

**ODMH Office of Children, Families and Prevention:**  
**Children's Community Behavioral Health (CCBH) Annual Report**  
**SFY 2010**

**2010 ODMH Office of Children, Families and Prevention:  
Children’s Behavioral Health (CCBH) Annual Report SFY 2010**

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**2010 ODMH Office of Children, Families and Prevention:  
Children's Behavioral Health (CCBH) Annual Report SFY 2010**

**Introduction**

The Children's Community Behavioral Health (CCBH) is a component of the System of Care (SOC) initiative and focuses on the provision of effective community treatment services needed to maintain children and youth (ages 0 through 17) in their homes and communities. The priority population is children and youth who have intensive behavioral health needs and/or who are at risk of removal from an early care and education setting, or are at risk of removal from their homes or communities due to behavioral health issues.

The framework for the SOC initiative describes the Ohio Family and Children First (OFCF) Cabinet's commitment to implement a coordinated continuum of services and supports for all children and families, with an emphasis on behavioral health care. SOC includes a broad, flexible array of effective services and supports that strengthen the capacity of families and communities, and provide effective individualized services. SOC includes an organized, coordinated network (i.e., OFCF) that integrates services, supports, planning, coordination and management across multiple levels and focuses on the provision of effective services needed to maintain children and youth in their homes and communities.

SOC has promoted and supported:

- Increased access to prevention, early intervention and treatment in natural settings for children and families, i.e. in homes, child care, schools and other community environments
- Community-based, family-centered solutions
- Stronger parent advocacy and empowerment
- Outcome-based, effective services and evidenced-based programs
- Increased collaboration and accountability among child-serving agencies
- Alignment and redirection of resources to increase capacity

The foundational SOC components are:

- Children's Community Behavioral Health (CCBH)
- Family Centered-Services and Supports (FCSS)
- Early Childhood Mental Health Consultation (ECMHC)
- Behavioral Health-Juvenile Justice (BHJJ)

The CCBH funds can support clinical intervention and treatment, clinical programs that address gaps in treatment services, and wraparound services. Services that can be provided with CCBH funds include early childhood mental health treatment; Intensive Home-Based Treatment; co-occurring mental health and substance abuse treatment; trauma-informed care; wraparound services; and clinical programs that address gaps in treatment services. There is collaborative planning led by the Alcohol, Drug Addiction and Mental Health/Community Mental Health/Alcohol and Drug Addiction Services (ADAMH/CMH/ADAS) Boards in partnership with the OFCF in order to best address local needs consistent with the Board's ODMH/ODADAS Community Plan. CCBH services are designed to be child-centered, family-driven, and are to be provided in the least restrictive environment to meet the treatment needs of the child or youth.

The Children's Community Behavioral Health (CCBH) Annual Report for SFY 2010 was required to be submitted by the ADAMH/CMH/ADAS Boards or a designee. The goal of the CCBH Annual Report is to demonstrate how the CCBH funds are being utilized within each county.

**2010 ODMH Office of Children, Families and Prevention:  
Children's Behavioral Health (CCBH) Annual Report SFY 2010**

**Executive Summary**

As determined by local needs and resources, many different treatments and therapies were provided throughout Ohio through the utilization of CCBH funds in SFY 2010. These treatments helped to provide stability for children and families as well as giving them the opportunity to maintain placement in their community and diminishing the need for out-of-home overnight placements. Without the availability of CCBH funds in SFY 2010 many counties reported they would not have been able to meet the needs of children and families.

Through the utilization of Intensive Home-Based Treatment, almost half, 43.33%, of the reporting counties stated that out-of-home placements were avoided or significantly decreased. Fifty (50) counties (56.8%), reported utilization of CCBH funds in SFY 2010 for Intensive Home-Based Treatment.

Mental health treatment provided in schools was supported with CCBH funds for SFY 2010 in 38 counties (43.2%). Many counties reported an increase in the ability to provide mental health treatment in schools for children and their families throughout Ohio. Roughly 11 counties (12.22%) reported mental health treatment in schools as one of their noteworthy accomplishments through the utilization of CCBH funds in SFY 2010.

Early Childhood Mental Health (ECMH) Treatment was provided to children and families throughout Ohio, but only a portion of counties utilized CCBH funds to provide this treatment. Other sources of funding may have been utilized to provide additional ECMH treatment locally. CCBH funds were utilized to provide Play Therapy in 17 counties (19.3%), in 6 counties (6.8%) to provide DINA Small Group Therapy and Filial Therapy, in 8 counties (9.1%) with Trauma Focused CBT and 14 counties (15.9%) provided Parent Child Interaction Therapy. Therapeutic Daycare/Preschool was not funded with CCBH funds in SFY 2010.

Numerous additional treatments provided through the utilization of SFY 2010 CCBH funds included Integrative Family and Systems Treatment (I-FAST), Wellness Recovery Action Plan services (WRAP) services, Juvenile Court-based Mental Health Therapy, Family Peer Support Services, Consultation and Education, Devereux Early Childhood Assessments (DECA), Sex Offender Treatment, Respite for youth in crisis, Incredible Years, mentoring and supporting clinical programming, assessments, and multi-dimensional psychiatric evaluations.

The Children's Community Behavioral Health (CCBH) funds distributed for SFY 2010 totaled \$6,540,953.27. Twenty-two (22) percent of the total, \$1,466,249.07, was utilized for Medicaid match. The federal government requires that each state/local government match the federal government funds for Medicaid reimbursement. In Ohio, this is approximately a 60% federal and 40% state/local match. Eight counties utilized 100% of their CCBH funds in SFY 2010 for Medicaid match and 31 counties (34.44%) reported that none of the CCBH funds were utilized for Medicaid match.

## **QUESTION 1: Identifying Information**

There are a total of 90 responses for the Children's Community Behavioral Health Annual Report for SFY 2010. Community Mental Health (CMH) Boards, Alcohol, Drug Addiction and Mental Health (ADAMH) Boards, Mental Health & Recovery Services (MHRS) Boards, and the Alcohol & Drug Addiction Services (ADAS) Boards are responsible for administering and managing CCBH funds at the county level consistent with local needs. These boards (or their designee) are responsible for the completion of this annual report for each of the counties in their board area. Respondents included board staff, executive directors, associate directors and designated providers from each of the 50 board areas serving the 88 counties in Ohio. In this report, the Butler County and Lorain County ADAS Boards responses are compiled with each of their county's CMH Boards responses, with the exception of fiscal questions (questions #2 & #5). The Mahoning County ADAS Board & Mahoning County Mental Health Board submitted their responses jointly.

## **QUESTION 2: Amount of CCBH funds spent in this county in SFY 2010:**

The 52 participating boards (50 joint & 2 separate ADAS Boards) reported their allocated CCBH funds were fully expended for each county within their board area. The individual county amount was calculated to represent the board area in which it belongs. For a complete list of CCBH funds spent in SFY10 by county and by board area see, *Appendix B*.

## **QUESTION 5: Were CCBH funds used to pay Medicaid match? If yes, how much?**

The federal government requires that each state/local government match the federal government funds for Medicaid reimbursement. In Ohio, this is approximately a 60% federal and 40% state/local match.

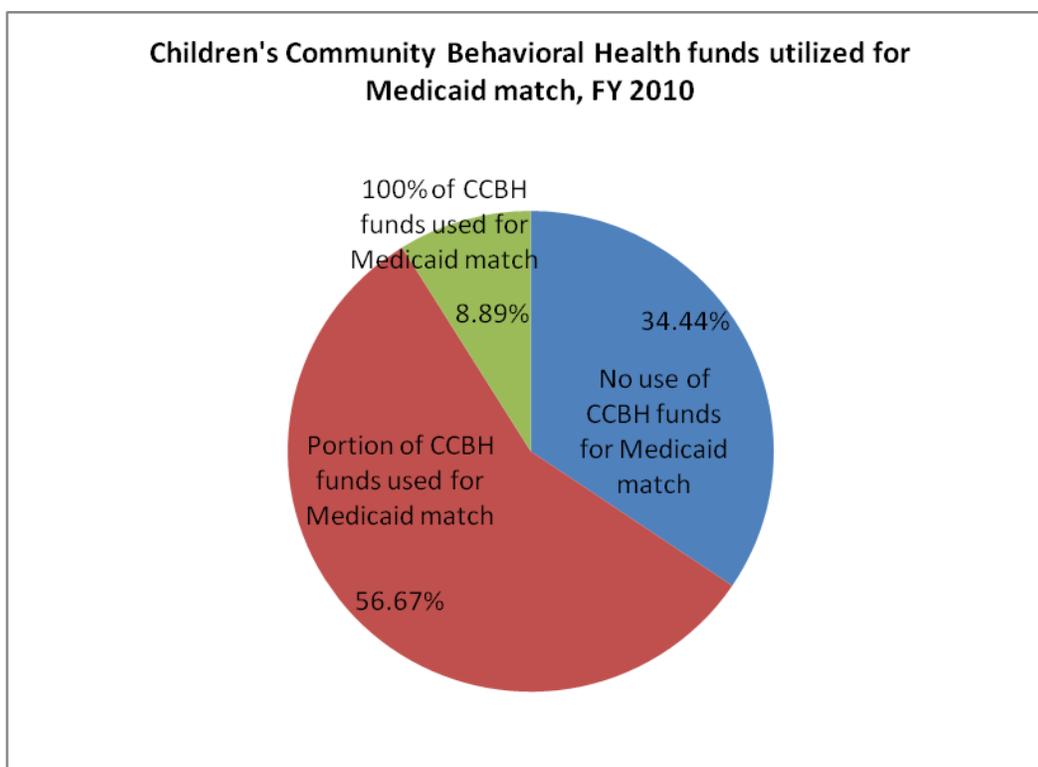
The 52 participating boards were asked to report if any portion of their CCBH funds were used for Medicaid match and if so, they were to report the corresponding amount, by county. The individual county amount was calculated to represent the board area in which it belongs. For a complete list of CCBH funds spent in SFY10 by county and by board area see, *Appendix B*.

There were a total of 90 responses (88 counties + 2 of these counties with separate CMH & ADAS board reports) for the Children's Community Behavioral Health Annual Report for SFY10. There are 31 counties (34.44%) that reported not having used any CCBH funds in SFY10 for Medicaid match. Eight (8) of the counties (8.89%) reported using 100% of the CCBH funds for Medicaid match in SFY10. Therefore, 51 counties (56.67%) reported using only a portion of CCBH funds for Medicaid match (See Figure 1). For a complete list of CCBH funds used for Medicaid match in SFY10 by county and by board area see, *Appendix B*.

Of the total 50 board areas, 23 board areas (46%) reported not having used any of the CCBH funds in SFY10 for Medicaid match. Another 23 board areas (46%) reported using only a portion of CCBH funds for Medicaid match. The remaining 4 board areas (8%) reported using 100% of the CCBH funds for Medicaid match in SFY10.

The Children's Community Behavioral Health funds used for Medicaid match totaled \$1,466,249.07 (22.42%) of the total \$6,540,953.27 CCBH allocated funds for SFY 2010.

**Figure 1**



**Utilization of CCBH funds for Early Childhood Mental Health, Out-of-home Overnight treatment and various others**

The respondents for the Children’s Community Behavioral Health (CCBH) Annual Report were asked to indicate whether or not CCBH funds were used to provide specific services to children including, early childhood mental health treatment, out-of-home treatment overnight, and various others.

**QUESTION 6: Were CCBH funds used during SFY10 to provide early childhood mental health treatment in any of the following? Check either ‘yes’ or ‘no’ for each item below, as applicable:**

Early Childhood Mental Health (ECMH) is the social, emotional and behavioral well-being of children birth – six years, including the developing capacity to: experience, regulate and express emotion; form close, secure relationships; and explore the environment and learn. The Ohio Department of Mental Health (ODMH) supports an ECMH initiative that provides parents and caregivers of young children with the knowledge and skills necessary to help their children develop into mentally healthy individuals.

Respondents were asked to mark either ‘yes’ or ‘no’ for the following early childhood mental health treatments: Play Therapy, DINA Small Group Therapy, Filial Therapy, Trauma Focused Cognitive Behavioral Therapy, Parent-Child Interaction Therapy and Therapeutic Daycare/Preschool. Below are the summaries for each early childhood mental health treatment.

**Play Therapy** – Play Therapy is the systematic use of a theoretical model to establish an interpersonal process wherein trained play therapists use the therapeutic powers of play to help prevent or resolve psychosocial difficulties and achieve optimal growth and development for children ages 0 – 6.

Respondents in 17 counties (19.3%) reported use of CCBH funds to provide Play Therapy as an early childhood mental health treatment in their county.

DINA Small Group Therapy – DINA Therapy is a small group therapy treatment program for ages 4 – 8 that is delivered in 2-hour weekly small group sessions lasting 20-22 weeks.

Respondents in 6 counties (6.8%) reported use of CCBH funds to provide DINA Small Group Therapy as an early childhood mental health treatment in their county.

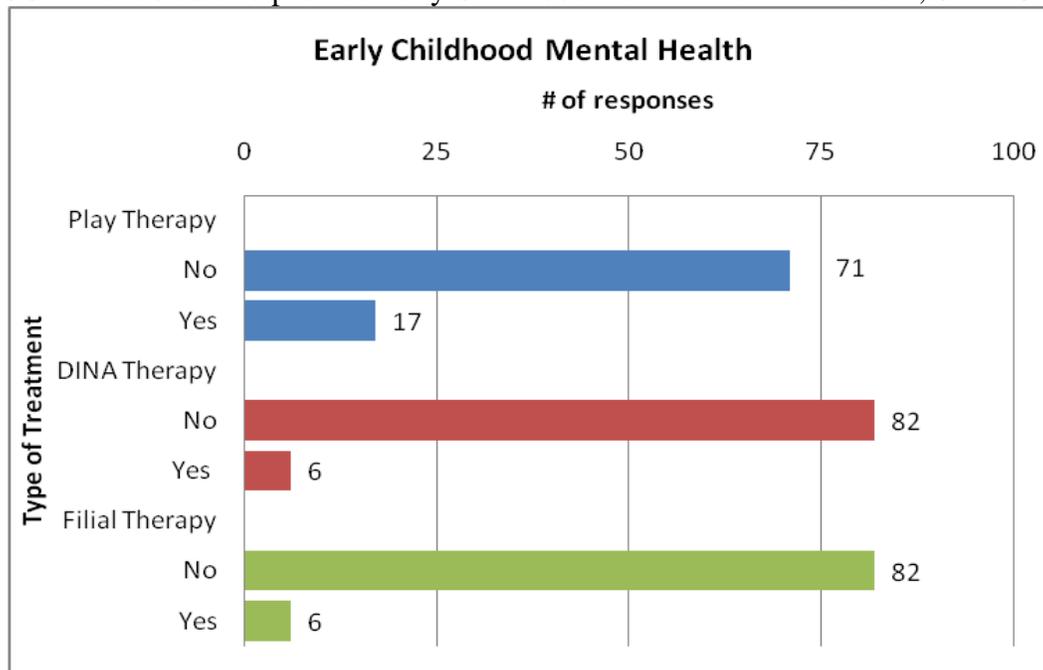
Filial Therapy – Filial Therapy facilitates the interpersonal and emotional development of the child and provides parents with the training and experience in a comprehensive set of parenting skills. The child’s and the parent’s mastery of skills and behaviors of the play session can be transferred to appropriate settings outside the play sessions.

Respondents in 6 counties (6.8%) reported use of CCBH funds to provide Filial Therapy as an early childhood mental health treatment in their county.

The information provided in Figure 2 represents the number of counties (out of 88) that reported utilization of CCBH funds in SFY 2010 for Early Childhood Mental Health treatments. Counties may be providing these treatments through other funding sources, such as Medicaid.

**Figure 2**

CCBH funds used to provide Early Childhood Mental Health Treatment, SFY 2010



Trauma Focused Cognitive Behavioral Therapy (CBT) – Trauma Focused CBT is an evidence-based treatment (EBT) developed and tested by Drs. Esther Deblinger, Judith Cohen, and Anthony Mannarino to help children and their caregivers overcome the negative effects of traumatic life events. Trauma Focused CBT is a clinic-based, short-term treatment that teaches children skills in stress management, cognitive processing, communication, problem solving, and safety. It is essential that the child’s primary caregiver participates in the treatment in order to enhance parenting skills and manage caregivers’ own reactions to the child’s trauma.

Respondents in 8 counties (9.1%) reported use of CCBH funds to provide Trauma Focused CBT as an early childhood mental health treatment in their county.

Parent Child Interaction Therapy (PCIT) – Parent Child Interaction Therapy is an evidence-based treatment (EBT) supported by over 20 years of research and practice by PCIT practitioners and researchers throughout the United States. PCIT is a mastery-based therapy that averages 14 sessions. The intervention uses a two-stage approach aimed at relationship enhancement (Child Directed Interaction or CDI) and child behavior management (Parent Directed Interaction or PDI). PCIT focuses on improving the caregiver-child relationship and increasing children’s positive behaviors. For more information see, [www.pcit.org](http://www.pcit.org)

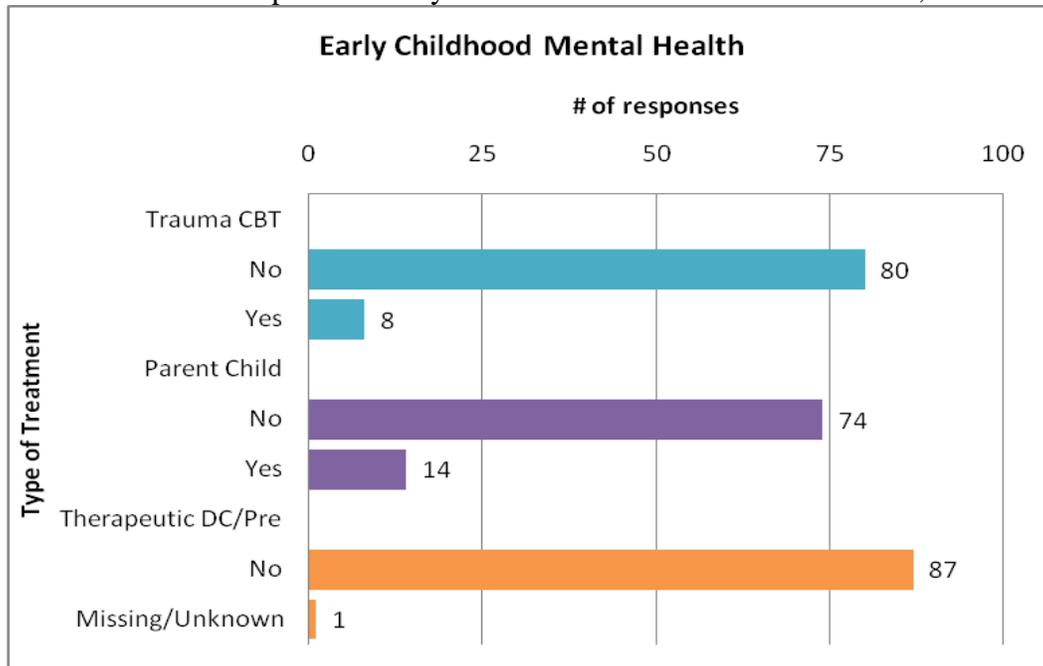
Respondents in 14 counties (15.9%) reported use of CCBH funds to provide Parent Child Interaction Therapy as an early childhood mental health treatment in their county.

Therapeutic Daycare/Preschool – Therapeutic Daycare/Preschool is a structured program for children ages 0 – 6 that provides stability, nurturance and behavior management in a therapeutic environment for children experiencing emotional and/or behavioral challenges.

Respondents in 1 county (1.1%) did not report usage or non-usage of CCBH funds to provide Therapeutic Daycare/Preschool as an early childhood mental health treatment in their county.

The information provided in Figure 3 represents the number of counties (out of 88) that reported utilization of CCBH funds in SFY 2010 for Early Childhood Mental Health treatments. Counties may be providing these treatments through other funding sources, such as Medicaid.

**Figure 3**  
CCBH funds used to provide Early Childhood Mental Health Treatment, SFY 2010



For additional information on Early Childhood Mental Health, please go to <http://mentalhealth.ohio.gov> and enter “Early Childhood Mental Health Consultation & Treatment” in the search box.

