Youth Behavioral Health

May 2014

Recommendations Phase II Implementation Tasks

Interagency Human Services and Public Schools Behavioral Health Work Group

Fairfax County Public Schools

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Section I. Background

Purpose

Charge to Interagency Behavioral Health Youth Services Workgroup

- Increase the communication and effectiveness of interaction between youth and family serving agencies and services providers;
- Identify gaps in services in behavioral health system (substance abuse and mental health) for youth;
- Recommend possible solutions to address existing gaps in services;
- Prioritize service needs; and
- Improve the mental health delivery system for youth and families identified but not in intensive case management services already provided via the CSA – Systems of Care.

Short-term - Immediate Work

1. Identify existing needs

2. Outline resources and service capacity available to respond to needs, including those available through county agencies, the school system and providers in the community

3. Identify gaps and strategies to address gaps

4. Prioritize services and associated required resource allocation recommendations to address gaps

5. Develop recommendations for implementation of an Interagency Youth Services Management and Coordinating Team to manage resource requirements and outcomes

Long-term Work

1. Recommend options for a service delivery model using available resources to meet the needs of youth and families

2. Develop service protocols to ensure successful implementation of system-wide goals, outcomes and accountability measures for the following components:

On April 23, 2013, the Fairfax County Board of Supervisors provided guidance directing this study: "Staff is directed to identify requirements to address youth behavioral human services requirements in schools and the broader community.

Work with the Fairfax County Public Schools (FCPS) and the nonprofit community (including the Partnership for Youth) to identify the array of youth services that are necessary to address the most pressing needs within the community.

The discussion will focus on work already underway as part of the collaboration between the County and FCPS to identify the appropriate prevention, early intervention and treatment services that are necessary to deal with behavioral health issues and to best leverage the current services provided within the schools as well as more broadly in the community.

A comprehensive recommendation will be provided to the Human Services Committee of the Board of Supervisors (to which the School Board will be invited) in fall 2013.

Funding of $200,000 will be held in reserve until the Board approves the recommendations for its use."

a. Intake, assessment, triage, referral, transition across levels of care (handoff to CSA), lead case management assignment

b. Review, develop, and implement a uniform set of requirements in cross system treatment planning tool.

c. Review, develop, and determine how to track system performance measures and outcomes

Establish formal agreements that clearly identify roles, responsibilities and service flow between participating county agencies, the school system and partnering entities.

This report is the **second report** on work identified as "longer term" for purposes of initial implementation on approved actions to coordinate joint human services and public schools activities that may be addressed within existing resources and requested for resources in the County's FY 15 budget process.[1]

Scope of project – phase II

- Refine definition of recommended target population
- Identify child/youth serving points of entry
- Establish screening, referral, intake procedures
- Resource recommendations – budget, staffing, contracting
- Care coordination model defined
- Services definitions and treatment standards completed
- Quality Assurance – practice standards and performance measures completed
- Accountability Plan – job descriptions and governance
- Implementation schedule and key milestones plan

[1] Reference "Youth Behavioral Health Services: Interim status report and recommendations: September 2013; Interagency Youth Behavioral Health Services Work Group available at: http://www.fairfaxcounty.gov/living/healthhuman/reports/youth-behavioral-health-service-report.pdf.

FY 2014 Budget Guidance form the Board of Supervisors

The Board of Supervisors approved the FY 2014 Adopted Budget Plan, which included a request for $1.0 million in funding for contractual behavioral health services and creation of 3 positions to address the gap. The Board directed staff to provide an update on these services, including "opportunities for enhanced collaboration with the Fairfax County Public Schools, a clear explanation of the use of funds approved for the expansion, options for acceleration of future funding, and a report on the demand of services in FCPS and Fairfax County."

Recommendations: Summary

The Interagency work group includes staff from the Fairfax-Fall Church Community Services Board, the Fairfax County Health Department, Public Schools, Juvenile and Domestic Relations District Court Services, Family Services, Neighborhood and Community Services, and Administration for Human Services. The goal for this work is to identify and implement appropriate treatment services for children and youth, and specifically to establish a service delivery model for children currently not receiving behavioral health services- especially those suffering from anxiety and depression.

The Interagency Youth Behavioral Health Work Group presented its first set of recommendations to the joint School Board and the Board of Supervisors policy team in the fall of 2013 (see http://www.fairfaxcounty.gov/living/healthhuman/reports/youth-behavioral-health-service-report.pdf to read the report.) The group efforts are focused on four key areas:

Interagency Youth Behavioral Health Services Work Group Recommendations – Fall 2013

Improved Performance through Best Practice Training and Accountability Systems

New Services Design to Address Youth Behavioral Health Gaps in Systems of Care Continuum

CSB Youth Services Division Resource Plan

Behavioral Health Supports to Youth in co-located sites and alternative schools

Health Promotion and Wellness Priorities

Improving Access to Behavioral Health Care for Youth and their Families

CSA non-mandated funding

- A way to improve access for children with anxiety and depression to obtain mental health treatment in the community through outpatient services. This is a service gap in our community. The group recommended an initial $1.0 million in county funding for this service as part of the

FY 2015 Advertised Budget Plan. (*Note: The Board of Supervisors approved this amount at its adoption of the County budget on April 29, 2013).*

- How the county provides free/reduced care for families that need it – through the Fairfax-Falls Church Community Services Board, the Fairfax County Public Schools, through community-based providers and contractors. And more importantly, with restricted resources, how do we target it to those most in need, not waste any resource, and ensure that what is provided is quality care?

- Linking families to insurance coverage so they can obtain behavioral health services for adults and children if they qualify for Medicaid or a private/subsidized plan through the new health marketplace.

- Helping families who need better information on available quality providers, help accessing their insurance as well as their own resources, and how to assess what is effective.

Phase Two Recommendations

1. **Recommended population – Youth with Mental health or substance use concerns**
   Youth with emerging behavioral health issues who have not been able to access appropriate, timely and matching treatment services in the community.

2. **Identifying youth – Screening Strategies for Community, County and School Professionals Serving youth**
   For Youth ages 12 and above, the Work Group recommends use of the GAIN – short screen - Global Appraisal of Individual Needs. For youth under the age of 12, the group continues to research options. The behavioral manifestations of the youth should be the main driver for referral decisions.

3. **Health benefits screening and application assistance**
   Referral and case management services will be available for youth assessed as in need of behavioral health outpatient treatment. Ongoing monitoring of the youth's functioning will occur to determine whether interventions have been effective and if additional services are needed. Contact with the family and other workers that may be involved with the family will be required through a multi-disciplinary team approach. The service team recommends use of the CANS assessment tool as part of this process.

4. **Emerging Behavioral Health Concerns**
   The team was tasked with reviewing and selecting the primary diagnostic categories and evidenced based/informed treatment services that would best meet the needs of the population of youth and families that have been selected to be served, as identified in the first phase of the workgroup's efforts. The following behavioral health concerns are recommended

to be targeted in the first phase of implementation for **earlier interventions in the "tier two" identified population**: **Depression/Dysthymia, Anxiety, Conduct Concerns, Trauma and Substance Use.**

5. **Definitions and treatment intervention recommendations**
   See detailed recommendations on the various treatment options recommended for the five chosen diagnostic categories (page 17).

