Advisory Committee to the
Court Appointed Special Advocate
and Children's Justice Act Programs

AGENDA
In-Person Committee Meeting

Virginia Department of Social Services
5600 Cox Road, Glen Allen, VA 23060
York River Room, 111B
April 25, 2025
10:00 AM – 12:00 PM

1. **Welcome, Roll Call and Introduction of Guests**

2. **Review and approval of January 24, 2025 Minutes**

3. **Appointment of Nominations Committee**

4. **Center for Evidence Based Partnerships Presentation on the Needs Assessment and Gaps Analysis of Virginia's Family First Implementation Efforts – Michael Southam Gerow, Director**

5. **Final Outcome of Tracked General Assembly Bills**

6. **CJA Program Update**
   - **Virginia MDT Stakeholder Group**
     - Annual Survey
     - MDT 101 and Good to Great Training Series
7. **CASA Program Update**

8. **Citizen Review Panel**
   - Development of 2025 CRP Recommendations

9. **Adjournment**

CASA
Court Appointed Special Advocates
FOR CHILDREN
VIRGINIA DEPARTMENT OF
CRIMINAL JUSTICE SERVICES

VIRGINIA COURT APPOINTED SPECIAL ADVOCATE PROGRAMS

What CASA Does

Court Appointed Special Advocate (CASA) volunteers are appointed by juvenile court judges to cases involving child abuse and neglect. These specially trained citizen volunteers provide a consistent presence and a voice in court for children, helping to ensure the best possible outcome for child victims of abuse and neglect. CASA volunteers provide victims with a chance to thrive during one of the most vulnerable times in their young lives by ending the cycle of violence, and assisting the court in securing safe, permanent homes.

FY2024 CASA PROGRAM STATISTICS AND HIGHLIGHTS

- 27 operational CASA programs in Virginia
- 6 new localities received CASA services
- 3,260 children received advocacy services, representing a 1% increase over the previous fiscal year
- 1,331 citizen volunteers active on cases, a comparable number to the previous fiscal year
- 138,202 volunteer advocacy hours, valued at $4,613,183, were contributed, which represents a 10% increase over the previous fiscal year
- 14,468 key challenges were tracked and monitored on children served by CASA volunteers; this represents a 1% increase from the previous fiscal year and a 25% increase since FY2019

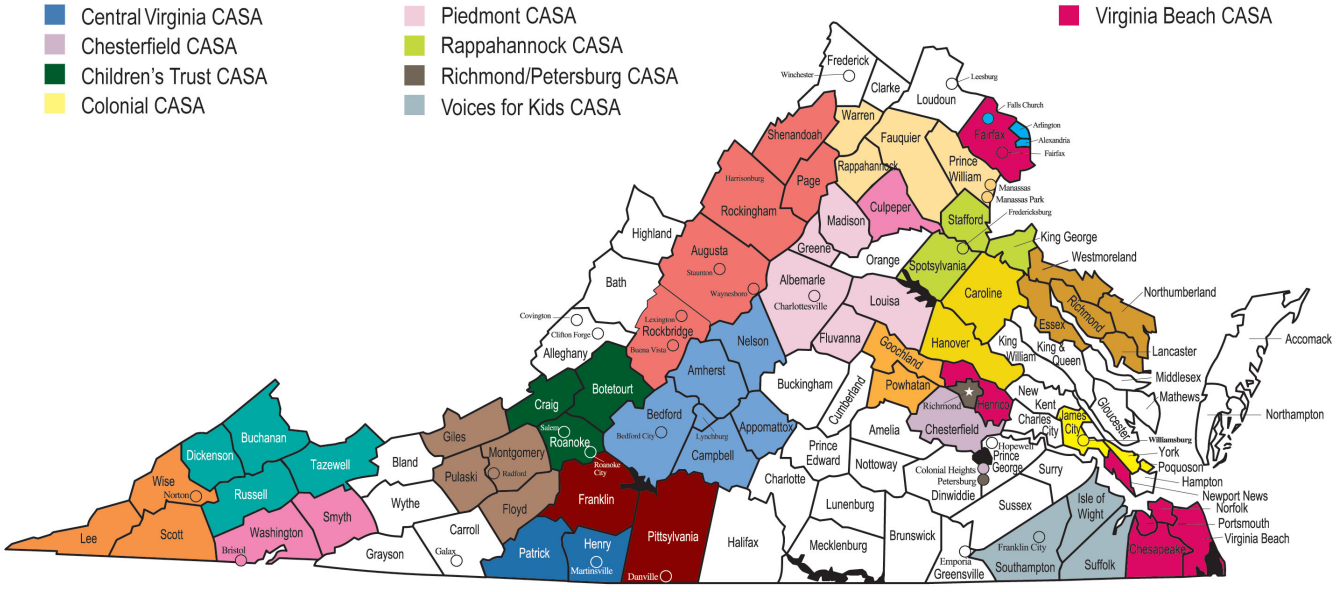
Programs in Virginia

Multi-Jurisdictional Programs

- 28th Judicial District
- 29th Judicial District
- Alexandria/Arlington CASA
- CASA Child Intervention Services
- Blue Ridge CASA for Children
- CASA of the New River Valley
- Central Virginia CASA
- Chesterfield CASA
- Children's Trust CASA
- Colonial CASA
- FOCUS on Youth CASA
- Franklin County/Pittsylvania County CASA
- Goochland/Powhatan CASA
- Hanover CASA
- LPOY CASA
- Northern Neck CASA
- Piedmont CASA
- Rappahannock CASA
- Richmond/Petersburg CASA
- Voices for Kids CASA

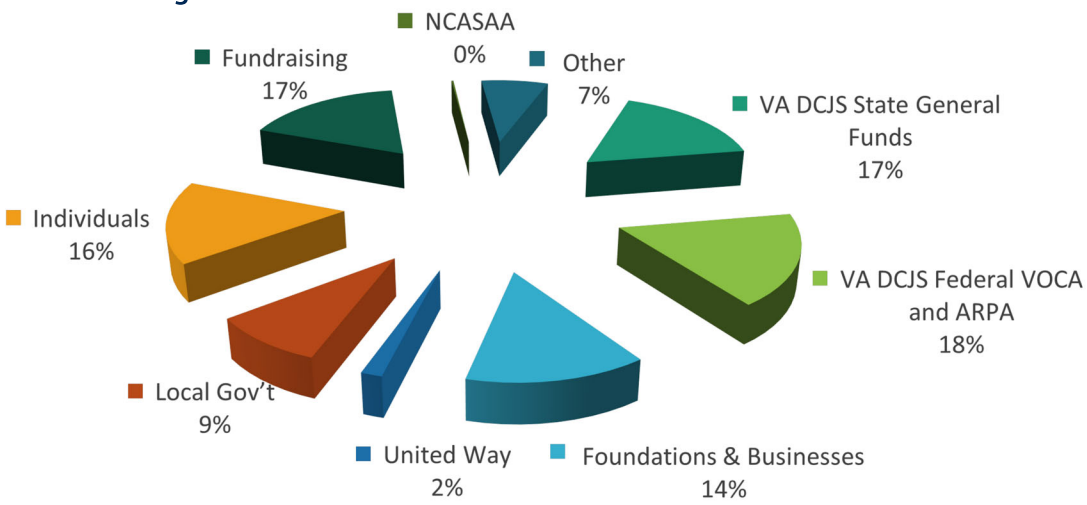
Single Jurisdiction Programs

- Chesapeake CASA
- Fairfax CASA
- Henrico CASA
- Newport News CASA
- Norfolk CASA
- Portsmouth CASA
- Virginia Beach CASA



VIRGINIA CASA PROGRAMS HAVE DIVERSE FUNDING

2023–2024 CASA Program Income



TOTAL INCOME = $9,212,642*

**as of January, 2025*

SCOPE OF THE PROBLEM

Abuse and Neglect in Virginia in FY2024

- 39,841 children involved in Child Protective Services family assessments
- 4,474 abused and neglected children in founded Child Protective Services investigations
- 30 children died as a result of abuse or neglect
  - Data as of December 3, 2024 with 43 investigations pending final disposition
- 5,109 children in foster care
- 46% of the children in Virginia's foster care system are between the ages of 13 and 19

Young People Aging Out of Foster Care

CASA programs are dedicated to improving outcomes for older youth continuous, youth centered advocacy until age 21. CASA volunteers focus advocacy to create successful independence if other permanency efforts are not achieved for older youth who may age out of the system. Without support, research shows that, when compared with their peers, young people aging out of care, on average are:

- Less likely to have a high school diploma
- Less likely to be pursuing higher education
- More likely to experience unemployment
- Less likely to be earning a living wage
- More likely to experience homelessness
- More likely to have had a child without being married
- More likely to become involved with the criminal justice system

(Barth, 1990; Cook, 1991; Courtney & Barth, 1996; Courtney &. Piliavin, 1995, 1998; McDonald, Allen, Westerfelt & Piliavin, 1996)

CASA Volunteers Make an Impact in the Lives of Children

- 83% of CASA volunteer recommendations are accepted and incorporated into judicial court orders
- 88% of children had one CASA volunteer throughout the duration of their case. Scientific research indicates the presence of one caring, stable adult relationship is one of the keys to building skills of resilience.[1, 2]

[1] *National Scientific Council on the Developing Child. (2015). Supportive Relationships and Active Skill-Building Strengthen the Foundations of Resilience: Working Paper 13. www.developingchild.harvard.edu*

[2] *Levine, S. (2003). Psychological and social aspects of resilience: A synthesis of risks and resources. Dialogues in Clinical Neuroscience, 5, 273-280. doi: 10.31887/DCNS.2003.5.3/slevine*

CASA Programs are Economical

Of the various interventions provided to a child, CASA provides a cost effective service. In Virginia in FY2024, it costs:

- $2,830 to provide CASA advocacy services to one child
- $5,952 to $8,820 to provide basic foster care to one child
- An average of $25,000 to serve one child in Therapeutic Foster Care and $45,036 for Residential Treatment
- $236,920 to serve one child in the direct care of Virginia's Department of Juvenile Justice

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For questions regarding the administration of the Court Appointed Special Advocate (CASA) Program and funding in Virginia, please contact: Melissa O'Neill • 804-239-0473 • melissa.o'neill@dcjs.virginia.gov

2024 CASA Program Survey Key Findings

The Virginia CASA State Leadership Team developed the 2024 CASA Program Survey to determine the needs of local CASA programs. The survey is used to update the State Leadership Team strategic plan. The response rate for the survey was 100%. The survey was launched in January 2025 and results were compiled in February 2025. The Virginia Department of Criminal Justice Services Research Center assisted in the deployment of the survey and prepared the final data analysis.

Below is a summary of the key findings from the Survey Report.

CASA Programs need volunteers despite some increases in recruitment

- 15 of the 27 CASA programs (56%) reported they were unable to serve all the children referred by the courts.
    - Of those, 12 (80%) reported that they were unable to serve the children referred due to lack of available volunteers.
- **17** CASA programs (63%) reported an increase in the number of inquiries from potential CASA volunteers.
- 14 CASA programs (52%) reported in increase in the number of CASA volunteers trained.
- 13 CASA programs (48%) reported an increase in the number of new CASA volunteers sworn in to serve children.
- In programs experiencing resignations, top reasons for volunteer resignations
    - Moved from the area 48%
    - Resigned/Retired 30%
    - Health Issues 26%
    - Employment Situation 26%

CASA Programs continue to experience turnover in leadership

- **6** CASA programs (22%) experienced a change in Executive Director or Program Director leadership positions.

Volunteer recruitment methods have not changed

- The top two volunteer recruitment methods were word of mouth (89%) and social media (81%).

CASA programs have experienced changes in judicial leadership

- 10CASA programs (37%) reported a new judge appointed last year.

CASA programs observed high levels of local DSS worker turnover

- 93% of CASA programs (25) report an increase in local department of social services personnel turnover.

CASA programs prefer virtual training modalities

- The majority of programs reported participating in virtual CASA College trainings including the Director Series **(67%)**, Program Staff CASA Conversations **(93%)**, and Volunteer Advo-Chats **(96%).**
- Virtual trainings also ranked highest **(100%)** among the training formats most likely to attend in the future.

Virginia CASA programs are fiscally responsible (22 of 27 CASA Programs responded to these questions about these questions)

- Of those responding, all reported that in the past three fiscal years, they raised the funds needed to meet their current operational budgets.
- All reported having an average of 10.6 months of unrestricted savings for operating expenses (5 programs did not report).

CASA/CJA Advisory Committee Citizen Review Panel 2025 Recommendations

DRAFT 4-4-25

CASA/CJA Advisory Committee Citizen Review Panel Overview

The Virginia Department of Social Services has the responsibility to identify three Citizen Review Panels in order to comply with the requirements of the Child Abuse and Prevention Treatment Act (CAPTA) pursuant to sections106(c)(4)(A)(i) and (ii). The CASA/CJA Advisory Committee serves as one of three Citizen Review Panels (CRP) in Virginia.

CAPTA directs each panel established as a CRP to examine the policies, procedures and practices of state and local departments of social services and where appropriate, review specific cases to evaluate the extent to which the state is fulfilling its child protection responsibilities in accordance with its CAPTA State plan. A panel may also examine other criteria it considers important to ensure the protection of children including the extent to which the state and local CPS system is coordinated with the Title IV-E foster care and adoption assistance programs of the Social Security Act. CRPs are also authorized to review child fatalities and near fatalities in the State.

1. Child Abuse Prevention

The Virginia Department of Social Services (VDSS) should continue to focus timely prevention efforts that ensure safety and well-being of the child and support families in ways that provide support and enhance timely permanency. This includes providing services to prevent removal, and services to support adoptive and kinship families.

a. Family First Prevention Services Act (FFPSA)

VDSS should continue implementation of the Family First Prevention Services Act (FFPSA) and build capacity for evidence-based practices and services. Primary and secondary prevention efforts should focus on avoiding further social services engagement and continued need for tertiary services. Services should include respite for all members of the family including siblings in the home. VDSS should consider including the development and integration of best practices of the Science of Hope framework in working with children and families. Education stability should be included as a prevention strategy.

b. Parental Child Safety Placement Program Implementation

The Virginia Parental Child Safety Placement Program (PCSPP) intends to prevent unnecessary foster care entry by supporting temporary, time limited placements with relatives or fictive kin when a child's safety is at risk. The program requires accountability for such pre-court placements. Legislation was passed in 2024, and the goal of the program is to provide services to the family while assessing safety for the child.

The Advisory Committee seeks updates on the implementation of the PCSPP. Information should include reports on the number of cases served, length of time cases are served, outcomes of efforts, interventions and services provided, how many cases were non-compliant, and what steps the Department took when cases were non-compliant.

c. Child Abuse Prevention Services Model

The VDSS should develop mechanisms for reporting on its prevention services model. This would include establishing criteria and definitions of the various levels of prevention interventions. Consideration should include reports on the number of prevention (pre-court intervention) cases served, length of time cases are served in prevention, outcomes of prevention efforts, interventions and services provided, how many prevention cases were non-compliant, and what steps the Department took when cases were non-compliant.

2. System Improvement

a. Workforce Support and Development

The Virginia Department of Social Services (VDSS) continues to focus on family engagement practices as a cornerstone of the child welfare system. To implement family engagement practices effectively, more trained workers are needed. Efforts should be expended to explore interagency collaboration regarding delivery of case management services and implementation of lived experience navigator services to guide parents. VDSS has experienced the impacts of a reduced workforce due to the lingering effects of the pandemic, fiscal constraints, and vicarious trauma. Retention of workers is important to maintain uniformity and strengthen the workforce.

b. Cross System Collaboration

VDSS should encourage local Departments of Social Services (LDSS) to improve communication and collaboration across jurisdictions when investigating child abuse and neglect and participate in a local multidisciplinary team (MDT), if available. Per Virginia Code § 15.2-1627.5, LDSS-Child Protective Services Unit representation is a required member on a local MDT.

VDSS should encourage LDS agencies to improve cross systems collaboration to support thorough investigations of child abuse and neglect. This should include cross systems joint training opportunities. Upon commencement of dependency proceedings, VDSS should encourage inclusion of attorneys, relatives and other actors in service planning (i.e., family partnership meetings and team meetings).

c. Data Collection and Evaluation

The Advisory Committee makes several data collection and evaluation recommendations. The pandemic presented numerous challenges, especially for frontline workers. The VDSS should continue to examine the preparedness for the COVID19 pandemic and begin planning for the next pandemic that will inevitably strike. Included in this planning should be helping teachers and other mandated reporters to identify child abuse and neglect in a virtual environment.

VDSS should continue to study trends in the reductions of the number of child abuse and neglect complaints and determine if the reduction in complaints trends actually equates to a reduction in harm to children.

VDSS aligned in-home services, CPS ongoing practice, prevention services, and the implementation of the Family First Prevention Services Act. The Advisory Committee requests continued collection of data and evaluation of this alignment.

The Advisory Committee requests data and information around the efforts to implement more Evidence-Based Services under the Family First Prevention Services Act along with progress in securing providers that are properly certified and authorized to provide Evidence-Based Services. The Advisory Committee recommends the Department continues collaboration with the Center for Evidence-Based Practices-Virginia to support localities' efforts to build service array capacity.

The Advisory Committee requests data and information on the PCSPP to include the number of cases served, length of time cases are served, outcomes of efforts, interventions and services provided, how many cases were non-compliant, and what steps the Department took when cases were non-compliant.

The Advisory Committee requests data on the number of Relief of Custody cases served by VDSS including the interventions and services provided.

As the Virginia Department of Social Services builds the new Child Welfare Information System (CWIS), the Committee requests updates and asks the Department to seek stakeholder input into the development of data points for the system.

Report to the CASA/CJA Advisory Committee

April 25, 2025, 10 a.m. – 12 p.m.

Court Appointed Special Advocate (CASA) Programs

Prepared by: Melissa O'Neill, CASA Coordinator - DCJS

I. CASA Network State Leadership Team Updates

The SLT is a partnership between the CASA Network and DCJS. DCJS participates on some but not all the committees. DCJS facilitated one meeting of the SLT during this reporting period.

