YOUTH BEHAVIORAL HEALTH SERVICES

September 2013

Interim status report and recommendations

Interagency Youth Behavioral Health Services Workgroup

YOUTH BEHAVIORAL HEALTH SERVICES

INTERIM STATUS REPORT AND RECOMMENDATIONS

CHARGE TO INTERAGENCY BEHAVIORAL HEALTH YOUTH SERVICES WORKGROUP

- Increase the communication and effectiveness of interaction between youth and family serving agencies and services providers;
- Identify gaps in services in behavioral health system (substance abuse and mental health) for youth;
- Recommend possible solutions to address existing gaps in services;
- Prioritize service needs; and
- Improve the mental health delivery system for youth and families identified but not in intensive case management services already provided via the CSA – Systems of Care.

Short-term - Immediate Work

1. Identify existing needs

2. Outline resources and service capacity available to respond to needs, including those available through county agencies, the school system and providers in the community

3. Identify gaps and strategies to address gaps

4. Prioritize services and associated required resource allocation recommendations to address gaps

5. Develop recommendations for implementation of an Interagency Youth Services Management and Coordinating Team to manage resource requirements and outcomes

Long-term Work

1. Recommend options for a service delivery model using available resources to meet the needs of youth and families
2. Develop service protocols to ensure successful implementation of system-wide goals, outcomes and accountability measures for the following components:

On April 23, 2013, the Fairfax County Board of Supervisors provided guidance directing this study:

"Staff is directed to identify requirements to address youth behavioral human services requirements in schools and the broader community.

Work with the Fairfax County Public Schools (FCPS) and the nonprofit community (including the Partnership for Youth) to identify the array of youth services that are necessary to address the most pressing needs within the community.

The discussion will 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.

A comprehensive recommendation will be provided to the Human Services Committee of the Board of Supervisors (to which the School Board will be invited) in fall 2013.

Funding of $200,000 will be held in reserve until the Board approves the recommendations for its use."

a. Intake, assessment, triage, referral, transition across levels of care (handoff to CSA), lead case management assignment

b. Review, develop, and implement a uniform set of requirements in cross system treatment planning tool.

c. Review, develop, and determine how to track system performance measures and outcomes

Establish formal agreements that clearly identify roles, responsibilities and service flow between participating county agencies, the school system and partnering entities.

This report provides information and recommendations on work identified as "short term" for purposes of initial implementation on actions to coordinate joint human services and public schools activities that may be addressed within existing resources and can be implemented during FY 14 or requested for resources in FY 15 budget process.

SERVICES AVAILABLE – INVENTORY

County and Schools staff from youth and child serving programs met from May 9th through July 25, 2013 to review existing services and behavioral health needs of youth and families in their respective programs. The following organizations participated in gathering information regarding internal services provided directly or contracted in support of behavioral health services to youth:

- Fairfax County Public Schools
- Fairfax Juvenile and Domestic Relations District Court
- Department of Family Services
- Fairfax County Health Department
- Department of Neighborhood and Community Services
- Office for Women & Domestic and Sexual Violence Services
- Fairfax-Falls Church Community Services Board

Interagency/disciplinary services

- Comprehensive Services for At Risk Youth (CSA)

Community Based Coalition

- Fairfax Partnership for Youth

Each organization assessed their programs and provided information regarding:

Services Inventory – Youth and Families

- **Description of the population, eligibility and priorities**
- **Programs and services offered**
- **Experience of someone coming into the service system**
- **Description of services and levels of intensity within the service continuum**
- **Partners for each service area**
- **Exit/discharge from services and transitions**
- **Gaps in the present system/who is least likely to get service (now and in future based on current climate and direction**
- **What works well / what are key outcomes?**
- **Recommendations for changes**
- **Current trends in the field locally and nationally**

RESOURCES AVAILABLE – YOUTH SERVICES INVENTORY SUMMARY

This chart provides a brief summary of program descriptions provided by county and schools staff in presentations provided to the Work Group in April-July 2013. Copies of detailed submissions are available at http://fairfaxnet.fairfaxcounty.gov/Dept/DAHS/Pages/default.aspx.

Program Description of County funded/supported 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*						
Services	**Population Served**	**Description of Service (describe catchment/population)**	**Tools/Evidence-Based Practice & Method of Treatment**	**Information (referrals, web sites, etc.)**	**Resources - Staffing/Budget**	**Assessment of service (need more, need to evaluate/redesign/ measures of effectiveness available**
Fairfax Falls Church Community Services Board						
Prevention (and intervention) Services		Youth with early signs behavioral health concerns. Goal to prevent many of the long-term effects on a person's physical and mental health, social relationships, educational progress, financial stability, and employment.	Screening, brief counseling or education, skill building programs, and/or programming for people experiencing early signs of problems.		FY2014 Adopted: $1,964,724 16.0 SYE (10 vacant as of Sept. 2013)	Cost-benefit ratios for early treatment and prevention for addictions and mental illness programs range from 1:2 to 1:10. $1 in investment yields $2 to $10 savings in health costs, criminal and juvenile justice costs, educational costs, lost productivity, and other costs.

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Assessment and evaluation services	**Juvenile Forensics** Youth ages 12-17 Incarcerated/in detention or in community and referred by JDRC for treatment planning. Emergency Evals:13 Full psychological assessments: 25. Special Requests by Judges: 25 Interagency Screening (state mandated) 77 ADS full evaluation: 19 Court written consultations: 21 Diversion Screening:80 Trauma Evaluations:8	**Assessment/evaluation** -Mental Health assessments and screenings -Competency evaluations; -Sanity at the time of offense -Full psychological evaluations. **Treatment** Co-occurring treatment services to youth sentenced to the JDC BETA program Crisis intervention services to youth sentenced to Juvenile Detention general population	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		13 SYE (6 vacancies as of Sept. 2013)	Treatment services greatly reduced in BETA and JDC. Cost shifting to the JDRC for psychological evaluations.

