

Fairfax-Falls Church
System of Care

Principles,
Program and
Practice
Standards

April, 2017

Fairfax-Falls Church SYSTEM OF CARE (SOC)

VISION, MISSION & PRINCIPLES

Vision

Provide a spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, so that all children and youth in the Fairfax-Falls Church community are socially, emotionally, mentally and behaviorally healthy and resilient.

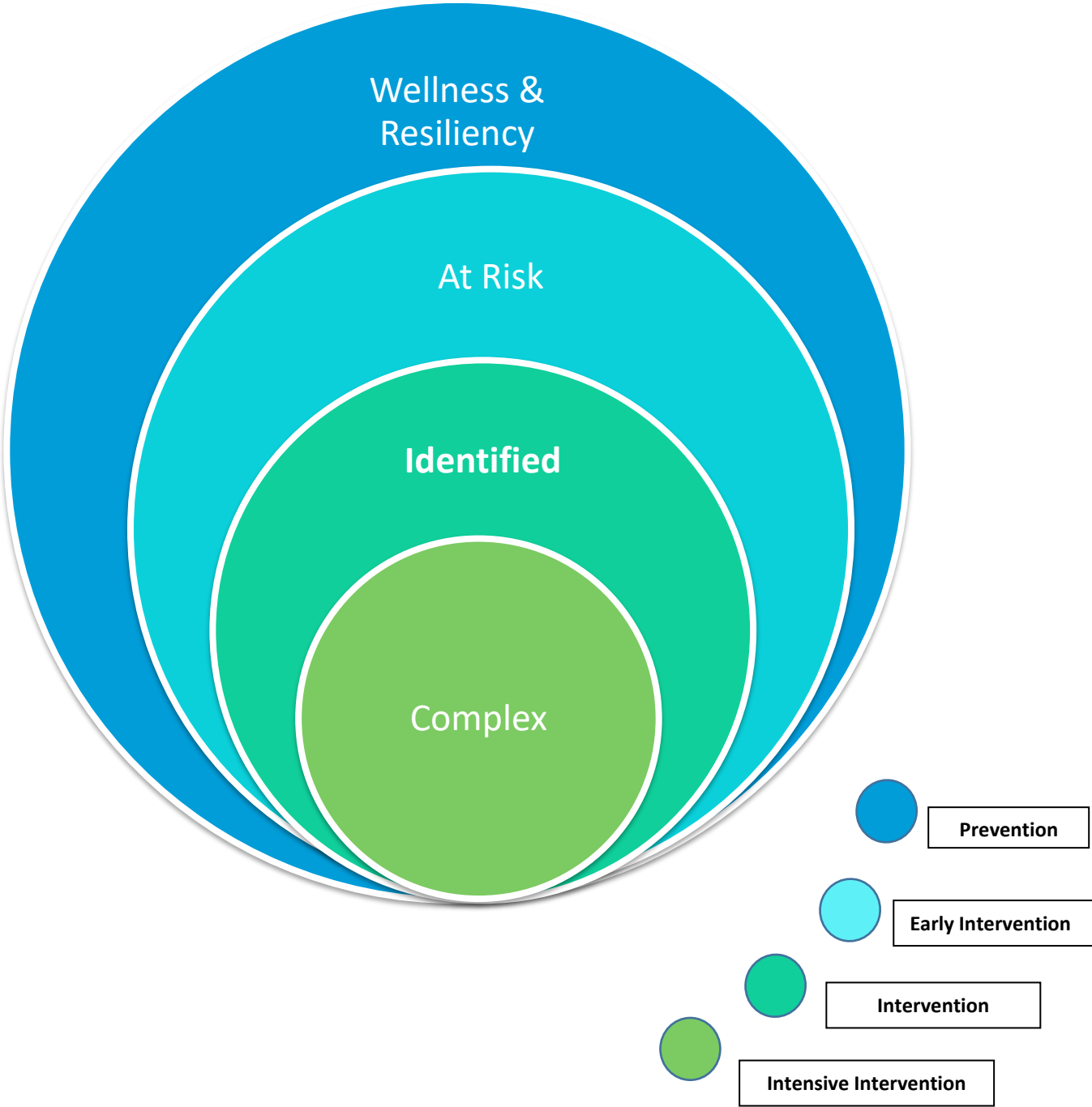
Mission

We, the Fairfax-Falls Church community, collectively ensure all children, youth and their families have equitable and easy access to a continuum of quality, integrated and/or coordinated services, supports, and opportunities to promote resiliency and further their social, emotional, mental and behavioral health.

SYSTEM OF CARE PRINCIPLES

1. Our System of Care supports families so they can provide care and safety for their children, youth and young adults in an environment in which they can grow and succeed.
2. Our System of Care strives to effectively serve all children, youth and young adults in our community.
3. Our System of Care strives to provide services for our children, youth, young adults and families that are racially, culturally and linguistically responsive.
4. Our System of Care strives for racial and social equity in the access and provision of services to our children, youth, young adults and families.
5. Our System of Care is youth-guided and family-driven to promote the well-being of the children, youth and young adults in our community.
6. Public agency staff, service providers and the family support network partner with the family to make optimum use of resources in order to meet the needs of our children, youth, and young adults.
7. Flexible and individualized services are offered and provided based on the identified strengths and needs of the children, youth, young adults and families.
8. With an integrated System of Care, children, youth, young adults and families are served and assisted through a comprehensive array of community based services and supports.
9. Working collaboratively, public agency staff, service providers and families are accountable for achieving measurable outcomes, addressing children/youth/young adults, family and community safety and the efficient use of resources.

Children's Behavioral Health Wellness Continuum



System of Care Program and Practice Standards

Background

In October 2011, the Fairfax-Falls Church Community Policy and Management Team (CPMT) approved practice standards based on CPMT and system of care principles, for serving children and youth with significant behavioral and/or emotional issues or developmental disabilities with a significant behavioral component. In January 2017, an inter-agency workgroup including family run organization representatives convened to review, revise and consolidate the original document. This revision incorporated the concepts of a continuum of services from prevention, early intervention, intervention, and intensive intervention and equitable access into this document.

