Memo to the CPMT
January 25, 2019

Administrative Item A-1: APPOINTMENT OF NEW FAMILY ASSESSMENT AND PLANNING TEAM (FAPT) MEMBER

ISSUE:
CPMT approval of the following person to serve on the FAPT:

FCPS

- Lisa Rueda

RECOMMENDATION:
Approval of the appointment of the nominee as a FAPT representative.

BACKGROUND:
Training for new FAPT members and substitutes was completed on September 26, 2018. Lisa Rueda has attended training and shadowed for approximately 2 months and is prepared to serve as an alternate for FCPS on the FAPT.

FISCAL IMPACT:
None.

STAFF:
Sarah Young, FAPT Coordinator

MEMO TO THE CPMT
January 25, 2019

Administrative Item A-2: Endorse Funding Proposals for FY 2019 Healthy Minds Fairfax Budget (Revised)

ISSUE:

A revised FY 2019 Healthy Minds Fairfax budget is presented for endorsement.

BACKGROUND

On May 28, 2018, the CPMT approved a budget of $721,565. At the mid-point of the fiscal year, we have determined that we will have a budget surplus of approximately $40,000. The surplus is due to projects scheduled to begin at the beginning of FY 2019 did not begin until later in the fiscal year. The Children's Behavioral Health Collaborative Management Team (CBHCMT) approved additional projects to support the continued implementation of the Blueprint strategies in FY 2019. The projects recommended by the CBHCMT are listed in priority order.

FY 2019 Projects Previously Endorsed by the CPMT	
1. Short Term Behavioral Health Services:	$85,000
2. Short Term Behavioral Heal Services Expansion	$49,000
3. Expanded Multicultural Mental Health Services (did not begin until January, 2019)	$98,000
4. Provider Database	$31,500
5. Recovery Youth Peer Support Group	$11,318
6. System of Care Training	$9,059
Total	$721,565

CBHCMT Recommended FY Projects Due to Budget Surplus	
1. Universal implementation of the Signs of Suicide (SOS) program at Fairfax County Schools	$12,000
2. Creation of regional teams within Fairfax County Schools to address school refusal	$20,000
3. Provision of behavioral health services to clients in a local pediatric primary care office by a George Mason University psychology resident	$10,000
4. Consultation from the Family Run Executive Director Leadership Association to family-led organizations	$4,900
Total	$47,400

ATTACHMENTS
FY 2019 Funding Proposals

STAFF
Jim Gillespie, HMF Director
Peter Steinberg, CBHC Program Director

Healthy Minds Fairfax Funding Proposal 1

Universal Suicide Prevention Programs for all middle and high schools in Fairfax County Public Schools

Fairfax County Public Schools (FCPS), Department of Intervention and Prevention Services is submitting a request for funding in the amount of $12,500 for the purchase of approximately 20 SOS Signs of Suicide Program for middle and high schools who currently do not have the program. This would allow FCPS to provide universal implementation of suicide prevention programming for youth in grades 6th through 12th grade.

SOS is a universal, evidence-based program depression awareness and suicide prevention program designed for middle-school (ages 11–13) or high-school (ages 13–17) students. The goals of the program include reducing suicide and suicide attempts in youth by increasing knowledge and encouraging help-seeking behaviors on behalf of oneself or others, reinforcing the importance of seeking treatment for depressive or suicidal thoughts and feelings, as well as reducing the stigma of mental illness. In addition, the program increases "gatekeeper" education, and encourages community-based partnerships between parents, schools and community agencies to support student mental health. These outcomes align directly with the Fairfax County Youth Suicide Review Team's 2016 Annual report which recommends promoting evidence-based risk assessments, educating parents and you on suicide warning signs, and expanding peer gate keeper trainings for teens.

Questions to be addressed:

- *A brief description of the project and how the project will project accomplish a Blueprint strategy or action step*?

  FCPS has 23 middle and 28 high schools in addition to secondary and nontraditional school programs that serve more than 100,000 students in grades 6th through 12th grade. Currently, SOS is implemented in the majority of high schools and most middle schools in select grades which are determined by data sources such as the Fairfax County Youth Survey, School Climate Surveys, and community specific knowledge of the needs of each school community. There are however a number of schools without an SOS program, schools with outdated versions of SOS programs, and schools who wish to expand utilization of the SOS programming but are unable to do so due to funding issues.

  Providing every middle and high school with the funding to purchase the Signs of Suicide Prevention Program (SOS) aligns directly with the Children's Behavioral Health System of Care Blueprint in the areas listed below.

  Goal 4: Increase Awareness & Reduce Stigma

  Action Step – Train schools and community-based organizations in the implementation of Signs of Suicide and Lifelines.

  Goal 9: Reducing Incidents of Youth Suicide in our Community

  Strategy E – Train behavioral health providers in evidence-based practices specific to the treatment of youth with suicidal ideation and behaviors.

  Goal 10: Increase the availability and capacity for evidence-based practices/interventions along the continuum of prevention through treatment

  Strategy C - Train County, school staff and providers on EBP's including how and when to use them.