The following is a highlight of accomplishments of the SLT committees during this reporting period.

A. Training Committee

The revision of the Virginia Case Studies pre-service training curriculum is now complete. During this reporting period, the committee concentrated on enhancing the training components for facilitators. As part of this effort multiple resources have been developed, including a facilitator's guide, sample agendas and planning guides, sample activities to reinforce key concepts, and an implementation guide. These materials are currently in draft form and undergoing final review and edits by the team.

B. Data Committee

DCJS led the development and implementation of the CASA Program Survey to identify statewide program needs and gather data in partnership with the SLT Data Committee. Conducted every three years, this survey serves as a valuable resource for planning efforts by DCJS and the SLT. The CASA Program Survey was completed in January. The Survey results were compiled by the DCJS Research Center, and the report was finalized in February.

The Data Committee met once during this reporting period to review the CASA program survey results and set goals for the remainder of 2025. The CASA Manager User Group (CMUG) met twice during the reporting period.

DCJS continued to monitor technical support requests from local programs regarding CASA Manager. Overall, the volume of support requests has reduced and there are not any trends emerging within the tracked calls. The Data

Committee determined there is value in continuing to track support requests, with a shift in focus to identifying needs and gaps in service and functionality. Additionally, there is consensus from the Data Team that overall, CASA Manager has made improvements in the system and responsiveness to users.

C. Marketing Committee

The SLT continues its partnership with The Idea Center, allocating a portion of CASA Network funds to support the most effective digital marketing initiatives aimed at volunteer recruitment. SLT members received details on the success of the campaign at the last SLT meeting.

The Marketing Committee is developing strategies to assist local CASA programs with enhancements for local program social media and digital marketing campaigns.

D. Diversity, Equity, Inclusion, Accessibility, and Belonging (DEIAB) Committee

The DEIAB Committee is facilitated and chaired by a local CASA program director. Due to recent changes at the federal level requiring National CASA to remove all references and requirements related to Diversity, Equity and Inclusion and gender ideology from its standards, training, website, and foundational documents, the committee awaiting further guidance from National CASA.

E. Legislative Committee

The Legislative Committee is chaired by a local CASA program director and is meeting monthly. The committee monitors state and federal legislation of impact to the CASA programs. The committee continues to work with the CASA Program network to determine the actual costs for operating a local program that complies with state regulations and national standards.

II. Network Support Meetings

DCJS facilitated three CASA Network Support meetings and two New Director Support calls using virtual technology during this reporting period. These meetings assist local programs with navigating program operations and management concerns.

III. DCJS CASA Grant Program

DCJS announced the grant application process for the FY2026 CASA grants. The total amount available to local CASA programs is $1,533,840 in state general funds and $1,499,900 in federal VOCA funds. This year, DCJS is offering a one-time supplement of Children's Justice Act (CJA) funds in the amount of $22,000 for the limited purpose of

reimbursing volunteers for mileage for travel on behalf of the children to whom they are appointed. The total amount available for CASA program grant awards totaled $3,055,940. Applications were received and are currently being reviewed for approval by the Criminal Justice Services Board at the May 2025 meeting. Programs will receive award notices in June 2025.

IV. CASA Regulatory Revision

The approved draft of the proposed changes to the CASA regulations remains at the approval stage by the Attorney General's office.

V. DCJS Staffing Update

DCJS received approval to hire a part-time CASA Program Training Coordinator. This position will support statewide training efforts including implementation of the Case Studies pre-service curriculum and the CASA College training series.

Report to the CASA/CJA Advisory Committee

April 25, 2025 10 a.m. – 12 p.m.

Children's Justice Act (CJA)

Prepared by: Jenna L. Foster, Children's Justice Act Coordinator - DCJS

I. CJA Mini Grants for Programs Working with Child Victims of Abuse or Neglect

DCJS awarded one-time grants to 25 child serving agencies in Virginia. Several Juvenile and Domestic Relations Courts received funding to create child-friendly waiting rooms. The funding period is April 1-September 30, 2025.

II. Multidisciplinary Team (MDT) Support

In January, DCJS convened a meeting of the Virginia MDT Stakeholder Group to address training and technical assistance needs for 2025. Since Child Advocacy Centers of Virginia (CACVA) focuses on MDTs with CAC involvement, DCJS's MDT efforts will focus more on localities that need MDT support that are not served by a local CAC or satellite center. Four training sessions have been scheduled:

MDT 101: Building a Strong Foundation for MDT Success (Virtual)

Thu, 04/24/2025 - 10:00am – 1:00pm
Thu, 08/21/2025 - 10:00am – 1:00pm

Good to Great: Enhancing MDT Effectiveness and Functioning (In Person)

Danville, VA - Tue, 09/09/2025 - 10:00am – 4:00pm
Tappahannock, VA - Tue, 10/28/2025 - 10:00am – 4:00pm

MDT 101 (virtual) Registration: https://www.dcjs.virginia.gov/training-events/mdt-101-building-strong-foundation-mdt-success
Good to Great (in-person) Registration: https://www.dcjs.virginia.gov/training-events/good-great-enhancing-mdt-effectiveness-and-functioning

III. ChildFirst Scholarships for Law Enforcement

Beginning October 1, 2025, the CJA program will scholarships for 10 law enforcement officers to enroll in CACVA's ChildFirst training. These scholarships cover tuition for the week-long forensic interviewing training. At least four of these scholarships must go to law enforcement officers from rural jurisdictions in Virginia.

IV. Domestic and Sexual Violence (DVSV) Children's Programming Workgroup

In March, the DVSV Children's Programming Workgroup traveled to YWCA South Hampton Roads to learn more about the children's programming in their domestic violence shelter and to tour the Norfolk Family Justice Center. The Family Justice Center (FJC) model appears better suited to communities that have ample transportation offerings. DCJS is exploring similar models that may work in rural communities, which often have limited public transportation options.

DRAFT

Pursuant to § 2.2-3707.1 of the Code of Virginia this DRAFT of the minutes of the Court Appointed Special Advocate (CASA) and Children's Justice Act (CJA) Advisory Committee is available to the public. The public is cautioned that the information is provided in DRAFT form and is subject to change by the Advisory Committee prior to becoming final. Once the minutes have been finalized, they will be marked "FINAL" and made available to the public.

COURT APPOINTED SPECIAL ADVOCATE/CHILDREN'S JUSTICE ACT PROGRAM ADVISORY COMMITTEE MEETING MINUTES

January 24, 2025

A meeting of the Advisory Committee to the Court Appointed Special Advocate and Children's Justice Act programs was held virtually on January 24, 2025.

Members Present
Randy Bonds
Jackie Robinson Brock
Judge Eugene Butler
Shamika Byars
Morgan Cox
Davy Fearon
Katharine Hunter
Sandy Karison
Jeannine Panzera
Giselle Pelaez
Pat Popp, Vice-Chair
Eric Reynolds
Lora Smith (for Shannon Hartung)
Judge Thomas Sotelo, Chair

Members Not Present
Lana Mullins
Ashley Thompson

Guests
Rachel Miller (VDSS Staff to the Citizen Review Panel)
Jeff Williams (VDOE)

Staff Present
McKayla Burnett
Jenna Foster
Laurel Marks
Melissa O'Neill
Terry Willie-Surratt

I. **Call to Order:** Judge Thomas Sotelo, Committee Chair, called the meeting to order at 10:01 AM. Members introduced themselves.

II. **Approval of Minutes:** The committee received and reviewed the draft minutes of the October 25, 2024, meeting. Shamika Byars made a motion to approve the minutes and Randy Bonds provided the second. The motion was approved with Sandy Karison and Davy Fearon abstaining.

III. **Conflicts of Interest and Financial Disclosure Reminder:** The committee was reminded that as members they are required to complete annual financial disclosure statements. Members should have received emails with instructions for completing the forms. Additionally, every two years, members must complete the Conflict of Interest Act training. Those members required to complete the training this year will be notified.

IV. **General Assembly Session: Presentation of Bills of Interest**
DCJS and members of the committee reported on bills of interest introduced during the 2025 General Assembly session regarding the investigation, prosecution and judicial handling of child abuse cases.

V. **Presentation of Licensed Childcare Updates**
Jeff Williams, Director of Child Care Health and Safety at the Virginia Department of Education (VDOE), gave a presentation to the Advisory Committee outlining the responsibility of VDOE around licensing childcare facilities across the Commonwealth. In cases of alleged abuse or neglect, VDOE collaborates with the local Department of Social Services (DSS) and law enforcement during investigations. The DCJS Child Death Investigation Protocol (CDIP) training will be modified to include a section on childcare-related deaths and VDOE's role in their investigation as part of the Unsafe Sleep section.

VI. **Presentation of Human Trafficking MDT Mandate**
McKayla Burnett, State Trafficking Response Coordinator at DCJS, gave a presentation on the mandate to establish Human Trafficking Multi-Disciplinary Teams across the state. The new mandate, which went into effect on July 1, 2024, requires the team to meet at least once annually, and that the DCJS State Trafficking Coordinator or their designee be invited to at least one Human Trafficking MDT annually in each locality. She shared details about the training and resources created by the DCJS Human Trafficking team.

VII. **CJA Program Update:** The CASA/CJA Advisory Committee was provided with a written report prior to the meeting detailing significant activities of the CJA program this quarter. The following additional updates were provided:

a. Discussion related to the current MDT training provided by the Virginia MDT Stakeholder Group (convened and facilitated by DCJS) and the future enhancements of training content to better support developing MDTs throughout the Commonwealth.
b. An MDT locality-specific contact list is being developed now and will be updated annually based on self-reported information.
c. The mandatory CJA Grantees Meeting will be held on March 31, 2025, in Bethesda, Maryland.

VIII. **CASA Program Update:** The CASA/CJA Advisory Committee was provided with a written report prior to the meeting detailing significant activities of the CASA program this quarter. The following additional updates were provided**:**

a. A budget amendment of $161,500 was submitted for the CASA programs in response to the findings of the CASA Expansion Study report.
b. In December 2024, the National CASA Association issued an updated set of standards for local programs, marking the fourth revision in seven years.

IX. **Citizen Review Panel:** Prior to the meeting, committee members received copies of the Virginia Department of Social Services (VDSS) response that was provided to the Citizen Review Panel's 2024 recommendations in accordance with the Child Abuse Prevention and Treatment Act (CAPTA). They also received a copy of the 2024 recommendations to prepare for discussions on potential revisions for 2025.

Members discussed initial recommendations and will submit additional suggestions to Melissa O'Neill before the next meeting for consideration. Recommendations must be finalized at the April meeting.

X. **New Business:** Members provided updates, information and news from their respective agencies and disciplines.

XI. **Adjourn:** Pat Popp made a motion to adjourn the meeting, and Giselle Pelaez provided the second. The motion carried and the meeting adjourned at 12:03 PM.

Next meeting dates:

Friday April 25, 2025
Friday July 25, 2025 – Virtual

The Court Appointed Special Advocate/Children's Justice Act Advisory Committee (CASA/CJA)
POLICY FOR THE REMOTE PARTICIPATION OF MEMBERS

1. AUTHORITY AND SCOPE

a. This policy is adopted pursuant to the authorization of Va. Code § 2.2- 3708.3 and is to be strictly construed in conformance with the Virginia Freedom of Information Act (VFOIA), Va. Code §§ 2.2-3700—3715.

b. This policy shall not govern an electronic meeting conducted to address a state of emergency declared by the Governor or the Board of Supervisors. Any meeting conducted by electronic communication means under such circumstances shall be governed by the provisions of Va. Code § 2.2-3708.2. This policy also does not apply to an all-virtual public meeting.

2. DEFINITIONS

a. "Advisory Committee" means the Court Appointed Special Advocate/Children's Justice Act Advisory Committee (CASA/CJA Advisory Committee) or any committee, subcommittee, or other entity of the CASA/CJA Advisory Committee.

b. "Member" means any member of the CASA/CJA Advisory Committee.

c. "Remote participation" means participation by an individual member of the CASA/CJA Advisory Committee by electronic communication means in a public meeting where a quorum of the CASA/CJA Advisory Committee is physically assembled, as defined by Va. Code § 2.2-3701.

d. "Meeting" means a meeting as defined by Va. Code § 2.2-3701.

e. "Notify" or "notifies," for purposes of this policy, means written notice, such as email or letter. Notice does not include text messages or communications via social media.

3. MANDATORY REQUIREMENTS

Regardless of the reasons why the member is participating in a meeting from a remote location by electronic communication means, the following conditions must be met for the member to participate remotely:

a. A quorum of the CASA/CJA Advisory Committee must be physically assembled at the primary or central meeting location; and

b. Arrangements have been made for the voice of the remotely participating member to be heard by all persons at the primary or central meeting location. If at any point during the meeting the voice of the remotely participating member is no longer able to be heard by all persons at the meeting location, the remotely participating member shall no longer be permitted to participate remotely.

4. PROCESS TO REQUEST REMOTE PARTICIPATION

a. On or before the day of the meeting, and at any point before the meeting begins, the requesting member must notify the CASA/CJA Advisory Committee Chair (or the Vice-Chair if the requesting member is the Chair) that they are unable to physically attend a meeting due to (i) a temporary or permanent disability or other medical condition that prevents the member's physical attendance, (ii) a family member's medical condition that requires the member to provide care for such family member, thereby preventing the member's physical attendance, (iii) their principal residence location more than 60 miles from the meeting location, or (iv) a personal matter and identifies with specificity the nature of the personal matter.

b. The requesting member shall also notify the CASA/CJA Advisory Committee staff liaison of their request, but their failure to do so shall not affect their ability to remotely participate.

c. If the requesting member is unable to physically attend the meeting due to a personal matter, the requesting member must state with specificity the nature of the personal matter. Remote participation due to a personal matter is limited each calendar year to two meetings or 25 percent of the meetings held per calendar year rounded up to the next whole number, whichever is greater. There is no limit to the number of times that a member may participate remotely for the other authorized purposes listed in (i)— (iii) above.

d. The requesting member is not obligated to provide independent verification regarding the reason for their nonattendance, including the temporary or permanent disability or other medical condition or the family member's medical condition that prevents their physical attendance at the meeting.

e. The Chair (or the Vice-Chair if the requesting member is the Chair) shall promptly notify the requesting member whether their request is in conformance with this policy, and therefore approved or disapproved.

5. PROCESS TO CONFIRM APPROVAL OR DISAPPROVAL OF PARTICIPATION FROM A REMOTE LOCATION

When a quorum of the CASA/CJA Advisory Committee has assembled for the meeting, the CASA/CJA Advisory Committee shall vote to determine whether:

a. The Chair's decision to approve or disapprove the requesting member's request to participate from a remote location was in conformance with this policy, and

b. The voice of the remotely participating member can be heard by all persons at the primary or central meeting location.

6. RECORDING IN MINUTES

a. If the member is allowed to participate remotely due to a temporary or permanent disability or other medical condition, a family member's medical condition that requires the member to provide care to the family member, or because their principal residence is located more than 60 miles from the meeting location the CASA/CJA Advisory Committee shall record in its minutes (1) the CASA/CJA Advisory Committee's approval of the member's remote participation; and (2) a general description of the remote location from which the member participated.

b. If the member is allowed to participate remotely due to a personal matter, such matter shall be cited in the minutes with specificity, as well as how many times the member has attended remotely due to a personal matter, and a general description of the remote location from which the member participated.

c. If a member's request to participate remotely is disapproved, the disapproval, including the grounds upon which the requested participation violates this policy or VFOIA, shall be recorded in the minutes with specificity.

7. CLOSED SESSION

If the CASA/CJA Advisory Committee goes into closed session, the member participating remotely shall ensure that no third party is able to hear or otherwise observe the closed meeting.

8. STRICT AND UNIFORM APPLICATION OF THIS POLICY

This Policy shall be applied strictly and uniformly, without exception, to the entire membership, and without regard to the identity of the member requesting remote participation or the matters that will be considered or voted on at the meeting. The Chair (or Vice-Chair) shall maintain the member's written request to participate remotely and the written response for a period of one year, or other such time required by records retention laws, regulations, and policies.

Child Welfare

HB 1727

Status: Approved

An Act to amend and reenact §§ 16.1-241, 20-49.1, 20-49.4, 20-124.1, 63.2-903, 63.2-1202, 63.2-1222, and 63.2-1233 of the Code of Virginia, relating to establishment of parent and child relationship; persons who committed sexual assault.
SUMMARY AS INTRODUCED:

Establishment of parent and child relationship; persons who have committed sexual assault. Provides that no parent and child relationship shall be established when a biological parent has been convicted of rape, carnal knowledge, or incest, or has been found by clear and convincing evidence to have engaged in such prohibited conduct, and the child was conceived of such violation or conduct. The bill further provides that a person with a legitimate interest in the child does not include a person whose interest derives from or through a person who has been convicted of or found to have engaged in such conduct by clear and convincing evidence. The bill provides that consent for adoption is not required of a birth father when such father has been found by clear and convincing evidence to have engaged in rape, carnal knowledge, or incest and the child was conceived of such conduct; under current law, such consent is not required when the birth father has been convicted of rape, carnal knowledge, or incest.

HB 1728

Status: Acts of Assembly Chapter

An Act to amend and reenact § 18.2-67.9 of the Code of Virginia, relating to testimony by child victims and witnesses using two-way closed-circuit television or other securely encrypted two-way audio and video technology; standard.
SUMMARY AS PASSED:

Child victims and witnesses using two-way closed-circuit television or other securely encrypted two-way audio and video technology; standard. Allows the court to order that the testimony of a child be taken by two-way closed-circuit television or other securely encrypted two-way audio and video technology if it finds that the child is unavailable to testify in open court in the presence of the defendant, the jury, the judge, and the public if the court finds, by clear and convincing evidence, based upon expert opinion testimony, that the child will suffer at least moderate emotional trauma that is more than nervousness or excitement or some reluctance to testify as a result of testifying in the defendant's presence and not in the courtroom generally where such trauma would impair the child's ability to communicate.

