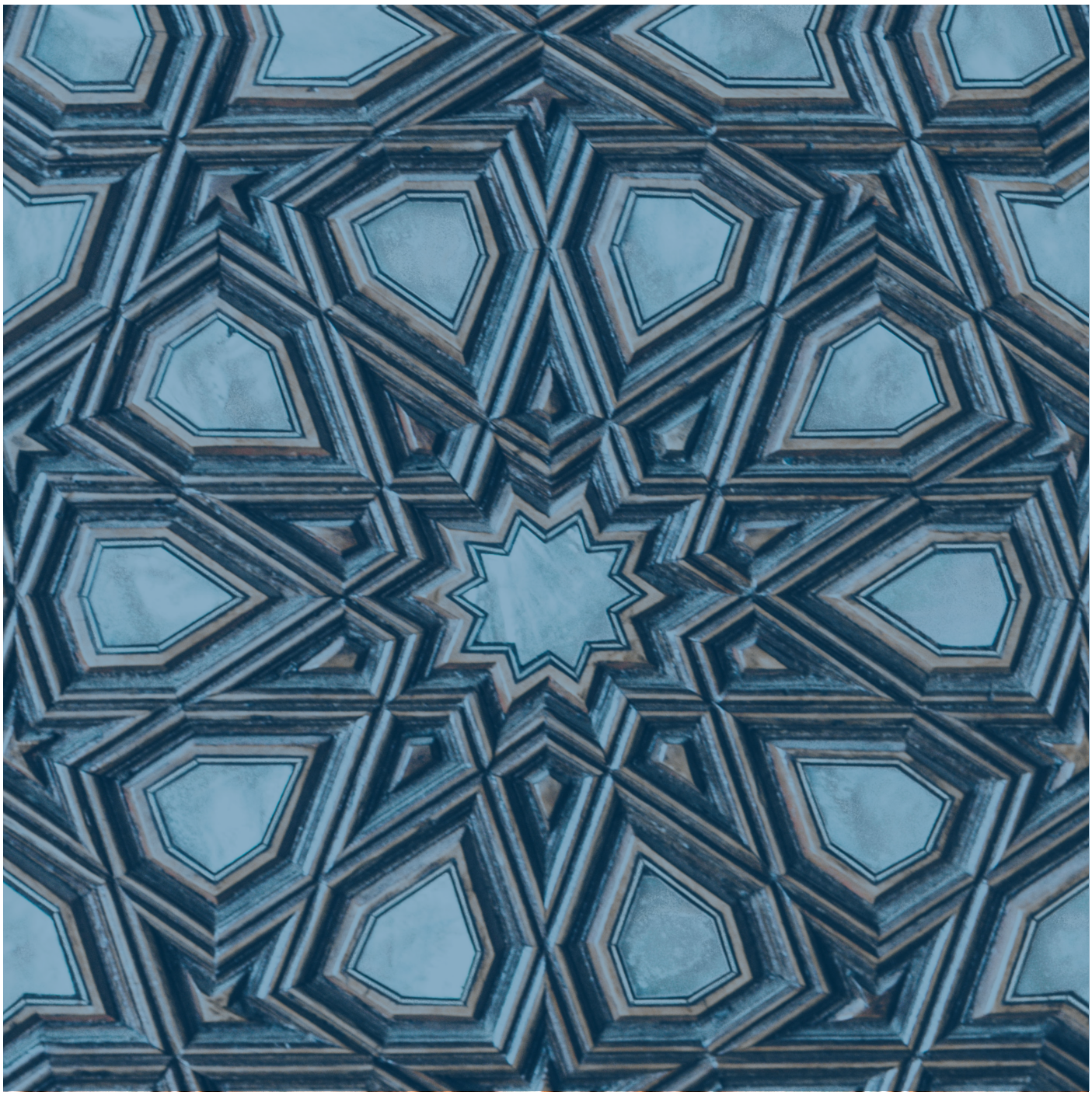
ADAMH
Alcohol, Drug and Mental Health Board of Franklin County

Community Needs Assessment ★ 2020

Executive Summary



Report by:
Measurement Resources

Introduction

The Alcohol, Drug and Mental Health (ADAMH) Board of Franklin County's mission 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. In this role, ADAMH is responsible for coordinating the ongoing assessment of needs of all Franklin County residents for services and supports across Franklin County's continuum of care. In 2020, ADAMH initiated a comprehensive needs assessment to better understand the behavioral health system strengths and opportunities and quantify the met and unmet service needs. Preliminary results of the 2020 Franklin County Community Needs Assessment findings are presented in this Executive Summary.