6. **Service Utilization Criteria**
   Entry and use of services is voluntary unless a youth is court ordered into care and service:
   - The Youth will be assessed for risk, health status, stability, level of distress, symptoms, degree of problems, life/skills functioning.
   - The family will be assessed for the following:
     - Youth and family commit to being full participants in a treatment plan
     - Youth and family desire and are willing to consistently attend services
     - Severe stress and family issues indicate need for case management to assist the youth and family issues.

7. **Quality Assurance – practice standards and performance measures**

8. **Training**
   To effectively implement this process, staff training is needed on the Global Appraisal of Individual Needs (GAIN –Short Screen). Behavioral health staffs in FCPS and HS need additional training on available community resources and referral for insurance access. All behavioral staff needs additional evidence-informed mental health and substance use treatment training on practice standards and regulations.

9. **Parent and Family Engagement**
   Our practice standards emphasize youth and family choice in service planning and provider selection. For families with private health insurance, assistance will be offered to access these resources.

   The work group recommends further investment in peer supports and family support services as a component of treatment.

10. **Procedures**
    To provide a service system for these youth and families, formal policies and procedures need to be established for use by all human services and public schools programs. Such policies and procedures provide for structure to ensure more consistent system operation and provide adherence to best practice, risk management, legal, or other local, state, mandates.

11. **Electronic Health Records**

    The work group recommends utilization of an electronic health record for behavioral health service planning and documentation of key system reporting requirements. The CSB Credible system is a viable option for use by third party providers.

12. **Reimbursement and fees**

    The work group recommends a standard reimbursement and fee policy for access to the services.

13. **Systems of Care Implementation**

    The Work Group recommends continuation of the interagency staff meetings on a monthly basis for the continuation of the implementation plan and to operationalize the new Systems of Care office.

14. **Implementation schedule and key milestones plan**

    Direct the Interagency Youth Behavioral Health Work Group to meet with interested community behavioral health providers to review proposed services. The purpose is to determine interest in completing contractual agreements for provision of services to individual youth and their families.

    Explore options for access and oversight to ensure compliance with the County health integration efforts through the Fairfax County Health Collaborative. Request participation of the consultant services supporting the completion of the CSB Youth Services Division Resource Plan.

15. **Systems of Care Implementation**

    The Work Group recommends continuation of the interagency staff meetings on a monthly basis for the continuation of the implementation plan and to operationalize the new Systems of Care office.

16. **Address Gaps in Early Intervention Family Supports**

    Additional services are needed for linking families to parent education services. Curriculum is needed for families with children who have conduct concerns, and those who have suffered from exposure to trauma.

Section II. Detail on Recommendations

Recommended population – Youth with Mental health or substance use concerns

Youth with emerging behavioral health issues who have not been able to access appropriate, timely and matching treatment services in the community.

Identifying youth – Screening Strategies for Community, County and School Professionals Serving Youth

Identification and Screening involves a formalized process for identifying youth who exhibit risk factors that may indicate he or she is experiencing mental health concerns or is possibly using substances. The behaviors may interfere with his or her ability to function at home, in school or in the community. The behaviors may affect learning. The child may be acting in a manner that is harmful to others or to him or herself. Further information is gathered to help determine whether some form of treatment is necessary.

Certain behaviors that indicate the need for screening could include:

- School attendance
- School discipline problems
- Criminal offenses or other conduct disorders
- Suspected or known substance use
- Signs of depression, anxiety or trauma
- Behavioral problems due to challenges in home, school, community/adjustment and transition issues

❖ *Every child has talents, skills abilities*

❖ *Data needs to drive responses*

❖ *There is a human element to all interactions – youth, parents, families and the community all share responsibility for a child's well being*

Should these conditions and/or behaviors be evident, school and county staff in contact with the individual youth, as well as parents, and the youth himself/herself, should seek help. The work group reviewed a variety of tools to help adults and youth to determine if they need services. The materials are found in Appendix I.

GAIN – tool

For Youth ages 12 and above, the Work Group recommends use of the GAIN – short screen.

"GAIN" stands for "Global Appraisal of Individual Needs". Advantages: The GAIN takes 5 to 10 minutes for a youth to fill out. It is designed to determine the likelihood someone would have a diagnosis and

need a full assessment. The GAIN-SS license can be purchased for a nominal fee. The training for this is online at their website. The GAIN is a family of instruments with varying uses and ranging in administration time from 5 minutes for the GAIN Short Screener to 2 hours for the GAIN-I . More information about the different GAIN instruments is available at: http://www.gaincc.org/instruments.

Screening Questions[2]

When was the last time that you...

- Had a disagreement in which you pushed, grabbed, or shoved someone?
- Took something from a store without paying for it?
- Sold, distributed, or helped to make illegal drugs?
- Drove a vehicle while under the influence of alcohol or illegal drugs?
- Purposely damaged or destroyed property that did not belong to you?

Do you have significant psychological, behavioral, or personal problems that you want treatment for or help with? (If yes, please describe below)

Training and Cost

County, community and Public Schools staff recommended to obtain on-line certification on the use of the GAIN-Short Screen tool includes:

- FCPS Psychologists /Social Workers
- FCPS Guidance Counselors
- DNCS Teen Center/Youth staff
- DFS Social Workers
- Health Dept. Nurses
- HCD Resource staff
- JDRDC truancy/probation staff
- FCPD School Resource officers
- Community youth providers
- (Nonprofit and faith)

The tool is available on line. The training and certification is estimated to require one-two hours to obtain approval for use. GAIN ABS is purchased as a yearly subscription and the cost is based on the number of users within an agency. The cost for ABS is $180 per user/per year, plus a one-time $100 setup fee per account, and a licensing fee of $100 covering 5 years of use of the GAIN for an agency. For every 10 GAIN ABS user spots purchased, an agency receives 5 additional user spots at no cost.

[2] Excerpted from Chestnut Health Systems: use by permission www.chestnut.org

For use of a paper version of the instrument, a GAIN license will give an agency access to the paper-versions of our instruments. GAIN licensing costs $100 per agency and covers 5 years of use.

Training & Certification

Online GAIN Administration training and certification is highly recommended if an agency will be using the GAIN-Q3 or GAIN-I. Online learning format allows trainees to complete online learning modules and have the option to participate in a review phone call. Following completion of the training process, trainees begin a certification process. Two levels of certification are available: Administration certification, which is intended for those who will focus on administering the assessment, and Local Trainer certification, which is intended for those who will be training others to administer the assessment and recommending them for certification. The cost per person to complete training and certification to the Local Trainer level is $2,400 for the GAIN-I and $1,500 for the GAIN-Q3. The cost per person to complete training and certification to the Administration level is $1,800 for the GAIN-I and $1,200 for the GAIN-Q3. We also offer an online course specific to the GAIN Short Screener.