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Assessment and evaluation services *continued*	**Substance Abuse Services** Seriously Emotionally Disturbed (SED) or at risk of SED Children; youth; families: 0-21 years of age. Predominantly uninsured or Medicaid.	Youth and families served FY 2012:678 Individual, group, and family therapy. Infant and Early Childhood Program (IEC); Case Management for service/resource coordination, CSA, and medication management. Day treatment (2 programs: Northwest TAP (15 slots); Falls Church Horizons(10 slots). School based services provided to Cedar Lane and Quander Road (10 hours per week each); several pre-schools; South County Headstart.	-CSB Credible assessment -Conners; -Beck - Depression Inventory -Sass; -Treatment: trauma-focused CBT -MRT and -trauma-informed care -play-therapy; - Motivational Interviewing -Stages of Change; -Various family therapy models (systems; structural; strategic); -Solution-focused therapy; -psychiatric medication -Cams Suicide intervention		78.0 SYE (includes Managers, therapists, and Psychiatric time)	Service utilization based on consumer-focused treatment plan goals and objectives for treatment and case management

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	Virginia Independent Clinical Assessment Program (VICAP)	Youth served FY 2013:				
Treatment services	**Crossroads Youth Residential** 14-17 adolescent males. Youth served in FY 2013: 30 (holding census to 10 in 2013/2014)	Adolescent males with high substance abuse involvement; co-occurring disorders and higher sociopathic traits	Therapeutic recreation; art therapy; Moral Recognition Therapy (MRT); N/A, A/A; CBT; DBT; Collaborative Assessment and Management of Suicidality (CAMS); Motivational Interviewing; Stages of Change; DDCAT: CARF accreditation; Case Management and linkages to the community	http://www.fairfaxcounty.gov/csb/services/ Referrals to outpatient and day treatment ADS programs; other county public child serving agencies; FCPS	21 SYE including manager and supervisors, plus 6 relief counselors (7 vacancies as of Sept. 2013)	
	Sojourn House Residential Adolescent Females 13-17	Medicaid Level B therapeutic group home. three to nine months Profiles: Co-occurring, depression and mood	-TF-CBT -Adolescent DBT - Medication management	Multiple county child serving agencies, FCPS;	9 SYE's including supervisors, plus 6 relief counselors	While program has met its fiscal expectations vacancies were at the 63% level for

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	Youth Served FY 2013: 20	instability disorders, PTST/Multi-trauma exposure. Provision of case management, therapeutic services and community "wraparound" referrals and supports as part of treatment plan.	-Stages of Change - Motivational Interviewing - Collaborative Assessment and Management of - Suicidality (CAMS) training -DDMHT assessment for co-occurring disorder.	community providers and families.	(3 vacancies as of Sept. 2013)	the last fiscal year. Expectation is for 85%. CARF accreditation
	Leland House Residential Male/Female adolescents 12-17 in psychiatric crisis	Length of stay: Up to 45 days Youth served FY 2013: Profiles: app. 65 per year	-Circle of Courage concepts with individual, family and group modalities. -CBT and Behavior interventions including process orientation	www.umfs.org	UMFS Contractor	
Psychiatric, nursing/pharmacy services		Length of service: as needed while in services				
After Care and Transition Supports Resource Team	Resource Team CSA referred youth needing behavioral	Provides mandated discharge planning from hospitals;	Case management services and care coordination; high	http://fairfaxnet.fairfaxcounty.gov/Dept/C	7.5 SYEs	Cannot meet demands of CPMT/CSA expectations due to

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	health consultation and lead case management. 460 new Family Partnership Meeting (DFS) referrals annually. FY 2013: 480 family cases (6 SYEs)	Manages state/regional hospitalization bed funds (LIPOS program); Completes transition plans for youth released from juvenile corrections (State Dept. Juvenile Justice). Monitors youth court ordered into mandatory outpatient treatment Participates in assigned Family Partnership Meetings. Participates in ongoing FRM/TBP CSA care coordination meetings. Provides lead CSA case management and system support to short term residential contract services (Leland House).	fidelity wraparound principles.	SB/Pages/default.aspx	(3.5 vacancies as of September 2013)	vacancy factor and competing mandated demands

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Fairfax County Public Schools						
Prevention (and intervention) Services	187,000 enrolled students (embedded at every level, every school across FCPS) Over 50,000 individual and group counseling sessions provided (2012-13) Over 400 appointments and multiple phone consultations June – August 2013	Classroom instruction on mental wellness - i.e. positive peer relationships, bullying, goal setting, managing stress, pro-social skills Group and individual counseling 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 • Social Skills Curriculum • Unstuck & On Target • Touch Base • Girl Power • Coping Cat	Wellness Week/Depression Awareness Bullying Awareness Resiliency Project Website Annandale Resourcing Project	98 school psychologists 95 school social workers	Reduced discipline referrals Youth survey data Reduction in residential placements Improved attendance Increased student engagement

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			PREPaRE trained – national crisis response curriculum			
	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
Assessment and evaluation	187,000 school-aged students • 423 Threat Assessments • 1,500 Suicide Assessments Initial evaluations: 4,937 Re-evaluations: 7,902	Progress Monitoring/Consultation Assessment services available to all students: • Threat Assessment • Behavioral Assessment • Suicide Risk Assessment • Mental Health Assessment Depression Screenings – all 28 high schools and some middle schools Evaluation services available for special	Assessment: evidence informed standard protocols Evaluation: Standardized, normed protocols	Referral sources: Student Teacher/staff Parent Blackboard site with a tool for school self-assessment on depression & suicide		