**QUESTION 7:** Were CCBH funds used during SFY10 to provide out-of-home treatment overnight in any of the following? Check either ‘yes’ or ‘no’ for each item below, as applicable:

Out-of-home care means overnight detention facilities, shelter facilities, certified children’s crisis care facilities, certified foster homes, placement in a prospective adoptive home prior to the issuance of a final decree of adoption, organizations, certified organizations, child day-care centers, type A family day-care homes, child care provided by type B family day-care home providers and by in-home aides, group home providers, group homes, institutions, state institutions, residential facilities, residential care facilities, residential camps, day camps, public schools, chartered non-public schools, educational service centers, hospitals, and medical clinics that are responsible for the care, physical custody, or control of children.

Respondents were asked to mark either ‘yes’ or ‘no’ for the following out-of-home treatments overnight: Therapeutic or Treatment Foster Care, Residential Treatment Facility licensed by ODMH (or certified by ODMH to provide mental health services on-site), and Psychiatric Hospital. Below are the summaries for each out-of-home treatments overnight.

Therapeutic or Treatment Foster Care – Therapeutic or Treatment Foster Care is a foster home that incorporates special rehabilitative services designed to treat the specific needs of the children received in the foster home and that receives and cares for children who are emotionally or behaviorally disturbed, chemically dependent, mentally retarded, developmentally disabled, or who otherwise have exceptional needs.

Respondents in 16 counties (18.2%) reported use of CCBH funds to provide Therapeutic/Treatment Foster Care as an out-of-home treatment overnight for consumers in their county.

Residential Treatment Facility (RTF) – Residential Treatment Facilities are publicly or privately operated homes or facilities that meet one of the following classifications: a) Type 1 provides room and board and personal care services, and mental health services to one or more children and adolescents with a serious emotional disturbance or in need of mental health services, who have been referred by or are receiving mental health services from a hospital, mental health agency, or practitioner; b) Type 2 provides all of the Type 1 services to one or two children.

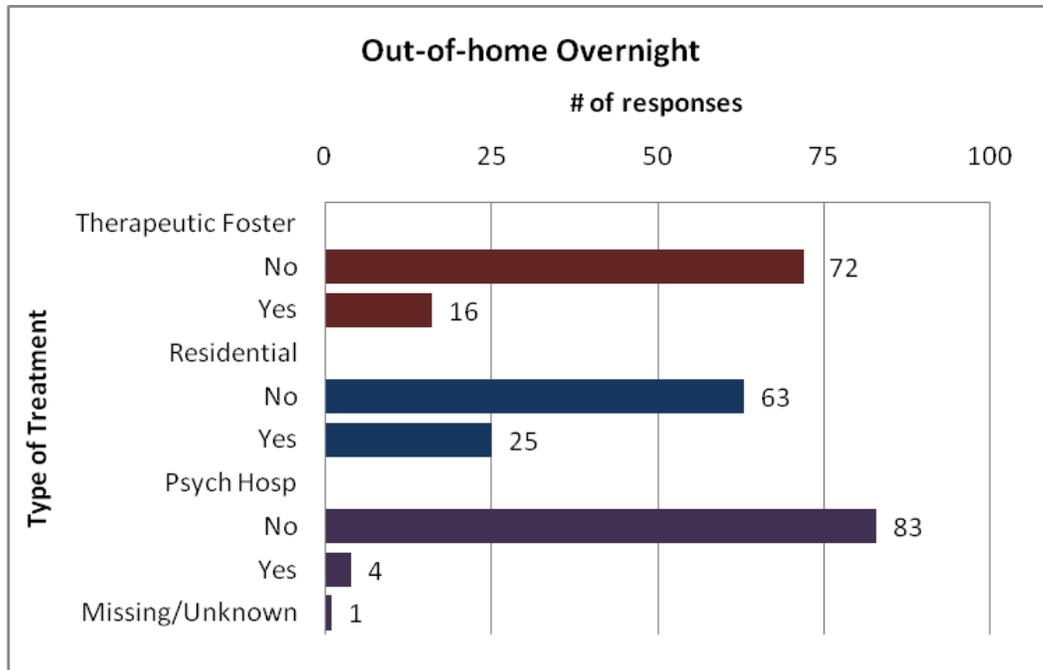
Respondents in 25 counties (28.4%) reported use of CCBH funds to provide out-of-home overnight Residential Treatment for consumers in their area.

Psychiatric Hospital – Psychiatric Hospital means a hospital engaged primarily in providing specialized care to inpatients diagnosed with mental illness.

Respondents in 4 counties (4.5%) reported usage of CCBH funds to provide Psychiatric Hospitalization as an out-of-home overnight treatment to consumers within their area.

The information provided in Figure 4 represents the number of counties (out of 88) that reported utilization of CCBH funds in SFY 2010 for Out-of-home Overnight treatments. The low or no usage of these funds for this purpose is a good thing as one of the primary goals of funds is to reduce the risk of removal from home or community due to behavioral health issues. Counties may be providing these treatments through other funding sources, such as Medicaid.

**Figure 4**



**QUESTION 8: Were CCBH funds used during SFY10 to provide any of the following? Check either ‘yes’ or ‘no’ for each item below, as applicable:**

Respondents were asked to mark either ‘yes’ or ‘no’ for the following services: Intensive Home-Based Treatment, Multi-Systemic Therapy, Functional Family Therapy, Mental Health Services provided in schools, Co-occurring Mental Health and Substance Abuse Treatment, Substance Abuse Treatment, and Other. Below are the summaries for each of the services.

Intensive Home-Based Treatment (IHBT) – Intensive Home-Based Treatment is a comprehensive service provided to a youth and his/her family that integrates community psychiatric supportive treatment (CPST) service, mental health assessment service, crisis response, behavioral health counseling and therapy service, and social services with the goals of either preventing the out-of-home placement or facilitating a successful transition back to home.

More information can be found in the ODMH Certification Standards for Community Mental Health Agencies at:

[http://b9962ed140049a571a710839f1f71c989aaf09ce.gripelements.com/licensurecert/rules\\_cert\\_standards/5122-29-28.pdf](http://b9962ed140049a571a710839f1f71c989aaf09ce.gripelements.com/licensurecert/rules_cert_standards/5122-29-28.pdf)

Respondents in 50 counties (56.8%) reported usage of CCBH funds to provide Intensive Home-Based Treatment to consumers/families in their county.

Some components of IHBT are reimbursable as discrete services covered under the current Medicaid state plan. ODMH, the Ohio Department of Job & Family Services (ODJFS) and the Center for Innovative Practices (CIP) are engaged in preliminary work to prepare for conversations with the Centers for Medicare & Medicaid Services (CMS) for IHBT as an integrated Medicaid reimbursable service.

Multi-Systemic Therapy (MST) – Multi-Systemic Therapy is a proprietary program with a mandatory licensing fee. MST is a family and home-based treatment that strives to change how youth function in their natural

settings that promote positive social behavior while decreasing anti-social behavior. For a complete description and/or more information see: [www.mstservices.com/overview\\_a.pdf](http://www.mstservices.com/overview_a.pdf)

Eleven counties (12.5%) reported usage of CCBH funds to provide Multi-Systemic Therapy to consumers/families within their county.

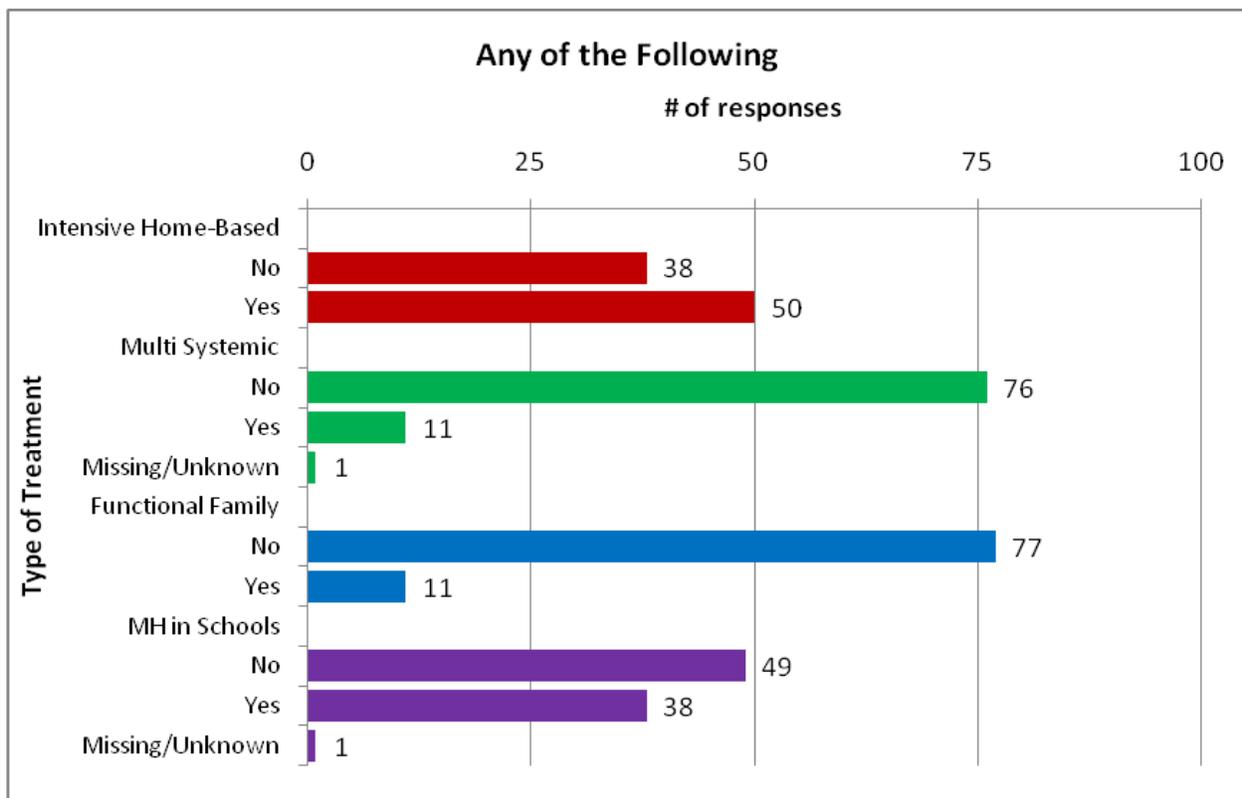
**Functional Family Therapy (FFT)** – Functional Family Therapy is a short-term, high quality intervention program with an average of 12 sessions over a 3-4 month period. Services are conducted in both clinic and home settings, and can also be provided in a variety of other settings including schools, child welfare facilities, probation and parole offices/aftercare systems, and mental health facilities. FFT is a strength-based model. For a complete description and/or more information visit: [http://www.fftinc.com/about\\_model.html](http://www.fftinc.com/about_model.html)

Respondents in 11 counties (12.5%) reported usage of CCBH funds to provide Functional Family Therapy to consumer and/or families within their area.

**Mental Health Services in Schools** – Respondents from 38 counties (43.2%) reported usage of CCBH funds to provide Mental Health Services in Schools located within their area.

The information provided in **Figure 5** represents the number of counties (out of 88) that reported utilization of CCBH funds in SFY 2010 for various other treatments. Counties may be providing these treatments through other funding sources, such as Medicaid.

**Figure 5**



**Co-occurring Mental Health (MH) and Substance Abuse (SA) Treatment** – Respondents in 16 counties (18.2%) reported usage of CCBH funds to provide Co-occurring MH and SA Treatment to consumers and/or families within their area.

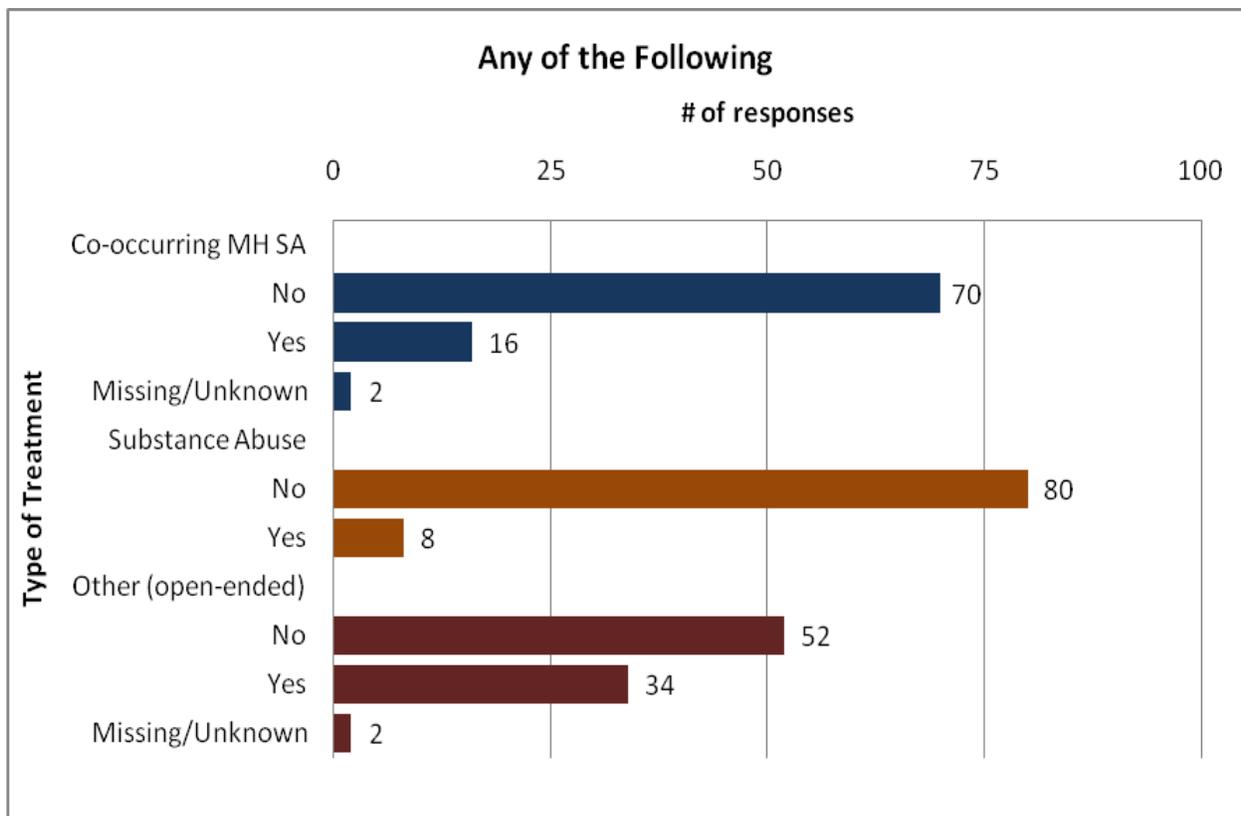
Substance Abuse (SA) Treatment – Respondents in 8 counties (9.1%) reported usage of CCBH funds to provide Substance Abuse Treatment to consumers and/or families within their area.

Other – Respondents were asked to mark ‘yes’ or ‘no’ if they utilized CCBH funds for ‘other’ services within their area. This question was expanded upon in Question 9 and open-ended responses will be discussed below, in the “Responses to Open-ended Questions” section of this document.

Respondents in 34 counties (38.6%) reported usage of CCBH funds to provide ‘Other’ services to consumers and/or families within their area.

The information provided in Figure 6 represents the number of counties (out of 88) that reported utilization of CCBH funds in SFY 2010 for various other treatments. Counties may be providing these treatments through other funding sources, such as Medicaid.

**Figure 6**



## Responses to Open-Ended Questions

**QUESTION 3: Describe your county's model for planning, decision making and distribution of funds. Include in this description how you collaborate with your local Family and Children First Council and other community organizations, as applicable:**

Respondents were asked to describe their county's model for the collaborative planning, decision making, and distribution of the Children's Community Behavioral Health (CCBH) funds in SFY 2010. There were 90 respondents (88 CMH Boards + 2 ADAS Boards) answering this question. The open-ended results were reviewed and summarized, and results are presented below.

The over arching theme for this question indicated some form of collaboration with the local Family and Children First Council (FCFC) or a sub-committee of that council. One board area did report the inability to collaborate for determining CCBH funds use due to local Medicaid match demands.

Other community organizations are included in the county's model for planning, decision making and distribution of SOC/CCBH funds. These collaborative efforts are different for each county, but include such organizations as local Mental Health & Recovery Services (MHRS) Boards; Community Mental Health (CMH) Boards; Inter-Systems planning body; Executive Inter-Systems committee; ADAMHS Boards; Department of Job & Family Services; Juvenile Court, including probation officers and/or case managers; local schools and their districts, including School Mental Health Liaisons and/or Superintendents; DD (formerly MRDD); NAMI; local child and mental health providers; Educational Service Centers; Community Resource Teams (CRT); Board of Social Concerns; Finance Oversight Committee; Oversight Council; County Commissioners; FCFC Executive Committee and Administrative Council; as well as funders, families, advocates and other stakeholders.

This is a brief list of some of the community organizations that are or could be included in the planning, decision making and distribution of SOC/CCBH funds in SFY 2010. For more information or to see complete responses see *Appendix C*.

**QUESTION 4: Describe any noteworthy achievements accomplished with CCBH funds in your county this year:**

Respondents were asked to describe any noteworthy achievements that were accomplished with the use of the Children's Community Behavioral Health (CCBH) funds in SFY 2010. The open-ended results were reviewed and themes were recorded as presented below.

For more information or to see complete responses see *Appendix D*.

There were many notable achievements accomplished with CCBH funds in SFY 2010 for many of the counties throughout Ohio (see [Figure 7](#)).

Almost half of the respondents, 43.33% (39/90 respondents), reported a significant reduction, or complete evasion, in the number of out-of-home placements for children and families within their communities.

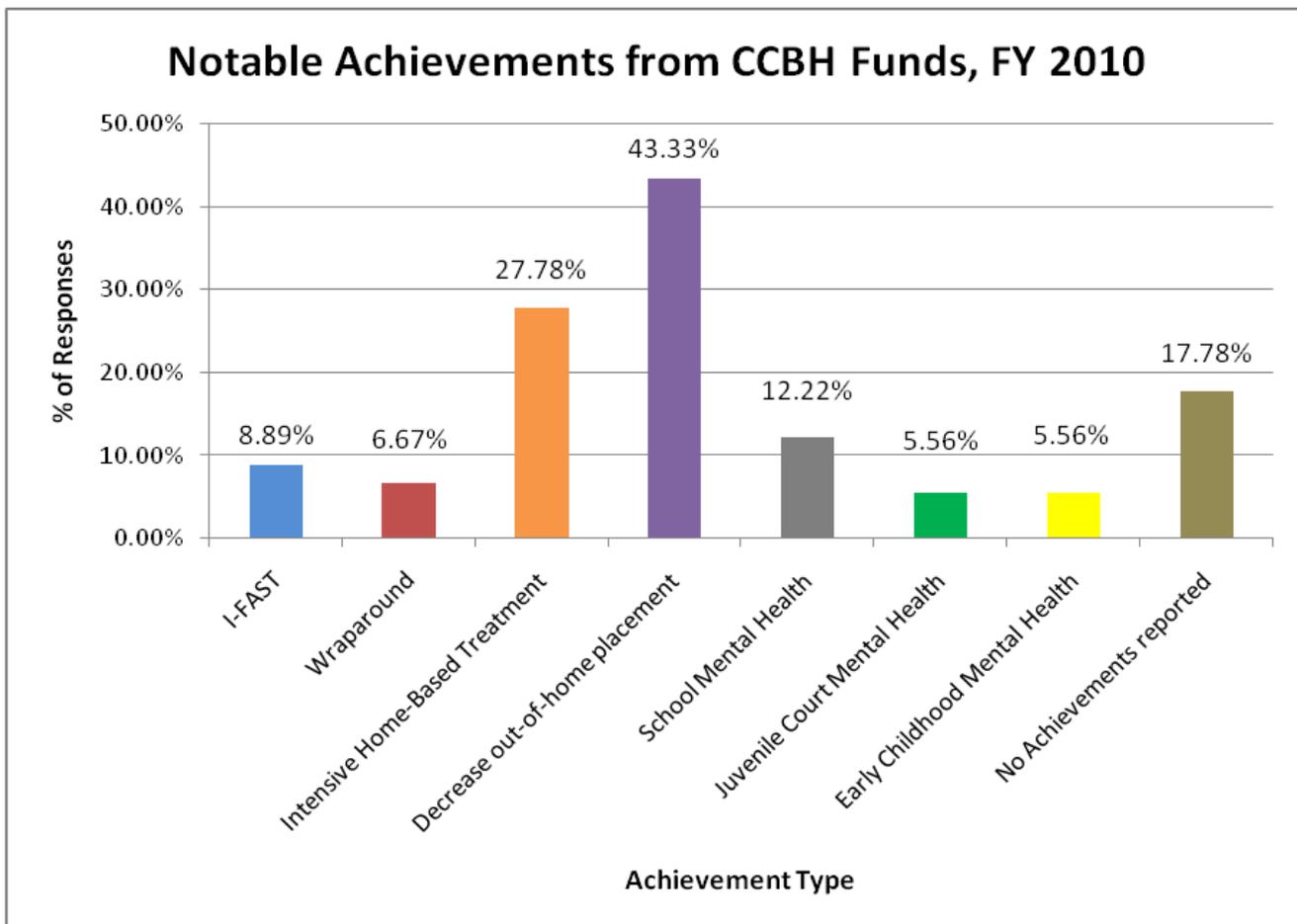
Many of the counties, 25 (27.78%), reported the utilization of Intensive Home-Based Treatment to alleviate out-of-home and/or residential placements for children and families within their communities.