- *Have other funding sources been explored?*

Schools fund the purchase of the SOS program. The upfront cost of $495 and $150 annual renewal fee is cost prohibitive for many of our middle and high schools.

- *What is the recent data indicating extent of need (if available) for the proposed project?*

  According to the most recent Fairfax County Youth Survey, 27.3% of youth in grades 8, 10 and 12 report having experienced depressive symptoms in the past year to include feeling so sad or depressed for two or more weeks in row that they stopped doing previously enjoyed activity. 14.5 percent of youth reported having considered suicide in the past year and 5.9 percent of our middle and highs school youth in Fairfax County reported actually attempting suicide.

- *What is the evidence that the proposed intervention will achieve the desired outcomes with the target population?*

  When implemented with fidelity, the SOS Signs of Suicide Prevention Program has a demonstrated effect of increasing student's knowledge and adaptive attitudes about suicide risk and depression, as well as a 40-60% reduction in self-reported suicide attempts in randomized control studies (Asletine et al., 2007 & Schilling et al., 2016).

- *How will the program be sustained after the funding?*

  Schools would provide the $150.00 annual renewal fee for the online version of SOS which is far less than the initial purchase fee of $495.00 and which would make it significantly more affordable for schools. PTA, student-led, or other forms of fundraising for the annual cost could be a proactive way for the school community to demonstrate their support of mental wellness in their school as well as destigmatizing mental health issues.

- *What are the outcome measures including how will the data be collected and reported back to the CBHC?*

  The Fairfax County Youth Survey can provide outcome measures both at the pyramid and district level annually, and over time, by looking at the percentage of students responding to questions on the survey who report that they have experienced symptoms of depression, suicidal ideation, or attempted suicide. Annual data can be reported back to the CBHC by sharing and comparing the annual survey of wellness screenings conducted in FCPS with the annual results of the Fairfax County Youth Survey.

Healthy Minds Fairfax Funding Proposal 2

Create Regional Teams in Fairfax County Public Schools to Address School Refusal Behaviors Using Evidence-Based Practices

Fairfax County Public Schools (FCPS) Department of Intervention and Prevention Services is submitting a request for funding in the amount of $20,000 for an 8-week training program provided by the Center for Anxiety & Behavioral Change. The training will be provided to school psychologists and school social workers who will become subject matter experts in the area of school refusal. These clinicians will be assigned to regions within FCPS and will be available to consult with region leadership and school staff on questions of chronic absenteeism and school refusal within.

The Center for Anxiety & Behavioral Change offers a School Refusal Training Institute as an 8-session, consultation series for mental health providers of youth who refuse school and, if funded, the Center will offer the course to our school-based clinicians at a reduced rate.

If funded, this project will support county-wide efforts to improve attendance and reduce dropout rates, resulting in improved graduation and completion rates and college, career, and civic readiness. The Virginia Department of Education has revised Standards of Accreditation to provide a more comprehensive view of school quality and expand accountability beyond pass rates on Standards of Learning and high school graduation and completion. Under the revised standards, chronic absenteeism is a factor in school accreditation, where chronic absenteeism incorporates all types of absences and is defined as missing more than 10% of the school year. For the 2017-2018 school year, Fairfax County Public Schools is identified in the Federal Accountability Detail Report as having 8.4% of students missing more than 10% of the school year. This translates to **14,957** students who were chronically absent last school year in FCPS.

Consistent school attendance and emotional wellbeing are critical to FCPS's Portrait of a Graduate vision. Short-term consequences for school refusal and poor attendance include poor academic performance, family difficulties, and problems with peer relationships. Long-term consequences in children with school refusal and poor attendance include higher high school dropout rates, adult psychiatric care, criminal offense, lower socioeconomic status, and damaged family relationships. Currently, FCPS is spending over $320,000 per year to educate students receiving psychiatric homebound. If funded, it is anticipated that this project will put appropriate supports in place so these vulnerable students are able to continue to attend school and be available for learning.

Questions to be addressed:

- *A brief description of the project and how the project will accomplish a Blueprint strategy or action step?*

The project aims to train FCPS school psychologists and school social workers on evidence-based practices and strategies to address the underlying emotional concerns and behaviors associated with school refusal, while deepening partnerships with private and community providers offering complementary services.

The proposed training program will be available to up to a total of 40 psychologists and social workers within FCPS who work with students demonstrating school refusal behaviors. The training will be presented by the Center for Anxiety & Behavioral Change, meeting for two hours per week over an eight-week timeframe, with follow-up consultation. Participants in the program will learn how to use Dialectical Behavioral Therapy, Cognitive Behavioral Therapy, and exposure therapy strategies to enhance students' ability to attend school and face circumstances and situations within the school building or school day that they may find anxiety provoking. Long-term outcomes will include improved mental wellness and school success.

This project will primarily work toward Blueprint Goals 10C and 12D by increasing the capacity of the clinical staff within the schools to provide necessary interventions to students at risk of school failure due to significant social/emotional concerns. With this training, school clinical staff will be able to better coordinate with private and community providers to support students.

