

**Josiah H. Beeman Commission
Meeting of June 29, 2007
12000 Government Center Parkway
Room 232**

In attendance:

Mary Ann Beall, Chair, Fairfax-Falls Church Community Services Board
Mary Ann Bergeron, Executive Director, VA Association of Community Services Board
Gary Cyphers, Deputy Executive Director, Communications & Members Services
American Public Human Services Association
David Dangerfield, Retired Chief Executive Officer, Valley Mental Health
Larry Davidson, Associate Professor of Psychology in Psychiatry, Director of the Program
for Recovery and Community Health at Yale University School of Medicine
Joan Dodge, Senior Policy Associate, National Technical Center for Children's Mental
Health (Georgetown University)
Diane Grieder, Owner/President, Alipar, Inc.
Chuck Hall, Executive Director, Hampton-Newport News Community Services Board
Sonia Jurich, Senior Research Associate, RMC Research Corp., Arlington, Virginia
Ronald Manderscheid, Director, Mental Health and Substance Use Programs Constella
Group, Inc.
Mattie Palmore, Vice Chair, Fairfax-Falls Church Community Services Board,
Special Magistrate
Russell Pierce, Regional Coordinator of Recovery and Inclusion Services, Pathway Homes,
Fairfax, VA
Yvette Sangster, PAIMI Program Director, Protection and Advocacy for Individuals with
Mental Illnesses (Georgia Advocacy Office)
James Scott, Delegate, 53rd District, Virginia House of Delegates
James Stewart, Inspector General, Office of the Inspector General for Mental Health,
Mental Retardation and Substance Abuse Services
Carol Ulrich, President, National Alliance for Mental Illness of Northern Virginia,
Member of Virginia Chief Justice's Commission on Mental Health Law Reform

Verdia Haywood, Deputy County Executive, Fairfax County
Margo Kiely, Josiah H. Beeman Commission Staff Director
Kathaleen Karnes, Management Analyst, Fairfax County
Jaclyn Wing, Support to the Beeman Commission
Gary Axelson, CSB Director Clinical Operations and Staff Liaison to Beeman Commission
Brian Worthy, Special Projects Manager

Denise Donatelli, Clinical Psychologist, Woodburn Center - Youth & Family Mental Health
Services
Kolleen Martin, Mental Health Manager, Juvenile Forensics
Steve Sheard, CSB – Manager, Mental Health Youth & Family Residential Programs
Jean Bartley, Director, Youth & Family Mental Health Resource Program
Gary Lupton, Director of Utilization, Management, and Quality Assurance
Kathy Froyd, Director, Children, Youth and Family Division, Department of Family Services
Jas Tuischer, Constella Group, Inc.
Evelyn Kiley, Legislative Analyst, County Executive's Office

Lynne Crammer, Member, Fairfax-Falls Church Community Services Board
Jim Thur, Executive Director of the CSB
Gail Ledford, Department of Family Services - Comprehensive Services Act
Mary Kudless, Deputy Director of the CSB
Jim Dedes, Director of Court Services
John DeFee, Director of Mental Health Services
Will Williams, Director, Alcohol and Drug Services
Pat McConnell, Director of Youth Services for Alcohol and Drug Services
Laura Yager, Prevention, Resource Dev & Community Relations
Denise Raybon, Countywide Prevention Coordinator

2PM Meeting started with Margo Kiely introducing the agenda for Friday and Saturday.

This was followed by a self-guided introduction of Commissioners, presenters, and guests. After introductions, Margo Kiely spoke of various issues and topics regarding scheduling and future Commission meeting guests.

Youth and Family Services:

Jean Bartley and Steve Sheard came as representatives of Mental Health's Youth and Family Division. Their presentation was aimed at giving the Commission a brief overview of programs and responsibilities.

Ms. Bartley talked about a variety of services the agency provides to the community and differentiated between clinical services provided directly to consumers within the mental health system and those services provided to consumers in partnership with and on referral from other agencies. Mr. Sheard discussed the Division, its programs and its challenges. Among them: meeting the demand from other agencies and programs; case management consuming time from other responsibilities; hiring and retaining nurses and psychiatrists; an insufficient infrastructure to maintain growth; lack of ability to track changes in the population including, but not limited to, the increased frequency of autism, co-occurring/co-morbid diagnoses, youth aging out of the school special education services, and the needs of sexually offending youth. Instituting an electronic health record was also discussed.

