FSG REIMAGINING SOCIAL CHANGE

Greater Cincinnati Youth Mental Well-Being

Collaborative Needs Assessment

By Miya Cain, David Claps, Allison Kaika, and Abigail Ridgway

January 2024

Table of Contents

Introduction

Greater Cincinnati[1] is grappling with a youth[2] mental health crisis. Mental health needs have grown more acute, children face challenges at ever earlier ages, mental health providers are strained, and caregivers are overwhelmed. Recent heartbreaking youth suicides have galvanized collective action from committed leaders across the community.

The region is a national leader in youth behavioral health care, quality improvement systems, and collaborative infrastructure. At the same time, siloed funding, decreasing social connections, limited opportunities for social-emotional skill building, and a health system stretched beyond capacity make it challenging for youth and their families to flourish.[3] Moreover, marginalized communities, including Black, Latinx, low-income, and LGBTQ+ communities, face disproportionate barriers to well-being. Community leaders wish to shift the underlying challenges holding these problems in place so that they support youth mental well-being in perpetuity.

In response to this context, over 205 leaders from more than 115 unique youth-serving organizations met for monthly community meetings between August – December 2023 to identify the top challenges and opportunities to improve the mental well-being of young people and their families across Greater Cincinnati. These meetings were open to all who wished to attend, with attendance growing at each meeting as more people were referred by their peers. Many other voices contributed to the process through interviews with over 25 community leaders and 7 representative focus groups of nearly 60 young people and their families (see *Appendix D. Community Insights* for detail on focus groups).

The needs assessment that emerged from that community input along with supplementary secondary data identifies root challenges of poor youth mental well-being outcomes and suggests potential opportunities to change the conditions that hold these problems in place. All problem definitions and opportunity identifications are based on input from young people, parents and caregivers, providers, practitioners, and other community members in the Greater Cincinnati area who contributed their time and perspectives to the co-creation of this assessment.

The purpose of this report is not only to create a shared, community-wide awareness of these challenges and opportunities, but to provide a platform for developing a collaborative plan of action to address them. In the first half of 2024, this collaborative effort will transition from diagnosing challenges to creating a shared plan of action, which will be released in summer 2024. We invite you to join us on this critical journey.

This work was made possible by the support of 12 local funders[4] who are committed to building a collaborative youth mental well-being strategy for Greater Cincinnati.

[1] "Greater Cincinnati" in this assessment is loosely defined as the City of Cincinnati and its surrounding counties in Southwest Ohio and Northern Kentucky; Data and community insights from Indiana are not included in this assessment as only 1% of the state's residents reside in the Cincinnati Metropolitan Statistical Area as defined by the U.S. Census Bureau.

[2] "Youth" in this assessment includes young people from ages 0 to 24.

[3] "Families" refers to a broad range of caregivers that support young people, such as siblings, parents, grandparents, aunts, uncles, foster parents, and other important caregivers.

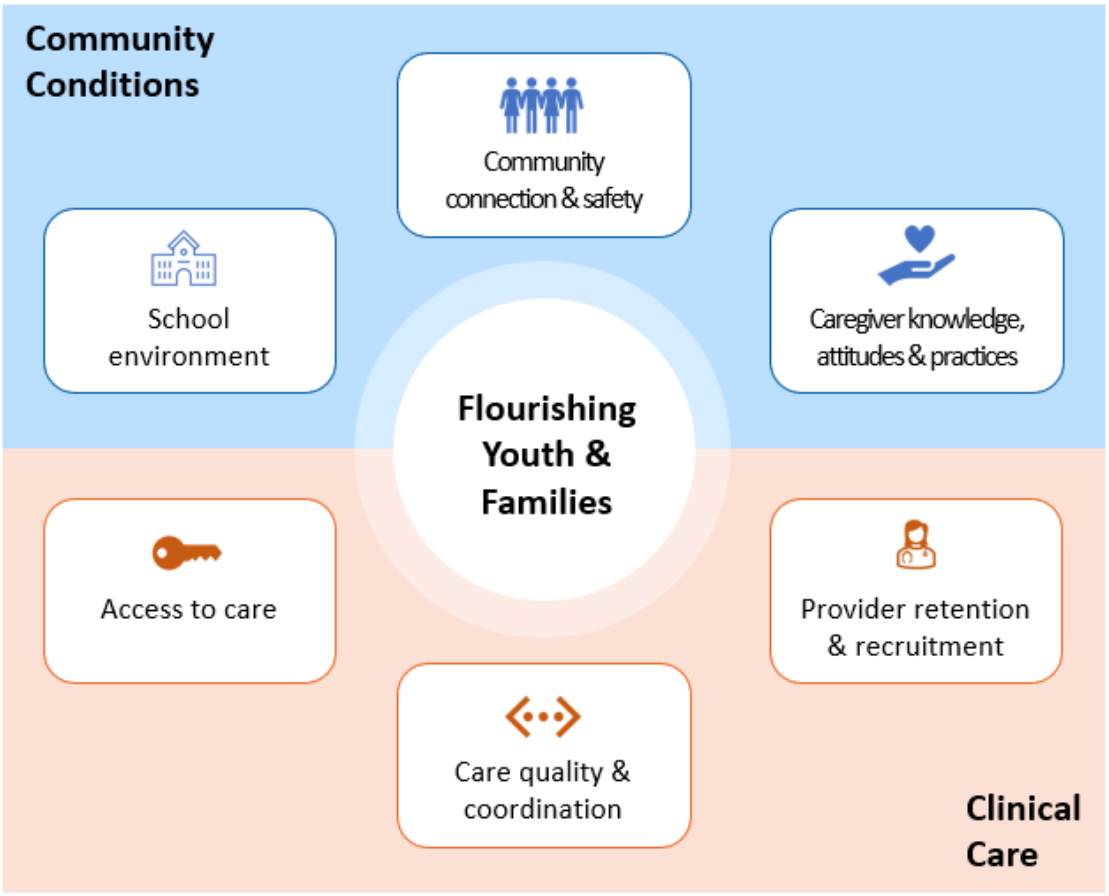
[4] See *Appendix A* for list of funders who supported this needs assessment and continue to support the work.

Structure of this Needs Assessment

Youth, parents and caregivers, providers, practitioners, and other community members identified **6 main focus areas of challenges and opportunities** for improving youth mental well-being in Greater Cincinnati (see image below). For each focus area, the needs assessment features a description of the challenges or main barriers to well-being followed by potential opportunities for addressing these barriers.

Given that the areas of challenge and opportunity exist along a spectrum reflecting the variety of clinical and non-clinical factors that impact well-being, the focus areas in this assessment are organized into two groups: **1) Community Conditions** and **2) Clinical Care.** This organization is intended to support ease of comprehension as well as support a framework for moving work forward in the future.

The Six Main Focus Areas of Challenges and Opportunities Explored in this Assessment

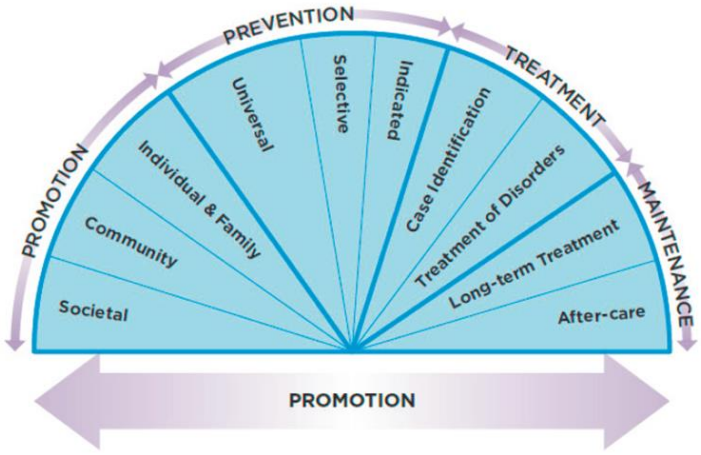


The focus areas reflect many aspects of the Mental, Emotional, and Behavioral (MEB) Interventions Spectrum (see image below) – a framework which highlights the wide spectrum of key tools for fostering MEB health in children and youth.[5] As a rule of thumb, the 3 areas discussed within Community

[5] "Fostering Healthy Mental, Emotional, and Behavioral Development in Children and Youth: A National Agenda," National Academies of Sciences, Engineering, and Medicine, 2019, https://doi.org/10.17226/25201

Conditions generally fall within the promotion and prevention portions of the spectrum, whereas the 3 areas discussed within Clinical Care generally fall within the treatment and maintenance portions of the spectrum. At the same time, there are challenges and opportunities that do not necessarily fall neatly along those lines.

Spectrum of Mental, Emotional, and Behavioral (MEB) Interventions[6]



Navigating the Assessment

The next section contains a **summary of the key findings** which outlines the key challenges and opportunities elevated by the community across the 6 main focus areas. This assessment will then dive into **greater detail for the 3 focus areas within Community Conditions and the 3 focus areas within Clinical Care**. These detailed sections also **include quotes from youth, caregivers, behavioral health providers, and other practitioners** interviewed. This assessment **ends with next steps**, describing the actions this collaborative will embark on in 2024, and with an appendix containing the case studies referenced throughout.

[6] "Fostering Healthy Mental, Emotional, and Behavioral Development in Children and Youth: A National Agenda," National Academies of Sciences, Engineering, and Medicine, 2019, https://doi.org/10.17226/25201

Summary of Key Findings

Focus areas	Challenges	Opportunities
Community connection and safety 	Youth are not residing in safe, connected, supportive community environments that provide them with all they need to thrive. They are coming of age in a time of great social change and dealing with the immediate threats of community violence and discriminatory policies. These challenges are compounded for youth from marginalized communities (e.g., Black, Latinx, low-income, LGBTQ+) where systemic racism and underinvestment exacerbate threats to well-being.	1. Train young people in **community organizing and advocacy**. 2. Implement **trauma-informed** policies and practices throughout the community. 3. Expand **violence intervention** programs throughout the community. 4. Create **dedicated community spaces** for youth to gather.
School environments 	Youth do not always experience school as a safe and supportive environment that supports their development and mental well-being. On the contrary, many young people experience significant amounts of bullying, stress, and harsh discipline and find that the adults in schools are not always well-equipped to protect and support their well-being.	1. Offer ongoing mental health and well-being **training** for school faculty and staff. 2. **Equip youth** to support the mental well-being of their peers. 3. Create **wellness spaces** for decompression, self-regulation, and mental health support in schools. 4. Shift **school priorities and messaging** to further emphasize student well-being. 5. Conduct universal **mental health screenings** in all schools.
Caregiver knowledge, attitudes, and practices 	Resulting from stigma or lack of insight, caregivers[7] are not always well-versed in or do not always acknowledge mental health as a real issue for themselves or the youth they care for. This can be a barrier to care when youth are in need. Caregivers also struggle with their own trauma and face socio-economic barriers, and may at times lack the resources, social-emotional skills, tools, and support needed to create a healthy and supportive home environment for youth.	1. Offer widely accessible **mental health training and social-emotional skill building** opportunities to caregivers. 2. Create a **support program for caregivers** with children experiencing mental health challenges. 3. Promote and centralize access to **caregiver resources** that assist them in creating better home environments. 4. Engage **employers** to be trauma-informed and to support employee family well-being. 5. Challenge **youth to design solutions** to advance adult mental health awareness and education.

[7] "Caregivers" are defined in this assessment as adults responsible for caring for children in home environments (e.g., parents, grandparents, foster parents, older siblings)

Access to care 	Young people and their families struggle to access behavioral health treatment because services are not adequately funded, making them unaffordable, delayed or unavailable altogether. Low reimbursement rates, a lack of parity for behavioral health, a lack of insurance coverage and difficulty navigating cost all prevent young people from getting the care they need.	1. Create a shared **policy agenda** to unlock sustainable funding for services that support and address behavioral health needs. 2. Pilot **holistic care** approaches with private funding and share results with policy makers to grow public funding. 3. Advocate for **businesses to invest in insurance plans** that provide more behavioral health coverage. 4. Tax **private sector contributors** to poor mental well-being to increase wellness funding.
Care quality and coordination 	The siloed behavioral health system makes it difficult for young people and their families to find and receive quality care at the right time to effectively meet their needs. Once care is accessed there is an inconsistent application of evidence-based, trauma-informed, and culturally responsive care, especially for historically marginalized communities.	1. Improve integration of **health information systems** to connect young people between providers and create seamless referrals. 2. Develop **integrated care models** that offer screenings and facilitate referrals in central hubs and primary care offices. 3. Galvanize **universities and 2-year colleges** to create supportive systems and environments for young adults and to connect them with care if needed. 4. Incentivize providers to offer the highest quality care to young people and their families by shifting payers to **outcomes or values-based payment** plans. 5. Fund learning opportunities for providers increase their **cultural competency** and facility with **trauma-informed approaches.**
Provider retention and recruitment 	High financial barriers to access education and training for positions that are low in pay and produce high rates of burnout results in low provider retention and decreases the quality of care. For providers of color, these factors are compounded with historic marginalization making it especially difficult to increase diversity in the field. Behavioral health providers leave the field due to stressful work environments, heavy workloads, limited support, and low pay with few opportunities for on-the-job training and growth.	1. Create a **pooled fund** to reduce the barriers to entry into the behavioral health field. 2. Incentivize and support existing providers to stay in the field through **increasing pay and benefits and forgiving loans** through a mix of public and private funding.

Discussion of Opportunities in this Assessment

The intent of this assessment is to aggregate and elevate the challenges and opportunities generated by the collaborative process with youth and family focus groups, interviews with field practitioners and providers, and the multiple 100+ person stakeholder convenings in a comprehensible, accurate, and equitable fashion (e.g., not only elevating ideas generated by adults).

The opportunities discussed in this assessment are designed to be illustrative and spark further idea generation. Examples from the field within the opportunities sections are also illustrative, include a mix of national and place-based models, and are not to be interpreted as an endorsement of the described activity or program.

This implies that the opportunities elevated and described within this assessment may or may not fit formal requirements for fundable programming as outlined by the Ohio Department of Mental Health and Addiction Services (OMHAS), Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID), and other public and private funders such as community foundations or private foundations. Public health agencies such as OMHAS and DBHDID may only fund programming that fits their formal program requirements, as required by departmental policy or state stature, and employ evidenced-based models. In particular, these agencies have codified definitions for fundable prevention programming.

Prevention is defined by OMHAS as follows:

> "Prevention aims to **reduce underlying risk factors** that increase the likelihood of mental, emotional and behavioral health disorders (MEB) and simultaneously to **promote protective** factors to decrease MEB health disorders… Prevention promotes the health and safety of individuals and communities. It focuses on **reducing the likelihood** of, **delaying the onset** of, or **slowing the progression** of or **decreasing the severity** of MEB health disorders."[8]

OMHAS provides dedicated prevention funding streams for specific primary prevention "interventions designed to reduce the occurrence of new MEB health disorders," with more limited funding available for select early intervention and health promotion strategies. These evidence-based interventions are delivered by a subset of services agencies who have achieved certification as prevention specialists.

Prevention is defined by DBHDID as follows:

> "Prevention efforts focus on **reducing or delaying the initiation of substance, mental health issues, and their related consequences**… DBHDID's Behavioral Health Prevention and Promotion Branch supports the use of **evidence-based prevention strategies to**

[8] "OhioMHAS Prevention Services Guidance Document," Ohio Mental Health & Addiction Services, November 2019; https://mha.ohio.gov/static/Portals/0/assets/SchoolsAndCommunities/Educators/School%20Based%20Prevention/Prevention-Services-Guidance.pdf

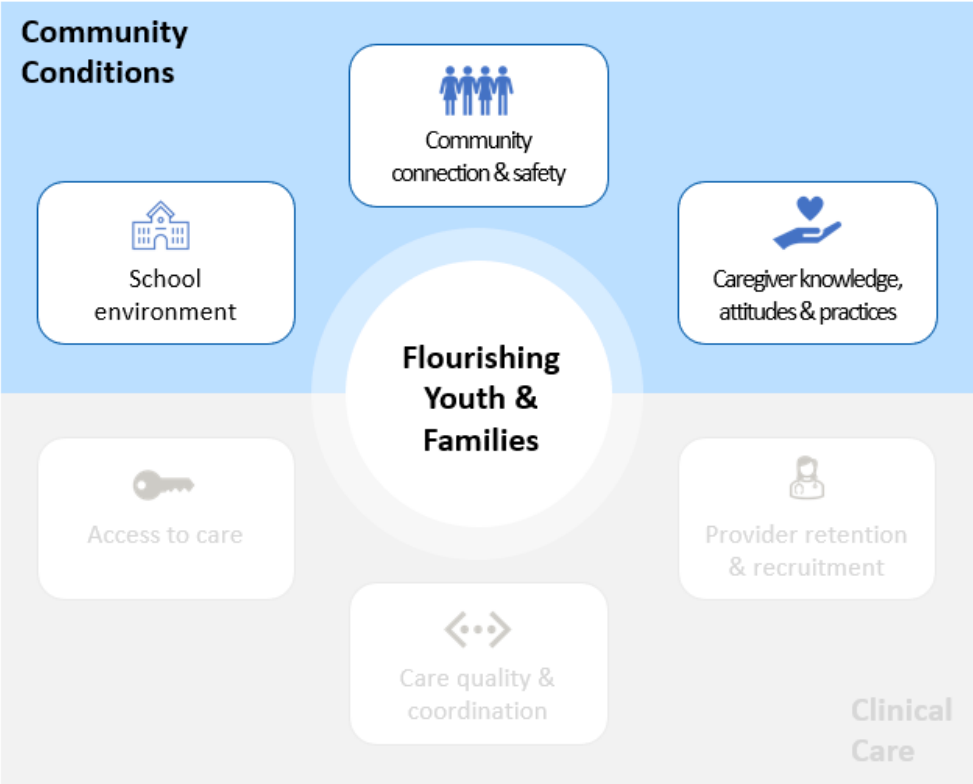
> **decrease risk factors and increase protective factors** and resilience to **reduce the rates of substance use and suicide** among residents of the commonwealth."[9]

Like Ohio, Kentucky's state-funded prevention programs are carried out by certified prevention specialists.

As the collaborative moves into planning and action in 2024, it will be the collaborative's charge to consider opportunities alongside the program requirements of potential funders, requirements for evidence-based strategies, and any other constraints surfaced or standards set by the forthcoming governance structure that will manage this effort.

[9] Behavioral Health Prevention and Promotion Branch, Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities, https://dbhdid.ky.gov/dbh/bhpp.aspx

Community Conditions



This section includes a broad variety of challenges and opportunities related to developing **community, school, and home environments** that will support youth mental, emotional, and behavioral health and well-being in Greater Cincinnati. Many of the activities discussed in the following 3 sections fall under the categories of promotion and prevention within the MEB Intervention spectrum. This includes but is not limited to awareness building; formal training and education; strengthening of inter-personal relationships; community building; and cultivating physical, emotional and psychological safety.

Community Connection and Safety

Challenge: Youth are not residing in safe, connected, supportive community environments that provide them with all they need to thrive. They are coming of age in a time of great social change and dealing with the immediate threats of community violence and discriminatory policies. These challenges are compounded for youth from marginalized communities (e.g., Black, Latinx, low-income) where systemic racism and underinvestment exacerbate threats to well-being.

It cannot be understated how clearly youth identified community life as a primary influence on their mental well-being. At the center of the challenges associated with community life are young people's lack of physical and psychological safety brought on by large systemic challenges, such as gun violence, trauma, and a lack of meaningful connection to each other and the larger community. They note how difficult it has been to re-form communities following COVID-19, and their general observation of a lack of community orientation around them.[10]

> *"People don't have a strong community. People don't know there are means to get to where you want to go. I think isolation and lack of community takes that away. Feeling like you are in community that cares about me makes me do well." –V., White female, 18+*

Contemporary social issues are causing stress and changing community life. With the proliferation of social media and other internet platforms, today's youth have access to large amounts of information that influences their perception of their community and their self-image. Climate change, inflation, gun violence, and community displacement, are among the issues that youth are concerned about and consuming media about online. Youth also see these shifts in their real life, amplifying their existing worries (i.e., they consume media about gun violence and experience it in their neighborhoods). The COVID-19 pandemic also created new stressors for youth and the associated trauma and loss of community life accelerated a pre-existing trend of rising youth mental health challenges.[11]

> *"[We] keep on hearing about climate change and how it's just getting worse, and nothing is being done about it... And the rising costs of college and living expenses… There are a lot of daunting challenges that we're facing, not just as an individual but as society today." –J., White male, 18+*

> *"Young people don't feel like they have these opportunities. It's really discouraging to think their children won't have a fighting chance. It was devastating for me to realize about global warming." – V., White female, 18+*

These stressors produced by large, societal shifts are taking place at a time when young people's ability to cope is more strained than ever. For one, the pandemic reduced access to the people and places youth could seek as sources of comfort. It also reduced classroom time, which aside from impacting academic outcomes also reduced opportunities for social-emotional learning (SEL) – a foundational set of interpersonal, self-awareness, and self-control skills that show up throughout a child's K-12

[10] In this report, COVID-19 refers to the heightened impacts of the pandemic experienced from 2020-2022.
[11] Thompson, D., "Why American Teens Are So Sad," The Atlantic, April 2022, https://www.theatlantic.com/newsletters/archive/2022/04/american-teens-sadness-depression-anxiety/629524/

curriculum. A lack of SEL is consequential, as it has been shown to be a promoter of youth mental well-being.[12] Additionally, researchers have documented shifts in brain development amongst today's youth. The research suggests that youth are feeling the effects of stress at an earlier age than ever before, at ages when their brains have yet to develop mature ways of coping.[13]

> *"When school went online [during COVID-19] it was easy to feel alone and feel like you [didn't] really have anybody to talk to, any friends or anything like that. That can really help you feel sad." –K., White male, 15-18*

Youth are feeling disconnected from their community and others. Research studies have documented the rise in loneliness amongst young people since the onset of COVID-19, exacerbating a pre-existing trend.[14,15] Interviews with local youth suggest this is true in the Cincinnati region as well, as they often report feeling disconnected from one another and the adults outside their home with whom they've had trusted relationships – an important protective factor against poor mental health outcomes.[16] Reengaging in person proved to be daunting for some as many report struggling with social anxiety. Young people sometimes feel uncomfortable socializing in person because they no longer have a sense of belonging to a particular community.