Assessing Strengths and Opportunities Using an Inclusive Mixed-Methods 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 mechanisms for eliciting specific experiences. The data summarized in this report came from the following sources:

- ADAMH Internal Data
- Review of Publicly Available Community Data
- 25 System Expert Interviews
- 10 Focus Groups of 51 Community Members
- Social Service Provider Survey
- Community Survey

Table 1 presents the demographic breakdown of the community survey sample to that of the Franklin County population. The general community survey was administered with the goal of mirroring Franklin County broadly with respect to the distribution of age and race. A full comparison of sample and Franklin County demographics can be found in Appendix A.

Provider survey: n=317; 80 unique organizations. Community survey: n=1,635.

Table 1. Comparison of Community Member Survey Respondents and Franklin County

Demographic	Community Survey		Franklin County
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	1%	1%	2%
Multi-Racial	4%	4%	4%

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 and up	8%	12%
Sex Originally Listed on Birth Certificate	**%**	**%**
Female	84%	48%
Male	16%	52%

Behavioral Health Continuum of Care Service Demand and Gap

The continuum of care is represented in ADAMH's six service categories: prevention, family supports, recovery supports, housing services, treatment services, and crisis services.

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.

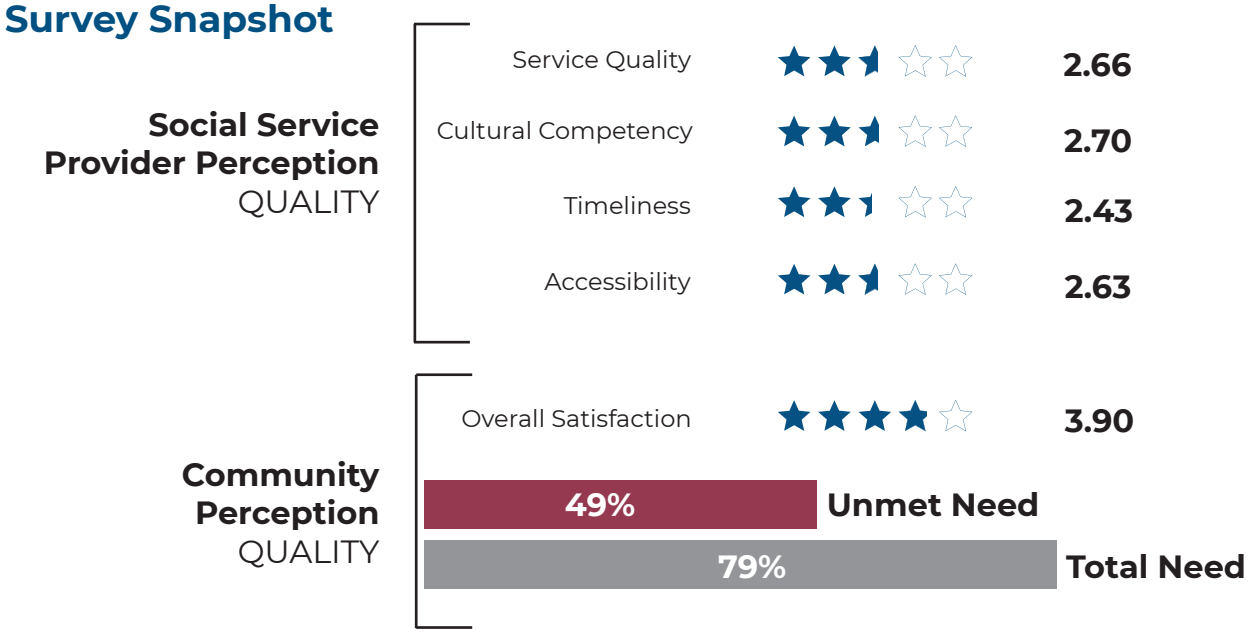
Crisis Services

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

The following section demonstrates an opportunity to improve the quality of services across the continuum. Additionally, there are unmet needs identified in every line of service, with specific members of our community experiencing significantly higher unmet need. Please see Appendix B for more information about the data presented on the following pages.