What are Practice Standards?

Practice standards are guidelines used to determine what a human services professional involved with a youth with behavioral or emotional issues should or should not do. Standards may be defined as a benchmark of achievement which is based on a desired level of excellence. They are based on our values and principles, and articulate our common agreement on how youth and families should be served.

Scope of the Standards

The Standards are consistent with the philosophy and practices of family partnership meetings, intensive care coordination and the service continuum of prevention, early intervention, intervention and intensive intervention services. The practice standards will be implemented within the current funding and resource capacity. The CPMT is committed to continue to secure the resources necessary to fully implement the standards.

Use of the Standards

Inter-agency: The Standards directly inform the policies, procedures and practices of existing processes, such as CSA, for coordinating services for children, youth, young adults and families across agencies. They form the basis of an inter-agency training plan for staff serving youth with emotional and behavioral issues. They provide a framework for the implementation of evidence-based treatments.

Intra-agency: Public and private youth-serving agencies are asked to integrate the Standards into their policies, procedures and practices for serving youth and families with behavioral and/or emotional issues, including staff training and supervision. The Standards should be considered in the design and operation of agency programs.

Public-private: The Standards are incorporated into contracts with private and public providers, and disseminated to private youth and family-serving agencies and organizations.

Families: The Standards are disseminated to family advocacy and support organizations, and to families participating in public services, either “as is” or in a more family-friendly format.

System of Care Program and Practice Standards

Participation in Service Planning: Our system supports families to fulfill their primary responsibility for the safety, the physical and emotional health, the financial and educational well-being of their children. Voices of youth and parents are heard, valued, and considered in the decision-making regarding safety, permanency, and well-being as well as in service and educational planning and in placement decisions.

