hpio health policy institute of ohio™

Health **Policy** Brief

Strategies to prevent Adverse Childhood Experiences (ACEs) in Ohio

3 Promoting positive social norms and intervening to lessen harm

Promoting positive social norms, such as a shared sense of responsibility for the health and well-being of children, can prevent adverse childhood experiences (ACEs). Treatment for mental health conditions and substance use disorders (SUD) among parents and other caregivers can also reduce risks for ACEs. At the same time, when ACEs do occur, there are many trauma-informed interventions that can reduce harm and prevent similar adversity for future generations.

Since 2020, the Health Policy Institute of Ohio (HPIO) has released a series of policy briefs on ACEs in Ohio. As part of that work, HPIO outlined a comprehensive and strategic approach to preventing ACEs, elevating 12 key evidence-informed strategies. As displayed in figure 1, this brief examines the implementation status of four strategies that:

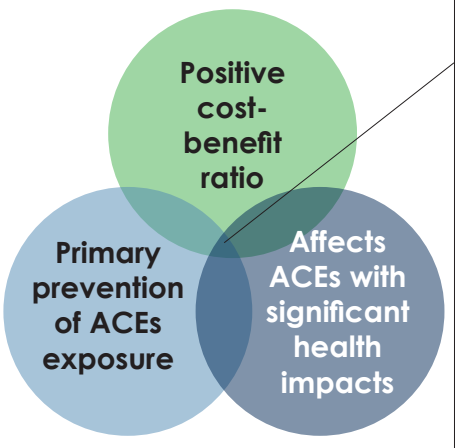
- Promote social norms that protect against violence and adversity
- Intervene to lessen immediate and long-term harms

The brief also highlights examples of strategy implementation in Ohio and identifies strengths, gaps and recommendations related to each strategy. HPIO conducted key informant interviews with eight organizations, listed on p. 19, to inform this work.

3 key findings for policymakers

- **Everyone has a role to play in preventing ACEs in Ohio.** Creating a culture with a shared responsibility for the health and well-being of children can prevent ACEs.
- **Trauma-informed care can prevent ACEs and reduce the harm they cause.** Trauma-informed care is an integral part of any approach to mitigating the impacts of ACEs and preventing ACEs for subsequent generations, especially in systems with which people who have experienced trauma regularly interact (e.g., education, health care, juvenile and criminal justice systems, children services).
- **Further support is needed to strengthen the behavioral health workforce.** Treatment for mental health conditions and/or substance use disorders among parents and other caregivers can prevent ACEs, but many Ohio counties, especially rural counties, do not have a sufficient number of behavioral health treatment providers.

Figure 1. **Key strategies for preventing ACEs in Ohio**



For more information on the key strategies identified, please see **A strategic approach to prevent ACEs in Ohio**

12 key strategies

1	• Early childhood education programs • Early childhood home visiting	Ensuring a strong start for children
	• Medical-legal partnerships • Family income supports	Strengthening economic supports for families
2	• Parent, caregiver and family skills training • School-based violence, bullying and intimate partner violence prevention programs • School-based social and emotional instruction	Enhancing skills so that parents and youth can handle stress, manage emotions and tackle everyday challenges
	• Mentoring programs for delinquency	Connecting youth to caring adults
3 (This brief)	• Community-based violence prevention	Promoting social norms that protect against violence and adversity
	• Drug courts • Trauma-informed care • Behavioral health treatment	Intervening to lessen immediate and long-term harms

Promoting social norms that protect against violence and adversity

Policymakers and community leaders can promote positive social norms that protect against violence and adversity. Examples of these norms include a shared responsibility for the health and well-being of children, reduced stigma related to seeking help, and positive parenting practices, such as safe and effective discipline.[1] Adoption of these norms increases **collective efficacy** and prevents violence. Changing norms is often most effective through a multi-pronged approach, reaching people where they are in schools, workplaces and the community.[2]

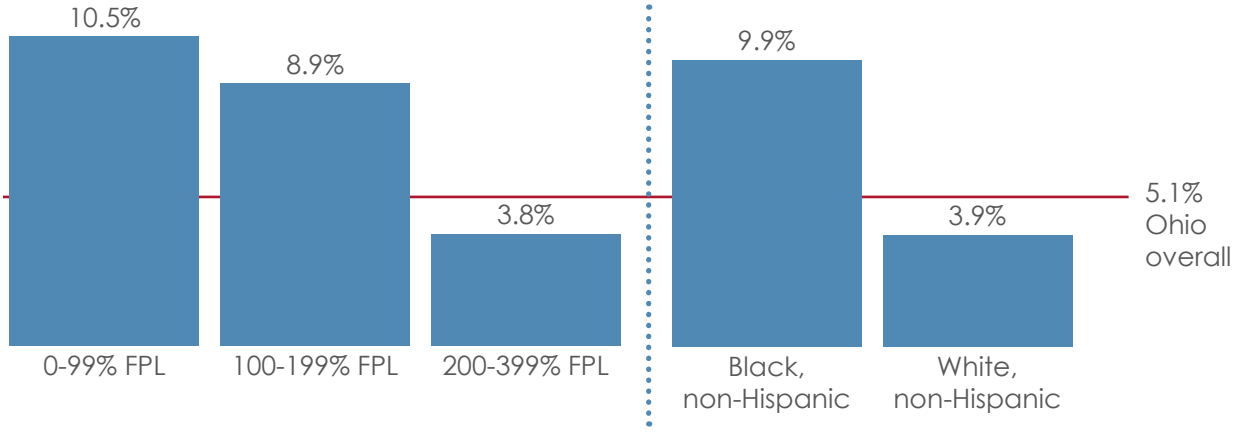
Collective efficacy: Mutual trust among neighbors combined with a willingness to intervene on behalf of the common good. A neighborhood's collective efficacy is a strong predictor of its violent crime rates.[3]

This section highlights policies and programs that prevent violence, promote positive social norms and increase safety for children.

Strategy No. 1: Community-based violence prevention

Community-based violence prevention includes programs and policies that support healthy relationships and increase neighborhood safety. As displayed in figure 2, 5.1% of Ohioans overall reported that their child did not live in a safe neighborhood. Ohioans earning a wage 0-99% of the **federal poverty level (FPL)** and Black Ohioans were more likely to report this. Structural racism has resulted in concentrated disadvantage in segregated neighborhoods, which leads to higher levels of violent crime in these neighborhoods.[4]

Figure 2. **Neighborhood safety in Ohio, by income and race, 2020-2021**
Percent of respondents who reported their children did not live in a safe neighborhood



Source: Child and Adolescent Health Measurement Initiative. 2020-2021 National Survey of Children's Health (NSCH) data query. Data Resource Center for Child and Adolescent Health supported by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Retrieved Nov. 9, 2023, from www.childhealthdata.org.

There are strategies to increase community safety and reduce violence through the promotion of norms that are incompatible with violence, such as bystander intervention programs and policies that increase taxes on alcoholic beverages.

