FAIRFAX-FALLS CHURCH CHILDREN'S SERVICES for AT-RISK CHILDREN, YOUTH & FAMILIES

June 26, 2020
Community Policy and Management Team (CPMT)
Virtual Meeting due to COVID-19

Agenda

FINAL

1:00 p.m. -- Convene meeting ~

1. **MINUTES:** Approve minutes of May 29, 2020 meeting

2. **ITEMS:**

- **CSA Administrative Items**
  Item A – 1: Approve FY 21 CPMT Calendar of Meetings

- **CSA Presentation Item**
  Item P – 1: Foster Care Prevention Services: Results from the 2020 Data Analytics Fellowship Academy (Not In Packet)

- **CSA Information Items**
  Item I – 1: Budget Report
  Item I – 2: Quarterly Residential Entry and FAPT Report
  Item I – 3: Quarterly Serious Incident Report
  Item I – 4: Quarterly CPMT Data Report

- **HMF Information Item**
  Item I – 5: Status report on the recommendation listed in the Innovative Behavioral Health Strategies for the Underserved Populations (June 18, 2018).

- **NOVACO – Private Provider Items**
- **CPMT Parent Representative Items**
- **Cities of Fairfax and Falls Church Items**
- **Public Comment**

3:00 p.m. – Adjourn

FAIRFAX-FALLS CHURCH CHILDREN'S SERVICES for AT-RISK CHILDREN, YOUTH & FAMILIES

May 29, 2020
Community Policy and Management Team (CPMT)
Virtual Meeting due to COVID-19 Emergency Procedures

Meeting Minutes

Attendees: Tisha Deeghan (home)**,** Michael Becketts (office), Jacqueline Benson (home), Annie Henderson (home), Teresa Johnson (home), Chris Leonard (home), Jane Strong (Fairfax), Michael Lane (office), Lesley Abashian (City Hall), Staci Jones Alexander (home), Richard Leichtweis (home), Christy Gallagher (home), Nancy Vincent (office), Daryl Washington (office), Robert Bermingham (office, Fairfax Courthouse), Rebecca Sharp (home)

Absent: Gloria Addo-Ayensu, Deb Evans, Joe Klemmer, Deborah Scott,

SOC Attendees: Jim Gillespie, Desiree Gordon, Peter Steinberg, Tracy Davis

Stakeholders and CSA Program Staff Present: Janet Bessmer, Patricia Arriaza, Sarah Young, Kim Jensen, Samira Hotochin, Chris Metzbower, Xu Han

FOIA Related Motions:

The CPMT chair called the meeting to order and went through a roll call of members who stated their name and location. She then passed the gavel to Vice-Chair Dr. Leichtweis. Ms. Deeghan moved that each member's voice may be adequately heard by each other member of this CPMT. *All members agreed and motion carries.*

Second, Ms. Deeghan stated that having established that each member's voice may be heard by every other member, we must next establish the nature of the emergency that compels these emergency procedures, the fact that we are meeting electronically, what type of electronic communication is being used, and how we have arranged for public access to this meeting.

The State of Emergency caused by the COVID-19 pandemic makes it unsafe for this CPMT to physically assemble and unsafe for the public to physically attend any such meeting, and that as such, FOIA's usual procedures, which require the physical assembly of this CPMT and the physical presence of the public, cannot be implemented safely or practically. She further moved that this CPMT may conduct this meeting electronically through a dedicated audio conferencing line, and that the public may access this meeting by calling Toll Free Call In: **1 877 336 1829** Participant access code: **8628844**.

The motion was seconded by Michael Lane; all members agreed; motion carries

Finally, Ms. Deeghan moved that it is next required that all of the matters addressed on today's are statutorily required or necessary to continue operations and the discharge of the CPMT's lawful purposes, duties, and responsibilities.

Seconded by Michael Lane; all members agree; motion carries

1. **MINUTES:** Approve minutes of January 24, 2020 meeting. *Motion made by Christy Gallagher; seconded by: Bob Bermingham; approved by all members.*

2. **ITEMS:**

- **CSA Administrative Items**
  Item A – 1: Approve Revisions to the CPMT Bylaws
  Primary edit was changing word "ensure" to "provide" in mission statement, as well as editing the title of school members. Both the final version and the markups are in the packet for your review. *Motion made by Michael Lane; seconded by Christy Gallagher; approved by all members.*

  Item A – 2: Approve Reappointment of CPMT Private Provider Representative and Appoint FAPT members for a two-year period. *Motion made by Michael Lane; seconded Daryl Washington; Approved by all members.*

- **HMF Administrative Items**
  Item A - 3: Endorse FY 2021 Expenditure Plan
  No questions regarding summary provided in packet. Plan has been endorsed by Family Advisory Board. Summary of programs that will be funded was provided by Peter Steinburg. *Motion made by Bob Bermingham; second by Jane Strong; approved by all members.*

  Item A - 4: Endorse Establishment of a Healthy Minds Fairfax Family Advisory Board.
  Board consists of parent representatives from CPMT, FAPT, Children's Behavioral Health Collaborate Management Team, and Family Organization Network. This group will meet monthly and review/provide feedback on any pending CPMT items. They will also be available to provide feedback to any of the HMF workgroups. Two informal meetings have been conducted and the group feels this is very productive. Comments from parent representatives on Family Advisory Board: Jackie Benson – grateful that parents now have a platform to voice feedback since often issues arise once programs are implemented. *Motion made by Rebecca Sharp; seconded by Christy Gallagher; approved by all members.*

- **Contract Items**
  Item C – 1: Approve Child Specific Contract for Change Academy Lake of the Ozarks.
  Attempted to use a VA residential provider but was not successful. Eight other programs were considered, but youth was not accepted for various reasons. *Motion made by Daryl Washington; seconded by Michael Lane; approved by all members.*

  Item C – 2: Approve Child Specific Contract for Youth Villages Memphis
  Current placement feels that they cannot meet his needs due to several elopement incidents/attempts. They are requesting to move him to their Tenness location which can better meet his needs. *Motion made by Rick Leichtweis; seconded by Jane Strong; approved by all members.*

- **CSA Information Items**
  Item I – 1: Review CSA Budget Report –
  Reduction in funds spent is partially due to COVID-19 pandemic as well as delayed invoicing. No questions regarding report.

  Item I – 2: Review CSA Emergency Operating Procedures
  - CSA has been working with providers to continue services using various means (specifically telehealth) to ensure we are following state guidelines.
  - CSA has been working with schools to ensure distance learning was available and to meet the needs of students with IEPs. As well as ensuring plans are eligible for CSA reimbursement.
  - CSA created a process to extend current services based on an existing service plans to avoid the need for in-person meetings from mid-March – May 30. After May 30 meetings will need to be held electronically or in person following CDC guidelines.
  - We have been using DocuSign for legal signatures and assisting with electronic documentation.
  - FAPT meetings have continued virtually without gaps.

- CSA has Waived Parental Contribution (COVID-19 Waiver) for March, April, May, and June to provide financial relief for families.
- Case managers have been granted permission to visit facilities via teleconference since most facilities are not allowing nonfamily visits at this time.

Question: have you seen any providers close? As of right now no. There were some concerns of private educational providers closing due to school closures, however now, with support from Fairfax, providers were able to remain open.

Item I – 3: Review Proposed CPMT Meeting Schedule for FY21
We are still not sure if these meeting dates will be held virtually or in person, but we wanted everyone to have these dates for review. We will request approval of the final schedule next meeting.

- **HMF Information Item**
  Item I – 4: Children's Behavioral Health Quarterly Progress Report
  - An interagency group has completed our first ever Children's Behavioral Health population data report. The report is designed to gather community level and population level data to show the impact of HMF and areas to focus on. The report has been presented to CBHC Management Team and Family Advisory Board and will be presented to CPMT in June.
  - SAMSHA grant will be expiring Sept 30, 2020. Extension has been requested through January 31, 2021.
  - NAMI Northern VA, provider of FSPs, will no longer provide this service.
  - HMF website has received an increase in visits from families in need of services. The Family Advisory Board has been asked to spread the word and gather feedback regarding the site.
  - Partnership with State VA Mental Health Access program to support pediatricians in providing quality mental health care is continuing. Due to the Governor's current budget freeze, we will likely need to provide funding for psychiatric consultation for the next year and may need to sponsor another REACH training program. Within the next few years, we will be able to pull these funds and use the resources on other initiatives.
  - Two of our providers were awarded training funds. National Counseling Group has started accepting Multi Systemic Therapy (MST) referrals. An additional provider will be trained in Functional Family Therapy (FFT) in June and will be adding the service to their contract. Stakeholder groups are being held for MST and FFT. Both services are currently available to the community.

- **NOVACO – Private Provider Items**
  Rick Leichtweis – Private Providers' primary focus has been the impact of sudden school closures on private day schools, as well as changes in facility visitations.
- **CPMT Parent Representative Items – None**
- **Cities of Fairfax and Falls Church Items**
  Lesley – appreciate all the work and effort by providers and staff and the way the community has come together during this time.
- **Public Comment – None**

Adjourn 2:15pm - *motion made by Bob Bermingham; seconded by Rick Leichtweis; approved by all members.*

MEMO TO THE CPMT

June 26, 2020

Administrative Item A-1: Approve FY21 CPMT Meeting Schedule

ISSUE: That the CPMT approve the public calendar of meetings for FY 2021.

BACKGROUND:
The CPMT typically meets nine times per year on the fourth Friday of every month. Typically, the November and December meetings are combined to accommodate the holiday season, one meeting is held over the summer, and the March meeting may be canceled to allow attendance at the CSA Symposium's CPMT Roundtable. Attendance by members is critical to maintain a quorum. The calendar will be posted on the county's public website and the Healthy Minds Fairfax site to fulfill requirements for notice of public meetings.

RECOMMENDATION: That the CPMT adopt this calendar for FY21.

ATTACHMENT: Proposed FY21 CPMT Meeting Schedule

STAFF:
Janet Bessmer, CSA

Community Policy & Management Team (CPMT)

Meeting Location:

Fairfax County Government Center, 12000 Government Center Pkwy, Fairfax, VA 22035

CPMT SCHEDULE FY21 *(July 2020 – June 2021)*			
Meeting Date	**Room #**	**Time**	**Notes**
Jul. 24, 2020	232	1:00-3:00pm	May be a virtual meeting or a hybrid with an in-person option
Sept. 25, 2020	123-C	1:00-3:00pm	
Oct. 23,2020	232	1:00-3:00pm	
Dec. 4, 2020	232 (Pending)	1:00-3:00pm	Nov/Dec Meeting Combined
Jan. 29, 2021	TBD	1:00-3:00pm	
Feb. 26, 2021	TBD	1:00-3:00pm	
Apr. 30, 2021	TBD	1:00-3:00pm	
May 28, 2021	TBD	1:00-3:00pm	
Jun. 25, 2021	TBD	1:00-3:00pm	

Schedule Approved by CPMT:

MEMO TO THE CPMT
June 26, 2020

Information Item I-1: May Budget Report & Status Update, Program Year 2020

ISSUE:
CPMT members monitor CSA expenditures to review trends and provide budget oversight.

BACKGROUND:
The Budget Report to the CPMT has been organized for consistency with LEDRS reporting categories and Service Placement types.

The attached chart details Program Year 2020 cumulative expenditures through May for LEDRS categories, with associated Youth counts. IEP-driven expenditures for Schools are separated out. Further information on the attachment provides additional information on recoveries, unduplicated youth count, and:

-Average cost per child for some Mandated categories
-Average costs for key placement types, such as Residential Treatment Facility, Treatment Foster Home, Education placements.

Total Pooled Expenditures: Pooled expenditures through May 2020 for FY20 equal $31.1M for 1,071 youths. This amount is an increase from May last year of approximately $2.4M, or 8.31%. Pooled expenditures through May 2019 for FY19 equaled $28.6M for 1,113 youths.

	Program Year 2019	Program Year 2020	Change Amt	Change %
Residential Treatment & Education	$3,280,619	$4,490,149	$1,209,530	36.87%
Private Day Special Education	$15,775,250	$15,814,656	$39,406	0.25%
Non-Residential Foster Home/Other	$5,869,721	$6,982,077	$1,112,356	18.95%
Community Services	$3,380,238	$3,519,329	$139,091	4.11%
Non-Mandated Services (All)	$1,178,506	$939,609	($238,897)	-20.27%
Recoveries	($874,980)	($757,847)	$117,133	-13.39%
Total Expenditures	**$28,609,354**	**$30,987,973**	**$2,378,619**	**8.31%**
Residential Treatment & Education	134	133	(1)	-0.75%
Private Day Special Education	296	300	4	1.35%
Non-Residential Foster Home/Other	329	364	35	10.64%
Community Services	783	731	(52)	-6.64%
Non-Mandated Services (All)	206	191	(15)	-7.28%
Unique Count All Categories	**1,748**	**1,719**	**(29)**	**-1.66%**
Unduplicated Youth Count	**1,113**	**1,071**	**(42)**	**-3.77%**

Note: The number of youths served is unduplicated within individual categories, but not across categories.

Expenditure claims are submitted to the State Office of Children's Services (OCS) through May.

RECOMMENDATION:
For CPMT members to accept the May Program Year 2020 budget report as submitted.

ATTACHMENT:
Budget Chart

STAFF:
Timothy Elcesser, Xu Han, Terri Byers and Usman Saeed (DFS)

NOTE:

[1] Residential services continue to drive up the cost in FY20 than FY19.

- Education-residential Medicaid placement up $360k YTD than last year, mainly due to one youth receiving translation service $423k, expense down without translation serv
- Residential treatment facility services up $830k due to more youths received more services.

[2] Private day expense bounced back in May, more that FY19 YTD May, in line with serving more youth this year than last year.

- Non-Mandated services down by $239K, still lower than FY19 due to serving 52 fewer youths.

[3] Treatment Foster Home up $1M, serving 14 additional youths, still being the main area driving cost up in non-residential categories.

[4] May pooled expenditure includes $1.5M Mar payment, catching up low level of invoicing activity in Apr, also includes $1.75M Apr payment, in alignment with payment level history. Signal of providers resume normal level of invoicing process.

[5] Total pooled expenditure is projected to be at $40.7M, more than our FY20 allocation of $38.3M. This amount is still within the Board of Supervisors appropriated amount. We will have to request supplement allocation to OCS(Office of Children Services).