1. Youth and families are supported to fully participate in meetings and/or activities related to planning for services and meeting their identified needs. Case managers will encourage and support youth and family participation in all service planning activities, taking into consideration abilities and any (documented) clinical and/or safety concerns.
2. Family members, youth, and other supportive adults are prepared for participation in the meetings, including an orientation to all programs, processes, policies and practice standards.
3. Youth and families, public agency representatives and private providers meet and consult regularly to share and exchange information about the full range of services and supports that are least restrictive for that individual. Additionally, they will identify and address barriers while striving to safely maintain the youth with their family in the community.
4. Meetings take place at times and locations convenient for youth and families in order to encourage participation.

Service Integration and Care Coordination: Our system embraces the concepts of shared resources, decision making and responsibility for outcomes. All stakeholders work collaboratively with each other and the family to gain maximum benefits from available resources. Youth with emotional, behavioral, intellectual or developmental challenges receive integrated services and care coordination in a seamless manner.

Team-based planning processes encompass a variety of structures and models. A group of people, chosen by the family and connected to them through natural, community, and formal support relationships work together to develop and implement the family's plan; address unmet needs; and work toward the family's vision. Best practice models for team-based planning include family partnership meetings and high fidelity wraparound youth and family teams.

Care Coordination is a process-oriented activity that ensures ongoing communication and collaboration with youth and families with multiple needs. The activity can include: facilitating communication between the family, natural supports, community resources, and involved child-serving providers and agencies; organizing, facilitating and participating in team meetings at which strengths and needs are identified and safety planning occurs. The activity provides for continuity of care by creating linkages to and managing transitions between levels of care and transitions for older youth to the adult service system.

Because the care coordination function targets multi-system involved youth and families, it is most effective when performed by someone without formal responsibility for system mandates in child welfare, education or juvenile justice. For youth with complex mental health issues, care coordination

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would be provided by a case manager with mental health expertise. Public agency staff, most typically the designated CSA case manager, take on care coordination responsibilities. Other team members, including the family, may assume care coordination when deemed appropriate by the team.

5. Care coordination and a team-based planning process will be offered to all youth with significant behavioral or emotional challenges and who require services/resources that necessitate collaboration among multiple agencies/systems and/or coordinated interventions by multiple agencies and programs. The intensity of care coordination will be based on:
 - Youth's behavioral/emotional needs
 - Youth's risk behaviors
 - Caregiver and family strengths and supports
 - Cultural considerations
 - Community supports
6. Care coordinators, in consultation with other public agency case manager(s), will assist the family in selecting team members, and facilitate the team coming together. They also work with the youth, family and other members of the team to implement the service plan, through a team-based planning process and communication with individual team members, including home visits, and provider site visits as needed.
7. When a team-based planning process is initiated, all team members will actively participate. When possible, the team of public agency representatives should be composed of individuals with prior relationships with the family.

Active participation means:

 - Identifying and accessing appropriate resources to meet youth and family needs
 - Problem solving
 - Participating and supporting team decision making
 - Openly discussing how to resolve disagreements
 - Deciding on staff transitions and service terminations based on the consensus of the team, not unilaterally
 - Accepting and completing team roles and assignments
 - Engaging, motivating, and encouraging families to understand their critical role in achieving desired outcomes.
8. Team-based planning processes include the youth and family, extended family, representatives of youth-serving agencies that provide services to the youth and family, and others who are important in the family's life or know and can access potential resources.
9. The team-based planning process necessitates that differences of opinion and concerns are raised in the team meetings and are resolved by the team. Unilateral service planning decisions are inconsistent with the practice standards.

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Service Planning and Delivery Process: Service planning is highly individualized to reflect the strengths, needs, and preferences of the family. Such plans address the most critical needs across all life domains, and are more effective than system-specific plans.

