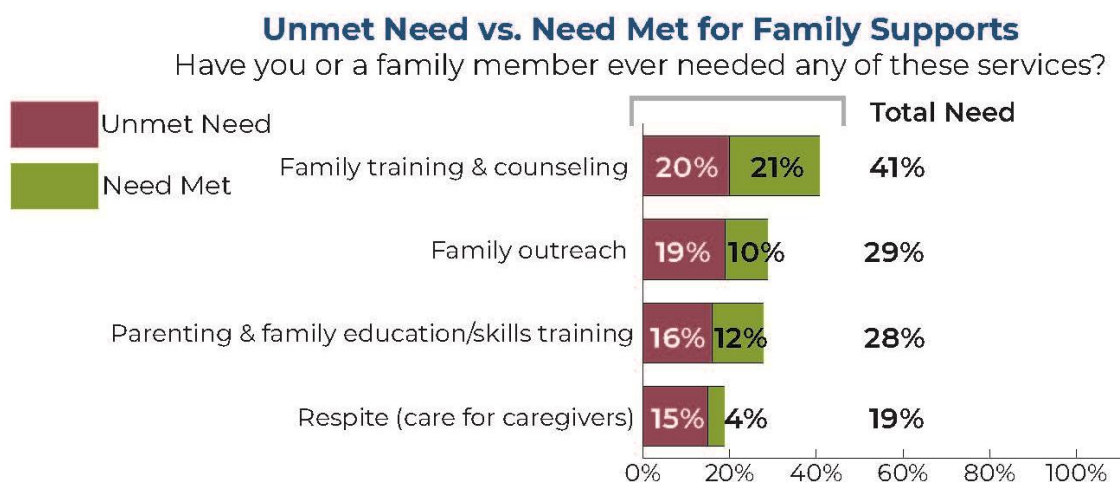
Also shown in Figure 3, community members who have received family supports in Franklin County have a more positive perception of the quality of services. In terms of accessibility, 53% of the survey population needed at least one family support for themselves or a family member at some point in their lives. Of those, 35% were unable to get the family supports they needed.

Figure 3. Family Supports Quality Snapshot



Overall, 41% of Franklin County residents surveyed indicated needing family training and counseling and 29% reported needing family outreach (Figure 4). The overrepresentation of families with children under 18 living at home in this sample may also be driving this high demand.

Figure 4. Family Supports Service Needs and Unmet Needs



“[All services] are siloed by age group. Parents have to take their kids one place; grandparents go to a different place. This makes things inaccessible. But also, services aren’t designed for interventions for families as a social unit—not only for treatment, but as a unit that can support each other.”
—System Expert

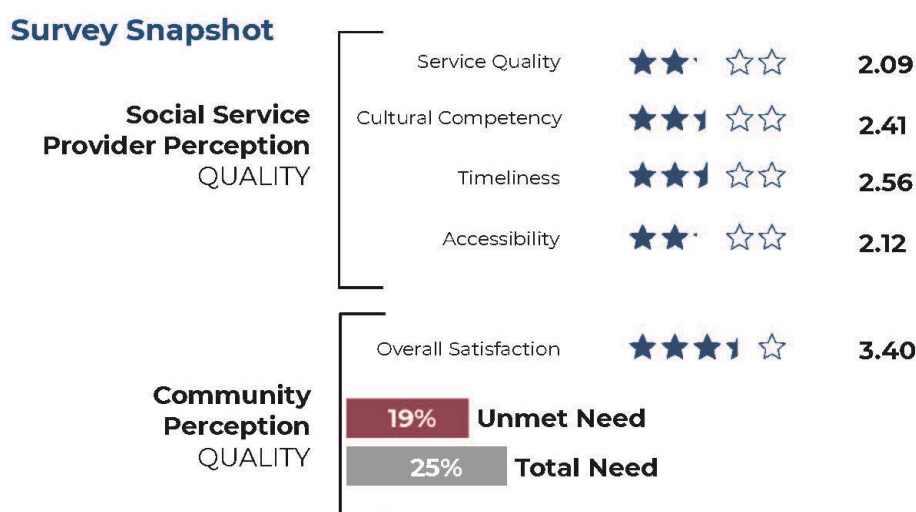
Housing Services

From the social service providers' perspective, the service quality, cultural competency, timeliness and accessibility of housing services in the community is low (Figure 5). Housing services have the lowest quality rating across the continuum. All stakeholders see housing affordability and availability impacting the quality, timeliness, and accessibility of housing services. Additionally, both providers and the community said that housing programs are not designed to be tailored to individual needs (i.e., moving from crisis stabilization to independence). This puts community members at risk of continuous recidivism to more resource-intensive services.

“The Independent housing system was not designed for the [high intervention] population it is now serving. The mobile case management it was designed to have is no longer there. [At the same time] ADAMH is putting people straight out of hospital in independent living, but those people need close mobile case management.”
—System Expert

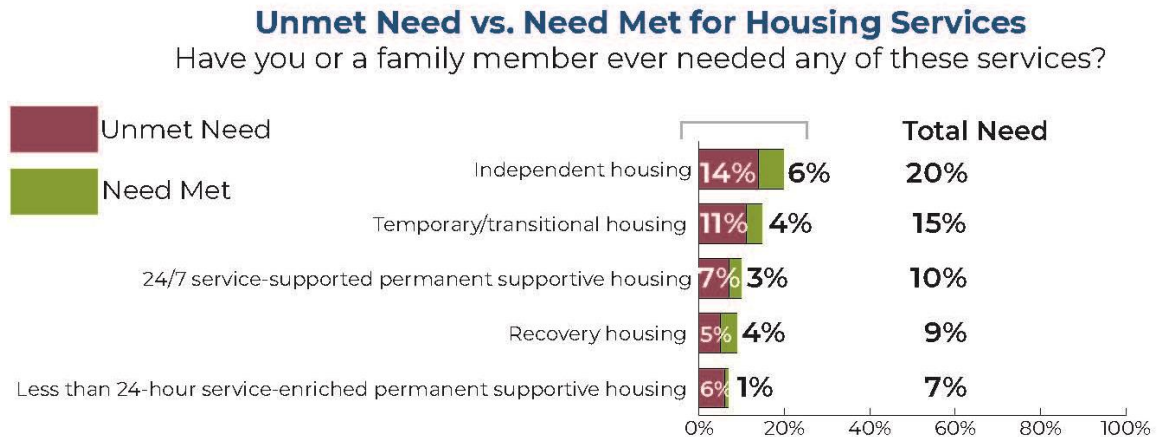
Figure 5 also reflects the more positive perceptions that community members who have received housing services in Franklin County hold related to the quality of services than that of providers, but the perception is still low. In terms of accessibility, 25% of the survey population needed at least one housing service for themselves or a family member at some point in their lives. Of those, 19% were unable to get the housing services they needed.

Figure 5. Housing Services Quality Snapshot



Overall, the greatest need for those surveyed is for independent housing. A total of 20% of community members surveyed said they needed independent housing services for themselves or a family member. Of those, only 6% received the independent housing needed, 14% did not. Independent housing is also the area with the largest service gap within the housing services category (Figure 6).

Figure 6. Housing Services Needs and Unmet Needs

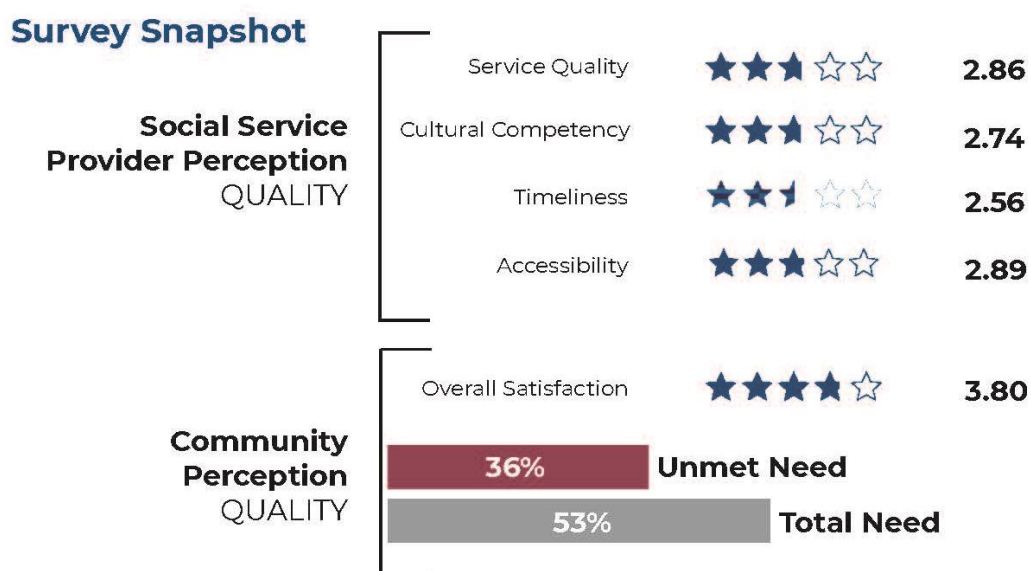


Recovery Supports

Social service providers perceive the service quality, cultural competency, timeliness and accessibility of recovery supports in the community to be low (Figure 7). When providers were asked in the survey why they rated the quality of recovery support low, they identified the lack of accessible transportation. Additionally, providers indicated that education and employment opportunities were either not commiserate with individuals' abilities or were not equipped to address the unique needs of individuals with criminal backgrounds, mental illness, addiction, or have transportation or other barriers. Additionally, providers said that the quality education and employment services vary across the different organizations that provide these services. Finally, providers also said there is a lack of awareness of these types of services and limited outreach, impacting their perceptions of quality.

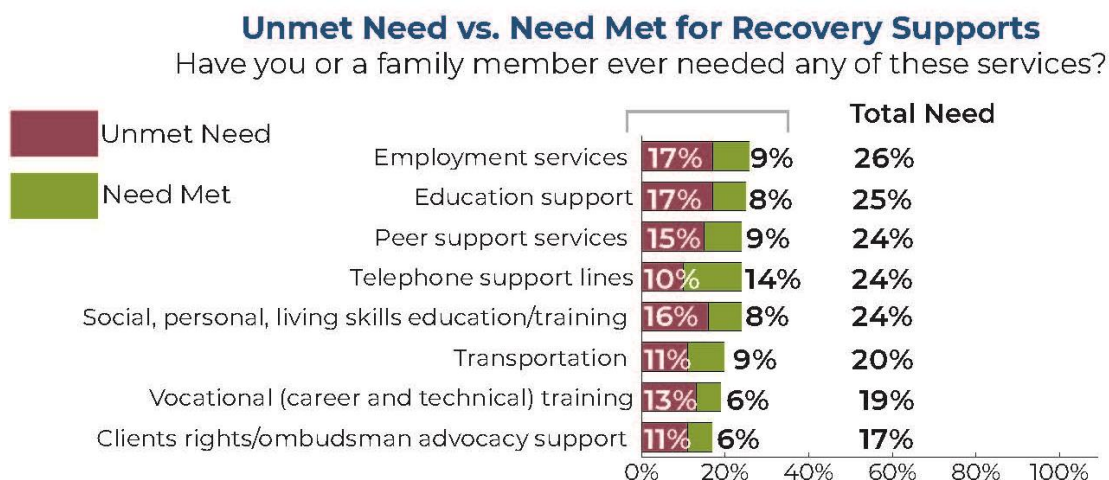
Figure 7 also illustrates the more positive perceptions of community members who have received recovery supports in Franklin County related to the quality of services than providers. Community Members' perceptions were more neutral than negative. In terms of accessibility, 53% of the survey population needed at least one recovery support for themselves or a family member at some point in their lives. Of those, 36% were unable to get the recovery supports they needed.

Figure 7. Recovery Supports Quality Snapshot



Overall, 26% of community members surveyed reported needing employment services and 25% reported needing education support. However, 17% did not receive the employment or education services they needed (Figure 8).

Figure 8. Recovery Supports Needs and Unmet Needs



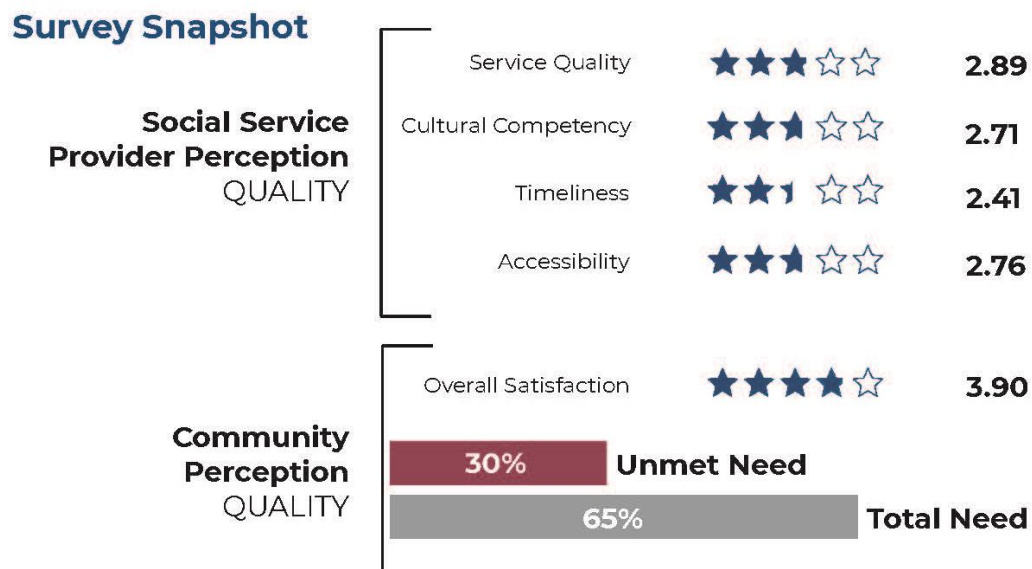
“I had someone who I brought to what was supposed to be an ESL support group, but it was really just for Spanish speakers. There needs to be AA and other support groups for other language groups.”—Community Member

Treatment Services

Social service providers rated the service quality, cultural competency, timeliness and accessibility of treatment services in the community as low (Figure 9). This low rating is the result of their clients continuing to struggle with being linked to affordable, timely, and appropriate treatment services. This struggle stems from long wait lists, difficulty navigating insurance policies and benefits, and programs that are not designed with clients' unique experiences (i.e., chronic homelessness, past negative experiences with providers) and identities (i.e., gender or cultural) in mind.

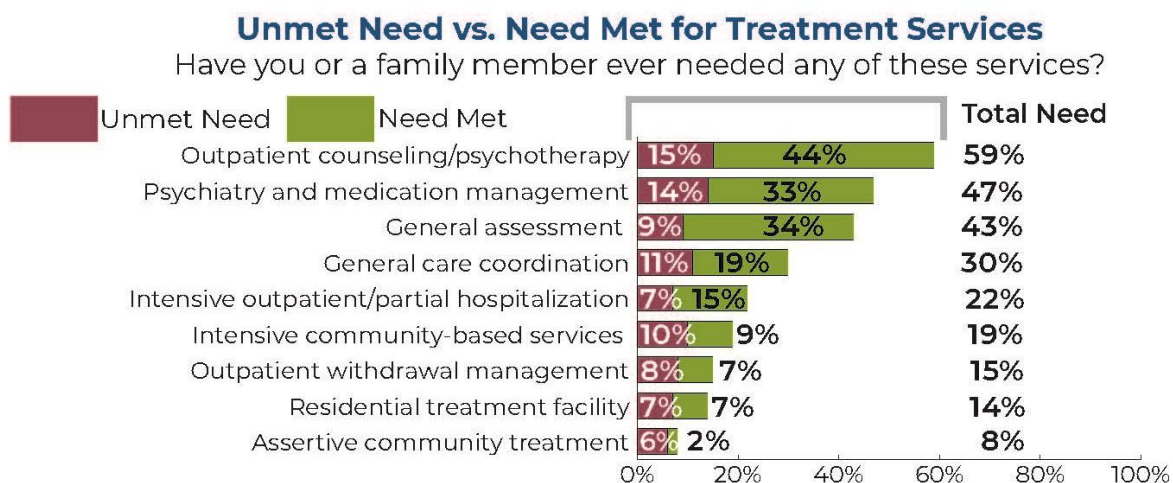
Figure 9 indicates the degree to which community members who have received treatment services in Franklin County have a more positive perception of the quality of services than providers. In terms of accessibility, 65% of the survey population needed at least one treatment service for themselves or a family member at some point in their lives. Of those, 30% were unable to get the treatment services they needed.

Figure 9. Treatment Services Quality Snapshot



Overall, the greatest demand within the treatment services category is for outpatient counseling/psychotherapy, with 59% of the community members surveyed reporting needing this service. Of those who needed outpatient counseling/psychotherapy, 44% received the service they needed, and 15% did not. Over 40% of those surveyed also reported needing psychiatry and medication management and/or general assessment (Figure 10).

Figure 10. Treatment Services Needs and Unmet Needs



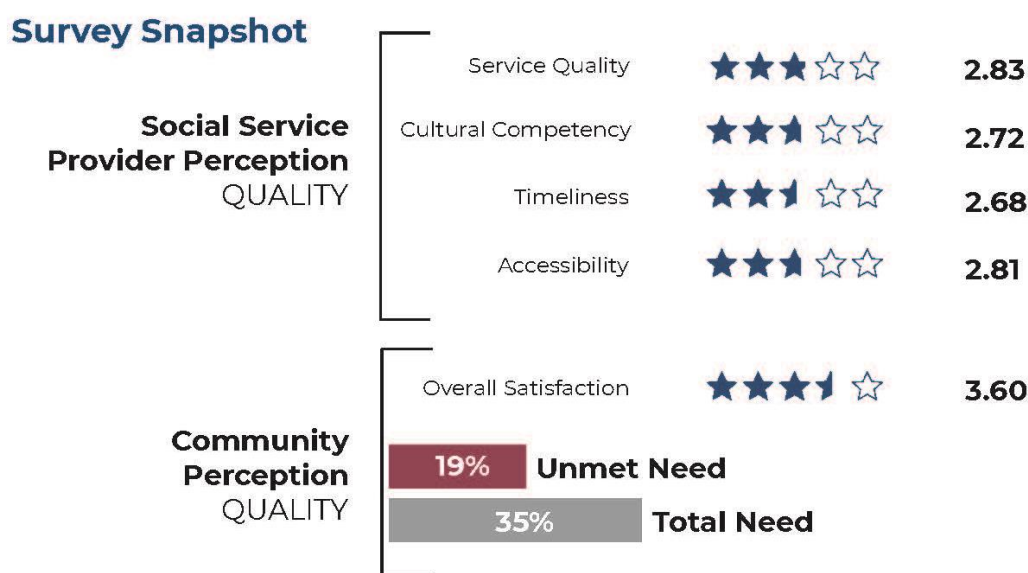
“The system is not set up for people to find the right clinician for them, there is a need for normalizing the expectation that it takes time to find the right service/provider for you. But, with wait times being months, people feel like they have to stick with whoever they got first, because they don’t know when they would be able to get an appointment with someone else.” —Community Member

Crisis Services

Social service providers gave the service quality, cultural competency, timeliness and accessibility of crisis services in the community a low rating (Figure 11). This rating reflects providers' frustration surrounding the lack of choice in crisis services. Providers further defined lack of choice as being limited in terms of types (i.e., services for youth, functional individuals in crisis, etc.) and capacity of available services. Additionally, providers witness their clients not being adequately stabilized. This is often due to programs being driven by business models and poor programming policies that are rooted in fee-for-service models (number served, units billed) over quality outcomes.