Data Management

GAIN data management services allow for collection of common datasets for utilization review purposes. This process allows an agency to identify training needs (e.g., able to identify common errors in staff's interviews). A Site Characteristics Profile report with 40+ charts providing a breakdown of an agency's population is available. The costs for data management services depend on services chosen.

For Children under Age 12

For Youth ages 12 and above, the Work Group recommends use of the GAIN – short screen - Global Appraisal of Individual Needs. For youth under the age of 12, the group continues to research options. The behavioral manifestations of the youth should be the main driver for referral decisions.

Proposed Client Flow – Youth Behavioral Health Work Group

Administer **SCREENING INSTRUMENT**

GAIN Short Screener Who should be trained to use?
Community youth providers
(Nonprofit and faith)
CrisisLink
FCPS School Counselors
DNCS Teen Center/Youth staff
Health Dept. Nurses in Schools
DFS Social Workers
JDRDC intake staff
FCPD School Resource officers
HCD Resource staff

Youth exhibits behaviors that cause concern for their well-being
Anxiety Depression Conduct Substance Use Trauma

Determination of Need
FCPS Psychologists /Social Workers
CSB Youth Outpatient staff
Contract providers
Further assessment for Anxiety, Depression, ODD, Trauma
ASSESSMENT INSTRUMENTS
Clinical interviews
Examples of assessments might include:
Achenbach Child Behavioral Checklist
Connors Comprehensive Rating Scale
Behavior Assessment System for Children (BASC-2)

TIER III Behavioral health
Needs higher level services
CSA eligible
Referral to Family Assessment Planning Team and intensive care coordination when indicated

EXISTING SERVICES ARRAY

SERVICE NAVIGATION
Determination of insurance
Medicaid eligibility
CSA
County funded
PROVIDER SELECTION
Specialty care needed
language, disability, SMI complexity, availability
CARE COORDINATION SERVICES
Service plan creation
Family concurrence on plan
Services order(s) initiated
Electronic Health Record created
CASE MANAGEMENT SERVICES
CANS Administered at 3 week
treatment for youth
with behavioral health treatment needs or at time
of assessment if not meeting BH needs criteria
Referral for additional services/wrap around
Initiate group peer family services

Insurance or Self pay?

Medicaid? No Insurance? Access Barrier?(language, cultural, disparities)

Referral to Utilization Management Systems of Care Office
Treatment plan and determine level of services required
Youth and Family assessments shared

TIER II Services NEW SERVICE ARRAY **Assessment indicates Treatment Needs** in one or more of following:
Outpatient Services and Medication
Anxiety: Behavioral and Cognitive Behavioral Therapy
Depression: combined medication (SSRI) and CBT treatment
Conduct Concerns:
- Parent management training programs
- Cognitive Behavioral Treatment

Trauma: Trauma-Focused Cognitive Behavioral (TF-CBT).
Substance Use: CBT, MI,12 Step AA/NA, Family TX Typical timeframe: 10-16 week individual/90 day group

Operational Measures:
- # SCREENINGS DONE (by referral source)
- # Families referred for behavioral
- health services
- # ASSESSMENTS
- # families/individuals eligible for
- services
- # families receiving
- financial assistance for services
- #families declining at
- assessment phase

Cost
System Measures: see chart

Community Health providers Pediatricians Primary Care providers

Private practice clinicians

Areas for additional procedures/policy discussion with community treatment providers and vendors:
- NEED DETERMINATION re level of service between tier II family supports and behavioral health treatment
- Participation - what happens
- Treatment plan documentation and reporting –integration of system **with overall County primary care/behavioral health integration strategies**.

TIER II Behavioral Health Services EXISTING SERVICE ARRAY (but continued gap in availability)

Assessment indicates Family Supports Needed; Behavioral health treatment for youth not indicated AND referrals for early intervention service array for families is needed –parent education, Head Start, kinship supports

Services to Families

Health benefits screening and application assistance

Referral and case management services will be available for youth assessed as in need of behavioral health outpatient treatment. Ongoing monitoring of the youth's functioning will occur to determine whether interventions have been effective and if additional services are needed. Contact with the family and other workers that may be involved with the family will be required through a multi-disciplinary team approach**. The service team recommends use of the CANS assessment tool as part of this process.**

Referrals for Outpatient Behavioral health services

Each referring Human Services or Schools referral processes are outlined below:

CSB Referrals

Service requests come from the public to the CSB Entry Line. Those families who meet the Medicaid/no insurance criteria, and do not meet the CSB priority population criteria will be referred to the Systems of Care office for assessment of need and enrollment into available services.

Fairfax County Public School Referrals

Referrals will be made by School Social Workers and Psychologists. School social workers and school psychologists provide a full range of assessment and counseling services to students ages 2-22. Services include mental health assessment, suicide assessment, small group counseling (with parent consent), individual counseling (with parent consent), and parent/teacher behavioral consultation and analysis. In many cases, the school-based mental health services are sufficient in terms of addressing the referral concern and the student's presentation of school based issues or concerns (underperformance, behavior, attendance, etc.). For children in special education services, a comprehensive psychological evaluation is completed and will be available for youth referred for additional behavioral health services.

In some cases, however, the student requires ongoing counseling services, has urgent or life-threatening mental health needs, has made a serious or very serious threat, has significant attendance issues that do not improve after repertoire of interventions, or requires extensive care coordination and case management due to complexity of individual needs or family circumstances and the school psychologist/social worker need to refer the child and family to a community or private mental health provider.

For students with health insurance coverage, the referral will be to the family's participating mental health service provider(s). In some cases, there is not an available clinician and the family will be referred to the Systems of Care office.

For all psychiatric emergencies, students and families will be assisted in accessing the appropriate public or private provider for emergency services, for both the insured, Medicaid and uninsured populations.

When circumstances necessitate a referral, (above indicators, no insurance/Medicaid, no available private provider), prior to referral, the FCPS clinician will complete the brief GAIN which will provide the primary areas of concern and possible appropriate treatment approaches or modalities. Parents will be provided with the information from the GAIN and a release will be requested so that the results can be shared. The SOC staff will be given the GAIN tool, along with other relevant assessment data and the youth will be scheduled (in coordination with parents/guardian), for an intake appointment.

Juvenile and Domestic Relations District Court

Referrals will be made by Juvenile & Domestic Relations District Court Services Unit (CSU) intake officers and probation officers. Intake officers screen juvenile complaints for status offenses such as running away and truancy, as well as delinquent behavior. In cases where it is appropriate to handle the complaint informally, known as "Diversion," the intake officer will refer youth and families to services to address the underlying behavioral health issues. The CSU provides diversion programing for substance abuse screening and education (in collaboration with CSB) and short term family counseling, as well as informal probation case management. Diversion is limited to a 90 day period by the Code of VA.

In some cases, the youth and family requires ongoing mental health and/or substance abuse counseling services, or displays urgent or life-threatening mental health needs, has made a serious or very serious threat, has significant behavior issues that do not improve after 90 days, or requires extensive care coordination and case management due to complexity of individual needs or family circumstances and the intake officer needs to refer the child and family to a community or private mental health provider.