10. Service planning and coordination activities include:
 - a. Developing an individual care plan to include discharge/transition planning
 - b. Incorporating the youth and family's unique strengths and needs, including LGBT+ youth in our community
 - c. Natural supports and sustainable community-based services when present
 - d. Written objectives with methods for meeting them through formal services and informal supports, and building on family strengths & cultural supports
 - e. Timely access to realistic, practical services
 - f. Use of strength-based, trauma informed principles matched to the youth and family's needs
 - g. Evidence-based/informed approaches when indicated
 - h. Assessing for triggers and the function of at-risk behaviors and identification of triggers in order to develop a relevant crisis plan to prevent, address and effectively respond to them.

11. When the first choice of community resources is not available, identify "next best" alternatives. Where barriers are identified and documented, report these to agency and interagency leadership to address and resolve (e.g., waiting lists, lack of right resource.)

12. Services offered which will prepare the youth and family for a successful transition home will identify:
 - Needs that prevent the youth from being at home, and be included in treatment plans
 - Needs of caregivers and family members that have an impact on readiness for the youth to return home, with a statement of how they will be addressed
 - The minimum time period necessary to address the needs which required family separation
 - Services offered by the out-of-home placement which will stabilize and/or prepare the youth and family for the youth's transition home
 - Any other needs or issues related to discharge planning/returning the youth to their family.

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Community-Based Care and Placement Decisions: Public agency representatives and private providers engage families with the goal of safely meeting the needs of all youth while living with their families in the community.

13. When a youth's safety cannot be maintained while living with their family in the community, the first consideration for placement is with extended family or a responsible adult with whom the youth has a significant relationship, and is capable of providing a safe and nurturing home, in consideration of the safety of the youth and community.
14. Out-of-home placements will be made with full parental involvement and knowledge of their responsibilities, including but not limited to:
 - Family participation in service planning and treatment
 - Family visits with the youth placed out-of-home
 - Family responsibility to contribute to the cost of care, and to access funding resources such as health insurance, Medicaid and CSA.
15. In order to support timely and successful reunification, youth placed in residential facilities will be supported in visiting at least monthly by their family, and at least quarterly by the case manager or other public agency member of the youth's team. The case manager shall work proactively to identify barriers to visitation by the family and shall assist and support the family in overcoming them.

Equitable Access & Cultural Competency: County, community and private agencies embrace and value the diverse cultures of their children, youth and families. Youth and families will have equitable access to services that support their family.

16. Essential services, easy-to-understand print and multimedia, trainings and planning processes will be accessible and communicated in a way that youth and families can understand, meet their needs and respect their cultural preferences, within legal and regulatory limits.
17. If the family does not speak English as their primary language, the family will have an interpreter (onsite or telephonic) available to them during the meetings, trainings or activities. Onsite interpretation is recommended as funding is available. Interpreters should be proficient in behavioral health terminology and details of the programs. Staff will be trained on how to best use an interpreter.
18. In order to ensure equitable access, public agency representatives and private providers, in collaboration with the youth and family, will become knowledgeable of the needs and accommodations required to address their unique circumstances. Public agency representatives and private providers may need to secure specialized training or supervision to achieve proficiency in understanding the unique needs listed below. Knowledge of resources and agency/community partnerships is also needed to ensure equitable access. Consideration will be given to:

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- Learning styles, communication levels and language assistance needs and where possible, involved professionals will provide supportive accommodations so that the youth and family can actively and fully participate.
- Youth and/or participating family member(s) with disabilities, gender self-identification concerns, and/or relevant faith and cultural values and beliefs present so that these can be attended to in an informed and respected manner during all collaborations.
- Transportation/geography, presence or lack of financial resources and insurance constraints, age (transition age youth or young children) and time access (time of meetings/length of meetings), so that they do not create access barriers to the youth and family. When any are present, all participating members will work to mitigate the impact on providing support and services.