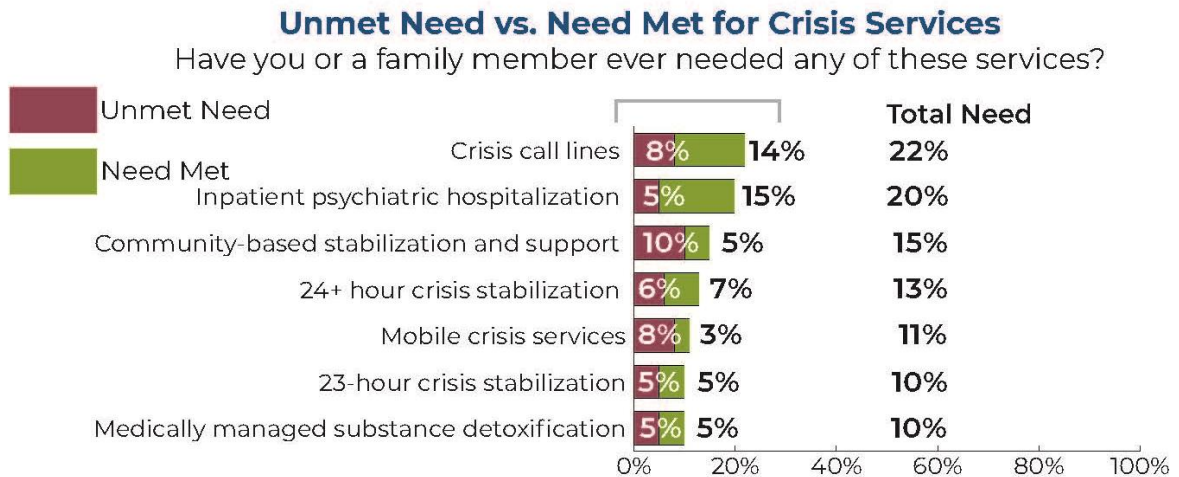
Also shown in Figure 11, community members who have received crisis services in Franklin County indicated a more positive perception of the quality of services than providers, but providers' perception is relatively low. In terms of accessibility, 35% of the survey population needed at least one crisis service for themselves or a family member at some point in their lives. Of those, 19% were unable to get the crisis services they needed.

Figure 11. Crisis Services Quality Snapshot



Overall, 1 in 4 community members surveyed reported needing crisis call lines and/or inpatient psychiatric hospitalization. Community-based stabilization was the largest unmet need among individuals surveyed (Figure 12).

Figure 12. Crisis Services Needs and Unmet Needs



“The difficulty of navigating services and resources just allows things, sometimes preventable situations, to escalate into crisis. It just results in people calling 911, so people don’t get the help they need and it costs the system.”

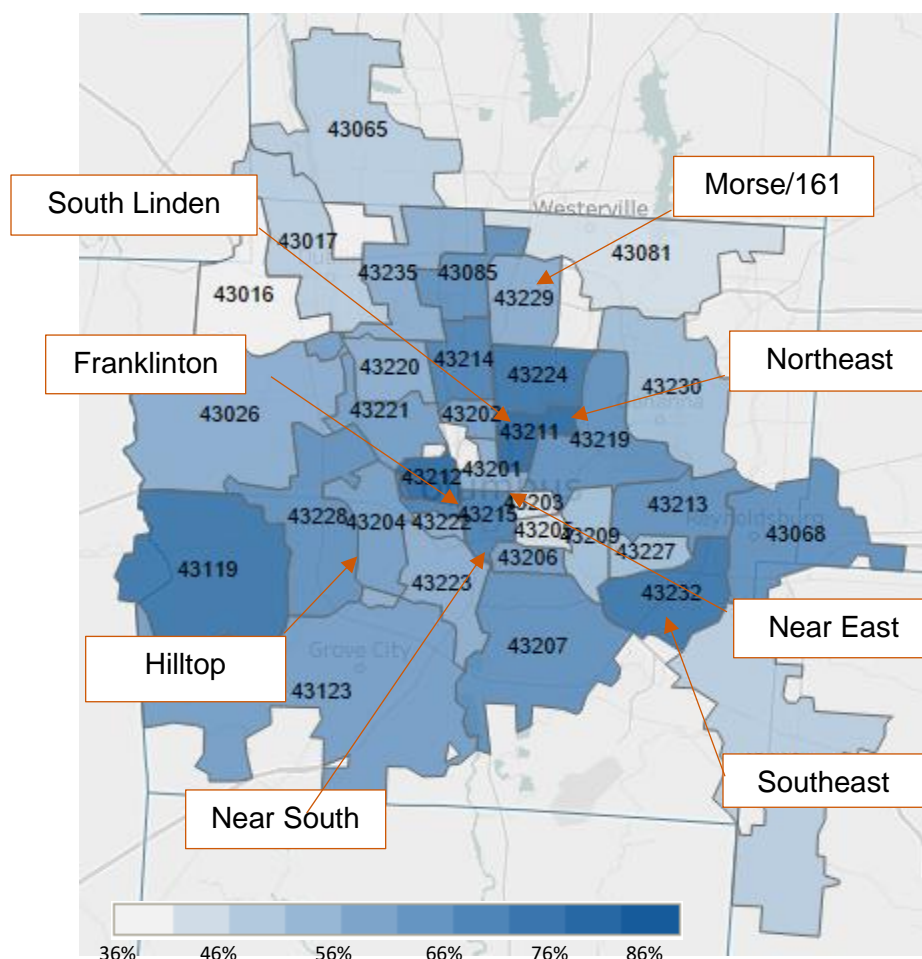
—System Leader

Prioritizing Unmet Needs

The data in the previous sections demonstrated there is a need across every service along the continuum of behavioral health services. To assist in the prioritization, the needs and unmet needs can be thought of in relative terms. Table 2 lists the 12 services with the highest need (25% of the surveyed population reported need) and largest gap (15% or more of the surveyed population reported an unmet need).

Table 2. Prioritization of Highest Unmet Needs	Total Need	Unmet Need
Prevention Services		
Summer camps	40%	21%
Early intervention; early childhood mental health programs	39%	21%
Youth-led programs	32%	21%
School-based and after-school prevention programs	34%	19%
Community-based prevention programs	34%	18%
General information about mental health and addiction	61%	17%
Suicide prevention programs	30%	16%
Family Supports		
Family training and counseling	40%	20%
Family outreach	28%	19%
Parenting and family education/skills training	28%	16%
Recovery Supports		
Education support	25%	17%
Employment services	26%	17%
Treatment Services		
Outpatient counseling/psychotherapy	59%	15%

Map 1. Service Gaps by ZIP Codes in Franklin County²



Additionally, unmet needs in behavioral health services can also be looked at by ZIP code. This map shows the percent of people indicating on the population survey that they needed but did not receive at least one service for themselves or a family member. The ZIP codes with the highest rate of service gaps are 43119, 43211, 43212, and 43232 ZIP codes. More details about the specific service gaps in each ZIP code can be found in the Behavioral Health Service Demand and Gaps Supplemental Excel File.

In comparing behavioral health service gap hot spots to the CelebrateOne and Franklin County Health Maps, there is significant overlaps in hot spots for infant mortality, emergency

room visits, drug overdose deaths and Narcan administration. This suggests collaboration with prenatal services, emergency rooms, hospitals, first responders and other efforts to address a range of concerns could also benefit behavioral health. Specifically, these collaborations could focus on areas with the greatest hot spot overlaps which are in ZIP codes 43068, 43204, 43207, 43211, 43228, 43229, 43232. Additionally, these hot spots also reflect communities that have experienced disinvestment and higher rates of individuals living at 200% of poverty (See Map C1 in Appendix C).

Populations Reporting Significantly Higher Unmet Needs

Based on the survey, focus group and system expert interview data, specific community members had higher unmet needs in the continuum of services.³ Table 3 shows that Black/African American community members experience unmet needs across the continuum.

² ZIP codes with fewer than 10 survey responses were not included in this analysis.

³ Analysis reporting on service needs and unmet needs are reported as odds ratios based on multinomial logistic regressions. The odds reported for unmet needs are the odds of reporting “needing and not receiving” services relative to “needing and receiving” the services. The odds ratios reported for service needs are the odds of reporting “needing and receiving” services relative to “not needing” services.

Additionally, individuals with lower education, disabilities or lower income also experience unmet needs in several areas of the continuum.

Table 3. Community Population with Significantly Higher Unmet Needs in the Continuum of Service

Population	Prevention Services	Family Supports	Housing Services	Recovery Supports	Treatment Services	Crisis Services
Bisexual, queer, pansexual, or questioning their sexual identity					•	•
Black families	•	•	•	•	•	
Individuals with a disability			•	•	•	
Individuals speaking English as a second language	•					
Family with children/youth	•	•				
Immigrant, Nepali and Asian community members*	•			•		
Justice-involved adults				•	•	
Individuals with lower education	•	•	•			•
Individuals with lower income	•	•		•		
Multi-racial individuals				•		
Retired individuals	•					
Transgender individuals			•		•	
Unemployed individuals				•		•
Veterans				•		

* These three communities reported higher unmet needs in the same two categories, however specific unmet needs varied by community.

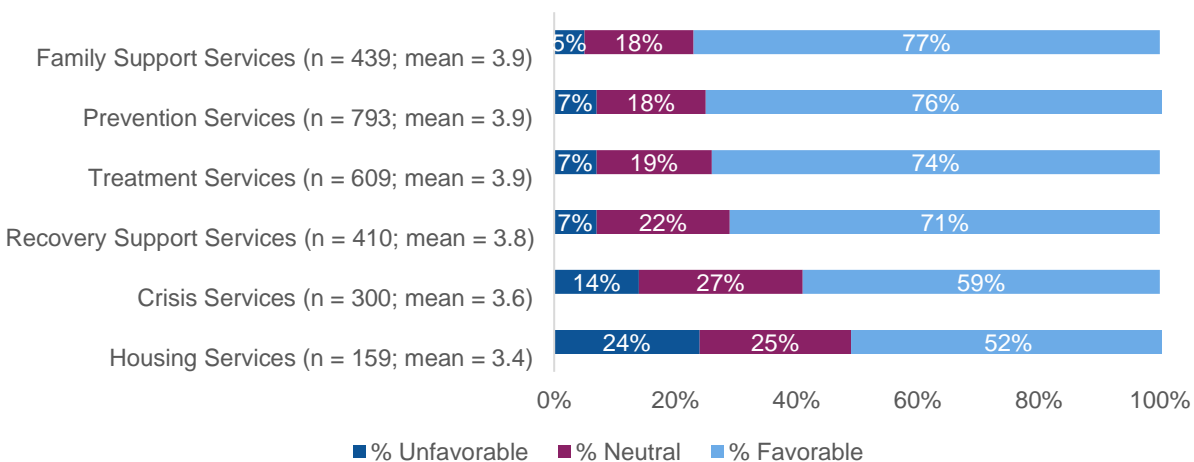
3. Community Experience

Understanding the community members' experience with behavioral health services provide insights into the unique challenges faced by different populations. Below summarizes the clients' satisfaction with the behavioral health services they received, pointing to opportunities to improve experiences. Additionally, a detailed discussion of the barriers community members face offers additional insights into opportunities for improvement.

Client Satisfaction with Services in the Broader Community

Research shows that individuals who have more positive experiences with their providers are more likely to stay engaged and have a chance to reach their best outcomes. To assess this, community members who reported receiving a service were asked to rate their experiences with providers, their overall satisfaction, and whether they would recommend their provider to others.^{4,5} As shown in Figure 13, community members, on average, have neutral to favorable perceptions of the mental health and addiction services they received. This suggests there is a need for improvement across all service categories from the perception of clients who have accessed services.

Figure 13. Community Member Satisfaction and Experience in Services Received



Client Satisfaction Related to Specific Populations

Experiences in services can be different for each individual based on their own characteristics. Community survey data highlighted favorable and unfavorable experiences which are disproportionately impacting the specific populations. Insights into strategies that could improve the client experience in mental health and addiction services are best discovered in an analysis to pinpoint factors that are contributing to more positive or more negative perceptions. In

⁴ The items for each service category were transformed into scale scores. All six scales demonstrated acceptable internal consistency with Cronbach's alpha ranging from .91 to .95.

⁵ The scale scores were then categorized into unfavorable, neutral, or favorable responses. All scales are based on a 5-point scale; unfavorable responses consistent of scale scores from 1.0 to 2.4; neutral responses consist of scale scores ranging from 2.5 to 3.4; favorable responses consist of scale scores ranging from 3.5 to 5.0.

assessing differences in perceptions of services based on respondent demographics, some key differences emerged.⁶

Improving the Experiences in Crisis Services Needs to Include Addressing the Traditional Gender and Sexual Orientation Lens Through Which Services are Developed and Delivered

One's experience in crisis services may be influenced by one's gender identity and sexual orientation. Based on community survey responses, transgender, genderqueer, gender nonconforming, and individuals who identified as another gender category had significantly *less favorable* perceptions of crisis services than females.⁷

Crisis Services Should Have Many Access Points and Comprehensive Supports

In the community survey, individuals with children under 18 years in their home reported significantly more positive perceptions of crisis services compared to individuals without children.⁸ This may be related to the system of care access points that are available to families and children through school-based services, pediatric providers and other collaborations designed to link children and families to needed services. Improving the crisis services for adults may include applying the same level of intentional design as the design of services for families with children. Adults without children are also part of a family, need a network of support and have specialized or natural points of access to the system of services.

Individuals in Recovery Services with Lower Levels of Education or Unemployed May Not Have Good Rapport with Providers

One's experience in treatment may be impacted by their level of education. Mental health and addiction treatment providers often have a professional degree and license. However, individuals accessing treatment services who do not fit that description may not have a very positive experience. Individuals who report "some college" as their educational attainment reported significantly less favorable perceptions of treatment services relative to those with a bachelor's degree or higher.⁹

Similarly, compared to individuals who are employed full time, individuals who are unemployed and looking for work have a lower perception of recovery staff being respectful, services being timely, and have a lower general satisfaction with the recovery services.¹⁰

Client Barriers to Services

Barriers to mental health and addiction services as reported by the Franklin County community members who were surveyed can be categorized into three overarching categories: 1) Practical barriers; 2) Barriers rooted in social determinants of health; 3) Barriers related to a lack of culturally relevant services and service providers. These barriers are experienced by individuals

⁶ In this Community Needs Assessment, all differences in perceptions of services by demographics were tested using multiple regression accounting for age, income, ethnicity, race, gender, whether or not there are children in the home, employment status, sexual orientation, and region born (i.e., U.S.-born or born outside of the U.S.)

⁷ $b = -1.7, p < .05$

⁸ $b = .47, p < .05$

⁹ $b = -.27, p < .05$

¹⁰ $b = -.56, p < .05$

throughout our community and in all service categories. Social determinants of health and systemic racism compounds the impact of all barriers.

Practical Barriers

Awareness and Availability

Community members' unawareness of services and lack of services that are immediately available at a convenient time were identified as barriers to accessing services. Community members and providers within other service systems (i.e., probation officers, social workers, etc.) lack knowledge of which mental health and addiction services are available in Franklin County. Not knowing about services and long wait lists keep more than half of community members from obtaining services and are also the most common barriers to services reported by providers (Figure 14).

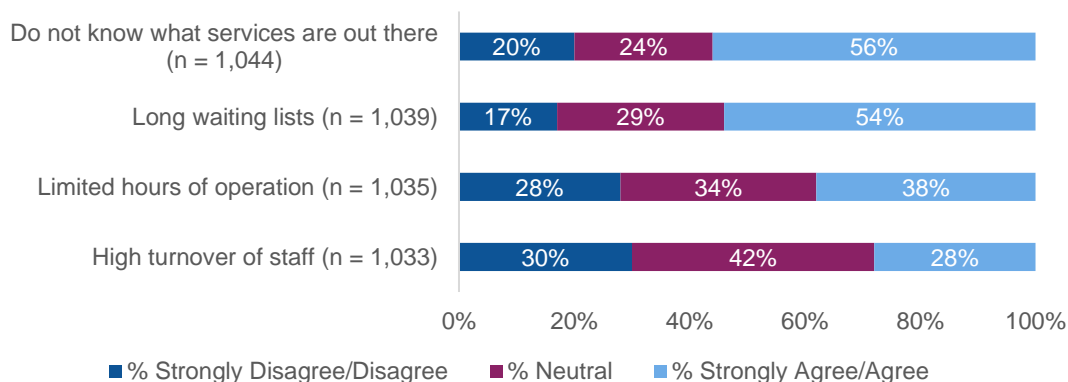
High turnover of service staff not only limits available appointments, but it is also defeating to clients when they build trusting relationships with clinicians, caseworkers, or other service providers and have to start over again. Instability on behalf of the service provider can also inhibit clients' treatment progress and continuity of services across service lines.

"24-hour crisis shelters were defunded and closed, they go to the ER and it's the ER's problem. When they get kicked out of the ER, they get arrested and now it is the justice system's problem." —System Expert

"When a person comes to a point of wanting help, the on-ramps are not known, the inroads are not clear." —Systems Expert

Figure 14. Community Member Perceptions of Awareness and Availability Barriers to Care Overall

How much do you agree/disagree that the following keeps you and/or a family member from getting help with needed mental health or addiction services



The weaknesses of the system, from the providers' perspective, are the limitations of the available services. Approximately 41% of the social service providers who left a comment in the provider survey about the weaknesses of the system (n=112) suggested services are limited. Limitations are brought on by capacity, funding or policy restraints, and the general siloed approach programs take in serving an individual.

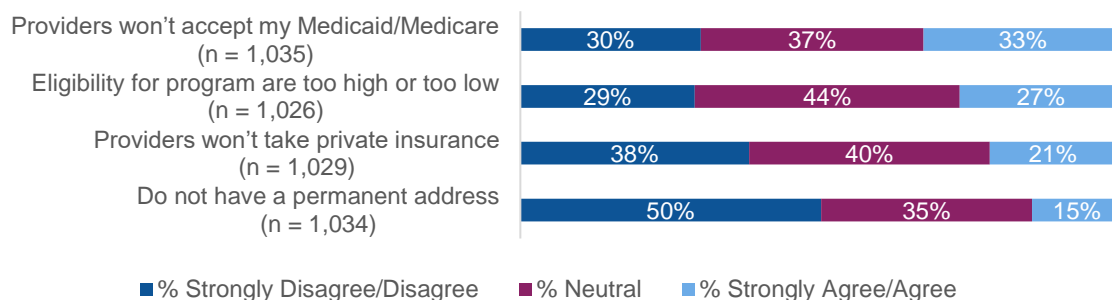
From the perspective of social service providers, these limitations result in long wait times. Though social service providers listed "wait lists" generally as a weakness, some providers specifically identified wait lists in psychiatry, assessment, addiction recovery, drug rehab, detox, and Children's Hospital. These limitations can prevent individuals from getting the additional services needed. Finally, 100% of social service providers who identified limited service supports listed housing as an unmet need.

Eligibility

Services are inaccessible in that there is limited knowledge of how to navigate eligibility and restrictive insurance practices among providers. Navigating service eligibility is extremely challenging for community members and providers within other service systems (i.e., probation officers, social workers, etc.) alike. Eligibility standards being either too high or too low keep 27% of community members from accessing services. A provider not accepting Medicaid/Medicare keeps 33% from obtaining services, while 21% of community members are kept from obtaining services due to providers not accepting private insurance. Furthermore, 15% of community members reported their lack of a permanent address keeps them from accessing or keeping engaged in services (Figure 15).

Figure 15. Community Member Perceptions of Eligibility Barriers to Care Overall

How much do you agree/disagree that the following keeps you and/or a family member from getting help with mental health or addiction services if you/a family member needed it?



Barriers Rooted in Social Determinants of Health

Accessibility

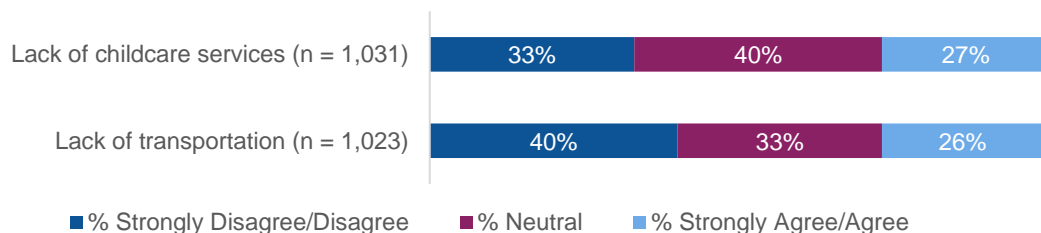
Many community members are unable to access services that may be available due to lack of transportation, childcare, or the ability to prioritize services over meeting basic needs. According to system experts and community members, there is little continuity between systems of mental health and addiction services and basic needs services. As a result, community members' attention on wellness is forced to compete with meeting basic needs.

