FAIRFAX COUNTY SUCCESSFUL CHILDREN AND YOUTH POLICY TEAM

April 6, 2016, 9:30 a.m. – 12 noon
Gatehouse Administration Center, Room 3050

Agenda

1. **Welcome and Introductions** (15 minutes)

2. **Member Updates on Actions and Assignments** (15 minutes)

3. **Action Items**

    a. **Action 1: SCYPT Endorsement of Fairfax-Falls Church Children's Behavioral Health System of Care Blueprint for 2016-2019** (110 minutes)

4. **Recap of New Action Steps or Assignments** (5 minutes)

5. **Items and Announcements Presented by SCYPT Members** (5 minutes)

6. **Adjourn**

Next Meetings

Executive Committee: Wednesday, May 4, 9:30 a.m., Government Center 232
SCYPT: Wednesday, June 1, 9:30 a.m., Gatehouse 3050

SCYPT Action Item A-1
April 6, 2016

ACTION ITEM A-1

TITLE:
Endorsement Fairfax-Falls Church Children's Behavioral Health System of Care Blueprint for 2016-2019

ISSUE:
SCYPT endorsement of Children's Behavioral Health System of Care Blueprint and recommendations for policy change and resource allocation.

RECOMMENDATION:
Staff recommend that the SCYPT endorse the Blueprint and its recommendations for policy change and resource allocation to strengthen the behavioral health system of care for children and youth.

BACKGROUND:
In May 2014, the SCYPT endorsed a plan to increase behavioral health services for children and youth. The Board of Supervisors included funding in the FY 2015 and FY 2016 budgets to begin implementation of the plan, which included the development of a Systems of Care Office and new short-term behavioral health services for children and youth. (The plans, as proposed, can be found within the SCYPT meeting materials for September 2013 and May 2014, available at http://bit.ly/scypt.) The plan also called for long-term development of additional strategies to strengthen the system of care. Over the past several months, the Systems of Care Office has engaged a diverse set of stakeholders to identify strategies and actions to be implemented over the next three years. These strategies and actions are presented in the Fairfax-Falls Church Children's Behavioral Health System of Care Blueprint for 2016-2019. The Blueprint has been thoroughly vetted and adopted by the Fairfax-Falls Church Community Policy and Management Team.

The Blueprint is for calendar years 2016 through 2019, and fiscal years 2017, 2018, and 2019. Goals and strategies will be implemented by Fairfax County human services departments and Fairfax County Public Schools, with the support and leadership of family and consumer organizations, other non-profit agencies, and service providers in the community. Blueprint strategies were informed by private and community stakeholders with expertise in children's behavioral health, and recent local studies and reports related to children's behavioral health, including, but not limited to: the FCPS and CSB strategic plans, the CDC "Epi-Aid" study, the Northern Virginia Suicide Prevention Plan, the Community Health Improvement Plan, the Equitable Growth Profile, and the study of disproportionate minority contact in the juvenile justice system.

The Blueprint includes 15 goals, each with a set of strategies and associated action steps. Strategies are designed to increase access to behavioral health services, ensure services are individualized and inclusive, provide for full family participation, integrate and coordinate care, ensure a continuum of services from birth to adulthood, and provide for a comprehensive array of services.

To facilitate the implementation of the plan, the following recommendations are being made to the SCYPT:

SCYPT Action Item A-1
April 6, 2016

1. Endorse the Blueprint as a plan to strengthen the behavioral health system of care.
2. Endorse the following policy priorities, and development and adoption of policy proposals, for Fiscal Year 2017:
    a. Adopt Culturally and Linguistically Appropriate Services (CLAS) standards among behavioral health providers;
    b. Require cultural competency training for County, FCPS, and County-contracted providers;
    c. Identify and require relevant trainings on the unique needs of LGBTQ youth with behavioral health needs; and
    d. Increase the presence and effectiveness of family leadership through partnering with family organizations.
3. Endorse funding in the Fairfax County Fiscal Year 2017 budget for:
    a. The continuation of the crisis textline;
    b. The development and implementation of family navigator services;
    c. The expansion of short-term outpatient treatment services; and
    d. The expansion of child psychiatry services.
4. Endorse the following administrative priorities for Fiscal Year 2017:
    a. Explore way to maximize Medicaid funding;
    b. Explore ways to share student data and service information; and
    c. Develop an accurate and accessible real-time database of behavioral health care providers.

ATTACHMENTS:
Fairfax-Falls Church Children's Behavioral Health System of Care Blueprint for 2016-2019
Behavioral Health Services Inventory

STAFF:
Jim Gillespie, Fairfax County Systems of Care Office
Betty Petersilia, Fairfax County Systems of Care Office
Rick Leichtweis, Fairfax County Inova Kellar Center
Mary Ann Panarelli, Fairfax County Public Schools
Jesse Ellis, Fairfax County Neighborhood and Community Services

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.

<u>Outcome measures</u>:
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.

<u>Outcome measures</u>:
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 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

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

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 community.	• 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 requirements, and SOC practice standards. • Post information in accessible sites, use FAMILY ORGANIZATIONS and other parent organizations for distribution, offer in-person informational sessions.	• CSA, Family Organizations • CSA, Family Organizations • CSA, Family Organizations	• 1-12/17 • 1-12/17 • 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 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.
		• CSB/FCPS
		• CSB/FCPS
		• CSB/FCPS
		• CSB/FCPS
			• 7/17-12/18
			• 7/17-12/18
			• 7/17-12/18
			• 7/17-12/18

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 intellectual disabilities or chronic residential needs.	• Develop strong network of jobs that utilize the strengths of the DD population as they 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/FCPS/DFS • CSB/CSA • CSB/FCPS/FCCPS	• 7-12/18 • 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.	• Interagency workgroup facilitated by CSB and DFS, Family Organizations	• 7/16-12/17
	• Train primary care providers & human services staff on using appropriate screening tools & referral process to services.	• CSB,HD, Family Organizations	• 7/16-12/17
	• Ensure implementation in County-operated/funded primary care settings.	• CSB, HD	• 7/16-12/17
	• Assess and evaluate what age range can best be served under CSB's Youth & Family Services.	• CSB, FCPS, FCCPS	• 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.	• CSB, FCPS, FCCPS	• 7/16-6/17
	• 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, DFS	• 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.**

Behavioral Health Services Inventory - Behavioral Health Capacity in Fairfax County Public Schools and Fairfax County Government Across the Continuum of Supports *Mental Health and Substance Abuse Services*						
Services	**Population Served**	**Description of Service (describe catchment/population)**	**Tools/Evidence-Based Practice & Method of Treatment**	**Information (referrals, web sites, trainings, etc.)**	**Resources - Staffing/Budget**	**Assessment of service (need more, need to evaluate/redesign/ measures of effectiveness available**
Community Services Board						
Medical Services - ***(Psychiatric, Nursing, and Pharmacy)***	Ages 5-18 # Served - 748	Psychiatry, nursing and pharmacy services to youth served in CSB programs, as needed. Services are provided face-to-face or via telepsychiatry.		http://www.fairfaxcounty.gov/csb/	FY15 Budget – $1,295,031	
Prevention ***(Wellness, Health Promotion, and Prevention Services)***	Ages 3-18 # Served – 1,447	Evidence-based services to youth to mitigate risks of mental health and substance abuse issues and prevent need for more intensive services. Services are designed to strengthen emotional health by teaching skills and coping strategies. Programs include Mental Health First Aid, Kognito suicide prevention training, Raising Safe Kids, Girls Circle, Nurturing Parents Program, Too Good for Drugs, etc.	Screening and intervention. Health and awareness-raising campaigns including: Suicide Prevention; Mental Health Promotion; Underage Drinking; Tobacco Cessation/ Prevention; Primary Health Care Integration; Prescription Drug Abuse Prevention; Peer Support; and Safe Handling of Medications	http://www.fairfaxcounty.gov/csb/services/wellness-health-promotion.htm	FY 2015 Budget – $1,192,703	Cost-benefit ratios for early treatment and prevention for addictions and mental illness programs range 1:2 to 1:10, $1 in investment yields $2 to $10 cost savings in health, criminal and juvenile justice, educational, and lost productivity, as well as other costs

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Community Services Board (continued)						
Prevention ***(Wellness, Health Promotion, and Prevention Services*** ***(continued)***			• Counseling or education ▪ Skill building programs ▪ Programming for youth experiencing early signs of substance use or mental health illness ▪ Coordinated community-focused workshops designed to promote healthy behaviors and lifestyles to include: Mental Health First Aid; Girls Circle; Leadership & Resiliency; Too Good for Drugs; Road DAWG; ACT Against Violence: Parents Raising Safe Kids			

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Community Services Board (continued)						
Wellness, Health Promotion, and Prevention Services ***(Al's Pals: Kids Making Healthy Choices)***	Ages 3-8	Services are designed to develop social and problem-solving skills and self-control to prevent use of tobacco, alcohol, and other drugs.	Early childhood prevention curriculum and teacher training to develop pro-social skills, self-control, problem-solving, healthy decision making and positive coping	http://www.vfhy.org	FY15 budget - $60,000	
Call Center ***(Engagement Assessment & Referral)***	Ages 5-18 # Served - 1,313	Assessment, information and referral services, including services provided by CSB as well as community partners. Based on an initial assessment and urgency of need, youth are either referred to Emergency Services, offered a scheduled appointment with a clinician specializing in services for youth, or referred to community partners.	Engagement, Assessment and Referral services: Call Center - entry and referral services	http://www.fairfaxcounty.gov/csb/services/assessment.htm	FY 2015 Budget - $184,441	

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Community Services Board (continued)						
Emergency – ***(Emergency, Mobile Crisis and Crisis Hotline***	Ages 5-18 # Served - 1,231	Comprehensive walk-in services available 24/7 at the Merrifield Center for youth in acute mental health or substance abuse crisis, including psychosis, intoxication, suicidality, aggression, and illness impacting their ability to care for themselves. The Mobile Crisis Unit (MCU), operating 8am-12am, is the "mobile" component to Emergency Services responding in the community to evaluate and intervene with at-risk youth. Crisis hotline services include response to phone and text 24/7.	Crisis Intervention; psychiatric evaluations; medications; admissions - voluntarily and involuntarily - to Crisis Stabilization Units or Psychiatric Hospitals Emergency Services: recovery-oriented crisis intervention, crisis stabilization, risk assessments, evaluations for emergency custody orders and temporary detention orders, voluntary and involuntary admission to public and private psychiatric hospitals and the three regional crisis stabilization units. It also provides psychiatric and medication evaluations to include prescribing and prescribe and dispensing medications.	http://www.fairfaxcounty.gov/csb/services/acute-care.htm	FY15 Budget – $778,106	Service utilization based on "response time" (from initial presentation until seen by ES/MCU clinical staff for assessment/intervention) and also percentage of individuals served diverted from psychiatric hospitalization