Prevention Services

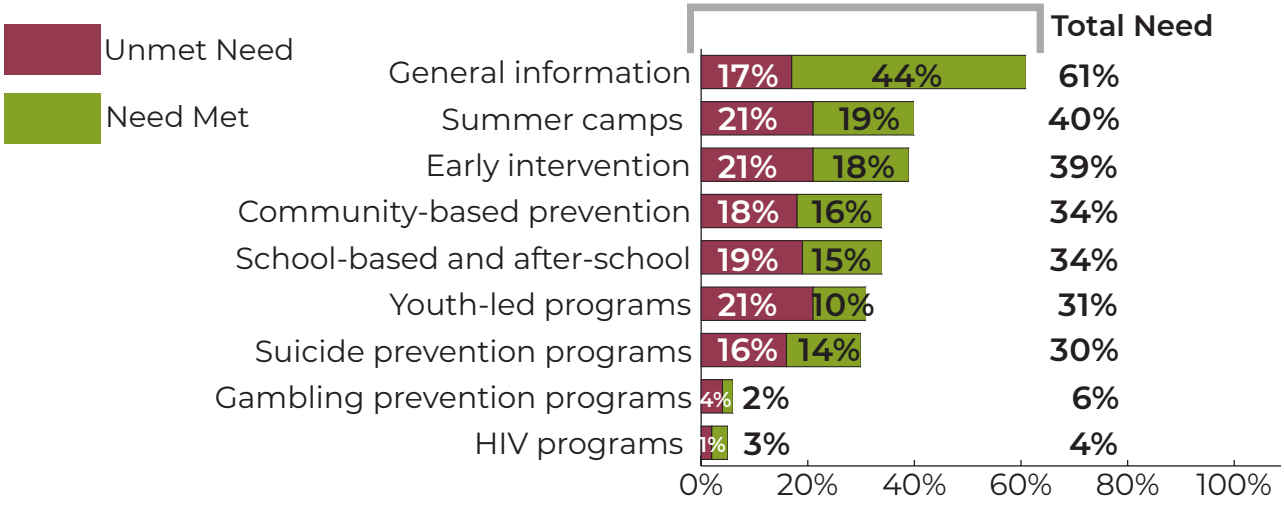
Survey Snapshot



From the provider perspective, the concerns with quality of prevention services is driven by the general lack of awareness of services that are available, and the quality of communication between providers. Some providers feel the communication network is overwhelming with information about available services, 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.

Unmet Need vs. Need Met for Prevention Services

Have you or a family member ever needed any of these services?

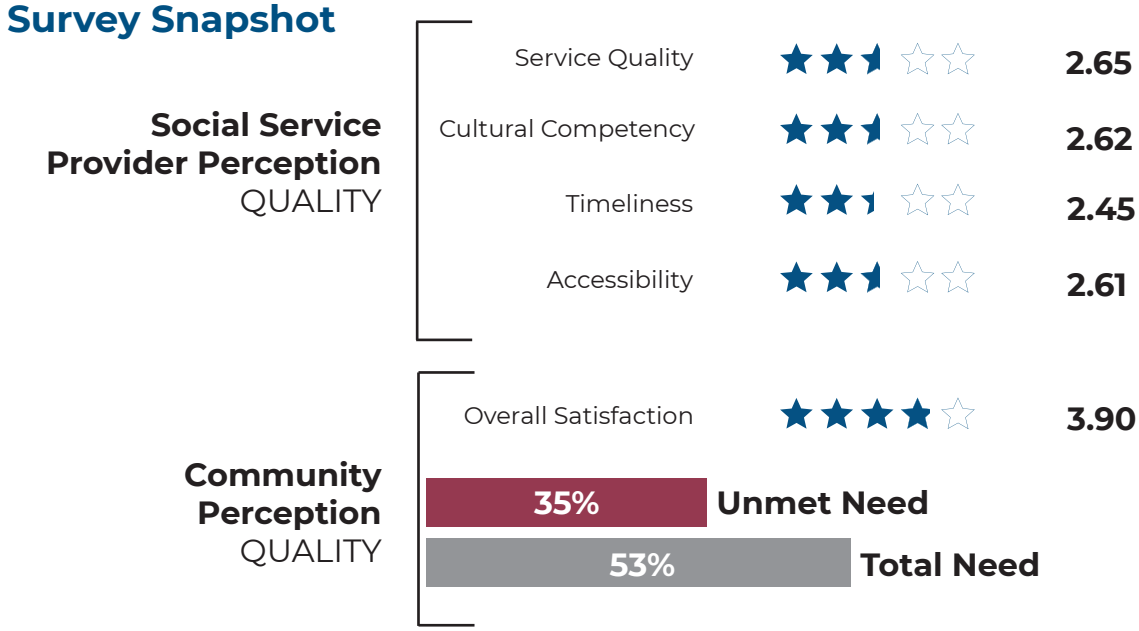


Overall, more than 60% of Franklin County residents surveyed indicated needing general information about behavioral health prevention services. More than one in five survey respondents indicated needing prevention programs for youth and early intervention. These findings may be reflective of the survey's overrepresentation of women with children living in the home.