“I was actually caught off guard... in respects to how COVID-19 impacted the cancelation of treatment appointments. Even people who need their appointments to obtain their medication have canceled their appointments at high rates, even though we have gone telehealth... I assumed that people would have prioritized their mental health during COVID-19. However, this time just shows the extent to how difficult it is or rather how inaccessible mental health services are perceived to be.” —System Expert

When compared to the limited time available in a day for caring for children and meeting basic needs, mental health services are perceived as a need that can be put off or a need that is inaccessible to the point that it is too overwhelming to pursue. Survey results show lack of childcare is a significant barrier to services for families with children. This challenge has been heightened due to school closings amid the COVID-19 pandemic. Also, nearly 1 in 3 community members agreed that lack of transportation and/or childcare prevents them or their family from receiving services (Figure 16). Community members who participated in focus groups and the majority of system experts in interviews identified that services are inaccessible because they are not available within or near all communities. Thus, there is a reliance on public transportation to receive services. According to focus groups and system experts, the public transportation system in Central Ohio prevents community members from accessing services because buses either do not come to their neighborhoods, or the schedule of buses and having to take multiple bus lines takes too much time, not allowing individuals to keep work hours, care for children and account for travel time to services. “Just because a service is on a bus line does not make it accessible,” explained a system expert.

Figure 16. Community Member Perceptions of Access Barriers to Care Overall

How much do you agree/disagree that the following keeps you and/or a family member from getting help with mental health or addiction services if you/a family member needed it?

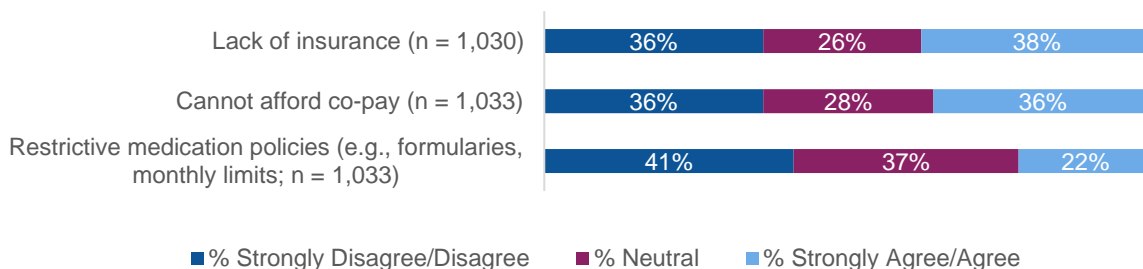


Affordability

Community members report the lack of financial means or insurance to pay for services. Lacking insurance and/or not being able to afford co-pays keep nearly 4 in 10 community members from receiving services (Figure 17). In the provider survey, social service providers¹¹ further explained in open-ended comments insurance is an access barrier because insurance policies may limit the services one can receive. It may also create a financial burden if the client does not have insurance or if the insurance has a high co-pay. This access barrier can cause community members to remain unserved or underserved.

Figure 17. Community Member Perceptions of Affordability
Barriers to Care Overall

How much do you agree/disagree that the following keeps you and/or a family member from getting help with mental health or addiction services if you/a family member needed it



It is common to find families whose incomes are too high to qualify for financial assistance, but not high enough to cover the cost of living or of services. On average, individuals/households with annual incomes between \$20,000 and \$39,999 were more likely to agree that co-pays keep them from receiving services than individuals/households who had yearly incomes of \$60,000 or greater.¹²

“Under-coverage of insurance is a big issue and often leaves people in a hole. [They are] not making enough money to afford care and making too much to qualify for assistance.”
—Service Provider

Lack of Culturally Relevant Services

According to the experiences of system experts and community members, the mental health and addiction system of services severely lacks culturally relevant service approaches for Latino, Black or African American, Asian, New American, immigrant, and other minority groups. According to system experts, the lack of culturally relevant services is historically rooted in most evidence-based practices in the mental health and addiction fields being based on majority, cisgender, white experiences and pathologies. Also, according to system experts, there has been an overall lack of organizational development funds provided to minority-focused

¹¹ 48% of social service providers who commented in open-ended comments about barriers to services.

¹² Scoring, on average, .32 points higher on a 5-point scale ($b = .32, p < .05$)

providers, which has restricted the administrative capacity for expert providers among racial and ethnic minority groups to compete for funds and expand their services.

From focus groups with community members and in interviews with system experts, services are specifically found to be inaccessible to minority communities in that:

- Services and awareness campaigns are not being provided in their first languages and language surrounding emotions and health are lost in translation when using interpreters. Stigmas related to mental health, addiction and services are culturally, gender and religiously relevant and there is a lack of information resources and awareness campaigns that address differences in stigmas.
- The system lacks services that account for language barriers and variation of languages within cultural groups. Appointment times remain the same, even though translations take up appointment time.
- There is distrust of healthcare providers and government agencies that assist with access to services rooted in historical mistreatment and unethical experimentation on vulnerable communities. According to system experts, some Asian cultures, Black and African American individuals would be more likely to pursue services if they were provided by or connected with their community's faith-based institutions they trust. Primary healthcare is normalized among some Asian communities, so the system's lack of continuity between family doctors and mental health is specifically a barrier to Asian communities. In another example, Latino parents perceive schools as a trusted source for mental health referrals (granted that parent, teacher, and school relations are good).
- Services lack approaches that account for culturally relevant experiences of racism and trauma.
- Services lack awareness of intergenerational differences among immigrant families.
- Finally, failing to recognize an individual as a member of a social/family unit is a barrier to holistic services. The role of family members is rooted in the culture of the family and through understanding of how to serve the family as a unit will improve service outcomes for all clients.

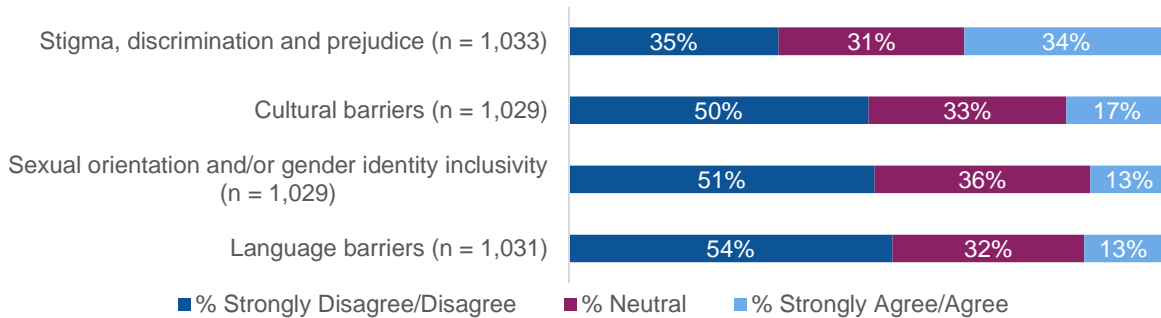
“On a basic level it is important for patients to see themselves reflected in the providers who are giving them care. That is something as a system we could work on. How do we develop those professionals and keep them engaged in our system... ADAMH needs to challenge partners to diversify and reflect their populations, including [ADAMH] itself.” —System Expert

Cultural Stigma

Some community members do not want to access health providers outside their community due to experiences of prejudice from healthcare providers; a general lack of understanding of how to navigate appointments, insurance, and paperwork; and that with stigmatized issues such as mental health, people are in need of speaking to someone with which they can relate and with which they share a language. Among community members, more than a third experience barriers to service due to stigma, discrimination and/or prejudice (Figure 18).

Figure 18. Community Member Perceptions of Inclusion Barriers to Care Overall

How much do you agree/disagree that the following keeps you and/or a family member from getting help with mental health or addiction services if you/a family member needed it?



Barriers Related to Specific Populations

Barriers affect different communities to varying extents. Community Needs Assessment results highlighted common barriers which are disproportionately impacting specific populations. Populations discussed here include the aging community, people with disabilities, people who do not have a college degree, justice-involved adults, undocumented immigrants, county border residents, and youth.

“I find support in [staff member]. I think there needs to be more people like her out in the community to help. At Home by High helps in more ways than a counselor does at a mental health facility, so I think giving those types of organizations more money would help everyone.”
—Community Member

Aging Community

Experiences of severe isolation by the aging community not only takes a toll on their mental health, but it is also a significant barrier to obtaining information about and accessing services. And when they do access services, older adults often **feel patronized by service providers**, “Some people treat us all like we are senile which is not the case, we have lived for a long time and know more than people think we do.”

Older adults report anxiety and depression are exacerbated by everyday tasks like remembering to pay rent when automatic payment systems are not an option or going to the grocery store and **fearing for their safety while walking or waiting for transportation**. Lack of transportation is another barrier in and of itself for the aging community. COVID-19 has only intensified isolation and fear of going to public places and has made it more difficult for older adults to ask for help from their loved ones, as they know the family also has harder schedules due to COVID.

County Border Residents

Eligibility for government-funded services is based on home addresses or residency. However, county borders often cut through neighborhoods, making one neighbor eligible for services but not the other. Households at the border, but outside county limits, are impacted by transportation barriers, because they are closer to Franklin County services, but **only qualify for services located at more rural hubs of services** for their county of residence.

People with Intellectual or Developmental Disabilities

Eligibility is a significant barrier for individuals with developmental and intellectual disabilities. There are **few skilled practitioners and psychiatrists that practice in dual-diagnosed developmental disability and substance use disorders** within the system. Furthermore, treatment centers can deny service to individuals below a certain IQ level and there are no places that specialize in prevention or addiction treatment for individuals with intellectual disabilities. Individuals with a disability and who cannot work also experience significantly higher barriers to service due to lack of transportation,¹³ not being able to find providers who accept Medicaid/Medicare,¹⁴ and not having information as to what services are available.¹⁵

“People think that it is not possible for individuals with intellectual disability to have alcohol or other drug disorders. But alcohol or other drug disorders occurs at all levels of functioning... I have issues making referrals to alcohol or other drug disorder services, and I fear [ID/DD community members] may be victimized in group treatment situations, and they can have the tendency to learn new unhealthy behaviors hearing them from others in the group... There needs to be more training [for how to identify and support ID persons] for everybody in the system, from receptionists to case managers to doctors to nurses.”

—System Expert

¹³ Compared to individuals who work full time (b = .69, p < .05)

¹⁴ Compared to individuals who work full time (b = .54, p < .05)

¹⁵ Compared to individuals who work full time (b = .52, p < .05)

People Who Do Not Have a College Degree

According to survey results, community members who have lower levels of education reported the **most types of barriers to services**. On average, people without a bachelor's degree or higher agreed that the below are barriers to services:¹⁶

- Lack of insurance¹⁷
- Providers do not accept Medicaid/Medicare¹⁸
- Do not have a permanent address¹⁹
- Language barriers²⁰
- Restrictive medication policies²¹
- Providers do not take private insurance²²
- Lack of childcare services²³
- Limited hours of operation²⁴
- Lack of transportation²⁵

Justice-Involved Adults

Services are inaccessible to justice-involved adults, who are also in recovery, in that their **terms of probation**, employment requirements, housing challenges, and other basic needs **compete with their mental health needs**. In order to better access mental health services, justice-involved adults first need eligibility barriers to employment and housing leases to be lowered.

Undocumented Immigrants

Services are inaccessible to undocumented immigrants in that many services require them to disclose their identity. There is **a fear disclosing their identity** and housing to government-funded organizations, leading individuals to forego services altogether.

Youth

Services are inaccessible to youth across cultural groups in that there is a severe lack of knowledge of mental health, of addiction and of services in general, and of a fear of talking about mental health with adults they know. Youth rely on internet searches, of which the **volume and conflicting information is too overwhelming to navigate**. Some youth are aware of hotlines to call and youth prefer being able to talk to hotlines about services, rather than trying to sift through internet searches. In addition to not having access to information on services, youth **fear asking adults they know for support**. Youth fear causing adults they love to worry and/or fear adults are quick 'to make a bigger deal out of it,' rather than just listening and talking. Youth are feeling as if they should be able to help themselves, their friends, and their family members when it comes to mental health and addiction needs.

¹⁶ All statistics reported are in comparison to those with a bachelor's degree.

¹⁷ High school degree (b = .76, p < .05); Some college (b = .50, p < .05)

¹⁸ Some college (b = .52, p < .05)

¹⁹ No high school degree (b = .38, p < .05); Some college (b = .35, p < .05)

²⁰ Some college (b = .22, p < .05)

²¹ Some college (b = .31, p < .05)

²² Some college (b = .33, p < .05)

²³ Some college (b = .35, p < .05)

²⁴ Some college (b = .32, p < .05)

²⁵ High school degree (b = .44, p < .05); Some college (b = .38, p < .05)

Barrier Takeaways

- Availability: Lack of awareness of services, limited appointments, and limited operating hours.
- Eligibility: Complex system of eligibilities, insurance system.
- Accessibility: Lack of transportation, childcare, or the ability to prioritize services over meeting basic needs.
- Affordability: Affordability of medication not only includes prescription insurance, but also affordable transportation, doctor visits, and blood work required to manage medications.
- Lack of culturally relevant services: Service not in first language or not translated in a culturally relevant way, awareness of cultural stigma or the role of family.
- Populations with unique barriers to consider are older adults, county border residents, people with intellectual or developmental disabilities, individuals with lower education, individuals who are justice involved, undocumented immigrants, and youth.

4. Social Service Provider Experience

Similar to clients, the experiences of social service providers who are somewhat familiar with ADAMH provides insights into opportunities to improve the system of care. Below is a review of social service providers' feedback from the provider survey and interviews with system experts.

Social Service Provider Experience and Satisfaction with ADAMH

Providers themselves had neutral experiences with ADAMH. Figures 19 and 20 show that there is great opportunity to improve internal customer service relationships with providers. However, providers also have a positive regard for what ADAMH brings to the community in terms of value (Figure 21). Specifically, 8 out of 10 providers agree that ADAMH has a positive impact on the lives of Franklin County residents. Providers (77%) also see that ADAMH is committed to ensuring residents have access to mental health and addiction services.

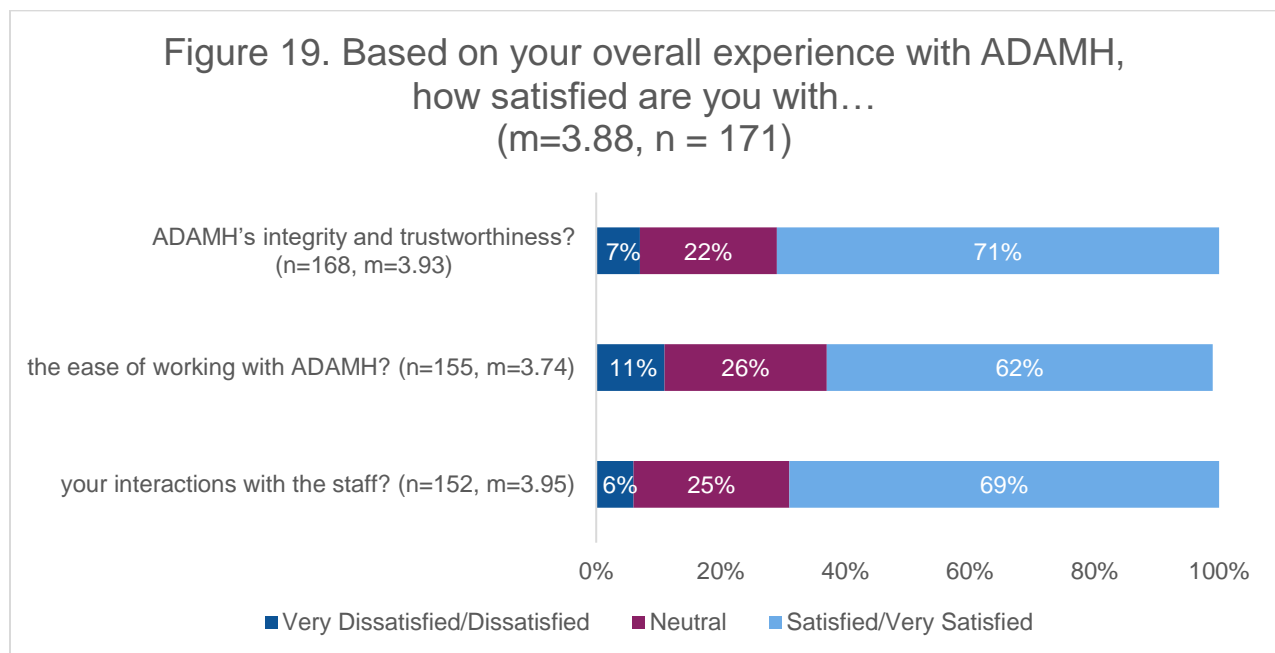


Figure 20. Please rate the quality of each element of ADAMH.
(m=3.14, n = 186)

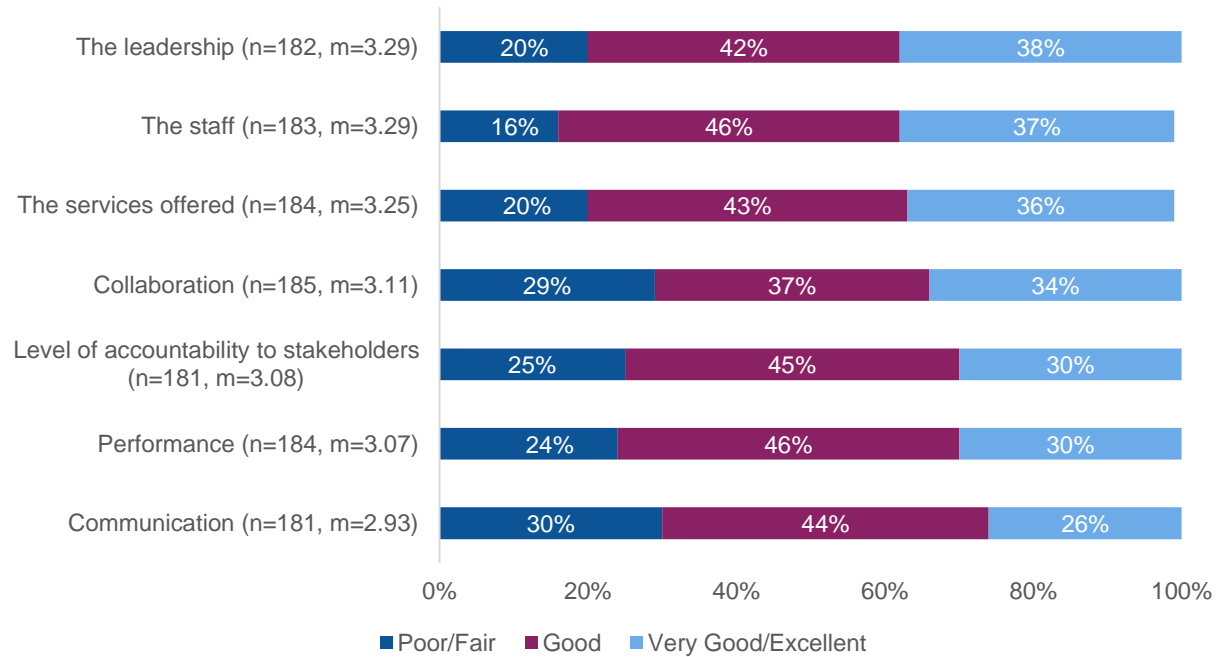
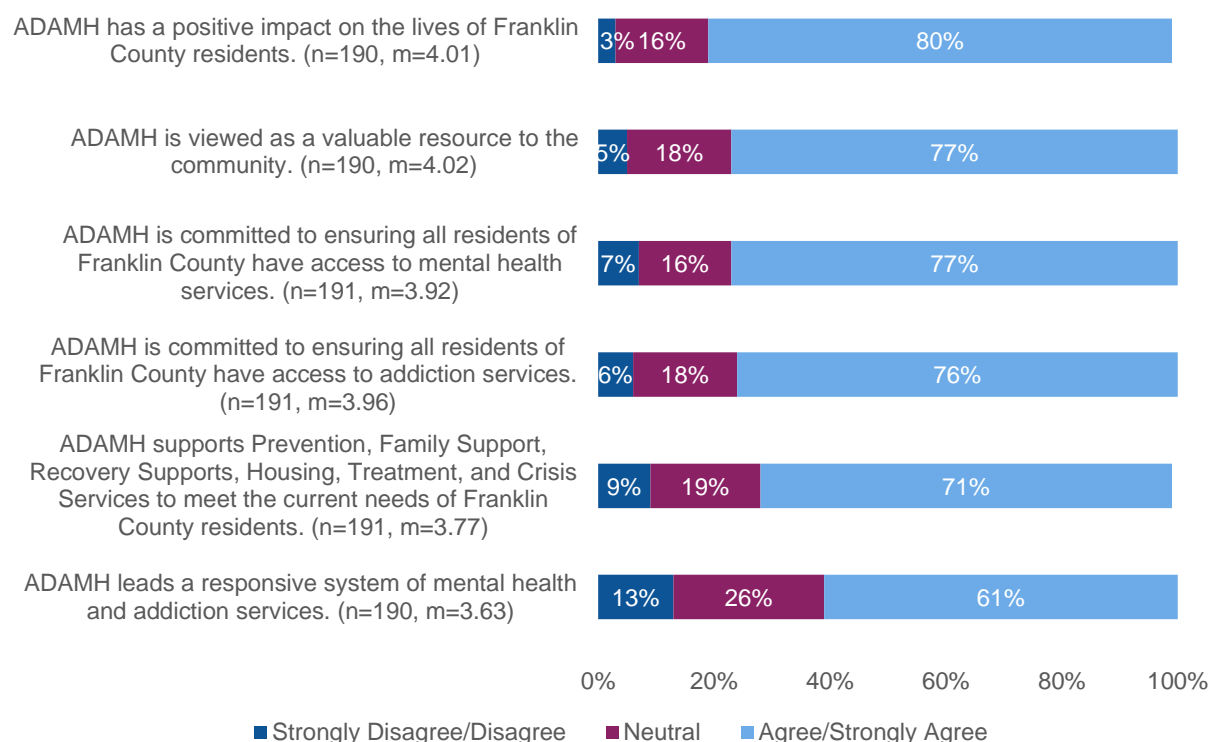


Figure 21. Based on your experiences with ADAMH, please select how much you agree or disagree with the following statements.
(m=3.88, n = 191)



Barriers Social Service Providers Face

Organizational Quality

System experts link some barriers to service and racial disparities in service outcomes to ADAMH practices and other system barriers. Conversely, system experts perceive this as a strength in that ADAMH policy changes have the capacity to bring greater equity to accessing and receiving mental health and addiction services.

