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

April 30, 2021
Community Policy and Management Team (CPMT)

Agenda

FINAL

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

1. **MINUTES:** Approve minutes of March 26, 2021 meeting

2. **ITEMS:**

   - **CSA Administrative Items**
     Item A – 1: Nomination of Parent Representatives for Board Re-Appointment
     Item A – 2: Submission of OCS Annual Gap Survey

   - **Presentation Item P – 1:** Update on Children's Mental Health During Covid-19 Pandemic

   - **CSA Information Items**
     Item I – 1: CSA Budget Report
     Item I – 2: FY22 CPMT Meeting Schedule
     Item I – 3: CPMT Quarterly Data Report
     Item I – 4: CSB Proposal to Expand CSA Case Support Services

   - **HMF Information Item**
     Item I – 5: Children's Behavioral Health Blueprint Quarterly Report

- **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

March 26, 2021
Community Policy and Management Team (CPMT)
Virtual Meeting due to COVID-19 Emergency Procedures

Meeting Minutes

Attendees: Stacy Alexander (home), Michelle Boyd (home), Deb Evans (home), Annie Henderson (Fairfax), Joe Klemmer (home), Michael Lane (home), Richard Leichtweis (office), Chris Leonard (office), Rebecca Sharp, Jane Strong (home), Nancy Vincent (home), Daryl Washington (home), Deborah Scott (home),

Attended but not heard during roll call: Robert Bermingham, Jacqueline Benson

Absent: Gloria Addo-Ayensu, Cristy Gallagher, Lesley Abashian, Michael Becketts,

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

CSA Management Team Attendees: Adam Cahuantzi, Patricia Arriaza, Janet Bessmer, Xu Han, Jessica Jackson, Andrew Janos, Kamonya Omatete, Sarah Young, Stephanie Pegues, Mary Jo Davis, Chris Metzbower, Tim Elcesser, Barbara Martinez

Stakeholders and CSA Program Staff Present: Janet Bessmer, Patricia Arriaza, Sarah Young, Samira Hotochin, Lisa Morton, Xu Han, Kristina Kallini, Suzette Reynolds, Chris Metzbower, Shana Martins

FOIA Related Motions:

I move that each member's voice may be adequately heard by each other member of this CPMT.
Motion made by Chris Leonard; all members agree, motion carries.

Second, 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.

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. I further move that this CPMT may conduct this meeting electronically through a dedicated Zoom conferencing line, and that the public may access this meeting by calling Toll Free Call In: 1 888 270 9936 Participant access code: 562732. It is so moved.
Motion made by Chris Leonard; seconded by Joe Klemmer; all members agree, motion carries.

Finally, it is next required that all 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.
Motion made by Chris Leonard; seconded by Joe Klemmer; all members agree, motion carries.

Approved:

1. **MINUTES:** Approve minutes of January 29, 2021. *Motion made by Rick Leichtweis; second by Joe Klemmer; all members agree, motion carries.*

2. **ITEMS:**

- **CSA Information Items -**
  Item I – 1: FY 21 Budget Report – Presented by Xu Han. Review of expenditures through Feb 2021. Explored comparison between 2020 and 2021 expenditure. Decrease in expenditures due to COVID.
  Item I – 2: 2021 OCS Audit Self-Assessment – Presented by Patricia Arriaza. CSA will be undergoing a full audit mid-April (process will take approximately two months). CSA self-assessment results indicate that the program is in full compliance with the majority of sections. Notable findings from the self-assessment and fraud survey were shared.
  Item I – 3: 2021 CSA Legislative Update – Presented by Janet Bessmer. Information related to CSA program from General Assembly Special Session which was focused on Special Education services.
  Item I – 4: FAPT/Residential Entry Report – Review of first and second quarter for FY21. CSA processing time has

- **NOVACO – Private Provider Items –** meeting last month was cancelled (rescheduled for April 5) so no update from meeting. Rick Leichtweis shared that there has been a notable increase in TDOs of children on the spectrum/ID. Many children/adolescents coming in are on the spectrum, which is concerning as TDO is not appropriate for this population. Task force has been developed to address this issue. CSB is working on getting medical clearance done at Merrifield so youth do not need to go to ER.
- **CPMT Parent Representative Items –** Jackie Benson shared that it is difficult to find Tricare providers. The ones who do accept Tricare, they have no availability for Tricare patients because of the extra paperwork, etc. required by Tricare. Ms. Benson also shared that during Family Advisory Board meeting parents discussed their concerns regarding summer break and lack of structured activities for youth due to COVID. Chris Leonard suggested to have a separate discussion regarding summer break options.
- **Cities of Fairfax and Falls Church Items –** Falls Church will have youth going back to school full days (4 or 5 days depending on grade) after spring break.
- **Public Comment –** no comments

Adjourn 1:45pm –*All members approved.*

Next Meeting: April 30, 2021 1:00 – 3:00pm (via Zoom)

Approved:

MEMO TO THE CPMT
April 30, 2021

Administrative Item A -1: Nomination of CPMT Parent Representatives to the Board of Supervisors for Re-Appointment

ISSUE: That CPMT Parent Representatives are nominated by the CPMT for re-appointment by the Board of Supervisors for two-year terms.

BACKGROUND:
To fulfill Virginia Code requirements, Fairfax-Falls Church CPMT Bylaws provide for five parent representatives who are not employees of any public or private provider of services to youth, to be approved by the CPMT and the Board of Supervisors for terms of up to two years. Re-appointments may be made for additional consecutive terms upon approval of the CPMT and Board of Supervisors.

The CPMT nominating committee interviewed prospective parent representatives on July 16, 2019. The candidates represent a range of lived experience to include adoption, blended families, military, kinship care, and dual diagnosis of medical and behavioral health care needs. The committee recommends that the following individuals be nominated to the Board of Supervisors for reappointment to the CPMT:

- Staci Jones Alexander
- Jacqueline Benson
- Cristy Gallagher
- Annie Henderson
- Joe Klemmer

RECOMMENDATION: That the CPMT recommend to the BOS re-appointment of Staci Jones Alexander, Jacqueline Benson, Cristy Gallagher, Annie Henderson, and Joe Klemmer.

FAMILY ADVISORY BOARD COMMENT: The Family Advisory Board reviewed on April 12, 2021 and has indicated they have no additional comment.

ATTACHMENT: None

INTERNAL CONTROL IMPACT: None

FISCAL IMPACT: Parent Representatives qualify for a stipend of $100 per meeting.

STAFF: Janet Bessmer, CSA Manager

MEMO TO THE CPMT

April 30, 2021

Administrative Item A-2: FY2021 Assessment of Critical Service Gaps

ISSUE:
Each year the Office of Comprehensive Services (OCS) issues a survey to local CPMTs to assess critical gaps and barriers in services needed by children to be served successfully in the local community (§2.2-5211.1). The needs assessment fulfills one of the primary responsibilities of the CPMT – to coordinate long range, community-wide planning to develop resources and services needed by children and families in the community (§ 2.2-5206).

BACKGROUND:
As part of the annual assessment, the Service Gap survey was sent to more than 600 people. Responses were received from184 people from the school system and across public human service agencies, providers, CPMT and CSA Management Team members, parents, and advocates. Survey respondents were asked to identify three (3) to five (5) services that they feel are important to further develop in the community.

In addition to asking for information on service gaps, the survey asks respondents to identify the populations and age groups most affected by those gaps. The results are aggregated and reported to the CPMT and the state. State-wide and regional results can be found on the OCS website (https://www.csa.virginia.gov/OCSData/ServiceGapSurvey).

Service Gaps Ranked by Number of Responses:

Crisis Intervention/Stabilization	59
Trauma Focused/Informed Services	54
Short-term Diagnostic	42
Residential Treatment	35
Respite	35
Parent Coaching	33
School-based Mental Health Services	32
Family Therapy	31
Group Home	31
Child Mentoring	27
Intensive In-Home	27
Assessment	26
Applied Behavior Analysis	25
Medication Management	22
Therapeutic Day Treatment	22
Independent Living Services	21

Acute Psychiatric Hospitalization	20
Case Management	19
Therapeutic Foster Care Homes	19
Functional Family Therapy	18
Group Therapy	17
Cognitive Behavioral Therapy	15
Family Support Partner	15
Multi-systemic Therapy	12
Family Foster Care Homes	11
Private Day School	11
Family Partnership Facilitations	10
Parent Child Interaction Therapy	10
Intensive Care Coordination	9
Motivational Interviewing	9
Residential School	8

FAMILY ADVISORY BOARD COMMENT:
This report will be presented at the next family advisory board meeting for review and comment. The OCS deadline did not permit submission to the FAB prior to the CPMT meeting.

RECOMMENDATION:
It is recommended that the five highlighted service gaps be submitted to the Office of Children's Services on behalf of the Fairfax-Falls Church CPMT.

STAFF:
Patricia E. Arriaza, CSA Management Analyst

Additional Survey Results:
Survey respondents were able to select up to five (5) services which they feel are important to develop in the community so the number of responses for the populations and age groups shared below will reflect that.

Populations affected by service gaps, ranked by the number of survey responses:

- Potentially Disrupting or Disrupted Foster Care Placements 327
- Autism 252
- Intellectual Disability/Developmental Disability 232
- Substance Abuse 226
- Sex Offending/Sexually Reactive Behaviors 173
- Potentially Disrupting or Disrupted Adoptions 132
- Youth Involved with the Juvenile Justice System 114
- Youth with Multiple Mental Health Diagnoses 95
- No, there are not any specific populations 88

Top population affected by top 5 identified service gaps, ranked by the number of survey responses:

1. Crisis Intervention/Stabilization – Youth with Multiple Mental Health Diagnoses
2. Trauma Focused/Informed Services - Youth with Multiple Mental Health Diagnoses
3. Short-term Diagnostic - Youth with Multiple Mental Health Diagnoses
4. Residential Treatment - Youth with Multiple Mental Health Diagnoses, Substance Abuse
5. Respite - Autism

Age Groups affected by service gaps, ranked by the number of survey responses:

- High School Age (14-18) 374
- Middle School Age (11-13) 288
- Transition Age (19-21) 251
- Elementary School Age (6-10) 180
- No, there are not any specific age groups 159
- Pre-School Age (0-5) 113

Top age group affected by top 5 identified service gaps:

1. Crisis Intervention/Stabilization – High School Age (14-18)
2. Trauma Focused/Informed Services - High School Age (14-18)
3. Short-term Diagnostic - High School Age (14-18)
4. Residential Treatment - High School Age (14-18)
5. Respite - High School Age (14-18)

Additional Service Gaps according to respondents:

- Aggression Replacement Therapy
- Alternative therapy (equine, music, art, etc.)
- Assessment and crisis intervention/stabilization services with a focus in keeping the youth in the home/community.
- DBT
- FFT in Spanish
- foster homes that will work with adolescents and children with high special needs
- Help parent with job loss
- High quality attachment therapy
- Intensive Adolescent Substance Abuse Services
- Intensive Outpatient Service (IOP)
- More private day school options for those students with behavioral / emotional needs
- outpatient therapy that is affordable or covered by insurance

- Psychiatric providers for medication management
- Psychological evaluations for parents and youth
- psychological evaluations in Spanish
- Recreational activities for parents, youth and families
- Respite for non-Medicaid clients
- Services for Autistic children beyond ABA
- services to help those who are are aging out of teen years and launching into young adulthood.
- Substance Use Services at all levels
- Substance use therapy & residential
- System provider skills at having critical/difficult conversations for plan development
- Young adult independent living program that don't just serve the homeless youth.

Barriers

Survey respondents were also asked to rank on a 5-point scale (1 being "Not At All" to 5 being "A Great Deal") the level of impact listed barriers have on the community's ability to develop services identified. The responses from 122 respondents are detailed below:

Barrier	1 Not at All	2	3	4	5 A Great Deal	Rating 3 and above
Provider availability	8	10	21	33	50	104
Need for greater collaboration and consensus	17	18	33	35	19	87
Lack of funding	21	21	29	23	28	80
Need for more information and data	22	27	33	24	16	73
Lack of transportation	22	28	41	12	19	72

Respondents were able to add additional comments under each identified barrier. Responses are shared below.

Provider availability:

- This may also have been negatively influenced by the Covid 19 Pandemic
- Especially for ABA
- The providers are often waitlisted or they discontinue services due to lack of staffing resulting in needed services not being delivered.
- Many quality providers do not accept Medicaid or other insurance which becomes a barrier.
- There is often waitlist for providers that offer higher quality services.
- Few providers have availability these days.
- There are limited options, so there is an unmet demand.
- No provider is going to work with severe aggression.
- multilingual and multicultural therapist
- There have been multiple times when a provider(s) who offer a certain service are not available or that the service is not available from CSA as a contracted service.
- huge problem with providers only providing virtual
- I feel like this really is not an issue either.
- Challenges with crisis services and individuals willing to accept insurance
- Lack of quality provider availability.

- some programs (like ABA, Respite, or DBT) can have significant waitlists that impact youth and families timely access
- CSA providers have a hard time hiring Spanish-speaking therapists because there is a shortage of licensed Spanish-speaking therapists in our area and the agencies do not pay enough to attract and keep them. There is an urgent need for providers of FFT and psychological evaluations for Spanish-speaking clients.
- Specifically for substance abuse services outside of the CSB.
- Providers need to be available when parents are available (evenings and weekends).
- Wait times to get in can be 5 to 8 weeks for a quality provider.
- There continues to only be 2 in home respite providers. There have been struggles with getting ABA services via an in network insurance provider which has led to exploring ABA via CSA. There is often at least 1 agency who is able to serve families. Recently CCFS (known for psychosexual evaluations, trauma focused therapy, etc.) stopped taking new referrals and there are few providers alike to CCFS.
- It is mainly difficult to find providers that have Spanish speakers workers when it is referred to ABA services. Children are placed on waiting list or an English speaker worker is assigned that face a barrier in communication and including the Spanish speaker parents.
- Difficult to find respite providers (even before Covid) able to support aggressive/behaviorally challenged youth. Need more providers that can assess trauma through thorough assessment. Providers not taking new referrals due to not enough staff. Need short-term options similar to Leland for younger children. CR2 model not always appropriate for these families.
- Problems both in terms of quantity and quality.
- Costs for the development of specific and needed services is often prohibitive for smaller providers, reducing the number of providers and services available.

Need for greater collaboration and consensus:

- Our case manager has been very open and able to affectively communicate with us.
- I have been very pleased with the support provided by CSA.
- Our family was severely impacted when our aggressive ASD/ID daughter was discharged prematurely from group home. We could not get her back in for six months.
- Coordination of services for families can be quite disjointed.
- Generally speaking there is collaboration and consensus in the team process. Sometimes youth's parents have a different level of service in mind - either higher or lower level and that is difficult to change at times.
- There seems to be a disconnect between policy/procedure and practical application. For example, getting an assessment at the CSB for "risk" and it getting kicked back into the home environment does not help anyone.
- Sometimes cases seem like they are hot potatoes and the most appropriate agency backs out.
- It would help for agencies to collaborate and give input on what is needed before cuts are made.
- There remains a strong preference for non EBT for trauma in our CSA case managing and contracted provider community, which leads to poor, sometimes dangerous, outcomes.
- My teams tend to be generally collaborative in nature-everyone has a voice, recommendation, and families have a choice
- The multi agencies collaborate and communicate very well with one another.
- There has been little discussion of treatment of youth sex offenders
- There's no communication within agencies
- There is little to no collaboration between the court and the CSB. Court-ordered MH/SA evaluations are currently going unanswered for upward of a year due to backlogs and nit-picking denial of service. Even when the court becomes directly involved by speaking 1-on-1 with a CSB representative, the follow-through with the family is non-existent.
- There are times when team members agree with a plan for use of a service (e.g. mentoring) to address a need despite at least one team member and/or at times the service provider (e.g. mentor) agreeing that this is the best plan of action. This can result in more time spent on an intervention

that people agree to but that does not result in change or lasting changes (i.e. not resulting in the "intended outcome").
- The people I worked with were competent and understanding. They faced unsurmountable bureaucratic barriers when it came to securing services. Overall, there was a lot of talking and little action.
- It would be beneficial in having more joint training to develop needed services.

Lack of funding:

- Also, lack of clarity about how much parents should access private insurance first (or if they can't find something through it)
- When trying to get in home services for my daughter, she was identified as needing services but was not bad enough (needing to go to an RTC in the near future) to get community funding to help.
- Some quality providers are too expensive and don't accept insurance.
- There is not a lack of funding, but accessing the funding can be challenging.
- I understand there's no funding for young adults with mental illness or disability, other than the services that take Medicaid insurance.
- No issues with support for funding
- Funding should be a priority when a child poses a huge safety risk being at home.
- Funding for services for language minorities and for Trauma caused by white supremacy culture and racism does not seem to be available.
- I have not experienced Lack of Funding as a barrier, more lack of available service.
- Not really sure if is lack of funding as much as it is obtaining funding.
- The reason provided for many of the programs closing was due to budget cuts.
- funding has been an issue in the past when non-mandated funds ran out, but that has not been an issue thus far this year
- There are plenty funding
- The fapt process can take too long. There are not enough fapt meetings to fill the need.
- The agencies that contract with CSA do not pay their therapists well enough to attract and maintain well-qualified staff. For example, intensive in-home therapy, although it is for children with the most complex needs, is mostly provided by unlicensed, inexperienced staff who do not use evidence-based treatments.
- It takes anywhere from 4 to 8 weeks.
- There is enough funding. The existence of funding is not the problem. The labyrinth of paperwork and meetings to access the funding is the problem. The continued byzantine maintenance paperwork is a continuation of the problem. The general feeling of case managers is that the system currently in place is meant to discourage accessing funds.
- I am not sure where there is not more substance abuse treatment
- Overall a lack of targeted priorities, not funding
- I imagine that is the underlining cause of all the problems.
- Sharing costs with public private partnerships to develop needed services could lead to more services being available for children and families.

Need for more information and data:

- The outcome of success for a particular clients would be helpful to determine the fit/match for service and provider.
- I have a sense the information is there; it is not always clear where to look
- More families need to be involved so county knows the difficulties we have.
- access to data
- I believe there does need to be more information and data, thus doing surveys like this is important to see where there are gaps.
- The teams tend to have the information they need to assess and recommend services

- Probably? Anecdotally, substance abuse is rampant in Fairfax County in high schools
- Rich data sources, not collaborative
- More data could always be helpful if it is then used in a way that could be helpful for system improvements :) There is not currently much data received by providers and tracked regarding outcomes and there are still different measures used by agencies to measure success. Having one set of measures CSA looks for to determine success (if possible) that could be used with all providers (or providers of each type of service) and is reported on, could be useful.
- Evaluations at the beginning of treatment
- Spanish speaking providers.

Lack of transportation:

- This may also have been negatively influenced by the Covid 19 Pandemic
- This is one of the largest barriers to accessing services for families that are marginalized.
- Not applicable to us
- Emergency response teams need to be educated more on autism
- transportation to services if they family is not receiving Medicaid or Medicare.
- right now this has not been an issue as there are a lot of telehealth options available. However, previously, this has been an issue.
- I believe transportation issues are better handled.
- For Day Treatment programs, lack of transportation is an issue, unless it is an IEP placement where transportation is provided.
- transportation services for some-specifically to outpatient programs-continues to be a barrier to treatment for some youth and families
- Transportation can be an issue due to parent work schedule and childcare.
- Fairfax County is large, and it can take hours to get across on the bus.
- Pre-paid bus cards are an easy solution here. A well thought out process on how to access those cards would help, too. For example, if a worker is currently barred from face-to-face visits, a signature page for accepting the card is not a helpful part of the process.
- When there are few quality resources in the County and clients rely on public transportation, it complicates ability to get there, increases time away from work/family/other responsibilities.
- This has not been much of an issue in the past year. However, challenges with transportation or physical distance and travel time between a home and certain program (e.g. PHP) has impacted some service planning.
- Virtual meetings have been very helpful to families with transportation challenges. Thank you!

Other barriers identified:

- struggling youth with private insurance turning 18 - struggle to find appropriate mental health support / respite services / providers to work with the youth as they are still students within FCPS
- School aged students requiring group homes often end up being placed outside of Fairfax County either by an agency or their family.
- Services to youth with Autism/DD are very expensive and still not readily available in the community to parents. Better coordination between schools, CSA, and CSB ID/DD services might be helpful.
- we have had several high school students who are substance involved and are not agreeable to treatment and/or working with MST/inhome workers. Court involvement is non-existent. Need help in this arena with SA and possible MH
- There are no real good substance abuse programs that would include short term, crisis stabilization, detox and longer care facilities. Also if families have insurance this can also be too costly. There are no clinically strong intensive substance abuse programs
- Lack of placements
- Information available to community of what is available.

- Services offered in other languages, particularly dialects such as Mam and Ixil. Also other languages from African countries, India, & other Southeast Asian countries.
- Certain families are at a much higher risk when a child has aggression. These families should be placed with a different case worker and flagged so they are given priority one when their child is in crisis.
- Assessment of community needs for older adolescents and transitional age young adults.
- Agencies need to work in spirited collaboration. Too many agencies share why they can't serve someone rather than sitting down and discussing how we can serve people as a genuine, collaborating team. We are person-centered when it suits us.
- Really just what has been said above...better collaboration instead of passing a case around so having a case manager that works through this process with the client and family is important.
- Delays in service initiation
- turnover of teams/reps has been difficult this year for some of the youth/families I work with. There was a lot of turn over in CSB assignments which impacted case manager and rep changes. For some families multiple times...which is disruptive to youth-especially those who have attachment/trust issues.
- training, organizational commitment, fidelity support to ebps for family tx.
- Language and cultural understanding
- There needs to be better training for the staff providing CSA services. I wish there could be some sort of arrangement where CSA would pay for training for a therapist (e.g, EMDR, TFCBT, trauma-informed play therapy), if they would sign a contract agreeing to serve a certain number of CSA clients.
- Length of time for CSA services to start deters some families and workers.
- Language
- Lack of community support
- Lack of providers and trained/certified providers.
- We need more providers well versed about the different cultures and languages in the community.
- Lack of diversity and other languages for providers. Use of an interpreter for services is not best practice.
- There are some extremely strong and skillful case managers in the system and some who really struggle to provide case management services. This seems like a barrier to address given the impact strong vs poor case management can have on a youth/family.
- Non-English speaking providers
- Lots of paperwork involved in getting anything done. Approval processes slow and cumbersome.
- Reimbursement rates for therapeutic services reduce the number of providers willing to provide services.
- Parental schedule is difficult, now weekend services available
- Costs and lack of providers who accept insurance
- need for SA programs for teens ... barrier: parents have a predisposed opinion of SA programs for youth and they are typically negative. SA/AA for teens is lacking.
- Sometimes when agencies don't utilize CSA as frequently it becomes a barrier as the process is not as easy.
- equal access to equitable salaries
- poor partnerships w families
- Parents awareness of resources available to them
- cultural differences
- Some insurance providers do not cover sex dysfunction treatment. This includes Tricare
- Transparency in CSB costs.
- Little interest in prevention. Often the crisis can be prevented with an earlier intervention.

- The number of therapists available to work for Medicaid or insurance rate reimbursement is dwindling by the minute. Many are leaving the field for better paying jobs or to work for large corporations providing mental health.
- The lack of services that are provided in schools: assistance in the classroom, one on one assistance, daily or weekly social skills, assistance with helping to students verbalize needs and concerns since Autistic children have difficulty in this area, more OT services in school, sensitivity training for teachers and education on what Autistic children look like regarding symptoms at all different levels of functioning

2021 Annual Service Gap Survey Results

Top 5 Identified Service Gaps

Ranked by the number of survey responses

All Respondents (n=184)	
Crisis Intervention/Stabilization	59
Trauma Focused/Informed Services	54
Short-term Diagnostic	42
Residential Treatment	35
Respite	35

Parents (n=38)	
Crisis Intervention/Stabilization	8
Intensive In-Home	8
Family Therapy	7
Residential Treatment	7
School-based Mental Health Services	7

Populations Affected by Service Gaps

Ranked by the number of survey responses

• Potentially Disrupting or Disrupted Foster Care Placements	327
• Autism	252
• Intellectual Disability/Developmental Disability	232
• Substance Abuse	226
• Sex Offending/Sexually Reactive Behaviors	173
• Potentially Disrupting or Disrupted Adoptions	132
• Youth Involved with the Juvenile Justice System	114
• Youth with Multiple Mental Health Diagnoses	95
• No, there are not any specific populations	88

Top Population(s) Affected by Top 5 Identified Service Gaps

Ranked by the number of survey responses

- Crisis Intervention/Stabilization – Youth with Multiple Mental Health Diagnoses
- Trauma Focused/Informed Services - Youth with Multiple Mental Health Diagnoses
- Short-term Diagnostic - Youth with Multiple Mental Health Diagnoses
- Residential Treatment - Youth with Multiple Mental Health Diagnoses, Substance Abuse
- Respite - Autism

Age Groups Affected by Service Gaps

Ranked by the number of survey responses

High School Age (14-18)	374
Middle School Age (11-13)	288
Transition Age (19-21)	251
Elementary School Age (6-10)	180
No, there are not any specific age groups	159
Pre-School Age (0-5)	113

Top Age Group Affected by Identified Service Gaps

The High School Age (14-18) group was selected by the most number of respondents for each of the top 5 identified service gaps:

- Crisis Intervention/Stabilization
- Trauma Focused/Informed Services
- Short-term Diagnostic
- Residential Treatment
- Respite

Barriers

Survey respondents ranked on a 5-point scale (1 being “Not At All” to 5 being “A Great Deal”) the level of impact listed barriers have on the community’s ability to develop services identified.

Barrier	1 Not at All	2	3	4	5 A Great Deal	Rating 3 and above
Provider availability	8	10	21	33	50	104
Need for greater collaboration and consensus	17	18	33	35	19	87
Lack of funding	21	21	29	23	28	80
Need for more information and data	22	27	33	24	16	73
Lack of transportation	22	28	41	12	19	72
						73

MEMO TO THE CPMT

April 30, 2021

Presentation Item P - 1: Children's Mental Health During the COVID-19 Pandemic

ISSUE: That the Board of Supervisors requested staff and key stakeholders including parents provide an update and data regarding youth mental health in our community during the COVID-19 pandemic.

BACKGROUND: On February 9, 2021, the Board of Supervisors requested staff to present data on youth mental health; the attached report and presentation to the CPMT covers a broad selection of data to provide a comprehensive overview. The report also shares a limited number of key initiatives that have been implemented over the past year in response to identified challenges.