"Because I am a provider and have not heard of the services or programs happening I would have to rate the accessibility as poor." —System Expert

Family Supports

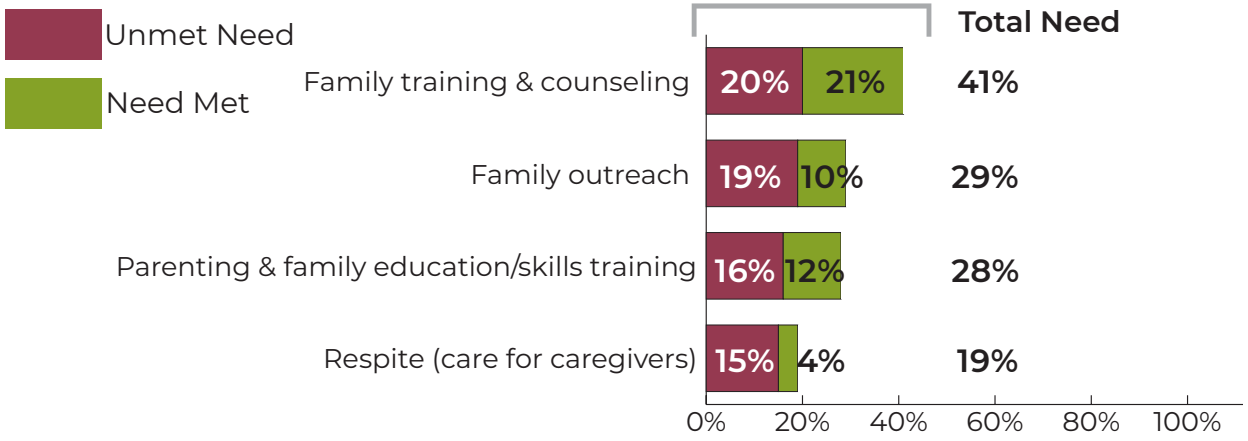
Survey Snapshot



Providers reported that the complexity of navigating the eligibility requirements for family support, the lack of services that are available and the ability of services to meet the needs of family units are reasons they rated the quality of family supports low. Additionally, focus group and system experts agree that family supports lack a holistic approach to serving families. This was especially true for minority families but would improve the quality of outcomes for all families.

Unmet Need vs. Need Met for Family Supports

Have you or a family member ever needed any of these services?



Overall, 40% of Franklin County residents surveyed indicated needing family training and counseling, and 30% reported needing family outreach. The overrepresentation of families with children under 18 living at home in this sample may also be driving this high demand.

"[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, service 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

Survey Snapshot

Social Service Provider Perception
QUALITY

Service Quality	2.09
Cultural Competency	2.41
Timeliness	2.56
Accessibility	2.12

Overall Satisfaction	3.40

Community Perception
QUALITY

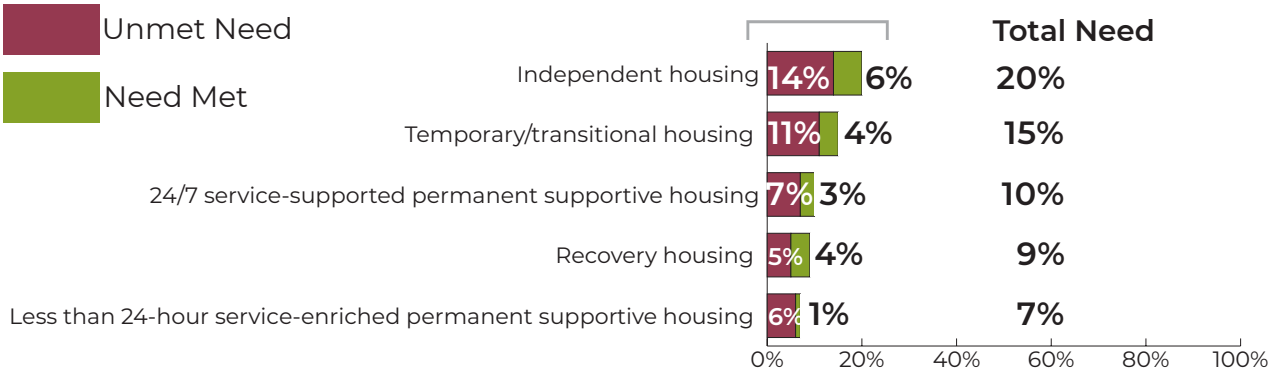
19% **Unmet Need**

25% **Total Need**

Housing services have the lowest quality rating across the continuum. All stakeholders see housing affordability and availability impacting the quality, timeliness, and accessibility of supportive housing for those with mental health and substance use disorders. Additionally, providers and community members reported that housing programs are not tailored to meet individual needs, leading to insufficient solutions that result in individuals returning repeatedly for additional housing services.

Unmet Need vs. Need Met for Housing Services

Have you or a family member ever needed any of these services?