Limited Capacity

System leaders report a shortage of community behavioral health providers (i.e., case management, licensed therapists, other clinical staff). For the professionals in the field, providers experience high turnover among these positions, often caused by productivity demands and dissatisfaction with pay. Providers suggested that having more case managers and other clinical staff may address the other system weaknesses such as care coordination and reducing wait lists.

Limited Collaboration Between Partners and Systems of Care

System experts agree that ADAMH is lacking initiative when it comes to collaborating with external service systems related to social determinants of health and that overlap with the needs of their mental health service users. System experts identified ways shown below in which ADAMH lacks external relationships:

- ADAMH Franklin County does not coordinate with neighboring ADAMH county boards, despite having shared interests and barriers to border residents.
- ADAMH has limited collaboration with universities, faith-based institutions, and minority-based organizations to develop culturally relevant best practices into “evidence-based” methodologies.
- Because of the lack of collaboration, ADAMH has less effective interventions and equity of services within the housing and justice systems.

Funding Bureaucracy

Non-Inclusive Funding Practices that Limit Community-Based Organizations From Competing for Dollars

ADAMH funding structures are inaccessible to community-specific providers in that:

- Funding applications and performance reporting have high administrative demands.
- Grant allocation processes are not transparent, with the same large agencies continuously receiving funds and smaller organizations not receiving feedback as to why they were not supported with grants.
- Application processes devalue the expertise of community-based groups because their service methodologies are not clinically studied, but rather culturally informed by first-hand experience.
- Funds are often restrictive, not allowing expenses for providing food, conducting outreach, or translation. “Why can we hand out Narcan and not food? Food and water are life-saving measures, too,” explains a system expert. This is especially true for smaller, culture-specific organizations who report outreach costs being higher than the award costs. Not being able to give clients food severely limits engagement because the clients are too undernourished to effectively engage.
- Community-based providers best suited to conduct outreach and provide services to target populations are often only engaged as sub-contractors to larger agencies based outside the community. Without primary contracts and grants, community organizations are prevented from investing in key tasks, such as developing best practices into ‘evidence-based’ methodologies and paying competitive salaries to recruit and retain staff.

Restrictive Funding Practices that Limit Quality of Services

System experts perceived federal, state and ADAMH's grant processes to value quantity of services over quality of services. Funding structures incentivize organizations to focus on providing services and treatment types needed by majority populations, making it difficult for organizations that specialize in minority cultures rather than volume of services. Additionally, providers are incentivized by this structure to repeat the same services for a single patient multiple times, even if a more appropriate and effective service could be given by a competing

provider. This also disincentivizes providers from giving longer appointments to individuals needing interpretation services, as it would lower the number of patients seen in a day.

Community-based organizations identified the need to be able to conduct remote assessments in communities and homes, arguing that precautions can be taken without violating HIPAA confidentiality. Allowing remote assessments would improve access to communities who face social determinants of health barriers such as transportation or lack of childcare. The possible closing or restricted growth of community-specific organizations due to the discussed policies will further contribute to a service system wherein culturally relevant services to minority communities are lost.

5. System Strengths and Opportunities

Franklin County's behavioral health system has several strengths that support the system in achieving success. Understanding the perceptions of ADAMH gives insight into the strength in which ADAMH can lead the system of care. System experts perceive ADAMH to be well positioned to bring about systemic change in the mental health and addiction services system.

Positioned to Bring About Systematic Change

First, system experts have great confidence in ADAMH's new leadership. In particular, partners are encouraged by ADAMH leadership's cultural awareness, political knowledge and collaborative skills. From a relationship perspective, ADAMH is now better positioned to collaborate with housing, workforce, judicial and other public service systems in order to systematically lower social determinant of health barriers to all service lines for all communities. These positive perceptions can be used to energize partnerships and collective advocacy to address social determinant of health.

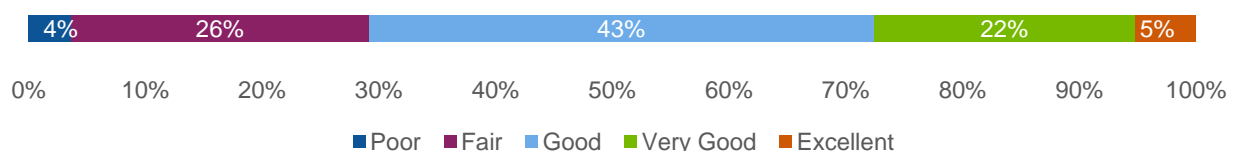
Second, some barriers to services are linked to ADAMH policies. However, system experts perceive ADAMH to have greater autonomy than other service systems in Franklin County. Leveraging its autonomy, ADAMH has the opportunity to greatly increase the accessibility and effectiveness of services with a few strategic policy pivots (see "ADAMH Practices Perceived to Limit Access to Services"). "ADAMH is doing a lot of important work and cares greatly, we just need to make more accessible to all," explained a system expert.

Third, system experts agree ADAMH has had a great capacity for creatively utilizing funds from the opioid crisis to build a stronger system overall, not just treating opioid-related needs. Also, "COVID-19 shows the resiliency of the ADAMH system, being long underfunded, it knows how to pivot," said a provider.

Fourth, ADAMH's autonomy also allows them to support emerging best practices. In particular, ADAMH supports Narcan and clean needles distribution, HEP-A testing outside clinic settings, and developing more relevant emergency room protocols for patients needing mental health services.

Finally, on average, community social service providers who completed the provider survey were "familiar" with ADAMH. Only 5% of respondents were "not at all" familiar. Of those who have some familiarity with ADAMH, seven out of 10 believe ADAMH is doing a good, very good or excellent job at addressing the community's mental health and addiction service needs (Figure 22).

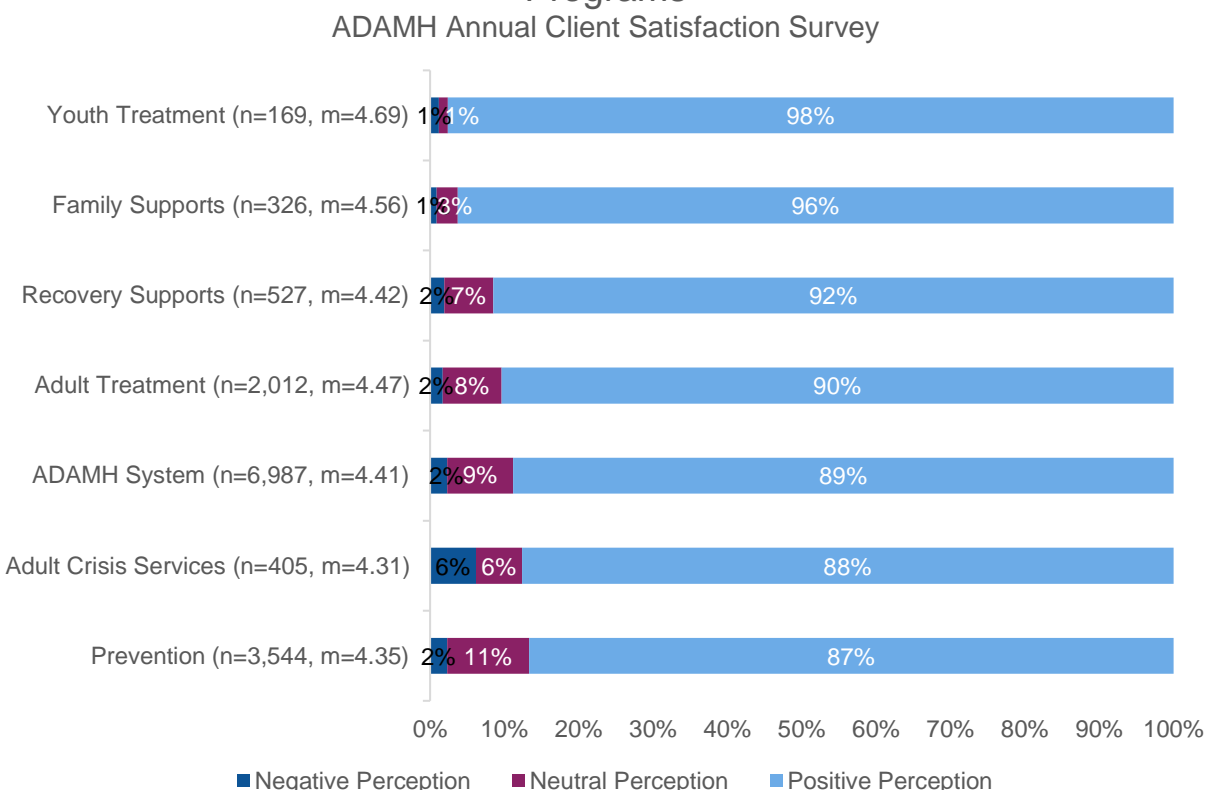
Figure 22. How is ADAMH doing at addressing the community's mental health and addiction service needs through their work?
(m=3.00, n = 192)



Making Quality and Impactful Services Accessible

Though ADAMH does not provide actual direct services, the clients of the contracted providers are surveyed every year to monitor the quality of services for which they are being paid. The results of the 2019 survey show that clients have highly positive perceptions across all service categories with the highest rating in youth treatment and family supports (Figure 23). Another encouraging result is that the client perceptions in each service category and overall are higher among ADAMH clients than service clients from the general community.²⁶

Figure 23. 2019 Client Satisfaction with ADAMH Funded Programs



According to the 2020 Levy Fact Book, there continues to be an increasing need for behavioral health services. In 2019, ADAMH saw a 47% increase in clients served through contracted services from 2017. Additionally, 85% of clients live below the federal poverty level. Over 70% of ADAMH's resources come from a property tax levy. In 2020, this tax levy was approved to ensure services continue to be available to community members regardless of their ability to pay. The 2020 Levy Fact Book outlines details of ADAMH investments, projects and impacts.

Range of Services and Commitment of Providers In Our Community

Over half of the social service providers who left a comment in the provider survey about the strengths of the system (n=124) identified one or more of the services currently available. Specifically, the services most frequently identified were crisis services, treatment, prevention,

²⁶ The satisfaction items included in the Community Needs Assessment to assess the quality of experience of the general population in mental health and addiction services in general was designed based on ADAMH's 2019 survey.

and school-based services. Nearly 20% of the social service providers identified individual and organization providers as system strengths. The strength lies in their commitment to their work, care for their clients and doing their best in their environment.

6. Broader Behavioral Health Trends in Franklin County

A review of community level behavioral health trends allows ADAMH to put the needs and unmet needs into context. Below is a brief summary of key behavioral health outcomes, a framework for understanding the role or social determinants of health, and a summary of community members' perspective on the need to instill hope and a sense of community. See Appendix D for supporting data figures and tables.

Behavioral Health Outcomes

Previous research and community data highlight the growing need for mental health and addiction services in Franklin County. Pre-pandemic trends in mental health and addiction indicators suggest a greater need for downstream strategies and targeted efforts. For example, rates of depression and substance related injury and death rates are increasing.

Mental Health

Major depressive episodes are on the rise (Figure 24),ⁱ especially among young adults. Figure 14 shows the historical rates of death by suicide in Franklin County. This behavioral health trend shows a consistent difference in the rates by race with the suicide death rates for white individuals being the highest and for Black individuals being the lowest. However, since 2016, the suicide death rates for Black individuals has doubled where rates among other races have declined. (See Figures D1 and D2 in Appendix D for additional data).

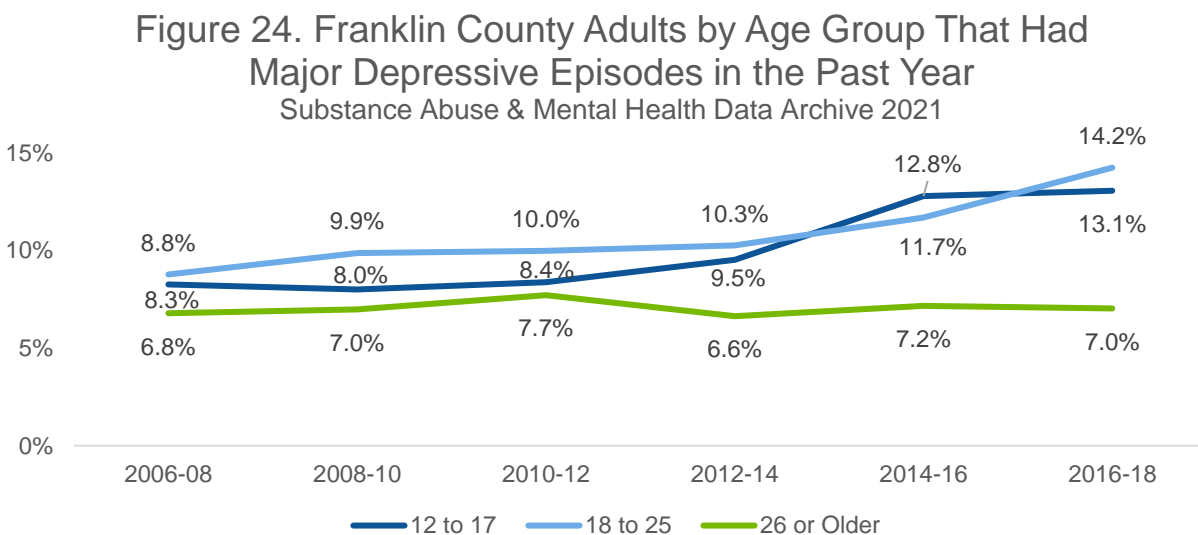
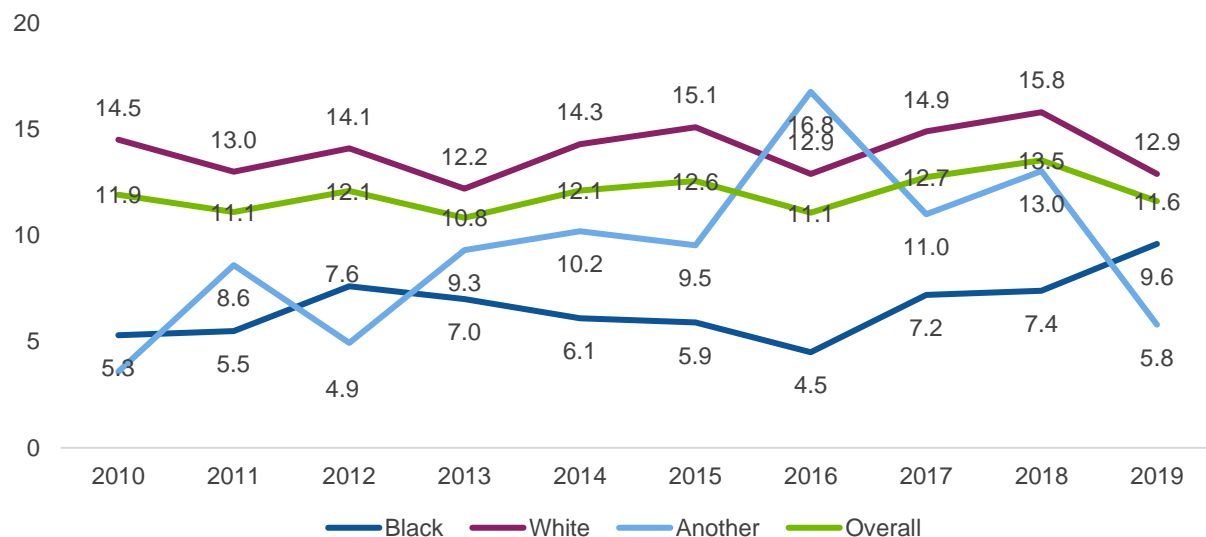


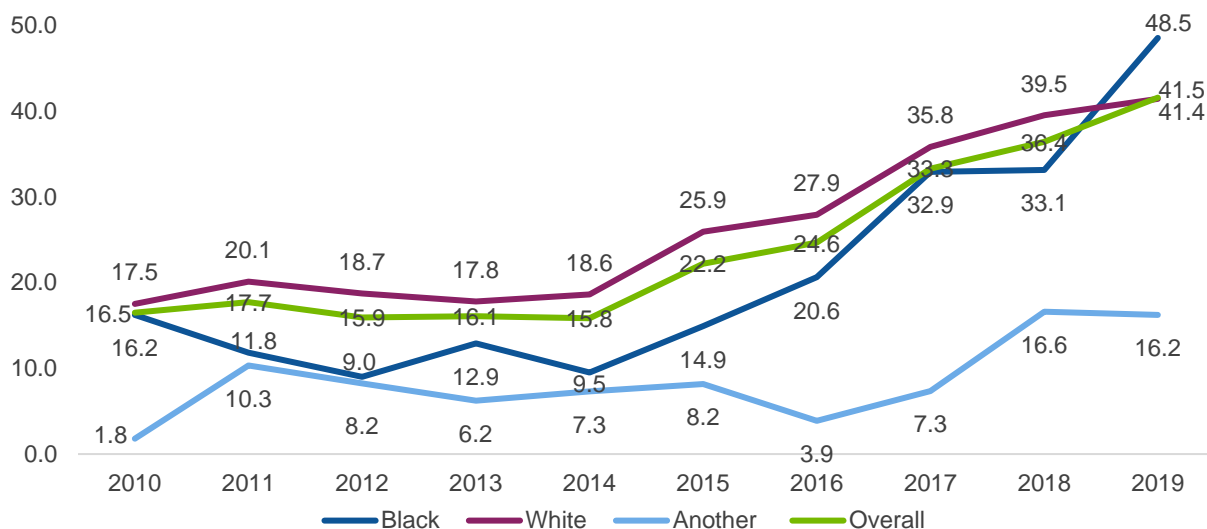
Figure 25. Franklin County Suicide Deaths by Race
Ohio Public Health Information Warehouse



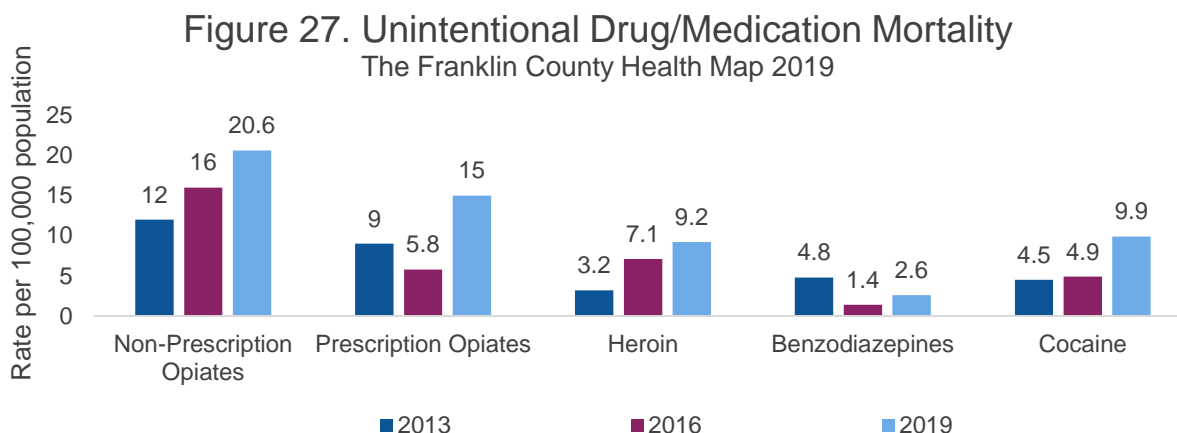
Substance Use

In Franklin County, the overall overdose death rate has continued to increase to 41.5 with the rate of death among Black community members having a noticeable spike from 33.1 to 48.5 between 2018 and 2019 (Figure 26).