ATTACHMENT:
Not in Packet (NIP) Request Provided to the Board of Supervisors: Data on Children's Mental Health

STAFF:
Jesse Ellis, NCS
James Gillespie, CSB/HMF

County of Fairfax, Virginia

MEMORANDUM

DATE: April 23, 2021

TO: Board of Supervisors

FROM: Christopher A. Leonard
Deputy County Executive

SUBJECT: Request for Data on Mental Health for the Youth Population

Staff from Fairfax County Government, Fairfax County Public Schools (FCPS), and key partners have met regularly throughout the pandemic in formal and informal settings to share data and experiences related to youth mental health. These discussions have helped inform systemic approaches to support children, youth, and families. On February 9, 2021, the Board of Supervisors requested staff to present data on youth mental health; the attached report covers a broad selection of data in order to provide a comprehensive overview. It also shares a limited number of key initiatives that have been implemented over the past year in response to identified challenges.

The COVID-19 pandemic has had wide-ranging impacts on Fairfax County residents of all ages. A chief concern has been how the mental health of children and youth has been affected. Disruptions to school, cancellations of extracurricular activities, lost family income resulting in struggles to obtain basic needs, health scares, and long-term illnesses and deaths of loved ones have combined in a perfect storm of traumas and stressors impacting many, but not all, youth.

This report reviewed available data from many key service providers, and combined it with qualitative feedback from multiple discussions with providers, parents, and caregivers, to illustrate how youth are doing right now.

Service access data indicate that some key services that rely on referrals from schools and other youth-serving organizations have experienced declines in utilization. The decreases were especially pronounced at the beginning of the pandemic, but many are now running close to or at historical levels. More intensive services, however, have remained in demand throughout the pandemic. In fact, demand for inpatient and residential services has continued to be very high and difficult to meet. There has not been an increase in youth suicides, nor have crisis services reported increased demand.

Given the continuing circumstances of the pandemic, the available data is limited, but analysis of such does point to two primary observations. First, there has not been a significant increase in the number of youth seeking services for mental wellness challenges. To be sure, the numbers were concerning pre-COVID, and remain so. But the data do not suggest a spike in depression, anxiety, suicidality, or other concerns.

Second, for a segment of youth, the issues are overwhelming. Based on feedback from providers, these youth mostly had pre-existing mental health diagnoses or related challenges. For these youth, the combination of multiple stressors, limited access to supportive coping strategies, and reduced services could be overwhelming. Their parents and caregivers often struggled to find respite, making it more difficult for them to seek their own help or to provide consistent support. For these youth and families, the situation can range from stressful to dire.

The data do not clearly show that racial and ethnic disparities have increased as a result of the pandemic. However, given the disproportionate health, economic, and social impacts that the COVID-19 pandemic has had on the Black and Hispanic population in Fairfax County, it is reasonable to expect that the stressors noted above have disproportionately affected Black and Hispanic youth and families. We also know that service access was already disproportionately more difficult for people of color before the pandemic. Further, English language learners and immigrants have faced additional barriers to accessing services and information.

As schools and other programs and activities continue to open up in-person opportunities, we all need to be prepared for a range of situations and outcomes. Staff will continue to closely monitor data indicators to enable updated real-time analysis as best possible. Short-term and long-term planning should reflect the current realities and take into account lessons learned over the past year. The report will be shared with FCPS and other key stakeholders, and with the Successful Children and Youth Policy Team (SCYPT). The SCYPT will use the data and recommendations to help guide the development of new, and revision of existing, strategies to promote youth behavioral health.

If you have any questions about the report, please contact Jesse Ellis, Prevention Manager in the Department of Neighborhood and Community Services, at jesse.ellis@fairfaxcounty.gov or 703-324-5626.

Attachment

cc: Bryan J. Hill, County Executive
Joseph M. Mondoro, Chief Financial Officer
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Scott S. Brabrand, Superintendent, Fairfax County Public Schools

YOUTH MENTAL HEALTH IN FAIRFAX COUNTY DURING THE COVID-19 PANDEMIC

REPORT TO THE BOARD OF SUPERVISORS

APRIL 2021

EXECUTIVE SUMMARY

The COVID-19 pandemic has had wide-ranging impacts on Fairfax County residents of all ages. A chief concern has been how the mental health of children and youth has been affected. Disruptions to school, cancellations of extracurricular activities, lost family income resulting in struggles to obtain basic needs, health scares, and long-term illnesses and deaths of loved ones have combined in a perfect storm of traumas and stressors impacting many, but not all, youth.

This report reviewed available data from many key service providers, and combined it with qualitative feedback from multiple discussions with providers, parents, and caregivers, to illustrate how youth are doing right now.

Service access data indicate that some key services that rely on referrals from schools and other youth-serving organizations have experienced declines in utilization. The decreases were especially pronounced at the beginning of the pandemic, but many are now running close to or at historical levels. More intensive services, however, have remained in demand throughout the pandemic. In fact, demand for inpatient and residential services has continued to be very high and difficult to meet. There has not been an increase in youth suicides, nor have crisis services reported increased demand.

Given the continuing circumstances of the pandemic, the available data is limited, but analysis of such data does point to two primary observations:

First, there has not been a significant increase in the number of youth seeking services for mental wellness challenges. To be sure, the numbers were concerning pre-COVID, and remain so. But the data do not suggest a spike in depression, anxiety, suicidality, or other concerns.

Second, for a segment of youth, their current needs are intensive and overwhelming. Based on feedback from providers, these youth mostly had pre-existing mental health diagnoses or related challenges. For these youth, the combination of multiple stressors, limited access to supportive coping strategies, and reduced services could be overwhelming. Their parents and caregivers often struggled to find respite, making it more difficult for them to seek their own help or to provide consistent support. For these youth and families, the situation can range from stressful to dire.

The data do not clearly show that racial and ethnic disparities have increased as a result of the pandemic. However, given the disproportionate health, economic, and social impacts that the COVID-19 pandemic has had on the Black and Hispanic population in Fairfax County, it is reasonable to expect that the stressors noted above have disproportionately affected Black and Hispanic youth and families. We also know that service access was already disproportionately more difficult for people of color before the pandemic. Further, English language learners and immigrants have faced additional barriers to accessing services and information.

As schools and other programs and activities continue to open up in-person opportunities, we all need to be prepared for a range of situations and outcomes. Staff should continue to closely monitor data indicators to enable updated real-time analysis as best possible. Short-term and long-term planning should reflect the current realities and take into account lessons learned over the past year.

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INTRODUCTION

The COVID-19 pandemic has had wide-ranging impacts on Fairfax County residents of all ages. A chief concern has been how the mental health of children and youth has been affected. Disruptions to school, cancellations of extracurricular activities, lost family income resulting in struggles to obtain basic needs, health scares, and long-term illnesses and deaths of loved ones have combined in a perfect storm of traumas and stressors impacting many, but not all, youth. On top of that, many youth and families have continued to be impacted by events related to racial justice and inequity (not to mention the ongoing inequities themselves). While national data cannot yet point to a definitive answer, there are plenty of news stories (such as these recent ones from the PBS NewsHour and ProPublica) that highlight worrisome trends and the impacts on individual families. National surveys, such as the COVID Experiences Survey, while limited, suggest that students in virtual learning environments experienced worsening mental health during the fall, as did their parents. The US Census Bureau's Household Pulse Survey (as analyzed by the Kaiser Family Foundation) indicated 39 percent of adults, including 57 percent of people ages 18 to 25 and 41 percent of people with kids in the home, reported symptoms of depression or anxiety in the first half of February.

Youth mental health is not a new or emerging discussion in Fairfax County. Significant analyses of data and community engagement led to the development of the Children's Behavioral Health Blueprint, a strategic plan for the improvement of access to and quality of behavioral health prevention and intervention services for children and youth in Fairfax County. Implementation of the Blueprint has managed through the collaborative Healthy Minds Fairfax initiative since 2016.

Nearly 30 percent of eighth, tenth, and twelfth grade students reported depressive symptoms on the 2019-2020 Youth Survey (administered in Fall 2019, prior to the pandemic). The percentage of students reporting depressive symptoms (defined as, within the past year, feeling so sad or hopeless almost every day for two weeks or more in a row that the student stopped doing some usual activities) has slowly been rising since 2015. The percentage of sixth graders reported prevalence of depressive symptoms (24.8%) is at its highest rate since 2011. Hispanic students, females, and LGBQ students report the highest levels of depressive symptoms. Youth Survey data indicate that while depressive symptoms have increased, the prevalence of suicidal ideation and attempts have remained at fairly similar levels over the past several years.[1] See Appendix C for more details.

Staff from Fairfax County Government, Fairfax County Public Schools (FCPS), and key partners have met regularly throughout the pandemic in formal and informal settings to share data and experiences related to youth mental health. These discussions have helped inform systemic approaches to support children, youth, and families. On February 9, 2021, the Board of Supervisors requested staff to present data on youth mental health; this report covers a broad selection of data in order to provide a comprehensive overview. It also shares a limited number of key initiatives that have been implemented over the past year in response to identified challenges.

[1] The 2020-2021 Youth Survey was cancelled, as it could not be administered in school. Please note, though, that if the survey had been administered this year as usual, data would not have been available until Fall 2021. In other words, the data could not have been used to inform this report or any actions during the 2020-2021 school year.

THE CURRENT STATE OF YOUTH MENTAL HEALTH

County-level youth mental health data is limited and difficult to interpret in real time. What we do know about the current state of youth mental health in Fairfax County is based on six types of sources:

1. *FCPS student surveys.* In December and February, FCPS conducted surveys of students to gauge how well they were doing this school year. The surveys included a question on stress level that replicates the question on the Fairfax County Youth Survey. FCPS plans to continue regular surveying to track trends and emerging issues.

2. *Suicide data.* A behavioral health issue is the most common risk factor for death by suicide. But, when examined at the Fairfax County level, it can be difficult to compare suicide rates year-to-year. The number of deaths by suicide, when broken down by subpopulation, are too small to indicate statistically significant differences between two years. But broader trends, either over multiple years or across subgroups, can provide insight.

3. *Patterns in accessing services*. There are myriad providers of mental health services in Fairfax County, and just about as many ways to access them. Even pre-pandemic, measuring what we can about service utilization is not the best indicator of need or prevalence of concerns. Most mental health services are provided by private therapists, counselors, and other providers, and local data on their utilization is not readily available.[2] Further, many outpatient providers stopped providing services early in the pandemic, even though the vast majority have since reopened. Intensive care (e.g., crisis, residential, and inpatient) services are more limited, tend to be provided or funded by government, and never closed. Data related to those services are more broadly available.

4. *Discussions with providers.* Many of the nuances explaining how things have changed due to COVID are not easily captured in the data. For example, utilization data do not clearly indicate differences in acuity or shifts in prevailing symptoms. Therefore, it is important to present what we are hearing from providers we regularly work with.

5. *Discussions with parents and caregivers.* While the individual and collective stories shared by families are not necessarily representative of all families or the county as a whole, they provide important insight into the issues children, youth, and their caregivers are facing and how the pandemic has changed things for a number of residents.

6. *Patterns in reports of youth behaviors and victimization.* Even in "normal" times, there is limited real-time population data on risky or dangerous youth behavior or youth victimization. But Police, Juvenile Court, and Child Protective Services data can show if there have been significant changes in reporting of these incidents, which are often signs of or risk factor for mental wellness challenges.

[2] A recent white paper by FAIR Health demonstrated a significant increase in March and April 2020 over the prior year in the share of private health care claims that were for youth mental health issues nationally. However, the data did not clearly show if the overall number of claims rose; the data may be indicating that the number of people accessing mental health services did not decline as steeply as the number of people of all ages accessing other health care services. Further, the report indicated wide variance in data by state, meaning there could be even further differences at county and other local levels.

FCPS Student Survey Data

To assess a number of outcomes and trends, FCPS administered a comprehensive survey to students in December 2020. The survey included a question on student stress that replicates the question on the Fairfax County Youth Survey. (There are slight methodological differences between the surveys, but the data is generally comparable.) As FCPS reports,

> The question, which typically appears on the Fairfax County Youth Survey, asked students to rate their stress level from 1 (low) to 10 (high). Students at all three school levels reported elevated stress levels this year compared to last year, with the largest difference reported by high school students (average stress level of 5.8 in Fall 2019 versus 7.3 in Fall 2020…. The magnitude of the difference between Fall 2019 and Fall 2020 in average stress levels was large for high school students (ES=.60), small at middle school (ES=.17), and not meaningful at the elementary level (ES=.05).

There were no meaningful differences in stress levels among racial and ethnic groups.

Two-thirds of middle and high school students participating in a focus group as part of the same study reported that "the lack of separation between school and home were major contributors to their stress level. The focus group data is supported by additional survey data that indicated student workload was perceived by over 43 percent of high school students and 31 percent of middle school students as 'too much,' while homework load was perceived by 71 percent of high school students and 47 percent of middle school students as 'too much.'" (Figures 13 and 14).

A follow-up survey in February reflected a decreasing prevalence of high stress, driven by a sharp decrease among high school students.

Suicide Data

Deaths by suicide decreased in the Fairfax Health District in 2020 (the suicide rate was not statistically significantly different, though). The trend was similar for virtually all age groups, including for children, youth, and young adults. The suicide rate for 10- to 17-year-olds, at 4.1 per 100,000 residents, was the lowest it has been in recent years. (It is possible that the suicide numbers and rates may be revised upwards if the Office of the Chief Medical Examiner determines other deaths were by suicide.) See Appendix D for more details.

Again, the relatively low number of suicides in a given year makes year-to-year comparisons tricky even in normal times. A feared spike in suicides related to the pandemic does not appear to have occurred, however. These data may seem counterintuitive, but being at home with family can serve as a protective factor against suicide. Some youth have improved relationships with their parents and caregivers. Other places (such as New Jersey and Hawaii) are also beginning to release data showing declines in suicides in 2020.

Any death by suicide is one too many. And these data should not be interpreted as indicating that COVID was not a contributing factor to the deaths that did occur. While these data do not confirm our worst fears about the pandemic (i.e., much higher than expected numbers of suicides), they still indicate the need for providing ongoing education and mental health screening in order to support early identification of referrals for youth needing mental health services.

Service Access Data

Since 2013, visits to the Emergency Department (ED) for suicide attempts and suicidal ideation have sharply increased, especially for youth and young adults. In the past couple of years, it appeared that the trend was levelling off, or possibly even decreasing. But in calendar year 2020, the rates for 10-to-17-year-olds and for 18–24-year-olds again rose quickly, with each age group experiencing over 700 visits per 100,000 residents. For 10–17-year-olds, this represents close to 900 visits to the ED in 2020. See Appendix E for more details.

It is important to note that the rise in ED visits has not been accompanied by similar increases in deaths by suicide or in self-reported suicide attempts or suicidal ideation by youth, as shown earlier. Rather than an indication of increased suicidal thought and behavior, it is likely that the increased ED visit rates are indicative of greater willingness to seek help. Since 2013, Fairfax County has invested significantly in efforts to promote gatekeeper trainings (such as Mental Health First Aid and Question, Persuade, and Refer (QPR)), avenues to reach out for help (such as the PRS CrisisLink hotline, textline, and chatline), and anti-stigma initiatives (such as mini-grants for youth-led projects and Our Minds Matter clubs in nearly every high school). Each of these seeks to ensure Fairfax County residents of all ages understand mental illness, how to recognize the signs and symptoms of someone in crisis, and how to reach out for help. Increased visits to the ED, like increased calls to CrisisLink or increased demand for therapy, are a likely outcome of this work. The increase in ED visits may also indicate that the ED provided one of the only in person options at the start of the pandemic conditions. It will be important to continue to note the patterns in these numbers as more services return to in person options.

That is not to say that it is acceptable that 800 kids have visited the ED because they are struggling with stressors and suicidal ideation. We still have much work to do to decrease these numbers. And we have work to do to help families easily access the best and most effective sources of crisis care to include a continuum of services, reserving the ED for the most acute care.

Dominion Hospital and Inova child and adolescent inpatient programs are at capacity and running wait lists, as are outpatient programs such as partial hospitalization program and eating disorder programs. The increased demand for residential treatment is being reported across providers and referral sources. The challenge is exacerbated by a reduction in available beds due to COVID distancing precautions. As a result, there are higher than usual numbers of youth “boarding” in Emergency Departments (EDs) – for days and as long as a week – as they wait for an available residential placement. Many presenting at the ED are youth with Autism Spectrum Disorder who are very aggressive and non-verbal.

Fairfax County Public Schools (FCPS) is a primary referral source for mental health services. The closure of school by the Governor prompted schools to change service access, in line with most other mental health providers. Given the abruptness of the needed closure, providers and families had to adjust to new online and telehealth service delivery models. Year-to-date referrals for August through January to mental health providers are slightly down from the 2019-2020 school year. Mental health concerns may not be as easily identified by school staff in the virtual setting. Given the distant learning environment, some families may be seeking mental health support independently of the school since they have the children home with them, and they may not have felt the need to involve the school at this point. Or, parents may be choosing to hold off on seeking mental health services until more in person community-based services become available. School social workers continue to participate in a similar number of family team-based meetings and provide similar numbers of CSA case management services for youth and families. School social worker referrals for non-mental health needs (e.g., financial support, basic

needs, medical care), however, are up 13% since last year; over 10,000 such referrals have been made already this school year. Over 5,000 families have been provided resources to support distance learning access. These types of needs are likely due to the increase in job loss and other family income loss. It is important to note that per Maslow's hierarchy of needs, physiological and safety needs may be a priority for a family prior to addressing mental health needs. As community-based referrals are being provided, virtual student mental wellness checks are also provided to support student school engagement. Due to limited prevention and early intervention services in the community, school social workers spent more time providing intensive case management services and navigating additional barriers to support families in need.

The number of youth accessing Fairfax-Falls Church Community Services Board (CSB) Emergency Services decreased significantly in the spring of 2020 but has since returned to near normal levels. However, during the same time frame, there was only a slight decrease in the number of crisis intervention services that resulted in hospitalization, suggesting that youth with the most acute needs may have continued to seek out services.

The number of children and youth entering CSB outpatient behavioral health services has plummeted as a result of COVID. Between July 2020 and February 2021, 456 new children and youth were assessed for services, compared to 950 during the same period last year, a 52 percent decrease. The major cause of the decline has been the shift of nearly all school-age children to virtual learning, which has made it much more difficult for school professionals to note emerging concerns related to behavioral health and wellness. In the school building counselors and other school staff can observe students and speak to them informally, which is more difficult with virtual learning. More broadly, issues around school attendance, school behavior and academic performance are often a first signal to parents of a wellness concern and are frequently an impetus to seeking treatment. With the return to in-person schooling it is anticipated that referrals to CSB and private mental health providers will increase.

The number of children and youth served in CSB's intensive case management services has declined only slightly, probably because the level of complexity and risk leads these families to connect with the CSB through referrals from Emergency Services and the network of child-serving agencies.

Although it does not appear that COVID has differentially impacted access to CSB behavioral health services by race or ethnicity, there are ongoing patterns of differential utilization. Hispanic youth are significantly overrepresented among CSB outpatient clients (50 percent of clients are Hispanic, versus 27 percent of the FCPS student population), and Black youth are moderately over-represented (14 percent of clients, versus 10 percent of FCPS). As a Medicaid provider with fees based on income, the CSB is one of the few mental health treatment options for many low- and moderate- income residents. The clients of CSB's intensive programs more closely mirror the racial and ethnic composition of the county as whole, reflecting the fact that behavioral health issues occur among residents of all races, ethnicities, and socioeconomic statuses, and that the high cost of intensive services place them beyond the ability of most households to access privately. See Appendix F for more details on CSB service data.

Over 80 percent of the children, youth and families served by the CSB have successfully transitioned to telehealth, and in-person sessions are available to those who need them. Telehealth sessions have removed the burden on families of transporting their children to treatment, and in some cases have successfully engaged youth who may not have agreed to come to the office.

These trends are evident in Children's Services Act (CSA) services. The CSA provides for a range of services for youth with significant behavioral health needs. Through February, the unduplicated number of youth served in FY 2021 was down 12 percent, to 833, as compared to the prior year to date. But there was essentially no change (a decrease of 4 percent) in residential treatment. Community-based, day program, and other non-residential services all experienced significant decreases.

Provider Feedback

The quantitative data only tell part of the story. Regardless of the numbers of youth they are seeing, providers consistently are telling of children and youth experiencing extreme levels of stress, complex trauma, and severe anxiety. The pandemic is not affecting all youths' mental health. But for many, the impacts are profound. These youths' needs are stressing the system, and threaten to overwhelm it if similar, but currently unrecognized, issues are brought to light as youth return to school and other settings.

PRS CrisisLink initially saw a rise in acuity of contacts from youth in the spring of 2020 as youth and families adjusted to the pandemic, the lack of school per statewide closures, and eventually virtual learning. The biggest increase in acuity centered around common themes of uncertainty, fear of getting sick, and financial and environmental factors increasing stress at home. Students accessing mental health treatment prior to the pandemic also expressed feelings associated to their therapy appointments being cancelled or providers leaving the workforce due to their own childcare concerns. This was echoed by the adult populations served. Youth consistently shared concerns about their therapy/counseling sessions being held virtually adding to concerns of not having privacy to share with their providers. Over time these adjustment challenges presented less frequently.

Thematically, PRS CrisisLink has observed children who are in supportive homes without prior existing mental health issues present with increased anxiety about illness or atypical family conflict. Youth who had previous mental wellness challenges and family conflict report these issues in greater intensity and frequency. Common stressors over the past six months have included reduced contact with friends, jealousy seeing other youth who are not taking precautions sharing on social media excluding the youth who are taking precautions, a heighted intensity of political discourse within families, and worries about families and teachers getting sick with COVID.

PRS CrisisLink has not observed any major increases of suicide ideation as the total number of acute suicide ideation has remained stable in comparison to previous years. PRS CrisisLink has seen an increase in contacts by youth however, specifically contacting the National Suicide Prevention Lifeline number versus local numbers. PRS CrisisLink is experiencing a greater number of child abuse reports, family violence exposure, and financial and housing related stress and trauma. Youth are reporting signs of traumatic stress in greater numbers with reduced concentration, poor sleep, fatigue, and anxiety/hyperarousal when compared to previous years.

Private mental health therapists have shared that they are seeing a more acute level of depression and anxiety than usual. They describe youth who experienced difficult transitions to online learning and now that some are comfortable with virtual school, they are having anxiety about going back. Youth miss their friends and are truly experiencing loneliness and a sense of isolation, but worry about the risks inherent with returning to school. For some of these students, the process of deciding whether to return to school in person heightens their anxiety. With limited coping supports available for youth, therapists are seeing (and recommending) more youth on medication.

Parent and Caregiver Feedback

FCPS conducted seven "check-in" surveys of parents from October through February to capture data on how families were coping throughout the school year. Numbers were slightly lower at first, but since November, about 80 percent of parents have reported that their children were coping well. Parents of middle and elementary school students have been slightly more likely to report this than parents of high school students. About three quarters of parents have report their child received mental health resources from FCPS, and about half said the resources were helpful.

The Healthy Minds Fairfax Family Advisory Board (FAB), comprised of parents and caregivers of children and youth who are or have been engaged in the behavioral health system of care, provided staff monthly reports of coping, trauma, crisis, and resilience. FAB members have explained how families who were struggling to identify and access appropriate mental health services and supports including in-home and crisis treatment prior to COVID are even more impacted under pandemic conditions. Availability of services, even in virtual telehealth settings, is limited. Access to child and adolescent psychiatrists is very limited and particularly for families who rely on Medicaid, wait times are long.

Furthermore, the intensity of needs has increased for some children, youth, and young adults. Those who live with the impact of trauma appear to be even more susceptible to the dysregulation prompted by COVID precautions and fears. For many children, youth, their families and even the education and social services professionals who function as critical allies, windows of stress tolerance have been severely limited. During this period of heightened COVID-related vigilance, some children and youth are more easily triggered into a stress response, and they have fewer tools and supports at their disposal to pull on to support a return to regulation. In addition, there is concern that children and youth are not being seen in person and cases of abuse are being missed.

Parents have also raised concerns about all the unstructured time during last summer and the upcoming summer. Many regular summer plans, like summer camps, were not able to meet in person.

Children and youth who have been learning virtually but returning to in person school may have an increase in stress both socially and academically as they adjust to the new schedule. Parents suggest that plans be put in place to identify and intervene when students show signs of stress with the return to school. In addition, parents recommend there be opportunities to provide school staff critical information about the children and youth who have been at home with parents and caregivers for nearly a year.

There is significant need for respite services for families raising children, youth and young adults with emotional and behavioral health conditions. Without access to in-person school, day care, after school programs and community offerings, many parents and caregivers have struggled since last spring to care for their children, assist with virtual learning, and manage safe households while balancing their own work, job search, and physical and mental health and wellness needs.

A survey conducted by the National Federation of Families, which was primarily aimed at parents of children with mental wellness challenges, found parents across the country echoing the sentiments of the FAB. The FCPS Office of Research and Strategic Improvement is continuing its study of FCPS' virtual instruction efforts this year with reports planned for release within the next month and next fall.

Youth Behaviors and Victimization

For years, we have known that the vast majority of youth entering the juvenile justice system have experienced trauma and/or had behavioral health concerns. Their behaviors are often related to their trauma and other issues. Any meaningful look at youth mental wellness should also examine the extent to which youth are being victimized – whether through assaults or through child abuse and neglect – and being arrested or otherwise entering the juvenile justice system.

Juvenile and Domestic Relations District Court (JDRDC) has experienced a significant decline in youth referred and deemed eligible for diversion. For the 11 months of March 2020 through January 2021, 41 youth were referred to diversion programming, down from 283 for March 2019 through January 2020, an 86 percent decrease. These youth receive the Global Assessment of Individual Needs, Short Screen (GAIN-SS). The GAIN-SS is a brief instrument designed to screen both adults and youth for possible psychiatric disorders, substance use disorders, or crime and violence problems. Youth receiving a score of three or more (indicating three or more symptoms within the last year) are referred to private providers or the Community Service Board for further assessment. There has been no significant difference over past years in the percentage of youth referred to the CSB as a result of their GAIN-SS scores.

Similarly, youth placed in secure detention or shelter care receive the Massachusetts Youth Screening Instrument – 2 (MAYSI-2) upon entering either facility. This is a self-administered tool that helps to determine if a detained youth needs immediate mental health services. A significant decline in the number of youth completing the MAYSI reflects a drop-off in the youth being served in secure detention or shelter care. However, as with diversion, there is no real difference between this year and past years in the percentage of youth with high MAYSI scores indicating a need for immediate mental health treatment. See Appendix G for more details on JDRDC data.

The number of juvenile arrests by the Fairfax County Police Department (FCPD) sharply decreased in 2020, falling by 49% from 2019. More kids spending more time at home is likely the primary reason, but it can be reassuring to know that there haven't been observable spikes in criminal activity or arrests for substance use. Trespassing was the only category of offense that saw an increase in 2020, but that is less likely due to an actual rise in delinquent behavior and more likely due to an increase in restricted access to places due to COVID.