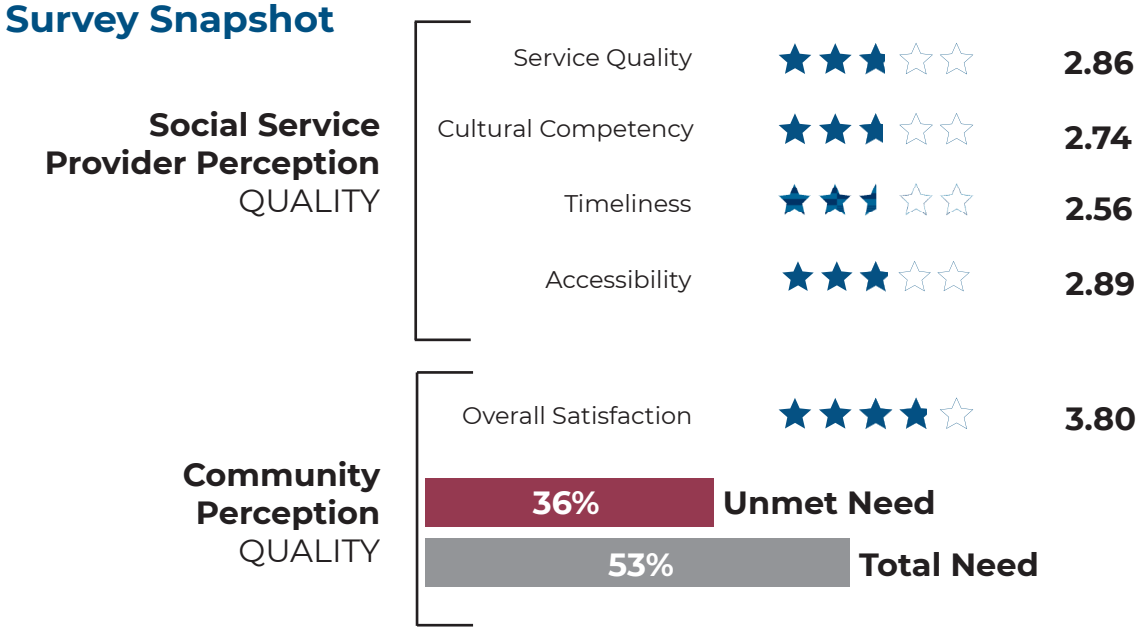


Overall, the greatest demand for those surveyed is for independent housing. This is also the greatest service gap in this category. Additionally, 11% of individuals who needed temporary/transitional housing did not receive this service.

"The independent housing system was not designed for the [high intervention] population it is now serving. [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

Recovery Supports

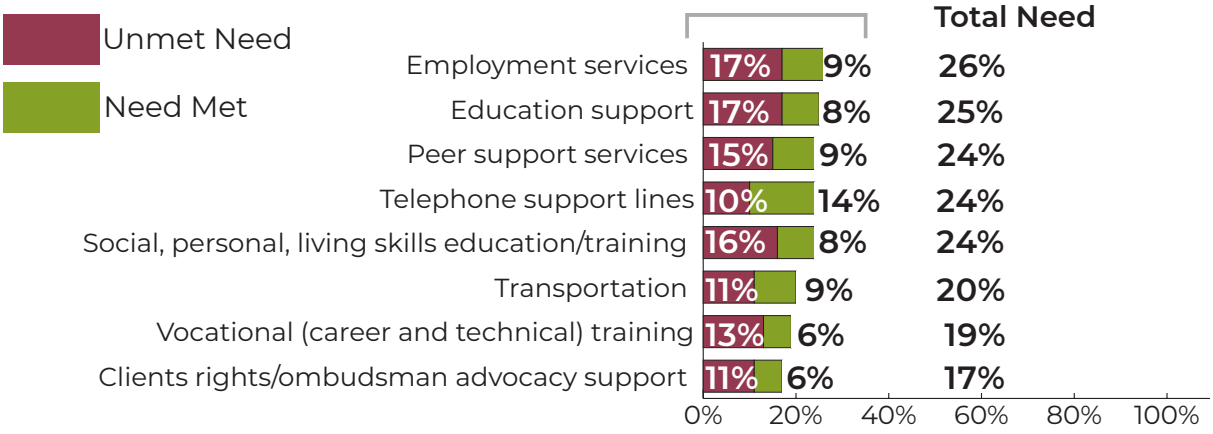
Survey Snapshot



When providers were asked in the survey why they rated the quality of recovery support low, they identified the lack of accessible transportation, as well as limited connection to quality education and employment opportunities. Additionally, providers said there is a lack of awareness of these types of services and limited outreach, impacting their perception of quality.

Unmet Need vs. Need Met for Recovery Supports

Have you or a family member ever needed any of these services?

