MEMO TO THE CPMT

February 22, 2019

Information Item I-1: Review Recommendations from JLARC Report on Child Welfare

ISSUE:

The JLARC (Joint Legislative Audit and Review Commission) Report "Improving Virginia's Foster Care System" reported a number of deficiencies in Virginia's foster care system.

BACKGROUND:

The JLARC requested this study in September 2017. JLARC staff reviewed data from multiple sources and conducted numerous interviews. The report was released on December 10, 2018. VDSS is supportive of implementing many of the report's recommendations and some money has been put into the proposed state budget to help fund some of the needed work.

ATTACHMENT:

- Highlights from the JLARC Report "Improving Virginia's Foster Care System"
- Cover, TOC, Summary and Recommendations from the report

STAFF:

Oriane Eriksen - Acting Division Director for the DFS Children, Youth and Families Division
Kamonya Omatete – Foster Care and Adoption Program Manager for DFS/CYF

Highlights from the JLARC Report "Improving Virginia's Foster Care System"

JLARC staff conducted this study in 2018 by reviewing data from multiple sources and conducting interviews with staff and leaders from state and local agencies.

Findings

Their findings are organized into the following sections:

1. Ensuring the health and well-being of children in foster care – such as caseworker visits with children and ensuring children in foster care have needed health screenings and immunizations
2. Appropriate foster care placements – especially placements with relatives and maximizing the use of non-relative foster families rather than congregate care
3. Reducing long stays in foster care – focusing children achieving permanency through reunification, adoption, or placement with relatives
4. Staffing capacity for the delivery of foster care services – focusing on caseloads for foster care staff
5. State supervision of Virginia's foster care system – examining the state supervised/county administered structure and real or perceived limits to the state's authority over practice in local agencies.

Recommendations

- 34 recommendations were made across the five areas above, some requiring legislative action and some requiring executive action.
- In general, we support these recommendations

What this means for Fairfax

- We examined every finding in the report regarding statewide practice and looked at our data to see how we fared in those areas
- In general, our data shows that we are performing better than the state a whole. For example:
    - The report found concerns about the frequency of workers' visits with children; we have consistently met the state target
    - The report found concerns about the percent of children living in congregate care settings; we have consistently exceeded the state target.
    - The report found concerns about staff's caseloads; we have consistently maintained caseloads that meet best practice standards.
- There are areas of concern in the report that we struggle with as well:
    - We wish to strengthen our recruitment of foster families so we can ensure children are matched with appropriate families in close proximity to their home communities
    - We wish to have more children placed with relative foster families to promote family bonds
    - We wish to increase the percent of children leaving foster care to permanent families through reunification, adoption or placements with relatives and reduce the number of youth aging out of foster care.

JLARC
JOINT LEGISLATIVE AUDIT AND REVIEW COMMISSION

Summary: Improving Virginia's Foster Care System

WHAT WE FOUND

Requirements to ensure children's health and safety are followed in most foster care cases, but lack of adherence to requirements in some cases puts children at risk

In most cases, the basic steps required by federal and state laws to ensure the safety of children in foster care are being followed in Virginia, and most children are receiving required physical and mental health services. However, a lack of adherence to federal and state requirements for ensuring children's health and safety, even if they are infrequent, creates avoidable risks for children in the government's custody.

A review of foster care cases by the Virginia Department of Social Services (VDSS) found that basic safety requirements have not always been followed. In 98 sampled cases (four percent), the requirements to ensure the safety of placement settings were not followed. Additionally, despite the requirement that caseworkers visit children at least once a month—and the importance of these visits for monitoring children's safety and well-being—caseworkers in some local departments were found to not be conducting monthly visits, and some children in foster care are not being visited for multiple consecutive months. Evidence also shows that children do not always receive required health screenings, and the proportion of children in foster care in Virginia who did not receive required screenings in FY16 was higher than in some other states.

WHY WE DID THIS STUDY

In 2017, the Joint Legislative Audit and Review Commission directed its staff to study the foster care and adoption services delivered by Virginia's local departments of social services and supervised by the Virginia Department of Social Services (VDSS). JLARC staff examined the extent to which local departments follow requirements to ensure the safety and well-being of children in foster care and effectively manage foster care cases; the appropriateness of foster care placements; efforts to place children in permanent homes; and the role of VDSS in supervising the delivery of foster care and adoption services.

ABOUT VIRGINIA'S FOSTER CARE SYSTEM

Virginia's foster care system is intended to provide temporary protection and care for children who cannot remain safely in their homes. About 5,300 Virginia children are in foster care, and total federal, state, and local spending on foster care and adoptions amounts to nearly $500 million annually. Both the number of children in foster care and expenditures for administering the system have increased in recent years.

VDSS has recently taken steps to collect case-level information that—once it is prioritized by VDSS staff—will allow VDSS to identify practices that unnecessarily place children's health and safety at risk and work with local departments to resolve identified problems.

Expanded state-level policies and investments are needed to place more children in family-based foster care settings

Local departments of social services do not do enough to place children in foster care with relatives, and the state does not take sufficient steps to ensure non-relative foster families are available to care for children when relatives are unavailable. Although state requirements, federal law, and child welfare best practices prioritize placement with

relatives, local departments in Virginia are not using relatives nearly as frequently as other states. In 2016, only six percent of children in foster care were placed with relatives, about one-fifth as often as the national average (32 percent). Virginia's low rate of placement with relatives can be explained, at least in part, by inconsistent efforts by caseworkers to identify relatives who may be willing and able to assume the role of foster parent.

A key resource for family-based placements, particularly when relatives are not an option, are non-relative foster families, but the statewide shortages of non-relative foster families in Virginia are long standing and well known. Despite the persistent nature of these shortages, Virginia still has no plan, dedicated funding, or staff to systematically recruit non-relative foster families, in contrast to other states.

Because of the shortage of both relative and non-relative foster families, many local departments have had to rely on costlier, more restrictive placements for children whose needs are not effectively met in such placements. Virginia's use of congregate care (group homes and residential treatment centers) is higher than other states' and has been increasing. A substantial proportion of children in congregate care settings in Virginia do not have a clinical need to be there, according to two separate indicators of clinical need and observations from foster care caseworkers across many local departments of social services. In some instances, short stays in congregate care are necessary for children in foster care, but research shows that unnecessary time in congregate care can have negative effects on children's healthy development. In some other states, the rates of congregate care placements have been a factor in federal class-action litigation against state child welfare systems.

