FAIRFAX-FALLS CHURCH

CHILDREN'S BEHAVIORAL HEALTH SYSTEM OF CARE BLUEPRINT FOR 2016-2019

Approved by the
Community Policy and Management Team
March 25, 2016

Background
CSA System of Care Development

In 2001 a System of Care (SOC) initiative was undertaken by Fairfax-Falls Church Community Policy and Management Team (CPMT) to enhance the community's ability to meet the needs of youth and families with the most complex issues and highest risk factors. One of the first achievements of the SOC initiative was the founding of Leland House, a partnership with United Methodist Family Services to provide short-term residential crisis stabilization to prevent unnecessary hospitalization and residential placement.

In 2010 Fairfax-Falls Church CPMT initiated intensive care coordination (ICC) for youth in or at-risk of residential placement, and family partnership meetings for children in or at risk of foster care placement. CPMT contracted with the Fairfax-Falls Church CSB for ICC with a capacity of up to seventy-two families on an ongoing basis. In early 2013 ICC capacity was increased to one hundred families through a contract with United Methodist Family Services. In July 2013 the CPMT submitted a successful proposal to the Virginia Department of Behavioral and Developmental Services to partner with a family organization to provide parent support partners to families in ICC. ICC in Fairfax-Falls Church is based on the high-fidelity wraparound model. To date over 80% of youth at risk of residential placement who participated in ICC have been successfully maintained in the community.

Concurrent with these activities to improve services and service planning processes, CPMT focused on changing the values and principles underlying the local child-serving system. In 2009 CPMT endorsed national system of care principles as the basis for serving children and youth with complex emotional and behavioral issues in the Fairfax-Falls Church community. In 2010 the number of CPMT parent representatives was doubled, from two to four. In 2011 CPMT approved detailed practice standards for integrating SOC principles into child-serving programs and processes. In 2012 CPMT approved a re-design of local team-based planning processes to better implement wraparound principles and practice standards such as family-driven care, team-based processes, individualized service planning and a strength-based approach. In 2013 CPMT approved a comprehensive system of care training plan for staff at all levels and in all systems. This commitment of key leaders and stakeholders to a common mission, vision and goals for serving youth and families has paid off in improved outcomes:

- Placements in long-term residential and group home programs have been reduced by 53%, from 157 youth in January 2009 to 74 in January 2016.
- ICC successfully prevented over 80% of youth served from entering residential placement
- 85% of youth served through CSA to prevent foster care remained with their families
- Youth had fewer risk behaviors and improved mental health, measured by CANS

Board of Supervisors System of Care Initiative

In FY 2014 budget guidance the Board of Supervisors directed staff to identify the array of youth services necessary to address the most pressing needs within the community, with focus on work already underway as part of the collaboration between the County and FCPS to identify the appropriate prevention, early intervention and treatment services that are necessary to deal with behavioral health issues and to best leverage the current services provided within the schools as well as more broadly in the community.
In the FY 2015 budget the Board of Supervised approved an increase of $1,080,571 to expand behavioral health services for youth and families as a result of the recommendations presented to the Human Services Committee of the Board of Supervisors on October 1, 2013. These recommendations were the direct result of the guidance included by the Board of Supervisors as part of the FY 2014 Adopted Budget Plan directing staff to identify requirements to address youth behavioral human services requirements in schools and the broader community. FY 2015 funding created a new program unit to implement a Systems of Care model by connecting the continuum of supports and services across County agencies. FCPS and community partners. The new unit is to develop new policies and procedures on providing care coordination and service delivery, as well as oversight, to the various entities delivering services along the continuum. Additionally, the new unit will be responsible for implementing contractual services for individuals with emerging mental health and substance use issues.

System of Care Planning Process

Planning Team
In 2015 Deputy County Executive appointing a planning team to develop a vision and mission for the initiative, and establish goals, strategies and action steps and a timetable for their accomplishment. Represented on the 30 member planning team were:

- Community Services Board
- Fairfax County Public Schools
- Juvenile and Domestic Relations District Court
- Neighborhood and Community Services
- Department of Family Services
- Health Department
- Systems of Care
- Non-profit family organizations
- Community-based behavioral health service providers
- Family representatives
- George Mason University faculty

See Appendix for a complete list of planning team members.

Planning Process
The Planning Team engaged in a planning process based on the *Toolkit for Expanding the System of Care Approach* developed by the Georgetown University National Technical Assistance Center for Children's Mental Health. Georgetown University staff facilitated the planning process at no cost to the county. In November and December 2015 the Planning Team developed a proposed plan that includes the following elements:

- Shared vision statement
- Mission statement
- Principles
- Broad goals/desired outcomes
- Specific core strategies needed to reach the goals and outcomes
- Specific action steps to implement each strategy

Planning Framework
The proposed multi-year System of Care plan is based on these principles:

- Planning should be inclusive of the entire continuum of services and supports for children's behavioral health needs.
- There should be a systems focus, beyond just service planning.
- Children, youth and families must be able to "see" the range of services and navigate the system with and without support from professional staff.
- Services should be evaluated regularly. There should be a focus on population outcomes as well as service performance.
- Planning should be both descriptive of current service system and prescriptive of needed changes.

System of Care elements addressed in the plan include:

- ***Access***: Promoting the ability of families, youth, and professionals to obtain services and navigate the behavioral health system.
- ***Quality***
- ***Promoting Trauma-Informed Practice***: Ensuring trauma-informed practices and approaches are integrated into services at all levels.
- ***System coordination and linkages***
- ***Planning and delivery of services and supports***
- ***Family and youth involvement*** at policy, planning and service delivery levels
- ***Reducing racial and ethnic disparities in service delivery and outcomes,*** including cultural/linguistic competence

Data to Inform the Planning Process

Data to inform the Planning Team came primarily from two sources: results of a System of Care Expansion Self-Assessment survey (developed by Georgetown University), completed by 82 public, private and community stakeholders with expertise in children's behavioral health; and recent local studies and reports related to children's behavioral health published within the last several years, to include, but not limited to:

- Systems of Care Services Committee Report and Recommendations: November 2009
- Systems of Care Developmental Disabilities Report and Recommendations: June 2010
- Systems of Care Family and Youth Advocacy/Engagement Committee Report and Recommendations: July 2010
- Virginia Department of Juvenile Justice Study of Disproportionate Minority Contact: 2011
- Disproportionate Minority Contact for African American and Hispanic Youth: 2012
- Community Health Improvement Plan: 2013
- Youth Behavioral Health Interagency Human Services and Public Schools Work Group Report and Recommendations: May 2014
- Youth Behavioral Health Resource Plan for the Fairfax- Falls Church Community Services Board of the Fairfax County Health and Human Services System: October 2014
- Northern Virginia Suicide Prevention Plan: November 2014
- Taking Measure of Children in Fairfax-Falls Church Families: April 2015
- CDC Investigation of Undetermined Risk Factors for Suicide Among Youth Ages 10-24
- Fairfax County Youth Survey Report: School Year 2014-2015
- CSB Strategic Plan
- FCPS Strategic Plan
- Equitable Growth Profile of Fairfax County: 2015

Scope of the Children's Behavioral Health System of Care Plan

- This multi-year plan is for calendar years 2016 through 2019, and fiscal years, 2017, 2018, and 2019. The Plan will be reviewed and revised at least annually by the CPMT and the SCYPT. It represents goals and strategies to be implemented by and with the support of Fairfax County human services departments and Fairfax County Public Schools. It is important to acknowledge that much work related to system of care is, and will continue to be, supported and led by family, consumer and other non-profit organizations, and provider agencies, in the community at large. Wherever possible and appropriate, the public entities responsible for implementation of particular strategies noted in the plan will work in conjunction with these agencies and organizations. Moreover, consistent with the system of care principles, it is envisioned that families and consumers will be intricately involved in planning, implementation and evaluation of activities related to all levels of behavioral health care from prevention through intensive intervention for children, youth and families in the Fairfax - Falls Church community.

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Fairfax-Falls Church System of Care Vision, Mission and Principles

Vision:

Provide a spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, so that all children and youth in the Fairfax-Falls Church community are socially, emotionally, mentally, and behaviorally healthy and resilient.

Mission:

We, the Fairfax-Falls Church community, collectively ensure all children, youth, and their families have equitable and easy access to a continuum of quality, integrated and/or coordinated services, supports, and opportunities to promote resiliency and further their social, emotional, mental, and behavioral health.