Under current law, the court may order such testimony be taken by two-way closed-circuit television if it finds that (i) the child has a substantial inability to communicate about the offense or (ii) there is a substantial likelihood, based upon expert opinion testimony, that the child will suffer severe emotional trauma from so testifying.

The bill also extends the application window for the party seeking such order from seven to 14 days before the trial date or such other preliminary proceeding to which such order is to apply.

HB 1733

Status: Acts of Assembly Chapter

An Act to amend and reenact § 16.1-277.02 of the Code of Virginia, relating to petitions for relief of care and custody of a child; investigation by local department of social services; Office of the Children's Ombudsman work group; report.
SUMMARY AS PASSED HOUSE:

Petitions for relief of care and custody of a child; investigation by local department of social services; Office of

the Children's Ombudsman work group; report. Requires a local department of social services, as a part of its investigation after the referral of a request for a petition for relief of the care and custody of a child, to (i) refer the parent to the local family assessment and planning team and (ii) create a written report. The bill directs the Department of Social Services, in coordination with the Virginia League of Social Services Executives, to create a template for and provide guidance on what should be included in such written report.

The bill also directs the Office of the Children's Ombudsman to convene a work group composed of relevant stakeholders to (a) determine the factors a court should consider when determining whether there is good cause shown for a petitioner's desire to be relieved of the care and custody of a child and (b) explore the potential benefits and considerations of raising the standard of evidence for granting temporary relief of custody from the current standard of preponderance of the evidence to clear and convincing evidence. The bill directs the work group to submit a report of its findings and recommendations to the Chairs of the House and Senate Committees for Courts of Justice and the Virginia Commission on Youth by November 1, 2025. Certain provisions of the bill have a delayed effective date of January 1, 2026. As introduced, this bill was a recommendation of the Virginia Commission on Youth. This bill is identical to SB 1372.

HB 1777

Status: Acts of Assembly Chapter

An Act to amend and reenact §§ 2.2-438, 2.2-441, 2.2-445, and 2.2-446 of the Code of Virginia, relating to Office of the Children's Ombudsman; foster youth's right to receive information.
SUMMARY AS INTRODUCED:

Office of the Children's Ombudsman; foster youth's right to receive information. Requires the Department of Social Services or a local department of social services, a children's residential facility, or any child-placing agency to provide certain information along with the contact information for the Office of the Children's Ombudsman to a biological parent, prospective adoptive parent, or foster parent, as well as to any child in foster care age 12 or older upon the opening of a foster care case for such child. The bill also provides that, in relation to complaints made to the Ombudsman, if such child is the complainant, the Ombudsman need not gain the consent of the Department or local department of social services, the children's residential facility, the child-placing agency, or the foster parent or guardian of the child or other person having custody or care of the child to receive information from or communicate with the child. This bill is identical to SB 1406.

HB 1854

Status: Acts of Assembly Chapter

An Act to amend and reenact §§ 16.1-241, 16.1-278.15, and 20-124.1 of the Code of Virginia, relating to person with a legitimate interest; parent whose rights have previously been terminated; custody and visitation.
SUMMARY AS PASSED HOUSE:

Party with legitimate interest; parent whose rights have previously been terminated. Allows a parent whose rights previously have been terminated to be considered a party with a legitimate interest for the purposes of filing a custody or visitation petition, provided that the child whose custody or visitation is at issue (i) is at least 14 years of age, (ii) has had a permanency goal previously achieved by adoption, (iii) has had his adoptive parents die or each of such child's adoptive parents has permanently been relieved of custody of such child and each adoptive parent has had his parental rights terminated, and (iv) is in the custody of a local board of social services, and provided that the parent whose rights had previously been terminated has (a) complied with the terms of any written post-adoption contact and communication agreement entered into and (b) maintained a positive, continuous relationship with the child since termination. Under current law, a party with a legitimate interest does not include any person whose parental rights have been terminated by court order, either voluntarily or involuntarily.

HB 2115

Status: Approved

An Act to amend and reenact § 16.1-263 of the Code of Virginia, relating to summonses of a juvenile; custody, visitation, and support proceedings.
SUMMARY AS INTRODUCED:

Summonses of a juvenile; custody, visitation, and support proceedings. Provides that the court may direct the issuance of a summons to a juvenile on its own motion or upon request of a party to a custody or visitation petition. The bill further provides that the court may direct the issuance of a summons to a juvenile on its own motion or for good cause shown by a party to a support proceeding requesting the issuance of such a summons. The bill is a recommendation of the Committee on District Courts.

SB 801

Status: Approved

An Act to amend and reenact §§ 2.2-5209, 2.2-5211, and 2.2-5212 of the Code of Virginia, relating to Children's Services Act; state pool of funds.
SUMMARY AS PASSED SENATE:

Children's Services Act; state pool of funds. Makes a number of changes to the Children's Services Act state pool of funds for the provision of public or private nonresidential or residential services for troubled youth and families, including (i) removing from the purpose of the state pool of funds the consolidation of categorical agency funding and the institution of community responsibility for the provision of services; (ii) removing language specifying that references to funding sources and current placement authority for the target population served by the state pool of funds are for the purpose of accounting for the funds and should not be intended to categorize children and youth into funding streams in order to access services; (iii) modifying the target population served by the state pool of funds by (a) removing references to the Department of Education's private tuition assistance and the Interagency Assistance Fund for Noneducational Placement for Handicapped Children and (b) adding children and youth who are determined to be a child in need of services, as such term is defined in relevant law; (iv) removing the requirement that the financial and legal responsibility for certain special education services remains with the placing jurisdiction, unless the placing jurisdiction has transitioned all appropriate services; (v) requiring that the uniform assessment instrument used to determine eligibility for funding through the state pool of funds be approved by the State Executive Council for Children's Services; and (vi) modifying the eligibility criteria for funding through the state pool of funds by adding language that (a) specifies that the child or youth's emotional or behavioral problems have resulted in the child or youth, or place the child or youth at imminent risk of, entering purchased residential care and (b) includes the determination by a court that the child or youth is a child in need of services, as such term is defined in relevant law. The bill also includes technical changes. As introduced, this bill was a recommendation of the Virginia Commission on Youth.

SB 1277

Status: Approved

An Act to amend and reenact § 8.01-396.2 of the Code of Virginia, relating to minor witnesses; appointment of guardian ad litem in circuit court.
SUMMARY AS INTRODUCED:

Minor witnesses; appointment of guardian ad litem in circuit court. Authorizes a circuit court to appoint a discreet and competent attorney-at-law as guardian ad litem for a minor witness called to testify in a matter before the circuit court involving certain sex offenses. Under current law, a general district court may appoint a guardian ad litem for a minor witness called to testify in any proceeding and the circuit court may continue the appointment or appoint a new

guardian ad litem for such matter on appeal.

SB 1372

Status: Acts of Assembly Chapter

An Act to amend and reenact § 16.1-277.02 of the Code of Virginia, relating to petitions for relief of care and custody of a child; investigation by local department of social services; Office of the Children's Ombudsman work group; report.
SUMMARY AS PASSED SENATE:

Petitions for relief of care and custody of a child; investigation by local department of social services; Office of the Children's Ombudsman work group; report. Requires a local department of social services, as a part of its investigation after the referral of a request for a petition for relief of the care and custody of a child, to (i) refer the parent to the local family assessment and planning team and (ii) create a written report. The bill directs the Department of Social Services, in coordination with the Virginia League of Social Services Executives, to create a template for and provide guidance on what should be included in such written report.

The bill also directs the Office of the Children's Ombudsman to convene a work group composed of relevant stakeholders to (a) determine the factors a court should consider when determining whether there is good cause shown for a petitioner's desire to be relieved of the care and custody of a child and (b) explore the potential benefits and considerations of raising the standard of evidence for granting temporary relief of custody from the current standard of preponderance of the evidence to clear and convincing evidence. The bill directs the work group to submit a report of its findings and recommendations to the Chairs of the House and Senate Committees for Courts of Justice and the Virginia Commission on Youth by November 1, 2025. Certain provisions of the bill have a delayed effective date of January 1, 2026. As introduced, this bill was a recommendation of the Virginia Commission on Youth. This bill is identical to HB 1733.

SB 1406

Status: Acts of Assembly Chapter

An Act to amend and reenact §§ 2.2-438, 2.2-441, 2.2-445, and 2.2-446 of the Code of Virginia, relating to Office of the Children's Ombudsman; foster youth's right to receive information.
SUMMARY AS INTRODUCED:

Office of the Children's Ombudsman; foster youth's right to receive information. Requires the Department of Social Services or a local department of social services, a children's residential facility, or any child-placing agency to provide certain information along with the contact information for the Office of the Children's Ombudsman to a biological parent, prospective adoptive parent, or foster parent, as well as to any child in foster care age 12 or older upon the opening of a foster care case for such child. The bill also provides that, in relation to complaints made to the Ombudsman, if such child is the complainant, the Ombudsman need not gain the consent of the Department or local department of social services, the children's residential facility, the child-placing agency, or the foster parent or guardian of the child or other person having custody or care of the child to receive information from or communicate with the child. This bill is identical to HB 1777.

SB 1460

Status: Governor's Recommendation

An Act to amend and reenact §§ 19.2-327.15, 19.2-327.17, 19.2-327.18, and 19.2-327.19 of the Code of Virginia, relating to issuance of writ of vacatur for victims of human trafficking.
SUMMARY AS PASSED:

Issuance of writ of vacatur for victims of human trafficking. Amends the procedure that allows victims of human

trafficking, defined in the bill, to file a petition of vacatur in circuit court to have certain convictions vacated and the police and court records expunged for such convictions. This bill is identical to HB 2393.

Governor's Recommendation

(SB1460)

GOVERNOR'S RECOMMENDATION

1. Line 48, enrolled, after trafficking;

strike

and

2. Line 49, enrolled, after adjudication

insert

; and (vi) that the petitioner has ceased to be a victim of human trafficking or has sought rehabilitative services

Counts: HB: 6 HJ: 0 SB: 5 SJ: 0

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Science for behavioral health systems change: evolving research-policy-public partnerships

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Potent partnerships among researchers, policymakers, and community members have potential to produce positive changes in communities on a range of topics, including behavioral health. The paper provides a brief illustrative review of such partnerships and then describes the development and evolution of one partnership in particular in Virginia. The origin of the partnership is traced, along with its founding vision, mission, and values. Some of its several projects are described, including (a) needs assessment for implementation of evidence-based programs (EBPs) pursuant to the Family First Prevention Services Act; (b) statewide fidelity monitoring of key EBPs; and (c) projects to synergize state investments in specific EBPs, like multisystemic therapy, functional family therapy, and high fidelity wraparound. The paper concludes with some themes around which the center has evolved to serve the state and its citizens more effectively.

KEYWORDS

partnerships, implementation science, evidence-based programs, public mental health system, children's mental health

1 Introduction

Readers may be familiar with the ancient parable, dating from early Buddhist and Jainist texts, of the discovery of an elephant by a group of people who were blind. Depending on the version of the story, their efforts to describe the creature led to conflict, confusion, and a less than ideal understanding of the situation. If they had found a way to unify their perspective, perhaps they would have been able to perceive the elephant in its totality. The wisdom found in this story applies to many human endeavors. Faced with large and complex problems requiring multiple individuals to act in a coordinated way, we can struggle to work together to achieve common goals. Public policy implementation poses particularly daunting challenges due to the scope of the problems, the complexity of the systems involved, and the variety of expertise needed to guide action. Research-practice-policy partnerships (hereafter, RPPPs) have long been an important tool in the effort to avoid the elephant effect when implementing new public policy, as they aim to leverage the diversity of skills and knowledge present in a community to enhance the chances of stronger outcomes.

Ideally, RPPPs join a variety of individuals, especially those with expertise in scientific methods, those with practical implementation knowledge and abilities, those affected by any proposed policy, and those with political or other power to affect change. RPPPs are common in many areas of policy implementation including, for example, water use, prevention of medical illness, and education (1–3), and they have been shown to predict policy that supports adoption of evidence-based treatment (4). In this paper, we focus on such partnerships in the behavioral health space, an area with many such arrangements, and one that is prone to challenges in policy implementation due to the many intersecting systems involved. We briefly review the history of partnerships in behavioral health before describing the work of the Center for Evidence-based Partnerships in Virginia (CEP-Va). We trace the origins of CEP-Va and describe an early project in the partnership. We conclude by discussing how our approach to partnership has evolved.

The history of connecting behavioral health research findings to clinical practice and policy has been advocated as a means to reduce the long-lamented research-to-practice gap (5, 6). The tenets of academic and public collaboration to help integrate study results and best practices with the complex realities of service delivery have shaped the missions of a number of organizations across the country. An early example of this kind of partnership is the Connecticut Mental Health Center, founded in 1966 as a collaboration between the state and Yale to provide community services, train community-based clinicians, and conduct academic research (7). In 1976, the scope of work grew to include the Consultation Center—a service, research, and training hub. Also in Connecticut, an effort to improve statewide services and manage growing funds led to the formation of the Children's Fund of Connecticut, now the Child Health and Development Institute, a nonprofit entity. A third entity in Connecticut is the Innovations Institute. Originally founded in 2005 at the University of Maryland and now housed in the University of Connecticut's School of Social Work, the Innovations Institute aims to build child, youth, and family-serving public systems that respond to evidence as well as individual and cultural needs, including expanding the workforce responsible for delivering services (8).

Similarly, the University of Washington and Washington State Healthcare Authority (HCA) partnered to create the Evidence-Based Practice Institute (EBPI) to promote evidence-based programs (EBPs) in the state. Originally founded in 2007 by a Washington state bill to improve publicly-administered behavioral healthcare for children, the Institute publishes reports on EBPs in the state, provides guidance for how to report EBPs being provided in the state, publishes a quarterly breakdown of provided EBPs funded by Medicaid, and conducts outreach and partnership efforts to connect quality data reporting and improvements in state-funded behavioral healthcare. The Institute is now housed within CoLab for Community & Behavioral Health Policy in the University of Washington School of Medicine's Department of Psychiatry and Behavioral Sciences.

In Louisiana, another partnership was established in response to the finding that a gross majority of Medicaid providers reported delivery of EBPs but fewer than half were able to endorse any of the structural components shared by EBPs (e.g., training curriculum for staff) (9, 10). Few providers reported using research-supported practices related to quality assurance such as fidelity monitoring or structured supervision for supporting practitioners in direct service. These findings led to the founding of the Center for Evidence to Practice at Louisiana State University in 2017. To achieve the vision of a state with universal access to high-quality behavioral healthcare delivered by a newly trained or retooled workforce, the center helps the state and its service delivery partners select and implement behavioral health interventions supported by evidence, along with working to understand and address challenges to EBP sustainment.

There are many other excellent partnerships between academic and policy-making organizations in the US that space precludes our mentioning [e.g., California, see (11); Hawai'i see (12, 13); New York State OMH, see (14)]. Many have a similar origin story, emerging in response to a crisis, a lawsuit, or other critical events and becoming sustainable due to the commitment of individuals in critical leadership positions. RPPPs in the behavioral health space have diverse structures. Some are located at academic institutions. Others are independent consultation or research entities. Though each tends to promote behavioral health broadly, the foci of these RPPPs understandably differ based on the sources of funding supporting them and the initiatives active in the state. As a result, behavioral health RPPPs share common challenges and have many unique ones as well. The origin story for the Center for Evidence-based Partnerships in Virginia (CEP-Va) is similar to many such RPPPs, and we turn next to that story.

2 The center for evidence-based partnerships in Virginia

Like many states, Virginia has long struggled with its behavioral health system, too often landing in the bottom quartile in national rankings despite some notable initiatives, including the enactment of the Children's Services Act (1993) and the establishment of community services boards (CSBs) that provide regions across the state with a wide range of services (15, 16). In 2017, the state's behavioral health agency, Department of Behavioral Health and Developmental Services (DBHDS), worked in tandem with Governor McAuliffe's Administration, the state's General Assembly, and other stakeholders to initiate a major reform of Virginia's behavioral health system called the System Transformation Excellence and Performance (17, 18). STEP-VA required the state's 40 CSBs to provide nine core services to children and adults: (a) same-day access, (b) primary care screenings, (c) outpatient behavioral health services, (d) behavioral health crisis intervention and stabilization services, (e) peer support and family support services, (f) psychiatric rehabilitation services, (g) veterans behavioral services, (h) targeted case management, and (i) care coordination by July 1, 2021 through several implementation phases (19). Prior to this initiative, CSBs were only required to provide emergency and case management services for adults.

Following on the heels of the STEP-VA initiative, the Virginia Department of Medical Assistance Services (DMAS) and DBHDS formed the Behavioral Health Redesign Workgroup, whose aim was to build a blueprint for a new approach to behavioral healthcare in Virginia via Medicaid expansion. The Redesign group included representatives from various organizations across the state, such as provider organizations, CSBs, professional organizations, advocacy organizations such as the National Alliance on Mental Illness (NAMI), managed care organizations (MCOs), and hospital and healthcare organizations, to contribute perspectives and disseminate information back to their organizations (20). A major focus of their work was the integration of evidence-based programs (EBPs) into all levels of

Virginia's service array. Initially called Project BRAVO (Behavioral Health Redesign for Access, Value and Outcomes), the initiative is now called the Behavioral Health Enhancement (21).

In addition to initiatives like STEP-VA and the Behavioral Health Enhancement, the state also embarked on work related to the 2018 passage of the Family First Prevention Services Act (FFPSA). This landmark federal legislation ushered in major changes for child welfare agencies. Relevant to the other behavioral health initiatives in the state, FFPSA emphasized the development and strengthening of strong arrays of EBPs in communities as a means to reduce use of foster care and other out of home placements. As a result of these multiple EBP-related initiatives, state agencies and their leaders worked to create synergy among EBPs. For example, multisystemic therapy (MST) and functional family therapy (FFT) were introduced throughout Virginia in 2016 by the Department of Juvenile Justice (DJJ) in an effort to reduce recidivism. These two EBPs were also selected by the Virginia Department of Social Services (VDSS) to include in their first Family First Prevention Services Act (FFPSA) prevention plan in 2019. As part of the collaboration around FFPSA, leaders organized an approach coordinating work across all three branches of state government to maximize alignment. Another collaboration was between DBHDS and the Office of Children's Services (OCS), a major funder of family services. These two state agencies have partnered for years to increase access to High Fidelity Wraparound (HFW) throughout Virginia, a service that reduces out of home placements, a notable goal for the state. Together, these various initiatives have brought a clear focus across multiple state agencies on how best to increase access to quality mental health services across different treatment settings and across the continuum of services.