Accountability: We are accountable at the individual youth and family, system, and community levels for desired outcomes, safety and cost effectiveness.

19. Public agency supervisors are responsible for coaching, teaching and reinforcing their staff to practice in accordance with the SOC Practice Standards.
20. Parent/legal guardians, youth, public agency representatives and private providers are responsible to complete roles and assignments, and make decisions in consultation with the team. The team will respect the youth and family's right to make their own decisions within legal and regulatory limits. All team members are also accountable for team recommendations and will explain and support them in the court process or other decision-making processes, as needed.
21. Teams, case managers and care coordinators will be accountable to their own agencies and to inter-agency bodies such as FAPT and CPMT for the prudent investment of public resources and for the timely and accurate collection of data and other steps necessary to achieve desired outcomes.
22. Families will contribute toward the cost of care through processes that assess their ability to pay, through accessing their health insurance, and through other financial resources as appropriate.
23. Providers will implement their stated treatment model (e.g., models that are evidence-based, evidence-informed, or practice-based evidence) with fidelity.

SOC Practice Standards: Definition of Terms

Care Coordination: A process-oriented activity that provides ongoing communication and collaboration with youth and families with multiple needs. The activity can include: facilitating communication between the family, natural supports, community resources, and involved child-serving providers and agencies; organizing, facilitating and participating in team meetings at which strengths and needs are identified and safety planning occurs. The activity provides for continuity of care by creating linkages to and managing transitions between levels of care and transitions for older youth to the adult service system.

Case Management: A goal-oriented activity that assists youth and families that could include: identifying strengths and needs; identifying, brokering and linking to community services and resources, including CSA; assisting in obtaining entitlements; advocating on behalf of families; providing support and consultation to families; facilitating access to intensive services; and providing crisis planning, prevention, and intervention services.

Case Manager: Paid professional to perform the above-mentioned activities.

Child: A person between birth and full growth typically 12 years, generally corresponding to the end of elementary school.

Crisis plan: A dynamic document that details the actions that the members of the youth's team develop and are prepared to implement if a particular risk is realized. The crisis plan describes how community/public safety is provided or needs are met, addressing placement, school, working with law enforcement and the community.

Culturally Competent: The capacity to provide services in an effective manner that is sensitive to the culture, race, ethnicity, language and other differences of an individual. Such services may include, but are not limited to, use of bilingual and bicultural staff, provision of services in culturally appropriate alternative settings, and use of bicultural paraprofessionals as intermediaries with professional staff.

Evidence Based: An approach or treatment that shows evidence of positive outcomes based on peer-reviewed randomized controlled trials or other equivalent strong methodology.

Family: Parent or parents, legal guardian, siblings, grandparents, spouse and other primary relations whether by blood, adoption, legal or social relationship.

Family-Driven: Families have the primary decision making role in the mental health care of their own children as well as the policies and procedures governing care of all children in their community.

This includes: choosing supports, services and providers; setting goals; designing and implementing programs; monitoring outcomes; and determining the effectiveness of all efforts to promote the mental health and well-being of children and youth. All decisions will be based on the safety and well-being of the child.

Family Partnership Meeting (convened by DFS): Family Partnership Meetings (FPMs) are structured planning and decision-making meetings, designed to engage families and their supports in creating plans for children's and youth's safety, well-being and permanence. This relationship-focused and collaborative approach provides structure for decision-making. It further empowers and supports the social services specialists, families and the stakeholders. Meetings are held for the following critical decision points:

- High Risk or Very High Risk Assessment Planning,
- Emergency Removal,
- Placement Preservation/Change of Placement/Disruption or Dissolution of Adoption,
- Permanency Planning/Prior to Change of Goal, and
- Concurrent Planning

Family Partnership Meeting (convened by CSA): A structured team based model that engages youth and families, uses their strengths and needs to develop plans in collaboration with supports (natural/community and/or agency). These meetings are facilitated by a neutral third party.