System of Care Principles	
Services are supportive to children and their families, providing them with the opportunity to succeed in the community to the fullest extent possible;	**Our system will support families to fulfill their primary responsibility for the safety, the physical and emotional health, the financial and educational wellbeing of their children.**
Needs of children and families will be met in the least restrictive way, with families fully participating in the decision making process; **The family unit will remain intact whenever possible, and issues are to be addressed in the context of the family unit;** **Services will be community-based whenever possible, and children will be placed outside of the community only when absolutely necessary.**	**Children are best served with their own families. The system aims to keep children and families together and prevent entry into long-term out of home placement.**
All agencies providing services will work together, cooperatively, with each other and with the family, to gain maximum benefit from the available resources.	**Our system embraces the concepts of shared resources, decision making and responsibility for outcomes. All stakeholders will work together collaboratively with each other and the family to gain maximum benefits from available resources.**
Services are flexible and comprehensive to meet the individual needs of children and families;	**Children and families will receive individualized services in accordance with expressed needs.**
Services are easily accessible to residents of the community, regardless of where they live, their native language or culture, their level of income, or their level of functioning;	**Our families will receive culturally and linguistically responsive services.**
Services are integrated into the community, in the neighborhoods where the people who need them live;	**Children with emotional, intellectual or behavioral challenges will receive integrated services and care coordination in a seamless manner.**
Services are family focused to promote the well-being of the child and community;	**Our system will be youth guided and family driven with the family identifying their own strengths and needs and determining the types and mix of services and desired outcomes within the resources available.**
Services are responsive to people and adaptable to their changing needs;	**County, community and private agencies will work to eliminate racial and ethnic disparities in outcomes, and will embrace, value and celebrate the diverse cultures of children, youth, and their families.**
Services are provided through collaborative and cooperative partnerships between people living in their community and public and private organizations.	**We will be accountable at the individual child and family, system, and community levels for desired outcomes, safety and cost effectiveness.**

EXECUTIVE SUMMARY

FAIRFAX-FALLS CHURCH CHILDREN'S BEHAVIORAL HEALTH SYSTEM OF CARE

BLUEPRINT FOR 2016 – 2019

In FY 2015 BOS funding created a new program unit to implement a System of Care (SOC) model by connecting the continuum of supports and services across County agencies, FCPS and community partners. The new unit is to develop new policies and procedures on providing care coordination and service delivery, as well as oversight, to the various entities delivering services along the continuum. In addition, the new unit will be responsible for implanting contractual services for individuals with emerging mental health and substance use issues. In November and December 2015, under the capable facilitation of a senior policy associate from the Georgetown University National Technical Assistance Center for Children's Mental Health, a 30 member planning team comprised of county human service staff, school staff, non-profit representatives, family organizations, family representatives and George Mason University faculty was convened. The planning team was charged to develop a vision and mission for the initiative and establish goals, strategies and action steps and a timetable for their accomplishment.

The following comprises the work of the planning team in the development of the fifteen goals that make up the attached *blueprint* of the Behavioral Health System of Care for Children, Youth and Families.

Goal 1: Deepen Community System of Care Approach

Deepen the system of care approach to inform the entire continuum of behavioral health services for children, youth and families through: (1) a governance structure that guides the entire continuum, (2) financing strategies that support sustainability and improve capacity and, (3) continuous improvement to service quality and access.

The strategies set forth in this goal address establishing a Children's Behavioral Health System of Care (BHSOC) oversight committee; creating cross-system behavioral health practice standards, policies and procedures; generating support for these efforts from the general public, policy makers and local administrators at the state and local levels; and furthering the development of partnerships with community organizations and agencies in different sectors for coordination, financing and support of the SOC approach. It further calls for a system mapping process to maximize, braid or combine funds. Additional strategies include striving for more inclusion of providers and families in the development of SOC training policy and annual planning; collecting and reporting on community outcomes and assessing gaps; and finally, reviewing intake, assessment, triage and referral protocols with the goal of supporting families in accessing both public and community provided resources.

Goal 2: Data Systems

Increase collaboration through the implementation of a cross-system data sharing.

Efforts here are in the direction of increasing data sharing and using the cross-system data to improve decision-making and resource use. This cross-system data sharing can lead to the improvement of process and outcome evaluations, reduce duplication and improve efficiency and increase the use of data in community reporting and planning processes.

Goal 3: Family and Youth Involvement

Increase the presence and effectiveness of family leadership through a sustained family-run network.

The strategies focus on strengthening and expanding family leadership; increasing the presence of family and youth involvement in system planning, implementation, evaluation of services and system improvement; and expanding evidenced based peer to peer groups and family/community networks.

Goal 4: Increase Awareness and Reduce Stigma
Use social messaging to promote awareness and help seeking behaviors and reduce the stigma surrounding mental illness and behavioral health care.
In an effort to accomplish the above, strategies revolve around educating and informing the public to increase their understanding of mental illness, its signs and symptoms and how to support others to get help. It also addresses involving youth to combat stigma and creating a speaker's bureau of approved presenters for the school and community to access.

Goal 5: Youth and Parent/Family Peer Support
Develop and expand youth and parent/family peer support services.
The creation of a Family Navigator program to assist families in "navigating the system" and expansion of evidence-based peer to peer groups round out the strategies of this goal.

Goal 6: System Navigation
Educate/inform/assist families on how to access services and navigate the system to include developing an accurate and accessible database of behavioral health care providers that includes information on if they are accepting new clients, if they accept insurance and their areas of expertise.
This goal is a most needed and ambitious one as it addresses developing an accurate, accessible, real time data base of behavioral health care providers and creating a clearinghouse for information on children's behavioral health issues and resources that is accessible in person, by telephone and on line.

Goal 7: Care Coordination and Integration
Improve care coordination and promote integration among schools, primary care providers and mental health providers, including the integration of primary and behavioral health care.
More and more research points to the efficacy of integrating primary and behavioral health care. In that vein, strategies here relate to providing behavioral health consultation to primary care providers, implementing tiered levels of integration and increasing the use of behavioral health screenings and referrals in primary care settings.

Goal 8: Equity/Disparities
Implement targeted strategies to address disparities in outcomes and access based on race, ethnicity, sexual orientation, socio-economic status, geography and other factors.
Strategies involve increasing access and availability to behavioral health services for underserved populations, using Culturally and Linguistically Appropriate Services standards, training in cultural competence for County, FCPS and County-contracted providers along with additional support structures for LGBTQ youth.

Goal 9: Reducing Incidents of Youth Suicide in our Community
Reduce the incidence of youth suicide in our community.
As we continually work to provide a safe and supportive community for our children and youth, the focus in this goal addresses developing universal suicide and/or depression screening protocols for community organizations; having guidelines for service providers on the availability and effective use of crisis services, developing a common and coordinated approach to youth suicide postvention; continuing and promoting the suicide prevention hotline and text line; and training behavioral health providers in evidence-based practices for suicidal youth.

Goal 10: Evidence-Based and Informed Practices
Increase the availability of and capacity for evidence-based practices/interventions along the continuum of prevention through treatment.
Trauma is ever present in many of the children and youth seeking our services. These strategies target the development of core competencies in trauma treatment needed by the treating clinicians and creating definitions and criteria for evidence-based and evidence-informed practice, along with training County/FCPS staff and contracted providers in evidence based practices.

Goal 11: Trauma-Informed Care Community

Enhance the community's ability to effectively identify and respond to children and families who have been exposed to trauma.

While many of our children and youth present with symptoms of trauma, our provider network of trauma informed practitioners needs to increase along with the community's understanding of what trauma informed care means. Strategies to target these concerns include educating non-clinical staff and the community at large on the impact of trauma and trauma informed practices; ensuring there is sufficient clinical capacity to provide the trauma specific interventions for our children and youth; having a shared cross-system screening and referral process for individuals impacted by trauma; and integrating the concepts of trauma-informed care into our organizational structure.

Goal 12: Behavioral Health Intervention

Address the needs of children and youth with emerging behavioral health issues who have not been able to access appropriate, timely and matching treatment services in the community.

Intervening early when children and youth present with emerging behavioral health issues can reduce the intensity of the symptoms and duration of treatment. These strategies attend to creating capacity to address the behavioral health needs of children from 0-7; developing/identifying a validated cross-system screening process to determine the needs, resources and desirable outcomes; creating a training consortium in partnership with a university and private provider partners; and expanding a current pilot initiative of providing timely and available behavioral health services to school age children and youth with emerging behavioral health issues who have not been able to access services. In addition, there is a need to expand the Diversion First initiative to include youth who come in contact with the criminal justice system and reduce youth substance use and abuse.

Goal 13: Service Network for High Risk Children

Develop an improved service network for high risk children to include appropriate evidence-based practices, care coordination, and crisis intervention/stabilization, in order to improve the outcomes for those served.

This goal includes a myriad of strategies the highlights of which are implementing an evidence-based parenting program for adolescents and specifically for children under 12; increasing the capacity for youth to receive appropriate case management services; developing a communication plan to share information about services and care coordination offered through the SOC process; providing IT infrastructure to support data collection for fidelity monitoring and outcome evaluation along with electronic records management; and exploring opportunities to serve youth on diversion/probation who need intensive behavioral health services.