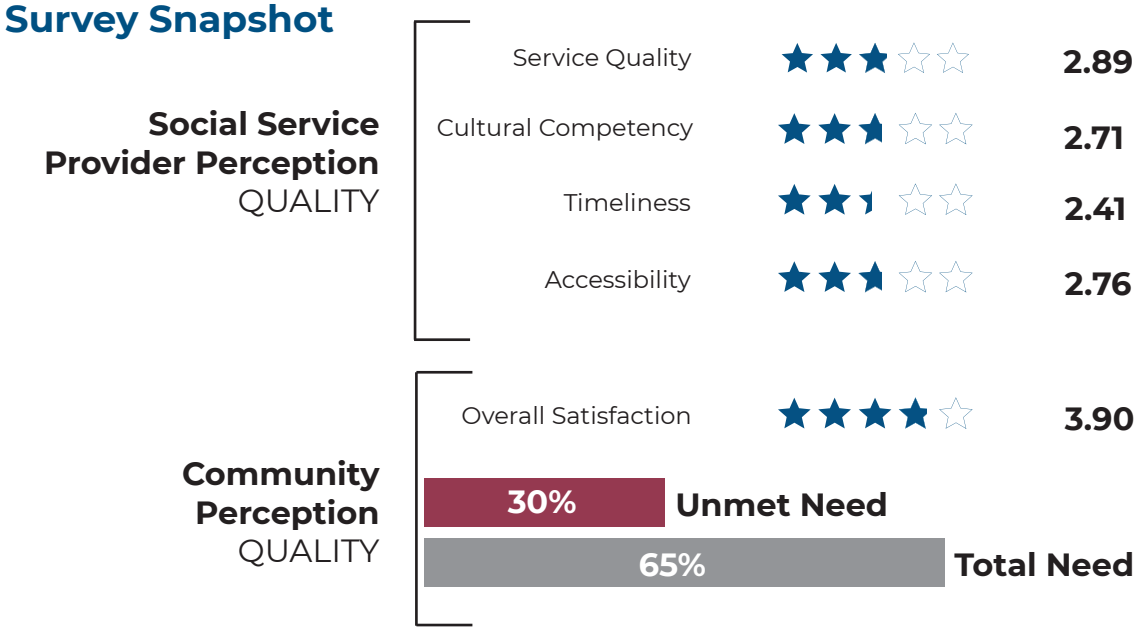


Overall, 26% of community members surveyed reported needing employment or education support. However, two-thirds of those who identified a need did not receive the service they needed.

"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

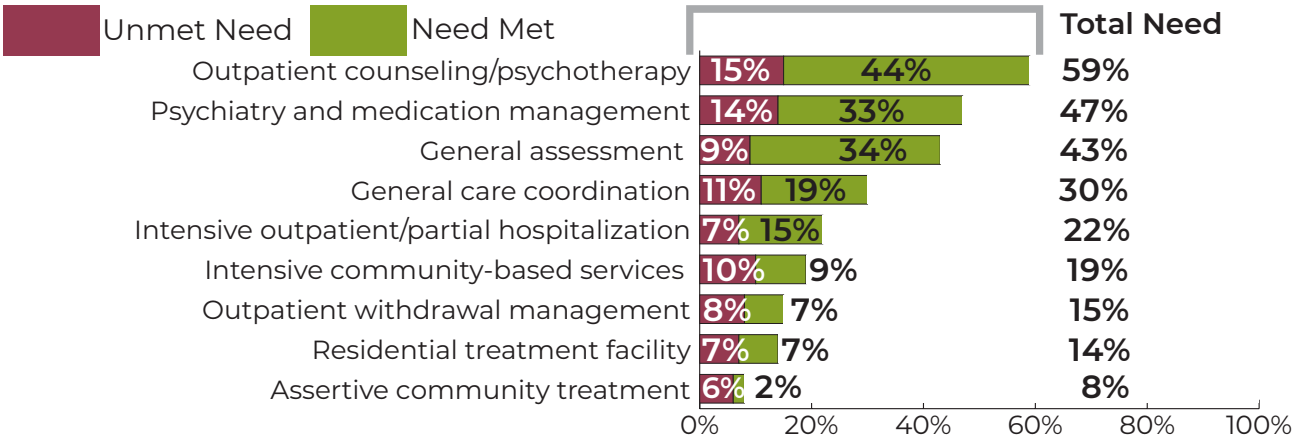
Survey Snapshot



Providers rated the quality of treatment services low because their clients continue to struggle with being linked to affordable, timely and appropriate treatment services. This is often due to long wait lists, various issues related to insurance, and ability of services to meet the unique needs of clients.

Unmet Need vs. Need Met for Treatment Services

Have you or a family member ever needed any of these services?