Program Year 2020 Year To Date CSA Expenditures and Youth Served (through May Payment)

Mandated/ Non-Manda	Residential/ Non-Residential	Serv Type Descrip	Local Match Rate	County & Foster Care	Youth in Category	Schools (IEP Only)	Youth in Category	Total Expenditures
Mandated	**Residential**	Residential Treatment Facility	57.64%	$1,914,007	61		0	$1,914,007
		Group Home	57.64%	$197,997	6		0	$197,997
		Education - for Residential Medicaid Placements	46.11%	$153,014	9	$821,197	12	$974,210
		Education for Residential Non-Medicaid Placements	46.11%	$99,359	9	$1,052,276	9	$1,151,635
		Temp Care Facility and Services	57.64%	$252,299	27		0	$252,299
	Residential Total			$2,616,676	112	$1,873,473	21	$4,490,149
	Non Residential	Special Education Private Day	46.11%	$218,356	5	$15,596,300	295	$15,814,656
		Wrap-Around for Students with Disab	46.11%	$331,814	56		0	$331,814
		Treatment Foster Home	46.11%	$4,592,226	131		0	$4,592,226
		Foster Care Mtce	46.11%	$1,499,614	138		0	$1,499,614
		Independent Living Stipend	46.11%	$97,088	21		0	$97,088
		Community Based Service	23.06%	$2,492,959	573		0	$2,492,959
		ICC	23.06%	$1,026,370	158		0	$1,026,370
		Independent Living Arrangement	46.11%	$430,675	17		0	$430,675
		Psychiatric Hospital/Crisis Stabilization	46.11%	$30,660	1		0	$30,660
	Non Residential Total			$10,719,763	1100	$15,596,300	295	$26,316,062
Mandated Total				**$13,336,438**	**1212**	**$17,469,773**	**316**	**$30,806,211**
Non-Mandated	**Residential**	Residential Treatment Facility	57.64%	$31,849	3		0	$31,849
		Group Home	57.64%	$64,194	2		0	$64,194
	Residential Total			$96,043	5	$0	0	$96,043
	Non Residential	Community Based Service	23.06%	$658,579	151		0	$658,579
		ICC	23.06%	$184,986	35		0	$184,986
	Non Residential Total			$843,565	186	$0	0	$843,565
Non-Mandated Total				**$939,609**	**191**	**$0**	**0**	**$939,609**
Grand Total (with Duplicated Youth Count)				**$14,276,047**	**1403**	**$17,469,773**	**316**	**$31,745,820**

Recoveries	**-$757,847**
Total Net of Recoveries	**$30,987,973**
Unduplicated child count	**1,071**

Key Indicators		
Cost Per Child	**Prog Yr 2019 YTD**	**Prog Yr 2020 YTD**
Average Cost Per Child Based on Total Expenditures /All Services (unduplicated)	$25,705	$28,934
Average Cost Per Child Mandated Residential (unduplicated)	$36,861	$41,964
Average Cost Per Child Mandated Non- Residential (unduplicated)	$24,728	$27,585
Average Cost Mandated Community Based Services Per Child (unduplicated)	$3,913	$4,351
Average costs for key placement types		
Average Cost for Residential Treatment Facility (Non-IEP)	$19,359	$31,377
Average Cost for Treatment Foster Home	$30,649	$35,055
Average Education Cost for Residential Medicaid Placement (Residential)	$27,949	$46,391
Average Education Cost for Residential Non-Medicaid Placement (Residential)	$45,699	$63,980
Average Special Education Cost for Private Day (Non-Residential)	$53,295	$52,716
Average Cost for Non-Mandated Placement	$5,721	$4,919

Program Year 2020 Year To Date CSA Expenditures and Youth Served (through May Payment)

Category	Program Year 2019 Allocation	Year to Date Expenditure (Net)	Percent Remaining
SPED Wrap-Around Program Year 2020 Allocation	$717,020	$323,166	55%
Non Mandated Program Year 2020	$1,630,458	$885,782	46%
Program Year 2020 Total Allocation	$38,340,860	$30,987,973	19%

MEMO TO THE CPMT

June 26, 2020

Information Item I- 2: FY 20 Quarter 3 Residential Entry and FAPT Report

ISSUE: That the CPMT receive regular management reports about the utilization and performance of residential placements.

BACKGROUND:

As per § 2.2-5206 the powers and duties of the Community Policy and Management teams, each CPMT "shall manage the cooperative effort in each community to better serve the needs of troubled and at-risk youths and their families and to maximize the use of state and community resources. Every such team shall:

13. Review and analyze data in management reports provided by the Office of Children's Services in accordance with subdivision D 18 of § 2.2-2648 to help evaluate child and family outcomes and public and private provider performance in the provision of services to children and families through the Children's Services Act program. Every team shall also review local and statewide data provided in the management reports on the number of children served, children placed out of state, demographics, types of services provided, duration of services, service expenditures, child and family outcomes, and performance measures. Additionally, teams shall track the utilization and performance of residential placements using data and management reports to develop and implement strategies for returning children placed outside of the Commonwealth, preventing placements, and reducing lengths of stay in residential programs for children who can appropriately and effectively be served in their home, relative's homes, family-like setting, or their community;"

The CSA program provides quarterly data reports to the CPMT to facilitate oversight of key outcomes.

ATTACHMENT:
Third Quarter FY 20 Residential Entry and FAPT Report

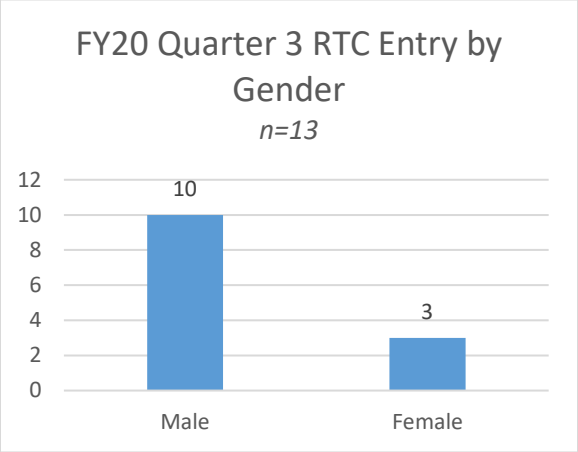
STAFF:
Kim Jensen, UR Manager
Sarah Young, FAPT Coordinator

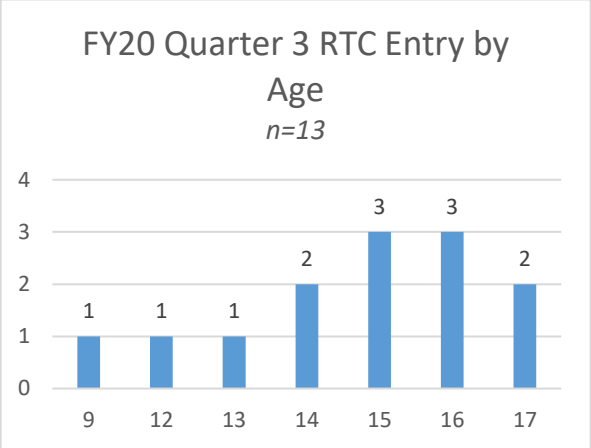
FY 20 THIRD QUARTER RESIDENTIAL ENTRY AND FAPT REPORT

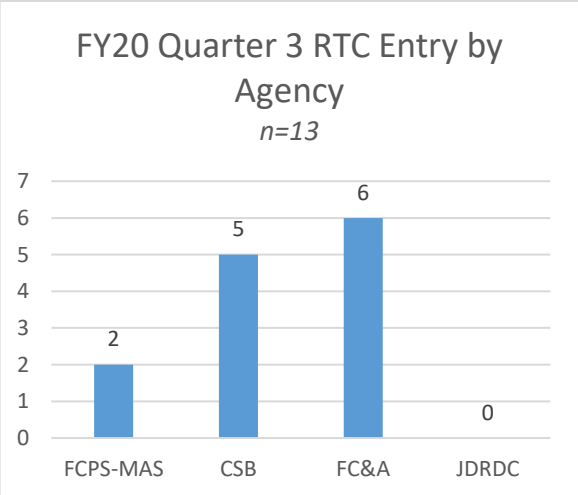
Residential Entry Report

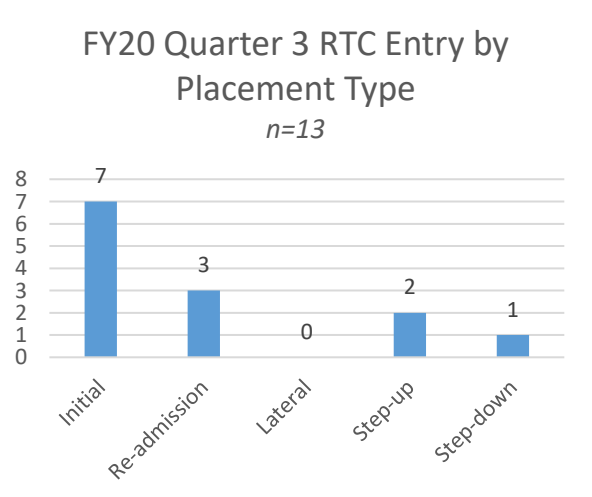
As stated in the local CSA policy manual under Section 4.4 Multi-Disciplinary Teams and Family Assessment and Planning Teams, *prior to the residential placement of a child across jurisdictional lines, the FAPT shall (i) explore all appropriate community services for the child, (ii) document that no appropriate placement is available in the locality, and (iii) report the rationale for the placement decision to the CSA Program Manager who shall inform the CPMT at its next scheduled meeting.*

Thirteen youth entered long-term residential settings FY20 Quarter 3, Jan (5), Feb (3), and Mar (5).









CANS: Actionable Needs

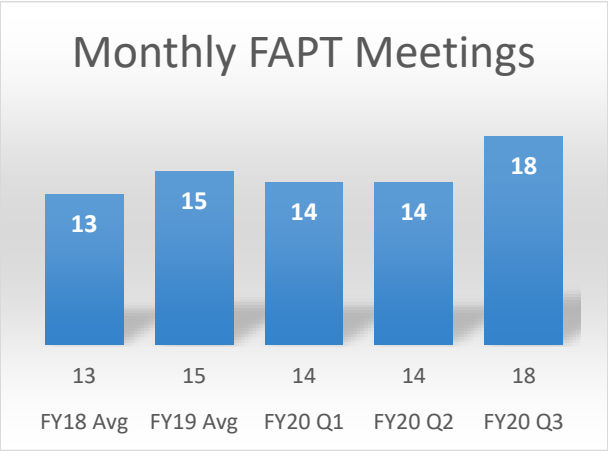
Across the 13 youth, the most frequently identified "Actionable" needs on the CANS were as follows:

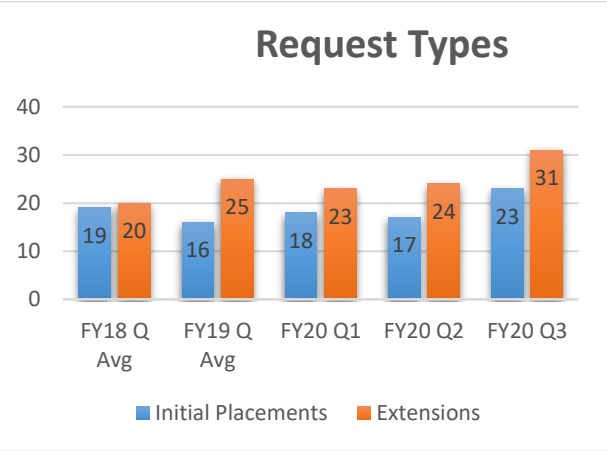
- Impulse/Hyper – 10
- Danger to Others – 8
- Oppositional – 7
- Conduct – 7
- Oppositional – 7
- Anxiety – 7

FAPT Report

For the third quarter of FY20 (Jan 2020-Mar 2020):

- **54** meetings were held
- **23 (43%)** were new requests for placement:
  - 2 of these youth had a community-based plans developed in lieu of a plan for placement out of the home; the rest developed plans for RTC or GH placement
  - 5 youth had been placed prior to the FAPT meeting; 3 were placed by FC&A and 2 were parent placements
  - 14 of these youth were actively receiving community-based services at the time of the FAPT referral, including 6 who were active with ICC
- **31 (57%)** were requests for extensions of existing placements, all of whom received an extension of anywhere from 3 weeks to 3 months
- One Parent Request for Appeal was made during this quarter; the CPMT panel upheld the FAPT plan for community-based services.
- For this quarter the average time it took from receipt of a complete FAPT request in the CSA office to the actual FAPT meeting date was **14.6** calendar days





Respectfully submitted by *Kim Jensen, UR Manager and Sarah Young, FAPT Coordinator*

MEMO TO THE CPMT
June 22, 2020

Information Item I - 3: Serious Incident Report, FY20 Quarter 3

ISSUE: That the CPMT receive information about the disposition of reports of serious incidents that impact youth and families receiving services within the system of care as they relate to contractual requirements and service delivery.

BACKGROUND: The contract (Agreement for Purchase of Services) specifies provider requirements for reporting serious incidents to both the case managing agency and to the CSA program. The CSA policy manual contains procedures describing staff responsibilities in the event of serious incidents for youth receiving CSA funded services.

When serious incidents occur, contracted providers are required to give verbal or email notification of the incident to the case manager and guardian within 24 hours and a written report to the CSA Utilization Review Manager within 72 hours of the incident. This centralized reporting enables the CSA Program to review and collate reports by both the individual youth and facility.

This update includes information on adverse incidents for youth receiving CSA-funded services that have the potential to impact the safety/well-being of youth due to allegations of:

- Alleged criminal activity by the provider to include abuse/neglect of clients;
- Legal/Risk Management issues to include unsafe conditions;
- Ethical/Licensure issues to include boundary and dual relationships; and
- Contractual violations/fiscal issues to include failure to report SIRs and billing misconduct.

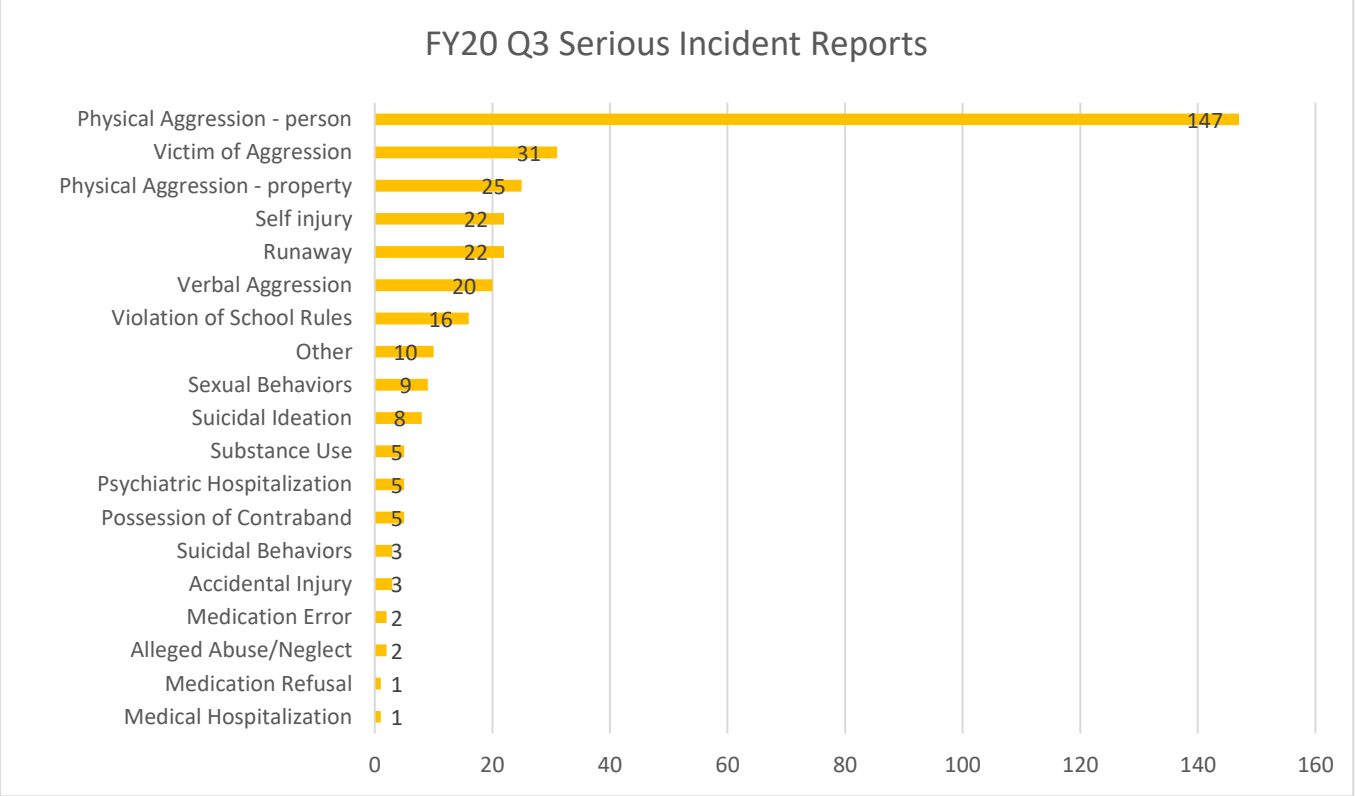
When the incident meets the criteria stated above, the CSA UR Manager and the CSA Contracts Coordinator review the details and decide if immediate action is needed to ensure the safety of the involved youth and other youth in the program/facility. During periods of investigation, contracts are "frozen" and removed from the local CSA Provider Directory and notifications are made to case managers of youth served by the provider. Based on information provided by UR Manager and Contracts Coordinator, the CSA Management Team makes a decision regarding future referrals and contracts. The CSA Program Manager informs appropriate Human Services Leadership when a situation requires such escalation. When necessary, case managers, CSA staff, and contracts analyst make site visits to assess the facility and any continued risk to the youth receiving services funded by the County.