For youth with health insurance coverage, the referral will be to the family's participating mental health service provider(s). In some cases, there is not an available clinician and the family will be referred to the Systems of Care office.

For all mental health emergencies, youth and families will be referred to the Community Services Board or if assessed by CSB not to need inpatient hospitalization, to the Systems of Care office if there is no insurance or Medicaid.

When circumstances necessitate a referral, (above indicators, no insurance/Medicaid, no available private provider), prior to referral, the intake officer will complete the brief GAIN which will provide the primary areas of concern and possible appropriate treatment approaches or modalities. Parents will be provided with the information from the GAIN and a release will be requested so that the results can be shared. The SOC staff will be given the GAIN tool, along with other relevant assessment data and the youth will be scheduled for an intake appointment.

Other Agencies

The Department of Family Services, Health Department, the Department of Neighborhood and Community Services and community service providers will develop protocols for specific programs and divisions for screening and assessment referrals.

Emerging Behavioral Health Concerns

The team was tasked with reviewing and selecting the primary diagnostic categories and evidenced based/informed treatment services that would best meet the needs of the population of youth and families that have been selected to be served, as identified in the first phase of the workgroup's efforts.

The category of tier II youth determined to be in the "gap" for services are those with emerging behavioral health issues who have not been able to access appropriate, timely and matching treatment services in the community.

The primary work has focused on selecting a number of diagnostic categories that would best describe the **majority** of youth for this behavioral health initiative and the best evidenced based/informed treatment practices based on current research.

The group believes these recommendations will provide the best guidance and parameters for any provider to provide the most focused and appropriate treatment interventions for those youth and families targeted in this effort.

DIAGNOSTIC CATEGORIES CHOSEN:

1. **Depression/Dysthymia**
2. **Anxiety**
3. **Conduct Concerns**
4. **Trauma**
5. **Substance Use**

Note: The following information regarding diagnosis information and treatment recommendations were compiled from the most recent Report of the Virginia Commission on Youth report titled "Collection of Evidenced-based Practices for Children and Adolescents with Mental Health Treatment Needs, 4th edition and the most recent report from NIH-National Institute on Drug Abuse: "Principles of Adolescent Substance use Disorder Treatment: A Research-Based Guide."

DEFINITIONS AND TREATMENT INTERVENTIONS FOR THE CHOSEN DIAGNOSTIC CATEGORIES[3]

Depression and Dysthymia

Major Depressive Disorder (MDD) is characterized by a period of at least 2 weeks during which the youth experiences sadness, hopelessness, guilt, loss of interest in usually pleasurable activities and/or irritability most of the time. Youth must also experience at least 4 of the following to be given the diagnosis:

- Significant change in weight
- Sleep disturbance
- Changes in amount of physical activity
- Fatigue or loss of energy most of the time
- Excessive feelings of worthlessness or guilt
- Difficulty thinking or concentrating and/or
- Recurrent thoughts of death or suicide

It is important to note that the youth's mood differs from their usual mood and not attributable to bereavement, a general medical condition and/or substance abuse.

Dysthymia is a mood disorder in which the symptoms are less severe than MDD when the youth has experienced a persistent depressed mood for most of the day, more days than not for at least one year. The youth must experience a depressed mood and have at least two of the following symptoms:

- Altered appetite (eating too much or too little)
- Sleep disturbances (sleeping too much or two little)
- Fatigue or loss of energy
- Low self esteem
- Difficulty thinking or concentrating
- Sense of hopelessness

The most commonly co-occurring disorders that occur with MDD are dysthymia, anxiety disorders, disruptive disorders, and substance use disorders.

[3] Diagnosis definitions and treatment recommendations compiled from "Collection of Evidenced-based Practices for Children and Adolescents with Mental Health Treatment Needs, Virginia Commission on Youth 4th edition.

Evidence-based Treatments: NIMH asserts that treating depressive disorders in children and adolescents often involves short term psychotherapy and/or medication and targeted interventions addressing the home or school environment.

- Evidenced based/informed treatments are Cognitive Behavioral Therapies (CBT) and Interpersonal therapy and the research has indicated that treatment gains were achieved regardless of treatment site (school, clinic, primary care facility, hospitals or research settings).
- In addition, a Treatment for Adolescents and Depression Study (TADS) results indicated that a combined medication and CBT treatment approach is superior to a medication and CBT treatment alone and better than a placebo.

Anxiety Disorder

Anxiety disorders are those disorders that cause children and adolescents to feel frightened, distressed and uneasy for no apparent reason and impede daily activities or functioning. Youth with anxiety problems experience significant and often lasting impairment, such as poor performance at school, work, social problems and family conflict. Separation anxiety disorder (SAD) is the only anxiety disorder that applies specifically to children, while the other anxiety disorder diagnoses may be applied to both children and adolescents. The different DSM IV anxiety disorders for children and adolescents are:

- *Separation Anxiety Disorder* (SAD)- A disabling and irrational fear of separation from caregivers.
- *Social Anxiety Disorder/Social Phobia*-A disabling and irrational fear of social encounters with non-family members.
- *Post-traumatic Stress Disorder* (PTSD)-Re-experiencing, avoidance, and hyper-arousal symptoms following a traumatic event.
- *Specific Phobias* (SP)- A disabling and irrational fear of something that poses little or no actual danger.
- *Generalized Anxiety Disorder* (GAD)-Chronic, exaggerated and overwhelming worries about multiple everyday routine life events or activities.
- *Panic Disorder*- Chronic fears of having panic attacks after having at least one un-cued panic attack.

Evidenced Based Treatments: The treatments for anxiety disorders are usually multimodal.

- While wide ranging treatments have been described in the literature, only two primary treatments have been described as evidenced based: CBT and medication.
- Also what seems to work is educational support which provides educational information on anxiety to family members usually in a group setting.
- Other common elements to behavioral and CBT include psycho-education to the youth, relaxation and cognitive reframing skills/techniques. Most of these include parental involvement and some versions include the parents attending all sessions so they can assist outside of therapy.

Behavioral and Cognitive Behavioral Therapy are the most studied and best supported treatment for anxiety disordered youth. This typically involves exposure therapy and involves using a hierarchy or fear ladder so the youth can be exposed to moderately stressful situations and work towards more difficult situations, thereby gaining mastery and self-confidence. Both therapies have been found to be helpful to youth of all ages, can be administered in individual and group setting and has been delivered in schools, clinics, hospitals, daycare centers and home as well across a variety of racial and ethnic groups.

Oppositional Defiant (ODD) and Conduct Disorder Disorders (CD)

Disruptive behavior disorders (DBDs) are a cluster of disorders defined by the persistent presence of negative, defiant or rule breaking behaviors which are disruptive to the youth's social, academic, familial or personal functioning. DBDs include ODD and CD. DBDs are associated with a pattern of behaviors that lead to negative life consequences, including social, academic, occupational functioning, substance abuse and potential incarceration.