> *"The struggle is making friends because I'm better at making online friends… But when I get face-to-face with somebody… I don't think I'm ready for this whole full-on conversation… and then that's when all the suicidal thoughts come back and the depression and then that's when I just like, cut off everybody." –V, White, 18+*

> *"Now my social anxiety is so bad… Making adult friendships is so much harder than when you're a teenager. And so right now my biggest struggle is feeling like I'm isolated, even though I know I'm not actually isolated. And then like, trying to overcome my own anxiety about making new friendships as an adult, because it shouldn't be that hard, right? Like, it's so hard." –E., White female, 18+*

Systemic issues of violence and discrimination are eroding young people's sense of community safety. Like other American cities, Cincinnati has seen a surge in violence in recent years. Violent crime is spiking in some parts of the city – up by 20%+ in some city police districts[17] – and shootings involving

[12] "Connecting Social and Emotional Learning with Mental Health," Collaborative for Academic, Social, and Emotional Learning at the University of Illinois at Chicago, January 2008, https://files.eric.ed.gov/fulltext/ED505361.pdf

[13] Richtel, M., "'It's Life or Death': The Mental Health Crisis Among U.S. Teens," The New York Times, May 2022, https://www.nytimes.com/2022/04/23/health/mental-health-crisis-teens.html

[14] Baah, N., "Young People Are Lonelier Than Ever, Vice, April 2022, https://www.vice.com/en/article/z3n5aj/loneliness-epidemic-young-people

[15] Thompson, D., "Why American Teens Are So Sad," The Atlantic, April 2022, https://www.theatlantic.com/newsletters/archive/2022/04/american-teens-sadness-depression-anxiety/629524/

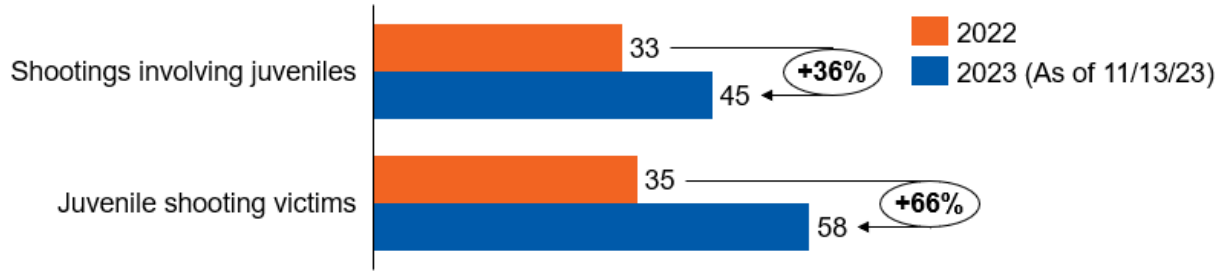
[16] Pringle, J., "The relationship between a trusted adult and adolescent outcomes: a protocol of a scoping review," Systematic Reviews, November 2018, https://www.doi.org/10.1186/s13643-018-0873-8

[17] "Gun violence in Cincinnati," FOX19 Cincinnati, June 2023, https://www.youtube.com/watch?v=7da7o8PAR8U

youth have risen sharply despite the overall number of shootings reducing over the past 3 years.[18,19] Since the passage of 2022's "constitutional carry" gun law in Ohio, which allows adults 21 and older to carry and conceal a firearm without training or a permit, young adults' ease in legally acquiring a gun has increased.[20]

Local youth suffer from neighborhood violence, not only because violence in their neighborhoods has disrupted their abilities to return to routines post-pandemic and challenges safe passage to school, but also because they are victims themselves. In Cincinnati, as of November 2023, there have been 58 juvenile shooting victims, compared to 35 for all of 2022.[21] Youth and those that work closely with youth express how despondent they feel about neighborhood violence – and for some of the most impacted youth, they struggle to see how the future could be better.

Shootings Involving Juveniles, Cincinnati[22]



"Some neighborhoods can be rough. If it was a safe community and less violence and stuff like that, I just feel like people should be out there having great communication with their community. Once upon a time everybody was getting along in their little neighborhood, and everybody knew each other." –Z., African American female, 18+

"Gunshots and violence are going off in the parking lot or the gas station across the street and the kids don't even duck. They are so used to it… We talk to a lot of young teenagers and young adults and we're talking about future planning. You can't even ask these young people for a 4- or 5-year plan… They don't see themselves living that long. That is a major mental health issue." –Local behavioral health provider

[18] LeBus, M. "Juvenile shootings higher than they have been in 10 years, CPD report says," FOX19 Cincinnati, November 2023, https://www.fox19.com/2023/11/14/juvenile-shootings-higher-than-they-have-been-10-years-cpd-report-says/
[19] "Reported Shootings," CincyInsights, https://insights.cincinnati-oh.gov/stories/s/Reported-Shootings/xw7t-5phj
[20] "When does Ohio's constitutional carry law go into effect?," Akron Beacon Journal, June 2022, https://www.beaconjournal.com/story/news/local/2022/06/08/ohios-permitless-carry-firearm-law-takes-effect-june-13/7553463001/
[21] LeBus, M. "Juvenile shootings higher than they have been in 10 years, CPD report says," FOX19 Cincinnati, November 2023, https://www.fox19.com/2023/11/14/juvenile-shootings-higher-than-they-have-been-10-years-cpd-report-says/
[22] Ibid.

"Everyone in this city has a gun, every child. It is shocking to people that I don't carry a gun. More people do than don't." –Local judicial official

Additionally, local youth commented on the rise in legislation impacting LGBTQ+ people. In Ohio, the House of Representatives has introduced multiple bills that impact LGBTQ+ people, including one bill that challenges youth's access to gender affirming care and their participation in sports teams consistent with their gender identity.[23] In Kentucky, SB 150 was successfully passed this year, which includes similar restrictions and also bars youth from using restrooms consistent with their gender identity, prohibits school instruction on sexual orientation and gender identity at all levels, and allows teachers to not use a student's preferred pronouns, to name a few.[24]

"Even politics affect my mental health. It's crazy how all these laws are changing and they're trying to restrict people from doing a transition or whatever. It holds me back from exploring myself because you never know what's coming for you. And it feels very dangerous, and you know, all these killings and everything. I'd be scared to go to LGBTQ+ parades and stuff." –T., African American male, 18+

The rise in gun violence and legislation impacting LGBTQ+ people is layered on top of the ongoing, systemic challenge of racism that shapes life in Cincinnati and elsewhere. Research shows a link between experiences of racism and discrimination and poor mental health outcomes amongst youth.[25] The stress and trauma caused by experiencing racism leads to an increased likelihood of psychiatric disorders – such as PTSD and eating disorders.[26] A study in Ohio shows that Black youth that experience discrimination are 4 times more likely to report frequent mental distress – which is associated with emotional, developmental, and behavioral challenges for which treatment or counseling is needed.[27]

The impact of racism on youth mental health is exemplified by the way the juvenile justice system disproportionately criminalizes Black youth. In Ohio, more than half of youth in Department of Youth Services facilities are Black, despite self-reported data that shows Black and white youth commit offenses at similar rates. Ohio judges are also more likely to place white youth in community-based alternatives to prisons than Black youth.[28] A snapshot of data from a local agency bears this out; two-thirds of their youth clients in incarceration diversion programs are white.[29]

---

[23] "Ohio House Passes Multiple Anti-LGBTQ+ Bills; Human Rights Campaign Condemns Passage & Urges Against Senate Passage," Human Rights Campaign, June 2023, https://www.hrc.org/press-releases/ohio-house-passes-multiple-anti-lgbtq-bills-human-rights-campaign-condemns-passage-urges-against-senate-passage

[24] Ring, T., "Kentucky Passes One of Nation's Worst Anti-LGBTQ+ Laws by Veto Override," The Advocate, March 2023, https://www.advocate.com/politics/gender-affirming-care-ban-kentucky

[25] Bernard, D. et al., "Racial discrimination and other adverse childhood experiences as risk factors for internalizing mental health concerns among Black youth," Journal of Traumatic Stress, https://doi.org/10.1002/jts.22760

[26] "What are the effects of racism on health and mental health?" Medical News Today, December 2022, https://www.medicalnewstoday.com/articles/effects-of-racism#overview

[27] Steinman, K. et al., "Perceived Racial Discrimination and the Health of Black Youth in Ohio," Ohio Journal of Public Health, December 2020, https://www.researchgate.net/publication/348023852_Perceived_Racial_Discrimination_and_the_Health_of_Black_Youth_in_Ohio/fulltext/5ff29b49a6fdccdcb82a7d52/Perceived-Racial-Discrimination-and-the-Health-of-Black-Youth-in-Ohio.pdf

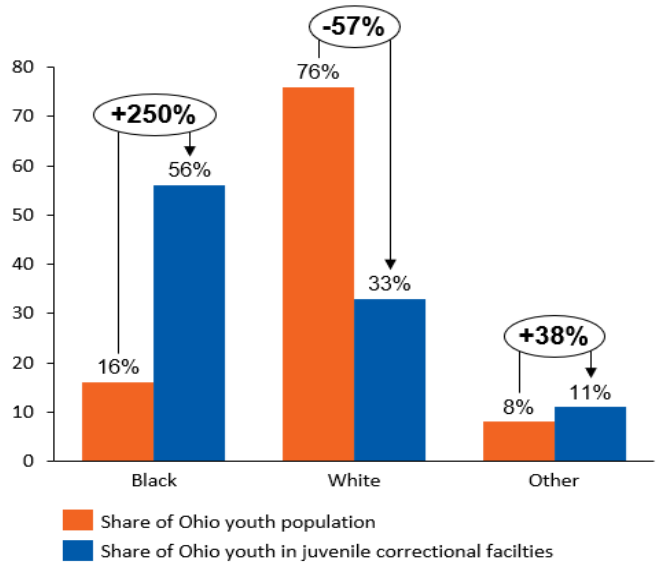
[28] "Promise Over Punishment," Policy Matters Ohio, January 2021, https://www.policymattersohio.org/research-policy/quality-ohio/justice-reform/promise-over-punishment

[29] Client data on incarceration and diversion, Cincinnati-based social services agency

Despite studies that show that 60% to 70% of youth in detention centers have a diagnosable mental illness,[30] this data suggests that white youth are often given the benefit of the doubt and seen as needing mental health support, while Black youth are seen as needing to be punished for the same behaviors. Unfortunately, this bias results in Black youth disproportionately experiencing the trauma of the juvenile justice system, which often has a lasting negative impact on a young person's mental well-being.

> *"Kids that have been incarcerated are almost 100% African American. Kids who are in diversion programs are almost 100% Caucasian kids. We finally have the data to show those disparities." –Local behavioral health provider*

Youth Incarceration Rates by Race in Ohio, 2018[31]



Youth do not have adequate access to safe, free community spaces outside of home and school. Youth and those that work closely with youth frequently give voice to the lack of safe, supportive, and free community spaces where youth can casually gather. This finding is consistent with the documented loss of "third spaces" – public spaces for gathering in our communities (e.g., cafes, churches, halls) that are vital for fostering community connection.[32] Youth mention that they are rarely consulted on what a nurturing community space would look like for them – that the adults do not trust them to make decisions on their own needs. In the absence of such spaces, youth sometimes gather in spaces where

[30] Gardner, P., "An Overview of Juvenile Mental Health Courts," American Bar Association, September 2021, https://www.americanbar.org/groups/public_interest/child_law/resources/child_law_practiceonline/child_law_practice/vol30/september_2011/an_overview_of_juvenilementalhealthcourts/

[31] Harvell, S. et al., "Data Snapshot of Youth Incarceration in Ohio," Urban Institute, May 2020, https://www.urban.org/sites/default/files/publication/102218/data-snapshot-of-youth-incarceration-in-ohio_0.pdf

[32] Butler, S. et al., "'Third places' as community builders," The Brookings Institution, September 2016, https://www.brookings.edu/articles/third-places-as-community-builders/

adults do not want them (and may have written policies to keep them out), such as in stores, malls, or parking lots. As a result, some youth gather little outside of school or home and have supplanted their in-person socialization with online communities.

> *"What we hear most often is – 'there's nothing for us to do.' Even though we have the rec centers, there is nothing to do after school. [Youth want to have] fun – just a place where they can go and hang out, hear some music, play video games – a place to kick back. 'We don't have a place to kick back,' is what they say." –Local behavioral health provider*

> *"I want the community to feel more communal. COVID-19 played a part in it – people don't know how to socialize anymore. We don't get that 1:1 in person communication anymore. We are pack creatures – meant to be around each other. It's hard to find a space where people can sit and hang together that doesn't involve money or alcohol." – M., White female, 18+*

Opportunities to increase safety and connection throughout the community environment

This section details the following community-generated opportunities:

1. Engage young people in **community building**, **organizing**, and **advocacy**.
2. Implement **trauma-informed policies** and practices throughout the community.
3. Expand **violence intervention programs** throughout the community.
4. Create **dedicated community spaces** for youth to gather.

---

1. Train young people in community building, organizing, and advocacy. Young people in the Cincinnati area are clear about what they want the world to look like for themselves and their peers. They can name the community challenges around them and how they are affecting their lives and mental well-being. Some young people interviewed shared they want to take an active role in being part of the solution. Local community organizing groups could provide training for young people on the principles of community organizing and advocacy and oversee initiatives to help them implement organizing efforts. For instance, adults could support young people that are very concerned about the problem of gun violence to advocate for the changes in gun policies that would improve their safety and well-being.

> *"I'm figuring out how to get involved in the community, like doing more than just going to work and being to yourself. I know it's hard because sometimes local communities have nothing going on. But even going outside and talking to people—that's being part of your community." –D., African American male, 18+*

2. Implement trauma-informed policies and practices throughout the community. Being trauma-informed means understanding how experiences of trauma impact individuals and communities and designing supports that are empathetic and bespoke to their needs. Organizations across a variety of sectors – government agencies, community organizations, and private sector employers, for example – can become more trauma-informed by redesigning their policies and practices toward supporting their unique set of stakeholders in recovering from and thriving in the face of trauma, ultimately leading to healthier, more resilient communities.

Example: Through city legislation, Baltimore became the first city in the nation to mandate trauma-informed training across all city agencies and requires them to rewrite policies to reduce re-traumatization of its citizens. A delegation from Baltimore recently came to Cincinnati in the fall of 2023 to share insights and meet with City and County leaders around similar work in the Cincinnati area. In Baltimore, this legislation grew from local youth, who, following a school shooting, became more vocal about their experiences of trauma and demanded that their city legislature act. Several local community organizations also play a role in implementing this act; they are charged with implementing training throughout the city and its agencies and offering mindfulness, self-care, and healing activities and resources [See Case Study: Healing City Baltimore in the Appendix for more information].[33,34,35,36]

> *"I wish that people themselves, and communities as a whole, were much more appreciative of some of the traumas and experiences of other people. Provide a means for the opportunity to go to therapy, get resources or do communal activities to foster their connections to prevent loneliness and isolation. I think that community support would also rally around people who have either been victimized or people who are held vulnerable." –J., White male, 18+*

3. Expand violence intervention programs throughout the community. Violence intervention programs are present throughout the country and take various forms, all with the goal of reducing neighborhood violent crime. Such programs have received renewed attention in recent years as gun violence has surged throughout the country. A common element of such programs is "violence interrupters" – trained community workers who build relationships with perpetrators and victims of violence and look for ways to encourage de-escalation and mediation. They also connect community members to resources such as employment opportunities and social services. Some of these programs also involve local community organizations and law enforcement agencies working toward shared strategies to reduce violence in particular neighborhoods or amongst targeted groups of community members.

Example: In 2018, Washington, DC's Office of Neighborhood Safety and Engagement launched its violence intervention initiative.[37] *This initiative focuses on priority neighborhoods throughout the city most impacted by gun violence, employs full-time violence interrupters, and has partnerships with several community-based organizations. The city recently began a multi-year evaluation of the program to determine community impact and outcomes.*[38]*The initiative's strategy is 3-pronged:*

1. *Community: Aims to reduce the culture of violence by investing in community capacity building, partnering with community pillars to lead empowerment and healing events in the community, and neighborhood canvassing to increase understanding of needs.*

---

[33] "Our Efforts," Healing City Baltimore, https://healingcitybaltimore.org/our-effforts
[34] "The Movement: Origins & Efforts," Healing City Baltimore, March 2022, https://www.youtube.com/watch?v=CaFctQjuNY8
[35] "Understanding Trauma & What We're Doing About It," Healing City Baltimore, November 2022, https://www.youtube.com/watch?v=kavu3byV2tY
[36] "The Elijah Cummings Healing City Act," Dare to Reimagine, January 2021, https://www.daretoreimagine.org/case-studies/baltimore-trauma-responsive-city
[37] "Violence Intervention Initiative," Government of the District of Columbia Office of Neighborhood Safety and Engagement, https://onse.dc.gov/service/violence-intervention-initiative
[38] Gathright, J., "D.C.'s Violence Intervention Programs to Receive In-Depth Evaluation," DCist, April 2023, https://dcist.com/story/23/04/11/dc-violence-interruption-data-effectiveness/

2. *People: Give those at-risk a safe space to heal and opportunities to improve their lives through trust-based and informal counseling and connections to resources.*
3. *Groups: Reduce cyclical and retaliatory violence by identifying sources of disputes, create spaces for dialogue, hold mediations, and negotiate ceasefires* [39]

The City of Cincinnati funds similar work via grants from its Human Services Fund to 20+ local community organizations.

4. Create dedicated community spaces for youth to gather. Provide young people with the opportunity to design their own community spaces and trust them to articulate the functions they need to serve. Youth want to use their own community spaces for casual gatherings and building social connections. Aside from casual gatherings, some youth mention community artmaking, mental health support groups, and community organizing as possible uses for a youth space.

> *"The need for additional spaces for our kids to go to let loose, have fun without any monetary requirements… Our communities are really not built for community, and I would love to see that happen in the future." –Local parent*

Existing local assets that may support pursuit of these opportunities:

- **There are existing community spaces that could be reimagined with youth input**; YMCAs, libraries, Boys & Girls Clubs, Edge Teen Center, and others
- **There are existing providers of trauma-informed training;** Mayerson Center for Safe and Healthy Children's Joining Forces for Children leads trainings with county and city leaders and some school districts including: CPS, Princeton City, Norwood City, and Northwest Local), Tristate Trauma Network, YMCA, and others
- **There are existing state policies to support suicide prevention;** Ohio's SAVE Act requires schools to implement an evidence-based suicide prevention program; 988 Suicide and Crisis Lifeline is being administered in Ohio through the Ohio Department of Mental Health and Addiction Services, and others
- **There are existing violence interruption programs throughout the city;** Grantees of the city's Human Services Fund, Urban Leagues' Community Partnering Center, Cincinnati Works' Phoenix Program, Save our Youth Kings & Queens, and others

[39] "Violence Intervention Initiative," Government of the District of Columbia Office of Neighborhood Safety and Engagement, https://onse.dc.gov/service/violence-intervention-initiative

School Environment

Challenge: Youth do not always experience school as a safe and supportive environment that supports their mental well-being. On the contrary, many young people experience significant amounts of bullying, stress, and harsh discipline and find that the adults in schools are not always well-equipped to support their well-being.

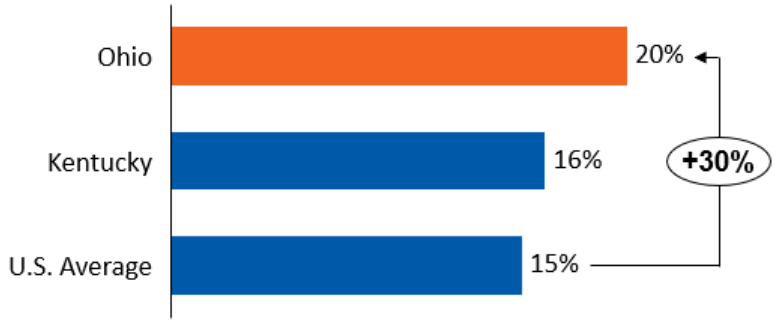
Cincinnati area youth spend significant portions of their lives attending school, and they express a strong desire to feel safe, understood, and supported by their peers and adults in the school environment. However, despite the best efforts of well-intended but overburdened teachers and school leaders, many local youth do not experience school in this way and frequently mention the stress of bullying, heavy workloads, and harsh disciplinary policies as underlying causes.