Eleven respondents (12.22%) reported that they were able to provide, increase, or continue School Based Mental Health Services as a notable achievement accomplished with the utilization of CCBH funds in SFY 2010.

Other notable achievements accomplished with the utilization of CCBH funds for SFY 2010 included I-FAST (8.89%); Juvenile Court Mental Health (5.56%) or increased communication/cooperation from the Juvenile Court system; Early Childhood Mental Health treatment (5.56%); and Wraparound services (6.67%).

Sixteen (17.78%) of the ninety respondents did not report or had no notable achievements to report at this time.

**Figure 7**



**QUESTION 9: If ‘Other’ was selected in question 8, please specify:**

Respondents were asked to mark ‘yes’ or ‘no’ if they utilized CCBH funds for ‘other’ services within their area for Question 8. Their open-ended responses were recorded in Question 9, the responses will be discussed below. For more information or to see complete responses see *Appendix E*.

There were 34 counties (38.6%) reported usage of CCBH funds to provide ‘Other’ services to consumers and/or families within their area including Wellness Recovery Action Plan (WRAP), Integrated Family and Systems Treatment (I-FAST), respite and mentoring services, psychiatric evaluations, assessments, crisis intervention, adolescent sex offender programming, consultation, education, school-based mental health as well as juvenile court-based mental health and family peer support services (see [Figure 6](#) above).

## SUMMARY

The Children's Community Behavioral Health (CCBH) is a component of the SOC initiative and focuses on the provision of effective community treatment services needed to maintain children and youth (ages 0 through 17) in their homes and communities. **The priority population is children and youth who have intensive behavioral health needs and/or who are at risk of removal from an early care and education setting, or are at risk of removal from their homes or communities due to behavioral health issues.**

CCBH services are designed to be child-centered, family-driven, and are to be provided in the least restrictive environment to meet the treatment needs of the child or youth.

The Children's Community Behavioral Health (CCBH) funds distributed for SFY 2010 totaled \$6,540,953.27. Twenty-two (22.42%) percent of the total, \$1,466,249.07, was utilized for Medicaid match.

Through the utilization of CCBH funds many of the overnight out-of-home placements were diminished or avoided all together and other services such as Intensive Home-Based Treatment were provided to alleviate out-of-home placements. Almost half of the reporting counties stated that out-of-home placements were avoided or significantly decreased through IHBT. Fifty (50) counties, 56.8%, reported utilization of CCBH funds in SFY 2010 for Intensive Home-Based Treatment.

Many different treatments and therapies were provided throughout Ohio with CCBH funds in SFY 2010. These treatments helped to provide stability for children and families as well as giving them the opportunity to thrive in their own homes and communities. Without the availability of CCBH funds in SFY 2010 many counties reported they would not have been able to meet the behavioral health needs of their children and families.

## Appendix A

System of Care: Children's Community Behavioral Health (CCBH) Annual Report SFY 10 Questionnaire

### **System of Care: Children's Community Behavioral Health (CCBH) Annual Report**

**For July 1, 2009 through June 30, 2010**

**DUE AUGUST 14, 2010**

#### Instructions:

This report is the SFY Annual Report required to be submitted by the ADAMH/CMH/ADAS Boards. The report can be filed by the Board or its designee. A separate report must be filed for each county in multi-county Board areas. This report must include the amount of CCBH funds spent on Medicaid match in each county (not each Board area). The report must be filed electronically by August 14, 2010.

Please note as indicated in the Ohio Department of Mental Health's SSFY 2011 Community Allocation Guidelines dated June 28, 2010 on page 6, Boards will be eligible to receive their SSFY 2011 2nd and subsequent quarterly allocations contingent on filing the SFY 10 annual report by the required deadline. This report must be completed in its entirety. Any fields left blank will inhibit submission of the report.

If a field is not applicable, please enter "NA". When filling out this electronic form, please remember to click "Done" after completing. If you do not click "Done" the survey will not be sent to ODMH.

#### **1. CCBH Annual Report**

County name (Choose one. Please remember that a separate report is required for each county within a multi-county board area.):

Name of organization submitting report:

Name of individual submitting report:

Email address:

Phone number:

#### **2. Amount of CCBH funds spent in this county in SFY10:**

**3. Describe your county's model for planning, decision making and distribution of SOC/CCBH funds. Include in this description how you collaborate with your local Family and Children First Council and other community organizations, as applicable:**

**4. Describe any noteworthy achievements accomplished with CCBH funds in your county this year:**

**5. Were CCBH funds used to pay Medicaid match? If yes, how much?**

**6. Were CCBH funds used during SFY10 to provide early childhood mental health treatment in any of the following? Check either 'yes' or 'no' for each item below, as applicable:**

Play therapy

DINA small group therapy

Filial therapy

Trauma-focused cognitive-behavioral therapy

Parent-child interaction therapy

Therapeutic daycare/preschool

**7. Were CCBH funds used during SFY10 to provide out-of-home treatment overnight in any of the following? Check either 'yes' or 'no' for each item below, as applicable:**

Therapeutic or treatment foster care

Residential treatment facility licensed by ODMH (or certified by ODMH to provide mental health services on-site)

Psychiatric hospital

**8. Were CCBH funds used during SFY10 to provide any of the following? Check either 'yes' or 'no' for each item below, as applicable:**

Intensive home-based treatment

Multi-systemic therapy

Functional family therapy

Mental health services provided in schools

Co-occurring mental health and substance abuse treatment

Substance abuse treatment

Other

## Appendix B

### Utilization of Children’s Community Behavioral Health (CCBH) Funds in SFY10

County/Board Area	CCBH funds spent for this county/Board area in SFY 10	CCBH funds used for Medicaid match	Percentage of CCBH funds used for Medicaid match
Allen	\$88,297.00	\$55,106.00	
Auglaize	\$38,059.00	\$23,752.00	
Hardin	<u>\$25,881.00</u>	<u>\$16,152.00</u>	
	\$152,237.00	\$95,010.00	62.41%
Ashland	\$45,487.00	\$0.00	0%
Ashtabula	\$72,656.00	\$66,019.13	90.87%
Athens	\$62,845.00	\$3,993.04	
Hocking	\$33,914.00	\$2,159.33	
Vinton	<u>\$24,798.00</u>	<u>\$76.63</u>	
	\$121,557.00	\$6,229.00	5.12%
Belmont	\$74,935.33	\$12,583.35	
Harrison	\$24,551.45	\$0.00	
Monroe	<u>\$21,056.22</u>	<u>\$0.00</u>	
	\$120,543.00	\$12,583.35	10.44%
Brown	\$45,038.00	\$20,727.00	46.02%
Butler (ADAS)	\$38,243.00	\$0.00	0%
Butler (CMH)	\$76,487.00	\$65,424.00	85.54%
Clark	\$73,037.00	\$17,500.00	
Greene	\$79,182.00	\$39,199.73	
Madison	<u>\$30,142.00</u>	<u>\$23,559.91</u>	
	\$182,361.00	\$80,259.64	44.01%
Clermont	\$76,085.00	\$0.00	0%
Columbiana	\$71,758.00	\$0.00	0%
Crawford	\$23,506.45	\$11,820.95	
Marion	<u>\$70,185.55</u>	<u>\$21,709.43</u>	
	\$93,692.00	\$33,530.38	35.79%
Cuyahoga	\$685,779.00	\$0.00	0%
Defiance	\$39,860.61	\$8,935.20	
Fulton	\$39,860.61	\$8,935.20	
Henry	\$32,791.99	\$6,300.08	
Williams	<u>\$31,537.58</u>	<u>\$9,177.52</u>	
	\$144,050.79	\$33,348.00	23.15%
Delaware	\$73,146.00	\$0.00	
Morrow	<u>\$10,930.00</u>	<u>\$0.00</u>	
	\$84,076.00	\$0.00	0.00%
Erie	\$56,339.00	\$47,820.00	
Ottawa	<u>\$30,338.00</u>	<u>\$18,433.00</u>	
	\$86,677.00	\$47,820.00	55.17%
Fairfield	\$55,482.00	\$0.00	0%

County	CCBH funds spent for this county in SFY 10	CCBH funds used for Medicaid match	Percentage of CCBH funds used for Medicaid match
Franklin	\$458,172.35	\$0.00	0%
Gallia	\$45,016.56	\$45,016.56	100.00%
Jackson	\$48,228.40	\$48,228.40	
Meigs	<u>\$33,206.04</u>	<u>\$33,206.04</u>	
	\$126,451.00	\$126,451.00	
Geauga	\$46,140.00	\$0.00	0%
Hamilton	\$382,568.00	\$0.00	0%
Hancock	\$45,220.00	\$0.00	0%
Huron	\$46,947.00	\$46,947.00	100.00%
Jefferson	\$61,226.00	\$0.00	0%
Licking	\$91,732.00	\$77,736.00	87.55%
Knox	<u>\$20,664.00</u>	<u>\$20,664.00</u>	
	\$112,396.00	\$98,400.00	
Logan	\$41,017.01	\$0.00	0%
Champaign	<u>\$39,960.99</u>	<u>\$0.00</u>	
	\$80,978.00	\$0.00	
Lorain (CMH)	\$85,221.00	\$0.00	0%
Lorain (ADAS)	\$42,610.00	\$0.00	0%
Lucas	\$256,327.00	\$0.00	0%
Mahoning	\$140,731.00	\$3,688.52	2.62%
Medina	\$57,913.00	\$0.00	0%
Miami	\$51,651.83	\$13,292.55	18.04%
Darke	\$42,774.91	\$6,205.02	
Shelby	<u>\$41,168.26</u>	<u>\$4,967.26</u>	
	\$135,595.00	\$24,464.83	
Montgomery	\$242,262.00	\$169,583.40	70.00%
Muskingum	\$102,283.00	\$11,306.00	22.69%
Coshocton	\$41,994.00	\$18,400.00	
Guernsey	\$45,629.00	\$0.00	
Morgan	\$9,992.00	\$9,468.00	
Noble	\$13,789.00	\$1,396.00	
Perry	<u>\$38,792.00</u>	<u>\$16,709.00</u>	
	\$252,479.00	\$57,279.00	
Portage	\$65,733.00	\$0.00	0%
Preble	\$36,450.00	\$17,525.11	48.08%
Putnam	\$35,132.13	\$3,948.03	11.24%
Richland	\$76,776.00	\$76,776.00	100.00%

County	CCBH funds spent for this county in SFY 10	CCBH funds used for Medicaid match	Percentage of CCBH funds used for Medicaid match
Ross	\$53,479.77	\$32,225.06	
Pike	\$48,163.11	\$33,311.58	
Pickaway	\$40,695.27	\$27,001.50	
Fayette	\$34,146.32	\$32,252.52	
Highland	<u>\$47,744.53</u>	<u>\$43,792.96</u>	
	\$224,229.00	\$168,583.62	75.18%
Scioto	\$66,414.19	\$54,835.27	
Adams	\$18,724.23	\$18,724.23	
Lawrence	<u>\$88,788.58</u>	<u>\$60,185.05</u>	
	\$173,927.00	\$133,744.55	76.90%
Seneca	\$40,293.00	\$19,530.97	
Sandusky	\$61,591.00	\$31,613.34	
Wyandot	<u>\$15,838.00</u>	<u>\$5,520.75</u>	
	\$117,722.00	\$56,665.06	48.13%
Summit	\$213,845.00	\$0.00	0%
Trumbull	\$112,245.00	\$38,630.50	34.42%
Tuscarawas	\$58,800.00	\$44,000.00	
Carroll	<u>\$37,439.00</u>	<u>\$4,869.78</u>	
	\$96,239.00	\$48,869.78	50.78%
Union	\$33,920.00	\$0.00	0%
Van Wert	\$57,302.19	\$10,181.26	
Mercer	\$23,817.15	\$10,202.15	
Paulding	<u>\$16,941.66</u>	<u>\$8,825.16</u>	
	\$98,061.00	\$29,208.57	29.79%
Warren	\$49,494.00	\$0.00	
Clinton	<u>\$43,325.00</u>	<u>\$0.00</u>	
	\$92,819.00	\$0.00	0.00%
Washington	\$50,701.00	\$50,701.00	100.00%
Wayne	\$71,935.00	\$0.00	
Holmes	<u>\$41,224.00</u>	<u>\$0.00</u>	
	\$113,159.00	\$0.00	0.00%
Wood	\$51,973.00	\$0.00	0%
<b>TOTAL</b>	<b>\$6,318,376.27</b>	<b>\$1,612,416.47</b>	<b>25.52%</b>

**Appendix C**  
**Open-ended response to Question 3: Planning, Decision Making & Collaboration**

Allen	Allen County utilizes the local FCFC as part of the planning process for distribution of SOC/CCBH funds. The Mental Health & Recovery Services Board works with FCFC and Family Resource Centers (children's agency) to determine annual needs for treatment services for these populations. Proposals and program structures are developed through the Board's Program Feasibility Analysis (PFA) process which describes the program/services to be offered, the target number served, projected cost per participant, and includes a series of logic models to measure outcomes. These outcomes and milestones are measured quarterly and reported to the Board quarterly and SOC/CCBH constituents at least annually.
Auglaize	Auglaize County utilizes the local FCFC as part of the planning process for distribution of SOC/CCBH funds, through the intersystem process and the ECMH subcommittee. The Mental Health & Recovery Services Board works with FCFC and Family Resource Centers (children's agency) to determine annual needs for treatment services for these populations. Proposals and program structures are developed through the Board's Program Feasibility Analysis (PFA) process which describes the program/services to be offered, the target number served, projected cost per participant, and includes a series of logic models to measure outcomes. These outcomes and milestones are measured quarterly and reported to the Board quarterly and SOC/CCBH constituents at least annually.
Hardin	Hardin County utilizes the local FCFC as part of the planning process for distribution of SOC/CCBH funds. The Mental Health & Recovery Services Board works with FCFC and Family Resource Centers (children's agency) to determine annual needs for treatment services for these populations. In Hardin County, the agency works closely with the Kenton City Schools and the Hardin County Educational Services Center to identify needs and targeted locations. Proposals and program structures are developed through the Board's Program Feasibility Analysis (PFA) process which describes the program/services to be offered, the target number served, projected cost per participant, and includes a series of logic models to measure outcomes. These outcomes and milestones are measured quarterly and reported to the Board quarterly and SOC/CCBH constituents at least annually.
Ashland	While the Board took the lead in the planning process, both the provider agency and FCFC had input into the existing needs and the best mechanism (including intervention model) to meet those needs. The need for Intensive Home Based Services remains in the county. The Board, FCFC and Appleseed Community Mental Health Center (Provider) all agree that an intensive home-based model is critical to help those at-risk youth and families. Appleseed has worked intensively with David Grove from the Family Therapy Institute of Columbus to implement the Integrative Family and Systems Treatment (I-FAST) model. This model was seen as a "good fit" for the need in the county and provider agency implementing the service.
Ashtabula	The MHRS Board representative to the FCFC Service Coordination Team (SCT) outlines the parameters of the funding each SSFY. The SCT and the Board plan for use of the funds to meet the behavioral health needs of Non MCD eligible youth that come through the SCT process who need intensive and/or targeted clinical services to meet their identified needs. The child/family are opened to the SCT process and monitoring. This also gives the family access to state FCFC funds to meet the respite/family stability needs that emerge as the child and family move through the process. The SCT agrees that should they not be expending the funds in a manner that would ensure that all of the funds are expended on services for Non Medicaid children during the SSFY, the Board will expend some of the funds near the end of the SSFY to cover the Medicaid costs of Medicaid eligible children receiving intensive behavioral health services in the community. The SCT feels very strongly that these funds need to be reserved for services to children receiving services in their own home, in their own community or as part of a plan to reunify a child with his/her family. Thus, the funds are not used to pay for out-of-home placements.
Athens	Athens County follows the state requirements for the service coordination mechanism of the Family and Children First Council. This mechanism is developed at the local level through the Inter-Systems planning body. It is approved by the full council and implemented through Inter-Systems coordination and wrap around family teams. All children who receive funding through CCBH funds must be approved by the Executive Inter-Systems committee of the full council. This guarantees local decision making with administrative oversight. The local ADAMHS Board is a member of all of the participating committees. Children must be approved and receiving services through the inter-Systems cluster before requesting access to CCBH funding. Each child's family must be participating in a wrap around team approach to care as prescribed in the service coordination mechanism. The team can request funding for services that are approved by CCBH. The Inter-systems committee approves, modifies or denies access to CCBH funds dependent on the nature of the request. Emergency procedures are in place within the system to respond to emergency requests. The intersystem's Executive Committee has final approval for the placement or treatment decision. The ADAMHS Board participates at every level of the decision making process, except for the individual family teams (the ACFCFC coordinator participates on all family teams where

	CCBH funding is requested. Confidentiality issues are honored in all family team sessions.
Hocking	The Hocking County Family and Children First Council's executive committee determines the usage of the CCBH funds. Members collaborate as a committee to determine the greatest needs for the children we serve. The Board actively participates in decisions around the best use of these funds with community partners. The Board allocates the majority of its CCBH funds to the council to support the needs of the most difficult children in our system.
Vinton	Vinton County Family and Children First Council members and the representative from the Athens-Hocking-Vinton 317 Board came together to discuss the use of the funds for youth in Vinton County High School. There has been a real need for access to a mental health professional in the high school during the school day. These young people may never seek help outside of school hours due to a variety of factors. These factors may include the stigma of being seen at a mental health facility, fear of parents, or a lack of transportation to access services. The use of these funds to extend access to mental health services in the school two hours a day has been well received by the local educational system. more than 350 student contacts were made and viable linkages to other support services as well as the mental health system has provided valuable help to many students in need in Vinton County.
Belmont	We continue to utilize the managed care approach that has worked successfully for us for the last several years. Our service coordination team consists of a representative from the Mental Health and Recovery Board, DJFS, Juvenile Court, Developmental Disabilities, school districts, local child serving agencies, local mental health providers, the Family and Children First Service Coordinator and family/advocates. This team functions as a sub-committee of the Belmont County Family and Children First Council. All decisions regarding a child's placement in a residential facility and the length of the child's stay in the facility are made as a group. This approach has allowed us to control expenditures and leverage our dollars in order to maintain other community services for children/adolescents.
Harrison	We continue to utilize the managed care approach that has worked successfully for our community for the last several years. Our services coordination team consists of a representative from the Mental Health and Recovery Board, DJFS, Juvenile Court, Developmental Disabilities, school districts, local child serving agencies, local mental health providers, the Family and Children First Service Coordinator and family/advocates. The team functions as a sub-committee of the Harrison County Family and Children First Council. All decisions regarding a child's placement in a residential facility and the length of the child's stay in the facility are made as a group. This approach has allowed us to control expenditures and leverage our dollars in order to maintain other community services for children/adolescents.
Monroe	We utilize the managed care approach that has worked successfully for our community in Monroe County for the last several years. Our service coordination team consists of a representative of the Mental Health and Recovery Board, DJFS, Juvenile Court, other local child serving agencies (as appropriate to an individual case ), local mental health providers (as appropriate), school districts, the Family and Children First Services Coordinator and the family/advocate. The service coordination team functions as a sub-committee of the Family and Children First Council. All decisions regarding a child's placement in a residential facility and the length of stay of the child in the placement are made by the group. This approach has allowed us to control expenditures and leverage our dollars in order to maintain other community services for children/adolescents.
Brown	Brown County contracted \$20,000 with our provider Talbert House dba Brown County Recovery Services. These funds are to be utilized for the Non-Medicaid population of children and families who are at risk of removal from their homes or from their educational setting. The remaining \$25,038 is utilized by the Board to pay for services for children who are being "clustered" by the Family and Child Team in conjunction with OFCF. These monies are used for Medicaid match, evaluations, partial hospitalization, and residential placement if all other options are exhausted and other services deemed necessary by the Family and Child Team to meet the needs of these children and their families. In Brown County the Family and Child Team consists of members from the ADAMHS board, DJFS, Developmental Disabilities, schools, Brown County Educational Service Center, Brown County Recovery Services, and Juvenile Court.
Butler (ADAS)	The Resource Management Committee of the Butler County Family & Children First Council (comprised of the directors of the agencies providing funding for the provision of specialized multi-need services to specially identified children and their families and funding for the operational expenses of the Butler County Family & Children First Council) reviews possible uses for CCBH funds and endorses the use of CCBH funds provided to the Butler County ADAS Board for outpatient addiction treatment services for multi-need youth. The ADAS Board is a mandated and active member of the Butler County Family & Children First Council. The ADAS Board executive director is currently serving as vice-chairperson for the Council.
Butler (CMH)	The Board's Executive Director is an active member of the Executive Committee of the FCFC which recommended to the FCFC Administrative Council to utilize SOC/CCBH funds to provide service