They both discussed various difficulties in some specific programs. Programs mentioned were: Juvenile Detention, Child Abuse and Neglect, Mental Health Resource Team, Youth and Family Assessment, Infancy and Early Childhood Programs, and Residential programs. The challenges that arch across all programs are: longer assessment wait due to lack of staff; not enough staff to meet current demand, nor to meet workload; funds deficiency; administrative tasks cutting into time for other duties; program closures leading to displaced children; and lack of options for aging-out children. A positive point with the program is the fact that entry is clear cut. Outpatient assessment is done as an entry function as in the adult program, Day treatment requires a direct call for a screening, and Juvenile Forensics entry comes from the juvenile court or other probation staff.

Additional questions that were raised were:

- What does this program provide to CSA?
- Do you have child/adolescent psychiatry?

- How do you decide to start a new service vs. staffing an old service that has need?
- How do you measure productivity?
- How does Case Management for an aging-out child go to the adult program?

Child Welfare and Mental Health:

Kathy Froyd, Director of the Children, Youth and Family Division of the Department of Family Services started the presentation by talking about the community based program's strong relationship with the Mental Health program. The agency's goal is to provide safety and well being for children, and provide more access to families. There are 275 staff members in the division including social workers, child protective services, and foster care; and five locations, including a child advocacy center.

The agency handles many conditions affecting children. The most frequent are sexual abuse and post traumatic stress disorder. The current public child welfare system combined with poverty and trauma yields families with multi-layered problems which the agency is not fully capable of handling. At present, 80% of mental health service referrals from this agency go to the private sector and 20% to the public mental health system. It was noted that a majority of families who need mental health services have had no prior contact with the mental health system. Families have various needs including: timeliness and responsiveness for children needing assessment and treatment; focus on family and youth, support, and service directing; treating cases as a family rather than individual; and being culturally appropriate and multi-lingual in a diverse community.

Current issues:

- The separation between Mental Health and Alcohol and Drug Services: A lot of children and families suffer from co-occurring and even with the best effort, there is no logical approach to proceed to get the services needed.
- The disproportionate number of African-American children in foster care. Statistics say African-American children don't end up in services until it is long past being a problem which can be addressed within the family.
- Ms. Froyd said that accessing Mental Health services can be complex and difficult. In the current Mental Health system and believes that the tools which are available do not meet the needs of families. The public system, in addition, has a limited capacity to take care of victims of sexual abuse.
- Ms. Froyd also believes the system needs better capacity to deal with issues of attachment and loss, and Post Traumatic Stress Disorder. Kids in the foster care system can have more Mental Health issues and trauma than even soldiers that come home from war.
- She said there is a need to move from a deficit-based to a competency-based model, and a more community based system.

Ms. Froyd stated that DFS looks forward to further developing shared goals and outcomes with the CSB.

Mental Health and Substance Abuse Challenges & Services:

Jim Dedes started the presentation with a visual explanation of the juvenile justice system. Current problems with the system are inadequate resources, a long wait time, need of more staff and multi-lingual staff, more training on helping kids with mental health issues,

and need a greater emphasis on specialty treatment programs. The system has a Spanish speaking group, but not all languages have instantaneous help available. It's hard to help kids who are not simply delinquent but who also have significant mental health issues. The youth population is increasingly dual-diagnosed and co-occurring, many taking or requiring psychotropic medications. The nursing staff is good, but we need more doctors to come in and help. Court-involved youth need seamless entry into the Mental Health system. There's need for more regional programs, especially for sex offender children. We also need more partnering with other organizations.

Numbers and Tools:

The MAYSI-2 evaluation tool is used. Around 2000 kids are detained for alleged criminal offenses yearly, and there's never been an escape. Of those children detained, 41% of them score high on the MAYSI-2 scale for suicide risk, and, in that group, more girls than boys are at risk. Even with the evaluation tool, alcohol/drug use is under-reported. Of the 1000 kids on probation, approximately 25% will receive Mental Health or Substance Abuse services, and most will receive those services from the CSB.

Positives:

Mr. Dedes said that Mental Health provides quality dedicated forensic services to the juvenile justice system in the Courts and in the Juvenile Detention Center. Mental Health works with the Inter-disciplinary team for truants and runaways. CSB gets a lot of credit for developing the drug treatment program with us, he said. The juvenile detention center has a court psychologist and Mental Health therapist. Woodburn helps a lot with Temporary Detention Orders to keep things from getting to the point of crisis. Our Beta program is wonderful, but it is always at full capacity and there is a waiting list.

One of the Commission members attests to the fantastic job of the Beta program.

