Center for Evidence-based Partnerships in Virginia
Year 1, Q1 Progress Report to VDSS

Version date: Oct. 8, 2021

Q1 SUMMARY of ACTIVITIES

The first phase of the Needs Assessment and Gaps Analysis (NAGA) project included six individual projects, each designed to satisfy the aims of NAGA in a unique way and through various methods. Quantitative and qualitative data for analyses were collected from up to approximately 478 participants. Detailed findings, presented in a separate report, led to the identification of several service gaps across VDSS regions as well as crucial considerations for implementation of EBPs. Each project was carried out with the goal of informing one or more of the Center's duties for the contract:

1. **Contextual Analysis**: Detailed review of various policy documents relevant to FFPSA and the contract to help the NAGA team become more aware of the relevant context for the project and to guide preliminary data visualization mapping.
2. **Stakeholder Survey**: Survey sent to participants from several NIRN trainings.
3. **Interview Series**: One on one interviews held with approximately 40 stakeholders
4. **Listening Forums**: VDSS assisted in organizing 11 listening sessions, helping the Center register over 200 attendees. Approximately 175 community members showed up to voice opinions concerning mental health needs respective to their locality.
5. **Public Services Inventory**: Center team began a process of characterizing the behavioral health service arrays of each CSB coverage area.
6. **Eligible Provider Analogue**: Companies, agencies, and individual clinicians licensed to provide behavioral health services to families are in the process of being collected to begin to elucidate service capacity of the current workforce.

RECOMMENDATIONS:

Given the initial findings from the six projects listed, we formulated several initial recommendations for VDSS to consider to strengthen workforce capacity to meet needs and close services gaps. Please note that we intend to continue to refine our recommendations as more data come available. Thus, these ten are what we recommend at this point in time, given what we know. Recommendations are not presented in any particular order.

1. Strengthen LDSS engagement with families through frontline personnel training in Motivational Interviewing (MI)
2. Integrate family/peer support partners, or peer recovery specialists, into LDSS operations
3. Strengthen evidence-based service planning of frontline personnel via adoption of and training in Managing and Adapting Practice (MAP)
4. Implement well-supported EBP from clearinghouse to provide options for school age children (e.g., BSFT) or consider building a plan for implementing a supported program (e.g., Triple P)
5. Further analyze systems crossover and present avenues for improving coordination with other child-placing agencies or departmental entities represented at the local level, namely DJJ, CPMT/CSA coordinators, and CSBs
6. Supplement the service arrays of the CSBs listed above the line in Table 1b in NAGA Report, in addition to those detected by VDSS data personnel
7. Build VDSS community outreach presence as model for local departments

8. Align with Virginia ONE and its initiatives dedicated to racial equity
9. Further invest in FSS retention and improvement of DSS workplace culture
10. Consider broadening VDSS's current target population for FF funding from in-home/high-risk cases only to those categorized as family support cases, which are families who require tangible social aid to maintain housing, nutrition, etc.

NAGA Report
Initial Phase

Version: October 8th, 2021

The Center for Evidence-Based Partnerships in Virginia (hereafter, the Center) set out to help address questions posed by our VDSS partners regarding the needs of families they serve and where in Virginia specific services could be implemented to better strengthen families. VDSS's plan to help enhance the state's behavioral health service array was made possible by the Family First Prevention Services Act, passed in 2018 to permit new allocations of Title IV-E spending towards evidence-based service programming. In response to VDSS's request, the Center developed the Needs Assessment Gaps Analysis (NAGA) project and began to assess the mental health needs and service gaps within VDSS's five regions.

NAGA Aims

- Provide ongoing, data-based estimates of current mental health service capacity within each region in Virginia
- Determine the appropriateness of preexisting services for Family First (FF) target population
- Recommend evidence-based programs (EBPs) designed to address identified needs of FF target population
- Identify systems factors that have been shown to impact EBP sustainment in effectiveness trials

The first phase of NAGA included an initial needs assessment to identify *behavioral health needs* that prevent families and individual caregivers from maintaining child safety at home. These factors can include specific mental health concerns, or descriptions of behaviors, that are observed to be disruptive to family wellbeing, such as excessive drug use or exposure to violence. Behavioral health needs were examined within context, according to region, locality, systems of care, to begin to form hypotheses related to systemic drivers and environmental correlates to health.

Once needs and systemic-level factors began to be identified, the Center started to plan how to characterize the current service landscape of all five VDSS regions. It is important to evaluate whether appropriate services, including programs indicated through use of research and empirical evidence, are thought to be available within the community regardless of whether they are meeting stakeholder threshold for effectiveness. Determining which services are present requires either access to administrative records that document services as rendered and paid for, or a mixed-methods approach that relies on multiple sources and types of data. All information and data collected were used to inform the recommendations described herein. As this is our initial report and the work of NAGA is designed to be ongoing, these recommendations may (and hopefully will) be refined and change over time, as new data come available.

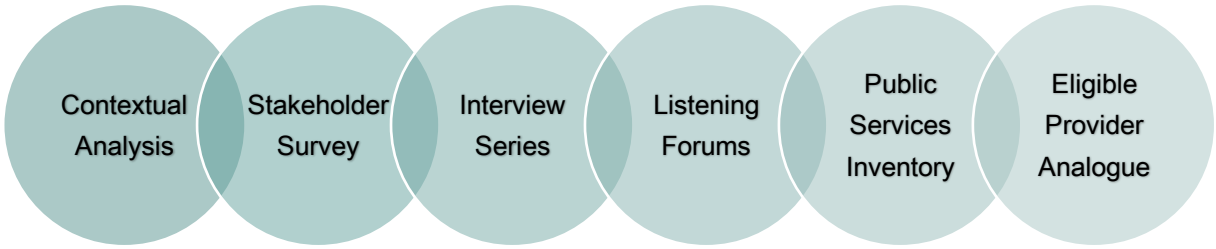
NAGA Roadmap

The Center designed NAGA to be representative of a suite of approaches for data collection and synthesis. This means NAGA can be applied to other organizational structures or agencies interested in receiving a deeper look into the existing knowledge, workflows, assumptions, and expectations of their workforce and those of intersecting systems. This type of approach centers meaning discovery over statistical comparison and guides the development of research questions and hypotheses related to desired outcomes.

For VDSS, the initial components of NAGA include six *projects* whose titles reflect a particular method of measurement (see Figure 1). Projects where qualitative and descriptive data were collected from groups of participants include the Stakeholder Survey, Interview Series, and Listening Forums. The other three projects, the Contextual Analysis, Public Services Inventory, and the Eligible Provider Analogue are essentially foundational databases that continue to build and hone their contents over time. They represent the Center's initial knowledge

banks that were designed to serve as continuous sources of information to be updated regularly. All six projects were designed to respond to inquiries tasked to the Center by our VDSS partners.

Figure 1. *NAGA projects presented in chronological order of design*



In Figure 2, a broad "roadmap" illustrates how the Center envisions NAGA's extension beyond its first phase. Since NAGA is comprised of methods, it can be applied to other topics or inquiries posed by our state partners. For our partners at VDSS, we imagine NAGA's design could help to serve as a feedback model and integrated into current continuous quality improvement (CQI) in development.

Figure 2. *NAGA Roadmap*

NAGA PROJECT #1: Contextual Analysis

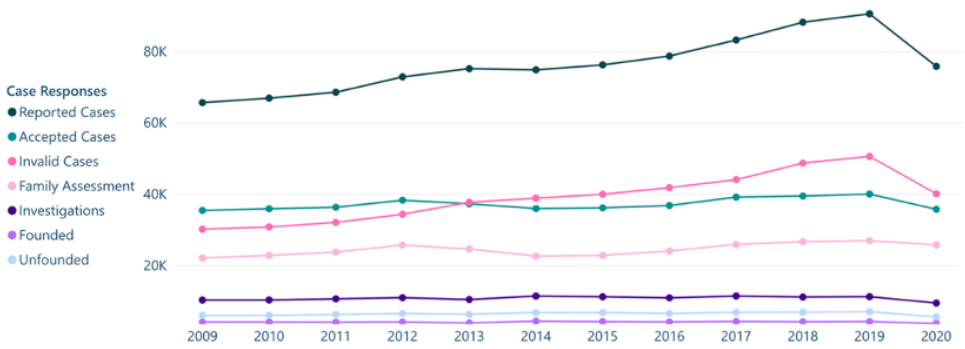
For the Center to provide recommendations that would be useful to its partners and fellow Virginians, context had to be ascertained to serve as a foundation and reference point for other NAGA findings. For our initial contextual analysis, we focused on (a) archival records and (b) maps built from archival data sets relevant to the overall project (e.g., CPS referral by locality, foster care entry by locality). Information gleaned from these two sources was then compared alongside data visualizations provided by our VDSS partners. We describe our data sources and our initial findings next.

Archival records. Records include documents affiliated with any state or federal government body, legislative proceedings, state and county-level resource evaluations, publicly available meeting recordings, and public datasets released by non-profit organizations. The following were accessed to help provide context for the first report:

- Code of Virginia: Chapter 52 Children's Services Act
- 2011 DBHDS Plan for Community-Based Children's Behavioral Health Services in Virginia (Item 304.M Final Report)
- 2015 Child and Youth Crime Victims Stakeholder Survey (Linking Systems of Care initiative)
- 2016 QIC-WD VDSS Site Profile
- 2016 Cross-Systems Mapping Events, Vision 21: Linking Systems of Care
- 2018 Virginia Behavioral Health Redesign Stakeholder Report (Virginia Department of Health)
- 2018 CDC Social Vulnerability Index
- 2018 DMAS Stakeholder Workforce Survey
- 2018 Linking Systems of Care for Children and Youth Virginia
- 2019 CSA Service Gap Survey
- 2019 DSS Local Board Member Handbook
- 2019 VDSS Child and Family Services Manual: Ch. 8 Achieving Permanency Goal Return Home
- 2020 Community Health Needs Assessment prepared for Health Planning District 9 by Community Health Solutions
- 2020 Virginia Child Protective Service Accountability Referrals and Agencies Annual Report
- 2021 DBHDS Systems of Care Grant Application Rationale
- 2022-2023 DBHDS Community Services Performance Contract for CSBs

Child welfare data mapping. Trends associated with child protective service (CPS) involvement were examined through map visualizations to further define locality-level need and potential service gaps according to region. The Center leveraged findings from needs assessments conducted in the past to select which variables related to child maltreatment to include and potentially map, such as CPS referrals and referral recidivism, foster care entry, economic climate, and caregiver substance use correlates.