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Community Services Board (continued)						
			MCU: Services include crisis intervention, crisis stabilization, risk assessments, evaluations for emergency custody orders and temporary detention orders, voluntary and involuntary admission to public and private psychiatric hospitals and the three regional crisis stabilization units. Civil Commitment: Clinical psychologist evaluations; provide expert testimonies for jurisdictional system			
Early Intervention ***(Infant & Toddler Connection)***	Ages 0-3 # Served 3,372	Assessment and early intervention services for infants and toddlers who have a developmental delay or a diagnosis that may lead to a developmental delay. Services include physical, occupational and speech therapy; developmental			FY 15 Budget - $ 6,896,186 (Cost Center G762004) $4,020,660 (Cost Center 1760001	

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Community Services Board (continued)						
		services; medical, health and nursing services; hearing and vision services; service coordination; assistive technology (e.g., hearing aids, adapted toys and mobility aids); family training and counseling; and transportation.				
Outpatient ***(Y & F Outpatient)***	Ages 4-18 and families # Served - 2,237 Outpatient VICAP Ages 4-21	Assessment, therapy, case management, and crisis intervention services to youth who have mental health, substance use and/or co-occurring disorders and their families. Includes school-based services at Cedar Lane and Quander Road, several pre-schools and South County Headstart as well as the Virginia Independent Clinical Assessment Program (VICAP) providing independent clinical assessment in the Medicaid and FAMIS children's community mental health	Family-focused outpatient services for children and adolescents who have mental health, substance use and/or co-occurring disorders. ▪ Infant and Early Childhood program ▪ Case management for service/resource coordination, CSA, and medication management ▪ School based services provided to Cedar Lane and Quander Road (10 hours per week each), several pre-schools and South County	http://www.fairfaxcounty.gov/csb/services/outpatient.htm	FY15 Budget - $5,421,521	Service utilization based on consumer-focused treatment plan goals and objectives for treatment and case management

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Community Services Board (continued)						
		rehabilitative service authorization process.	Headstart ▪ VICAP- staff conduct Medicaid screening/eligibility determinations (40 per month) (FY15 assessments completed, 303			
Day Treatment	Ages 13-18 and families #Served - 55	Day treatment services for youth with mental health and/or substance use issues whose treatment needs cannot be met through office visits at an outpatient site. Youth attend the program all day, five days/week for three to six months. FCPS provides an alternative school at the site, with youth attending school in the morning and therapy in the afternoon.		http://www.fairfaxcounty.gov/csb/services/outpatient.htm	FY15 Budget - $825,592	

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Community Services Board (continued)						
Youth Resource Team – ***Discharge Planning and Case Management)***	Ages 5 - 22 and families # Served - 111	State-mandated discharge planning for youth in the Commonwealth Center for Children and Adolescents and state-funded private hospital placements as well as case management services for children with serious emotional disturbance or co-occurring disorders, including those mandated to be served under the Comprehensive Services Act (CSA).	Discharge planning from hospitals ▪ Manage state/regional hospitalization bed funds (LIPOS program) ▪ Transition plans for youth released from juvenile corrections (State Dept. Juvenile Justice •Monitor youth in court ordered outpatient treatment		FY15 Budget – $701,571	
Intensive Care Coordination ***(Wraparound Fairfax)***	Ages 3-18 and families # Served - 123	Intensive wraparound services for youth who are at high risk for residential or out-of-home placement, or who are currently served away from home and transitioning back to their home community. Services include home-	Wraparound and intensive care coordination is a family-driven, team-based service planning and implementation process that develops community-based service strategies, which integrate the needs of the child, the family and the requirements of the		FY15 Budget – $649,380	

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Community Services Board (continued)						
		based services, respite care and other ancillary services, such as recreation and transportation, to support the family's plan of care.	mandated child service agencies. Services provided include: assessment; facilitation; monitoring service plans; and case management support. Services are provided for up to 15 months and are designed to enable youth to remain safely in the community with their families.			
Case Management & Treatment ***(Mental Health Initiative)***		Mental health case management and treatment services for youth with serious emotional disturbance who reside in the community and are not mandated to be served under the Comprehensive Services Act (CSA).	▪ Licensed and standardized psychological testing instruments for depression, anxiety, thought disorders, TF CBT ▪ motivational interviewing, stages of change ▪ CAMS suicide intervention, ▪ Psychiatric evaluation and treatment	http://www.fairfaxcounty.gov/csb/services/court-based.htm	FY15 Budget – $515,529	Treatment services greatly reduced in BETA and JDRDC. Cost shifting to the JDRDC for psychological evaluations.

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Services	**Population Served**	**Description of Service (describe catchment/population)**	**Tools/Evidence-Based Practice & Method of Treatment**	**Information (referrals, web sites, trainings, etc.)**	**Resources - Staffing/Budget**	**Assessment of service (need more, need to evaluate/redesign/ measures of effectiveness available**
Community Services Board (continued)						
Youth & Family Contracts – ***(Residential Treatment - Leland House)***	Ages 12-17 adolescent boys and girls	Leland House, an eight bed psychiatric crisis care residential program, provides therapeutic services for adolescents experiencing a psychiatric emotional or behavioral crisis who are unable to remain in their family home or current setting until the crisis is resolved. Services are designed to divert adolescents from more intensive and long-term service options, such as psychiatric hospitalization.	Leland is a 45 day crisis stabilization program utilizing Circle of Courage concepts with individual, family and group modalities; CBT and behavior interventions, including process orientation.	http://www.fairfaxcounty.gov/csb/services/intensive-community.htm	FY15 Budget - $592,203	
Youth & Family Contracts – ***(Emergency Shelter, Case Management***	Emergency Shelter Ages 13-17 Outreach and Case Management Ages 18-24 # Served 67	Alternative House provides emergency shelter, support coordination, outreach and case management services to homeless youth.	▪ 24/7 Shelter services for homeless youth 13-17 years of age ▪ Outreach and case management services to youth 18-24 years of age, who are homeless, and locate and refer youth to suitable low-cost housing that is convenient to work, school and/or other sources of support ▪ Provide training, support and referrals to prevent future homelessness	https://thealternativehouse.org	FY 15 Budget - $173,685	

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Community Services Board (continued)						
Support Coordination	Ages 5-18	Assessment, evaluation, case management and monitoring services for youth with intellectual/developmental disability, as well as their families, to access essential services and supports to meet basic needs and attain maximum level of independence, productivity and integration into the community.	Assessment, Collaborating with the individual to develop and monitor a service plan, Family and community supports, Counseling, Crisis intervention, Intake and discharge planning, and Assist with accessing community-based services outside the CSB .	http://www.fairfaxcounty.gov/csb/services/support-coordination.htm	FY15 Budget - $2,393,597	
Residential Treatment ***(Crossroads Youth)***	Program Closed 6/30/2015	Residential treatment services to adolescent males aged 14-17 with high substance abuse involvement, co-occurring disorders and higher sociopathic traits			FY15 Budget – $1,461,448	

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Community Services Board (continued)						
Residential Treatment ***(Sojourn)***	Program Closed 12/31/14	Residential treatment services in an eight-bed community-based therapeutic group home, Medicaid Level B, for girls aged 13-17 with serious emotional disturbance and/or co-occurring substance use disorders. A three to nine months program for girls experiencing co-occurring, depression, mood instability disorders, and PTST/multi-trauma exposure experiencing depression. Treatment plans include case management, therapeutic services and community wraparound referrals and support			FY15 Budget – $615,431	
Respite ***(ACRS Direct ACRS Contracts)***	Ages 5 – 18 # Served 144	Subsidy for respite care services for families of youth with intellectual disabilities or serious mental illness.	Group homes, Supervised apartments, Drop-in sponsored living, Respite Care	http://www.fairfaxcounty.gov/csb/services/community-residential.htm	FY 15 Budget - $212,341	

Behavioral Health Services Inventory - Behavioral Health Capacity in Fairfax County Public Schools and Fairfax County Government Across the Continuum of Supports *Mental Health and Substance Abuse Services*						
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Community Services Board (continued)						
Court Involved Youth ***(Assessment, Evaluation, and Case Management)***	Ages 12-17 # Served 314	Assessment, evaluation, individual and family therapy, crisis intervention and case management services for youth involved with the Juvenile and Domestic Relations District Court by reason of run-away, out of control or truant behavior or criminal activity.	Assessment, evaluation, consumer monitoring and emergency treatment services		FY15 Budget – $815,682	
Court Involved Youth ***(Mental Health Juvenile Detention)***	Ages 12-17	Assessment, evaluation, consumer monitoring and emergency treatment services for children and adolescents placed in juvenile detention centers.	Assessment, evaluation, consumer monitoring and emergency treatment services		FY15 Budget – $111,724	
Court Involved Youth ***(Mental Health Child & Adolescent Services)***	Ages 12-17	Intensive care coordination and wrap-around services for youth involved with the Juvenile and Domestic Relations District Court as well as psychiatric services for youth placed in juvenile detention centers.	ICC, wrap-around and psychiatric services	http://www.dbhds.virginia.gov/individuals-and-families/mental-health-services	FY15 Budget – $75,000	

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Community Services Board (continued)						
Behavioral Health - ***(Turning Point)***	Ages 16 – 25 # Served 21	Early intervention and treatment of behavioral health needs for young adults experiencing First-Episode Psychosis (FEP). Recovery After an Initial Schizophrenia Episode (RAISE) model and Coordinated Special Care (CSC) team-based, collaborative, recovery-oriented approach involving the youth, treatment team, and family.	RAISE and CSC team-based recovery (youth, treatment team, and family), outreach, medication, cognitive and behavioral skills training, supported employment and education, case management, and family psycho-education.	http://www.dbhds.virginia.gov/individuals-and-families/mental-health-services/coordinated-specialty-care-for-young-adults	FY15 Budget - $422,691	
Regional Suicide Prevention	Ages 5 - 18	Comprehensive suicide prevention and intervention planning initiative between CSB, other human service agencies, FCPS, and community and faith-based partners. Includes web-based and text referral services for individuals at-risk of suicide 24/7.	Screening, counseling and referral services	http://www.fairfaxcounty.gov/csb/region/	FY15 Budget - $0	

