Ohio Department of Mental Health and Addiction Services (OhioMHAS)
2026-2028 Community Assessment and Plan (CAP):

Legislative Requirement Section

Crisis Services Plan

Overview

The Ohio Department of Mental Health and Addiction Services (OhioMHAS) will issue crisis funding in SFY 2026-2027 to directly support standardized and quality crisis access in communities to appropriately reduce behavioral health related arrests or emergency room visits, and to help meet the needs of individuals and families to prevent or stabilize a substance use or mental health crisis. These funds will help ensure crisis services are a part of an integrated crisis system focused on managing individuals' behavioral health and medical needs. ADAMH Boards should work in collaboration with regional partners and providers to plan for regional service provision. The amount of funding will be provided at a later date following the approval of the new biennium budget.

In addition to completing this CAP element in the online application, please also complete the Crisis Services Table 2 Excel spreadsheet and email it to QPRBoardDocs@mha.ohio.gov. To help complete the spreadsheet, a copy of the data your Board provided previously for the Crisis Services Dashboard will be included. You may copy and paste this data, but please review for accuracy and update as needed. Please note that this year we are asking for some additional information to be included for each provider. Detailed instructions will be in the spreadsheet.

Definitions for each type of crisis service are provided at the end of this template. For Question 2 and for the Crisis Services Table 2 Excel spreadsheet, please ensure you use the definitions so types of crisis services can be accurately counted.

Template

Board name	Preble County Mental Health & Recovery Board
Date	1/21/2026

Key

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

1. ✱**Describe the Board's Crisis Planning Committee/Task Force. If you do not have a Crisis Planning Committee/Task Force, please provide your plan to implement one in your community.** (Note, this open-ended question has a character limit of 4,000 [approximately one typed page]. You will not be notified if your entry is greater than 4,000 characters and we will not be able to access it. Please ensure that your entry is less than 4,000 characters.)

   Preble County does not currently have a Crisis Planning Committee (CPC). Preble County Mental Health and Recovery Board will implement this committee to serve as a collaborative, cross-system body responsible for planning, coordination, and continuous improvement of the county's behavioral health crisis response system. CPC will meet regularly to align partners, review data, and guide implementation of evidence-informed crisis services.

   Membership will include representatives from the PCMHR Board; local law enforcement agencies; emergency medical services and fire departments; hospital and emergency department leadership; community mental health and substance use treatment providers; crisis service providers (including 988-related partners); the Preble County Sheriff's Office; the courts; public health; social services; and individuals with lived experience and family advocates. This multidisciplinary composition ensures that planning reflects system realities across public safety, healthcare, and community-based services.

   The CPC's responsibilities will include: (1) assessing community crisis needs and service gaps using local data (e.g., emergency department utilization, law enforcement contacts, and crisis line trends); (2) coordinating crisis response protocols across agencies to promote timely, appropriate, and least-restrictive interventions; (3) supporting the development and sustainability of the full crisis continuum, including prevention, mobile response, crisis stabilization, and follow-up care; (4) establishing communication pathways and training priorities for partners; and (5) monitoring outcomes to inform quality improvement.

   The committee will play a central role in aligning county efforts with state guidance and best practices, including promoting coordination with the 988 Suicide & Crisis Lifeline, improving diversion from jails and emergency departments when clinically appropriate, and strengthening post-crisis follow-up to reduce repeat crises. The CPC will also advises on funding priorities and implementation timelines to ensure resources are used effectively and equitably.

   If new initiatives are proposed, the CPC will serve as the primary planning forum to engage stakeholders early, develop shared goals, and ensure readiness prior to implementation. Through this structured, collaborative approach, Preble County will maintain a coordinated and responsive crisis system focused on safety, access, and saving lives.

2. ✱**Communicate the Board's current and planned crisis system in the following table.**

Crisis System Components	Service currently physically offered in your geographic board area (Yes/No)	New Service is planned for CY 2026 (Yes/No)	New Service is planned for CY 2027 (Yes/No)	New Service is planned for CY 2028 (Yes/No)
Crisis call centers	No	No	No	No
Mobile Crisis Services – Adult	Yes	Yes	No	No
Mobile Crisis Services – Youth (non-MRSS)	Yes	Yes	No	No
Mobile Response and Stabilization Services (MRSS)	Yes	No	No	No
Crisis Access Services	No	No	No	No
Behavioral Health Urgent Care	No	No	No	No
Crisis Intervention with Observation	No	No	No	No
Crisis Residential Services	No	No	No	No
Inpatient Psychiatric Services	No	No	No	No
Withdrawal management	No	No	No	No
SUD Crisis Residential	No	No	No	No
Other				

3. ✱**Describe how you collaborate with your 988 call center. How is 988 data used to support your crisis system?** (Note, this open-ended question has a character limit of 4,000 [approximately one typed page]. You will not be notified if your entry is greater than 4,000 characters and we will not be able to access it. Please ensure that your entry is less than 4,000 characters.)