Program example: **Green Dot**

Bystander intervention programs teach community members to support healthy relationships and safely intervene in dangerous situations.[5] **Green Dot** is an example of a program that engages witnesses to safely interrupt situations that are imminently or potentially high-risk for violence. The program also educates witnesses on proactive behaviors (also called green dots) that model and endorse positive community norms that are incompatible with violence.[6]

This evidence-informed program has been adapted and implemented in Ohio colleges (e.g., **Ohio University**, **Bowling Green State University**, **Kent State University** and the **University of Dayton**). Both high school and college Green Dot programs show significant reductions in interpersonal violence.[7] Community Green Dot programs have been shown to increase collective efficacy and decrease social norms that are tolerant of domestic sexual violence.[8]

Additionally, while not implementing Green Dot to fidelity, many programs utilize its components. For example, **SAFE on Main** in Warren County educates on possible bystander responses in school-based programs.

Policy example: **Alcohol taxes**

State taxes on alcoholic beverages are an example of an evidence-informed policy that prevents community violence. Increasing excise or sales taxes on alcoholic beverages reduces excessive drinking, underage drinking and alcohol-related harms, including alcohol-impaired driving.[9] Higher alcohol taxes are also associated with decreased violence, including violence toward children.[10] Research estimates that a 25-cent tax increase per drink would reduce alcohol consumption by 9.2% and reduce heavy drinking by 11.4%.[11]

Community-based violence prevention in Ohio

In recent years, policymakers have taken positive steps to promote the implementation of community-based violence prevention programs. On April 14, 2023, Gov. DeWine announced that his administration would award $20 million in grants to support more than three dozen community-based intervention programs in their work to prevent violence and support victims of crime as part of the **Community Violence Prevention Grant Program**.

The two most recent state budgets (**House Bill 33** and **House Bill 110**) also included provisions requiring higher education institutions to continue developing and modeling best practices in line with emerging trends, research and evidence-based training for preventing and responding to sexual violence on campus. This may facilitate implementation of evidence-based programs, like Green Dot, on college campuses. Additionally, starting in the 2023-2024 school year, **Ohio law** will require one hour or one standard class period of instruction per year for students in grades 6-12 on safety training and violence prevention. See HPIO's **Strategies to prevent ACEs in Ohio: Building skills and strengthening connections to caring adults** brief for more information on policies that encourage violence prevention in schools.

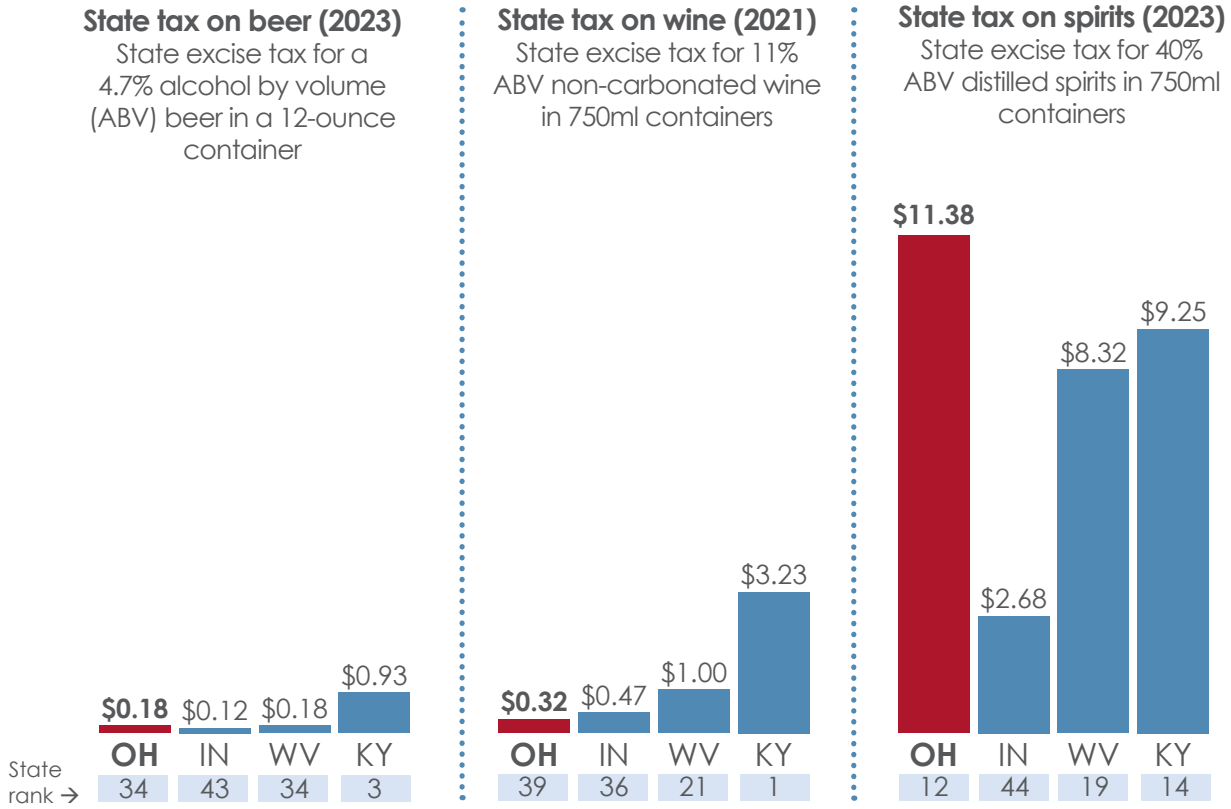
Sexual violence prevention funding from the Centers for Disease Control and Prevention (CDC) started declining about 20 years ago, according to a key informant at the Ohio Department of Health. In the last 10 years, funding has increased, but has not reached the level it was at 20 years ago. Other Ohio agencies provide funding for human trafficking and violence prevention, but the funding is fairly limited.[12]

Alcohol taxes in Ohio

Compared to neighboring states, Ohio has a relatively high excise tax on spirits; a relatively low tax on beer and wine; and a relatively high excessive drinking rate (see figure 3). Despite evidence on the connection between alcohol and poor health outcomes[13], recent policies in Ohio have increased access to alcohol across the state, such as:

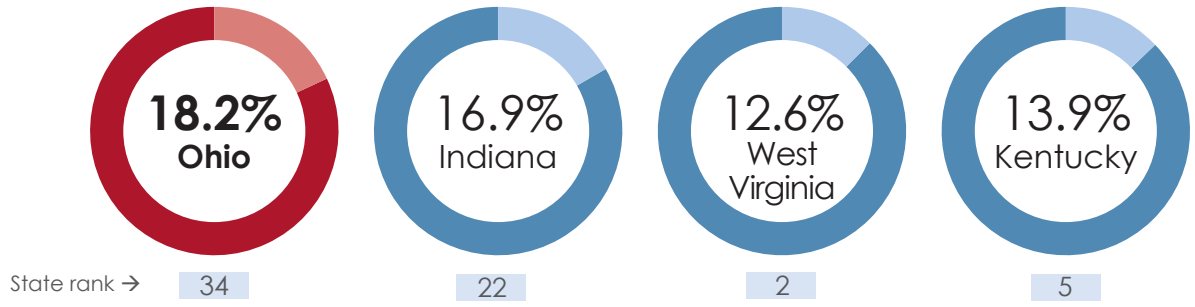
- House Bill (HB) 47 (2015) created **Designated Outdoor Refreshment Areas** (DORAs)
- Senate Bill 102 (2021) increased the allowable acreage of DORAs as well as the number of DORAs allowed in a local community
- HB 110 (2021) expanded exemptions to alcohol taxes
- Since 2017, liquor taxes have increased by 15%[14], while beer and wine taxes have not increased[15]