UPDATES TO CSA MANAGEMENT TEAM: During FY20 Q3, three SIRS were presented to CSA Management Team - all three incidents occurred at the same facility during FY20 Q2 and received followed up. CSA management team approved the follow up process for all the incidents on 1/13/2020 and it was decided that a call would be scheduled with the provider on 2/3/20 to express concerns.

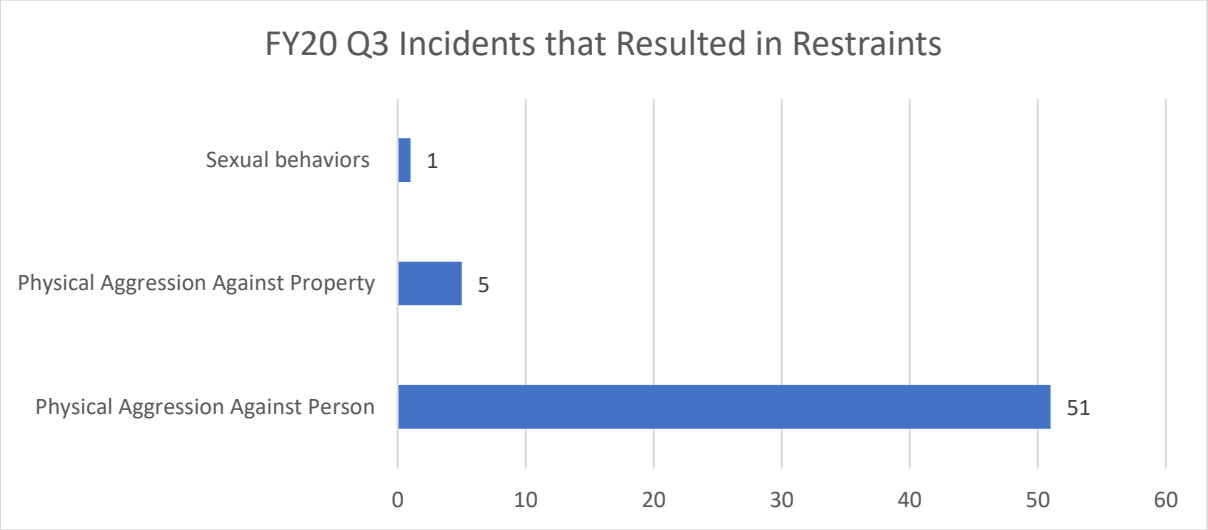
- One incident involved a youth being restrained for 47 minutes, followed by another serious incident resulting in concussion like symptoms. UR staff followed up with the provider and the provider responded with the youth's behavior plan being updated to include more frequent reinforcement for safe behaviors, as well as the youth agreeing to talk to staff in private when disagreements occur. He has not been restrained since October 2019.
- A youth was restrained 10 separate times on 2 separate days. UR staff followed up with the provider and it was reported that this youth's goal was to become hospitalized in order to be discharged from the out-of-home placement. This youth was psychiatrically hospitalized on 12/30/19 and was discharged from this placement on 3/22/20.
- A youth gave himself a tattoo while being under the provider's supervision, which placed the provider's supervision in question. UR staff followed up with the provider and learned that the youth administered the tattoo by removing ink from an ink pen and replacing it with a sewing needle. Staff reported that youth receives privacy while handling bathroom needs and the tattoo could have been administered during that time. The youth was seen by a doctor and it was determined that there were no signs of infection. A CPS case was reported for lack of supervision and the case was determined to be unfounded on 1/6/2020.

VOLUME OF SIRS:

FY20 Q3 resulted in a total of 336 serious incident reports. Forty-one percent (140 of 336) of the SIRs reported this quarter occurred at three different facilities. One youth at one of these facilities accounted for 22 out of the 46 incidents that were reported at the facility.



In this quarter we began capturing the initial behavior that resulted in a restraint. A total of 57 restraints were reported this quarter, with 51 of the 57 restraints resulting from physical aggression against a person, 5 from physical aggression against property, and 1 because of sexual behavior. Twenty-nine of the 57 restraints occurred at one day school, involving two youths. There was a significant decrease in the number of restraints from Q2 to Q3 – Q2 saw 127 restraints. This decrease is attributed to 5 providers reporting significantly fewer restraints.



Follow up continues to be conducted on serious incidents that require more information to ensure that youth are safe in their placements.

STAFF:

Patricia E. Arriaza, Children's Services Act, Management Analyst III, Program Operations

Shana Martins, Children's Services Act, Management Analyst II, Quality Improvement

MEMO TO THE CPMT

June 26, 2020

Information Item I- 4: Quarterly CPMT Data Report, FY 20 Quarter 3

ISSUE: That the CPMT receive regular management reports about utilization of services, duration of services, outcomes and performance measures.

BACKGROUND:

As per § 2.2-5206 the powers and duties of the Community Policy and Management teams, each CPMT "shall manage the cooperative effort in each community to better serve the needs of troubled and at-risk youths and their families and to maximize the use of state and community resources. Every such team shall:

13. Review and analyze data in management reports provided by the Office of Children's Services in accordance with subdivision D 18 of § 2.2-2648 to help evaluate child and family outcomes and public and private provider performance in the provision of services to children and families through the Children's Services Act program. Every team shall also review local and statewide data provided in the management reports on the number of children served, children placed out of state, demographics, types of services provided, duration of services, service expenditures, child and family outcomes, and performance measures. Additionally, teams shall track the utilization and performance of residential placements using data and management reports to develop and implement strategies for returning children placed outside of the Commonwealth, preventing placements, and reducing lengths of stay in residential programs for children who can appropriately and effectively be served in their home, relative's homes, family-like setting, or their community;"

The CSA program provides quarterly data reports to the CPMT to facilitate oversight of key outcomes including the number of youth in long-term residential placements, length of stay and metrics for Intensive Care Coordination.

ATTACHMENT:
Quarterly CPMT Data Report

STAFF:
Patricia Arriaza, Management Analyst III

RBA

Results-Based Accountability
Performance Plan
FY 2020, Quarter 3 Report to CPMT

SUMMARY	
Name of Work	**Children's Services Act (CSA) for At-Risk Youth – Systems of Care**
Agency	Human Services within the Department of Family Services (DFS)
Contact (Name, Phone, Email)	Patricia E. Arriaza, Management Analyst III, 703-324-8241, patricia.arriaza@fairfaxcounty.gov
Purpose	The Children's Services Act (CSA) for At-Risk Youth and Families is a law enacted in 1993 that establishes a single state pool of funds to purchase services for at- risk youth and their families. The state funds, combined with local community funds, are managed by local interagency teams who plan and oversee services to youth. The mission of the CSA is to create a collaborative system of services and funding that is child-centered, family-focused and community-based when addressing the strengths and needs of troubled and at-risk youth and their families in the Commonwealth.
Customers	At-risk youth between the ages of 0 to 21 and their families as defined by VA § 2.2-5212
Total Customers	Youth served: FY19:1,252; FY18: 1,311 ; FY17: 1,428 ; FY16: 1,494; FY15: 1,343; FY14: 1,200
Total Staff Year Equivalents (SYE)	FY2019: 11; FY2018: 10; FY2017: 10; FY2016: 10; FY2015: 10; FY2014: 10
Total Budget	FY2019: $38.3 million for CSA pooled funding; $1,068,171 for program administration FY2018: $38.6 million for CSA pooled funding; $1,053,393 for program administration FY2017: $40.8 million for CSA pooled funding; $1,057,286 for program administration FY2016: $41.9 million for CSA pooled funding; $988,075 for program administration FY2015: $39.8 million for CSA pooled funding; $947,889 for program administration FY2014: $38.0 million for CSA pooled funding; $909,356 for program administration

Results-Based Accountability Performance Plan

Children's Services Act (CSA) System of Care

Summary of Annual and Quarterly[1] Performance Measures	
How Much Was Done?	
1.1	Total Youth Served Annually
1.2.1	Annual CSA Pool-fund Expenditures
1.2.2	Annual CSA Expenditures by Service Type
How Well Was It Done?	
2.1	**Restrictiveness of Living Outcome Goal 1: Increase in percentage of youth participating in CSA who live in family settings.**
2.1.1	Number of youth in a long-term congregate care setting
2.1.2	Percentage of youth participating in Intensive Care Coordination who are successfully prevented from entering residential or group home placement six months and twelve months after initiation of services
2.2	**Restrictiveness of Living Outcome Goal 2: Children participating in CSA living in congregate care are returned as quickly as possible to a family setting.**
2.2.1	Average number of days (length of stay) CSA participating children live in congregate care – measured in current setting and at post-discharge
2.2.2	Number of youth entering long-term congregate care settings
2.2.3	Number of youth exiting long-term congregate care settings
2.2.4	Percentage of youth participating in Intensive Care Coordination who are successfully returned from residential or group home placement within three months of initiation of services
2.3	**Permanency Outcome Goal: Prevent entry into foster care for reasons other than maltreatment**
2.3.1	JDRDC and DFS data on Relief of Custody Petitions: # ROC petitions filed/# children entering foster care from ROC petitions
2.3.2	Number of children entering foster care from CHINS petitions

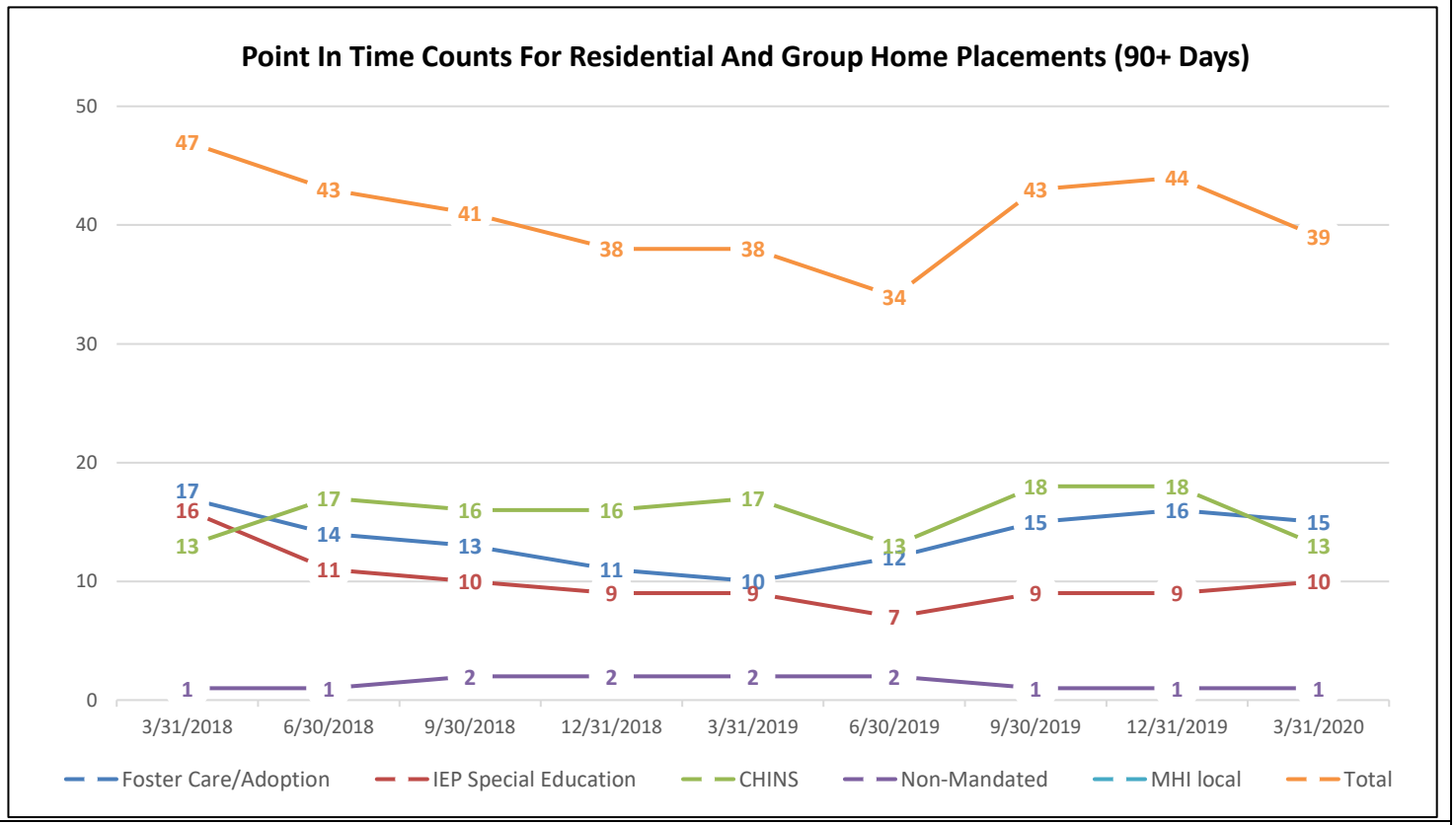
[1] Quarterly performance measures highlighted in blue.