Black and Hispanic youth already were arrested at a higher rate than their White and Asian peers, and the percentage of arrests that were of Hispanic youth increased in 2020 to 41 percent. Arrests for drug offenses, assault, and "other offenses" (i.e., not one of the 30 primary offense categories listed in the Police report; see Appendix I for details) were even more disproportionately of Hispanic youth in 2020 than in prior years.

Overall, these numbers do not suggest that youth have been engaging in more dangerous, illegal, or otherwise risky behavior. This is most likely due to reduced opportunity; youth have gotten together less often, and places where they tend to congregate have been closed or limited their capacity. Some of the types of offenses (e.g., substance use) are also as likely to reflect reduced reporting as they are to reflect changes in behavior.

FCPD saw a significant decline in youth as victims of assault in 2020. It is difficult to infer much from this data. First, there was a similar significant rise in 2019, so a trend is not apparent. Second, with more

people staying at home, there is likely less opportunity for violent situations (outside of the home). And third, as mentioned earlier, there are less "eyes on kids" to notice signs of abuse and report potential situations. The number of minors as victims of sexual offenses did not significantly change in 2020 over past years. See Appendix H for more details on police data.

The number of calls to the Child Protective Services hotline during school months is significantly lower in 2020 compared to the last two years, by as much as 37 percent. School staff are the largest group of professionals who report concerns about possible child abuse and neglect. Without the ability to see children in person, school staff are less able to see signs of possible harm. And yet, some children may be at higher risk of harm. The isolation caused by the pandemic has led to the loss of support networks for many families, which has been especially stressful for families with children. Some children may be at risk because there isn't a responsible adult who can watch or take care of them. CPS professionals continue to be concerned about children's safety in this environment. See Appendix I for more details on CPS data.

Youth victimization data show the kinds of trends expected when school is out. It seems unlikely that victimization declined during the pandemic. It remains to be seen, as reporting becomes more prevalent, whether there was any increase.

Why Some Kids are Struggling

There is not a simple answer to why some youth are struggling so much. The issues they are facing are complex and regularly changing. But they tend to fit into two broad categories. First, the pandemic has resulted in a number of significant stressors on youth and families, essentially making the past year a series of traumatic experiences or even one long traumatic experience. Second, many of the programs and services that have traditionally helped youth cope have been limited throughout much of the past year.

Stressors

The COVID-19 pandemic has impacted Fairfax County's children, youth, and families in myriad ways. Disruptions to school, cancellations of extracurricular activities, lost family income resulting in struggles to obtain basic needs, health scares, and long-term illnesses and deaths of loved ones have combined in a perfect storm of traumas and stressors impacting many, but not all, youth. On top of that, many youth and families have continued to be impacted by events related to racial justice and inequity (not to mention the ongoing inequities themselves).

Northern Virginia Family Service (NVFS), which primarily serves low-income immigrant youth and families, reports circumstances in line with COVID's disproportionate impact on people of color and low-income communities. It is not uncommon for a young person they serve to have lost multiple family members. Add to that burden the loss of traditional grieving processes – no funerals, no family from out of town to support you – and the increased pressures that come from loss of income, and the stress can be overwhelming for a young person. Income losses have hit families of color particularly hard, as they were most likely to be employed in service jobs that have been cut or had their hours dramatically reduced.

The most common theme is one of a sense of isolation. Meaningful connections with others – peers, teachers, other caring adults – are critical to mental health, wellness, and one's ability to cope. And it is difficult to develop and maintain some of these relationships in an overly virtual environment, with school online and so many extracurricular activities canceled or significantly reduced. There's been very little change in that environment over the past year, stripping many kids of the supports and structures they typically rely on for coping. This lack of change can be especially difficult for youth with depression, as it becomes increasingly difficult to get out of ruts. When healthy coping mechanisms aren't as available, youth can turn to risky behavior, such as gangs, self-harm, and substance use.

Family-based stressors have increased for many in Fairfax County as noted by job changes that may lead to health issues, food insecurity, and housing challenges. Many youth have experienced the deaths of multiple people close to them, fueling a sense of hopelessness. Parents and caregivers with their own mental wellness challenges are facing the same limitations in accessing services, limiting their ability to support their kids in schooling and other needs. There is very little opportunity for parents and caregivers to get respite or other relief, and little time or opportunity for them to develop new parenting skills.

For parents who cannot work at home, adequately supervising their virtually learning children has been a continual challenge. Meeting the educational needs of children with special needs is especially challenging. Parents feel they must place either their employment or their children's education, or both, at risk. Families feel disconnected from teachers and from support staff such as counselors and social workers, despite the many efforts of school staff to reach out.

Finances are a common stressor for families, and even more so during COVID. Low-income families and families of color are much more likely to have lost employment or suffered reduced hours (as are youth who had jobs themselves), than many others in our community. Women in particular have been disproportionately affected by decreased employment opportunities and the expectation that they will oversee their children's learning at home. Loss of child care for younger children has required some mothers to leave employment, and may youth have had to assume child care responsibilities. Providers are receiving more reports about violence (e.g., intimate partner violence) in homes related to financial strain. Families struggling with self-sufficiency may be less likely to seek out mental health services, as their attention is focused on meeting basic needs.

Anxiety, fear, and uncertainty go hand-in-hand and manifest themselves in multiple ways. For some, these situations are leading to emergent mental wellness challenges. For others, they are exacerbating existing issues. Typical coping resources have been unavailable, for many this includes-being with friends, extended family, talking with teachers or other school staff. Many of these are not available or seem unavailable due to virtual means of communication. Youth living in violent or unsafe homes may be in a permanent state of stress functioning, unable to find respite in school and extracurricular activities. Youth can be confused by changing, conflicting, and vague information: What is it safe to do? What's the best way to protect yourself? When is school starting and how will it work? Knowing all this is weighing on their kids, some parents have reported being wary of trying to address their kids' mental health issues, fearful that it could overwhelm them.

For some students, distance learning is a stressor. Many students are thriving in the virtual environment. Sustaining attention in a virtual environment may be more difficult for many students and the connectivity demands add stressors to school participation. English language learners and students with disabilities may face additional challenges in the virtual learning environment. The lack of familiarity and

onscreen fatigue may be reasons students are not attending, however, other worries as noted may contribute to school attendance concerns. School staff have monitored attendance and teams have worked to engage students and families who have experienced challenges during distance learning.

Service Access

Access to prevention, early intervention, and intensive intervention services has been limited throughout the pandemic. Capacity at many inpatient and residential programs that youth are referred to has been limited due to physical distancing requirements. Primary prevention programs such as after-school programs and youth sports play a critical role in connecting youth with caring adults and peers, building a strong foundation of support and social emotional development. Early in the pandemic, these programs were overwhelmingly shut down. They have since returned, many in-person. Virtual programs have mostly emphasized outreach and connection, working to support their participants as best they can. But the lost opportunities and relationships from last spring and summer can have a long-lasting impact for some youth.

Similarly, many outpatient providers stopped seeing clients last spring. Most since returned, providing telehealth services. Healthy Minds Fairfax has worked with providers to share best practices for telehealth, helping to increase capacity and access. While some youth thrive in in-person settings, many do very well in telehealth. As a result, telehealth has made mental health services more accessible at times (for example, when transportation had been a barrier for treatment). Although, communities that have been disproportionately impacted by the pandemic may also face barriers to accessing telehealth services due to limited digital access and/or digital literacy. And missed service at the onset of the pandemic may have a lasting impact on some youth, and some youth may not have returned to services at all after initial interruptions.

School staff are collaborating with families and community agencies, in order to best support students and families during distance learning, and as students return to school buildings. Plans to identify and support students who experience social and emotional difficulties have been regularly and repeatedly communicated with families through a variety of means and modalities. Parents have consistently been encouraged to reach out to their child's teacher, administrator, school counselor, school social worker, and/or school psychologist if they have concerns about their child. Many families and students have reached out to these trusted adults. Additionally, the continuation or addition of morning meetings and advisory periods have provided opportunities for school staff to check in with students. The processes to obtain more assistance have been reviewed with parents and school staff. However, the access by virtual means is not as familiar and comfortable as in person options.

School staff have received training, emphasizing the incorporation of social and emotional learning across academic environments. Additionally, there has been a focus on continued relationship building, especially in a virtual environment. Staff have also received training in recognizing the signs and symptoms that a student may be experiencing a wellness challenge with referral procedures for virtual and in-person learning environments.

School Counselors, School Psychologists and School Social Workers continue to provide counseling intervention services both virtually and in-person in order to support the students' social and emotional wellness. These staff members have been leading Multi-Tiered Systems of Support (MTSS) meetings and have systematically consulted with school teams to improve students' learning, behavior, and social-emotional wellness. They have facilitated Tier 1, whole-group Social Emotional Learning lessons. They

have provided Tier-2 evidence-based counseling groups, and they have been providing direct counseling services to individual students with the most intensive needs. They have continued to conduct suicide risk assessments and have responded to crisis situations. All of these supports have occurred throughout the course of the pandemic. Outreach to students and families has been strengthened with the focus supporting virtual and hybrid learning. This opportunity has been a shift to support families within their home environment as school personnel support families with student learning in both the school and home environment. It is also important to note that some students are thriving a virtual school environment.

KEY FINDINGS

Data and experiences from the past year point to two primary observations regarding the state of youth mental health in Fairfax County.

First, there has not been a significant increase in the number of youth seeking services for mental wellness challenges. To be sure, the numbers were concerning pre-COVID, and remain so. But the data do not suggest a spike in depression, anxiety, suicidality, or other concerns. Suicide rates and emergency services utilization have remained stable (especially if increased Emergency Department visits were primarily driven by a lack of alternatives early in the pandemic). There has not been an overwhelming rush for FCPS or CSB services, despite increased outreach and access points. Utilization of assessment and outpatient services initially decreased but have slowly been recovering, approaching pre-pandemic levels.

Second, for a segment of youth, the issues are overwhelming. This is evident in the increased demand for residential and inpatient services and in the descriptions of need and acuity from parents, caregivers, and providers. Based on feedback from providers, these youth mostly had pre-existing mental health diagnoses or related challenges (some early research out of the National Institute for Mental Health suggests this is a common risk factor). For these youth, the combination of multiple stressors, limited access to supportive coping strategies, and reduced services could be overwhelming. Their parents and caregivers often struggled to find respite, making it more difficult for them to seek their own help or to provide consistent support. For these youth and families, the situation can range from stressful to dire.

The data do not clearly show that racial and ethnic disparities have increased as a result of the pandemic. However, given the disproportionate health, economic, and social impacts that the COVID-19 pandemic has had on the Black and Hispanic population in Fairfax County, it is reasonable to expect that the stressors noted above have disproportionately affected Black and Hispanic youth and families. We also know that service access was already disproportionately more difficult for people of color before the pandemic. Further, English language learners and immigrants have faced additional barriers to accessing services and information.

It is tempting to hope that when schools and other programs and activities reopen, everything will be better. However, we can't fully know for sure what will happen. It is expected that reporting and referrals will go up as more and more adults get to interact with youth. Increased reporting and demands for service should not be taken automatically as a sign that needs are increasing. But it is also reasonable to expect that, for some youth, the adjustment to returning to school and activities can be stressful itself. We all need to be prepared for a range of situations and outcomes.

NEXT STEPS AND RECOMMENDATIONS

The return to school and other activities will likely change the nature of this issue. But it is not likely to make things better or easier in the near term. First, we should be prepared for a significant increase in referrals. Once teachers, coaches, counselors, and others are able to again interact with youth in-person, they will be better able to recognize signs and symptoms of issues such as mental distress, abuse and neglect, and substance use. Second, just as the transition to virtual schooling and other elements of the shutdown increased stress and anxiety, a transition back can do the same for many kids. They will need support through the transition period, and for a significant amount of time after that.

We can use this moment to help propel a new comprehensive plan for children's behavioral health. Over the past five years, the behavioral health system of care for children and youth in Fairfax County has greatly improved in access and quality as a result of implementing strategies in the Healthy Minds Fairfax Blueprint. It is time to, through the Successful Children and Youth Policy Team (SCYPT), reassess our needs and identify the most impactful strategies to continue to improve, with an enhanced focus on equity and building on the lessons learned over the past year. Such a plan should keep at its foundation the partnership across County, FCPS, and private and community-based providers that is necessary to a functional system of care. Future plans should continue to build on what we know works: evidence-based practice, a focus on social emotional learning, effective case management, care coordination, and youth and family engagement. A trauma-informed approach will help ensure we effectively support youth and families in ways that promote healing. A foundation in racial and social equity will help reduce disparities through a targeted universalism approach that allows for improvements that benefit all to be coupled with interventions and strategies for populations and communities who need them most. And we must continue to focus on building resilience through healthy relationships, connections, and other protective factors. Data from the Fairfax County Youth Survey, amplified through our Three to Succeed campaign (see Chart 1 below), make clear that youth thrive when they have protective factors such as engaged and caring adults in their lives.

Lessons from the pandemic point towards other key considerations for a new plan:

We should consider universal screenings and wellness checks for all youth. Such checks cannot be a one-time occurrence, though. They should be performed not just once students return to school, but regularly, as this will be a long and challenging transition back. (FCPS will be conducting a school-wide screener in the fall regarding student social and emotional learning needs.) **Screenings must be backed with reliable and available services.** Screenings themselves are ineffective if they are not backed by solid connections to services for those who need them. **We should be exploring immediate opportunities to expand services.** This can include looking at how we use existing funding and resources and identifying new resources. How can we build on the momentum and increased capacity for telehealth to broadly expand access on a permanent basis?

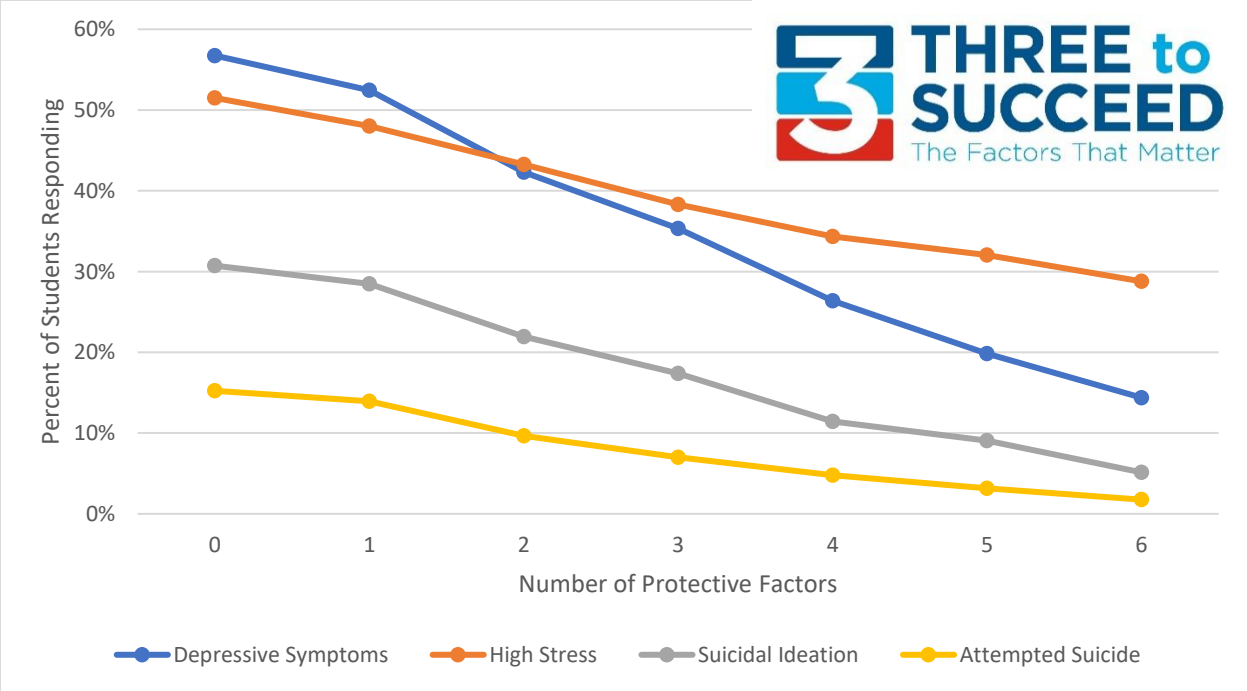
We need to ensure that parents, caregivers, and other adults continue to have resources and information easily available and know where to turn for support. Kids need trusted adults – parents and others – to regularly communicate clearly what is happening, what to expect next, and what's unknown. The uncertainties and regular changes of the past year call for adults to help youth with perspective setting and understanding. When things change, we need to explain why. When youth are concerned or scared or confused, we need to ask about it and understand.

We need to ensure a continuum of services across primary prevention, early intervention, intensive intervention, and crisis services – and regular interaction among providers and families involved in each.

We need to pay particular attention to graduating seniors to ensure they have the skills and supports to transition to young adulthood. This report focused on school-age youth. But some of the worst mental health outcomes right now are being experienced by young adults and college students.

Where services and strategies can be identified that would make an immediate impact, resources should be identified to facilitate their timely implementation, without waiting for the completion of a long-term plan. As schools and other programs and activities continue to open up in-person opportunities, we all need to be prepared for a range of situations and outcomes. Staff should continue to closely monitor data indicators to enable updated real-time analysis as best possible. And short-term and long-term planning should reflect the current realities and take into account lessons learned over the past year.

Chart 1. Three to Succeed for Mental Health Outcomes. Source: 2019-2020 Fairfax County Youth Survey. The more protective factors youth have in their lives, the less likely they are to experience depressive symptoms, high stress, or suicidal ideation, or to attempt suicide. Protective factors include caring and interested adults, engagement in community service and extracurricular activities, and internal assets such as willingness to accept responsibility. Learn more at bit.ly/3toSucceed.



APPENDIX A: KEY SYSTEM RESPONSES

Since the beginning of the pandemic, Fairfax County Government, FCPS, and community-based partners have been working to identify youths' mental health needs and put into place strategies to better support them. What follows is not an exhaustive list, but a sample of the kinds of efforts that have been implemented over the past year.

- The CSB has implemented a direct referral process from school social workers, psychologists and counselors to outpatient services for students with the most pressing behavioral health needs. This process is a "warm hand-off" that includes communication between CSB and school mental health professionals to coordinate care and ensure that students with serious behavioral health issues do not fall through the cracks.

- Short Term Behavioral Health Services: Short Term Behavioral Health Services is a free counseling service operated by Healthy Minds Fairfax. Children and youth whose family's income is up to 400% of the poverty level can receive up to 8 free counseling sessions. Healthy Minds Fairfax contracts with private providers to provide the services. During the COVID emergency, Healthy Minds Fairfax has temporarily opened this program to all middle and high school aged youth.

- Fairfax Recharge: Free Respite Care: Healthy Minds Fairfax received funds though the Coronavirus Aid, Relief, and Economic Security (CARES) Act to support Formed Families Forward program, Kinship to Recharge Program. This program provided free respite care to caregivers raising a relative's child and whose income did not surpass 300% of the poverty level. After CARES Act funds ended, Formed Families Forward with financial support from Healthy Minds Fairfax opened this program to all eligible families. Families are eligible to receive free respite care if their income is below 300% of the poverty level, the family has been impacted by COVID, and the caregivers are caring for a child or youth with behavioral or emotional health needs. Families are responsible for identifying the provider and Formed Families Forward will perform a background check on the provider. Families can receive up to 15 hours a week for 8 weeks.

- The Behavioral Health Clinicians Availability During the COVID-19 Crisis is a booklet of providers who provide mental health treatment to Fairfax residents, their availability, population they serve, the services they provide, and how to pay for their services.

- Trauma Informed Strategies for Working With Youth and Families During the Pandemic, and the follow-up When Out of School Time Centers Reopen and Programs Resume were jointly developed by the Fairfax County Trauma-Informed Community Network, the Fairfax County Out of School Time Network, and Opportunity Neighborhoods.

- The Department of Family Services has created a CYF Assistance from a Distance page with all our virtual family supports and developed new online parenting resources such as their Parenting Tips and Resources page and Pocket Dad Videos.

- FCPS has reached thousands of parents through their Healthy Minds blog and Healthy Minds podcast, all sharing relevant and timely behavioral health information.

- The Fairfax County Out of School Time Network hosted a 6-session training series for nearly 100 youth program providers on creating impactful virtual experiences, as a key strategy to address isolation and disengagement of youth.

- The Department of Family Services, in partnership with FCPS and NCS, created a flyer with Possible_Signs_of_Child_Abuse_and_Neglect and distributed it widely in the community to help adults determine when a child may be at risk of harm and how to make a report to the Child Protective Services hotline.

- FCPS has adapted prevention and intervention services to maintain services throughout the school year. School counseling, social work, and psychology staff have been leading Multi-Tiered Systems of Support (MTSS) meetings and systematically consulting with school teams to improve students' learning, behavior, and social-emotional wellness. They have been pushing into classrooms and facilitating "Tier 1" whole-group social emotional learning (SEL) lessons for entire classrooms. They have been conducting "Tier 2" evidence-based counseling groups for identified groups, and they have been providing direct counseling services to individual students with the most intensive needs. In addition, FCPS staff have been conducting suicide risk assessments and responding to crisis situations. All of this has occurred throughout the course of the pandemic.

- Healthy Minds Fairfax established a Community of Telehealth Providers to bring together therapists from the private and public sectors to share ideas on best practices in providing telehealth to children and youth. Topics discussed during the meetings have focused on how to keep children and youth engaged in telehealth services and how to provide evidence-based treatment during a telehealth session. Healthy Minds Fairfax is currently surveying therapists who provide telehealth services to learn more about their experiences and what resources may be helpful to them.

- As it became apparent toward the end of last school year that many (and eventually all) FCPS students would continue to learn virtually during the current school year, FCPS set out to improve both the resources and supports that were available for effective virtual instruction. These included providing more synchronous instruction than had been available in Spring 2020, setting higher expectations for the expected quality of virtual instruction, establishing an enhanced focus on student wellbeing and social emotional learning, as well as providing professional development and instructional resources to support students' academic and well-being needs.

APPENDIX B: RESOURCES FOR FAMILIES AND OTHERS

from the Fairfax Falls-Church Community Services Board. Printable flyers with this information in English and Spanish can be found at
https://www.fairfaxcounty.gov/community-services-board/news/2020/child-mental-health-concern

Parenting can be difficult, even under the best of circumstances. Now the coronavirus pandemic has brought major changes to every aspect of our lives – how we live, work, teach, and play – making parenting more stressful. Many of us are worried about how our children are handling the social isolation of distance learning, alongside the usual trials and challenges of growing up.

"Just as you are looking out for your child's physical health during the pandemic, keep an eye on their mental health too," recommends James M. Gillespie, Healthy Minds Fairfax Director and CSB Youth and Family Services Director. He adds, "Having less contact with friends and family and not being able to do enjoyable activities can increase stress and lead to emotional or mental health concerns in children."

If you're worried about your child, have a talk with them to find out how they are doing. Give them your full attention. Listen carefully, repeat what you heard and ask if you got it right. When they feel heard and understood, they're more likely to share with you.

Notice what is going on with your child. You know your child best.

Here are some things to look for:

- Becoming more irritable, hyperactive, energetic, fidgety, or aggressive.
- Excessive sadness, fears or worries.
- A steep in drop in grades, getting into trouble at school or not attending school.
- Loss of appetite, significant weight gain or loss, lack of sleep or too much sleep.
- Withdrawal from activities, family, or friends.
- Alcohol or drug use.
- Thoughts of suicide or harming themselves or others – Do not be afraid to ask your child if they are having these thoughts. Your asking will not put those thoughts in their head. Rather, it tells them you care and that you will help keep them safe.

HOW TO GET HELP

Below are several options for you to speak with a mental health professional. Do not worry about making the wrong choice. Every number leads to someone who can help.

- Contact your child's pediatrician.
- Call your health insurance company or visit their website to search for a behavioral/mental health provider.
- Contact the Fairfax-Falls Church Community Services Board (CSB) at 703-383-8500, weekdays from 9 a.m. to 5 p.m.
- Walk into the CSB's Merrifield Center (8221 Willow Oaks Corporate Drive, Fairfax, VA 22031) weekdays from 9 a.m. to 5 p.m.
- Contact your child's school counselor, school public health nurse, social worker, or psychologist.

- Take a free, confidential online mental health screening and practice talking with your child about mental health concerns by taking a free, online Kognito training. [Though these courses are designed for educators, parents can use the same skills in talking with their own children.]
- Visit the CSB or Healthy Minds Fairfax websites to get mental health information and local resources. Also available on the CSB website is information about *Mental Health First Aid, Question, Persuade and Refer*, and *ACE Interface*, which educate parents and others on mental health issues and how to respond.

IF YOUR CHILD IS HAVING A MENTAL HEALTH CRISIS, THESE SERVICES ARE AVAILABLE 24/7

Below are several options for you to speak with a mental health professional. Do not worry about making the wrong choice. Every number leads to someone who can help.

- Call the PRS CrisisLink hotline at 703-527-4077, 1-800-273-8255 or text "CONNECT" to 855-11.
- Call Children's Regional Crisis Response Children's Regional Crisis Response (CR2) at 571-364-7390.
- Call CSB Emergency Services at 703-573-5679.
- Bring your child to the CSB's Merrifield Crisis Response Center, 8221 Willow Oaks Corporate Drive, Fairfax, VA 22031.
- Call 911 if it is a life-threatening emergency. Make sure to notify the operator that it is a psychiatric emergency and ask for an officer trained in crisis intervention or trained to assist people experiencing a psychiatric emergency.

Make the call today – there's never a wrong time to reach out for help for your child.

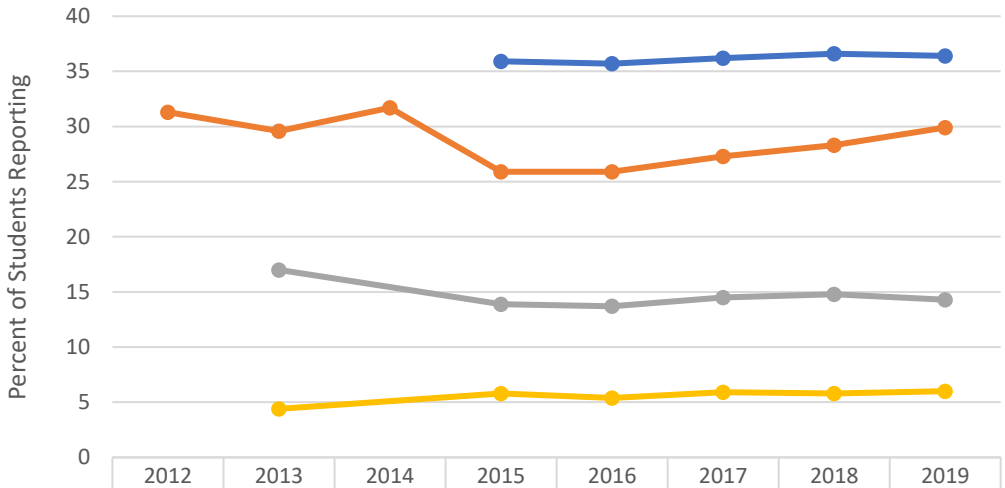
APPENDIX C: FAIRFAX COUNTY YOUTH SURVEY DATA

The prevalence of suicidal ideation, suicide attempts, and high stress have remained fairly steady over the past several years. The percentage of youth reporting depressive symptoms, however, has slowly increased since a low in 2015. (For the purposes of the survey, "depressive symptoms" is defined as "During the past 12 months, did you ever feel so sad or hopeless almost every day for two weeks or more in a row that you stopped doing some usual activities?") The prevalence of depressive symptoms, suicidal ideation, and suicide attempts are all lower than national rates. Stress prevalence is not compared to a national benchmark.