Figure 3. **State alcohol taxes and excessive drinking in Ohio and neighboring states**



Source: Tax Foundation

Percent of the population reporting excessive drinking, 2021



Note: Excessive drinking is defined as the percent of adults either binge drinking, defined as consuming more than 4 (women) or 5 (men) alcoholic beverages on a single occasion in the past 30 days, or heavy drinking, defined as having 7 or more (women) or 14 or more (men) drinks per week. State rankings are from the Health Policy Institute *Health Value Dashboard*, April 2023.
Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance Survey, as compiled by America's Health Rankings.

Implementation example: COMPASS Green Dot

Program description

COMPASS is a rape crisis center that serves Carroll, Stark and Tuscarawas Counties, providing many services including prevention education, crisis hotline services and medical and legal advocacy. In 2020, COMPASS worked with an existing prevention task force to implement Green Dot in Tuscarawas County. While the task force was trained to administer the program, COMPASS marketed Green Dot through social media, window clings and community-wide events. COMPASS provided one training for Tuscarawas County community members in 2021 but was unable to provide more due to pandemic-related barriers. COMPASS recently approved an updated strategic plan to reestablish Green Dot in the county and seeks to partner with the campus Green Dot at Kent State University at Tuscarawas. In the meantime, COMPASS promotes elements of Green Dot on social media (such as bystander intervention and local "green dots") and integrates components into its school curriculum.

Population served

COMPASS' prevention work outside of Green Dot is integrated into communities and 25 schools in Tuscarawas County. Their school curriculum contains elements of Green Dot, such as bystander intervention. They also provide crisis services for those impacted by sexual violence on three college campuses in the counties they serve.

Funding

COMPASS receives funding through an Ohio Department of Health Rape Prevention Education grant and other rape crisis funding and is a subsidiary of Goodwill Industries of Greater Cleveland and East Central Ohio.

Workforce

For general prevention work, COMPASS staff must complete a 40-hour sexual violence crisis intervention training and 30 hours of continuing education every two years to be aligned with current prevention practices and policies. Program staff had to undergo specific training to implement Green Dot.

Outcome evaluation

While COMPASS has not completed a formal outcome evaluation, a COMPASS analysis of social media interactions found that sharing local "green dots" of community members garnered strong engagement and resonated with the community.

Implementation considerations for community-based violence prevention

Best practices

- **Be creative in program reach.** Violence prevention programs reach their community in creative ways, like a **Knox County program** that requires employees of DORA-approved bars to complete bystander intervention training, integrating violence prevention into everyday life. Additionally, every time a DORA cup is purchased, a portion of the proceeds is dedicated to community prevention.
- **Adapt programs based on community needs.** Programs can aim to be locally and culturally relevant and connect with the community over shared norms and values. Community members should be engaged throughout program planning and implementation, and program staff should reflect the communities they serve as much as possible.
- **Collaborate with partners seeking a common goal.** Organizations can collaborate on implementing programs with other agencies and service providers with similar missions. For example, **Warren County Connect** is a coalition of organizations focused on prevention that assist one another in their goal of nurturing healthy families and communities.

Challenges

- **Funding.** Lack of funding was cited by many key informants as a challenge. One program administrator mentioned that if funding were increased, the program could begin developmentally appropriate education in earlier years of school to build a stronger foundation for violence prevention. It can be difficult for programs to obtain buy-in from schools because of sensitive topics within the curriculum. Balancing the cost of obtaining buy-in with the cost of implementing the program to fidelity compounds the challenge of limited funding.
- **Grant requirements.** Different communities in Ohio may have specific needs that violence prevention programs should aim to address. However, the specific requirements of grants often do not address the variety of needs across Ohio, nor the capacity of organizations to implement these requirements.
- **Partnership with schools.** Oftentimes, small non-profit organizations do not have the administrative capacity and funding to fully implement evidence-informed programs, such as Green Dot, in schools. With an already busy schedule, schools may not be receptive to including all components of the program, which can limit its effectiveness.

Community-based violence prevention: Next steps for Ohio

To improve implementation of community-based violence prevention programs and policies across Ohio, policymakers and other stakeholders should consider the strengths, gaps and recommendations in figure 4.

Figure 4. **Strengths, gaps and recommendations related to community-based violence prevention**

Strengths	Gaps	Recommendations
• Many Ohio universities have implemented Green Dot, and elements of the program have been deployed in schools and communities across the state. • Community Violence Prevention Grants are a step in the right direction of increased funding. • Ohio has a high tax on liquor compared to other states.	• Burdensome grant requirements can limit a program's effectiveness and ability to meet the community's needs. • Schools and communities often do not have the resources to implement large-scale evidence-informed programs, and obtaining buy-in takes time and money. • In recent years, opportunities to consume alcohol in a community setting have increased, while beer and wine taxes have not changed.	• Policymakers and other funders can expand grant requirements to align with the needs of community-based providers. • State policymakers can assist local organizations with implementation of prevention programming through trainings and technical assistance. For example, key informants mentioned the need for the development of a toolkit with best practices for violence prevention to guide local programs. • State and local policymakers can increase funding to community-based programs for prevention, such as bystander training for DORA-approved establishments. • Ohio policymakers can raise beer and wine taxes.

Intervening to lessen immediate and long-term harms

ACEs exposure is linked to a variety of poor outcomes through adulthood, but there are interventions to mitigate these negative effects. Such interventions can also prevent ACEs for subsequent generations. This section highlights:

- Drug courts and family treatment courts
- Trauma-informed care
- Behavioral health treatment

Strategy No. 2: Drug courts and family treatment courts

Drug courts are a type of specialized docket that serve as an alternative to standard courts and are used to mitigate the prolonged effects of drug and alcohol use on the lives of adults and children. The primary objective of drug courts is to address the root causes of substance use and improve the health and well-being of participants through treatment and rehabilitation.[16] Drug courts often deploy case management, drug and alcohol testing, medications for opioid use disorder (i.e., medication-assisted treatment) and other types of treatment services.[17]

Studies show that drug courts are effective. For example, when compared to traditional case depositions, drug courts have been shown to significantly reduce recidivism (i.e., the likelihood that the person will commit another criminal offense after release from jail or prison[18]) by 38-50%[19]; 75% of drug court participants in the United States were not arrested for at least two years after leaving a program.[20]