Additional casework is needed to improve the likelihood that children in foster care will find a permanent home

Federal and state law require local departments to minimize the time children spend in foster care by working diligently to reunify children with their birth parents as soon as it is safe and appropriate to do so, or to find relatives or others willing to permanently care for children when timely reunification is not possible. Compared to children in other states, a higher proportion of children "age out" of Virginia's foster care system before finding a permanent family. For example, of children 12 and older who entered foster care between 2012 and 2016, 54 percent aged out before finding a permanent home—approximately double the 50-state average (25 percent). Virginia has been among the worst three states annually for children aging out of foster care since at least 2007.

Compared to other states, Virginia takes fewer children into foster care, and it is commonly assumed that the children who enter foster care in Virginia have more severe challenges and are more difficult to place. This assumption is sometimes used to explain lengthy stays in foster care in Virginia, but analysis shows that a more likely explanation is the combination of inadequate casework by local departments and certain barriers outside caseworkers' control, such as the court system and service availability.

Reunification with birth families appears to be the type of permanency with the greatest opportunity for improvement in Virginia. VDSS data indicates that local departments are not involving birth parents and other key individuals in critical decision points in the foster care process, and children in Virginia are significantly less likely to be reunified with their birth parents than children in other states.

Some children are waiting an unnecessarily long time for adoptions to occur, due in part to the practices of local departments with respect to the "termination of parental rights" (TPR) process. TPR permanently eliminates all legal rights and responsibilities of birth parents and is legally required to occur before a child may be adopted. However, in some cases foster care caseworkers do not request TPR at the milestones required by federal and state law, delaying a child's ability to become eligible for adoption. The often lengthy TPR appeals process in Virginia can also prolong the amount of time taken for children to be placed in a permanent home, and steps need to be taken to ensure birth parents are aware of a voluntary TPR option that could potentially avoid the appeals process and make children eligible for adoption sooner.

Fifteen percent of caseworkers carry high foster care caseloads, and high caseloads affect nearly one-third of children

Fifteen percent of foster care caseworkers in Virginia carry caseloads of more than 15 children at a time—higher than the widely accepted caseload standard of 12 to 15 children per caseworker. Caseworkers with these high caseloads are in 32 local departments distributed across all five regions of the state. The number of foster care caseworkers with caseloads of more than 15 has been increasing, and a relatively large number of children in foster care are affected. Foster care caseworkers with high caseloads were collectively responsible for managing the cases of 1,657 children (31 percent of all children in foster care). Higher foster care caseloads are associated with lower rates of routine medical exams, fewer in-home visits by caseworkers, and fewer contacts between children and their birth families each month, according to JLARC analysis of VDSS data.

VDSS has not effectively supervised the foster care system and does not have an effective means to identify and resolve poor performance

Many stakeholders—social services staff, foster parents, judges, and others—expressed concerns about the lack of accountability in Virginia's foster care system and the impact this has on children and families. VDSS has historically narrowly interpreted its supervisory responsibilities, which are set in statute, and past VDSS leaders have equivocated about the state's ability to assertively supervise foster care services and hold local departments of social services accountable. The current VDSS commissioner has signaled that VDSS may be more proactive in its supervisory role under his leadership, but state law should be clarified to ensure that VDSS has unequivocal statutory direction regarding its responsibilities for holding local departments accountable for providing foster care services in a manner consistent with federal and state

laws. For example, although the commissioner of VDSS has the statutory authority and responsibility to intervene when local departments of social services fail to provide services to those who need their assistance, current state law is not clear about the *circumstances* under which VDSS should intervene to resolve cases in which children are not receiving needed services.

To improve its effectiveness as supervisor of the system, VDSS also needs to more closely monitor local departments' child welfare practices. VDSS initiated a case review process in 2017 to identify problems with the administration of child welfare services, but the results of the case reviews—which have been conducted for nearly two years—have not been systematically reviewed by central office staff, and VDSS has no process to ensure that identified problems are resolved. The information from case reviews could be leveraged to make improvements, and the current case review process could be replaced with a more comprehensive and structured quality assurance review process that prioritizes those departments that appear to be at the greatest risk of providing inadequate services.

WHAT WE RECOMMEND

Legislative action

- Direct VDSS to examine the results of regional consultants' 2017 and 2018 case file reviews and certify that all safety-related concerns identified in those reviews have been resolved.
- Direct VDSS to develop and maintain a strategic plan for recruiting foster families and to maintain a statewide inventory of foster families.
- Direct VDSS to identify all children who do not have a clinical need to be in a congregate care setting and take steps to move them to a more appropriate placement.
- Establish a standard for the number of foster care cases managed by a single caseworker.
- Specify VDSS's supervisory responsibilities for the state's foster care system and the actions it is authorized to take to ensure local departments comply with state foster care laws and regulations.

Executive action

- Require local department staff to routinely search for the relatives of children in foster care and issue clear guidance to local departments on the existing policies that can facilitate the approval of relatives to serve as foster parents.
- Identify children who have been in foster care for longer than 36 months and provide technical assistance and resources to local departments to minimize prolonged stays in foster care for these children.
- Develop clear guidance that should be distributed to all birth parents on their ability to voluntarily terminate parental rights.

The complete list of recommendations is available on page vii.

MEMO TO THE CPMT

February 22, 2019

Information Item I- 2: Legislative Update

ISSUE: That the CPMT be informed of legislative activity that may impact CSA.

BACKGROUND:
Several bills have been proposed to study alternatives for delivery of special education services in public school settings if greater flexibility in use of CSA funding were permissible. These bills appear to be prompted by the rising CSA special education expenditures. Rate setting has also been proposed as another strategy and is currently being studied.

