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On behalf of: Union County, Madison County, Jefferson County
Family and Children First Councils (Union, Madison and Jefferson)
Boards of Developmental Disabilities (Union, Madison, and Jefferson)
Mental Health and Recovery Board of Clark-Greene-Madison Counties
Jefferson County Prevention and Recovery Board
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ABSTRACT

Proposal Abstract

This proposal is submitted by the Mental Health & Recovery Board of Union County (MHRBUC) as a continuation and expansion of Strong Families, Safe Communities (SFSC). Over the past two years, MHRBUC has successfully transitioned planning and services for multisystem youth into a structured Youth Systems of Care. In partnership with our co-applicant Madison County, Union County has created an innovative learning community for our region, including non-Strong Families, Safe Communities counties.

The proposal contained in this narrative will continue the work that was started in FY 2018 and FY 2019 and add Jefferson County as a funded partner. The scope of work for Union County as the primary applicant will also be expanded in order to build on the excellent models of service coordination and high-fidelity wraparound that have been established. Union County will continue to convene the Strong Families, Safe Communities learning collaborative and provide funding and mentorship to Madison and Union Counties as they seek to establish or expand their system of care for multisystem youth.

The collaboration approach will include the following: Maintaining and expanding current levels of service coordination and high-fidelity wraparound; expand the SFSC Learning Collaborative to new counties; ensure staffing and supports for service coordination and high-fidelity wraparound; cross-train all counties in evidence-based practices, CANS assessment, cultural competence, and other program elements; and provide formative and summative evaluation for the project. Funds are requested for a two year period with FY 2020 funds requested at $325,000 and FY 2021 at $325,000.

1. Problem Statement

This application is submitted on behalf of the Mental Health and Recovery Board of Union County (MHRBUC), the behavioral health planning and funding authority (political subdivision) for Union County, Ohio. Union County, Ohio, is a relatively prosperous county of 56,741 people. The county is located in Central Ohio and is contiguous on the southern border to Franklin County (Columbus, OH). Union Co. is among the fastest growing counties in Ohio with per capita income well above the state average. However, the rapid change in the county has brought an increase in population and a widening disparity of wages and increased social concerns. The southern part of the county is dynamic and has high service-sector and manufacturing job growth. The northern part of the county has characteristics more like Ohio's Appalachian communities with limited employment, social isolation, and absence of transportation services. Overall, however, there is a fairly good quality of life, unemployment is low and there is a strong sense of community.

Madison County has not experienced the level of growth seen in Union County. Per capita income is under the median for Ohio by more than 15%. Jefferson County per capita income is 21% under the state median. Resources available in these counties are overwhelmed, and both counties are looking to increase approaches that show efficacy in reducing these costs and improving the lives of the children and families they represent.

As rural communities, sustaining effective service coordination is challenging. This is particularly true if the communities are not using effective, evidence-based approaches (Mendenhall, et al., 2013). Youth and families in rural communities face unique barriers including stigma, transportation, service availability and financing (Pullmann, VanHooser, Hoffman, & Hefflinger, 2009). Over the past decade, the number of children facing significant distress has increased dramatically. The trend has followed the trajectory of the opiate epidemic and has left the three partner counties – Union, Madison, and Jefferson - challenged to find new resources and approaches.

However, since the original Strong Families, Safe Communities application in 2017, Union County has experienced some significant decreases in the expenditures for out-of-home placements, a primary indicator of successful collaboration among child-serving agencies. Madison County, continues to see out-of-home placement costs rise, however, and has committed to root-cause analysis of this increase. The addition of Jefferson County to our collaborative brings in an additional county that has experienced escalation of out-of-home placement costs. The following table illustrates the costs for placement in the three counties and total child populations, comparing 2016/2017 to 2018/2019:

Comparative Costs for Out-of-Home Placement 2016-17 to 2018-19 (Source: PCSAO Factbook)

County	2017 Child Population	2017 Placement $	2019 Child Population	2019 Placement $	Difference Population	Difference Cost
Union	13,672	$ 1,010,889	16,545	$529,365	↑ 21%	↓ 48%
Madison	9,215	$ 627,348	9,729	$949,421	↑ 6%	↑ 51%
Jefferson	13,199	$2,073,560	12,974	$1,328,986	↓ -2%	↓ 36%

Indexed for population, these numbers reflect both success with the need to maintain and expand current efforts, and concerns with the need to intensify or alter the level of intervention. For Union County, this table illustrates the impact of highly coordinated services and our need to expand our system of care for continued success. For Madison and Jefferson Counties, the need to reevaluate current approaches remains notable. It demonstrates Union County's growing expertise in Youth Systems of Care and our ability to provide technical assistance to other counties, yet underscores priority need for Union County to maintain and expand the models and efforts established in the past two years.