Goal 14: DD/Autism Services

Develop expanded continuum of care of services for youth with DD/Autism.

These strategies identify that a needs assessment and service inventory of existing services and supports is necessary to identify critical service gaps for this population leading to a plan that will be developed to address the critical service gaps; that an outreach campaign and social messaging will help to promote earlier identification of children with DD/Autism; and that this population needs additional transition planning, access to crisis stabilization, case management, care coordination along with a community awareness campaign educating the community about the special needs of these children and youth.

Goal 15: Transition Age Youth

Provide coordinated services and supports for youth and young adults of transition age, both those still in school and those who have left school. Reduce the number of youth of transition age who are living with unidentified and untreated serious mental illness who have signs and/or symptoms of a serious mental health condition that emerged before they transition out of youth-serving systems/programs.

This goal addresses a long known need to improve transition planning for youth in need of adult behavioral health services. This goal's strategies address adapting a primary care transition model of resources and tools for use in behavioral health care; ensuring that "navigators" have knowledge and understanding of unique transition issues and requirements; reflecting these unique needs in navigation tools; improving transition planning for transition age youth in need of adult behavioral health services.

GOAL 1: Deepen Community System of Care Approach

Deepen the system of care approach to inform the entire continuum of behavioral health services for children, youth and families through: (1) a governance structure that guides the entire continuum (2) financing strategies that support sustainability and improve capacity and (3) continuous improvement to service quality and access.

Outcome measures:

Reduction in percentage of students responding to the youth survey that they felt so sad or hopeless almost every day for two weeks in a row that they stopped doing some usual activities.
Reduction in the percentage of students responding to the youth survey that they had seriously considered suicide in the past 12 months.
Reduction in the percentage of students responding to the youth survey that they had attempted suicide in the past 12 months.
Reduction in the incidence of youth suicide.
Reduction in the number of youth in long-term residential or group home placements.
Increased functioning of high risk youth as measured by a standardized assessment instrument.
Reduced risk behaviors of high risk youth as measured by a standardized assessment instrument.

Strategies	Action Step(s)	Who….	When
Governance Structure			
A. Establish a Children's Behavioral Health System of Care oversight committee as the locus of SOC management and accountability.	• Establish system of care oversight committee by supplementing the membership of the existing CPMT to include and additional member each from DFS, DNCS and JDRDC, and two additional members from CSB, and two additional parent representatives. Explore adding representatives from the Northern Virginia Psychiatric Society and the Northern Virginia Medical Society.	• Deputy County Executive	• 4-6/16
B. Establish cross-system behavioral health system of care practice standards, policies and procedures.	• Review existing CSA System of Care practice standards, policies and procedures and expand or revise as necessary to incorporate the BH-SOC population. • Develop and implement protocols for monitoring system-wide adoption of system of care principles, practice standards, policies and procedure. • Identify and address confidentiality & exchange of information issues across the behavioral health system that impede effective service delivery. • Explore use of an electronic health record for BH-SOC service planning documentation of system reporting requirements.	• CSAMT & BHSOCAC • CSAMT & BHSOCAC • CSAMT & BHSOCAC • BH-SOC	• 7/16-6/17 • 1-6/17 • 7-12/16 • 1-6/17
C. Generate support for the SOC approach among the general public and policy makers and administrators at the state and local levels.	• Collect and regularly report to policy makers and administrators data on outcomes and cost savings. • Utilize internal county staff to create a logo and other visible identifiers for the SOC. • Consider how to identify the tiers of the SOC to include CSA, BH, and Prevention. • Re-brand/Re-name the CSA program as part of the SOC division to accommodate the state name change for CSA. • Utilize the new brand in social messaging, websites, program stationary, etc.	• County Executive's Office, SOC, DNCS • County Executive's Office, SOC, DNCS	• 7-12/16 • 7/16-6/17

D. Continue to develop partnerships with community organizations and agencies in different sectors for coordination, financing and support of the SOC approach.	• Deepen partnerships with providers and provider organizations in developing new services. • Develop partnerships with insurance companies to support the ability of families to use their insurance benefits to secure timely and appropriate behavioral health care.	• Inter-agency workgroup facilitated by BH-SOC and DAHS • Inter-agency workgroup facilitated by BH-SOC	• 7/17-6/18 • 1/18-12/19
Financing Strategies			
E. Conduct a fiscal mapping of public youth behavioral health system resources to identify gaps and areas of redundancy, and opportunities to maximize and braid or otherwise combine funds.	• Review existing services system for opportunities to increase use of Medicaid funding. • Develop a cross-system plan for redeploying funds from higher-cost to lower-cost services while maintaining funds in the child-serving system. • Study the costs and benefits of implementing case rates or other risk-sharing financing approaches. • Coordinate county budgeting, including Diversion First, to maximize the possibility of high priority children's behavioral health needs being funded. • Develop and implement a community plan to support the ability of families to use their insurance benefits to secure timely and appropriate behavioral health care. • Study the costs and benefits of implementing Pay for Success or other risk-sharing financing approaches. • Conduct a study to identify alternative methods of budgeting the required local CSA match and identify the advantages and disadvantages of each in terms of cost effectiveness and supporting students in the least restrictive educational setting that meets their needs.	• Inter-agency workgroup facilitated by BH-SOC • Inter-agency workgroup facilitated by DAHS • Inter-agency workgroup facilitated by DAHS • County Human Services Leadership Team • Inter-agency workgroup facilitated by BH-SOC • Inter-agency workgroup facilitated by BH-SOC • CEXO, FCPS, DAHS, CSA	• 1-6/17 • 4/16-6/17 • 7/18-6/19 • 4/16-6/17 • 1/18-12/19 • 7/17-6/18 • 1-12/17
Service Quality and Access			
F. Expand existing SOC training policy and annual planning to include providers and families, and to address community resources, insurance access, evidence-based/informed treatments, and high fidelity wraparound.	• Revise existing SOC policy and develop training curricula to include providers and families, and to address community resources, insurance access, evidence-based/informed treatments, ICC /high fidelity wraparound, and the CANS and GAINSS. • Maintain a master calendar of local children's behavioral health-related training events.	• SOC Training Committee • SOC Training Committee	• 7-12/16 • 1-12/17

G. Collect and regularly report on community outcomes, and assess gaps in the array of services and supports necessary for the success of the SOC in preventing and treating behavioral health issues.	• Develop and implement an ongoing process for collecting and regularly reporting system and community outcomes. • Develop and implement a method for assessing gaps in the array of services and supports necessary for the success of the SOC in preventing and treating behavioral health issues; identify resources necessary to develop and conduct such an assessment.	• BH-SOC and DNCS Prevention Unit	• 7-12/16 • 1-12/17
H. Review intake, assessment, triage, referral protocols across all levels of care, and lead case management assignments with the goal of supporting families in accessing both public and community provided resources.	• Explore common screening and referral methods for use in primary care, entry and referral, and social services settings. • Address how families of youth with behavioral health issues with severe stress and family issues can access case management. • Coordinate discharge for youth presenting to emergency departments for substance use or suicidality to indicated follow-up care. • Explore implementation of SBIRT model.	• HD, CSB, BHSOCAC • CSAMT, BHSOC • CSB, HD • CSB	• 7/16-6/17 • 1-12/17 • 7/16-6/17 • 7-12/16

GOAL 2: Data Systems

Increase collaboration through the implementation of a cross-system data sharing.

Strategies	Action Step(s)	Who….	When
A. Increase cross-system data sharing.	• Identify legal and practical barriers to data sharing and develop strategies to mitigate them, when possible. Engage outside consultants for technical and legal assistance if necessary. • Establish cross-system data sharing agreements. • Develop an infrastructure to support information sharing across systems beyond consents to the development of an informational IT system.	• HSIT Governance Group	• 4/16 – 12/18
B. Use cross-system data to improve decision-making and resource use.	• Identify and implement ways to use cross-system data to improve process and outcome evaluations. • Identify and implement ways to use cross-system data to reduce duplication and improve efficiency in areas such as intake and assessment. • Increase the use of data in community reporting and community planning processes.	• CPMT	• 1/19 – 12/19

GOAL 3: Family & Youth Involvement

Expand family-driven and youth-guided services and expand family and youth involvement in the planning and delivery of services.