Oppositional Defiant Disorder is an enduring pattern of uncooperative, defiant and hostile behavior to authority figures without major antisocial violations. Youth must demonstrate at least 4 of the following for at least 6 months to meet diagnostic criteria:

- Often loses temper
- Often argues with adults
- Often actively defies or refuses to comply with adult's requests or rules
- Often deliberately annoys people
- Often blames others for his or her mistakes or misbehavior
- Is often touchy or easily annoyed by others
- Is often angry or resentful
- Is often spiteful or vindictive

ODD behaviors almost always manifest in the home setting and with adults the youth knows well. Behaviors may or may not be present in the school and/or community setting and may not present in the mental health professional's settings.

Conduct Disorder is a disorder where a child or youth exhibits persistent and critical patterns of misbehavior. Like ODD there may be issues of controlling one's temper, however they also:

- Violate the right of others including aggression towards people or animals,
- Engage in destruction of property,
- Exhibit deceitfulness, theft, or serious violation of rules.

To make a diagnosis, the child or adolescent must show at least 3 major symptoms in the past 3 months, with one of the symptoms having occurred in the past 6 months in various settings. There is also significant impairment in the child's social and academic life.

Evidence-based treatment: There are a number of evidence based treatment approaches for DBDs. The key strategies of these approaches include:

- Identification and reduction of positive reinforcement of undesirable behavior
- Increased reinforcement of pro-social and compliant behavior
- Utilization of appropriate consequences for disruptive behaviors
- Emphasis on predictability and immediacy of parental contingencies

The specific treatments for DBDs include:

- Parent management training programs
- CBT and CBT with Parent Management Training
- Multi-dimensional Treatment foster Care

Medication treatments for DBDs have not been well studied and some recommend only using medications when EBT fail. Certainly medications may be beneficial when there are co-occurring disorders. This would make it more likely that the youth will be able to participate and benefit from intervention strategies.

Trauma

A traumatic event is an event which threatens injury, death or the physical body of a child or adolescent while also causing shock, terror or helplessness. It also refers to both the experience of being harmed by an external agent as well as the response to that experience, thus leading itself to both emotional and psychic trauma which if not treated can have significant impact.

Trauma typically exists along a spectrum which ranges from global (many impacted) to individual impact. Complex trauma is when ”children experience multiple traumatic events that occur within the caregiving system-the social environment that is supposed to be the source of safety and stability in a child’s life” Simple trauma usually refers to a single event and is more likely to lead to post-traumatic stress disorders.

According to DSM IV, a youth is exposed to a traumatic event if they experience the event personally, witness another individual’s experience of the event or learn about a close associate’s traumatic experience. Trauma exposure is not a diagnosable disorder and does not dictate later psychopathology. Individual differences and risk factors can moderate the influence of exposure to trauma as well as the development of its symptoms.

National Child Traumatic Stress Network (NCTSN)

Domains in which a child may experience long term impairment following exposure to complex trauma:

Physical/Physiological: Hypersensitivity; numbness; problems with coordination and balance; increased somatization.

Medical: Asthma; autoimmune disorders; pseudo-seizures; sleep disturbances; disordered eating.

Cognitive: Attention; executive functioning; learning; lack of sustained curiosity; problems processing new information; difficulties with language; impairments in auditory, visual, or spatial perception and comprehension.

Attachment/Relationships: Distrust of and/or uncertainty about those around them; difficulties with boundaries; interpersonal difficulties.

Behavioral: Behavioral (impulse) control; self-destructive behavior; aggression; difficulty complying with rules; oppositional behavior; excessive compliance.

Emotional: Affect regulation; dissociative symptoms; amnesia; low self-esteem; shame or guilt; disturbances of body image; lack of predictable sense of self.

Treatment Goals - Trauma

Children and youth exposed to traumatic events have a higher probability of developing mental health conditions. Behavioral health treatment can help these children and youth build resilience and recover by connecting them with supportive adults, providing evidence-based treatment, and training providers in trauma-informed care.

With appropriate care, these children and youth demonstrate:

- **Reduced behavioral and emotional problems**
- **Increased behavioral and emotional skills**
- **Reduced trauma symptoms**
- **Reduced substance use problems**
- **Improved functioning in school and in the community**
- **Improved ability to build relationships**

• • • • • •

(adapted from: http://www.samhsa.gov/children/SAMHSA_ShortReport_2012.pdf)

Evidence-Based Treatment: Only one family of treatments has been studied enough to be an evidenced based treatment practice: Trauma-Focused Cognitive Behavioral (TF-CBT). It has been found to be more effective in treating childhood PTSD symptoms across 6 separate randomized clinical trials. Parents who participate in the treatment with their children have also been shown to have decreased trauma distress and depression and improved parenting skills.

TF-CBT treatment includes core elements that make up the acronym PRACTICE:

- Children and parents are provided with Psycho-education about trauma and PTSD symptoms and parents are provided with parenting skills to aid in the management of the child's symptoms.
- Relaxation skills are provided.
- Affective expression and modulation skills are treatment components.
- Cognitive coping skills are provided.
- A Trauma narrative is developed and processed.
- In vivo mastery of trauma reminders is introduced to differentiate between reminders and dangerous cues in the environment.
- Conjoint sessions, where the child and parent focus on having the child share his or her narrative and working on family communication is also included.
- Enhancing safety focuses on safety planning in the future.

School based group CBT uses PRACTICE components and has also shown some promise. All elements, except for the trauma narrative (individual activity) are provided in a group format and parents are rarely involved.

Medication treatments have been found to be useful in treating anxiety disorders, but there is inadequate support for the treatment of PTSD alone. In general, employing TF-CBT to treat PTSD prior to adding medications is warranted and treating medical personnel are urged to choose medications based on the evidence of a co-occurring disorder for treating a comorbid condition.

Substance Use

While it is not uncommon for adolescents to experiment, research has shown that children who experiment with substances at a young age are more likely to use other drugs later in life. Abusing drugs during adolescence has been associated with a number of negative consequences that include:

- Physical aggression
- Academic and occupational problems
- Delinquency and criminal behavior
- Developmental problems
- Long term health problems

A core concept has evolved, based on scientific study, that addiction is a brain disease that develops over time as a result of the initial voluntary behavior of substance use. Recent studies have also shown that binge drinking damages the adolescent brain more than the adult brain and further suggests that adolescents are more vulnerable than adults to the impact of alcohol on learning and memory. In addition, heavy drinking in early or middle adolescence with resulting damage, can lead to diminished control over cravings for alcohol and poor decision making.

There are two diagnostic categories of substance use disorders:

Substance Abuse is a maladaptive pattern of substance use that leads to significant impairment or distress and includes one or more of the following symptoms exhibited within the past year:

- Failure to fulfill obligations at work, home or school.
- Engages in recurrent use of substance in situations that can be physically harmful.
- Recurrent legal problems related to substance use.
- Continued substance consumption, regardless of recurrent or persistent interpersonal or social problems which are caused or exacerbated by substance use.
- These symptoms must have never met the criteria for substance dependence for the class of substance.