2.3.3	Number of children entering foster care from delinquency petitions	
2.4	**Fiscal Accountability Outcome Goal 1: Fairfax-Falls Church CSA leverages state and local fiscal resources to serve youth and families efficiently**	
2.4.1	Per capita cost per youth receiving CSA services	
2.4.2	Per capita cost per youth receiving residential/ group home services	
2.4.3	Annual per-child unit cost of residential/group home services	
2.5	**Fiscal Accountability Outcome Goal 2: Fairfax-Falls Church is making maximum use of Medicaid as an alternative to CSA or locality funding**	
2.5.1	Percentage of placements in Medicaid-enrolled facilities	
2.5.2	Percentage of Medicaid placements receiving Medicaid reimbursement	
2.6	**Parent Satisfaction Survey**	
2.6.1	Percent of parent survey respondents who are satisfied with CSA services	
	Is Anyone Better Off?	**Headline Measure (HM)**
3.1	**Restrictiveness of Living Outcome Goal 1: Increase in percentage of children participating in CSA who live in family settings.**	
3.1.1	Percentage of CSA youth who received only community-based services	
3.2	**Permanency Outcome Goal: Prevent entry into foster care for reasons other than maltreatment.**	
3.2.1	Percentage of children receiving CSA-funded services through the foster care prevention mandate who are successfully prevented from entering foster care	
3.2.2	Percentage of children with families participating in CSA-funded family partnership meetings through the foster care prevention mandate who are successfully prevented from entering foster care after the family partnership meeting	

3.3	**Functional Outcome Goals: Child and Adolescent Needs and Strengths (CANS) outcomes improve for children served by the CSA system of care from initial assessment to second assessment.**	
3.3.1	Percent of positive change in CANS outcomes by domain level of need	
3.4	**Functional Outcome Goal 1: Children participating in CSA-funded services will experience a decline in behaviors that place themselves or others at risk.**	
3.4.1	Percent of positive change in Child Risk Behavior by actionable rating	
3.5	**Functional Outcome Goal 2: Children participating in CSA-funded services will experience a decline in behavioral or emotional symptoms that cause severe/dangerous problems.**	
3.5.1	Percent of positive change in Behavioral/Emotional Needs by actionable rating	
3.6	**Functional Outcome Goal 3: Children participating in CSA-funded services will experience an increase in identified strengths that are useful in addressing their needs and developing resiliency.**	
3.6.1	Percent of positive change in Strength Domain by actionable strength	
3.7	**Functional Outcome Goal 4: Needs and issues of parents/caregivers of children participating in CSA-funded services that negatively impact their care-giving capacity will be reduced.**	
3.7.1	Percent of positive change in Planned Permanency Caregiver functioning by actionable need	

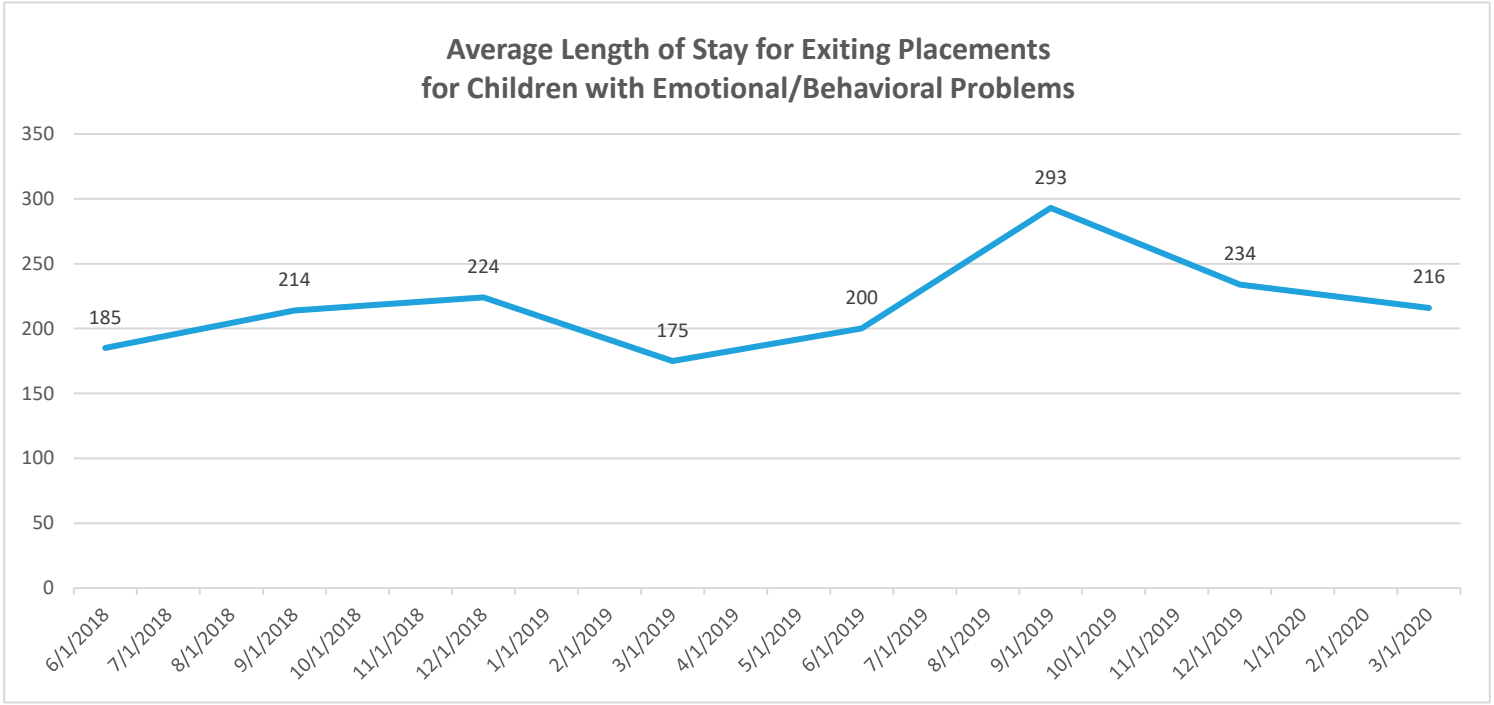
Results-Based Accountability Performance Plan

Children's Services Act (CSA) System of Care

FY 2019 Q3			
How Well Measure	**Number**	**Title**	**Value**
	2.1	**Restrictiveness of Living Outcome Goal 1: Increase in percentage of children participating in CSA who live in non-residential settings.**	
	2.1.1	Number of youth placed in a long-term congregate care setting	39
Graphs/Charts			
Notes	**Analysis**: The total point in time count saw a decrease in the 3rd quarter, mirroring the decrease in CHINS placements. The PIT count decreased by 5 from Q2 to Q3. **Planned Action:** Continue to monitor.		

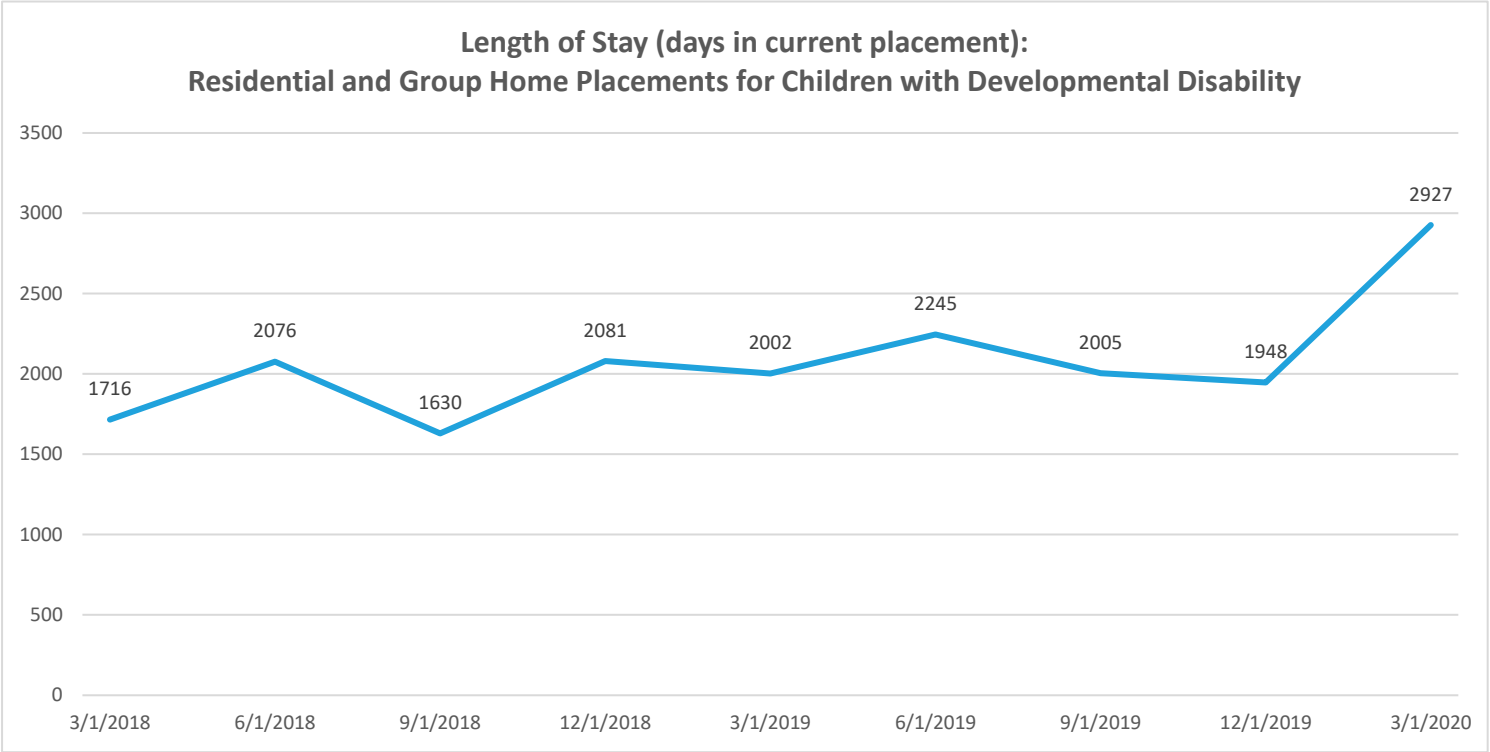
Results-Based Accountability Performance Plan

Children's Services Act (CSA) System of Care

FY 2019 Q3			
How Well Measure	**Number**	**Title**	**Value**
	2.2	**Restrictiveness of Living Outcome Goal 2: Children participating in CSA living in congregate care are returned as quickly as possible to a family setting.**	
	2.2.1	Number of days CSA participating children live in congregate care before being returned to a family setting	216 days for youth with emotional /behavioral disabilities
Graphs/Charts			
Notes	**Analysis:** Best practice indicates that youth with emotional/behavioral problems should be returned to a family setting within 6-9 months [180-270 days]. The length of stay for youth with primarily emotional/behavioral problems exiting placement (n=20) was 216 days at the end of the 3rd quarter (LOS ranged from 43 to 343 days). Ages ranged from 12 to 18, with average age being 16 years. Of the 20 exits, 1 was from Fairfax County Public Schools, 8 were from Foster Care and Adoption, 8 from the Community Services Board, 1 from Falls Church District Court and 2 from Fairfax County Juvenile and Domestic Court. **Planned Action:** Continue to monitor.		

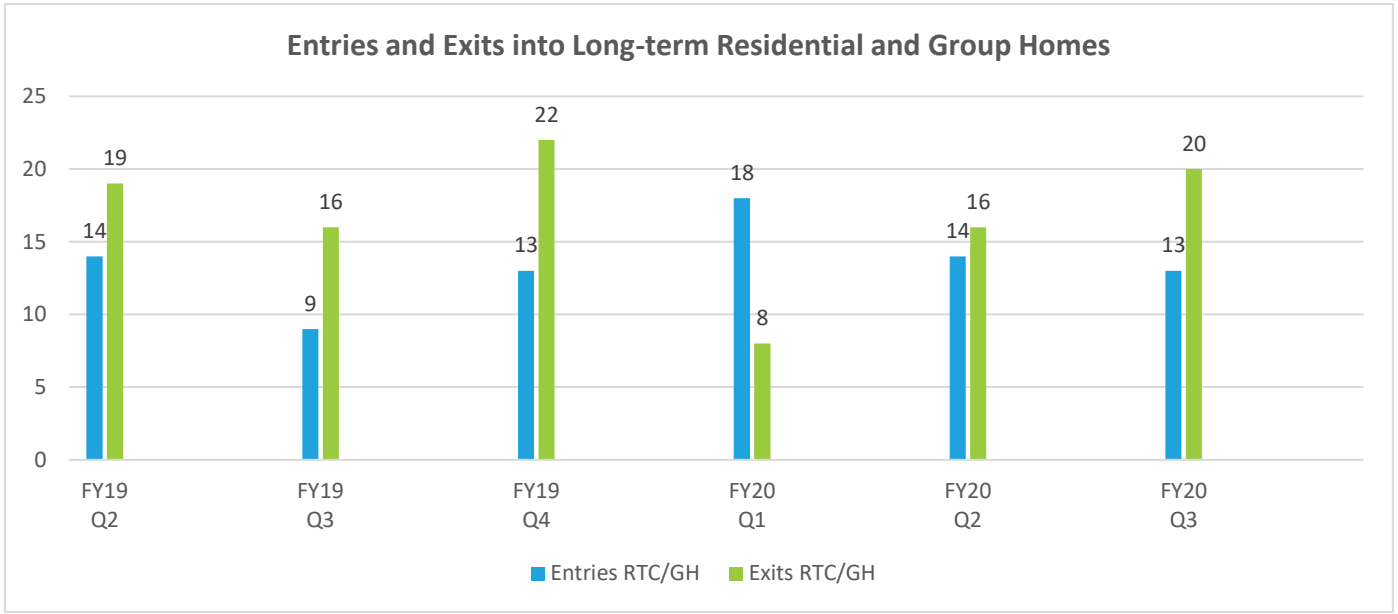
Results-Based Accountability Performance Plan

Children's Services Act (CSA) System of Care

FY 2019 Q3			
How Well Measure	**Number**	**Title**	**Value**
	2.2	**Restrictiveness of Living Outcome Goal 2: Children participating in CSA living in congregate care are returned as quickly as possible to a family setting.**	
	2.2.1	Number of days CSA participating children live in congregate care before being returned to a family setting	2927 days for youth with developmental disabilities
Graphs/Charts			
Notes	**Analysis:** The length of stay for youth with primary needs from developmental disabilities (n=4) was 2927 days, range of LOS is 1,790 to 3,857 days. The four placements are from Fairfax County Public Schools – 2 youths are at Grafton, 1 at Devereux, and 1 at Benedictine. The ages range from 18 to 22, with the average age being 20. **Planned Action:** Continue to monitor.		

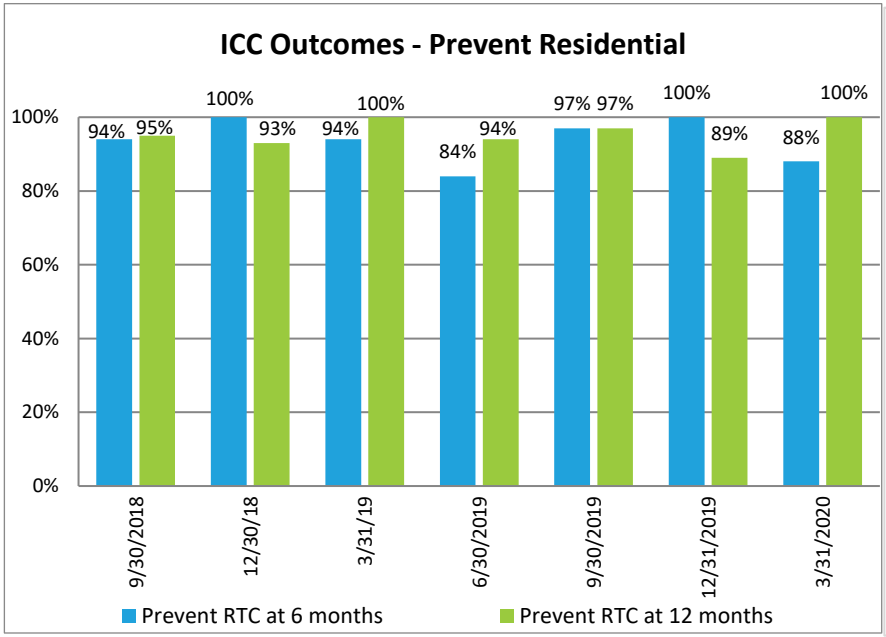
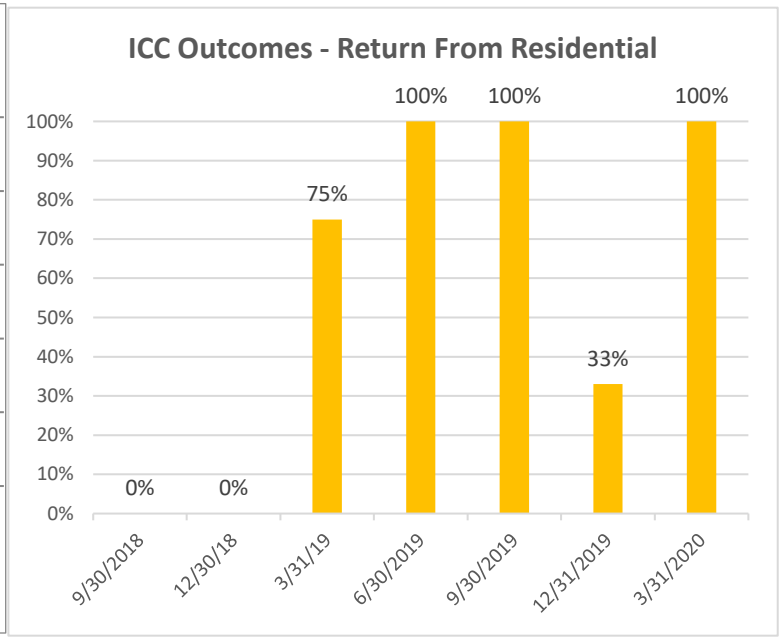
Results-Based Accountability Performance Plan

Children's Services Act (CSA) System of Care

FY 2019 Q3			
How Well Measure	**Number**	**Title**	**Value**
	2.2	**Restrictiveness of Living Outcome Goal 2: Children participating in CSA living in congregate care are returned as quickly as possible to a family setting.**	
	2.2.2	Number of youth entering long-term congregate care settings	13
	2.2.3	Number of youth exiting long-term congregate care settings	20
Graphs/Charts			
Notes	**Analysis:** There were 14 entries and 20 exits this quarter. **Planned Action:** Utilize ICC as a resource for youth to support successful return to a community/family-based setting. Utilize Leland House and crisis stabilization services to meet youth with intensive needs in the community, even during a crisis.		