Given the numerous initiatives, state leaders believed that without intention and coordination, the many related projects would be difficult or impossible to sustain past the launch and even more difficult to evaluate. These leaders, across multiple agencies, leveraged their multi-year collaborations to create an early vision for a center of excellence, located at a state university, designed to provide an independent perspective on the state's efforts. They approached Dr. Michael Southam-Gerow, an expert in implementation science at Virginia Commonwealth University in Richmond, VA, the state's capital city, and began to develop a scope for a center of excellence. After multiple iterations, the state team reconvened with enthusiasm and synergy to plan for the funding of the center on the heels of record or near-record budgets for behavioral health redesign in late 2019. Thus, the Center for Evidence-based Partnerships in Virginia (CEP-Va) was born.

The naming of the center as CEP-Va was a product of the state agency partners and Dr. Southam-Gerow, the newly-identified center director, considering the purpose they hoped for from the center. The focus on partnership, thus, was intentional from the beginning. CEP-Va's collaborative notion with state and local entities is what defines the center. In an effort to capture state leaders' intentions and ensure internal alignment, the director and postdoctoral researcher (now associate director), Dr. Rafaella Sale, established the vision, mission, and values that guide the center through a rigorous exercise.

Vision. *We believe all people have a right to resources that promote well-being including high-quality behavioral health services within their own communities. To achieve this vision, we engage in and promote relationships as a key mechanism for large-scale change.*

Mission. *The Center builds partnerships with stakeholders in public and private organizations to leverage collective support and effort for initiatives designed to improve access to behavioral health services in the Commonwealth. Through thoughtful use of evidence, the Center provides scientific input to stakeholders on the performance of the behavioral health system and paths for enhancing workforce capacity. Alongside its partners, the Center co-designs plans to move Virginia toward equitable, accessible, and evidence-informed behavioral health services.*

Values. *(a) Inclusion. (b) Integrity. (c) Teamwork. (d) Transparency.*

Before CEP-Va could be fully launched, the COVID-19 pandemic hit and the state budget was redistributed to address the intense needs that arose. After 6 months, the planning team reassembled with the same intention of launching the center, though with few funds to move forward. CEP-Va launched in late 2020 through a small block grant via DBHDS as a temporary funding solution. The state governance committee, chartered officially through the Department of Health and Human Resources, was formed in January 2021 to be comprised of representation from all child-serving agencies in the state. The governance committee has grown since its inception as other state agencies were invited and joined, with the ultimate goal enhancing collaboration among every state agency with a stake in behavioral health. The recruitment of state agency representatives has not been without challenges, with some agencies coming to the table more slowly.

Since its initiation under Dr. Southam-Gerow's leadership, additional projects have been added to CEP-Va's portfolio, allowing the team to expand. Indeed, the CEP-Va team has needed to evolve many times during its short existence. In the earliest days, CEP-Va operated like many start-up endeavors, with the small team working across all projects and wearing many hats for the team.

After an initial set of hiring in year two, the team re-organized into three loosely organized groups, including an ongoing needs assessment team, a training team, and a data team. In year three, with additional team members joining, more organization was possible. A leadership team emerged and that team created a set of teams with moderately distinct portfolios of projects, including (a) an engagement and consultation team, (b) a technical assistance materials team, (c) a training team, (d) a service coverage and quality assurance team, (e) a quality improvement studies team, (f) a research team, and (g) an admin team. It is notable that the CEP-Va team is multi-disciplinary and includes team members with degrees in psychology, social work, and public health. Although originally structured by the specific deliverables in its state contracts, CEP-Va has been able to evolve into teams that address key goals derived from its mission and vision and inspired by the founding ambitions of the many state leaders who wanted to work with an independent, academic center.

Details on the funding of CEP-Va may be helpful for others in the field. To date, CEP-Va's funding has been from state agencies and from private industry (health insurance companies), with most of those funds coming from state agencies. Although the funding to date has been adequate to support the deliverables associated with each contract, there remains a challenge to meet some administrative tasks that cross-cut these projects. An important near-term goal for CEP-Va is to secure infrastructure funding to support the growth of the organization. To this point, the university home has not committed funds to CEP-Va, though support does come in the form of space and other resources. We turn now to a brief review of a few of the projects on which CEP-Va has focused.

3 CEP-Va's scope of work

CEP-Va's portfolio of projects has expanded greatly in the 3 years since its inception. Although the initial projects focused broadly on several state initiatives, a dominant focus of the early years has been on working closely with the Virginia Department of Social Services (VDSS) in its effort to implement system-wide changes related to the FFPSA. Among the many changes pursuant to FFPSA, the law (a) required each state to file a prevention plan outlining the EBPs to be used by the system; (b) provided funding for training in EBPs from the newly created Title IV-E Prevention Services Clearinghouse, and (c) established fidelity monitoring requirements for all EBPs being implemented. FFPSA presented numerous opportunities and challenges for states, leading VDSS to seek out CEP-Va as a partner in its implementation.

An initial FFPSA-related task for CEP-Va was to help VDSS determine how and where to expand and supplement community service arrays across the state using federal dollars newly allocated through FFPSA. A notable challenge for Virginia lies in its being locally (vs. state) administered, one of only nine such states in the US (22). Local administration means that although the state can set guidelines and some policies, individual counties make some key decisions, including funding of services. Thus, in locally administered states, performance of the child welfare system can vary across counties much more than in state-administered states. As such, understanding local practices, policies, and preferences is paramount. To begin addressing the challenges, CEP-Va developed a unique, ethnographic approach to assess and monitor mental health needs and service gaps within and across Virginia's five regions and 133 localities. More details are provided in Section 4.

CEP-Va has also served two separate but related roles for Virginia: (a) primary coordinator of EBP training funded by FFPSA monies and (b) creator of fidelity monitoring reports for each of the EBPs in Virginia's Family First prevention plan. We briefly describe each of these in turn.

Training. As noted, one result of the FFPSA was a major federal investment in EBP training monies to expand service capacity. VDSS works with CEP-Va to solicit applications from providers to support implementation of EBPs. To accomplish the goal, CEP-Va developed a multiphase training model (see Figure 1) that begins with an *outreach* phase aimed at identifying providers aspiring to expand EBP services and providing information about EBP training available. The next phase, *fit assessment*, focuses on working closely with provider organizations to determine the EBP(s) that best fit the needs of their workforce and the communities they serve. *Role agreement* is the next phase, where CEP-Va develops a training plan that carefully identifies the roles for each player involved in EBP implementation, and outlines the training process and responsibilities in the system for the provider. Once the training plan is complete, the *preparation* phase begins, which includes an organizational workshop wherein the EBP purveyor's training team meets with the practitioners to be trained, leadership from the provider organization, relevant community partners and referral brokers, state representatives from VDSS and other agencies, and the training support team from CEP-Va. Notably, the preparation phase has evolved in some important ways based on experiences and barriers faced by previous implementation sites. For example, during this phase, CEP-Va works with the provider organization and community workers to expand the service area, when possible, to ensure wider access to the newly established EBP by linking financial support to whole community access. Further, CEP-Va works with the provider organization to build a sound financial plan and ensure sustainability of the service across funding sources. Once the organizational workshop is completed, the formal training process begins, as does the *monitoring* phase. CEP-Va provides scaffolding and support throughout each phase, helping providers reach milestones required for attaining and maintaining site-level certification as an EBP provider in Virginia.

Fidelity monitoring. CEP-Va is also responsible for assisting VDSS in meeting its federal fidelity monitoring requirements. The FFPSA mandates fidelity monitoring for all EBPs in a state's Family First Prevention Plan for which Title IV-E funds were used to pay for services. CEP-Va worked with VDSS and EBP purveyor organizations to develop fidelity models for all EBPs in the state plan and establish data sharing agreements to ensure access to data for the planned reports (see Appendix for glossary of terms). The lack of federal guidance represented an initial challenge. Although the FFPSA stated that fidelity monitoring was required, few details were provided, including what, if any, federal reporting of the resulting data would be.

Another challenge related to fidelity monitoring was that the FFPSA stated that fidelity monitoring was required for services funded by Title IV-E. Virginia, like most states, has struggled to fund evidence-based services through Title IV-E. Because of the state's early commitment to EBPs, Medicaid established rates for some EBPs and quickly became the major funder of those services. Because FFPSA stipulates that Title IV-E funds may only be used as the payer of last resort, EBPs in Virginia were required to be funded via Medicaid when a family is eligible before Title IV-E funds could be accessed. As a result, developing fidelity reporting for families whose services were solely funded by Title IV-E would only address a small sample of Virginia families. Instead, CEP-Va opted to monitor and report fidelity for EBPs across all funding sources, allowing a more robust and useful fidelity snapshot for the state, consistent with CEP-Va's overall goals of supporting the state's system broadly versus an individual agency.

Figures 2, 3 display samples from recent reports on two of the EBPs in the state's plan, functional family therapy (FFT) and multisystemic therapy (MST). Both programs have established metrics for multiple fidelity indicators, and our partnership with the purveyors has permitted us to tailor these reports for Virginia. Depicted here are two of the key team fidelity indicators as defined by the purveyor organizations: therapists per team (for FFT) and fidelity scores (for MST). As Figure 2 depicts, Virginia's teams have struggled to maintain minimum team-size standards. Although the number of therapists per team was above the benchmark for three of the past four quarters, the loss of a single therapist on the average team in half of the quarters would lead to the team being out of compliance. The challenge of maintaining team size is due to many factors captured within CEP-Va needs assessment studies (e.g., workforce shortage, rate changes). In Figure 3, data on fidelity performance for the state's MST teams are displayed. Fidelity for MST is measured using the Therapist Adherence Measure-Revised (TAM-R), a caregiver-report of the therapist's fidelity to the principles guiding MST. The purveyor of MST has established that a score of 0.61 or higher on the TAM-R represents an acceptable level of fidelity. Figure 3 thus represents the percentage of teams in Virginia meeting or exceeding that standard. Note that for each quarter, the number of teams and number of cases is reported as

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Phase 0: Outreach	Phase 1: Fit Assessment	Phase 2: Role Agreement	Phase 3: Site Prep	Phase 4: Monitoring	Phase 5: Maintenance
Purpose: Provide any clarity needed about funding, training and/or available EBPs before applying for funding	**Purpose:** Determine best EBP for site, clarify more specific training details and responsibilities before deciding to move forward with a training plan	**Purpose:** Ensure a shared understanding and agreement of roles between the provider, CEP-Va, and the purveyor	**Purpose:** Prepare the site for initial implementation, which includes an organizational workshop and practitioner training	**Purpose:** Evaluate training/ implementation performance, troubleshoot issues, determine year 2 funding	**Purpose:** Complete EBP-specific fidelity/adherence, continue developing the EBP and ensuring long-term sustainability at the site
Timeline: Before application is complete	**Timeline:** Before the training plan is drafted	**Timeline:** After training plan is drafted, but before it is finalized	**Timeline:** After training plan is finalized, before organizational workshop	**Timeline:** First year following organizational workshop	**Timeline:** Year 2 and later

FIGURE 1
CEP-Va training model.

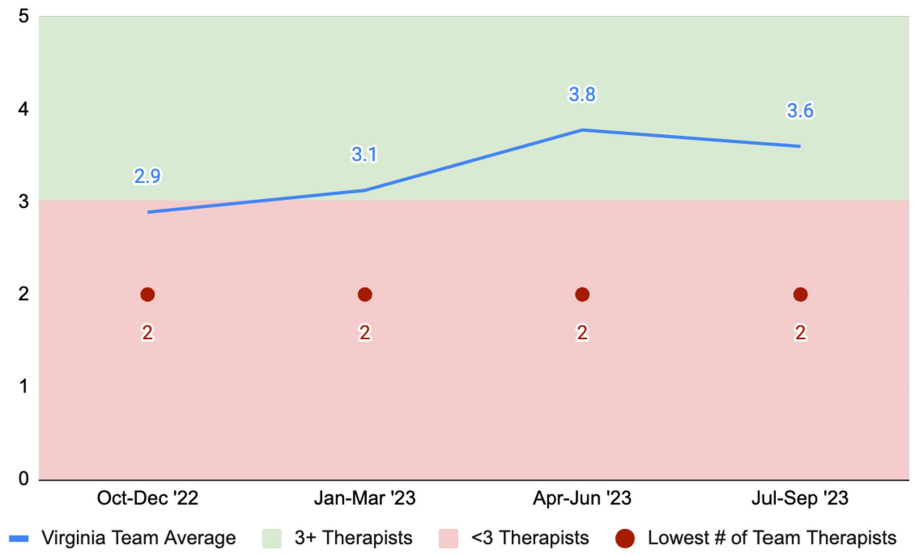

FIGURE 2
Therapists per team for FFT.

added context. Despite the staffing challenges, MST demonstrated strong fidelity scores statewide, with two-thirds or more of teams meeting or exceeding the fidelity standard.

Although FFPSA implementation has been a major driver of CEP-Va activity, another early CEP-Va project was a statewide credentialing database for EBPs. The initial state goal was a single authoritative source to track practitioners trained in at least one of the various EBPs the state was implementing. CEP-Va's work has yielded two separate online applications. The first, the EBP Registry, is the most straightforward realization of the concept identified by the state. The Registry contains information about each practitioner trained in an EBP, including their workplace, training, and current status in the EBP (or EBPs). Although the Registry relied on a survey to gather some of the data, training status was validated through a CEP-Va developed process to ensure accuracy. The Registry, however, is only searchable by practitioner license number, and thus is only used by the practitioners themselves to confirm and update their own data. The reason for this choice was that provider companies were concerned that a searchable registry of practitioners trained in EBPs would be used as a recruitment tool for companies seeking to hire previously-trained practitioners.

CEP-Va next developed the EBP Finder, a tool that leveraged data from the Registry and was designed for—and in collaboration with—service planners incorporating human-centered design elements [e.g.,

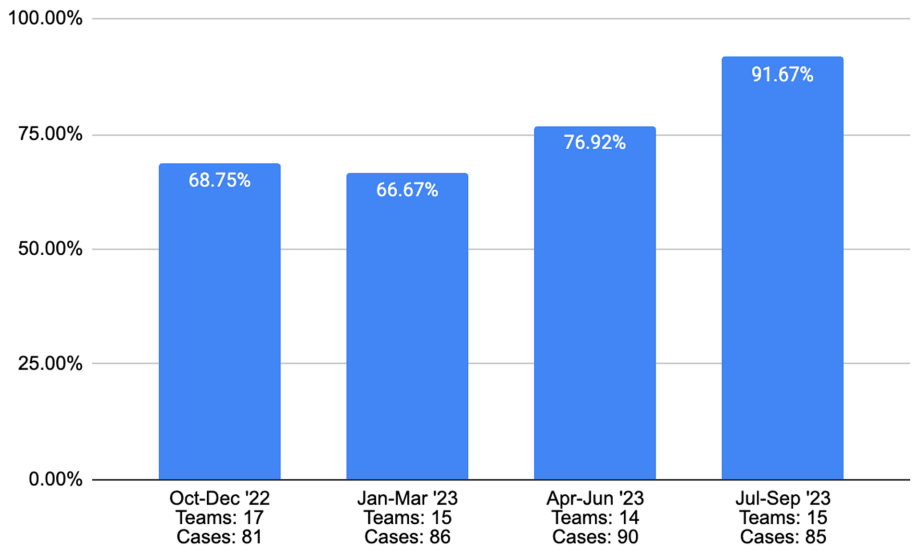

FIGURE 3
Percent of VA MST teams meeting or exceeding the average fidelity score target.

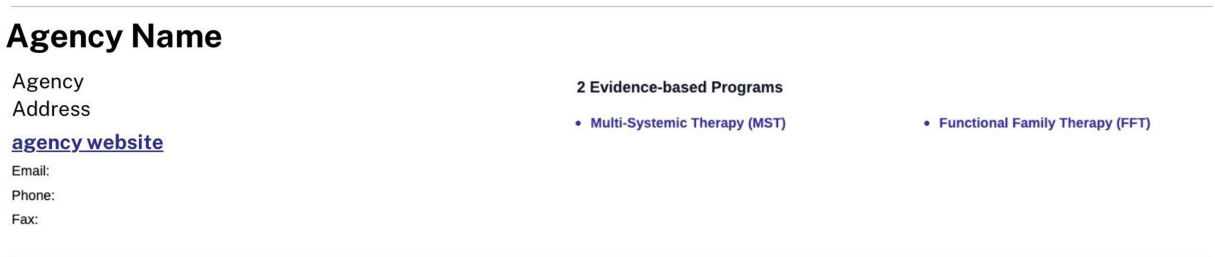

FIGURE 4
Snapshot of an EBP finder card.

(23)]. The Finder provides a list of EBPs available by provider company, filterable by EBP, locality, or both. Figure 4 depicts a sample result from using the Finder. In this example, the provider agency listed has been trained and certified to deliver two EBPs at this location.

A final example of CEP-Va's scope of work is one not spelled out in any of the contracts. Because of the vision, mission, and values of the organization, CEP-Va sought to develop points of communication with its partners, borrowing from community engaged scholarship methods (24–26). As a first approach, CEP-Va began to establish advisory groups with key partners. The first two of these were with provider organizations and managed care organizations (MCOs). The members of the former group were invited after developing a set of selection criteria to ensure representation of the diversity of the state, including demographics of the communities served, state region, size of the provider organization, age of the provider organization, and business model (e.g., for-profit, non-profit). The MCO advisory group is composed of one or more representatives from each of the seven MCOs with Medicaid contracts in Virginia. The focus of the MCO group is sustainment of EBPs, with recent focus being on the adequacy of rates and their provider networks for services demonstrated to reduce residential placement. Future advisory groups will include family members and service planners.