Family treatment courts are a form of drug court that cater to children and families of individuals charged with drug-related crimes. While standard drug courts focus on treatment and recovery for individual criminal defendants, family treatment courts were created to reduce instances of child maltreatment (i.e., abuse and neglect) that stem from substance use disorder.[21] Family treatment courts use a multidisciplinary, family-centric approach to providing treatment for individuals with a substance use disorder so that families can stay together throughout the process.[22]

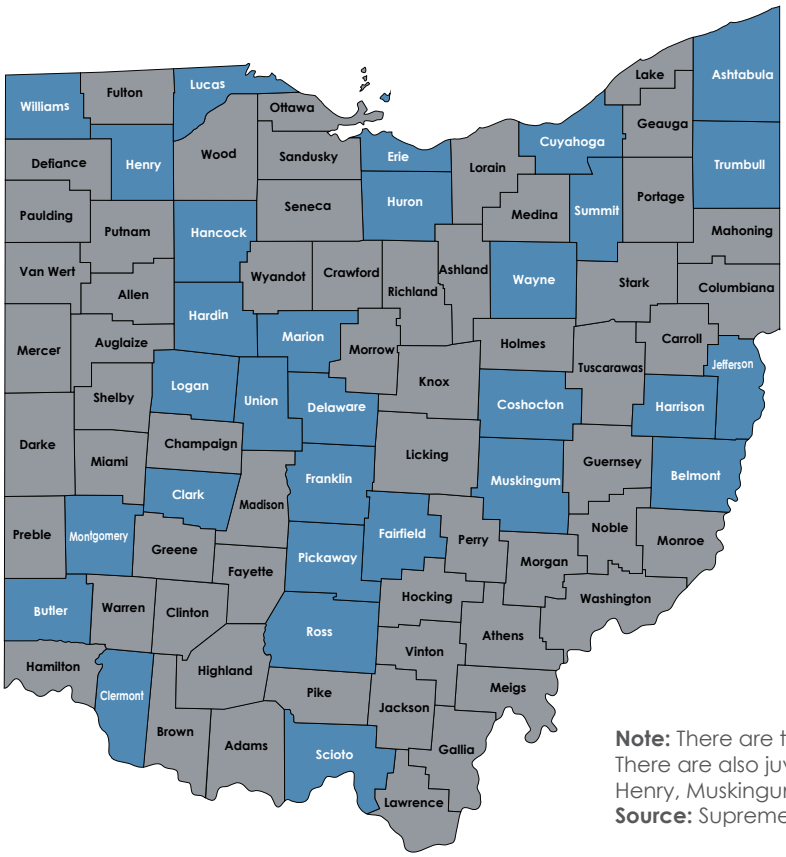
From January through December 20, 2023, over 3,100 Ohio children were removed from their homes by a juvenile court agency, public children services agency or the Department of Youth Services because of parental substance use.[23] Approximately 34.2% of all child removals in Ohio in 2023 were due to parental substance use.[24] Participants of family treatment courts are more likely to complete substance use treatment and achieve successful reunification with their children.[25]

Drug courts and family treatment courts in Ohio

Ohio has made significant investments in drug courts. Since the early 2000s, the state has provided funding for the development and sustainability of drug courts. Most of the state's funding for drug courts comes from the Ohio Department of Mental Health and Addiction Services (OhioMHAS). From 2019 to 2020, OhioMHAS increased funding for drug courts by 50%, from $5 million to $7.5 million.[26] **The Specialized Docket Subsidy Project** provides funding for drug court expenses including behavioral health treatment services, drug/alcohol testing, medically assisted treatment (MAT) and recovery support costs. Resources have also been dedicated to collecting data for future analysis, research and education. In 2023, there were over 110 operational drug courts in Ohio, with at least one in every county.[27]

Ohio has also operationalized funding initiatives to reform family treatment courts. Between 2014 and 2015, the federal Office of Juvenile Justice and Delinquency Prevention (OJJDP) awarded the Supreme Court of Ohio over $550 million to expand the scale of family treatment courts.[28] There are currently 31 family treatment courts, serving 30 counties throughout the state (as displayed in figure 5).[29] Funding continues to be available through federal grants and local Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Boards.

Figure 5. **Ohio counties with family treatment courts, 2023**



Note: There are two family treatment courts in Lucas County. There are also juvenile treatment courts in Clark, Delaware, Henry, Muskingum, Summit and Williams counties.
Source: Supreme Court of Ohio

Implementation example: Franklin County Family Recovery Court

Program description

The Franklin County Family Recovery Court is a system designed to help children and families impacted by SUD and child abuse and neglect. Through a multidisciplinary team effort, the program aims to empower parents to avoid crime, recover from addiction and effectively reunify with their children. The program includes:

- A multi-phase approach to help participants progress through the program
- A specialized workforce with experience on the intersection of substance use and child maltreatment
- An emphasis on the "village network," building connections between participants to foster overall and individual growth

Program participants are referred through Columbus's common pleas court when it is determined that child maltreatment is related to the parent's substance use. Participants will often lose custody of their child and regain custody upon successful completion of the Family Recovery Court program.

Population served

Participants are parents who have an open adjudicated court case involving substance misuse. The family treatment court has achieved successful outcomes with participants of different ages and races. Generally, mothers participate at higher rates than fathers.

Funding

Funding comes from OhioMHAS, the county and philanthropy. Treatment is funded separately.

Workforce

A multidisciplinary team is required to operate a successful family treatment court. The Franklin County Family Recovery Court team includes a judge, prosecutors and defense attorneys, case coordinators, social workers and clinical personnel. Team members in Franklin County all have some level of experience or training with family treatment drug courts. Members of the team also participate in state organized continuing education to stay up to date on the latest information regarding substance use treatment. Drug courts are recertified by the Ohio Supreme Court's commission on specialized dockets every three years.

Outcome evaluation

Several data points are tracked, including graduations and babies born without drugs in their system.

Implementation considerations for drug courts and family treatment courts

Best Practices

- **Complementary treatment and social services.** Providing mental and physical health services, including dental treatment, and/or social services (e.g., housing assistance, vocational/educational services) simultaneously can improve outcomes, depending on participant needs.
- **Regional specificity.** There are differences in substance use trends between rural and urban communities.[30] Courts can leverage flexibility in the model to adapt to the people they serve and address their unique needs.
- **Multidisciplinary teams.** In addition to the standard court staff (e.g., magistrate, lawyers), key informants cited that a team that includes a variety of perspectives (social work, case management, etc.) and specializes in working with parents who have SUD results in the best participant outcomes. Additionally, frequent meetings with the participant to review progress fosters communication and decision-making.
- **Drug court monitoring and evaluation.** Participant progress and outcomes (e.g., attendance, graduation rates, drug test results) and drug court adherence to best practices can be continuously evaluated to determine program effectiveness.