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		education consideration and in support of discipline/hearings office cases; Evaluations for students in residential facilities throughout US				
	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 – 8 psychologists; 8 school social workers		
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	As above		33 school social workers 42 school psychologists	Reduction in residential placement Reduction in suspensions and expulsions

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		personnel, treatment facilities, and families				Maintenance in least restrictive environment
Case Management/ Care Coordination	Students accessing CSA services Lead case managed 151 cases in 2012-2013	Collaborate with county agency personnel to secure necessary services for students and families Coordinate all services for families that are available through FCPS Coordinate services available from sources external to FCPS	CANS 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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Department of Family Services						
Prevention/Early Intervention Healthy Families Nurturing/parent education programs Community school linked services OFC – Head Start	HFF – 558 families, 457 children served in FY13 PEP – 479 families, 567 children served in FY13 CSLS – 19 families, 63 children served during the pilot (11/11-4/13)	Preventative services are provided to families with risk factors and/or with early signs of child abuse / neglect issues. Services include home visiting for new parents (HFF), parenting education groups for parents and children (PEP), and care coordination for families with students with attendance issues in certain schools (CSLS).	-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, Strengthening Families Curriculum (adolescent focus) CSLS Assessment	Healthy Families America website	HFF 29.5.SYE nonprofit staff; 6 SYE county staff PEP – 12.75 SYE CSLS – 6.5 SYE	County funding for prevention services has been repeatedly cut/ under-resourced. Higher demand than capacity to meet need. Evidence-based and have outcomes that demonstrate their efficacy include. measures: Improvement in parenting attitudes (PEP), Improvement in parent-child interaction (HFF), Lack of CPS referrals (HFF), improved school attendance.
Treatment/Care Coordination Foster care & Adoption	FC&A – 401 children served in FY13	Intervention with families who have either experienced or are at risk of child abuse / neglect.	SDM Safety Assessment, SDM Risk Assessment,		FC&A – 82 SYE CPS – 52.5 SYE	The CYF Division of DFS is in the implementation phase of an

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CPS Protection & Preservation Services Family Partnership Program	CPS – 2,350 reports of child abuse / neglect in FY13 PPS – 825 families, 1,732 children served in FY13 FPP – 725 meetings held in FY13	Services include case management & care coordination. ***Mental health and substance abuse treatment services are funded through Comprehensive Services Act (below).***	SDM Strengths & Needs Assessment		PPS – 51 SYE FPP – 8 SYE	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
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		0.5 SYE S-25 (partial use of program's Educator)	Pre- and post-test of participants
Intervention services	Children whose mothers are attending DV	Curriculum based "Children Matter!" groups that explore several topics	Multi-session groups divided by age		0.33 SYE S-27 (partial use of Children's	Pre- and post-test; RBA measures have been established for

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	support groups in the community and at Artemis House (DV crisis shelter)	related to violence, safety, and resiliency			Services Coordinator); approximately 5 trained volunteers	this program, as well
	Parent consultations New program so there is no data for FY13	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
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	
Juvenile and Domestic Relations District Court						
Probation Supervision	A youth must have been under the age of 18 years when charged but may continue receiving	Probation Officers supervise approximately 600 juveniles on a daily basis, placed on probation by the Juvenile Court for	Available continuum of services within the CSU that allows staff to place youth in most appropriate	In a point-in-time survey of 33 JDRDC CSU juvenile probation	***CSB Juvenile Forensic Unit; 2 FT psychologists (S28)*** ***2 PT psychologists (S28)***	Additional need for the following services: -Group counseling

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	services until age 21 years. If the behavior of a youth comes under the statutory authority of the JDRDC, the CSU must provide probation supervision and case management services.	offenses ranging from truancy, runaways, to misdemeanor offenses of larceny, vandalism, to felonies of Burglary, Grand Larceny, to serious violent felonies such as Malicious Wounding, Gang Participation, Sexual Assaults, and Robbery. JDRDC has jurisdiction over offenses that occur in the 19th District; Fairfax County, Fairfax City, Towns of Herndon and Vienna, regardless of where the youth resides.	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,	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	***-1 limited term*** ***1 FT Substance Abuse Counselor III*** ***2 FT Substance Abuse Counselors II Intake*** Contracts with Multicultural Clinical Center to provide psychological evaluations, and sex offender assessment and treatment with an annual budget of $163,000.	-Sexual victimization -Outpatient substance abuse treatment -Drug/alcohol education -Anger management -Individual counseling -Inpatient substance abuse treatment -Mental health evaluation -Mental health counseling Need an additional supervisory level staff person (s-30) to manage the staff

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			cognitive behavioral interventions	intake and services.		and array of services being provided by the Forensics unit.
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	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.	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		1 FT psychologist (S28) 1 FT Senior Clinician (ADS–S25)(currently vacant and on hold by CSB)	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 as is currently the case.

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	serious offense or are repeat offenders that require immediate removal from the community.	Residents may also have a history of abuse and neglect and/or gang involvement	tool to measure criminal thinking and motivation and the Family Assessment Measure III			
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	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	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,		1 FT psychologist (S28)(currently vacant and on hold by CSB) 1 FT Mental Health Therapist (S23) 1 FT Senior Clinician (S25) -grant funded (currently vacant)	

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	health, substance abuse and educational challenges. The Detention Center had 558 admissions last fiscal year. SCII had 212 admissions last fiscal year.	assaults, robbery and murder. The JDC/ SCII staff handles the day to care of the residents. The CSB mental health clinicians review all intakes and screen youth for mental health 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	Motivational Interviewing, Individual, Group and Family Psychotherapy, Expressive Therapy (Sand-Tray). 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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		when clients are released from detention or SCII.				
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		Programs with Fee for Services: CSB - Diversion 101 for substance abuse ASAP - SAFE (substance/alcohol focused education) NASP - YES (shoplifting program)	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.