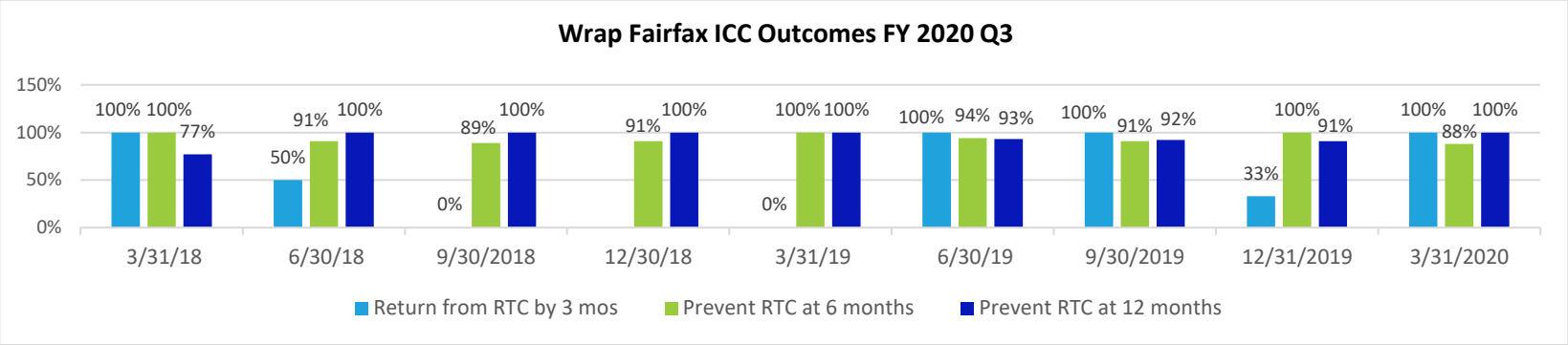
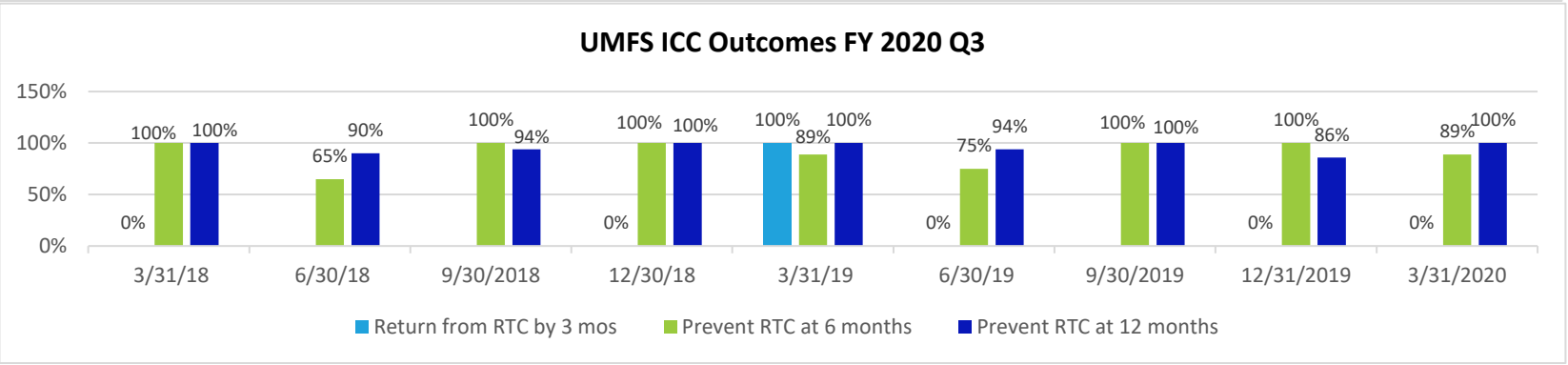
Results-Based Accountability Performance Plan

Children's Services Act (CSA) System of Care

FY 2019 Q3			
How Well Measure	**Number**	**Title**	**Value**
	2.2	**Restrictiveness of Living Outcome Goal 2: Children participating in CSA living in congregate care are returned as quickly as possible to a family setting.**	
	2.1.2	Percentage of youth participating in Intensive Care Coordination who are successfully prevented from entering residential or group home placement six months and twelve months after initiation of services	88% / 100%
	2.2.4	Percentage of youth participating in Intensive Care Coordination who are successfully returned from residential or group home placement within three months of initiation of services	100%
Graphs/ Charts			
Notes	**Analysis:** 88% (22 of 25) of youth were maintained in the community 6 months after initiation of ICC services. 100% (n=31) of youth remained in the community 12 months after the initiation of ICC services. 100% (n=1) youth returned from residential within three months of initiation of ICC. **Planned Action:** Use fidelity monitoring tools developed by the Wraparound Evaluation & Research Team (WERT) to monitor the providers' fidelity to the Wraparound model. The ICC Stakeholder group continues to meet quarterly to address system implementation issues as needed.		

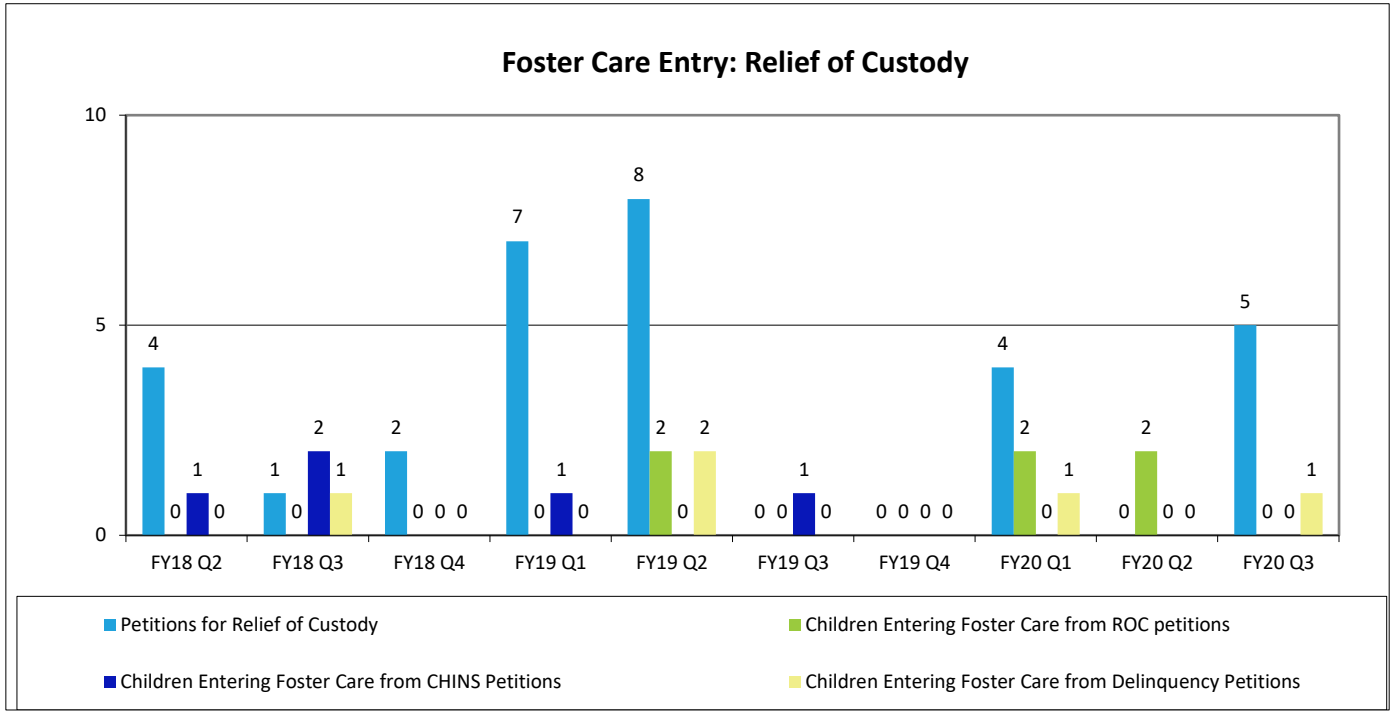
Results-Based Accountability Performance Plan

Children's Services Act (CSA) System of Care

FY 2019 Q3			
How Well Measure	**Number**	**Title**	**Value**
	2.2	**Restrictiveness of Living Outcome Goal 2: Children participating in CSA living in congregate care are returned as quickly as possible to a family setting.**	
	2.1.2	Percentage of youth participating in Intensive Care Coordination who are successfully prevented from entering residential or group home placement six months and twelve months after initiation of services	Wrap FFX 88%/ 100% UMFS 89%/ 100%
	2.2.4	Percentage of youth participating in Intensive Care Coordination who are successfully returned from residential or group home placement within three months of initiation of services	Wrap FFX 100% UMFS --%
Graphs/ Charts	 		
Notes	**Analysis: Wraparound Fairfax:** 88% (14 of 16) of youth were maintained in the community 6 months after initiation of ICC services. 100% (n=11) of youth remained in the community 12 months after the initiation of ICC services. 100% (n=1) youth referred while in RTC returned home within 3 months of initiation of ICC. **UMFS:** 89% (8 of 9) of youth were maintained in the community 6 months after initiation of ICC services. 100% (n=20) of youth remained in the community 12 months after the initiation of ICC services. No youth were referred to UMFS while in residential care.		

Results-Based Accountability Performance Plan

Children's Services Act (CSA) System of Care

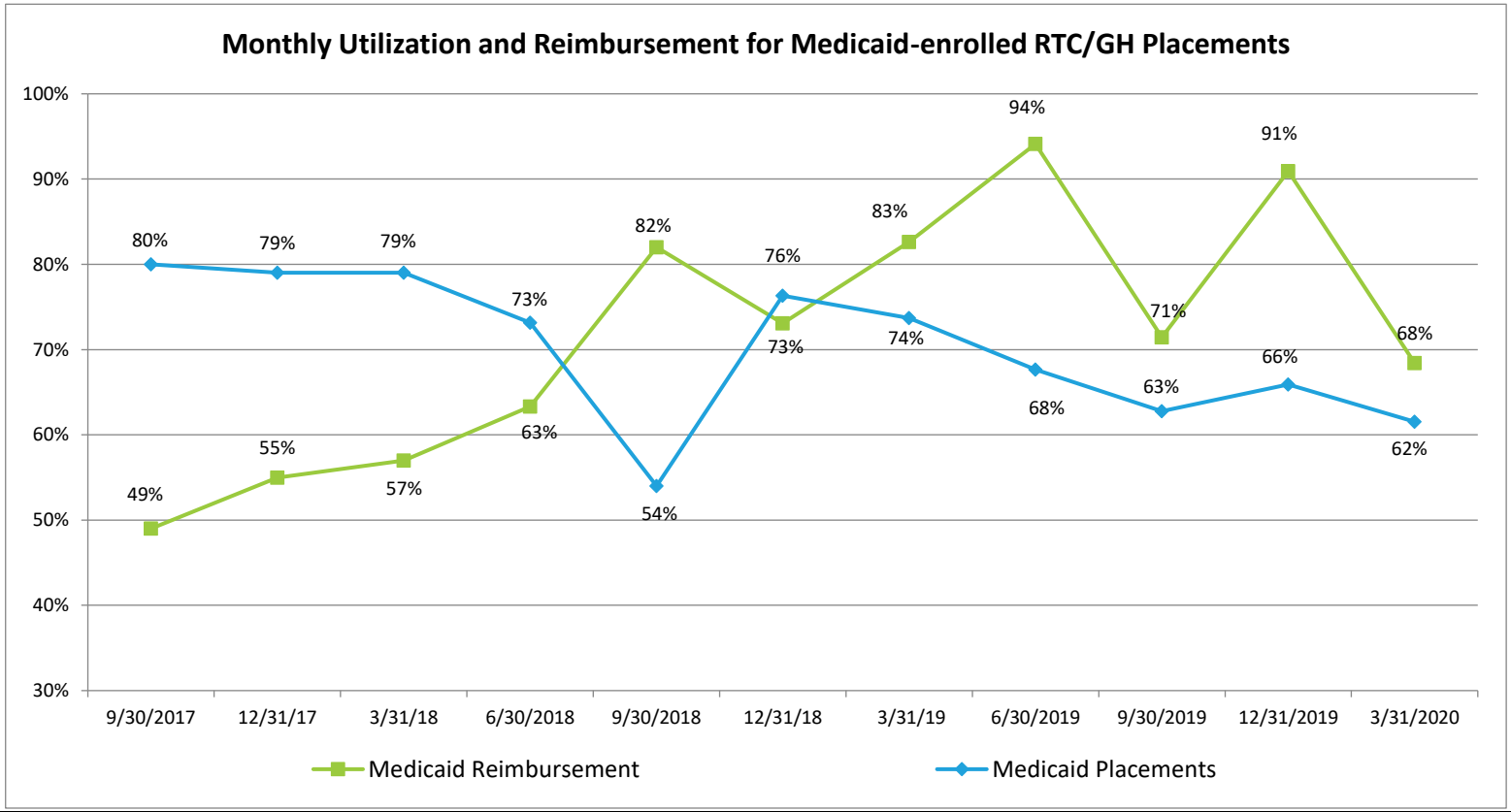
FY 2019 Q3			
How Well Measure	**Number**	**Title**	**Value**
	2.3	**Permanency Outcome Goal: Prevent entry into foster care for reasons other than maltreatment**	
	2.3.1	JDRDC and DFS data on Relief of Custody Petitions: # ROC petitions filed/# children entering foster care from ROC petitions	5 Received/ 1 filed / 0 entry
	2.3.2	Number of children entering foster care from CHINS petitions	0
	2.3.3	Number of children entering foster care from delinquency petitions	1
Graphs/ Charts			
Notes	**Analysis**: 5 ROCs were received, 3 are pending, 1 was resolved, and 1 was filed. **Planned Action**: Continue to monitor.		

Results-Based Accountability Performance Plan

Children's Services Act (CSA) System of Care

FY 2019 Q3			
How Well Measure	**Number**	**Title**	**Value**
	2.5	**Fiscal Accountability Outcome Goal: Fairfax-Falls Church CSA leverages state and local fiscal resources to serve youth and families efficiently**	
	2.5.1	Percentage of placements in Medicaid-enrolled facilities	68%
	2.5.2	Percentage of Medicaid placements receiving Medicaid reimbursement	62%

Graphs/Charts



Notes

Analysis: 62% (24 of 39) of placements this quarter were with Medicaid providers. 15 were placed in non-Medicaid providers because the child is not able to be served in Va, is court-ordered, or is in a non-Medicaid group home. Of the Medicaid placements, the potential for Medicaid reimbursement (Medicaid eligible youth admitted to Medicaid providers) is 19 (79%). Reasons for inegilibility: 2 have no legal status, 2 are over income for Level B group home and 1 is over age 21. Of the 19 Medicaid-eligible placements, 13 (68%) were approved for Medicaid; 6 are pending.