Girls consistently report depressive symptoms at higher rates than boys. Hispanic students and LGBQ students report symptoms at higher rates than their peers. Similar disparities are evident for other mental health outcomes, including suicidal ideation and suicide attempts.

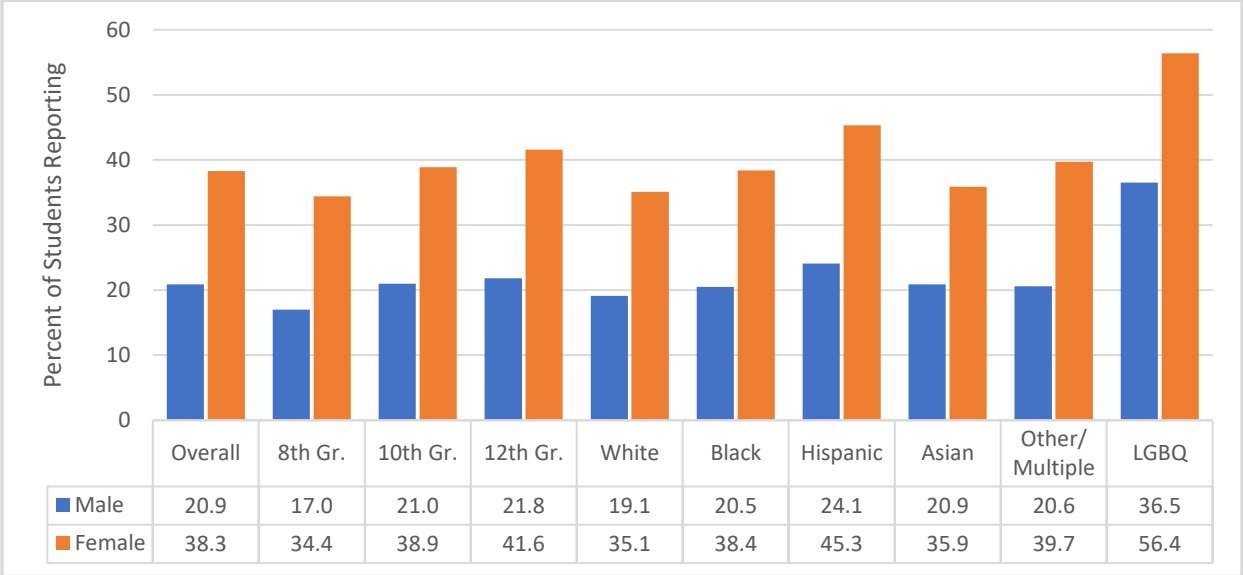
A separate survey administered to sixth grade students revealed similarly high rates of depressive symptoms. On the 2019-2020 Youth Survey, 24.8 percent of sixth graders, including 28.8 of girls and 20.8 percent of boys, reported depressive symptoms.

Chart C.1. Mental Health and Suicide Trends Among 8th, 10th, and 12th Grade Students, 2012-2019. Source: Fairfax County Youth Survey.



	2012	2013	2014	2015	2016	2017	2018	2019
High Stress				35.9	35.7	36.2	36.6	36.4
Depressive Symptoms	31.3	29.6	31.7	25.9	25.9	27.3	28.3	29.9
Suicidal Ideation		17.0		13.9	13.7	14.5	14.8	14.3
Suicide Attempt		4.4		5.8	5.4	5.9	5.8	6.0

Chart C.2. Depressive Symptoms Among 8th, 10th, and 12th Grade Students, 2019. Source: 2019-2020 Fairfax County Youth Survey.



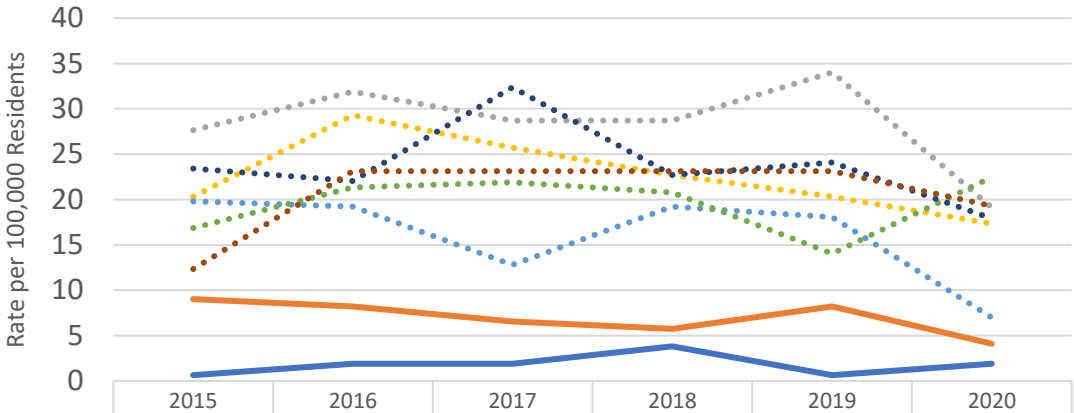
	Overall	8th Gr.	10th Gr.	12th Gr.	White	Black	Hispanic	Asian	Other/ Multiple	LGBQ
Male	20.9	17.0	21.0	21.8	19.1	20.5	24.1	20.9	20.6	36.5
Female	38.3	34.4	38.9	41.6	35.1	38.4	45.3	35.9	39.7	56.4

APPENDIX D: SUICIDE RATES

Suicide rates in the Fairfax Health District (Fairfax County, Fairfax City, and Falls Church City) decreased for all but one age group in 2020. The small numbers of suicides at any age group can result in significant yearly differences in rates. There were a total of 5 suicides in 2020 among youth ages 10 to 17, and 3 among younger youth.

Because there are typically fewer than 10 suicides per year among youth in Fairfax, we generally do not present data disaggregated by race.

Chart D.1. Suicide Rate per 100,000 Residents by Age and Year, Fairfax Health District, 2015-2020. Source: Fairfax County Health Department.



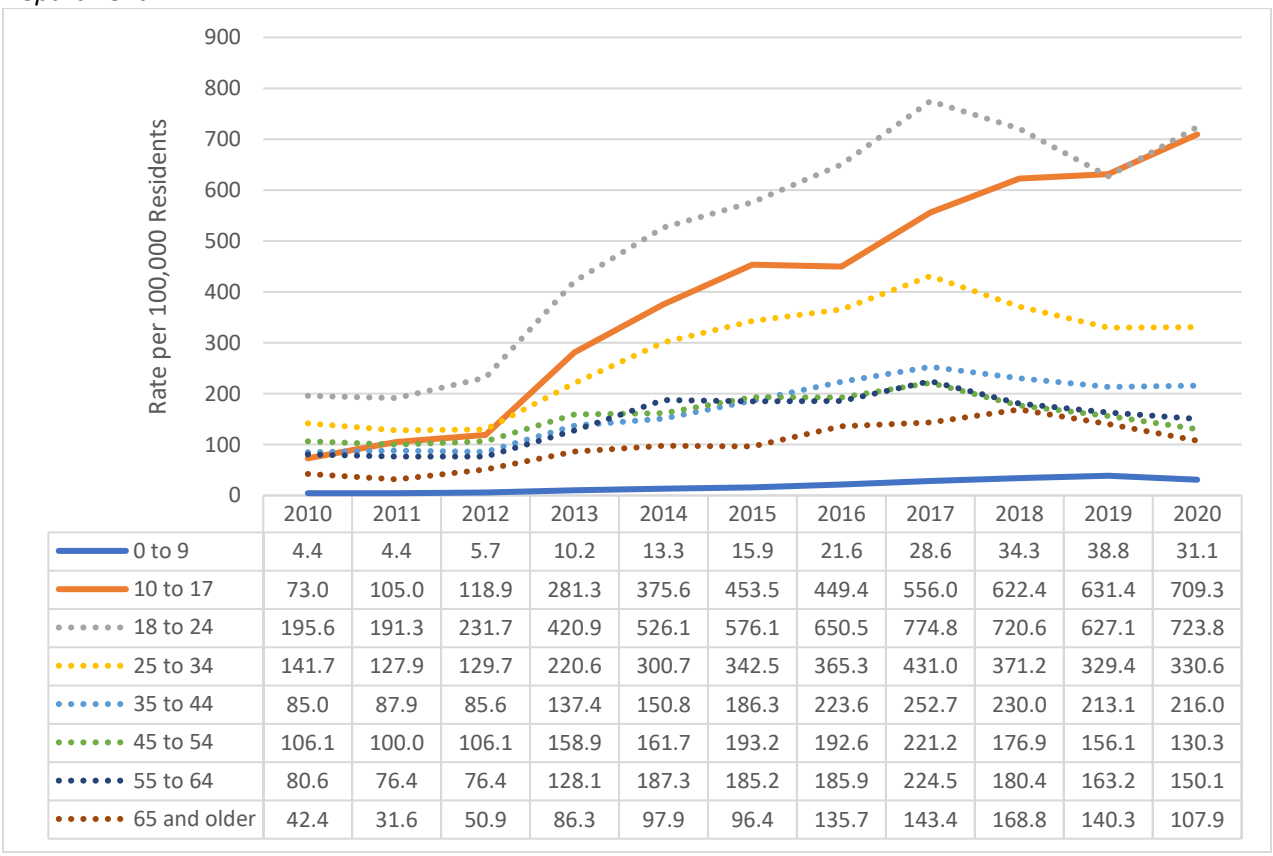
	2015	2016	2017	2018	2019	2020
0 to 9	0.64	1.91	1.91	3.81	0.64	1.91
10 to 17	9.02	8.20	6.56	5.74	8.20	4.10
18 to 24	27.63	31.89	28.70	28.70	34.01	19.13
25 to 34	20.33	29.29	25.71	22.72	20.33	17.34
35 to 44	19.79	19.21	12.81	19.21	18.05	6.99
45 to 54	16.85	21.34	21.90	20.78	14.04	22.46
55 to 64	23.41	22.04	32.37	22.72	24.10	17.90
65 and older	12.33	23.13	23.13	23.13	23.13	19.27

Appendix E: Emergency Department Visits for Suicidal Ideation or Attempt

Emergency Department visits among youth and young adults had been rapidly rising over the past decade, in part because of reduced stigma and greater willingness to seek help. A decline or leveling off over the past few years was replaced with another spike in 2020. It is possible that the increase was related to limited options for service early in the pandemic.

The majority of ED visits do not have race or ethnicity data attached, compromising the quality of disaggregated data. Therefore, data by race or ethnicity is not included here.

Chart E.1. Emergency Department Visits for Suicide-Related Ideation or Behavior, Rate per 100,000 Residents by Age and Year, Fairfax Health District, 2010-2020. Source: Fairfax County Health Department.



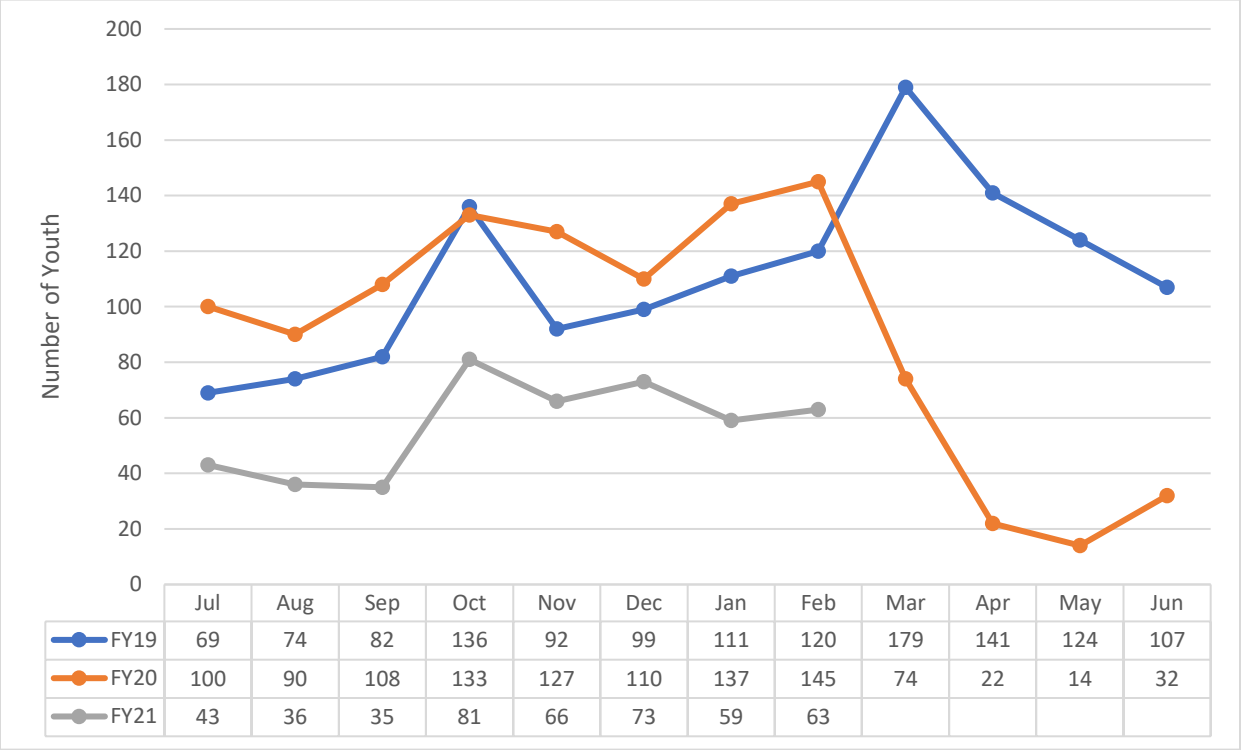
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
0 to 9	4.4	4.4	5.7	10.2	13.3	15.9	21.6	28.6	34.3	38.8	31.1
10 to 17	73.0	105.0	118.9	281.3	375.6	453.5	449.4	556.0	622.4	631.4	709.3
18 to 24	195.6	191.3	231.7	420.9	526.1	576.1	650.5	774.8	720.6	627.1	723.8
25 to 34	141.7	127.9	129.7	220.6	300.7	342.5	365.3	431.0	371.2	329.4	330.6
35 to 44	85.0	87.9	85.6	137.4	150.8	186.3	223.6	252.7	230.0	213.1	216.0
45 to 54	106.1	100.0	106.1	158.9	161.7	193.2	192.6	221.2	176.9	156.1	130.3
55 to 64	80.6	76.4	76.4	128.1	187.3	185.2	185.9	224.5	180.4	163.2	150.1
65 and older	42.4	31.6	50.9	86.3	97.9	96.4	135.7	143.4	168.8	140.3	107.9

APPENDIX F: COMMUNITY SERVICES BOARD SERVICE DATA

Fewer youth have accessed assessment and outpatient services at the Fairfax-Falls Church Community Services Board (CSB) since the pandemic began. However, emergency and intensive services have continued to be accessed near or at historic rates.

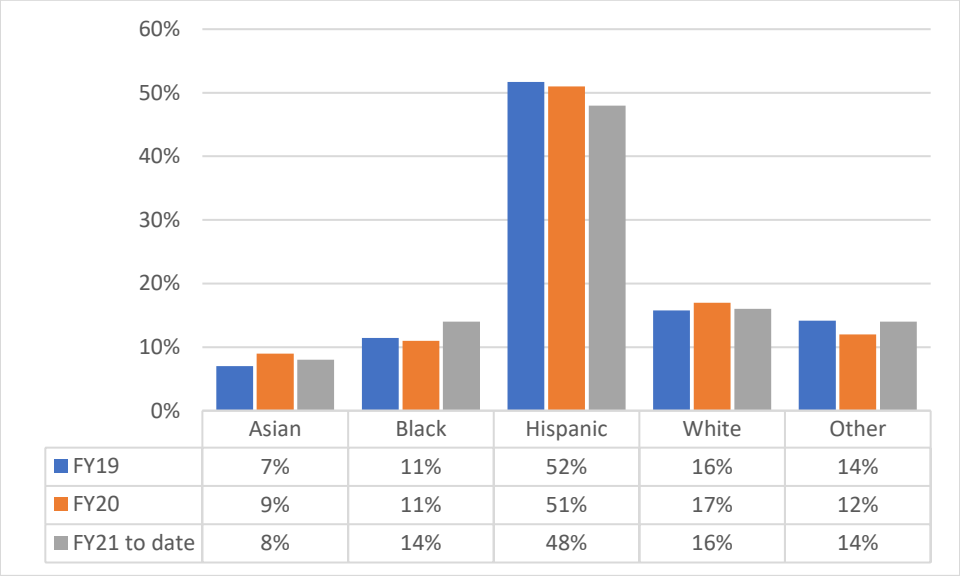
Although it does not appear that COVID has differentially impacted access to CSB behavioral health services by race or ethnicity, there are ongoing patterns of differential utilization. Hispanic youth are significantly overrepresented among CSB outpatient clients (50 percent of clients are Hispanic, versus 27 percent of the FCPS student population), and Black youth are moderately over-represented (14 percent of clients, versus 10 percent of FCPS). As a Medicaid provider with fees based on income, the CSB is one of the few mental health treatment options for many low and moderate income residents. The clients of CSB's intensive programs more closely mirror the racial and ethnic composition of the county as whole, reflecting the fact that behavioral health issues occur among residents of all races, ethnicities, and socioeconomic statuses, and that the high cost of intensive services place them beyond the ability of most households to access privately.

Chart F.1. Number of Youth Receiving CSB Assessment Services by Month, FY2019 – FY2021. Source: Fairfax-Falls Church Community Services Board.



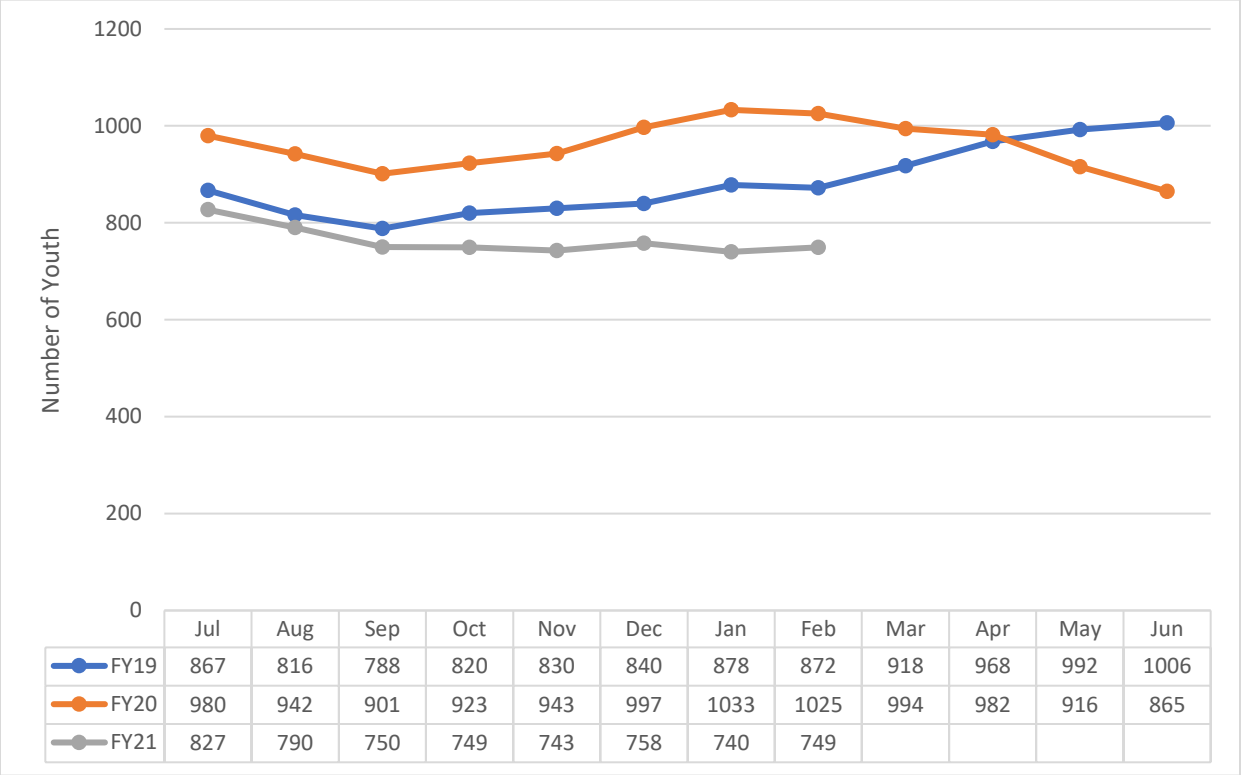
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
FY19	69	74	82	136	92	99	111	120	179	141	124	107
FY20	100	90	108	133	127	110	137	145	74	22	14	32
FY21	43	36	35	81	66	73	59	63				

Chart F.2. Race/Ethnicity of Youth Receiving CSB Assessment Services, FY2019 – FY2021. Source: Fairfax-Falls Church Community Services Board.



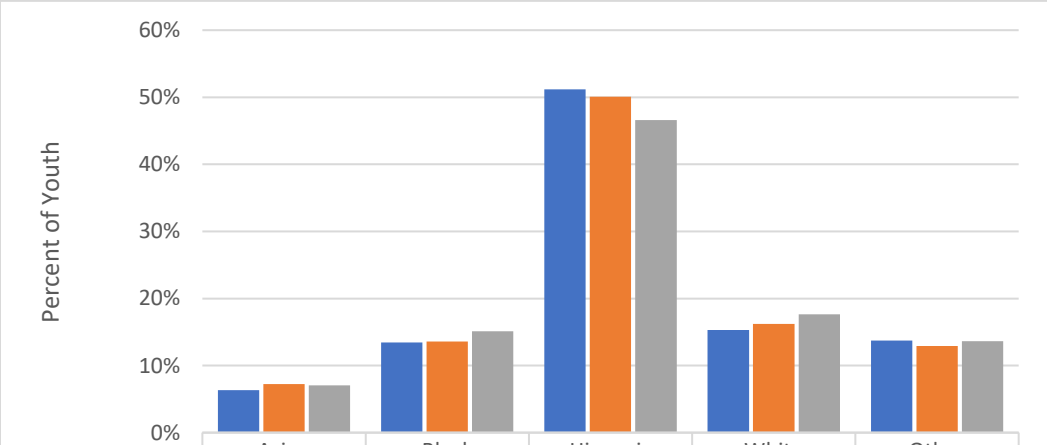
	Asian	Black	Hispanic	White	Other
FY19	7%	11%	52%	16%	14%
FY20	9%	11%	51%	17%	12%
FY21 to date	8%	14%	48%	16%	14%

Chart F.3. Number of Youth Receiving CSB Outpatient Services by Month, FY2019 – FY2021. Source: Fairfax-Falls Church Community Services Board.



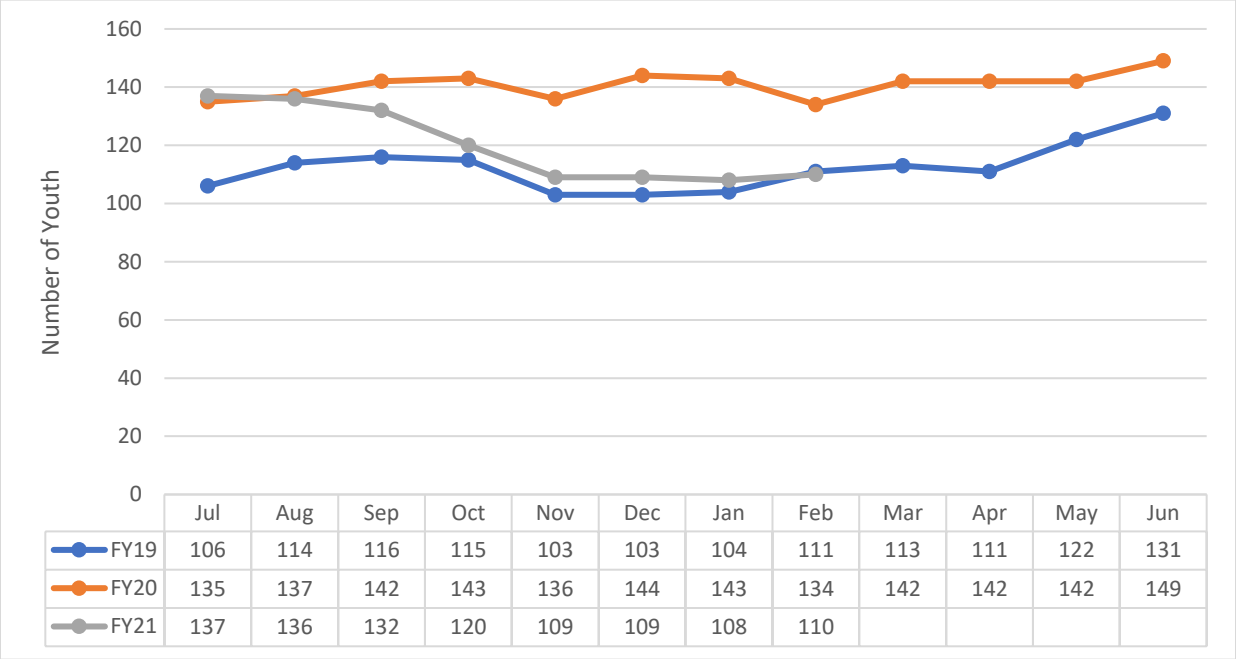
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
FY19	867	816	788	820	830	840	878	872	918	968	992	1006
FY20	980	942	901	923	943	997	1033	1025	994	982	916	865
FY21	827	790	750	749	743	758	740	749				

Chart F.4. Race/Ethnicity of Youth Receiving CSB Outpatient Services, FY2019 – FY2021. Source: Fairfax-Falls Church Community Services Board.