Figure 26. Franklin County Drug Overdose Deaths by Race
Ohio Public Health Information Warehouse



Additionally, there has been an increase in the unintentional drug/medication mortality rates which has increased from 16 people per 100,000 in 2016 to over 24 per 100,000 in 2019, (Figure 27). With the rise that has been seen in opiates, heroin, and fentanyl, Narcan has been used to combat the number of overdoses. People who are identified as white do have a higher death rate from most drugs than Black individuals. However, the Black population does have a higher death rate in relationship to fentanyl and analogues, cocaine, and other synthetic drugs.ⁱⁱ



According to most recent data from the Behavioral Risk Factor Surveillance System (BRFSS),ⁱⁱⁱ and the Franklin County Health Map 2019,^{iv} alcohol related injuries are at their worst since 2013 and deaths are nearly the same, (Figures D3 and D4). The percent of alcohol related driving deaths that have occurred at the county level for Franklin County have changed very little, increasing from 33.7% in 2012 to 34.8% in 2018, while the overall rate for Ohio has decreased from 36.1% to 32.7% (Figure D5).

Although the majority of the data sources used for this Community Needs Assessment were published prior to the spring of 2020, experts agree mental health and addiction disorders will be exacerbated due to the COVID-19 pandemic. The consequence for behavioral health services is an influx in the need for services, specifically related to conditions perpetuated by a pandemic, extended periods of isolation, and economic uncertainty.

Behavioral Health Trends: Key Takeaways

- INCREASE IN DEPRESSION, SUICIDE AND MENTAL ILLNESS.
- INCREASE IN DRUG-RELATED DEATHS.
- MOST NOTICEABLE SPIKES IN DRUG AND SUICIDE RELATED DEATHS AMONG BLACK COMMUNITY MEMBERS.
- WITH PRE-PANDEMIC BEHAVIORAL HEALTH STATS GETTING WORSE, THE IMPLICATIONS ARE AN INCREASED NEED FOR BEHAVIORAL HEALTH SERVICES.

Partnership and Strategies to Address Social Determinants of Health

Like all other communities, Franklin County has evidence of disparities in outcomes and social determinants of health based on an individual's age, race, gender, and ZIP code. These social determinants of health^v are social and environmental factors that increase the likelihood of poor physical and behavioral health outcomes when left unaddressed. The social determinants of health framework for Franklin County Public Health is displayed below.



Community members and social service providers perceive Franklin County to be doing a “fair” to “good”²⁷ job at improving social determinants of health with perceptions being lowest for housing and neighborhoods.²⁸ For the purposes of this Community Needs Assessment and the availability of data, we focused on economic stability, education, housing and neighborhoods, and transportation.

Economic Stability. Though mental health and addiction impacts people at every income level, individuals living in poverty experience greater risks of long-term adverse mental health outcomes.^{vi} In adults, poverty is linked to depression, anxiety, psychological distress and suicide. In children, poverty is associated with lower school achievement; worse cognitive, behavioral, and attention-related outcomes; higher rates of delinquency, depressive and anxiety disorders; and higher rates of almost every psychiatric disorder in adulthood.^{vii} In Franklin County, poverty is twice as prevalent among Black and multiracial individuals than white individuals (see Figure D6). As a result of the COVID-19 pandemic, even more families are experiencing income instability as government and organizational policies have restricted the operation and normal work experiences in some industries.

For behavioral health providers, this means the negative effects of poverty may be driving one's mental health. Therefore, strategies and partnerships to address poverty will improve the overall

²⁷ Provider Survey: n=215, Mean = 2.31, Community: n=1,642, Mean = 2.72 with 1 = poor, 2 = fair, 3 = good, 4 = very good, 5 = excellent

²⁸ Provider Survey: n=215, Mean = 1.97, Community: n=1,638, Mean = 1.9, with 1 = poor, 2 = fair, 3 = good, 4 = very good, 5 = excellent

mental health. More specifically, strategies and partnerships that are relevant to Black and multiracial individuals may be even more productive.

Housing and Neighborhoods. Individuals living in under-resourced neighborhoods experience violent crime and poor environmental living conditions such as mold, asbestos or lead at a greater rate than those living in neighborhoods with greater resources. These living conditions are linked to chronic disease and poor mental health.^{viii} Residential segregation is also a social determinant of health as it is linked to health disparities, poor housing conditions, higher crime rates, low economic mobility, and poor access to healthcare.^{ix} The ongoing racism and disinvestment in certain neighborhoods perpetuates conditions that put residents at greater risk for poor physical and behavioral health.

Education. Access to education at all levels is linked to one's access to quality health care and physical and behavioral health outcomes. Access to early childhood education helps young children get a healthy start and is a key strategy for early intervention. Education significantly predicts one's ability to earn a wage that is above poverty levels. In Franklin County, high school graduation rates are lowest among Black/African American individuals and individuals from another race.²⁹ Additionally, when looking at trends in similar communities, data suggest there are significant barriers in Franklin County preventing the Black/African American community from graduating high school (Figures D7 and D8).

Transportation. Transportation is one of the most frequently cited barriers to accessing needed services and resources. Although, the majority (81%) of people living in Franklin County commute to work in their own vehicle, 7.5% of households do not have their own vehicle. Furthermore, only 2.4% of the population is utilizing public transportation, (Figure D9). This 5% gap represents over 67,000 people³⁰ in Franklin County who do not have access to public or personal transportation.

System experts agree, collective impact efforts are needed with housing, workforce, judicial and other public service systems in order to systematically lower social determinants of health barriers to all service lines for all communities.

“ADAMH does not need to create a bus company. But, they can use their position to influence other agencies and to advocate for transportation. It is a barrier in all systems. Employers need it, hospital systems, housing system, grocery stores need it. ADAMH can use their power to work with others to get healthy food access into Linden and so on.”
—System Expert

²⁹ An individual who identifies as Another Race and did not identify as American Indian or Alaskan Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, White or Caucasian or Multiracial

³⁰ American Community Survey 1 Year Population Estimate, 2019. 1,316,756 multiplied by 5.1%

Social Determinants of Health Key Takeaways

- Poverty for Black and multiracial individuals is more than twice as high as it is for white.
- Ongoing racism and disinvestment in certain neighborhoods perpetuate conditions that put community members' health at risk.
- Data show there are significant barriers in Franklin County preventing the Black/African American community from graduating high school.
- There are an estimated 67,000 people in Franklin County who do not have access to public or personal transportation.
- Expand partnerships with community-based organizations that are working to address social determinants of health.

The Need to Inspire Hope

In focus groups and interviews, community members and providers agree for the need for services to include programs that inspire hope and build a network of neighborhood-based support. For adults and youth alike, building hope also includes workforce development and academic support opportunities. Hope is required in order to motivate community members to both seek and prioritize other mental health needs. Youth, for example, most often perceived the need for mentoring, extracurricular activities, workforce development and academic support that are provided in small group settings. Youth need individualized services, but youth have also identified that their mental health needs are rooted in feelings of isolation, albeit a range of types of isolation.

In another example, aging communities have reported extreme isolation and fear, particularly due to their safety in neighborhoods and due to COVID-19 where the few community-building programs that provided socialization have ended. Older adults explained that socializing brings them a sense of hope and happiness. Having hope is what motivates them to seek mental health or addiction services in the first place. Older adults also express a need for group programming that includes other age groups so they are not further isolated from younger members of the community.

Building a Community of Support

Additionally, there is the need for programs that build communities of support. In doing so, system experts believe this will: 1) build trust between the mental health providers and cultural minority groups; 2) increase mental health and addiction awareness, as information can be shared more easily and accurately where there are communication networks in place; 3) increase access to services, as individuals will be able to ask for help more easily; and 4) better involve social networks to support long-term positive treatment outcomes.

Unique Behavioral Health Trends by Population Groups

To capture the experiences of community members who are typically underrepresented in survey data and general community trend data, this Community Needs Assessment had a focused data collection effort. The following section outlines unique needs of specific population groups that were uncovered through secondary sources, interviews, and specific population

focus groups. Results highlight how specific demographic characteristics predisposes individuals to greater systematic barriers.

Aging Adults/Older Adults

Mental health concerns for adults who are nearing retirement age or over (60 years plus) is a growing concern. In recent years, there has been an increase in the proportion of older adults reporting mental distress, depression, and dying by suicide. Also, as discussed in the “*Summary Assessment of Older Ohioans*,” disparities occur based on race and/or income in both the number of older adults smoking and the number of unintentional drug overdose deaths for those age 65 and older. The overdose death rate statewide for older adults has doubled over the past decade.^x And the rate of overdose deaths for Black/African Americans in Ohio is more than six times greater than their white counterparts (24.3 compared to 4 deaths per 100,000).^{xi}

Youth and Young Adults

Based on the local study, “*Cultivating Opportunities for Youth to Flourish in Franklin County*,” almost a quarter of Columbus’s youth and young adult population have reported experiencing mental health challenges in the past year.^{xii} In 2018, the suicide rate was 12.8 per 100,000 youth between the ages of 15 and 24 in Franklin County.^{xiii} Unfortunately, there are several problematic trends for youth and young adults in Franklin County that may be causing the rise in behavioral health outcomes.

In 2017, it was estimated that nearly 3,000 youth experience literal homelessness annually in Franklin County. Often youth and young adults end up homeless after experiencing trauma, while the trauma itself does not cause the homelessness, it’s the youth and young adult’s ability to cope or handle the stress and recover from the trauma, leading to homelessness. Further, there has been an increase in the number of youths who are in the foster care system increasing from 13.2 in 2015, to 13.7 per 1,000 youth in 2018.^{xiv}

In Fiscal Year 2019, the Ohio Department of Youth Services received 12% of its total admissions from Franklin County. In contrast Cuyahoga County represented nearly 20% of the total admissions. The services provided through Ohio Department of Youth Services include providing mental health and substance abuse treatments, which is to help prevent youth from committing new offenses. Across Ohio, males make up over 90% of admissions, Black youth make up 53% of admissions, while white youth only account for 34%.^{xv}

LGBTQ+ Persons

Sexual and gender minority persons have higher rates of reported anxiety, mood disorders, substance use, and suicidal ideation.^{xvi} Further, Lesbian, Gay, and Bisexual people misuse prescription pain relievers more often than those who identify as the sexual majority.^{xvii} Additionally, the LGBTQ+ community are more often prescribed opioid pain relievers than their counterparts, but this could be because more LGBTQ+ individuals are placed in environments where pain management is more common, such as, when a Transgender person undergoes gender confirmation surgery or HIV/AIDS pain management.^{xviii}

Transgender individuals have a high prevalence rate of suicide attempts at roughly 40% over their lifetime.^{xix} For the LGBTQ+ community overall, suicide prevalence is most likely to occur during the teen years and early 20s, and is nearly four and a half times higher than their non-LGBTQ+ counterparts (29.4% to 6.4% attempt suicide).^{xx}

New Americans – Refugees

New Americans (including undocumented immigrants) and/or Refugees often suffer a wide range of mental health and substance use problems at an increased rate of incidence as those born and raised in the United States. New Americans and Refugees often suffer from Post-Traumatic Stress Disorder (PTSD) and depression that stems from the reason they moved to the United States. Several New Americans are leaving countries because they were suffering from war, famine, political oppression, other economic reasons, or just wanting to improve the quality of life for themselves and their families.

Reports detail that various New American populations experience rates of suicide and PTSD at higher rates than non-New Americans. Specifically, Bhutanese refugees have a suicide rate that is nearly twice as high as non-refugees, a rate of depression that is three times higher, and suffer a rate that is 10 times higher than the general public for PTSD diagnoses.^{xxi}

Somali immigrants also face hardships with coming to the United States and Central Ohio. Many of the community members have memories of living in active warfare or conflict areas, resulting in the development of PTSD, depression, and adjustment disorder. These problems, if left untreated, can affect their children and others in their community as well, due to the caregivers' inability to fully nurture the developing youths.

First Responders

Those that serve the community including police, firefighters, and Emergency Medical Services (EMS) often respond to tragic happenings in the community from domestic violence, houses burning, car accidents, drug overdoses, and deaths among many other extreme cases. These instances often cause first responder to suffer physically and potentially emotionally or mentally. Studies have shown that first responders, specifically fire service responders have a rate that is nearly five times higher than the civilian population for suffering from PTSD and depression. Suffering from these conditions can often lead to other manifestations of poor physical and mental health if left untreated. This can impact their ability to make decisions and cause detrimental impacts to the performance of the unit's response in providing needed services to those in the community. For Columbus, the Training Bureau created a Member Support Unit in September 2019, in response to these concerns, to raise awareness of mental health topics, provide training and peer outreach.^{xxii}

A successful behavioral health system of care must include collaboration among multiple systems of care to ensure all community members have access to services that are right for their circumstance.

Table 4. Summary of Behavioral Health Needs for Unique Populations								
	Depression	Suicide	Drug Overdose	Trauma	PTSD	Substance Misuse	Anxiety	Mood Disorders
Aging Adults	X	X	X					
Youth		X		X				
LGBTQ+		X				X	X	X
New Americans/ Refugees	X	X		X	X			
First Responders	X				X			

7. Key Takeaways

The results of the Community Needs Assessment highlight the service needs, unmet needs and barriers across the system of care. Additionally, analysis identifies the differences between community members' experiences. The following are the key takeaways:

- There is an opportunity to operationalize service quality standards and build a framework for evaluating system quality and effectiveness. The results from The Community Needs Assessment showed that stakeholder perceptions of the quality of behavioral health services are low across the system of care. Themes from open-ended comments in surveys as well as feedback from focus groups and system experts suggest building the capacity and cultural relevance of services will improve quality. With these results in mind, ADAMH will build out their Results Based Accountability evaluation framework to ensure quality improvement across all investments.
- An overwhelming theme from all data sources is that information about behavioral health and behavioral health services are not readily accessible for both providers and community members. Feedback from focus groups and system experts further explain that communications that are not in a person's first language and that do not account for cultural stigmas around behavioral health impact the quality of information that is available.
- Unmet service needs exist across the continuum. Prevention and treatment have the largest service needs. Prevention, family supports, recovery supports, and treatment services have the largest unmet need. Specifically, the following have the highest need and unmet need:
 - Prevention Services: Summer camps; early intervention; early childhood mental health programs, youth-led programs, school-based and after-school prevention programs; community-based prevention programs; general information about mental health and addiction; suicide prevention programs
 - Family Supports: Family training and counseling, family outreach, parenting and family education/skills training
 - Recovery Supports: Education support, employment services
 - Treatment Services: Outpatient counseling/psychotherapy
- Prioritize ZIP codes with highest service gaps. The percent of people indicating a service gap in at least one service is most frequent in 43119, 43212, 43232, and 43211 ZIP codes. Additionally, prioritize ZIP codes with high rates of ESL. These include 43224, 43229, 43231, 43016, 43219, 43213.
- The complexity of mental health and addiction and the interrelated factors (i.e., social determinants of health) that impact an individual's ability to achieve well-being makes it necessary for a behavioral health system to collaborate with other systems of care. Opportunities for innovative partnerships to address social determinants of health are in common hot spots, which include 43232, 43207, 43211, and 43223.

8. Strategic Considerations

The following strategic considerations were generated based on feedback from community partners at the Community Partner Meeting on January 29, 2021. During this meeting, invited guests were presented with the preliminary results of the Franklin County Community Needs Assessment, then broke into small groups to identify strategic priorities that address the needs presented. Feedback was focused on the most important considerations that will allow ADAMH leaders to efficiently and effectively develop strategies and investments that help ADAMH fulfill their mission and vision over the next five years. The recommendations listed are consistent with themes found throughout the various data collection methods and should be the basis for future strategic-planning conversations.

Build cultural relevance through language and communication.

Across the continuum and stakeholder groups, there is need for a system to be more relevant to the people being served. Being relevant is not just the extent to which providers are culturally competent. Based on feedback from community members, community social service providers, system experts and participants of the community partner meeting, cultural relevance encompasses engaging and connecting to an individual or family within the context of their own culture. In summarizing stakeholder feedback, building cultural relevance includes a more intentional focus on language and meaningful communication across the lifespan. Finally, participants of the community partner meeting urge ADAMH to be specific about the desired change and how it will be measured. Below are key takeaways from the community partner meeting:

- Language. ADAMH needs to reinforce cultural and linguistic standards; translation services also need to be culturally relevant, focusing on the cultural interpretation of language being used.
- Communications and messaging. All information should be available in community members' first languages; Messaging should be age and life-stage appropriate (e.g., messages that speak to older populations and well as younger populations).

Innovate strategies to recruit and retain a client-reflective workforce and system leadership.

Community members, social service providers and system experts agree that staff turnover is a barrier to quality care. High staff turnover rates are the results of relatively low pay, productivity demands, administrative paperwork demands and the generally high-stress nature of behavioral health services. Additionally, all stakeholders recognize the current behavioral health leadership and workforce is not reflective of the community. Participants in the community partner meeting prioritized the following to address a more client-reflective workforce:

- Consider new strategies for addressing the pay gap and productivity demands to ensure clients are receiving consistent, high quality services.
- Commit to diversity, equity and inclusion strategies for building board leadership and system leadership.
- Build non-traditional partnerships for more workforce diversity including non-mental health community-based programs, historically Black colleges and colleges that serve Appalachian communities.

- Create care coordinator/advocate positions that do not require a license to connect people to services.
- Empower cultural community leaders/trusted messengers.

Expand culturally relevant programs across the continuum.

The need for culturally relevant programs was also a strong theme in the Community Needs Assessment. Community members, social service providers and system experts shared their experiences with programs that missed the mark in terms of speaking directly to the context (i.e., age, race, family, etc.) of the individuals being served. The opportunity to expand culturally relevant programs lies in centering the client experience, addressing biases that exist within current programs and practices, and elevating the successful work being done in specific communities. Below are the priorities identified from the community partner meeting:

- Centering the client: One strategy for centering client experience is for providers to co-create services with consumers.
- Addressing the bias in the system: For behavior-related problems, white students may be directed to mental health services whereas Black students may be expelled or suspended. This suggests a need for school administrators, counselors, student wellness and behavioral health specialists, etc., to build understanding of behavior-based mental health conditions and how their biases may impact actions.
- Elevating community-based programs: There is a need to invest resources into grassroots programs that are reaching specific populations (e.g., individuals with disabilities, non-English speaking communities, males of color age 18–24, etc.) to build evidence for programs that are working in that community. Additionally, work with more “boots on the ground” community leaders and service providers to develop strategies that are community-based.