4 Examples from CEP-Va's curriculum vitae

A key initial effort includes the development of an ongoing approach for detecting and monitoring implementation barriers across the state, the Needs Assessment and Gaps Analysis (NAGA) project. NAGA was designed to serve as a springboard for recommended additions to the array of EBPs in the Family First Prevention Plan and to guide the investment of training funds in accordance with regional needs. Detected barriers initiate studies that either end or grow in response to state partner feedback. CEP-Va developed an iterative plan and established some key databases for its use. CEP-Va's efforts were modeled to be ethnographic (27) and inclusive of the historical and social context to understand how extant systems and their structural linkages influence the various partners in a system, including provider companies, service coordinators, practitioners, and individual families. For its first study, CEP-Va designed and implemented multiple individual projects, leveraging various mixed methods approaches. Some projects focused primarily on qualitative and descriptive data, and others quantitative in nature. Over the past 3 years, the work has resulted in three published reports (28–30). Throughout each iteration of NAGA, CEP-Va maintains a

focus on the specific needs of VDSS and the child welfare system, as well as the aims of the state's many behavioral health partners. In the next few pages, we will describe more examples of the evolution of CEP-Va's approach to its work.

One constant in CEP-Va's work has been to leverage extant work in Virginia as a starting point, a process referred to as contextual analysis. To accomplish the goal, CEP-Va has amassed a library of needs assessments and other studies conducted in Virginia over the past decade. These 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. Establishing the library has permitted CEP-Va to appreciate how much is already known and understood by policymakers and researchers, to identify knowledge gaps to be filled, and to pinpoint interest convergence among state agencies.

One initial result of building this library was a need to focus on specific Community Service Boards (CSBs), the state's safety-net of publicly-funded community mental health centers. CEP-Va found that almost half (46%) of Virginia's annual foster care entries in the past 10 years came from the catchment areas of just 13 of the state's 40 CSBs. Further, through examining the link between poverty and foster care entry, it was found that, out of the state's 133 localities, the 24 localities with the highest concentration of people living below the poverty line accounted for 33% of children who entered foster care annually. Figure 5 displays the average annual foster care entry rate by locality, with areas of highest poverty concentration highlighted in blue. A key recommendation emerged from these data: support and prioritize the CSBs in these regions, especially by strengthening their deployment of high quality services, including EBPs. A second analysis of data for the Sale et al. report changed the list of priority CSBs somewhat, yet continued to emphasize the importance of supporting CSBs in general.

A second set of findings from CEP-Va studies concerned the challenges facing the workforce in Virginia and across the US [e.g., (31, 32)]. Through a variety of data sources including the library of needs assessments, interviews, and listening fora, a set of obstacles to EBP implementation became clear. In Virginia, as in many states, the licensed workforce accelerated its departure from the public mental health sector during the COVID-19 pandemic. This increasing turnover created struggles for provider agencies to hire and maintain the staff required to implement an EBP. Thus, despite annual training budgets of more than $1 M from VDSS alone, there was limited demand for training. And even when training was initiated, workforce turnover occurred in nearly all cases. As a result, CEP-Va supported the Governor's Office via their initiative entitled Right Help, Right Now, to examine how restrictions in Virginia regulations or practices exacerbate workforce challenges. One result of this work was a report on how different states in the US deploy unlicensed mental health workers, which indicated opportunities for Virginia to extend the use of an already existing workforce (30).

A related barrier to EBP implementation that arose in CEP-Va's qualitative work across the state concerns the payment rates for EBPs in Virginia. At the outset, effort was made by the main payors for services to ensure rate alignment, meaning that all funders would use the same rate for the same service. These payors included Medicaid, OCS via Children's Service Act funds, the Department of Juvenile Justice via diversion grants, and VDSS via Title IV-E funds. Although successful at first, the effort for alignment was derailed and rates for some EBPs began to differ by payor in both reimbursement amount and structure for reporting. Specifically, Medicaid rates for MST and FFT were set for billing in 15 min increments vs. *per diem* like other funders. The result was that provider organizations struggled to use the Medicaid funding in a profitable way, leading to stagnation or decline in the number of MST and FFT teams across the state. It was also a challenge to initiate new EBPs without a specific Medicaid rate because of the requirement to use Medicaid funding if the family was eligible for Medicaid. This constraint led Medicaid providers to seek payment via less-than-optimal

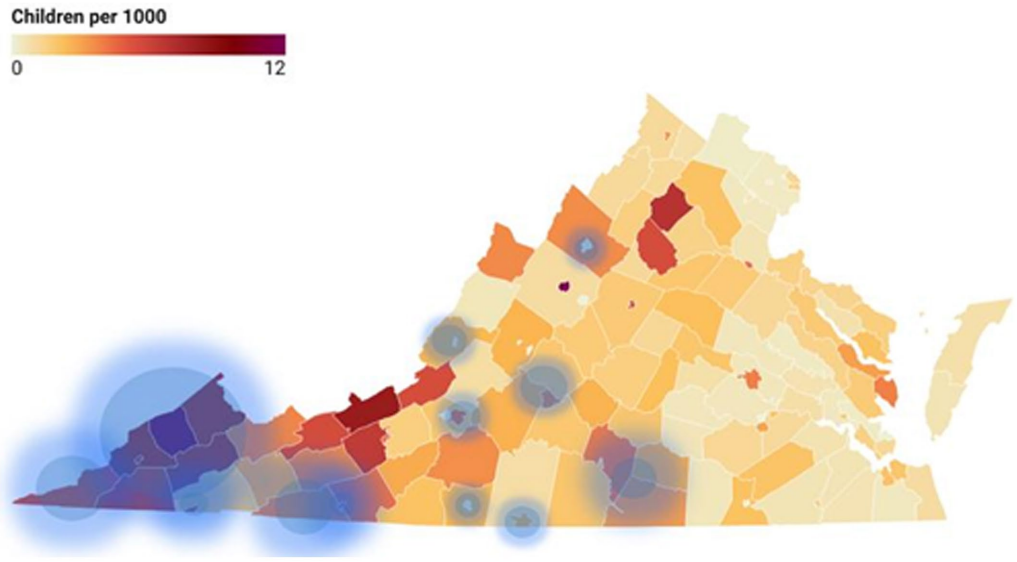

FIGURE 5
Foster care entry rate FY2021 by locality with families living below poverty level.

reimbursement rates. As one example, brief strategic family therapy (BSFT), an intensive family therapy approach, was paid as an intensive in-home service, a Medicaid service category designed to be delivered by unlicensed practitioners despite the state requirement to staff BSFT with licensed professionals.

To assist the state with these challenges, CEP-Va has taken several steps. First, CEP-Va has used its partnership with multiple state agencies to create regular meetings of key state leaders from the Medicaid agency and other payors to troubleshoot the issues. CEP-Va's role has been to identify and clarify the challenges and then generate a solution-focused conversation. As noted earlier, CEP-Va has engaged an advisory group composed of representatives from the Medicaid MCOs in Virginia, with an aim to involve them in creating a financial environment conducive to implementation of quality services like EBPs. That advisory group formed a subcommittee specifically focused on the challenges facing MST and FFT teams in the state. One early result of this effort is that one of the MCOs has begun a plan on how to offer enhanced rates for MST and FFT in Virginia. Individual MCOs are permitted to offer rates that exceed the standard Medicaid rate.

Another way CEP-Va has worked to address the rate challenges has been in its work with provider companies seeking EBP training. Through engagement with the companies, CEP-Va evaluates the available workforce at the agency, gaps in service coverage in the region, and the agency's state and MCO contracts. Doing so aids CEP-Va and the agency determine which EBP will be most suited for their community, workforce, and reimbursement options, ensuring a better chance of financial sustainability despite these rate challenges.

Last, CEP-Va has worked closely with VDSS to identify EBPs for which there is not an existing Medicaid rate and for which such a rate is not planned. One example is High Fidelity Wraparound (HFW), a team-based case coordination approach that requires few licensed workers and can be paid at a higher rate via Title IV-E and state pooled funds alone, because there is not a Medicaid rate, and HFW is not a Medicaid service.

One last example of how CEP-Va's work has evolved based on the data and its partnerships concerns High-Fidelity Wraparound (HFW). HFW is a community-based, team-based, strengths-focused, collaborative, and individualized process designed to provide a coordinated set of services and support for families with children and youth, from birth to age 21, with complex emotional, behavioral, or mental health needs. HFW is centered on 10 principles, including (a) family voice and choice, (b) cultural competence, and (c) strengths-based. The approach has a rich and developing evidence base supporting its use (33), with evidence suggesting that successful implementation of HFW requires fidelity to the core principles, making training and ongoing coaching a requisite for quality HFW.

HFW has a relatively long history in Virginia and has had the support of multiple state agencies shortly after its introduction. For many years, Virginia had funded training and fidelity monitoring efforts via federal grants, an approach that was successful for some time. Training needs were met by a private provider that founded the Virginia Wraparound Implementation Center (VWIC) while fidelity monitoring was accomplished in several different ways over the years. Although these efforts led to solid expansion of HFW across Virginia, by 2019, there was concern that growth had plateaued or even started to decline. Reliance on federal grants for sustainment of a service incurred several risks. Because funding was frequently uncertain year to year, trainers were difficult to retain, opting to take on full-time employment with more stability. Further, some funding had supported robust fidelity monitoring and others had not. Over time, the provider community did not view fidelity monitoring as a requisite for providing the service. Last, when a grant was not funded, there was a scramble to find funds to tide the operations over for another grant cycle or two. All of these factors left the survival of HFW in a precarious state in Virginia.

CEP-Va was tasked with the development of a sustainment plan for HFW. CEP-Va's plan of action for the state included several initiatives. First, CEP-Va worked with VDSS to include HFW in a revision of its FFPSA Prevention Plan. Including HFW, considered a Promising Practice in the Title IV-E Clearinghouse, meant that VDSS would have a stake in the service and would be required to conduct an evaluation for the approach. CEP-Va then collaborated with VDSS to write an evaluation plan for HFW in Virginia, one that would focus on the entire state's HFW implementation rather than the work funded by Title IV-E alone, as was the requirement. CEP-Va would serve as the evaluator, partnering with VWIC to build a feedback system for teams with the training entity.

Next, CEP-Va brokered a deal among state agencies to pool funds and build a funding plan for VWIC. The initial plan included 3 years of funding designed to permit the organization to build out the training and administrative team needed to sustain the work. VWIC's stability meant that the state now had a consistent training entity for HFW.

Last, CEP-Va worked with leaders from many state agencies to select HFW as the focus for a multi-year transformation zone [e.g., (34, 35)] project in collaboration with the Frank Porter Graham Child Development Institute. The choice meant even more focus on and multi-agency support for HFW in Virginia.

In a brief time, CEP-Va has begun to make an impact on the behavioral health landscape of Virginia. Across projects, the CEP-Va team has held to its founding mission, vision, and values. However, CEP-Va has also evolved in its work, as the team and projects have both expanded. Although much work remains, CEP-Va is a good example of the promise held by sustained engagement of partnerships among policymakers, scientists, practitioners, and other community members.

5 Conclusion

Research-practice-policy partnerships (RPPPs) hold great promise to shorten the time frame needed to bring impactful scientific findings to communities and help mitigate social problems. RPPPs are also supremely challenging to maintain, given the various and different forces that influence the behaviors of researchers, practitioners, and policymakers. In our few years in Virginia, several themes have emerged guiding our evolution and we conclude this paper by discussing two of them. Though it is plausible that these themes are Virginia-specific, we hope that they can be helpful for others engaged in this important and difficult work.

The first theme concerns the too oft-overlooked fact that the mental health system operates in a business context. Some early implementation work assumed that the mere existence of EBPs would lead to system-wide change. The thinking was that once providers knew EBPs were available, they would implement them. However,

because services were already in place across the system–and that system had adapted to those services–there was (and still remains) a need for significant system disruption to incorporate EBPs.

As discussed earlier, the financing of mental health care represents an enormous test for those who would implement any new service. For EBPs to be implemented, there must be a clear business advantage to them. Some EBPs have understood that necessity from the beginning, and have made their case in policy realms and with financial data. For most EBPs, though, this sort of analysis remains incomplete, posing a significant challenge. The current service system is less expensive than one involving EBPs. EBPs require specialized training and ongoing, paid credentialing. Many also require ongoing fidelity and outcome data collection, in addition to supervisory oversight, including meetings, that reduce productive hours for an employee. In short, EBPs cost more than service as usual to implement. So why, provider companies will rightfully ask, would we change our business practice to a less profitable approach?

Despite the extra cost, EBPs may make good business sense insofar as they reduce future costs, especially with regard to out-of-home placements and other high-cost services. However, specific data are needed to support this hypothesis and for each EBP. Making the moral argument that EBPs are higher quality services is not going to be adequate, given the realities of the US healthcare system. There are likely other cost advantages to EBPs that could be tested in science and then leveraged to support their uptake. For example, if EBPs lead to better outcomes, practitioners may experience improved job satisfaction, tempting them to stay in their current job. Current turnover in mental health positions is costly for provider companies. So, if EBPs lead to better retention, then they save the provider money.

In short, sorting the financing of behavioral health will not be enough alone to lead to a major uptick in access to EBPs. However, failure to sort it will keep things stuck in neutral. Accordingly, we have taken several steps at CEP-Va to ensure that there is a focus on the finance side of our implementation work. First, at the recommendation of an RPPP colleague, our team engaged a national expert on EBP financing to learn more. Further, as mentioned earlier, we created multiple multi-agency meetings to address financing issues at the state level. Primary goals for these meetings are raising awareness of the salience of rates, continuing to align rates across services, and advocating for new rate studies to ensure EBPs are incentivized. Most recently, we have begun to explore working with colleagues in the university's business school and within Virginia's provider community to offer business consultation to provider organizations. Although many companies have business backgrounds and/or training in business practices, many provider organizations are run by professionals trained in mental health programs like social work or psychology, with curricula lacking in business training.

A final theme from the early days of CEP-Va has been the centrality of honest relationships. Recall the fable that opened the paper of the individuals who are blind encountering an elephant. The work of RPPPs requires enormous changes to systems involving thousands of individuals, and systems that affect the lives of millions. Such changes require sustained and focused work, effort that requires depth of knowledge and expertise across many different fields. The work also requires human relationships, as it is in those relationships that the solutions are designed, the parts assembled, and the design realized. As all who work in RPPPs know, these solutions can take years to plan and enact. Often, many of the participating partners will have pressures that encourage them to eschew the long-term project in favor of a one-time splashier initiative. As a colleague from another RPPP said in a recent meeting, our task as intermediary organizations can be to remind the state of its own goals and initiatives—to help the state stay on target rather than chase the latest fad. It is easier to accomplish that goal in the context of longstanding partnerships based on transparent communication. At CEP-Va, we have stayed true to our vision, mission, and values. By doing so, we have built strong relationships with numerous partners. And through those relationships, Virginia is beginning to see some positive changes.

Data availability statement

The original contributions presented in the study are included in the article/supplementary material, further inquiries can be directed to the corresponding author.

Author contributions

MS-G: Conceptualization, Data curation, Funding acquisition, Methodology, Resources, Supervision, Writing – original draft, Writing – review & editing. RS: Conceptualization, Data curation, Formal analysis, Investigation, Methodology, Supervision, Writing – original draft, Writing – review & editing. AsR: Data curation, Formal analysis, Methodology, Visualization, Writing – original draft, Writing – review & editing. VS: Conceptualization, Project administration, Writing – original draft, Writing – review & editing. JW: Formal analysis, Investigation, Writing – original draft, Writing – review & editing. BB: Formal analysis, Investigation, Writing – original draft, Writing – review & editing. AlR: Investigation, Validation, Writing – original draft, Writing – review & editing. MS: Formal analysis, Investigation, Writing – original draft, Writing – review & editing. AS: Formal analysis, Investigation, Writing – original draft, Writing – review & editing.

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Conflict of interest

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

Publisher's note

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Appendix

Terms defined.

Evidence-based practices	specific strategies embedded in interventions that have been proven through highly-controlled research trials to lead to better outcomes, i.e., empirically-supported
Evidence-based program(s)	manualized treatment packages that have been shown to work in research trials when delivered close to exactly the way they were developed
Evidence-based service(s)	a broad umbrella term for which programs exist underneath, referring the all the service components (ex., evidence-based programs, case coordination) that together contribute to a family receiving high-quality care
Feedback system	routine schedule of measuring indicators of quality or impact on outcomes, usually through a digital platform or data dashboard, for the purpose of guiding and informing delivery of a program or practice in real time
Fidelity	the degree to which a program adheres to specific model standards as determined by model developers
Implementation	multi-phasic process of integrating scientific findings into routine practice that emphasizes identification of factors that affect uptake of a novel practice or intervention
Policymakers	state and local governmental employees who are tasked with writing regulations and rules in an effort to apply and abide by federal and state laws
Practitioners	individual therapists, clinicians, counselors delivering services directly to children and/or families in any setting; includes unlicensed clinicians
Progress monitoring	general activity of collecting data for the purpose of assessing any type of movement toward a goal, objective, or desired status
Provider	companies or agencies that deliver behavioral health services; not individual direct service providers such as therapists or clinicians
Purveyor	program developers, trainers, or vetted spokespeople who represent an evidence-based program, and have a clear stake in how the program is delivered
Referral brokers	individuals in a service system such as caseworkers or case management specialists who refer families to behavioral health service providers
Sustainment	the active maintenance of gains or defined outcomes related to an innovation; ultimate goal of implementation

Center for Evidence-based Partnerships Virginia FFT Fidelity and Outcome Report

Coverage Period: October 2024 - December 2024

AUTHOR
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Statement of Purpose

Functional Family Therapy (FFT) is an evidence-based program (EBP) for youth ages 11-18 exhibiting behavioral or emotional problems and their families. The current report is prepared by the Center for Evidence-based Partnerships in Virginia (CEP-Va) and presents relevant fidelity and outcome data in Virginia per the Family First Prevention Services Act (FFPSA) from October 1, 2024, through December 31, 2024.