	<p>coordination as a part of the Community Wraparound. Also, a portion of the funds is regulated by a multi-system collaborative known as the Community Resource Team (CRT). CRT is comprised of representatives from each child serving system along with a parent representative. Board staff actively participates in the FCFC Administrative Council Meetings and auxiliary committees.</p>
Clark	<p>The model is a partnership between and among Clark FCFC member agencies. Mental Health &amp; Recovery Board (MHRB) provides leadership and facilitates this planning process. SOC/CCBH funds are coupled with local funds committed by other FCFC member agencies. MHRB contracts with the provider agencies on behalf of Clark FCFC and is the fiscal agent. IHBT services continue to be provided through MHRB contract with Oesterlen Services for Youth. The MHRB facilitates planning and coordinating of IHBT services with community cross-system stakeholders. The group meets at least quarterly and reviews extensive outcomes data, program developments (including effectiveness and efficiencies), policies and procedures for the IHBT program.</p>
Greene	<p>For the past three years, the Mental Health &amp; Recovery Board (MHRB) has awarded System of Care, CCBH funding to Integrated Youth Services (IYS). IYS was Greene County's only stand-alone youth community behavioral health provider. Over the past three years, IYS worked closely with the Greene County Family and Children First Council and the MHRB to improve access to treatment services for families with children 0-6. This early childhood group has been identified by a variety of community stakeholders as needing additional treatment and supportive services. Thus, FCFC, MHRB, and IYS provided leadership in early identification and referral to treatment services for families in need. Because of budget cuts and the current economic environment, the IYS Board, in collaboration with the MHRB, decided to cease operations June 30. Youth services have since transitioned to the adult behavioral health provider, TCN Behavioral Health Services, Inc. The youth division is named Family Solutions Center. In the future, MHRB will work with Family Solutions Center, in collaboration with FCFC, to distribute SOC/CCBH funds.</p>
Madison	<p>The model is a partnership among the Mental Health &amp; Recovery Board (MHRB), Mental Health Services for Madison County, and Madison County Family Council member agencies/stakeholders. MHRB provides leadership and facilitates this planning process.</p>
Clermont	<p>In Clermont County, CCBH funds are targeted to multi-need children and youth with behavioral health disorders across all child-serving systems. The funds are used to provide supports and services to maintain the child in the community or to return a child to the community following an out of home placement. The Clermont County Mental Health &amp; Recovery Board is the Administrative Agent for the Family and Children First Council. FCF Council works collaboratively with local agencies to develop a plan for use of these funds, and that plan is approved annually by Council. In SSFY 2010, FCF contracted with Camelot Community Care to provide intensive home-based treatment. Any agency or parent/guardian is able to make a referral to determine eligibility to access CCBH services. FCF accepts the referrals, determines eligibility, establishes service delivery and tracks outcomes of children receiving CCBH funded services.</p>
Columbiana	<p>The Columbiana County Mental Health &amp; Recovery Services (MHRS) Board is the administrative agent for our local Family &amp; Children First Council, and we are co-located. The use of CCBH funds in SFY 2010 were based on priorities included in the MHRS Board strategic plan and Community plan, as well as those in the FCFC planning process. Information on needs was obtained from formal needs assessment of key informants and from mandated members of the FCFC. Based on the ODMH SFY 2010 guidelines for use of these funds for primarily clinical services, both the MHRS Board and the FCFC formally voted to allocate a major portion of these funds to support intensive home-based services for high risk youth and families, with a lesser amount directed to providing mental health services in the schools. The Mental Health &amp; Recovery Board contracted with the Counseling Center of Columbiana County to provide both of these services under this grant. The Counseling Center is an active member of the Family &amp; Children First Council, participating in both Mandated (monthly) and General member (bi-monthly) meetings, as well as sub-committees as appropriate.</p>
Crawford	<p>In Crawford County, we use the wraparound process to assist families at risk for an out of home placement. If wraparound is not successful, we then bring the case to the attention of the Family and Children First Clinical Team. The team meets at least quarterly with our provider agency, Community Counseling Services, Family and Children First, and other child serving systems such as Children's Services, Juvenile Court, MRDD, Capstone Alternative School and other schools. We spend time at each meeting staffing cases of children at risk for out of home placement or those who are preparing to return to the community and/or their biological family. The process allows us to identify early those children at risk for being placed outside the home and find ways to wrap services around the family to keep the family intact. All child serving agencies have someone designated to participate in wraparound and/or the clinical team.</p>
Marion	<p>In Marion County, we use the wraparound process to assist families at risk for an out of home placement. If wraparound is not successful, we then bring the case to the attention of the Family and Children First Clinical Team. The team meets once a month with our provider agency, Marion Area Counseling Center,</p>

	Family and Children First, and other child serving systems such as Children's Services, Juvenile Court, MRDD, and schools. We spend time each month staffing cases of children at risk for out of home placement or those who are preparing to return to the community and/or their biological family. The process allows us to identify early those children at risk for being placed outside the home and find ways to wrap services around the family to keep the family intact. All child serving agencies have someone designated to participate in wraparound and/or the clinical team.
Cuyahoga	The planning method on behalf of children, youth, and families is through the "Service Coordination Team" (SCT) mechanism, which is governed through Family and Children First Council (FCFC). FCFC convenes all child-serving systems and community partners to develop a seamless entry way for children and families to access formal and informal supports. Community partners and agency providers participate in team meetings to determine the needs of youth and their families to efficiently and effectively meet their needs.
Defiance	The funding supported intervention and a treatment gap in services was allocated to each of our counties based on a director's meeting with agencies, F&CF Directors, ADAMHs Board. The decision was based on a collaborative plan to service coordination needs. This process has been in place the past years.
Fulton	The funding supported intervention and a treatment gap in services was allocated to each of our counties based on a director's meeting with agencies, F&CF Directors, ADAMHs Board. The decision was based on a collaborative plan to service coordination needs. This process has been in place the past years.
Henry	The funding supported intervention and a treatment gap in services was allocated to each of our counties based on a director's meeting with agencies, F&CF Directors, ADAMHs Board. The decision was based on a collaborative plan to service coordination needs. This process has been in place the past years.
Williams	The funding supported intervention and a treatment gap in services was allocated to each of our counties based on a director's meeting with agencies, F&CF Directors, ADAMHs Board. The decision was based on a collaborative plan to service coordination needs. This process has been in place the past years.
Delaware	The CCBH funds were used as originally determined in the ABC Base Plan when it was first developed. The decision on how best to use these funds was made by the Delaware County Interagency Youth Cluster which is a subcommittee of the FCFC.
Morrow	The CCBH funds were used as planned and determined in the original ABC Base Plan. This plan was developed in partnership with the Morrow County Interagency Youth Cluster which is a sub committee of the FCFC. This provides partial funding for the Mental Health School Liaison position serving all four county school districts, which requires collaboration with the districts and all the community social service agencies.
Erie	The Board participates on the Family and Children First Council in Erie and Ottawa Counties. Public forums are held at least twice a year to obtain other stakeholders and community residents input into the perceived needs of the community. The Board also attends various meetings at the courts, job and family services, and other social service agencies to coordinate client funding needs.
Ottawa	The Board participates on the Family and Children First Council in Erie and Ottawa Counties. Public forums are held at least twice a year to obtain other stakeholders and community residents input into the perceived needs of the community. The Board also attends various meetings at the courts, job and family services, and other social service agencies to coordinate client funding needs. In Ottawa County the Board also participates on the Board of Social Concerns that is a monthly meeting of all social service organizations in Ottawa County.
Fairfield	The Fairfield County FCFC Executive Cluster Pooled Fund was developed in 2003 to maximize the use of flexible resources. The Pool is in its seventh year of operation, after approximately fifteen years of dividing the costs of treating and housing at-risk youth between the Fairfield County Juvenile Court, Fairfield County Developmental Disabilities, Child Protective Services and the ADAMH Board. In addition to spending large amounts of local dollars on a handful of children, the majority of these funds were devoted to supporting out-of-home placements. In the last seven years' utilization of the pooled approach, Fairfield County has developed and funded local, more cost effective services that are also more effective for children and their families. These include: Juvenile Court-based Mental Health Intervention; Home-based Family Mental Health Treatment; Family Support Services. Other services paid through the pooled fund include: Specialized intensive services, including out of home placements; respite; supportive services. The Executive Cluster Pooled Fund will include item 335-404 Treatment (Behavioral Health), FCSS and contributions from Pooled Fund partners (Juvenile Court, Board of DD, ADAMH Board and Fairfield County Job and Family Services.) funds in the decision processes utilized to manage the Executive Cluster Pooled Fund. By utilizing categorical funding to support the services indicated in individual service coordination plans, all funds can be maximized according to their own purposes and target population. The Fairfield County ADAMH Board has empowered the Fairfield County Executive Cluster to determine the annual use of Children's Behavioral Health (404 Treatment) funding allocated to the county. The development and support of local services to reduce out-of-home placements has been the

	<p>priority. The annual county allocation of Family Centered Supports and Services funds are included in the MSY Committee budget planning and are utilized for respite, mentoring and other supportive services that support a child and family's Family Service Coordination Plan. Day to day decisions regarding the use of those funds within the prescribed parameters are made by the MSY Coordinator on a case by case basis.</p>
Franklin	<p>The local Family and Children First Council coordinates the Oversight Council, Cabinet, and Finance Oversight Committee for the purpose of collaboration, communication, planning, decision-making and distribution of SOC/CCBH funds in Franklin County. The Cabinet consists of the CEO's of the major organizations and funders, such as ADAMH, DD, FCCS, Juvenile Courts, Franklin County JFS, Columbus Public Schools, Health, United Way, which has greatly improved the collaboration in this County in terms of the youth and families needing multi-systemic service coordination. The Oversight Council also includes representatives of County Commissioners in addition to the representatives above, and provides direction to the other "working" committees and Cabinet. We collaborate with the FCF Council through this process in order to maximize coordination and communication to provide the best and appropriate services to the youth and families who are served by many or all of the entities represented on the Cabinet.</p>
Gallia	<p>This Board had no opportunity for collaborative planning for utilization of these funds due to the demand for Medicaid match. The increasing demand from out of county Medicaid providers required that the entire amount be designated as match. The Family &amp; Children First Council was fully informed regarding the rules and processes for behavioral health Medicaid. Both this Board and the local FCFC agree that Medicaid services should be managed and monitored locally in order to assure that locally defined priorities are served with these funds.</p>
Jackson	<p>Although a report was provided to the FCFC regarding the use of these funds, Medicaid rules prevented us from engaging in a collaborative planning process. The increasing presence of out-of-county providers, as well as our inability to locally monitor efficacy, required that all funds be designated to Medicaid match.</p>
Meigs	<p>Although a report was provided to the FCFC regarding the use of these funds, Medicaid rules prevented us from engaging in collaborative planning. The increasing number of out-of-county providers, as well as our inability to locally monitor efficacy of treatment, required that all funds be designated as Medicaid match.</p>
Geauga	<p>The Board contracts with our mental health center to provide continuity of care for children and their families. The program works closely with the Family and Children First Council. The council has three committees, multi-disciplinary, screening, family stability, that are involved in case review, recommendations and referrals. All three committees make referrals to the In-home Based Treatment Program. In addition the Council has funded part of the treatment for the clients who do not have the means to pay. This is done on a case by case basis. The In-Home program conducts a staffing for each case at least every 30 days. Invited to the staffing are other professionals involved with the family. This could include probation officers, the case coordinator for the Family and Children First Council, school personnel, other treatment providers, CASA (court appointed special advocate), Job and Family Services case workers and family members. These staffing are crucial to the case coordination and developing supports for the families. They are typically well attended and appreciated by all.</p>
Hamilton	<p>The Hamilton County Family Peer Support (FPS) Program is made possible through Ohio Department of Mental Health SOC/CCBH funding and local dollars of the Hamilton County Mental Health and Recovery Services Board, and is provided in partnership by Talbert House and Beech Acres Parenting Center. The Hamilton County Behavioral Health Transformation Plan was created as the result of collaborative meetings between the Hamilton County Family and Children's First Council, Hamilton County Mental Health Board, Hamilton County Alcohol and Drug Services Board, Hamilton County Jobs and Family Services, Hamilton County Juvenile Court, Hamilton County MR/DD Board, behavioral healthcare providers, funders, and family organizations. Through these planning meetings, it was proposed that having a Family Peer Support person at the point of early intervention in the school setting would be a means of prevention and/or better access to help the child and family access the right services at the right time without the need for out of home placement or custody relinquishment. Talbert House and Beech Acres Parenting Center were identified as the agencies to implement the FPS because of their demonstrated experience in recruiting, training and supporting family peer persons. The FPS Program's focus is to successfully and effectively support families who have a need for behavioral healthcare services through early identification and supportive advocacy. Many of these families are involved with the child welfare, juvenile justice and educational system. The FPS Program works to intervene early and identify needs and connect families with the "right-sized" service. When families can access needed behavioral healthcare services swiftly, custody relinquishments and/or out of home placements can be avoided. The initial pilot of this program involved hiring and training ten FPS staff who have "walked the walk" with their own children. These FPS staff were trained to walk "hand-in-hand" with the families of the identified children as they negotiate the various systems/services including schools, social services, juvenile court, community services, self help groups, and other naturalistic supports. In 2009, the Hamilton County Family and Children First Council and Hamilton County Mental Health and Recovery Services Board</p>

	<p>convened meetings to reaffirm the achievements of the FPS Program. Through these discussions, the effectiveness of the FPS Program was expanded to provide services in three additional Family and Children First Schools (Sharpsburg Elementary School, Rothenberg Preparatory Academy, and Taft Elementary). In total the FPS Program operated in 18 schools within Hamilton County, with a variance of neighborhoods from inner city to suburban neighborhoods. Ohio Department of Mental Health SOC/CCBH and HCMHRSB funds were utilized to cover staff and program expenses for each of the 18 targeted schools. Each school has one lead FPS staff, who serves as the primary provider and contact at the school for parents, school staff and community partners. This lead FPS staff is supported by additional team members who bring content knowledge, community resources and systems coordination to the program. The team works together in managing referrals, planning/implementing events and sharing their expertise- even to the point of working with a parent at another school if there is a need based upon a particular staff's experience/strengths. Referrals to the FPS Program were received by school personnel, agency staff or community partners. Outreach activities and events were conducted within the schools as a means to clarify the availability of the program as well as the potential needs of the parent community. Parental access to these funds were also available through wrap around/flexible dollars that were used to address any potential barriers or needs that existed as parents sought behavioral healthcare services for their child and/or family. Essential activities that were provided as components of the FPS Program are as follows: Peer Support - walking hand in hand with parents, offering encouragement, peer support and follow up; Network Building - opportunities to connect parents to other parents and create partnerships with school/community agency personnel through groups, roundtables, seminars, trainings, etc.; Resource Identification and Networking – creation of a collection of resources and establishment of community and systems partnerships that serve as networks of support for staff and parents; The goal is to assist parents with readily available information to create and maintain a support system of usable resources; Resource Connection - assistance to parents with navigating and accessing resources; Provide follow up to ensure resources are obtained and utilized; Parental Engagement (Voice) – ensure that parents are involved at system events and planning; Parent Resource/Family Peer Support Center - the program has partnered with school sites to develop a parent resource center serving as a community clearinghouse of information and as a means to enhance access to the program by parents and staff; Each resource center is equipped with a computer kiosk for internet access and many resources.</p>
Hancock	<p>These funds supported MST and Intensive-home based services. The local Family First Council has a subcommittee, the Family Stability Committee, which reviews all requests for out of home placements as well as monitors youth in placement. This committee has all the child placing agencies on its composition and includes city and county school representation. The MST program fidelity reports and waiting lists for MST and the Intensive home-based program are also reported to this group. Generally, MST referrals are made by the court.</p>
Huron	<p>To make decisions about prioritizing use of these funds, the processes available at both the county's FCFC and the ADAMHS Board were utilized. Both of these entities had this matter reviewed by their Planning Committees and full Boards. The ADAMHS Board juxtaposed the programmatic priorities presented against its severe budget cuts. The Planning Committee of the FCFC included superintendents of the largest school system in the county, the ESC and the DD Board, as well as parent representatives, the DJFS Children's Services Administrator, the FCFC Coordinator and the ADAMHS Board Director, who chairs that committee. Hence, there was significant input by the major county family and children serving systems in use of these funds. With most youths in treatment qualifying for Medicaid due to the significant economic distress of this county (i.e., Huron County had the highest unemployment rate in Ohio for a period of time), using these funds for Medicaid-reimbursable outpatient mental health treatment services provided to Medicaid-eligible youths, prioritizing those most at risk of out-of-home placements, was decided upon as well as Medicaid-reimbursable treatment services provided to Medicaid-eligible youths in residential treatment facilities, as those costs had to be paid by Ohio's ADAMHS/CMH Boards. Utilization of funds in this way allowed the Board to retain some funds for non Medicaid-eligible youths and some for non Medicaid-reimbursable services. Without these funds, the full continuum of care for youths would not have been available.</p>
Jefferson	<p>Collaboration with the Jefferson County FCFC and Jefferson Co. Juvenile Court occurred on a regular basis. Any at-risk youth were sent for an assessment to identify any treatment needs or referral/eligibility for other community resources. Additionally, there was regular contact with the social educators (placed at 3 of the 6 school districts in the county) to identify any multi-need youth and families. Any subsequent services were structured to meet the individual needs of the client/family.</p>
Lake	<p>Our system continues to work collaboratively with the Lake County Family and Children First Council, our county's primary child/adolescent behavioral health provider, Lake County Department of Jobs and Family Services, our Juvenile Court, Lake County MRDD and education to evaluate the needs of children/adolescents and their families. The entities meet monthly to evaluate the effectiveness of funds invested and to prioritize services to children/adolescents with the highest level of need. If and when</p>

	residential placement is necessary, the organizations work together to ensure that placement is as short as possible and appropriate services are in place for a smooth transition back into a community setting. Whenever possible, the organizations work to find and fund appropriate alternatives to residential placement.
Licking	Through the Licking County CFFC planning process we determined the need for a position to facilitate intersystem team planning and meetings for children, youth and their families at risk of out of home placement. This position of Inter-system Team Facilitator was created and is housed with the LCCFFC fiscal agent. 404 funds are being used to support a portion of this position. We are blending funding from United Way and a local foundation grant for this position.
Knox	We have worked with both the Knox and Licking Council's to determine the best mechanism to use these funds. At the conclusion of the ABC Blueprint project the Knox County FCFC determined it was most important to use these funds to help provide basic treatment services to children and youth for CPST, Counseling and Psycho Pharm Management.
Logan	The MHDAS Board is represented at FCFC and at a variety of other collaborative subcommittees of the FCFC. In these meetings there is opportunity to discuss gaps in services, need for increased capacity in current services and outcomes of services. In these meetings, as well as, in meetings with the provider agency we were able to look at what services are being requested frequently and which of those services were not adequately funded already with Board dollars or other sources of funding that would allow us to meet a community need by either increasing the capacity or providing for a service gap. In addition to the feedback received from community partners, the Board also considered making sure that the focus supported priorities that were established in the Community Plan document.
Champaign	The MHDAS Board has representation at FCFC and at a variety of other collaborative subcommittees of the FCFC that meet regularly. In these meetings, there is opportunity given to discuss gaps in services, need for increased capacity in current services as well as satisfaction and outcome of the services. In these meetings, as well as individual meetings, with the provider agency we were able to look at where the requests for services are concentrated and of those things which ones are not adequately funded already by the MHDAS Board or other sources of funding that would allow us to better meet a community need. In addition to the feedback received from community partners, the Board also considered making sure that the focus supported priorities that were established in the Community Plan document.
Lorain (ADAS)	The distribution of funds and the calibration of the "services mix," is determined through the Boards Community Plan Process. Information relative to needs and service priorities arise through various venues including- but not limited to: Executive Director meetings, Program Directors Meetings, Community That Cares (Planning Process- Prevention), Community Corrections Board, Intersystem Partnership, Analysis of available data (claims, BH, Outcomes, Census, etc.). Family and Children's First Council is an active participant in Communities that Care. Once priorities are clarified - the ADAS Boards releases Request for Information Packets for area providers. RFI submissions are reviewed by the ADAS Board and funds fund distribution is garnered via a resolution process within the Board Committee Structure.
Lorain (CMH)	Lorain County Board of Mental Health (LCMHB) utilized the SOC/CCBH funds to address two populations of high risk youth; those under five with emerging mental health symptoms and those at risk for out of home placement. With SOC/CCBH Funding, LCMHB was able to support early childhood interventions with families of children under five who demonstrated emotional and behavioral symptoms beyond what is developmentally appropriate (and possibly suggestive of emerging mental health concerns). In addition to in-home filial therapy, young children and their families were given the opportunity to participate in Parent Child Interaction Therapy. On the other end of the spectrum, a larger portion of grant funds were used to support the provision of Intensive Home Based Treatment (IHBT) for youth at risk of out of home placement. SOC/CCBH grant funds allowed for youth who lacked Medicaid to receive high quality IHBT services from Beech Brook. This program was recognized as among the best in Ohio when it was funded by ODMH two years ago. By providing high intensity services to the youth at highest risk and early intervention services to those young children with emerging mental health issues, LCMHB was able to respond to the systems needs. Theses services compliment the array of prevention services that have been supported through the Children's and Families First Council of Lorain County.
Lucas	For SFY 2010 the Lucas County Child and Family First Council decided to continue to combine the CCBH and FCSS funding streams in order to continue to offer the FAST\$ program, which provides supportive services, parent advocacy, and wraparound services to youth at risk of out of home placement and their families. As a part of Lucas County's continuum of care, the FAST\$ program fills a gap between traditional community based behavioral health care services (medication management, office and home-based therapies, crisis stabilization) and the very intensive service coordination for very high risk, multi-need youth and families provided by Lucas County's Family and Children First Council, with the intent to reduce the need for the more intensive services and supports, including out-of-home placement. In fiscal year 2010 (FAST\$ 10), NAMI of Greater Toledo continues to be the administrator of the FAST\$ program, broker and fiscal agent for services, and provider of parental support and parent advocates. Lucas County