Figure 3. *Child protective services case response trends*



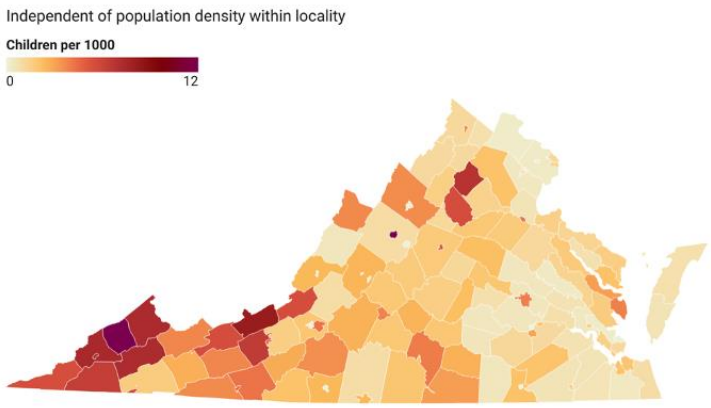
Referrals to child protective services dropped nationally as well as in Virginia during the global pandemic (see Figure 3); therefore, efforts were taken to compile and examine trends prior to March 2020, unless noted otherwise.

CPS referral. It is common to examine referrals to CPS to approximate occurrence

of child maltreatment. However, the CPS referral rate of any locality depends on the ways in which communities have been set-up and structured to facilitate interaction amongst its members (i.e., exposure to mandated reporters). In other words, referral rates are likely to be more indicative of the community-based behavioral health services and accessibility to them within a given area than the nature and level of child maltreatment. A higher referral rate to social services is more likely to reflect a community's capacity to provide services and supports to its more vulnerable populations, which is an important consideration for future implementation of services.

Referral recidivism, while may not directly relate to child maltreatment, provides a more precise estimate than referral counts alone. Community-level drivers, like lack of access to effective behavioral healthcare, continue to contribute to how often a family is referred. Examining how often the same families return provides additional information associated with individual localities. A high return rate may indicate an overextended workforce, an inefficient or insufficient reporting procedure, or another factor associated with how local departments determine risk. Additional context is helpful when using this variable to make decisions regarding service gaps and community needs, which will be provided when revisited below.

Figure 4. *Average yearly foster care entry rate by locality*



Foster care entry. The rate in which children referred to CPS enter the foster care system provides data related to a local department's approach and typical procedures for serving families. To prevent localities with higher child population density from rising to the top of list due to volume alone, foster care entry is examined as a rate, i.e., the number of children per 1,000 children in each locality's child population. Values include 10-year annual averages using public data from 2009-2019 (Annie E. Casey Kids Count Data). Figure 4 illustrates foster care entry rates by locality.

Table 1a. *Top 25 localities with the highest annual foster care entry rates listed beside foster care entry counts in Virginia and their associated CSBs*

Locality	**Rate**	**Count**	**CSB** (R/U)
Dickenson	11.95	35	Dickenson (R)
Staunton*	11.91	55	Valley (R)
Giles	8.20	28	New River Valley (R)
Norton	7.88	7	Planning District One (R)
Wise*	7.45	56	Planning District One (R)
Buchanan	7.32	29	Cumberland Mtn. (R)
Russell*	7.27	38	Cumberland Mtn. (R)
Rappahannock	6.86	9	Rappahannock-Rapidan (R)
Pulaski*	6.44	39	New River Valley (R)
Scott	6.33	25	Planning District One (R)
Bristol	5.81	21	Highlands (R)
Bland	5.59	6	Mount Rogers (R)
Madison	5.55	15	Rappahannock-Rapidan (R)
Craig	5.55	5	Blue Ridge (U)
Lee	5.53	25	Planning District One (R)
Charlottesville*	5.43	40	Region Ten (R)
Galax	4.69	7	Mount Rogers (R)
Radford	4.43	8	New River Valley (R)
Roanoke City*	4.31	96	Blue Ridge (U)
Carroll	4.28	24	Mount Rogers (R)
Fredericksburg	4.26	27	Rappahannock Area (U)
Charlotte	4.04	11	Crossroads (R)
Richmond City*	3.96	160	Richmond BHA (U)
Mathews	3.95	5	Mid Pen.-Northern Neck (R)
Lynchburg*	3.88	61	Horizon (R)

*It is important to note that localities with an asterisk (*) would remain in the top 25 if foster care entries were measured by *counts*, and not controlling for population density.

Since one of the primary goals of NAGA is to elucidate service gaps, localities have been listed with their associated CSBs in Table 1a. CSBs precede an identifier in parentheses related to their classification as urban (U) or rural (R). DBHDS defines population densities of 200 people or more per square mile as the threshold for categorization.

Table 1b presents foster care entry rate according to CSB coverage area. CSBs are listed in order of greatest average foster care entry rate to lowest average foster care rate. Averages were calculated using the non-zero rates exhibited by each locality within a given CSB.

The non-zero state average for foster care entry is a rate of 2.54. CSBs with a greater rate, listed above the green line in Table 1b, account for approximately **46%** of the total number of annual foster care entries.

Table 1b. *CSB foster care entry rates*

CSB/BHA	Avg annual entry rate	Avg annual entry count	Percent of total entries
Dickenson	11.95	35	1.30
Planning District One	6.80	113	4.20
Cumberland Mtn.	6.13	98	3.64
Valley	5.54	70	2.60
New River Valley	4.70	109	4.05
Mount Rogers	4.14	85	3.16
Richmond BHA	3.96	160	5.94
Highlands	3.77	38	1.41
Harrisonburg-Rockingham	3.64	67	2.49
Rappahannock-Rapidan	3.58	93	3.45
Blue Ridge	3.19	145	5.38
Piedmont	2.73	70	2.60
Horizon	2.60	145	5.38
Alleghany Highlands	2.48	7	0.26
Region 10	2.27	113	4.20
Portsmouth	2.12	47	1.75
Norfolk	1.99	98	3.64
Crossroads	1.95	37	1.37
Southside	1.90	34	1.26
Rappahannock Area	1.88	131	4.86
Mid Pen.-Northern Neck	1.83	42	1.56
District 19	1.77	58	2.15
Danville-Pittsylvania	1.74	34	1.26
Rockbridge Area	1.56	10	0.37
Northwestern	1.55	76	2.82
Alexandria	1.45	43	1.60
Goochland-Powhatan	1.39	12	0.45
Hampton-Newport News	1.30	98	3.64
Arlington	1.20	50	1.86
Virginia Beach	0.98	101	3.75
W Tidewater	0.92	26	0.97
Colonial	0.85	15	0.56
Eastern Shore	0.72	7	0.26
Henrico Area	0.70	44	1.63
Fairfax-Falls Church	0.67	101	3.75
Chesterfield	0.52	43	1.60
Hanover	0.52	12	0.45
Prince William	0.52	67	2.49
Chesapeake	0.46	27	1.00
Loudon	0.27	31	1.15

Economic climate. Poverty and associated economic hardships are well-established risks factors for child maltreatment and removal. Figure 5a lists the counties and independent cities where poverty is most concentrated in the state according to the Virginia ONE dashboard. Almost all of the counties and independent cities listed in Figure 5a were represented in Figure 4 and Tables 1a-b. Listed areas in Figure 5a overlap with 8 service provision areas from Table 1a-b: Blue Ridge Behavioral Healthcare, Crossroads CSB, Cumberland Mountain CSB, Dickenson County Behavioral Health Services, Highlands CSB, Mount Rogers CSB, Planning District One Behavioral Health Services, and Richmond BHA. The remaining 4 CSBs include Southside, District 19, Rockbridge Area, and Danville-Pittsylvania. These 12 CSBs cover the areas for which **33%** of the estimated volume of children who entered foster care annually resided.

Figure 5a.[1]

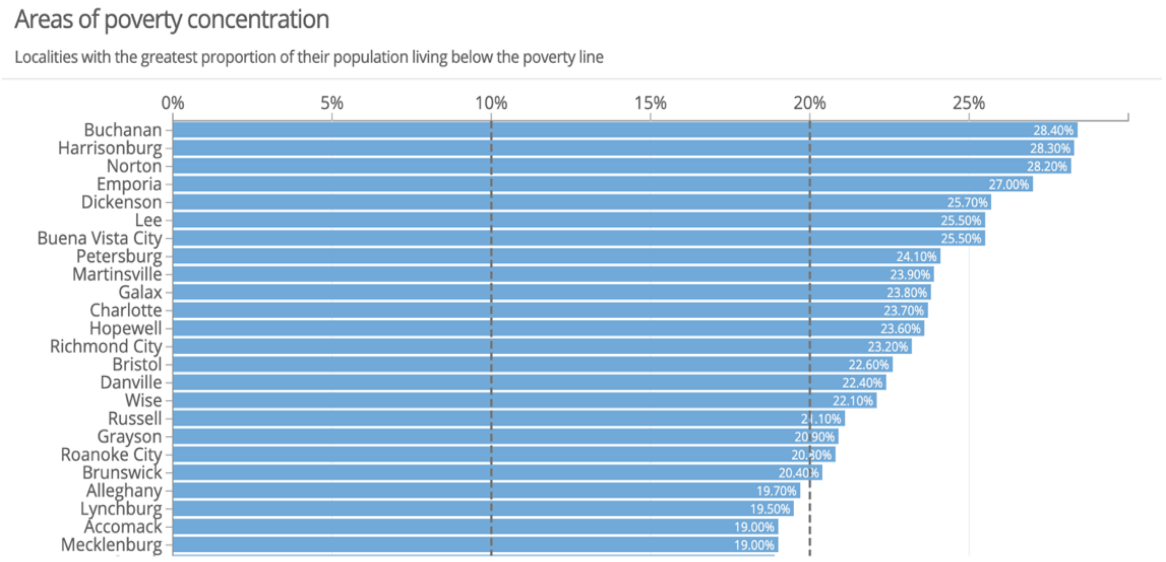


Figure 5b. *Average yearly foster care entry rate by locality with economic climate overlap*