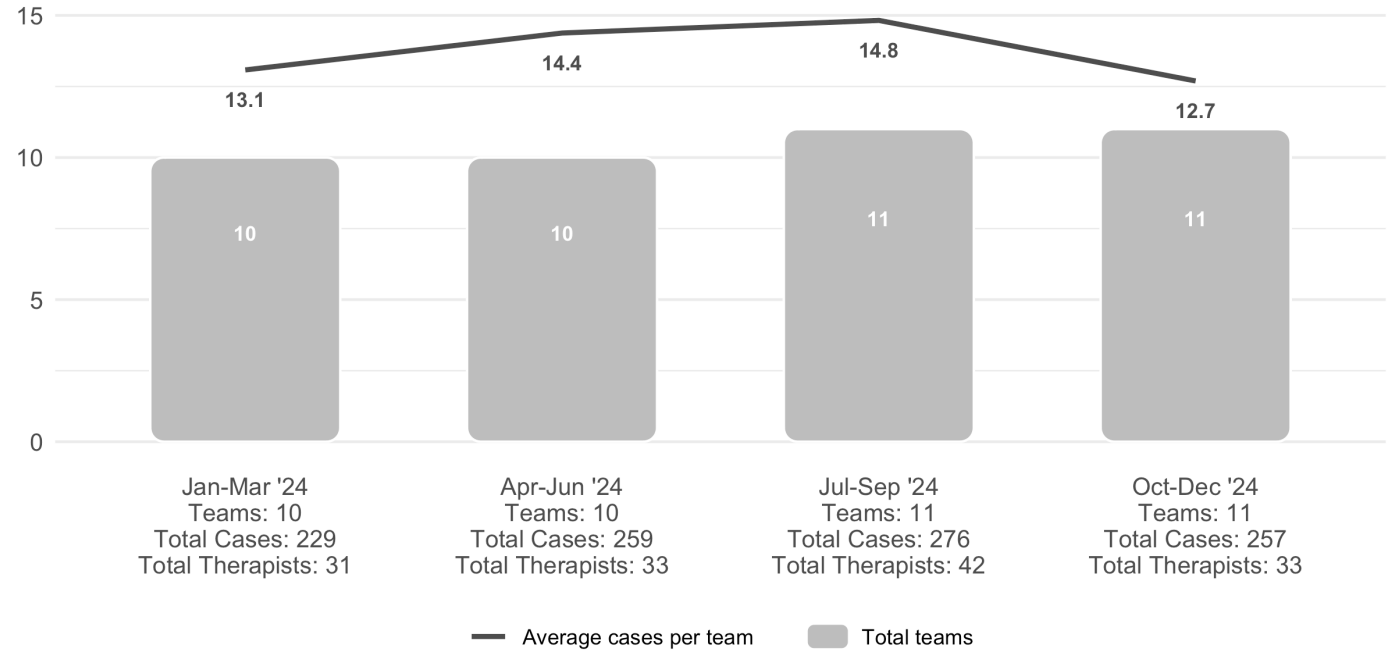
The CEP-Va Fidelity Model for FFT

CEP-Va has developed fidelity and outcome models for fidelity reporting for all evidence-based programs in the Family First Prevention Plan developed by Virginia's Department of Social Services (VDSS) and approved by the Administration for Children and Families. For each model, we used the empirical literature and recommendations from the treatment developer. Pragmatic issues were also considered when developing the models, including data availability and burden on provider companies, practitioners, and/or families. All final models were approved by the EBP developer or the EBP training company selected by VDSS. Model is detailed here.

Historical Status of Virginia FFT Team Workforce and Caseloads

Team and Case Data

Figure 1. *Active Teams with Average Caseload Across Virginia*



This quarter, the total number of FFT teams with at least one active FFT case across the state was 11. The average number of active and closed cases per team in this quarter dipped to 12.7, as seen in Figure 1.

A more detailed breakdown of team statuses maintains this stability across quarters, as seen in Table 1.

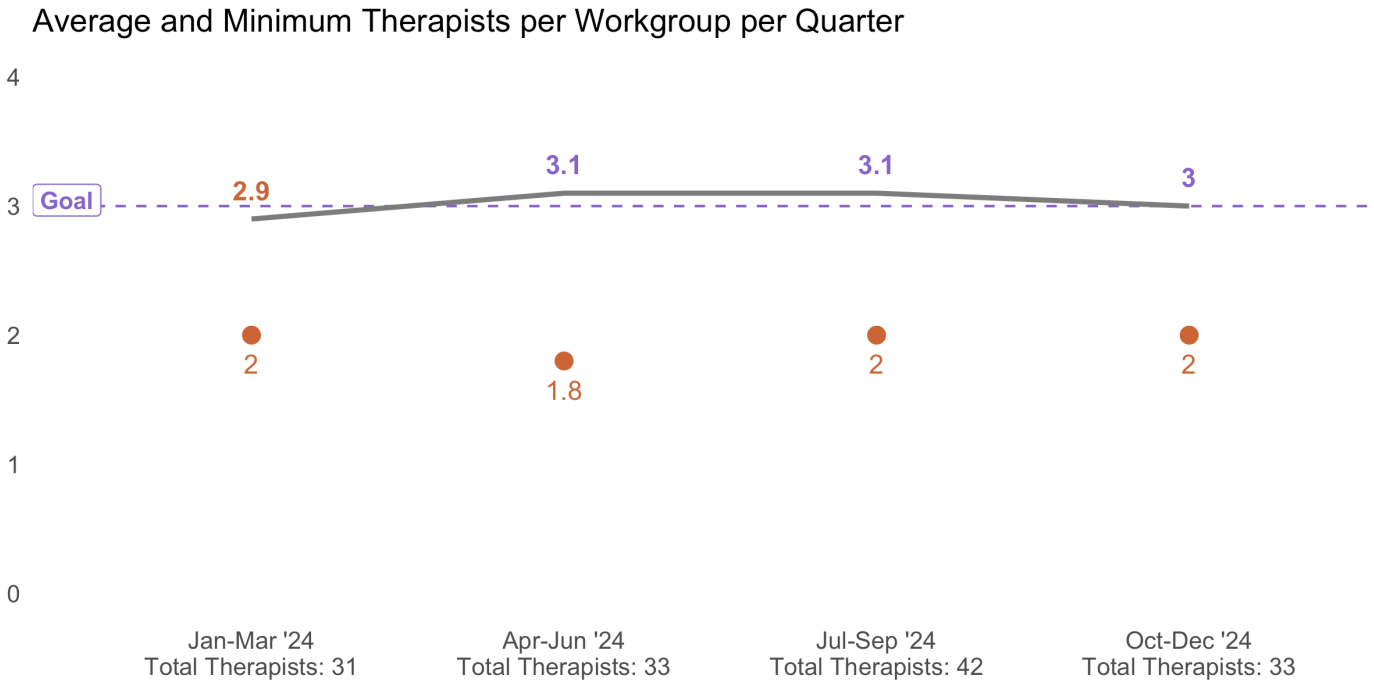
Table 1. *Team Status Detail*

Quarter	Teams operating	New teams	Closed teams
Jul-Sep 2021	9	0	0
Oct-Dec 2021	9	0	0
Jan-Mar 2022	10	1	0
Apr-Jun 2022	9	0	1
Jul-Sep 2022	9	0	0
Oct-Dec 2022	9	0	0
Jan-Mar 2023	9	1	1
Apr-Jun 2023	9	0	0
Jul-Sep 2023	10	1	0
Oct-Dec 2023	10	0	0
Jan-Mar 2024	10	0	0
Apr-Jun 2024	10	0	0

Quarter	Teams operating	New teams	Closed teams
Jul-Sep 2024	11	0	0
Oct-Dec 2024	11	0	0

Full-time Therapists

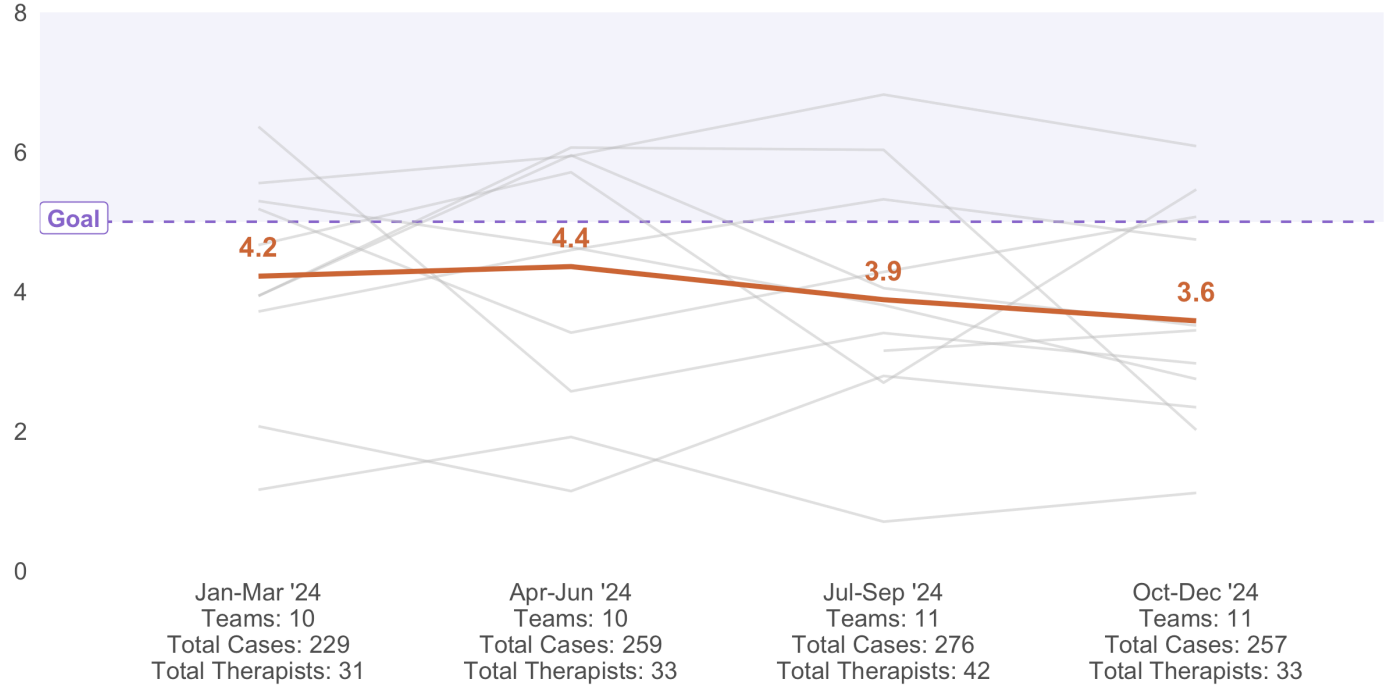
Figure 2. *Average Number of Team Therapists*



FFT, LLC, the training organization for the model, has set a target of three therapists per team, represented by the dashed line in Figure 2. In Q4 2024, the average number of therapists per team, weighted for the number of days they served on the team in the quarter, dipped just slightly to 3. The orange dots represent the team with the lowest number of therapists for each reporting period.

Cases per Therapist

Figure 3. *Average Number of Cases per Therapist*



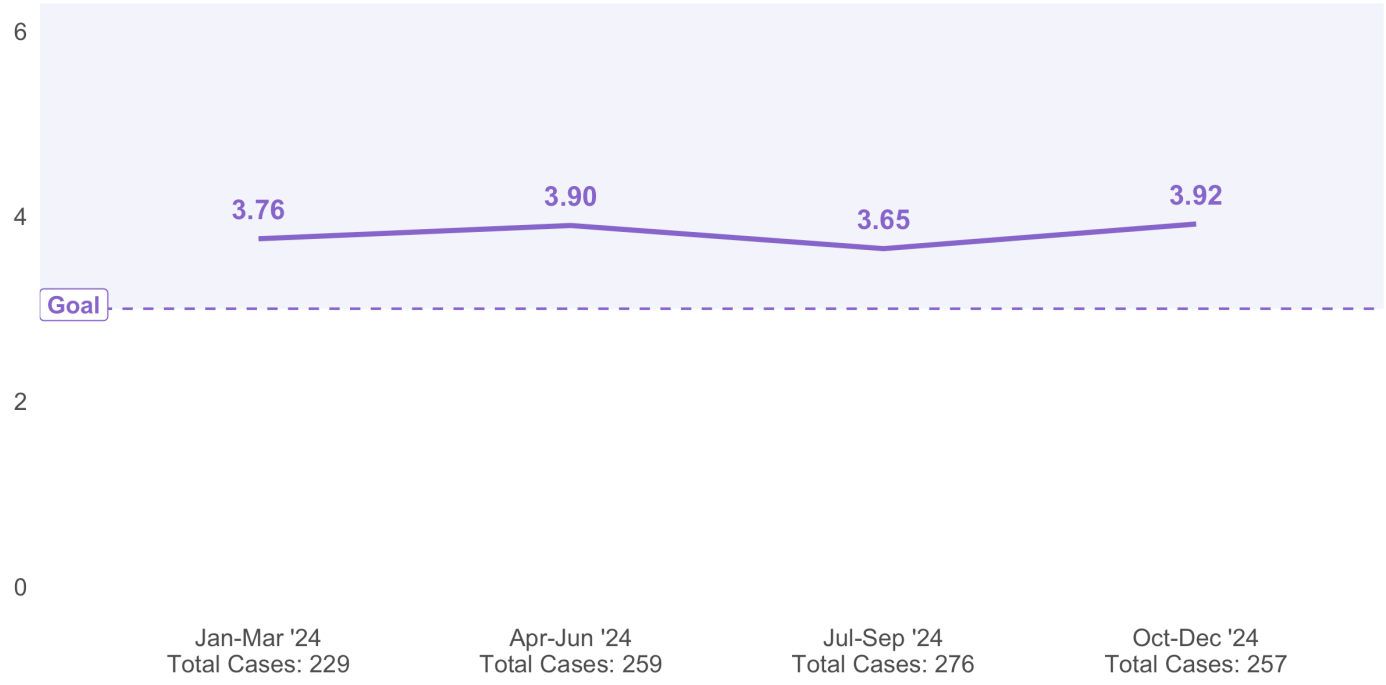
FFT, LLC expects therapists to carry a caseload between 5 and 15 cases, as represented by the lavender area. Figure 3 depicts each team's average number of cases per therapist (gray lines), and the average across the state (orange line).

Cases are weighted by the number of days the case was active in the quarter.

Measure of Final Fidelity using Clinical Adherence and Clinical Competence Ratings

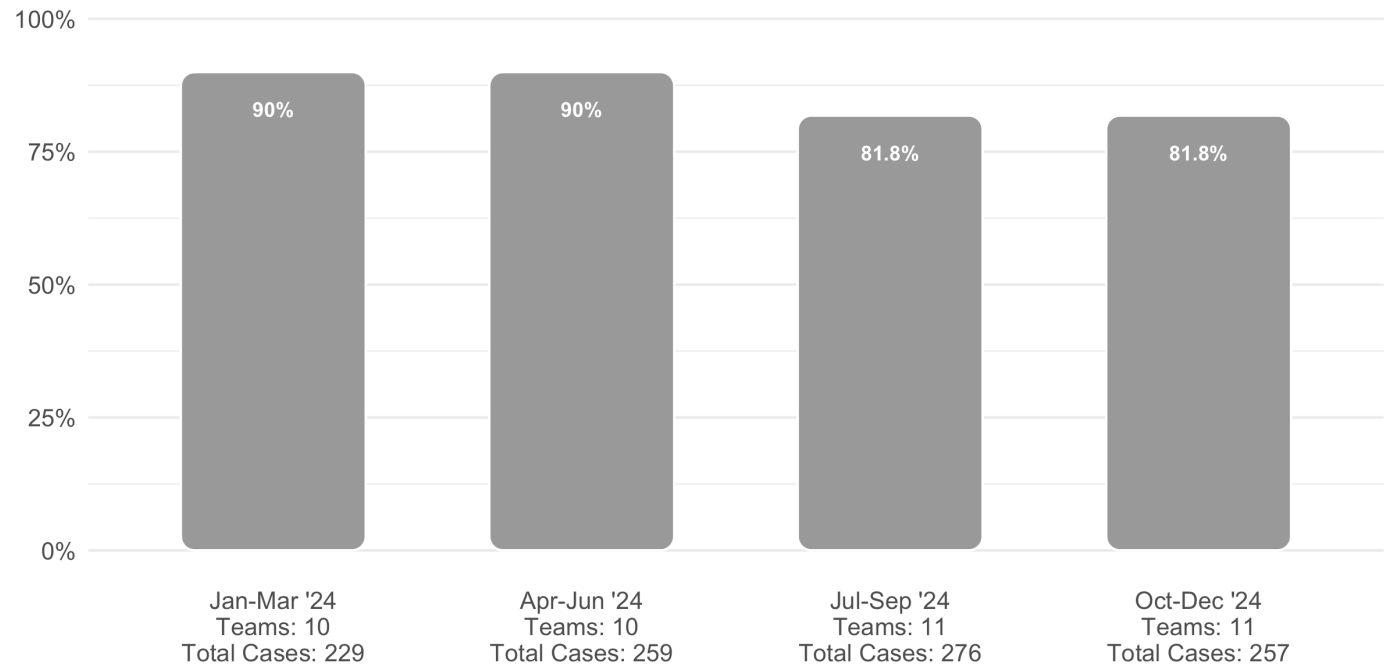
Fidelity Scores Across Teams

Figure 4. *Average Final Fidelity Scores Across Virginia Teams*



The final fidelity score is a combination of a clinician's clinical adherence score, or how well the clinician applies the model components in the proper sequence, with the clinical competence score, or how skillfully the clinician applies the model. These ratings are given by supervisors during weekly case reviews, with an acceptable level of fidelity considered 3.0 or greater (on a 6-point scale), represented by the lavender area in Figure 4. The average fidelity score of all cases in the state for each quarter is depicted by the purple line, which rose slightly to 3.92.