Challenges

- **Acknowledge the role of poverty and provide appropriate interventions.** Key informants explained that child neglect cases that occur as a result of poverty often come through the family treatment court system. Unlike some other states, Ohio does not exempt financial inability to provide for a child in its definition of child maltreatment. Defining differences between neglect and poverty is important in ensuring the reunification of families who enter the drug court system. Other interventions may be needed in cases of the latter.[31]
- **System mistrust.** Evidence suggests that many mothers exhibit negative perceptions towards children services and similar governmental programs[32], in part due to traumatization and fear of the system.[33] According to a key informant, many of the parents who are now participants in a drug court grew up in the children services system. When parents trust the family treatment court teams, the program is more likely to be effective.[34]
- **Reduced in-person contact.** Key informants emphasized the importance of face-to-face contact for building accountability among drug court participants. The transition to virtual meetings during the COVID-19 pandemic reduced participants' ability to build relationships with drug court staff and other participants. A hybrid model can strike a balance between the convenience of virtual meetings with the benefits of in-person interaction.

Drug courts: Next steps for Ohio

To improve implementation of drug courts and family treatment courts in Ohio, policymakers and other stakeholders can consider the strengths, gaps and recommendations in Figure 6.

Figure 6. **Strengths, gaps and recommendations related to drug courts and family treatment courts**

Strengths	Gaps	Recommendations
• Ohio has an extensive drug court system, with every county being served. • Ohio's specialized docket system has generated funding to sustain existing drug courts and establish additional courts.	• Despite drug courts being present in every county in Ohio, there are only 30 counties with a family treatment drug court. • Trepidation among participants and an absence of trust in drug court teams can negatively impact program effectiveness. • The post-pandemic transition to virtual meetings has limited human connections and rapport building needed for effective implementation.	• Drug courts and family treatment courts can take steps to increase awareness and understanding of their programs' value among professionals and providers that interact with individuals struggling with substance use. • Programs can prioritize in-person attendance and build new ways for program staff to meet with participants face-to-face to enable participants to build healthy relationships and hold each other accountable. • Family treatment court programs can increase trust among participants through frequent meetings between parents, children and providers. • Programs can monitor and follow up with drug court graduates to track long-term impacts of drug court participation, including recidivism.

Strategy No. 3: Trauma-informed care

While not all ACEs are necessarily experienced as traumatic, they have the potential to be. Trauma can alter child brain development and negatively influence health and well-being into adulthood. For example, trauma exposure can lead to an inability to:

- Cope with normal stresses of daily life
- Form trusting relationships
- Manage cognitive processes, such as memory, attention and thinking
- Regulate behavior or control the expression of emotions[35]

Trauma-informed care (TIC) is an integral part of any approach to mitigating the impacts of ACEs and trauma and preventing ACEs for future generations. TIC is based on an understanding of and responsiveness to the impacts of trauma. It can be integrated into an organization's culture and policies, shaping the way people receiving services and service providers interact. One important goal of TIC is to avoid re-traumatization.

Although the trauma-informed care model is adaptable, the approach is grounded in six key principles:

1. **Safety**. TIC creates a sense of emotional and physical safety.
2. **Trustworthiness and transparency**. Decisions are conducted with transparency in an effort to build trust with all involved with the organization.
3. **Peer support.** Mutual self-help among people with lived experience of trauma helps build safety, hope and trust and contributes to recovery and healing.
4. **Collaboration and mutuality**. Importance is placed on partnering and leveling of power in the organization. This demonstrates the importance of relationships to healing and that everyone has a role to play in a trauma-informed approach.

5. **Empowerment, voice and choice**. Effort is made to create an environment of support and empowerment. Clients are supported in decision-making, choice and goal setting for their recovery.
6. **Cultural, historical and gender issues.** TIC promotes culturally-responsive policies and protocols; avoids cultural stereotypes or biases; leverages the healing power of traditional cultural connections; and recognizes and addresses historical trauma.[36]

This model can be implemented in a variety of systems and settings that engage people with histories of trauma, including education, physical and behavioral health care, the juvenile and criminal justice systems and child protective services.

Trauma-informed care in Ohio

State policymakers have promoted TIC over the past 10 years in a variety of ways, as described below.

Ohio Trauma-Informed Care Certificate program

The **Ohio Trauma-Informed Care Certificate** demonstrates knowledge and skill development in trauma-informed competencies, as established by the Ohio Department of Job and Family Services (ODJFS) and OhioMHAS. Professionals working in the social services, public assistance and early childhood fields can achieve three levels of certification for free. Between January 2021 and November 2023, 1,238 Ohio professionals received a trauma aware credential (level 1), 1,769 earned a trauma-informed credential (level 2), and 557 achieved a trauma competent credential (level 3).[37] Other entities also offer trauma-related training.

Trauma Competent Care Initiative

Since 2013, OhioMHAS and the Ohio Department of Developmental Disabilities (DODD) have collaborated on a statewide Trauma Competent Care Initiative focused on enhancing trauma-competent knowledge and practices among practitioners, facilities and agencies with a diversity, equity and inclusion lens.[38] The initiative largely works through **six regional trauma-competent care collaboratives,** which serve as repositories of knowledge, best practices and shared resources. OhioMHAS, DODD and the newly-created Ohio Department of Children and Youth each have a trauma-informed care coordinator, and several other state agencies participate in a trauma-competent care interdepartmental team.

The state's 11th annual Trauma-Informed Care Summit is in May 2024. The goal of the summit is to move systems beyond being trauma-informed to providing trauma-responsive, competent care, services and supports.

Handle with Care

Handle with Care is a trauma-informed, cross-systems approach to ensure that children who are exposed to adverse events receive appropriate interventions and support from teachers and school staff. When a school-age child experiences something like a house fire, death of a family member or a domestic violence episode, for example, the local law enforcement notifies school officials by sending the name of the child and simply the words "handle with care." OhioMHAS supports an Ohio Handle with Care statewide leader (through Hopewell Health Centers), who provides training, resources and consultation to any counties wanting to implement the process. A majority of Ohio counties have at least started to implement Handle with Care.

Guidance to become a trauma-informed school or district

Trauma negatively affects learning, behavior and social outcomes.[39] Trauma-informed schools create a culture and environment where students feel physically, socially and emotionally safe. All members of the school community undergo trauma training. Building connections and relationships is prioritized, as well as teaching students self-regulation techniques.

The Ohio Department of Education and Workforce (ODEW), formerly the Ohio Department of Education, offers free training opportunities, **resources** and technical assistance for schools and districts wishing to learn more about trauma-informed practices. Schools can use **student wellness and success funding** and/or **disadvantaged pupil impact aid spending** for this purpose.

Foster care and children services

Children in foster care have often experienced high rates of ACEs and trauma.[40] Ohio has taken steps in recent years to make positive changes to the foster care and children services systems.