Improve point-of-connection to services through more robust information dissemination.

Information about behavioral health and behavioral health services is the largest need in the community. Additionally, the lack of awareness of services is a consistent theme among community members and service providers. Furthermore, the disconnection and siloes between providers and systems of care create barriers for accessing services. Members of the community partner meeting suggest the broader community needs more access to and knowledge of services. To address this need, stakeholders prioritized developing more robust information dissemination strategies about wellness and behavioral health services. This includes partnering with faith and culture organizations, dentists, primary care providers, other health and non-behavioral health providers to provide information, direct referrals, or liaisons. Below are the takeaways from the community partner meeting:

- Resources and information need to be available where people seek information.
- Working with faith-based organizations and other secondary contacts with high contact to their communities to provide connection to behavioral health services.
- Focus prevention strategies on connecting people to services (e.g., family liaisons).
- Prioritize prevention and the various options available to different populations/communities for these services.

Integrate with other systems of care to increase “on-ramps.”

There is a need for more on-ramps/points-of-entry to behavioral health services. To respond, members of the community partner meeting prioritized working with other systems to ensure a direct on-ramp to prevention and behavioral health services is established. Below is a summary of the priorities voiced from the community partner meeting:

- Collaboration and integration between small/local organizations, communities, larger state, county, and city organizations.
- Reaching into housing, education, dentistry, primary care, and other health/public services so that there is a lane to mental health; ensure direct connections can be made from other everyday systems of care.
- Emergency rooms are not the optimal place for addressing mental health issues. Social services providers who come into contact with a wide range of people (e.g., prevention hotlines, community liaisons, intake and first-point-of-contacts, etc.) need to be able to connect individuals to professionals who can address mental and behavioral health issues.

Expand family-based supports.

From social services providers to community members and system experts, there is a perception that the system of care is not adequately serving the family unit. Community members and system experts shared that each family member can play a positive or negative role in achieving well-being. In some families, the role of family members is deeply rooted in the culture. Additionally, families with children living at home are more likely to experience barriers in accessing needed services. Providers also shared that the siloed nature of the system does not allow for a holistic family approach. Below are specific priorities for expanding family-based supports identified by community partner meeting attendees:

- Supports for families with someone in prison. Sometimes the family is part of the problem and helping them before their incarcerated family member gets released may help the reentry process.
- Engagement to help parents understand what their children’s future can look like in terms of life possibilities. Having this vision can help parents guide their children.
- Families with children with disabilities need a better blending of child-centered and family-centered services, as well as supports for family members.

Prepare for a post-COVID-19 landscape.

A major threat to the behavioral health system is the adverse impact of COVID-19 on the health of organizations, providers and community members. Once the community reopens, providers, system experts and community partner meeting participants agree that there will be a stress on providers to meet service demand, build trust and address the behavioral health conditions that were brought on or exacerbated by an extended time of isolation. From community partner feedback, these conditions include:

- Restoring of families, individuals, and relationships with providers.
- Addressing compulsion and addiction to screens (e.g., computers, tablets, movies, video games, etc.)

Additionally, with the surge of telehealth and digital solutions brought on by the pandemic, stakeholders urge ADAMH to understand the digital divide and make sure services are available in multiple modalities.

Establish continuous community engagement strategies

The network of providers and system leaders believe ADAMH is positioned to be a leader in innovative, collaborative behavioral health. Ongoing community engagement of the network of providers and other stakeholders can ensure accountability for progress. Robust community engagement includes regular communication and feedback regarding progress towards strategic goals with a variety of experiences represented in leadership and committees. It is recommended that ADAMH using the following strategies for ongoing community engagement:

- The ADAMH Results-Based Accountability Performance and Impact Dashboard.
 - The dashboard demonstrates ADAMH's direct and timely progress towards priorities.
 - ADAMH's internal dashboard can be reviewed quarterly with advisory committees.
 - ADAMH's online, public facing dashboard can be reviewed on demand.
- Quarterly advisory committee meetings for system experts, community providers and community advocates/champions.
 - Reviews progress towards priorities
 - Discusses strategies from community conversations to overcome barriers in moving strategies forward or pivot.
- Ongoing community conversations for community members, co-hosted in neighborhood settings (suggest every other month)
 - Discusses what they see/experience in their neighborhood related to the priorities.
 - Provide strategies for ADAMH to overcome barriers in moving strategies forward or pivot.

9. Conclusion And Strengths, Weaknesses, Opportunities and Threats Analysis

ADAMH is part of a large system of mental health and addiction services and has the capacity and autonomy to drive innovation. There is a need for strong leadership in the system of mental health and addiction services as demonstrated through the results of this community needs assessment. Additionally, behavioral health access and outcomes are intertwined with social determinants of health and structural barriers making collaborative and flexible strategies necessary to address the needs of Franklin County's diverse community.

Franklin County Behavioral Health System Strengths, Weaknesses, Opportunities, and Threats (SWOT)

To help assist the community with decision-making, the findings of all data collection efforts are synthesized into a SWOT (strengths, weaknesses, opportunities, and threats) analysis (see Table 5). By definition, Strengths (S) and Weaknesses (W) are considered to be internal factors over which ADAMH has some measure of control. Also, by definition, Opportunities (O) and Threats (T) are considered to be external factors over which ADAMH has much less direct control. The purpose of the SWOT analysis is to understand the needs, gaps, and unique experiences in the Addiction and Mental Health Services System (The System) in Franklin County.

The SWOT analysis is the foundation for evaluating the internal potential, limitations, probable/likely opportunities, and threats from the external environment. It includes all positive and negative factors inside and outside the system that affect success. A consistent study of the environment in which the system operates helps in forecasting and predicting changing trends. These factors can then be included in the decision-making process of the organization.

An overview of the four factors (Strengths, Weaknesses, Opportunities, and Threats) is given below.

1. **Strengths**—Strengths are the qualities that enable the system to accomplish the shared mission. These are the basis on which success can be made and continued/sustained. Strengths can be either tangible or intangible. These are what the system is well-versed in, what the system has expertise in, the traits and qualities the employees possess (individually and as a team) and the distinct features that give the system its consistency.
2. **Weaknesses**—Weaknesses are the qualities that prevent the system from fully accomplishing the mission. These weaknesses deteriorate influences on the system's success and growth.
3. **Opportunities**—Opportunities are presented by the environment in which the system operates. These arise when a system can benefit from conditions in its environment to plan and execute strategies that enable it to become more successful.
4. **Threats**—Threats arise when conditions in the external environment jeopardize the reliability and success of the system's efforts. They compound the vulnerability when they relate to the weaknesses. Threats are uncontrollable. When a threat comes, the stability and survival can be at stake.

Table 5 provides a graphical representation of the findings of the system's SWOT analysis. Each strength, weakness, opportunity, and threat are further outlined and explained with support from the Community Needs Assessment in the following sections.

Table 5. Franklin County Mental Health and Addiction Services System SWOT

Strengths
<ul style="list-style-type: none"> • General satisfaction among clients who engaged in ADAMH-funded services • Social service providers perceive ADAMH is effective at addressing community needs • ADAMH policy changes have capacity to increase equity in services • Confidence among partners in new leadership's cultural awareness, political knowledge, collaborative skills • System experts see ADAMH as positioned to bring about systemic change • COVID-19 demonstrates flexibility of funds and coordination potential among agencies • Improved emergency room protocols for mental health patients • ADAMH has greater autonomy and can use that to make creative, strategic changes, and be less tied to political trends • Has consistent funding year after year and continue to serve more clients
Opportunities
<ul style="list-style-type: none"> • Political capital to lead collective impact efforts with housing, workforce, judicial, and other public systems to address social determinants of health • The community needs a large agency with the capacity to coordinate with surrounding county ADAMH boards to work toward regional, longer-term goals • The wide range of existing services • Social service providers and system experts recognize the commitment and passion of the existing providers • Education can be supported to increase diversity of clinical/supervisory staff
Weaknesses
<ul style="list-style-type: none"> • Perception that ADAMH is insular, lacking coordinated collective impact with other service systems • Funding system makes it difficult for small, community-based organizations to provide needed services • Lack of culturally relevant services for minority groups • System experts believe there is a lack of accountability of providers to give quality services • Non-transparent funding allocations • Restrictive funds that limit consumers' service type options and do not pay for outreach/administration • Grant process is perceived to value quantity over quality and serving the largest populations • Long wait lists • Stakeholders familiar with ADAMH have moderate-to-low perceptions of the quality of ADAMH staff, communication, collaboration, and accountability • Historical unproductive relationship with housing and judicial systems
Threats
<ul style="list-style-type: none"> • General lack of community awareness of mental health and addiction services • In every service category, 1–21% of individuals need but do not receive services • Pre-COVID-19 trends in substance use and mental health indicators show conditions are not improving • Perceptions of service quality, staff cultural competency and timeliness of mental health and addiction service is moderate to low among social service providers with housing having the lowest perception • Social service providers perceive service coordination as “fair” to “good” • Slightly negative perceptions among social service providers of the efforts to address social determinants of health with housing and neighborhoods being the lowest • Insurance policies may limit the services one may receive • An individual's race, gender, sexual orientation, family status and/or foreign-born status is likely to influence health outcomes • Poverty and social determinants of health lead to disparity in access in every way, in every service line • Franklin County is a drug/human trafficking hub • Federal and State funding structures divide mental health from housing and other social services systems • Stigma around mental health and services continue to be an issue to accessing care • System experts perceive there is a lack of political will and a systemic prejudice toward minority-led provider organizations • There is a lack of affordable and reasonable transportation throughout Central Ohio • Impacts of COVID-19 on the sustainability of agencies • State's reimbursement policies for care undermine smaller organizations • Perception that experienced-informed best practices for minority-focused services are less valued than “evidence-based” studies of services based on majority culture.

SWOT Summary

Strengths

Franklin County's behavioral health system has several strengths that support the system in achieving success. Social service providers and system experts view ADAMH as an agency who could lead the mental health and addiction services system through important changes. The new leadership is seen as aware, knowledgeable, and collaborative. Additionally, ADAMH has relative autonomy to make creative decisions and leverage political capital. The community perceives ADAMH's historically consistent funding and the passage of a new tax levy should allow ADAMH to ensure high-quality, impactful services for all members of the Franklin County community.

Opportunities

As ADAMH considers strategic decisions, there are environmental strengths and assets (i.e., opportunities) that can be leveraged to support the mental health and addiction services system's success and impact in the community. First, the community recognizes the dedication and passion of service providers. Second, Franklin County's Behavioral Health Network consists of wide-reaching comprehensive interventions and targeted services for specific communities. This diversity of services allows ADAMH to have impact in a variety of settings. The diversity of existing front-line staff and their expertise in the field can be leveraged for system success. Finally, system stakeholders desire ADAMH to provide leadership around developing a more coordinated system, so long-term outcomes can be achieved.

Weaknesses

The success of any strategic action may be compromised without accounting for and addressing ADAMH's identified weaknesses. Overall, social service providers, system experts and community members who are most knowledgeable of ADAMH report opportunities for improvement in the quality of ADAMH staff, communication, collaboration, and accountability. Additionally, community members and stakeholders perceive ADAMH funded services to have long wait lists and lack cultural relevance, which are factors that keep people from getting the help they need.

Social service providers report complex administration requirements (i.e., application requirements), limitations put on funds, and a focus of quantity over quality does not allow for small community-based organizations to compete in Franklin County's behavioral health system. Often these smaller organizations are the ones who specialize in reaching very specific language or other numerically small community groups.

Finally, there is a perception that ADAMH could be more intentional in developing a more coordinated system of care (e.g., collective impact initiatives) and provide more accountability to contracted services. Stakeholders report that without commitment to collaboration and data-driven quality improvement, system impact will continue to perpetuate the status quo.

Threats

If not considered, external factors may jeopardize the reliability and success of ADAMH's strategic efforts. In general, the Franklin County community at large lacks awareness of available services and how to navigate getting help. Due to this lack of awareness, the community has slightly negative perceptions of the quality and impact of the system of care in Franklin County.

Trends related to community-level indicators around mental health and addiction outcomes are getting worse. Rates of depression and substance related injury and death rates are increasing. In 2020, the global pandemic (COVID-19) created an environment where fear and program closures prevented people from getting help. Additionally, stigma around mental health and addiction services continues to be an issue in Franklin County. In every service category, there is a percentage of people who need but do not receive services. Community members who need and do not receive a service are more likely to be Black, multiracial, have less than a bachelor's degree, have a disability and are unable to work, unemployed, bisexual, queer, pansexual, or questioning their sexual identity.

Threats that permeate all parts of the system (i.e., policy, funding, programs, workforce, etc.) are the unconscious biases and historical discrimination that leave a system ineffective for certain members of the community. Even in Franklin County, social determinants of health and one's own personal characteristics (i.e., race, gender, sexual orientation, etc.) impacts one's access and outcomes. Additionally, smaller community-based organizations who serve small minority groups perceive they are unable to compete in the system for funding or be recognized for best practices that work for their communities.

Understanding Franklin County's behavioral health system's current SWOT analysis results when interpreting the system demands, gaps, and barriers will lead to the most effective interventions and system changes. Empowered with the results of this Community Needs Assessment, ADAMH can be a stronger leader in mental health and addiction services collaboration to combat the contemporary needs of the community and improve quality of life in Franklin County.

Appendix A: Social Service Provider Survey Respondents

Table A1. Social Service Provider Survey Respondents		
Demographic	n	%
Do you live or work in Franklin County, Ohio?		
Yes	445	98.5%
No	7	1.5%
Age Range		
Under 20 years	1	1%
20 to 34 years	50	28%
35 to 44 years	45	26%
45 to 64 years	66	38%
65 years and up	14	8%
Median Age = 43.5		
What is your race?		
American Indian or Alaskan Native	1	0.6%
Asian	3	1.7%
Black or African American	39	22.0%
Native Hawaiian or Other Pacific Islander	0	0.0%
White or Caucasian	129	72.9%
Another Race	2	1.1%
Multiracial	3	1.7%
Decline to state	13	
Are you of Hispanic, Latino, or Spanish origin?		
No, I am not of Hispanic, Latino, or Spanish origin.	173	97.7%
Yes, I am of Hispanic, Latino, or Spanish origin.	4	2.3%
Decline to state	10	
Which of the following best describes your role in mental health or addiction services? (Select all that apply)		
Recipient of services	26	15.3%
Family member of a recipient of services	45	26.5%
Other advocate	68	40.0%
State or local administrator/policy maker/elected official	7	4.1%
None of these	68	40.0%
Multiple	30	17.6%
Decline to state	17	
Do you have children under age 18 in your home?		
Yes	173	97.7%
No	4	2.3%
Decline to state	10	
What sex was originally listed on your birth certificate?		
Female	147	83.1%
Male	30	16.9%
Decline to state	12	
Do you think of yourself as:		
Female	144	80.9%
Genderqueer/gender nonconforming neither exclusively male nor female	2	1.1%
Male	30	16.9%

Table A1. Social Service Provider Survey Respondents		
Demographic	n	%
Additional gender category (please specify):	1	0.6%
Transgender woman/trans woman/male-to-female (MTF)	0	0%
Transgender man/trans man/female-to-male (FTM)	1	0.6%
Decline to state	11	
Do you think of yourself as:		
Heterosexual or straight	144	85.2%
Something else	0	0%
Lesbian or gay	10	5.9%
Queer, pansexual, and/or questioning	6	3.6%
Bisexual	9	5.3%
Don't know	0	0%
Decline to state	17	
In what region were you born?		
Another country/region	4	2.2%
Eastern Africa (Sudan, Ethiopia, Somalia, Kenya, etc.)	5	2.7%
Eastern Europe (Poland, Russia, Greece, Austria, etc.)	0	0%
India	0	0%
Mexico	0	0%
South Eastern Asia (Philippines, Vietnam, Thailand, Indonesia, etc.)	0	0%
United States or U.S. Territory	173	95.1%
Western Africa (Nigeria, Ghana, Sierra Leone, Mali, etc.)	0	0%
Decline to state	6	
What language(s) do you speak at home? (Select all that apply)		
Arabic	2	1.1%
Amharic	2	1.1%
Chinese	0	0.0%
English	177	95.7%
French	2	1.1%
Hindi	0	0.0%
Igbo	0	0.0%
Marathi	0	0.0%
Nepali	2	1.1%
Russian	0	0.0%
Somali	0	0.0%
Spanish	7	3.8%
Telugu	0	0.0%
Twi	1	0.5%
Yoruba	0	0.0%
Another language	4	2.2%
Multilingual	12	6.5%
Decline to state	6	
What is the highest level of education you have completed?		
Less than high school	0	0%
Some high school	1	0.5%
High school diploma/GED	5	2.7%

Table A1. Social Service Provider Survey Respondents		
Demographic	n	%
Some college or associate degree	11	6.0%
Bachelor's degree	50	27.5%
Graduate degree or higher	115	63.2%
Decline to state	6	

Table A2. Service Characteristics	n
What parts of Franklin County does your organization serve? (Select all that apply)	
Bexley	87
Canal Winchester	85
Columbus	174
Dublin	90
Gahanna	89
Grandview Heights	86
Grove City	91
Groveport	87
Hilliard	93
New Albany	81
Pickerington	78
Reynoldsburg	98
Upper Arlington	87
Westerville	94
Whitehall	98
Worthington	92
Other	38
Multiple areas	452
Which of the following systems do you represent? (Select all that apply)	
ADAMH Network	58
Non-ADAMH Network	31
Youth-Serving Community	53
Older Adult-Serving Community	40
Cultural and Ethnic Minority Communities	47
Medical and Public Community	41
Criminal Justice System	23
First Responders	14
Homeless Service Community	39
Faith-Based Communities	18
Other Community Supports	43
Individuals with lived experiences with mental health and addiction services	57
LGBTQ+ Services	32
Other	29
Which of the following service categories apply to the mental health and addiction services you provide? (Select all that apply)	
Prevention	104
Crisis	92
Treatment	101

Table A2. Service Characteristics	n
Family Supports	95
Housing	70
Recovery	66
Other	27
Multiple	135

List of Providers Represented in the Survey:

1. 6 Roses
2. ADAMH
3. Adult Protective Services
4. Alivs
5. Amethyst, a program of Alvis180
6. Asian American Community Services
7. At Home by High
8. Bhutanese Community of Central Ohio
9. Boundless
10. Buckeye Clinic
11. The Buckeye Ranch
12. Central Ohio Area Agency on Aging
13. Columbus Center for Human Services
14. Columbus City Schools
15. Columbus Early Learning Centers
16. Columbus Kappa Foundation
17. Columbus Urban League
18. Community health student
19. Community Housing Network
20. Compassion Outreach Ministries of Ohio
21. CompDrug
22. Concord
23. Decline
24. Educational Service Center of Central Ohio
25. Ethiopian Tewahedo Social Services
26. Franklin County
27. Franklin County Family and Children First Council
28. Franklin County Office of Justice Policy and Programs
29. Franklin County Public Defender
30. Franklin County Senior Options
31. Freedom Recovery
32. Furniture Bank
33. LifeCare Alliance
34. Lighthouse
35. LOSS Community Services
36. Maryhaven
37. MCGC Hospital
38. Mid-Ohio Food Collective
39. Mount Carmel Street Medicine
40. Multiethnic Advocates for Cultural Competence
41. National Church Residences
42. National Youth Advocate Program
43. Nationwide Children's Hospital
44. Nemeth Counseling
45. NetCare Access
46. North Central
47. North Central Mental Health
48. North Community Counseling Centers
49. Office on Aging
50. Ohio Guidestone
51. OhioHealth
52. The P.E.E.R. Center
53. Private provider
54. Reaching Higher Heights 4 Life
55. River Vista Health and Wellness
56. Schottenstein Chabad House Friendship Circle LifeTown
57. Senior Options
58. Serving Our Neighbors Ministries
59. Small Business Owner
60. Southeast Healthcare
61. St. Vincent Family Center
62. Syntero, Inc.
63. Talbot Hall, The Ohio State University Wexner Medical Center
64. The Center for Family Safety and Healing
65. The Ohio State University
66. The Ohio State University Wexner Medical Center
67. Veterans Services Commission
68. ViaQuest
69. Westerville Fire Department
70. YMCA of Central Ohio
71. YMCA of Central Ohio - RRH Program
72. YMCA of Central Ohio - Van Buren Center

Appendix B: Comparison of Community Member Survey Respondents and Franklin County

Table B1. Comparison of Community Member Survey Respondents and Franklin County			
Demographic	Community Survey		Franklin County
	%		%
Age Range			
Under 20 years (18 & 19)	3.6%		3%
20 to 34 years	21.3%		25%
35 to 44 years	30.4%		13%
45 to 64 years	36.9%		24%
65 years and up	7.7%		12%
Median age:	44		34
What is your race?	% Survey Selection	% One Race Alone	
American Indian or Alaskan Native	2.2%	0.3%	0.2%
Asian	2.5%	1.9%	5.3%
Black or African American	23.7%	21.7%	22.6%
Native Hawaiian or Other Pacific Islander	0.3%	0.1%	<0.1%
White or Caucasian	74.0%	71.4%	66.3%
Another Race	1.1%	0.9%	1.8%
Multiracial	3.9%	3.8%	3.8%
Are you of Hispanic, Latino, or Spanish origin?			
No, I am not of Hispanic, Latino, or Spanish origin.	95.3%		94.5%
Yes, I am of Hispanic, Latino, or Spanish origin.	4.7%		5.5%
Do you have children under age 18 in your home?			
Yes	60.7%		27.5%
No	39.3%		72.5%
What sex was originally listed on your birth certificate?			
Female	84.1%		48%
Male	15.9%		52%

Table B1. Comparison of Community Member Survey Respondents and Franklin County				
Demographic	Community Survey		Franklin County	
Which of the following categories best describes your employment status?	Raw Survey Response	Survey Population	Franklin County Labor Market	Franklin County Population
Not employed, looking for work	7.7%	9.5%	5.4% ³¹ (unemployment rate)	3.6% ³²
Retired	8.3%	19.3% (not in labor force)		31.9% ³³ (not in labor force)
Not employed, NOT looking for work	5.8%			
Disabled, not able to work	5.3%			
Employed, working full time	62.1%	90.5%	94.6% ³⁴ (employment rate)	64.4% ³⁵
Employed, working part time	10.8%			
Decline to state				
What is your individual approximate yearly income?			Household Incomes ³⁶	
Less than \$20,000	21.2%		14.5%	
\$20,000 – 39,999	26.0%		17.7%	
\$40,000 – \$59,999	18.0%		16.1%	
\$60,000 or above	34.8%		51.7%	
What is the highest level of education you have completed?			*Population 25 and older	
Less than high school	1.0%		2.9%	
Some high school	3.6%		5.9%	
High school diploma/GED	12.0%		24.6%	
Some college or associate degree	27.2%		26.5%	
Bachelor's degree	25.2%		25.3%	
Graduate degree or higher	31.2%		14.8%	

³¹ BLS monthly unemployment data for November 2020 in Franklin County

³² Denominator based on the total population of 16 years and over from ACS data table DP03, 2019 5-year estimate. The numerator is the count of people reported as unemployed from BLS monthly employment data for November 2020 in Franklin County.