Bill	Description	Status
SB 1104	Community policy and management teams; use of funds. Provides that the state pool of funds for community policy and management teams may be used for wrap-around services, as defined in the Policy Manual of the Children's Services Act and subject to specific appropriation, that are provided in a public school setting. The bill requires the Office of Children's Services to report annually to the Chairmen of the House Committee on Appropriations and the Senate Committee on Finance regarding the use of wrap-around services in public school settings.	Passed by Indefinitely 2/12/19
SB 1576	Department of Education; pilot program; feasibility of educational placement transition of certain students with disabilities. Requires the Department of Education and relevant local school boards to develop and implement a pilot program for up to four years in two to eight local school divisions in the Commonwealth. In developing the pilot, the Department is required to partner with the appropriate school board employees in each such local school division to (i) identify the resources, services, and supports required by each student who resides in each such local school division and who is educated in a private school setting pursuant to his Individualized Education Program; (ii) study the feasibility of transitioning each such student from his private school setting to an appropriate public school setting in the local school division and providing the identified resources, services, and supports in such public school setting; and (iii) recommend a process for redirecting federal, state, and local funds, including funds provided pursuant to the Children's Services Act, provided for the education of	Passed by Indefinitely 2/13/19

	each such student to the local school division for the purpose of providing the identified resources, services, and supports in the appropriate public school setting. The bill requires the Department of Education to make a report to the Governor, the Senate Committees on Education and Health and Finance, and the House Committees on Education and Appropriations on the findings of each pilot program after two and four years.	
Budget 282	Senate: Delays the final report on a study of private date special education rates (included in the biennium budget passed by the 2018 GA) from July 2019 to October 2019. Also directs the Department of Education and the Office of Children's Services to establish an implementation workgroup for developing and refining the collection and reporting measures as recommended in the Private Day Special Education Outcomes report from November 2018	
Budget 282	Governor Northam's Budget: Removes a $50,000 cap on the amount of state funding that can be used by localities for administrative costs.	House/Senate: No change.

ATTACHMENT: None

STAFF:
Janet Bessmer, CSA Manager

MEMO TO THE CPMT
February 22, 2019

Information Item I-3: December Budget Report & Status Update, Program Year 2019

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 2019 cumulative expenditures through December 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 December 2018 equal $12.2M for 858 youth. This amount is a decrease from December last year of approximately $1.1M, or 8.56%. Pooled expenditures through December 2017 equal $13.3M for 839 youth.

General comparisons to the previous year based on LEDRS reporting categories is presented below:

	Program Year 2018	Program Year 2019	Change Amt	Change %
Residential Treatment and Education	$2,058,401	$1,360,967	($697,433)	-33.88%
Private Day Special Education	$7,608,126	$7,076,088	($532,038)	-6.99%
Non-Residential Foster Home and Community Services	$4,006,087	$3,612,530	($393,557)	-9.82%
Non-Mandated Services (All)	$93,306	$579,338	$486,032	520.90%
Recoveries	($414,034)	($420,408)	($6,374)	1.54%
Total Expenditures	**$13,351,885**	**$12,208,516**	**($1,143,369)**	**-8.56%**

	Program Year 2018	Program Year 2019	Change Amt	Change %
Residential Treatment and Education	102	74	(28)	-27.45%
Private Day Special Education	283	269	(14)	-4.95%
Non-Residential Foster Home and Community Services	750	717	(33)	-4.40%
Non-Mandated Services (All)	47	166	119	253.19%

Total Youth Counts (Unique Count in each category)	**1,182**	**1,226**	**44**	**3.72%**

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

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

RECOMMENDATION:
For CPMT members to accept the December Program Year 2019 budget report as submitted.

STAFF:
Yin Jia, Xu Han, Terri Byers (DFS)

Program Year 2019 Year To Date CSA Expenditures and Youth Served (through December)

Mandated/ Non-Mand	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%	$420,189	33		0	$420,189
		Group Home	57.64%	$102,492	6		0	$102,492
		Education - for Residential Medicaid Placements	46.11%	$137,939	11	$159,081	4	$297,020
		Education for Residential Non-Medicaid Placements	46.11%	$125,113	8	$371,497	8	$496,610
		Temp Care Facility and Services	57.64%	$44,656	4		0	$44,656
	Residential Total			$830,389	62	$530,578	12	$1,360,967
	Non Residential	Special Education Private Day	46.11%	$40,101	3	$7,035,987	266	$7,076,088
		Wrap-Around for Students with Disab	46.11%	$69,542	15		0	$69,542
		Treatment Foster Home	46.11%	$1,341,626	83		0	$1,341,626
		Foster Care Mtce	46.11%	$422,037	93		0	$422,037
		Independent Living Stipend	46.11%	$331,603	24		0	$331,603
		Community Based Service	23.06%	$1,067,931	400		0	$1,067,931
		ICC	23.06%	$349,424	97		0	$349,424
		Independent Living Arrangement	46.11%	$24,966	4		0	$24,966
		Psychiatric Hospital/Crisis Stabilization	46.11%	$5,400	1		0	$5,400
	Non Residential Total			$3,652,631	720	$7,035,987	266	$10,688,618
Mandated Total				**$4,483,020**	**782**	**$7,566,565**	**278**	**$12,049,585**
Not Mandated	**Residential**	Residential Treatment Facility	57.64%	$45,041	4		0	$45,041
		Temp Care Facility and Services	57.64%	$2,885	1		0	$2,885
	Residential Total			$47,927	5	$0	0	$47,927
	Non Residential	Community Based Service	23.06%	$416,461	129		0	$416,461
		ICC	23.06%	$114,951	32		0	$114,951
	Non Residential Total			$531,412	161	$0	0	$531,412
Not Mandated Total				**$579,338**	**166**	**$0**	**0**	**$579,338**
Grand Total (with Duplicated Youth Count)				$5,062,359	948	$7,566,565	278	$12,628,924
Recoveries								-$420,408
Total Net of Recoveries								$12,208,516
Unduplicated child count								858
Key Indicators								