MEMO TO THE CPMT
June 26, 2020

Information Item I-5: Status report on the recommendation listed in the Innovative Behavioral Health Strategies for the Underserved Populations (June 18, 2018).

BACKGROUND:

At the CPMT meeting on October 26, 2018, the Healthy Minds Fairfax Underserve Populations Workgroup presented their final report, Behavioral Health Strategies for the Underserved Populations. The work group was charged to address the Children's Behavioral Health System of Care Blueprint strategies for increasing access and availability to behavioral health services for underserved populations. Of primary concern was the development and implementation of culturally competent strategies in partnership with the community.

Specifically, the Blueprint tasked this workgroup with the following:

1. Develop a common definition of "underserved populations;"
2. Identify the underserved communities/populations (geographically, age range, etc.);
3. Identify main strengths and barriers to providing and accessing behavioral health services; and
4. Develop strategies and recommendations to address identified barriers.

After reviewing multiple reports, the workgroup defined underserved populations as

"any child or family, as members of our community in need of behavioral health services, who cannot access those services due to real or perceived barriers. Access issues may also be due to the navigation process for the parent or the child. These barriers and other logistical challenges help to prevent children and families from receiving immediate behavioral health services when needed in a timely manner. Underserved children are not necessarily predicted by socioeconomic status, geography within the community, ethnic group, or access to insurance benefits."

Based on recommendations in the report, Healthy Minds Fairfax is entering the third year of contracting with Northern Virginia Family Service to expand their Violence Prevention and Intervention Program (VPIP) to continue to expand services to Latino youth in underserved areas in Fairfax County. Members of the Underserved Workgroup continue to work with the Community Services Wellness, Health Promotion, and Prevention team to increase the number of Youth Mental Health First Aid to faith/youth leaders. Healthy Minds Fairfax provided funding to Our Minds Matter, a peer-based program to change the culture about mental health, to adapt its curriculum from a school-based program to a community-based program. Additionally, Healthy Minds Fairfax facilitated a relationship between Our Minds Matter and Neighborhood and Community Services so the Our Minds Matter program can be offered to youth attending the South County Youth Center. Moving forward, the Healthy Minds Fairfax Underserved Workgroup plans to discuss targeted approaches to meeting the mental health needs of LGBTQ youth and to discuss measures to reduce the increasing suicide rate of black youth.

Original Workgroup Members:

Elizabeth Petersilia
Program Manager, Healthy Minds Fairfax

Birgit Snellenburg
Program Manager, Youth & Family Outpatient, Community Services Board

Ramona Carroll
Interfaith Coordinator, Neighborhood & Community Services

Jenifer Henry-Jones
Community Developer, Region 3, Neighborhood & Community Services

Michael Monahan
Clinical Coordinator, Department of Family Services

Courtney Porter
Director, Research & Development, Juvenile and Domestic Relations District Court

Jenny Sell
Graduate Social Work Intern, Healthy Minds Fairfax

Desiree Gordon
Management Analyst, Healthy Minds Fairfax

Sharon Frost
Director of Child Placement Services, Northern Virginia Family Services

Kathi Sheffel
Homeless & Foster Care Liaison, Fairfax County Public Schools

Current Workgroup Members

Peter Steinberg
Program Manager, Healthy Minds Fairfax

Birgit Snellenburg
Program Manager, Youth & Family Outpatient, Community Services Board

Ramona Carroll
Interfaith Coordinator, Neighborhood & Community Services

Jenifer Henry-Jones
Community Developer, Region 3, Neighborhood & Community Services

Desiree Gordon
Management Analyst, Healthy Minds Fairfax

Sharon Frost
Director of Child Placement Services, Northern Virginia Family Services

Kathi Sheffel
Homeless & Foster Care Liaison, Fairfax County Public Schools

ATTACHMENT:
Innovative Behavioral Health Strategies for Underserved Populations

STAFF:
Peter Steinberg, Healthy Minds Fairfax

6/18/2018

Innovative Behavioral Health Strategies for Underserved Populations

Underserved Populations Workgroup
FAIRFAX COUNTY GOVERNMENT

Table of Contents

Workgroup Members:

Elizabeth Petersilia
Program Manager
Healthy Minds Fairfax

Birgit Snellenburg
Program Manager, Youth & Family Outpatient
Community Services Board

Ramona Carroll
Interfaith Coordinator
Neighborhood & Community Services

Jenifer Henry-Jones
Community Developer, Region 3
Neighborhood & Community Services

Michael Monahan
Clinical Coordinator
Department of Family Services

Courtney Porter
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Juvenile and Domestic Relations District Court

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Desiree Gordon
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Sharon Frost
Director of Child Placement Services
Northern Virginia Family Services

Kathi Sheffel
Homeless & Foster Care Liaison
Fairfax County Public Schools

Introduction

Fairfax County's Board of Supervisors authorized the creation the Children's Behavioral Health System of Care. The initiative works to improve the quality of children's behavioral health services and increase families' ability to access services for themselves and their children. Thirty community stakeholders, including Fairfax County Health and Human Service agencies, Fairfax County Public Schools, behavioral health non-profits, family-run organizations and one brave teen worked together in creating the Children's Behavioral Health System of Care Blueprint. The Blueprint charged this workgroup, as part of the Healthy Minds Fairfax (formerly Children's Behavioral Health System of Care) Initiative, to address increasing access and availability to behavioral health services for underserved populations. Of primary concern is the development and implementation of culturally competent strategies in partnership with the community.

Specifically, the Blueprint tasked this workgroup with the following:

1. Develop a common definition of "underserved populations;"
2. Identify the underserved communities/populations (geographically, age range, etc.);
3. Identify main strengths and barriers to providing and accessing behavioral health services; and
4. Develop strategies and recommendations to address identified barriers.

After reviewing multiple reports,[1] the workgroup defines underserved populations as

> *"any child or family, as members of our community in need of behavioral health services, who cannot access those services due to real or perceived barriers. Access issues may also be due to the navigation process for the parent or the child. These barriers and other logistical challenges help to prevent children and families from receiving immediate behavioral health services when needed in a timely manner. Underserved children are not necessarily predicted by socioeconomic status, geography within the community, ethnic group, or access to insurance benefits."*

While Fairfax County exhibits a vast network of public and private providers and partnerships, Fairfax County's 2016 Human Services Needs Assessment indicates a lack of accessible and affordable out-patient treatment options. In addition, the report indicated needs around intensive care coordination or case management as well as services for young adults as they age out of the system.[2] At the same time, Fairfax County's Youth Survey[3] and a myriad of other studies and research articles identify pockets of youth from specific cultural and racial groups experiencing more significant behavioral health symptoms and stress than others in our middle and high school populations. These groups include Latina youth, Asian/Pacific Islander girls, and African American girls.

Fairfax County Youth Survey Summary Findings

The workgroup used findings from The Fairfax County Youth Survey to assist in identifying groups for participation in focus groups. These findings are presented below.

[1] See Appendix A for a list of reports reviewed during this process.
[2] Fairfax County. (May 2016). Fairfax County Human Services: 2016 Needs Assessment
[3] Fairfax County. (September 2017). Youth Survey

The annual Youth Survey asks students in 8th, 10th and 12th grade several questions related to mental health and assets that build resiliency. General findings from the 2016 survey indicate 36 percent of students report high levels of stress within the past month; while 26 percent of students report feeling sad or hopeless almost every day for two weeks or more during the past year. Findings on these two indicators differ by race with 39 percent of Asian/Pacific Islanders reporting higher levels of stress compared to Black (31%), Hispanic (34%) students and White (36%) students. Hispanic youth (31%) report feeling sad or hopeless at higher rates than White (24%) or Black (25%) youth. Girls are more likely than boys to report high stress (45%) or feelings of sadness/hopelessness (33%). These levels increase as students get older, with 12th grade respondents (regardless of race or gender) indicating higher levels of stress and feelings of sadness/hopelessness than their younger peers.[4]

Research[5,6] identifies several "assets that build resiliency." Those included on the Youth Survey include questions around parents available to help; teachers notice and compliment good work; adults are available to talk in the community; extracurricular activities are available in the community; volunteer opportunities; and students recognize accepting responsibility for actions and mistakes is important. Overall, 94 percent of students report availability of extracurricular activities; while, 82 percent of students reported they can ask their parents for help with a personal problem. Seventy-nine percent of students reported accepting responsibility is important and 63 percent reported that their teachers notice and compliment them when they do a good job. Finally, 43 percent of students have adults in their community available to talk.

Research[7] indicates that youth with three or more assets that build resiliency thrive in health, school, and daily life and are less likely to engage in risky behaviors. Special analyses on data from the 2016 Youth Survey evaluated differences on youth reporting three or more assets by race and gender. For the purposes of this workgroup, special emphasis was placed on youth indicating *less than three assets*, as these students could be considered underserved or in need of services. According to the survey, 17 percent of girls and 18 percent of boys reported less than 3 assets.

The special analysis found over 50 percent of Hispanic, Asian/Pacific Islanders and Other girls indicating less than three assets reported feeling sad or hopeless almost every day for two weeks or more sometime in the last 12 months. Boys with less than three assets across all races were less likely to report feelings of sadness or hopelessness. In addition, the majority of girls (regardless of race) with less than three assets reported higher levels of stress than those with three or more assets to build resiliency. High levels of stress also increase with age for youth having fewer than three assets, with 12th grade girls reporting higher levels of stress than 8th grade girls. Findings for boys with less than three assets followed similar trends for high levels of stress.

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[4] Fairfax County (September 2017) 2016 Youth Survey Highlights. Found at http://www.fairfaxcountyyouthsurvey.com/highlights.php?year=2016&cat=11&grp=I3

[5] Centers for Disease Control and Prevention. (2009) School Connectedness: Strategies for Increasing Protective Factors Among Youth. Atlanta, GA: U.S. Department of Health and Human Services.

[6] Bernard, B. (ND). The Foundations of the Resiliency Framework. Found at http://www.resiliency.com/free-articles-resources/the-foundations-of-the-resiliency-framework/

[7] Ibid

Based on these findings, the workgroup included representatives from the Asian/Pacific Islander and Hispanic communities (see Table 1) among the focus group participants.

Data & Methods

To assess the Fairfax County community's concerns and suggestions, focus groups were utilized to collect data. Focus groups allow for in-depth insight into how people think and feel without the time burden of individual interviews. Additionally, the interaction of participants and non-verbal communication are two benefits of focus groups. Interaction between participants of diverse backgrounds allows individuals to make connections and pose questions they normally would not have and non-verbal communication can provide valuable insight to group dynamics in addition to specific dialogue.[8]

A total of 15 focus groups were conducted between April and October 2017. One hundred seventy-six individuals participated in the 15 focus groups (see Table 1 below for a demographic breakdown of participants). Facilitators asked local groups, communities and teen centers if they would be willing to participate in the focus groups.[9] The focus group participants included teens, mothers, fathers, and community leaders from the Latino, Asian, African American, West African and White populations. A facilitator and note-taker then met with each group asking prescribed questions about accessing services, barriers to services, and suggested strategies for improvement.

Table 1: Demographics of Focus Group Participants

	Number	Percent
Gender		
Male	57	32%
Female	119	68%
Race/Ethnicity		
Asian*	37	21%
African American/West African	69	39%
Hispanic	58	33%
White	12	7%
Age		
Youth	69	39%
Adults	107	61%
Total Participants	**176**	

*Asian includes Korean, Indian and Middle Eastern participants

[8] Nagle, B. & Williams, N. (). Methodology brief: Introduction to focus groups. *Center for Assessment, Planning, & Accountability*.

[9] The focus groups included several Mother's Groups; Father's Groups; Korean Leaders; Parent Café; Youth Groups; Faith Community in Action Group; and Groups from local Community Centers. The groups are not specifically identified to protect the anonymity of participants.

On average, group sessions lasted for 90 minutes and were conducted with a group facilitator and a note taker. Interpreters were used as needed for non-English speaking participants. Focus group notes were linked to the qualitative software program Atlast.Ti and coded for thematic content and/or patterns both based on questions developed by the workgroup (see Table 2) and distinct participant comments. Codes were modified and combined throughout the analysis process resulting in the broad themes discussed in the findings section below.

Table 2: Focus Group Questions

1. Do you think that you or someone you know has the mental health or substance abuse services you need in your community?
2. How do you access services?
3. What gets in the way of you or someone seeking mental health or substance abuse help?
4. Here are some barriers that have been identified? What else do you think makes things difficult in accessing services?
5. How do we/you overcome the things that you said were difficult in accessing help?
6. Do you feel the services you were provided respected your values and beliefs?
7. What are some solutions to make things easier for you to access mental health or substance abuse services?
8. Who do you go to for help for your child if they are having problems?
9. What are some positive experiences you have had with county service providers?

Findings

In general, analysis of the focus groups revealed several themes under each of the broader categories: access; barriers; and suggested strategies. Themes around accessing services included access through schools, religious institutions, and community centers; themes regarding barriers were in community awareness about mental health, lack of trust, overworked employees, and cultural concerns; and themes around strategies include education, community resources, and county resources

When asked "Do you think that you or someone you know has the mental health and substance abuse services needed in the community?" many participants stated yes. One participant indicated receiving support from the police and another indicated that "*Fairfax County has all the services anyone needs*." However, while services might be available, not all services are accessible.

Access

Overall participants identified various ways they or someone they know access mental health or substance abuse services. Participants indicated accessing services through schools, religious institutions, community connections (including community centers, health departments, teen centers, and cultural community), the courts, probation, or military bases.

Access Through Schools

Most participants felt that the schools "*were the easiest to get to*" when accessing services, with several participants indicating school mental health professionals (counselors, social workers, psychologists) as the go-to person to access services. Participants felt that *"counselors [school mental health professionals] tend to lead services and are more knowledgeable"* generating a feeling of comfort or at least a place to start for students and families. In addition to school mental health professionals, participants identified favorite teachers and the parent/school liaison as potential access points within the schools.

> "*I would feel more open to a school professional than an outside person.*"

Youth participants indicated that they are close to teachers or security personnel at schools and will reach out to them if they need help.

> "*Kids start sharing when they go on retreats outside of church with youth pastors and Sunday School teachers, more so than with their parents*."

Access Through Religious Institutions

Other participants relied on religious institutions as the entry way to the system and/or to provide the services. Asian participants specifically indicated that families and youth are more connected with their religious institution. In response to discussions about religious institutions, participants stated that "*youth pastors are under a tremendous burden,*" indicating a need for more resources or additional training. Other participants stated that *"the clergy needs to be more vocal around this and not [be] shy around the issue. Encouraging others to get help.* Participants from the faith communities recognized their roles in educating their congregations saying *"We have to normalize it. Speak in the [correct] language. [It's] easy for 'us' to speak about this because we understand it."* However, they also stated a need to understand their limitations and role in connecting individuals with other resources *"away from the church." "Pastors are sometimes more like CEOs and do not have the connections to their communities like they used to."*

Access Through Community Center

Community Centers and teen centers were mentioned as potential ways to access mental health services, with several participants specifically mentioning the Creekside Community Center, Fairfax County Teen Centers, and the Culmore Community Center.

Access Through Other Avenues

Only a few participants discussed accessing services in ways other than schools or religious institutions, with one participant expressing positive comments around services received through probation. Other participants mentioned accessing behavioral health services through general medical practitioners or pediatricians.