Regardless of the level of success under Strong Families, Safe Communities, these numbers continue to strain local systems including Children's Protective Services, the juvenile courts, and local behavioral health providers. Out-of-home placements are only one indicator of the strength of a community's system of care, and the need for additional resources. In Union County, service coordination and high-fidelity wraparound services have exploded to the point that they will be unsustainable without the addition of continued Strong Families, Safe Communities resources.

2. Strategies and Interventions

a) Proposed Models of Care

SAMHSA System of Care Model (SOC) – All strategies will align with SAMHSA System of Care (SOC) model that includes the following elements: family driven, individualized, strengths-based, evidence-informed, youth guided, culturally and linguistically competent, community based and least restrictive, and collaborative across agencies and systems.

High-Fidelity Wraparound – this model is a family and youth-centered approach that builds a collaborative support system of strengths-based, natural supports based on the unique needs of youth and their families. Services are community-based, culturally competent, and "unconditional" (that is, wraparound continues toward the goals on the wraparound plan despite challenges until the youth/family determine they are no longer needed). Families have voice and choice.

Service Coordination – this model utilizes many of the same principles of wraparound but may be less intensive, focusing instead on care coordination between and among systems and the family. Service coordination exists on a continuum from information and referral to admission to High-Fidelity Wraparound.

Community Response Teams (CRT) – this "real time" model is used to divert youth from further system involvement and ultimately prevent out-of-home and out-of-school placement by creating alternative community solutions in a timely manner. CRTs also help regulate the number of families referred to the Service Coordination/Wraparound Process to avoid overuse of the model while still meeting the needs of the family. CRTs develop a brief service coordination plan that helps the family meet their goals, streamline referrals, and get connected to community resources.

Dialectical Behavior Therapy (DBT) - this approach is an evidence-based practice to assist youth who have experienced trauma, significant emotional dysregulation, self-harm, and intensive behavioral issues manage their emotional regulation.

Parent Peer Support - assists families with advocacy, activities of daily living, transportation, and shared lived experience. Parent peer support mentors will serve on High Fidelity Wraparound teams, provide evidence-based parent education, and ensure access to care information and is aligned with Systems of Care principles. The Parent Peer Support Specialists will be trained through NAMI of Ohio and through the Parent Advocacy Connection (PAC).

Youth Peer Support: Alternative Peer Groups (APG) - is a community-based, family-centered, professionally staffed, positive peer support program that offers prosocial activities, counseling, and case-management for people who have lived experience with substance misuse, mental health concerns, or self-destructive behaviors. APGs are for adolescents who have multisystem needs because the main focus is to offer and shape a new peer group that utilizes positive peer pressure to achieve recovery goals. In addition, APGs focus on making recovery more fun than using by organizing and staffing sober social functions throughout the week, weekends, and summers. This model will be used as an evidence-based enhancement for Youth Move.

Intensive Home-Based Treatment (IHBT) - is a mental health treatment option designed to meet the needs of youth with serious emotional disturbances who are at risk of out-of-home placement or who

are returning home from placement, such as inpatient hospitalization or residential treatment. IHBT focuses on the mental health issues that put the youth at risk, while promoting positive development and healthy family functioning (Begun Center, Case Western Reserve University).

b) Trauma Informed Approaches

The first two years of the Mental Health and Recovery Board of Union County's Strong Families, Safe Communities project focused on developing a key trauma intelligence among clinical staff, youth serving agencies, wraparound facilitators, and parent peer mentors. Trauma-focused practitioner trainings will continue to be offered as new staff enter the system(s) and as innovations in trauma treatments become available.

In addition to practitioner training, there will be a focus on developing trauma-informed school environments. This will be designed to align with the Social and Emotional Learning (SEL) standards promulgated in the *Each Child, Our Future: Ohio's Strategic Plan for Education 2019-2024.* Trauma-informed school environments use a holistic lens to foster student growth and development; prioritize attachment to school and caring adults; promote physical, emotional, and academic safety for students and staff; and proactively address trauma by teaching students self-regulation techniques (Ohio Department of Education, 2019).