> *"I know a lot of my friends don't want to wake up and go to school. I think that if it was more supportive and people felt like it was a safe and comfortable [place] to go, then it would be a better time." –T., White male, 15-18*

> *"Coming back to school [has been] really hard because you still feel like you don't have anybody and because you don't really know anybody. Even now it feels like I don't really have a good connection with anyone." –K., White male, 15-18*

Bullying at school impacts young people's sense of well-being. Local youth reported in focus groups that frequent experiences of bullying impact their sense of safety and belonging at school. Available statistics suggest that local youth may be experiencing bullying more frequently than their peers across the country. In 2021, 19.5% of high schoolers in Ohioans reported bullying on school property, compared to 16% of Kentuckians and 15% nationally.[40] When youth do report bullying, some express that school staff do not have adequate resources to meaningfully intervene, which at times erodes their psychological safety and contributes to feelings of hopelessness.

High Schoolers in Ohio Bullied on School Property, prior 12 months, 2021[41]



[40] High School YRBSS, Center for Disease Control and Prevention, 2021, https://www.cdc.gov/healthyyouth/data/yrbs/index.htm
[41] Ibid.

"I was one of those kids who got bullied and it's not a good feeling. I just feel like with schools it's always 'come to me. Bullying is not tolerated in school.' Then they either tell you 'Oh, just ignore them' or they give them a warning." –Z., African American female, 18+

"Some rumors started and me and my friend both kind of experienced cancel culture… We were receiving death threats… Being on the other side of [the rumor] was definitely a different perspective and difficult to go through." – A., White female, <15

Students report stress caused by academic pressure. Many young people have shared that the pressure they face in school to perform impacts their mental well-being. In focus groups, youth noted that expectations pile on and shared that they are not receiving adequate support to manage workloads and cope with school-related stress. The impact of school-related stress is evident in local data documenting when youth initially seek mental health care or enter crisis. Data from a Cincinnati-based behavioral health provider shows a yearly increase in referrals in the spring and fall at the time when new school terms begin.[42] This is consistent with studies that have documented a seasonality to when youth first seek mental health care.[43]

"It's unrealistic standards, and each year it just gets harder and harder. We're told, '[you] live my life for school', and that's my job and so it's difficult when I'm doing bad at my 'job' and getting nothing in return, except for like punishments and stuff. I think a lot of people would feel more comfortable sending their kids off to school [if] sending your kids to school [gave] you peace of mind, knowing that it's a safe space." –A., White female, <15

"I feel like teachers… they're assigning homework and all this stuff, and you have to study for the test the next day, but like, you have six other classes and teachers doing the same exact thing. It just piles up. So just if teachers and just like people [were] more understanding... we don't work [in a paying job], but we go through the same stuff, too." –M., African American female, 15-18

When youth exhibit signs of mental health distress, school staff are not always equipped to intervene. Youth want teachers to take an active interest in their lives and be invested in their success. They hope by getting to know them better, teachers will be better able to recognize when they are having a bad day and offer support. However, youth report that teachers, burdened by the intense demands of the job and new challenges resulting from the pandemic, sometimes struggle to build these positive, nurturing relationships. This can result in a perceived lack of empathy from teachers.

"I'll walk into class, and I'll say 'hi' and the teacher won't say 'hi' back to me. That's a problem. I know being a teacher is a hard job, my mom's a teacher. But it makes it difficult to dedicate so much of my time and energy to a class all to get a letter grade and for them to not acknowledge my existence, let alone know my name and we're on

[42] Behavioral health referral data, Cincinnati-based provider

[43] Marshall, R. et al., "Mental Health Diagnoses and Seasonal Trends at a Pediatric Emergency Department and Hospital, 2015–2019," Hospital Pediatrics, March 2021, https://doi.org/10.1542/hpeds.2020-000653

the third week of school and I'm still 'the girl in the gray shirt'… Their class is like what my job is right now. They don't care about me." –A., White female, <15

"It's a school building full of kids who are depressed. They [adults] say 'you can talk to me' but then [they] don't come across as someone that you can talk to. They'll say that the first day of school, and then after that, they're the cause of half of the issues you have." –M., African American female, 15-18

Additionally, adult interviewees noted that children who are struggling with their mental health and lack adequate social-emotional skills are more likely to exhibit outbursts in school that teachers are not resourced to handle. When outbursts do occur, teachers sometimes assume the student has an underlying behavioral challenge and at times resort to disciplining the behavior instead of inquiring if a mental health need may be at the root. When a student's mental health needs are unmet and challenging behaviors continue, it can result in the student being removed from school (e.g., emergency removal for the rest of the school day; placement in an alternative school). This compounds the problem by removing even more opportunities for social-emotional skill and relationship building.

Student disciplinary action impacts Black and the youngest students the most and influences overall perceptions of school as a hostile environment. Disciplining student behavior when mental health support may be more appropriate impacts students of different races inequitably. Similar to national data that shows Black students are disciplined at higher rates,[44] a recent study from the ACLU of Ohio found that during the 2021-2022 school year, Cincinnati Public Schools' Black students compared to white students were 6 times more likely to receive out-of-school suspension, 8 times more likely to be expelled without instruction, and 21 times more likely to be placed in an Alternative Placement Center (i.e., an alternative to out-of-school suspension and expulsion program that provides additional academic, therapeutic and behavioral instruction).[45,46] It should be noted that when the district updated its code of conduct for the 2023-2024 school year, it increased its emphasis on using restorative practices (i.e., interventions that prioritize supporting the student's emotional well-being) instead of punitive action when responding to behavioral infractions.[47,48]

Mental health providers and educators have also noted the concerning rise in disciplinary action toward very young students. While Ohio Department of Education policy[49] and Cincinnati Public Schools policy[50]

[44] "Student Discipline and School Climate in U.S. Public Schools," U.S. Department of Education Office of Civil Rights, November 2023, https://www2.ed.gov/about/offices/list/ocr/docs/crdc-discipline-school-climate-report.pdf

[45] "The Promise Center," Cincinnati Public Schools, https://www.cps-k12.org/promisecenter

[46] "New Data Shows Over-Policing, Racial Disparities, and Lack of Accountability in Cincinnati Public Schools," ACLU of Ohio, July 2022, https://www.acluohio.org/en/press-releases/new-data-shows-over-policing-racial-disparities-and-lack-accountability-cincinnati

[47] Mitchell, M., "CPS superintendent recommends code of conduct changes," Cincinnati Enquirer, July 2023, https://www.cincinnati.com/story/news/education/2023/07/19/cincinnati-public-schools-updates-code-of-conduct-to-address-behaviors/70431199007/

[48] "Restorative Practices," Cincinnati Public Schools, https://www.cps-k12.org/Page/2387

[49] "Reduction of suspensions and expulsions for grades prekindergarten through three," Ohio Department of Education & Workforce, October 2020, https://education.ohio.gov/getattachment/Topics/Student-Supports/Creating-Caring-Communities/Reduction-of-pk-3-Suspensions-and-Expulsions.pdf.aspx

[50] "Code of Conduct 2023-2024," Cincinnati Public Schools, https://www.cps-k12.org/codeofconduct

both prohibit out-of-school suspension or expulsion for students in 3rd grade or lower except in cases that pose significant danger to school safety, some interviewees note that the practice persists. National data mirrors this local observation; preschoolers are expelled at three times the rate of children in kindergarten through 12th grade.[51]

Black students compared to white students in Cincinnati Public Schools are:[52]

6x more likely to receive out-of-school suspension

8x more likely to be expelled from school without instruction

21x more likely to be placed in an Alternative Learning Center

Opportunities to create a safer and more supportive school environment

This section details the following community-generated opportunities:

1. Offer frequent and ongoing **mental health and well-being training** for school faculty and staff.
2. Equip youth to support the **mental well-being of their peers**.
3. Create **wellness spaces** for decompression, self-regulation, and mental health support in schools.
4. Shift school priorities and messaging to further **emphasize student well-being**.
5. Conduct **universal mental health screenings** in all schools.

1. Offer frequent and ongoing mental health and well-being training for school faculty and staff. These trainings should equip school faculty and staff to better understand how mental health and brain development impact youth behaviors, how to implement trauma-informed practices, and identify warning signs that point to more serious mental health concerns. Outcomes from the trainings should include increased ability to recognize signs and symptoms of mental health challenges amongst youth, increased ability to connect students to appropriate resources, and increased empathy and understanding of youth behavior that results in reduced reliance on disciplinary action. Explore how these trainings can become a part of an educator's regular professional development trainings so they are embedded and delivered continuously.

[51] "Understanding and Eliminating Expulsion in Early Childhood Programs," Early Childhood Learning and Knowledge Center, U.S. Department of Health & Human Services, December 2023, https://eclkc.ohs.acf.hhs.gov/publication/understanding-eliminating-expulsion-early-childhood-programs

[52] "New Data Shows Over-Policing, Racial Disparities, and Lack of Accountability in Cincinnati Public Schools," ACLU of Ohio, July 2022, https://www.acluohio.org/en/press-releases/new-data-shows-over-policing-racial-disparities-and-lack-accountability-cincinnati

Example: Alberta Family Wellness Institute funded the development of "A Brain Story," a free online certification course that trains participants on how experiences during childhood shape our brains and influence our human relationships. The course equips participants with knowledge of the importance of healthy brain development during childhood and how to support lifelong mental and physical well-being. School faculty members that have completed the training report increased empathy and understanding of behavior toward their students and decreased likelihood of viewing children struggling with executive function or self-regulation as "bad kids." [See Case Study: A Brain Story in the Appendix for more information].[53,54]

2. Equip youth to support the mental well-being of their peers. Many young people mention their preference to discuss mental health with peers as opposed to or in addition to adults. Additionally, many youth with lived experience of mental health challenges express their desire to share their story and to support their peers' well-being. Youth-led prevention programs in schools can meet both of these desires. The central features of these programs may include students acting as supporters and trusted listeners for peers who are struggling with mental health concerns, guided under the supervision of qualified adults. Outcomes of these programs can include youth having better understanding of mental health topics, increased feelings of support from and connection to their peers, and increased connections to care providers when they need them.

Example: Sources of Strength Ohio is a state-level implementation of the national Sources of Strength well-being program for K-12 students. The program has both elementary (K-grade 6) and secondary (grades 7-12) adaptations of the program. The elementary program is an evidence-based classroom curriculum aiming to help students build resiliency, help-seeking behaviors, and connectivity. The secondary program introduces adult advisors and youth peer leaders who are tasked with developing awareness campaigns in their schools, which often utilize creative art making, storytelling, and games – and is an approved program under Ohio's SAVE Students Act. Studies of the secondary program implemented across a diversity of schools (i.e., urban, rural, suburban, and tribal) across the country suggests increased connection of suicidal students to adults, increased student perception of adult support for suicidal youth,[55] *and that it may reduce deaths by suicide.*[56]

Example: Hope Squad is a national youth peer support model active in 1,200+ educational institutions, including some Cincinnati area schools. Students nominate peers to the Hope Squad. Once selected, Hope Squad members are trained by a local mental health agency partner on how to act as a trusted support system, identify suicide warning signs, and connect students to trusted adults. Successful adaptations of Hope Squad have been shown to reduce mental health stigma, increase referrals to care, and reduce deaths by suicide. [See Case Study: Hope Squad in the Appendix for more information].[57,58,59]

[53] "Brain Story Certification," Alberta Family Wellness Initiative, https://www.albertafamilywellness.org/training/
[54] FSG Evaluation, 2020
[55] "Evidence base," Sources of Strength, https://sourcesofstrength.org/about/#evidence-base
[56] Wyman, P. et al., "Impact of Sources of Strength on adolescent suicide deaths across the three randomized trials," Injury Prevention, July 2023, https://doi.org /10.1136/ip-2023-044944
[57] "Mission & History," Hope Squad, https://hopesquad.com/mission-history/
[58] "Evidence & Grant Application Information," Hope Squad, https://hopesquad.com/evidence/
[59] "What is Hope Squad?" Hope Squad, October 2020, https://www.youtube.com/watch?v=fZzanuKgJ4M

"I think it'd be helpful if we could train kids on how to actually handle [issues in their friends' lives] because a lot of time people feel most comfortable reaching out to friends." –A., White female, 15-18

"Having that support system and having the upperclassmen and the lowerclassmen just all together in one room and sharing the same problems. Being there for one another to be like, 'oh, yeah, I understand that. Here's how I dealt with that.'" –A., Native American female, 15-18

"[Hope Squad teaches us] how to identify exactly what that person is feeling and if they don't know, help them reach a conclusion about how they're feeling, show them that it's okay to go get help, who to contact when you need help – and not just texting the Hope Squad advisor, knowing who that person should go to." –S., White female, <15

3. Create wellness spaces for decompression, self-regulation, and mental health support in schools. Aside from youth clearly naming a desire for safe spaces more generally, youth stand to benefit from dedicated wellness spaces within schools. Wellness spaces can assist students in decompressing from academic stress, finding space away from bullies, and self-regulation via sensory activities during periods of overwhelm. These spaces can also serve as the touchpoint for a school-based counselor or other wellness-dedicated staff within the school.

Example: Trillium Family Services, the largest provider of youth and family behavioral health services in Oregon, launched a program called "Keep Oregon Well in Schools" with pilots at schools in the Portland, Oregon metropolitan area. Trillium implements prevention-based models in all participating schools, and one school built a dedicated wellness space for students. The wellness center has a variety of spaces for social-emotional skill building, serves as a space for student decompression and conversation, and is where students can interface with a counselor. [See Case Study: Keep Oregon Well in Schools in the Appendix for more information].[60,61,62,63,64]

"I would love to see more physical spaces for kids in school, kind of like a muscle room, if you will… So that when they need space to just float, to walk around, that they can get that energy off, and we are trained to recognize that that's what they need as opposed to a disciplinary action." –Local parent

4. Shift school priorities and messaging to further emphasize student well-being. Community leaders consistently express how the role of school is more than academic education – it is also for creating a holistic environment that supports youth well-being and future life success. School leaders hold a similar mental model, but such philosophies can sometimes be drowned out by messaging around academic achievement or by political barriers to greater investment in health and well-being topics. To the extent

[60] "In Schools," Trillium Family Services, https://www.trilliumfamily.org/keep-oregon-well-in-schools
[61] "Programs & Services," Trillium Family Services, https://www.trilliumfamily.org/programs-and-services
[62] "Keep Oregon Well in Schools at Kraxberger Middle School," Trillium Family Services, December 2018, https://www.youtube.com/watch?v=YlhAXl_ZJlA
[63] "Keep Oregon Well in Schools at Centennial Park School," Trillium Family Services, December 2018, https://www.youtube.com/watch?v=MErUpRSq_LA
[64] "Keep Oregon Well in Schools: Denise Wright of Centennial School District," Trillium Family Services, July 2018, https://www.youtube.com/watch?v=KgLtx_aC0e4

achievable within these constraints, schools could explore ways to further expand efforts to increase messaging and accountability tools in support of health and well-being related topics' inclusion in curriculum, school success measures for student well-being, and practices that centers cultural inclusion – which has been shown in research to foster resilience and healing.[65]

5. Conduct universal mental health screenings in all schools. Researchers estimate that ~80% of young people experiencing mental health concerns fail to receive treatment, especially young people living in under-resourced areas or belonging to low-income families.[66] Universal mental health screenings are proven to be an important tool toward identifying these students so they can be connected to care before the severity of their needs intensifies. Screening is especially critical amongst adolescent youth, as it is believed that about half of all mental health disorders onset by this time.[67] Momentum for universal screenings is building – in 2022, the United States Preventive Services Task Force recommended screening young people ages 12-18 for depression and anxiety.[68,69]

> *"My doctor told me they'd give me a screening for anxiety. If you got 25 points or higher you had anxiety, and I got a 37. Ever since I got diagnosed, with the help of my mom and my dad of course and like my friends and family, I haven't been beating myself up as much and believing in myself more, and it's made my confidence go up. So, there's a happy ending to that story." –R., White female, <15*

Examples of existing local assets that may support pursuit of these opportunities:

- **School-based counselors**; currently present in all Cincinnati Public Schools
- **MindPeace Rooms**; spaces for emotional self-regulation currently in 56 schools in the Greater Cincinnati region; 26 are in Cincinnati Public Schools
- **There are many mental health trainings that can be implemented for school-based staff;** from 1N5, Peer Health Exchange, Mayerson Center for Safe and Healthy Children's Joining Forces for Children, the Consortium for Resilient Young Children's Resilient Children Families Project, and others
- **There are existing mental health education and support programs for youth**; All Ohio Department of Education approved evidence-based prevention programs for schools including Teen Mental Health First Aid; Beech Acres Beyond the Classroom, Positive Behavioral Interventions and Supports (PBIS), and others
- **There are existing school-based prevention funding opportunities**; OMHAS Prevention Services, ODE Student Wellness and Success Fund, and others

---

[65] Kirmayer, L. et al. "Rethinking Resilience from Indigenous Perspectives," The Canadian Journal of Psychiatry, February 2011, https://doi.org/10.1177/070674371105600203

[66] Wood, B. et al., "Universal Mental Health Screening Practices in Midwestern Schools: A Window of Opportunity for School Psychologist Leadership and Role Expansion?" Contemporary School Psychology, October 2022, https://doi.org/10.1007/s40688-022-00430-8#ref-CR37

[67] Goodman-Scott, E. et al., "The case for universal mental health screening in schools," Counseling Today, September 2019, https://ct.counseling.org/2019/09/the-case-for-universal-mental-health-screening-in-schools

[68] "Depression and Suicide Risk in Children and Adolescents: Screening," U.S. Preventive Services Task Force, October 2022, https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/screening-depression-suicide-risk-children-adolescents

[69] "Anxiety in Children and Adolescents: Screening," U.S. Preventive Services Task Force, October 2022, https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/screening-anxiety-children-adolescents

Caregiver Knowledge, Attitudes, and Practices

Challenge: Caregivers[70] are not always well-versed in or do not always acknowledge mental health as a real issue for themselves or the youth they care for, resulting in stigma, adverse experiences for youth, and lack of access to care when youth are in need.

In focus groups, many young people demonstrated strong awareness and willingness to discuss mental health topics. However, many also observed that their caregivers often lacked the level of awareness needed to support their mental health needs. At the root of this is that many caregivers suffer from stigma around mental health, leading them to miss warning signs in their children or to be critical of them when they seek support. Additionally, caregivers may have untreated mental health disorders and their own experiences of childhood trauma, which can impact their children's development and may contribute to adverse experiences for children in the home.[71]

> *"My parents didn't believe in any mental health help or therapy or anything like that or medicine… To them that was the same as any type of drug. Getting on medication was hard emotionally because it felt like, 'Oh, no, I'm going to be dependent on this. It's the same as being on any other drug.'" –D., White male, 18+*

When caregivers contribute to adverse environments at home, children experience trauma that can impact their mental health. While some local youth have advantaged and safe upbringings, many are subjected to adverse environments in their home life. Adverse childhood experiences (ACEs) are traumatic events in childhood such as abuse or neglect that can increase the risk of poor physical and mental health outcomes.[72] Children in both Ohio and Kentucky are more likely to experience 2 or more ACEs, at 15.9% and 19.5% respectively, than the national average – 14.0%. In both states, children living in poverty, Black children, and Latinx children are at a higher risk.[73] In particular, child maltreatment, which includes physical, emotional, and sexual abuse or exploitation, is more prevalent in Ohio and Kentucky compared to the national average – 9.3 and 14.7 per 1,000 children, respectively, compared to 8.1 per 1,000 children nationally.[74] This has huge impacts for local youth mental well-being—for example, in Hamilton County, about half of all suicides occur to youth who have been victims of maltreatment.[75]

[70] "Caregivers" are defined in this assessment as adults responsible for caring for children in home environments (e.g., parents, grandparents, foster parents)

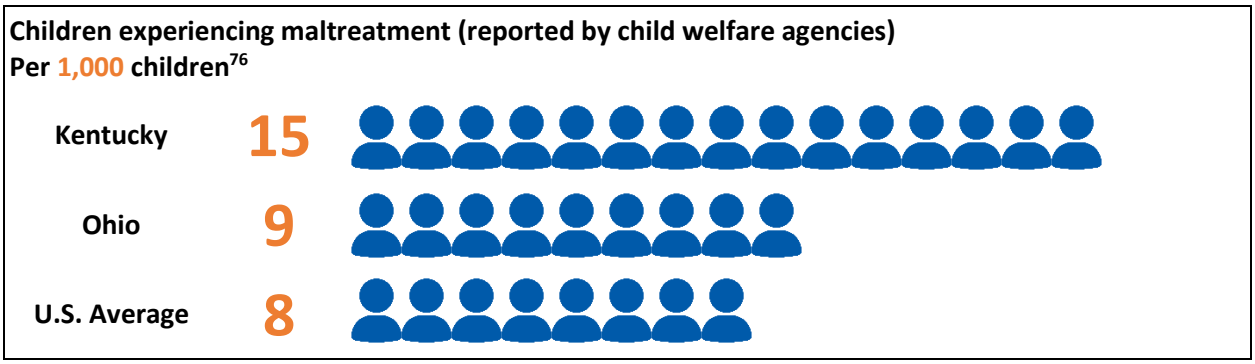
[71] Folger, A. et al., "Parental Adverse Childhood Experiences and Offspring Development at 2 Years of Age," Pediatrics, April 2018, https://publications.aap.org/pediatrics/article-abstract/141/4/e20172826/37806/Parental-Adverse-Childhood-Experiences

[72] "Adverse Childhood Experiences (ACEs)," Center for Disease Control and Prevention, June 2023, https://www.cdc.gov/violenceprevention/aces/index.html

[73] America's Health Rankings, United Health Foundation, 2023, https://www.americashealthrankings.org

[74] "State-level Data for Understanding Child Welfare in the United States," Child Trends, April 2023, https://www.childtrends.org/publications/state-level-data-for-understanding-child-welfare-in-the-united-states

[75] "Hamilton County Child Fatality Review," Hamilton County Public Health, 2018, https://www.hamiltoncountyhealth.org/wp-content/uploads/2018_Annual_Report.pdf



The high rates of maltreatment likely contribute to the region's higher rates of foster care placement. Kentucky has experienced a foster care crisis for several years, with 5.0 per 1,000 children placed in foster care compared to 2.8 across the country. Ohio is not far behind at 3.7 per 1,000 children.[77] If families have the resources and skills to create positive environments that support wellness for children at home early on, they can help to prevent mental health challenges and a need for intervention down the line.