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Community Services Board (continued)						
Regional Crisis Stabilization ***(Regional Developmental Children's Crisis Stabilization)***	Ages 5 - 18	Services are designed to provide a system of care for children with intellectual and developmental disabilities in crisis due to mental health or behavioral challenges, diverting them from unnecessary institutional placements. Services include continuing care coordination, psychiatric and behavioral health specialist services and training for families and providers.		http://www.fairfaxcounty.gov/csb/region/	FY15 Budget - $0	
Regional Crisis Stabilization ***Mental Health Children's Crisis Stabilization***	Ages 5 - 18	Crisis stabilization, psychiatric support, and local inpatient psychiatric hospitalization services	Care coordination, psychiatric and behavioral health specialist services, and training for families and providers.	http://www.fairfaxcounty.gov/csb/region/	FY15 Budget - $356,438	

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Department of Family Services						
Prevention/Early Intervention		Preventative services are provided to families with risk factors and/or with early signs of child abuse/ neglect issues. Services include home visiting for parents with new infants (HFF), parenting education groups for parents and children (PEP), and leveraging community and school partnerships to identify formal and informal sources of family support to improve child and family well-being (NN).	HFF – Ages & Stages Questionnaire (ASQ-3) validated Developmental Screening Tool, Nurse Child Assessment Satellite Training (NCAST) Parent-Child Interaction Assessment -PEP – Adult-Adolescent Parenting Inventory (AAPI-2), Nurturing Parenting Curriculum, Incredible Years Curriculum (0-4), Active Parenting (adolescent) -NN – NCFAS evidence-based family functioning assessment tool	*Healthy Families America* http://www.preventchildabuse.org/index.php/about-us/about-hfa *Nurturing Parenting* http://www.nurturingparenting.com *Incredible Years* http://incredibleyears.com/programs/parent *Active Parenting* http://www.activeparenting.com/ *National Family Preservation Network* http://www.nfpn.org/assessment-tools	HFF 29.5.SYE nonprofit staff; 6 SYE county staff (RBA says 31.93) PEP – 7.5 SYE (from RBA, includes grant) NN – 11 SYE (3 grant funded) (from RBA)	County and state funding for prevention services is vulnerable as it has been repeatedly cut/ under-resourced. Higher demand than capacity to meet need. Programs are evidence-based and have outcomes that demonstrate their efficacy. Measures include: Improvement in parenting attitudes (PEP), Improvement in parent-child interaction (HFF), Lack of CPS
Healthy Families	HFF – 530 families, 515 children served in FY15					
Parenting Education programs	PEP – 347 families, 501 children served in FY15					
Neighborhood Networks	NN – 63 families, 163 children served in FY 15					
OFC – Head Start						

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Department of Family Services (continued)						
Treatment/Care Coordination		Intervention with children and families who have either experienced or are at risk of child abuse/ neglect. Services include case management, care coordination, and placement services ***Mental health and substance abuse treatment services are funded through Comprehensive Services Act (****see CSA section).*	SDM Safety, Risk Strengths& Needs Assessments Family Partnership Meetings Family Finding Permanency Coordination Strengthened parent-child visitation practices		FC&A – 85 SYE CPS – 54.52 SYE PPS – 52 SYE FEP – 8 SYE	The CYF Division of DFS is in the implementation and monitoring phase of an extensive realignment effort. An evaluation of services is a component of this effort. Measures include keeping children safely with their families, decreasing the length of time children are in foster care, increasing the # of children who exit foster care to permanency The lack of evidence-based treatment providers
Foster care & Adoption	FC&A – 368 children served in FY15					
CPS	CPS – 2,506 reports of child abuse / neglect in FY15					
Protection & Preservation Services	PPS – 624 families, 1,732 children served in FY15					
Family Engagement Program	FEP – 725 meetings held in FY13					

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Department of Neighborhood and Community Services						
Community & Teen Centers	Programs for school-aged children	After School Programs-free drop-in program recreation activities, homework assistance, field trips, snacks •RecQuest Program-structured 11-week summer camp for children 6-12 with emphasis on developing lifelong leisure skills. •Technology Programs (Computer Learning Centers & Computer Clubhouses) - computer instruction, graphics, music, robotics • Family & Community Programs/Community Events: Holiday Socials; Prevention Programs; health/wellness; ESL Programs; Family Movie Nights County staff provides positive role models for teens and they provide teens with the skills necessary to make good decisions, improve personal resiliency and to have fun.	Results Based Accountability (RBA)-Finalizing measurable outcomes as to how our participants are better off through Results Based Accountability. Positive Behavioral Intervention Support (PBIS)-an incentive program that rewards positive behaviors being implemented in community and teen centers along with FCPS to measure the success of behavior changes. Kids at Hope - The "Kids at Hope" philosophy is founded on the belief that all children are capable of success...no exceptions.	Coordinated Services Planning (222-0880 emergency services line) are social workers able to provide resources for families in need.	Community/teen center staff certified in Mental Health First Aid needed. Partnership with VIP/Teen Centers Summer Programs-NCS teen centers and FCPS partnered this summer, one in each region, for the month of July to provide a camp program for middle and high school-age youth.	Youth with behavioral health needs that staff not equipped to deal with. -Center staff have a strong rapport with the youth and serve as positive role models -Centers provide a safe and supervised place for youth to participate in recreation programs after school and summer. Strong partnerships and collaborations with community.

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Department of Neighborhood and Community Services (continued)						
Family Resource Centers	Parents/families in the Culmore and Central Springfield communities	Family Resource Centers serve families in the Culmore and Springfield/Franconia communities. They focus on parenting and family support and offer a variety of programs, resources, and activities	Evidence-based parenting programs, such as Parents Raising Safe Kids	Coordinated Services Planning (222-0880 emergency services line) are social workers able to provide resources for families in need.	Alternative House runs the centers through a contract with the County	
Therapeutic Recreation	Individuals with disabilities	Therapeutic Recreation Services offers a variety of programs, social clubs, and camps to provide opportunities for people with disabilities to acquire the skills that enable them to participate in the recreation and leisure programs of their choice. Staff also provides support and advocacy to individuals who wish to participate in general recreation activities		*http://www.fairfaxcounty.gov/ncs/trs*		

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Department of Neighborhood and Community Services (continued)						
Middle School After-School Program	Middle school students	Fairfax County Public Schools offers comprehensive, high-quality after-school activities that provide opportunities for middle school. After-school activities are being implemented so that youth have greater opportunities for success in developing the attitudes, skills, knowledge, and abilities to live healthy lives, become productive adults, and to thrive in the workplaces and communities of the 21st century. Free and offered 5 days/week.				Implemented by FCPS. 75% of funding comes from NCS, and NCS serve as key liaisons and partners in program development and delivery.
Partners in Prevention Fund	Children, youth, and families	Implementation of evidence-based prevention programs on a variety of topics by community-based organizations	Current programs include: • Suicide Prevention: SOS and Lifelines • Teen Dating Abuse Prevention: Safe Dates • Obesity Prevention: Energize our Families, Media Smart Youth, Catch Kids Club Parenting: Strengthening Families, Parents Raising Safe Kids		Community-based organizations are contracted by NCS to implement the programs	

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Fairfax County Public Schools						
Prevention and intervention Services	187,000 enrolled students (embedded at every level, every school across FCPS) Psychology and social work individual and group for 2014-15 = 74,000 1297 calls to Parent Clinic; some handled as telephone consults and 357 appointments scheduled June – August 2015	Classroom instruction/lessons on mental wellness - i.e. positive peer relationships, bullying and harassment, goal setting, managing stress, pro-social skills Group and individual counseling including trauma informed care Mentoring Programs Staff and Parent trainings Parent Clinic - multiple languages Crisis Response and Support	School-based collaborative teams: -Positive Behavior Intervention Supports (PBIS) -Attendance committee -Child study/student support team -Local Screening Committees Evidence informed Tools/Methods i.e.: -Check & Connect -SOS/ACT -Social Skills Curriculum - HOPS - Kimochis -Unstuck & On Target -Safe Dates -Girl Circle - Boys Council -Coping Cat -PREPaRE trained - national crisis response curriculum	Wellness Week/Depression Awareness Bullying and Harassment Awareness & Training grades 7-12 Annual staff training on sexual and gender based harassment Depression and Positive Mental Health website Crisis Intervention website Bullying Prevention and Intervention website Military Connected Youth website Resiliency Project Website	112 school psychologists 102.5 school social workers	Reduced discipline referrals Youth survey data Reduction in residential placements Improved attendance Increased student engagement

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Fairfax County Public Schools (continued)						
Prevention and intervention Services ***(continued)***	All secondary and elementary school staff – required training Available to all secondary school students	On-line avatar based training on suicide prevention		Kognito *at-risk* suicide prevention training Kognito *Step In Speak Up* recommended Kognito *Friend to Friend* presented in 10th grade health and available to all students		
	All school staff and parents; selected youth age 16 and over	Youth Mental Health First Aid		YMHFA for students, staff and parents	11 school psychologists and 11 school social workers trained as trainers	
	Students attending non-traditional schools/programs	Counseling, behavioral support, teacher/parent consultation			3 school-based psychologists & 5 social workers	As above and Improved graduation rates

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Fairfax County Public Schools (continued)						
Assessment and evaluation	187,000 school-aged students threat assessments 2014-15 - 453 suicide risk assessments 2014-15 =3,038 2014-15 initial = 4,924 Re-evaluations 2014-15 = 8,620	Progress Monitoring and Consultation -Assessment services available to all students: -Threat Assessment -Behavioral Assessment -Suicide Risk Assessment -Mental Health Assessment Depression screening – 19 high schools and 12 middle schools – *schools that did not do a formal screening did depression education activities* -Evaluation services available for special education consideration and in support of discipline/hearings office cases; Evaluations for students in residential facilities throughout US	Assessment: evidence informed standard protocols Evaluation: Standardized, normed protocols	Referral sources: Student Teacher/staff Parent	See above (112 school psychologists 102.5 school social workers perform these functions)	Increased parent/guardian engagement
	Preschool Aged Children 2 - 5years old Available to all FC residents	Developmental evaluations	Play based and standardized evaluations of development; sociocultural histories with parents	Early Childhood Assessment Team – 7 psychologists; 7 school social workers		