Strategies	Action Step(s)	Who….	When
A. Increase the presence and effectiveness of family leadership through a sustained family-run network.	• Seek opportunities to partner with family organizations through grant and other program expansion and improvement opportunities to meet identified needs through family engagement. • Identify key elements of organizational sustainability and effectiveness and provide resources to support the development of these elements within family organizations. • Leverage existing capacity of family organizations to provide information and education for families on behavioral health support and services.	• BHSOC, Family Organizations	• 7/16-6/17

B. Increase family and youth involvement in system planning and implementation.	• Develop policies and procedures to ensure family organization involvement in:
	  • Identifying family needs and assessing system responsiveness;
	  • Developing new services and supports;
	  • Developing tools and processes to help families navigate the BH system.
	• Develop and implement a process to regularly gain feedback and input from a diverse array of youth with lived experience, through existing advocacy and leadership organizations.
	• Develop policies and procedures to ensure family and youth involvement in service delivery, when appropriate.
	• Annually document progression to continually measure and assess the need for additional training and support.
		• BHSOC, CSAMT and BHSOCAC
		• CSAMT and BHSOCAC
		• BHSOC, CSAMT and BHSOCAC
		• BHSOC, SOC Training Committee, Family Organizations
			• 7-/16-6/17
			• 7/17-6/18
			• 7-/16-6/17
			• ongoing

C. Include youth and family participation in the evaluation of publicly and privately provided services, with prompt action for improvement when necessary.	• Develop and implement processes for youth and family participation in the evaluation of services provided through CSA and other public purchase of service programs. • Develop and implement processes for youth and family participation in the evaluation of services provided by the CSB and other county departments • Develop and implement processes for youth and family participation in the evaluation of services provided by private organizations, to include financing options.	• CSAMT, Family Organizations • CSB and BH-SOC with BHSOCAC consultation, Family Organizations • BHSOCAC, Family Organizations	• 4/16-6/17 • 7/16-6/17 • 7/17-6/18
D. Expand evidence-based peer to peer groups, family/community networks.	• Conduct an inventory of existing parent/family peer support services and identify gaps • Develop an expansion plan, to include possible financing strategies.	• CSB, BH-SOC, Family Organizations	• 7-12/16 • 1-6/17

GOAL 4: Increase Awareness & Reduce Stigma

Use social messaging to promote awareness and help-seeking behaviors and reduce the stigma surrounding mental illness & behavioral health care			
Strategies	**Action Step(s)**	**Who….**	**When**
A. Implement "gatekeeper trainings" to increase layperson understanding of mental illness, recognition of signs and symptoms of mental illness or emotional crisis, and support of others in accessing help.	• Continue to promote the availability of existing CSB-provided trainings, including the Kognito suite of trainings and Mental Health First Aid. • Implement policy changes in large human and social services organizations to require relevant trainings for staff working directly with clients. • Train schools and community-based organizations in the implementation of Signs of Suicide and Lifelines. • Identify additional effective training opportunities and develop plans for their implementation.	• CSB, FCPS, NCS • PMHT, DFS • NCS Prevention Unit, CSB, FCPS • CSB, FCPS, PMHT	• 4/16-ongoing • 7/16-ongoing • 7/16-ongoing • 4/16-12/16
B. Promote youth-led initiatives to combat stigma associated with mental illness, treatment, and accessing help.	• Provide mini-grants to youth-led initiatives. • Promote the scalable products of the youth-led initiatives.	• CSB, Promoting Mental Health Team, Suicide Prevention Alliance of Northern Virginia	• 4/16-ongoing • 4/16-ongoing
C. Increase public awareness of issues surrounding mental illness and behavioral health care.	• Develop and place public service announcements promoting help-seeking behaviors in movie theaters, social media, and other locations. • Develop and promote basic information via fact sheets, websites, and other publications. Translate materials into common languages. • Educate local media outlets on the Recommendations for Reporting on Suicide. Develop procedures for local public information officers to promote the guidelines. • Develop and implement strategies to promote mental health discussion within local ethnic communities.	• HD, Suicide Prevention Coalition of Northern Virginia • Suicide Prevention Coalition of Northern Virginia • HD • HD, Faith Communities in Action, Family Organizations	• 4-6/16 • 4/16-6/17 • 4/16-12/16 • 4/16-6/17
D. Maintain a speaker's bureau and/or list of approved presenters to school and community groups.	• Establish criteria for, and promote a list of, approved speakers and programs on suicide prevention and mental illness.	• FCPS, Promoting Mental Health Team, Family Organizations	• 7/16-6/17

GOAL 5: Youth and Parent/Family Peer Support

Develop and expand youth and parent/family peer support services.

Strategies	Action Step(s)	Who….	When
A. Create a Family Navigator program. **<u>Outcome measure</u>:** Provide family navigator services for 240 youth and their families annually.	• Research and develop a Family Navigator program, in conjunction and coordination with existing programs and services currently available. • Implement family navigators to help families navigate the system.	• BH-SOC	• 4-6/16 • 7/16-6/17
B. Expand evidence-based peer to peer groups, family/community networks.	• Conduct an inventory of existing parent/family peer support services and identify gaps • Develop an expansion plan, to include possible financing strategies.	• CSB, BH-SOC, Family Organizations	• 7-12/16 • 1-6/17

GOAL 6: System Navigation

Educate/inform/assist families on how to access services and navigate the system to include developing an accurate and accessible database of behavioral health care providers that includes information on if they are accepting new clients, if they accept insurance, and their areas of expertise.

Outcome measures:
Provide family navigator services for 240 youth and their families annually.

Strategies	Action Step(s)	Who….	When

A. Develop an accurate, accessible and real time database of behavioral health care providers that includes information on if they are accepting new clients, if they accept insurance, and their areas of expertise, with functionality to assist families in understanding behavioral health issues and in navigating the system to access services.	• Develop or select, and implement, on-line application (s) that fulfill the following functions:
	  ○ Provider information and availability;
	  ○ Behavioral health information; and
	  ○ System navigation support.
	• Develop a plan for ongoing support of the application such that information remains current and relevant.
		• Inter-agency workgroup facilitated by BH-SOC, CSB, DNCS and Prevention Unit	• 7/16-6/18

B. Create a clearing house for information on children's behavioral health issues and resources. Staffing should include expertise on insurance and have appropriate language capacity. The clearing house should be accessible in person, by telephone and on-line.	• Leverage existing capacity of the CSB and the FCPS Family Resource Center to provide information and education for families on behavioral health support and services. • Develop a plan for increasing families' access to existing CSB and BH-SOC knowledge of using insurance to secure services. • Develop a proposal for creating a children's behavioral health clearing house, to include possible financing mechanisms.	• BH-SOC, CSB, FCPS • CSB, BH-SOC • Inter-agency workgroup facilitated by BH-SOC and DNCS Prevention Unit, Family Organizations	• 7/16-6/17 • 7/16/6/17 • 1/19-12/19

GOAL 7: Care Coordination and Integration

Improve care coordination and promote integration among schools, primary care providers and mental health providers, including the integration of primary and behavioral health care

Outcome measures:
All county and federally funded primary care settings include fully integrated primary and behavioral health care for children and youth
Primary care providers serving at least 10% of the county's children and youth have access to behavioral health care consultation

Strategies	Action Step(s)	Who….	
A. Provide behavioral health consultation to primary care providers and patients.	• Develop an on-line behavioral health clearinghouse of services and providers (including capacity and how to access them). • Implement systems navigators to help patients and providers navigate the system. • Develop a plan for providing behavioral health consultation service for private providers, to include proposed financing mechanism.	• Inter-agency workgroup facilitated by BH-SOC, CSB/HD	• 7/16-6/17 • 7/16-6/17 • 7/17-6/18
B. Promote resources to implement tiered levels of integration based on capacity and readiness. • Information sharing • Co-location • Full integration • Behavioral health homes • Telemedicine	• Develop a community plan for implementing tiered levels of integration in order to increase access to appropriate behavioral health services for all children and youth and their families, to include resource requirements and financing strategies. • Implement full integration in County-operated/funded primary care settings. • Promote full integration in federally funded primary care settings. • Complete and disseminate FCPS "Return to Learn" protocol to families and human services organizations.	• Inter-agency workgroup facilitated by BH-SOC • HD/CSB/BHSOC • HD/CSB/BHSOC • FCPS	• 1-6/17 • 7/17-6/18 • 7/17-6/18 • 7/16-12/16
C. Increase the appropriate implementation of behavioral health screenings and referrals in primary care settings.	• Identify common and appropriate tools and referral processes. • Train primary care providers on using appropriate screening tools and on referring patients to care. • Implement in County-operated/funded primary care settings. • Promote implementation in federally funded primary care settings. • Explore implementation of SBIRT model.	• Inter-agency workgroup facilitated by HD/CSB • HD with inter-agency support/CSB • HD • HD • CSB	• 7-12/16 • 1-6/17 • 1-6/17 • 1-6/17 • 7-12/16

GOAL 8: Equity/Disparities

Implement targeted strategies to address disparities in outcomes & access based on race, ethnicity, sexual orientation, socio-economic status, geography, & other factors.