Goal 10: Evidence-Based and -Informed Practices, *Increase the availability and capacity for evidence-based practices/interventions along the continuum of prevention through treatment*

> **Strategy C** -- Train County, school staff and providers on EBPs, including how and when to use them.

Goal 12: Behavioral Health Intervention, *Address the needs of children with emerging behavioral health issues who have not been able to access appropriate, timely, and matching treatment services in the community.*

> **Strategy 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.

- *Have other funding sources been explored?*

The FCPS Office of Intervention and Prevention services spent Medicaid funding to register one of our school psychologists to attend a School Refusal Training Institute offered through the Center for Anxiety & Behavioral Change. Led by Dr. Lindsay Scharfstein and overseen by Dr. Jonathan Dalton, this institute is leading an 8-session consultation series for mental health providers of youth who refuse school. The course delineates evidence-based cognitive-behavioral approaches to the assessment and treatment of school refusal. Techniques address underlying emotional concerns and simultaneous school re-entry. There is ample opportunity for case discussion and consultation. The sessions began in September and take place on a monthly basis through April.

This training, while applicable, is directed toward community practitioners rather than school-based clinicians. Additionally, this funding source is not sufficient to accommodate the volume of clinicians within FCPS.

- *What is the recent data indicating extent of need (if available) for the proposed project?*

Although there are many reasons for student absence, one of the most difficult reasons to address is the presence of an underlying mental health issue. For some of these students, deeper problems with anxiety can lead to school refusal behaviors as they avoid going to school on a regular basis or have problems staying in school. Research indicates that anxiety-based school refusal affects between 5 and 28% of children at some point during their education. Within FCPS, a subset of students with school refusal go on to require psychiatric homebound instruction, whether for more intensive treatments or due to an inability to attend school because of their acute psychiatric symptoms. Data from the FCPS Out of School Support Office indicate that school refusal was on an upward trend, rising from 169 students receiving psychiatric homebound instruction in 2013-2014 to 190 in 2014-2015. New procedures instituted in 2015 to explore a wide range of interventions have contributed to reducing these numbers to 104 students for 2017-2018. Even with more rigorous processes to assist students and families in addressing school refusal with mental health services and other interventions, psychiatric homebound instruction still accounted for 23% of all homebound instruction for FCPS in 2017-2018. Additionally, these students were out of school on homebound instruction for an average of 48 days. Data further illustrate that school refusal is more prevalent in secondary school, with over 88% of students receiving psychiatric homebound instruction in 2017-2018 between 7th and 12th grade.

- *What is the evidence that the proposed intervention will achieve the desired outcomes with the target population?*

The American Academy of Family Physicians proposes treatment of school refusal to include education and consultation, behavior strategies, and family interventions. The Academy supports child-focused behavioral interventions including systematic desensitization, relaxation training, emotive imagery, contingency management, social skills training, cognitive behavior therapy, dialectical behavior therapy, and other exposure-based interventions. Parent management training and school consultation are two other essential components in intervention. The training will teach clinicians the use of many of these recommended interventions for school refusal. With the proposed professional development and consultation with the Center for Anxiety & Behavioral Change, the goal is for school clinicians to be an effective part of a team working towards reducing chronic absenteeism attributed to anxiety through evidence-based practices and strategies.

Upon completion of the evidence-based training addressing school refusal, school psychologists and school social workers will apply their knowledge through skills and strategies to address school refusal and guide school teams on best practices to ensure positive outcomes for students. These evidence-based practices and interventions will lead to improved attendance rates and reduced referrals for psychiatric homebound instruction.

- *What are the outcome measures including how will the data be collected and reported back to the CBHC?*

To evaluate the effectiveness of the professional development in helping school clinicians effect change in students experiencing school refusal, outcome data will include the percent absent rate for these students after interventions in comparison to percent absent rate prior to interventions. For clinicians participating in the professional development, they will identify students with school refusal at their schools and collect the pre and post intervention percent absent rate. Additionally, data regarding the

number of students receiving psychiatric homebound instruction and the average number of days out of school will be compared year-to-year for 2018-2019 to 2019-2020.

Healthy Minds Fairfax Funding Proposal 3

Create Regional Teams in Fairfax County Public Schools to Address School Refusal Behaviors Using Evidence-Based Practices

Fairfax County Public Schools (FCPS) Department of Intervention and Prevention Services is submitting a request for funding in the amount of $20,000 for an 8-week training program provided by the Center for Anxiety & Behavioral Change. The training will be provided to school psychologists and school social workers who will become subject matter experts in the area of school refusal. These clinicians will be assigned to regions within FCPS and will be available to consult with region leadership and school staff on questions of chronic absenteeism and school refusal within.

The Center for Anxiety & Behavioral Change offers a School Refusal Training Institute as an 8-session, consultation series for mental health providers of youth who refuse school and, if funded, the Center will offer the course to our school-based clinicians at a reduced rate.