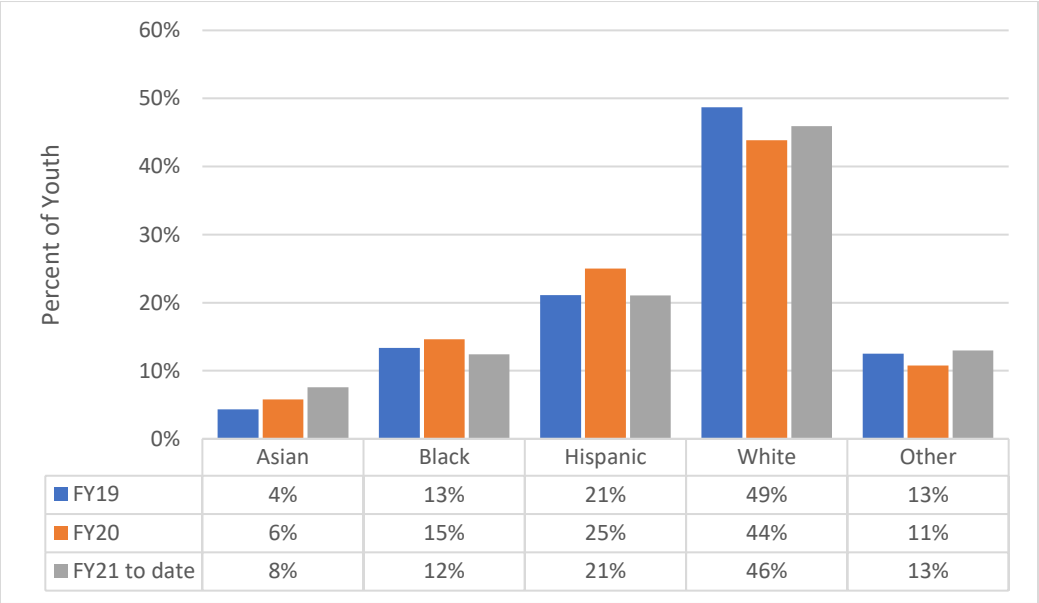
	Asian	Black	Hispanic	White	Other
FY19	6%	13%	51%	15%	14%
FY20	7%	14%	50%	16%	13%
FY21 to date	7%	15%	47%	18%	14%

Chart F.5. Number of Youth Receiving CSB Intensive Mental Health Treatment Services by Month, FY2019 – FY2021. Source: Fairfax-Falls Church Community Services Board.



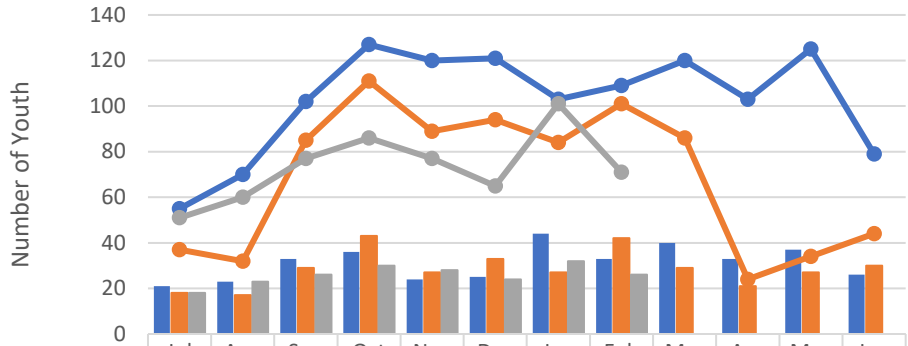
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
FY19	106	114	116	115	103	103	104	111	113	111	122	131
FY20	135	137	142	143	136	144	143	134	142	142	142	149
FY21	137	136	132	120	109	109	108	110				

Chart F.6. Race/Ethnicity of Youth Receiving CSB Intensive Mental Health Treatment Services, FY2019 – FY2021. Source: Fairfax-Falls Church Community Services Board.



	Asian	Black	Hispanic	White	Other
FY19	4%	13%	21%	49%	13%
FY20	6%	15%	25%	44%	11%
FY21 to date	8%	12%	21%	46%	13%

Chart F.7. Number of Youth Receiving CSB Crisis Intervention Services, and the Number Requiring Hospitalization, by Month, FY2019 – FY2021. Source: Fairfax-Falls Church Community Services Board.



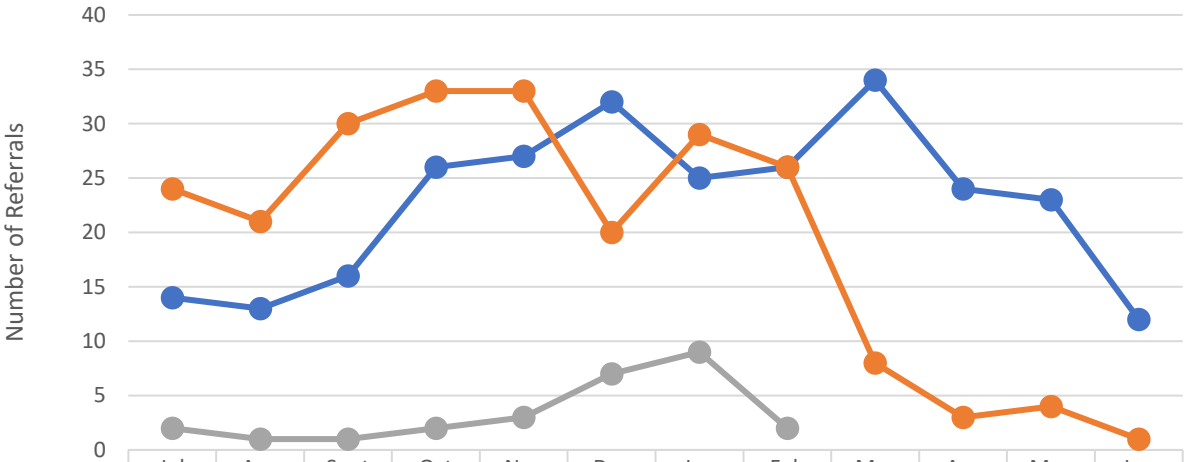
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
FY19 Svcs Requiring Hospitalization	21	23	33	36	24	25	44	33	40	33	37	26
FY20 Svcs Requiring Hospitalization	18	17	29	43	27	33	27	42	29	21	27	30
FY21 Svcs Requiring Hospitalization	18	23	26	30	28	24	32	26				
FY19 Services	55	70	102	127	120	121	103	109	120	103	125	79
FY20 Services	37	32	85	111	89	94	84	101	86	24	34	44
FY21 Services	51	60	77	86	77	65	101	71				

APPENDIX G: JUVENILE AND DOMESTIC RELATIONS DISTRICT COURT DATA

While the percentage of youth entering the Juvenile Court's diversion program in need of behavioral health services has remained constant (Chart G.2.), the numbers being served are significantly down since April 2020 (Chart G.1.). Likewise, while the percentage of youth entering the Juvenile Court's secure detention or shelter care programs in need of immediate behavioral health services has remained constant (Chart G.4.), the numbers being served are significantly down since April 2020 (Chart G.3.).

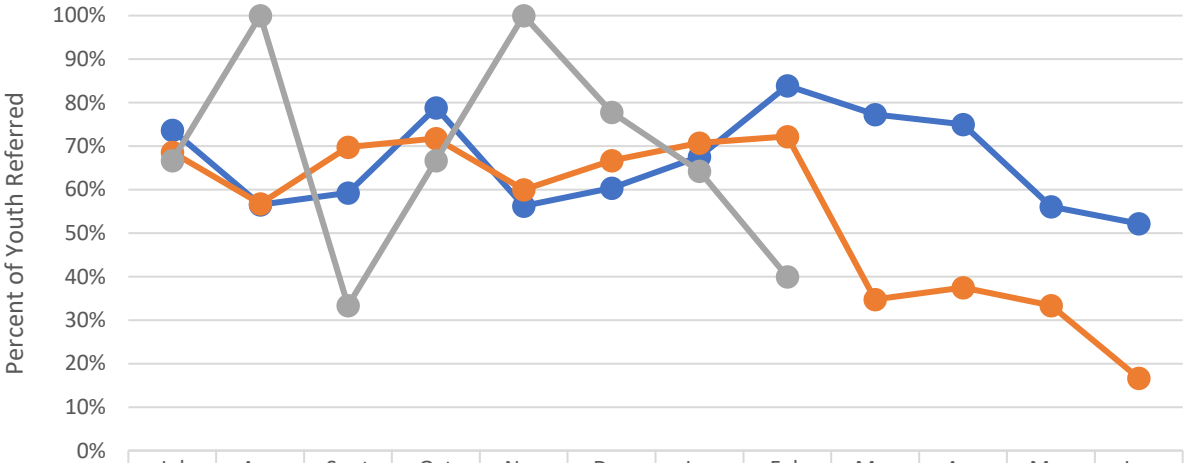
Racial and ethnic disparities do not appear to have been exacerbated by the pandemic.

Chart G.1. Number of Juvenile Court Diversion Referrals for Behavioral Health by Month, FY2019-FY2020. Source: Fairfax County Juvenile and Domestic Relations District Court.



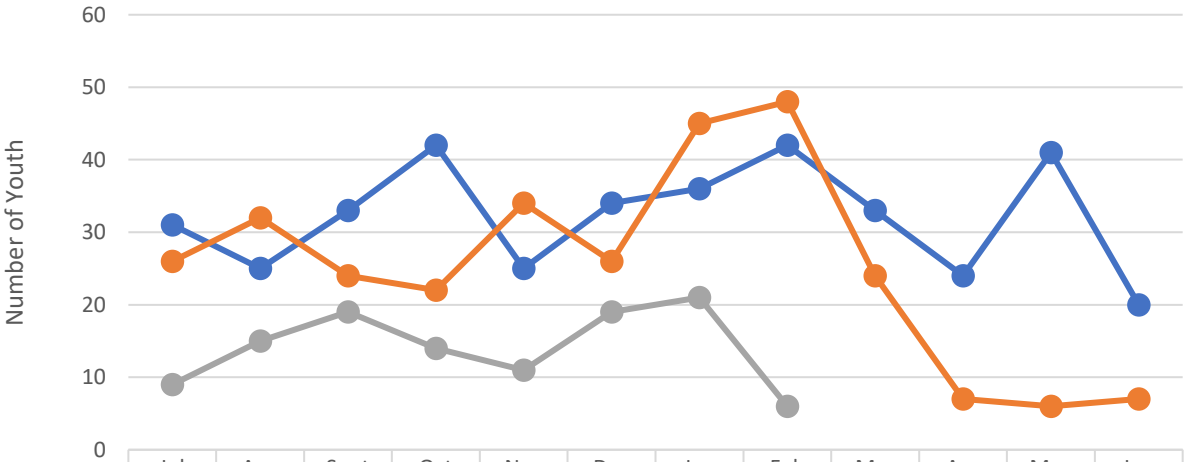
	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
FY19	14	13	16	26	27	32	25	26	34	24	23	12
FY20	24	21	30	33	33	20	29	26	8	3	4	1
FY21	2	1	1	2	3	7	9	2				

Chart G.2. Percent of Juvenile Court Diversion Screenings Referred for Behavioral Health by Month, FY2019-FY2020. Source: Fairfax County Juvenile and Domestic Relations District Court.



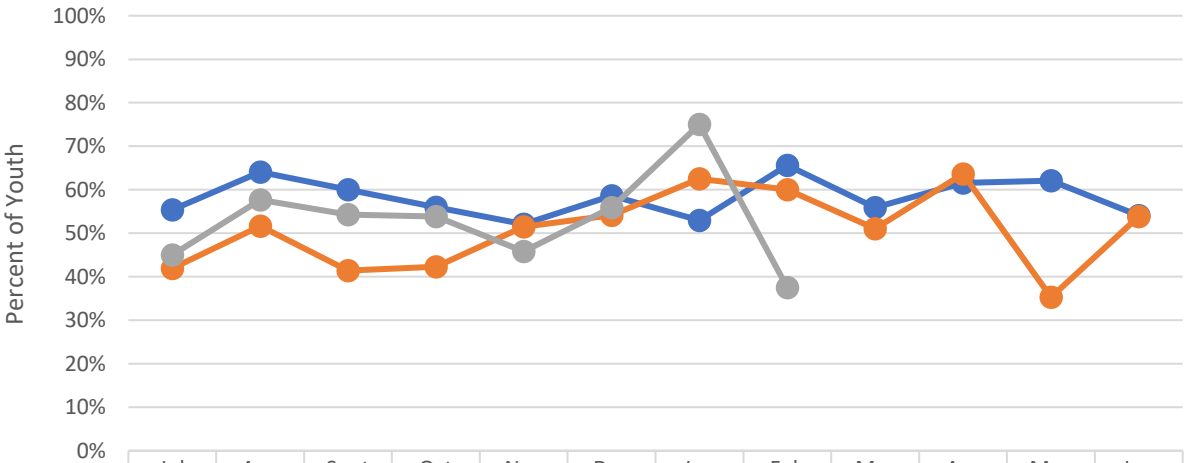
	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
FY19	74%	57%	59%	79%	56%	60%	68%	84%	77%	75%	56%	52%
FY20	69%	57%	70%	72%	60%	67%	71%	72%	35%	38%	33%	17%
FY21	67%	100%	33%	67%	100%	78%	64%	40%				

Chart G.3. Number of Juvenile Court Screenings Indicating Need for Immediate Mental Health Treatment by Month, FY2019-FY2020. Source: Fairfax County Juvenile and Domestic Relations District Court.



	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
FY19	31	25	33	42	25	34	36	42	33	24	41	20
FY20	26	32	24	22	34	26	45	48	24	7	6	7
FY21	9	15	19	14	11	19	21	6				

Chart G.4. Percentage of Juvenile Court Screenings Indicating Need for Immediate Mental Health Treatment by Month, FY2019-FY2020. Source: Fairfax County Juvenile and Domestic Relations District Court.



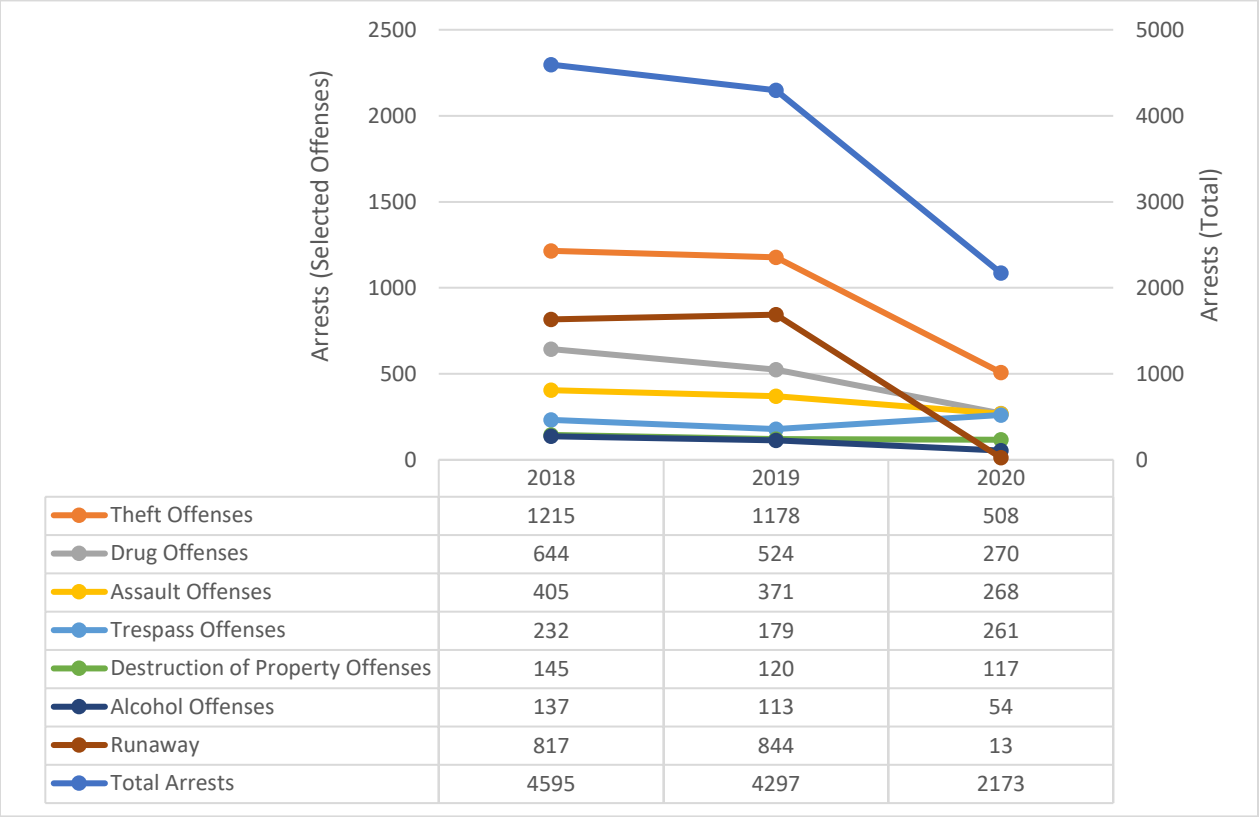
	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
FY19	55%	64%	60%	56%	52%	59%	53%	66%	56%	62%	62%	54%
FY20	42%	52%	41%	42%	52%	54%	63%	60%	51%	64%	35%	54%
FY21	45%	58%	54%	54%	46%	56%	75%	38%				

APPENDIX H: POLICE DATA

The total number of arrests of people under age 19 decreased significantly in 2020, including for most major and behavioral health-related offenses. While Black and Hispanic youth have consistently been arrested at higher rates than their White and Asian peers, the proportion of arrests of Hispanic youth increased even more in 2020.

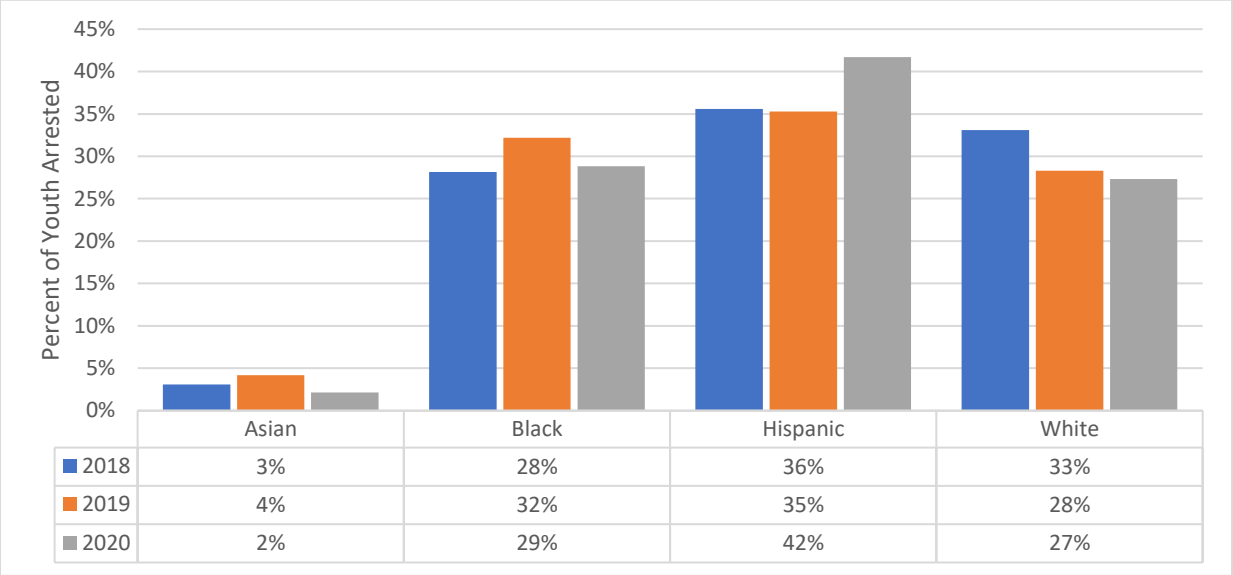
The number of youth reported as victims of assault decreased in 2020, but after a similar increase in 2019, it is not clear if the decrease is COVID-related.

Chart I.1. Youth Arrests, Total and for Selected Offenses, 2018-2020. Source: Fairfax County Police Department.



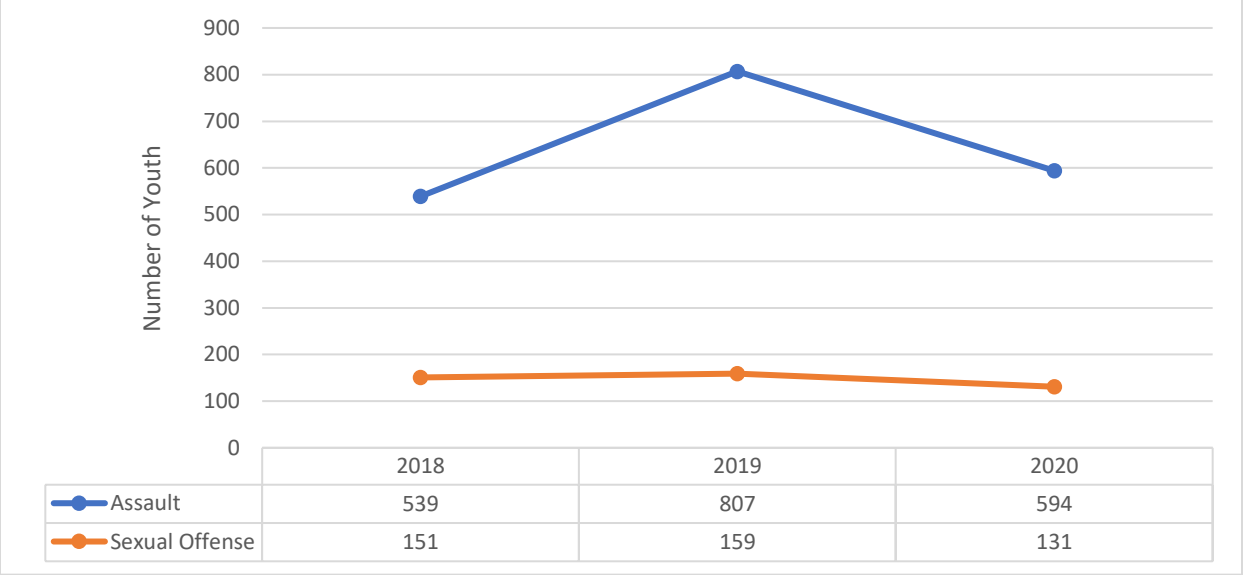
	2018	2019	2020
Theft Offenses	1215	1178	508
Drug Offenses	644	524	270
Assault Offenses	405	371	268
Trespass Offenses	232	179	261
Destruction of Property Offenses	145	120	117
Alcohol Offenses	137	113	54
Runaway	817	844	13
Total Arrests	4595	4297	2173

Chart I.2. Youth Arrests by Race and Ethnicity, 2018-2020. Source: Fairfax County Police Department.



	Asian	Black	Hispanic	White
2018	3%	28%	36%	33%
2019	4%	32%	35%	28%
2020	2%	29%	42%	27%

Chart I.3. Youth Victims of Assault and Sexual Assault, 2018-2020. Source: Fairfax County Police Department.

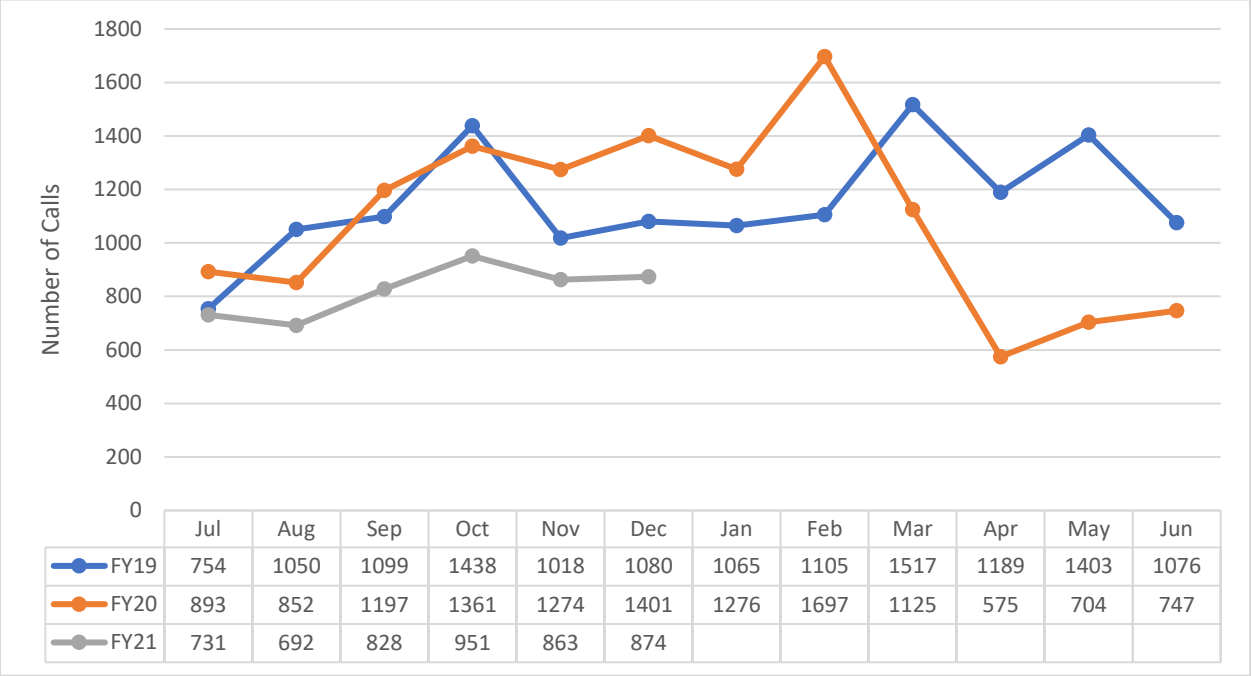


	2018	2019	2020
Assault	539	807	594
Sexual Offense	151	159	131

APPENDIX I: CHILD PROTECTIVE SERVICES DATA

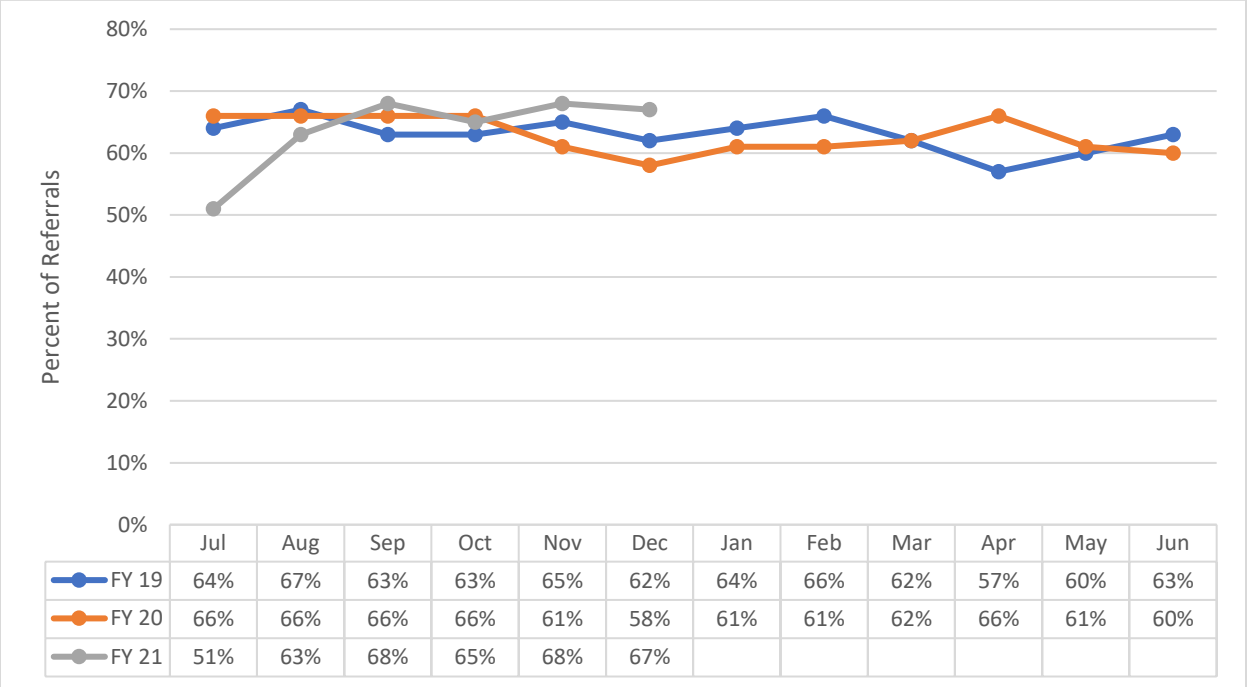
Calls to the Child Protective Services (CPS) hotline have been lower than expected during school months throughout the pandemic. The percentage of calls that are screened in or out, though, has not changed. This measures whether or not the concerns shared in the calls meet criteria for child abuse and neglect referrals and get assigned to CPS for a response. These data point to the value of school staff and other adults engaging with youth outside the home. When school (and other activities) are out, the number of calls goes down, and yet many children may remain at risk of harm.