Preble County collaborates closely with its designated 988 Suicide & Crisis Lifeline call center, Sojourner Recovery Services, as a core component of the county's behavioral health crisis continuum. This collaboration is coordinated through the Preble County Mental Health & Recovery Board (MHRB) and is designed to ensure timely access to crisis support, effective coordination with local resources, and continuity of care for individuals experiencing behavioral health crises.

Coordination with the 988 call center focuses on clear communication pathways, shared protocols, and alignment of roles across the crisis system. MHRB works with the 988 provider to ensure callers from Preble County are routed appropriately and that call center staff are knowledgeable about local crisis services, including mobile response, crisis stabilization options,

and outpatient follow-up resources. When appropriate, 988 counselors coordinate warm handoffs to local providers or emergency services, emphasizing least-restrictive and clinically appropriate responses.

The county supports ongoing collaboration through participation in planning meetings, cross-system discussions, and coordination with crisis service providers and public safety partners. This ensures that 988 operations are integrated into the broader crisis response framework rather than operating as a standalone service. The goal is to reduce unnecessary emergency department utilization and law enforcement involvement while improving access to timely behavioral health support.

988 data is used to inform planning, monitoring, and quality improvement efforts across the crisis system. Aggregate data such as call volume, call type, time of day, geographic trends, and referral outcomes are reviewed to identify service gaps, emerging needs, and opportunities for system enhancement. This data helps guide decisions related to staffing, training priorities, resource allocation, and service expansion.

Additionally, trends observed through 988 data will be shared with the new Crisis Planning Committee to support coordinated problem-solving and strategic planning. Data will be used to assess the effectiveness of crisis interventions, identify populations at higher risk, and inform prevention and outreach efforts. All data sharing is conducted in compliance with applicable privacy and confidentiality requirements.

4. ✱**What gaps, based on the crisis system in Question #2, are currently present in the Board area? Describe the target population most impacted by this gap in terms of age, gender, race, geographic location, special population status, etc.** (Note, this open-ended question has a character limit of 4,000 [approximately one typed page]. You will not be notified if your entry is greater than 4,000 characters and we will not be able to access it. Please ensure that your entry is less than 4,000 characters.)

   Based on the current crisis system described in Question #2, several gaps remain within the Preble County Mental Health & Recovery Board service area that limit timely access to appropriate crisis care and place increased strain on emergency and public safety systems.

   A primary gap is limited availability of in-person crisis response and stabilization options, particularly outside of traditional business hours. While individuals can access crisis support through 988, there are constraints in the local capacity for rapid, on-site response and short-term stabilization, especially during evenings, nights, and weekends. As a result, individuals experiencing acute behavioral health crises are more likely to rely on emergency departments or law enforcement, even when a less restrictive and more clinically appropriate response may be warranted.

   This gap most significantly impacts adults and transition-age youth experiencing serious mental illness, substance use disorders, or co-occurring conditions. Individuals with repeated crisis episodes, high acuity needs, or limited natural supports are particularly affected. Rural residents face additional barriers due to transportation challenges and longer response times, which can delay care and escalate crises.

Additionally, disparities persist for older adults, individuals with disabilities, and residents in geographically isolated areas who may have difficulty navigating available resources or accessing crisis services in a timely manner. While Preble County serves a predominantly rural and largely white population, equity considerations remain important, particularly for individuals with limited access to transportation, technology, or culturally responsive services.

Addressing these gaps requires strengthening the local crisis continuum by expanding timely, community-based crisis response and stabilization options, improving coordination across systems, and enhancing follow-up and continuity of care. These efforts are critical to reducing reliance on emergency departments and law enforcement, improving outcomes for individuals in crisis, and ensuring equitable access to behavioral health crisis services across the Board area.

5. ✱**Crisis System Funding Sources and Amounts.**

Total Crisis System Funding: **Identify the amount of funding that supports the crisis continuum**			
Funding Source	**Amount Planned in CY 2026**	**Amount Planned in CY 2027**	**Amount Planned in CY 2028**
Local Levy	**70549**	**70549**	**70549**
Local Grants *(grants not funded via OhioMHAS)*			
State GRF	**139282**	**139282**	**139282**
5TZ0			
OhioMHAS Funded Grants (non-GRF)			
Other Funding:			

6. ✱**Describe the Board's plan to enhance, expand, or continue to support the crisis system in your board area. Include the goals identified in the CAP and capital funding plans to support expansion of the continuum. Also include plans to address any gaps identified in Question 4 above.** (Note, this open-ended question has a character limit of 4,000 [approximately one typed page]. You will not be notified if your entry is greater than 4,000 characters and we will not be able to access it. Please ensure that your entry is less than 4,000 characters.)