A Brief Overview of Systems of Care & CSA:

Gail Ledford started the presentation by introducing and discussing the Systems of Care. The current structure in place is very old, and its parts have been around as separate entities for a long time. The idea is to bring it all together so that the elements can work as one child-centered, community-based entity. CSA's goal is to deliver effective, in-community services and equal access services for all kids. There is some hardship in getting contract providers to come to the area because it's moderately expensive here, and start-up funding is lacking.

CSA initiatives:

The CSA is more of a process than a program. One of the initiatives that was set up is Mental Health's Crisis Care program for children at Leland House; it is a short-term stay, crisis stabilization program aimed at avoiding psychiatric hospitalizations. CSA also has a utilization review to ensure that resources are being effectively managed and deployed. The northern Virginia region has a sex offender work group with very effective training for sex offending youth and victims. Family Services also has a specialized team for sex offenders. Every child served by the CSA by age 14, and still in the system, needs to have a transition plan in place. Any child in day treatment or residential care is not case managed by just anyone, but by a dedicated unit we work closely with, Ms. Ledford said. There are challenges such as needing more staff resources. Mental Health treatment cannot be done by a generalist approach -, it needs a specific approach.

Funding:

The CSA pool is not all local dollars, but is also state funded. There's a fixed budget that's stringently kept. It is a challenge because two populations are mandated: youth in foster care, and kids with an IEP. We have to make available some funding because if there's a specific population influx, they have to be cared for. Schools do not contribute money. When schools bring a kid in with an IEP calling for residential care cost goes to another fund. Once a child is CSA eligible, money doesn't come from the general fund account of the school system, but from general funds that are not appropriated to the school system.

Managing clients:

There are a few children that wind up being placed out of state, despite best efforts to focus services locally. This occurrence depends on bed space, placement appropriateness, family location, and family friendliness. The total may be approximately 5% of the 1059 children currently in the system. Virginia Medicaid won't pay for these children, and we cannot get any kind of balance with this. There has been a change in state law to affect kids with Mental Health needs in the foster care system. There is mental health treatment in the alternative schools of the Fairfax County School System. Of the kids in treatment, 51% have a DSM diagnosis; the other 49% are kids in foster care, cases of abuse or neglect, or those with a conduct disorder. It is unknown what percentage gets Mental Health service from the CSB. Many are CSA handled because the agency servicing them has exhausted its own resources. Some are involved with the Mental Health system, but that system serves lots of families that will not be able to find their way to CSA. If a family or child within the CSB has a situation that gets complex or worse a referral would be made, but CSA would still be in charge. Prevention would be a good cost saving measure.

Systems of Care:

Joan Dodge presented on the Systems of Care and how they could better treatment for children and families. Ms. Dodge gave an overview of the Mental Health system in America, its progression, and needed changes. Ms. Dodge then spoke about what wasn't working in the system. Examples cited were inappropriate use of inpatient and residential treatment, lack of parity, fragmentation between acute and extended care, lack of coordination, and the overrepresentation of children of color in foster care and detention. There was the notion that more than just Medicaid eligible families should be covered. Examples given were families who are not exactly poor or uninsured, but have exhausted private insurance on a child with serious emotional or behavioral problem; and families that can't get a specific service through the private sector.

The Systems of Care idea started in 1986 and is an important framework for reform and a way to build a system, but is not necessarily one model. Components at all levels are all interdependent, and need people on the same page to function. There are a lot of various system pieces that have to be looked at between one sector and another. Of the 121 Systems of Care communities, 57 are active and got funding from grants. Alexandria is the only community in this area that got the grant. Other programs worth mentioning: Milwaukee's Wraparound system, which started with few kids, expanded to juvenile justice, child welfare, mental health, and has very strong care management; school-based Systems of Care Chicago; and non-profit Dawn Project in Indiana, which runs 115 services (not programs, but services). Other Systems are listed on the SAMHSA website. A

reminder was made to keep in mind that there's no perfect system, and there's no one model to look at and say that it is the best.

Assessment Chart: There are specific questions on whether or not this chart can be made into an assessment for the system, or if this sort of assessment has already been done. Calls for it to be made into a "report card" are vocalized. The most specific question in regards to a possible evaluation would be that on a 1-10 rating scale moving from less favored to more favored, where is the CSB? Emphasis was put on the importance of finding out this status information and then figure out how to move it forward. A suggestion is made that the Core Elements can be used as a check off list to map systemic progress. It is also noted that Resilience should be used along with Recovery when discussing children.

Margo Kiely reviews the objectives and agenda for Saturday.

Meeting adjourned at 5:15pm.