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Fairfax County Public Schools (continued)						
Treatment	Students with significant social/emotional/ behavioral/ developmental concerns	Intensive intervention and counseling services provided in public day school sites, multiple comprehensive services sites, and special education centers; collaboration with private providers, agency personnel, treatment facilities, and families	As above		35 school social workers 38 school psychologists	Reduction in residential placement Reduction in suspensions and expulsions Maintenance in least restrictive environment Number of referrals to community based services and emergency services
	High school students who require short-term mental health stabilization interventions	Intensive intervention and counseling to the students; parent education; and community connections when a student's capacity to participate in the educational setting is severely impacted by mental health issues or when a student is experiencing difficulty with transitioning back to the educational setting after receiving mental health services outside of the school environment	Cognitive behavioral approaches and evidence informed practices	Project AWARE High Schools (Centreville, Fairfax, Falls Church, South Lakes and West Potomac)	Behavioral Health Clinicians: 3 school psychologist; 2 school social workers	Student access to short-term mental health stabilization interventions Increased success with transitions back into the school setting from a mental health challenge

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Fairfax County Public Schools (continued)						
Case Management/ Care Coordination	Students accessing CSA services Lead case managed 202 cases in 2014-2015	Collaborate with county agency personnel to secure necessary services for students/ families; Coordinate all services for families available through FCPS and externally	Child and Adolescent Needs And Strengths assessment	All school social workers are trained on the CANS and the process		Effectiveness reduced by lack of availability to convene a team based planning meeting; Difficulty securing services

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Health Department						
Patient Care Services (PCS), Women, Infant & Children (WIC), and Community Health Care Network (CHCN)	Students, parents, and staff in FCPS, FCCPS, maternity/post-partum clients, WIC clients: nursing women, infants, or children under five years of age, children and youth of all ages seeking services in clinics CHCN: Teens and adults enrolled and receiving care at the three CHCN clinics	Focus on prevention with a goal of healthy babies/children/youth through a variety of programs including maternity and other services in the clinic and field. Identification of needed behavioral health services of our clients (receiving public health services) and referral of these individuals to appropriate resources. These youth are identified through the School Health Room, Health Department Clinics, Field Services including Maternal Child Health (MCH), Healthy Families Fairfax (HFF), and Nurse Family Partnership, Individual Child Development Clinics, and Community Health Care Network (CHCN). CHCN provides limited behavioral health services and an on-site mental health therapist is available.	Edinburgh Postnatal Depression Scale (EPDS) Patient Health Questionnaire (PHQ-4 and 9) Behavioral Health Risks Screening Tool Abuse Assessment Screen (A.A.S.)/Domestic Violence and Trauma Screening Tools Generalized Anxiety Disorder 7-Item Scale (GAD-7) Cognitive Behavioral Therapy (CBT) Solution-focused Therapy Motivational Interviewing (MI) Dialectical Behavior Therapy (DBT) Acceptance/Mindfulness-based Therapies Stress Management Classes	Referrals for further screening or treatment to: CSB, FCPS psychologists, social workers, and counselors, HFF, MCH, Nurse Family Partnership, DFS-CPS, Office for Women & Domestic & Sexual Violence Services, Northern Virginia Family Services (NVFS)	CHCN: 3 FTE's: mental health therapists on contract with Molina Healthcare Inc. 1 psychiatrist from CSB who visits each CHCN site once a month. Mental Health Coordinator for our Perinatal Maternal Mental Health Project services via Northern VA Family Services available for Healthy Families clients through their CareFirst grant	A need for more postpartum support groups for individuals with limited English proficiency. Better accessibility to behavioral health resources. Universal screening tool for children and youth that can be used in any setting and is accepted as a referral document for services Improve A.A.S. screening tool to include questions on human trafficking, strangulation, stalking and reproductive coercion. Need for staff training on updated tools and appropriate follow-up. Development of trauma-informed services/workforce

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Juvenile and Domestic Relations District Court						
Probation Supervision	Probation Officers supervise approximately 600 juveniles daily. Youth must have been under the age of 18 years when charged but may continue receiving services until age 21 years. Jurisdiction over offenses occurring in the 19th District; (Fairfax County, Fairfax City, Towns of Herndon/Vienna) regardless of youth residence.	Youth placed on probation by the Juvenile Court for offenses ranging from truancy, runaways, to misdemeanors (larceny, vandalism) to felonies (Burglary, Grand Larceny) and serious violent felonies (Malicious Wounding, Gang Participation, Sexual Assaults, and Robbery). If behavior of youth comes under the statutory authority of the JDRDC, the CSU must provide case management services and probation supervision	Available continuum of services within the CSU that allows staff to place youth in most appropriate level of intervention while maintaining youth in the local community Use of structured decision making tools at key decision points in system – Detention Assessment Instrument, Youth Assessment and Screening Instrument – that allow CSU staff to more effectively target services Strengthening field probation and residential staff behavior change skills – motivational interviewing, cognitive behavioral interventions	In a point-in-time survey of 33 JDRDC CSU juvenile probation officers responsible for the supervision of 550 juvenile offenders, with 2/3 of those staff responding, it was reported that 173 of these juveniles had an identified behavioral health need. Of those 173 cases, 15 juveniles were on a waiting list for CSB intake and services.	CSB Juvenile Forensic Unit; 2 FT psychologists (S28) 1 PT psychologists (S28) vacant -2 limited term PT psychologists (1 vacant) 1 FT Substance Abuse Counselor II (vacant/shared costs CSB/JDRDC) 2 FT Substance Abuse Counselors II Intake (vacant) Contracts with Multicultural Clinical Center to provide psychological evaluations, and sex offender assessment and treatment with an annual budget of $163,000.	Additional need for the following services: -Group counseling -Sexual victimization -Outpatient substance abuse treatment -Drug/alcohol education -Anger management -Individual counseling -Inpatient substance abuse treatment -Mental health evaluation and counseling Need an additional supervisory level staff person (s-30) to manage the staff and array of services being provided by the Forensics unit.

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Juvenile and Domestic Relations District Court (continued)						
Beta Post-Disp. Sentencing/ Treatment Program	Program serves adolescent males between 14 and 18 years of age. It is typically six months residential services and six months of community aftercare. Youth are under court probation supervision and typically have a new offense or a violation of probation that is adjudicated by the court and results in the court ordered placement. Youths entering the program have either committed a very serious offense or are repeat offenders that require immediate removal from the community.	Youth are currently under court probation supervision in Fairfax County, have committed a wide range of criminal offenses both felony and misdemeanor which includes crimes against persons and property. Crimes involving fraud, health and safety, peace and order and the administration of justice. In addition to the criminal history the resident population also may be addressing issues of ADHD, Conduct disorder, Mood disorder, depression, PTSD, Substance Abuse/Dependence, bipolar or Oppositional Defiance Disorder. Residents may also have a history of abuse and neglect and/or gang involvement. Residents have typically not been successful in outpatient services.	The program provides individual, group and family counseling and an on-site Alternative School. They utilize Cognitive Behavior Therapy, Dialectical Behavior Therapy, Motivational Interviewing, Multi-Family Group based on the Nurturing Parenting Program and the Phoenix curriculum. The program uses the Adverse Childhood Experiences Assessment(ACE), Texas Christian University Assessment tool to measure criminal thinking and motivation and the Family Assessment Measure III		1 FT psychologist (S-28) 1 SAC II (S-23)	In the best interest of clients, service needs to be reliable and on-going. We have experienced repeated reductions in positions (4 to 2) as well as job freezes where no substance abuse services were available for the clients.

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Juvenile and Domestic Relations District Court (continued)						
Mental Health Unit in JDC and SCII	Two programs serve male and female youth between 13 and 18 years of age. The SCII program services status and lower level criminal offenders. The detention center serves more serious offenders who are considered to be a danger to themselves or others. In addition to the criminal/ status history the residents have a host of other issues which include mental health, substance abuse and	Most of the youth are residents of Fairfax County but we also have youth from other jurisdictions in the Commonwealth as well as individuals from other states who may commit crimes in Fairfax County. Youth have been court ordered into the programs with offenses ranging from truancy, runaways (SC II only) to misdemeanor offenses of larceny, assault etc., to felony offenses of burglary, grand larceny, malicious wounding, gang participation, sexual assaults, robbery and murder. The JDC/ SCII staff handles the day to day care of the residents. The CSB mental health clinicians review all intakes and screen youth for mental health	The JDC staff administers the MAYSI II and the clinicians review all results and respond accordingly based on need. Clinicians also do mental status exams with residents identified through the MAYSI instrument. For trauma assessments they use the Trauma Symptoms Index and the Adolescent Psychopathology Scale. Staff utilize Cognitive Behavior Therapy (CBT), Trauma Focused CBT, Motivational Interviewing, Individual, Group and Family Psychotherapy, Expressive Therapy (Sand-Tray).		1 FT psychologist (S28) (assigned 20+ hours per week to emergency services). 1 FT Mental Health Therapist (S23) 1 FT Senior Clinician (S25) -grant funded	

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Juvenile and Domestic Relations District Court (continued)						
Mental Health Unit in JDC and SCII (continued)	educational challenges. The Detention Center had 558 admissions last fiscal year. SCII had 212 admissions last fiscal year.	concerns. They consult with JDC staff on managing youth in the program, provide crisis stabilization, screening for psychiatric hospitalization as well as referring youth for medication assessments. Provides court ordered emergency evaluations and trauma assessment and referral services. Assist case managers and families in identifying community resources to address service needs when clients are released from detention or SCII.	While youth entering these programs have a host of mental health issues the primary areas are Substance Abuse/Dependence, Conduct Disorder, Mood Disorder and PSTD.			

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Juvenile and Domestic Relations District Court (continued)						
Juvenile Intake	Juvenile Intake Officers screen estimated 5,000 complaints each year from citizens, family members, school officials, and law enforcement to determine the appropriate response such as diversion from official court action to formal petitions to issuance of detention orders.	Intake officers provide diversion services to youth and families including Diversion Hearings, where sanctions and referral to mandatory treatment programs are imposed, and Monitored Diversion (90 day period of informal probation supervision) where case management supervision is provided including assessment and program referrals. In FY 2013 886 were diverted, 92 Monitored Diversion cases, 782 Informal Diversion hearings, and 12 cases referred to Restorative Justice.	Intake officers use a Structured Decision Making model for determining which cases are appropriate for diversion in lieu of formal court action. In cases where a petition is taken, the intake staff utilizes a Detention Assessment Instrument to determine if a youth must be taken into custody, released into a detention alternative program, or released. Intake staff utilize Motivational Interviewing model in communicating with youth and parents, and the Youth Assessment Screening Instrument when planning for diversion case management.		Programs with Fee for Services: CSB - Diversion 101 for substance abuse ASAP - SAFE (substance/alcohol focused education) NASP - YES (shoplifting program) Calvary Counseling Center - TIP (shoplifting program) 2.5 FTE Family Counselors	On-going family counseling services beyond crisis intervention and diversion period. Access to immediate mental health services for youth and families who require clinical assessment and treatment for significant issues ranging from depression, trauma, suicidal ideation, etc., in locations accessible to the family and in their native language. Access to immediate substance abuse evaluation and treatment services that can be available with the duration of the 90 day diversion period at locations that are accessible to the family and in their native language.