The Preble County Mental Health & Recovery Board's plan to enhance, expand, and sustain the local crisis system is grounded in the goals identified in the Board's CAP, with a focus on strengthening the full crisis continuum and addressing the gaps identified in Question #4.

A primary goal is to expand timely access to community-based crisis response and stabilization services, particularly during evenings, nights, and weekends. In addition, the Southwest hospital region has applied for a mobile crisis grant through the Ohio Department of Behavioral Health to further strengthen regional capacity for in-person crisis response. Consistent with the CAP, the Board plans to strengthen coordination with 988 partners and local providers to improve real-time linkage to in-person supports when clinically appropriate. This includes supporting service

models that promote rapid response, reduce reliance on emergency departments and law enforcement, and prioritize least-restrictive interventions.

Equity and geographic access are central considerations in the Board's plan. Given Preble County's rural geography, the Board will prioritize strategies that address transportation barriers and service access for residents in outlying areas. Efforts will focus on ensuring that crisis services are accessible to individuals regardless of income, insurance status, housing stability, or involvement with the justice system.

Ongoing system monitoring and quality improvement are embedded in the Board's approach. The Crisis Planning Committee will use data from 988, emergency departments, law enforcement, and providers to track outcomes, identify emerging needs, and adjust strategies as needed. These data-informed efforts will support sustainable expansion of the crisis continuum and ensure resources are aligned with community needs.

Through coordinated planning and alignment with CAP goals, the Preble County Mental Health & Recovery Board is committed to building a responsive, equitable, and effective crisis system that improves access to care, reduces system strain, and supports better outcomes for individuals and families experiencing behavioral health crises.

7. ✱**Describe the outcome measures you are collecting to indicate success and manage continuous quality improvement (i.e., persons served, linked vs. non-linked, access to care/wait times, etc.).** (Note, this open-ended question has a character limit of 4,000 [approximately one typed page]. You will not be notified if your entry is greater than 4,000 characters and we will not be able to access it. Please ensure that your entry is less than 4,000 characters.)

The Preble County Mental Health & Recovery Board uses a set of outcome measures to assess effectiveness, guide continuous quality improvement (CQI), and ensure accountability across the behavioral health crisis system. These measures are aligned with state guidance, CAP goals, and best practices for monitoring crisis system performance.

Key outcome measures include the number of individuals served through crisis services, including contacts through 988, in-person crisis responses, crisis stabilization services, and related crisis supports. The Board monitors trends in utilization to understand demand, identify emerging needs, and assess whether services are reaching priority populations.

System impact measures are used to assess broader outcomes. The Board also receives crisis notifications for individuals entering local hospitals for mental health–related conditions. These notifications allow the Board and providers to conduct timely follow-up, support linkage to community-based services, and reduce the likelihood of repeat crisis events or prolonged hospital utilization. These include emergency department utilization related to behavioral health crises, repeat crisis contacts, and involvement of law enforcement when responding to individuals experiencing behavioral health emergencies. Reductions in avoidable emergency department visits and law enforcement involvement are viewed as indicators of improved crisis system functioning.

The Board also incorporates qualitative and equity-focused measures into CQI efforts. Feedback from individuals served, family members, and system partners is used to assess satisfaction, perceived effectiveness, and areas for improvement. Data are reviewed with attention to geographic access, age, and special population considerations to identify and address disparities in service delivery.

The Board collects key performance indicators (KPIs) from crisis and treatment providers and reviews these metrics during quarterly meetings to evaluate performance, identify trends, and guide continuous quality improvement efforts. Findings are used to refine protocols, adjust resource allocation, inform training priorities, and guide future investments. Through ongoing monitoring and continuous quality improvement, the Preble County Mental Health & Recovery Board ensures that crisis services remain responsive, effective, and aligned with community needs.