³³ This is the number of people based on the total population of 16 years and over from ACS data table DP03, 2019 5-year estimate minus those that are in the labor force as determined by BLS monthly employment data for November 2020, divided by total population of 16 years and over from ACS data table DP03, 2019 5-year estimate.

³⁴ BLS monthly employment data for November 2020 in Franklin County; of those in the labor force that are employed

³⁵ BLS monthly employment data for November 2020 in Franklin County; divided by total population of 16 years and over from ACS data table DP03, 2019 5-year estimate

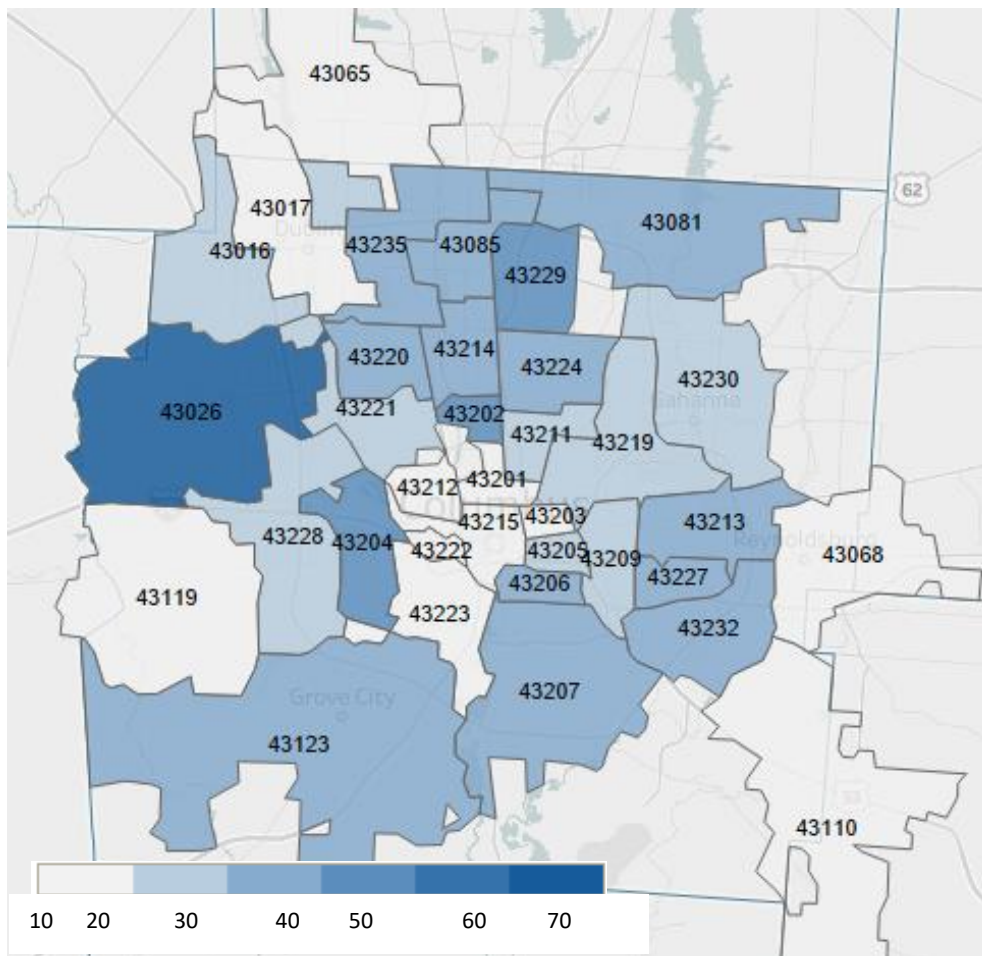
³⁶ The survey question and the ACS data that aligns to these income ranges are not the same. To find the Franklin County Ratio of those within these income ranges, equal distribution was assumed for the ACS data and the proportion applied so as to estimate those that are within the survey income brackets.

Additional Demographics

Table B2. Community Member Survey Respondents		
Demographic	Community Survey	
Do you think of yourself as:		
Female	82.8%	
Male	15.1%	
Genderqueer/gender nonconforming neither exclusively male nor female	1.0%	
Additional gender category	0.3%	
Transgender woman/trans woman/male-to-female (MTF)	0.2%	
Transgender man/trans man/female-to-male (FTM)	0.6%	
Do you think of yourself as:		
Heterosexual or straight	85.0%	
Bisexual	6.1%	
Lesbian or gay	4.1%	
Queer, pansexual, and/or questioning	2.7%	
Something else	1.1%	
Don't know	1.1%	
In what region were you born?	Percent selected overall	Percent of Born not in U.S.
Eastern Africa (Sudan, Ethiopia, Somalia, Kenya, etc.)	0.9%	15.5%
Western Africa (Nigeria, Ghana, Sierra Leone, Mali, etc.)	0.4%	6.9%
Eastern Europe (Poland, Russia, Greece, Austria, etc.)	0.2%	3.4%
Mexico	0.7%	12.1%
India	0.2%	3.4%
South Eastern Asia (Philippines, Vietnam, Thailand, Indonesia, etc.)	0.7%	12.1%
Another country/region	2.6%	46.6%
United States or U.S. Territory	94.5%	
What language(s) do you speak at home? (Select all that apply)	Percent selected overall	Percent selected One alone
Arabic	0.7%	0.1%
Amharic	0.1%	0.1%
Chinese	0.2%	0.0%
English	97.5%	90.3%
French	1.0%	0.1%
Hindi	0.3%	0.0%
Igbo	0.2%	0.2%
Marathi	0.0%	0.0%
Nepali	1.0%	0.4%
Russian	0.1%	0.0%
Spanish	4.4%	0.6%
Somali	0.6%	0.6%
Telugu	0.0%	0.0%

Table B2. Community Member Survey Respondents		
Demographic	Community Survey	
Twi	0.3%	0.0%
Yoruba	0.1%	0.0%
Another language	2.2%	0.4%
Multilingual	7.3%	7.3%
Which of the following best describes your role in mental health or addiction services? (Select all that apply)	Percent selected overall	Percent selected One alone
Recipient of services	50.9%	23.0%
Family member of a recipient of services	59.2%	29.1%
Service provider	9.0%	1.9%
State or local administrator/policy maker/elected official	1.9%	0.6%
Other advocate	17.3%	8.0%
Additional role	6.5%	2.5%
Multiple Selections	34.9%	34.9%

Map B1. Survey Responses by ZIP Code



Appendix C: Data Description for Service Category Profiles

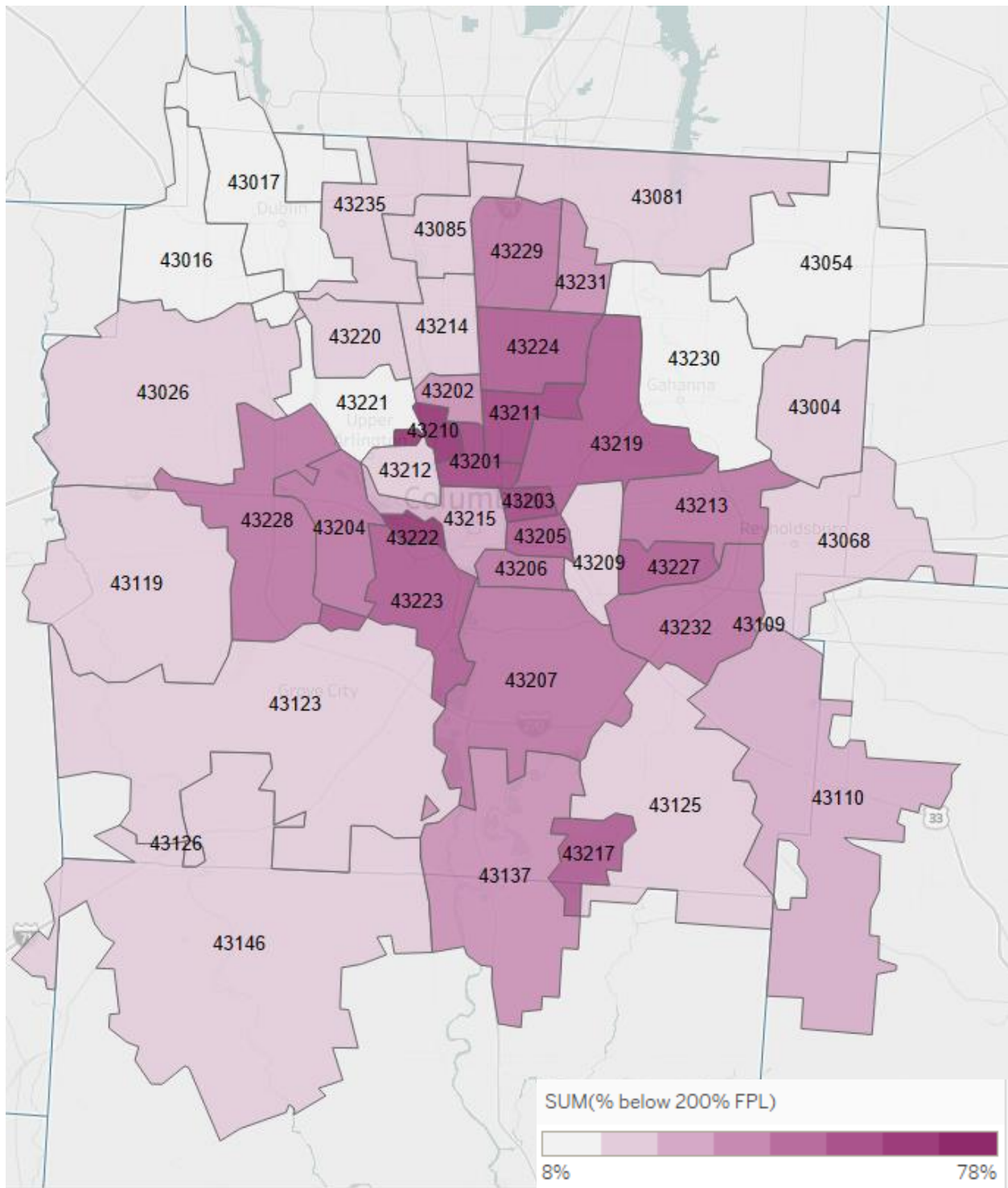
Quality: To determine the community's perception of the quality of services along the system of care, social service providers were asked to rate the overall service quality, cultural competence of staff, and timeliness of services within the six service categories. Items were rated on a 5-point scale with 1 = poor, 2 = fair, 3 = good, 4 = very good, and 5 = excellent. Similarly, community members who reported having at least one service in a service category were asked to rate experiences with providers, their overall satisfaction, and whether they would recommend their provider to others. This was also a 5-point scale with 1 = strongly disagree, 2 = disagree, 3 = neutral, 4 = agree, and 5 = strongly agree. To understand who may be having more positive or negative perceptions of services, community member survey data were analyzed using multiple regression analysis.

Total Need: Total Need was captured in the community survey. Respondents were asked to indicate whether they “did not need,” “needed, but did not receive,” or “needed and received” 42 different services across six service areas. Total Need is the number of people who “needed, but did not receive,” or “needed and received” any of the services.

Unmet Need: Unmet Need was captured in the community survey based on the number who indicated “needed but did not receive” any one service. Multinomial logistic regressions were used to determine who is more likely to experience unmet need. Additionally, qualitative data were used to provide details about any other specific unmet needs.

Barriers to Accessing Services: In the community survey, respondents were asked to rate the extent to which they agree or disagree that a particular barrier keeps themselves or a family member from getting help on a 5-point scale (with 1 = strongly disagree, 2 = disagree, 3 = neutral, 4 = agree, and 5 = strongly agree). To assess differences in barriers to accessing services, a multiple regression analysis was performed for each of the 17 barriers asked of respondents on the survey. Additionally, focus groups with community members and interviews with system experts provided context and more detailed perspectives based on lived and professional experience.

Map C1: Percent of Population Living at 200% of Poverty



Appendix D: Supporting Figures and Tables for Behavioral Health Trends in Franklin County

Behavioral Health Outcomes

Mental Health

Figure D1. Franklin County Adults by Age Group That Had Serious Thoughts of Suicide in the Past Year
Substance Abuse & Mental Health Data Archive 2021

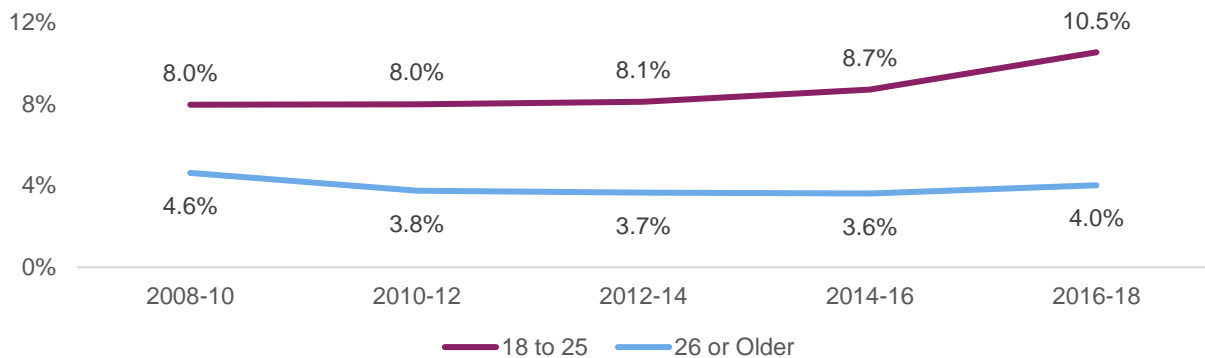
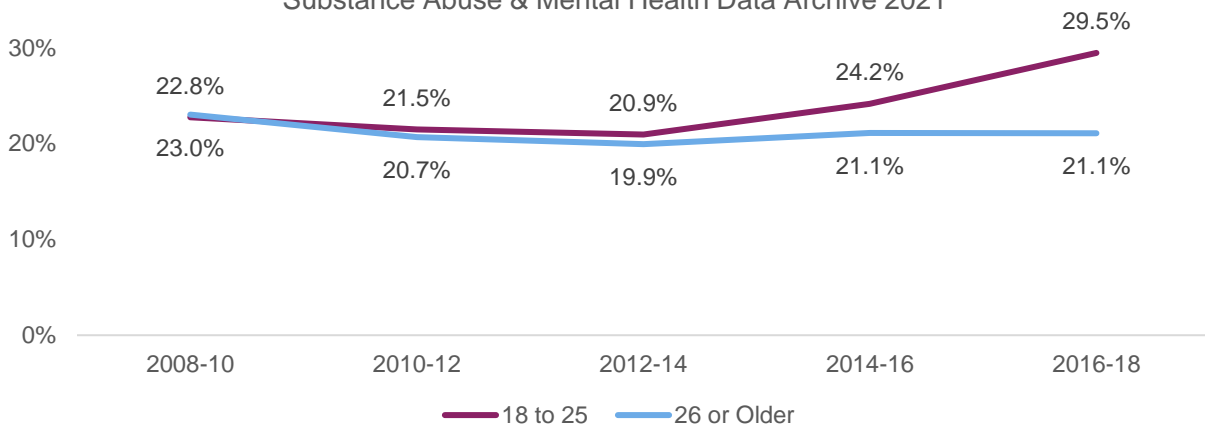


Figure D2. Franklin County Adults by Age Group That Had Any Mental Illness in the Past Year
Substance Abuse & Mental Health Data Archive 2021