Behavioral Health Services Inventory - Behavioral Health Capacity in Fairfax County Public Schools and Fairfax County Government Across the Continuum of Supports *Mental Health and Substance Abuse Services*						
Services	**Population Served**	**Description of Service (describe catchment/population)**	**Tools/Evidence-Based Practice & Method of Treatment**	**Information (referrals, web sites, trainings, etc.)**	**Resources - Staffing/Budget**	**Assessment of service (need more, need to evaluate/redesign/ measures of effectiveness available**
Juvenile and Domestic Relations District Court (continued)						
Boys Probation House / Foundations Program ***(Girls)***	Serves youth 13 to 18 9 to 12 month placement. Youth are under court probation supervision and have a new offense or a violation of probation that is adjudicated by the court and results in the court ordered placement. Youth entering these programs have failed to benefit from community and home based services. They have committed a serious offense or are repeat offenders or involved in extreme high risk behavior in the community. Many of the youth in BPH will be placed there on a suspended commitment to the Department of Juvenile Justice. BPH had 26 admissions last fiscal year. Foundations had 22 admissions last fiscal year.	Youth are Fairfax County residents who have committed a wide range of criminal offenses or are status offenders with extreme high risk behaviors and lacking adequate supervision. In addition to the criminal and status offense history the resident populations also may be addressing issues of Substance Abuse/ Dependence, ADHD, Conduct Disorder, PTSD, Abuse and Neglect, Domestic Violence, Mood Disorder, Depression, Attachment and Anxiety Disorders, Emotional and Cognitive Disabilities, Family Dysfunction, immigration issues and gang involvement.	The program provides individual, group and family counseling. An on- site Fairfax County Alternative School. They utilize Cognitive Behavioral Therapy (CBT), Dialectical Behavioral Informed Practices, Motivational Interviewing, Expressive Therapy (Sand-Tray), Trauma Focused CBT, Family Systems Approach to interventions and counseling.		CSB-SAC I (S-20) Assigned to Foundations CSB-No clinician at BPH (S-25). Was assigned to CSB system in November 2015. Other CSB Forensic staff will be assigned to give limited substance abuse services to BPH.	We need two Substance Abuse Sr. Clinicians (S-25). Cost is approximately $67.000.00 plus benefits for each position. We need additional services for Psychological Assessments for all youth entering these programs. Cost approximately $35,000.00.

Behavioral Health Services Inventory - Behavioral Health Capacity in Fairfax County Public Schools and Fairfax County Government Across the Continuum of Supports *Mental Health and Substance Abuse Services*						
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Juvenile and Domestic Relations District Court (continued)						
Transitional Living Program (TLP)	Serves youth 17-19 6-8 months in placement. Youth are under court supervision and have a new offense or violation of probation that is adjudicated by the court and results in court ordered placement. Youth entering this program have failed to benefit from community and home-based services and are aging out of the system and may not be able to remain at home. They had 14 admissions for fy2014	Youth are Fairfax County residents who have committed a wide range of offenses or have been previously sentenced to commitment to DJJ. Residents may be addressing substance abuse or mental health issues.	The program is designed to provide independent living skills, continued education and general purpose counseling around pro-social skills utilizing CBT and MI		No CSB Services	

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Juvenile and Domestic Relations District Court (continued)						
Interdisciplinary Team (IDT)	When a child is adjudicated as a Child in Need of Supervision (Truancy or Runaway) or a Child in Need of Services the client may be referred to the Interdisciplinary Team for further assessment and recommendations for disposition. There were 36 cases referred to the IDT for calendar year 2015.	Youth referred to the IDT are residents of Fairfax County who have been adjudicated of status offenses or found to be in need of services.	Multiple disciplines provide assessments for completion of IDT report unique to client. Assessments are determined by the needs of each client and may include: Family assessment; Substance Abuse Assessment, Mental Health Assessment and YASI Pre-Screen Assessment.		CSB representative provides assessment as needed to address client's needs.	Current CSB representative

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Office of Comprehensive Services for At Risk Youth						
Prevention Services	None					
Treatment Psychiatric services	Referral Sources FY 2015: -FCFS - 58 -CSB - 18 -DFS/PPS - 2 -DFS Foster Care & Adoption - 60 -JDRDC - 13 -Falls Church City Schools - 7 Ages 8-23	Placement of youth outside of their family homes in licensed residential care programs for 24-hour supervised care to groups of youth. Residential programs provide intensive treatment services including: medication management, nursing care, occupational therapy, crisis stabilization, assessment, social skills training, group therapy, individual therapy, and family therapy.			$9,404,944 38 community providers	CPMT has set the goal of reducing use of long-term psychiatric residential treatment by 10% annually, and re-investing those resources into in-home services, care coordination and other community-based services.

Behavioral Health Services Inventory - Behavioral Health Capacity in Fairfax County Public Schools and Fairfax County Government Across the Continuum of Supports *Mental Health and Substance Abuse Services*						
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Office of Comprehensive Services for At Risk Youth (continued)						
Treatment Intensive in home	Referral Sources FY 2015: FCPS – 174 DFS: CPS – 21; PPS – 106 -Foster Care & Adoption - 77 JDRDC: - 18 CSB - 47 Falls Church City Schools - 1 Falls Church Juvenile Court - 4 Ages: 0-23	Services provided to youth and their families when the youth are living at home. Intensive services are provided typically, but not solely, in the residence of a youth who is at risk of being removed from the home or who is being transitioned home from an out-of-home placement. Services may include: crisis intervention and treatment; individual and family counseling; life, parenting, and communication skills; and 24 hour per day emergency response.	Applied Behavior Analysis (ABA)		$2,411,545 23 community providers	Placements in long-term residential and group home programs were reduced by 46%, from 157 youth in January 2009 to 70 in September 2015, largely due to the effective use of intensive in-home services and intensive care coordination. Service expansions are funded through re-investment of residential expenditures.

Behavioral Health Services Inventory - Behavioral Health Capacity in Fairfax County Public Schools and Fairfax County Government Across the Continuum of Supports *Mental Health and Substance Abuse Services*						
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Office of Comprehensive Services for At Risk Youth (continued)						
Treatment Outpatient Therapy	Referral sources: FCPS -36 DFS: CPS – 15; PPS – 31; Foster Care & Adoption - 110 JDRDC - 6 Falls Church Juvenile Court – 4 FCCPS - 1 CSB - 9 Ages: 0-23	Individual, family or group therapy	Trauma informed care		$617,592 43 Providers used in FY 2015	CSA only funds outpatient therapy when Medicaid or private insurance are not available to do so.
Care Coordination	190 children served in FY 2015 (CSB-137; UMFS-72) FCPS: -110 DFS: CPS-3; Family Preservation-13; Foster Care & Adoption-9 CSB-55 JDRDCt-16 Falls Church City Schools-1 Falls Church Juvenile Court-1	Intensive level of support for youth at high risk for residential or out-of-home placement; and youth in placement and transitioning back to their home community Services and supports, are guided by the needs of the youth secondary to the completion of a strengths and needs discovery, are developed through a wraparound planning process that results in an individualized and flexible plan of care for the youth and family.	High Fidelity Wraparound		$1,011,308 2 providers	Placements in long-term residential and group home programs were reduced by 46%, from 157 youth in January 2009 to 70 in September 2015, largely due to the effective use of intensive in-home services and intensive care coordination.

Behavioral Health Services Inventory - Behavioral Health Capacity in Fairfax County Public Schools and Fairfax County Government Across the Continuum of Supports *Mental Health and Substance Abuse Services*						
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Office for Women and Domestic and Sexual Violence Services						
Prevention Services	Youth & children who may or may not have been affected by violence	Respect Ur d8 – teen dating program; awareness of safe dating issues	Multi-session offerings for teens		0.75 SYE S-25 (partial use the Youth Education & Outreach Specialist's position)	Evaluations are completed by participants at the end of the presentation
	Adult Women – Spanish speaking	Mujeres Transformando Vidas (Women Transforming Lives)	Weekly meetings		0.25 SYE S-27 (partial use of Prevention & Education Coordinator's position)	Evaluations are completed by group members bi-annually
Intervention services	Children whose mothers are attending DV support groups in the community	Curriculum based groups explore several topics related to violence, safety, and resiliency	Multi-session groups divided by age		0.33 SYE S-25 (partial use of Children's Counselor); approximately 5 trained volunteers	Client report of effectiveness of services as measured using RBA goals
Intervention services (continued)		Parent consultations	2 parent consultation sessions address specific needs of family related to children	Education on child development and strategies for helping their children for parents whose homes have been impacted by DV	0.25 SYE S-27 (partial use of Children's Services Coordinator	Parent feedback as collected and measured using RBA goals

Behavioral Health Services Inventory - Behavioral Health Capacity in Fairfax County Public Schools and Fairfax County Government Across the Continuum of Supports *Mental Health and Substance Abuse Services*						
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Office for Women and Domestic and Sexual Violence Services (continued)						
Intervention services (continued)	Children and teens who have been victims of non-incest sexual violence	8-10 sessions with a trained counselor for issues related to victimization FY 2013 : 38 clients	Licensed counselors and social workers provide trauma-informed counseling		0.30 SYE S-27 (partial use of Sexual Assault Counselor)	Client report of effectiveness of services as measured using RBA goals

One Fairfax

SUCCESSFUL CHILDREN AND YOUTH POLICY TEAM

MEETING APRIL 6, 2016

9:30AM-NOON

Agenda

Welcome and Introductions

Process for Presentations to the SCYPT

Action Items

- Action 1: SCYPT Endorsement of Fairfax-Falls Church Children's Behavioral Health System of Care Blueprint for 2016-2019

Member Updates on Actions and Assignments

Recap of New Action Steps or Assignments

Items and Announcements from SCYPT members

Ground Rules

- Everyone's input is important
- Start on time/end on time
- Listen with an open mind, and for commonalities
- Keep your commitments/ follow up and follow through
- Balance the need for thorough input with the need to move forward
- Don't just disagree, offer a doable alternative idea
- Speak to the point on the floor
- Define terms and acronyms
- Think broadly
- Support your position with data

Welcome and Introductions

Role of SCYPT members:

Provide strategic direction to the child and youth serving (and supporting systems);