Substance Dependence is a cluster of cognitive, behavioral and physiological symptoms indicating that the individual continues to use the substance despite significant substance related problems. The ensuing maladaptive pattern that leads to significant impairment or distress must include 3 or more of the following:

- Symptoms occurring anytime during a 12-month period
- Tolerance
- Withdrawal
- Taking larger quantities of substance over a longer period than intended.
- Persistent and possibly unsuccessful efforts to cut down or control substance use.
- Significant amounts of time spent obtaining, using or recovering from the effects of the substance.
- Important social, occupational or recreational activities are reduced or no longer participated in because of the substance abuse
- The substance use is continued despite recognizing the role of substance use in persistent or recurrent physical or psychological problems.

Evidenced Based Treatment supports the effectiveness of various treatment approaches for adolescents. Most treatment interventions have been tested over periods of 12-16 weeks, but for some longer treatments may be warranted.

- Cognitive- Behavioral Therapy (CBT) teaches participants how to anticipate problems and helps them develop effective coping strategies. They learn to monitor their feelings and thoughts and recognize distorted thinking patterns and cues that trigger their substance abuse, identify high risk situations, and apply an array of self-control skills that include emotional regulation, anger management, practical problem solving, and substance refusal.
- Contingency Management provides adolescents an opportunity to earn low-cost incentives in exchange for participating in drug treatment and not using drugs.

- Motivational Interviewing helps the adolescent by providing non-confrontational feedback by empathic, yet directive intervention. The need for treatment is discussed and the therapist tries to elicit self-motivational statements from the adolescent to strengthen their motivation and build a plan for change.
- 12 Step programs AA/NA to enhance outpatient attendance and extend the benefits of addition treatment.
- Family based approaches address the wide array of problems in addition to the young person's substance problems, including family communication and conflict, other co-occurring behavioral, mental health and learning disorders, problems with school or work attendance and peer networks. These family based approaches include: Brief Strategic Family Therapy; Family Behavior Therapy; Functional Family Therapy; Multi-dimensional Family Therapy and Multi-systemic Therapy.
- Medication can be used in the treatment of substance use disorders and may be used in the initial stages of treatment for detoxification purposes, as directed by a medical professional. When medication is utilized for the treatment of a co-occurring disorder, a cautious approach as well as an integrated treatment strategy is crucial. Medication should be prescribed only to those children and adolescents who displayed psychiatric symptoms prior to the substance use or only if the symptoms are present during periods of abstinence. Children and adolescents diagnosed with a co-occurring mood disorder, ADHD, severe aggressive behavior or an anxiety disorder are most frequently prescribed medication.

Service Utilization Criteria

Entry and use of services is voluntary unless a youth is court ordered into care and services. Outpatient and case management is available for youth and families experience issues noted above. As a part of entry and use of service, a full bio-psychosocial assessment occurs, and a treatment recommendation plan is discussed and jointly developed with the youth and ideally the family. The treatment plan contains information on the need for services, goals, objectives, attendance and other requirements, services provided, and time frames for completing treatment plan. A projected discharge time and plan is developed at the first treatment plan session. Services consist of individual/ group therapy, crisis intervention, case and medication management.

Assessment Procedures

A child will be assessed for the following:

- The child has experienced physical or psychological stressors that have put him or her at risk for more serious psychological, behavioral, or other problems.
- Severe and persistent symptoms that place youth at risk or causes them not to function well
- Risk to self or others may be present but is not imminent
- Medically stability
- Degree of Problems: Problems in emotions, behavior or cognition, arising from mental health concerns; substance use, co-occurring disorder(s) that indicate need for Outpatient Service treatment to improve problems, prevent further deterioration or to stabilize the situation. The level of intensity of problems is low to mid-moderate.
- The youth shows problems in social, interpersonal or family functioning.
- The youth shows problems in occupational/educational functioning arising from a MH/SA/Co-occurring disorder(s).
- The youth expresses increasing level of distress and is not able to handle things with available coping skills.
- For substance use, ASAM (American Society for Addiction Medicine) admission criteria will be used. A Urine Drug Screen (UDS), test stick, and Breathalyzer are considered when progress is not occurring, when substance use is suspected, or when substance use and medications may have a potential adverse interaction. After a positive screen, additional random screens are considered and referral to a substance use. These screening methods are used in substance programs to most effectively determine alcohol/drug use.

The family will be assessed for the following:

- Youth and family commit to being full participants in a treatment plan
- Youth and family desire and are willing to consistently attend services
- Severe stress and family issues indicate need for case management to assist the youth and family issues.

When Treatment is not effective or additional time is needed

Once a youth and his or her family are participating in outpatient treatment, there are times when additional services may be needed or an extended period of time participating in the services is needed. In general the treatment objectives are not met but a reasonable expectation exists that continued treatment will have an impact on symptoms and wellbeing.

Completion of Services

- Treatment objectives are met
- Level of functioning has improved – youth is doing better
- Youth and/or family demonstrate a lack of progress in treatment as evidenced by a lack of compliance attention to the treatment plan and absence of treatment poses no imminent risk to self or others
- Individual's history and current progress in treatment provide evidence that additional services will not create further improvements and /or change.
- Treatment is primarily supportive in nature; Referral to community resources is appropriate
- Youth and family decline continued treatment
- Youth or family are not consistently attending counseling appointments, not showing up, or
- Youth requires higher level of care such as Day Treatment or Residential
- ASAM (American Society for Addiction Medicine) Youth Outpatient Discharge Criteria met.

The Work Group recommends the following considerations be incorporated in the decisions for extended outpatient treatment authorization:

- Youth and family are attending counseling appointments
- Treatment provided is leading to improvements in symptoms and quality of life
- Unresolved issues, if present, do not present risk to ability to maintain improvements
- Youth continues to experience both psychiatric symptoms and problems in everyday life
- Youth has benefited and made progress with Outpatient Services but requires additional treatment to reach ability to sufficiently function and maintain improvements
- The youth has developed new symptoms and current improvements are unlikely to be unless new symptoms are targeted for change
- Family continues to require treatment to support youth's improvement.

These criteria are consistent with best practices incorporated into the American Society for Addiction Medicine) -Substance use Program Admission Criteria guidelines. (See Reference at http://www.asam.org/education/fundamentals-of-addiction-medicine-resources.)

Section III. Systems Performance and Measures of Effectiveness

Quality Assurance – practice standards and performance measures

Systems Outcomes and Proposed Measures of Effectiveness[4]			
Level	**Topic**	**Description and central focus of measures**	**Crosswalk to SAMHSA Domains**
System/ Payer	**1. Access**	Percentage of the referrals that: • Utilize community behavioral support services •Attendance rates for services included in family plan	Health
	2. Utilization	Rates and percentages for: • Outpatient services • Participation in ongoing community peer and family programs • Percentage referred for services through Family Assessment and Planning Teams	Other (*Infrastructure)*
	3. Cost	Cost of care • Expenditures per family – year one	Other *(Infrastructure)*
Provider	**4. Practice**	Key practices relevant for youth with behavioral health conditions • Percentage of referred youth reporting WHAT? • Youth and family engagement/involvement/voice and choice • Medication usage, delivery and adherence • Side-effects • Medication management • Follow-up after prescribing of behavioral health related medication	Other *(Infrastructure)*
	5. Living Environment	• Child later enters residential services • Child later enters foster care	Home
Youth/ Family Functioning	**6. Behavioral Health and Physical Health**	Behavioral health factors • Clinical assessment and level of functioning • Caregiver strengths/risks • Symptom severity/reduction/management • Youth daily living skills General physical health measures • Weight and nutrition, Body Mass Index (BMI) screening • Management of chronic conditions • Assessment of potential physical effects of behavioral health medications • Dental care	Health
	7. Employment, Education and Other Responsibilities	• School placement, attendance, achievement • Employment • Volunteer activities	Purpose

[4] Adapted for community based services from proposed systems measures for residential care from National Building Bridges Initiative (BBI): "Building Consensus on Residential Measures: Recommendations for Outcome and Performance Measures."