	<p>divides the FAST\$ program into two sections- Supportive and Intensive. FAST\$ 10 had 50 slots in the Supportive section for individual children and 25 slots in the Intensive section for families. Both Supportive and Intensive sections receive supportive services for the identified children. Parents in both sections were offered Parent Advocates through NAMI Ohio's PAC model, with NAMI of Greater Toledo serving as regional parent advocacy coordinator for Lucas County, responsible for recruiting, training, and supervising Parent Advocates. Intensive Families also participate in a wraparound modeled planning process facilitated by the Family Care Manager (position is CCBH funded) and have access to funds for non-traditional family interventions (also through CCBH funds). Each referring agency had a predetermined number of slots to fill for both supportive and intensive sections, and each slot had a cap on the amount of money that could be spent on services. NAMI of Greater Toledo staff collaborated with individual children's treatment teams (including the family, the child, behavioral health clinicians, and representatives from other systems relevant to the child such as Lucas County Juvenile Probation, Lucas County Children's Services, and Lucas County Board of Developmental Disabilities) to prioritize the recommendations for supportive services provided at referral, assist the team in budgeting the allocated money for services, set up and maintain services for the child and family, and make necessary revisions to services as indicated by the team. Oversight of Lucas County's FAST\$ program is provided through monthly meetings attended by NAMI of Greater Toledo, Lucas County Mental Health and Recovery Services Board staff, Lucas County Family and Children First Council staff, representatives of referring agencies, and other community behavioral health agencies. Lucas County Family Council has decided to move the current inter-system coordination model from a traditional Cluster model to a Wraparound model using the FAST\$ Program as a foundation on which to build. The implementation was targeted to begin 07/01/10. Therefore, the decision was made to continue utilizing the combined CCBH and FCSS funds which provides supportive services, parent advocacy, and wraparound services to families until that time.</p>
Mahoning	<p>The Directors of both the Mental Health Board and Alcohol and Drug Addiction Services Board agreed to combine the funding received by the two boards. The Mental Health Board established contracts for: mental health services for indigent crisis kids; substance abuse treatment and clinical intervention for youth; and psychiatric and counseling services. The remainder of the funding was directed to the service coordination mechanism to pay for the services families may require through service coordination. A Service Coordination Steering committee, composed of representatives from Children Services Board, Mental Health Board, Alcohol and Drug Addiction Services Board, Juvenile Court, MR/DD, and Family and Children First Council (FCFC) meet monthly to review and monitor the service coordination mechanism. FCFC Administrator discussed availability of funding and its allowable usage at FCFC Advisory Council meetings, Executive Committee meetings, Service Coordination Steering Committee meetings, and on council list serves. Mahoning County Family and Children First Service Coordination Mechanism works with local providers to offer families a continuum of services. A team works with the family to create a Family Service Coordination Plan that outlines measurable goals, tasks required to complete goals, team member responsibility, outcomes and timelines. Natural supports and services / funding available through the various state and local agencies are utilized first. CCBH, FCSS and RECLAIM fund services in the Family Service Coordination Plan that are not able to be provided by natural supports or state and local agencies. Requests for use of funds are received by FCFC Service Coordination staff who assess criteria / restrictions of funds, match fund to service and / or family, estimate costs per child, approve invoices, track expenditures / outcomes, and work with fiscal agents for accountability. If, for any reason, needed services or supports are not available, team members brainstorm creative solutions and a member will be selected to address the gap in service. Reports regarding service coordination activities and outcomes are reported to the FCFC Planning Committee and Executive Committee for consideration, feedback, and utilization in other planning efforts.</p>
Medina	<p>The Medina County ADAMH Board made the decision to distribute the SOC/CCBH funds to Solutions Behavioral Healthcare, Inc. as Solutions is the primary child/adolescent agency in the county. In SFY10, Solutions developed the Family Intervention Response Team (FIRST) which offers Intensive Home Based Treatment (IHBT), Community Psychiatric Supportive Treatment (CPST), and Family Resource Specialists (social-recreation) designed to work with families whose youth are identified as severely emotionally disabled and who 1) are at risk of out-of-home placement, and/or 2) are transitioning back home from out-of-home placement, and/or 3) require intensive services to stabilize in the community. With the addition of the FIRST program, Solutions is a "One Stop Shop" who is able to provide MH and AOD outpatient treatment (including the Medina County Juvenile Drug Court program and IOP for adults) and psychiatric services from early childhood into late adulthood, so as to minimize the splintering of care. Solutions CEO is the current chair of the Family and Children First Council. Also, Solutions is an active member of the Inter-Collaborative Assessment Treatment Team (both on the Clinical and Administration side) which is Medina County's service coordination mechanism. Solutions also is an active participant in the Mid-CAT and Senior ICAT Teams, in addition to participating in the Family Assistance Coalition</p>

	<p>Team, Share Cluster, and Youth Violence Task Force. Solutions also actively collaborates with: 1) Medina County Schools providing prevention and intervention services; 2) Medina County Juvenile Court providing treatment services for youth involved in traditional probation or in the specialized Juvenile Drug Court Program and Family Resource Court; 3) Medina County Job and Family services proving a liaison staff, along with providing treatment services; 4) Medina Municipal Court providing a therapist; and 5) Medina County Domestic Relations Court providing supervised visitation.</p>
Miami	<p>The Tri-County Board of Recovery &amp; Mental Health Services in coordination with the Miami Co. FCFC and its community partners are responsible for the planning, decision making, and distribution of SOC/CCBH funds. During the first six months of SFY10, the Miami Co. FCFC redesigned their service coordination mechanism plan. By January 2010, the Miami Co. wraparound team had been established. With this re-design, CCBH funds were transitioned from purchasing in home coaching to purchasing intensive home based mental health treatment services for the most at risk families being served by the Wraparound program. Currently this funding has the capacity to support 14 families receiving intensive home based mental health treatment services by two licensed therapists. To date, the intensive home based treatment providers have been at maximum capacity and there is discussion on how to fund additional in home treatment providers. The priority families being referred to intensive home based treatment services are families whose children are either at imminent risk of out of home placement or whose children are being transitioned back into their home from an out of home placement.</p>
Darke	<p>The Tri-County Board of Recovery &amp; Mental Health Services in coordination with Darke County FCFC and its community partners are responsible for the planning, decision making, and distribution of SOC/CCBH funds. As in past years, the Darke co. FCFC has utilized their CCBH funds to support intensive home based treatment services recommended by the Intersystem Diversion Team (IDT). The Intersystem Diversion Team (IDT)'s mission is to be a value-driven service commitment to the family to improve quality of life and reduce stressors so parents can focus on the needs of their children. It is collaboration between Darke County Education Service Center, Health Department, Job and Family Services, Juvenile Court, Mental Health Clinic, MR/DD Board, Recovery Services, Family Health Services Inc., Gateway Youth Programs/CORSP, Greenville Schools, Family and Children First Service Coordinator, IDT Facilitator, and the parent/legal guardian. The IDT process provides: Risk Assessment; Identification of relevant resources; Development of a Family Service Plan with recommended interventions and individuals responsible; Service Coordination to team and family members; Wrap-Around support with flexible funds; and Promotion of active family participation in problem-solving. A Family Service Plan is written with the parent during the meeting. Responsibility for recommended interventions and time frames to address the recommendations are identified on the FSP. The IDT Facilitator contacts the parent when the referral is received to schedule the core team meeting; to review the consent to share information and to review parent concerns, needs, and strengths. Composition of Family Team meetings is identified at the core team meeting. Family teams include the parent, direct services and family support system.</p>
Shelby	<p>The Tri-County Board of Recovery &amp; Mental Health Services in coordination with Shelby County FCFC and its community partners are responsible for the planning, decision making, and distribution of SOC/CCBH funds. As in past years, the Shelby Co. FCFC has utilized their CCBH funds to support intensive home based and treatment services recommended by the Diversion Assessment Team (DAT). DAT is comprised of a MRDD support services assistant, Shelby Co. School &amp; Court Liaison, Intensive Children's Community Support Specialist from Shelby Co. Counseling, an outpatient therapist from Catholic Social Services, an advocate from the Gateway for Youth Program (Council on Rural Services), the Director of Special Education from Sidney Local Schools, the Chief Probation Officer from Shelby Co. Juvenile Court, the project director from the Help Me Grow program at Shelby Co. Health Department, the Shelby Co. Children Services Administrator, and the director of Family and Children First Council. The mission of the collaboration is to prevent a referral to Children's Services and keep families together by providing necessary wraparound family centered services for at risk children who without intervention would likely be removed from their home. The services include intensive home based treatment services, respite, in home coaching, academic tutoring, transportation, therapeutic services, parenting, and at times childcare when funding permits.</p>
Montgomery	<p>The ADAMHS Board released an Request for Information to three child serving mental health treatment agencies, that has been actively participating in the county-wide Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) Steering Committee, to submit a Service Description that is consistent with the county's priorities intervention for children/adolescents that their caregivers. These priorities included: a) Early Childhood Mental Health Treatment. b) Trauma focused Care and c) Community and Home Based services. The countywide Trauma Focused CBT Steering Committee is a collaboration between the ADAMHS Board and the Office of Family and Children First Council and other community organizations, i.e., Children Services, Wright State University/School of Professional Psychology, Children Medical Center, Artemis Center, Care House, etc. The three agencies (DayMont Behavioral Health Care, Samaritan</p>

	Behavioral Health and South Community) submitted service descriptions that were approved by the ADAMHS Board of Directors for funding from October 1, 2010 through June 30, 2010. Each agency was allocated \$80, 754 to target Children Services referrals, Child Care providers referrals, Medically Indigent families, School referrals, Juvenile Court referrals and ICAT referrals (not to include out-of-home placements in residential care).
Muskingum	The Board's Child and Family Services Coordinator is actively involved with the Family & Children First Councils and the Creative Options Committees in our six county area. Funds in Muskingum County were used for a variety of services. Residential Services were for youth referred from Children Services and Juvenile Court \$36,510. Home Based Services both from Creative Options referrals and other referrals to avoid Creative Options if possible \$49,481. The remaining funds were spent on Medicaid Match \$11,306 and non Medicaid \$4,986.
Coshocton	The Board's Child and Family Coordinator is actively involved with the Family and Children First Councils and the Creative Options Committees in our six county area. Unfortunately some of the funds had to be used for Medicaid Match and non Medicaid case management. Some funds were used for residential services. When a placement is made Juvenile Court and Children Services are involved.
Guernsey	The Board's Child and Family Services Coordinator is actively involved with the Family & Children First Councils and the Creative Options Committees in our six county area. In Guernsey County the funds were used for residential services and home based.
Morgan	The Board's Child and Family Services Coordinator is actively involved with the Family and Children First Councils and the Creative Options Committees in our six county area. In Morgan County all the fund were used for Medicaid Match and non Medicaid case management.
Noble	The Board's Child and Family Services Coordinator is actively involved with the Family and Children First Councils and the Creative Options Committees in our six county area. Most of the funds in this county were used for home based services for cases referred through the Creative Options process.
Perry	The Board's Child and Family Services Coordinator is actively involved with the Family and Children First Councils and Creative Options Committees in our six county area. For Perry County \$17,596 was spent on residential services, \$16,907 on Medicaid and \$4,289 on non Medicaid. The residential services were for referrals from Children Services.
Portage	Collaboration for planning and coordination of the CCBH funds occurred between the Mental Health and Recovery Board of Portage County, Portage County Department of Job and Family Services, and Portage County Board of Mental Retardation and Developmental Disabilities (now the Portage County Board of Development Disabilities). The result of this collaboration was the decision to utilize the funds to assist in the payment of out-of-home services for children who are involved in multiple systems, are still in custody with their parents, and who were presented and discussed at the Interagency Clinical Assessment Team (ICAT). ICAT is a clinical group under the Portage County Family and Children First Council. These funds helped keep children in the custody of their parents while assisting in the purchase of needed residential, group home and/or therapeutic foster care (per diem costs only). The funds were shared equally between the three groups listed above.
Preble	Board staff met with the FCFC Executive and Finance committees to discuss appropriate uses of the CCBH funds. The final recommendation for utilization of the funds was presented to the full FCF Council and Preble County Mental Health & Recovery Board prior to final allocation. Due to system cuts for SFY10, it was determined that funds would best be used to fund mental health treatment for youth. The majority of funds were allocated to Samaritan Behavioral Health, Inc. the sole ODMH certified mental health treatment provider in Preble County. Additional funds were allocated in CPE as match for youth treatment services to ODMH certified treatment providers outside of Preble County.
Putnam	The model for planning, decision making, and distribution of SOC/CCBH funds that Putnam County is currently following is the Family & Children First Council Service Coordination Mechanism. Under this model, the Wraparound program provides a family-focused level of care and community based service coordination to families with chronic or unmet needs. Wraparound facilitators work with individual families to build up natural support systems, link to appropriate community resources, encourage collaboration with other community organizations involved with the family, and to strengthen the family bonds. All families served through Wraparound are monitored by the Family Coordination Team on a monthly basis. Team membership may include FCFC Coordinator, FCFC Chair, ADAMHs Board representative, juvenile court representative, children's service representative, Educational Service Center representative, and a county school psychologist.
Richland	Due to reductions from other line item, The Board elected to direct all SOC/CCBH funds to cover the Medicaid Match portion for those youth enrolled in the Multi-Systemic Therapy (MST) program. This program has been jointly supported by the Family and Children's First Council, The Board, Children Services and Juvenile Court. We felt that this was the only way to continue to fund MST in its entirety and allow MST to avoid financial reductions faced by other programs.

Ross	Kathy Wolfe, the Cluster Coordinator of Ross County’s Family and Children First Council have an office in the Child Development Center (CDC) located on the campus of Ohio University’s Chillicothe Campus. The CDC is also the home of several Head Start pre-school classrooms. Having Kathy present in the building enables quick response when a child is identified as potentially in need of mental health services. We have developed a good working relationship in referring children to Cluster (not limited to pre-school children) and in doing so, access to and referral for services are expedited.
Pike	The Family and Children First Council meet, at least monthly. Scioto Paint Valley Mental Health Center case managers attend all meetings that deal with coordination of services for clients of the Center (or for potential clients of the Center). The team – which includes the parents and any representative of an agency involved with the family – meet to address the problems and create the plan for addressing these problems.
Pickaway	Scioto Paint Valley Mental Health Center clinicians routinely meet with “Team for Youth” of our Family and Children First Council to staff high risk youth and to “wrap” services around the family. I-FAST case managers conduct home visits and school visits and share this information with the youth’s clinical team at Team for Youth. Generally these meetings are monthly and referrals are facilitated during those meetings. In cases that are emergent, the Team for Youth meet as needed.
Fayette	Cluster meets the first Friday of every month August – June. All agencies send a representative for their organization. (Not all attend). Referrals can be made by an agency or organization or individual. Referral forms are made available to be filled out. Ellen Barrett is the chairperson and helps many people with information and referral.
Highland	The Highland County Family and Children First Council meet on a monthly basis and the Cluster (Youth Collaborative Group) meets on the first Wednesday of the month. The Family & Children First Council discusses the various services, any changes, and hope to improve and facilitate referrals. During the Cluster meeting, there may be discussions on a particular case and how the agencies involved might work together to meet the needs of the child and his or her family.
Scioto	In order for a child or agency to access funding from CCBH the child/agency has to have active case plan involving services from more than one agency. That plan is reviewed by Creative Solutions and the Review Team to see if there are other funding options. The case is recommended for funding from CCBH and sent to the Administrative Sub Committee for final expenditure of funds. Providers bill the Council on a monthly bases and the Council submits itemized bills to the ADAMHS Board.
Adams	The Adams County Family Children First Councils Service Coordination Committee made suggestions for the type of services needed. Requests were put out and contracts were set in place.
Lawrence	Lawrence County Family Children First Council has various committees that meet monthly to discuss the needs and service gaps of our youth in our county. The committee members are from various mental health agencies, MR/DD, parent reps., DJFS, and other child serving agencies. The committees plan and collaborate on how to spend the allocated CCBH funds. The committees then bring these needs before the council for discussion and a vote of approval.
Seneca	The Mental Health and Recovery Services Board of Seneca, Sandusky & Wyandot Counties (Board) and Firelands Counseling & Recovery Services (FCRS), a provider agency, actively participate on community committees in an effort to collaborate with the Family & Children First Council and other community organizations such as Juvenile Court, DJFS, school personnel, faith-based representatives and family representatives. The Board and FCRS participate on committees that have addressed the HB 289 requirements, the Family & Civic Engagement/HB1 process and currently the Shared Planning Process. As part of this participation, both the Board and FCRS share and evaluate data on youth and families in order to assess county needs particularly in regards to behavioral health issues. They also assist with determining gaps in services. These processes have contributed to the determination to implement home-based services in Seneca County and to provide Incredible Years programming.
Sandusky	The Mental Health and Recovery Services Board of Seneca, Sandusky & Wyandot Counties (Board) and Firelands Counseling & Recovery Services (FCRS), a provider agency, actively participate on community committees in an effort to collaborate with the Family & Children First Council and other community organizations such as Juvenile Court, DJFS, and school personnel. The Board and FCRS participate on committees that have addressed the HB 289 requirements, the Family & Civic Engagement/HB1 process and currently the Shared Planning Process. As part of this participation, both the Board and FCRS share and evaluate data on youth and families in order to assess county needs particularly in regards to behavioral health issues. They also assist with determining gaps in services. These processes have contributed to the determination to implement home-based services in Sandusky County and to provide Strengthening Families programming.
Wyandot	The Mental Health and Recovery Services Board of Seneca, Sandusky & Wyandot Counties (Board) and Firelands Counseling & Recovery Services (FCRS), a provider agency, actively participate on community committees in an effort to collaborate with the Family & Children First Council and other community organizations such as Juvenile Court, DJFS and school personnel. The Board and FCRS participate on