Chart H.1. Number of Calls to the Child Protective Services Hotline by Month, FY2019-FY2020. Source: Fairfax County Department of Family Services.



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
FY19	754	1050	1099	1438	1018	1080	1065	1105	1517	1189	1403	1076
FY20	893	852	1197	1361	1274	1401	1276	1697	1125	575	704	747
FY21	731	692	828	951	863	874						

Chart H.2. Percent of Child Protective Services Referrals Screened Out by Month, FY2019-FY2020. Source: Fairfax County Department of Family Services.



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
FY 19	64%	67%	63%	63%	65%	62%	64%	66%	62%	57%	60%	63%
FY 20	66%	66%	66%	66%	61%	58%	61%	61%	62%	66%	61%	60%
FY 21	51%	63%	68%	65%	68%	67%						

CONTRIBUTORS

Thank you to the following people who helped prepare this report:

The Healthy Minds Fairfax Family Advisory Board:
- Staci Alexander
- Jackie Benson
- Siobhan de Courcy
- Lee Ellis
- Cristy Gallagher, who compiled the group's input
- Anne Henderson
- Kelly Henderson
- Joe Klemmer
- Kishawna Scarborough

Rick Leichtweis, Inova Kellar Center
Laurie Levine, private provider
Laura Mayer, PRS CrisisLink
Meredith McKeen, Northern Virginia Family Service
Mike Repie, Dominion Hospital
Lily Sutherland, private provider

Michael Axler, Fairfax County Public Schools
Mary Jo Davis, Fairfax County Public Schools
Bethany Demers, Fairfax County Public Schools
Cindy Dickinson, Fairfax County Public Schools
Stephanie Gray, Fairfax County Public Schools
Deb Scott, Fairfax County Public Schools

Janet Bessmer, Fairfax County Department of Family Services
Jesse Ellis, Fairfax County Department of Neighborhood and Community Services
Jim Gillespie, Fairfax-Falls Church Community Services Board
Brendan Hooke, Fairfax County Police Department
Chloe Lee, Fairfax County Office of Strategy Management for Health, Housing, and Human Services
Patrick Lucas, Fairfax County Police Department
Chris Metzbower, Fairfax County Department of Family Services
Linda Mount, Fairfax-Falls Church Community Services Board
René Najera, Fairfax County Health Department
Courtney Porter, Fairfax County Juvenile and Domestic Relations District Court
Sandi Slappey, Fairfax County Department of Family Services
Peter Steinberg, Fairfax County Department of Family Services

For any questions, please contact Jesse Ellis, Prevention Manager, Fairfax County Department of Neighborhood and Community Services, jesse.ellis@fairfaxcounty.gov.

MEMO TO THE CPMT
April 30, 2021

Information Item I-1: March Budget Report & Status Update, Program Year 2021

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 2021 cumulative expenditures through March 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 March 2021 for FY21 equal $20.6M for 880 youths. This amount is a decrease from March last year of approximately $3.7M, or 15.1%. Pooled expenditures through March 2020 for FY20 equal $24.2 M for 986 youths.

	Program Year 2020	Program Year 2021	Change Amt	Change %
Residential Treatment & Education	$3,353,359	$2,749,972	($603,387)	-17.99%
Private Day Special Education	$12,330,911	$11,420,003	($910,908)	-7.39%
Non-Residential Foster Home/Other	$5,670,168	$4,105,530	($1,564,638)	-27.59%
Community Services	$2,766,276	$2,299,143	($467,133)	-16.89%
Non-Mandated Services (All)	$704,070	$682,871	($21,200)	-3.01%
Recoveries	($610,673)	($694,258)	($83,585)	13.69%
Total Expenditures	**$24,214,112**	**$20,563,261**	**($3,650,851)**	**-15.08%**
Residential Treatment & Education	105	97	(8)	-7.62%
Private Day Special Education	294	262	(32)	-10.88%
Non-Residential Foster Home/Other	333	286	(47)	-14.11%
Community Services	645	545	(100)	-15.50%
Non-Mandated Services (All)	137	160	23	16.79%
Unique Count All Categories	**1,514**	**1,350**	**(164)**	**-10.83%**
Unduplicated Youth Count	**986**	**880**	**(106)**	**-10.75%**

RECOMMENDATION:
For CPMT members to accept the March Program Year 2021 budget report as submitted.

ATTACHMENT:
Budget Chart

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

NOTE:

There is an overall decrease across all service types with 106 fewer youths served as compared to the same period of last year. Average cost of total expenditure has also decreased by 5%

Residential Treatment & Education decreased by $603k with 8 fewer youths served. RTC enrollment PIT count FY21 is about 2/3 of that in FY20.

There is also a decrease in Private Day Special Education by $910k with 32 fewer youths served. Prior Months' invoices to MD/DC providers started to get paid in March (payment were withheld before to DC and MD providers due to issue of rates above 2% cap)

Non-Residential Foster Home/Other has decreased by $1.5M with 47 fewer youths served then in same period last year. PIT count for TFC is at 75% level of FY20 due to more youths are placed with relatives and resulting TFC cost and transportation cost are down.

Community Services decreased by $467k, Non-Mandated Services expenses have decreased by $21k with 23 more youths served. More kids are served but having a higher level of needs that enable them for mandated category due to COVID. ICC referrals are down due to hardship for professional to interact with Children face to face and identify needs.

Program Year 2021 Year To Date CSA Expenditures and Youth Served (through March Payment)

Mandated/ Non-Mandat	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%	$772,001	42			$772,001
		Group Home	57.64%	$206,899	8			$206,899
		Education - for Residential Medicaid Placements	46.11%	$51,358	5	$753,388	16	$804,746
		Education for Residential Non-Medicaid Placements	46.11%	$32,635	2	$877,505	14	$910,140
		Temp Care Facility and Services	57.64%	$56,186	10			$56,186
	Residential Total			$1,119,079	67	$1,630,893	30	$2,749,972
	Non Residential	Special Education Private Day	46.11%	$220,112	6	$11,199,891	256	$11,420,003
		Wrap-Around for Students with Disab	46.11%	$97,209	31			$97,209
		Treatment Foster Home	46.11%	$2,571,903	111			$2,571,903
		Foster Care Mtce	46.11%	$997,329	113			$997,329
		Independent Living Stipend	46.11%	$96,271	18			$96,271
		Community Based Service	23.06%	$1,806,516	439			$1,806,516
		ICC	23.06%	$492,626	106			$492,626
		Independent Living Arrangement	46.11%	$342,818	13			$342,818
	Non Residential Total			$6,624,785	837	$11,199,891	256	$17,824,676
Mandated Total				**$7,743,864**	**904**	**$12,830,784**	**286**	**$20,574,648**
Non-Mandated	**Residential**	Residential Treatment Facility	57.64%	$57,805	5			$57,805
	Residential Total			$57,805	5			$57,805
	Non Residential	Community Based Service	23.06%	$556,933	135			$556,933
		ICC	23.06%	$68,133	20			$68,133
	Non Residential Total			$625,066	155		0	$625,066
Non-Mandated Total				**$682,871**	**160**		**0**	**$682,871**
Grand Total (with Duplicated Youth Count)				**$8,426,735**	**1,064**	**$12,830,784**	**286**	**$21,257,518**

Recoveries	**-$694,258**
Total Net of Recoveries	**$20,563,261**
Unduplicated child count	880

Key Indicators

Cost Per Child	Prog Yr 2020 YTD	Prog Yr 2021 YTD
Average Cost Per Child Based on Total Expenditures /All Services (unduplicated)	$24,558	$23,367
Average Cost Per Child Mandated Residential (unduplicated)	$38,544	$38,194
Average Cost Per Child Mandated Non- Residential (unduplicated)	$23,178	$22,534
Average Cost Mandated Community Based Services Per Child (unduplicated)	$3,963	$4,115
Average costs for key placement types		
Average Cost for Residential Treatment Facility (Non-IEP)	$27,055	$18,381
Average Cost for Treatment Foster Home	$29,801	$23,170
Average Education Cost for Residential Medicaid Placement (Residential)	$37,867	$38,321
Average Education Cost for Residential Non-Medicaid Placement (Residential)	$66,291	$56,884
Average Special Education Cost for Private Day (Non-Residential)	$41,942	$43,588
Average Cost for Non-Mandated Placement	$5,139	$4,268

Program Year 2021 Year To Date CSA Expenditures and Youth Served (through March Payment)

Category	Program Year 2021 Allocation	Year to Date Expenditure (Net)	Percent Remaining
SPED Wrap-Around Program Year 2021 Allocation	$663,010	$95,473	86%
Non Mandated Program Year 2021	$1,630,458	$635,222	61%
Program Year 2021 Total Allocation	$38,657,566	$20,563,261	47%

MEMO TO THE CPMT

April 30, 2021

Information Item I - 2: FY22 CPMT Meeting Schedule Draft

ISSUE: That the CPMT approve the public calendar of meetings for FY 2022.

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. The calendar will be presented at the next meeting of the CPMT for formal adoption.

ATTACHMENT: FY22 CPMT Meeting Schedule Draft

STAFF:
Janet Bessmer, CSA

Community Policy & Management Team (CPMT)

Meeting Location:

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

CPMT SCHEDULE FY22 *(July 2021 – June 2022)*			
Meeting Date	**Room #**	**Time**	**Notes**
Jul. 30, 2021	TBD	1:00-3:00pm	Virtual
Sept. 24, 2021	TBD	1:00-3:00pm	
Oct. 29, 2021	TBD	1:00-3:00pm	
Dec. 3, 2021	TBD	1:00-3:00pm	
Jan. 28, 2022	TBD	1:00-3:00pm	
Feb. 25, 2022	TBD	1:00-3:00pm	
Apr. 29, 2022	TBD	1:00-3:00pm	
May 27, 2022	TBD	1:00-3:00pm	
June 24, 2022	TBD	1:00-3:00pm	

Schedule Approved by CPMT:

MEMO TO THE CPMT

April 30, 2021

Information Item I- 3: Quarterly CPMT Data Report, FY 21 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 E. Arriaza, Management Analyst III, Program Operations

RBA

Results-Based Accountability
Performance Plan
FY 2021, 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)	FY2020: 11; 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

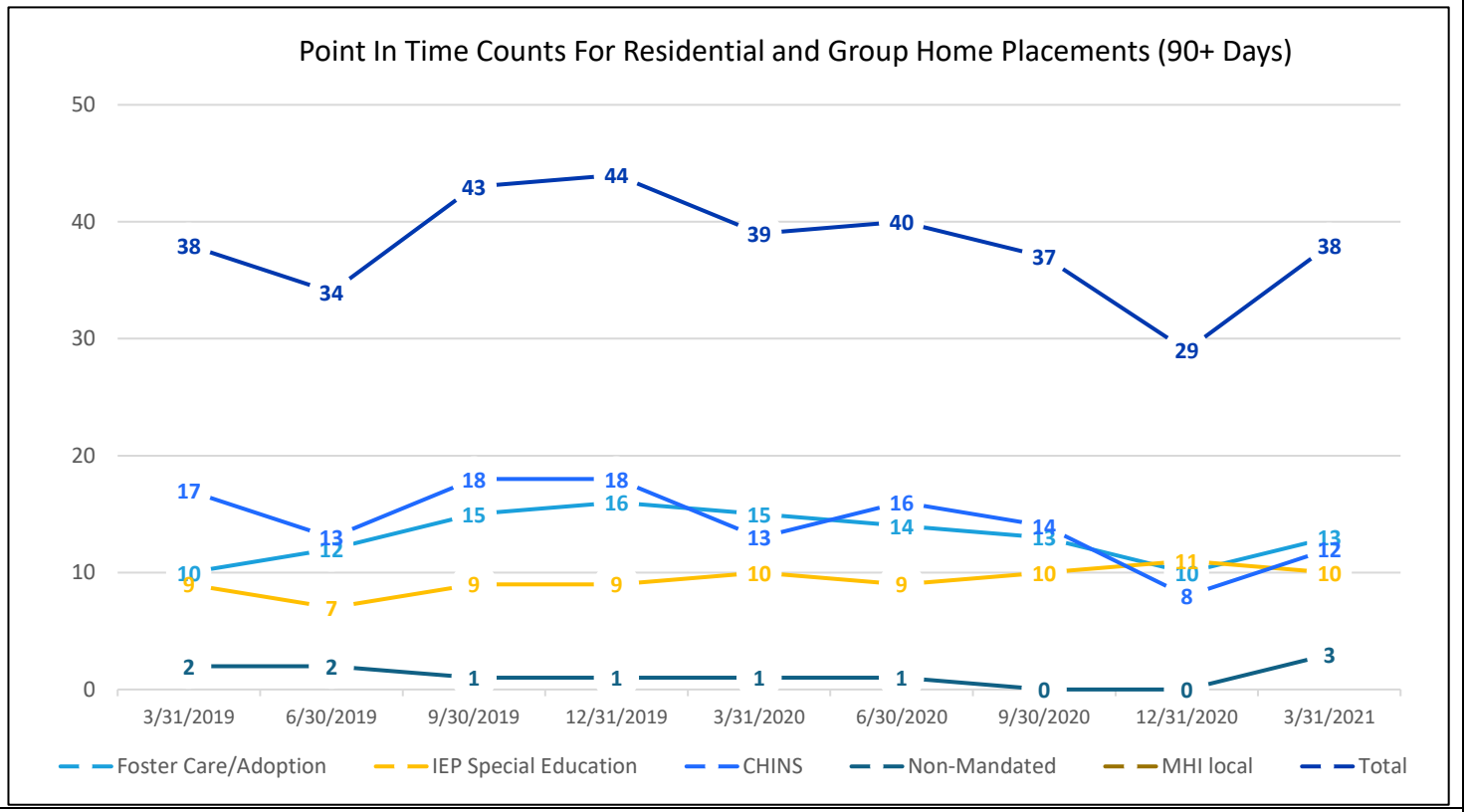
[1] Quarterly performance measures highlighted in blue.

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	

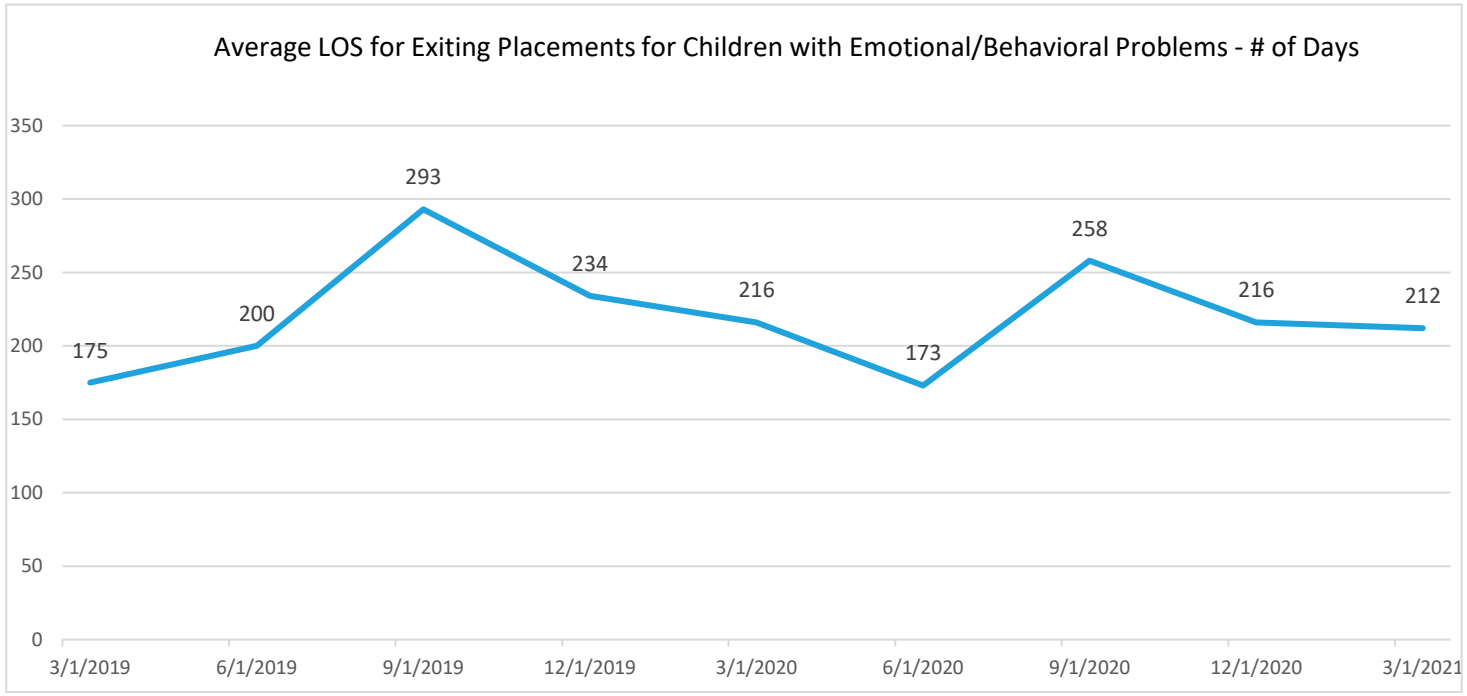
Results-Based Accountability Performance Plan

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	38
Graphs/Charts			
Notes	**Analysis**: The total point in time count increased by 9 youth, mirroring the increases seen Foster Care/Adoption, CHINS, and Non-mandated populations. **Planned Action:** Continue to monitor.		

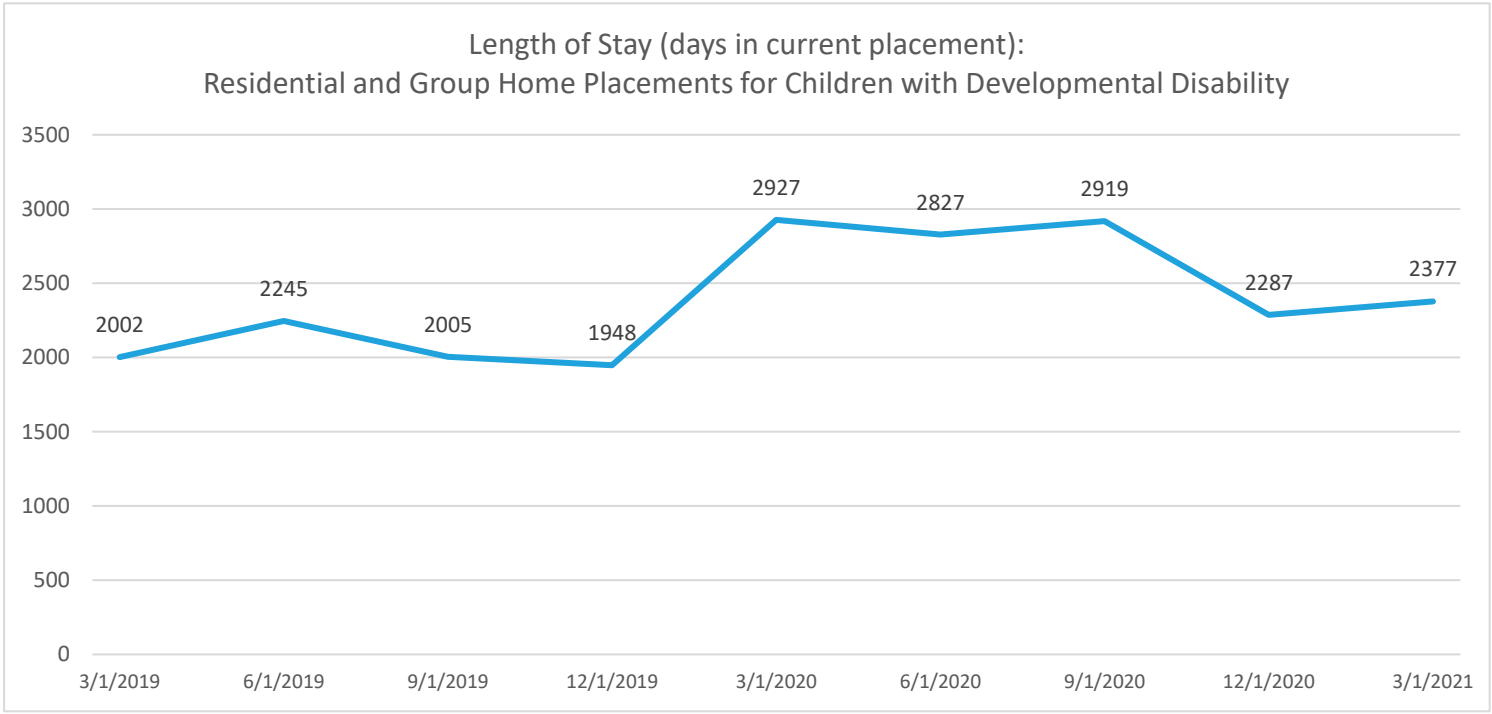
Results-Based Accountability Performance Plan

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	212 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=6) was 212 days at the end of the 3rd quarter (LOS ranged from 30 to 330 days). Ages ranged from 13 to 18, with average age being 15 years. Two of the youth are African American, 3 Caucasian and 1 is Asian. Of the 6 exits, 5 were from the Community Services Board and 1 from Foster Care/Adoption. **Planned Action:** Continue to monitor.		

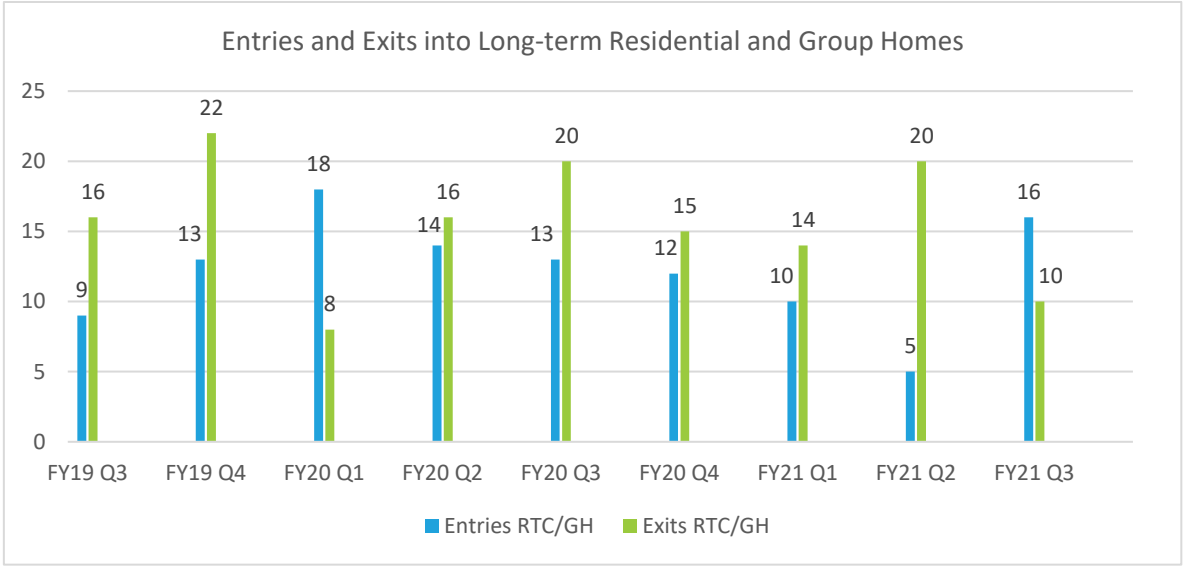
Results-Based Accountability Performance Plan

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	2377 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 2377 days, range of LOS is 204 to 4,222 days. The four placements are from Fairfax County Public Schools – 1 youth is at Grafton, 1 at Chamberlain, 1 at Benedictine and 1 at Devereux. The three youth are Caucasian and 1 is African American. The ages range from 17 to 22, with the average age being 20. **Planned Action:** Continue to monitor.		