Systems Outcomes and Proposed Measures of Effectiveness[4]			
Level	**Topic**	**Description and central focus of measures**	**Crosswalk to SAMHSA Domains**
Youth/ Family Functioning (continued)	**8. Family and Community**	Measures of social supports and community engagement • Community/neighborhood strengths/weaknesses • Justice involvement • Social relations • Parental rights	Home/ Community
Experience of Care	**9. Experience of Care**	Opinions about the care and the supports received and satisfaction with services, transitions and outcomes; reports of services received	Other

Proposed Goals for Youth:

1) live in a safe, stable and supportive environment,

2) have the ability to undertake key activities of daily living (such as self-care, recreation, work and school activities),

3) engage in meaningful activities with supportive relationships and social networks, and

4) maintain good physical and behavioral health. [5]

[5] Adapted from Building Bridges (BBI) Performance Guidelines and Indicators Matrix3 and the BBI Outcomes Tip Sheet; http://www.buildingbridges4youth.org/sites/default/files/Building%20Bridges%20Matrix%20Final%20for%20web.pdf.

Section IV. Implementation Recommendations

Training

To effectively implement this process, staff training is needed on the following:

Referring staff – GAIN –SS

Behavioral health staff in FCPS and HS: - Resource and referral training

-Evidence-informed mental health and substance use treatment practice standards and regulations

Considerations

FCPS and HS have different mandates from various funding sources and statutory or regulatory requirements. Different methods exist in agencies of identifying service opportunities for youth and families. Staff capabilities in managing and utilizing a service system for entry and service provision is a significant area needing training for service provision.

Parent and Family Engagement

Our practice standards emphasize youth and family choice in service planning and provider selection. For families with private health insurance, assistance will be offered to access these resources.

The work group recommends further investment in peer supports and family support services as a component of treatment.

Procedures

To provide a service system for these youth and families, formal policies and procedures need to be established for use by all human services and public schools programs. Such policies and procedures provide for structure to ensure more consistent system operation and provide adherence to best practice, risk management, legal, or other local, state, mandates.

Electronic Health Records

The work group recommends utilization of an electronic health record for behavioral health service planning and documentation of key system reporting requirements. The CSB Credible system is a viable option for use by third party providers.

Reimbursement and fees

The work group recommends a standard reimbursement and fee policy for access to the services.

Implementation schedule and key milestones plan

- The Interagency Youth Behavioral Health Work Group be directed to meet with interested community behavioral health providers to review proposed services. The purpose is to determine interest in completing contractual agreements for provision of services to individual youth and their families.
- Explore options for access and oversight to ensure compliance with the County health integration efforts through the Fairfax County Health Collaborative. Request participation of the consultant services supporting the completion of the CSB Youth Services Division Resource Plan.

Systems of Care Implementation

The Work Group recommends continuation of the interagency staff meetings on a monthly basis for the continuation of the implementation plan and to operationalize the new Systems of Care office.

Address Gaps in Early Intervention Family Supports

Additional services are needed for linking families to parent education services. Curriculum is needed for families with children who have conduct concerns, and those who have suffered from exposure to trauma. The majority of existing services reside in the Department of Family Services, where the target population is families with children (the majority of whom are in the birth to age 12 age range) whose children have not received a mental health diagnosis but are referred to programs due to family or child risk factors including poverty, delays in child development, family histories of abuse or neglect, and other family stressors that are affecting the children's well-being.

The children may exhibit delayed development, difficulty in school/irregular school attendance and have behavioral/emotional issues. These may be due to low levels of parental involvement, lack of parenting skills, poor family bonding/family conflict, inaccurate knowledge and expectations about child development, birth anomalies or inadequate prenatal care. High levels of family stress may be due to parental unemployment and/or unstable housing, non-resident immigration status, disability or chronic health issues, or due to untreated mental illness (depression, anxiety) or substance abuse on the part of the parents.

Prevention and early intervention services are educational and supportive in focus, however needs and resources for therapeutic/treatment services for parents may also be identified.

Appendix I.

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Chestnut Health Systems

GAIN-Short Screener (GAIN-SS)
Version [GVER]: GAIN-SS 2.0.3

What is your name? a._____ b. ____ c. _____
(First name) (M.I.) (Last name)

What is today's date? (MM/DD/YYYY) ____/____/_____

The following questions are about common psychological, behavioral, and personal problems. These problems are considered significant when you have them for two or more weeks, when they keep coming back, when they keep you from meeting your responsibilities, or when they make you feel like you can't go on. After each of the following questions, please tell us the last time that you had the problem, if ever, by answering, "In the past month" (3), "2-12 months ago" (2), "1 or more years ago" (1), or "Never" (0).	Past month	2 to 12 months ago	1+ years ago	Never
	3	2	1	0
1. When was the last time that you had significant problems…				
a. with feeling very trapped, lonely, sad, blue, depressed, or hopeless about the future?	3	2	1	0
b. with sleep trouble, such as bad dreams, sleeping restlessly, or falling asleep during the day?	3	2	1	0
c. with feeling very anxious, nervous, tense, scared, panicked, or like something bad was going to happen?	3	2	1	0
d. with becoming very distressed and upset when something reminded you of the past?	3	2	1	0
e. with thinking about ending your life or committing suicide?	3	2	1	0
2. When was the last time that you did the following things two or more times?				
a. Lied or conned to get things you wanted or to avoid having to do something?	3	2	1	0
b. Had a hard time paying attention at school, work, or home?	3	2	1	0
c. Had a hard time listening to instructions at school, work, or home?	3	2	1	0
d. Were a bully or threatened other people?	3	2	1	0
e. Started physical fights with other people?	3	2	1	0
3. When was the last time that…				
a. you used alcohol or other drugs weekly or more often?	3	2	1	0
b. you spent a lot of time either getting alcohol or other drugs, using alcohol or other drugs, or feeling the effects of alcohol or other drugs?	3	2	1	0
c. you kept using alcohol or other drugs even though it was causing social problems, leading to fights, or getting you into trouble with other people?	3	2	1	0
d. your use of alcohol or other drugs caused you to give up, reduce or have problems at important activities at work, school, home, or social events?	3	2	1	0
e. you had withdrawal problems from alcohol or other drugs like shaky hands, throwing up, having trouble sitting still or sleeping, or that you used any alcohol or other drugs to stop being sick or avoid withdrawal problems?	3	2	1	0