Figure 5. *Percent of VA Teams with Average Final Fidelity Score Meeting or Exceeding the FFT Target*



Another way to consider fidelity data is depicted in Figure 5: the percentage of teams averaging the FFT, LLC final fidelity score of 3.0 or higher in a given quarter. For the last two quarters, 82% of teams

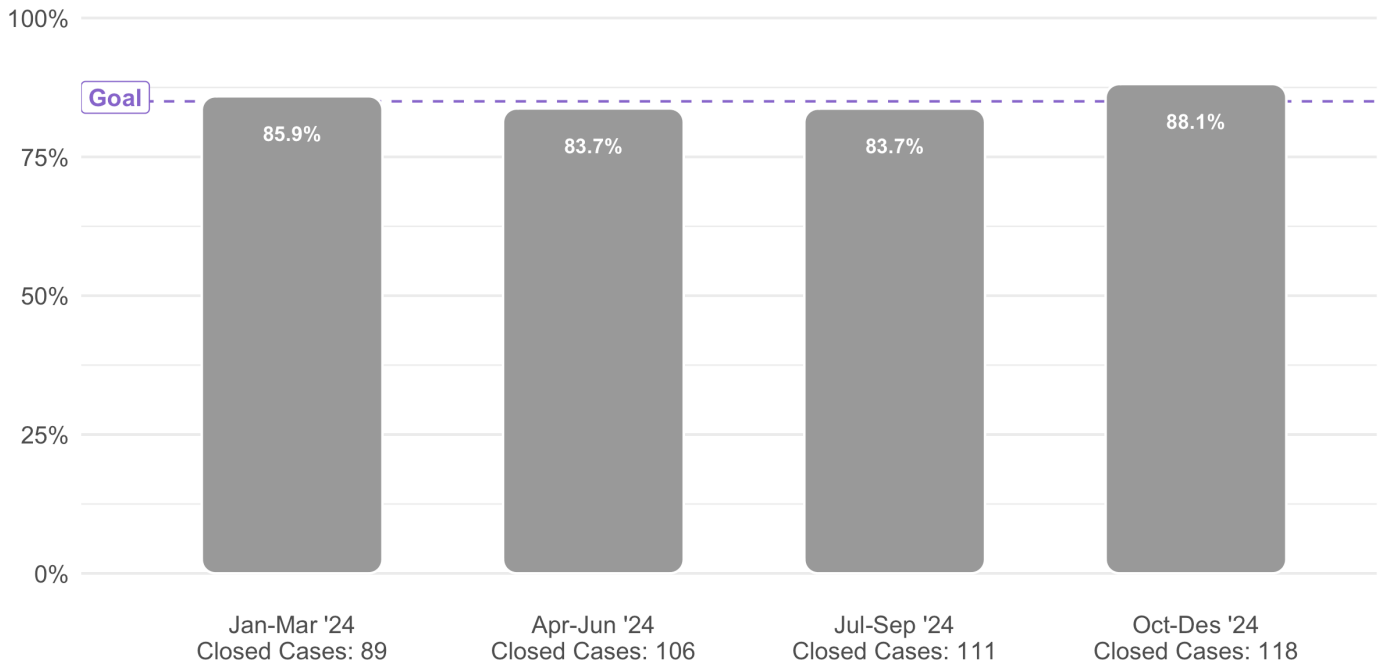
maintained an average fidelity above the threshold.

Outcome Measures

Data for all families are included whether or not their treatment was completed in a planned fashion. Exceptions to this include cases withdrawn for funding reasons, cases where the family moved out of the service area, cases where referral sources referred a case elsewhere, or with placements that resulted from actions carried out before the start of treatment. Cases for which the status of these outcome measures was recorded as “unknown/not applicable” are also included in these calculations.

Remaining in Community

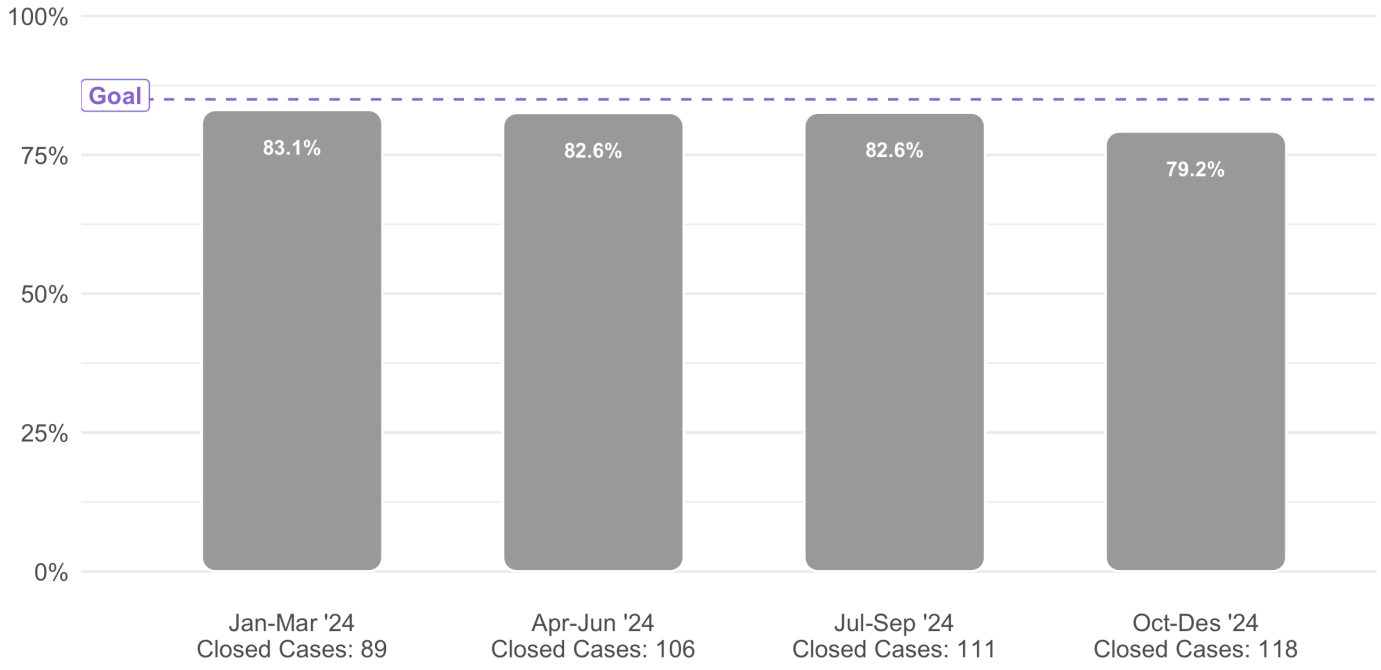
Figure 6. *Percent of VA Youth Remaining in Community*



FFT, LLC defines remaining in community as not being placed formally outside of the home (group home, foster home, addiction treatment facility) but may be living with a relative in the community. This quarter, 88% of youth who completed treatment lived in the community at time of discharge.

Attending School

Figure 7. *Percent of VA Youth Attending School*



For this indicator, a youth is included if they are attending school or vocational programs, or intend to (in the cases of summer or applying to college). The reported share of youth attending school or work this quarter is 79%.

Law Violations

Figure 8. *Percent of VA Having No New Law Violations*

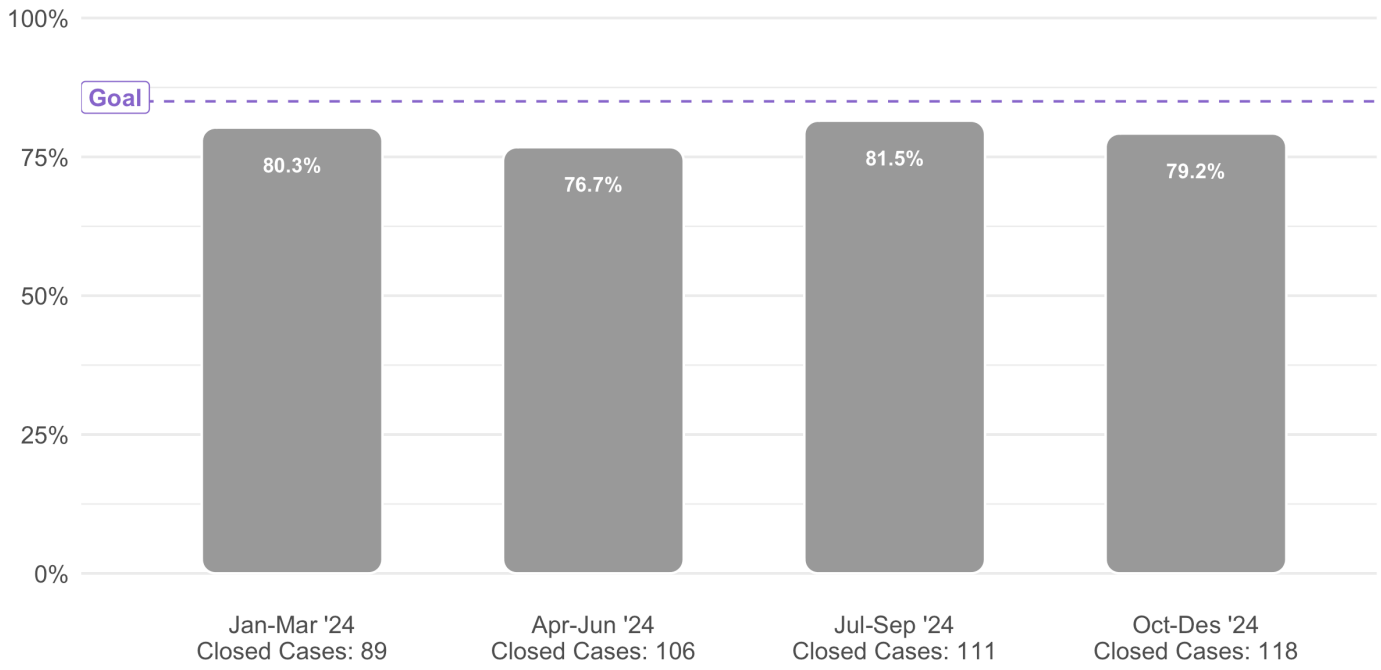


Figure 8 illustrates the share of youth having no new arrests, either when counseling finished or if treatment ended for a reason within the therapist's control. During this reporting period, that number was 79%, 6 points below the FFT, LLC goal of 85% of youth.

Funding Source

Beginning in 2025, funding source information will appear in a separate report for all Family First EBPs.

Figure 9. *Funding Source for All Active and Closed FFT Cases in Virginia*

Figure 9 displays data on the number of cases funded by major payors in the state, as reported by provider companies. The top two payors are Medicaid, which funded 66% of all cases, and the Department of Juvenile Justice, which funded 18%.

Figure 10. *Funding Source in Virginia Across Four Quarters*

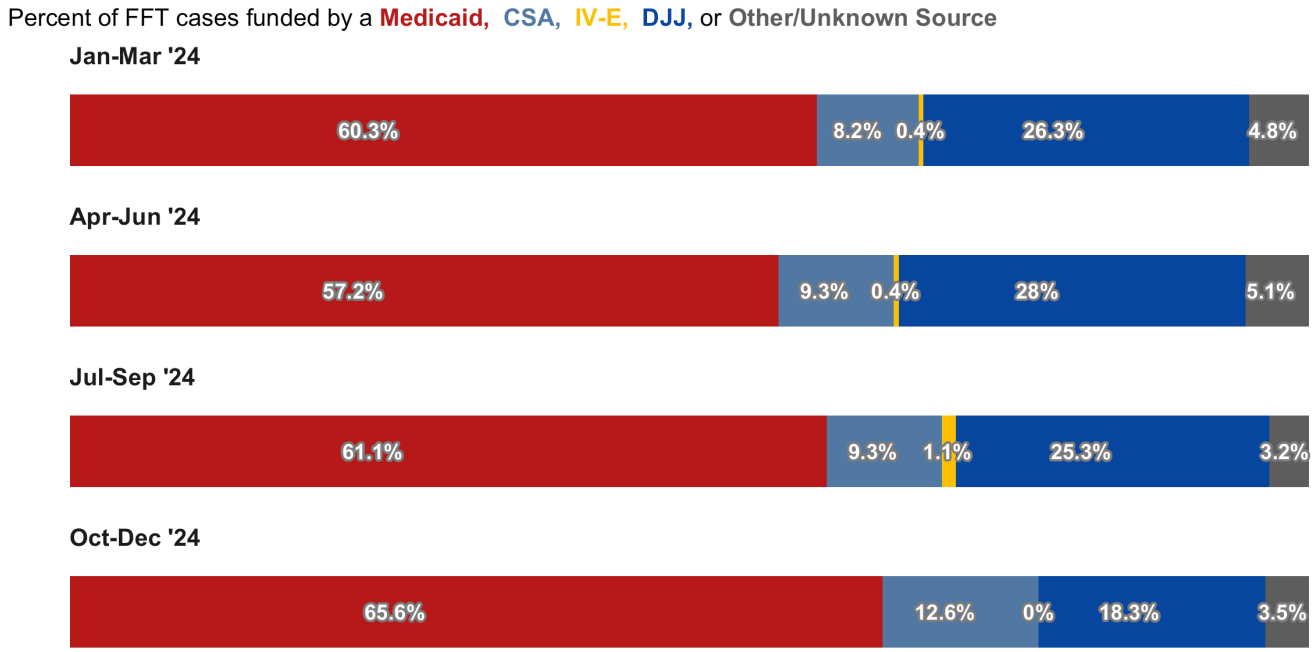


Figure 10 illustrates that in 2024, provider agencies reported that between 0 and 1.1% of cases were funded with Title IV-E funding.

Demographic Information

Table 2. *Reported Age, Gender, and Race of Youth Receiving Treatment from January to March 2024*

Summary of 259 Case Characteristics by Age, Gender, and Race

Characteristic	n	%
Age		
10-13	68	26.5
14-16	138	53.7
17-19	50	19.5
Unknown	1	0.4
Gender		
Female	100	38.9
Male	152	59.1
Nonbinary, self-described, or other	5	1.9
Race		
Bi-Racial	24	9.3
Black	57	22.2
Spanish origin, Hispanic, or Latino	21	8.2
Unknown or other	28	10.9
White	127	49.4

Service Coverage Area

Figure 11. *Provider-reported Service Coverage Areas*

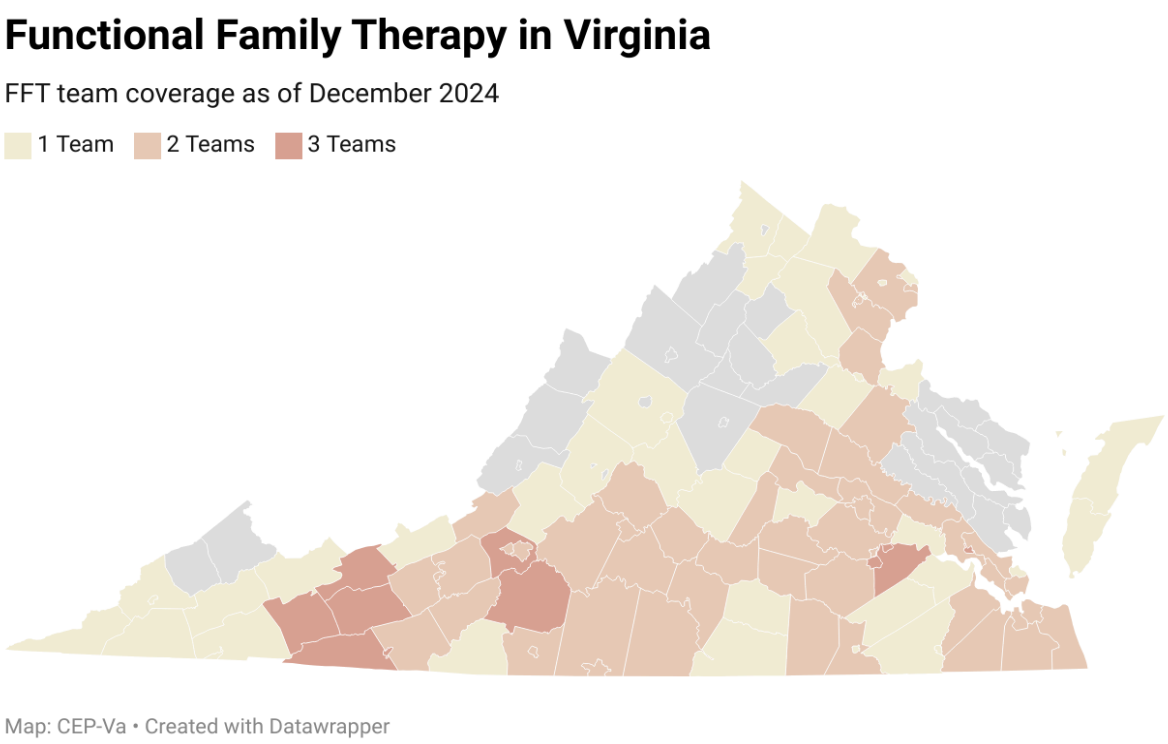


Figure 11 displays the areas in the state covered by open and staffed FFT teams. This data is collected quarterly from provider agencies and reflects the localities from which teams can accept FFT referrals for any of the major funding sources.

Report to the Virginia Department of Social Services:
Needs Assessment and Gaps Analysis 3.0

Virginia's Family First Implementation Efforts: Progress and Paths Forward

Original release Date: 11/20/2024
Revision date: 1/13/2025

Suggested citation: Sale, R., Robinson, A., Sandman, A., Wu, J., Oliver, J., Boggs, B., Riso, A., & Southam-Gerow, M. A. (2024). Virginia's Family First Implementation Efforts: Progress and Paths Forward. Report to Virginia Department of Social Services.