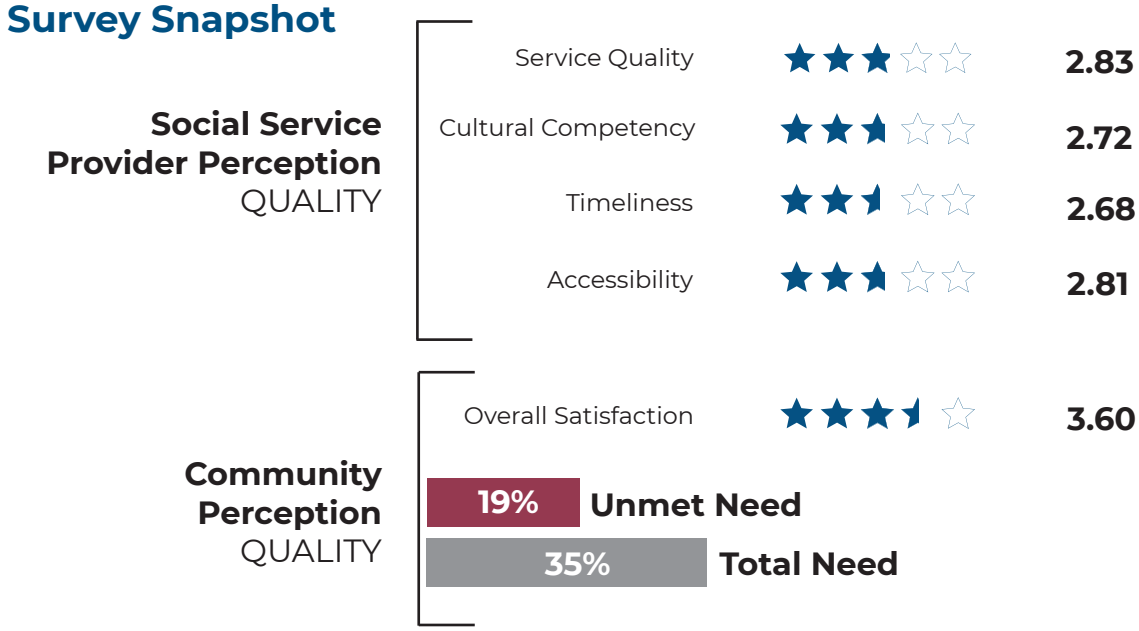


Overall, the greatest demand is for outpatient counseling/psychotherapy, with 59% of the community members surveyed reporting needing this service for themselves or a family member. Over 40% of those surveyed also reported needing psychiatry and medication management services. Those needing general assessment services also exceeded 40%.

"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

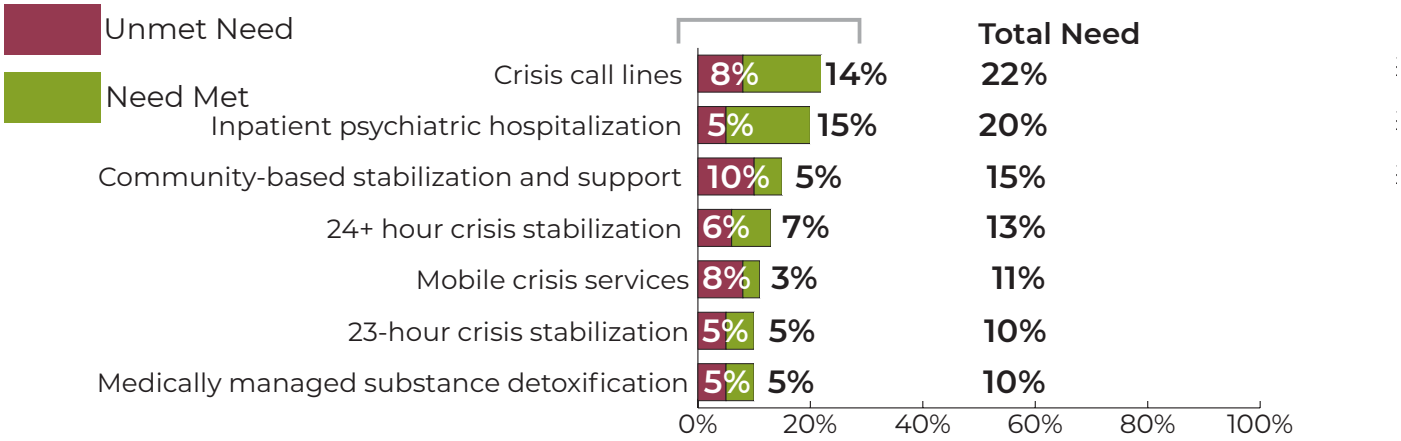
Survey Snapshot



The quality of crisis services was rated low by providers because they feel there is simply no choice in crisis services. Lack of choice is due to limited types (i.e., services for youth, functional individuals in crisis, etc.) and capacity of available services. Additionally, providers see clients not being adequately stabilized. Providers perceive this is often due to programs being driven by business models and poor programming policies.

Unmet Need vs. Need Met for Crisis Services

Have you or a family member ever needed any of these services?



Overall, 1 in 4 community members surveyed reported needing crisis call lines or inpatient psychiatric hospitalization, or both of these services. Community-based stabilization has the largest unmet need among individuals surveyed.

"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 Expert

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.