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, etc.)**	**Resources - Staffing/Budget**	**Assessment of service (need more, need to evaluate/redesign/ measures of effectiveness available**
			communicating with youth and parents, and the Youth Assessment Screening Instrument when planning for diversion case management.		Calvary Counseling Center - TIP (shoplifting program) 2.5 FTE Family Counselors	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.
Boys Probation House / Foundations Program **(Girls)**	Serves youth 13 to 18 years of age. Nine to twelve month placement. Youth are under court probation supervision and have	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	The program provides individual, group and family counseling. An on- site Fairfax County Alternative School. They utilize Cognitive Behavioral Therapy		CSB previously provided Substance Abuse Assessments and Psycho-educational group as well as some limited	We need two Substance Abuse Sr. Clinicians (S-25). Cost is approximately $67.000.00 plus benefits for each position.

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, etc.)**	**Resources - Staffing/Budget**	**Assessment of service (need more, need to evaluate/redesign/ measures of effectiveness available**
	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	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.	(CBT), Dialectical Behavioral Informed Practices, Motivational Interviewing, Expressive Therapy (Sand-Tray), Trauma Focused CBT, Family Systems Approach to interventions and counseling.		individual counseling. These services were eliminated with budget cuts.	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*						
Services	**Population Served**	**Description of Service (describe catchment/population)**	**Tools/Evidence-Based Practice & Method of Treatment**	**Information (referrals, web sites, etc.)**	**Resources - Staffing/Budget**	**Assessment of service (need more, need to evaluate/redesign/ measures of effectiveness available**
	last fiscal year. Foundations had 22 admissions last fiscal year.					
Health Department						
Patient Care Services (PCS), Women, Infant & Children (WIC), and Community Health Care Network (CHCN)	Students in FCPS, 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.	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	Edinburgh Postnatal Depression Scale (EPDS) Behavioral Health Risks Screening Tool Abuse Assessment Screen (A.A.S.)	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	CHCN: 3 full time mental health therapists on contract with Molina Healthcare. 1 physician from CSB who visits each CHCN site once a month.	A need for more postpartum support groups in languages other than English. Better accessibility to behavioral health resources.

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, etc.)**	**Resources - Staffing/Budget**	**Assessment of service (need more, need to evaluate/redesign/ measures of effectiveness available**
		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.		Services, Northern Virginia Family Services		

Existing Resources and Service Capacity for Youth Behavioral Health Services

Public Schools

- Wellness/prevention services
- Suicide and Risk Assessment
- Mental health services and treatment
  - Group and individual counseling –general population and target populations (alternative schools)
  - Crisis intervention and stabilization in school settings
  - Parent clinic and consultation
  - Referrals for community/public behavioral health treatment
  - Case management services for CSA enrolled youth
  - Psychological Evaluations

Community Services Board

- Wellness/prevention services
- Medicaid managed care eligibility determination (VICAP)
- Mental health and substance services and treatment
- Psychiatric evaluations
- Court ordered psychological evaluations
- Individual, group and family treatment (residential, outpatient , day treatment)
- Intensive Services Coordination
- Targeted Case Management focused and at risk youth
- Psych. Hospital Discharge Planning
- Emergency Services

THE GAP ANALYSIS

Behavioral Needs for Youth in Fairfax County Identified by child serving agencies and partners in the Community - July 2013	
Topic/Category	**Concerns/Issues**
Access barriers to youth behavioral health care services	Perceived shortfall in overall number of qualified community-based mental health service providers to address chronic mental health needs of children and parents.
	Insufficient number of qualified mental health providers accepting insurance payment, especially for psychiatric or evidence-based treatment (example: Cognitive Behavior Therapy)
	Insufficient access to qualified Medicaid community-based service providers.
	Demand exceeds available public funding. Waitlists for mental health evaluation and treatment for youth in child serving system agencies, as well as families not assigned case managers.
	Barriers force system to "escalate' or allow crisis to occur to gain access to mental health and/or substance abuse treatment services. Case management and intervention services are often not accessible to families until the youth's behavior is presenting significant difficulties in multiple settings, presenting a risk of out of home care. *(Example: youth does not have diagnosed mental health condition and does not meet service criteria for mandated services in child protective, foster care, juvenile justice or school programs)*
	Lack of system definition of "crisis" that opens access to mandated funding/programming
	Youth's parent must often navigate alone through the complex social service and behavioral health programming in Fairfax; the absence of a coordinated and streamlined cross FCPS and HS information and referral service, (including technology to allow for self-referral) results in delays in timely access to available resources and services.
	Approaches to working with families are often based on operational needs of programs serving them (as noted in DDPET report) *Example: cost and resources devoted to evening and weekend services in community or homes.*
	Inconsistent and incomplete information sharing with parents, particularly on insurance coverage, available providers, Medicaid providers, public providers, referral practices and eligibility information creates disparities in access to services. FCPS and HS training is offered on a program basis. The lack of a coordinated, cross system training curriculum that is resourced, consistently updated and routinely offered, results in lack of timely information developed, shared and utilized across both systems.
	Youth and families with few financial resources lack transportation, health insurance and other resources which are barriers to obtaining mental health/substance abuse treatment.
Improved Information and Referral strategies	FCPS Parent Resource Center – increased awareness needed to reach families in need of resources and information; need for coordination