Youth Behavioral Health Interagency Human Services and Public Schools Work Group

Interagency Youth Behavioral Health Services Work Group

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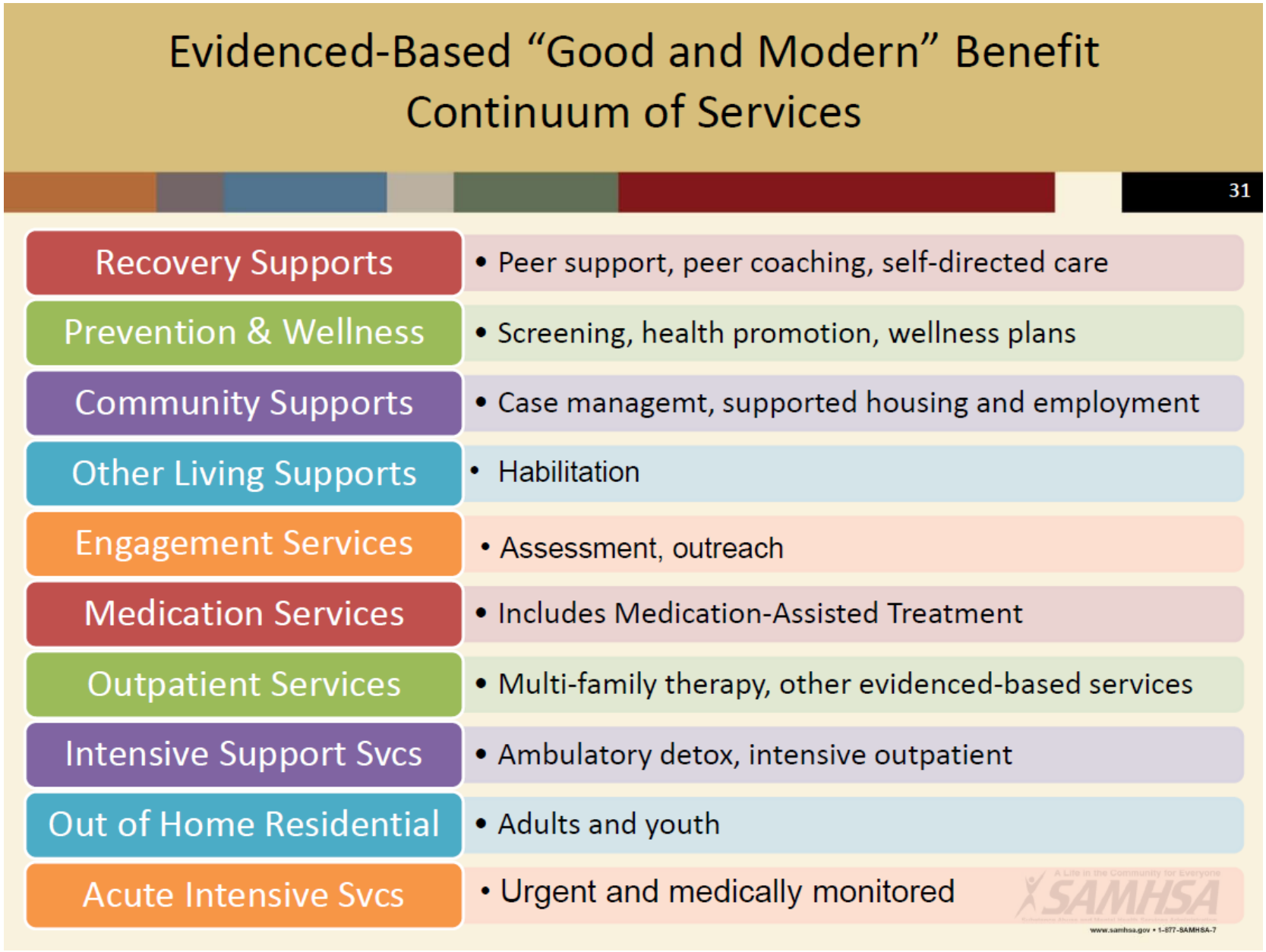
Resources

1. Substance Abuse & Mental Health Services Administration - http://www.samhsa.gov/
2. Fairfax County Youth Survey http://www.fairfaxcounty.gov/demogrph/pdf/2012_youth_survey_report.pdf
3. "Creating an Integrated Approach to the Care of Vulnerable Populations in Fairfax County: A Work Plan" www.fairfaxcounty.gov/healthreform/
4. "Mental Health Care for Youth: Who Gets It? How Much Does It Cost? Who Pays? Where Does the Money Go?" December 2001: http://www.rand.org/pubs/research_briefs/RB4541/index1.html
5. "APA's Response to the Surgeon General's Action Agenda for Children's Mental Health Report of the APA Working Group on Children's Mental Health to the Board of Directors, American Psychological Association"; December 2001 http://www.apa.org/pi/families/resources/national-agenda.pdf

Local/State Models

6. "Transforming Children's Behavioral Health Care: A Plan for Improving the Behavioral Health of New Hampshire's Children"; The **New Hampshire** Children's Behavioral Health Collaborative – 2013" http://www.endowmentforhealth.org/uploads/documents/resource-center/cbhphires.PDF and http://healthynh.com/
7. **Ramsey County MN** Children's Mental Health Collaborative: Weaving together parents' voices and systems of care for children's mental health http://www.rccmhc.org/about.cfm
8. **Indiana** - http://www.childrenscoalitionin.org/wp-content/uploads/2011/06/Physical-and-Mental-Health.pdf
9. Governing Council model – **Maricopa County, Arizona** - http://mihs.org/fhc-board/fhc-board/\
10. Integrated health Care dashboard for youth behavioral health – Arizona: http://www.azdhs.gov/bhs/dashboard/documents/scorecard-summary-gsa-child.pdf
11. Training tools: West Virginia: https://livewell.marshall.edu/mutac/?page_id=686&page_id=686 (CBT Training, CSMHA quick Guide for CBT; Cognitive B. Therapy Skill disorders)


Evidenced-Based "Good and Modern" Benefit Continuum of Services
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Recovery Supports
• Peer support, peer coaching, self-directed care
Prevention & Wellness
• Screening, health promotion, wellness plans
Community Supports
• Case managemt, supported housing and employment
Other Living Supports
• Habilitation
Engagement Services
• Assessment, outreach
Medication Services
• Includes Medication-Assisted Treatment
Outpatient Services
• Multi-family therapy, other evidenced-based services
Intensive Support Svcs
• Ambulatory detox, intensive outpatient
Out of Home Residential
• Adults and youth
Acute Intensive Svcs
• Urgent and medically monitored
SAMHSA

National Quality Strategy

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STRATEGIES

1. Making care safer by reducing harm caused in the delivery of care.
2. Ensuring that care engages each person and family as partners.
3. Promoting effective communication and coordination of care.
4. Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease.
5. Working with communities to promote wide use of best practices to enable healthy living.
6. Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models.

A Life in the Community for Everyone
SAMHSA
Substance Abuse and Mental Health Services Administration
www.samhsa.gov • 1-877-SAMHSA-7