In 2019, Gov. DeWine created the Children Services Transformation Advisory Council to conduct a comprehensive review of the children services system and make recommendations for improvement. The Advisory Council's November 2020 **final report** included the following two recommendations related to trauma-informed training:

- Create a new trauma-informed training program for kinship caregivers that emphasizes the importance of supportive birth parent and kinship relationships, along with co-parenting best practices. This recommendation has been partially implemented.
- Develop trauma-informed training for all foster families, caseworkers, agency staff, courts, service providers, mandated reporters (such as teachers and counselors), kinship caregivers and parents. This has been fully implemented.[41]

Implementation considerations for trauma-informed care

Best practices

- **Cross-sector, cross-systems approach**. Addressing trauma requires multi-pronged, cross-agency efforts. There needs to be widespread awareness of trauma and its effects and a comprehensive approach inclusive of prevention, early intervention and treatment.[42]
- **Involve people with histories of trauma in planning**. Engaging people with lived experience when designing trauma-informed programs and policies ensures services are truly responsive and relevant to the needs of trauma survivors.
- **Maintain strong leadership**. Becoming a trauma-informed organization requires steady support of leaders and can require considerable work to generate buy-in.
- **Begin trauma training early in postsecondary education for healthcare and education professions.** Postsecondary education in these fields should incorporate training on trauma and TIC, including cross-disciplinary training.[43]

Challenges

- **Staff turnover**. Working with individuals who have experienced trauma puts staff at risk of burnout and secondary trauma. Organizations can prioritize staff wellness and take steps to prevent secondary trauma, such as providing paid leave for staff to care for their mental health.
- **Trauma screening too early in care**. Although screening for trauma has been found to be important in clinical settings, some patients may not want to share their trauma histories without an established relationship with a provider. Efforts to establish community trust and ensure diverse patient voices are listened to and understood by the organization can be helpful.
- **Not knowing where to start**. Transitioning to a trauma-informed organization can seem overwhelming. Organizations can start by reviewing their policies and practices and thinking through how they can be strengthened, even incrementally, to be more trauma responsive.

Trauma-informed care: Next steps for Ohio

To improve the implementation of TIC across Ohio, policymakers and other stakeholders can consider the strengths, gaps and recommendations in figure 7.

Figure 7. **Strengths, gaps and recommendations related to trauma-informed care**

Strengths	Gaps	Recommendations
• Ohio has six regional trauma-competent care collaboratives, designed to be responsive to local needs. • All professionals, foster families and kinship caregivers involved in Ohio's children services and foster care system are required to undergo trauma training. • **Handle with Care** allows early intervention after children experience a traumatic event. A majority of Ohio counties have at least started to implement the program.	• Aside from the free **Ohio Trauma-Informed Care Certificate** program, there is no dedicated state funding to assist organizations, such as schools and healthcare providers, to become trauma informed. • Of the health and human services state agencies, only OhioMHAS, DODD and the newly-created Ohio Department of Children and Youth have a staff member dedicated to trauma-informed care.	• State and local policymakers can take steps to ensure more Ohioans are familiar with trauma and its effects, such as through a public awareness campaign. • State and local policymakers can offer more assistance, including dedicated funding, to encourage schools and healthcare providers to become trauma-informed. • State and local policymakers can require trauma training for all child-serving public employees.

Strategy No. 4: Behavioral health treatment

Children and adults who have been exposed to ACEs are more likely to experience mental health and substance abuse challenges[44], collectively referred to as behavioral health conditions. Those impacted by these conditions can benefit from behavioral health treatment. Further, behavioral health treatment for parents and other caregivers, when needed, can prevent ACEs among children.

There are many types of behavioral health treatment programs and services with varying levels of intensity (as displayed in the box); the complete range is referred to as a continuum of care. Services are also provided in a variety of settings (e.g., telemedicine, outpatient facilities, individual clinicians' offices, school-based health centers, primary care clinics with integrated behavioral health, residential facilities, homes, community behavioral health centers, inpatient hospitals, etc.). Additionally, there are specific evidence-based treatments for people with histories of trauma, such as eye movement desensitization and reprocessing (EMDR) therapy, trauma-focused cognitive behavior therapy and the Child and Family Traumatic Stress Intervention.[45]

However, treatment is only one component of the behavioral health system; prevention and recovery services and supports are also important components of the continuum. Further, care should be culturally-competent, patient- and family-centered, trauma-informed, and integrated and collaborative (among providers, prescribers and others outside the traditional healthcare system) to yield best results.[46]

Examples of behavioral health treatment services and supports:

- Early identification through Screening, Brief Intervention and Referral to Treatment (SBIRT)
- Outpatient services such as individual and group therapy/ counseling, including those provided via telemedicine or in a school setting
- Crisis response, including Mobile Response and Stabilization Services (MRSS)
- Inpatient treatment, including at psychiatric hospitals
- Residential treatment, such as at qualified residential treatment programs and psychiatric residential treatment facilities
- Medications for opioid use disorder (i.e., medication--assisted treatment)
- Intensive home-based services
- Respite services for caregivers

This policy brief provides a high-level overview of behavioral health treatment in Ohio, including several important state-level initiatives, below.

Behavioral health treatment in Ohio

State policymakers have taken a variety of steps to increase access to mental health and substance use disorder (SUD) treatment services for those in need. Yet, according to HPIO's ***2023 Health Value Dashboard***, 25% of Ohio adults with mental illness reported needing mental health treatment or counseling within the past year and not receiving it.[47] This was also true for 18.2% of Ohio children ages 3-17.[48]

Funding and administration

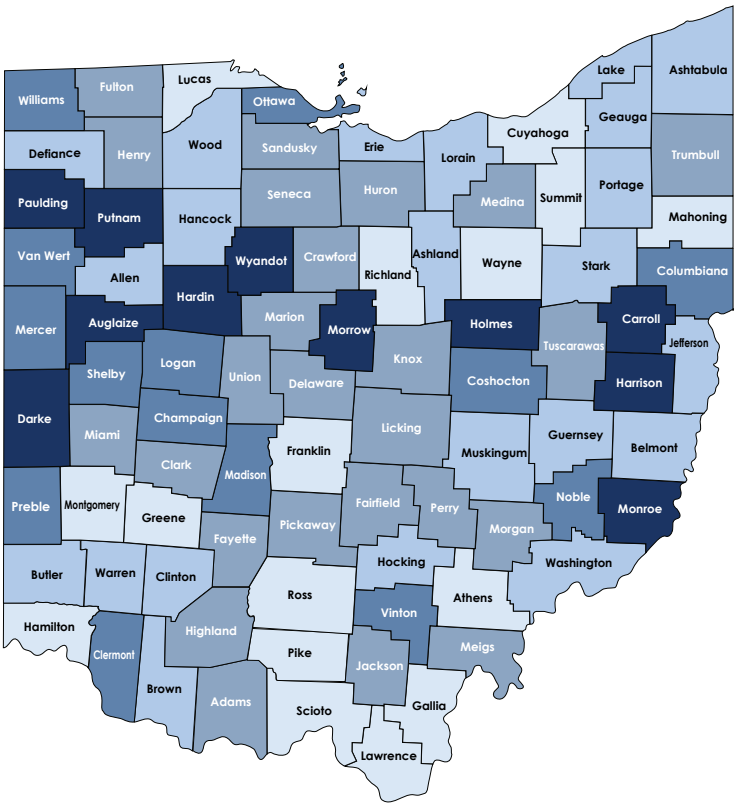
OhioMHAS provides statewide leadership for a wide array of mental health and addiction programs and services and distributes federal and state funding to the local Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Boards. The 50 ADAMHS Boards[49], which cover all Ohio counties, are responsible for local planning and management of services.[50] They do not directly deliver treatment services, but they provide funding and reimbursement to local providers. Providers can also receive Medicaid, commercial and other types of insurance reimbursement for services.