Serve as visible champions on children and youth issues within the community and within one's sector and organization;

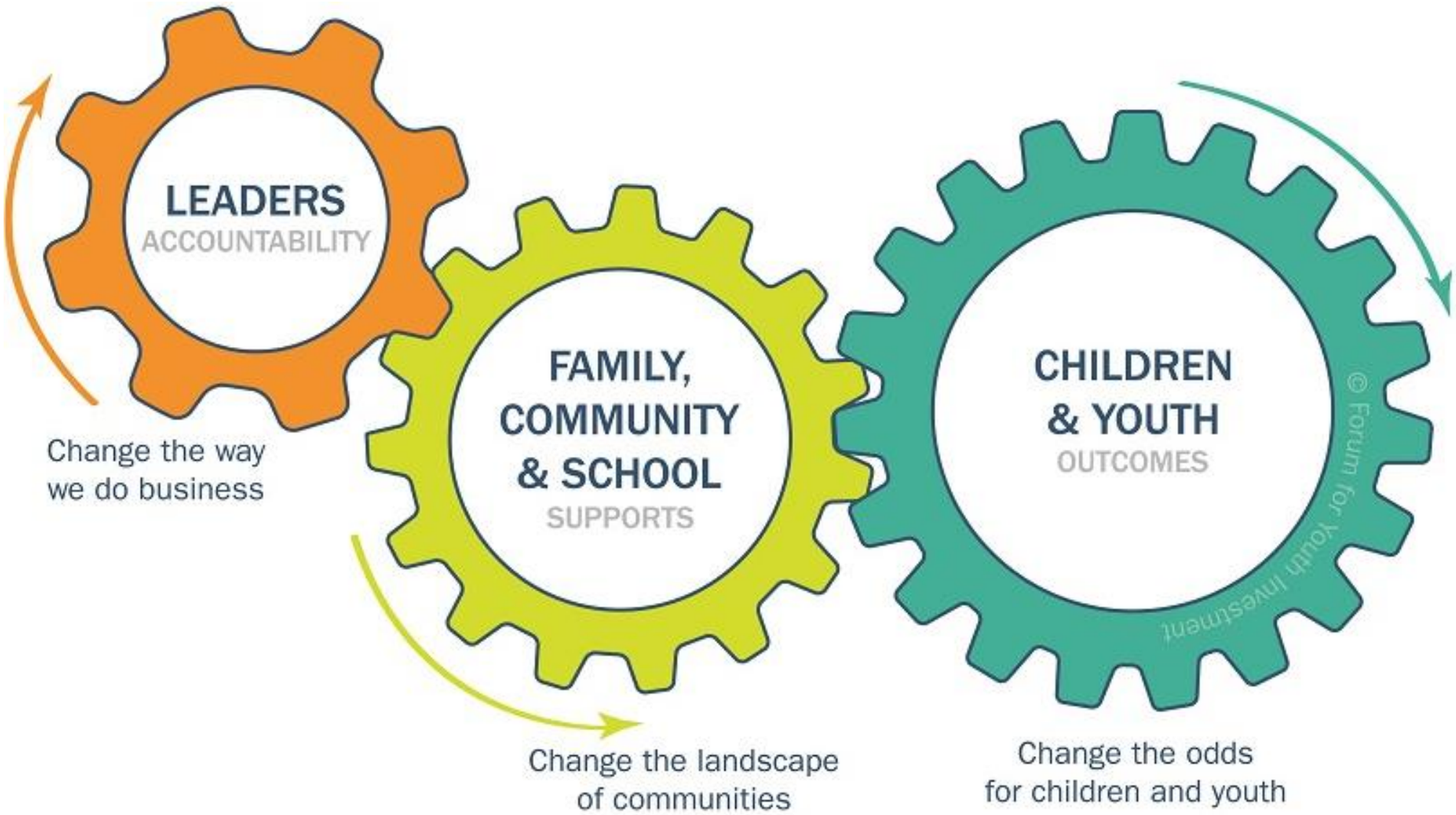
Model desired changes/policy directions within one's organization/sphere of influence;

Direct resources (funding, people, advocacy, attention, etc.) to address identified issues;

Provide perspectives from one's sector and serve as voices of the sector, able to discuss current trends and efforts; and

Review and provide data to aid in decision-making.

The Ready by 21 Theory of Change

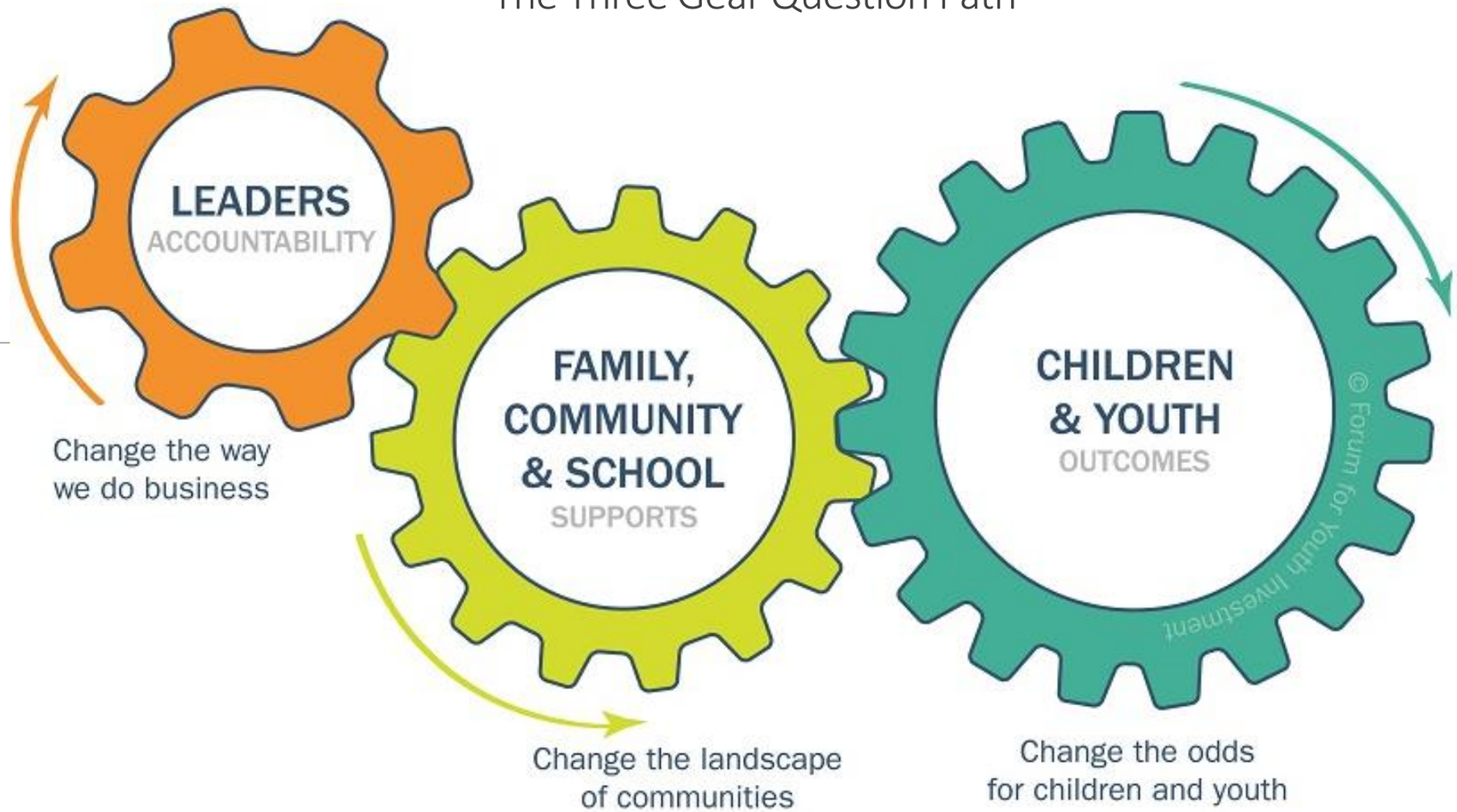


Ready by 21 focuses on the small gear

challenging leaders to think differently & act differently…

Moving the small gear makes a BIG difference

The Three Gear Question Path



Who have we engaged? (coalitions? providers? youth? the broader community?)
Where are our efforts focused? (specific geographies, age groups, issues?)
How well are we managing the community change process?
Taking actions that:

- Align with our goals?
- Implement a powerful set of strategies?
- Address priority populations & communities?

Who supports our youth? (schools? CBOs? Families? faith community? Employers?)

Where are the supports located?

How well are these supports being provided?

- How accessible?
- How coordinated?
- How well-used?
- What is the quality of these supports?

Who are the youth in our community? (what descriptors? age? family status? special needs?)

Where do these young people and their families live, learn, work?

How well are the youth in our community doing:

- Academically & Vocationally?
- Emotionally & Physically?
- Socially & Civically?

Format for Presentations to the SCYPT:

Overview

The Issue: Why is this an issue? What are we trying to do? Is there a mandate? Who asked us to address it?

Target Population: What do we know about them?

Outcomes and Indicators: what does the child and youth data tell us? How does it impact the SCYPT outcomes and indicators?

Services Landscape: who provides the services on this issue/population? How well are the services being provided? Are there opportunities for improvement and closing gaps?

Connections: how does this issue connect to other major initiatives? Have we engaged them?

Strategic planning: what are the intended outcomes of the plan? What are the strategies? What is the timeline?

Policy and Resource Needs: What policy changes are needed? What resources are needed? Specifically from the SCYPT?

Next Steps: If endorsed by SCYPT, what other next steps are needed?

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

PRESENTATION TO THE SCYPT
APRIL 6, 2016

RICK LEICHTWEIS, PH.D., SENIOR DIRECTOR, INOVA KELLAR CENTER
MARY ANN PANARELLI, FCPS DIRECTOR OF INTERVENTION AND PREVENTION SERVICES
BETTY PETERSILIA, LCSW, FAIRFAX COUNTY BEHAVIORAL HEALTH SYSTEM OF CARE MANAGER
JAMES GILLESPIE, LCSW, MPA, FAIRFAX COUNTY SYSTEMS OF CARE DIRECTOR
JESSE ELLIS, NEIGHBORHOOD AND COMMUNITY SERVICES PREVENTION MANAGER

Children's Behavioral Health System of Care Blueprint

The Blueprint

- Continuum from prevention to intensive intervention
- Identifies goals, strategies, actions steps and metrics
- Four year plan: 2016-2019

Overview

The Children's Behavioral Health System of Care Blueprint is for calendar years 2016 through 2019, and fiscal years 2017, 2018, and 2019. Goals and strategies will be implemented by Fairfax County human services departments and Fairfax County Public Schools, with the support and leadership of family and consumer organizations, other non-profit agencies, and service providers in the community.