Barriers

Lack of Knowledge and Understanding

Participants stated that many people do not view mental health the same way as physical health. *"The topic in general is not being openly discussed."* However, for those participants who do want help many do not where to start. *"Parents don't connect with school counselors, [believing] they are there for academics not mental health."*

> *"The system is too big, first the school, then South County, DFS, CPS, NCS, CSP, it's too intimidating. [I] don't have the confidence to answer all the questions asked, [I] don't trust the staff and feel judged."*

Many youth and adult participants commented specifically on a lack of understanding on behalf of parents indicating that parents believe that mental health concerns are *"just a phase*" or are ignorant of the issue. *"Parents don't connect to the stress of today, they expect youth to 'deal with it'."* Peers and parents can be judgmental, making it difficult for youth to come forward and seek help. One participant stated, *"People would make fun of me if I asked for help."* Another participant said *"Kids our age don't think about things like that. Not that they don't care if they have a problem but they don't want to be seen to have a problem. Sometimes when you get older people don't judge you as much but when you're young you can get bullied and stuff like that."*

> *"A friend took a pregnancy test and youth did not want family to know. [The] counselor called her parents and she got in trouble. We lose trust in counselors and don't know where to go."*

Lack of Trust with the System

There was a general lack of trust with the system among all participants (youth and adults), especially around the ideas of confidentiality and privacy. Youth reported that there was a lack of understanding between student and counselors about what would be kept in confidence versus what would not. There were general feelings among youth that the *"School does not help me, there is no confidentiality with the counselor since the counselor has to tell my parents."* In addition, participants reported that *"Teachers' stigmas and perceptions [around mental health] need to be addressed"* to ensure youth are receiving appropriate support. One participant stated, *"might be afraid to ask, think the person will tell what you've shared, don't believe there is confidentiality."*

Outside of the school environment, participants report feeling a lack of privacy when accessing services. *"People see me."* A few participants found service providers unhelpful and inconsistent in their follow up. Additionally, several participants indicated a fear of deportation due to what they hear on the news. People are *"fearful of being deported because going back to their home country is dangerous. People back there believe that individuals who are deported go back with money."*

> *"There are people in the community who are afraid of asking for help—afraid that the government will take their children away if parents can't care for them. I believe they instill fear in you so you won't ask for help."*

Stigma/Labels of Mental Illness

Many participants spoke about the stigma associated with mental health as a barrier to seeking behavioral health services. Specifically, participants mentioned losing respect in the community if they sought mental health treatment or were known to have a mental illness. "Once you go to a therapist or a psychologist something is wrong with you." Other participants spoke about religious stigmas referring to beliefs that those with mental illness were possessed or labeled as witches within the religious communities.

> *"School counselors can only invest in a few students. They cannot invest a lot into many students. They are limited in what they can do."*

Overworked Employees

Participants also identified overworked school counselors and employees as an additional barrier. Participants stated that students receive services but teachers don't always know what is going on with the students or how to help them, even if they were the one making the referral. Other participants stated that the counselor-to-student ratio is an issue making it difficult to deal with anything that is not school related. Another participant stated that anxiety around testing and SOLs is not taken seriously. *"My child was passed from teacher to counselor to assistant principal and finally to the school health aide,"* but nothing was done. One youth also stated that *"Counselors are too personal, it's weird to talk to them, [I] don't feel that they are going to help. They are not going to understand, just tell you what to do."*

Cultural Concerns

Many participants spoke about specific cultural concerns that can act as barriers to accessing services. In general, participants spoke about the stigma surrounding mental health and losing respect in their community. Other participants did not feel comfortable discussing their issues because of cultural differences and beliefs. They do not believe it is right to discuss these issues. A few participants also mentioned the belief that medication will make them crazy.

> *"It is difficult to find a therapist who knows how to take a youth's faith into consideration during the counseling experience."*

Specifically, those participants more connected with their faith stated that many times the religious aspect of counseling is left out. Other participants seeking help through their religious institutions indicated that religion is seen as a magic bullet. *"We're told to '"Just go pray, read bible verses' and '"Place our reliance in God'."*

> *"I am frustrated that I can only speak Spanish. I called the [Mobile] Crisis line and received a call two days later because they did not have a Spanish speaker at the Mobile Crisis line at that time."*

Finally, most participants commented on the lack of cultural competency and diversity among service providers, including the lack of services in languages other than English (Korean and Spanish were specifically named). Participants felt that counselors need to understand the "world view" of their clientele. *"Counselors do not have diversity training. Providers do*

not understand norms and cultures of different groups. Mental health clinicians do not represent the community. The community will not go to them."

Additional Barriers

Participants also mentioned several additional barriers such as insurance not covering behavioral health, other financial concerns, availability of services, and lack of space with private providers. One participant stated that a private provider would *"only accept cash."*

Some participants also discussed the idea that people are in survival mode and must manage all their needs. One participant described it as *"A wheel that is too scary to jump off and get help because you may not be able to get back on the wheel and manage daily life as a single mother with bills, kids, and other responsibilities."* Several participants also discussed the availability or hours of services stating these *"should be appropriate for the population trying to access it."*

"You guys charge too much."

Other barriers included transportation concerns, *"finding the right kind of help,"* and family concerns. One participant mentioned that parental mental health might prevent youth from receiving services and privacy rights prohibit other family members from intervening. Another participant stated that *"One parent may not agree with getting treatment"* making it difficult for the youth and rest of the family. Some youth participants also indicated that parents don't always believe them. "*Parents don't acknowledge and don't believe they have a mental illness."*

Suggested Strategies

Education

Participants discussed education as the number one strategy. All participants indicated that parents and youth need a better understanding and awareness of mental health issues to reduce stigma and judgment. Some general suggestions included providing early education to children about mental health and substance abuse, normalizing mental health though education, educating the community about available services and raising overall awareness.

"Educating students that are facing puberty and hormonal effects and distinguish them from the effects of depression and anxiety that can happen at this time."

More specific suggestions included educating youth about general mental health who in turn educate their peers. Another participant suggested *"Game night with parents, youth and counselors to build understanding of mental health issues. This also allows parents to give back to the schools and the community."* Educating parents is also important. "*Increasing parental involvement in understanding what is going on with their children, especially around mental health."* Be cognizant about education within different cultures. *"In shame-focused cultures, you don't talk about your issues. It's not about you, but you get the help indirectly. Create a video that's not your family but it is [like] your family."*

Community Resources

Many participants discussed using existing community groups or creating peer groups to facilitate access to services and letting people know they are not alone in their experiences. One participant suggested *"starting a peer group to help students in need seek professionals."* Another participant stated that *"providing community groups focused on positive social interaction and behavior management skills for the K to 6th grade youth and families"* would be helpful as well as having community liaisons participate and bridge services between providers and the community. Participants also discussed the benefits of the "Parent Café"[10] and the need to expand participation. One participant also suggested monthly meetings within religious institutions to discuss the topic of mental health openly with confidence and privacy.

> *"We need to access others in the community who do not see the benefits of the Parent Café as a resource to support services."*

Youth participants also indicated that reaching out to those who have *"been through it"* or asking *"friends or someone they know that won't let others know and help them get past it"* as possible strategies within the community. Another participant indicated that *"If the help is not in a safe or familiar place, they probably won't go, that's why services in the community center is a good idea."*

Improving County Resources

Several participants discussed a need to improve county resources in various areas. One participant indicated a need to improve training in empathy, interpersonal communication, cultural competency and crisis management. *"When someone is in crisis, [workers] need to acknowledge our emotions first."* Some participants also felt there was a disconnect between county workers and the African American community stating a need to *"improve cultural competency of what African Americans face, not just what people from other countries face when they deal with accessing services."* One group stated that, while services were available, they lacked diversity. *"Services can address the needs of the Hispanic Community but not the African American Community."*

> *"Go where the kids are. Therapists should be in the schools. Have a mental health check-up/check-in day with donuts. Parents don't have to take off, don't have to worry about transportation or traffic."*

Other suggestions included increasing trauma-informed providers, providing general customer service training for all county and school staff and hire mental health professionals that are diverse in gender

[10] Parent Café is an innovative model that builds on protective factors that keep families strong. Parents build their own sense of competence and power by building relationships and connecting with other parents who share common experiences, successes, and challenges. DFS sponsored Parenting Education Programs (PEP) hosted Parent Café throughout the County for anyone in a parenting role who wishes to participate in weekly group meetings. Groups are parent-led with parents picking the topic of discussion for each meeting while a trained group facilitator plays a supportive role by guiding the discussion. Using speakers, parent participation and skilled facilitation Parent Café is able to address a range of topics from social-emotional development and praise to family health and domestic violence. Three non-profits partnered to host a Parent Café at their community sites, allowing PEP to reach parents who typically do not participate in formal parenting classes. During FY2017, a total of five groups were held in the South County and North County regions of Fairfax, reaching over 60 parents.

and race and represent LGBTQ communities. Additionally, youth participants indicated that more promotion about the teen centers and the various services offered would be helpful to the community.

Other Suggested Strategies

Participants also discussed other strategies that might be helpful in increasing access to services. One participant suggested having a late bus system at the school to allow youth to access counseling. Another indicated that more home-based services would be useful. Several participants mentioned the possibility of using social media to educate and treat mental health among youth.

Discussion

Several themes mentioned above warrant additional discussion. One area highlighted as a lack of trust with the system is deportation. Recent government administration and legislative changes have affected immigration and are frequently in the news. Participants indicated a fear of deportation due to what they hear on the news and that going back to their home countries can be dangerous. The workgroup reached out to several agency contacts to gain insight into the community concerns surrounding deportation and how this fear impacts access to services.

Three of the Department of Family Services' Divisions: Children, Youth and Families; Self-Sufficiency; and the Office for Children report concerns about clients not applying for services related to deportation fears. Within the past year, several instances have highlighted these concerns. Staff in DFS's Children, Youth and Families Division report two families not allowing nurses/home visitors into their homes last winter due to fears of deportation; however, no additional reports since then. In February 2017, the Self Sufficiency Division began tracking the number of requests to close a family's public assistance case due to staff concerns related to possible client deportation fears. There were 9 requests in February, 4 in March and then 1 for April and 1 for May. Since then, there have been no further requests. Self Sufficiency Division caseloads have not dropped and applications have remained steady or increased in the last few months. While deportation concerns appear to exist, it does not seem to be widespread or an indication that community members are not accessing services.[11] Local Agencies should continue to monitor these concerns and adjust policies when appropriate.

Another area discussed among participants was a lack of information sharing between teachers, counselors and other school personnel. Confidentiality rules for mental health providers and others may be affecting this information sharing. Further research should focus on identifying ways to combat these barriers. In addition, some participants mentioned going to teachers or school officials for help while others cited a mistrust of school. This could be due to personal preferences and/or cultural differences. However, even with some participants indicating a mistrust of school personnel, the number one access point to behavioral health care was through the schools.

Recommendations

Overall, the focus group participants expressed a variety of opinions and shared valuable feedback with facilitators. Many referenced accessing mental health services through schools or religious institutions.

[11] Fairfax County Department of Family Services, Cross Division Services

Primary barriers to accessing services included lack of trust, lack of knowledge, cultural concerns, and overworked employees. Areas for possible improvement primarily focused on education of youth and parents, increasing access (location, transportation, proximity, etc.) and knowledge of community resources and improving county customer service (i.e. training).

Recommendations fall within three larger categories: Therapeutic, Prevention and Marketing/Outreach. Some recommendations are applicable and reach all underserved populations and others are more targeted to specific groups.

Therapeutic

Therapeutic recommendations include a continued focus on building competencies amongst behavioral health professionals (county and private) in evidence based treatment models such as Cognitive Behavioral Therapy, Trauma Focused Cognitive Behavioral Therapy, Dialectical Behavioral Therapy, and Motivational Interviewing (see Evidence-Based Practices Workgroup's final recommendations for additional information on these treatment models). Specific recommendations include increasing **Trauma Informed Individual and Family Mental Health Counseling** to Latino youth in underserved areas in our community, possibilities include Culmore, Springfield or Herndon through the expansion of Violence Prevention and Intervention Program (VPIP) at Northern Virginia Family Services (NVFS).

Culturally competent, language specific trauma-recovery mental health services are integrated into the home, school or community setting based on assessment and the family's needs. Bilingual, bicultural counseling services are designed to strategically focus on problem resolution and skill building. Services are provided within the school, community, home or office, based on client preference and access needs. To effectively provide services to youth in both the community and school-based setting, time spent coordinating the various parties is essential to a cohesive, well communicated effort. NVFS' Mental Health Counselors therefore work with school personnel, parents and community-based staff on cases to facilitate treatment goals, referrals and emergency services. Even deeper investigation of specific culturally competent treatment approaches needs to occur to expand our therapeutic intervention options with our underserved populations. In addition, further outreach to and more discussion with current treatment providers to our underserved populations needs to take place. There are three recommended approaches to accommodate an increase in cultural competence in a therapeutic setting: The Cultural Formulation Framework (CFI), the Multi-Dimensional Ecological Comparative Approach (MECA) and Shared-Decision Making.

The Cultural Formulation Framework (CFI) is a set of 14 questions developed by the American Psychiatric Association and DSM-5 Cross Cultural and Issues Subgroup[12] and can be used across all settings (see Appendix B). CFI relies on the idea that most individuals are part of multiple cultures used to develop their identities and attempts to clarify the contribution of "culture" by assessing the client's view point. CFI assesses 4 domains: cultural definition of the problem, cultural perceptions of the cause, context and support, cultural factors affecting self-coping and past help seeking and current help

[12] DeSilva, R., Aggarwal, N.K. & Lewis-Fernadez, R. (2015). The DSM-5 cultural formulation interview and evolution of cultural assessment in psychiatry. *Psychiatric Times. 32(6)* Retrieved from http://www.psychiatrictimes.com/special-reports/dsm-5-cultural-formulation-interview-and-evolution-cultural-assessment-psychiatry

seeking. The information gathered through the framework enhances the cultural validity of the diagnostic assessment, facilitates treatment planning and promotes client engagement and satisfaction.[13]

The Multi-Dimensional Ecological Comparative Approach (MECA) defines culture as multidimensional and fluid with varying access to ecological resources.[14] Similar to CFI discussed above, MECA operates under the belief that all individuals are multicultural belonging to and participating in multiple cultural and contextual groups. The client is the expert in defining their culture. MECA focuses on 4 major domains: migration and acculturation, ecological context, family organization, and family life cycle. However, MECA indicates that culture-specifics should not be the sole focus of concern for assessment and clinical practice but rather consider universals or idiosyncratic histories, culture-specific aspects (ethnic values, religious rituals), and each ecological niche.[15]

Tying in with both CFI and MECA above, **Shared-Decision Making** is another framework used within the medical[16], education[17] and behavioral health[18] fields to address cultural relevance across groups. Based on the concept of self-determination the model has 3 steps: 1) introducing choice; 2) describing options, often by integrating the use of client decision support, and providing high quality information, asking what they already know, and assessing whether it is correct, and 3) helping clients explore preferences and make decisions by exploring their reactions to information.[19] The model depends on a positive relationship between client and therapist and respecting what matters most to the client as individuals.

In addition to the frameworks discussed above, we recommend a more **flexible delivery model** allowing for therapy services to be delivered either in-home or in settings closer to clients' community. These services could be embedded in nearby community centers (e.g. Culmore, Springfield Family Resource Center), houses of worship or schools.