> *"We separate a lot of kids from their families. We have a lot of foster care in general. We have a lot of that based on parental mental health usually. Very few child abuse cases are based on violent adults. It's based on not knowing how to regulate your emotions or struggling with another mental health challenge." –Local official*

Caregivers' own mental health needs are going untreated. Often at the root of youth's experiences of ACEs is their caregiver's own mental health challenges. Local health data across the 12 Ohio and Kentucky counties within the Cincinnati metropolitan area reveals that in 10 counties adults report frequent mental distress and poor mental health days at rates significantly above the average American (i.e. at rates 10%+ greater the national average [relative percentage, not percentage points]).[78] Additionally, when adult mental health isn't addressed and thus caregivers are not operating at their best, youth note that their basic needs are sometimes not met (e.g., emotional care, parent-child connection) or they take on larger roles in the household, such as caring for a younger sibling, resulting in increased burden and stress.

> *"Parents [are] not dealing with their own undiagnosed, untreated health issues whether they be physical, mental, or emotional." –Local parent*

> *"Every generation before my grandpa, there was a suicide [in my family] and it was usually a male, and it was usually the father of the family. So, it's so interesting to me that my dad and his family are so like, 'hush hush, don't talk about mental health' when it very clearly runs in the family." –E., White female, 18+*

---

[76] Ibid.

[77] "State-level Data for Understanding Child Welfare in the United States," Child Trends, April 2023, https://www.childtrends.org/publications/state-level-data-for-understanding-child-welfare-in-the-united-states

[78] County Health Rankings, UW Population Health Institute & Robert Wood Johnson Foundation, 2023, https://www.countyhealthrankings.org/

Caregivers suffer from generational mental health stigma. Youth frequently mention that their parents and elders stigmatize mental health issues. Generally, young people observe that their caregivers do not view mental illness as a serious health matter nor care to discuss it. Local youth often had stories of a parent, grandparent, or other family member with an unaddressed mental health condition and shared its impact on family life. Sometimes, family members with mental health conditions were completely ostracized. Some youth mention that caregivers cannot comprehend or empathize with how their experiences of stress, worry, and contemporary social problems impact their mental health. Stigma also prevents many adults from recognizing and accepting their own mental health needs. Youth note that their ability to recognize their own challenges and efforts to improve their well-being are delayed—sometimes by years—because they have not seen it modeled by the adults around them.

> *"When they were our age, it wasn't okay to talk about mental health. If you weren't okay, it was 'suck it up, deal with it' but I still think that parents don't know everything. I want to say [parents are] reluctant to change. I think that learning something new is scary, especially if you're an adult and you realize that everything taught to you [was] toxic." –E., White female, <15*

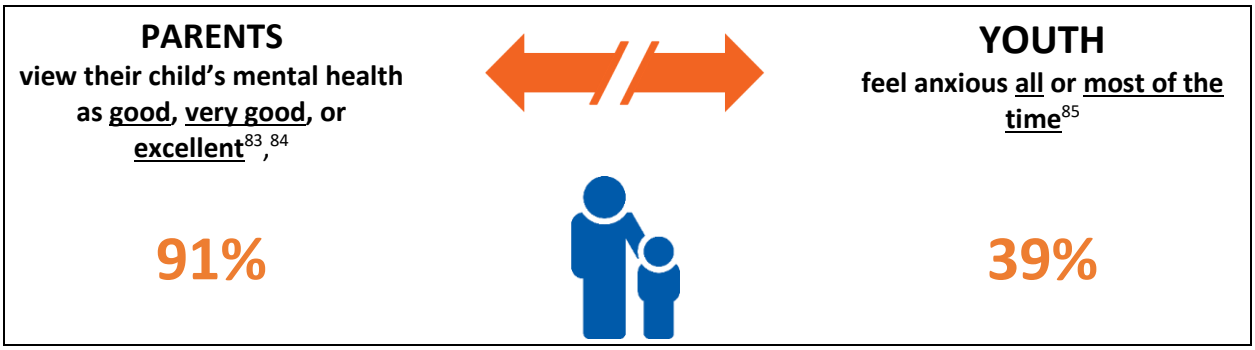
> *"The root causes, it starts at home… We learn what we learn from our surroundings and how we were raised. How can we know or have an understanding of mental health when our parents don't even know? When we go to our parents, and we say 'depressed,' they say stuff like, 'depressed your ass.'" –E., African American female, 15-18*

> *"I know a lot of older adults, they like grew up not connecting with mental health. It will be like 'oh, you're not depressed. You don't even know what depression is. You don't have anxiety. Anxiety is fake. You're doing this on purpose. You're trying to get attention.'" – D., African American female, 18+*

> *"My dad doesn't believe in mental disorders. He's like, 'the mind is more powerful than all those things. You can overcome anything if you put your mind to it.'" – M., White female, 18+*

Caregivers too often miss signs that their child is struggling with their mental health. Adult stigma and general unfamiliarity with topics surrounding mental health contribute to adults having incorrect perceptions of their child's current mental health. Local survey data exemplifies the disconnect between what youth report and what caregivers perceive: 9 out of 10 local caregivers surveyed believe their child's mental health is good, very good, or excellent,[79,80] while 4 out of 10 youth report feeling anxious all or most of the time.[81,82]

[79] "Community Health Needs Assessment," Cincinnati Children's Hospital Medical Center, 2022, https://www.cincinnatichildrens.org/about/community/health-needs-assessment
[80] Youth 18 and under
[81] "2022 Student Survey, Alcohol & Drug Misuse by Youth in Southwest Ohio," PreventionFIRST!, 2022, https://www.prevention-first.org/media/centers/CPS/Student%20Survey%202022_Regional%20One%20Page%20Summary.pdf
[82] Grade 7-12



Caregivers are not always equipped to intervene when youth need mental health support. Early intervention is known to prevent mental health conditions from progressing into higher levels of acuity that require formal diagnosis and treatment. Unfortunately, youth mention experiences of their caregivers not knowing how or when to intervene when they show signs of mental health challenges, which at times leads to worse conditions.

Some youth note that their behaviors connected to underlying mental health challenges were met with harsh disciplinary action, or in some cases, corporal punishment. Others note that even if an adult senses a need for early intervention, they are so unfamiliar with the system that they do not know what to do. Some adult interviewees note this is particularly true for kids with neurodivergent characteristics. Unable to spot the symptoms, adults will often punish the behaviors associated with ADHD, autism, and other neurodivergent conditions, or not seek assistance for the youth at all.

> *"I feel like it starts with families. Families need to be more open and understanding. A lot of families sweep things under the rug, and they expect you to be fine and okay. I feel like my mother's biggest issue was that she was never okay. She wasn't okay enough to raise children. Her mental health was so messed up that she just wasn't what she was supposed to be for her children." –S., African American female, 18+*

> *"I feel like if my parents were not raised to be embarrassed when they were going through something mentally, then I think it would have been a lot easier for them to be understanding. I'm not angry at my parents for how they handled mental health issues because that's how they were raised and how their parents were raised." –L., White female, 18+*

> *"I think that parents will take anything that they aren't satisfied with, and they'll point at a kid and say, 'why aren't you like them?' or 'they're getting straight A's – why aren't you?' And I think that's really detrimental." –E., White female, <15*

[83] "Community Health Needs Assessment," Cincinnati Children's Hospital Medical Center, 2022, https://www.cincinnatichildrens.org/about/community/health-needs-assessment

[84] Weighted average of result from online survey and phone survey

[85] "2022 Student Survey, Alcohol & Drug Misuse by Youth in Southwest Ohio," PreventionFIRST!, 2022, https://www.prevention-first.org/media/centers/CPS/Student%20Survey%202022_Regional%20One%20Page%20Summary.pdf

Opportunities to support caregivers in becoming more well-versed in mental health and better equipped to create positive, nurturing home lives for children

This section details the following community-generated opportunities:

1. Offer **widely accessible mental health training and social-emotional skill building** opportunities to caregivers.
2. Create a **support program for caregivers with children experiencing mental health challenges**.
3. Promote and **centralize access to parent resources** that assist them in creating better home environments.
4. Engage **employers to be trauma-informed** and to support employee family well-being.
5. **Challenge youth to design solutions** to advance adult mental health awareness and education.

---

1. Offer widely accessible mental health training and social-emotional skill building opportunities to caregivers. Provide opportunities for parents to learn about and be trained in identifying mental health signs and symptoms in their children and to build social-emotional skills that lead to improved home environments and help their children build resiliency. Consider increasing access to caregiver depression screenings, substance use counseling and treatment, and other opportunities to support caregiver awareness and mental, emotional, and behavioral health. Offer these opportunities in community spaces that caregivers frequent, such as schools and churches. Consider ways to incentivize caregivers to participate, such as offering prizes or compensation for completion. Conduct door-to-door outreach to parents so that they are aware of training opportunities or consider offering in-home training to caregivers to make their participation as light-lift as possible.

2. Create a support program for caregivers with children experiencing mental health challenges. Borrow elements of support models in other settings (e.g., cancer support groups) to create a model for caregivers supporting other caregivers caring for a child with mental health needs. Program leaders would bring lived experience and would be trained in supporting caregivers supporting youth with mental health needs. Their role would be to provide emotional support to their peers, share information on mental health resources, and help caregivers connect their children to care.

3. Promote and centralize access to parent resources that assist them in creating better home environments. Some families lack the financial resources to provide healthy food or stable, safe housing. Other families are affected by unexpected situations that change the dynamics at home, such as a divorce, a layoff, or the death of a loved one. Parents in these situations may find themselves unable to provide the desired level of physical and emotional support for their children and may need parenting assistance, social and emotional support, or material support to help them promote a nurturing environment for children in their care. Moreover, parents and caregivers may need support dealing with any childhood trauma (or other trauma) that they have faced. It is important in these instances that parents be adequately connected to community resources that can help. Supporting "one door" efforts or creating umbrella organizations that centralize all resources and messaging across disparate community organizations and government agencies could help families better navigate and access available supports.

Example: One model for supporting caregivers is home visiting, in which practitioners provide in-home parenting support; health and development screenings; monitor progress on developmental milestones;

and provide referrals to community resources when needed.[86] There are over 15 evidence-based home visiting models recognized by the U.S. Department of Health & Human Services, including the Nurse Family Partnership, Early Head Start Home-Based Option, Family Connects, and Minding the Baby.[87] The CDC has demonstrated that the costs of home-visiting by Nurse Family Partnership and Child-Parent Centers are far exceeded by the benefit they provide to individuals and communities.[88] Other models of support, like Parenting Institutes and Universal Parenting Places, are community-based centers where parents can meet other parents, engage in facilitated bonding activities with their children, receive counseling, or seek guidance on a challenging issue such as discipline.

> *"More programs for kids or for single mothers that are having a hard time feeding their kids. Better daycare systems and better resources that actually help people. Also, more therapy and more support groups." —Local parent*

4. Engage employers to be trauma-informed and to support employee family well-being. Businesses that foster positive work environments through trauma-informed practices support employee well-being and thus increase their employees' ability to create safe and stable homes for their children. Cultivating a sense of safety, trustworthiness and transparency, collaboration, and empowerment are amongst the principles of trauma-informed approaches in the workplace.[89] The Division of Violence Prevention in the Centers for Disease Control and Prevention (CDC) recommends five main ways that employers can support a healthier workforce: 1) Model safe, stable relationships in your organization, 2) Create a family friendly workplace, 3) Take a comprehensive approach to employee wellness, 4) Provide parenting resources for employees, 5) Consider the role of state and local policy in improving employees' and their children's access to safe, stable, nurturing relationships and environments.[90] Trauma-informed practices have real business benefits as well – businesses benefit from lower turnover, fewer sick days, increased productivity, and higher quality work.[91]

<u>Example</u>: Vigor Alaska shipyard has incorporated a morning stretch and meditation for the industrial crews working intensely physical and stereotypically "masculine" jobs. One hour a week of peer counseling is also available during the workday and is considered paid time. The interpersonal skills and techniques for mindfulness have transferred directly into their home lives: "Employees have said the skills they have learned at work have carried over into their home lives. They are not as stressed or frustrated, leaving them with more energy to put into family and free time." [92]

---

[86] Caudell-Feagan, M. et al, "States and the New Federal Home Visiting Initiative: An Assessment from the Starting Line," Pew Center on the States, August 2011, https://www.pewtrusts.org/-/media/legacy/uploadedfiles/wwwpewtrustsorg/reports/home_visiting/homevisitingaugust2011reportpdf.pdf

[87] "Evidence-based Models Eligible to Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Grantees," Home Visiting Evidence of Effectiveness

[88] "Child Abuse and Neglect Prevention Calculator," Centers for Disease Control and Prevention, https://wisqars.cdc.gov:8443/CANcalc/initWizard?buttonName=mainPage.

[89] Manning, K., "We Need Trauma-Informed Workplaces, Harvard Business Review, March 2022, https://hbr.org/2022/03/we-need-trauma-informed-workplaces

[90] "Boost Your Competitive Edge: Actions for a Healthy, Productive Workforce," Centers for Disease Control and Prevention, 2018, https://www.cdc.gov/violenceprevention/pdf/Essentials_Sup_3_Employer-Role.pdf

[91] Ibid.

[92] Burke, J., "The Alaska Shipyard Where the 'Manliest Men' Meditate Each Morning," The Guardian, March 2018, https://www.theguardian.com/us-news/2018/mar/06/alaska-shipyard-meditation-men-masculinity

5. Challenge youth to design solutions to advance adult mental health awareness and education. Design opportunities, such as a school- or community-based competition, for youth to propose ideas toward improving adult awareness of mental health and reducing stigma. Offer incentives to participants and for those whose ideas are selected for implementation. This empowers youth to have a central role in the solutions and will surface new ideas for the community to consider.

Example: In 2023, the Pan American Health Organization launched the Youth Voice contest, challenging youth to submit their creations (e.g., poetry, songs, videos) that articulated their visions for solving the mental health crisis. Submissions were judged across several age brackets (e.g., 10-14) and winners received cash prizes as well as having their creation used in PAHO social media and as part of their mental health communications and campaigns.[93]

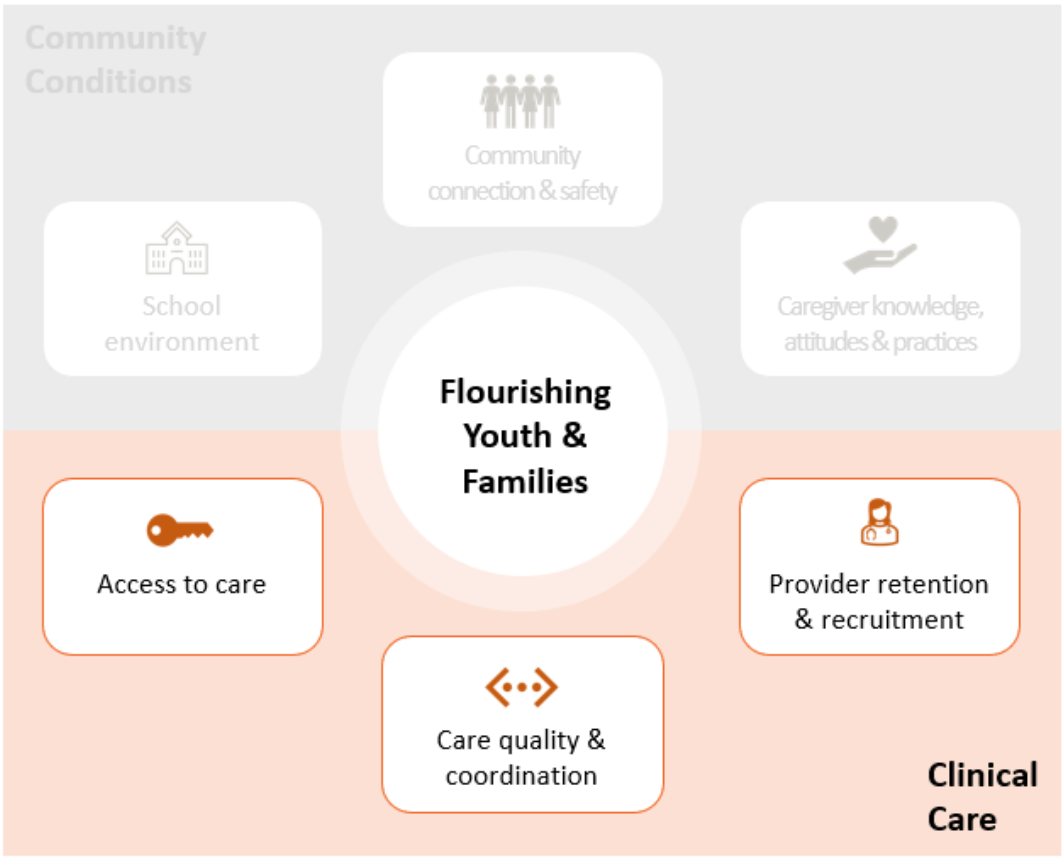
> *"I'm really interested in public art and placemaking… We're literally just doing community engagement. Trying to create representation for marginalized voices that haven't had the chance to be heard, especially in public art. I feel like having beautiful things around you, it really impacts your mental health and how you move through the world." –M., White female, 18+*

Existing local assets that may support pursuit of these opportunities:

- **There are existing mental health and social-emotional skill building adult training resources available**; Mental Health First Aid, Question-Persuade-Refer (QPR) training, Transform Foundation's Parenting for Emotional Wellness, 1N5, Consortium for Resilient Young Children, Youth at the Center adult allies training, Mayerson Center for Safe and Healthy Children's Strong Resilient Youth, Envision Partnership's parent resource card, and others
- **There are existing efforts to centralize caregiver resources**; at United Way of Greater Cincinnati; The Health Collaborative, Cradle Cincinnati, and others
- **There are existing efforts to assist employers in supporting family wellbeing;** Beech Acres Parent Connext, and others
- **There are existing community efforts to assist citizens in recovering from childhood trauma**; Avondale Development Corporation's Trauma Ambassadors, Greater Cincinnati Resilience Coalition's Resilience Advocates, and others
- **There is a strong network of community organizations supporting caregivers**; YMCAs, Beech Acres, Every Child Succeeds, community centers, churches, pediatricians, employers, and others
- **There are programs intended to support caregivers with babies** including Every Child Succeeds, Moving Beyond Depression, Healthy Moms and Babes, and others

[93] "Youth Voices on Mental Health Contest 2023," Pan American Health Organization, 2023, https://www.paho.org/en/youth-voices-mental-health-contest-2023

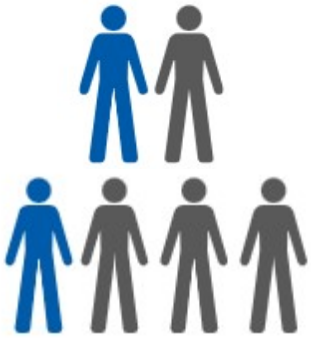
Clinical Care



This portion of the needs assessment includes a broad variety of challenges and opportunities related to developing a system of care that increases **access, quality, and coordination**, and better supports **providers** who care for youth mental, emotional, and behavioral health and well-being in Greater Cincinnati. Many of the activities discussed in the following 3 sections fall under the categories of treatment and maintenance within the MEB Intervention spectrum. This includes but is not limited to outpatient behavioral health management (e.g., individual therapy, medication management); intensive outpatient; acute crisis care; partial hospitalization; inpatient services; residential programs; longer term treatment; and aftercare.

Access to Care

Challenge: Young people and their families struggle to access behavioral health treatment because services are not adequately funded, making them unaffordable or unavailable. Rooted in a lack of parity for behavioral health coverage, low reimbursement rates, limited coverage, and nonexistent infrastructure for prevention funding create cyclical challenges of limited access and worsening outcomes for young people and their families seeking care.