SCYPT Shared Community Outcome

Children and youth are socially, emotionally, and behaviorally healthy and resilient.

Prevalence of Behavioral Health Issues

1 in 5 children (20%)

46.3% lifetime prevalence (13-18 year olds)

Only **half** receive treatment

Rates of treatment vary with disorder

National Alliance on Mental Illness

Fairfax County

Children & Youth

186,000

Enrollment FCPS

Following National Statistics

- **36,000** with diagnosable condition
- **3,960** with significant impairment
- **1,800** with extreme functional impairment

Youth Survey

Report Issues with:

- Depression
- Suicide
- Substance Abuse

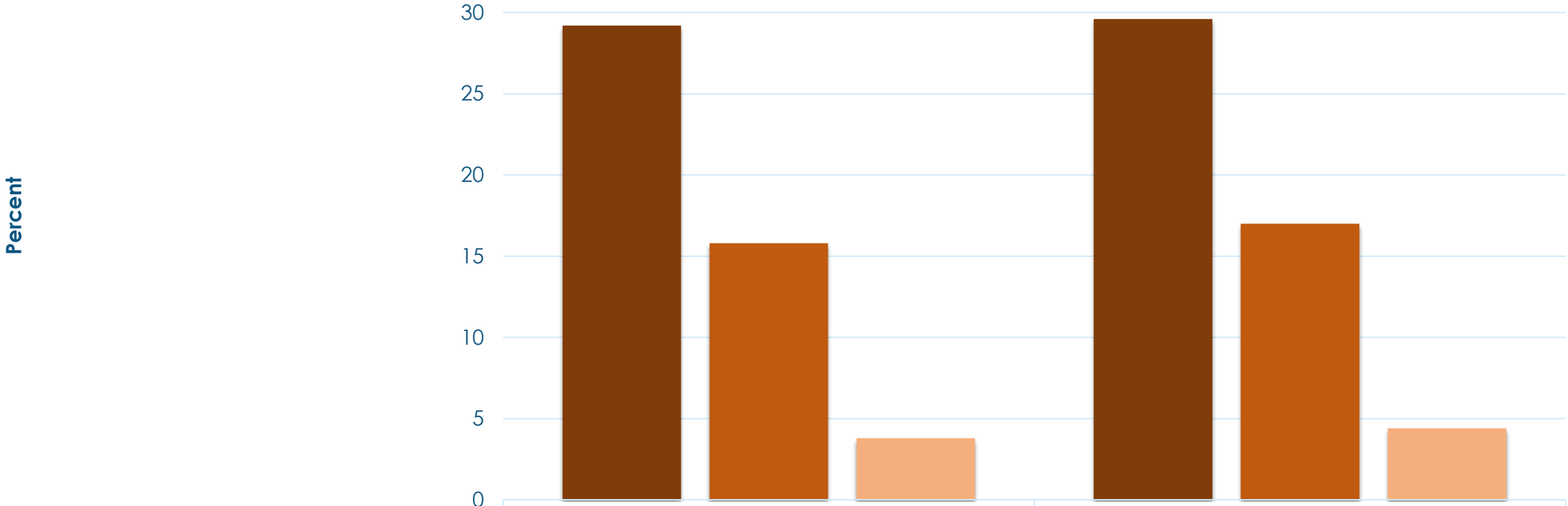
Access Issues

- Shortage of Pediatric Psychiatrists
- Insurance and Payor Issues
- Language and Culture

Youth Survey Data

Select Behavioral Health (depressive symptoms, suicidal ideation, attempted suicide)

Percentage of students reporting depressive symptoms/suicidal ideation/suicidal behavior within the last year, 2011 and 2013

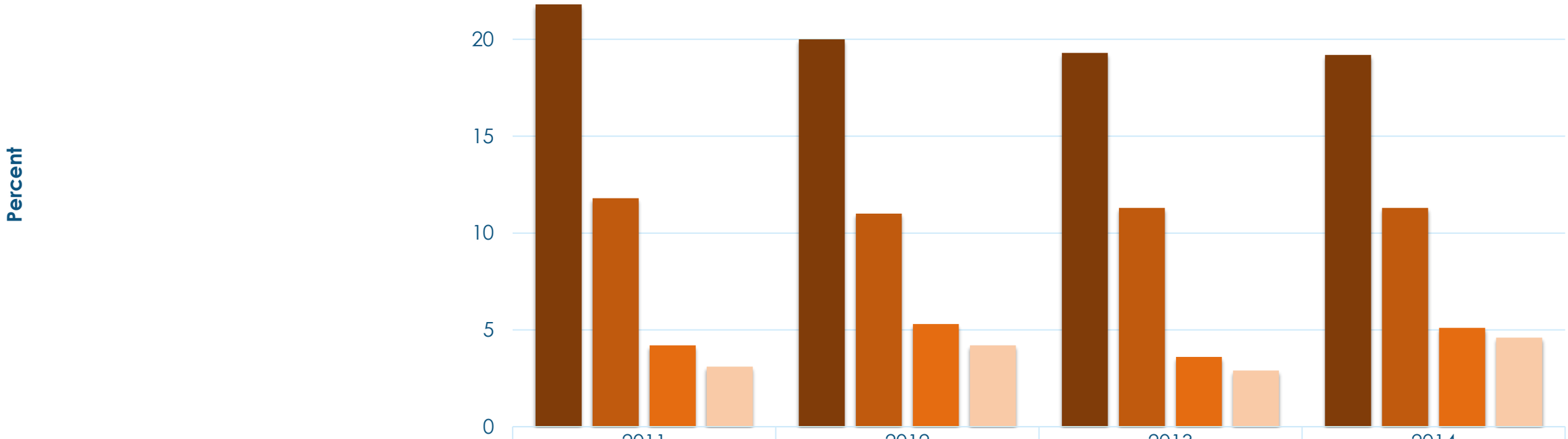


	2011	2013
Reported feeling sad or hopeless	29.2	29.6
Considered attempting suicide in the last year	15.8	17
Attempted suicide in the last year	3.8	4.4

Youth Survey Data

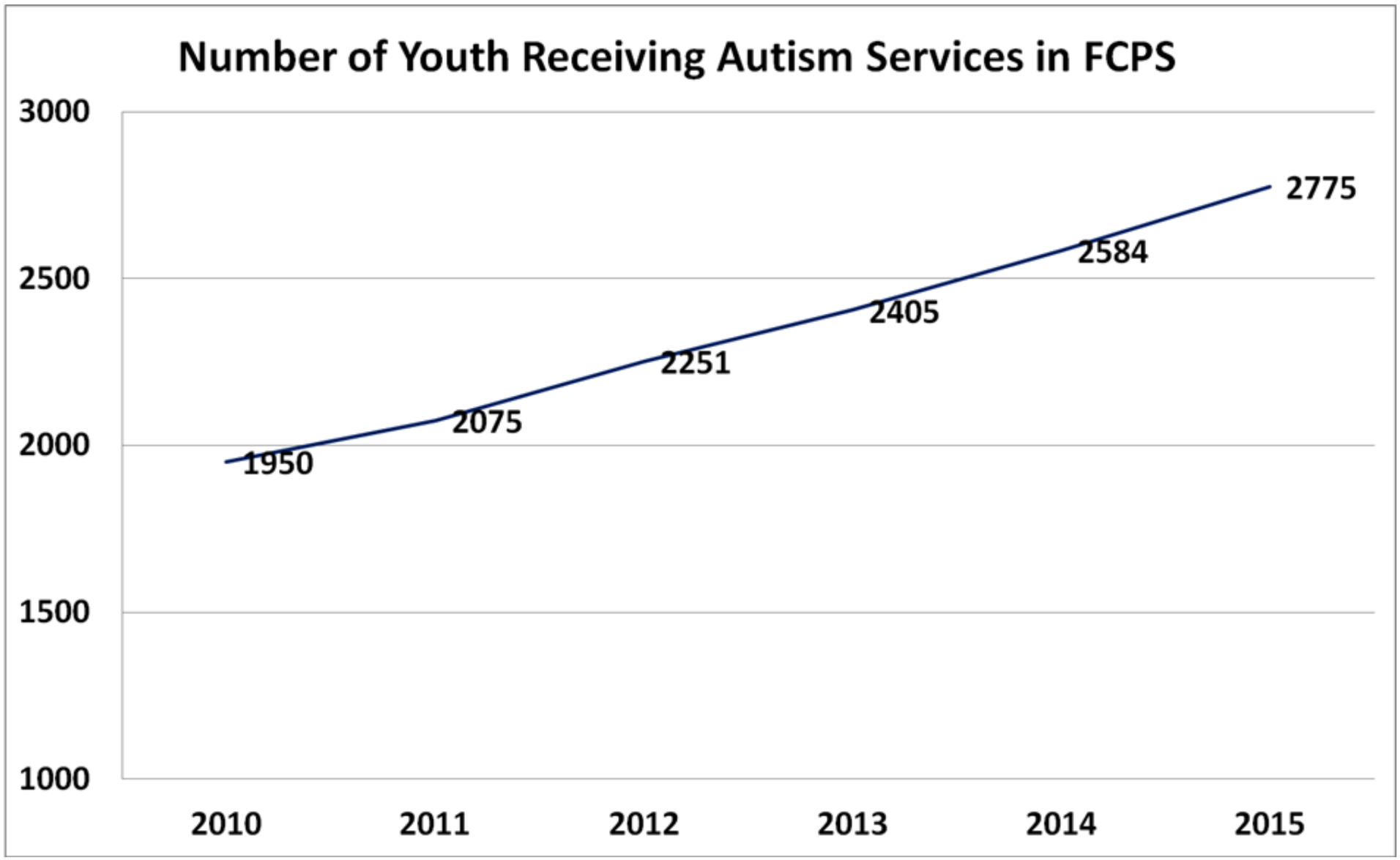
Select Substance Use (alcohol, marijuana, painkillers, other prescription drugs)

Percentage of students reporting substance use within the past 30 days, 2011-2014



	2011	2012	2013	2014
Alcohol	21.8	20	19.3	19.2
Marijuana	11.8	11	11.3	11.3
Painkillers without a doctor's order	4.2	5.3	3.6	5.1
Prescription drugs other than painkillers without a doctor's order	3.1	4.2	2.9	4.6