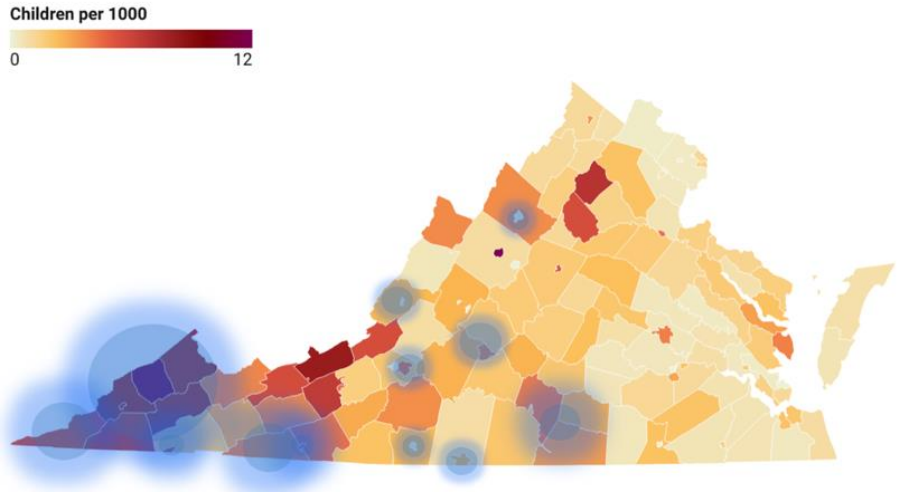


Figure 5b illustrates this overlap geographically, with emphasis added to the areas where both indicators covered so far (foster care entry rate and economic climate) at their highest levels converge.

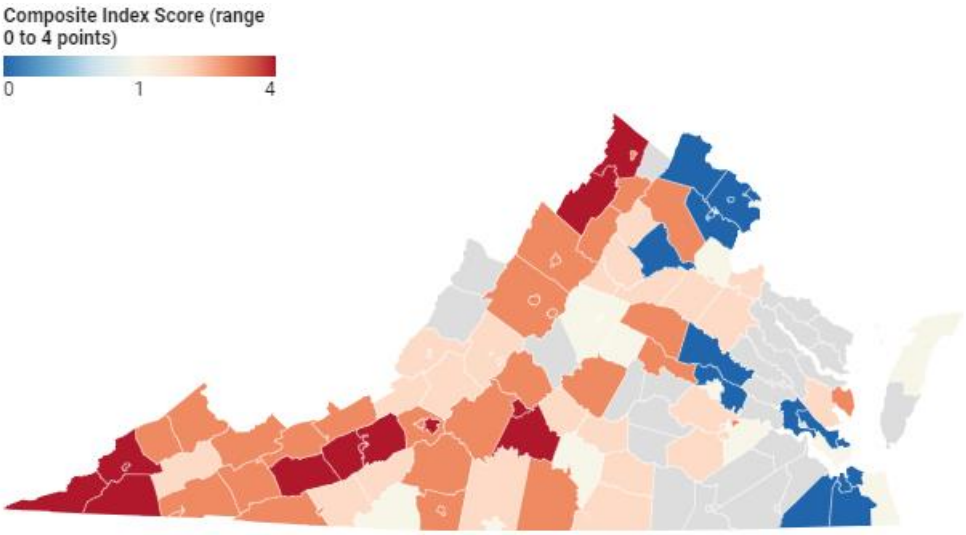
[1] *Note.* For the purposes of NAGA, localities where greater than 92% of their population achieved a high school diploma were removed to prevent capturing individuals who are likely to receive external income or funding such as financial aid while enrolled in higher education. For example, Radford has a poverty rate of 36%, a high school diploma rate of 95%, and is home to approximately 10,000 undergraduate and graduate students. The diploma threshold did not remove all independent cities or localities with college populations.

Caregiver substance use disorder. One of the fastest growing reasons for child removal is parent or caregiver misuse of alcohol and/or drugs. To see where substances impact family preservation and child wellbeing, the Center and VDSS personnel worked together to identify four data indicators collected internally that may relate to caregiver substance use disorder (SUD). These indicators include, a) caseworker-reported caregiver substance abuse, in addition to locality-specific retrospective data such as, b) identified circumstance for removal, c) referral recidivism, and d) prior substance exposed infant (SEI) allegations. See Table 2. To calculate the composite index, a locality was assigned a point for every criterion that rose above the state average, final values ranging from 0-4. The composite index allows all four data variables from Table 2 to be represented with one map visualization (Figure 5) where different colors reflect number of criteria met per locality.

Table 2. *VDSS composite index criteria*[2]

Variable	Definition	Timeframe	State avg
Caregiver SUD	Proportion of screened in referrals where caretaker SUD was indicated by the caseworker	3-year average, 2019-2021	29%
Referral recidivism	Proportion of screened in referrals received in month where child had 3 or more prior referrals	12-month average, 2020-2021	22%
Reason for removal	Proportion of entries into foster care where parent drug abuse was noted as a causal circumstance	5-year average, 2017-2021	33%
SEI prevalence	Proportion of screened in referrals where child is under 5 and caregiver has a prior SEI allegation	3-year average, 2019-2021	3%

Figure 5. *VDSS composite index*



For caregiver SUD composite index, 13 localities (9 counties, 4 independent cities) met all criteria (index = 4) and are served by 6 different CSBs. Most of these CSBs were captured in Table 1a, except for one, Northwestern CSB. Approximately **26%** of the volume of children who entered foster care between 2009 and 2019 resided within jurisdiction of these 6 CSBs.

[2] *Note.* Based on the multi-year annual average of entries into care, LDSS with fewer than five entries as their average were not assigned an Index score for the maps/to determine CSB hotspots, but their data were included in the CSB and regional aggregate summaries.

NAGA PROJECT #2: Stakeholder Survey

A survey distributed by our partners at OCS returned 177 participants. See Table 3 for sample characteristics. All five regions were proportionately represented, except Western (n = 14); therefore, survey findings associated with the Western region should be interpreted relative representation.

The goal of the stakeholder survey was to assess organizational readiness for EBP implementation, stakeholder familiarity and knowledge of EBPs, and availability of the EBPs currently present in Virginia. Majority (59%) of stakeholders provided their contact information to the Center for the opportunity to participate in a future survey for monetary compensation (n = 105).

Organizational readiness. Ten items related to how ready or prepared an organization is for change, in this case EBP implementation, were presented to stakeholders to indicate level of agreement. Each item contained a Likert scale that ranged from *Strongly disagree* (1) to *Strongly agree* (5). Overall, stakeholders reported a high level of organizational readiness for EBP implementation. Items with some variability across responders have been grouped according to region in Table 4.

In Table 4, values closer to 5 indicate higher agreement with an item. For instance, stakeholders in the Northern region were less likely to agree with the statement, *We can manage the politics of implementing new EBPs*, than those from the Western region, on average.

Table 3. *Stakeholder survey sample demographics*

Demographic	**n**	**%**
Region		
Northern	45	26.3
Central	41	24.0
Piedmont	36	21.1
Eastern	35	20.5
Western	14	8.2
Job title *(check all that apply)*		
Service provider	25	--
Broker	24	--
Senior leader	50	--
Clinical/admin. supervisor	26	--
Program manager	39	--
Other	48	--
Race/Ethnicity		
White	137	80.6
AA/Black	25	14.7
Native Amer./Alaskan	4	2.4
Eastern/Southern Asian	2	1.2
Hispanic	*7*	*4.0*
Gender		
Female (majority)	154	88.5
Highest degree/education		
M.A./M.S.	104	59.8
B.A./B.S.	57	32.8
Ph.D./Psy.D./MD	7	4.0
H.S. diploma	2	1.1
Other	4	2.3
Primary setting		
Social services	79	45.7
Community service board	28	16.2
Juvenile justice	19	11.0
School district	16	9.2
Private provider	6	3.5
Other	25	14.5

Table 4. *Organizational readiness by region*

Selected items	**M (SD)**				
	Northern	Central	Eastern	Piedmont	Western
We are motivated to implement new EBPs.	4.51 (0.64)	3.92 (0.98)	4.27 (0.72)	4.40 (0.74)	4.64 (0.50)
We will do whatever it takes to implement new EBPs.	3.98 (0.88)	3.59 (1.02)	3.94 (0.86)	3.99 (0.79)	4.31 (0.75)
We can manage the politics of implementing new EBPs.	3.61 (0.92)	3.72 (0.86)	3.55 (0.83)	3.86 (0.88)	4.21 (0.97)
We can handle the challenges that might arise in implementing new EBPs.	3.68 (0.85)	3.77 (0.81)	3.58 (0.75)	3.91 (0.78)	4.08 (0.86)

EBP familiarity and availability. Stakeholders were also presented with a list of services including behavioral health interventions and EBPs, treatment families that EBPs commonly belong to (e.g., *parent management training*), and general therapeutic practices (e.g., play therapy, exposure therapy). Stakeholders were asked how familiar they were with each service and each service's current availability to the families living within their locality. If the service was endorsed as *available*, additional questions were presented related to typical waitlists. If *not available* was endorsed, stakeholders were asked whether that service was needed, to which they could reply *yes* (3 levels), *no*, or *unsure*.

Tables 5a-e present survey findings for EBP familiarity and availability broken down by VDSS region. The list of services in each table represent a sample of the full list of services presented to stakeholders. These were chosen based on their range and association to the evidence base. The green columns contain percentages of respondents that endorsed a service as being available currently and familiar to the responder. An individual's responses to the items in the green columns influenced whether they were asked either if they believed the service was needed (blue column), or how long they estimate the waitlist being after referral to the service.