About half of adults in Kentucky and Ohio who have a mental illness receive no treatment[94]

1 in 4 adults in Kentucky and Ohio with a cognitive disability cannot get care because of cost[95]

Many people in the Greater Cincinnati area in need of mental health care are unable to access it. About half of adults in Kentucky and Ohio who have a mental illness receive no treatment.[96] 1 in 4 adults in Kentucky and Ohio with a cognitive disability cannot get care because of the cost. About 10% of children in Kentucky and Ohio have private insurance that does not cover mental or emotional care at all. Demand is also increasing. The Ohio Department of Mental Health and Addiction Services found that demand for behavioral health services increased 353% from 2013-2019, spiked again during COVID-19, and is expected to continue to increase. [97] Needless to say, coordinated funding to increase availability and affordability of care is essential for Greater Cincinnati.

Parity for behavioral health care is not being met.[98] Despite federal parity requirements for behavioral health (see Federal Mental Health Parity and Addiction Equity Act box below), the application of these

[94] "Access to Care Data 2022," Mental Health America, https://mhanational.org/issues/2022/mental-health-america-access-care-data

[95] "OhioMHAS Announces Comprehensive Plan to Address Ohio's Behavioral Health Workforce Challenges," Ohio Mental Health and Addiction Services, October 26, 2023, https://bit.ly/OMHASworkforceplan

[96] "Access to Care Data 2022," Mental Health America, https://mhanational.org/issues/2022/mental-health-america-access-care-data

[97] "OhioMHAS Announces Comprehensive Plan to Address Ohio's Behavioral Health Workforce Challenges," Ohio Mental Health and Addiction Services, October 26, 2023, https://bit.ly/OMHASworkforceplan

[98] "Evaluating State Mental Health and Addiction Parity Statutes: A Technical Report," Kennedy-Satcher Center for Mental Health Equity, 2018, https://well-beingtrust.org/wp-content/uploads/2019/06/evaluating-state-mental-health-report-wbt-for-web.pdf

requirements is interpreted variably. States have the flexibility to pick and choose which services Medicaid covers.[99] In addition, private employer plans have no requirement to cover any behavioral health services. Parity protections are only relevant if these employers choose to offer plans with behavioral health coverage. This means that families with private insurance often do not have the level of coverage necessary to afford the services that they need. Moreover, employers and insurance companies are promoting high-deductible plans because they are less expensive for businesses and more profitable for payers, but this makes care more expensive for young people and their families. Families who cannot access insurance because of their immigration status or other reasons have little to no support to afford care.

Federal Mental Health Parity and Addiction Equity Act (MHPAEA) generally requires that mental health conditions and substance use disorders be treated by a health plan in the same or similar matter as medical and surgical conditions.

"The Benefits Cliff"

Many young people and their families face a steep and crippling "benefits cliff" once they make enough money to be ineligible for Medicaid. Many families cannot afford the deductibles of their new insurance plans once they transition from Medicaid. If they *can* afford those deductibles, they are still faced with a drop-off in services because private insurance does not cover coordination (e.g., case management) or other services (e.g., school-based services) at the rate that Medicaid covers them, or at all. The unwinding of the COVID-19 Medicaid expansion is exacerbating this problem. In fact, **86,053 (6%) of children in Ohio were dropped** from Medicaid or the Children's Health Insurance Program over a 6-month period in 2023.[100] Overall, it is estimated that nearly **200,000 Ohioans and 280,000 Kentuckians may have lost their Medicaid benefits as of November 2023**.[101,102,103]

[99] Pestaina, K., "Mental Health Parity at a Crossroads," Kaiser Family Foundation, August 2022, https://www.kff.org/mental-health/issue-brief/mental-health-parity-at-a-crossroads/

[100] Wildow, S., "Ohio among the largest drops in children enrolled in Medicaid, feds say," Dayton Daily News, December 2023, https://www.daytondailynews.com/ohio/ohio-among-the-largest-drops-in-children-enrolled-in-medicaid-feds-say/V2IN5XPR7NEJ3LKWUSKTAJCUYI/

[101] Staver, A., "Nearly 200,000 Ohioans set to lose Medicaid benefits by April: What you need to know," The Columbus Dispatch, February 2023, https://www.dispatch.com/story/news/politics/2023/02/06/medicaids-pandemic-benefits-are-ending-heres-what-you-need-to-know/69855592007/

[102] "Fact Sheet: COVID-19 Public Health Emergency Transition Roadmap," U.S. Department of Health and Human Services, February 2023, https://www.hhs.gov/about/news/2023/02/09/fact-sheet-covid-19-public-health-emergency-transition-roadmap.html

[103] Mudd, A., "With the COVID emergency declaration over, 280K Kentuckians may lose Medicaid. What to know," Lexington Herald Leader, May 2023, https://www.kentucky.com/news/coronavirus/article275189296.html

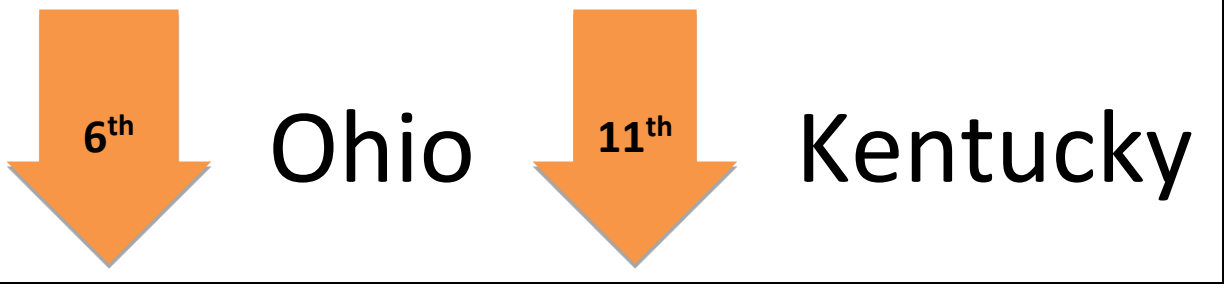
"We don't have insurance through work, so we pay for it privately and it's very expensive. Then we constantly get rejected. My son had two accidents last year and I was trying to get him to see a therapist because he had a lot of trauma…It was very hard to find one that was available, that would take our insurance." — Local parent

"If I could wave a magic wand, I would change that payers are expected to reimburse in the same way that physical health is reimbursed. They are not willing to repay at the same rates, and so providers cannot break even. There's a reason there's no behavioral health center of excellence. It's because they cannot afford it. Until we can change that, we are going to continue to struggle." – Local funder

The lack of enforced parity leads to low reimbursement rates for behavioral health care. Both private insurance and Medicaid reimbursement rates for behavioral health care are limited in the Greater Cincinnati area. Ohio and Kentucky have some of the lowest Medicaid reimbursement rates for mental health services in the entire country (6th and 11th lowest rates, respectively).[104] Many providers cannot afford to offer their services because reimbursement rates are so low, and many providers choose not to accept Medicaid or private insurance at all. As a result, in Ohio a young person's mental health office visit is 10 times more likely to be out-of-network than a primary care visit. [105]

Ohio and Kentucky have some of the lowest reimbursement rates in the U.S.

on a state-to-national Medicaid fee index comparing reimbursement rates for selected mental health services across state Medicaid programs with a national average (2022).[106]



"Marketplace insurance sucks... We pay over $2000 a month for bad insurance…My son had 2 accidents. The first one was covered. The second one I got charged $150K…Then you have to appeal or write letters [to get reimbursed]. The insurance companies want to exhaust you." –Local parent

"We have an unusually large number of people using Medicaid (1 in 3 Kentuckians) and Kentucky's mental health Medicaid reimbursement rates are one of the worst in the country. The last thing that therapists want to do is serve Medicaid patients…that is the

[104] Zhu, J. et al., "Medicaid Reimbursement for Psychiatric Services: Comparisons Across States and With Medicare," Health Affairs, April 2023, https://www.doi.org/10.1377/hlthaff.2022.00805

[105] "Mind the Gap: Creating a Robust Continuum of Behavioral Health Care for Young Ohioans," Children's Defense Fund Ohio and Mental Health & Addiction Advocacy Coalition, April 2021, https://www.childrensdefense.org/wp-content/uploads/sites/6/2021/04/MindTheGap_4.2021.pdf.

[106] Zhu, J. et al., "Medicaid Reimbursement for Psychiatric Services: Comparisons Across States and With Medicare," Health Affairs, April 2023, https://www.doi.org/10.1377/hlthaff.2022.00805

crux of the problem…and if we don't address Kentuckians on this side of the river, it simply bleeds over to the Ohio side." – Local social service provider

Moreover, insurance reimbursement policies are not set up to fund prevention. Insurers require a formal diagnosis to cover costs for services, so prevention-focused efforts—such as mental health screenings or coaching on non-violent communication to address bullying—are not always integrated into a patient's course of care unless it can be linked to a diagnostic code. There are strict requirements for reimbursement at the federal, state, and local levels and people have to jump through hoops to fund prevention, since it is not "clinical". A lack of inclusion of prevention or organization around the definition of prevention itself prevents providers from providing care before needs become acute.

"There isn't an opportunity for us to be in a school, identify a young person who is struggling, and be able to intervene without assigning a diagnosis, opening a case, and billing for services. […] If we're not getting these kids upstream before they get to a place where they need us, we're not impacting the system." – Local behavioral health provider

"We have very specific things that we have to do. […] The youth and families must fit the system versus the system fitting the youth and families. […] There are families that need support that don't have a formal diagnosis and really shouldn't." – Local behavioral health provider

Low reimbursement rates and a lack of prevention funding limit the capacity of providers to meet the needs of young people and their families. Due to the limited coverage offered by payers and the government, prevention and treatment services are not funded at the necessary level to meet the needs of youth and families. Consequently, a greater number of those individuals need care. Providers who accept Medicaid and other forms of insurance are often fully booked and cannot accept new patients. Even though the Greater Cincinnati area has a high capacity for youth behavioral health services, wait lists for community behavioral health centers are long. For example, one of the largest youth behavioral health providers in Greater Cincinnati had 1,268 young people on their waitlist with a median wait time of 3 months in September of 2023.[107] If more behavioral health providers could break even or make a profit, then they would readily expand their services to meet the needs of young people and their families.

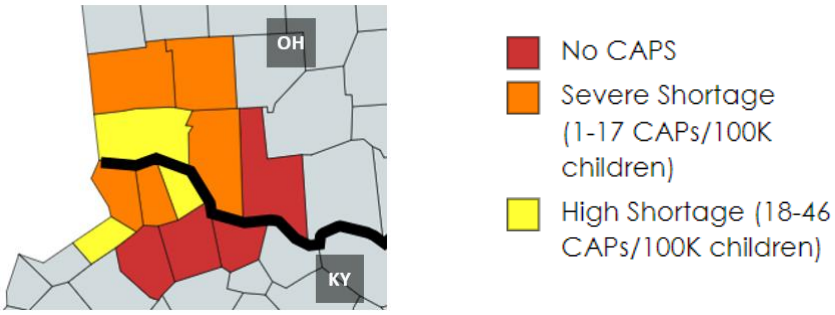
"[All the therapists] are booked. Either they don't take our insurance, [or] it's many weeks before [we can be seen]. My friend had a son who threatened to kill himself at school and it was STILL hard to find a therapist for him." – Local parent

Gaps in funding for behavioral health services exacerbate workforce shortages. As of 2022, one third (33%) of the twelve Ohio and Kentucky counties included in the Cincinnati Metropolitan Statistical Area have no practicing child and adolescent psychiatrists.[108]

[107] Anonymous local behavioral health provider

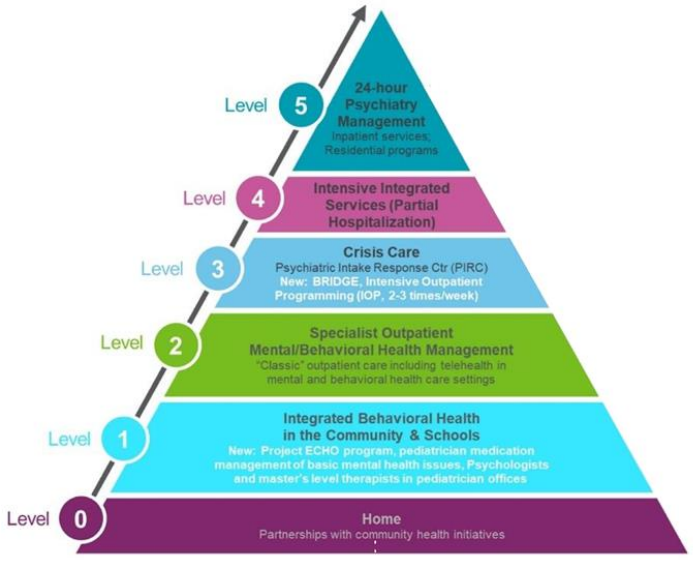
[108] Workforce Maps by State (2022), American Academy of Child and Adolescent Psychiatry, https://www.aacap.org/aacap/Advocacy/Federal_and_State_Initiatives/Workforce_Maps/Home.aspx

Child and Adolescent Psychiatrist (CAP) Workforce Availability[109]



In addition, families and young people have little to no options for step-up and step-down services in between low-intensity outpatient and inpatient treatment**.** In other words, there are limited options for partial hospitalization, intensive outpatient programs, crisis intake and response (levels 3-4 in the below graphic). As a result, young people either stay in inpatient treatment longer than needed, decreasing the capacity of the system overall, or they are discharged without support, increasing chances of a relapse into acute care.

Cincinnati Children's Hospital Medical Center's System of Care Framework[110]



"Outpatient therapy is level 2; Inpatient care is level 5. Service lines 3-4 [intensive outpatient and partial hospitalization] are severely underdeveloped. Things that would keep kids stable at home are not built to scale or accessible to most kids." – Local behavioral health provider

[109] Ibid.

[110] Sorter, M. et al., "Addressing the Pediatric Mental Health Crisis: Moving from a Reactive to a Proactive System of Care," Journal of Pediatrics, May 2023, https://doi.org/10.1016/j.jpeds.2023.113479

"When we look at step down options, the behavioral system has not historically had that support. Kids are discharged from the hospital to school-based treatment that cannot meet their needs, and they come back again." – Local behavioral health provider

Moreover, while an estimated 80% of kids get their mental health care in schools, many school systems are under-resourced and overwhelmed with young people's needs. While Cincinnati Public Schools is ahead of the curve in placing a mental health provider in every school, many students are not able to access that care. Moreover, while schools serve as central hubs of mental well-being services, they may not be well-coordinated to best meet the needs of individual young people. With the increase in need for social-emotional development and acuity of existing behavioral health needs since COVID-19, schools are not equipped to provide each individual child with the level of behavioral health services that they need to be successful.

"[Commercial insurance] is a huge barrier for kids in school. Many families have insurance, but the co-pay or co-insurance is still a barrier." – Local behavioral health provider

Opportunities to address the gaps and shortcomings in the behavioral health funding in Greater Cincinnati so that every child can get the care they need at a price they can afford

This section details the following community-generated opportunities:

1. Create a **shared policy agenda** to unlock sustainable funding for services that support and address behavioral health needs.
2. Pilot **holistic care approaches** with private funding and share results with policy makers to grow public funding.
3. Advocate for **businesses to invest in insurance plans** that provide more behavioral health coverage.
4. **Tax private sector contributors** to poor mental well-being towards prevention programs.

1. Create a shared policy agenda to unlock sustainable funding for services that support and address behavioral health needs. A shared policy agenda from key organizations and community leaders across the Greater Cincinnati area could be focused on (1) recognizing licensure and streamlining Medicaid coverage across state lines and (2) advocating for behavioral health parity at the state and federal level. Those with lived experience must be central to developing and advocating for these policy changes. The collaborative can leverage data from the Ohio Labor Department demonstrating the difference in parity between physical health and behavioral health needs getting authorization for Medicaid reimbursement services. They could work with the Kentucky Health Insurance Assistance Program and Ohio Mental Health Insurance assistance offices to submit consumer complaints about lack of parity as proof that action is necessary. The recent recommendations from United States Prevention Services Taskforce (USPSTF) for payers to fund and reimburse more prevention-based services and programs are also useful inputs.

2. Pilot holistic care approaches with private funding and share results with policy makers to grow public funding. Pilots could focus on funding risk-reduction and non-intensive clinical care as part of behavioral health services. Data can be collected to demonstrate the outcomes of increasing the capacity of the system, reducing long-term-term costs, decreasing acute needs, and increasing overall access to care. HealthVine, Cincinnati Children's Hospital Medical Center's Accountable Care

Organization (ACO), could serve as a key advisor and/or anchor organization for such a pilot as current funders of holistic care models. The collaborative could also build on the integrated behavioral health services offered at Cincinnati Children's Hospital Medical Center's and TriHealth.

> *"Once we bring up a new emotion or go through a new struggle, they're instantly 'Let's find treatment, let's find cure, let's...' No, we need to stop focusing on treatment and focus on getting to the root cause [of] why I may be feeling this way instead of trying to suppress it because they tell us all day that medicine will not treat or cure anything." –E., African American Female, 15-22*

3. Advocate for businesses to invest in insurance plans that provide more behavioral health coverage. Organize and educate a coalition of major employers to increase their coverage of behavioral health services through opting into plans with parity of behavioral health coverage. This could impact a large segment of caregivers and young people without changing government policy.

Example: Leaders in Polk County, Florida saw the significance of treating the "whole person" in their programming and implemented mental health parity in their county employee health benefits in 2008. Polk County, Florida saw the significance of treating the "whole person" in their programming and implemented behavioral health parity in their employee health benefits in 2008. Under a new plan with Aetna for an EAP and behavioral health treatment, the Polk County government provides no distinction in coverage between behavioral health and medical visits. While there are some specific guidelines, there are no limits on hospital days or on the number of psychological or psychiatric outpatient visits. The plan covers treatment in residential facilities for drug addiction and withdrawal and all medications are covered at a 100% level, including those for common comorbidities such as depression, bipolar disorder, and hypertension. As a result of this investment in holistic care, Polk County saw reduced incidences of residential treatment among staff. And, while behavioral health care utilization rose slightly in the first year, total health care costs did not increase [See Case Study: Polk County, Florida – Instituting Parity for Behavioral Health Coverage in the Appendix for more information].[111]

4. Tax private sector contributors to poor mental well-being towards prevention programs. Companies that contribute to poor youth mental well-being, such as vape companies, gun companies, social media companies, and/or food companies could be held accountable for their impact through a state and/or county tax. Policy makers and advocates have demonstrated the political will for holding the private sector accountable. The state of Kentucky has recently joined 32 other states in a lawsuit against Meta, the parent company of Facebook and Instagram, for knowingly designing features that contribute to children becoming addicted to its social media platforms. The lawsuit seeks payments in damages and a change to current practices.[112]

Example: In the first six years since marijuana's full legalization, the state of Colorado generated over $1B in marijuana tax revenue which has been used to fund special programs for schools, affordable housing, and youth substance abuse prevention, among other areas. Inspired by the revenue potential and acutely aware of the local funding gaps in behavioral health care, Eagle County explored the

[111] Polk County Florida, Center for Workplace Mental Health, April 2016, https://www.workplacementalhealth.org/Case-Studies/Polk-County-Florida

[112] Knef, S., "'A chaotic good': Experts weigh in on the pros and cons of social media," Spectrum News 1, November 2023, https://spectrumnews1.com/ky/louisville/news/2023/11/05/kentucky-joins-lawsuit-against-meta

feasibility of a supplementary county-level marijuana tax to be earmarked for funding local public behavioral health services. The county commissioned a poll to gauge support for new local marijuana sales and excise taxes, which showed likely support by two-thirds of voters. Once placed on the ballot in 2019, the proposed sales and excise taxes, capped at 5% each, passed with 73% of the vote. A cross-sector oversight committee recommended that the county board of commissioners use the new taxes to fund 1) school-based counselors; 2) jail-based counselors; and 3) a new crisis stabilization unit at a local community organization [See Case Study: Eagle County, CO – Funding Mental Health via Marijuana Sales and Excise Tax in the Appendix for more information].[113,114,115,116,117]

Existing local assets that may support pursuit of these opportunities:

- The Ohio Labor Department has data demonstrating differences between physical health and behavioral health authorizations for Medicaid reimbursement, proving parity is not being met.
- Greater Cincinnati has an emerging multi-system youth project that provides a single point of access for multi-system youth and a care coordinator attached to their family. It has a braided/blended funding model that makes it possible. This effort is driven by the Hamilton County Mental Health and Recovery Services Board, Hamilton County Jobs and Family Services, and other organizations.

[113] Wyrick, R., "Eagle County voters approve marijuana tax to fund mental health programs," Vail Daily, November 2017, https://www.vaildaily.com/news/eagle-county-marijuana-tax-to-fund-mental-health-programs-riding-to-landslide-victory-in-early-election-returns/

[114] Boyd, P., "After slow start, Eagle County marijuana tax dollars finish strong in 2020," Vail Daily, January 2021, https://www.vaildaily.com/news/after-slow-start-eagle-county-marijuana-tax-dollars-finish-strong-in-2020/

[115] "Marijuana Tax," Town of Eagle, https://www.townofeagle.org/768/Marijuana-Tax

[116] Wyrick, R., Eagle County poll indicates support for marijuana tax that could generate $2M a year, Summit Daily, August 2017, https://www.summitdaily.com/news/eagle-county-poll-indicates-support-for-marijuana-tax-that-could-generate-2m-a-year/

[117] "Legalized marijuana brings in billion dollar tax haul for Colorado," WXYZ-TV Detroit, October 2018, https://www.youtube.com/watch?v=wObLXzU2bxs

Care Quality and Coordination

Challenge: The siloed behavioral health system makes it difficult for young people and their families to find and receive quality care at the right time to effectively meet their needs. Once care is accessed there is an inconsistent application of evidence-based, trauma-informed, and culturally responsive care, especially for historically marginalized communities.