Indicator: Rise in Autism Spectrum Disorder



The Services Landscape

- Over 1,500 private therapists
- Eight nonprofit organizations and one public agency (CSB) that provide outpatient treatment on a sliding fee scale
- Twenty-two intensive in-home services providers
- Twenty Applied behavioral analysis providers
- Two private and one public intensive outpatient or day treatment providers
- Five private and one public substance abuse services provider
- Two crisis stabilization programs
- Seven hospitals
- 18 group homes and 12 residential treatment centers within 100 miles

Primary Public Services

FCPS

- Short term cognitive behavior therapy
- School functioning
- Behavior Assessments & Intervention Plans
- Psychiatric homebound case management
- Transition back to school

CSB

- Outpatient therapy for children, youth & families
- Medication management
- Behavioral health assessment, evaluation and counseling for court involved youth
- Emergency Services and Crisis Intervention
- Intensive Services

Meeting the Challenge

A Response that is:

- Intentional
- Strategic
- Coordinated

Coordinating the Initiative:

The Community Policy and Management Team

Membership:

- Directors of Juvenile and Domestic Relations District Court, Community Services Board, Family Services, Neighborhood and Community Services, Health Department, Administration for Human Services
- Deputy County Executive for Human Services (Chair)
- FCPS Special Services, Special Education Procedural Support, Intervention and Prevention Services
- City of Falls Church Public Schools and Human Services
- City of Fairfax
- Four parent representatives
- Two provider representatives

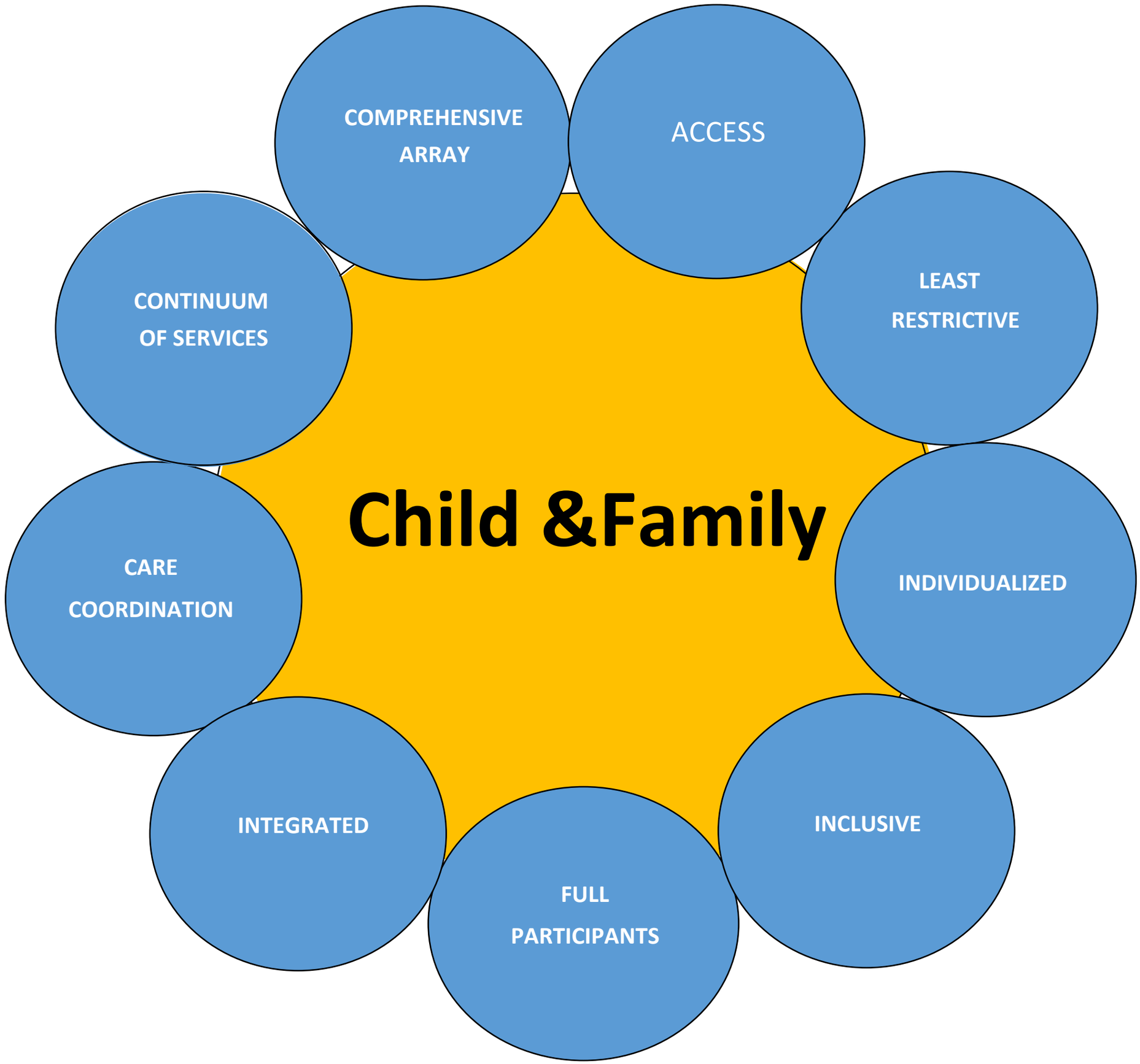
Connections:

Data to inform the Blueprint came primarily from private and community stakeholders with expertise in children's behavioral health; and recent local studies and reports related to children's behavioral health, including:

- Youth Behavioral Health Interagency Human Services and Public Schools Work Group Reports: September 2013 and May 2014
- FCPS Strategic Plan
- CSB Strategic Plan
- CDC Investigation of Undetermined Risk Factors for Suicide Among Youth Ages 10-24
- Northern Virginia Suicide Prevention Plan: November 2014
- Disproportionate Minority Contact for African American and Hispanic Youth: 2012
- Equitable Growth Profile of Fairfax County: 2015
- Community Health Improvement Plan: 2013

Service Quality

- Accessibility: Multiple barriers potentially prevent families from accessing timely and appropriate behavioral health services, including lack of Medicaid providers, an increasing number of private therapists who do not accept insurance, more high deductible/high co-pay plans, and lack of child psychiatrists.
- Quality: With few exceptions, consumers cannot access data on the quality or effectiveness of behavioral health providers.
- Coordination: Services for children and youth with the most complex issues are generally well coordinated, but less so for those with serious but less complex issues. There is little coordination between primary and behavioral health care.
- Effectiveness: Although little data is available, it appears that most providers do not use evidence-based treatments.


COMPREHENSIVE ARRAY
ACCESS
CONTINUUM OF SERVICES
LEAST RESTRICTIVE
Child &Family
CARE COORDINATION
INDIVIDUALIZED
INTEGRATED
FULL PARTICIPANTS
INCLUSIVE

Blueprint Strategies: Access to Services

- Implement targeted strategies to address disparities in outcomes and access
- Increase access & availability to behavioral health services for underserved populations
- Identify the main access barriers & address them
- Develop outreach campaign to promote early identification and awareness of youth with DD/Autism

Blueprint Strategies: Individualized and Inclusive Services

- Increase services offered in languages other than English
- Develop policy & procedures to require trainings for staff & County contracted providers in cultural competency
- Train County, school and contracted behavioral health providers in evidence-based practices.

Blueprint Strategies: Full Family Participation

- Involve family and youth in the development of new services and supports, and the evaluation of services
- Conduct gatekeeper trainings to increase the layperson's understanding of trauma and mental illness, signs and symptoms and how to offer support in accessing help
- Promote youth-led initiatives to combat stigma
- Create a Family Navigator program
- Promote mental health discussion within local ethnic communities

Blueprint Strategies: Integrated Care and Coordination

- Create a clearinghouse for information on children's behavioral health issues & resources, accessible on line & in person
- Provide behavioral health consultation to primary care providers
- Promote integration of behavioral health and primary health care settings

Blueprint Strategies: Continuum of Services from Birth to Adulthood

- Conduct a needs assessment, service inventory and gap assessment for youth with Developmental Disabilities and/or Autism
- Develop a plan to address the critical service gaps
- Improve transition planning for children with intellectual disabilities
- Create capacity to address behavioral health needs of children 0-7
- Ensure access to crisis stabilization, case management, care coordination services for youth with DD/Autism

Blueprint Strategies: Comprehensive Array of Services

- Develop guidelines for service providers on availability & the effective use of crisis services
- Increase clinical capacity to meet the needs for trauma specific, evidence-based interventions
- Implement evidence-based parenting programs for parents of adolescents and children under 12
- Increase staffing for intensive care coordination & case management

Policy Priorities for FY17

- Adopt Culturally & Linguistically Appropriate Services (CLAS) Standards among behavioral health providers
- Require cultural competency training for County, FCPS and County-contracted providers
- Identify and require relevant trainings for the unique needs of LGBTQ youth with behavioral health needs
- Increase the presence & effectiveness of family leadership through partnering with family organizations

Service/Funding Priorities for FY17

- Crisis Textline: $96,000
- Family Navigator Services: $409,000
- Expansion of Short-term Outpatient Treatment Services: $555,000
- Child Psychiatry: $175,000 - $245,000

Administrative Priorities for FY17

- Explore ways to maximize Medicaid funding
- Explore ways to share student data and service information
- Develop an accurate, accessible real-time database of behavioral health care providers

Next Steps and Recommendations

- That the SCYPT endorse the Children's Behavioral Health System of Care Blueprint
- That the Community Policy and Management Team develop and implement an FY 2017 Action Plan based on the Blueprint
- That the Blueprint be reviewed and revised at least annually by the CPMT and the SCYPT.
- That the CPMT return to the SCYPT in the Fall with FY 2018 service/funding priorities.

Contact Information

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Member Updates on Actions and Assignments :

1. Develop key points for working with the County Council of PTAs on identifying a parent member of the SCYPT (Jesse Ellis, George Becerra, Megan McLaughlin)
2. Finalize the charter document and discuss outreach for new members with the Executive Committee (Jesse Ellis)
3. Set up a process for selecting the next community member co-chair (Jesse Ellis and Jack Dobbyn)
4. Convene a working group on Disconnected Youth (Jesse Ellis)
5. Develop a “dashboard” of key metrics regarding school readiness/early care and education initiatives, to be shared with the SCYPT in June (Anne-Marie Twohie)
6. Share information on the laptop donation drive (Megan McLaughlin)
7. The internet access working group will return in June with specific options for SCYPT to discuss (County and FCPS team)

Recap new Action Steps and Assignments:

Items and Announcements from SCYPT members