County of Summit ADM Board
2026–2028 Community Assessment & Plan (CAP)

To meet statutory requirements, local ADAMH boards must submit a community plan to the Ohio Department of Behavioral Health (ODBH) that describes the current conditions and issues in their regions and their identified priorities for prevention, treatment, and recovery services. Beginning in 2023, this process will occur every 3 years with required annual updates.

The County of Summit ADM Board conducted the following assessment through a community survey, focus groups, review of available data, information from providers, Global Ends, Summit County Public Health's Community Health Assessment (CHA), and a variety of other available resources. Below are the assessment results of this data.

Assessment *(Red "Xs" indicates the outcome has been identified as a "Top 3 Challenge" for that section.)*

	Major Challenge	Moderate Challenge	Minimal Challenge
MENTAL HEALTH AND ADDICTION **CHALLENGES**			
CHILDREN, YOUTH, AND FAMILIES			
Mental, emotional, and behavioral health conditions in children and youth (overall)		X	
Youth depression	X		
Youth alcohol use			X
Youth marijuana use		X	
Youth other illicit drug use			X
Youth suicide deaths	X		
Children in out-of-home placements as a result of parental substance use disorder (SUD)	X		
Chronic absenteeism among K–12 students			X
Suspension and expulsions among K–12 students		X	
Adverse childhood experiences (ACEs)	X		
ADULTS			
Mental health and SUD conditions among adults (overall)	X		
Adult serious mental illness	X		
Adult depression		X	
Adult substance use disorder	X		
Adult heavy drinking		X	
Adult illicit drug use		X	
Adult suicide deaths	X		
Drug overdose deaths		X	
Problem gambling		X	
Adverse childhood experiences (ACEs)	X		
MENTAL HEALTH AND ADDICTION **SERVICE GAPS**			
OVERALL SERVICE GAPS IN CONTINUUM OF CARE			
Prevention services, programs, and policies	X		
Mental health treatment services		X	
SUD treatment services	X		

Crisis services	X		
Medication-assisted treatment (MAT)			X
Recovery supports		X	
Mental health workforce (mental health professional shortage areas)	X		
Criminal justice			X
SUD treatment workforce	X		
ACCESS FOR CHILDREN, YOUTH, AND FAMILIES			
Unmet need for mental health treatment, youth		X	
Unmet need for substance-use/addiction treatment, youth	X		
Lack of well-child visits		X	
Lack of child screenings: depression and developmental		X	
Lack of child screenings: developmental		X	
Lack of child screenings: anxiety		X	
Lack of follow-up care for children prescribed psychotropic medications		X	
Lack of school-based health services			X
Uninsured children			X
Other child/youth access challenges: youth peer supporters	X		
ACCESS FOR ADULTS			
Unmet need for mental health treatment, adults		X	
Unmet need for outpatient MAT, adults			X
Unmet need for outpatient MAT		X	
Unmet need for non-MAT substance-use/addiction treatment, adults	X		
Low SUD treatment retention		X	
Lack of follow-up after hospitalization for mental illness challenges			X
Lack of follow-up after ED visit for mental health	X		
Lack of follow-up after ED visit for substance use	X		
Unmet service need for criminal justice-involved adults			X
Unmet service need for uninsured adults			X
Other adult access challenge, specify: undocumented	X		
SOCIAL DETERMINANTS OF HEALTH			
Social and economic environment			
Poverty	X		
Unemployment or low wages		X	
Low educational attainment			X
Violence, crime, trauma, and abuse	X		
Stigma, racism, ableism, and other forms of discrimination	X		
Social isolation	X		
Social norms about alcohol and other drug use	X		
Attitudes about seeking help		X	
Family disruptions (divorce, incarceration, parent deceased, child removed from home, etc.)	X		
Physical environment and health behaviors			
Lack of affordable or quality housing	X		
Lack of transportation		X	

Lack of broadband access			X
Lack of access to healthy food		X	
Lack of physical activity		X	
Lack of fruit and vegetable consumption		X	
Food insecurity			X