A lack of compatible infrastructure across the care system burdens parents and young people with the responsibility to find providers, document and transfer records, and explain their history to providers. Few primary care providers have the resources to connect patients to behavioral health care. Many providers do not know what services are available for their patients within the treatment system. Young people who age out of pediatric care are rarely connected with an adult provider to facilitate continuity of care. Since providers use different, incompatible Electronic Health Record (EHR) systems, it is difficult for a provider to access a young person's previous records. This leaves families and young people to search for providers and transfer their information on their own, which can ultimately discourage or delay effective care.

> *"We need better system navigation tools. We have a lot of coordinators, but we still cannot seem to connect. It would be useful to have better systems-level knowledge of which community agencies, service lines, and levels of care have capacity, and which do not." – Local behavioral health provider*

> *"Right now, families are left to articulate everything that has happened [to them and their child]. They are in a state of crisis. They are overwhelmed and this isn't their area of expertise. It's not the most effective way of doing it to have a family say, 'This is where we are. This is what's going on.'" – Local behavioral health provider*

The lack of coordination across different services hampers quality care for young people who need to see multiple providers simultaneously. When young people have co-occurring behavioral and other challenges (i.e., developmental disabilities, neurological conditions, other health problems), they need to see providers across the care system. The lack of coordination and communication across providers increases chances for misdiagnosis and mistakes in treatment and, ultimately, decreases the effectiveness of treatment.

> *"I was noticing things with my child... nobody clocked that it could possibly be autism…We didn't get to autism until after the third mental health hospitalization because my child was experiencing suicidal ideation to point where they made a plan [to take their life]." – Local parent*

> *"We need more support for dual diagnosis. Funding is separate and fragmented for developmental diagnoses and psychiatric or mental health diagnoses." – Local behavioral health provider*

Some young people are not receiving evidence-based treatment from providers. Studies have shown that evidence-based practices for behavioral health are not routinely implemented, especially in early care and complex behavioral health challenges. Due to limited capacity and resources, opportunities to increase providers' confidence and competency levels are scarce. There is no accountability mechanism or incentive to provide standardized high-quality care. As a result, when evidence-based practices are not applied, young people and their families suffer—often in silence.

"Some adults listen, but I feel like people are definitely quick to throw medicine at kids. A lot of kids are on medication, and it takes away from [people's lives]. For example, my brother has ADHD, and it was really bad, but the medicine took away his social life…He was really depressed…I feel like some adults push your feelings to the side and you don't know what to do." - Z, African American Female, 15-18

"When a child is not connected to the right level or type of care, they end up being in care longer. So, now other kids can't access care because the system is clogged with kids who are not improving as quickly as they can be. Part of the issue of access means improving the quality issue. – Local behavioral health provider

Trauma-informed practices are inconsistently implemented, perpetuating upsetting experiences. Many clinical providers are not trained in trauma-informed care or are not able to effectively apply the practices they have been taught. In particular, many pediatric clinicians don't have the resources or training to implement trauma-informed approaches. Negative clinical experiences can result in worsened behavioral health challenges and decreased trust in the system of care, and they may cause some patients to decline treatment altogether.

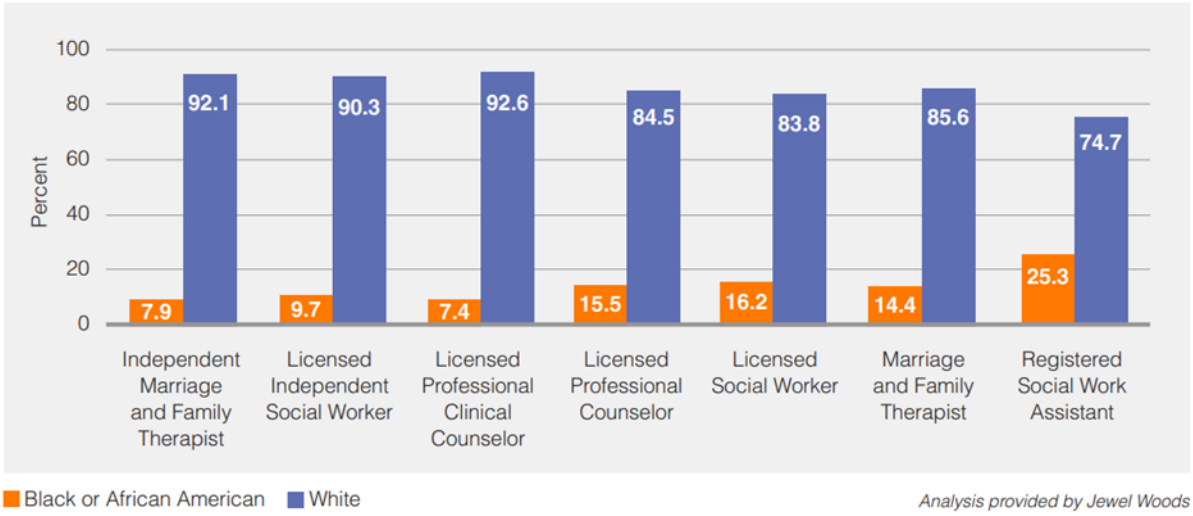
"I feel like [my therapist] should be able to understand, instead of me getting [blamed for my traumatic experiences]. I feel like that's why I've been struggling lately. How am I supposed to have a professional person to talk to, but I feel like I'm just talking to myself in a session when she's supposed to be there to help? I'm basically alone." – V., White Female, 18+

"A young person who was in our foster care clinic had a developmental delay and other challenges. They expressed some suicidal ideation and there was a need to admit the young person to inpatient care. When emergency transit was called, the police arrived and restrained the young person and transported them in a police car with handcuffs. It disrupted the placement, created psychological distress for our team, and increased the trauma for the kid." – Local behavioral health provider

Youth feel like providers do not understand their cultural or social contexts and downplay their experiences. Young people and their families have a hard time finding providers that share aspects of their identity (e.g., race/ethnicity, sexual orientation, gender identity), making it harder to develop trust. This is especially challenging for Black youth and LGBTQ+ youth in Greater Cincinnati. Historic segregation and disinvestment limit access to capital and advancement opportunities for providers of color. Data shows that as providers' certification level increases, the racial diversity of the group decreases (see below for Black providers). Only 5% of psychiatrists in Ohio are from the Black community.[118]

[118] "Behavioral Health in Ohio: Improving Data, Moving Toward Racial & Ethnic Equity – Report 2: Opportunities for the Workforce," Central State University, Multiethnic Advocates for Cultural Competency, Mental Health & Addition Advocacy Coalition, Ohio University, February 2023, https://mhaadvocacy.org/wp-content/uploads/2023/06/Report2_Final2.pdf

Ohio Counselors & Social Worker Race and Professional Degree[119]



Moreover, evidence-based approaches are predicated on the experiences and studies of majority-white populations. Communities of color are more likely to be misdiagnosed, less likely to receive evidence-based treatment, less likely to be included in research, and less likely to experience culturally responsive behavioral health care. Providers may have unaddressed biases that lead to misdiagnoses and lower quality of care. A lack of training and enforcement of diversity, equity, and inclusion (DEI) training in behavioral health care perpetuates this challenge. This may be in part due to a lack of diversity in staff and leadership at behavioral health care organizations and insufficient prioritization of DEI.

> *"I had to let them [a behavioral health provider] know, 'listen here, I don't know what you think and what you think you know about Black children, but my child is an individual. So, you're going to individualize what you know to him. You are going to learn about him…' A lot of doctors or even mental health [providers] want the story to fit nicely into a bow." – Local parent*

> *"I had a therapist once; I went to her because everything online sounded good, and she was a professor at a school nearby for Gender Studies… I've never been so triggered by a therapist before in my life. She would constantly ask me if I was a lesbian. I'm like, I'm a trans guy. I've been out living this way since I was like, 15. … she would always misgender people that she was talking about… She would always ask me things like - was I abused as a kid- she'd be like, 'when you were being abused, did you feel like a boy then?'...The main thing that really triggered me is that she is in a school teaching people about this stuff." – D., White Male, 15-22*

[119] Ibid.

Opportunities to make it seamless for youth and families to receive the evidence-based, trauma-informed, culturally responsive care that they need.

This section details the following community-generated opportunities:

1. Improve integration of **health information systems** to connect young people between providers and create seamless referrals.
2. Develop **integrated care models** that offer screenings and facilitate referrals in central hubs and primary care offices.
3. Galvanize **universities and 2-year colleges** to create supportive systems and environments for young adults and to connect them with care if needed.
4. Incentivize providers to offer the highest quality care to young people and their families by shifting payers to **outcomes- or values-based payment plans**.
5. Fund **learning opportunities for providers** increase their cultural competency and facility with trauma-informed approaches.

---

1. Improve integration of health information systems to connect young people between providers and create seamless referrals. HealthVine, the Accountable Care Organization (ACO) at Cincinnati Children's Hospital Medical Center, is a national leader in developing Electronic Health Record (EHR) sharing technology. The collaborative could build on HealthVine's work to develop an expanded Health Information Exchange (HIE) that allows providers to share information about patients across the system, search for community behavioral health resources, identify availability and capacity (similar to the MindPeace database), and then track and follow up on referrals. To accompany this system, the collaborative could expand the group of family navigators, like those used by TriHealth and Cincinnati Children's Hospital Medical Center, to make sure families have trusted guidance from those with limited experience to take advantage of a more connected system.

> *"The biggest opportunity we have is to create a digital environment that makes it seem that we are working within the same systems even though we aren't. That means [knowing] who all is involved in the treatment of this kid and their treatment plans. [Knowing] how I reinforce what you are doing, and you do that for me. How do we ensure we are not prescribing medications to these kids that shouldn't be prescribed together? Right now, we don't even know who all is involved in the care of a child." – Local behavioral health provider*

Example: OneCare Vermont, an Accountable Care Organization, built a successful community care coordination program that includes an online centralized platform called Care Navigator.[120] The platform allows for real-time collaboration between providers and community organizations and serves as a hub for sharing and collecting data related to a patient's needs and progress. The data supplements the information in the EHRs that are in use across the ACO's network. For example, the platform includes relevant claims data for individual patients, such as the number of emergency department visits and primary care visits. The platform also includes encounter notifications from the state's Health Information Exchange (HIE). All providers in the ACO's network involved in a patient's care may access

[120] "OneCare Vermont ACO Case Study: Community Care Coordination Program," Centers for Medicare and Medicaid Services, October 2020, https://www.cms.gov/priorities/innovation/media/document/aco-casestudy-onecarevermont

Care Navigator to review goals and care activities, update the health status summaries, and define care needs and preferences.

2. Develop integrated care models that offer screenings and facilitate referrals in central hubs and primary care offices. These care hubs could be designed by youth and for youth to provide a range of care including physical care, social services, career and life coaching, and behavioral health care (see Allcove Centers example below). Another option could be to add lower levels of behavioral health care to existing central social service hubs like Citylink. In existing primary care offices, consider expanding Cincinnati Children's Hospital Medical Center's and TriHealth's integrated behavioral health services approach. Then, any family that comes in for a routine check-up would also get screened for behavioral health needs and connected to care, if needed.

> *"A lot of resources are buried here in Hamilton County. You can't get access to these resources until you've already tried to kill yourself and then you end up on the eighth floor. It's like our young people are crying out and they're going unheard…They just want to be heard." – Local parent*

> *"[We need] a dedicated spot for our people to go to with no judgment, where they can get holistic medicine, management, therapeutic services of all types. No matter what kind of insurance, no insurance, a sliding scale, whatever. But just a safe space for us to go and be safe and just relax our shoulders… Like your grandma's home, but better. It smells like chocolate chip cookies. And it's just like I said, whole body, mind, spirit."– Local parent*

Example: Allcove Centers are integrated, drop-in youth behavioral health centers designed by and for young people to increase access to holistic care based in California. Allcove offers free and low-cost behavioral, physical, and social health support resources to young people aged 12-25. Services range from therapy sessions, health testing and referrals, educational support, peer support groups, family support services, quiet spaces to relax and do work, recreational activities, and classes to build skills. Each Allcove center is designed to meet the needs of its community's youth with the direction of a Youth Advisory Group and input from a Community Consortium of local individuals and organizations who have a vested interest in supporting the well-being of young people in the community. Allcove is the first effort of its kind to implement the integrated youth mental health model in a country without a national health insurance program. Consequently, Allcove used private funding to launch its first center [See case study: Allcove Centers – Integrated Youth Behavioral Health Care in the Appendix for more information].[121,122]

3. Galvanize universities and 2-year colleges to create supportive systems and environments for young adults and to connect them with care if needed. Many support systems drop-off after a young person turns 18. This gap leaves some young people without anywhere to turn. Universities, 2-year colleges, and vocational schools can serve as a hub of social support to help young people transition to adulthood

[121] McGorry P. et al., "Designing and scaling up integrated youth mental health care" World Psychiatry, January 2022, https://www.doi.org/10.1002/wps.20938

[122] Rickwood D. et al., "Sixteen years of innovation in youth mental healthcare: Outcomes for young people attending Australia's headspace centre services," PLOS ONE, June 2023, https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0282040

by connecting them to needed social services, while also providing early screenings and referrals for behavioral health needs.

> *"The number one hospital in the US for pediatrics is Children's. I received great care until I was 18. The adult care in Cincinnati is sub-par. If these places in Cincinnati would want to help young people, they would provide information or resources [so we know where to go when we turn 18]." – V, White Female, 18+*

4. Incentivize providers to offer the highest quality care to young people and their families by shifting payers to outcomes- or values-based payment plans. These structures provide funding for care systems to treat chronic and episodic needs through different approaches. Moreover, they incentivize training and learning opportunities, both internally and across an accountable or managed care organization. These outcomes or values should be determined and measured in partnership with young people and their families. This effort for quality improvement can build on the work of the Mayerson Center for Safe and Resilient Children's Joining Forces for Children, Cincinnati Children's Hospital Medical Center's HealthVine's Pediatric Improvement Network for Quality (PINQ), and Cradle Cincinnati Learning Collaborative who have all have created ways for providers to connect and learn from each other to improve quality of care.

> *"Imagine a doctor saying, 'How best can I support you in your wellness journey?' I mean, who's ever been asked that by their doctor, right?" – Local parent*

Example: Tennessee established value-based payment plans through their state Medicaid program, TennCare. Through these value-based payment (VBP) plans, Managed Care Organizations (MCOs) offer payments based on quality improvement measures established by the national committee for quality assurance. VBP plans offer opportunities to simultaneously raise reimbursement rates for providers through bonus payments and to increase the quality and effectiveness of treatment for patients. These plans include services such as depression and anxiety screenings and wellness visits, a coordinated care program for those with serious behavioral health challenges, home and community-based services, and more. Tennessee's incentive program pays plans an additional $0.03 per member per month for improvement. As of 2015, 85% of the 33 measures tracked since 2007 have shown improvement over time, and 47 measures improved from 2014 to 2015, including ER/inpatient utilization, follow-up after inpatient care, medication management, and more. Plans have created data sharing opportunities between MCOs, incentivizing payers to learn about and share effective treatment approaches among one another [see case study: TennCare – State Medicaid Values Based Payment Plans in the Appendix for more information].[123,124]

5. Fund learning opportunities for providers increase their cultural competency and facility with trauma-informed approaches. The collaborative could partner with Ohio Mental Health and Addiction Services, which is funding Culturally and Linguistically Appropriate Services training for providers to increase cultural competency. The collaborative can work with the local colleges and universities to

[123] Honsberger, K. et al., "Tennessee: Using Managed Care Incentives to Improve Preventive Services and Care for Children, National Academy for State Health Policy," January 2018, https://nashp.org/wp-content/uploads/2018/01/Tennessee-Case-Study-2018.pdf

[124] "2017 Annual HEDIS / CAHPS Report: Comparative Analysis of Audited Results from TennCare MCOs," Division of Health care Finance & Administration, August 2017, https://www.tn.gov/content/dam/tn/tenncare/documents/hedis17.pdf

develop curriculum and scholarships for interdisciplinary, culturally responsive training for current students and as expanded training for community behavioral health providers. The collaborative can also build on and expand the DAD Initiative's work with Historically Black Colleges and Universities to bring black psychology students to Cincinnati to train local providers on cultural humility.

Example: The Hogg Foundation for Mental Health awarded $440,000 to support the Integrated Behavioral Health Scholars Program at University of Texas. This interdisciplinary training prepares medical and behavioral health students to collaborate on patient care in integrated care teams with a focus on cultural responsiveness [see case study: The Hogg Foundation – Widening the workforce pipeline in the Appendix for more information].[125,126]

Existing local assets that may support pursuit of these opportunities:

- 1N5 has a tool on their website where a person can type in their zip code and the type of support they seek, in order to learn what resources are available.
- The United Way has a collection of community resources accessible by dialing 211.
- There is an EHR 360 resource guide that community members can use to find needed support.
- Community Engagement Collective has a Greater Cincinnati Black Indigenous People of Color Mental and Behavioral Health Provider Directory for those seeking care from someone that shares aspects of their identity. Jamaa Health is a national database of black health care professionals.
- MindPeace has a database of all mental health providers that is real-time and updated. It is currently used for schools, but it could be available to everyone.
- TriHealth has a pediatric behavioral health navigator that helps connect families to the services they need that might be within or outside of TriHealth. CCHMC also has a behavioral health navigator to support their patients.
- Cincinnati's Health Information Exchange is designed to help providers share information across systems.

[125] "What we do," Hogg Foundation for Mental Health, https://hogg.utexas.edu/what-we-do
[126]"Integrating Mental Health Care in the Medical Setting," Hogg Foundation for Mental Health, https://hogg.utexas.edu/what-we-do/success-stories/integrating-mental-health-care-in-the-medical-setting

Provider Retention and Recruitment

Challenge: Expensive training, low retention, and high burnout among providers decrease the quality of care for young people and their families. For Black, Indigenous, and other providers of color, these factors are compounded by the impacts of historic marginalization, making it especially difficult to enter and remain in the behavioral health field. Providers leave the field due to stressful work environments, heavy workloads, limited support, and low pay with few opportunities for on-the-job training and growth.

Prospective behavioral health providers must often overcome significant financial barriers to entry. Candidates must achieve at least a master's level degree and complete an *unpaid* internship to become a Licensed Clinical Social Worker (LCSW), Licensed Professional Counselor (LPC), or Licensed Mental Health Counselor (LMHC). This severely limits the number of people who are able to enter the field, especially those from families without generational wealth or income security, contributing to the lack of diversity in the field. On the few occasions that they are available, students from historically marginalized backgrounds may not be aware of or may not be able to access scholarships and loans. The high cost of training has led to a shortage of providers, particularly in rural areas like Union County, Indiana; Bracken County, Kentucky; and Clermont County, Ohio, where the ratio of mental health providers is two to four times lower than the national average. [127]

Once in the field, keeping providers practicing is a challenge. The rate of turnover for behavioral health providers is high due to stressful work environments, limited support, and low pay rates. The average tenure of any provider in the field of behavioral health in the U.S. is about 1-2 years. [128] This average tenure spans the field—from nurses who specialize in behavioral health to therapists to family advocates. High turnover decreases tenure-based institutional knowledge and reduces opportunities for young people and their families to build trust with their providers. Non-competitive pay rates do not attract providers to the field or incentivize them to stay. Low reimbursement rates for behavioral health services restrict compensation for providers, further contributing to turnover.

> *"[High turnover] perpetuates a lack of institutionalized knowledge of evidence-based practices. Pay rates are lower and these jobs are really hard to do, especially when we start talking about intensive home-based treatments." – Local behavioral health provider*

Heavy workloads and a lack of resources lead to disillusionment and burnout for providers. The low reimbursement rates for behavioral health services often cause providers to take on heavy workloads. The pressure to bill their time and the limited capacity of the system can put providers in situations where they do not have the qualifications, training, or time needed to effectively treat a young person's needs. These instances are demoralizing to providers who want to provide high quality, individualized care.

> *"Who's going to really take the time to get to know me and really help me and not just pass me around? A lot of times I know that people in that field is overworked as well, so*

[127] County Health Rankings, UW Population Health Institute & Robert Wood Johnson Foundation, 2023, https://www.countyhealthrankings.org/

[128] "Behavioral Health Specialist Demographics and Statistics in the US," Zippia The Career Expert, https://www.zippia.com/behavioral-health-specialist-jobs/demographics/

they're just sifting through people and not really taking time to get to know them as a person." – E., African-American female, 18+

On-the-job opportunities for advanced or extended training are rare. There are limited opportunities to increase providers' confidence and competency levels to ensure consistent application of evidence-based practices for the highest quality of care for the benefit of both the patient and provider. Moreover, providers are rarely provided the social-emotional support they need to protect their well-being. The increasing acuity of young people's behavioral health challenges creates high-stress work environments that take a toll on providers' mental health. Providers are exposed to challenging situations that may be triggering and cause them to leave the field.