Cost Per Child	**Prog Yr 2018 YTD**	**Prog Yr 2019 YTD**
Average Cost Per Child Based on Total Expenditures /All Services (unduplicated)	$15,897	$14,229
Average Cost Per Child Mandated Residential (unduplicated)	$28,187	$23,067
Average Cost Per Child Mandated Non- Residential (unduplicated)	$14,498	$14,009
Average Cost Mandated Community Based Services Per Child (unduplicated)	$2,617	$2,670
Average costs for key placement types		
Average Cost for Residential Treatment Facility (Non-IEP)	$13,314	$12,733
Average Cost for Treatment Foster Home	$16,213	$16,164
Average Education Cost for Residential Medicaid Placement (Residential)	$11,132	$19,801
Average Education Cost for Residential Non-Medicaid Placement (Residential)	$33,471	$31,038
Average Special Education Cost for Private Day (Non-Residential)	$26,903	$26,305
Average Cost for Non-Mandated Placement	$2,295	$3,490

Program Year 2019 Year To Date CSA Expenditures and Youth Served (through December)

Category	Program Year 2019 Allocation	Year to Date Expenditure (Net)	Percent Remaining
SPED Wrap-Around Program Year 2019 Allocation	$732,674	$64,046	91%
Non Mandated Program Year 2019	$1,630,458	$475,660	71%
Program Year 2019 Total Allocation	$39,593,010	$12,208,516	69%

MEMO TO THE CPMT

February 22, 2019

Information Item I- 4: CPMT Representation at Strategic Plan Forum for BACs

ISSUE: That Representatives from the CPMT are invited to attend a forum regarding the county's Strategic Plan on March 7.

BACKGROUND:
Fairfax County is embarking on a strategic planning process with the community to **shape the future together**. As stated by County Executive Bryan Hill, "there's going to be one set of County priorities that will be generated by the Board of Supervisors, community and staff and endorsed by the Board of Supervisors."

As the strategic planning process unfolds in 2019, we will have:

- Defined priorities for 2020 and beyond, organized around 7-10 areas
- Developed a set of community-centric and quantifiable performance indicators for each priority area
- Prioritized strategies and implementation paths to achieve the outcomes on key performance indicators
- Integrated other planning efforts such as economic success, Fairfax County Public Schools strategic plan, One Fairfax and more

County staff, with assistance from a consultant, is in the process of engaging stakeholders with the goal of hearing from as many individuals as possible. Because Boards, Authorities, and Commissions (BAC) are a critical component of this engagement effort, an engagement forum specifically for BAC representatives has been scheduled for March 7, 2019 from 7pm to 8:30pm at the Government Center, conference center rooms 9/10/11. Due to the number of BACs and space constraints, we are asking each BAC to work with its staff coordinator to identify 1-2 representatives to attend this forum.

If you are not one of the representatives attending the BAC forum, you are encouraged to still have your voice heard by:

1. **Taking a short five-question online survey**
2. **Joining a community conversation in person between Feb. 13 and March 6**

Information on both of these opportunities can be found on the website for the Strategic Plan process: fairfaxcounty.gov/strategicplan

RECOMMENDATION: That CPMT approve two members to attend the forum on behalf of the CPMT.

ATTACHMENT: None

STAFF: Janet Bessmer, CSA Manager

MEMO TO THE CPMT

February 22, 2019

Information Item I- 5: Healthy Minds Fairfax Blueprint Quarterly Report

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

BACKGROUND:
When CPMT approved the Blueprint in March 2016 it directed that staff provide quarterly progress reports. The full progress report for the period October through December 2018 is attached, with a summary below.

Areas of Strategic Focus:

Access

Accomplishments:

- Counseling staff for the regional mobile stabilization and response service has been expanded by two (17%) for FY19, to support safely diverting youth from hospitalization.
- The Northern Virginia Family Service Violence Prevention and Intervention Program has been expanded by one counselor to serve more Latino youth with or at risk of behavioral health issues. The expanded capacity is in the Herndon/Reston area.
- At mid-year, Short-Term Behavioral Health Services has already served 94 youth, compared to 130 for all of last year.
- The FCPS/CSB school-based substance abuse intervention program was launched in the following pyramids: South Lakes, Herndon, Langley, West Potomac, Robinson and Bryant/Mountain View high schools.

Challenges:

- The Give an Hour pro-bono therapy service does not have enough clinicians to serve referrals.

Planned Activities

- Functional Family Therapy is being considered for youth with chronic school absences related to behavioral concerns. Contracting issues are currently being addressed to support implementation of this intervention.
- Regional Teams will be created in Fairfax County Public Schools to Address School Refusal Behaviors Using Evidence-Based Practices

Awareness and Stigma

Accomplishments:

- HMF had resource tables at the Northern Virginia Pediatric Conference on November 2-3, at the Northern Virginia Mental Health Foundation's Pathways to Wellness Conference on October 12 and at the first annual Fairfax County Health and Human Services Forum on November 16.
- the Trauma-Informed Community Network (TICN) presented a new version of Trauma 101, specifically for parents, at the FCCPTA Family Engagement Conference in October.

Challenges: None identified

Planned Activities

- The TICN continues to host full day sessions of their Trauma-Informed Supervisor Training,and have reached hundreds of supervisors from county human services agencies, schools, and non-profit partners. They will be presenting the new Trauma 101 session for parents at the Virginia statewide PTA conference in early 2019.
- Universal Suicide Prevention Programs will be provided for all middle and high schools in Fairfax County Public Schools

Coordination and Integration

Accomplishments:

- The Virginia Department of Health has been awarded a federal grant to establish a statewide pediatric mental health access program. Inova Kellar Center is a Northern Virginia partner.

- The CSB Resource Team has filled 7 vacant positions (more than half their staff) and their new staff are completing required training. They will be accepting new referrals in March.

Challenges: None identified

Planned Activities:

- A new navigation website will be ready this winter for testing by families and other stakeholders.
- In May another cohort of local pediatricians will participate in intensive behavioral health training.
- Through HMF funding a George Mason University psychology resident will be placed in a local pediatric primary care office to provide behavioral health services.

Family Engagement

Accomplishments:

- A "Parent's Guide to Evidence-Based Treatments" training was held on November 14, 2018. Fourteen people participated in the training.
- Halfway through the fiscal year 65% (91 versus 55) more families have been served with Parent Support Partners than in all of FY18.
- HMF funding has been allocated for consultation from the Family Run Executive Director Leadership Association to guide further development of a family-led organization network through implementation of a resource mapping/needs assessment among the regional nonprofits and development of a set of recommendations and action steps for the Northern Virginia Network. The Network met twice during the quarter, covering topics including legislative and policy updates on issues impacting children and families in Virginia, meeting with faculty of the Center for Nonprofit Management at GMU, and discussion of options for formalization of the Network.