	committees that have addressed the HB 289 requirements, the Family & Civic Engagement/HB1 process and currently the Shared Planning Process. As part of this participation, both the Board and FCRS share and evaluate data on youth and families in order to assess county needs particularly in regards to behavioral health issues. They also assist with determining gaps in services. These processes have contributed to the determination to implement home-based services in Wyandot County.
Stark	Stark County continues to prioritize our service coordination model with leadership from our Stark County Family Council. The Service Coordination Committee (SCC), which is comprised of our child serving system executives, meets twice monthly to discuss system issues and barriers and to problem solve gaps in services. Each of the executives appoints a clinician or administrator from their system to serve on the Service Review Committee (SRC) that meets weekly to review funding and placement recommendations that emerge from the individual family teams. Family Council’s Wraparound Supervisor also serves in a clinical review role to assure that children in residential placement are receiving the right services for the right duration in collaboration with their families and local providers. The information gathered and the progress of children in placement is reported to the SRC and referrals to Hi Fidelity Wraparound are made as needed to assist with integration back into the community. Hi Fidelity Wraparound continues to be the primary service within Stark County’s Service Coordination Mechanism. Family Council is home to 1 FTE Hi Fidelity Wraparound Supervisor, Three Hi Fidelity Wraparound Facilitators (1 of them is funded by Family Court), and 1 FTE Family Support Specialist. The family support component of the Wraparound Department is made available as needed to families that do not meet the threshold for Wraparound, but have significant issues that would benefit from family support. Family Council also utilizes NAMI and PAC as needed for parent advocacy needs. Capacity for Hi Fidelity Wraparound services has increased in the past 2 years with the addition of a Hi Fidelity Wraparound Supervisor and a Hi Fidelity Wraparound Facilitator at Community Services of Stark County, Inc., one of our mental health provider agencies which focus on serving youth with significant mental health challenges. This provider is billing Medicaid for a portion of the cost.
Summit	Families and Children receive services from the Family and Children First Council primarily through the Cluster, which is a collaborative of 12 child and family serving agencies in the county. Needs are assessed by the Cluster partners which include the Summit County ADM Board/Child Guidance & Family Solutions, Children Services, Juvenile Court, and DD. There are also members represented by schools, health departments, and substance abuse, DYS, The ARC and Children’s Hospital. The Cluster is supervised by the FCFC director and adheres to the County Service Coordinator plan. Services are funded primarily through local pooled dollars in addition to FCSS: SOC funds. Agencies also enter into collaborative funding agreements between each other to meet children’s needs either through out of home placement or wraparound services. Target populations are: children, ages birth through twenty one years old, at risk for out of home placement; youth with behavioral/mental health needs who are returning to the community from placement; and youth and families who are in need of community based, wraparound, services in order to strengthen the family and maintain the youth in the community. Referrals for parent mentors, if the parent wants it, to help support the family in navigating agencies and resources is also a priority for the Cluster. Met needs include successful collaboration and prioritizing of “at risk youth”, particularly those multi-need youth requiring intervention such as residential placements or intensive wraparound services to prevent or following out-of-home placement. Family advocacy/parent mentoring has been met with a partnership with Mental Health America’s PEERS program. Summit County recently became a HOME Choice provider and has been able to link youth to that program for case management and also receive funding that will be used for supportive services to maintain children in their home. Unmet needs include funding for additional staff/resources to expand the county FCFC’s service coordination mechanism, a more preventative model of addressing youth and family concerns prior to a need for placement out of the home or into Children Services custody. There is only one System of Care coordinator for the county to address this need. There are also only 2 Cluster coordinators to provide service coordination for the whole county. There is a continuing need for mentors for youth and respite. These are very costly services and help maintain the child in the home and stabilize/support the family. Programming also included the operation of an Integrated Co-occurring Treatment Program (ICT) for Co-Occurring Disorders. This program is a collaborative effort of Child Guidance and Family Solutions (CG&FC), the Family and Children’s First Council (FCFC), the Summit County Juvenile Court, the Mental Health America and the University of Akron. The principle target populations are those youth with a diagnosable mental illness and identified substance abuse problem. Primary referral sources include Crossroads/Juvenile Court and CG&FS.
Trumbull	Wraparound is the method chosen locally for providing service coordination in Trumbull County and the Children’s Community Health Care funds were an important component of providing services contained in Wraparound plans. In close consultation with the Trumbull County Mental Health and Recovery Board, it was determined that a portion of the funds would be used to support allowable services in Family Wraparound Plans and a portion would be used to provide the required Medicaid match for Trumbull

	<p>County children. Planning, decision making and distribution of these funds occurred through the Trumbull County Family Wraparound Oversight Committee, a standing committee of the Trumbull County Family and Children First Council. All mandated members of the Council, including a member of the Trumbull County Mental Health and Recovery Board, are represented on the committee. These committee members are committed to high-quality, creative solutions to complex family problems and they review plans and budget requests carefully during meetings. At the twice-monthly Wraparound Oversight Committee meetings, the members review new referrals, and conduct case reviews of enrolled families, reviewing and approving family service plans and budgets. The committee also provides additional suggestions to the teams and works to reduce barriers. During the business portion of the meeting, the committee engages in planning, review of resource utilization and policy development for Wraparound. The CCBH funds awarded to the Family Wraparound Oversight Committee by the Trumbull County Mental Health and Recover Board were used in combination with several other resources to create a pool of available funds used to support the county's Wraparound process. Other sources include FCSS, PRC and local contributions from child serving organizations. When financial resources are needed to support Wraparound plans, the Family Wraparound Oversight Committee relies on these available funds. The most appropriate funding source is chosen for services and ais often used in combination to support Wraparound plans.</p>
Tuscarawas	<p>Through the Tuscarawas County Family and Children First Council, we are able to identify strengths and areas to strengthen regarding our service delivery system. Council, along with the local child serving system, has placed as a priority maintaining the family unit when possible and safely appropriate. A concern identified through Council during the past few years is how to continue to deliver evidence-based practices to children and families both in a therapeutic setting and in natural environments to help maintain the child in his or her home. CCBH funding allowed for the opportunity for local clinicians to go to homes, schools, and other settings to provide treatment. The funding has also allowed Council and the ADAMHS Board to provide reimbursement for services to families who may have otherwise been unable to receive services, the specific types of clinical services (i.e. TF-CBT), or the amount of clinical services necessary to treat the issues that are impacting family stability. Local agencies that serve this population and have identified child and family stabilization as their priority have received CCBH funding.</p>
Carroll	<p>Due to Carroll County's rural location and economic difficulties, mental health treatment often falls low on families' priority lists. Through the Carroll County Family and Children First Council, this issue was identified as a significant concern for residents. To address this, the child-serving systems in Carroll County determined that a priority would be to serve children in their school buildings with the opportunity for the school mental health providers to travel to the homes. This decision was supported by the Council member agencies and a plan was developed for school based counselors. CCBH funding has been used primarily for this purpose as well as for office-based clinical interventions to maintain children in their homes when safe and appropriate.</p>
Union	<p>The Council for Union County Families has become the umbrella organization through which discussion, planning and decision making for programs and initiatives involving youth and families in Union County. A sub-committee of CUCF, previously known as Systems That Care group, is the specific body that oversaw the SOC/CCBH fund and made recommendations for how they were to be used. These funds (or similarly state funds) have been used to support the home-based therapy programs operated in the county by Consolidated Care, Inc. The decision to concentrate funding efforts to support home-based programs was made initially in 2000-2001 by the group that evolved into the Systems of Care (consisting of UCDJFS, UC Juvenile Court, Mental Health and Recovery Board and family Council), and an Multi-Systemic Therapy program was launched in late 2001. Additional funding was used in 2005 to start a Functional Family Therapy program, and over time, FFT proved to be a more effective fit for our county, leading to the ending of the MST program in 2007. The funds previously used to support the MST program were used to provide an intensive home-based program for families with younger children with serious mental health and behavioral concerns as well as an adolescent alcohol and drug treatment program. Currently, these programs remain supported by local funds, Medicaid reimbursements and state funds, including the SOC/CCBH funds. It is the intent of the CUCF and other county groups to continue to support such programs in order to best aid UC families.</p>
Van Wert	<p>Clinical tier meetings are held and treatment plan developed with family input. The plan is reviewed at the inter agency Service Coordination Committee. Members include Director of ADAMHS Board, DD Board, JFS Children s Services Supervisor, Juvenile Court Services/Probation Officer and School Reps. Decisions are made on case funding and demonstration of clinical progress reviewed monthly. This group provides input to the ADAMHS Board as to prioritization of use of these dollars and unmet service needs and existing service expansion. In SFY 08 a home based service was initiated in Mercer County thru this process. Dollars are initially allocated on a per capita basis after a subtracting an amount for encumbered residential dollars and required Medicaid match.</p>

Mercer	Clinical tier meetings are held and treatment plan developed with family input. The plan is reviewed at the inter agency Service Coordination Committee comprised of supervisors of primary children services agencies in county. Decisions are made on treatment plan funding and demonstration of clinical progress is reviewed on monthly basis. This group provides input to the ADAMHS Board as to service priorities, or unmet service needs. In SFY 08 a home based program was developed, designed, and initiated as part of this process. After an allowance is made for encumbered residential costs and required Medicaid Match a per capita distribution is allocated to each county for first 6 months.
Paulding	Clinical tier meetings are held and treatment plan developed with family input. The plan is reviewed at the inter agency Service Coordination Committee. Members include Director of ADAMHS Board, DD Board, JFS Children’s Services Supervisor, Juvenile Court Services/Probation Officer, and School Reps. Decisions are made on case funding and demonstration of clinical progress reviewed at these monthly meetings. This group provides input to the ADAMHS Board as to prioritization of use of these dollars and unmet service needs and existing service expansion. In, SFY08 a home based service was initiated in Mercer County via this process. Home Based Services were reviewed in Van Wert and Paulding Counties in SFY10. Dollars are initially allocated on a per capita basis after allowance for encumbered residential dollars and required Medicaid Match.
Warren	<p>Planning: The Warren County FCFC Clinical Committee is composed of representatives from WC Juvenile Court, WC Children’s Services, WC Board of Developmental Disabilities, Mental Health Recovery Services of Warren &amp; Clinton Counties (MHRSWCC), and is managed through WC Educational Service Center’s Coordinated Care Division (contract entity for Warren County’s Service Coordination functions). This group makes funding decisions for children primarily through the utilization and monitoring of a pooled fund. Likewise, the committee plans for the utilization of the CCBH funds. For SFY 10, the funds were designated for Intensive Home Base Services (IHBS), as they have been in the past, and written into the provider’s contract with MHRSWCC for direct clinical services. Decision-Making: In the Family Service Coordination meetings, the family along with involved service providers determines the best matrix of services appropriate for the child’s needs. This frequently includes IHBS. When this is the case, a referral is made for these services and funded through the provider’s contract with MHRSWCC. The Warren County FCFC Clinical Committee meets on a monthly basis to review cases. Distribution: MHRSWCC serves as the fiscal agent for the CCBH funds. The IHBS provider bills for services through MACSIS and this is applied to the CCBH funds for all non-Medicaid children and for non-Medicaid billable services. MHRSWCC has made a decision not to use CCBH funds for Medicaid match at this time (due to the time and labor intensive work it would require to calculate this). This fiscal year, the demand for IHBS (non-Medicaid billable clients and services portion) was lower than the historical utilization, thus the remaining funds were able to be used for overages in the area of Early Childhood Mental Health Treatment and School-Based Mental Health Treatment (for non-Medicaid billable clients and services). Both these service categories have expanded so rapidly, the service provision was well above what was provided in previous fiscal years. This is contributed to an expanded contract with Head Start for on-site services, a successful Early Childhood Mental Health Consultation program, as well as additional public schools receiving for school-based services. These are seen as a preventative measures so a child does not progress to the point of requiring IHBS.</p>
Clinton	<p>Planning: The Clinton County FCFC Case Review Team is composed of representatives from CC Juvenile Court, CC Children’s Protective Unit, CC Board of Developmental Disabilities and Mental Health Recovery Services of Warren &amp; Clinton Counties (MHRSWCC). This group makes funding decisions for children seen for service coordination. Likewise, the team plans for the utilization of the CCBH funds. For SFY 10, the funds were designated for Intensive Home Base Services (IHBS). Decision-Making: The Clinton County FCFC Case Review Team meets on a monthly basis to review cases. When IHBS is recommended and agreed upon by the team, CCBH monies were approved on a case by case basis for use for the cost of non-clinical wrap around services associated with the provision of IHBS. Distribution: MHRSWCC serves as the fiscal agent for the CCBH funds. The IHBS provider invoiced for the services on a per diem rate, this was approved by the FCFC Service Coordinator, and then the invoice passed to MHRSWCC for payment directly to the provider.</p>
Washington	Executive Director is member of local Family and Children First Council. All CCBH funds used to help pay for Medicaid eligible services provided to children, including those referred by the local F&CF Council.
Wayne	As an active partner of the Wayne Family and Children’s First Council, the Wayne-Holmes Mental Health and Recovery Board allocates funds to Wayne FCFC to be overseen by the Wayne FCFC Diversion Team, for the purposes of serving Wayne County children with behavioral health concerns. The Wayne County FCFC Diversion Team reviews all Child Community Behavioral Health referrals, and verifies the services to be provided and confirms that all referrals also receive Service Coordination in conjunction with other behavioral health services. Those services include: Behavioral Health Aide, Case Management Services, Home Based Intervention, Out Patient, and Psychiatric Services. The Diversion Team oversees all out of

	home placements, and strives to support and maintain children in their home and community before out of home placements are required. CCBH funds are used primarily for community based intervention, and then, when required have been used to help fund the mental health portion of jointly funded out of home treatment.
Holmes	Holmes County FCFC continues to prioritize intensive community and home-based services to improve family functioning and prevent out of home placement. Both county FCFCs have pooled a large segment of their CCBH funds (proportionate to county and youth population) in order to provide home-based intervention services to families in their respective counties. This HBI professional meets with and reports to the Holmes County Service Funding Committee as part of our service coordination efforts. Holmes County FCFC is also kept updated on CCBH activities. Required revisions to the Holmes County Service Coordination Mechanism were approved in July 2010 and include ORC 121.37 and FCSS-required collaborative pieces, as well as family self-referral and PAC. All HCFCFC member agencies, as well as area agencies are involved in CCBH, as applicable.
Wood	Decisions are made through the Family Children First Council, in open sessions. Members include; courts, parents, JFS, Education, MH and BH providers for children and adults, a County Commissioner, Developmental Disabilities, County Health Dept., and others are representative of FCFC. Decisions are made through collaboration and cooperation among the members.

**Appendix D**  
**Open-ended response to Question 4: Noteworthy Achievements**

Allen	Allen County implemented Dinosaur School as part of the evidence-based The Incredible Years program. The Dinosaur Child Training Program includes: Making New Friends and Learning School Rules Understanding & Detecting Feelings; Detective Wally Teaches Problem Solving Steps; Tiny Turtle teaches Anger Management; Molly Manners Teaches How to be Friendly; Molly Explains How to Talk with Friends; Dina Dinosaur Teaches How to Do Your Best in School
Hardin	Services were offered to several schools in Hardin County, working with young children on site.
Ashland	Appleaseed clinicians and case managers continue to receive good training from David Grove from I-FAST. We are half way through our training and I believe that we are starting to see some solid results. Some clinicians are not holding onto families as long as they used to and the time of discharge is starting to indicate a shorter stay than when we first started the program. Although there is no data at this time, it is anticipated that data collecting will begin when the training has ended sometime in August. We are hearing positive reports from the schools on clinicians who are attempting to reach out to teachers, principles, etc. for those families served at Appleaseed. The family systems paradigm is also being taught to a few adult therapists and case managers who are beginning to conceptualize cases with the I-FAST mindset. More recently, in a meeting with adult parole officers in Ashland some excitement was generated when they learned that Appleaseed is taking a systems approach toward treating families. They are interested in the prospect of applying the I-FAST model to those people who are on parole and have identified mental health concerns. As a result of this meeting, there will be another meeting with Judge Woodward, to see if a program can be created to fit the needs of the court that also seems to be family oriented. In addition, the director of the IDDT program now sees the value and place for the I-FAST approach and I am meeting with him to discuss ways to incorporate it within this model. With the I-FAST paradigm, we are learning to get people in and out of treatment in a shorter amount of time. This allows for less need to maintain clients (as in the old traditional model) and due to higher quality there is less of a need to replace clinicians who may leave the agency. In a nutshell, I believe that we are becoming "leaner and meaner" and rising to the challenge of cutbacks and budgetary constraints in the current economic environment. Another struggle, is working more closely with the juvenile court and with JFS. Greater communication and linkages have occurred with front line workers but there continues to be a need to connect with the administrative authorities to elicit support and greater buy-in for the program. I anticipate that this will happen over time. The School Liaison Program has helped sell the I-FAST model to teachers and the community which means there is greater buy-in from liaisons who have seen beneficial results. Appleaseed's Clinical Director will be in contact with other I-FAST sites in the state in order to see how they organized themselves to become blue ribbon sites.
Ashtabula	The SCT was able to continue to fund intensive in home services for youth and their families who were not Medicaid eligible and did not have the means to pay for such an intensive service. Families were able to stabilize and children were able to maintain with regular outpatient intervention. Additionally, the success of the intensive in home philosophy has led to recent developments with the county's child welfare agency. Over the past three months the county CSB has joined together with the MHRS Board, the FCFC SCT and an ODMH certified agency to reach out to the Center for Innovative Practices on IHBT to bring additional training and a solid evidenced-based model to the intensive in-home services. Our CSB has made a commitment to invest funds into using the IHBT process to reunify families, reduce out-of-home placements and bring children placed in out-of-county residential and foster care facilities back to the county. This will also allow us to focus the CCBH funds for SSFY 11 on these intensive services and monitor outcomes of the effort closely. Without the continued availability of these restricted funds to demonstrate the value of child focused, family centered treatment we would not be at this crossroads. Neither the MHRS Board nor the FCFC would have had the funds to continue this work without the CCBH dollars.
Athens	Up until the last quarter of the funding, only one child had received short- term residential placement. The goal for the county is to reduce residential placements and do a better job of serving the child in his or her own family. New treatment modalities in the county include Equine therapy, early childhood mental health and IHBT. The ACFCFC along with the college of medicine at Ohio University are implementing general training programs for trauma-based focused awareness for children. We would like to see more clinicians trained in trauma focused therapy.
Hocking	These funds helped to provide significant safe residential care for one of our most difficult children in our county. The child exhibited multiple self harming behaviors along with suicidal ideation.
Vinton	Increased access to mental health and other support services within the Vinton County school system.
Belmont	Through the cooperation of the Mental Health and Recovery Board, DJFS, Juvenile Court and

	Developmental Disabilities we not only shared the residential per diem cost but also share the Medicaid Match cost. This seems to be a unique funding arrangement which benefits our community in Belmont County.
Harrison	Through the cooperation of the Mental Health and Recovery Board, DJFS and Juvenile Court we continue to share the residential per diem cost.
Monroe	The children have been able to successful complete their school requirements and upon discharge from the residential placement they have been maintained in their local community.
Brown	We have been able to maintain several children in their homes that have been placed in out of home placements in the past. We have been able to help a few families receive comprehensive mental health evaluations for their children that weren't eligible for Medicaid but couldn't afford the assessment on their own. These assessments have led to an understanding of what services the children needed and what accommodations were needed in school settings.
Butler (ADAS)	The CCBH funds provided to the Butler County ADAS Board resulted in the provision of over \$38,000 of outpatient addiction treatment services for multi-need youth in Butler County.
Butler (CMH)	A family was considering placing their child into a residential facility due to his disruptive behaviors. CCBH funds were used to purchase intensive in-home services. As a result, the family was able to learn some new skills and the youth was able to remain in the home.
Clark	The IHBT program transitioned successfully from the licensed MST model and increased capacity to serve eligible families involved with Family and Children's Services. Caseload capacity was increased as well as the criteria expanded for eligible families. All outcomes became tracked by Oesterlen internally instead of relying on consultation services via MST Institute. Therapists also increased productivity. The IHBT program continues to strive for financial sustainability. An additional screening interview for eligible families assists program in prioritizing referred cases.
Greene	The SOC/CCBH funds served 117 children ages 0-6 and increased the level of service provided from SFY 2009 (by 515 units of service). Significant planning and collaboration occurred among stakeholders (including schools, families, FCFC, etc.), IYS Board, IYS staff, MHRB Board/staff, and TCN Board/staff to successfully transfer services from IYS to TCN by the end of the fiscal year. The goals were to 1) continue serving children and families with minimal disruption to clinical care; and 2) to preserve as many client-therapist relationships as possible. This process proved very successful in the short-term and the MHRB continues to monitor this progress.
Madison	Despite budget cuts, increased use of CCBH funds in Madison County (compared to SFY2009) helped maintain similar numbers of children and teens served in SFY2010 (221 youth) as SFY2009 (229 youth). The mix of children and teens changed somewhat with more teens being served and fewer children in SFY2010 compared to SFY2009.
Clermont	In SSFY 10, 12 children were referred to FCF and received CCBH funded services. All of these children demonstrated intensive behavioral health needs, and were at extreme risk for out of home placement. Of the 12, 8 children (67%) were maintained in their home, and all the children received intensive home-based treatment. Placement was averted or delayed significantly for all of these children as a result of the intensive home based services being provided when needed.
Columbiana	Regarding Intensive Home based/MST services: During SFY10, the Counseling Center worked with a total of 44 children/43 families; 32 cases received MST services and 12 received IHBT services. Of these 44 cases, 33 completed treatment and are now closed. The children were able to be maintained in their homes in 31 of these 33 cases (94%). The Counseling Center's MST Program Implementation Review for January - June 2010 indicates that 92% of the youth were in school and/or working; 83% had no new arrests during treatment; and 100% of the youth reported on for that period were living at home at discharge. Also, 100% of the families are reported to have the parenting skills to handle future problems, improved family relations, and improved networks of support. (All of these figures are based on 12 youth served by the MST program during January through June.) In addition, out-of-home placement costs were reduced over the past year due to this program. Regarding School Mental Health Services: Services were provided in 5 school districts to about 150 children. Services included brief screenings, consultation with school personnel, referral for other services, counseling. Outcomes included more consistent access to counselors; ability to address school issues and prevent behavior problems. Schools are very supportive of these services and would like to have more access to them, but funding is limited.
Crawford	We do not have any noteworthy achievements to report this year.
Marion	We do have any noteworthy achievements to report this year.
Cuyahoga	The SOC/CCBH funds have been highly favored to assist youth who are in need of support to ultimately remain in their communities with their families, which is in part the major goal county wide. The efforts on behalf of our system partners have been extraordinary, as they have demonstrated the true meaning of collaboration. This has resonated in the monthly SCT meetings facilitated by FCFC. The commitment of the group is a true illustration of how our systems partners work together on behalf of children.