Current Term for survey	Definition- taken from Roadmap to the Ideal Crisis System	Previous Term(s)	Licensure and Certification Official Classifications
Crisis call centers	Call center or crisis line: A direct-service telephone line that is answered 24/7 by staff that has been trained to work with individuals in urgent and emergent crisis and can connect individuals to needed resources and help support problem solving and coping skills. Warmline or helpline: A direct service in which trained peers or volunteers provide support via telephone during specified hours of operation. These lines are used for non-emergent situations, such as loneliness, anxiety or need for support, that could potentially worsen to an emergency if not addressed.	24-Hour Crisis Hotline/Textline; Warm Lines	*BH Hotline*
Mobile crisis teams	Mobile crisis services: Teams consisting of behavioral health specialists, usually professionals and peers, who can be deployed rapidly to meet an individual experiencing a crisis at their location in the community. These teams perform psychiatric assessments, de-escalate crises, determine next steps in an individual's treatment and connect the individual in crisis to needed services in the community. Mobile crisis workers may be deployed independently and/or work as co-responder teams with law enforcement, emergency medical services or other first responders.	Mobile Crisis Team/ Children Mobile Response Stabilization	*Adult – Crisis Intervention) (Youth – Mobile Response and Stabilization Services*
Crisis residential services	Residential crisis services: Provide a few days up to two weeks of 24-hour crisis intervention and monitoring for individuals in acute behavioral health crisis who cannot be served as outpatients but do not require inpatient psychiatric services. Services provided include 24-hour supervision, assessment and treatment of symptoms, individual and group therapeutic services, social services and referrals and handoffs to community resources. Different terms are used, such as crisis stabilization unit, crisis residential unit and crisis respite services, depending on the level of medical/nursing involvement and service intensity.	Short-Term Acute Residential Treatment	*Therapeutic Behavioral Services and Psychosocial Rehabilitation, Residential, Withdrawal, and Inpatient SUD) (SUD Qualified Residential Treatment Program (QRTP) for Youth*

Crisis Intervention with Observation	Extended (23-hour/48-hour) crisis observation: Provide up to 23 or 48 consecutive hours of direct and usually intensive supervised care in order to help individuals in acute crisis with either unclear or transient situations to have more thorough assessments and potentially resolve the crisis to avoid unnecessary hospitalization. Services provided include 24-hour observation and supervision, assessment and treatment of symptoms and referrals to appropriate community resources.	23-Hour Observation Level of Care	*Crisis Intervention, Therapeutic Behavioral Services and Psychosocial Rehabilitation, Residential, Withdrawal, and Inpatient SUD*
Crisis Access Services	Crisis Access services provide an array of behavioral health crisis services in a specific location. Locations can include a 24/7 crisis provider, local emergency department, jail, etc. Services provided include assessment, treatment, stabilization and referrals to appropriate community resources and follow-up care and often serve as a point of coordination for all the crisis services in the continuum for all age groups and populations.	Crisis Stabilization Services	*Therapeutic Behavioral Services and Psychosocial Rehabilitation, Residential, Withdrawal, and Inpatient SUD) (SUD Qualified Residential Treatment Program (QRTP) for Youth*
Inpatient psychiatric services	Inpatient psychiatric care: inpatient hospital-based psychiatric treatment in general hospital or freestanding psychiatric hospital settings, designed for individuals whose acute exacerbation of psychiatric symptoms render them unable to cope safely in the community and are too severe to be managed at a lower level of care. Services provided include a secure setting, 24-hour medical and nursing management, 24-hour observation and supervision, intensive assessment and treatment of symptoms, both individual and group therapeutic services, social services and development of a plan to transition the individual back into the community.	Level 1 Acute Care Psychiatric Inpatient	*Psychiatric Residential Treatment Facility (PRTF)*

Behavioral Health Urgent Care	Walk-in behavioral health urgent care services are conceptually equivalent to medical urgent care services. Behavioral health urgent care provides a valuable cost-effective alternative to ER utilization for behavioral health crises, just as medical urgent care provides similar value for diverting individuals with urgent but non-emergent medical needs. Behavioral health walk-in urgent care can provide easy access to a crisis response that does not initially require intensive or secure intervention. Individuals and families can access these services on their own, in convenient locations in the community or be directed to urgent care centers by the call center or crisis line (when that option is more appropriate than mobile crisis).	n/a	*Crisis Intervention*
Withdrawal management	Withdrawal management, or medical detoxification safely manages the acute physical symptoms of withdrawal associated with stopping drug use. The goal of withdrawal management is to enable a person to stop taking the addictive substance as quickly and safely as possible.	Detoxification Services	*Residential, Withdrawal, and Inpatient SUD, Ambulatory Withdrawal Management (Youth QRTP)*
SUD Crisis Residential	**Adult SUD Residential Crisis Services** (ASAM Level 3 Withdrawal Management): ASAM 3.7: Medically Monitored**, ASAM 3.2: Socially supported**, Option to consider: Sobering Center **Adolescent SUD Residential Crisis Services** (ASAM Level 3 WDM): ASAM 3.7: Medically Monitored**, ASAM 3.2: Socially supported**	n/a	*Residential, Withdrawal Management, and SUD Inpatient, SUD Case Management*
Other		Crisis Intervention Teams Peer Crisis Support/Peer Navigator	*Peer Crisis Support/Peer Navigator* *CBHC certificate 5122-26 with certified services* *Peer Support Svcs 5122-29-15* *General Services 5122-29-03* *Crisis Intervention 5122-29-10* *Referral and Information 5122-29-12* *Crisis Intervention Team (CIT)* *Same as Mobile Crisis Teams listed above*