Table 5a. *Percentage of stakeholders from the* ***Northern*** *region (n = 45) who agreed with the following*

Service	**%**		**Y/N, U**	Waitlist (mo.)
"In my locality, X is …	*…available."*	*…familiar."*	*…needed."*	
PCIT	39	78	14/14	<1-3
MST	67	94	3/3	1-2
FFT	72	94	2/2	<1-2
TF-CBT	75	97	3/3	<1-2
HFW	53	69	3/4	<1-2
Parenting skills classes	78	100	2/2	<1-3
Parent management training	14	33	8/11	<1
Play therapy	78	100	4/4	<1-2
EMDR	47	78	6/6	<1-2
Exposure therapy	17	69	4/5	1-3

Note. This means High Fidelity Wraparound was described as an ***available*** service to 53% of survey responders from the Northern region, 69% reported to be ***familiar*** with HFW, and 3 out of the 4 respondents that answered this question believes HFW is ***needed*** in their service area. The 53% of respondents that said HFW was available, estimated the ***waitlist*** to be from less than one month to two months.

Table 5b. *Percentage of stakeholders from the* ***Central*** *region (n = 41) who agreed with the following*

Service	**%**		**Y/N, U**	Waitlist (mo.)
"In my locality, X is …	*…available."*	*…familiar."*	*…needed."*	
PCIT	30	70	12/16	1-2
MST	46	70	8/10	1-3+
FFT	65	84	7/7	1-3
TF-CBT	46	84	7/8	<1-2
HFW	57	73	2/5	<1
Parenting skills classes	65	92	8/8	<1-3+
Parent management training	8	35	7/14	-
Play therapy	43	89	9/10	<1-2
EMDR	30	70	7/13	<1-2
Exposure therapy	3	51	7/12	-

Table 5c. *Percentage of stakeholders from the* ***Piedmont*** *region (n = 36) who agreed with the following*

Service	**%**		**Y/N, U**	Waitlist (mo.)
"In my locality, X is …	*…available."*	*…familiar."*	*…needed."*	
PCIT	35	71	12/18	<1-3
MST	77	65	1/1	<1-2
FFT	71	87	4/4	<1-2
TF-CBT	58	87	3/5	<1-2
HFW	48	77	6/7	<1-2
Parenting skills classes	71	90	5/5	<1-2
Parent management training	6	39	7/13	--
Play therapy	81	94	3/3	<1-3
EMDR	35	71	7/9	<1-2
Exposure therapy	6	61	3/9	--

Table 5d. *Percentage of stakeholders from the* ***Eastern*** *region (n = 35) who agreed with the following*

Service	**%**		**Y/N, U**	Waitlist (mo.)
"In my locality, X is …	*…available."*	*…familiar."*	*…needed."*	
PCIT	47	68	6/9	<1-3
MST	56	82	5/7	<1-2
FFT	62	85	2/4	<1-2
TF-CBT	53	82	7/7	<1-2
HFW	65	74	1/3	<1-2
Parenting skills classes	76	88	3/3	<1-3
Parent management training	9	38	8/9	<1
Play therapy	56	70	6/8	<1-2
EMDR	44	62	2/8	<1-2
Exposure therapy	12	50	3/9	1-3

Table 5e. *Percentage of stakeholders from the* ***Western*** *region (n = 14) who agreed with the following*

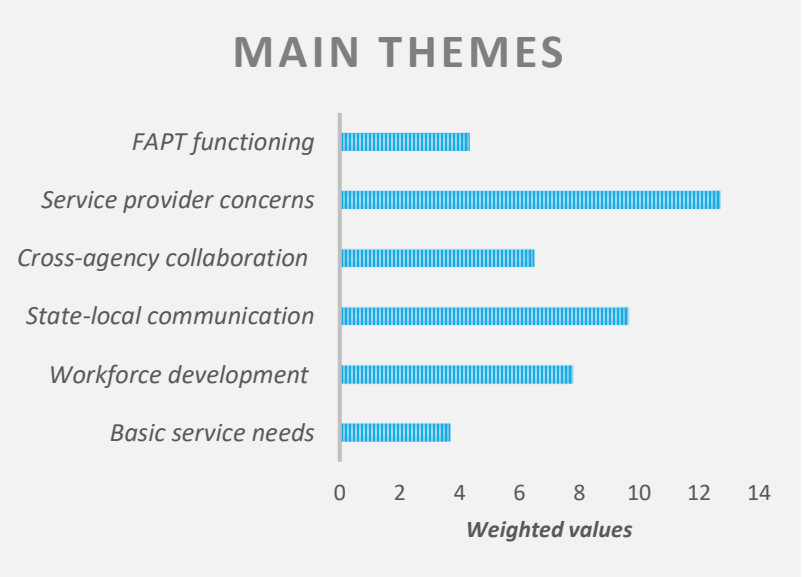
Service	**%**		**Y/N, U**	Waitlist (mo.)
"In my locality, X is …	*…available."*	*…familiar."*	*…needed."*	
PCIT	64	93	3/4	<1
MST	70	93	1/1	<1
FFT	50	100	2/2	<1
TF-CBT	100	100	--	<1-2
HFW	93	90	--	<1
Parenting skills classes	100	90	--	<1-2
Parent management training	0	21	2/5	--
Play therapy	79	100	1/1	<1-3
EMDR	64	100	1/1	<1
Exposure therapy	0	79	1/2	--

NAGA PROJECT #3: Interview Series

A series of one-on-one interviews (N = 40) were held from April 2021 to July 2021. Survey findings are related to opinions expressed during the time period in which they were collected, meaning they'd likely differ if interviews were conducted today. Subject-led interviews lasted from 30 to 90 minutes and conducted with state and local government employees and community members. Almost half of the interviewees consisted of local directors or assistant directors of DSS. The other half consisted of state leaders or employees from VDSS, DBHDS, DJJ, and OCS, current and past. A portion of interviewees were selected and subsequently invited to interview based on referral from a preceding interviewee. Ninety-two local directors of DSS were invited to participate via email and those who accepted were most likely to represent the Central, Northern, and Eastern regions.

Each meeting with an interviewee began with the general prompt, *What is needed to better serve the families that you work with?* adapted for the receiver. Follow up questions and additional prompts guided interviewees back to the original prompt, if needed (ex., *What do you think is missing to move a family from X to X?*).

Interviews provided qualitative information recorded in real time by the interviewer. Interview notes were then coded for themes separately by the Center's postdoctoral research scientist and two graduate research assistants. Notes were then compared and recoded once more. For a theme to emerge, multiple interviewees had to have mentioned the same topic with enough detail to form a concept. Topics and comments that shared a common underlying meaning were grouped into main themes, and specific details that further defined a main theme were labeled as subthemes.



Overall, most individuals spoke for the greatest amount of time about the quality of mental health services currently available to families living in their locality. Even though the interviewer's prompt was to identify specific mental health needs, five out of the six themes that emerged happened to be systemic in nature. Main themes have been illustrated in Figure 6 and described in full below accompanied by deidentified flagship quotes. To protect the anonymity of interviewees, only the region has been included in parentheses after an interviewee's quote.

Theme 1: Service provider concerns.

Subtheme 1a: What's available isn't accessible. Individuals working at the ground level in rural communities mentioned that mental health service providers are more often shared across more than two other localities. This may mean that families must present for services on a specific day at a specific time during the workday. Even if services are "available" within a certain locality, they are not likely to be accessible either because of provider-imposed barriers or geographical barriers exacerbated by a lack of public transportation in some areas.

Subtheme 1b: Profit is over-prioritized. Several different individuals living in rural areas stated that the companies who provide majority of mental health services in Virginia have in the past refused to deliver services to families in their area due to lack of profitability. Families are instead referred out of the area for services, which from the interviewee's perspective is "understandable" since their department only refers about one child a month for services. According to another interviewee, their local department solves the problem of not having service providers in the area by asking FSSs to provide mental health services to families in addition to their other responsibilities.

"Community provider companies and their directors have a lobby group, and they don't hold themselves accountable for poor care." (Piedmont)

Subtheme 1c: What's available isn't sufficient. Most of the interviews that were conducted with the subsamples of local government employees and community members included descriptions of the current services available in a less than positive light. Specifically, the mental health services provided by large companies did not meet interviewees' standards or expectations for practice.

"What we have now are workers taking kids to McDonalds and calling it therapy." (Central)

Participants reported that the type of problems exhibited by most families were complex and multigenerational; interviewees doubted that clinicians treating these families through in-home services were adequately trained and thus expressed pessimism that the services would lead to lasting benefit. As described by more than four interviewees, some providers do not get to the "root" of the problem, an observation cited by at least one interviewee as a reason that the same families repeatedly come up in their local department's referrals.

Theme 2: State-local communication.

Subtheme 2a: Role confusion. Often government interviewees expressed confusion and frustration over the multiple roles and initiatives playing out on the local level. For local directors, clarity was needed regarding the role and purpose of the advisory teams/boards. Similar sentiments were expressed by a few interviewees for regional directors and individuals sent to represent VDSS in meetings. One director theorized that VDSS purposely sends representatives who cannot answer questions or provide important information. The desire to receive guidance from state leaders was present; however, majority of local directors seemed unsure of knowing who was in charge of providing it.

Subtheme 2b: Lack of clarity in state communication. Some local government employees reported a lack of responsiveness from state leaders to their questions and requests. They described receiving information from state leaders often, but that the content did not seem to be calibrated nor applicable to their individual, local needs. Some individuals reported different opinions related to whether VDSS prioritizes risk avoidance over clearer guidance.

Many local departments reported planning to "wait and see" how others deal with the changes related to Family First, due to concern over the CSA rate mismatch and fear of potentially losing money. Some reported confusion around language used by state leaders to describe evidence-based services and prevention services within context of other community service categories. One local director suggested that template contracts to use with service provider companies or help with securing services in rural areas would have been useful guidance from state leaders. These instances cause concern for local directors, leading them to believe state leaders may not have thought through how services will be paid for locally.