OhioMHAS also regulates community behavioral health treatment providers and operates six regional psychiatric hospitals across the state. Annually, these hospitals serve approximately 4,000 Ohioans with serious mental illnesses.[51] They provide short-term, intensive treatment in both in-patient and community-supported environments.

Ohio's behavioral health workforce

Insurance reimbursement rates for behavioral health services are generally low (for both public and private insurers)[52], burnout is common, and there is a lack of adequate diversity in the current behavioral health workforce. Provider shortages cause challenges in accessing behavioral health treatment, especially for Ohioans living in rural counties (see figure 8). Holmes and Harrison Counties have the lowest rates of mental health professionals per population, meaning some people in these counties may not be getting the mental health services they need.

Figure 8. **Ratio of population to mental health providers, by county, Ohio, 2023**



Population count for every one mental health provider

- 1 to 300
- 301 to 500
- 501 to 800
- 801 to 1,300
- 1,301 to 6,500

Note: Mental health providers includes psychologists, clinical neuropsychologists, counselors, therapists, social workers, and health providers that treat alcohol and other drugs.
Source: University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps. 2023.

In October 2023, OhioMHAS released a **Behavioral Health Workforce Strategic Roadmap**, which was created with input from an advisory council, focus groups and key informant interviews. It is based on four pillars:

- Increasing career awareness
- Supporting recruitment
- Incentivizing retention
- Supporting contemporary practice

The roadmap includes 22 initiatives that will be implemented through 2027. One initiative is Ohio's Great Minds Fellowship, born from a partnership between OhioMHAS, the Ohio Department of Medicaid (ODM) and the Ohio Department of Higher Education. It will provide a total of $85 million of one-time federal funding for workforce recruitment and retention in mental health and SUD treatment professions.

Also, in its main operating budget for state fiscal years 2024-2025, the Ohio General Assembly authorized Medicaid rate increases of at least 10% for community behavioral health services[53] to help with workforce stability and access to care for Ohioans with Medicaid.

Other programs and initiatives to improve behavioral health outcomes in Ohio

RecoveryOhio. Established by Gov. Mike DeWine in January 2019 to coordinate the work of state agencies, boards and commissions, the goals of RecoveryOhio are to make treatment available to Ohioans in need, provide support services for those in recovery and their families, offer direction for the state's prevention and education efforts, and work with local law enforcement to provide resources to fight illicit drugs at the source. In its first year, the RecoveryOhio Advisory Council developed an **initial report** with 75 recommendations. RecoveryOhio produces an **annual report** on its progress toward implementing those recommendations.

Disparities and Cultural Competence (DACC) Advisory Committee. OhioMHAS convenes the DACC advisory committee to monitor and address behavioral health disparities and ensure cultural and linguistic competency in Ohio's behavioral health system. The **DACC 2021-2024 Strategic Plan** prioritizes six strategic goal areas.

School-Based Center of Excellence for Prevention and Early Intervention. Housed at Miami University, the Center received funding from OhioMHAS and ODEW to prioritize mental health and wellness for K-12 students and staff. It houses various school-based mental health initiatives, including a K-12 mental health provider workforce development program and the Ohio School Wellness Initiative, which offers schools a new behavioral health and wellness model.

OhioSTART

Particularly relevant to ACEs, the OhioSTART program provides wrap-around services to parents with substance use disorder to support long-term recovery and prevent their children from entering foster care.[54] The program matches families in the children services system due to parental substance use with a specialized children services worker and peer mentor (someone in long-term recovery with personal experience with child services).[55] START is a national program that, when implemented with fidelity, has been found to be effective in reducing maltreatment, neglect and out-of-home placements[56] and increasing sobriety and early recovery.[57] OhioSTART is currently in 53 counties.

Implementation example: Multisystemic therapy program at the Buckeye Ranch

Program description

Multisystemic therapy (MST) is an intensive, home-based treatment geared towards youth with serious emotional disturbances who are at risk of out-of-home placement.[58] In MST, a trained clinician works with the family/caregivers to identify and address the reasons behind the child's behaviors and all risk factors surrounding the youth. The clinician generally spends 4-5 hours per week with the family over a 3-5 month period; a central goal of MST is empowerment of parents and caregivers. There is strong evidence that MST reduces incarceration and recidivism[59], but it requires buy-in and support from community partners.

Population served

MST is generally implemented with at-risk youth, ages 12-17.5, with serious emotional or behavioral disorders. Most are court-involved, commonly with felony-level offenses, or are at risk of justice system involvement. Youth must have a long-term caregiver, so youth in foster care are not eligible for MST.

Funding

The Buckeye Ranch, a Central Ohio provider, has contracts with Franklin County Children Services and the juvenile court. Many services in MST are reimbursed via Ohio Medicaid or private insurance. The Buckeye Ranch is also an OhioRISE care management entity, so they receive funding from Aetna Better Health when working with youth enrolled in OhioRISE. When the youth does not have insurance, the Buckeye Ranch uses a sliding fee schedule and fills the gap with other sources of funding.

Workforce

A licensed social worker or counselor with a Master's degree is preferred to implement MST, but a Bachelor's degree is allowable. An initial five-day MST training and booster trainings are required.

Outcome evaluation

Tracking and evaluation of data and outcomes for continuous quality improvement purposes is central to the MST model. Examples of tracked program outcomes include family interaction, academic and behavioral components of school success, arrest rates and whether the youth stays in the home.

Implementation considerations for behavioral health treatment

Following are several best practices and challenges related to behavioral health treatment in general.

Best practices

- **Certified Community Behavioral Health Clinics**. The Certified Community Behavioral Health Clinic (CCBHC) model provides access to comprehensive behavioral health care to anyone regardless of ability to pay, place of residence or age. CCBHCs are required to offer a comprehensive array of services, get people into care quickly[60] and have crisis services available 24 hours a day, seven days a week.[61] Evaluations of this model find improvements in mental health functioning, decreased ED visits and incarceration, and other positive outcomes.[62] In 2022 and 2023, 15 Ohio providers received CCBHC grants from the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA).[63]
- **School-based services.** Enabling children to access services at school removes various barriers including transportation and parental employment challenges. This model has also been found to decrease disparities.[64]

- **Diverse workforce.** Many people prefer a provider who shares their race, ethnicity or other characteristics due to commonalities and shared experiences. When possible, this has been found to improve care outcomes.[65]
- **Innovative outreach approaches**. Creative awareness building and engagement efforts can reduce stigma related to behavioral health treatment and connect people to services and supports.
- **Cross-system collaboration**. Collaboration among systems, such as health care, education, public safety and the justice system, can lead to improved behavioral health outcomes.[66]

Challenges

- **Provider shortages**. Many areas of Ohio have behavioral health provider shortages and/or do not have access to the full continuum of services. One key reason for this is low reimbursement rates.
- **Barriers to accessing care**. Ohioans experience a variety of barriers to accessing care, one of which is transportation. While telemedicine can help with this, it is not available everywhere due to lack of internet access.
- **Stigma, resistance and mistrust**. There is still stigma around mental health and substance use disorders that can keep some individuals from seeking treatment. Mistrust of the healthcare system is another reason why some do not seek care.
- **Program cost**. MST and other intensive home-based treatments, for example, are expensive, because they involve intensive work with only a small number of families. This and other evidence-based models also require specialized training and fidelity monitoring, which can be costly.