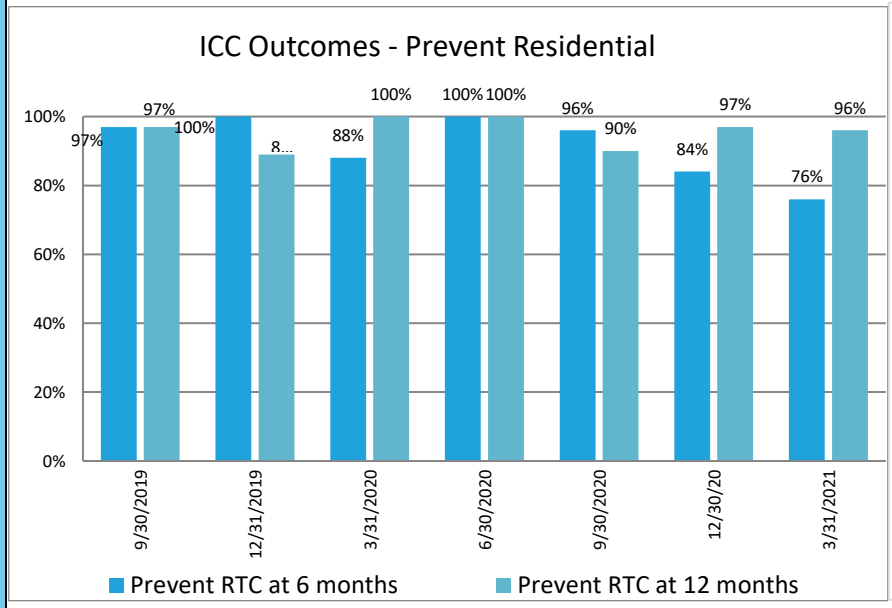
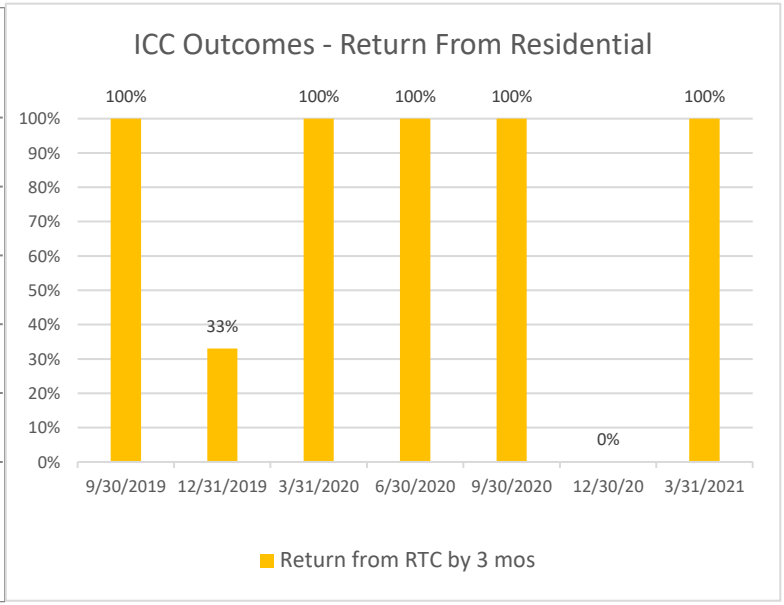
Results-Based Accountability Performance Plan

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	16
	2.2.3	Number of youth exiting long-term congregate care settings	10
Graphs/Charts			
Notes	**Analysis:** There were 16 entries and 10 exits this quarter. **Planned Action:** Inform families about evidence-based treatments available in the community, e.g. Multysistemic Therapy, Functional Family Therapy, etc. Utilize EBTs 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.		

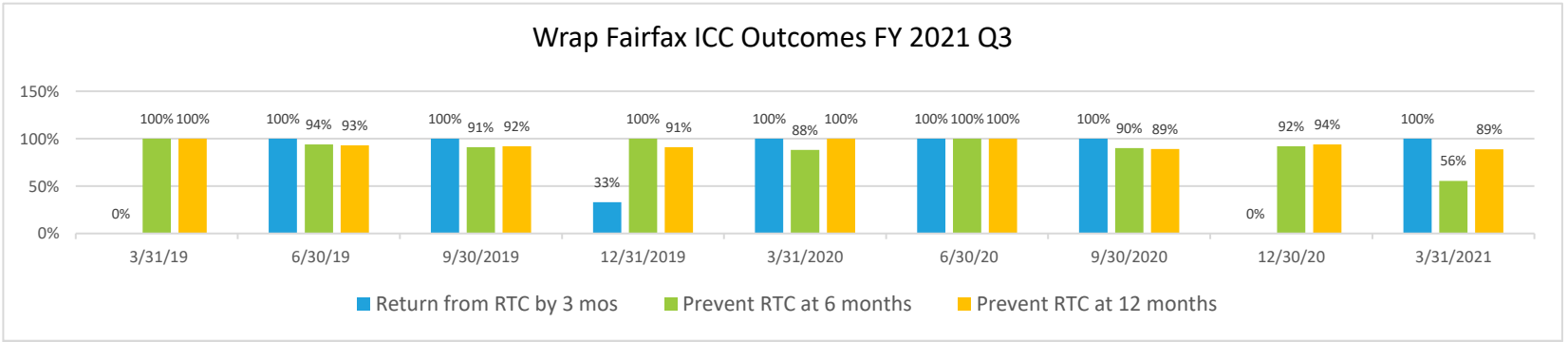
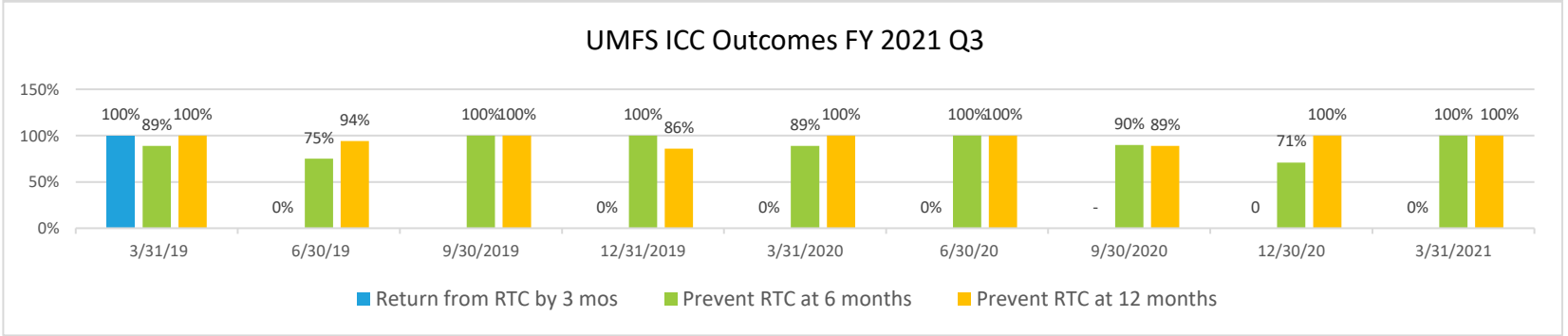
Results-Based Accountability Performance Plan

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	76%/96%
	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:** 76% (13 of 17) of youth were maintained in the community 6 months after initiation of ICC services. 96% (27 of 28) 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.		

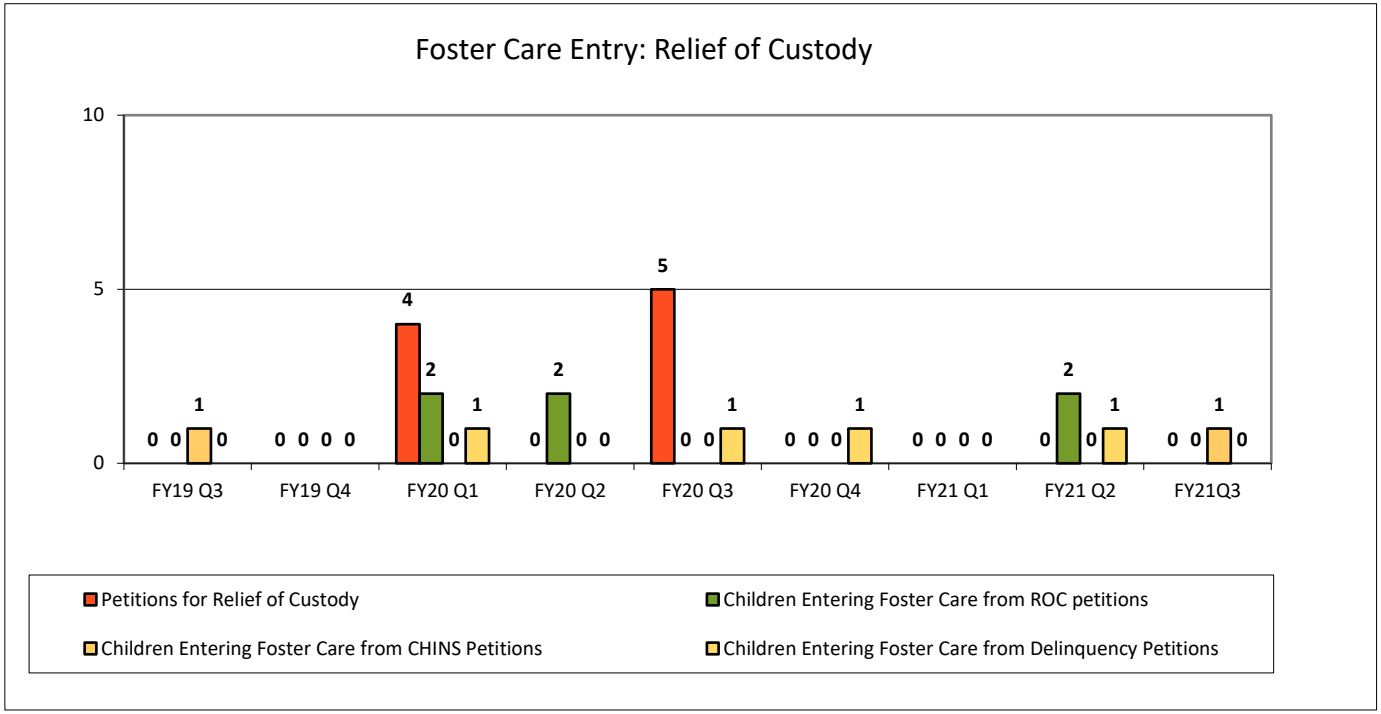
Results-Based Accountability Performance Plan

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 Fairfax:** 56% / 89% **UMFS:** 100% / 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 Fairfax:** 100% **UMFS:** --
Graphs/ Charts	 		
Notes	**Analysis: Wraparound Fairfax:** 56% (5 of 9) of youth were maintained in the community 6 months after initiation of ICC services. 89% (8 of 9) 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:** 100% (n=8) of youth were maintained in the community 6 months after initiation of ICC services. 100% (n=19) of youth remained in the community 12 months after the initiation of ICC services. No youth were referred to UMFS while in residential care.		

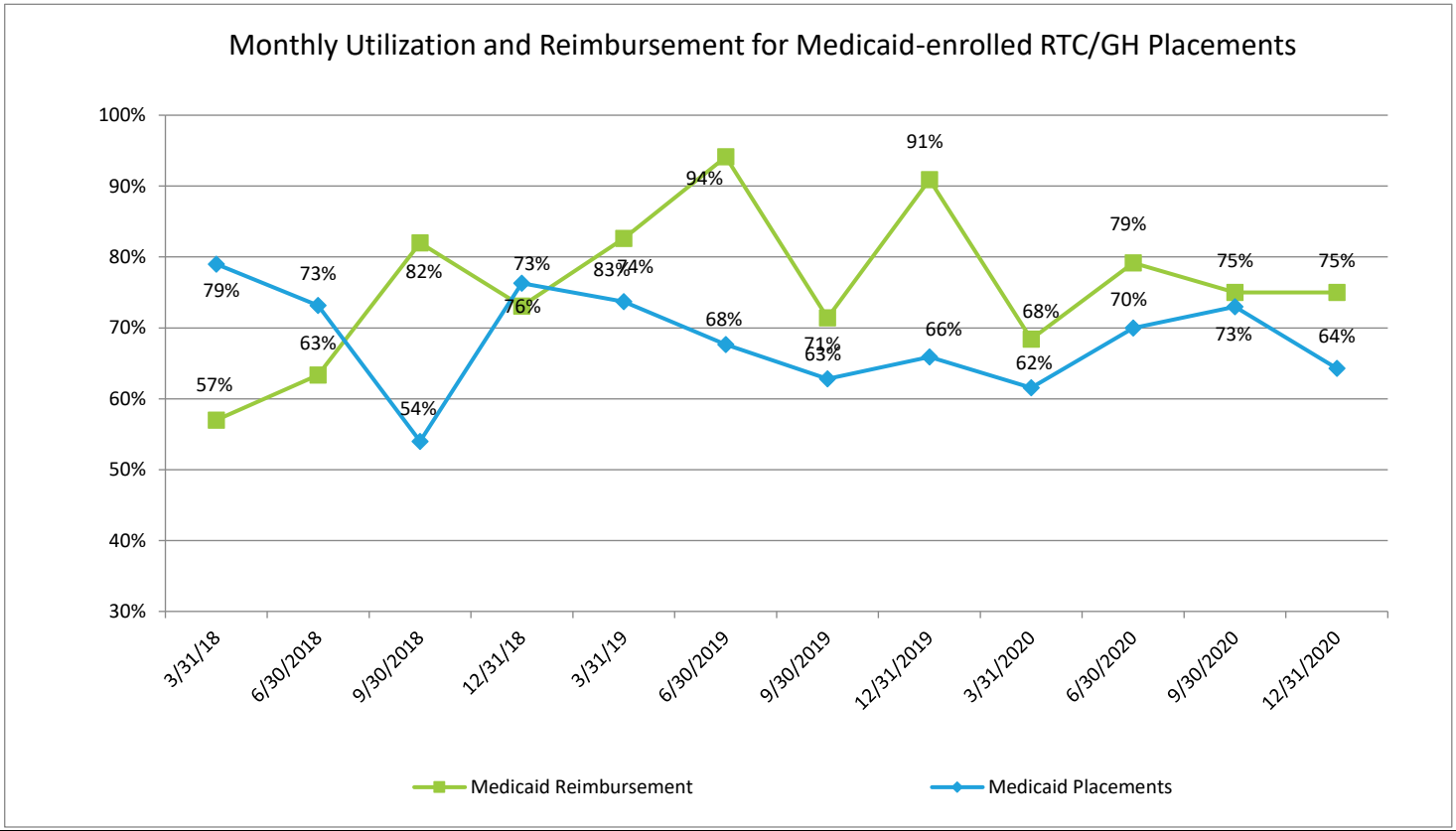
Results-Based Accountability Performance Plan

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	0 Received/ 0 filed / 0 entry
	2.3.2	Number of children entering foster care from CHINS petitions	1
	2.3.3	Number of children entering foster care from delinquency petitions	0
Graphs/ Charts			
Notes	**Analysis**: 0 ROCs were received, 1 youth entered foster care from a CHINS petition. **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	64%
	2.5.2	Percentage of Medicaid placements receiving Medicaid reimbursement	75%
Graphs/Charts			
Notes	**Analysis**: This quarter, total residential placements are up from 29 last quarter to 38. There are 26 (68%) Medicaid placements and 12 (32%) non-Medicaid placements. Of those 26 placements, 24 (92%) youth are eligible for Medicaid with 16 (67%) approved for RTC services; 1 (4%) denied; and 7 (29%) pending. The only denial is for continued stay at Fairwinds effective 11/9/2020 due to Magellan's decision that the youth no longer needed this level of service and should step down a level to Therapeautic Group Home.		

MEMO TO THE CPMT
April 30, 2021

Information Item I-4 : Proposal to Expand the CSB Resource Team

BACKGROUND:
At the January 29 CPMT meeting the FCPS representatives requested that the CSB consider an increase in the Resource Team's capacity to carry CSA cases, to reduce the incidence of school social workers carrying CSA cases involving very high complexity and risk. The request was generated by these factors:

- Four of the existing 13 CSB Resource Team positions are funded by the DBHDS Mental Health Initiative allocation, which prohibits them serving youth in residential placement or eligible for "mandated" Children's Services Act services, reducing the CSB's capacity to serve youth with the most complex needs and highest risk factors.
- Local hospital emergency departments are experiencing long delays in placing youth in hospitals, often resulting in stays in the emergency department of several days. Once hospitalized many youth are unable to discharge on a timely basis due to delays in accessing necessary services. Due to the lack of case management CSB capacity school social workers must sometimes assume discharge planning functions but often cannot respond as quickly and intensively as CSB case managers.

To address these factors the CSB proposes to increase its CSA case management by adding three Behavioral Health Specialist II positions, at a total annual cost of $339,690, to be funded through CSA purchase of case support services, with a total additional capacity of 45 CSA cases on an ongoing basis. CSB will present a proposal to the CSA Management Team to increase the targeted number of CSA case support interventions purchased from the CSB from 30 to 75.

ATTACHMENT:
None

STAFF:
Jim Gillespie, Director
CSB Youth and Family Services

MEMO TO THE CPMT

April 30, 2021

Information Item I - 5: Healthy Minds Fairfax Blueprint Quarterly Report July 2020 – March 2021

ISSUE: CPMT review of the quarterly progress report on implementation of strategies in the Children's Behavioral Health System of Care Blueprint

BACKGROUND:
When CPMT approved the Children Behavioral Health Blueprint in March 2016 it directed that staff provide quarterly progress reports. The full quarterly progress report for July 2020 through March 2021 is attached.

Accomplishments during the 3rd quarter:

- During this 3rd quarter of FY 2021, Short Term Behavioral Health Services (STBH) expanded to include the middle and high school students in Fairfax County and the cities of Falls Church and Fairfax.
- The HMF partnership with PRS for the provision of Family Peer Support Partner services was fully transitioned from NAMI.
- The HMF partnership with Formed Families Forward for the provision of the Respite to Recharge program that was a response to the COVID-19 crisis was operated in the 3rd quarter of FY 2021 and will be extended into the 4th quarter for the summer months until the start of the Fairfax County Public School year.
- The Jewish Social Services Agency (JSSA) has partnered with Fairfax County to provide case management services to transitional age youth (youth between the ages of 16 and 25). It is anticipated that they will begin to take referrals in May 2021. JSSA will also be developing a youth advisory board to Healthy Minds Fairfax.

Upcoming plans for the 4th quarter:

- Develop a children's behavioral health plan to provide an accessible, equitable and affordable continuum of community-based behavioral health care for children, youth, and families. This plan should promote the use of Evidence-Based approaches, assist families in accessing services through care navigation and case management supports, and increase children and youths' access to behavioral health services in school and through school referrals to community-based services.
- Develop and implement crisis and crisis prevention planning that involves families, hospital emergency departments, behavioral health crisis services, schools, pediatric primary care providers and behavioral health providers.
- The Eric Monday Foundation (EMF) will be working with the Fairfax County Athletic Council and FCPS to roll out implementation of its new online suicide prevention and mental health awareness training aimed at youth sports coaches. FCPS, Fairfax County, and key community partners worked with EMF to develop the training.

ATTACHMENT:
Quarterly Report on Blueprint Strategies, July 2020 – March 2021

STAFF:
Jim Gillespie, Healthy Minds Fairfax Director
Janet Bessmer, CSA Manager
Peter Steinberg, Children's Behavioral Health Collaborative Manager
Jesse Ellis, NCS Prevention Manager

GOAL 1: Deepen the Community "System of Care" Approach
Coordinator: Jim Gillespie

Governance Structure:

A. *Establish a Children's Behavioral Health System of Care oversight committee as the locus of SOC management and accountability.* Accomplished through designating CPMT as the oversight committee.

B. *Establish cross-system behavioral health system of care practice standards, policies and procedures.* Revised system of care principles and practice standards have been approved by the CPMT. In December 2017 CPMT approved revisions to local policies and procedures, based on the revised practice standards, and these have been incorporated in the SOC training curriculum.

Generate support for the SOC approach among the general public and policy makers and administrators at the state and local levels. Results Based Accountability (RBA) measures were developed for the BHSOC Blueprint, approved by CPMT in September 2017 and quarterly reports have been presented to since February 2018. In 2017 the system of care initiative was re-named Healthy Minds Fairfax (HMF).

C. *Continue to develop partnerships with community organizations and agencies in different sectors for coordination, financing and support of the SOC approach.*
HMF is partnering with the Northern Virginia Family Network, a network of more than 10 regional family- and children-focused nonprofit organizations.

Financing Strategies:

D. *Coordinate county budgeting, including but not limited to Diversion First, to maximize the possibility of high priority children's behavioral health needs being funded.* To complete these strategies a matrix of youth services has been developed and fiscal mapping conducted. This strategy has now been folded into a fiscal mapping strategy for children's services. It was presented to SCYPT in April 2019 and also to DMB leadership in June. Both groups received the fiscal map and its process quite well and gave approval to proceed with fine-tuning the data.

Service Quality and Access:

E. *Develop/facilitate trainings and outreach materials that increase awareness and knowledge of systems of care values and creates better informed consumers, providers and county and school system staff. Develop/facilitate trainings and outreach materials that increase awareness and knowledge of systems of care values and creates better informed consumers, providers and county and school system staff.* A master calendar for children's behavioral health trainings and events and a children's behavioral health resources page were added to the Healthy Minds Fairfax public website in August of 2018. In the first three quarters of FY21, the training events calendar and the community resources website pages received the following visits:

Number of visits/page views for training events calendar website page:

FY21 (1st Qtr)	FY21 (2nd Qtr)	FY21 (3rd Qtr)	FY21 (4th Qtr)	FY21 TOTAL	FY20	FY19
15/16	24/28	26/33	N/A	65/77	124/162	89/119

Number of visits/page views for community resources website page:

FY21 (1st Qtr)	FY21 (2nd Qtr)	FY21 (3rd Qtr)	FY21 (4th Qtr)	FY21 TOTAL	FY20	FY19
92/119	81/115	72/107	N/A	245/341	265/347	166/272

Due to COVID-19, trainings continued to be held using a virtual platform. In the 1st and 2nd Quarters of FY21, 12 trainings were held with a combined total of 864 participants. Trainings for case managers included Introduction to System of Care, introductions to several Evidence-Based Treatments such as Multisystemic Therapy, Functional Family Therapy and Parent Child Interaction. Case managers, Wraparound facilitators and family support partners were also provided a three-part training series to help them identify and work with natural supports for families. An introduction to EBTs was also held for families. The EBT trainings were recorded and are available online as resources for staff and families.

Number of Staff, providers & families trained on community resources, insurance access, evidence-based/informed practices, & High-Fidelity Wraparound:

FY21 (1st Qtr)	FY21 (2nd Qtr)	FY21 (3rd Qtr)	FY21 (4th Qtr)	FY21 TOTAL	FY20	FY19	FY 18
732	58	0	N/A	790	304	206	0

F. *Collect and regularly report on community outcomes and assess gaps in the array of services and supports necessary for the success of the SOC in preventing and treating behavioral health issues.* An inter-agency workgroup issued a Population Level Data Report on Youth Behavioral Health Needs in the Fairfax-Falls Church Community in February 2020. Presentation to the CPMT was delayed due to COVID and will be done when in-person meetings resume. The annual Office of Children's Services Gaps and Needs Survey will be presented to CPMT on April 30, 2021. The SOC Training Committee has promoted the implementation of an array of evidence-based interventions that are now available in our community such as MST, FFT, PCIT and TFCBT.

G. *Review intake, assessment, triage, referral protocols across all levels of care, and lead case management assignments with the goal of supporting families in accessing both public and community provided resources.* In FY 20 HMF funding expanded the regional mobile stabilization and response service by 15%. A significant increase in DBHDS funding support has resulted in eight more crisis counselors being hired and eliminated the need for county funding in FY 21.

GOAL 2: Data Systems

Coordinator: Janet Bessmer

A. *Increase cross-system data sharing.* CSA has implemented OpenText, an electronic document management system. CSA is also participating in the DFS process to replace or upgrade our management information system which has cross-agency case management functionality. CSA staff have also participated in meetings with OSM to discuss collection of data elements for the HHS performance metrics reporting.

B. *Use cross-system data to improve decision-making and resource use*. The FY20 Data Analytics Fellowship Academy (DAFA) evaluated CSA data on the effectiveness of Foster Care Prevention Services as provided across our system of care service agencies. The results were presented to the CPMT. In addition, the George Mason Psychology Department has provided free consultation on

the statistical analyses of CSA data to include client demographics, service utilization and CANS ratings. It is planned for these results to be shared with the CSA Management Team and CPMT in the future.

GOAL 3: Family and Youth Involvement

Coordinator: Jim Gillespie

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

The Northern Virginia Family Network, a network of more than 10 regional family- and children-focused nonprofit organizations meets quarterly to collaboratively address its mission of 'elevating the voices of families to improve outcomes for children, youth and young adults across systems of care'. In May 2020 the Network became a member of the newly formed HMF Family Advisory Board.

B. *Increase family and youth involvement in system planning and implementation.*

In February 2020 the CPMT parent representatives, FAPT parent representatives and representatives from NAMI-NOVA, the Autism Society of Northern Virginia and the Northern Virginia Family Network met to plan the establishment of a HMF Family Advisory Board (FAB). In May 2020 CPMT endorsed the establishment of the FAB as the family advisory board for CSA and Healthy Minds Fairfax, and in July the FAB established an FY 21 monthly meeting schedule. The FAB provided input on a report on children's mental health to be presented to the Board of Supervisors in April 2021. FAB's input resulted in the creation of a respite service for parents and caregivers of children with behavioral health issues and impacted by COVID. The Jewish Social Services Agency (JSSA) has partnered with Fairfax County to develop a youth advisory board to Healthy Minds Fairfax.

C. *Include youth and family participation in the evaluation of publicly and privately provided services, with prompt action for improvement when necessary.* In FY21 Q2, the CSA Monitoring and QA Plan was shared with providers and the Family Advisory Board for comments; it was presented to the CPMT at the December, 2020 meeting. Implementation of the Monitoring and QA plan are underway, with CSA staff reviewing and tracking SIRs and monthly progress reports, as well as ensuring that CSA funds are not being used to purchase Medicaid eligible services without the required documentation. In FY21 Q3, a survey company, Crossroads, Inc., will be on board to survey family satisfaction on provider services; the company will survey a pool of families on a monthly basis. This is a change from the previous survey process that was done on an annual basis. The change in the survey protocol will hopefully lead to a higher response rate. Concerns from families will also be able to be dealt with on a more timely basis as the Crossroads will forward any family concerns that need to be addressed on a monthly basis. CSA staff will provide the data necessary for Crossroads to fulfill the established Scope of Work. A report of the survey efforts will be complied after the 4th Quarter of FY21.

D. *Expand evidence-based peer to peer groups, family/community networks*. See Goal 5, Strategy B.

GOAL 4: Increase Awareness and Reduce Stigma

Coordinator: Jesse Ellis

A. *Implement "gatekeeper trainings" to increase layperson understanding of mental illness, recognition of signs and symptoms of mental illness or emotional crisis, and support of others in accessing help, using a cultural competency lens.* Gatekeeper trainings continue to be provided in a number of ways through Mental Health First Aid, and the Kognito suite of online trainings (including a peer training for teens), and Signs of Suicide. Eleven Kognito modules are now available, including early childhood, military families, postvention, and trauma-informed schools modules. HMF funding has helped expand the implementation of Signs of Suicide to cover all FCPS middle and high schools. The Eric Monday Foundation is finalizing a web-based training specifically for youth sports coaches; FCPS and multiple youth sports organizations have committed to implementing the training with their coaches and implementation will begin in May. The CSB is now offering Mental Health First Aid and QPR suicide prevention trainings virtually. An overview of gatekeeper trainings available through the county and elsewhere is available online.