	across HS and awareness of information; need more materials and training on mental health and substance abuse resources and information
Access barriers to youth behavioral health care for specific populations	Young adult/teen patients with postpartum depression -identification and access concerns as fees for services are perceived as a barrier.
	No systematic screening by private healthcare providers for referrals to Healthy Families Fairfax.
	Young mother and family support groups are primarily offered only in English; Spanish services are most often needed but unavailable.
	Limited availability of specific mental health and substance abuse treatments for youth with developmental disabilities, including autism
	Limited availability of specific behavioral health treatment for children under age 5.
Care Coordination Gaps	Youth discharged from clinical settings are not provided with adequate supports or coordination for transition to participation in community based programs. Service gaps continue at high end of continuum for CSA and privately funded placements.
	Care coordination for families and youth with behavioral health needs is severely insufficient.
	Youth whose parents lack the skill/ability/support to successfully advocate for their children in youth service delivery systems (example: accessing CSA non mandated funding)
Care coordination standards and intensity levels	Need for cross systems standards and definitions for management of care coordination for youth and families. Staff indicate need for protocols to determine the "right" level of intervention and for how long, including standards for different levels of intensity/service settings, including outpatient, day programming, residential, hospitalized settings
Data	Identification of needs of all county youth in public schools and private/home schooled
Early intervention strategies	Need for coordinated FCPS/HS approach to the continuum of supportive services. Staff indicate that evidence-based models have not been consistently tested to allow for policy decision making on most appropriate county funding investment for most efficient/least cost/most effective services
Funding	Private pay, insurance, Medicaid – pressure to find full coverage for services is burdening system staff
Identification of youth needing services	Identification/screening/predisposition and risk indicators for mental health/substance abuse disorders
Parents	Voluntary parental engagement and compliance with service plans for their child(ren)
	Lack of family supports in treatment/service planning
Public policy issues – legislative requirements/needs	Advocacy for Medicaid expansion Advocacy for essential health benefits through insurance coverage
	Expansion of waiver services for adults with disabilities, including developmental and chronic/life-long behavioral health conditions. Children with disabilities age out of child serving systems, and limited or no services are available to provide assistance to them as adults.

Process Change	Use of social media to engage youth in need of services
Utilization Management Tools and Credentialing requirements	Need for consistent and system-wide standards for treatment and therapeutic services by type of behavior/condition for specific youth populations for public direct/contracted services; current standards are program specific and funding source driven
Service Gaps	
Prevention Services Gaps	Prevention services at all age levels
	Wait list/no services for families in need of Family Preservation program services
Treatment Service Gaps	Treatment services and supports in home and community settings for youth with developmental disabilities, including autism.
	Specialized therapeutic recreation programs focused on youth with severe behavioral and mental health needs and only serve ages 3-12.
	Transportation
	Clinical services with language and culture competencies; Services in languages other than English and Spanish; Language and cultural competency for clinical services, counseling, outreach services; Services for youth and families with limited English proficiency
	Trauma counseling for victims of domestic violence: • Counseling to incest survivors (in circumstances where care-giver is perpetrator) • Services for teen offenders of dating violence and/or family violence • Services for children affected by domestic violence whose non-offending parent is not accessing services • Services for children whose offending parent is in ADAPT program • Victims and perpetrators of sibling bullying (minor children)
	Trauma informed services for children who have experienced abuse or neglect.
	Trauma informed treatment for youth exhibiting sexually reactive behaviors
	Increased capacity to serve students needing intensive school based services.
	Shortage of crisis shelter beds
Ongoing Services and Supports	Teen support groups
	Consumer-based parent-teen group program
	Family therapy (parents & children together)
	Group based parenting programs for parents of adolescents
	Parenting education programs for parents of children with conduct disorder and other special needs.
Staff Training	Need for improved cross system FCPS and HS communications regarding procedure changes resulting from budgetary requirements or policy directives.
	Need for comprehensive training curriculum identifying roles, responsibilities and therapeutic standards of care for child and youth behavioral health services for all FCPS and HS child serving staff.
	Referrals, coordination and training re: inclusion in teen and community centers

	System-wide process and procedures training for Temporary Detention Orders for youth in need of emergency involuntary inpatient hospitalization
	System-wide understanding and training on protocols for emergency mental health response from Mobile Crisis, written procedures , dissemination and training
Provider Outreach	Communications and training - to market programs to the community and service providers
Policy Clarifications on Service Prioritization	Clear , written policies and training on prioritization to access emergency mental health services for school involved youth in crisis
	Protocols for wait lists for the following populations: -Eligible CSA funding due to insufficient "non-mandated" funding -Youth waiting to access mental health and substance abuse treatment -Behavioral health services to teens living in shelter – and no follow-up services
	Service continuation gap/continuation and hand off for ongoing behavioral health treatment/support services for families when eligibility for CSA is completed (mandated populations) -outpatient services -residential/group living supports for children with SED, aging out of foster care and in need of adult supportive housing. Estimated 400-500 youth in need of additional "mid-level" services.
Transition/safe after care	Resources in 'high need/intensive" programs are time limited and do not follow client upon program completion – youth age out or return to community with limited support at "mid-tier" service level.
	Youth transitioning into adulthood without community supports

RECOMMENDATIONS

1. Implement system changes to improve information sharing, best practices, collaboration, and accountability of the system
2. Continue implementation of a "Systems of Care" approach – connect the continuum - Across County, School, and Community supports and services
3. Develop and implement CSB Youth Services Division Resource Plan
4. Review needs of youth served in multi-agency and co-located sites, including educational and treatment settings, with goal to best leverage supportive services, treatment and educational services to meet youth needs
5. Expand the scope of the mental health promotion/wellness priorities within the Prevention Fund
6. Improve access to behavioral health care for families with insurance and Medicaid
7. Review policies on use of CSA non-mandated funding

System changes/improvements

Recommendation 1: Implement system changes to improve information sharing, best practices, collaboration, and accountability of the system

- **Develop shared training on key behavioral health needs for mental health and substance abuse services and identification:**
    - Expand trauma informed training to all staff to ensure appropriate service/treatment practices
    - Develop a cross HS and FCPS training curriculum and implementation plan that is annually updated, with goal of bringing existing training programs to scale for school and county social workers, counselors, treatment and referring staff.
- **Revise system-wide management and oversight practices to improve accountability and performance**
    - Develop agency specific performance dashboards and incorporate in the Human Services systems accountability framework currently under development.
    - Create joint action plans that integrate funding, workforce, strategies and outcome measurement for prevention and early intervention initiatives and services.