If funded, this project will support county-wide efforts to improve attendance and reduce dropout rates, resulting in improved graduation and completion rates and college, career, and civic readiness. The Virginia Department of Education has revised Standards of Accreditation to provide a more comprehensive view of school quality and expand accountability beyond pass rates on Standards of Learning and high school graduation and completion. Under the revised standards, chronic absenteeism is a factor in school accreditation, where chronic absenteeism incorporates all types of absences and is defined as missing more than 10% of the school year. For the 2017-2018 school year, Fairfax County Public Schools is identified in the Federal Accountability Detail Report as having 8.4% of students missing more than 10% of the school year. This translates to **14,957** students who were chronically absent last school year in FCPS.

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Questions to be addressed:

- *A brief description of the project and how the project will accomplish a Blueprint strategy or action step?*

The project aims to train FCPS school psychologists and school social workers on evidence-based practices and strategies to address the underlying emotional concerns and behaviors associated with school refusal, while deepening partnerships with private and community providers offering complementary services.

The proposed training program will be available to up to a total of 40 psychologists and social workers within FCPS who work with students demonstrating school refusal behaviors. The training will be presented by the Center for Anxiety & Behavioral Change, meeting for two hours per week over an eight-week timeframe, with follow-up consultation. Participants in the program will learn how to use Dialectical Behavioral Therapy, Cognitive Behavioral Therapy, and exposure therapy strategies to enhance students' ability to attend school and face circumstances and situations within the school building or school day that they may find anxiety provoking. Long-term outcomes will include improved mental wellness and school success.

This project will primarily work toward Blueprint Goals 10C and 12D by increasing the capacity of the clinical staff within the schools to provide necessary interventions to students at risk of school failure due to significant social/emotional concerns. With this training, school clinical staff will be able to better coordinate with private and community providers to support students.

Goal 10: Evidence-Based and -Informed Practices, *Increase the availability and capacity for evidence-based practices/interventions along the continuum of prevention through treatment*

> **Strategy C** -- Train County, school staff and providers on EBPs, including how and when to use them.

Goal 12: Behavioral Health Intervention, *Address the needs of children with emerging behavioral health issues who have not been able to access appropriate, timely, and matching treatment services in the community.*

> **Strategy 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.

- *Have other funding sources been explored?*

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This training, while applicable, is directed toward community practitioners rather than school-based clinicians. Additionally, this funding source is not sufficient to accommodate the volume of clinicians within FCPS.

- *What is the recent data indicating extent of need (if available) for the proposed project?*

Although there are many reasons for student absence, one of the most difficult reasons to address is the presence of an underlying mental health issue. For some of these students, deeper problems with anxiety can lead to school refusal behaviors as they avoid going to school on a regular basis or have problems staying in school. Research indicates that anxiety-based school refusal affects between 5 and 28% of children at some point during their education. Within FCPS, a subset of students with school refusal go on to require psychiatric homebound instruction, whether for more intensive treatments or due to an inability to attend school because of their acute psychiatric symptoms. Data from the FCPS Out of School Support Office indicate that school refusal was on an upward trend, rising from 169 students receiving psychiatric homebound instruction in 2013-2014 to 190 in 2014-2015. New procedures instituted in 2015 to explore a wide range of interventions have contributed to reducing these numbers to 104 students for 2017-2018. Even with more rigorous processes to assist students and families in addressing school refusal with mental health services and other interventions, psychiatric homebound instruction still accounted for 23% of all homebound instruction for FCPS in 2017-2018. Additionally, these students were out of school on homebound instruction for an average of 48 days. Data further illustrate that school refusal is more prevalent in secondary school, with over 88% of students receiving psychiatric homebound instruction in 2017-2018 between 7th and 12th grade.

- *What is the evidence that the proposed intervention will achieve the desired outcomes with the target population?*

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Upon completion of the evidence-based training addressing school refusal, school psychologists and school social workers will apply their knowledge through skills and strategies to address school refusal and guide school teams on best practices to ensure positive outcomes for students. These evidence-based practices and interventions will lead to improved attendance rates and reduced referrals for psychiatric homebound instruction.

- *What are the outcome measures including how will the data be collected and reported back to the CBHC?*

To evaluate the effectiveness of the professional development in helping school clinicians effect change in students experiencing school refusal, outcome data will include the percent absent rate for these students after interventions in comparison to percent absent rate prior to interventions. For clinicians participating in the professional development, they will identify students with school refusal at their schools and collect the pre and post intervention percent absent rate. Additionally, data regarding the

number of students receiving psychiatric homebound instruction and the average number of days out of school will be compared year-to-year for 2018-2019 to 2019-2020.

- **A brief description of the project and how the project will project accomplish a Blueprint strategy or action step?**

Project Name: George Mason University Center for Psychological Services Partnership with Local Pediatric Practices

The Blueprint Strategy that will be addressed:
Goal 7: Care Coordination and Integration – Improve care coordination and promote integration among schools, primary care providers and mental health providers, including the integration of primary and behavioral health care. Specifically, Strategy B: Promote resources to implement tiered levels of integration based on capacity and readiness to include information sharing, co-location, full integration, behavioral health homes and telemedicine.