Challenges:

- Little progress has been made on including youth and families in the evaluation of services.
- Little progress has been made on regularly gaining feedback and input from youth with lived experience.

Planned Activities

- Short-Term Behavioral Health Services will be purchasing the services of an organization specializing in maximizing the response rate to parent satisfaction surveys.
- A new youth peer support group will be re-started in February 2019 with an broadened target population and an accompanying parent support group.
- The Transition Age Workgroup plans to survey transitional youth (ages 16-24) and parents of transitional youth to find out what their needs are and what services they that they need.

Quality

Accomplishments:

- In November 2018, 44 clinicians were trained in Trauma-Focused Cognitive Behavioral Therapy. Enrollment for the training included a commitment from clinicians to pursue certification.
- A master calendar for children's behavioral health trainings and events was added to the Healthy Minds Fairfax public website in August of 2018. In Quarter 2 the calendar received 367 visits.

Challenges:

- The response rate to surveys assessment the fidelity of intensive care coordination to High Fidelity Wraparound principles has been low. A plan for increasing the response rate will be implemented in January.

Planned Activities

- The Core Competency Training offered this year to approximately 70 clinicians treating adolescents will include a trauma specific session, which will be scheduled for spring of 2019.
- In 2019, approximately 50 clinicians working with children ages 7-12 will receive training in MATCH-ADTC- Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems.

System Transformation

Accomplishments: None identified

Challenges: None identified

Planned Activities

- The Transitional Age Youth workgroup will be proposing a policy statement that in summary states that behavioral health providers who work with children and youth are committed to help their clients transition their services from children and youth services to adult services.
- The Department of Neighborhood and Community Services is completing a fiscal mapping of county children's services.

ATTACHMENTS:
Quarterly Report on Blueprint Strategies to the Community Policy and Management Team: 2/22/19

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

FAIRFAX-FALLS CHURCH CHILDREN'S BEHAVIORAL HEALTH
SYSTEM OF CARE BLUEPRINT FOR 2016-2019
Quarterly Report on Blueprint Strategies to the Community Policy and Management Team
February 22, 2019

Healthy Minds FAIRFAX
Supporting Emotional Wellness in Youth and Families

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. The fifth CPMT parent representative, Terry Williams, has been appointed.

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.

C. *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 had resource tables at the Northern Virginia Pediatric Conference on November 2-3, at the Northern Virginia Mental Health Foundation's Pathways to Wellness Conference on October 12 and at the first annual Fairfax County Health and Human Services Forum on November 16.

D. *Continue to develop partnerships with community organizations and agencies in different sectors for coordination, financing and support of the SOC approach.* Work on this strategy was scheduled to begin in January 2018, but a workgroup has not yet been assembled.

Financing Strategies:

E. *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 SCYPT fiscal mapping strategy for children's services. Regarding the action step on identifying alternative methods of budgeting the required local CSA match, it was decided to wait to see if the General Assembly takes action on the issue of rising CSA private special education expenditures. The General Assembly directed that a study be done on the feasibility of state rate setting for private special education services.

Service Quality and Access:

A. *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 second quarter, the calendar received 367 page visits, up from 20 in quarter 1 and the resources page received 350 page visits, up from 7 in quarter 1. A "Parent's Guide to Evidence-Based Treatments" training was held on November 14, 2018. Fourteen people participated in the training.

B.

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

FY 19	FY18	FY17
14	0	0

C. *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.* The annual CSA service gap survey has been revised locally and by the state.

D. *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.* HMF funding has been used to expand the regional mobile stabilization and response service by 17%

GOAL 2: Data Systems

Coordinator: Jim Gillespie

A. *Increase cross-system data sharing.* The HS IT Advisory Committee meets monthly and is consulted on various topics such as Document Management, the "Front Door," and the Services taxonomy to ensure that recommendations meet CSA needs. CSA has requested to meet with planning facilitators to review the unique needs of the CSA program as an existing cross-agency collaboration.

B. *Use cross-system data to improve decision-making and resource use.* To begin in CY 2019

GOAL 3: Family and Youth Involvement

Coordinator: Jim Gillespie

A. *Increase the presence and effectiveness of family leadership through a sustained family-run network.* A group of family-led nonprofit organizations that serve families, children and youth in northern Virginia began meeting in fall 2017 and continues to meet periodically in person and virtually. The group includes representatives from about eight organizations who gather to share information about their own programming, and exchange ideas for addressing regional challenges and for leveraging potential collaborations. The group has invited participation of Voices of Virginia's Children to share information on state and regional policy and legislative efforts and their impact on local families and children.

B. *Increase family and youth involvement in system planning and implementation.* In December 2017 CPMT approved revisions to local policies and procedures.

C. *Include youth and family participation in the evaluation of publicly and privately provided services, with prompt action for improvement when necessary.* Parents and youth helped develop new CSA provider evaluation surveys, but implementation has been delayed due to the transition to a new state data and financial reporting system (LEDRS).

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), Signs of Suicide, and Lifelines.

B. *Promote youth-led initiatives to combat stigma associated with mental illness, treatment, and accessing help.* Awareness initiatives to combat stigma and promote help-seeking also continue. The RFP for mini-grants for youth-led projects to address stigma, funded by the regional suicide prevention grant, was

released in January by the CSB; proposals are in the process of being evaluated. Eleven high schools are currently implementing Our Minds Matter clubs, developed by the Josh Anderson Foundation.

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.

Number of views of PSAs promoting help-seeking behaviors:

FY19 YTD	FY18	FY17
646	6,597,856	3,298,928

Number of crisis texts and calls:

FY19 YTD	FY18	FY17
874 text conversations/4086 calls	1815/5597	1087/4927

D. *Maintain a speaker's bureau and/or list of approved presenters to school and community groups.* To be completed in FY19.