Discussion

Core training is needed across the youth and child serving agencies. Train all HS and FCPS staff performing "system navigation" tasks and provide common orientation for core knowledge areas:

Level I Core Knowledge Areas–

- Bullying prevention, protocols for referrals for perpetrators and victims
- Depression awareness/suicide prevention (level II intervention gap)

Level II Core Knowledge Areas -

- Threat assessment

- Suicidality assessment
- Crisis response (school, community, cluster response) – prepare crisis certification program
- Trauma response – expand capacity for strength based Post traumatic stress response (see FCPS model program/evaluate/implement county wide) (REF: William Steele/TLC/Achenbach tool)

Recommendation 2: Continue Implementation of a "Systems of Care" approach -Across County, FCPS, and Community supports and services

- Interagency Youth Behavioral Health Work Group to complete phase II tasks in Work Group charter by spring 2014.
- Inventory existing resources within the FCPS and HS service delivery structure to better serve the needs of youth and families needing more intensive services approach beyond a single agency response, and less intensive services/supports than those offered to high risk/need youth. Expand inter-agency work group to include additional community provider representation.
- Create a working model that clearly defines the County's "system of care" and that pulls together services and resources within mental health, education, child welfare, juvenile justice, and other agencies to maximize access to services for children and their families.
- Review options for service delivery models using available resources to meet needs of youth and families.
- Develop protocols to ensure effective cross system coordination of services
    - Intake, assessment, triage, referral, transition across levels of care (handoff to CSA), lead case management assignment
    - Review, develop, and implement a uniform set of requirements in cross system treatment planning tool
    - Review, develop, and determine how to track system performance measures and outcomes
    - Establish formal agreements that clearly identify roles, responsibilities and service flow between participating county agencies, the school system and partnering entities
- Utilize $200,000 set aside in FY 2014 for direct services to begin in spring 2014
    - Monitor CSB's personnel vacancies and expenses monthly and fill positions using CSB appropriated funds before accessing $200K set aside

- Establish a Systems of Care fund to implement model
    - Consider establishing a locally administered fund to enhance access to services for "mid-tier" youth – initial $1.0 million recommended
    - Bring model to system-wide implementation
    - Create Systems implementation oversight (through combination of redirected resources and savings)
    - Policy and operations procedures on providing care coordination and mental health/substance abuse services through combination of community providers, FCPS and HS program resources
- Present final Interagency Behavioral Health Work Group recommendations to SCYPT, School Board and Board of Supervisors by May 2014

Discussion

Significant services gap exists for youth with needs that can be categorized as between level II and level III services:

- Needs multi agency response
- Childs need not being met
- All other resources are exhausted
- Continue to exhibit symptoms
- Sex abuse history or trauma in past
- Multiple environmental and family concerns
- Access to health care limited due to family income or lack of available providers

A "Systems Care coordination" protocol is needed to address this gap. Youth in need of coordination include those involved with multiple agencies, however often the youth and family is not appropriate for CSA referring agencies to initiate a case management and care coordination function. In its work, the work group would work to:

- Determine estimated level of need (numbers of youth and families)
- Establish description of service
- Identify specialists within the human services and public school systems to develop assessment and service delivery protocols.
- Identify community partners funded through County funds, including CSA, which could develop purchased services program model for delivery of care.
- Utilize a team based planning approach
- Utilize CANS assessment for determining needs
- Utilize care coordination when one or more agencies are involved with the family

- Establish criteria for recruitment and therapeutic service capacity needed and incorporate support services for families in languages other than English.

Determining level of need

In analyzing the three most FCPS ED intensive programs, approximately 250 youth are enrolled in Fall 2013. Approximately an additional 250 youth are enrolled in private day or residential programs. Many of these individuals are receiving services funded through the CSA program funds at the highest need level.

Many children have the ability to recover and function at higher levels with proper support. For this reason, when we try to describe how many kids are in need of specific services, the service providers struggle, as most kids move between levels, spending short times (if they get appropriate services) at a higher level, stabilizing and return to better functioning, needing less support. The system needs to examine groups of youth served to determine the type of behaviors, frequencies, triggers requiring interventions and at what level and duration. A shared data system would allow identification and improved supportive services planning and delivery when a child becomes in need of funding and resources from multiple sources.

Recommendation 3: Develop and implement CSB Youth Services Division Resource Plan

- Work with the CSB Board and staff to address consistent criteria to ensure youth and families with the greatest need receive priority for timely and appropriate services. Outline expected service delivery staffing configuration.
- Identify expected population and service delivery design, incorporating expected outcomes and deliverables for Intensive clinical support in Public Day School and Day Treatment settings, Targeted Case Management, Outpatient services, Psychiatric evaluations, day treatment, emergency services, care coordination, treatment planning and support services
- Complete division redesign by June 2014
- Assume resources provided through County General Fund at current authorized position level as of September 2013
- Present subcommittee work with final recommendations to CSB Board and full interagency YBH work group by January 2014 with report to SCYPT in February 2014 (Subcommittee team Lead: CSB Deputy Director)

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Programming Improvements

Recommendation 4: Review needs of youth served in multi-agency and co-located sites, including educational and treatment settings, with goal to best leverage supportive services, treatment and educational services to meet youth needs

- Focus review on targeted populations: juvenile diversion population, youth returning to community from corrections, youth in alternative education programs

- Present Subcommittee work with final recommendations to interagency work group and SCYPT by February 2014 (Subcommittee team Lead: JDRDC Director)

Focus on health promotion and wellness

Recommendation 5: Expand the scope of the mental health promotion/wellness priorities throughout the continuum of supports provided to youth and families

- Maintain a resource commitment to primary prevention activities that provide the best opportunities to prevent suicide and the risk factors that accompany it.