Several cultural specific therapeutic approaches are also recommended including Cuerto/Dichos Therapy, Family Adelante, Nosotras, and Therapy for Black Girls. A culturally modified trauma-focused treatment for Latino youth, **Cuerto/Dichos Therapy** uses the concepts of Machismo, Marianismo, Familismo, Personalismo, Fatalismo, Dichos & Suentos, and Spirituality. Specifically, this treatment model uses folktales and Spanish proverbs to discuss acceptable behavior and moral messages as well as

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[13] ibid
[14] Falicov, C. J. (2017). Multidimensional Ecosystemic Comparative Approach (MECA). In Encyclopedia of Couple and Family Therapy. Eds J.L. Lebow et al. Springer International Publishing.
[15] ibid
[16] Godolphin, W. (2009). Shared decision making. Healthcare Quarterly, 29(Sp). Retrieved from http://healthcarequarterly.com/content/20947
[17] Liontos, L. B. (1993). Shared decision-making. OSSC Bulletin, 37(2).
[18] Joosten, E.A.G., DeFuentes-Merillas, L., de Weert, G.H., Sensky, T., van der Staak, C.P.F. & de Jong, C.A.J. (2008). Systematic review of the effects of shared decision making on patient satisfaction, treatment adherence and health status. *Psychotherapy & Psychosomatics, 77*, 219-226. Retrieved from https://pdfs.semanticscholar.org/61ed/c4ea9f50e7b3444282978dc25ef63d40416f.pdf
[19] ibid

allow clients to more easily express themselves.[20] Research shows Cuerto/Dichos Therapy reduces anxiety and depression in youth. Another service targeting the Latino population is **Familia Adelante** operating via word of mouth which validates the value of services to the families. The program identifies gaps in services for low to moderate income target populations and develops partnerships to provide those services including utilizing public/private partners, corporations, government, business, and volunteers.[21] **Nosotras** is a program for pregnant Latina women that identifies and eliminates barriers to reduce stress and anxiety, addresses risk factors associated with use/abuse of drugs, alcohol, tobacco and other drugs. Their services include interpretation, translation and access to health care services.[22]

Therapy for Black Girls targets the African American Community and provides an online space dedicated to encouraging the mental wellness of Black women and girls. The site presents mental health topics in a way that feels more accessible and relevant.[23] The site also provides a nationwide list of Black women therapists that you can connect to online or face to face including therapists in the Northern Virginia Area.

Prevention

Prevention efforts should include a multilayered approach addressing the systems and structures, including our own, that disproportionately affect youth as well as meet the needs of youth and their families as it relates to mental health treatment. Specifically, we recommend the continuation of **Restorative Justice Practices** in schools and juvenile justice agencies and out of school time settings for youth.

Secondly, we recommend funding additional opportunities for **Youth Mental Health First Aid** training for faith/youth leaders. Youth Mental Health First Aid is an 8-hour public education program which introduces participants to the unique risk factors and warning signs of mental health problems in adolescents, builds understanding of the importance of early intervention, and teaches individuals how to help an adolescent in crisis or experiencing a mental health challenge. In the most recent budget cycle, the Children's Behavioral Health Collaborative (CBHC) Management Team approved funding for this effort. In addition, the Community Services Board (CSB) subsequently received additional funding to cover costs.

In addition, we recommend the **incorporation of credible messenger programs** that seek to reduce stigma and provide support for youth across cultures. For example, "The Representation Project: The

[20] Aviera, A. (2002). Culturally sensitive and creative therapy with Latino clients. *California Psychologist*, *35*(4), 18-25. Retrieved from http://www.apadivisions.org/division-31/publications/articles/california/aviera.pdf
[21] Cervantes, R., Goldbach, J., & Santos, S. M. (2011). Familia Adelante: A multi-risk prevention intervention for Latino families. *The journal of primary prevention*, *32*(3-4), 225. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3205946/pdf/nihms-326426.pdf
[22] https://www.adelantetoledo.org/family-programs/
[23] https://www.therapyforblackgirls.com/

Mask You Live In"[24] is a film that follows boys and young men of color as they struggle to stay true to themselves while negotiating America's narrow definition of masculinity.

Other prevention efforts include **community partnerships** such as "Brother You're on My Mind." A partnership between the National Institute on Minority Health & Health Disparities (NIMHD)[25] and Omega Psi Phi Fraternity, Inc., the initiative raises awareness of the mental health challenges associated with depression and stress that affect African American men.[26] The partnership provides a free train the trainer program to educate faith and social communities around mental illness.

Additional recommended prevention efforts include the **use of technology** to reach youth and their families. For example, the "notOK App™"[27] was developed by teens for teens dealing with mental health issues. A youth suffering from a condition causing her to faint developed the application while suffering from depression and anxiety. The App allows users to press a button that sends a text message to up to five preselected contacts with the following statement: "Hey, I'm not OK. Please call me, text me, or come find me." There is also a link to the user's current GPS location that is sent along with the message. The app has just recently been released with an iOS and Android version for $2.99 per month. Additional apps were discovered during our work and a beginning review of the use of tele-psychiatry occurred. Both areas require more a focused examination and recommendations for their use.

Finally, prevention efforts need to continue to address stigma reduction. A review of the Change Direction.org campaign or a similarly effective one and it's across the county implementation needs to be explored further. Like tobacco and heart disease campaigns of yesteryear, if possible, we need to land on a "unifying" message that can be repeated far and wide across our community in a timely, effective messaging way, using social media, mailers, iPhone, videos, etc.

Marketing/Outreach

In general, members of the Faith Community, Fraternity or Sororities and Civic and Social Organizations should be engaged in getting the message out as well as assisting with the recruitment of service providers as appropriate. Additionally, messages around behavioral health should be distributed through culturally specific newspaper/online advertisements (local community papers, church newsletters, blogs, social media), flyers at places of business within the targeted communities, and radio advertisements (See Appendix C for a list of possible newspapers, local businesses and radio stations). Other potential avenues to increase community awareness of existing county services should include marketing campaigns targeted to child, youth, and family specific behavioral health and medical professionals and for- and non-profits.

Conclusion

In conclusion, this workgroup defined underserved populations; identified strengths and barriers to behavioral health and provided recommendations to address these barriers. This workgroup has put

[24] http://therepresentationproject.org

[25] https://www.nimhd.nih.gov/

[26] https://www.nimhd.nih.gov/programs/edu-training/byomm/

[27] https://www.notokapp.com/our-team/

forth two specific proposals to implement and expand Trauma Informed Individual and Family Mental Health Counseling and Youth Mental Health First Aid training (see recommendations above).

In addition, the workgroup completed an analysis of recommendations using Fairfax County's Juvenile and Domestic Relations Court Race Equity Bench Card. This analysis provided insight as to the need for an internal review of county agencies, non-profit private providers', and school systems' policies, procedures and practices with an equity lens. This review should include an evaluation regarding the presence or absence of quality control measures and accountability practices to the creation of barriers for our children, youth and families in accessing children's behavioral health treatment. That self-examination could also include developing a "master plan approach" or "roadmap", beyond the Blueprint, for the provision of children's behavioral health services to our county residents with appropriate linkages and clearly defined roads to collaboration.

We also recognized that youth experiencing "transition periods," be it in relationships, family living arrangements, moving from elementary to middle school, middle to high school, or high school to college are particularly at-risk groups. And finally, the involvement of youth and parents directly in the discussion/planning process and education/information dissemination process is imperative and one we need to improve.

We acknowledge that the next phase of work may require the continuation of this workgroup with additional members due to the breadth and depth of the recommendations. Additional workgroups may also be needed to further develop recommendations, assess feasibility, resources, capacity, funding, and partnerships for the strategies enumerated above. We recommend that CBHC Management Team consider this information alongside recommendations from other workgroups to assess next steps for implementation. With the support and endorsement of the CBHC Management Team, this workgroup is willing to continue working on these issues.

Appendix A: Reports Reviewed

1. Center for the Study of Social Policy (2012) Disproportionate Minority Contact for African American and Hispanic Youth
2. Equitable Growth Profile of Fairfax County: 2015
3. Fairfax County 2016 Youth Survey
4. Fairfax County Human Services, 2016 Needs Assessment Summary
5. Fairfax County Health Department, Cultural and Religious Beliefs about Mental Illness
6. Fairfax County Department of Neighborhood and Community Services, Coordinated Services Planning Density of Basic Needs Requests Maps
7. Fairfax County Juvenile and Domestic Relations District Court, Miscellaneous Statistical Reports
8. Fairfax County Public Schools, Strategic Plan
9. Virginia Department of Juvenile Justice (2011), Study of Disproportionate Minority Contact

Appendix B: Cultural Formulation Interview (CFI)

Cultural Formulation Interview (CFI)

Supplementary modules used to expand each CFI subtopic are noted in parentheses.

GUIDE TO INTERVIEWER	INSTRUCTIONS TO THE INTERVIEWER ARE ***ITALICIZED.***
The following questions aim to clarify key aspects of the presenting clinical problem from the point of view of the individual and other members of the individual's social network (i.e., family, friends, or others involved in current problem). This includes the problem's meaning, potential sources of help, and expectations for services.	*INTRODUCTION FOR THE INDIVIDUAL:* I would like to understand the problems that bring you here so that I can help you more effectively. I want to know about ***your*** experience and ideas. I will ask some questions about what is going on and how you are dealing with it. Please remember there are no right or wrong answers.

CULTURAL DEFINITION OF THE PROBLEM

CULTURAL DEFINITION OF THE PROBLEM

(Explanatory Model, Level of Functioning)

Elicit the individual's view of core problems and key concerns. *Focus on the individual's own way of understanding the problem.* *Use the term, expression, or brief description elicited in question 1 to identify the problem in subsequent questions (e.g., "your conflict with your son").*	1. What brings you here today? *IF INDIVIDUAL GIVES FEW DETAILS OR ONLY MENTIONS SYMPTOMS OR A MEDICAL DIAGNOSIS, PROBE:* People often understand their problems in their own way, which may be similar to or different from how doctors describe the problem. How would *you* describe your problem?
Ask how individual frames the problem for members of the social network.	2. Sometimes people have different ways of describing their problem to their family, friends, or others in their community. How would you describe your problem to them?
Focus on the aspects of the problem that matter most to the individual.	3. What troubles you most about your problem?

CULTURAL PERCEPTIONS OF CAUSE, CONTEXT, AND SUPPORT

CAUSES

(Explanatory Model, Social Network, Older Adults)

This question indicates the meaning of the condition for the individual, which may be relevant for clinical care. *Note that individuals may identify multiple causes, depending on the facet of the problem they are considering.*	4. Why do you think this is happening to you? What do you think are the causes of your [PROBLEM]? *PROMPT FURTHER IF REQUIRED:* Some people may explain their problem as the result of bad things that happen in their life, problems with others, a physical illness, a spiritual reason, or many other causes.
Focus on the views of members of the individual's social network. These may be diverse and vary from the individual's.	5. What do others in your family, your friends, or others in your community think is causing your [PROBLEM]?

STRESSORS AND SUPPORTS

(Social Network, Caregivers, Psychosocial Stressors, Religion and Spirituality, Immigrants and Refugees, Cultural Identity, Older Adults, Coping and Help Seeking)

Elicit information on the individual's life context, focusing on resources, social supports, and resilience. May also probe other supports (e.g., from co-workers, from participation in religion or spirituality).	6. Are there any kinds of support that make your [PROBLEM] better, such as support from family, friends, or others?
Focus on stressful aspects of the individual's environment. Can also probe, e.g., relationship problems, difficulties at work or school, or discrimination.	7. Are there any kinds of stresses that make your [PROBLEM] worse, such as difficulties with money, or family problems?

ROLE OF CULTURAL IDENTITY

(Cultural Identity, Psychosocial Stressors, Religion and Spirituality, Immigrants and Refugees, Older Adults, Children and Adolescents)

	Sometimes, aspects of people's background or identity can make their [PROBLEM] better or worse. By ***background*** or ***identity,*** I mean, for example, the communities you belong to, the languages you speak, where you or your family are from, your race or ethnic background, your gender or sexual orientation, or your faith or religion.
Ask the individual to reflect on the most salient elements of his or her cultural identity. Use this information to tailor questions 9–10 as needed.	8. For you, what are the most important aspects of your background or identity?
Elicit aspects of identity that make the problem better or worse. *Probe as needed (e.g., clinical worsening as a result of discrimination due to migration status, race/ethnicity, or sexual orientation).*	9. Are there any aspects of your background or identity that make a difference to your [PROBLEM]?
Probe as needed (e.g., migration-related problems; conflict across generations or due to gender roles).	10. Are there any aspects of your background or identity that are causing other concerns or difficulties for you?

CULTURAL FACTORS AFFECTING SELF-COPING AND PAST HELP SEEKING

SELF-COPING

(Coping and Help Seeking, Religion and Spirituality, Older Adults, Caregivers, Psychosocial Stressors)

Clarify self-coping for the problem.	11. Sometimes people have various ways of dealing with problems like [PROBLEM]. What have you done on your own to cope with your [PROBLEM]?

PAST HELP SEEKING

(Coping and Help Seeking, Religion and Spirituality, Older Adults, Caregivers, Psychosocial Stressors, Immigrants and Refugees, Social Network, Clinician-Patient Relationship)

Elicit various sources of help (e.g., medical care, mental health treatment, support groups, work-based counseling, folk healing, religious or spiritual counseling, other forms of traditional or alternative healing). *Probe as needed (e.g., "What other sources of help have you used?").* *Clarify the individual's experience and regard for previous help.*	12. Often, people look for help from many different sources, including different kinds of doctors, helpers, or healers. In the past, what kinds of treatment, help, advice, or healing have you sought for your [PROBLEM]? *PROBE IF DOES NOT DESCRIBE USEFULNESS OF HELP RECEIVED:* What types of help or treatment were most useful? Not useful?

BARRIERS

(Coping and Help Seeking, Religion and Spirituality, Older Adults, Psychosocial Stressors, Immigrants and Refugees, Social Network, Clinician-Patient Relationship)

Clarify the role of social barriers to help seeking, access to care, and problems engaging in previous treatment. *Probe details as needed (e.g., "What got in the way?").*	13. Has anything prevented you from getting the help you need? *PROBE AS NEEDED:* For example, money, work or family commitments, stigma or discrimination, or lack of services that understand your language or background?

CULTURAL FACTORS AFFECTING CURRENT HELP SEEKING

PREFERENCES

(Social Network, Caregivers, Religion and Spirituality, Older Adults, Coping and Help Seeking)

Clarify individual's current perceived needs and expectations of help, broadly defined. *Probe if individual lists only one source of help (e.g., "What other kinds of help would be useful to you at this time?").*	Now let's talk some more about the help you need. 14. What kinds of help do you think would be most useful to you at this time for your [PROBLEM]?
Focus on the views of the social network regarding help seeking.	15. Are there other kinds of help that your family, friends, or other people have suggested would be helpful for you now?

CLINICIAN-PATIENT RELATIONSHIP

(Clinician-Patient Relationship, Older Adults)

Elicit possible concerns about the clinic or the clinician-patient relationship, including perceived racism, language barriers, or cultural differences that may undermine goodwill, communication, or care delivery. *Probe details as needed (e.g., "In what way?").* *Address possible barriers to care or concerns about the clinic and the clinician-patient relationship raised previously.*	Sometimes doctors and patients misunderstand each other because they come from different backgrounds or have different expectations. 16. Have you been concerned about this and is there anything that we can do to provide you with the care you need?

Appendix C: List of Radio Stations, Newspapers, and Local Businesses

Faith Community

- Korean Central Presbyterian
- St Paul Chung Catholic Church
- Fairfax Korean Church
- First Asian Indian Presbyterian church
- Seoul Presbyterian Church
- Fairfax Baptist Temple
- Northern Virginia Chinese Christian Church

Newspaper

- Sing Tao Daily
- Inside NOVA
- Fall Church New Press
- Diverse: issues in Higher Education
- India Abroad: Newsletter https://www.indiaabroad.com/indian-americans/desi-radio-stations-target-growing-community/article_a4e9258c-5879-11e7-94e9-6b08562bb03a.html

Local Businesses

- Lotte Plaza Market
- H Mart
- Manila Oriental Market
- Patel Brothers

Radio

- India Abroad: WDCT-AM 1310, Sunday, 12 p.m. to 2 p.m
- South Asian: 8K Radio EBC- Frequency - 1170 AM & 97.1 FM HD2
- Zindagi- web only - http://radiozindagi.com/virginiaw
- Korean 1310 AM
- China radio international -1190 Am