Integration Plan - Strategies to Facilitate Integration of Behavioral Health Services in Primary Care Practices. Specifically, Strategy 9: Support Expansion of GMU's Center for Psychological Services Partnerships with Local Pediatric Practices Meet with GMU Center for Psychological Services to discuss their partnership with a local pediatric practice to assess opportunities for expansion.

Description of the project:
The purpose of the project is to provide co-located behavioral health services in a local pediatric primary care office in collaboration with the Mason Center for Psychological Services.

A Mason Psychology Resident would provide behavioral health services to clients of the local pediatric primary care office referred in house. The Resident would provide services 2 days per week, 5 hours/day, specific times TBD. A new patient would need a one-hour time slot, a follow up patient would need 40 minutes if uncomplicated anxiety, depression or ADHD. If the client is more complicated, an hour appointment would be set aside.

A Mason licensed clinical supervisor will be available 2.5 hours/week to provide supervision for all clinical cases at the Mason Center for Psychological Services. Supervisor will also be required to co-sign notes and have access to notes remotely. Supervisor will be available during the times the doctoral student is seeing clients, by phone, if needed for any emergencies.

Resident will meet with clinical supervisor at GMU Center for Psychological Services to ensure all clinical supervision needs are met for 2 hours/week; ½ hour week is set for notes, consultation, other administrative duties or extra supervision, as needed.

- **Have other funding sources been explored?**

The total project cost for one year is $26,398 and that amount is broken down as follows:

Mason Center for Psychological Services Office Supervisor $1,492
Mason Psychology Resident for 10 hours/week (12-month assistantship) $17,474
2.5 hours/week of licensed supervision (off site) x 48 weeks = $6432
General supplies $1,000

Other funding sources will be explored to share the cost of the project:

George Mason University: $1,492 (confirmed)
Healthy Minds Fairfax funding: $10,000 (unconfirmed)
Local Pediatric Primary Care Practice (TBD) funding: $14,906(unconfirmed)

Other sources of funding have not been explored to date as GMU is slowly building this collaboration and the first pediatric practice was able to fund the initial project. There is discussion regarding applying for grants as they continue to grow this program.

- **What is the recent data indicating extent of need (if available) for the proposed project?**

Please refer to the Needs Statement from the Behavioral Health Integration plan that was endorsed by the CPMT on June 22, 2018 which is attached.

- **What is the evidence that the proposed intervention will achieve the desired outcomes with the target population?**

One of the biggest issues when mental health referrals are made is that patients do not follow through. However, by co-locating the mental health care, there is a reduction in stigma, and an immediate increase in ease of access to services. Co-located care also enhances medical care in that pediatricians are able to directly consult with behavioral health providers regarding their patients, as well as coordinate care as needed. In the first pilot program of co-located behavioral health care employed with the proposed model with The Pediatric Group, Mason's advanced doctoral student had 154 behavioral health visits at the Chantilly office and 131 behavioral health visits at the Patriot Square office in the first 11 months of the program. This was set up such that one afternoon per week was in each office (for a total of 10 hours/week). On average, 8 patients were seen per week (taking into account some weeks off). Of note, there were very few no-shows across this time period, which is atypical for a behavioral health practice.

Anecdotally, families were extremely pleased with the ease of appointments, location of appointments and behavioral health coordination with their primary care physicians. Pediatricians reported feeling more comfortable prescribing medication for depression, anxiety and ADHD, and felt more supported when a mental health issue came up. Initial concerns about filling the behavioral health students time were unfounded. Data is still being collected on number of patients who completed 8 sessions successfully without needing further treatment.

Lastly, as we enter the 2nd year of this pilot program, The Pediatric Group has doubled the hours of the doctoral student for a total of 20/hours of week due to the success of the first year of services. This was related to the satisfaction of the patients seen, the increased coordination between primary care and behavioral health (which physicians felt was a huge support) and the clear need for more patients to be seen each week.

- **How will the program be sustained after the funding?**

As a condition for participation, the local pediatric primary care group that participates in this project for year 1 will be asked to sustain the project with their full financial support for year 2. We have every indication that the practice will be willing and able to do so if the initial year is successful.

In the pilot program, families are charged on a sliding scale basis, similar to the scale set at the GMU Center for Psychological Services ($75/session). This has the advantage of covering the cost of the services. However, the lowest income clients are not able to pay out of pocket, and as we work with physician practices to hire their own psychologist, they will be able to bill Medicaid and other insurances. To bill insurance, it is a Medicaid requirement that the supervisor be on site while all services are being provided. Off-site supervision is acceptable for sliding scale payment. However, by increasing behavioral health services "in house" practices will save on the cost of the GMU supervisor, while expanding the ability to serve more patients across all socioeconomic levels.