SAMHSA's Six Key Principles of Trauma-Informed Approaches (SAMHSA, 2014) will be utilized as will the Systems Framework from the National Child Traumatic Stress Network (2017). Two specific elements of SAMHSA's Six Key Principles will be emphasized. First, peer support will play an enhanced role in this project (SAMHSA TIC Principle #3, 2017). In 2016, Union County began funding Youth M.O.V.E. – initially through a grant from NAMI of Ohio and then with support of Strong Families, Safe Communities. While the tenets of Youth M.O.V.E. were widely adopted in our SFSC communities, the initiative itself became largely dependent on other youth-empowerment models (such as the Youth Empowerment Conceptual Framework, Holden et al., 2004). In order to add definition and an evidence-based practice infrastructure for youth with lived experience in mental health or substance use concerns, Alternative Peer Groups (APG) will be added as a model.

The second element to be emphasized in our trauma-informed development will be cultural, historical, and gender issues (SAMHSA TIC Principle #6, 2017). By the end of our first cycle of SFSC, issues for LGBTQ+ children and youth emerged as a need for training and programmatic attention. Focus groups were held with the Gay-Straight Alliance (GSA) from a local high school and revealed that what these youth desired most was information about their own experience (e.g. books, resources, library materials) and the need to communicate about their experience to adults in their immediate surroundings (e.g. teachers, parents, coaches, etc.). Materials were purchased for the GSA and the Mental Health & Recovery Board hosted an LGBTQ+ organization to train community members. Interest has continued to increase in additional training, supports, and resources. This attention to cultural and gender issues takes on great importance given the over-representation of persons who are LGBTQ+ in the behavioral health system (Herek, 2017) and the role of these concerns in several completed suicides in our communities.

3. Implementation Plan and Timeline

The advantage of this partnership among Union, Madison, and Jefferson Counties is the strengths and variation among similar-sized communities. Counties vary in their level of implementation of these practices and approaches, and a strong learning community has been formed. The addition of Jefferson County will allow Union County and Madison County to provide mentoring support while each addresses their own state of implementation and readiness. The following logic models illustrate the theories of change for the SFSC project, present a concise statement of our current conditions,

inventory our inputs and assets, outline our activities and outcomes, and establish timelines for completion. *(See Logic Models in the following section.)*

4. Demonstrated Capacity of System of Care Framework

Over the past two years, the Mental Health & Recovery Board of Union County has completely transformed our work into a "Systems of Care" framework. This is true in both the youth and adult systems. The Board now employs a "Youth Systems of Care Director" and an "Adult Systems of Care Director" and has aligned the strategic plan of the Board into a systems of care framework. Such work has already yielded large dividends in the infrastructure of the local behavioral health system. Professional development opportunities included attendance at the National Wraparound Conference and the State of Ohio System of Care Conference, 46 people trained to administer the CANS, training in gender-specific evidence-based practices, training in trauma-informed care, and LGBTQ+ 101 training. Union County served 70 youth in high-fidelity wraparound, 25 youth through the Community Response Team (CRT) process, and has effectively utilized Fidelity EHR to document the systems of care interventions. Madison County has expanded their capacity to serve youth and served 13 youth in High-Fidelity Wraparound, provided crisis stabilization and recovery supports to more than 30 youth, and continues to seek ways to improve their performance and reduce out-of-home placement costs. Jefferson County has the least experience with service coordination/wraparound and has not been a SFSC recipient.

The current SFSC initiative has supported two FCFC Systems of Care Coordinators (.5 FTE Union and .5 FTE Madison), two full time High-Fidelity Wraparound/Service Coordinators (1 FTE Union and 1 FTE Madison), 3 contract Parent Peer Mentors, and 7 High-Fidelity Wraparound Facilitators. This will expand to include an additional 1 FTE Wrap/Service Coordinator in Jefferson County and additional Parent Peer Mentoring.

5. Expected Outcomes and Numbers of Youth and Families to be Served
(See Table 1 Logic Model: SFSC Implementation Plan, Outcome Measures, and Timeline)

6. Plan for Evaluating Success
(See Table 3: SFSC Data Collection and Evaluation Plan)

7. Collaboration Approach and Partners
(See Table 1 and Table 2 Logic Models: SFSC Implementation Plan, Outcome Measures, and Timeline)

8. Sustainability Plan

Leadership in the three counties is aware that there are already significant dollars being expended on multisystem youth and families. The communities have three strategies that will help ensure sustainability: First, cost savings from more efficient and lesser restrictive interventions will be reinvested into maintaining those elements of this proposal that are shown to be most effective. For example, out-of-home placement costs in Union County decreased by 48%. The cost savings are significant and those funds can be redeployed. Second, this proposal seeks to build capacity in systems across the continuum of care. Where possible, training is designed on a "trainer of trainers" model to build ongoing expertise that can then be leveraged to train new providers and practitioners. Finally, it is clear that this needs to be an investment priority for the state and local communities. The Counties have committed to aligning these initiatives with the Governor's new multisystem youth and any new funding sources that become available. Provider agencies will also continue to explore new codes available under BH Redesign for reimbursement of some services and include the Medicaid Managed Care Organizations in Service Coordination and Wraparound initiatives.