Strategies	Action Step(s)	Who….	When
A. Promote the adoption of Culturally and Linguistically Appropriate Services (CLAS) Standards among BH providers.	• Based on the results of the local CLAS survey, implement a storytelling project to provide context for the need of CLAS Standard adoption. • Create an online clearinghouse for resources related to the CLAS standards.	• Partnership for a Healthier Fairfax – Healthy Workforce Team	• 4-12/16 • 7/16-617

B. Increase access and availability to behavioral health services for underserved populations.	• Identify underserved communities through a review of current population and service data.
	• Identify main barriers to accessing behavioral health services among these populations.
	• Develop and implement strategies to address identified barriers, which may include:
	  ○ Partner with community-based organizations with existing presence in or relationships with underserved communities to jointly serve individuals on-site or to promote access to available services.
	  ○ Implement expanded access to and use of telepsychiatry, mobile apps, and other technologies.
	  ○ Implement flexible service delivery options, including expanded hours and locations.
	  ○ Increase the availability of services offered in languages other than English.
		• CSB, BH-SOC	• 4-12/16
			• 4-12/16
			• 7/16-12/17

C. Require training in cultural competence for County, FCPS, and County-contracted behavioral health service providers.	• Identify criteria for required learning and practice outcomes. • Identify appropriate, relevant, and effective trainings. • Develop policy and procedure to require trainings for staff and County-contracted providers. • Provide trainings on a regular basis.	• CSB, SOC Training Committee, FCPS	• 1-6/18 • 1-6/18 • 1-12/18 • 7/18-ongoing
D. Implement support structures for LGBTQ youth.	• Identify and require relevant trainings to improve service options for the unique needs of LGBTQ youth with behavioral health needs. • Identify and implement best practices in supportive school and community opportunities for LGBTQ youth.	• CSB, SOC Training • FCPS, NCS, PMHT	• 1-12/17 • 1-12/17

GOAL 9: Reducing Incidents of Youth Suicide in our Community

Reduce the incidence of youth suicide in our community.

Outcome measures:
Reduction in percentage of students responding to the youth survey that they felt so sad or hopeless almost every day for two weeks in a row that they stopped doing some usual activities.
Reduction in the percentage of students responding to the youth survey that they had seriously considered suicide in the past 12 months.
Reduction in the percentage of students responding to the youth survey that they had attempted suicide in the past 12 months.
Reduction in the incidence of youth suicide.

Strategies	Action Step(s)	Who….	When
A. Develop protocols for community organizations on conducting universal suicide and/or depression screening.	• Develop criteria for protocol for community organizations, based on FCPS practice, national guidelines/recommendations, and best practice. • Develop model policy and procedure, vetted by community organizations. • Develop and publish a provider resource list (for referrals and crisis intervention) to accompany policy and procedure. (May be included in Clearinghouse.) • Publish model policy and procedure and resource list on Suicide Prevention Alliance of Northern Virginia website.	• CSB, FCPS, Promoting Mental Health Team (PMHT) • CSB, FCPS, PMHT • CSB, FCPS, PMHT • CSB, FCPS, PMHT	• 7-12/16 • 1-6/17 • 1-6/17 • 1-6/17
B. Develop and publish guidelines for service providers on the availability and effective use of crisis services.	• Develop a one-page fact sheet and guidelines for referring agencies/organizations on how and when to use crisis services. • Vet the proposed guidelines with community organizations. • Publish fact sheet and guidelines on CSB and Suicide Prevention Alliance of Northern Virginia websites.	• CSB, PMHT, PRS • CSB, PMHT, PRS, Family Organizations • CSB, PMHT, PRS, Family Organizations	• 7-12/16 • 7-12/16 • 7-12/16
C. Develop a common and coordinated approach to youth suicide postvention.	• Develop and share guidance and resources for community-based organizations on responding to suicide. • Develop a protocol on how different agencies/organizations can support schools and work together after a suicide. • Publish a clear overview of FCPS postvention protocol.	• FCPS, PMHT, CSB, Family Organizations • FCPS, PMHT, CSB • FCPS, PMHT	• 4-12/16 • 7-12/16 • 7-12/16
D. Continue to make available and promote the suicide prevention hotline, including textline.	• Provide adequate support to effectively manage crisis textline. • Continue the development and distribution of promotional materials to advertise the availability of the textline. • Explore implementation of a warmline.	• CSB, FCPS, PRS • CSB, FCPS, PRS • CSB, FCPS, PRS	• 4-6/16 • 4/16-ongoing

E. Train behavioral health providers in evidence-based practices specific to the treatment of youth with suicidal ideation and behavior.	• Identify evidence-based risk assessment, safety planning, and treatment of youth with suicidal ideation and behavior. • Train providers in evidence-based practices.	• SOC Training, PMHT, FCPS • SOC Training, FCPS	• 1-6/17 • 7/17-ongoing

GOAL 11: Trauma-Informed Care Community

GOAL 10: Evidence-Based and -Informed Practices

Increase the availability of and capacity for evidence-based practices/interventions along the continuum of prevention through treatment.

Strategies	Action Step(s)	Who….	When
A. Develop definitions and criteria for evidence-based and evidence-informed practice in prevention and intervention/treatment.	• Establish, within each tier or area, the criteria for identifying a practice as evidence-based or evidence-informed. See SOC EBT workgroup definitions and criteria for intervention/treatment level of SOC. • Establish a process for evaluating the need for an EBP, providing oversight/management of implementation, and assessing sustainability of the EBP and funding sources or other resources needed for successful implementation. • Evaluate implementation to assess the extent to which EBPs are delivered with fidelity.	• BHSOCAC, CSA and FCPS • BHSOCAC, CSA and FCPS • BHSOCAC, CSA and FCPS, Family Organizations	• 7/17-6/18 • 1-6/18 • 7-12/18
B. Establish a set of core competencies, based on service type, for all public and contracted provider staff.	• Establish the set of core competencies. (e.g., CSB's include motivational interviewing, CBT, and trauma-informed care.)	• BHSOCAC, SOC Training Committee, CSA, Family Organizations	• 7-12/18
C. Train County, school staff and providers on EBPs, including how and when to use them. Include a review of practices that are harmful.	• Identify existing trainings, opportunities to train trainers, and needs to develop in-house trainings, including financing opportunities. • Offer online training options. • Explore partnership with university and private provider community for training consortium to provide ongoing continuing education, certification and skill building. • Provide case management staff with an overview of effective practices to assist them with their monitoring function of purchased services. • Identify opportunities to provide ongoing technical support.	• SOC Training Committee (add FCCPS rep), CSA and FCPS, Family Organizations	• 1-6/19 • 1-6/19 • 1-12/18 • 1-6/19 • 7-12/19
D. Incentivize the use of EBPs among providers.	• Inform private providers about needs of youth and families and inform about EBT/EBP that are effective to meet those needs. • Add Contract requirements for specific training and provider certification. • Offer differential reimbursement rates for EBTs from certified providers. • Utilize a clearinghouse listing/recognition to identify providers with specific training and certifications/expertise.	• DAHS Contracts and CSA/BH-SOC	• 7-12/17 • 7-12/17 • 7-12/17 • 1-6/18

Enhance the community's ability to effectively identify and respond to children and families who have been exposed to trauma

Strategies	Action Step(s)	Who….	When
A. Ensure there is sufficient clinical capacity to meet the needs for trauma-specific, evidence-based interventions.	• Identify core competencies for providers of trauma-informed treatment strategies, based on national and local best practices. • Identify training and/or certification programs in which providers acquire the identified core competencies. If none can be found, explore opportunities to develop such trainings. • Identify opportunities to provide trainings, which may include "train-the-trainer" models, County/FCPS-led trainings, partner-led trainings, vendor-led trainings, online and distance learning, and more. • Sponsor trainings and supervision for County, FCPS, and contracted behavioral health providers serving SOC youth in the core competencies. • Develop and implement incentives to increase the number of providers with identified core competencies. Possible incentives may include contract requirements, agency policies, financial bonuses in contracts, "free" trainings/continuing education credits, and more.	• TICN, CSB, FCPS • TICN, CSB, FCPS • SOC Training Committee • SOC Training Committee • DAHS	• 4/16/-6/17 • 7/16-ongoing • 7/16-ongoing • 7/16-ongoing • 1/17-6/17
B. Train non-clinical staff in community-based organizations, schools, and county agencies to implement trauma-informed practices.	• Continue to implement the Trauma Awareness (Trauma 101) training. • Identify jobs that should be required or recommended for taking the training.	• TICN, FCPS • TICN, FCPS	• 4/16-ongoing • 4-12/16
C. Inform the community at large on the prevalence and impacts of trauma.	• Develop and implement social messaging campaign regarding the different types of trauma, the results of the Adverse Childhood Experiences (ACEs) study, common effects of trauma, and prevention efforts when there has been • Train families in trauma focused care	• TICN • TICN	• 1/18-6/19 • 7/19-ongoing
D. Develop shared screening and referral process for individuals impacted by trauma for school and human services agency staff using a nationally recognized screening tool.	• Ensure trauma and trauma-focused treatments and support services are included in common screening and referral tools and practices.	• CSAMT and BHSOCAC, FCPS, HD	• 7/16-6/17
E. Human service agency leaders will integrate the concepts of trauma-informed care into their organizational culture, with the goals of: • supporting a resilient workforce that is well equipped to respond to the needs of county residents who have experienced trauma; and • promoting policies, procedures and practices within their organizations that are in line with the principles of trauma-informed care.	• Identify human service agency managers and supervisors who would participate in a leadership/organizational training. • Utilize trainer identified by the TICN and the SOC Training committee to provide the training. • Utilize the training to develop a plan for supporting the human services workforce regarding secondary trauma. • Utilize the training to identify organizational changes that support the provision of trauma-informed care.	• CPMT, CSAMT, DFS • CPMT, CSAMT, DFS • CPMT, CSAMT, DFS • CPMT,CSAMT, HD, DFS	• 4-6/16 • 7/17-6/18 • 1/17-12/18 • 7-12/16