- **What are the outcome measures including how will the data be collected and reported back to the CBHC?**

Currently, data is being collected on all patients at baseline. We have baseline data on depression and anxiety, and are working to implement outcome data at the 5th and last visits. We are also implementing a client satisfaction measure, as well as tracking number of patient visits per patient, and overall at each practice. If this is funded, we will ensure that depression measures are tracked at both intake and end of treatment. Last, we will track cancellations and no-shows to compare against data at a community mental health center (GMU Center for Psychological Services).

Healthy Minds Fairfax Funding Proposal 4

Create Regional Teams in Fairfax County Public Schools to Address School Refusal Behaviors Using Evidence-Based Practices

Fairfax County Public Schools (FCPS) Department of Intervention and Prevention Services is submitting a request for funding in the amount of $20,000 for an 8-week training program provided by the Center for Anxiety & Behavioral Change. The training will be provided to school psychologists and school social workers who will become subject matter experts in the area of school refusal. These clinicians will be assigned to regions within FCPS and will be available to consult with region leadership and school staff on questions of chronic absenteeism and school refusal within.

The Center for Anxiety & Behavioral Change offers a School Refusal Training Institute as an 8-session, consultation series for mental health providers of youth who refuse school and, if funded, the Center will offer the course to our school-based clinicians at a reduced rate.

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Goal 10: Evidence-Based and -Informed Practices, *Increase the availability and capacity for evidence-based practices/interventions along the continuum of prevention through treatment*

> **Strategy C** -- Train County, school staff and providers on EBPs, including how and when to use them.

Goal 12: Behavioral Health Intervention, *Address the needs of children with emerging behavioral health issues who have not been able to access appropriate, timely, and matching treatment services in the community.*

> **Strategy 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.

- *Have other funding sources been explored?*

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This training, while applicable, is directed toward community practitioners rather than school-based clinicians. Additionally, this funding source is not sufficient to accommodate the volume of clinicians within FCPS.

- *What is the recent data indicating extent of need (if available) for the proposed project?*

Although there are many reasons for student absence, one of the most difficult reasons to address is the presence of an underlying mental health issue. For some of these students, deeper problems with anxiety can lead to school refusal behaviors as they avoid going to school on a regular basis or have problems staying in school. Research indicates that anxiety-based school refusal affects between 5 and 28% of children at some point during their education. Within FCPS, a subset of students with school refusal go on to require psychiatric homebound instruction, whether for more intensive treatments or due to an inability to attend school because of their acute psychiatric symptoms. Data from the FCPS Out of School Support Office indicate that school refusal was on an upward trend, rising from 169 students receiving psychiatric homebound instruction in 2013-2014 to 190 in 2014-2015. New procedures instituted in 2015 to explore a wide range of interventions have contributed to reducing these numbers to 104 students for 2017-2018. Even with more rigorous processes to assist students and families in addressing school refusal with mental health services and other interventions, psychiatric homebound instruction still accounted for 23% of all homebound instruction for FCPS in 2017-2018. Additionally, these students were out of school on homebound instruction for an average of 48 days. Data further illustrate that school refusal is more prevalent in secondary school, with over 88% of students receiving psychiatric homebound instruction in 2017-2018 between 7th and 12th grade.

- *What is the evidence that the proposed intervention will achieve the desired outcomes with the target population?*

The American Academy of Family Physicians proposes treatment of school refusal to include education and consultation, behavior strategies, and family interventions. The Academy supports child-focused behavioral interventions including systematic desensitization, relaxation training, emotive imagery, contingency management, social skills training, cognitive behavior therapy, dialectical behavior therapy, and other exposure-based interventions. Parent management training and school consultation are two other essential components in intervention. The training will teach clinicians the use of many of these recommended interventions for school refusal. With the proposed professional development and consultation with the Center for Anxiety & Behavioral Change, the goal is for school clinicians to be an effective part of a team working towards reducing chronic absenteeism attributed to anxiety through evidence-based practices and strategies.

Upon completion of the evidence-based training addressing school refusal, school psychologists and school social workers will apply their knowledge through skills and strategies to address school refusal and guide school teams on best practices to ensure positive outcomes for students. These evidence-based practices and interventions will lead to improved attendance rates and reduced referrals for psychiatric homebound instruction.

- *What are the outcome measures including how will the data be collected and reported back to the CBHC?*

To evaluate the effectiveness of the professional development in helping school clinicians effect change in students experiencing school refusal, outcome data will include the percent absent rate for these students after interventions in comparison to percent absent rate prior to interventions. For clinicians participating in the professional development, they will identify students with school refusal at their schools and collect the pre and post intervention percent absent rate. Additionally, data regarding the

number of students receiving psychiatric homebound instruction and the average number of days out of school will be compared year-to-year for 2018-2019 to 2019-2020.