Substance Use

Figure D3. Drunk Driving-Related Injuries

The Franklin County Health Map
2019

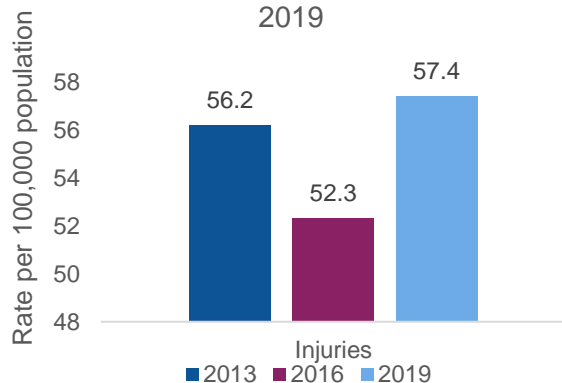


Figure D4. Drunk Driving-Related Deaths

The Franklin County Health Map
2019

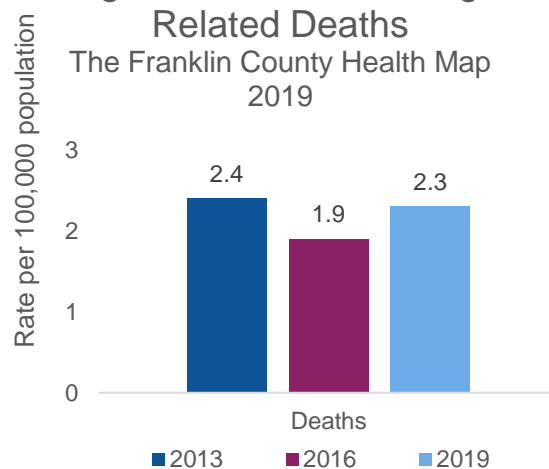
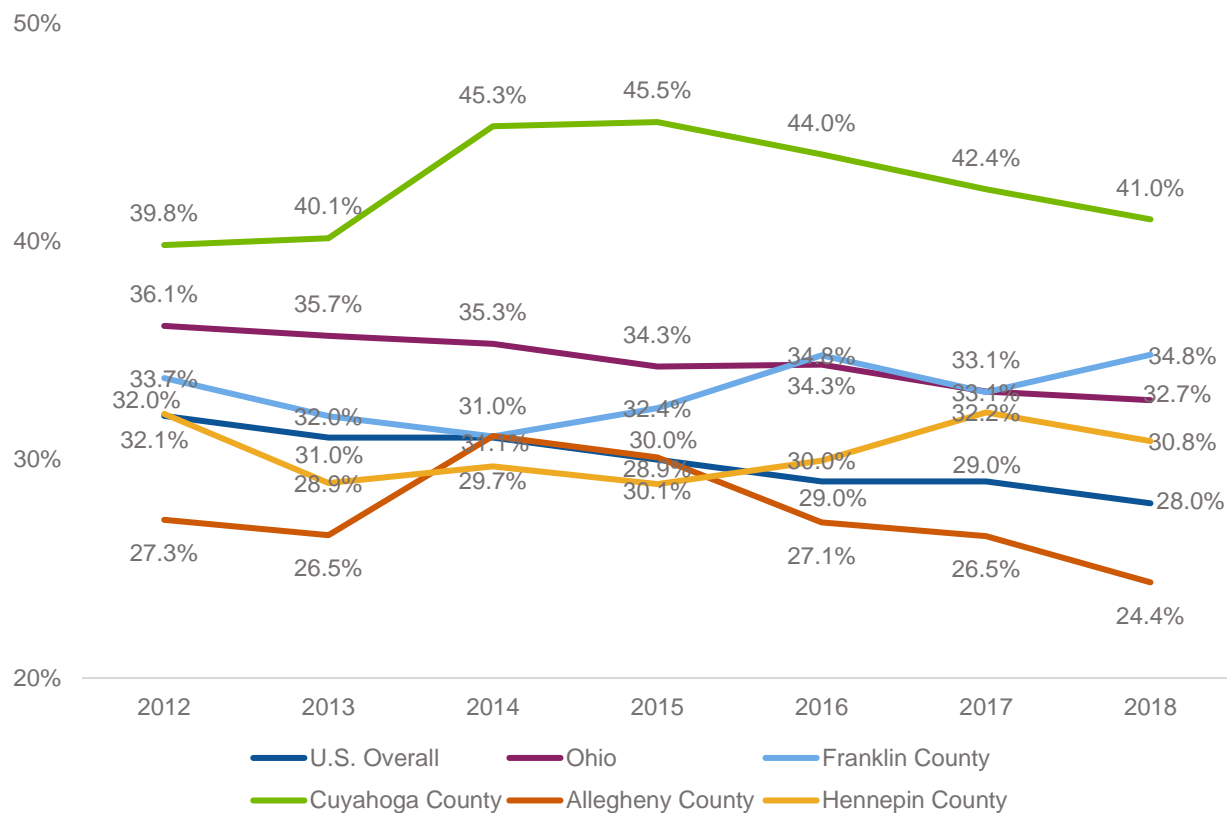


Figure D5. Percent of Traffic Deaths Due to Alcohol Involvement

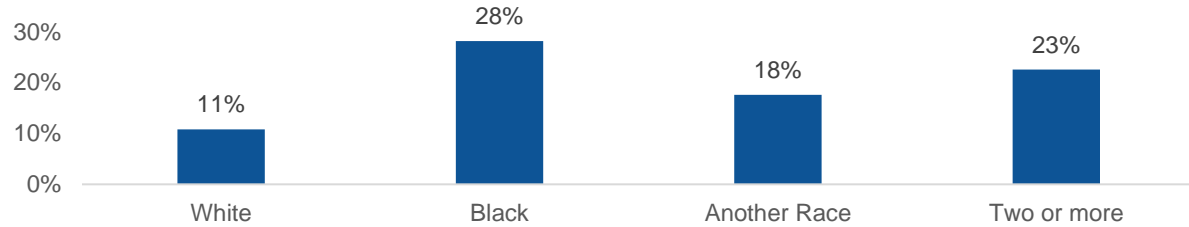
Fatality Analysis Reporting System



Social Determinants of Health

Economic Stability

Figure D6. Percent of Race that Lives at or Below 100% FPL in Franklin County 2019
American Community Survey S1701



Education

Figure D7. Percent of Race who are High School Graduates or Higher, Franklin County
American Community Survey S1501

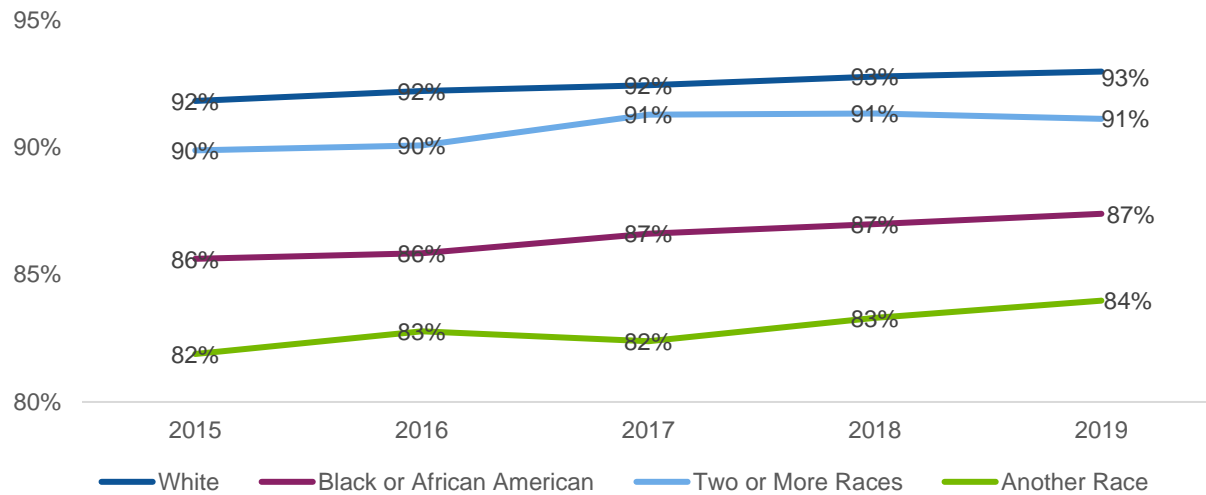
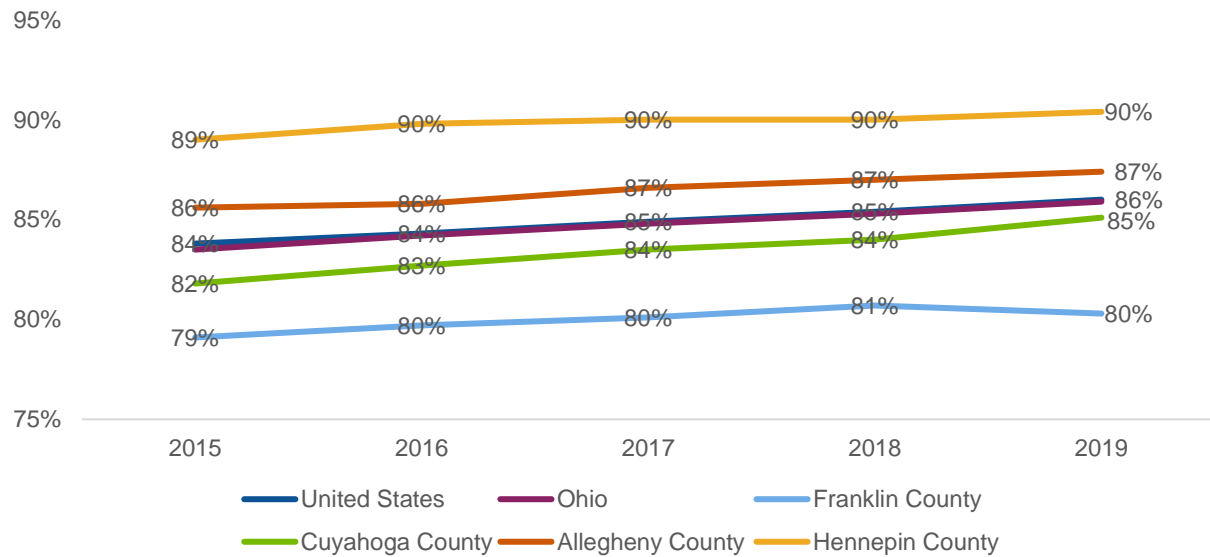
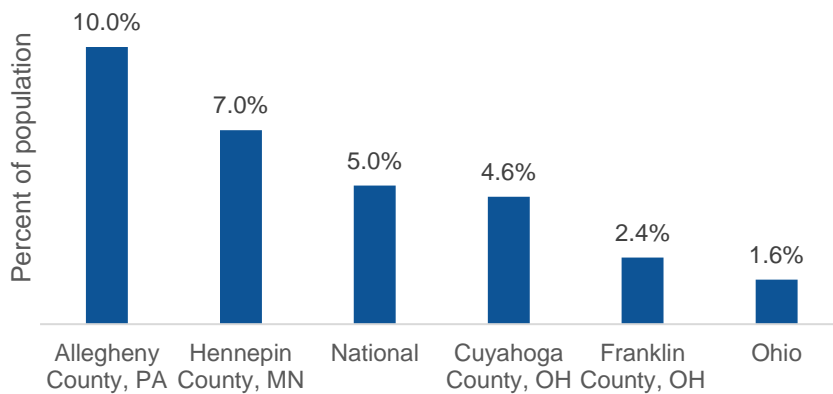


Figure D8. Percent of Black Individuals Attaining High School or Higher by Community Over Time
American Community Survey S1501



Transportation

Figure D9. Public Transportation Utilization Rate
American Community Survey, 5 Year Estimates
2019 Table DP03



Appendix E. Acknowledgements

Project Team

The individuals listed below provided guidance and subject matter expertise for the Community Needs Assessment. Thank you for your dedication to this important project.

- Erika Clark Jones, CEO, ADAMH
- Heber Howard, Director of Accounting and Financial Reporting, ADAMH
- Holly Dabelko-Schoeny, ADAMH Board Member
- Janie E. Bailey, Board Chair, Multiethnic Advocates for Cultural Competence, Inc.
- Jenny Schoning, parent of adult children living with mental illness
- Joe Florenski, Senior Project Manager, ADAMH
- Jonathan Thomas, Vice President of Planning and Evaluation, ADAMH
- Justin Curtis, Director of Enterprise Services, ADAMH
- Kevin Dixon, Vice President of Community and Cultural Engagement, ADAMH
- Kevin Ramsey, Consumer and Family Advocacy Council
- Lynette Cashaw-Davis, Community/Recovery Advocate and Co-Facilitator, Consumer and Family Advocacy Council
- Mackenzie Betts, Senior Community Relations Manager, ADAMH
- Mark Lambert, Senior Director of Finance, ADAMH
- Meg Griffing, Clinical Director, ADAMH
- Mitzi Kirkbride, ADAMH Board Member
- Nettie Ferguson, Community Prevention Manager, ADAMH
- Robert Lonardo, Data Solutions Manager, ADAMH
- Shelly Hoffman, Senior Director of Public Affairs, ADAMH
- Susan Beaudry, Vice President, Osteopathic Heritage Foundation
- Tracy Maxwell Heard, Executive Director, Multiethnic Advocates for Cultural Competence, Inc.
- Tracy McConkey, Budget and Contract Officer, ADAMH
- W. Shawna Gibbs, Director of Education and Special Initiatives, ADAMH

Community Champions

Thank you to the following individuals who were instrumental in shaping and coordinating the community focus groups.

- Ben Shinabery, Arts & College Preparatory Academy
- Bradley Severt, Arts & College Preparatory Academy
- Cora Munoz, Ph.D., Asian Festival, Health Pavilion
- Dorothy Hassan, My Project USA
- Erin Maus, Community Shelter Board
- Guadalupe Velasquez, Welcoming City
- Holly Dabelko-Schoeny, College of Social Work, The Ohio State University
- Katie Beaumont, At Home by High
- Kelli Johnson, Franklin County Office on Aging
- Kim Yates, North Central Mental Health Services

- Melinda McGuire, MSW, LISW, The Dempsey Family Education and Resource Center
- Molly Gauntner, Franklin County Municipal Court, Clerk's Office
- Nathaniel Jordan, Columbus Kappa Foundation
- OhioHealth Riverside Methodist Hospital
- Patricia Ufferman, MSW, LISW-S, VA Central Ohio Healthcare System
- Ramona Reyes, Columbus Catholic Social Services
- Stacy Potts, Healthcare for Homeless Veterans
- Susan Beaudry, Osteopathic Heritage Foundations, Ohio
- Twanna Roper, Faith Mission
- Yahaira Rose, Dominican Sisters of Peace
- Zerqa Abid, My Project USA

Organizations Who Helped with Focus Group and Survey Data Collection

Thank you to the many community organizations who supported the data collection for this Community Needs Assessment. Below is a list of organizations that worked directly with Measurement Resources Company (MRC) or a member of the Project Team to facilitate focus groups and survey data collection.

- 180 Demo
- Alvis
- Arts & College Preparatory Academy
- Asian American Community Services
- Asian Festival, Health Pavilion
- At Home by High
- Buckeye Ranch
- Canal Winchester (Madison Township)
- Center for Balanced Living/The Emily Program
- City of Westerville
- CleanTurn
- Columbus Metropolitan Housing Authority
- Columbus Chamber
- Columbus City Schools
- Columbus Division of Fire
- Columbus Foundation
- Columbus Kappa Foundation
- Columbus Public Health
- Columbus Urban League
- Community for New Direction
- Community Housing Network
- Community Shelter Board
- Dominican Sisters of Peace
- Equitas Health
- Ethiopian Tewahedo Social Services
- Franklin County Board of Developmental Disabilities
- Franklin County Community Based Correctional Facility
- Franklin County Department of Job and Family Services/Deputy Administrator
- Franklin County Municipal Court, Clerk's Office
- Franklin County Office of Justice Policy and Programs
- Franklin County Sheriff's Office
- Freedom a la Cart
- Future Ready Columbus
- GiveBackHack
- Godman Guild
- Governor's Office of Faith-Based and Community Initiatives
- Grandview Heights
- Greater Healthcare Collaborative
- Hilliard City School District
- Human Service Chamber of Franklin County
- iCare Health & Wellness Medical Center
- IMPACT Community Action
- Jefferson Township Fire Department
- Leadership Columbus
- Lutheran Social Services (LSS) Faith Mission
- *Metropreneur*
- MY Project USA

- NetCare Access
- New Albany
- New Albany-Plain Local School District
- North Central Mental Health Services
- Ohio Commission on Minority Health
- OhioHealth
- Physicians CareConnection
- Plain Township Fire Department
- Prairie Township
- PrimaryOne Health
- Rapid Response Emergency Addiction and Crisis Teams
- RecoveryOhio
- Reeb Avenue Center
- SocialVentures
- Somali American Leadership Council
- South Side Thrive Collaborative
- South-Western City School District
- The PEER Center
- United Way of Central Ohio
- Upper Arlington Fire Department
- Washington Township (Dublin)
- Welcoming City
- Westerville City School District
- Whitehall Fire Department
- Worthington
- YMCA

Local Reports and Studies

In addition to cited sources, the following reports informed this Community Needs Assessment.

- Buckeye Ranch
 - TBR Somali Program Community Profile 2018
- Children's Defense Fund-Ohio, The Columbus Foundation
 - Cultivating Opportunities for Youth to Flourish in Franklin County
- Columbus Division of Fire
 - Columbus Division of Fire Annual Report 2019
- Columbus Public Health
 - Mental Health Data Brief
- Columbus Urban League
 - Project Survival Strategic Planning Framework
- Community Shelter Board
 - Point-in-time Count of Homelessness in Columbus and Franklin County
- Division of Emergency Medical Services, Ohio Department of Public Safety
 - Allocation of Trauma Resources in the State of Ohio: A Data Driven Approach for Performance Assessment and Benchmarking
- ETSS (Ethiopian Tewahedo Social Services)
 - Annual Report 2018
 - Congolese History and Populations in Central Ohio
- Franklin County Court of Common Pleas, Division of Domestic Relations and Juvenile Branch
 - 2018 Annual Report
- Franklin County Public Health
 - Franklin County Health Map 2019; Navigating our way to a healthier community together
 - Community Health Assessment; Your Health, Your Community
 - Franklin County Community Health Improvement Plan 2018-2019 Annual Report
 - Franklin County National Alliance on Mental Illness (NAMI)
 - Report and Recommendations to City of Columbus

- Franklin County Urban Coalition
 - 2014 Franklin County Youth Survey; Drug-Free Communities Survey
 - Community Assessment for Franklin County Urban Coalition; Southside and Westside Communities 2015
 - Strategic Prevention Framework Store Observation Project; Final Report
- Health Policy Institute of Ohio
 - COVID-19 Minority Health Strike Force Blueprint
- LLS & Illuminology
 - 2019 Intimate Partner Violence Community Analysis
- Maryhaven
 - Community Conversations about Informed Gambling
 - Ohio Strategic Prevention Framework (SPF): Strategic Plan Map 1, 2, & 3
 - Asian American Gambling Focus Group Findings
 - Asian American Survey Results
- Nationwide Children's Hospital
 - 2019-2021 Community Health Needs Assessment
- National Summer Learning Association
 - Calculating the Return on Investment in Summer Learning
 - Doesn't Every Child Deserve a Memorable Summer?
- Ohio Department of Aging
 - Summary Assessment of Older Ohioans
- Ohio Department of Youth Services
 - Fiscal Year 2019 Annual Report
- Ohio Development Services Agency and OhioMHAS
 - Homelessness in Ohio: Bridging the Gap Between Resources and Results, Phase I
- Ohio Housing Finance Agency
 - Confronting Homelessness: Examining the Scope of Ohio's Silent Crisis and Its Local Solutions
- Ohio Opportunities for Ohioans with Disabilities
 - 2018 Vocational Rehabilitation Comprehensive Statewide Needs Assessment
- Ohio University Voinovich School of Leadership and Public Affairs
 - 2013 Franklin County Youth Survey
 - Opioid Overdose Signs, Symptoms, Response, and Treatment Data Brief
 - Opioid Knowledge and Opinions in Franklin County Data Brief
 - Naloxone Knowledge and Opinions in Franklin County Data Brief
 - Opioid Related Stigma in Franklin County Data Brief
- OhioHealth Rehabilitation Hospital
 - Community Health Needs Assessment
- OhioMHAS Bureau of Correctional Recovery Services
 - Outcome Summary Fiscal Year 2019
- Recovery-Oriented Systems of Care (ROSC) in Ohio
 - Statewide Assessment Results (2018)
- Rise Sister Rise
 - I Am Good Enough Mental Health Campaign
- Southside Community Collaborative

- Youth and Young Adults Needs Assessment for the Southside of Columbus, Ohio
- The Ohio State University College of Social Work
 - The New Americans Project: Assessing the Human Service Landscape in Central Ohio (January 2018)
- The Ohio State University Wexner Medical Center
 - Franklin County Health Map 2019; Navigating our way to a healthier community together
- Youth Empowerment and Support
 - Community Profile – Youth Empowerment and Support Program
- Youth to Youth International
 - Ensuring Youth Stay Drug and Alcohol Free

Works Cited

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- ⁱⁱⁱ Behavioral Risk Factors Surveillance System
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- ^v Franklin County Public Health Social Determinants of Health Framework. <https://myfcph.org/health-systems-planning/chip/>
- ^{vi} Health People 2020, Social Determinants of Health Topic Area: Poverty.
- ^{vii} Simon, K., Beder, M., Manseau, M., (2018) Addressing Poverty and Mental Illness. *Psychiatric Times*. 35(6).
- ^{viii} Health People 2020, Social Determinants of Health Topic Area: Quality Housing.
- ^{ix} County Health Ranking & Road Map. Residential Segregation – non-white and white. Retrieved from <https://www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model/health-factors/social-and-economic-factors/family-social-support/residential-segregation-non-whitewhite>
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