GOAL 12: Behavioral Health Intervention

Address the needs of children and youth with emerging behavioral health issues who have not been able to access appropriate, timely and matching treatment services in the community.

Outcome measures:
Reduction in percentage of students responding to the youth survey that they felt so sad or hopeless almost every day for two weeks in a row that they stopped doing some usual activities.
Reduction in the percentage of students responding to the youth survey that they had seriously considered suicide in the past 12 months.
Reduction in psychiatric hospitalization.

Strategies	Action Step(s)	Who….	When
A. Develop empirically validated cross system human services and schools screening process available to determine needs, resources, and desirable outcomes.	• Convene workgroup to develop uniform screening process and identify/develop screening tool that meets this need.; consider use of GAINSS and others • Coordinate with "navigation" website to post screening & process for its use. • Publicize use and availability of screening process through school and county child-serving agencies. • Explore clinical use of family strengthening, and toxic stress evaluation approaches outlined by the American Pediatrics Association's Resilience Project by primary health care providers.	• SOC office, CSB, FCPS, HD, Family Organizations • SOC office, CSB, FCPS, HD, Family Organizations • SOC office, CSB, FCPS, HD, Family Organizations • SOC office, CSB, FCPS, HD, Family Organizations	• 7/17-12/18 • 7/17-12/18 • 7/17-12/18 • 7/17-12/18
B. Create capacity to address behavioral health needs of children 0-7.	• Complete comprehensive inventory of current social-emotional services available to children 0-7. • Determine current need for expanded early childhood services to 0-7 population and their parents. • Develop pilot initiative to address timely social-emotional services to young children. • Create capacity for intervention services to young children (0-7) & their parents. • Train childcare and BH providers on social-emotional health of young children. • Increase availability of and expand access to parenting and home visiting programs.	• BHSOC. FCPS, CSB, DFS • BHSOC. FCPS, CSB, DFS • BHSOC. FCPS, CSB, DFS • BHSOC. FCPS, CSB, DFS • OFC • DFS, HD	• 1/18-12/18 • 1/18-12/18 • 1/18-12/18 • 1/18-12/18 • 1/18-12/18 • 1/18-12/18
C. Establish a training consortium in partnership with university and private provider partners (ex: GMU, INOVA) for ongoing training for staff and service providers.	• Convene SOC training committee and identified partners to develop a training consortium to address development of training in the areas of evidence-informed & promising practices and practice-based evidence approaches. The committee should identify possible funding options. • Focus initial training efforts to address the following symptom focus: depression, anxiety, trauma, conduct concerns and substance use disorder. • Include technical assistance and coaching in all training offered.	• SOC training committee, GMU reps, Inova Kellar, FCPS • SOC training committee, GMU reps, Inova Kellar, FCPS • SOC training committee, GMU reps, Inova Kellar, FCPS	• 1/18-12/18 • 1/18-12/18 • 1/18-12/18

D. Expand access to timely and available behavioral health services for school age children and youth with emerging behavioral health issues who have not been able to access such services.	• Increase capacity of Short Term Behavioral Health Service for Youth to address additional school communities with the most urgent need. • Develop access to short-term outpatient treatment for court involved youth on diversion with Behavioral Health System of Care funding, using the same eligibility criteria as the current Short-Term Behavioral Health pilot project. • Support university research efforts in the area of teen suicide (GMU's Family Focused Brief Intervention) – anticipated notification May 2016. • Expand FCPS based behavioral health services through the Virginia Tiered System of Support Model, Project Aware Program. o Measure: By SY 18-19 expand enhanced behavioral health services from 10 to all 13 high school communities with higher than average behavioral health needs. • Explore whether evidence-based group interventions exist which could effectively address the needs of significant numbers of youth on diversion or probation. • Address issues of language and cultural competence. • Include mental health treatment and referral to case management services when necessary	• BH-SOC Program • JDRDC and the BH-SOC Program • GMU, Promoting Mental Health Team • FCPS • JDRDC, CSB • BH-SOC • BH-SOC	• 4/16-6/17 • 7/16-6/17 • 7/16-ongoing • 4/16-ongoing • 7/16-6/17 • 7/16-6/17 • 7/16-6/17
E. Develop recommendations for the Board of Supervisors Public Safety Committee that reflect Diversion First initiatives needed for youth who come in contact with the criminal justice system.	• Perform mock walkthrough of present intersection between youth with behavioral health issues and criminal justice system. • Use results of walkthrough and data to build upon present diversion strategies already in place in the JDRC system, and make further transformation recommendations. • Perform analysis of behavioral health youth who are heavily involved in the criminal justice system and develop systemic strategies to intervene in that process.	• JDRC, CSB, BHSOC, DFS • CSB,JDRDC • CSB, JDRDC	• 4/16 – 12/16 • 4/16 – 12/16 • 1/17 – 12/17
F. Reduce youth substance abuse and use.	• Examine existing screening tools such as CANS, GAINS-SS and other available tools such as SBIRT, and develop consistent use of a tool across BHSOC service delivery to screen for substance use. • Develop protocols for referrals/follow-up if substance use is indicated on screening tool· Focus review of youth survey data trends to develop targeted prevention strategies for youth substance abuse. • Perform resource and gap analysis of private, school based, CSB, and JDRC substance abuse interventions. • Recommend and implement service enhancements based upon gap analysis.	CSB, DFS, JDRC, BHSOC CSB, DFS, JDRC, BHSOC, FCPS CSB, BHSOC, Prevention Office CSB, BHSOC, Prevention Office	• 1/17 – 6/17 • 7/17 – 12/17 • 1/18 – 6/18 • 7/18 – 12/19

GOAL 13: Service Network for High Risk Children

Develop an improved service network for high risk children to include appropriate evidence-based practices, care coordination, and crisis intervention/stabilization, in order to improve outcomes for those served.

Outcome measures:
Reduction in the percentage of students responding to the youth survey that they had attempted suicide in the past 12 months.
Reduction in the number of youth in long-term residential or group home placements.
Increased youth functioning as measured by a standardized assessment instrument.
Reduced youth risk behaviors as measured by a standardized assessment instrument.