- **A brief description of the project and how the project will project accomplish a Blueprint strategy or action step?**

Project Name: George Mason University Center for Psychological Services Partnership with Local Pediatric Practices

The Blueprint Strategy that will be addressed:
Goal 7: Care Coordination and Integration – Improve care coordination and promote integration among schools, primary care providers and mental health providers, including the integration of primary and behavioral health care. Specifically, Strategy B: Promote resources to implement tiered levels of integration based on capacity and readiness to include information sharing, co-location, full integration, behavioral health homes and telemedicine.

Integration Plan - Strategies to Facilitate Integration of Behavioral Health Services in Primary Care Practices. Specifically, Strategy 9: Support Expansion of GMU's Center for Psychological Services Partnerships with Local Pediatric Practices Meet with GMU Center for Psychological Services to discuss their partnership with a local pediatric practice to assess opportunities for expansion.

Description of the project:
The purpose of the project is to provide co-located behavioral health services in a local pediatric primary care office in collaboration with the Mason Center for Psychological Services.

A Mason Psychology Resident would provide behavioral health services to clients of the local pediatric primary care office referred in house. The Resident would provide services 2 days per week, 5 hours/day, specific times TBD. A new patient would need a one-hour time slot, a follow up patient would need 40 minutes if uncomplicated anxiety, depression or ADHD. If the client is more complicated, an hour appointment would be set aside.

A Mason licensed clinical supervisor will be available 2.5 hours/week to provide supervision for all clinical cases at the Mason Center for Psychological Services. Supervisor will also be required to co-sign notes and have access to notes remotely. Supervisor will be available during the times the doctoral student is seeing clients, by phone, if needed for any emergencies.

Resident will meet with clinical supervisor at GMU Center for Psychological Services to ensure all clinical supervision needs are met for 2 hours/week; ½ hour week is set for notes, consultation, other administrative duties or extra supervision, as needed.

- **Have other funding sources been explored?**

The total project cost for one year is $26,398 and that amount is broken down as follows:

Mason Center for Psychological Services Office Supervisor $1,492
Mason Psychology Resident for 10 hours/week (12-month assistantship) $17,474
2.5 hours/week of licensed supervision (off site) x 48 weeks = $6432
General supplies $1,000

Other funding sources will be explored to share the cost of the project:

George Mason University: $1,492 (confirmed)
Healthy Minds Fairfax funding: $10,000 (unconfirmed)
Local Pediatric Primary Care Practice (TBD) funding: $14,906(unconfirmed)

Other sources of funding have not been explored to date as GMU is slowly building this collaboration and the first pediatric practice was able to fund the initial project. There is discussion regarding applying for grants as they continue to grow this program.

- **What is the recent data indicating extent of need (if available) for the proposed project?**

Please refer to the Needs Statement from the Behavioral Health Integration plan that was endorsed by the CPMT on June 22, 2018 which is attached.

- **What is the evidence that the proposed intervention will achieve the desired outcomes with the target population?**

One of the biggest issues when mental health referrals are made is that patients do not follow through. However, by co-locating the mental health care, there is a reduction in stigma, and an immediate increase in ease of access to services. Co-located care also enhances medical care in that pediatricians are able to directly consult with behavioral health providers regarding their patients, as well as coordinate care as needed. In the first pilot program of co-located behavioral health care employed with the proposed model with The Pediatric Group, Mason's advanced doctoral student had 154 behavioral health visits at the Chantilly office and 131 behavioral health visits at the Patriot Square office in the first 11 months of the program. This was set up such that one afternoon per week was in each office (for a total of 10 hours/week). On average, 8 patients were seen per week (taking into account some weeks off). Of note, there were very few no-shows across this time period, which is atypical for a behavioral health practice.

Anecdotally, families were extremely pleased with the ease of appointments, location of appointments and behavioral health coordination with their primary care physicians. Pediatricians reported feeling more comfortable prescribing medication for depression, anxiety and ADHD, and felt more supported when a mental health issue came up. Initial concerns about filling the behavioral health students time were unfounded. Data is still being collected on number of patients who completed 8 sessions successfully without needing further treatment.

Lastly, as we enter the 2nd year of this pilot program, The Pediatric Group has doubled the hours of the doctoral student for a total of 20/hours of week due to the success of the first year of services. This was related to the satisfaction of the patients seen, the increased coordination between primary care and behavioral health (which physicians felt was a huge support) and the clear need for more patients to be seen each week.

- **How will the program be sustained after the funding?**

As a condition for participation, the local pediatric primary care group that participates in this project for year 1 will be asked to sustain the project with their full financial support for year 2. We have every indication that the practice will be willing and able to do so if the initial year is successful.

In the pilot program, families are charged on a sliding scale basis, similar to the scale set at the GMU Center for Psychological Services ($75/session). This has the advantage of covering the cost of the services. However, the lowest income clients are not able to pay out of pocket, and as we work with physician practices to hire their own psychologist, they will be able to bill Medicaid and other insurances. To bill insurance, it is a Medicaid requirement that the supervisor be on site while all services are being provided. Off-site supervision is acceptable for sliding scale payment. However, by increasing behavioral health services "in house" practices will save on the cost of the GMU supervisor, while expanding the ability to serve more patients across all socioeconomic levels.