GOAL 5: Youth and Parent/Family Peer Support

Coordinator: Jim Gillespie

A. *Create a Family Navigator program.* Through the Virginia Department of Behavioral and Developmental Services, the county has been selected as a sub-recipient for a federal SAMHSA grant that will fund family navigator/parent support partner services for the next three years. In October 2017 NAMI Northern Virginia was selected as the provider through September 2020. The goal is to serve approximately 100 youth and families annually. Halfway through the fiscal year 65% more families have been served than in all of FY18.

Number of families served by parent support partners:

FY19 year to date	FY18	FY17
91	55	32

B. *Expand evidence-based peer to peer groups, family/community networks.* In March HMF funding was approved for The Merrifield Crisis Response Center Peer Recovery Staff to implement a weekly Peer Group for teens who've been served by Emergency Services. The group began in May 2018 but has had difficulty attracting members. CSB developed a plan to re-start the group in February, to include a parent group.

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

FY19 year to date	FY18	FY17
0	2	0

GOAL 6: System Navigation

Coordinator: Peter Steinberg

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.
The focus continues to be on the development of the clearinghouse for children's behavioral health information below. Work has begun, however, in compiling the lists of training participants from the most recent offerings by the Fairfax Consortium for Evidence Based Practice.

Number of "hits" on new on-line navigation tool:

FY19 (YTD)	FY18	FY17
0 (begins in CY 19)	0	0

Percentage of users satisfied with on-line navigation tool:

FY19 (YTD)	FY18	FY17
Begins in CY 19	N/A	N/A

B. *Create a clearing house for information on children's behavioral health issues and resources.*
"Content gathering" is underway for the clearing house of children's behavioral health information to be added to our current Healthy Minds Fairfax website. In consultation with the CSB's web developer, Lara Larson, it appears possible for us to simply incorporate a design remodel within our existing web address and drop our new content there. This work of content development continues and will include review by members of the original work group and a "testing" process by consumers.

GOAL 7: Care Coordination and Integration
Coordinator: Jim Gillespie

A. *Provide behavioral health consultation to primary care providers and patients.*
The Virginia Department of Health has been awarded a federal grant to establish a statewide pediatric mental health access program, to include behavioral health consultation. Inova Kellar Center is a Northern Virginia partner.

B. *Promote resources to implement tiered levels of integration based on capacity and readiness.*
The county partnered with Inova to provide intensive behavioral health training to 65 pediatricians in October and December 2017. 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. The workgroup also developed a project to safely divert youth from hospitalization when appropriate through expansion of CR2 mobile crisis response services, which was approved for HMF funding in March.

Number of pediatric primary care psychiatric consults:

FY19 year to date	FY18	FY17
0	0	0

C. *Increase the appropriate implementation of behavioral health screenings and referrals in primary care settings.* The workgroup will be recommending screening tools for use in primary pediatric care, probably based on the recommendations of the REACH staff who presented the intensive behavioral health training for pediatricians.

GOAL 8: Equity/Disparities
Coordinator: Peter Steinberg

A. *Promote the adoption of culturally and Linguistically Appropriate Services (CLAS) Standards among BH providers.* The CPMT adopted the Culturally and Linguistically Appropriate Services (CLAS) Standards at its February 24, 2017 meeting. The Fairfax Consortium for Evidence Based Practice's training on LGBT

Best Practices and the ongoing work of the Underserved Populations workgroup discussed elsewhere is a reflection of these standards. There are no additional updates at this time.

B. *Increase access and availability to behavioral health services for underserved populations.* The Underserved Populations workgroup has completed its report and presented it to the CBHC Management Team on 7/30/18. With the support of the CBHC Management Team, the original work group is willing to continue its work to implement recommendations and explore the viability of recommendations that warrant more research. Funding from the CSB has made it possible to provide Youth Mental Health First Aid training to more Faith/Youth leaders in houses of worship where underserved youth live than originally anticipated. The Northern Virginia Family Service VPIP program expanded multicultural mental health services by one position to serve more Latino youth in our underserved communities; the expanded capacity is in the Herndon/Reston area.

C. *Require training in cultural competence and advancing equity in alignment with One Fairfax for County, FCPS, and County-contracted behavioral health service providers.* At the March 2018 CSA conference, 62 participants attended a workshop called "In Their Shoes", working from a strength based approach to cultural competency. Participants reported overwhelmingly that the presentation was helpful and content clear. The SOC Training Committee is currently reviewing a "one and done" training option vs. a longer training experience for staff and community partners. DFS staff shared their training approach for consideration and other trainers are being explored as well. It is anticipated that an early winter training will be offered to meet this need.

D. *Implement support structures for LGBTQ youth.* The Fairfax Training Consortium for Evidence Based Practice anticipates offering a second training focusing on the specific clinical skills therapists can use in their practice to help address the unique needs of this population this Fall. An additional research based educational approach called the Family Acceptance Project is also being reviewed for a possible training option through the Consortium.

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 will be 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 new 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 on implementing suicide postvention will be published on the redesigned website. An extension of the committee has begun meeting to discuss opportunities for coordinated community postvention outreach and services.

D. *Continue to make available and promote the suicide prevention hotline, including textline.* In FY2018, PRS CrisisLink answered 5,597 calls, a 14% increase over last year. Of these calls, 196 were from youth under 18, and 298 were from individuals 18 to 24; this represented a 42% increase in calls from these age groups. First and second quarter data indicate even higher call volume in FY19. The PRS CrisisText Connect program engaged in 1815 text conversations with 1582 unique individuals, a 41% increase over last year.

E. *Train behavioral health providers in evidence-based practices specific to the treatment of youth with suicidal ideation and behavior.* The Fairfax Training Consortium for Evidence Based Practice will offer a three-part training on Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or

Conduct Problems (MATCH-ADTC), beginning in February. To date this year, they have offered their Core Competencies training and a training on Trauma-Focused Cognitive Behavioral Therapy (TF-CBT).

Number of BH providers trained in evidence-based suicide prevention treatment:

FY19 year to date	FY18	FY17
70	178	0

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.* Content for this information is in development at present with a final review anticipated by October '18.