"We don't plan on using Family First at all and will continue to use [company] even though their quality is hit or miss." (Eastern)

Theme 3: Workforce development.

Subtheme 3a: Training needs. Majority of interviewees expressed the need for training. Most comments referenced clinicians providing in-home services (captured in Theme 1), FSSs, and state leaders.

The training curricula for FSSs was foremost characterized as being insufficient, in both content and format in which it is delivered. Since training modules are virtual, local directors shared concern around engagement and learning. Often FSSs are sent out into the field before they have completed their training out of necessity.

"[In reference to the CANS] It's a funding tool, not a decision-making tool because the workers know it's not valid." (Eastern)

FSSs conduct investigations and/or a family assessment for services to develop a prevention plan. Their assessment battery includes a structured decision-making tool, the CANS, and other paperwork requirements. The CANS was often referred to in a negative light based on the amount of time it takes to administer. One director estimated the CANS to take up to two hours, "if doing it right." The tool was also thought to be too subjective and to not pick up on trauma. Another director acknowledged that in the past staff have completed the measure in a way to receive the service that they, the FSSs, believed a family needed, versus what the tool may have found if completed as intended. FSSs were described to lack understanding of how to administer the CANS, which may be why many have trouble seeing the value it provides according to one local supervisor.

Lastly, about a quarter of interviewees indicated that state-level employees should be the ones receiving training. It was inferred that state agency leaders lack a comprehensive understanding of what it means to be *trauma-informed*. Individuals cited mistakes in the way in which ACES and trauma responses have been described by leaders, that leaders' conceptualization does not match what trauma-informed trainers are teaching at the local level. State leaders were also described as missing the context to understand the Family First law, such as why it was written and what it intends to do related to systems transformation. It is worth noting that a small number (3-4) of local directors believe they've been misrepresented by state leaders. They sense state leaders assume local employees do not understand what *evidence-based* or *prevention* means or that they haven't already found creative solutions worth considering for keeping children out of foster care placement. Two directors advised state leaders to visit sites to gain a better perspective of how their decisions play out at the local level.

Subtheme 3b: FSS burnout and turnover. Local DSS staff reported difficulty maintaining a full staff and retention of college graduates. Too high of caseload was reported as a major issue believed to drive burnout as well as potentially harmful work practices. Additional explanations included lack of preparedness for the field, vicarious trauma, paperwork burden, and insufficient training in treatment planning. Two interviewees stated that because LDSS supervisors are not clinicians themselves, their supervision is more likely to be restricted to administrative tasks, not clinical issues. Supervisors without clinical training may not have the skills required to provide emotional support to FSSs.

Theme 4: Cross-agency collaboration.

Subtheme 4a: CSB functioning. CSBs are charged with providing a basic service array for community members with mental illness, developmental concerns, and substance use disorder. This is the point of access for Medicaid-funded services, which is the CSB main funding stream. Case managers employed by CSBs were said to have very high caseloads, so the amount of time it takes to enroll someone into services varies from weeks to months.

"There are no EBP providers though to serve kids, and those making the decisions on where kids should get services are not trained to know." (Piedmont)

CSBs were overwhelmingly described by interviewees to fail to market their services consistently or transparently. Decisions made by service boards led interviewees to question whether board members have the right training to make

the type of decisions that they do regarding appropriate care. Referrals made by board members cause confusion.

The responsibilities of CSBs include providing information to parents about the FAPT process but this doesn't always happen; one community member stated sometimes CSBs don't know about FAPT unless a child-facing agency person is on the CSB team. Waitlists for services after intake were described as too long and "just not efficient." Two directors reported building a work around to bypass referring a family to their CSB by enrolling a family into services through a private company and then transferring the child to more intensive services. This route requires more providers but was described to be quicker than going through their local CSB.

"People need to understand that collaboration equals sharing money, period." (Western)

Subtheme 4b: DJJ. A popular sentiment with regards to cross-agency collaboration involved DJJ's role in care coordination with other child-facing representatives. Almost half of those interviewed expressed dissatisfaction with their DJJ partners ("weakest link") and their willingness to be team players with other child-facing agencies.

Frustration was expressed specifically around access to FFT/MST services. DJJ was said to block off access to these EBPs for the purpose of serving their juvenile population first, despite potential overlap with LDSS-involved cases, forcing families to go through the juvenile justice system in order to access higher quality services. Additionally, the referral process for CHINS cases was a focus of criticism for DJJ's ability to overstep the LDSS process of developing a prevention plan and go straight into foster care. Despite foster care being within an LDSS's domain, LDSSs may not know about a child sent from DJJ into foster care until after the child is placed. DJJ cases were estimated to account for approximately 55% of child in foster care placement. Local DJJ employees were also described as least likely to be trauma-informed in their interactions with family members and adolescents.

Theme 5: FAPT meetings.

Comments and explanations related to the 120 FAPTs in Virginia were separated from other themes given its specificity to the Center interviewer's opening prompt. Almost all interviewees brought up FAPT meetings as a topic for discussion, and views differed widely.

Subtheme 5a: Differing perspectives. Before local directors were interviewed, background information on FAPT, CPMT, and CSA was provided by state level employees. A child is referred to FAPT after a CPS referral is opened and investigated by an FSS to gather enough information to write a report to be reviewed by the FAPT. Services are funded by CSA, a separate line of funding from OCS managed by CPMTs (overseers of FAPTs). FAPTs are built by LDSSs and include representatives from school, the local CSB, DJJ, CSA, in addition to the parent of the child being discussed. Attendance for all members is mandatory. FAPT meetings intend to facilitate creativity amongst all its members for case management, to decide treatment referrals and/or other types of support (ex., purchase a cell phone for a child's caregiver so they can receive calls from their child's teacher). FAPT was meant to be an additional step only for families who could not pay for services themselves. VDSS has recently made it a priority for families to go through FAPT, or some type of multidisciplinary team meeting, in order to receive FF dollars for EBPs. Responsibilities of the CPMT include knowing which services are available in their locale.

Almost of the details related to FAPT were found to vary across LDSSs. At the local level, FAPT may live within the CSB of a certain area and involve little overlap with LDSS caseworkers. FAPTs may include the required team members in addition to representatives of private companies (e.g., National Counseling Group). LDSS employees may be a part of both the CSB and FAPT. FAPT meetings last 30 minutes, and all members must be present including the parent of the child involved and sometimes the child also. Two localities remarked parent attendance is *strongly encouraged*, not mandatory.

The mandate for all FAPT members to be present can lead to wait times of a week to one month after a family is referred to FAPT, not including the time between a CPS referral is made, opened, and investigated by an FSS. Once a decision is made by FAPT members, paperwork must be sent to the CPMT, or an affiliated CSB case manager pending on how a locality is set up, to receive official approval for funding. Estimates for this time period also ranged from one week to one month before the family can enroll into approved services or receive supports. Importantly, the FAPT process is dedicated to serve the child, not the caregiver. In order for a caregiver to receive services, they are told that they must present to their local CSB.

"First point of contact is make or break for that child's life trajectory, and the extra steps are just barriers… to the right services that could change everything." (Central)

Local employees differed in their value assessment of FAPTs. Localities with a well-informed and engaged CSA coordinator, such as those named from areas with greater funding and resources, were more likely to express positive views of FAPT, including that it was helpful to bring more folks together to brainstorm. LDSS directors that had previously found a work around to speed up the time it takes families to services were more likely to view FAPT negatively. FAPTs that have contracted with FSPs to provide guidance to families throughout its process were believed to function better than others.

Subtheme 5b: Decentering of families. VDSS and OCS have released guidance that requires LDSSs to go through FAPT or a FAPT-like process to receive FF funding for EBPs, when prior LDSSs only had to go through FAPT for additional funding for a case. Directors and local employees did mention the mandate for the parent and sometimes child to present to FAPT did not appear to be in the family's best interest and delays the process, regardless of their view on FAPT's usefulness. By the time a family reaches FAPT, information regarding the child's alleged maltreatment may had already been collected at the first point of detection (i.e., by the mandated reporter) as well once an FSS opens the case. FAPT may represent the third time a family is required to retell their story to potential strangers. This additional step appears to run counter to trauma-informed care for families.

"FAPT takes way too long, sometimes they meet once a month and a family is just waiting to start something, anything." (Central)

Further exposure to individuals outside of LDSS not only endangers a family's right to confidentiality, but the potential for re-traumatization before services are secured is high. It may also further impact the relationship or association that a family has with their local DSS, which has historically lacked trust. One community member who was interviewed disclosed personal experience with her local DSS after aging out of congregate care herself. She reported that she had presented to DSS in need of help with maintaining housing for her and her child, who was a toddler at the time. Instead of providing aid, her child was removed due to reason of insecure housing. The interviewee was required to undergo a competency assessment and complete parenting classes before she was able to have her child returned to her. The process took 6 months.

Theme 6: Basic service needs. Individuals from the Western, Piedmont, and Eastern regions were more likely to report than others that the only services available to families in their area included intensive in-home with BA-level clinicians, intensive care coordination, and residential services. One local employee disclosed that one of the recommendations that their team made to a family recently was to move out of the area to receive the type of services needed, and the service plan was written to include the family's relocation costs.