Defiance	Prevention of out of county placements.
Fulton	Prevention of out of home placements.
Henry	Prevention of out of home placements.
Williams	Prevention of out of home placements.
Delaware	The CCBH funds provide for a Mental Health Liaison to the Delaware County Juvenile Court. This position has evolved over time to best meet the needs of multi-system youth who are involved with the juvenile court. This past year the Liaison has been focusing more on working with parents of the court involved youth to help them to better address the issues affecting their child. Gains have been made in referrals and engagement with treatment providers for both youth and parents. There have also been gains in helping parents to understand their need for appropriate parenting skills, benefiting both them and their children.
Morrow	The most notable accomplishment of the Mental Health School Liaison position in Morrow County is that it is now well integrated into the districts. This is important to note as it is challenging to make inroads with the very private and often isolative culture of the county. The position allows for early interventions when children first develop problems, as opposed to when behaviors and situations reach a crisis level.
Erie	The Board and two treatment agencies have implemented I-FAST evidenced based treatment. Our agencies are consistently challenged to provide realistic and effective home-based treatment that meets local needs and can realistically fit within available budget and resource capabilities. The Integrated Family and Systems Treatment (I-FAST) was developed within the local mental health system and is based on existing evidence-based approaches and a strengths perspective for working with at-risk children and their families. I-FAST identified 3 evidence-based, core treatment components and integrated them into a coherent treatment protocol that builds on and is integrated with mental health agencies existing expertise in home-based treatment. The use of CCBH funds has allowed the training and implementation of I-FAST to occur.
Ottawa	The Board and two treatment agencies have implemented I-FAST evidenced based treatment. Our agencies are consistently challenged to provide realistic and effective home-based treatment that meets local needs and can realistically fit within available budget and resource capabilities. The Integrated Family and Systems Treatment (I-FAST) was developed within the local mental health system and is based on existing evidence-based approaches and a strengths perspective for working with at-risk children and their families. I-FAST identified 3 evidence-based, core treatment components and integrated them into a coherent treatment protocol that builds on and is integrated with mental health agencies existing expertise in home-based treatment. The use of CCBH funds has allowed the training and implementation of I-FAST to occur.
Fairfield	During SFY 2010, the Fairfield County CCBH (404 Treatment) funds were used to continue both the Intensive Home Based Therapy services provided by New Horizons Youth and Family Center and the Juvenile Court-based Mental Health Therapy program. Notably, the inclusion of transitional home-based services for youth returning home from out-of-home placements and the authorization of temporary visits by therapists to youth in detention was positive steps for these programs this past year.
Franklin	Collaboration and communication around the youth needing service coordination, assessment and appropriate services has increased greatly since implementing this collaborative effort. We have achieved far better communication with the Juvenile Courts for better care coordination, assessment and linkage to the most appropriate services. The BHJJ project is more fully integrated with the Juvenile Court environment. The Judges are now insistent that if new services are developed that BHJJ assessors have and understanding of the model and are incorporated as part of the pathway for referrals for youth involved in the Juvenile Court. A "side benefit" has been the advent and implementation/funding of evidenced-based practices, such as Multi-systemic therapy, Functional Family therapy, DINA small group therapy, and Parent-Child Interaction Therapy. There has been some reduction in youth referred and committed to the Ohio Department of Youth Services as a result of the collaborative efforts. As a community, we became more efficient at leveraging Medicaid to support the Behavioral Health and Juvenile Justice model, and allow for expansion, without additional funds. The BHJJ assessors completed over 700 assessments during the last fiscal year.
Gallia	Funds used for Medicaid Match.
Jackson	Funds used for Medicaid Match.
Meigs	Funds used for Medicaid Match.
Geauga	Noteworthy achievements – over the last four reporting periods (including Jan 2010-June2010) we have kept 87% of all referrals out of placements.
Hamilton	The FPS Program is provided in partnership by Talbert House and Beech Acres Parenting Center. In 2009-2010, the FPS Program enhanced the partnerships by adding additional program sites, revised goals

and revised tracking of program outcomes. The FPS Program was successful in delivering services to more than 900 parents and families across all targeted schools and in the community. CCBH funds were maximized and additional Hamilton County Mental Health and Recovery Services board dollars were leveraged as a means to ensure the services were delivered throughout the entire school/fiscal year. Accomplishments related to the 4 established goals are as follows: Goal 1: (1a) Decrease the number of children/ youth who have intensive behavioral health needs and/or who are at risk of removal from their homes or communities due to behavioral health issues. (1b): Decrease the incidents of custody relinquishments made solely for the purpose of meeting the behavioral health needs of the child/youth. Outcome Data: Goal 1a: Behavioral health continues to be a significant need. In the school-wide needs assessment across all schools, 44% of parents indicated that their child had a behavioral health need, 23% indicated that their child had a social problem, 38% indicated that their child had an academic problem and only 18% of parents endorsed that their child had no problem. Ohio Department of Education (ODE) disciplinary data showed a decline in "In School Alternative Discipline" rates (the primary mode of discipline in CPS schools from 249.6 incidences on average to 211 (13.9% decline) from 2007-08 to 2008-09. Data were pending for 2009-10 at the time of this report. Data were gathered at the ODE Power Reports website: <http://ilrc.ode.state.oh.us/>. Over a 3 year period, 2007to 2009, 15 schools reported a decline in general behavioral incidences dropping from 409 incidences to 320 incidences (average/school). Mental Health referrals increased at schools from 49 to 53 referrals at each school. 40% of schools reported spending more time on mental health referrals compared to one year ago. 11 schools served students with 5-10% of students receiving intensive intervention based on the Pyramid of Intervention, which is a 3 tiered model or framework for instruction and intervention utilized by most Hamilton County Public Schools. The Pyramids three tiers represent progressive levels of support and focuses efforts based on the tiers ultimately increasing a student's opportunity for academic, social and emotional success. ([www.cps-k12.org/general/Pyramid/pyramid.htm](http://www.cps-k12.org/general/Pyramid/pyramid.htm)). Four schools reported 20% of students receiving intensive intervention. Goal 1a was MET Goal 1b: Out of the families FPS served, less than 1% of children lived in foster care or residential setting during the previous 12 months due to difficulties in accessing behavioral health care. Goal 1b was MET. Goal 2: Strengthen the capacity of parents and families to meet the needs of their children who have intensive behavioral health needs and/or who are at risk for intensive behavioral health needs. Outcome data: Parents reported the following outcomes related to building capacity and school involvement: 87% reported that they built strengths and improved parenting capacity. 86% strengthened their support network. 80% built a support network for my child and family. 68% of parents learned how to access behavioral health programs and community resources. 65% attended parent-teacher conferences (higher than parent survey card average of 50%). 65% of parents were attending special school events such as Conflict Resolution, Peer Abuse & Bullying, Tackling Depression & Anxiety, and class to enhance parenting skills. Parents reported the following outcomes related to improving parenting and school connectedness: 68% reported that they had more positive parent-teacher interactions. 86% reported that they were better meeting the social-emotional needs of their child. 68% reported that they were successfully implementing parenting skills and strategies. On a scale of 1-10, FPS parents indicated that their connectedness to their school rated at a 7.7/10 (the highest rating to date). On a scale of 1-10, FPS parents indicated that their child's needs were being met at an 8.49/10 (the highest rating to date). In addition, through FPS's programming efforts 51% of parents reported that they became more involved in their child's school. In fact, one fourth became volunteers. Goal 2 was MET. Goal 3: Parents have access to primary healthcare, behavioral health, child welfare, juvenile court/justice, education, home, community and other needed services and resources. Outcome data: Parents reported their ability to get access to services as follows: 68% reported they learned how to access behavioral health programs/community resources. 87% reported improved access to needed services for parent and child. 51% reported improved access to primary health care resource services for their child. 50% reported improved access to legal/financial assistance information for their child/family. The Service Summary Database indicates the most common issues families received assistance with were: (1) Navigating community resources (56%); (2) Providing them with school and community information (56%); (3) Assisting with mental health referrals/services (27%) and Other (63%). The most common ways that parents report that they use FPS are to: (1) Get needed services for their family (91%); To meet their child's social and emotional needs (73%); and to (3) Build a support network for families (65.9%). 99% of families recommend the FPS program to another parent; 100% of teachers and school staff recommended the program to other schools. Goal 3 was MET. Goal 4: Address gaps in treatment by researching, educating and linking parents to needed services and resources. Outcomes: 78.6% of parents reported that they were able to get needed services for their child/family; 65.9% of parents reported that they built a support network for their child/family; 65.0% of parents reported that they are better able to meet their child's social & emotional needs. The quality of services were also rated high on the Parent Feedback/Impact forms with 99% of parents recommending the FPS Program to other parents and on the In-Service evaluation forms on which 97% of parents rated session as "Good" or "Excellent" (see

	<p>additional details below). School satisfaction forms (N=169) were also collected from teachers and principals and 100% of respondents recommended the program to other schools. Data support that Goal 4 was MET. Overarching Accomplishments and Success Indicators: 560 referrals were received and served face to face (up from 459 in 2008-09). 99% of families stated they would refer others to the FPS Program (up from 97% last year). The program continues to be valued by parents and families. More than 900 parents were delivered services in program sponsored events. This is consistent from last year and a 20% increase from 2007-08. Over 2000 parents and children attended school wide events where FPS Program was represented. The program was able to expand additional program sites and grade levels. Referral Needs Identified and Met: In its fourth year of operation, the FPS Program has achieved its goals and has shown improvement from the 2008-2009 academic year, including effectively meeting parents' identified needs. At referral the needs are identified by a checklist on the referral form. The top identified referral needs during 2009-10 were: (1) 60% wanted to receive peer support from another parent who is familiar with the behavioral health care system (a trend that has increased from 54.4% in 2008-09 and 33.8% in 2007-08). (2) 61% wanted to receive school and community information to strengthen the family's support network of usable resources (trends that have increased from 31.4% to 60.7% over a three year period (2007-2008, 2008-2009, and 2009-2010). (3) Connection to parent groups and engaging in informal networking were two new needs that emerged this year (36.2%; this issue was not rated in the top three last year). Services that parents received were parallel to top referral needs identified. Also, there was an increase in the variety of In-Service Trainings offered. The program offered trainings based on identified needs and often brought in speakers from community resources to present and provide useful information to enhance support networks. Parents reported high levels of engagement and satisfaction with these activities both in their survey ratings and in qualitative comments. In 2009-2010, there were over 900 participants who attended parenting groups, parent events, and roundtables. This rate was slightly higher than rates in 2008-09, and much higher than the 208 served in 2007-08, and 63 in 2006-07. Topics presented by FPS staff and community speakers included budgeting, communication, discipline, bullying, parenting skills, stress management, educational advocacy, substance abuse, and self-esteem. In addition the program participated in school wide events such as back to school fairs, open house, and family fun nights. Outcomes: 97% of parents reported satisfaction with In-Service Trainings (92% last year) 93% of parents reported that the material was helpful to them and their families (92% last year) Mean level of self-rated knowledge score from before and after the workshop increased from 3.64 (moderate) to 4.25 (high) respectively; 55% rated their knowledge as "high" or "very high" before the workshop and 97% rated their knowledge as "high" or "very high" after the workshop 95% of parents reported that they were somewhat or highly likely to use the information presented at workshops (94% last year) 97% rated the presenter as knowledgeable (good or excellent), as having useful handouts (good or excellent) and as being sensitive to cultural issues (good or excellent) 97% of parents reported that the material was relevant to parents and families (99% last year). Program Endorsements Principals, teachers and other school personnel endorsed the positive impact of the program on the school and students. A few of the feedback comments supporting the program's effectiveness are quoted as follows: This program added value by being able to hone in on the child and family's social-emotional needs, more than the teacher can. The program is able to support students and parents in crisis and alleviate some of the stress in the school. The staff are accessible and have intervened with parents/students in crisis (as needed). Services are rendered efficiently and consistently. Very positive, always willing to contact parents and work with them. Parent comments about services received were overwhelmingly positive and quoted as follows: "I needed help accessing community resources and getting anger management groups for my child." "The FPS Program was helpful because I had a house fire and lost everything: furniture, uniforms, and household items." "The program has helped families be stable and children be successful in school." "This program has helped advocate when dealing with teacher and outside groups when dealing with insurance representatives."</p>
Hancock	<p>One of our MST staff at the agency was named in a national contest, the MST clinician of the year in SFY 10. We continue to meet or exceed all of the Performance Improvement Requirements and the adherence measures established by the MST Center, including the low out of home placement rate and the low recidivism rate for delinquency.</p>
Huron	<p>These funds assisted the county to continue to have a full continuum of care available for youths and their families, albeit with a significant waiting list, and to continue its trend to reduce youths in out-of-county placements. However, since the remaining youths in residential treatment facilities were provided with more treatment services by those providers, the costs for youths in such placements did not go down for the Board.</p>
Jefferson	<p>Skills and educational groups were offered twice per week at Jefferson County Alternative School (located at the county jail) for any multi-need kids. The agency also provided diagnostic assessments and individual counseling on a weekly basis at this site. Without this funding source, these kids would not have benefited from any treatment or intervention. The funds also allowed in-home CPST services to</p>

	bolster family resiliency
Lake	The organizations have identified an appropriate resource which provides intensive home-based treatment to children/adolescents and their families in Lake County. When appropriate, we utilize this resource to help prevent and/or shorten out of county residential placements. This home-based treatment is not funded by CCBH funds.
Licking	We are estimating that based on the number of placements that were prevented as a result of the Inter-system Team Facilitator in Licking County the system saved approximately \$250,000 for SSFY 10.
Logan	One of the priority programs funded in part with SOC/CCBH funds is the Home and Community Based Services In-Home program. In that program they were able to serve 24 youth and their families in SSFY10. The referrals for those cases came primarily from the Family Court and a few cases from Children's Services. 13 of the 24 cases completed treatment in SSFY10 and of those 13, 85% of them remained in the home at the conclusion of treatment. 58% of those youth had a 10 point or greater improvement on their Problem Severity Score of the Ohio Scales outcomes. 83% had a 2 point improvement in Hopefulness scores on the same scale, and 92% showed a score of 4 or more on a 5 point scale for satisfaction. The TeenScreen depression and suicide risk screening tool was used in all 4 of the Logan County School districts this year. The SOC/CCBH funds supported the staff from CCI to present health classes with the SOS - "Signs of Suicide" curriculum and then follow up with a TeenScreen to all those youth with a signed parental consent. A total of 200 high school students were screened this past school year. This number has increased each year for the past 3 years as parents understand more about what the TeenScreen tool is about and as the youth are engaged in the health class prior to the permission slips going out. The percentage of youth identified as screening positive for a suicide risk remains about 30%.
Champaign	One of the priority programs funded in-part with SOC/CCBH funds is the Home and Community Based Services In-Home Program. In that program 39 youth and their families were served in Champaign County in SSFY10. 90% of those referrals came from the Family Court and the remainder from Children's Services and FCFC. 28 of the 39 youth completed the treatment during SSFY10. 93% of those who completed were living at home at the time of completion, as opposed to the 82% who were living at home when the HCBS program was started. 62% of those youth completing treatment showed a 10 point or higher improvement on the problem severity scale of the Ohio Scales Outcome tool. 76% had a 2 point improvement in hopefulness scores and 95% had a score of 4 or higher on a 5 point scale for satisfaction. The TeenScreen depression and suicide risk screening tool was used in 4 of the school districts in Champaign County at the high school level. The SOC/CCBH funds supported the staff from CCI to present "Signs of Suicide" (SOS) curriculum to health classes and then to follow up with TeenScreen to all those students who returned a parental consent for the screening. A total of 251 students were screened this past school year. This number has increased significantly over the past 3 years as parents understand more about what the TeenScreen tool is about and as the youth are engaged in the health class prior to the permission slips going out.. The percentage of youth who screen positive continues to be approximately 30% of those screened.
Lorain (ADAS)	Funds were used for delivery of addictions treatment services for Adolescents in Lorain County. Primarily to deliver in-home treatment and support services through the Adolescent Community reinforcement Approach Model (A-CRA). Since implementing A-CRA adolescent treatment services have the highest retention rate of any treatment service within the network of care. ACRA involves increased coordination with family members, court, and school systems.
Lorain (CMH)	Outcomes of the funded programs indicate that the SOC/CCBH funds made a significant impact in the lives of many Lorain County children and families in SFY2010. For example, Berea's Early Childhood Intervention program serviced 138 children in SFY2010. A sample of outcome data from this program included 39 children and demonstrated client improvement on every dimension of the Child Behavioral Checklist (CBCL) with statistically significant improvement demonstrated on 7 or 15 scales of the CBCL. Additionally 74% of children from the sample had a reduction in their Total Problems Scales (as rated by the parent) by the end of treatment. On a smaller scale thirteen clients receiving Parent Child Interaction had demonstrated improved internal, external and total scale scores. With regard to serving youth who were at risk of out of home placement, Beech Brook's IHBT program served 55 clients in SFY2010 and boasts that 66% of the clients (for whom the worker completed Ohio Scales as the start and end of the intervention) showed clinically reliable improvement in functioning and reduction of symptoms. Even more impressive 88% of the very high risk youth who were served by Beech Brook's IHBT program were maintained in the community. It is also noteworthy that, because of the SOC/CCBH funded IHBT program's success in stabilizing so many high risk youth, the Lorain County Juvenile Court has chosen Beech Brook as the provider for a newly established Youth Mental Health Court in Lorain County.
Lucas	SFY2010 has been a transitional year in Lucas County. These sources of funding will be utilized differently in the future. The FCSS funds will be rolled into the larger services coordination mechanism