- Direct the re-established countywide prevention coordination unit to incorporate specific behavioral health promotion strategies within their broader prevention plan, and to review population-level data, identify service gaps and other needs, and coordinate approaches among various stakeholders on a regular and ongoing basis.

Recommendation 6: Improve access to behavioral health care for families with insurance and Medicaid

- Review and leverage existing capacity at the FCPS Family Resource Center to enhance information and education for families on mental health supports and services.
- Review capacity within health navigation and coordination services throughout the system on ways to develop "help line" and/or automated tools to provide current information and assistance.
- Determine appropriate mechanisms for sharing information to front line FCPS and HS workforce, with goal of assuring information provided is updated, current, and reflects information on specialty services.
- Goal is to improve quality and consistency of information and referral to community mental health and substance abuse services and educate consumers on available treatments funded by insurance.

Discussion

There is a need for a cross agency developed, centrally supported, administered and implemented coordinated systems approach to provision of information and referral resources for families and youth on available behavioral health and support services. Goal is to improve quality and consistency of information and referral to community mental health and substance abuse services and educate consumers on available treatments funded by insurance. Resources include: CSA provider directory, human services resource guide, NVRC guide, CrisisLink, DNCS Coordinated Services Planning (222-0880 line), FCPS Family Resource Center, FCPS alternative school guide, private provider directories in community/trade associations, insurance company panels, Medicaid/Medallion and federal marketplace providers. The group will incorporate family support networks and services.

Recommendation 7: Review policies on use of CSA non-mandated funding

- Director the CSA Management Team to investigate options for revenue maximization of CSA funding to address mid-tier youth and family populations identified in this report and efficiently access state/federal revenues.

- Report to full work group December 2013

- Present recommendations from Interagency Youth Behavioral Health Work Group to CPMT by January 2014

NEXT STEPS

- Incorporate initial feedback from SCYPT
- Present preliminary recommendations to Human Services Board of Supervisors Committee - October 1, 2013
- Request approval to proceed with use of $200,000
- Establish detailed work plan on proposed recommendations with key deliverables and timeframes

MEMBERS

Interagency Youth Behavioral Health Services Work Group

Executive Sponsors

Patricia Harrison, Deputy County Executive, Fairfax County Government

Kim Dockery, Assistant Superintendent, Fairfax County Public Schools

Fairfax-Falls Church Community Services Board

Jean Bartley

Allen Berenson

George Braunstein

Patrick McConnell

Elizabeth Petersilia

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Mary Ann Panarelli

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Janet Bessmer

Office for Women & Domestic and Sexual Violence Services

Kathleen Kelmelis

Department of Family Services

Deb Forkas

Kamonya Omatete

Mary Phelps

Appendix

RESOURCES

Reference: Evidence Informed treatment and prevention/early intervention models (source: Fairfax County Systems of Care Services Committee Feb. 2010)

Inventory of Therapeutic Services	
Therapy	**Reference**
Juvenile Justice/ CHINS – Delinquent	
Multi-systemic Family Therapy (MST)	**http://mstservices.com/**
Functional Family Therapy (FFT)	**http://fftinc.com/**
Multi-dimensional Treatment Foster Care	**http://mtfc.com/**
Aggression Replacement Training (ART)	**http://www.ojjdp.gov/mpg/Aggression%20Replacement%20Training%20%20174;%20(ART%20%20174;)-MPGProgramDetail-292.aspx**
Child Welfare & Trauma/MH	
Trauma-focused Cognitive Behavioral Therapy (TF-CBT)	**http://tfcbt.musc.edu/ https://www.childwelfare.gov/pubs/trauma/**
Abuse-focused Cognitive Behavioral Therapy (AF-CBT)	**http://www.nctsnet.org/nctsn_assets/pdfs/promising_practices/AF-CBT_fact_sheet_3-20-07.pdf https://www.childwelfare.gov/pubs/cognitive/**
Trauma-informed Care	**http://www.samhsa.gov/nctic/**
Eye Movement Desensitization and Reprogramming (EMDR)	**http://azcfc.com/programs/emdr.asp**
Neuro-sequential Model of Therapeutics (NMT)/Circles of Courage	**http://www.reclaiming.com**
Dialectical Behavior Therapy (DBT)	**http://www.dialecticalbehavioraltherapy.net/**
Child Welfare/ Parenting	
Parent-Child Interaction Therapy (PCIT)	**http://www.pcit.org/**
Child-Parent Psychotherapy for Family Violence	**http://www.childtrends.org/?programs=child-parent-psychotherapy-for-family-violence-cpp-fv**
Brief Strategic Family Therapy	**http://bsft.org/**
Triple P – Positive Parenting Program	**http://www5.triplep.net/**
Strengthening Families	**http://strengtheningfamiliesprogram.org/**
Incredible Years	**http://incredibleyears.com/**
Co-occurring substance abuse, trauma, and mental health disorders	
Program for Assertive Community Treatment (PACT)	**http://www.nami.org/Template.cfm?Section=ACT-TA_Center&template=/ContentManagement/ContentDisplay.cfm&ContentID=49870**
Mobile crisis response and stabilization services	**Local programming**
CARE Model: Creating Conditions for Change	**http://rccp.cornell.edu/caremainpage.html**
Positive Behavior Intervention and Support	**www.pbis.org**