B. *Establish a set of core competencies based on service type for all public & contracted provider staff.* Sixty-eight therapists from Health and Human Services and private providers have been trained in the core competencies which include risk assessment and safety planning, Cognitive Behavioral Therapy, Dialectical Behavior Therapy, working with families and providing treatment to those who have experienced a trauma event.

C. *Train County, school staff and providers on EBPs, including how and when to use them. Include a review of practices that are harmful.* Part of the training in the core competencies includes how to provide them to their clients. Curriculum still needs to be developed or compiled from other sources in order to be ready to present to this audience. This work has been moved forward again to be addressed.

D. *Incentivize the use of EBPs among providers.*
The significant energy involved to launch the above-mentioned trainings and focus groups have delayed a full discussion of incentivizing the use of EBPS among providers. A preliminary discussion has begun with one initial idea of developing a provider directory which will include which trainings the provider attended. More ideas will be provided in the next quarter.

Number of BH providers trained in trauma evidence-based treatment:

FY19 year to date	FY18	FY17
113	0	0

Number of BH providers trained in evidence-based suicide prevention treatment:

FY19	FY18	FY17
70	178	0

GOAL 11: Trauma Informed Care

Coordinator: 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. In November 2018, 45 clinicians were trained in Trauma-Focused Cognitive Behavioral Therapy. The enrollment requirements for this training included a commitment from accepted clinicians to pursue certification. The Core Competency Training offered this year to approximately 70 clinicians treating adolescents will include a trauma specific session, which will be scheduled for spring of 2019. Also in 2019, approximately 50 clinicians working with children ages 7-12 will receive training in MATCH-ADTC- Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems. The offerings of the consortium should make a significant contribution to increasing the

clinical capacity of the local provider community to provide evidence-based trauma specific treatment, which has most certainly ben a gap up to this point in time.

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 4000 people with their 90-minute Trauma Awareness 101 Training, which is now available on-demand as a 30-minute webinar. The TICN continues to host full day sessions of their Trauma-Informed Supervisor Training, and have reached hundreds of supervisors from county human services agencies, schools, and non-profit partners. The TICN training subcommittee also developed a training on Secondary Traumatic Stress in the workforce (The Cost of Caring) that is now available regularly. Trainings and resources on developing trauma-informed spaces are also currently available.

The TICN worked to increase community awareness of trauma and its impact by developing and publishing a Trauma Awareness Fact Sheet that has been widely distributed, and supported mass printing of a trauma infographic poster from the National Council for Behavioral Health that was also widely distributed. The TICN now owns a copy of (and license to screen) the documentary *Resilience*, and the film is regularly loaned out for additional staff and community screenings, and has reached over 6,000 people to date. In addition, the TICN has developed a "Guide to Educating Children, Youth and Families about Trauma & Resilience" to prepare the human services workforce to provide psychoeducation to kids and families. The guide has already been widely distributed to a variety of audiences across the child and youth serving system.

C. *Inform the community at large on the prevalence and impacts of trauma.* The Trauma Informed Community Network continues to host and sponsor screenings of the documentary *Resilience*. Led by the TICN's representative from the Fairfax County Council of PTAs, the Network presented a new version of Trauma 101, specifically for parents, at the FCCPTA Family Engagement Conference in October; they have been invited to also present it at the Virginia statewide PTA conference in early 2019. Multiple members will be presenting at and attending the Virginia Summit on Childhood Trauma and Resilience.

D. *Develop shared screening and referral process for individuals impacted by trauma for school and human services agency staff using nationally recognized screening tool.* This is in development.

E. *Human service agency leaders will integrate the concepts of trauma-informed care into their organizational culture.* County Health and Human Services agencies are each implementing plans to ensure their organizations are trauma-informed. An update was provided in the May CPMT packet.

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.* This work group's report has been shared with the HMF Director with recommendations for a cross system screening process and anticipate its review by the CBHC Management Team and CPMT in Spring of 2019.

Number of BH screenings (semi-annual measure):

FY19 (YTD)	FY18	FY17
46	88	108

B. *Create capacity to address behavioral health needs of children 0-7.* The Office for Children has developed a 48-hr. Social-Emotional Competencies certificate program. With funding from HMF, they purchased materials and resources that supported the implementation of the first two

workshop series in this certificate program. OFC continues to seek funding to establish an early childhood mental health consultation system that will build the capacity of programs and strengthen the competencies of early childhood educators to promote children's successful social and emotional development.

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 Training Consortium for Evidence Based Practice presented its second training on Family Intervention for Suicide Prevention on June 4, 2018 with 66 mental health clinicians in attendance. The first Core Competency 3-day training for mental health clinicians will begin on August 31, 2018 into September. In November 2018, 45 therapists from Health and Human Services and private providers received training in TF-CBT. They are all, working towards their national certification in TF-CBT. Beginning in February 2019, 50 therapists will be receiving Match-ADTC training. MATCH-ADTC is a treatment model that focuses the most common behavioral conditions in children under 12. This treatment model focuses on treatment for depression, anxiety, post-traumatic stress, and conduct issues. It is also anticipated that a consultant will be hired with expertise in federal and state funding in dissemination and implementation of evidence-based practices for youth and families and grant proposals which will head us to potential grant/foundation applications for funding to address sustainability of the consortium.

D. It is also anticipated that a consultant will be hired with expertise in federal and state funding in dissemination and implementation of evidence-based practices for youth and families and grant proposals which will head us to potential grant/foundation applications for funding to address sustainability of the consortium.

E. *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.*
Despite not receiving additional funding for the Short Term Behavioral Health Service for Youth in the most recent budget, we will expand to 5 additional schools this year including Glasgow, Holmes and Poe Middle schools and, for the first time, serve two elementary schools, Annandale Terrace and Herndon. 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. School referrals totaled 173 this past school year, far surpassing last year's total of 75.

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

FY19 year to date	FY18	FY17
94	130	57

Give an Hour, the pro bono therapy initiative for children, youth and families in Fairfax County and their website went live on July 9, 2018. The focus of this initiative is on building up the pool of provider to help meet the needs of those being to referred to the program.