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.*

Other Franklin County Trends

Pre-pandemic trends in mental health and addiction indicators suggest a greater need for downstream strategies and targeted efforts. For example, rates of depression, as well as substance-related injury and death rates, are increasing. 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 are social and environmental factors that increase the likelihood of poor physical and behavioral health outcomes when left unaddressed.[i] A successful behavioral health continuum of care must include collaboration among multiple systems of care to ensure all community members have access to services that are right for their unique circumstances.

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

- Practical Barriers
  - o Awareness
  - o Availability (limited appointments and limited operating hours)
  - o Eligibility (complex system of eligibilities, insurance systems)
- Barriers Rooted in Social Determinants of Health
  - o Accessibility (lack of transportation, childcare, or the ability to prioritize services over meeting basic needs)
  - o 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
  - o Services and materials provided in an individual's first language
  - o Awareness of the differences in stigma related to behavioral health across groups of people
  - o Where and how information is presented
  - o Language surrounding emotions and health are lost in translation
  - o Distrust of healthcare providers and government agencies
  - o Failing to recognize an individual as a member of a social/family unit
  - o Account for experiences of racism and trauma
  - o Intergenerational differences among immigrant families

Additionally, community members, providers and system experts identified many system-level barriers that result in ineffective services. These barriers can be categorized into three overarching categories: 1) Organizational quality; 2) Funding bureaucracy; 3) Discrimination.

- Organizational Quality
  - o Communication among partners
  - o Collaboration between partners and systems of care
  - o Expectations around performance and outcomes are not clearly defined
- Funding Bureaucracy
  - o Restrictive funding practices that limit services
  - o Non-inclusive funding practices that limit community-based organizations from competing for dollars
  - o Inconsistent reporting and funding requirements
- Discrimination
  - o Disparity in access and outcomes (race, language, age, and sexual orientation, etc.)

i Franklin County Public Health Social Determinants of Health Framework. https://myfcph.org/health-systems-planning/chip/

Community Needs Assessment

Key Takeaways

The preliminary results of the community needs assessment highlight the service needs, unmet needs and barriers across the continuum of care. Additionally, analysis identifies the differences between community members' experiences. The following are the key takeaways of the preliminary results.

- The stakeholder perceptions of the quality of behavioral health services are low across the continuum. Themes from open-ended comments in surveys, as well as feedback from focus groups and system experts, suggest that building the capacity and cultural relevance of services will improve quality.

- An overwhelming theme from all data sources is that information is not readily accessible related to behavioral health and behavioral health services 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 conveyed.

- Unmet service needs exist across the continuum. Prevention and treatment have the largest service needs. Prevention, family support, recovery support, and treatment services have the largest unmet need.

- 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 and maintain well-being makes it necessary for a behavioral health system to collaborate with other social services and systems of care.

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 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 four 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 service 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.

Integrating with other systems of care to increase "on-ramps."

Like the need for more information about behavioral health services is the need for more on-ramps/points-of-entry to behavioral health services. To respond to this need, 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. Be low 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 continuum 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:

- Family 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.
- Parent 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.

Preparing 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.

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

Demographic	Community Survey		Franklin County ACS 5-Year Estimates 2019	
Comparison of Community Member Survey Respondents and Franklin County				
	%		%	
Age Range				
Under 20 (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 and up	7.7%		12%	
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%	
Multi-Racial	3.9%	3.8%	3.8%	
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%	
Have Children Under Age 18 in Home				
Yes	60.7%		27.5%	
No	39.3%		72.5%	
Sex Originally Listed on Birth Certificate				
Female	84.1%		48%	
Male	15.9%		52%	
Employment Status	Raw Survey Response	Survey Population	Franklin Co. Labor Market	Franklin Co. Population
Not employed, looking for work	7.7%	9.5%	5.4%[1] (un-employment rate)	3.6%[2]
Retired	8.3%	N/A	N/A	N/A

1 BLS monthly unemployment data for November 2020 in Franklin County
2 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.

Demographic	Community Survey		Franklin County ACS 5-Year Estimates 2019	
Comparison of Community Member Survey Respondents and Franklin County				
	%		**%**	
Not employed, NOT looking for work	5.8%	19.3% (not in labor force)	N/A	31.9%[3] (not in labor force)
Disabled, not able to work	5.3%			
Employed, working full time	62.1%	90.5%	94.6%[34] (employment rate)	64.4%[5]
Employed, working part time	10.8%			
Individual Approximate Yearly Income			Household Incomes[6]	
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%	
Highest Level of Education 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%	

3 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.
4 BLS monthly employment data for November 2020 in Franklin county; of those in the labor force that are employed.
5 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
6 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.

Appendix B: Data Description for Service Category Profiles

Quality: To determine the community's perception of the quality of services along the continuum 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 five-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 five-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 five-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.

Tel. 614.224.1057

447 E. Broad St.
Columbus, OH 43215

adamhfranklin.org

Report prepared by:

Tel. 614.947.8899

1480 Manning Parkway, Suite A
Powell, OH 43065

measurementresourcesco.com