Table 1 -Strong Families, Safe Communities MHA-20-21-BCYF-SFSC-010 Implementation Plan, Outcome Measures, and Timeline

Logic Model 1: Systems of Care Transformation – Union, Madison, and Jefferson Counties System of Care Initiative

Theory of Change: *If we can continue and expand the successes of Strong Families, Safe Communities, we will see improved youth outcomes, enhanced collaboration, and the addition of evidence-based, trauma-informed approaches.*

Situation *Our Current Condition*	**Inputs** *Assets We Use to Address the Condition*	**Outputs** *Interventions We Do to Change the Condition*	**Outcomes** *Change in the Condition as a Result of Activities*	**Measures and Evaluation** *Evidence that Change has Occurred*	**Implementation and Timeline** *When and Who is Responsible*
Service Coordination and Hi-Fidelity Wraparound are at various degrees of implementation and sophistication in the three counties. *Some SFSC partners are ready to expand services while others need more time to develop basic infrastructures.* *Training in current practices and technologies such as Wraparound, trauma informed care, and use of peer supports varies widely within and among systems.* *Data are collected in individual systems but are not shared or aggregated in meaningful ways to help inform interventions. Some counties have limited use of Fidelity EHR.*	County-to-County mentoring and SF/SC Learning Community System of Care Coordinators Wraparound Coordinators Wraparound facilitators Agency leadership Direct service providers Funding from SF/SC Funding from ADAMHS Boards Family and Children First Councils Shared funding across systems Staff time for training Experience with Wraparound and IHBT Parent Mentors Training: CANS, Systems of Care, Trauma Informed Care Fidelity Electronic Health Record	System of Care Coordinators continued or hired Wraparound Coordinators continued or hired Wraparound facilitators continued or hired Service coordination plan reflects new common vision and trauma-informed principles. Shared data system (Fidelity EHR) and family management system Peer support providers for both parents and youth engaged.	The System of Care will be integrated and shared among agencies based on SAMHSA System of Care principles System of Care demonstrates competence in High Fidelity Wraparound and Service Coordination Use of Fidelity EHR facilitates case management, communication and eliminates duplication Evaluation plan – qualitative and quantitative measures identified Systems have a shared understanding of the fundamental constructs of trauma informed care, peer support, and other key service technologies.	Service Coordination Plan completed Appropriate staff hired or continued to manage Systems of Care and Wraparound Trainings completed. Fidelity EHR implemented. Parent peer supporter continued or hired. Youth Peer Support (APG) staff hired. Outcome measurement including qualitative and quantitative data measures. Wraparound Fidelity Index (WFI E-Z) **Youth/ Families To Be Served:** **Union** Wraparound/MSY – 80 Peer Support/APG – 25 CRT – 25 **Madison** Wraparound/MSY – 15 Youth MOVE – 15 Recovery Supports – 30 **Jefferson** Service Coordination/ MSY – 12	**1st Quarter** Staff hired and/or contracted– System of Care Partners, Jefferson ESC, FCFCs System Visioning: Family and Children First Councils (FCFC) ADAMHS Boards System of Care partners **2nd Quarter** Data – Systems of Care Partners (FCFC, ADAMHS, System of Care partners) Training in Wraparound Parent Peer Support Established **3rd Quarter** CANS Implementation in Jefferson County **4th Quarter** Data reports generated Outcomes measures reported.

Table 2 Strong Families, Safe Communities MHA-20-21-BCYF-SFSC-010 Implementation Plan, Outcome Measures and Timeline

Logic Model 2: Practices for Strengthening Families – Union, Madison, and Jefferson Counties System of Care Initiative

Theory of Change: *If we can facilitate evidence-based practices on behalf of multisystem youth, families will be strengthened and aggressive/violent behaviors will be reduced and youth will be kept in least-restrictive settings.*