Formal Services: Services and supports provided by professionals (or other individuals who are “paid to care”) under a structure of requirements for which there is oversight by government agencies, national professional associations or the general public arena.

Individualized Care Plan: A dynamic document that describes the family, the team and the work to be undertaken to meet the family and child’s needs and achieve the family’s long-term vision. This is an evolving and changing document. Progress and updates are included as components of the care plan.

Intensive Care Coordination (ICC): The same as care coordination (see above) but targeted to youth at high risk of residential placement or in placement and transitioning back to the community. Per CPMT policy ICC interventions have expedited access to CSA-funded community-based services and supports.

Natural Supports: Individuals or organizations in the family’s own community, kinship, social, or spiritual networks, such as friends, extended family members, ministers, neighbors and so forth.

Outcomes: Child, youth, young adult, family or team goals stated in a way that can be observed and measured.

Racial Equity: The elimination of institutional and structural racism as evidenced when outcomes and opportunities for all people are not predictable by race.

Social Equity: Accounting for the intersection and compounding experience when other societal factors including poverty, gender, neighborhood of residence, language spoken, sexual orientation, are not predictors of outcomes and opportunities.

Strengths: The assets, skills, capacities, actions, talents, potential and gifts in each family member, each team member, the family, as a whole, and the community. Strengths help family members and others to successfully navigate life situations; thus, a goal of the team-based planning process is to promote these strengths and use them to accomplish the goals in the team’s care plan.

Strengths and Needs Assessment: A document that describes the strengths and needs of a child based on a strengths inventory including positive skills, attributes and features of the family. This would include a list to capture the needs of the family that are either verbally or behaviorally shared. This document will include background, summary and progress information on the family; a place to live; social/fun; emotional/behavioral; education/vocational; legal; medical; safety/crisis; spiritual; cultural; financial, including additional comments or information.

System of Care: A broad flexible array of effective services and supports for a defined multi-system involved population, which is organized into a coordinated network, integrates care planning and care management across multiple levels, is culturally and linguistically competent, builds meaningful partnerships with families and with youth at service delivery, management and policy levels, has supportive management and policy infrastructure, and is data-driven.”

Team-Based Planning Process: An umbrella term that encompasses a variety of structures and models. A group of people, chosen by the family and connected to them through natural, community, and formal support relationships who will work together to develop and implement the family’s plan; address unmet needs; and work toward the family’s vision. Team-based planning processes include the youth and family, extended family, representatives of youth-serving agencies that provide services to the youth and family, and others who are important in the family’s life or know and can access potential resources. Best practice models for team-based planning include family team meetings, wraparound teams and family group conferencing.

Trauma Informed: A trauma informed approach to the delivery of behavioral health services includes an understanding of trauma and an awareness of the impact it can have across settings, services and populations. It involves viewing trauma through an ecological and cultural lens and recognizing that context plays a significant role in how individuals perceive and process traumatic events, whether acute or chronic.

Treatment Plan: A written individualized comprehensive plan based on a completed mental health assessment documenting the child (youth, young adult) and family’s treatment goals, measurable objectives, the array of services planned, and the criteria for goal achievement.

Vision: A statement constructed by the youth and family, with help from their facilitator and possibly the team, that describes how they wish things to be in the future, individually and as a family.

Young Adult: An individual in the early years of adulthood, 18 – 22.

Youth: An individual between twelve/thirteen (12/13) and eighteen (18), generally corresponding to the middle and high school years.

Youth Guided: Youth have the right to be empowered, educated, and given a decision-making role in the care of their own lives as well as the policies and procedures governing care for all youth in the community. They have a sustainable voice with the focus being toward creating a safe environment enabling a young person to gain self-sustainability in accordance with their culture and beliefs. Within this youth guided approach, there is a continuum of power and choice that young people should have based on their understanding and maturity in this strength-based change process that is fun and worthwhile.



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Supporting Emotional Wellness
in Youth and Families



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