"Providers don't feel confident in being able to treat patients with high complexity needs. We need to fill those skill gaps to keep the workforce engaged and prevent burnout." – Local behavioral health provider

"Our volumes are high [for behavioral health in the emergency department]. We are seeing higher acuity and higher aggression [in young people]. Both are increasing staff stress and burnout." – Local behavioral health provider

Opportunities to recruit more diverse providers to the behavioral health field and better support our providers so they can thrive, learn, and have financially sustainable work to support our youth.

This section details the following community-generated opportunities:

1. Create a **pooled fund to reduce the barriers to entry into the behavioral health field.**
2. Incentivize and support existing providers to stay in the field through **increasing pay and benefits and forgiving loans** through a mix of public and private funding.

---

1. Create a pooled fund to reduce the barriers to entry into the behavioral health field. This fund could provide scholarships and stipends for previously unpaid training and internships to attract a diversity of providers to the field. The fund could prioritize supporting individuals from historically marginalized backgrounds and bilingual folks. Building on the model of the Ohio Great Minds Fellowship, one could pay social work and counseling students in their practicums and internships, and even offer scholarships (see Hogg Foundation example below). The fund might also subsidize or pay for license and test fees for employees of community-based health clinics. To garner interest in the field, they could fund a program to recruit high school students to devote 1-2 years of service as certified peer supporters placed within schools and youth development organizations, providing care as near-peers.

"[We need] more therapists or counselors who actually know what people experience . . . like counselors who have overcome depression or anxiety." – D., youth focus group (Cohear mental well-being study, 2022)

Example: The Hogg Foundation for Mental Health is expanding the behavioral health provider workforce by breaking down barriers to access to high-quality education and certification for individuals from diverse backgrounds. They do this through funding programs, scholarships, and fellowships, while working to shift state and federal policies. For example, every year the foundation awards around 20

graduate social work students from across Texas Ima Hogg Scholarships of $5,000. In addition, they target Spanish-speaking students in order to decrease the bottleneck for bilingual providers by awarding an estimated $1M to Spanish-speaking students at accredited graduate social work programs in Texas. They also support the American Psychological Association Accreditation Program to increase the number of internships accredited in the state and diversify existing opportunities, by funding the development and accreditation of eight internship programs across Texas ($3.0M). Lastly, they seek to develop the next generation of providers by awarding the Houston Health Department a grant to develop a curriculum to train and certify transition-age youth as Peer Wellness Specialists [see case study: The Hogg Foundation – Widening the workforce pipeline in the Appendix for more information].[129,130, 131]

2. Incentivize and support existing providers to stay in the field through increasing pay and benefits and forgiving loans through a mix of public and private funding. A scholarship program supported by private funders could forgive student loans for those who enter and remain in private practice. A paid sabbatical for community behavioral health providers who stay for over 5 years might also be offered. Collaborative funding could subsidize salaries or benefits plans for tenured providers at community behavioral health centers. For systemic change, the collaborative could also advocate for a state tax credit for people employed in the behavioral health field. The collaborative can build on the Hogg Foundation's model of establishing a peer policy fellows' program that focuses on advocacy and building relationships across the field. They could advocate for increasing the funding for more services, such as peer support services and preventive services, to be reimbursable by Medicaid.

Example: The Hogg Foundation for Mental Health is focused on changing the long-term trajectory of the provider workforce by training and supporting the next generation of policy advocates to unlock increased funding for holistic behavioral health services that offer sustainable livelihoods for providers. They do this through a Policy Fellows program. These fellows specifically and successfully advocated for peer support services to be an approved reimbursable benefit for Texas's Medicaid recipients during their fellowship [see case study: The Hogg Foundation – Widening the workforce pipeline in the Appendix for more information]. [132]

Existing local assets that may support pursuit of these opportunities:

- The Public Service Loan Forgiveness program can be leveraged to help support the workforce.
- The Ohio-based social work trainee / counselor trainee license for master's students doing their internship that allows students to provide care and for the provider to get reimbursement.
- Regional Behavioral Health Workforce Coalition was formed in 2022 to facilitate community-driven cross-sector collaboration to address short-term and long-term behavioral health workforce development barriers.
- Greater Cincinnati youth behavioral health providers (e.g., Best Point and CHNK Behavioral Health) are exploring expanding the behavioral health pipeline through partnerships with local universities.

[129] "Funding Opportunities," Hogg Foundation for Mental Health, https://hogg.utexas.edu/funding-opportunities
[130] "Cultivating the Next Generation of Psychologists," Hogg Foundation for Mental Health, https://hogg.utexas.edu/what-we-do/success-stories/next-generation-psychologists.
[131] "Peer Support for Young Adults," Hogg Foundation for Mental Health, https://hogg.utexas.edu/what-we-do/success-stories/youth-peer-support
[132] "Mental Health Policy Fellows and Policy Academy," Hogg Foundation for Mental Health, https://hogg.utexas.edu/what-we-do/policy-engagement/policy-fellows-academy

Next Steps

Going into 2024, the Greater Cincinnati youth mental well-being coalition will establish a more formal strategy and structure for addressing the challenges and pursuing the opportunities described in this report. Main components of the structure moving forward are as follows:

- **Working Groups:** During the first half of the year, we will move from meeting as a large planning group into a more focused set of topical working groups that will **create specific goals, strategies, and ways of measuring progress** for each of the areas profiled in this needs assessment.
- **Steering Committee:** Additionally, we will form a steering committee composed of working group members, leaders from the community institutions and systems that influence youth mental health, and youth and family advocates to **steward the overall direction** of the initiative, **ensure alignment of working group strategies**, and **marshal resources and support** for youth mental health.
- **Youth Fellows:** Most importantly, we will also form a dedicated youth fellowship to **guide the initiative's decision making** and ensure that initiative is grounded in the **perspective, leadership, and priorities of youth** themselves.
- **Backbone:** The initiative will have a backbone lead—independent staff dedicated to support functions—to **coordinate and align** among various groups in the collaborative.

Through these structures we will work together to develop a comprehensive long-term plan for improving youth mental well-being in the Greater Cincinnati region. Our goal is to launch this plan to the public in July 2024, sharing a set of goals, needed resources, and a plan for action as a rallying point for the community to come together around youth mental health and well-being.

The structures that support the planning process will transition to structures that lead implementation. Each working group will lead actions such as changing existing practices, instituting new programs, improving collaboration, advocating for policy changes, or organizing and mobilizing community members. **Given the urgency of the youth mental health crisis and the eagerness of partners to move forward, some early actions may begin before the launch of the plan.**

We also know that the journey ahead will not be linear, and we will institute **methods for assessing progress, reflecting, learning, and course correcting along the way**. While we learn from our successes and failures and adapt to the changing conditions in the community, we will hold fast to the goals and values that brought the group together in the first place, including a deep respect for youth leadership, a commitment to equity and justice, a desire to collaborate across sectors, and an intention to address root causes of pressing challenges to change systems long-term.

Our aspiration is that this initiative will become a gathering place for those called to serve the well-being of the youth in our community: a nerve center of learning and innovation, a catalyst of action and progress, a welcoming multigenerational community, and a home for hope. We invite you to join us in this effort to create a Greater Cincinnati region where all young people thrive. If you wish to participate in future efforts and are not yet on the contact list, please reach out to Ross Meyer at rmeyer@interactforhealth.org.

Appendix

Appendix A. Acknowledgements

Thank you to Cohear for planning and executing the 7 focus groups, enabling us to capture the perspectives of nearly 60 young people and families from around Greater Cincinnati.

Thank you to the other members of the coalition's core team for guiding the development of this assessment:

- Kate Schroder, President and CEO, Interact for Health
- Ross Meyer, VP Strategy, Interact for Health
- Deanna Hillard, Program Manager, Youth Mental Health, Interact for Health
- Jennifer Zimmerman, VP Evaluation and Impact, bi3
- Zohar Perla, Director of Evaluation and Learning, bi3
- Eli Meiners, Director, Client Success and Operations, Cohear
- Chris Carlson, Director, FSG

Thank You to our Funders

Interact for Health, bi3, The R.C. Durr Foundation, Jewish Foundation of Cincinnati, The Joe Burrow Foundation, The Manuel D. and Rhoda Mayerson Foundation, Millstone Fund, Fifth Third Foundation, Adam R. Scripps Foundation, TQL Cares, United Way of Greater Cincinnati, and an anonymous donor.

+ an anonymous donor

Appendix B. Case Studies

Case Study: Healing City Baltimore—Creating a Trauma-Informed City[133,134,135,136]	
Challenge	• Youth in Baltimore are regularly experiencing situations that can induce trauma—for example, violence, housing insecurity, food insecurity—and as a result are at higher risk of poor health outcomes. • In the wake of a school shooting in 2019**, local youth became more vocal about their experiences of trauma** and many testified before the city council demanding action.
Approach	• In response to youth testimony, City Councilmember Zeke Cohen embarked on a **year-long listening tour** to hear from community members about how to create a safer community and reduce youth experiences of trauma. • It was evident that young people wanted more prevention efforts that reduced the likelihood of trauma and encouraged healing. • The insights from the listening tour sparked the passing of the Elijah Cummings Healing City Act in 2020. This **law mandates trauma-informed training across all city agencies and requires them to rewrite policies** to reduce traumatization of citizens. • The Act established a 36-member advisory board that is responsible for identifying ways to reduce trauma for children and is made up of local youth, clinicians, researchers, equity experts, among others. • Several local community organizations and trained professionals are involved in the implementation of the Act. For example, Holistic Life Foundation, known for stewarding mindfulness work in Baltimore City Schools, is training city agencies and its staff in elementary practices in mindlessness, self-care, and healing. Peer support specialists are now working in community spaces around the city, such as in public libraries.
Outcomes	• The signing of the Act coincided with the launch of Healing City, a local grassroots movement advocating for community-led, healing-centered, and trauma-informed engagement and resources for mental health and wellbeing. • The eponymous Healing City Baltimore organization acts as an aggregator for information on mental health resources and events across the city, as a vocal advocate for mental health funding and centering community voice, and as the organizer of an annual healing summit. • Impacts and outcomes have not yet been shared publicly in a comprehensive manner, and it is not clear if there were new budget appropriations alongside the passage of the Act.

[133] "Our Efforts," Healing City Baltimore, https://healingcitybaltimore.org/our-effforts
[134] "The Movement: Origins & Efforts," Healing City Baltimore, March 2022, https://www.youtube.com/watch?v=CaFctQjuNY8
[135] "Understanding Trauma & What We're Doing About It," Healing City Baltimore, November 2022, https://www.youtube.com/watch?v=kavu3byV2tY
[136] "The Elijah Cummings Healing City Act," Dare to Reimagine, January 2021, https://www.daretoreimagine.org/case-studies/baltimore-trauma-responsive-city

Considerations	• Healing City exemplifies a movement that centers community voice, asking them to be part of the solution and to work as the implementors. It also models an initiative that highly values youth leadership.

Case Study: Alberta Family Wellness Initiative—A Brain Story[137,138]	
Challenge	• Adults in positions of power do not always understand how youths' individual **brain development impacts their mental health** and risk of substance use issues. • This lack of understanding can cause adults to blame a young person's poor behavior entirely on choice or temperament (i.e., a "bad attitude") without considering how brain development influences a young person's behavior and ability to navigate relationships. This leads adults to punish related manifestations of "poor behavior" instead of recognizing opportunities to address underlying mental health challenges.
Approach	• Funded by the Alberta Family Wellness Institute, Harvard University's Center for the Developing Child and FrameWorks Institute developed "The Brain Story," a **free online certification course that trains participants on how experiences during childhood shape our brain and influence our human relationships**. • This course is designed to equip individuals—including parents, educators, health professionals, and policymakers—with knowledge about the importance of healthy brain development during childhood and about how to support lifelong mental and physical health and wellbeing. • The hope is that mindsets of those that support youth will shift, leading to greater compassion, empathy, understanding of behavior, and ultimately will **shift adults' interpersonal and professional interactions with youth**.
Outcomes	• A 2019-2020 evaluation of the program that included interviews and a survey of 439 participants showed that the theory of change largely held true. For example, teachers interviewed now viewed students who were acting out in class or having trouble sitting as **experiencing challenges with executive function and self-regulation, rather than being willfully "bad kids,"** and expressed **increased empathy** for their students and their caretakers. • These mindset shifts meaningfully impacted behavior changes for participants. **Two-thirds indicated changes** in how they interact with children in their family, and amongst professionals, two-thirds indicated changes to how they interact with clients.
Considerations	• The Brain Story works both upstream and downstream by both educating adults on what makes a healthy environment for brain development, and if the child is already exhibiting challenges, helping them understand the underlying developmental science that has impacted their behavior. • The power of this certification lies in its applicability and participation by a multitude of sectors that holistically represent a full community of youth-

[137] "Brain Story Certification," Alberta Family Wellness Initiative, https://www.albertafamilywellness.org/training/
[138] FSG Evaluation, 2020

	serving adults—medical professionals, early childhood education, juvenile justice, etc. Any placed-based initiative that wishes to use this resource can create systems change by encouraging participation across a wide variety of adults across industries. • While this course is useful to all adults in youth-serving roles and industries, it is particularly impactful in schools and with teachers. Brain Story certification may be one way to help to address the racial bias that leads to disproportionate punishment for Black students in Cincinnati.

Case Study: Hope Squad—Suicide Prevention Peer Support Model[139,140,141]	
Challenge	• For many years, Provo City School District, one of the largest in the country, was **losing one to two students per year due to death by suicide.** • Compelled to take action, school administrator Dr. Gregory A. Hudnall set out to find a way to prevent more deaths.
Approach	• After assembling a multi-sector task force that included peers from the school district, parents, mental health agencies, members of city council, among others, and building on learning from students, Dr. Hudnall and team launched Hope Squad—**a peer support suicide prevention program for youth in K-12 and college institutions.** • Participating schools ask students to nominate trusted peers to the Hope Squad. Once selected, students, in partnership with a local mental health agency, are **trained in how to identify suicide warning signs, connect students to trusted adults, and act as a kind and trusted support system** to their fellow students.
Outcomes	• Nine years after launching in 2004, **youth suicides in Provo City School District went from one to two per year to zero.** • Since then, the program has expanded to 1,200 schools across 35 states and Canada. • In 2020, year one of the Ohio Hope Squad Comparison Study showed: Hope Squad schools have **reduced suicide-related stigma** and have significantly **increased referrals to care** in general and for those considered facing high-risk.
Considerations	• Hope Squad is already present in some Cincinnati-area schools, though it is not clear where and to what scale. Many community members familiar with the program have expressed fondness for it and desire to see it spread across the state, while many other community members have not been introduced to the program at all. • One Cincinnati youth from Mason High School said "[The kids in] Hope Squad are so diverse, but I feel so included. Having upper and lower classmen together, sharing the same problems, and sharing how they dealt with it is so important."

[139] "Mission & History," Hope Squad, https://hopesquad.com/mission-history/
[140] "Evidence & Grant Application Information," Hope Squad, https://hopesquad.com/evidence/
[141] "What is Hope Squad?" Hope Squad, October 2020, https://www.youtube.com/watch?v=fZzanuKgJ4M

	• Considerations include the need for interested school districts to develop a partnership with a local mental health agency for conducting student training and funding. • In-school counselors are an existing asset that would ease implementation of Hope Squad, as the program requires a trusted adult to meet with students who need support, especially if they face high risk.

Case Study: Keep Oregon Well in Schools[142,143,144,145,146,147]	
Challenge	• According to Mental Health in America's annual State of Mental Health survey, Oregon ranks as the **worst state in the country for youth mental health**. • As a result, community organizations and advocates around the state have been exploring new pathways and launching new programs aimed toward youth.
Approach	• Trillium Family Services, the state's largest provider of youth and family behavioral health services, already had a wide variety of offerings for youth across high and low levels of acuity and in both in- and out-of-school settings. • Through **grants from a local hospital system and the state's Medicaid provider**, Trillium began piloting a new program "Keep Oregon Well in Schools" in a handful of school districts in the Portland metropolitan area. • Trillium selected school districts based on prior relationships and an assessment of need (based on community utilization data). • Keep Oregon Well in Schools programming looks different across participating schools, but all follow a prevention-based model. • School-based activities and services may include creating a discreet gathering **space or lounge dedicated to student wellness, drop-in school counselor support, trauma-informed training with school staff, and mental health presentations** to students. • One school spotlighted in the program converted a detention space into a **student wellness center** managed by a Trillium-trained wellness coordinator and school-based counselor. The wellness center has a variety of spaces for social-emotional skill building, serves as a space for student decompression and conversation, and provides an avenue for students to meet with a counselor.
Outcomes	• Trillium plans to expand the program into other school districts throughout the Portland metropolitan region.

[142] "In Schools," Trillium Family Services, https://www.trilliumfamily.org/keep-oregon-well-in-schools
[143] "Programs & Services," Trillium Family Services, https://www.trilliumfamily.org/programs-and-services
[144] "Keep Oregon Well in Schools at Kraxberger Middle School," Trillium Family Services, December 2018, https://www.youtube.com/watch?v=YlhAXl_ZJlA
[145] "Keep Oregon Well in Schools at Centennial Park School," Trillium Family Services, December 2018, https://www.youtube.com/watch?v=MErUpRSq_LA
[146] "Keep Oregon Well in Schools: Denise Wright of Centennial School District," Trillium Family Services, July 2018, https://www.youtube.com/watch?v=KgLtx_aC0e4
[147] "Youth Ranking 2023," Mental Health America, https://www.mhanational.org/issues/2023/mental-health-america-youth-data

	• Trillium has not publicly shared program-specific outcomes.
Considerations	• The program was built on the philosophy of meeting community members where they are and the importance of prevention and early intervention efforts. • The program demonstrates a flexible approach to service implementation based on individual schools' needs and existing assets. • Keep Oregon Well in Schools is one of a wide variety of youth and family services Trillium offers. Youth can interface with the agency at the setting and level of care that best meets their needs.

Case Study: Polk County, Florida—Instituting Parity for Behavioral Health Coverage[148]	
Challenge	Behavioral health services are not sufficiently funded, which makes them unaffordable or unavailable to many youth and families. Many employers adopt limited insurance plans, which exacerbates affordability issues.
Approach	• Leaders in Polk County, Florida saw the significance of treating the "whole person" in their programming and implemented mental health parity in their county employee health benefits in 2008. • Under a new plan with Aetna for an Employee Assistance Program (EAP) and behavioral health treatment, the Polk County government provides **no distinction in coverage between mental health and medical visits**. • While there are some specific guidelines, there are no limits on hospital days or on the number of psychological or psychiatric outpatient visits. The plan covers treatment in residential facilities for drug addiction and withdrawal and all medications are covered at a 100% level, including those for common comorbidities such as depression, bipolar disorder, and hypertension.
Outcomes	• Incidences of **residential treatment have reduced**. • Mental health care utilization rose slightly in the first year after parity. However, total health care **costs have not increased**.
Considerations	• As a suburb between Orlando and Tampa, Florida, Polk County is a densely populated county, and the county employs around 4,500 people. To have a significant impact, larger employers would need to be engaged, requiring **collaborative education, awareness, and advocacy.** • If large employers in Cincinnati, such as Fifth Third Bank, Kroger, and hospitals were to implement parity coverage for behavioral health care, **tens of thousands of employees and their families could have increased access to care**.

[148] Polk County Florida, Center for Workplace Mental Health, April 2016, https://www.workplacementalhealth.org/Case-Studies/Polk-County-Florida

Case Study: Eagle County, CO—Funding Mental Health via Marijuana Sales and Excise Tax[149,150,151,152,153,154]	
Challenge	• Eagle County, CO is home to a small mountain resort community. The area's unique geographic location (i.e., distance from a major urban center) and very high cost of living exacerbate common behavioral health access issues seen across the country—affordability, proximity, and diversity of services offered. • The local hospital system, Vail Health, along with smaller community organizations, provide the majority of health services. This means that funding for health services are highly dependent on traditional funding flows such as insurance, government grants, and philanthropy.
Approach	• In the first six years since marijuana's full legalization, the state of Colorado generated over $1B in marijuana tax revenue which has been used to fund special programs for schools, affordable housing, and youth substance abuse prevention, among other areas. • Inspired by the **revenue potential** and acutely aware of the local funding gaps in behavioral health care, Eagle County explored the feasibility of a supplementary **county-level marijuana tax to be earmarked for funding local public behavioral health services.** • The county commissioned a poll to gauge support for new local marijuana sales and excise taxes, which showed likely support by two-thirds of voters. • Once placed on the ballot in 2019, the proposed sales and excise taxes, capped at 5% each, **passed with 73% of the vote**.
Outcomes	• A cross-sector oversight committee recommended that the county board of commissioners use the new taxes to fund: 1) school-based counselors; 2) jail-based counselors; and 3) a new crisis stabilization unit at a local community organization. • Since its implementation, **revenue generated from the taxes has surpassed estimates**.
Considerations	• Unlike other examples of marijuana sales or excise taxes, this one was specifically earmarked for behavioral health services. It is not clear how this distinction impacted the results of the feasibility survey as compared to support for a tax to fund public services more generally.