Situation *Our Current Condition*	**Inputs** *Assets We Use to Address the Condition*	**Outputs** *Interventions We Do to Change the Condition*	**Outcomes** *Change in the Condition as a Result of Activities*	**Measures and Evaluation** *Evidence that Change has Occurred*	**Implementation and Timeline** *When and Who is Responsible*
Youth and families have many multisystem needs that overwhelm them and lead to treatment dropout, noncompliance with rules of courts, symptom relapse, continued aggression and violence, and criminal recidivism. *Spending on out-of-home placements has increased in some counties and out-paces state averages in others.* *There is confusion and wide variation in the selection of appropriate evidence- based practices based on youth and family needs, especially for aggressive or violent youth or youth with dual diagnosis.* *Evaluation and outcomes data are afterthoughts and there is confusion over appropriate indicators and measures.* *Evidence based practices are inconsistently implemented and are not sustainable.*	System of Care Coordinators Wraparound Coordinators Wraparound Facilitators Agency leadership Direct service providers Funding from SF/SC Funding from ADAMHS Boards Family and Children First Councils Shared funding across systems Staff time for training Experience with Wraparound and IHBT and other evidence based practices Training: CANS Systems of Care, Trauma Informed Care training Current Youth Move/APG Peer Support programs Parent Mentors Fidelity Electronic Health Record	System of Care partners and practitioners trained in evidence-based practices. Consistent use of Fidelity EHR across counties. Interventions are selected based on the unique, presenting needs and strengths of youth and families. Parents and youth have access to peer support and education services.	Practitioners have confidence in selecting interventions that reflect the most current evidence based practices. Families and youth are strengthened by having voice in their services. Youth and families are offered interventions that are appropriate needs and not over-treated or under-treated. Incidents of violent or aggressive behavior are reduced. System of Care providers gain worker satisfaction as families and youth are more successful. Crisis stabilization needs will decrease. Costs for out-of-home placements and residential treatment services are reduced.	Fidelity measures for IHBT, Wraparound, CANS and other evidence based practices. Family satisfaction measures – quantitative and qualitative Number of violent or aggressive incidents reduced Real costs for placements and residential treatment reduced.	**2nd Quarter** Wraparound expanded – ADAMH, providers, FCFCs APG Expansion Data collection and outcomes measurements developed Families served with new EBPs **3rd Quarter** Fidelity data – Systems of Care Partners (FCFC, ADAMHS, System of Care partners) **4th Quarter** All evidence based practices implemented Data reports generated Outcomes measures reported.

Table 3. Strong Families, Safe Communities Data Collection and Evaluation Plan

Performance Measures	Data Source	Collection Frequency	Responsible Staff for Data Collection	Method of Data Analysis
Utilization Data (Client-level Engagement Data)				
Number of individuals receiving MH or related services after referral	Fidelity EHR, Provider utilization data; MCO Claims data	Monthly	Service Coordinators; Providers; Parent Peer Mentor	Nominal Measurement: Number served by provider, service access time/ LOS
Number of youth/families receiving services as a result of the grant	Fidelity EHR, Central Intake data, Provider enrollment reports; MCO Claims data	Quarterly	Systems of Care Coordinators; SOC Director Providers;	Aggregate data of all grant activities by service type
Clinical Outcomes (Results of Clinical Interventions)				
Clinical Engagement Diagnosis Symptomology Employment/Education Crime/Criminal Justice	Fidelity EHR SAMHSA Services Tool (SPARS) CANS CAFAS	Episode of Care – baseline, reassessment (180 days), discharge	Providers; Service Coordinators, Wraparound Facilitators	Care management review; team meetings; Child/Adolescent Functional Assess Scale (CAFAS)
Youth/Family Needs and Strengths; Social Support and Connectedness	CANS – Child and Adolescent Needs and Strengths	Episode of Care – baseline, reassessment (180 days), discharge	Providers; Service Coordinators, Wraparound Facilitators	Client-level and aggregate reporting of CANS scores
Client/Family Perception of Care	Client Satisfaction Instrument; Wraparound Fidelity Index (WFI-EZ) Youth focus groups	Discharge + 30 days; Semi-Annually	Providers, Service Coordinators; Wraparound facilitators; Parent Peer Mentor	Descriptive Statistics; Thematic Analysis
Evidence-Based Practice Adherence (EBP Fidelity Measures)				
Intensive Home-Based Treatment (IHBT)	IHBT Fidelity Measures Review	Quarterly	Providers; Evaluator; Clinical Consultants	Indexed Score on IHBT Fidelity Review
High Fidelity Wraparound	Wraparound Fidelity Index (WFI-4); Team Observation Measure (TOM); Annual Hi-Fi Wrap training	Case-based frequency; Annually	Wraparound Facilitators; youth/ family members; Wraparound Coordinator; SOC Coordinator; Contract trainers	Indexed scores and aggregate participant data; Training data
Child and Adolescent Needs and Strengths (CANS)	CANS fidelity assessment and annual training	Annually	Praed Foundation (developer of CANS) instruments, Systems of Care Coordinators	Completed assessments and trainings; CANS certifications completed