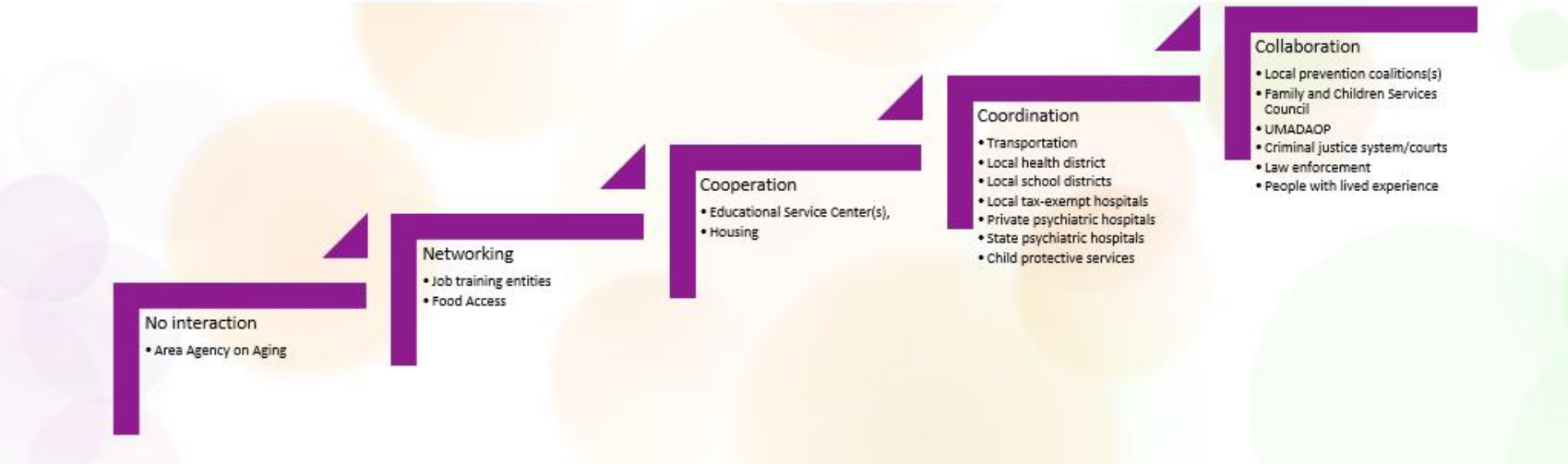
Partnerships and Collaborations

The highlighted areas below have been identified as the top 3 strengths out of the 9 listed that the ADM Board can draw upon to address the needs and gaps identified in our plan.

Collaboration and partnerships	Availability of specific resources/assets	Economic vitality
Engaged community members	Natural resources and greenspace	Creativity and innovation
Colleges or universities	Social support and positive social norms	Faith-based communities

The chart below indicates perceived level of collaboration with community partners. The following are definitions for each level of collaboration per ODBH:

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



In response to the image above, the ADM Board has identified priority areas to ensure that the community is aware of established partnerships. Additionally, the ADM Board has identified the following areas to strengthen over the course of this plan:

1. Establishing a working relationship with universities and job training entities
2. Enhancing public communications to highlight existing partnerships

Family and Children First Council
(Collaboration and services and reduction of home placements)
The ADM Board partners with the Family and Children First Council (FCFC) and other community stakeholders to promote a coordinated system of care for families with children/youth ages birth through 21 years. Collectively, the partners work to develop, implement, and evaluate coordinated responses to child and family issues for youth who are involved with multiple systems (e.g., SC Children Services, SC Developmental Disabilities, SC Juvenile Court, SC Educational Services Center, Akron Public Schools, OhioRise). A completed Child and Adolescent Needs and Strengths (CANS) assessment establishes the level of care needed. Representatives from the aforementioned community partners serve on the Service Review Collaborative (SRC) and meet weekly to review cases and approve funding requests for identified services for the appropriate level of care. This meeting is facilitated by the FCFC director who also maintains and monitors the budget of pooled funding from key partners.

January 2025 launched an expanded focus on prevention for our local FCFC. For Service Coordination/Wrap Around (SC/WA) referrals, there is no longer the requirement that youth be “open” within two systems. FCFC Coordinators work with the families to make sure they are not falling through the cracks, are connected to appropriate services/supports, and have a plan. There is no cost for FCFC SC/WA, and those with private insurance, no insurance, and any type of Medicaid can be served. Some innovative services that support families and children with significant need include Mobile Response Stabilization Services (MRSS), high fidelity wrap-around area coordination, intensive home-based services, family functional therapy, intensive outpatient services, out-of-home placement, and respite (including day respite hours). Additionally, SRC can pay for creative solutions that families or the child's team identifies that could meet their needs. Some examples include safe storage, specialized equipment, emergency rent, safety cameras, gas cards for transportation to out-of-home-placement, and more.

Part of the weekly SRC meetings with community partners involves approving requests for out-of-home-placements when that level of care has been identified through a CANs assessment. Every effort is made to ensure that out-of-home-placement is warranted as our experience has been that youth who can maintain in the community have far better outcomes. Prior to consideration for out-of-home placement, we expect that the family has tried less restrictive interventions first. Some of these interventions include intensive outpatient, intensive in-home services, respite, functional family therapy, and more. If out-of-home placement is the best option and other intensive services have been utilized, we immediately begin planning for when the youth returns home. Often, that

requires intensive family counseling while the youth is in out-of-home placement, individual work for parents, and wrap-around coordination.