B. *Promote youth-led initiatives to combat stigma associated with mental illness, treatment, and accessing help.* The CSB awarded eight mini-grants for youth-led projects to address stigma, funded by the regional suicide prevention grant, for FY21. Twenty-three high schools in Fairfax County are currently implementing Our Minds Matter clubs, developed by Our Minds Matter (formerly the Josh Anderson Foundation), and more are planning to do so.

C. *Increase public awareness of issues surrounding mental illness and behavioral health care.* The public service announcements developed by the Health Department have been running in theaters since June 2016. The contract for television and online placement ended in June 2018, so current data is based only on YouTube views.

While the number of texts received by PRS CrisisLink continues a slowly declining trend, the number of calls to the crisisline is significantly higher through the second quarter of FY21; the majority of calls came in through CrisisLink's local number and were not routed through the national number.

Number of views of PSAs promoting help-seeking behaviors:

FY21 (1st Qtr)	FY21 (2nd Qtr)	FY21 (3rd Qtr)	FY21 (4th Qtr)	FY21 TOTAL	FY20	FY19	FY18	FY17
132	174	45	N/A	351	270	619	6,597,856	3,298,928

Number of crisis texts/calls:

FY21 (1st Qtr)	FY21 (2nd Qtr)	FY21 (3rd Qtr)	FY21 (4th Qtr)	FY21 TOTAL	FY20	FY19	FY18	FY17
381/ 4500	364/ 4182	*	N/A	745/ 8682	1638/8289	1675/7780	1815/5597	1087/4927

*Information is unavailable at this time and will be updated on the next quarterly report**.**

D. *Maintain a speaker's bureau and/or list of approved presenters to school and community groups.* To be completed in CY21.

GOAL 5: Youth and Parent/Family Peer Support

Coordinator: Tracy Davis

A. *Create a Family Support Partner program.* The SAMHSA grant ended January 2021 and effective February 2021 PRS, Inc. became the provider through a county contract.

Number of families served by family support partners (unduplicated by FY):

FY21 (1st Qtr)	FY21 (2nd Qtr)	FY21 (3rd Qtr)	FY21 (4th Qtr)	FY21 TOTAL	FY20	FY19	FY 18
38	22	105	N/A	165	155	160	55

B. *Expand evidence-based peer to peer groups, family/community networks.*
In February 2019, the CSB launched "Heads Up" and "Talk It Out", resource groups for parents and teens (ages 14-17). The groups are available in weekly concurrent sessions. Teens talk about successful, sustainable recovery and resilience through mental health or substance use challenges. Parents acquire resources and discuss ideas on how to help their teen live their healthiest, fullest lives in the aftermath of trauma or through times of emotional distress. The groups became inactive in April 2020 due to COVID but re-opened virtually later in the quarter.

Number participating in expanded parent/family peer support service programming:

FY21 (1st Qtr)	FY21 (2nd Qtr)	FY21 (3rd Qtr)	FY21 (4th Qtr)	FY21 TOTAL	FY20	FY19	FY 18
10 parents, 4 youth	9 parents, 5 youth	14 parents, 5 youth	N/A	33 parents, 14 youth	91 parents, 72 youth	22 parents, 20 youth	0

GOAL 6: System Navigation

Coordinator: Tracy Davis

A. *Develop an accurate, accessible and real time database of behavioral health care providers that includes information on if they are accepting new clients, if they accept insurance, and their areas of expertise, with functionality to assist families in understanding behavioral health issues and in navigating the system to access services.* A listing of the REACH training pediatricians has been added to the redesigned Healthy Minds Fairfax website. The listing is maintained and updated on a regular basis and it has just been updated to add the November 2019, June 2020 and November 2020 REACH training participants.

Total Number of Visits for All Visitors to HMF Website:

FY21 (1st Qtr)	FY21 (2nd Qtr)	FY21 (3rd Qtr)	FY21 (4th Qtr)	FY21 TOTAL	FY20	FY19	FY18	FY17
4,613	4,442	6,962	N/A	16,017	14,811	8,649	2,848	0

Number of Visits for Returning Visitors:

FY21 (1st Qtr)	FY21 (2nd Qtr)	FY21 (3rd Qtr)	FY21 (4th Qtr)	FY21 TOTAL	FY20	FY19	FY18	FY17
2,412	2,247	4,024	N/A	8,683	8,062	5,968	1,994	0

Number of Visits for New Visitors:

FY21 (1st Qtr)	FY21 (2nd Qtr)	FY21 (3rd Qtr)	FY21 (4th Qtr)	FY21 TOTAL	FY20	FY19	FY18	FY17
2,201	2,195	2,938	N/A	7,334	6,749	2,681	854	0

FY21 (1st, 2nd, & 3rd Qtrs. combined) Top Content Viewed by Number of Visits:

Content	Visits
Children's Services Act Forms and Resources	3,223
Healthy Minds Fairfax Homepage	2,557
CSA Symposium	2,053
Children's Services Act	1,730
COVID-19 Mental Health Resources	777
What is a Family Partnership Meeting or Family Resource Meeting?	543
Evidence-Based Treatments and Interventions	436
Get Help In an Emergency	412
Family Assessment and Planning Team	364
About Healthy Minds Fairfax	306
Children's Services Act Staff Roster	298
Children's Services Act Case Management	276
Family Support Services	270
Community Policy and Management Team	261
Children's Behavioral Health Community Resources	245
For Providers	208
How Do I Pay for Services	197
How Can My Child's School Help?	191
Healthy Minds Fairfax Directory of REACH-Trained Pediatricians	172
Finding Supportive Services	168
CSA COVID-19 Information	167

B. *Create a clearing house for information on children's behavioral health issues and resources.* Current work on the website includes a feedback survey, a weblink policy and adding additional resources for the mental health screening tool. In addition, COVID-19 Mental Health Resources have been added to the website along with CSA COVID-19 Information.

GOAL 7: Care Coordination and Integration

Coordinator: Jim Gillespie

A. *Provide behavioral health consultation to primary care providers and patients.*

The Virginia Mental Health Access Program (VMAP) has launched, making psychiatric consultation and other resources available to pediatricians all over the state of Virginia. More information can be found at: http://www.virginiapediatrics.org/vmap/ In mid FY 21 the pediatricians gained the support of a care navigator. As of March 31, 138 Fairfax-Falls Church pediatric primary care providers were VMAP enrolled, and 171 unique patients have been served since September 2020. Through HMF funding a George Mason University 3 psychology residents are currently placed in a local pediatric primary care office to provide behavioral health services.

B. *Promote resources to implement tiered levels of integration based on capacity and readiness.* HMF is co-sponsoring a REACH behavioral health training for pediatricians to be held virtually in early June. 111 Fairfax-Falls Church are enrolled in the Virginia Mental Health Access Program, through which they have access to telephonic consultation. Psychiatric consultations for Fairfax pediatricians skyrocketed to 40 in the period October – December 2020. In 2018 an inter-agency workgroup headed by Dr. Gloria Addo-Ayensu developed a community plan to implement integration, including but not limited to consultation, facilitated referral, co-location and full integration, which was endorsed by CPMT in June 2018. The workgroup also developed a project to safely divert youth from hospitalization when appropriate through expansion of CR2 mobile crisis response services.

Number of pediatric primary care psychiatric consults:

FY21 (1st Qtr)	FY21 (2nd Qtr)	FY21 (3rd Qtr)	FY21 (4th Qtr)	FY21 TOTAL	FY20	FY19	FY 18
15	40	41	N/A	96	64	0	0

C. *Increase the appropriate implementation of behavioral health screenings and referrals in primary care settings.* The workgroup recommended screening tools for use in primary pediatric care, based on the recommendations of the American Academy of Pediatrics and the REACH curriculum.

GOAL 8: Equity/Disparities

Coordinator: Peter Steinberg

A. *Promote the adoption of culturally and Linguistically Appropriate Services (CLAS) Standards among BH providers.* This strategy has been achieved.

B. *Increase access and availability to behavioral health services for underserved populations.* Healthy Minds Fairfax continues to support the Northern Virginia Family Service Violence Prevention Intervention Program (VPIP). During this quarter 23 youth were referred for intensive services and 64 youth were referred to their workshops. All youth referred for services were Hispanic.

Require training in cultural competence and advancing equity in alignment with One Fairfax for County, FCPS, and County-contracted behavioral health service providers. Over 70 county and FCPS staff and contracted providers attended a half day training that focused on generational trauma.

C. *Implement support structures for LGBTQ youth.* This has been identified as a priority in the development of the new community plan.

GOAL 9: Reduce Incidence of Youth Suicide in our Community

Coordinator: Jesse Ellis

A. *Identify universal suicide and/or depression screening tool(s) for use by the community.* The team developing guidance and protocols for suicide/depression screening by community organizations has finalized a toolkit for publication; it has been incorporated into the new website.

B. *Develop and publish guidelines for service providers on the availability and effective use of crisis services.* The CSB has published information (including printable fliers) on accessing the Mobile Crisis Unit and on Involuntary Psychiatric Hospitalization of Minors.

C. *Develop a common and coordinated approach to youth suicide postvention.* A resource for community organizations and families on implementing suicide postvention has been published on the redesigned website. An extension of the committee has begun meeting to discuss opportunities for coordinated community postvention outreach and services. A new Kognito module on postvention is now available. The Conner Strong Foundation developed "Help is at Hand," a booklet with guidance and supports for survivors; plans for widespread availability and dissemination are in development.

D. *Continue to make available and promote the suicide prevention hotline, including text line.* The PRS CrisisText Connect program engaged in 1638 text conversations with 1389 unique individuals in FY20. This represents a slight decrease from FY19. However, the number of hotline calls answered continued to significantly increase. In FY20, PRS CrisisLink answered 8289 calls, a 7% increase over FY19, after huge increases in FY18 and FY17. Of these calls, 465 (an 43% increase over FY19) were from youth under 18, and 524 were from individuals 18 to 24. These trends continued through the first half of FY21, as PRSCrisisLink engaged in 745 text conversations, and answered 8682 calls.

E. *Train behavioral health providers in evidence-based practices specific to the treatment of youth with suicidal ideation and behavior.* The Core Competency Training that is now offered regularly includes a section that is specific to the treatment of youth with suicide behavior. Training on Family Intervention for Suicide Prevention (FISP) is also regularly provided through the Training Consortium.

GOAL 10: Evidence-Based and Informed Practices

Coordinator: Peter Steinberg

A. *Develop definitions and criteria for evidence-based and evidence-informed practice in prevention and intervention/treatment.*

This strategy has been met.

B. *Establish a set of core competencies based on service type for all public & contracted provider staff.*
This strategy has been met.

C. *Train County, school staff and providers on EBPs, including how and when to use them. Include a review of practices that are harmful.* The Fairfax Evidenced Based Training Consortium, which is

overseen by the Evidenced-Based Workgroup in partnership between Fairfax County and George Mason University, delivered the following trainings in the 3rd quarter:

Trauma Focused Cognitive Behavioral Therapy (TF-CBT): 40 clinicians
Family Intervention for Suicide Prevention (FISP): 50 clinicians
Core Competency Refresher: 16 clinicians.

D. *Incentivize the use of EBPs among providers.* All participants who become certified in the core competencies will be placed on a list of provides that will be housed on the Healthy Minds Fairfax website.

GOAL 11: Trauma Informed Care

Coordinator: Chrissy Cunningham and Jesse Ellis

A. *Ensure there is sufficient clinical capacity to meet the needs for trauma-specific, evidence-based interventions.* In the spring of 2018, the Fairfax Consortium for Evidence-Based Practice trained over 100 clinicians in the Family Intervention for Suicide Prevention (FISP), which is a trauma-informed treatment protocol for suicidal ideation. An additional 50 clinicians were trained in January 2021. Focus of FISP training moving forward will be on agencies and programs who are committed the implementing the model as their standard of care when youth present with suicidal ideation or self-harming behaviors.

In November 2018, 45 clinicians were trained in Trauma-Focused Cognitive Behavioral Therapy. The enrollment requirements for that training included a commitment from accepted clinicians to pursue certification. In the spring of 2020, an additional 24 clinicians attended TF-CBT training, which was provided virtually. In January 2021, an additional 30 clinicians attend virtual TF-CBT training. The consortium team continues to explore strategies to encourage and incentivize clinicians to complete the certification process, which includes a year of supervision with the trainer, the staffing of several cases, completion of the treatment protocol with 3 clients, and the passing of a written exam. Consortium staff assists the team with tracking the clinicians participation in the supervision component, and manages communication with trained clinicians to ensure we continue to update our internal list of certified providers. As demand for evidence-based treatment models increases, the team is also exploring new strategies to help case managers across our system connect not only with certified providers, but with providers who are in process and need clients to complete the protocol with. Together, these strategies should result in an increase in certified providers in our community in 2021 as the last 2 training cohorts become eligible for certification.

In 2019, 51 clinicians working with children ages 7-12 were trained in MATCH-ADTC- Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems. An additional 39 clinicians were trained in MATCH-ADTC using a virtual format this spring.

As evidence-based treatment models become more broadly available in our community, efforts have been made to familiarize staff in case management roles with the different treatment models and with how to connect their clients to providers who can offer them. Increasing demand for these evidence-based treatments from our system and our partners is an important part of incentivizing clinicians to participate in training, to follow-through with certification, and to use treatment practices with proven outcomes.

B. *Train non-clinical staff in community-based organizations, schools, and county agencies to implement trauma-informed practices.* The Fairfax County Trauma-Informed Community Network has reached over 7000 people with their 90-minute Trauma Awareness 101 Training, which is also available on-demand as a 30-minute webinar. The TICN continues to offer full day sessions of their Trauma-Informed Supervisor Training and has reached over 600 supervisors from county human services agencies, schools, and non-profit partners. Additionally, the TICN offers a full day training on Secondary Traumatic Stress (STS) in the workforce (The Cost of Caring), and a 2 hour Secondary-Traumatic-Stress and Self-Care Basics workshop, both of which have reached 500+ staff from county human services agencies and non-profit partners. A special version of STS training focused on navigating the pandemic has been delivered to almost 200 people to date. Additional trainings and resources are available on the TICN website, and include a mini-grant opportunity to fund small space improvement projects. Space improvement projects were completed last spring at the Health Department, Domestic & Sexual Violence Services, Juvenile & Domestic Relations District Court, Department of Family Services and at the Community Services Board. Funds for additional projects at county HHS agencies, as well as for small projects at community-based organizations were made available this year through grant funding from the Family & Children's Trust Fund of Virginia (FACT). Projects are currently underway at JDRDC, at the CSB, at Mountain View High School, at FCPS Pre-K & Early Head Start, and at 5 community-based organizations using these funds.

In spring 2000, the TICN added to their list of publications, which previously included a "Guide to Educating Children, Youth and Families about Trauma & Resilience" booklet for staff providing psychoeducation to kids and families. The new resource for professionals is entitled "A Guide to Trauma-Informed Approaches for Service Providers," and is available in both booklet and poster format, and is intended for staff in case management and care coordination roles. These resources have been widely distributed, as have two COVID-19 specific publications entitled, "Trauma-Informed Strategies for Working with Youth and Families During the COVID-19 Pandemic" and "Trauma-Informed Strategies for Working with Youth and Families When Out-of-School Time Centers Reopen and Programs Resume."

Inform the community at large on the prevalence and impacts of trauma. In February of 2019, a team of four TICN members from Fairfax-two from the CSBs Wellness, Health Promotion & Prevention Team, one from the NCS prevention team, and one from FCPS Social Work Services-attended an intensive 2-day course to become Master Trainers in the ACE Interface curriculum, an evidence-based program that the VA Department of Behavioral Health and Developmental Services has a license for, and is rolling out across the state to raise awareness in the community about the impact of Adverse Childhood Experiences, and the science of neurobiology, epigenetics and resilience. With support from DBHDS, the Fairfax Master Trainer Team convened the first ACE Interface presenter cohort in the state in April 2019, where 30 people from county HHS agencies, FCPS, non-profit, and family/parent organizations were trained to deliver the curriculum. A second presenter cohort was trained in late February 2021, increasing the capacity of the team to bring this information to a wider variety of audiences. ACE Interface Presentations-titled Building Resilient Communities and Understanding Adverse Childhood Experiences- have been delivered to over 1,000 people so far, and are currently available in a virtual format, which have drawn larger audiences than pre-pandemic in-person presentations. Thanks to grant funding from FACT, presenters from community, faith or parent organizations now have access to a stipend each time they complete a presentation. In partnership with DBHDS and other ACE Interface Master Trainer Teams from across the state, plans are currently underway for a PSA

related to the messages in the ACE Interface presentation, and for additional coordination of this work at the state a regional levels.

C. *Develop shared screening and referral process for individuals impacted by trauma for school and human services agency staff using nationally recognized screening tool.* One county HHS agency is currently screening clients using a validated trauma screening tool. Juvenile & Domestic Relations District Court began piloting the STRESS (Structured Trauma Related Experiences Symptom Screener) in select work units in 2016 and scaled to agencywide implementation in July 2019. Through technical assistance from the RFK National Resource Center for Juvenile Justice, JDRDC is currently working on refining workflow and referral processes to respond to the results of the screening. Expanding the capacity of the provider community to offer evidence-based treatments for trauma, the work of the training consortium, is a key component of ensuring that all of the necessary resources to effectively respond to trauma screening are in place.

D. *Human service agency leaders will integrate the concepts of trauma-informed care into their organizational culture.* County Health and Human Services agencies continue to implement plans to ensure their organizations are trauma informed. Evidence of lessons learned by agency leadership from across HHS in the Taking the Lead: Training for Leaders in High Stress, Trauma-Exposed Workplaces (training that was sponsored by the TICN in 2016) have been apparent throughout the response to the pandemic, and the TICN has received multiple requests for review of those training materials during this time.

GOAL 12: Behavioral Health Intervention

Coordinator: Peter Steinberg

A. *Develop empirically validated cross system human services and schools screening process available to determine needs, resources, & desirable outcomes.* The Brief Screening for Adolescent Depression (BSAD) is available for families and youth on the Healthy Minds Fairfax Website as well as the website for the Falls Church-Fairfax County Community Services Board. Healthy Minds Fairfax staff continues to work with human services to develop a protocol for screening tools.

Number of BH screenings

FY21 (1st Qtr)	FY21 (2nd Qtr)	FY21 (3rd Qtr)	FY21 (4th Qtr)	FY21 TOTAL	FY20	FY19	FY18	FY17
15	15	28	N/A	58	50	89	88	108

B. *Create capacity to address behavioral health needs of children 0-7.* CSA has expanded community-based interventions for youth to include access and funding for Parent-Child Interaction Therapy (PCIT). PCIT is a family centered treatment approach for children ages 2-7.

C. *Establish a training consortium in partnership with university and private provider partners (ex: GMU, INOVA) for ongoing training for staff and service providers.* The Fairfax Consortium on Evidenced Based Practice has entered its fourth year and we are in the early planning stages for the next year. All trainings that recently took place were delivered online. The consortium will be.

The trainings offered during this quarter are TF-CBT, Family Intervention for Suicide Prevention, and a refresher course in the Core Competencies.

D. *Expand access to timely and available behavioral health services for school age children and youth with emerging behavioral health issues who have not been able to access such services.* Healthy Minds Fairfax Short-Term Behavioral Health Services (STBH) is temporarily available to all middle school and high school age youth and children attending one of the five designated STBH elementary schools. As a reminder, this service continues to link income eligible youth and families from select school communities to timely and available short-term mental health counseling (up to 8 sessions), funded by Healthy Minds Fairfax. During this quarter, all services were provided via telehealth.

Number of youth served through Short-Term Behavioral Health Services:

FY21 (1st Qtr)	FY21 (2nd Qtr)	FY21 (3rd Qtr)	FY21 (4th Qtr)	FY21 TOTAL	FY20	FY19	FY18	FY17
20	67	64	N/A	151	205	215	126	57

E. *Develop recommendations for the Board of Supervisors Public Safety Committee that reflect Diversion First initiatives needed for youth who come in contact with the criminal justice system.* CSB and JDRDC staff continue to meet to address the behavioral health needs of the court that can be provided by the CSB.

- *Reduce youth substance abuse and use.* Substance Abuse Prevention Services (SAP) are available in all Fairfax County School pyramids including alternative schools. Youth can be referred to the CSB by FCPS and JDRDC for an additional substance use service. During this period 5 youth were referred for services.

GOAL 13: Service Network for High Risk Youth

Coordinator: Janet Bessmer

A. *Increase availability/capacity of provider community to offer trauma assessments and evidence-based trauma treatment; trauma services shall be offered in languages and in locations that are accessible to families.* This goal overlaps with roles of TICN and the Training Consortium. Private providers who offer trauma assessments and treatments are identified in the CSA provider directory. There continues to be a need for providers to offer evidence-based trauma assessments and treatment.

B. *Identify and implement an evidence-based parenting program designed for parents of adolescents (12+); language capacity and location/accessibility shall meet the needs of families.* Three providers are currently under contract to provide Functional Family Therapy.

C. *Identify and implement an evidence-based parenting program designed for parents of children (<12); language capacity and location/accessibility shall meet the needs of families.* Parent Child Interaction Therapy (PCIT) is currently being offered by two providers in our region. One provider has Spanish-speaking therapists.

D. *Monitor utilization of ICC and Case Support and increase capacity/staffing so that youth with identified behavioral health care needs receive appropriate case management services.* UMFS and Wraparound Fairfax are fully staffed. There appears to be adequate capacity at this time; however, referrals to the programs have been lower during the pandemic.

E. *Improve the utilization of the annual gaps survey of youth and parents in CSA-SOC to identify needed interventions.* The OCS survey for FY21 has just been completed and will be presented to the CPMT. The results can be used for further service development.

F. *Develop communication plan to share information about the services and care coordination offered through the SOC process with the broader provider community.* CSA produces a bi-monthly newsletter that contains training announcements and other information pertinent for system partners. See social marketing goals for more information about outreach efforts. DFS has been facilitating a quarterly home-based provider meeting to share information about FFPSA implementation and promote improved collaboration with providers. Two information sessions about EBTs were provided to nearly 300 county and school staff during the summer. CSA has also developed a specific page on their public and internal website with information and job aides regarding new services.

G. *Build system capacity to monitor fidelity to EBT models and conduct outcome evaluation for purchased services*. Fidelity monitoring efforts have been moved to the Virginia Wraparound Implementation Center, which is funded through a federal grant. Both Wraparound providers, UMFS and Wraparound Fairfax, have entered into MOUs with VWIC. As VWIC collects data on family satisfaction through the WFI-EZ survey and compliance of the model through file reviews using the DART, data will be entered into an online information system. CSA staff will have access to this data. A report out on the WFI-EZ and DART data collected from FY18 through FY20 was provided to the CSA Management Team and the ICC Stakeholders Workgroup.

H. *Provide IT infrastructure to support data collection for fidelity monitoring and outcome evaluation along with electronic records management.* CSA has implemented an electronic document management system, OpenText, and has been able to work remotely. Serious Incident Reports and other data are tracked and collected electronically.

I. *Explore opportunities for expanding available financial resources to serve youth on diversion or probation who need intensive behavioral health services.* CSA staff continue to collaborate with juvenile court leadership to make the CSA process accessible to probation officers. Training about MST and FFT have been provided to court staff.

J. *Increase family and provider membership on the CPMT.* FAPT parent representative positions have been filled. All vacant CPMT positions were filled as of September 24, 2019. The Family Advisory Board was established.

GOAL 14: **DD/Autism Services**
Coordinator: Tracy Davis

Develop expanded continuum of care of services for youth with DD/autism. The workgroup has refined the direction of the work on this goal. Two main deliverables were identified:

Deliverable #1: Revised SOC Blueprint Goal 14, DD/Autism Services, with updated action steps and dates

Deliverable #2: DD/Autism Services Case Management Recommendations with a Statement of Need

The two deliverables for Goal 14 stated above have been accomplished.

Updates on each blueprint strategy are addressed below:

A. *Conduct needs assessment and service inventory of the existing continuum of services and supports and identify critical service gaps for youth with DD/Autism.* Status: No further action is required on Strategy A. For Action Steps 1- 4: The workgroup had consensus that the urgent need is to serve the 1,000 youth that are on the DD waiver waitlist and that the largest service gap is for case management along with the need for behavioral supports, respite, crisis supports (such as Reach), transportation and attendant care giver support. The workgroup determined that there is no further needs assessment and inventory needed however consolidating the inventory information and possibly reexamining the needs could be addressed with the development of the subsequent blueprint following the completion of the current blueprint.

B. *Utilize results of needs assessment and gap analysis to develop a plan to address critical service gaps.* Status: No further action is required on Strategy B. For Action Steps 1- 5: The workgroup determined that there may be a need for focus groups/discussion with service providers such as Grafton, Jill's House and/or other homebased/ABA providers. Jill's House or Autism Society can bring together families to be sure the plan is addressing their needs. The Welcoming Inclusion Network (WIN) and CSB Supported Employment should be included in all future discussions to address critical gaps. The workgroup determined that these tasks may be completed in conjunction with priority strategy areas D, E, & F and therefore there is no further work required for this strategy. Reassessment of utilizing the results of the needs and service gaps should be addressed with the development of the subsequent blueprint following the completion of the current blueprint.

C. *Develop a system navigation, community awareness & outreach campaign to promote early identification of youth with DD/Autism who would benefit from referral to services.* Status: No further action is required on Strategy C. For Action Steps 1 – 7: The workgroup indicated that current efforts by CSB, FCPS, and family organizations are ongoing. Each organization will assume responsibility going forward for implementing the current efforts. Reexamining the needs and the services with regards to system navigation, community awareness & outreach to promote early identification could be addressed with the development of the subsequent blueprint following the completion of the current blueprint.

D. *Improve transition planning for children with intellectual disabilities or chronic residential needs.*

E. *Ensure access to crisis stabilization services designed for youth with DD/Autism with providers trained to serve this population*

F. *Increase case management and care coordination capacity for children and youth with DD, particularly for younger children.*

Status of Strategy E, F and G: Strategy E, F & G were identified as high priority areas. The objective for the workgroup is to address Blueprint Strategy E, F & G. The DD/Autism services workgroup presented a recommendation to take the CSA process that currently exists to accurately assess children for appropriate supports to prevent crisis and applying it to 347 of the more than 1,300 youth who have open cases with the CSB Developmental Disabilities Services Unit. On November 7, 2019, the recommendations were presented to the CSB DD Support Services

leadership team. The CSB will assume responsibility going forward for implementing the recommendations that they determine to be most beneficial. Obtaining additional positions to serve in a case management role appears to be the next area to be addressed.

GOAL 15: Transition Age Youth

Coordinator: Peter Steinberg

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

A. Health Minds Fairfax has partnered with the Jewish Social Services Agency (JSSA) to provide case management services to Transitional Age Youth, and it is anticipated that services will begin in May, 2021.