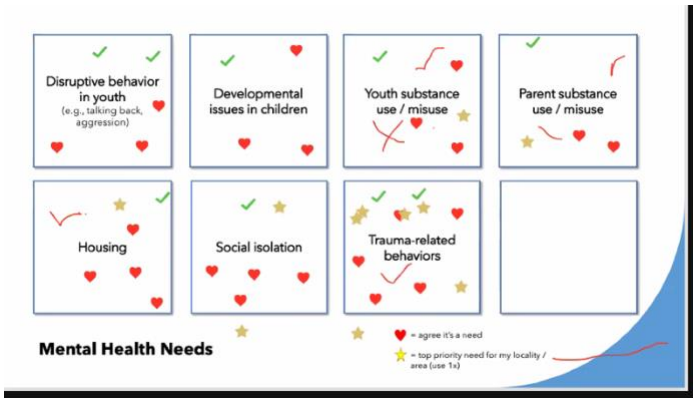
"Families in crisis are delayed when they need immediate access… I know they can go to the CSB and get in-home but it's not helpful. It's hardly a band-aid." (Piedmont)

The most cited need with regards to services included some type of intervention to aid parents/caregivers in managing stressors related to parenting. Parenting skills training for younger children with special developmental needs and behavior management were described to be in demand, versus skills related to the medical and physical aspects of childrearing (e.g., feeding, bathing). In addition to parenting support, caregivers have trouble locating mental health services for themselves and were described to struggle with drug abuse.

NAGA PROJECT #4: Listening Forums

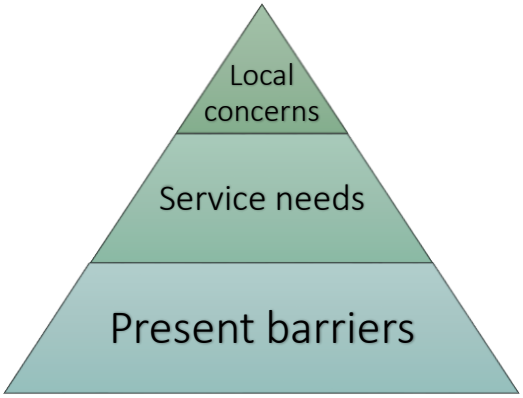
Eleven open forums that each lasted approximately 60 minutes each were held from 6/21/21 until 6/25/21. Advertisement included a flyer distributed by our VDSS partners. Those who reserved a seat ahead of time included state department and division leaders, local department directors and program managers, agency leaders and corporate interest, caseworkers, supervisors, trainers, and community members (n = 261). A sizable sample showed up, approximately 175, representing a 67% return of those interested.

Demographic information was collected to the extent possible given the forum virtual platform. Approximately a third of attendees was from the Northern region and represented the mental health provider community, both public and private companies. About a third of participants was an LDSS employee. The remaining third of attendees was made up of considerably equal parts from DJJ, DOE, and the community.



Attendees were asked a series of prompts to encourage discussion and engagement (example to the right). A series of cards were presented to attendees along with requests to cast votes to help identify how attendees conceptualized mental health needs and problems within their communities. To understand behavioral health needs of an area, individuals were presented with a series of common symptoms, problem descriptions, or behavioral health factors, ex. *disruptive behavior* or *caregiver substance use*. Additional prompts were provided as needed; topics covered were almost entirely audience-driven.

Local concerns. Despite the large number of attendees from all over the state from varied occupations, responses related to behavioral health needs were overwhelmingly similar across the forum series. Multiple individuals (more than 40 attendees) conveyed the importance of examining individual symptoms as part of a larger umbrella of trauma. That is, many attendees linked substance use, aggressive and oppositional behavior, emotional dysregulation, family dysfunction, and other symptoms to an individual's trauma response. Additionally, a few individuals did promote the need for early intervention services for children not meeting developmental milestones.



"So many people are on their own. I'm aware of the brutal beating a family takes when they go up against a system and advocate for those things they should already be getting." – Anonymous

Another behavioral health need that was popular amongst most attendees was the need for greater support for caregivers. Parents/caregivers were described to be the ones in need of additional attention and services and require the most help with regards to managing systems of care, their own stress response to stressors, and experiences of trauma. Of note, youth substance misuse was not named as an area of need, but caregiver substance use disorder was and largely discussed as an outcome to stress and lack of accessible services.

Service needs. In addition to local mental health concerns, a number of service-level comments were made either aloud or written live in a Google document that allowed anonymity. Attendees expressed the need for trauma-informed training for individuals on the frontline, such as local department personnel, as well as for direct service providers. Enhanced training for direct service providers, those delivering mental health services, was indicated as the most urgent or important target. Service quality was identified as a large issue throughout all of the regions. The services available to families were described as insufficient to meeting level of need, vague and unspecific to problem, and not intense enough for children to prevent residential. Supervision and/or greater oversight for those without a MA-level license to practice was also named in addition to better training for direct service providers overall.

"I don't understand why my colleagues call themselves trauma-informed. Is taking a child to court for behavioral issues related to trauma appropriate?" – Anonymous

"I've been a provider and I've been in all of the other roles of folks here [CSA, FSS]. Every agency and person approaches [treatment planning]] differently which is why some people cannot see that the process itself can be re-traumatizing." – Anonymous

Similar to what was discovered through the Interview Series, attendees voiced the need for better dissemination of information to community members regarding services available in their area. Attendees reported that CSBs do not publicize what they can offer in a standard way, which has led to confusion over what can be obtained in return for going through the referral process, in turn, lowering the likelihood of folks showing up for an intake. CSBs were believed to appear as though they themselves do not understand the services they offer. Some attendees indicated the way they've attempted to help families navigate services is by educating themselves on what keywords to use to be offered the needed services.

Last, support for direct service providers beyond clinical skills training was reported as a priority for state-level attention. Burnout was mentioned at least once in each forum session by attendees. Direct service providers, specifically FSSs and licensed clinicians, were described to suffer from vicarious trauma given the severity and intensity of their work. The compensation pushes providers out of the public service system and into private practice or telehealth. The lack of emotional support in combination with heavy caseloads have led to fewer professionals available to provide and accept referrals.

Present barriers. The last theme that forum attendees spent majority of time discussing or writing about involved the systemic barriers that currently bar families from accessing services that may be available, especially prevention services.

The most frequently nominated barrier was the siloed structure of child-facing local government agencies. Participants perceived that agencies do not communicate with each other even when they are tasked with treating the same family or child (i.e., absence of horizontal feedback loops) and service coordination being their main role responsibility. Poor collaboration and systems continuity across FAPT/CSA, CSB, DJJ, and schools, were cited as reasons many families fall through the cracks, escalate to require residential or inpatient hospitalization, and maintain governmental agency culture of being *reactive* instead of *proactive*. Consequentially, DJJ is the first point of contact for families according to many attendees.

"Each agency has their own procedures, and each agency doesn't like to play nice in the sandbox – not that they don't want to, but they can't." – CSA, Eastern

"I think efficiency of services encompasses all of it. [Families] that I work with and see, especially the birth families, just the setup of the system gets in the way of a family making progress." – Regional director of a non-profit provider agency

Across localities, the incentive to offer and provide effective services is greatly lacking. Attendees expressed the belief that large companies held greater power over governmental entities and prioritized profit over people. These are the companies that were perceived as more likely to hire BA-level individuals to provide services and declare they cannot afford to offer EBPs. Top-down guidance from the state for solving such issues was stated as either nonexistent or inapplicable. Decisions regarding type of services offered in an area did not seem to align with community needs, and community members do not have *voice and choice*. Additional barriers included paperwork burden, illogical routes folks must follow to receive services, the *red tape* involved with following top-down regulations for funding, federal and state deadlines, and the difficulty in keeping up with the various and varied rules to bill Medicaid.

"If DSS is in charge of where to place a child, then they need to have a broader mental health understanding of how trauma affects families." – Non-profit family coordinator, Northern

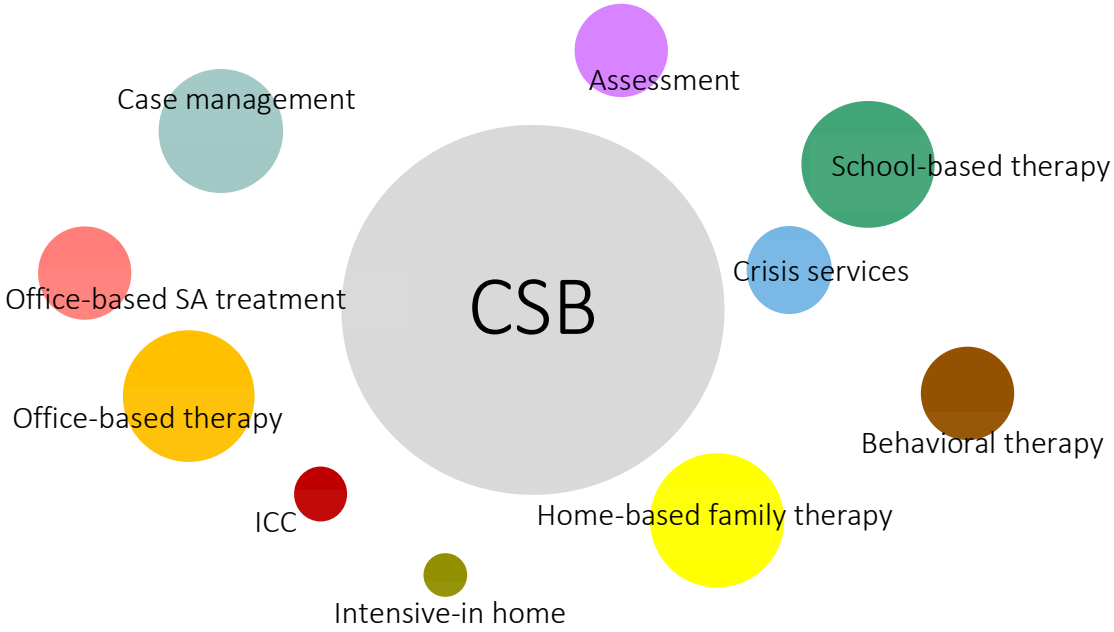
"There are too many hoops to jump through to get the help, the time to apply to the time you get the service can be discouraging and families lose their motivation to actually follow through and get the help." – Piedmont

"There's disconnect at the DSS level, we are making progress in shared language and better understanding of what trauma looks like… but we are not connecting the dots… Especially the courts. We need guidance." – Assistant Director, LDSS