	(newly implemented Wraparound) effective 7/1/2010. The CCBH dollars will be dedicated to other services gaps also effective 7/1/2010. Youth and families have been informed of this transition and ongoing discussions and communication has continued during this transitional year.
Mahoning	Several of the families served were considering placing their child in residential treatment prior to their referral into Service Coordination. However, only 3 of the 27 youth served in Wraparound were placed outside their home and 0 of the 6 youth in Intensive Home Based services were placed. One child served by Wraparound had been on probation prior to involvement with WA. The child has stabilized and is no longer formally on probation. The parent of another child who has received services has now become a family representative on Council.
Medina	The FIRST program served in its first year of operation: IHBT - 64 youth and families for 1,974.60 hours, CPST - 99 youth and families for 2,643.50 hours, and FRS 39 youth for 1,276.90 hours. The youth and families are responding favorably to the interventions provided by the FIRST team and have shown much success in reducing out-of-home placement and keeping children stabilized in the community. The parents and youth are reporting that they have never made so much progress in treatment despite many years of treatment at multiple agencies as they have since they have been in the FIRST program. Parents and court are reporting a decrease in problem behaviors. From a review of the pre- and post-tests of the Child Behavioral Checklist (CBCL), Youth Self-Report (YSR) and Teacher Report Form (TRF) the youth engaged in FIRST services are making progress.
Miami	Miami Co. FCFC partners have been committed to keeping families intact and taking necessary steps to reduce out of home placements. In the last 24 months, through the coordinated efforts of the FCFC community partners to evaluate and re-design the service coordination mechanism, there has been a 70% reduction in out of home placements (June 2008=141 placements). At the end of SFY10, there were 42 children in out of home placement in Miami County either through Miami Co. CSB or Miami Juvenile Court. It is believed the addition of intensive home based treatment services, purchased with CCBH funds, for the most vulnerable families will assist in further reducing the number of children removed from their homes in Miami County.
Darke	The IDT has produced the following outcomes reduced placements, increased collaboration among local service providers, increased local service to families, and increased intersystem training opportunities which has maximized use of local dollars. Flexible funds, which are pooled funds from 6 local agencies over the last 10 years, can be used to access help with wrap around services (housing, medical care, food, transportation, treatment, respite care, etc) that support children remaining with their families in intact homes. The team also has access to a residential facility, Michael's Resource Center, for up to 7 juvenile males which as lowered the need for out of county placement.
Shelby	DAT has produced the following outcomes reduced placements, increased collaboration among local service providers, increased local service to families, and increased intersystem training opportunities which has maximized use of local dollars.
Montgomery	The funding has increased the number of Medically Indigent families to access services once the family has exhausted the families' behavioral health private insurance benefits (representing 39 families). Additionally, the funding expanded the capacity to address trauma (physical, emotional, sexual, violence) of children/adolescents, as well as the female parent of the child/adolescent. The CCBH Funds assisted in significantly decreasing the number of out-of-home placements of children/adolescent served (less than 10 children were placed out of the home). Over 290 children served, 216 were able to remain in their biological parent(s) homes. Majority of the families received Trauma focused care to address his/her behavioral health challenges. Additionally over 40 children who had been in the custody of Children Services, received trauma focused care base upon their parent's alcohol and other drug use/abuse/dependency. This has reduced by 95% the involvement of the children with Children Services and 100% of the children have improved school attendance from 35 missed days to 5 missed days (average per child).
Muskingum	A 12 year old boy, who had lived with his mother and younger brother, had informally been put with another family through Creative Options to provide temporary respite due to the escalating conflict between him and his mother and also his younger brother. The home based referral was made because the client refused to return to his mother's home. Children Services, Juvenile Court and the school system and Creative Options were involved with the original referral meeting. Complicating the situation was the fact that the client had severe Type 1 diabetes requiring stringent diet and daily insulin administration. At both homes, inconsistencies in this regimen had led to emergency hospitalizations. Poor compliance was related to defiance as well as carelessness. After home based services were initiated, the client agreed to return home. The situation was somewhat complex but his mother and he worked closely with the intervention. By the time school started his mother had been able to establish an adequate parenting relationship to help her son adjust. Things continued to improve, they both made several significant changes. His performance in school improved and control of his sugar levels also improved and he required no further hospitalizations. Services were provided from 7/09 to 12/09 when the family agreed

	services were no longer needed.
Coshocton	A 13 year old juvenile sex offender was receiving the least restrictive care by obtaining group and individual counseling in the county. It became clear that he could not be safely maintained in the home (neither his mother's nor father's), the next available step became residential services from Thompkins Child and Adolescent Services. This allowed the family to stay involved working towards reunification. The only alternative was DYS which would not have been a good placement for this young man.
Guernsey	A ten year old boy was hospitalized twice at Bethesda within thirty days. The reason for hospitalization was the boy's constellation of symptoms, including: physical aggression, threatening to shoot his guardian (grandmother), threatening to take his own life and self and academic problems. Children Services, who made the home based referral, had an open case related to firearms in the home and cannabis possession. Both grandparents had chronic pain management issues treated with potentially addictive prescription analgesics. This was a family where the parenting adults (grandparents) were extremely cooperative and open. There were family stressors from a number of sources which inadvertently effected the client intensely and also parenting issues, both of which they worked with Thompkins Child and Adolescent Services to resolve. The case was opened in July of 2009 and closed in January 2010. The client was not hospitalized again and at the closure the presenting symptoms had been in remission for many months. His school performance which passed through some crises was also stabilized. In addition the grandparents demonstrated confidence that they understood the issues and therefore knew how to prevent future relapse.
Morgan	N/A
Noble	N/A
Perry	N/A
Portage	The funds were used in SFY2010 to purchase a combination of residential, group home and/or therapeutic foster care (per diem costs only) for 10 children who were presented at the Family and Children First Council ICAT meeting. More specifically, the funds were used to support placement at three group homes, two residential facilities, and three therapeutic foster homes. Of note, in Portage County, we are able to use therapeutic foster homes for children who remain in the custody of their parents/guardians and who are not involved with the Department of Job and Family Services. The foster care option for these children has been used to prevent residential placements when it is determined that the child needs a structured, safe and therapeutic home environment, which their parents are not able to provide at that time, but they do not require a residential placement. In addition, foster homes have been used to "step down" children from residential and group home placements before returning them to their parents/guardians.
Preble	Unfortunately, due to the need to use these funds for standard treatment services to youth, no noteworthy achievements were identified.
Putnam	The Wraparound program in Putnam County has significantly reduced the number of youth placed out of home since the program was implemented. Twenty-one families received services during this past year.
Richland	The most noteworthy accomplishment was the ability to maintain this program at the level it was intended and to serve 60 families this fiscal year. With a reduction of nearly \$300,000.00 to the system during SSFY 10, this was an amazing accomplishment.
Ross	A child enrolled in one of the local Head Start classrooms was identified immediately as having behavioral problems and possible mental health issues. Diagnostically, the child was identified as having a Pervasive Developmental Disorder. The child was observed as flinging himself to the floor, he spit; he kicked; he hit; he pinched; he threw items off shelves putting his person, other students and classroom staff at risk for injury; he used profanity while screaming. His behavior was disruptive to the extreme. The child was opened as a client of Scioto Paint Valley Mental Health Center and was assigned a mental health counselor, referred for psychiatric evaluation, and assigned an intensive case manager through our I-FAST program. The intensive case manager was able to work with the student one-on-one in the classroom helping the child learn and develop self-soothing and self-management skills and providing much needed support to the classroom staff. The I-FAST case manager also worked with the child's mother providing her support and working with her to develop additional ways for the mother to interact with her child improving the mother's ability to more effectively assist her son in de-escalating. The child was also referred to the Ross County Cluster which expedited other services for the child including, but not limited to, Occupational Therapy. Where, initially, the child spent the majority of his time in school in some state of severe agitation and was in danger of being asked to leave the program, he has been able to remain in Head Start and is now able to manage his own behavior. His outbursts occur with much less frequency and intensity. He is much more successful in soothing himself when he does become distressed. He has friends in the classroom and is able to interact appropriately for the most part.
Pike	Most of the funds were used for mentoring children with behavioral disorders. Several children who were at risk for being suspended or expelled from school were able to remain in school and, in fact, made

	significant progress. Some funds were used for summer camps designed to help children maintain gains they had made during the previous year (particularly in the area of emotion regulation and pro-social skills). Had these funds not been available, these children would not have had access to these intensive services.
Pickaway	Team for Youth sponsors “Camp Can Do” which is a six week skill building program conducted at the local YMCA for high risk youth. Skill building is done in the areas of emotional regulation, anger management interventions and how to make new friends. Family and Children First Council recently sponsored “Youth Day” during which the focus of the day’s activities were on wellness. Finally, Team for Youth has also covered the cost of planned respite and emergency respite for youth who are in crisis and involved in treatment. The result of all of these collaborations and programs is the improvement of quality of life for many children and their families.
Fayette	Several children have been able to achieve goals towards inculcating better social skills. Several families have received help with items to help with their children that are autistic. One case involved an autistic child that would wander if he got outside of the house. A special tracking watch was purchased which helped locate him when he got out of the home. Respite was also paid for to help children with behavioral issues to keep families together and to help children with behavioral issues to keep families together and to help keep children in their community and out of foster care.
Highland	One case involved an adolescent boy who had been placed with a relative. This child acted out constantly at school and with his relative. He often threatened violence to other students and his relative and was on the verge of being permanently expelled from his school. In addition, his relative no longer felt, due to age, that she could continue to have him live in her home if things didn’t change. It was clear that there was love between the two, and the possibility of having to place this child in foster care was not a positive one. This child was admitted to a Mental Health Center and to intensive I-FAST case management services. In addition, he received individual counseling. His primary provider worked with him at school and in his home. The intensive home treatment also involved working with the child and the relative together. Currently, the child has much improved his relationship with other students at school and is no longer in danger of being expelled. Finally, the relationship between him and his relative is much more stable and this has now become a permanent placement.
Scioto	1. Sustained Therapeutic Respite Care when other funding was lost. 2. Expanded Early Child MH Observation/Consultation to 20 public preschools and 2 preschool daycare centers.
Seneca	The provider agency, Firelands Counseling & Recovery Services (FCRS), is near completion of the certification process to provide the intensive home-based therapy model called Integrated Family & Systems Treatment (IFAST). By implementing this model in our county, the agency was able to expand the number of children and families served, as well as, introduce a more flexible model that serves more mental health disorders for children and adolescents. FCRS also provided the Incredible Years Dina Treatment Program to young children in Seneca County.
Sandusky	The provider agency, Firelands Counseling & Recovery Services (FCRS), is near completion of the certification process to provide the intensive home-based therapy model called Integrated Family & Systems Treatment (IFAST). By implementing this model in our county, the agency was able to expand the number of children and families served, as well as, introduce a more flexible model that serves more mental health disorders for children and adolescents. FCRS also provided the Strengthening Families Program to Sandusky County families.
Wyandot	The provider agency, Firelands Counseling & Recovery Services (FCRS), is near completion of the certification process to provide the intensive home-based therapy model called Integrated Family & Systems Treatment (IFAST). By implementing this model in our county, the agency was able to expand the number of children and families served, as well as, introduce a more flexible model that serves more mental health disorders for children and adolescents in Wyandot County.
Stark	We have been pleased with the results of our clinical review process for our youth in residential placements to increase access to targeted and effective treatment and decrease length of stay. Hi Fidelity Wraparound for youth with significant mental health challenges is now available at Community Services of Stark County, Inc.-one of our mental health organizations. Our DJFS/Children’s Services Department is planning to have a staff member trained to provide Hi fidelity wraparound - trainings are in process of being scheduled. Our MST program has developed a specialty in serving youth with problem sexual behaviors which has helped to decrease residential placements for this population.
Summit	5 youth were served with the CCBH 404 funds. Summit County continues to use CCBH funds braided with local pooled funds for short term residential care for mental health stabilization and evaluations. Once evaluations are completed the treatment team along with the parents determines the services needed and the least restrictive environment in which those services can be provided. We hope to be able to continue receiving the funds and continue to look at how they can be used towards home based services with a provider licensed by ODMH. However, using CCBH funds for short term stabilization has been

	very helpful in determining that a child can return to the community in a shorter period of time with wraparound services that are funded through local pooled dollars. The ICT Program provided Intensive home-based treatment, wraparound services, and care management services to 46 youth with co-occurring disorders during SSFY 2010. None of the 46 youth went to DYS and five were referred to residential treatment. All other youth were referred to similar or lower levels of care at the end of ICT.
Trumbull	The most important use of the funds was to support Wraparound facilitation for individual children. There are mental health agencies in the county who provide Wraparound facilitation for children receiving case management services. Much of the time devoted to the Wraparound process is not billable under current Medicaid rules. By supporting the time needed to adhere to Wraparound practices and principles, Trumbull County was able to offer high fidelity Wraparound to many more children than would otherwise have been possible. Supporting agencies that provide this valuable service assures the continued commitment of these organizations. Without this support, several agencies would not be able to continue because of the loss in revenue due to non-billable services.
Tuscarawas	Through the collaborative approach of Family and Children First Council agencies, the analysis of factors contributing to disruption of families, and the use of CCBH funding to support clinical interventions, Tuscarawas County has been able to decrease the number of children in out-of-home placement. This ongoing effort has resulted in the systems examining how each approach to children and families impacts the potential of placement. The mental health system was able to incorporate CCBH funding into part of their plan to maintain families and prevent disruption.
Carroll	Systems involved in Carroll County Family and Children First Council, specifically the Carroll County schools, Carroll County Job and Family Services, Carroll County Juvenile Court and Carroll County Department of Health and the Tuscarawas/Carroll ADAMHS Board, are unanimous in their support of school based mental health providers. Each system has voiced the necessity and success of this type of intervention and is committed to maintaining this treatment option. The opportunity to see the child in the school addresses the barrier of transportation that is the most common impediment to service delivery and has a clear impact on the mental health of the children and, therefore, the stability of the families. The coming together of different systems to support this mental health intervention and the impact of the treatment has been noteworthy accomplishments for Carroll County.
Union	The FFT program in Union County served 91 families in the last year, with 87% of families having positive outcomes (no further involvement with Juvenile Court or Children's Services and no out of home placements). FFT therapists in Union County do provide 24/7 on-call services to their client families, unlike most FFT programs. This has been beneficial in reducing the need for psychiatric hospitalizations and juvenile detention. FFT therapists in Union County consistently score at high levels in families reports collected by FFT. The FFT team is in Phase Three of FFT implementation, which is the final phase and has maintained the phase for three years. The Home-Based Family therapy program (HBT) provides services to families with younger children (ages 4 to 12, typically) who have serious needs. Many of these cases area also involved in the Wraparound program facilitated by CUCF. The HBT program served 67 families in the last year, with 92% of these families having no further involvement with DJFS, the Court or with out of home placements (other than use of respite services). The New Paths Adolescent AOD Program served 81 youth and families in the last year, with 75% of these families having successful outcomes. The New Paths program uses the cannabis Youth Treatment Series programming. Overall, only 9 of 231 families (less than 4%) served by these programs had a youth placed outside their home in the last year.
Van Wert	Allows access to specialty providers for purpose of appropriate diagnosis and input into development of community treatment plan. Provides funding for continuation of summer camp clinical components for at risk youth. A significant number of youth who are at risk for out of home placement are supported successfully in community due to these funds.
Mercer	Funding allows access to specialty providers for purpose of appropriate diagnosis and input into development of community treatment plan. Provides funding for continuation of summer camp clinical components for at risk youth. A significant number of youth who would otherwise be at a high risk for out of home placement are supported successfully in community.
Paulding	Allowed access to specialty providers for purpose of appropriate diagnosis and development of appropriate community treatment plan. Several youth who are at risk for out of home placement are supported successfully in community due to these funds.
Warren	The most substantial achievement has been the reduction in the number of children placed in residential treatment facilities (RTFs) through the Service Coordination process. In SFY 09, a total of 8 children were placed in RTFs and in SFY 10 we were able to reduce this to only 6. In fact, SFY10 began with 6 children in placement but we have been able to reduce this so that for the last 5 months of SFY10, only 2 children have been in residential placement each month. A total of 15 children were involved in IHBS during SFY10. Of these, only 1 was discharged to residential treatment, thus enforcing the fact that IHBS is effective in treating children in the community.

Clinton	The most substantial achievement has been the drastic reduction in the number of children placed by the Case Review Team in residential treatment facilities (RTFs). In SFY 09, a total of 9 children were placed in RTFs and in SFY 10 we were able to reduce this to only 5. In fact, since the beginning of CCBH (formerly ABC Base Funds) in SFY 05, the number placed has reduced by 65% (SFY05 = 14; SFY06 = 13; SFY07 = 15; SFY08 = 11; SFY09 = 9; SFY10 = 5). A total of 30 children were involved in IHBS during SFY10, 8 of which were funded through CCBH monies. Of these, only 1 was discharged to residential treatment (a rehab facility through juvenile court due to criminal charges), thus enforcing the fact that IHBS is effective in treating children in the community. It should be noted that CC Children's Protective Unit had custody of 4 of the 5 children due to abuse issues and, in 3 cases, placed the children in residential care and then requested assistance with funding from the Case Review Team. Two of these children were in residential care for the entire 12 months.
Washington	Board was able to meet Medicaid match requirements.
Wayne	The Child Community Behavioral Health Aide, in collaboration with Case Managers, Home Based Intervention, and School Based Therapists worked with 13 children from 7 to 17 years of age. Of those youth, all were maintained in their home, their schools and the community. With this intervention, as it is aligned with Service Coordination, Wayne County has seen a marked decreased in our out of home placement numbers, a reduction in length of stay and a shift from residential treatment to treatment foster care. We are better able to preempt the need for out of home placement, and create seamless discharge plans that prepare community resources for a young persons return.
Holmes	None of the youth involved in Holmes County CCBH experienced out of home placement. In addition, CCBH-involved youth were also linked to FCSS services as their needs changes. This provided a safety net for these youth and their families and facilitates effective service coordination.
Wood	What is noteworthy is that this money makes treatment to (99) very high risk youth available in our PH after school program.

**Appendix E**  
**Open-ended response to Question 9: ‘Other’ Services Provided**

Ashland	Integrative Family and Systems Treatment (I-FAST).
Ashtabula	Intensive outpatient therapy at a community mental health agency. To pay for a multi dimensional psychiatric evaluation for a child being clustered by the family and children team through FCF.
Brown	Funds helped keep basic services in place such as assessment, crisis intervention, and med-somatic services.
Crawford	Funds helped to maintain basic services like assessment, crisis intervention and med-somatic
Marion	Mentoring services for respite purposes.
Cuyahoga	WRAP.
Defiance	WRAP.
Fulton	WRAP.
Henry	WRAP services.
Williams	Consultation Services to Juvenile Court, including treatment docket.
Delaware	I-FAST (see 4 above).
Erie	I-FAST (see 4 above).
Ottawa	Juvenile Court-based Mental Health Therapy.
Fairfield	Family Peer Support Services..
Hamilton	The full range of outpatient treatment services for youths as well as treatment services provided in residential treatment facilities.
Huron	Consultation, Education.
Logan	Consultation, Education.
Champaign	Adolescent Community Reinforcement Approach (A-CRA).
Lorain	Early Childhood Interventions as indicated above.
Lorain	The CCBH funds paid the loaded wage of the Family Care Manager, who works exclusively with the FAST\$ program as a facilitator in a wraparound style planning process for 25 intensive slots. Funding also paid for non-traditional interventions to family issues impacting the identified child's behavioral health status as defined in wraparound planning sessions.
Lucas	Wraparound, clinical intervention & treatment with youth.
Mahoning	DECA Assessment and Resiliency-based model of early childhood care.
Montgomery	Sex Offender Treatment.
Coshocton	Wraparound Services.
Putnam	Planned Respite and Emergency Respite for youth in crisis and in treatment.
Pickaway	Incredible Years programming.
Seneca	Strengthening Families, individual therapy.
Sandusky	Respite and Mentoring.
Stark	Emergency placement for crisis stabilization, in home consultation for autistic child, mentoring, respite and transportation.
Summit	Service Coordination - Wraparound Facilitation.
Trumbull	Trauma Focused Cognitive Behavioral Therapy.
Tuscarawas	Trauma Focused Cognitive Behavioral Therapy.
Carroll	Adolescent sexual offender.
Van Wert	Adolescent sexual offender programming.
Mercer	Supports clinical programming for summer camp for at risk youth.
Paulding	Our Mental Health services are provided in a school (location) but after school hours.
Wood	