Number of youth served through pro-bono outpatient therapy services:

FY19 year to date	FY18	FY17
3	0	0

F. *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.

G. *Reduce youth substance abuse and use.* With the assistance of a HD epidemiologist and a review of data from youth survey, discipline, AOD intervention seminars for both high school and middle schools and a

ranking of the pyramids from greatest to least risk of expanding opioid concerns, along with a zip code review of where overdoses occurred, school pyramids were chosen. The FCPS school-based substance abuse intervention program was launched and is serving the following pyramids: South Lakes, Herndon, Langley, West Potomac, Robinson and Bryant/Mountain View high schools. This program will work collaboratively with CSB staff for initial trainings and throughout the year in other professional development activities.

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. TFCBT training was offered by the consortium, supplemented by CSA funding, for 44 clinicians in November, 2018.

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.* Functional Family Therapy is being considered for youth with chronic school absences related to behavioral concerns. Contracting issues are currently being addressed to support implementation of this intervention. A subgroup of the CSA Management Team is developing a proposal.

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.* DFS has provided foster parents with training in the Reflections curriculum, based on the ARC model (Attachment, Regulation and Competency) that the authors have adapted specifically for use with foster families. This curriculum has been well-received by foster families and DFS has plans to expand the training for other caregivers, including birth parents and kinship families. The contract for the ARC Reflections Train-the-trainer is pending. The CSA Management Team has also considered the need to adopt an evidence-based model for supervised visitation services.

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 Wrap Ffx are fully staff with ICC facilitators. UMFS has 4 with a supervisor who will carry cases part-time. Wrap FFX has 7 facilitators. The CSB Resource Team has filled 7 positions and their new staff are completing required training. They anticipate accepting new cases at the beginning of March.

E. *Improve the utilization of the annual gaps survey of youth and parents in CSA-SOC to identify needed interventions.* The state OCS survey has been utilized to evaluate needs; however, it may not be sufficiently sensitive to the level of work being conducted in the County at this time. Other community needs assessments should be evaluated to determine if gaps and needs are identified through other efforts such as the Under-Served Populations workgroup.

F. *Develop communication plan to share information about the services and care coordination offered through the SOC process with the broader provider community.* As part of the county's new website design, CSA and HMF have new pages on the county's public website. In addition, CSA has begun producing its monthly newsletter again that contains training announcements and other information pertinent for system partners.

G. *Build system capacity to monitor fidelity to EBT models and conduct outcome evaluation for purchased services.* At the December 2018 meeting, the Intensive Care Coordination (ICC) Stakeholders committee, which is comprised of staff from the CSA, ICC providers, NAMI, and referring agencies (DFS, JDRDC, FCPS), discussed the next round of the WFI-EZ survey that will take place in the third quarter of FY19.

There are a total of 70 eligible families that have participated in ICC, 30% of which will be randomly selected to receive the WFI-EZ. The annual file review, which uses the DART (Document Review Assessment Tool), will begin in March, 2019. Additionally, in order to help agency case managers fully understand the role of the ICC facilitator, an ICC/Wraparound training will be developed and offered. It is hoped that clarification of roles will improve the collaboration between all involved.

H. *Provide IT infrastructure to support data collection for fidelity monitoring and outcome evaluation along with electronic records management.* CSA is a participant on the Health and Human Services Integrative System Implementation Advisory workgroup which is overseeing a multi-year project that supports data analytics, electronic records management, and other functions utilized in CSA. CSA is working with DFS IT staff to discuss efficiency and streamlining through existing technology for incoming documentation and file maintenance. CSA is part of a pilot using NINTEX forms to replace the current encumbrance form and begin using an electronic workflow. Additional work is focused on reviewing options for portals for non-County entities including providers and schools as well as electronic workflows.

I. *Explore opportunities for expanding available financial resources to serve youth on diversion or probation who need intensive behavioral health services.* CSA staff have met with court staff to review the requirements for CSA-funded services and train staff to access these funds. Court staff have been active participants in recent CSA training and supervisory booster sessions. These discussions are ongoing.

J. *Increase family and provider membership on the CPMT.* Our CPMT parent representative positions and our vacancy on FAPT have now been filled.

GOAL 14: DD/Autism Services
Coordinator: Tracy Davis

Develop expanded continuum of care of services for youth with DD/autism. The interagency workgroup convened on 7/23/18, 8/27/18, & 11/1/18. The next meeting is scheduled for 12/13/18. The workgroup is working on refining the direction of the work on this goal. Two main deliverables have been identified:

Deliverable #1: Revised SOC Blueprint Goal 14, DD/Autism Services, with updated action steps and dates, to CBHC & CPMT
Deliverable #2: DD/Autism Services Case Management Proposal with a Statement of Need to CBHC & CPMT

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 that ends in 2019.

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 E, F & G 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. *Ensure that DD/Autism BH services are included in System Navigation.* Status: Strategy C may be combined with D in the revised version of this blueprint goal. Strategy C was identified as low priority area; the workgroup has determined that the timelines need to be adjusted.

D. *Develop outreach and social messaging campaign to promote earlier identification of youth with DD/Autism who would qualify for and benefit from referral to services.* Status: Strategy D may be combined with C in the revised version of this blueprint goal. Strategy D was identified as low priority area; the workgroup has determined that the dates will not be adjusted as they track to the completion of the current blueprint that ends in 2019.

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

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

G. *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 by obtaining project funding to take the CSA process that currently exists to accurately assess children for appropriate supports to prevent crisis. This funding will address the need/gap in services (insufficient case management staff, crisis services for younger children). The timelines will need to be adjusted.

H. *Strategy H - Develop community awareness campaign regarding special needs of youth with DD/Autism.* Status: This strategy was identified as low priority area; the workgroup has determined that the timelines will need to be adjusted. With regards to H.1., it was determined that no further action is required, however providing additional training could be addressed with the development of the subsequent blueprint following the completion of the current blueprint than ends in 2019.

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. The Transitional Age Youth workgroup has proposed a policy statement that in summary states that behavioral health providers who work with children and youth are committed to help their clients transition their services from children and youth services to adult services. The workgroup also developed a transitional assessment and action plan. Both will be presented to the CBHC in Winter 2019. The workgroup plans to survey transitional youth (ages 16-24) and parents of transitional youth to find out what their needs are and what services they that they need.