Hospital Services
(Discharge planning and potential challenges)
The ADM Board staff has regular contact with local, private, and the state hospital psychiatric hospital system to help plan for the discharge of Summit County residents. Patients are linked to local provider agencies prior to discharge. Since the previous CAP, the ADM Board has funded two hospital navigators to assist with identifying these patients and ensuring a warm handoff into the community. We are also in the final stages of construction of our residential step-down center to help facilitate transition from psychiatric hospitalization for those who may need additional supports. The Dr. Fred Frese Residential Center is expected to open in spring of 2026. Additional developments since the last CAP as a means to support diversions from hospitalization include the implementation of the Summit County Outreach Team (SCOUT), which is an adult mobile co-responder service in collaboration with the Akron Police Department, Akron Fire Department, and Portage Path Behavioral Health.

The ADM Board continues to be challenged by the long wait time to access state psychiatric hospitalization in our region. This setting serves our most ill and/or those that are indigent; therefore, there may not be other options for hospitalization. We also partner with our local hospitals, Summa Health Systems and Cleveland Clinic Akron General, for access to their psychiatric inpatient beds when available and appropriate.

Plan
Upon completion of the above assessment, the ODBH required goals from ten priorities: prevention, mental health treatment, SUD treatment, crisis services, MAT, recovery supports, criminal justice, pregnant women with SUD, parents with SUD, and youth. The below priorities also align with the County of Summit ADM Board’s Global Ends, which were set forth by its Board of Directors.

Goal #	CoC	Global Ends Alignment	Priority Strategy	Age Group	Priority Population	Capital Funds	Outcome Indicator	Data Source	Baseline Year	Baseline Data Value	Target Year	Target Data Value
1	Prevention	1.1A, 1.4	Redesigning prevention programming through needs assessment, enhancement of evidence-based practices, funding guidelines, and optimization of billing structures	All	All	No	Improvement in pre/post test of educational curriculum	SureImpact (program outcomes)	sfy26	0	2028	25%
2	MH Tx	1.1A, 1.5	Workforce initiatives: Gallup, to include consultation and Q12+ survey to system; SERP; continue to implement 3yr workforce plan	All	All	No	% imporvement on Engagement Mean	Gallup Access	2025	3.99	2028	4.19
3	SUD Tx	1.1B, 1.1C, 1.2B, 1.3	Continue improvement of residential access through RAL; expansion of SUD tx for adolescents	All	All	Yes	wait times for residential	RAL dashboard	2024	11.4	2028	5
4	MAT	1.1B, 1.1C, 1.2B, 1.5, 1.5A, 1.3	Revamping programming in detox and continue improvement of residential access through RAL	*Transitional Age *Adults *Older Adults	All	Yes	Increase in Buprenorphine	OARRS	cy2024	4.02k patients	2028	4.22
5	Crisis	1.1, 1.1C, 1.2B, 1.3, 1.5	Plan, build, and expand crisis services, including opening of the BH Wellness Center, and expanding of MRSS and SCOUT	*Transitional Age *Adults *Older Adults	All	Yes	Increase crisis services encounters	program outcomes dashboard	cy2024	3691	2028	4175
6	Recovery Support	1.1A, 1.3B, 1.2B	Offer peer support trainings & professional development for peers; survey of # of peers in system; funding programs with peer support services integrated	All	All	No	Increase in # of peer supporters in the system	surveymonkey (workforce development survey)	2025	109	2028	139
7	Criminal Justice	1.1B, 1.3, 1.5	Revamp of QRT Teams	*Transitional Age *Adults *Older Adults	All	No	Increase in # of jurisdictions that are actively covered by QRTs	ADM Board	fy26	4-31	2028	10
8	Pregnant w/ SUD	1.1, 1.1A, 1.1B, 1.1C, 1.2B, 1.3A	DDC consultation w/CWRU; enhance data collection	*Transitional Age *Adults *Older Adults	Pregnant Women w/ SUD	No	Increase #s in residential	RAL dashboard	sfy24	0	2028	9
9	Parents w/ SUD and Dependent Children	1.1, 1.2B, 1.3, 1.5	Capital project (Level II Recovery Housing)	*Transitional Age *Adults *Older Adults	All	Yes	Increase access to recovery house for parents with children under the age of 12 years old	ADM Board	2025	2	2027	5
10	Strategy for Youth	1.4B, 1.2A, 1.3B, 1.5	Suicide prevention programming; youth voice in suicide prevention coalition; information dissemination; engage in strategic prevention efforts with the suicide prevention coalition; exapansion MRSS; expansion of IHBT; continue collaboration with FCFC	*Children 9-12 *Adolescents 13-17	All	No	Decrease in youth suicides	ME Data	fy25	7	2028	0

Currently, the ADM Board reviews and monitors data on a weekly, monthly, quarterly, and annual basis, depending on the data indicator. The ADM Board's Quality Improvement Coordinator, along with the Manager of Evidenced-Based Practices and Outcomes, is responsible for collecting and monitoring the data. As part of OBDH's requirements, the ADM Board is expected to submit annual progress reports in February. Reports will indicate actual numbers achieved in comparison to the target. The ADM Board also evaluates a variety of other data sources in addition to those listed in our CAP as set forth by our Board of Directors. Reports are submitted to the Board of Directors throughout the year.