[149] Wyrick, R., "Eagle County voters approve marijuana tax to fund mental health programs," Vail Daily, November 2017, https://www.vaildaily.com/news/eagle-county-marijuana-tax-to-fund-mental-health-programs-riding-to-landslide-victory-in-early-election-returns/

[150] Boyd, P. "After slow start, Eagle County marijuana tax dollars finish strong in 2020," Vail Daily, January 2021, https://www.vaildaily.com/news/after-slow-start-eagle-county-marijuana-tax-dollars-finish-strong-in-2020/

[151] "Marijuana Tax," Town of Eagle, https://www.townofeagle.org/768/Marijuana-Tax

[152] Wyrick, R., Eagle County poll indicates support for marijuana tax that could generate $2M a year, Summit Daily, August 2017, https://www.summitdaily.com/news/eagle-county-poll-indicates-support-for-marijuana-tax-that-could-generate-2m-a-year/

[153] "Legalized marijuana brings in billion dollar tax haul for Colorado," WXYZ-TV Detroit, October 2018, https://www.youtube.com/watch?v=wObLXzU2bxs

[154] "Ohio Issue 2: Election Results 2023," The Washington Post, November 2023, https://www.washingtonpost.com/election-results/2023/ohio-issue-2/

	• The cross-sector oversight committee had 36 members from multiple sectors: providers, law enforcement, and citizens, among others. This committee can serve as a model of collective impact. • The taxation model builds on legacy harm reduction approaches where the perpetrator of public harm is taxed to fund programs to reduce its negative impact on society (i.e., alcohol and tobacco taxes to fund prevention and treatment programs related to these substances). This model has its limits for behavioral health, since poor outcomes cannot necessarily be linked to a primary actor. • The recent passage of Issue 2 in Ohio—which legalizes, regulates, and taxes marijuana—presents an opportunity for local jurisdictions to test feasibility of their own local taxation models and determine what such a tax could fund.

Case Study: Allcove Centers—Integrated Youth Behavioral Health Care[155,156,157,158,159]	
Challenge	The siloed behavioral health system makes it difficult for young people and their families to receive the right care at the right time.
Approach	• Allcove Centers are **integrated, drop-in youth behavioral health centers** designed by and for young people to increase access to holistic care based in California. • Allcove offers **free and low-cost behavioral, physical, and social health support resources** to young people aged 12-25. Services include therapy sessions, health testing and referrals, educational support, peer support groups, family support services, quiet spaces to relax and do work, recreational activities, and classes to build skills. • Each Allcove center is designed to meet the needs of its community's youth with the **direction of a Youth Advisory Group and input from a Community Consortium** of local individuals and organizations interested in supporting youth well-being.
Outcomes	• While Allcove Centers are too early in their tenure to determine impact, after 16 years of work, a similar Australian model (Headspace) saw **significant improvements in psychological distress and psychosocial functioning** for around one-third of participants, and just under **half improved their self-reported quality of life**.

[155] McGorry P. et al., "Designing and scaling up integrated youth mental health care" World Psychiatry, January 2022, https://www.doi.org/10.1002/wps.20938
[156] Rickwood D. et al., "Sixteen years of innovation in youth mental healthcare: Outcomes for young people attending Australia's headspace centre services," PLOS ONE, June 2023, https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0282040
[157] Kisely, S. et al., "Latest evidence casts further doubt on the effectiveness of headspace," The Medical Journal of Australia, September 2022, https://doi.org/10.5694/mja2.51700
[158] Kisely S. et al., "More smoke and mirrors: Fifteen further reasons to doubt the effectiveness of headspace," Australasian Psychiatry, April 2023, https://doi.org/10.1177/103985622311676
[159] "Evaluation of the National Headspace Program," KPMG, June 2022, https://www.health.gov.au/sites/default/files/documents/2022/10/evaluation-of-the-national-headspace-program.pdf

	• However, some practitioners argue results are not as significant as one would expect from the resources expended potentially due to the **short-term nature of their services**.
Considerations	• Allcove is the first effort of its kind to implement the integrated youth mental health model in a country without a national health insurance program. Consequently, **Allcove used private funding** to launch its first center. • Implementing an integrated youth behavioral health center model in Greater Cincinnati would require **blending or braiding private, philanthropic, and other funding streams** such as state or federal suicide prevention funds, school mental health, prevention and early intervention funds, innovation funds, and other emerging public funding opportunities.

Case Study: TennCare—State Medicaid Values Based Payment Plans[160,161]	
Challenge	Some young people do not receive the best evidence-based treatment, extending their treatment time and contributing to long waitlists.
Approach	• Through TennCare's value-based payment (VBP) plans, Managed Care Organizations (MCOs) offer **payments based on quality improvement measures** established by the national committee for quality assurance. • VBP plans offer opportunities to simultaneously **raise reimbursement rates** for providers through bonus payments and to **increase the quality and effectiveness of treatment** for patients. • These plans include a pediatric prevention effort with **depression and anxiety screenings** and **wellness visits**, a **coordinated care program** for those with serious behavioral health challenges, home and community-based services, and more. • Tennessee's incentive program **pays plans an additional $0.03 per member per month for improvement** in certain measures related to behavioral health.
Outcomes	• As of 2015, 85 percent of the 33 measures tracked since 2007 **have shown improvement over time**, and 47 measures improved from 2014 to 2015, including ER/inpatient utilization, follow-up after inpatient care, medication management, and more. • Plans have created **data sharing opportunities** between MCOs, **incentivizing payers to learn about and share effective treatment approaches** among one another.
Considerations	• VBP plans are only enticing to MCOs thinking about **long term services and financial goals**, as they seek to reduce the overall healthcare costs from higher acuity services through supporting a healthier population.

[160] Honsberger, K. et al., "Tennessee: Using Managed Care Incentives to Improve Preventive Services and Care for Children, National Academy for State Health Policy," January 2018, https://nashp.org/wp-content/uploads/2018/01/Tennessee-Case-Study-2018.pdf

[161] "2017 Annual HEDIS / CAHPS Report: Comparative Analysis of Audited Results from TennCare MCOs," Division of Health care Finance & Administration, August 2017, https://www.tn.gov/content/dam/tn/tenncare/documents/hedis17.pdf

	• Some providers need to **build capacity in order to meet new requirements** and approaches; providers often don't have the billing and data collection and reporting capacity to implement a values-based payment initiative. • In order for this approach to be successful in Greater Cincinnati, Kentucky, Ohio, and Indiana state **Medicaid agencies would have to find value in the approach** and develop values-based plans. This would require **significant advocacy and policy work**.

Case Study: The Hogg Foundation—Widening the Workforce Pipeline[162],[163],[164],[165],[166],[167],[168]	
Challenge	There are not enough diverse behavioral health providers to meet the needs of young people and their families due to high costs of certification, limited access to certification programs, limited training on cultural responsiveness, and high turnover and low retention in the field.
Approach	The Hogg Foundation for Mental Health supports the behavioral health provider workforce by **breaking down barriers to access to high-quality education**. They do this through funding programs, scholarships, and fellowships, while working to shift state and federal policies: • Awards around 20 **Ima Hogg Scholarships** of $5,000 yearly to graduate social work students from across Texas. • Supports the **American Psychological Association Accreditation Program** to increase the number of internships accredited by the in the state and diversify existing opportunities, by funding the development and accreditation of eight internship programs across Texas ($3.0M). • **Supports bilingual scholarship programs** by awarding an estimated $1M to Spanish-speaking students at accredited graduate social work programs in Texas to raise awareness for the need for cultural and linguistic diversity. • Awarded $1M to Houston Health Department to develop a curriculum to train and certify transition-age youth as **peer wellness specialists**. • Awarded $440,000 to support **the Integrated Behavioral Health Scholars Program** at University of Texas. This interdisciplinary training prepares medical and behavioral health students to collaborate on patient care in integrated care teams with a focus on cultural responsiveness. These scholars generally go on to provide services to marginalized communities.

[162] "What we do," Hogg Foundation for Mental Health, https://hogg.utexas.edu/what-we-do
[163] "Integrating Mental Health Care in the Medical Setting," Hogg Foundation for Mental Health, https://hogg.utexas.edu/what-we-do/success-stories/integrating-mental-health-care-in-the-medical-setting
[164] "Integrated Behavioral Health Scholars Program," UT Austin Dell Medical School, https://dellmed.utexas.edu/units/department-of-psychiatry/integrated-behavioral-health-scholars-program
[165] "Funding Opportunities," Hogg Foundation for Mental Health, https://hogg.utexas.edu/funding-opportunities
[166] "Peer Support for Young Adults," Hogg Foundation for Mental Health, https://hogg.utexas.edu/what-we-do/success-stories/youth-peer-support
[167] "Mental Health Policy Fellows and Policy Academy," Hogg Foundation for Mental Health, https://hogg.utexas.edu/what-we-do/policy-engagement/policy-fellows-academy
[168] "Cultivating the Next Generation of Psychologists," Hogg Foundation for Mental Health, https://hogg.utexas.edu/what-we-do/success-stories/next-generation-psychologists

Outcomes	• Ninety-one percent of Integrated Behavioral Health Scholars are working with **medically underserved communities** in Texas. Of these scholars, fifty five percent are working in **integrated settings** and twenty three percent are working for **public sector agencies**.
Considerations	• The Hogg Foundation began as a family funder and now sits within the University of Austin Texas's Division of Diversity and Community Engagement. Because of this relationship the Hogg Foundation is **uniquely positioned to address issues around education** through expertise and partnerships. • Provider workforce challenges have been ongoing for decades and are complex to address. They require **significant investment in changing policies, education, and care practices**.

Appendix C. Coalition Participants

Abby Beausir, Northern Kentucky Cooperative for Educational Services

Adam Roland, CHNK Behavioral Health

Akesa M-Ariba, Center for Closing the Health Gap

Alexis Kidd Zaffer, Seven Hills Neighborhood Houses

Alicia Ajiboye, Focus on Youth

Alicia Fine, Greater Cincinnati Behavioral Health Services

Alison Kaufman, Magnified Giving

Amber Kelly, Community Engagement Collaborative

Amy Floyd, Joe Burrow Foundation

Amy Orr, Talbert House

Amy S. Weber Hall, Hope Behavioral Health

Amy Thompson, Cincinnati Youth Collaborative

Amy Tuttle, Wordplay Cincy

Amy Weber, United Way of Greater Cincinnati

Andre Whaley, ETAC Lighthouse Ministries

Andrea Hischak, United Way of Greater Cincinnati

Andrew Hershey, Cincinnati Children's Hospital Medical Center

Angela Holman, TQL

Angela Klinedinst, Whitney/Strong

Angela Waugh, Opticare Counseling

Ashlee Young, Interact for Health

Ashley Glass, Black Women Cultivating Change

Ashley Tomlinson, GLAD House

Avani Modi, Cincinnati Children's Hospital Medical Center

Beth Platte, Crossroads

Bob Shapiro, Cincinnati Children's Hospital Medical Center/Joining Forces for Children

Bonita Campbell, Lighthouse Youth and Family Services

Bonnie Hedrick, St. Elizabeth Healthcare

Brad McClain, Tristate Trauma Network

Brandy Pendleton, Back2Back Cincinnati

Brian Brentlinger, Northern Kentucky Cooperative for Educational Services

Brian Cunningham, Grant Us Hope

Bruce Jeffery, YMCA

Candice Crear, From Fatherless to Fearless

Carlton Collins, The Heights Movement

Carmen Gaines, Women's Liberation Workshop

Caroline Lembright, Interact for Health

Carolyn Brinkmann, The Consortium for Resilient Children

Carrie Bunger, Beech Acres Parenting Center

Carrie Hampton, Best Point Education and Behavioral Health

Carrie Stoudemire, Hamilton County Mental Health and Recovery Services Board

Casey Morris, Boys & Girls Clubs of Greater Cincinnati

Cassidy Lekan, First Step Home

Catherine Engle, Centerpoint Health

Christi Valentini-Lackner, PreventionFIRST!

Christine Browner, 1N5

Colleen Cheek, Activities Beyond the Classroom

Corey Drushal, TQL

Danei Edelen, NAMI Brown County

Deanna Hillard, Interact for Health

Debbie Gingrich, Best Point Education and Behavioral Health

Dianna Rafferty Coley, The Foundation Office at Fifth Third Bank

Donna Mayerson, Donna Mayerson Foundation

Doug Arthur, Transform Consulting

Elizabeth Anne Wilson, Mercy Health

Elle Folger, Millstone Fund

Ellen Bates, Brighton Center

Ennis Tait, Ennis Tait Ministries

Eric Cummins, New Path Child and Family Solutions

Eric Washington, Cincinnati Health Department

Erin Kutchera, Modern Psychology and Wellness

Erin Saul, GreenLight Fund

Evie Alessandrini, Cincinnati Children's Hospital Medical Center

Gloria Walker, NAMI Urban Greater Cincinnati Network on Mental Illness

Grace Bowman, First Step Home

Grant Mussman, Cincinnati Health Department

Greg Kesterman, Hamilton County Public Health

Heather Cokl, Clermont Recovery Center a division of Greater Cincinnati Behavioral Health Services

Heidi Bohman, Mental Health America of Northern Kentucky & Southwest Ohio

Iris Roley, Communtiy Leader

James Sherry, Holly Hill Child & Family Solutions

Jamie Markle, Ignite Philanthropy

Jane Herms, Family Nurturing Center

Jason Troup, Back2Back Cincinnati

Jayla Lee, PreventionFIRST!

Jean Mize, The R.C. Durr Foundation

Jeffrey Anderson, Cincinnati Children's Hospital Medical Center

Jen Eismeier, Camp Joy

Jen Hansert, Brighton Center

Jena Bradley, bi3

Jennifer Mooney, NKY Health Department

Jennifer Sheard, Poppy's Therapeutic Center

Jennifer Zimmerman, bi3

Jessica McClure, Cincinnati Children's Hospital Medical Center

Jessica Moore, Cohear

Jessie Richardson, Envision Partnerships

Jill Miller, bi3

Joanna Lowry, Butler County Mental Health & Addiction Recovery Services Board

Jodi Harding, Talbert House

Joe Luria, Cincinnati Children's Hospital Medical Center

John Banchy, Best Point Education and Behavioral Health

John Heater, Big Brothers Big Sisters

John Parran, New Path Child and Family Solutions

Jolene Joseph, The HealthCare Connection

Jordan Bankston, Forever Kings

Jorge Perez, YMCA

Josh Arnold, Talbert House

Judith Mitchell, TriHealth

Julia Saldanha, NAMI Southwest Ohio

Julie Herrman, Holly Hill Child and Family Solutions

Julie Knutson, Big Brothers Big Sisters of Greater Cincinnati

Julie Raia, CHNK Behavioral Health

Kara Pagburn, CHNK Behavioral Health

Kara Schirmer, Great Parks

Kareem Moncree-Moffett, Youth Lead Alliance

Kari Bloom, Hamilton County Juvenile Court

Kate Junger, Cincinnati Children's Hospital Medical Center

Kate Kassis, Brighton Center

Kate Morris, Ignite Philanthropy

Kate Schroder, Interact for Health

Kathy Wade, Learning Through Art, Inc.

Katie Nzekwu, Found Village

Kayla Miller, Everybody is LITT Academy

Kelley Adcock, Interact for Health

Kelly Collison, Magnified Giving

Kelsey Smothers, Greater Cincinnati Behavioral Health Services

Kevin Richardson, Sunrise Children's Services

Kimberly Kass, Cincinnati Children's Hospital Medical Center

Krista Maier, Cincinnati Children's Hospital Medical Center

Kristen Smith, The Butler County Suicide Prevention Coalition

Kristina Latta-Landefeld, Envision Partnerships

LaNora Godfrey, Hamilton County Mental Health and Recovery Services Board

Lashun Scott, It's A New Day Behavioral Daycare

Laura Hershberger, Catholic Charities

Laura Mitchell, Beech Acres Parenting Center

Lauren Bartoszek, Health Collaborative

Lauren Mason, Northern Kentucky Children's Advocacy Center

Lee Ann Watson, Clermont Mental Health & Recovery Board

Libby Hunter, Adventure Crew

Linda Gallagher, Hamilton County Mental Health and Recovery Services Board

Linda Richey, Cincinnati Children's Hospital Medical Center

Lisa Amlung, Cincinnati Children's Hospital Medical Center

Lisa Anglin, St. Elizabeth Healthcare

Lisa Cooper, Cincinnati Children's Hospital Medical Center

Lisa Myers, Interact for Health

Liz Atwell, Mental Health America of Northern Kentucky

Margie Weaver, Hamilton County Jobs and Family Services

Maria Piombo, Central Clinic

Marjorie Reeves, St. Elizabeth Healthcare

Mary Delaney, Community Matters

Mary Wolff, Talbert House

Matt Feldhaus, Charlie Health

Meg Burrows, Cincinnati Public Schools

Melissa Saladonis, Cincinnati Children's Hospital Medical Center

Meredith Poynter, Mental Health & Addiction Advocacy Coalition

Michael Patton, Hamilton County Jobs and Family Services

Michael Sorter, Cincinnati Children's Hospital Medical Center

Michelle Lydenberg, Interact for Health

Mike Boberg, The Jewish Foundation

Mindy Garverick, NAMI Ohio

Mona Mansour, Cincinnati Children's Hospital Medical Center

Morgan Whaley, Love N Action CDC

Nancy Eigel-Miller, 1N5

Neil Tilow, Talbert House

Nia Baucke, Cohear

Nicole Pfirman, MindPeace

Ozie Davis III, Queen City Youth Development Program

Paige Brown, Preston Brown Foundation

Pamela Lindeman, Child Focus

Patrice McDowell-Brown, Preston Brown Foundation

Patti Ahting, Mental Health Recovery Board Serving Warren and Clinton Counties

Paul Haffner, Lighthouse Youth and Family Services

Penny Middaugh, Greater Cincinnati Behavioral Health Services

Rachael Parker, Learning Through Art, Inc.

Randy Allman, Butler Behavioral Health Services

Ray Compagna, Sunstone Life, Inc.

Rebecca Jones, Talbert House

Reem Aly, Ohio School Based Health Alliance

Rick Wurth, CHNK Behavioral Health

Robin Burrow, Joe Burrow Foundation

Robin Rich, Peer Health Exchange (former)

Ross Meyer, Interact for Health

Sailee Thakur, TriHealth

Sandra George, American Youth Foundation

Sara Mullins, St. Elizabeth Healthcare

Sarah Hayes, Cincinnati Public Schools

Sarah Zawaly, Joining Forces for Children

Selma Cikaric, St. Elizabeth Healthcare

Shannon Coleman, TriHealth

Shannon Russell, Greater Cincinnati Behavioral Health Services

Shannon Yung, Found Village

Shantel Thomas, Center for the Healing and the Hurt

Shawn Jeffers, Youth at the Center

Shelley Batch, Central Clinic

Sid Taylor, Focus on Youth

Sonya Carrico, Interact for Health

Stacie Strotman, Covington Partners

Stephanie Vogel, Northern Kentucky Health Department

Susan Shelton, MindPeace

Susan Sprigg, Cincinnati Children's Hospital Medical Center

Tamara Thrasher, GreenLight Fund

Tara Immele, Greater Cincinnati Behavioral Health Services

Tasha Taylor, Northern Kentucky Cooperative for Educational Services

Ted Folger, Millstone Fund

Tiffany Thomas, Talbert House

Tiffany White, Cincinnati Health Department

Tina Cheng, Cincinnati Children's Hospital Medical Center

Tom Carleton, Great Parks

Tommy Koopman, Mental Health Recovery Board Serving Warren and Clinton Counties

Tracy Cummings, Lindner Center for HOPE

Tricia Mullins, New Path Child and Family Solutions

Tyran Stallings, The DAD Initiative

Victoria Taylor, Butler Behavioral Health Services

Zohar Perla, bi3

Appendix D. Community Insights

From September - November 2023, Cohear organized and facilitated seven targeted focus groups with area youth (0-24) and their families. There were a total of 58 participants, a majority of whom were from traditionally marginalized groups. Focus Groups were organized by the following populations to ensure participants' feeling of comfort around discussing shared experiences:

- Families with young children (0-12)
- High School Age Youth
- LGBTIQA+ Youth and Young Adults
- Rural and Suburban Youth
- Black and Latino Youth
- Youth with experience with the foster/juvenile court/justice system

Age	%	Gender	%	Race	%
<15	14%	**F**	74%	**White**	38%
15-22	50%	**M**	24%	**Black**	53%
23-34	22%	**T (transgender)**	2%	**Hispanic**	7%
35-50	12%			**Native**	2%
51>	2%				

Focus Group Questions:

1. How do you **define** mental health?
2. Tell a **story** about how mental health presents in your life?
    a. **For Parents:**
        i. What challenges are you seeing your children experience?
        ii. Why do you think that is happening? Are there changes you have seen in your life that have made that worse?
        iii. What is happening in your community that is contributing to those challenges?
3. What mental health **challenges** are you or your friends experiencing?
4. What do you think are the **root causes** of various mental health issues?
5. What do you **want people to know** and/or do? (People in your community, school, and mental health care providers)
6. What **role** do you want to play in this process?
7. How would the community look if it was **supportive of your well-being**?
8. Of everything we have discussed, what is the **one thing you want to see** done in the next 5-10 years that would create the community that you want to see?
9. **For Youth with experience with the foster/juvenile court/justice system:**
    a. How do you think your experiences with Foster Care and/or the Justice System have impacted your mental health?