"Locally for us, our work can sometimes look like, we need to do a handoff but 'no no no, this isn't right for social services, you need to take it to community services,' and then they're like 'no no no, this needs to go to juvenile justice,' and instead of everyone seeing a complex situation or a complex family, they say 'oh no no, you take it,' even if we are supposed to be working together. Kids don't exist in bubbles and all of these [entities, agencies] need to work together to be efficient and effective." – Licensed social worker,

"Accessing systems for care is punitive often – whether it's the school or DBHDS or whatever – it's punitive and parents run into barriers and their discourages from asking for help or maybe they didn't use the right language. It's time we move beyond that. FAPT and DSS need to work together to make sure there is something for families from the beginning to when they come home." – Family Support Specialist, Central

NAGA PROJECT #5: Public Services Inventory

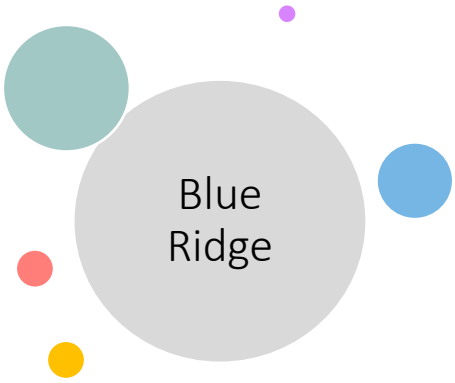


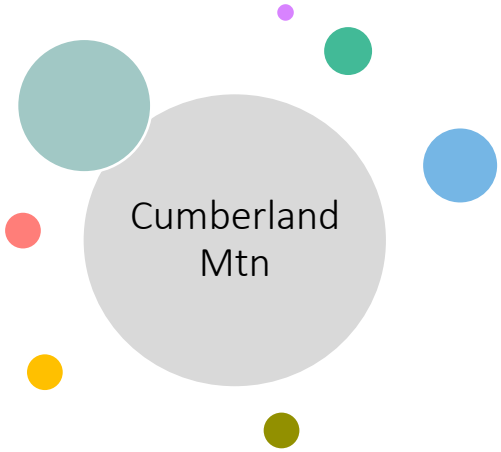
Our VDSS partners are interested in service arrays and where FF funding could help to fill essential service gaps dedicated to family wellbeing. The **KEY** above represents an abridged version of DBHDS guidance for the varieties of services that would constitute a complete service array for CSBs. Size of the satellite circles in the **KEY** represent a tiered approach geared toward prevention. For example, a CSB that is able to build their service arrays proactively would be more likely to highlight their *Office-based therapy* services over *ICC*. This is because *Office-based therapy* is a less intensive service and requires fewer resources than *ICC*.

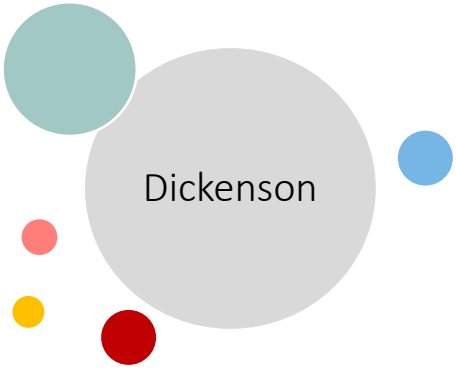
The following figures were built to represent the service arrays of a subsample of the CSBs detected in Table 1b. The 13 CSBs delineated in Table 1b cover the localities from which the highest rates of children are removed and enter foster care.

Service data to build these visuals was collected from the services advertised online through CSBs' respective websites. Because we are interested in whether services are currently available, information related to *availability* from website scans could either be confirmed or disconfirmed by data collected through other NAGA projects (such as the Interview Series or Listening Forums), or by speaking with frontline staff. In other words, qualitative information trumps online advertisement for whether a CSB will include a certain service satellite. Size of each satellite circle is associated with Center confidence that the service identified is being currently offered through that CSB, which could be based on a series of reasons. Clarity of language, or how a CSBs' terminology and language of describing their services aligns with DBHDS guidance for a complete service array, and degree of promise fulfillment, or how representative the service type is of the entire DBHDS service category (ex., group only for *Office-based therapy*, versus group *and* individual). The Center has begun to log adult services as well as youth-specific; however, for the purposes of the first phase of NAGA, only services for children or for both the child and caregiver have been presented herein.

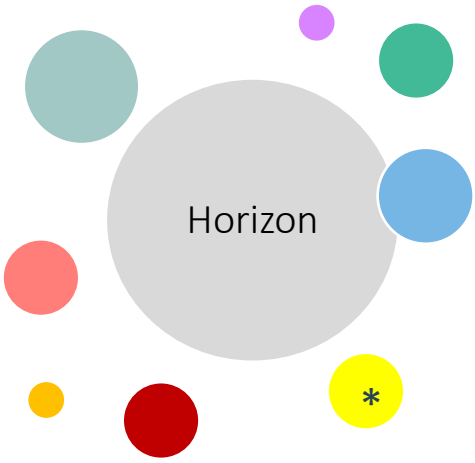
MST and FFT are captured under *Home-based family therapy*, and PCIT is captured under *Behavioral therapy*. If these EBPs happen to be provided, versus or in addition to non-EB services, then those satellite circles will contain an asterisk (*).

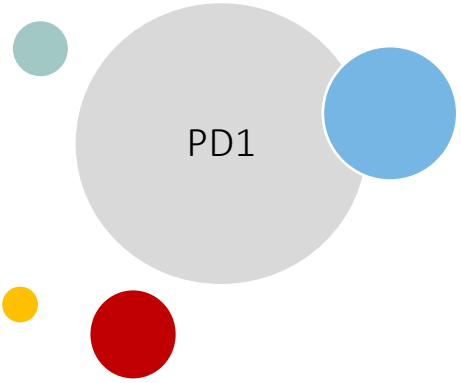

Blue
Ridge


Cumberland
Mtn


Dickenson


Highlands


Horizon
*


PD1

NAGA PROJECT #6: Eligible Providers Analogue

As a preliminary investigation into workforce capacity, the Center set out to develop a database to compile all licensed mental health providers and licensed service provider companies and agencies. The purpose for this decision is two-fold. A database that allows stakeholders to visualize licensed providers across the Virginia guides workforce development planning, such as where training opportunities should be advertised. It also tells us where companies or agencies are aggregated, meaning potential zones for contracting services at a competitive price or leveraging EBP representation.

According 2020 and 2021 surveys of providers completed by the Virginia Department of Health Professions, 6,302 Licensed Clinical Social Workers (LCSW) and 5,812 Licensed Professional Counselors (LPC) participated in the Virginia workforce in 2020, and 3,067 Licensed Psychologists participated in the Virginia workforce in 2021. The website Psychologytoday.com advertises 5,780 mental health clinicians across licenses, in the state of Virginia (gathered September 2021).

Figure 7. *Provider agencies providing outpatient, in-home or community based mental health or substance use treatment services.*

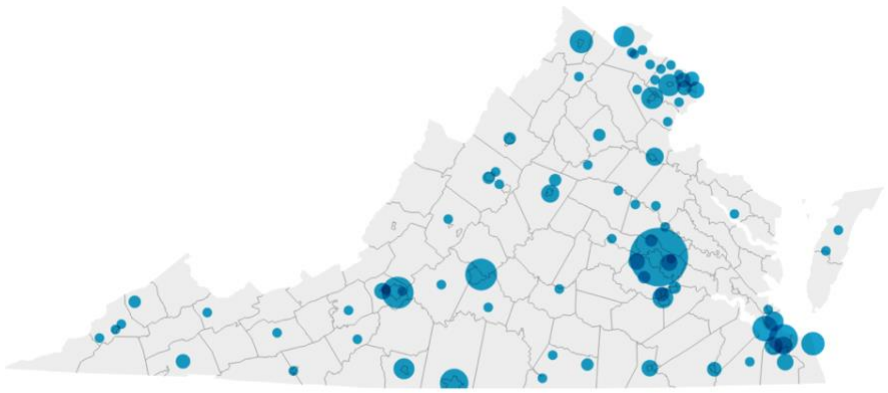


Figure 7 displays a preliminary examination of provider agencies (N = 267) that offer mental health or substance use treatment services in outpatient, in-home, or community-based settings, across the state Virginia. Larger circles indicate greater number of agencies within the area. Agencies were primarily identified from the DBHDS database of agencies licensed by the state to provide services. Coverage area differs across agencies, meaning the size of the circle doesn't necessarily reflect coverage area.

According to services listed on active agency websites (reviewed September 2021), 135 agencies offer Mental Health Skill Building services, 128 agencies offer general mental health outpatient services, 119 agencies offer Intensive In-Home (IIH) services, 84 agencies offer substance use treatment services, and 75 agencies offer Crisis Stabilization services. The map above represents coverage of companies and non-profit agencies, licensed at the systems level. Licensed clinicians with masters-level training may be employed within these organizations or not. However, it is also possible individuals without clinical training largely make up these companies' workforces. More information is needed to discern where clinicians licensed in Virginia reside and provide services.

The most important finding reported by the Healthcare Workforce Data Center has to do with trends of individuals becoming licensed as clinical social workers and professional counselors in the state. From 2015-2020, the number of LCSWs has increased by 27%, extending this workforce by 20%. Within the same period, the number of LPCs has increased by 62%, growing this workforce by 55% (February 2021 Healthcare Workforce Data Center Digest). This finding examined alongside past needs assessments provide preliminary evidence for the possibility that the issue of workforce capacity contains greater complexity than sheer number of people available to provide a service. It's possible other reasons, perhaps those that have to do with the management of various systems of care, are more likely to be driving the lack of licensed clinicians available to be employed in governmental roles.

RECOMMENDATIONS

Caveat on systems-related recommendations…
Considerations and recommendations related to structural barriers and cross-agency collaboration are viewed to be within the scope of NAGA because exclusion of them would mitigate the effectiveness of any new program implemented despite the advertised efficacy of an EBP.