- **What are the outcome measures including how will the data be collected and reported back to the CBHC?**

Currently, data is being collected on all patients at baseline. We have baseline data on depression and anxiety, and are working to implement outcome data at the 5th and last visits. We are also implementing a client satisfaction measure, as well as tracking number of patient visits per patient, and overall at each practice. If this is funded, we will ensure that depression measures are tracked at both intake and end of treatment. Last, we will track cancellations and no-shows to compare against data at a community mental health center (GMU Center for Psychological Services).

Proposal to Children Behavioral Health Collaborative (CBHC)/ Healthy Minds Fairfax: Family Leadership Development

- A brief description of the project and how the project will project accomplish a Blueprint strategy or action step?

This proposal addresses Fairfax-Falls Church Children's Behavioral Health System of Care blueprint (2016-2019) *Goal 3: Family and Youth Involvement; Objective A. Increase the presence and effectiveness of family leadership through a sustained family-run network*. The working group proposes to use CBHC-endorsed funds to guide further development of a family-led organization network through immediate consultation with national experts. Building on an informal network of family-led nonprofit organizations that has met seven times since November 2017, the consultation will offer much-needed guidance and experience in creating and sustaining family leadership to the Fairfax-Falls Church community. Specifically, we propose consulting with FREDLA, the Family Run Executive Director Leadership Association, a partner to SAMHSA's National Technical Assistance Network for Children's Behavioral Health (TA Network). FREDLA has deep experience offering professional development on family partnerships within state and local systems of care. The requested $4900 will provide for implementation of a resource mapping/needs assessment among the regional nonprofits, at least two on-site meetings of family-run

organizations, and development of a set of recommendations and action steps for the northern Virginia network.

- Have other funding sources been explored?

The informal network of family-led organizations has met seven times (five face-to-face and two by conference call) since November 2017, using resources of our own organizations to host meetings. Kelly Henderson of Formed Families Forward and Jeanne Comeau of NAMI Northern Virginia have organized and led the meetings to date, with regular participation of Mary Beth Testa, consultant to Voices for Virginia's Children. Regularly participating nonprofit organizations represent a range of children, youth, and family stakeholders, and each addresses underserved disability and special needs populations. Family-led organizations include CHADD of Northern Virginia and DC; Parents of Autistic Children; the Parent Educational Advocacy and Training Center (PEATC); The Arc of Northern Virginia; NewFound Families of Virginia; The Autism Society of Northern Virginia; The ConnerStrong Foundation; the Eric Monday Foundation; the Josh Anderson Foundation; NAMI Northern Virginia; and Formed Families Forward.

- What is the recent data indicating extent of need (if available) for the proposed project?

Meaningful engagement of families is critical to delivery of appropriate mental health, medical, education, transition and other services for those individuals and families impacted by special needs. Family engagement is strongly associated with improved child and family outcomes across child-serving systems (e.g., Garbacz, 2018; Kilmer, Cook, & Munsell, 2010: LaRocque, Kleiman, & Darling, 2011). Family engagement is a foundational principle on which Systems of Care are built (Stroul, Pires, et al., 2015). While Healthy Minds Fairfax has made strides in some areas of family engagement, namely launching and implementation of Family Support Partners and increasing the number of family members on the CSA Community Management & Policy Team (CPMT), our community would be strengthened by active, coordinated participation of family-led nonprofit organizations who can bring a strong, unified family voice to our System of Care.

- What is the evidence that the proposed intervention will achieve the desired outcomes with the target population?

To date, several family-run organizations have collaborated to bring "one-stop" information and resources to families with mental health needs. For example, CHADD, PEATC, NAMI Northern Virginia and Formed Families Forward presented joint sessions to families and professionals at mental health and wellness conferences hosted by Fairfax County Public Schools and

Loudoun County Public Schools as well as the annual FCPS Special Education Conference. In addition, information-sharing with several family foundations focused on suicide prevention have offered greater connections to services and supports for families who may already be affiliated with other organizations.

- How will the program be sustained after the funding?

We believe professional consultation from FREDLA is critical to taking our informal network to the next level, formalizing our shared vision of strong family voice in our region. The consultation will help us explore and affirm the best organizational format to operationalize the shared vision. The resulting recommendations and action steps will identify a sustainable operational framework to guide our organizations' respective contributions of time, talent, and other resources. We envision the resulting formal family network as being a "go to" resource for agencies, policymakers, and other organizations seeking guidance on and representation from family members of children, youth and young adults impacted by mental health and other special needs.

- What are the outcome measures including how will the data be collected and reported back?

Again, the consultation will assist us in quantifying the metrics that will guide our collaboration among family-run organizations. Among the anticipated measures are: coordinated presentations at regional conferences attended by families; regular and meaningful participation by family members in decision-making committees, workgroups, and other advisory bodies; youth and family participation in the evaluation of services provided by the Community Services Board and other county departments; and development and dissemination of practical strategies for true engagement of family members and youth participants in agency activities.

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