Strategies	Action Step(s)	Who….	When
A. Increase availability/capacity of provider community to offer trauma assessments and evidence-based trauma treatment; trauma services shall be offered in languages and in locations that are accessible to families.	• Sponsor TF-CBT and DBT training and certification for contracted private providers and CSB clinicians. • Identify providers who offer trauma assessments based on evidence-based assessment protocols using standardized assessment instruments. • Recruit providers who demonstrate specialized training in evidence-based trauma interventions; Consider rate differential for providers who are certified in a nationally recognized EBT for trauma. Prioritize providers whose location and/or language capacity is under-represented.	• SOC Training, CSA • CSA & BH-SOC • CSA, BH-SOC, DAHS	• 1-6/18 • 7-12/16 • 7-12/16
B. Identify and implement an evidence-based parenting program designed for parents of adolescents (12+); language capacity and location/accessibility shall meet the needs of families.	• Identify an evidence-based parenting curriculum designed for youth who have significant behavioral/ emotional needs. • Recruit provider to offer parenting program to families whose children are at-risk of or are currently in residential treatment.	• CSA • CSA	• 1-12/17 • 1-12/17
C. Identify and implement an evidence-based parenting program designed for parents of children (<12); language capacity and location/accessibility shall meet the needs of families.	• Evaluate the needs of parents whose children are involved with our child welfare system. • Identify evidence-based protocols for parent-child assessments and evidence-based interventions for supervised visitation and in-home services for youth involved in child welfare.	• DFS • DFS	• 1-12/17 • 1-12/17
D. Monitor utilization of ICC and Case Support and increase capacity/staffing so that youth with identified behavioral health care needs receive appropriate case management services.	• Evaluate areas where CSA/CSB policies need to be aligned (e.g., copayment policies). • Expand ICC and Case Support capacity when need has been demonstrated through monthly and quarterly data reports to the CSA MT.	• CSB/CSA • CSB/CSA	• 7/16-6/17 • 7/16-6/17
E. Improve the utilization of the annual gaps survey of youth and parents in CSA-SOC to identify needed interventions.	• Modify the state CSA survey to allow for more detailed information about needs and service gaps.	• CSA, Family Organizations	• 7-12/16

F. Develop communication plan to share information about the services and care coordination offered through the SOC process with the broader provider	• Identify private organizations that would benefit from information about the SOC. • Develop materials that are family-friendly and are easy references for professionals in the community. Include eligibility requirements for funding, copayment	• CSA, Family Organizations • CSA, Family	• 1-12/17 • 1-12/17

community.	requirements, and SOC practice standards. • Post information in accessible sites, use FAMILY ORGANIZATIONS and other parent organizations for distribution, offer in-person informational sessions.	Organizations • CSA, Family Organizations	• 1-12/17
G. Build system capacity to monitor fidelity to EBT models and conduct outcome evaluation for purchased services.	• Develop and implement provider evaluation process in FY17 contracts. • Utilize outcome data aggregated by service type for quality assurance purposes and identification of training needs. • Explore partnerships/contracts to perform these functions and/or for TA.	• CSA, NCS, DAHS • CSA, NCS, DAHS • CSA, NCS, DAHS	• 4/16-6/17 • 1/17-12/17 • 7/16-12/16
H. Provide IT infrastructure to support data collection for fidelity monitoring and outcome evaluation along with electronic records management.	• Include SOC Office in the HS IT governance workgroup. • Evaluate IT needs for reporting and administrative functions. • Evaluate the need for purchase of additional report functionality for current MIS to perform CANS outcome analysis at the service and child level.	• HS IT Governance; DFS IT workgroup • HS IT Governance, DFS IT workgroup	• 4-6/16 • 7-12/16 • 1-6/17
I. Explore opportunities for expanding available financial resources to serve youth on diversion or probation who need intensive behavioral health services.	• Explore using existing IDT process to develop CSA-qualified service plans. • Explore implementation of Multi-Systemic Therapy, including the level of need and possible financing mechanisms. • Train JDRDC on Medicaid intensive in-home services eligibility criteria to enhance access to Medicaid intensive in-home services for youth on diversion or probation. • Complete current project assessing the viability of regionalizing residential services for court-involved youth.	• JDRDC, CSA • JDRDC,CSA, CSB • JDRDC, CSB,CSA • JDRDC, CSA, Falls Church	• 7-12/16 • 7-12/16 • 7-12/16 • 4/16-7/17
J. Increase family and provider membership on the CPMT.	• Add one hospital provider and one parent representative to the CPMT.	• CPMT	• 7-12/16

GOAL 14: DD/Autism Services

Develop expanded continuum of care of services for youth with DD/autism.

Strategies	Action Step(s)	Who….	When
A. Conduct needs assessment and service inventory of the existing continuum of services and supports and identify critical service gaps for youth with DD/Autism.	• Identify stakeholders and system partners with expertise in DD/Autism to participate in needs assessment and future planning to include the impact of upcoming state waiver changes. • Conduct needs assessment and provide feedback on results to stakeholder groups and provider community. • Assess language capacity and accessibility/location of current service array. • Specifically assess the following service gaps, to include financing options, that have	• CSB/FCPS • CSB/FCPS • CSB/FCPS • CSB/FCPS	• 7/17-12/18 • 7/17-12/18 • 7/17-12/18 • 7/17-12/18

	been identified previously: ○ Transportation aides for DD youth with challenging behaviors or medically fragile conditions; ○ Licensed, affordable respite options for youth with DD; ○ assistance for goods not adequately covered by Medicaid or other payers; ○ In-community group home setting for adolescents with DD/autism/brain injury.		
B. Utilize results of needs assessment and gap analysis to develop a plan to address critical service gaps.	• Recruit providers with specific language capacity who serve this population. • Inform provider community about identified critical gaps in services annually. • Recruit providers to fulfill identified service gaps. • Conduct annual re-assessment of service gaps and needs for this specific population that is shared with stakeholders and private providers. • Conduct market rate analysis for ABA services and practice parameters for utilization management (# of hours, length of service).	• CSB/FCPS/DAHS • CSB/FCPS/DAHS • CSB/FCPS/DAHS • CSB/FCPS/DAHS • CSB/FCPS/DAHS	• 1/18-12/18 • 1/18-12/18 • 1/18-12/18 • 1/18-12/18 • 1/18-12/18
C. Ensure that DD/Autism BH services are included in System Navigation.	• Include BH service inventory for DD/Autism services in database of services and supports. • Train family navigators or other paraprofessionals for this population. • Develop referral system from school based Autism Services to CSB and other community based services.	• CSB, FCPS BHSOC • CSB, FCPS BHSOC • CSB, FCPS BHSOC	• 7/17-6/18 • 7/17-6/18 • 7/17-6/18
D. Develop outreach and social messaging campaign to promote earlier identification of youth with DD/Autism who would qualify for and benefit from referral to services.	• Identify target audience such as pediatricians, medical specialists, schools, and child care providers. • Provide regular outreach events to inform professionals serving these families about available services and supports offered by the school and community agencies. • Develop and post family-friendly information about DD/Autism services at non-profits and family organizations. • Partner with existing family organizations to provide joint training/information sessions for families about resources and eligibility for services. • Include service and support information to FCPS Office of Adapted Curriculum for distribution to parents.	• CSB/FCPS, Family Organizations • CSB/FCPS, Family Organizations • CSB/FCPS, Family Organizations • CSB/FCPS, Family Organizations • CSB/FCPS, Family Organizations	• 1-12/19 • 1-12/19 • 1-12/19 • 1-12/19 • 1-12/19
E. Improve transition planning for children with	• Develop strong network of jobs that utilize the strengths of the DD population as they	• CSB/FCPS/DFS	• 7-12/18

intellectual disabilities or chronic residential needs.	transition to adulthood. Work with Office for Public Private Partnerships and school transition specialists. • Require CSB ID staff to complete SOC/CSA policy and procedure training. • Develop written protocol or MOU for referral to CSB for youth who are served by the schools and require adult services.	• CSB/CSA • CSB/FCPS/FCCPS	• 7-12/16 • 7-12/17
F. Ensure access to crisis stabilization services designed for youth with DD/Autism with providers trained to serve this population.	• Assess service capacity and training of current mobile crisis provider. • Add requirements to current contract for youth mobile crisis for staff training in working with youth with DD/Autism. • Assess capacity of current acute psychiatric hospitals to serve youth with DD/Autism. • Include in service inventory hospitals that offer specialization in this area. • Consider contracting for short-term out of home crisis stabilization service. • Assess capacity of current respite providers and START program to offer respite care.	• CSB • CSB • CSB • CSB • CSB • CSB	• 1-6/17 • 1-6/17 • 1-6/17 • 1-6/17 • 1-6/17 • 1-6/17
G. Increase case management and care coordination capacity for children and youth with DD, particularly for younger children.	• Add DD-related requirements and responsibilities to ICC Intensive Care Coordinator job description. • Cross train CSB ID staff in CSA process for them to serve as lead case managers.	• CSB, CSA • CSB, CSA	• 7-12/16 • 7-12/16
H. Develop community awareness campaign regarding special needs of youth with DD/Autism.	• Offer training to police, fire and other first responders regarding response to youth with DD/Autism. Include as part of Crisis Intervention Training and Mental Health First Aid. • Identify and provide training to other community stakeholders such as judges and teachers. • Utilize family organizations to sponsor a community awareness campaign.	• CSB, Family Organizations • CSB, Family Organizations • CSB, Family Organizations	• 1-6/17 • 1-6/17 • 1-6/17

GOAL 15: Transition Age Youth

Provide coordinated services and supports for youth and young adults of transition age, both those still in school and those who have left school. Reduce the number of youth of transition age who are living with unidentified and untreated serious mental illness who have signs and/or symptoms of a serious mental health condition that emerged before they transition out of youth-serving systems/programs.