In Virginia, multiple barriers currently exist that prevent community members from accessing behavioral health services. This issue is further complicated by the lack of clarity in how services are categorized and funded, the non-standardized and inconsistent way services are advertised within and between agencies, and poor sustainability of past implementation attempts. The first wave of NAGA delivered findings that helped to clarify the nature of some of these barriers, such as reasons that help explain why some services are accessible only through certain junctions (e.g., DJJ). Implementation of new services in Virginia will require a coordinated, strategic approach to sustain additional services to preexisting local service arrays.

Further, programs labeled as *evidence-based* attained their status *in the absence of* the common and uncommon environmental barriers that impact how care is accessed and utilized. EBPs are designated as such after a series of strictly controlled trials further bolstered by powerful components that are not always included in the consumer version of most commercial EBPs (e.g., expert supervision and consistent data monitoring). EBPs do not take into consideration a child's home, school, county, and state. Mitigating factors that have been proven to decrease the effectiveness of EBPs, such as racism within an institutional system, are not examined in the trials required to call a program evidence-based, nor are the positive factors within a child's life that could be leveraged to improve effectiveness of an EBP, like multigenerational family support. All data examined insofar indicate that the systemic barriers found are likely to impact the cost efficiency of VDSS's investment of Family First dollars.

The following recommendations are presented with Center rationale, which is derived from the research evidence base as well as findings from the first phase of NAGA. Implementation strategies are also provided for some of the following recommendations in the form of "Potential next steps," if VDSS partners are interested in collecting more information, and the "Encouraged accompaniment" indicator, for when there is evidence to theorize that the outcomes expected from a recommendation would be facilitated by the adoption of another recommendation presented herein.

1. Strengthen LDSS engagement with families through frontline personnel training in Motivational Interviewing (MI)
    a. Rationale: MI is an evidence-based stylistic approach to behavior change that has been shown to be especially effective for adults with a substance use disorder, which many caregivers were described to struggle with, especially in the Western and Piedmont regions of Virginia. NAGA findings suggest potential receivers of MI training should include FSSs, their supervisors, group home and/or congregate care employees, any individual who comes into contact with families.
    b. Potential next step(s):
        i. Conduct independent review of current FSS curriculum
        ii. Center conducts interviews with select local supervisors to assess capacity

2. Integrate family/peer support partners, or peer recovery specialists into LDSS operations
    a. Rationale: Caregiver mental health and coping appear to be an important junction for intervention to maintain child safety in Virginia. Particularly in certain regions of Virginia, caregiver substance misuse may be a significant driver for child welfare involvement, but treatment for caregivers has been historically difficult to come by. If believed to require treatment for themselves, caregivers are told to find help through a different public system with its own set of barriers and little chance of accessing appropriate services. It is also likely

caregivers in distress pose additional challenges for FSSs, who are overburdened as it is. A family/peer support partner, or a peer recovery specialist, could help share the task of caring for a family by attending to the caregiver's psychological needs.

b. Potential next step(s):
    a. Analyze local practice of FSP or PRS as service facilitators by embedding them into local DSS operations (e.g., FPMs)
    b. Connect with local peer recovery resource centers or FSP service coordinators to collect more information

3. Strengthen evidence-based service planning via adoption of and training in Managing and Adapting Practice (MAP)

a. Rationale: MAP is an adaptable data management system that could streamline VDSS's current assessment battery (CANS, SDM) to guide decision-making around treatment planning. MAP also provides users with a comprehensive research database that matches individual assessment results to the treatment with the greatest supporting evidence. This type of system is most useful when working with families from diverse racial or ethnic backgrounds, as it provides up-to-date guidance based on the demographics of those that participated in the research studies.
b. Potential next step(s):
    i. Conduct independent review of current FSS curriculum
    ii. Center conducts interviews with select local supervisors to assess capacity
    iii. Partner with Virginia HEALS to combine with their efforts related to trauma screening

4. Implement well-supported EBP from clearinghouse to provide options for school age children (e.g., BSFT) or consider building a plan for implementing a supported program (e.g., Triple P)

a. Rationale: Current EBPs planned for FFPSA do not provide adequate coverage for school-age youth. BSFT provides a way to accomplish that goal. A disadvantage to BSFT is that it has overlap with FFT in approach.

5. Further analyze systems cross-over and present avenues for improving coordination with other child-placing agencies or departmental entities represented at the local level, namely DJJ, CPMT/CSA coordinators, and CSBs

a. Rationale: In some localities, DJJ is the primary agency that places children outside of their homes. To reduce the number of out of home placements at the state level, further examination into how and why these events occur at the local level is warranted. In order to build local service arrays with precision, VDSS may need reliable information regarding exactly how services are being chosen, expensed, and delivered by the direct service providers (those managed by for-profit companies and non-profit agencies) who've also been contracted by other governmental agencies, which differs locally across the state. An accurate understanding of workforce capacity cannot be determined without knowing more about the structure of services and present system of care within the same locality.
b. Potential next step(s):
    i. Conduct interviews with a representative sample of CSA coordinators
    ii. Conduct interviews with regional service coordinators contracted by DJJ
c. Encouraged accompaniment: Rec #6

6. Supplement the service arrays of the CSBs listed above the line in Table 1b, in addition to those detected by VDSS data personnel

a. Rationale: These are the service arrays that very likely require additional services or support to meet the needs of those living within these coverage areas based on the data related to foster care entry and caregiver SUD.

b. Potential next step(s):
    i. Examine the health and capacity of MST, FFT, and PCIT in these CSBs and whether greater support is needed
    ii. Examine the health and capacity of the early childhood interventions available in these coverage areas, which may open avenues for additional FF funding

7. Build VDSS community outreach presence as model for local departments
a. Rationale: The first phase of NAGA identified concerns around current leadership's vision for Family First, which was described to differ with federal guidance around the purposes of the Act. Efforts to strengthen families by engaging with families in a way that recognizes trauma was thought to be missing from VDSS's approach. Movement toward a culture change in child welfare will have to come from leadership and the choice to view families differently than the system has in the past. Community members with lived experience of the child welfare system could provide a direct channel of communication and feedback that would increase the validity of CQI findings (versus CQI cycles based on service provider input only).
b. Potential next step(s):
    i. Consult with community organizations, like TICN, already embedded in this work and currently serving as point of contact for community members
    ii. Explore training/consultation options through TICN for state-level government employees
    iii. Commit to working toward building a Birth Parent Advisory Council dedicated to permanency by removing arbitrary requirements for participation, or provide monetary compensation to those invited to participate
c. Encouraged accompaniment: Rec #8

8. Align with Virginia ONE and its initiatives dedicated to racial equity
a. Rationale: National leaders in child welfare are moving from acknowledging that systemic racism exists to finding ways to reduce racial and ethnic disproportionality in child welfare.
b. Potential next step(s):
    i. Conduct Virginia ONE interagency self-assessment to identify possible areas for growth
    ii. Engage Center to examine internal data, or collaborate with internal data managers, to help delineate service trajectory patterns influenced by race to aid partners in setting action goals

9. Further invest in FSS retention and improvement of LDSS workplace culture
a. Rationale: FSS were reported to begin field work before they have been fully trained out of necessity. This workforce population was named as experiencing the most significant occupational burnout compared to other direct service providers in Virginia. Employees at the management level communicated the need for more technical support and guidance applicable to the unique challenges in their locality.
b. Potential next step(s):
    i. Train LDSS supervisors in a reflective supervision model that considers trauma prevention and caseworker health
    ii. Reexamine health of graduate/undergraduate program pipelines and opportunities to build capacity (e.g., graded training format for entry into the field, broaden or strengthen recruitment efforts to community colleges)
    iii. Request an in-depth evaluation of DSS/FSS incentive structure

10. Consider broadening VDSS's current target population for FF funding from in-home/high-risk cases only to those categorized as family support cases, which are families who require tangible social aid to maintain housing, nutrition, etc.

a. Rationale: These families are also considered to be high risk since neglect is the most common reason children are referred for services and/or subsequently removed. This is likely due to the stressors and potential psychological harm associated with instability during a child's most critical periods for growth. Additionally, including these families into VDSS's target population definition would likely increase the number of referrals to EBP service providers, incentivizing them to remain within in the area.

SUPPLEMENTAL MATERIAL

Check-out writing prompts from listening forum attendees:

Describe what change looks like in your day-to-day work…

"Change looks like more accessible services and impact on the clients, children, and families… Change looks like all systems being on the same timeline."

"The ability to 'spread the wealth' – if one agency has figured out how to do a program well, they should be able to mentor another agency so that high quality services can be accessed by all."

"More informed leaders who have healthy relational skills, understand the needs of children regarding attachment and trauma and know how to support them effectively"

"Less black and brown children in the juvenile legal system, suspended, or diagnosed with ADHD. Black and brown children and families needs being met in a culturally-responsive way."

"Being able to get the right services to children we serve without worrying about who funds it."

"I have the actual time in my day to address the needs of youth, families, caseworkers, and departments before they reach a point of crisis."

"The reality of change in this agency right now is taking whatever legislation is thrown our way, trying our best to make it fit with the population (aren't services supposed to be client-driven??) and waiting for the fallout when somebody higher up tells us we failed and our 'stats don't measure up.' I am in a unique position as I have just taken over CSA, which was contracted to another agency in the past. I have been doing the CSA trainings as well as the DSS trainings and there are disparities between the two. Yet here we are, less than two weeks away from the big 'in-home' release, and the left hand cannot agree with the right. Staff in individual agencies cannot be ready for this change if they cannot fully decipher what the change is supposed to be."

Provide a sentence to convey your thoughts in this moment…

"So many times groups and forums like this bring ideas that everyone agrees are necessary, but nobody has the bandwidth or expertise to be able to carry it out."

"This is a very interesting and good forum that is much needed across all communities and it's the first time that I've felt part of the discussion."

"The problem is so overwhelming that I think we get stuck trying to develop solutions when they are accessible and sometimes obvious… We lack the right leaders with the right approach and creative energy."

"I am hopeful in that this much needed conversation and focus is taking place now."

"This discussion generated great ideas and I wonder if solutions will be built to address them in a realistic and efficient manner."