Behavioral health treatment: Next steps for Ohio

To improve behavioral health treatment across Ohio, policymakers and other stakeholders should consider the strengths, gaps and recommendations in figure 9.

Figure 9. **Strengths, gaps and recommendations related to behavioral health treatment**

Strengths	Gaps	Recommendations
• Ohio is taking steps to expand and strengthen the behavioral health workforce, including increasing Medicaid reimbursement rates. • Ohio has had strong state leadership around behavioral health, such as through its efforts to address the opioid and overdose crises. • Ohio is supportive of school-based health services and devoted funding to them in the last state operating budget. • The state has expanded access to medications for opioid use disorder (i.e., medication-assisted treatment). • The **DACC 2021-2024 Strategic Plan** was developed with the goal of eliminating disparities in behavioral health treatment access and outcomes.	• One in four Ohio adults and 18% of children are not able to access behavioral health treatment when in need.[67] • There are behavioral health workforce shortages in many areas of Ohio. • Stigma remains against mental health conditions and substance use disorder. • Many areas of the state lack access to some evidence-based services; for example, there are only MST programs operating in 10 Ohio counties.[68]	• State policymakers can continue efforts to increase the behavioral health workforce and diversity within it through financial incentives (e.g., loan forgiveness, scholarships and higher reimbursement), especially in areas with provider shortages. • State policymakers can encourage statewide implementation of CCBHCs. • State and local policymakers can fund implementation of OhioSTART programs in the remaining 35 counties. • State policymakers and Medicaid managed care organizations can mitigate transportation barriers to accessing care through increased funding for public transportation and improvements to non-emergency medical transportation.

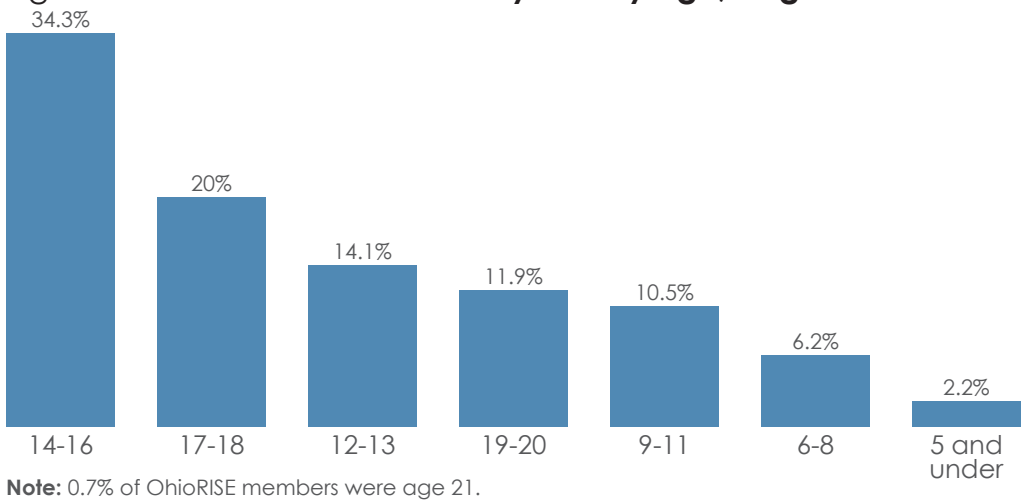
OhioRISE

Mental health challenges, developmental delays and risky behaviors, such as substance use, are more common among youth with ACEs exposure.[69] **OhioRISE** (Resilience through Integrated Systems and Excellence) is a specialized, voluntary managed-care program for children and youth with complex behavioral health and multisystem needs. Aetna Better Health of Ohio was selected to administer the program statewide, and OhioRISE services became available for those eligible in July 2022. As of August 2023, there were 24,257 children and youth enrolled.[70]

To enroll in OhioRISE, Ohioans ages 0-20 must be eligible for Ohio Medicaid and have significant behavioral health treatment needs, as measured by the Child and Adolescent Needs and Strengths (CANS) assessment or have a behavioral health inpatient hospital admission or MRSS (mobile response and stabilization services) crisis call. As of August 2023, 41,307 CANS assessments had been completed, with 87% of the children and youth determined to be eligible.[71]

As shown in figure 10, youth ages 14-17 made up 45.8% of OhioRISE members, and 62.4% were ages 13-18. Of all members, 64.4% were white, 28.9% were Black and the remaining 6.7% were other races or ethnicities or unknown.[72]

Figure 10. **OhioRISE children and youth by age, August 2023**



Note: 0.7% of OhioRISE members were age 21.
Source: Data provided by OhioRISE

Care coordination and cross-system collaboration are the primary responsibilities of OhioRISE. For example, OhioRISE members may need services associated with education, developmental disabilities, child protection, juvenile justice and/or behavioral health. Care coordinators work with families, providers and community partners to develop a single, comprehensive care plan and ensure that all partners are working together efficiently, with the least amount of burden on the family as possible.

There are three tiers of care coordination, ranging from limited care coordination for members with less intensive behavioral health needs (Tier 1) to intensive care coordination for those with more significant needs (Tier 3). Tier 1 services are provided by an Aetna care coordinator. Care coordination services for Tiers 2 and 3 are provided through **18 regional care management entities**.

Conclusion

Promoting positive social norms that protect against violence and adversity, as well as ensuring Ohioans have access to trauma-informed care and behavioral health treatment are important for ACEs prevention and recovery.

With all 12 evidence-informed strategies elevated by HPIO, the following recommendations should be considered:

- Ensure resources are allocated and strategies are adapted and tailored to the **children and families at greatest risk of ACEs**
- Reduce participation or engagement barriers that may prevent children and families most at risk for ACEs exposure from reaping the full benefits of a strategy (e.g., childcare, transportation, cultural/linguistic or accessibility barriers)
- Evaluate how the policy or program was implemented and whether it was effective in preventing ACEs and eliminating disparities and inequities

To inform examples of ACEs prevention strategies implemented in Ohio, HPIO conducted key informant interviews with staff from the following organizations:

- **Franklin County Court of Common Pleas**
- **COMPASS**
- **Safe on MAIN**
- **New Directions**
- **The Ohio Department of Health**
- **The Ohio Department of Mental Health and Addiction Services**
- **Aetna Better Health of Ohio/OhioRISE**
- **The Buckeye Ranch**

Acknowledgments

Authors

Becky (Sustersic) Carroll, MPA
June Postalakis
Emmanuel Scaria, HPIO intern

Contributors

Lexi Chirakos, PhD
Jacob Santiago, MSW

Graphic design and layout

Nick Wiselogel, MA

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