National/International Resources

1. Alliance for Children and Families – www.alliance1.org
2. American Institutes for Research – Children's Mental Health Resources www.air.org
3. California Clearinghouse for Evidence Based Practice in Child Welfare http://www.cebc4cw.org/
4. National Child Welfare Resource Center for Organizational Improvement http://muskie.usm.maine.edu/helpkids/
5. U.S. Department of Health and Human Services http://www.acf.hhs.gov/programs/cb/
6. Office for Victims of Crime, U.S. Department of Justice http://www.ojp.usdoj.gov/ovc/
7. Child Welfare League of America – www.cwla.org
8. Cochrane Collaborative – www.ich.ucl.ac.uk
9. National Association of Public Child Welfare Administrators http://www.fostercareandeducation.org/portals/0/dmx/2013/02/file_20130211_145758_xjnFqt_0.pdf
10. National Child Traumatic Stress Network www.nctsnet.org
11. National Clearinghouse on Child Abuse and Neglect - child welfare information clearinghouse www.childwelfare.gov
12. National Technical Assistance Center for Children's Mental Health http://gucchdtacenter.georgetown.edu/

Eligibility/Screening tools/criteria/approaches

1. Child and Adolescent Needs and Strengths (CANS), Virginia

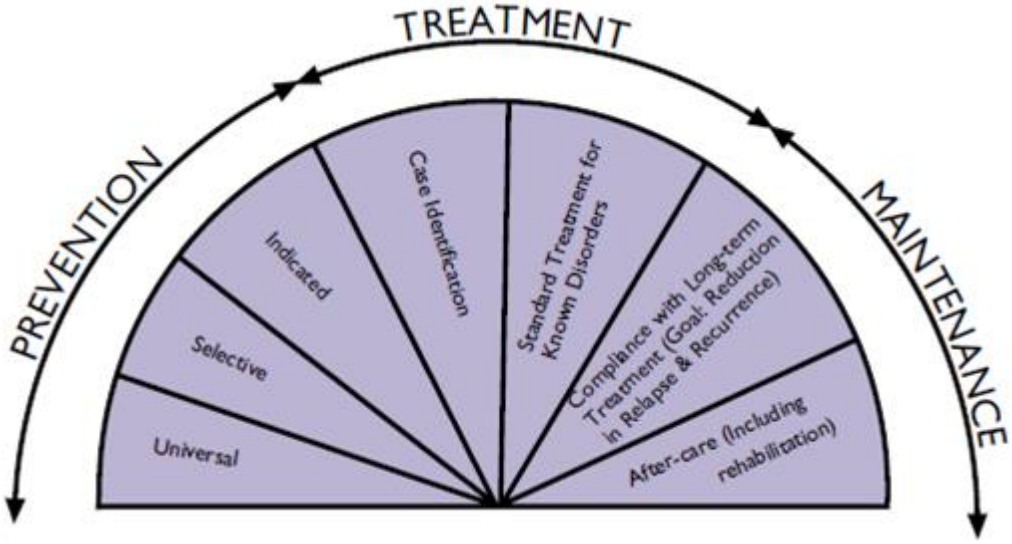
Comprehensive tool 5+, 2009

2. "Eligibility Screening", Anthem
3. "Magellan Medical Necessity Criteria", Magellan Behavioral Health, Inc.

4. **Healthy Families screening and referral instrument**
5. **YASI – Youth Assessment and Screening Instrument, Orbis Partners, www.orbispartners.com**
6. **"DJJ risk assessment model" – Risk and Protective Factors project (Catalano and Hawkins)**
7. **"Virginia Enhanced Maintenance Assessment Tool" (VEMAT), Virginia Department of Juvenile Justice**

Mental Health Screenings CRAFFT - http://www.ceasar-boston.org/CRAFFT/pdf/CRAFFT_SA_English.pdf This is a link for a Self-Administered CRAFFT (adolescents complete themselves) and includes multiple languages. Follow-up supports are needed so that adults involved with a young person know the post-screen next steps - accessing resources and following through. Patient Health Questionnaire - http://www.integration.samhsa.gov/images/res/8.3.4%20Patient%20Health%20Questionnaire%20(PHQ-9)%20Adolescents.pdf. Adolescent depression screening tool (that can be self-administered).	
Substance Abuse Screenings Alcohol Use Disorders Identification Test – **http://www.integration.samhsa.gov/AUDIT_screener_for_alcohol.pdf**)- A 10-item questionnaire that screens for hazardous or harmful alcohol consumption. Developed by the World Health Organization (WHO), the test correctly classifies 95% of people into either alcoholics or non-alcoholics. The AUDIT is particularly suitable for use in primary care settings and has been used with a variety of populations and cultural groups. It should be administered by a health professional or paraprofessional. CAGE - **http://www.integration.samhsa.gov/images/res/CAGEAID.pdf.** The CAGE is a commonly used, 5- question tool used to screen for drug and alcohol use. The CAGE Assessment is a quick questionnaire to help determine if an alcohol assessment is needed. If a person answers yes to two or more questions, a complete assessment is advised	
Behavioral health screening tools appropriate to primary care settings SBIRT - http://www.suicidology.org/stats-and-tools/suicide-warning-signs),	

http://www.cars-rp.org/publications/Prevention%20Tactics/PT8.13.06.pdf
In 1994, the Institute of Medicine commissioned an investigation on Mental Health Interventions that resulted in the development of the IOM Model summarized in the IOM "protractor." Levels of prevention are: universal (all populations), selective (e.g. populations with high risk factors), and indicated (**individuals with an indication of a problem such as early substance use**). **Early intervention is appropriate for "indicated."**



Continuum of Supports using **Positive Behavioral Interventions and Supports (PBIS)**

Source: www.pbis.org