Strategies	Action Step(s)	Who….	When

A. Adapt primary care transition resources/tools for use in behavioral health care, promote their adoption.	• Identify primary care transition services/tools relevant to BH transition population (e.g., www.gottransition.org). • Refine/revise relevant tools for use within BH settings. • Develop referral processes for transition age youth in need of BH services. • Train primary care providers & human services staff on using appropriate screening tools & referral process to services. • Ensure implementation in County-operated/funded primary care settings. • Assess and evaluate what age range can best be served under CSB's Youth & Family Services.	• Interagency workgroup facilitated by CSB and DFS, Family Organizations • CSB,HD, Family Organizations • CSB, HD • CSB, FCPS, FCCPS	• 7/16-12/17 • 7/16-12/17 • 7/16-12/17 • 7/16-12/17
B. Ensure navigators have knowledge and understanding of transition issues, requirements, etc., and that navigation tools reflect needs of individuals and families transitioning.	• Create inventory of services currently available to transition age youth. • Train navigators and human services, CSB & DFS call center staff on available "transition youth" services. • Identify gaps in services and report back to SOC Board/SCYPT for further analysis.	• Interagency workgroup facilitated by CSB, DFS	• 7-12/16 • 7-12/16 • 7-12/16
C. Improve transition planning for youth in need of adult behavioral health services.	• Develop written protocol or MOU for referral to CSB for youth served by the schools who require adult services. • Strengthen network of jobs that utilize the strengths of the youth as they transition to adulthood, and connect youth to it. Involve Office for Public Private Partnerships and school transition specialists.	• CSB, FCPS, FCCPS • CSB, DFS	• 7/16-6/17 • 7/16-7/17

GLOSSARY OF TERMS

ABA	**Applied Behavioral Analysis**	**A scientific approach to understanding behavior, how it is affected by the environment and how learning takes place. It is a mixture of psychological and educational techniques tailored to meet the needs of the individual. ABA uses these techniques to discourage socially inappropriate or problematic behaviors and replace them with more acceptable ones.**
ACEs	**Adverse Childhood Experiences**	**Certain experiences (childhood abuse, neglect, exposure to traumatic stressors) are major risk factors for the leading causes of illness & death as well as poor quality of life in the U.S. The ACE study is one of the largest investigations (CDC/Kaiser) ever conducted to assess associations between childhood maltreatment and later life health and well-being.**
BH	**Behavioral Health**	**Term often used interchangeably with "mental health". In this report, it refers to mental health and substance abuse services.**
BH-SOC	**Behavioral Health System of Care**	**See System of Care**
BHSOCAC	**Behavioral Health System of Care Advisory Committee**	**Comprised of County and FCPS managers, family organizations, provider and parent representatives. Its primary functions include identifying service gaps and system barriers, recommending solutions and supporting implementation.**
CANS	**Child & Adolescent Needs & Strengths**	**Screening tool used within human services to assess the needs and strengths of children and their families**
CBT	**Cognitive Behavioral Therapy**	**Form of psychotherapy that is effective for a variety of conditions, including mood, anxiety, personality, eating, addiction, dependence, tic, and psychotic disorders.**
CEXO	**County Executive's Office**	**County Executive's Office**
CLAS	**Culturally and Linguistically Appropriate Services**	**Culture-specific services and supports are provided. They are adapted to ensure access and effectiveness for culturally diverse populations. Providers represent the cultural and linguistic characteristics of the population served. Providers are trained in cultural and linguistic competence. Specific strategies are used to reduce racial and ethnic disparities in access to and outcomes of services.**
CPMT	**Community & Policy Management Team**	**Comprised of County Human Services department directors, FCPS, Cities of Fairfax & Falls Church, parent and provider representatives. Its primary functions include policy development, community planning and fiscal oversight for the System of Care.**
CSA	**Comprehensive Services Act, renamed Children's Services Act, effective July 1, 2015**	**State law that provides funding for private special education services, child welfare services and behavioral health services.**
CSAMT	**Comprehensive Services Act (Children's Services Act) Management Team**	**Comprised of County and FCPS managers. Its primary functions include oversight of contracts, budgeting, fiscal process, operating procedures and policy recommendations.**

CSB	**Community Services Board**	**County Agency**
DAHS	**Department of Administration for Human Services**	**County Agency**
DBT	**Dialectical Behavioral Therapy**	**A type of cognitive behavioral therapy. Its main goal is to teach the individual skills to cope with stress, regulate emotions and improve relationships with others. DBT is also designed to help individuals change patterns of behavior that are not helpful, such as self-harm, suicidal thinking and substance abuse.**
DCNS	**Department of Neighborhood & Community Services**	**County Agency**
DD	**Developmental Disability**	**A condition due to an impairment in physical, learning, language or behavior areas. These conditions begin during the developmental period, may impact day-to-day functioning and usually last throughout the person's life time.**
DFS	**Department of Family Services**	**County Agency**
EBP	**Evidence Based Practice**	**Providers use evidence based treatment modalities in their work with clients. (See EBT)**
EBT	**Evidence Based Treatment**	**In the child & adolescent mental health services field, the term "evidence-based" is most often used to differentiate therapies that have been studied with varying degrees of rigor from therapies that are used but have not been studied or have not been studied well.**
FCPS	**Fairfax County Public Schools**	**County school system**
FCCPS	**Falls Church City Public Schools**	**City school system**
GAIN-SS	**Global Appraisal of Individual Needs – Short Screener**	**The five-minute Global Appraisal of Individual Needs Short Screener (GAIN-SS) is primarily designed as a screener in general populations to quickly and accurately identify clients as having one or more behavioral health disorders. It also rules out those who would not be identified as having behavioral health disorders. It serves as a periodic measure of change over time in behavioral health. It is designed for self- or staff-administration with paper and pen, on a computer, or on the web.**
GMU	**George Mason University**	**Local state university**
HD	**Health Department**	**County Agency**
HS IT	**Human Services Information Technology**	**County Agency**
ICC	**Intensive Care Coordination**	**Program of intensive support for youth at risk of out of home placement or return home after an out of home placement.**
IDT	**Inter-Disciplinary Diagnostic Team**	**The Inter-Disciplinary Team is a multi-agency team comprised of representatives from Human Services agencies and FCPS. It is led by JDRDC Court Service Unit staff. The team evaluates all cases before the Court prior to disposition involving Child in Need of Services or Supervision (CHINS) that involve Habitual Truancy or Habitual Runaway complaints, and conducts assessments and evaluations as necessary in order to prepare a report (known as the IDT Report) to the Court with specific dispositional recommendations.**
IT	**Information Technology**	**Shorthand description for County Agency**

JDRDC	**Juvenile & Domestic Relations District Court**	**County Agency**
LGBTQ	**Lesbian, Gay, Bisexual, Transgender, Questioning**	**Initialism intended to emphasize a diversity of sexuality and gender-identity based cultures.**
MOU	**Memorandum of Understanding**	**Formal agreement (written) between two or more parties.**
FAMILY ORGANI-ZATIONS	**National Alliance on Mental Illness**	**Non-profit, grassroots mental health education, advocacy and support organization dedicated to building better lives for the millions of Americans affected by mental illness.**
NCS	**Department of Neighborhood & Community Services**	**County Agency**
OFC	**Office for Children**	**County Agency**
PMHT	**Promoting Mental Health Team**	**The Promoting Mental Health Team is a committee of the Partnership for a Healthier Fairfax. It has several responsibilities: to identify and share local resources that help promote behavioral health; to develop and consider services and initiatives for the SOC Program; to coordinate the implementation of the Northern Virginia Suicide Prevention Plan; to improve the capacity of the community to deliver services that promote social and emotional wellness; and to improve awareness of mental illness and how to promote mental health among public & community based organizations**
PRS	**Psychiatric Rehabilitation Services**	**Provide services to individuals with serious mental illness to help restore their functioning the community and their own sense of well-being.**
SIBIRT	**Screening, Brief Intervention and Referral to Treatment**	**Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs.**
SOC	**System of Care**	**A spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs; to ensure that all children, youth and their families have equitable and easy access to a continuum of quality, integrated and/or coordinated services, supports, and opportunities to promote resiliency and further their social, emotional, mental and behavioral health.**
SCYPT	**Successful Children & Youth Policy Team**	**Comprised of leaders from multiple sectors within Fairfax County. The team's role is to set community-wide goals and priorities for public policy as it relates to children, youth and families.**
TF-CBT	**Trauma Focused Cognitive Behavioral Therapy**	**An evidence-based treatment for children and adolescents impacted by trauma and their parents or caregivers. Research shows that TF-CBT successfully resolves a broad array of emotional and behavioral difficulties associated with single, multiple and complex trauma experiences.**
TICN	**Trauma Informed Community Network**	**A multi-disciplinary, multi-agency and community partners effort to implement and support Trauma Informed Care initiatives across the Human Services System.**