NAGA 3.0 Executive Summary

CEP-Va's Needs Assessment and Gaps Analysis (NAGA) process is an ongoing assessment approach that targets the identification of barriers and facilitators to inform implementation of new and pre-existing Title IV-E programs to prevent family separation. Studies are determined in collaboration with state partners and findings from ongoing projects.

In this report, we present a new set of studies along with updates on two ongoing initiatives: (a) Community Service Board (CSB) prioritization and (b) procurement of a state trainer for one intensive evidence-based program for young children. Most of the report is spent discussing the Pathways to Access Local Services (PALS) project, which was composed of four studies conducted to better understand how families get to services in their communities. PALS was designed to inform VDSS and other stakeholders of opportunities for enhancing timely care and preventing foster care entry.

Access to Title IV-E evidence-based programs (EBPs) has the potential to satisfy the aims of many, if not all, state partners invested in family well-being. A preliminary review of policies and practices in place today reveals that despite efforts by many, there remains an inefficient and duplicitous path for families to access any service. Higher quality services, like EBPs, remain even further out of reach.

In short, service providers are impacted directly and indirectly by policies that incentivize serving children outside of the Medicaid system through services that may not be effective. Fortunately, solutions for improving systems coordination and access to services are known and some of the foundational work has begun. In this report, several recommendations are made to address some of these concerns.

Three recommendations are considered primary:

1. Expedite implementation of a new and improved data system at VDSS
2. Revise policy and guidance for local workers related to accessing Title IV-E funds
3. Revise external Continuous Quality Improvement (CQI) cycles and processes

VDSS, as primary funder of NAGA, is the direct recipient of report recommendations but only one of the many state agencies implicated in them because of intricate connections amongst the various systems and settings in which families present. Progress and success will continue to be determined by VDSS's engagement with other agencies and agencies' willingness to accept the invitation to share ownership for change.

An additional seven recommendations were also offered:

4. Help local communities build capacity through intensive engagement
5. Improve guidance and policy on the intersection of funding sources
6. Partner with other agencies to increase rates for Medicaid providers
7. Expand pre-existing community pathways to improve access
8. Reduce burden of entry into Family First EBPs
9. Revise mandatory reporter training
10. Improve family engagement with Family First implementation

Needs Assessment and Gaps Analysis Report: Year 3 Introduction

Mission and Values of the Center for Evidence-based Partnerships

The Center for Evidence-based Partnerships in Virginia (hereafter, CEP-Va) builds partnerships with stakeholders in public and private organizations to leverage collective support to improve access to behavioral health services in the Commonwealth.

Governing partners include the Virginia Department of Behavioral Health and Developmental Services (DBHDS), Department of Medical Assistance Services (DMAS), Department of Juvenile Justice (DJJ), Office of Children's Services (OCS), Department of Criminal Justice Services (DCJS), Department of Health Professions (DHP), Department of Education (DoE), and the Virginia Department of Social Services (VDSS).

Through thoughtful use of evidence, CEP-Va provides scientific input to partners on the performance of the state's behavioral health system and paths for enhancing workforce capacity and effectiveness. CEP-Va also engages in instrumental support of partner priorities through projects including fidelity monitoring, program evaluation, management of training efforts, and development of decision support tools, including technical assistance materials and online search tools (www.EBPfinder.org).

What is NAGA?

VDSS's plan to help enhance the state's behavioral health service array is made possible by the Family First Prevention Services Act (FFPSA), passed in 2018, to permit new allocations of Title IV-E spending towards evidence-based service programming. CEP-Va 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 strengthen families.

In 2021, CEP-Va developed the Needs Assessment and Gaps Analysis (NAGA) approach to continuously assess and monitor mental health needs and service gaps within and across VDSS's five regions. The first report was submitted to VDSS partners in October 2021 (NAGA 1.0), and the second, most recent report in February 2023 (NAGA 2.0). In each report, a series of recommendations were presented.

The NAGA 3.0 report is organized as follows:

1. Findings from NAGA projects
2. Recommendations
3. Appendices

NAGA 3.0 Projects

NAGA 3.0 builds upon the versions that precede it. The recommendations that VDSS selected from NAGA 2.0 guided CEP-Va's activities throughout 2023 to mid-2024 and reviewed herein. See Appendix for summaries of both NAGA 1.0 and NAGA 2.0.

PROJECT 1: Prioritize CSBs for Family First EBPs.

VDSS chose to prioritize CSBs and their community partnerships with private providers in the allocation of Title IV-E funds as part of a cross-agency approach to service expansion. The CSB system is the state's primary mechanism for providing publicly-funded emergency and non-emergency behavioral health services in local communities and functions as the single point of entry to these services.

CSBs are primarily overseen and funded by DBHDS; however, they are also funded by and accountable to their respective local governments and boards of directors, DMAS, DHP, and two federal agencies. DBHDS distributes non-Medicaid state general funds to CSBs to cover the costs of services for uninsured individuals, to support staff salaries, and to contract with private providers to provide behavioral health services.[1]

Family First EBPs in CSBs

As of May 2024, CEP-Va has provided EBP funding to **ten (10)** CSBs, for costs related to Family Check-Up (FCU), Functional Family Therapy (FFT), Multisystemic Therapy (MST), and Parent-Child Interaction Therapy (PCIT). This investment includes full-site training for one CSB, staff replacement training, and infrastructure support.

Through its partnership with CSB stakeholders, CEP-Va identified several EBP implementation barriers specific to these settings:

1. EBPs with a behavioral orientation, such as FCU and PCIT, have been observed to ***differ from the organizational culture*** of many CSBs which remain targeted for individual adults and individual children without a caregiver present for treatment (Family First EBPs require significant engagement from the caregiver and sometimes other members of the family);
2. State-mandated intake requirements and referral procedures that begin once a family arrives at a CSB overlap significantly and ***may dilute functions*** of some Family First EBPs. *Example:* Family Check-Up includes its own family-assessment component that creates duplicity and extends the intake process for families. Implementation may require strategic top-down planning from the state level so EBPs are able to be delivered as designed.

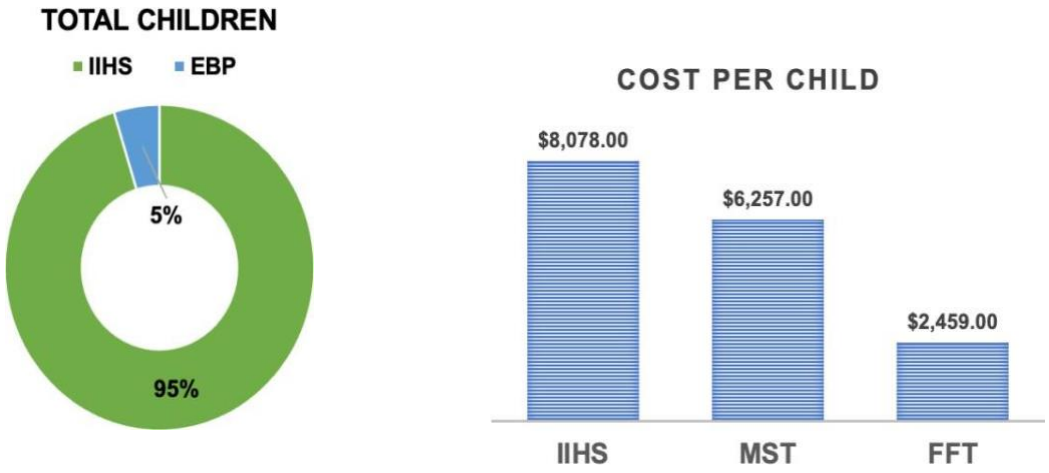
DMAS, another key funder of CSB services, determines the specific behavioral health services that are eligible for Medicaid reimbursement in Virginia thus influencing CSB service delivery. In

[1] JLARC (2022). CSB behavioral health services.

2018, DMAS began contracting with multiple Managed Care Organizations (MCOs) to manage community behavioral health services for the Medicaid population in Virginia. Each MCO develops its own training, reimbursement policies and processes, and credentialing to receive reimbursement. Because these MCOs operate statewide, CSBs must work with each individual MCO and be responsive to the requirements of several other entities. All CSBs are expected to enroll Medicaid-eligible individuals who present without coverage and to connect with their LDSS to complete that process.

Ongoing Challenges for Medicaid Providers

A primary service in the Virginia landscape for serving behavioral health needs in families via Medicaid has been Intensive In-Home Services (IIHS). Since DMAS introduced a Medicaid rate for FFT and MST services in 2021, those have also been utilized. In 2023, the uptake on the use of EBPs through Medicaid has been slow as represented by the rate of use of IIHS (*n* = 11,766) vs that of FFT and MST (*n* = 589), which are EBPs included in Virginia's Family First plan.



For MST and FFT, requests for additional funding are most likely to come from Medicaid providers struggling to retain staff. Like previous NAGA findings, several providers continue to choose to no longer serve Medicaid-eligible families to take advantage of CSA reimbursement for the same or similar service. Providers selecting payers according to reimbursement rate is a natural consequence of an unbalanced rate structure within a multi-payer system (See NAGA 2.0).

Compounding challenges for FFT and MST providers is that the rate changes occurred around the time of the COVID-19 pandemic. Figure 1 depicts FFT team size across the first several years of implementation of the services. FFT recommends 3-5 therapists per team, with 3 being the minimum. As the data show, team composition gradually rose after state support for the service was introduced in 2017, reaching levels well above the minimum required team sizes. Team size has been closely tied to fidelity in past research, as full teams are more likely to deliver the service as it was designed. However, **in 2020, team composition dropped dramatically and has declined since that time.** In short, the twin shocks of a global pandemic and significant rate

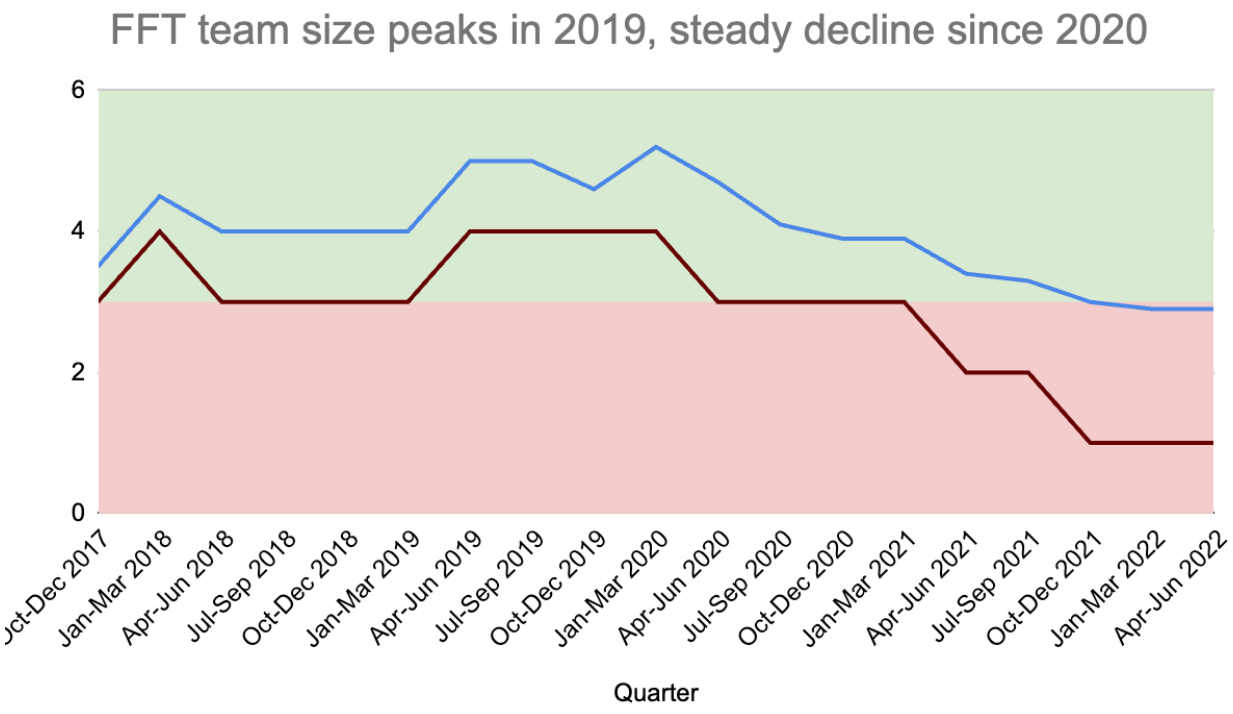
changes created challenges for implementation of FFT (see Table 1). A similar pattern was observed for MST.

Service descriptions provided by DMAS mandate providers to abide by purveyor requirements, which were not designed to consider billing constraints. For instance, regular communication with individuals outside of a child's family, such as school personnel, is embedded into MST's logic model. To mitigate lost time, practitioners describe having to schedule follow-ups with the caregiver each time to be compensated. Adjusting practice in this way represents a departure from the evidence, potentially suppressing treatment effects.

Any rate set by any funder must, a) account for all elements of an EBP, and b) the time lost carrying out activities required by the model outside of direct contact hours. Rate setting studies in the past[2] may not have adequately accounted for productivity lost during travel, consultation, and training time required by purveyors after initial the workshops.

Figure 1. FFT team size over time

Note. The green zone reflects the FFT national standard for acceptable team size and red reflects problematic team size. The red lines reflect the single lowest team size in Virginia for the time period, and the blue lines reflect the average across all teams.



[2] Mercer. (December, 2019). Rate setting methodology.

Main Findings: Family First EBPs in CSBs

Due to several administrative burdens along with statewide staffing shortages, many CSBs struggle to meet the minimum expectations the state has set for them, let alone expand services to include labor-intensive EBPs for which compensation is lacking.

Provider networks for Medicaid-reimbursable EBPs continue to be inadequate[3] for Virginia's children and their families. In general, rates priced too low are believed to hinder provider recruitment and service utilization. Rates priced too high are believed to attract a provider base that would not be able to achieve clinical results. Fortunately for Virginia, EBPs protect against service oversaturation *and* dilution of results because quality assurance is built into the model to prevent both scenarios through fidelity and outcomes monitoring. See NAGA 2.0 for in depth discussion.

PROJECT 2: PCIT Training Updates

In 2022, it was brought to CEP-Va's attention that a company unsanctioned by PCIT International's credentialing body was accepting payment for training and certification in PCIT, resulting in some clinicians being trained in a program that did not follow developer standards.

Shortly after NAGA 2.0 was released, a new rule was released by federal authorities that opened up purveyor eligibility. In a revised draft of the Title IV-E Prevention Services Clearinghouse Handbook of Standards and Procedures published on October 24, 2023,

> *Revisions to this section clarify that materials to satisfy this requirement may be presented in a web-based format and that "manual" can include recorded videos or online learning systems if these materials describe how to implement or administer the practice.* (Revision to section 2.1.2)

Together, these changes were interpreted such that the previously ineligible organization is deemed eligible to train. Given the determination that multiple purveyors are eligible, Virginia recognizes the certification statuses provided by both training organizations operating within the state. Confirmed PCIT clinicians certified by either organization are included in Virginia's registry of providers and searchable in the public EBP Finder developed and updated quarterly by CEP-Va.

[3] Research Triangle Institute. (April, 2024). Behavioral health parity.

PROJECT 3: Pathways to Access Local Services (PALS)

In NAGA 2.0, an in-depth examination into service coordination health of the public systems functioning at the local level was proposed. *Pathways to Access Local Services (PALS)* was designed to examine the coordinating structures and processes for getting a family to a Family First EBP. The aim was to determine opportunities for improving the assimilation of Title IV-E funding into the current service landscape.

PALS is comprised of 4 individual studies:

1. State Needs Assessment Information Library (SNAIL, a CEP-Va database)
2. Policy mapping
3. Listening sessions
4. Focus groups

PALS Study 1: SNAIL

The State Needs Assessment Information Library, or SNAIL:

a. Synthesizes various reports released by the child-serving agencies in the state, and
b. Builds an understanding of socio-historical context from the point of view of CEP-Va's governing state partner agencies.

Method. Virginia-specific needs assessments released by state agencies and affiliated organizations between 2014-2023 were collected and reviewed. A stepped review procedure with doctoral and undergraduate student coders was designed to detect themes shared by more than one agency. Each month, searches were conducted to find new reports using the following search terms: Virginia, statewide, behavioral health, needs, gaps, assessment, report, and mental health. Searches were also conducted including years (i.e., 2014), key partners, and agencies to ensure representation from each year and as many agencies as possible. A qualitative, inductive, thematic analysis was conducted. A total of 31 reports were included from ten state entities (See Appendix for a list of all analyzed reports).

I. Time Period: 2014 – 2017

Reports published in SNAIL's first time range included 3 themes:

a. infrastructure,
b. family service access problems,
c. training

Infrastructure, operationalized as systems coordination or how different workers interact across systems for families, emerged as a primary theme beginning in 2014.

- Improvements through increased funding and legislative action were most noted across state agencies' reports.
- Agencies collectively called for better inter-agency collaboration for building a comprehensive continuum of care and improving information sharing.

- Frontline workers desired more appropriate and efficient ways to collaborate across systems to avoid duplication of work.

Problems with ***family service access*** indicated that children's needs were often not being met by available services, and service access was often restricted. Transportation challenges were most commonly reported across several agencies as a logistical barrier for families to access services, especially in rural areas.

Enhanced ***training*** across multiple areas was suggested for all child-serving professionals such as local agency staff, providers, public school teachers, first responders, healthcare workers, and foster/adoptive parents, in mental health first aid, knowledge of crisis intervention teams, and more behavioral health training, especially for primary care providers.

Solutions offered pre-COVID:

- a centralized resource/referral resource,
- increased information sharing across regions and agencies,
- standardizing strategies and expectations across the state,
- strengthening partnerships across sectors

II. Time Period: 2018 – 2020

Two additional themes emerged during the second time period:

a. infrastructure,
b. family service access problems,
c. training,
d. workforce,
e. specific service gaps

Family service access problems and ***infrastructure*** issues were the two most common topics at this time shared amongst state agencies, specifically,

- challenges navigating through systems, insurance issues (e.g., limited service access for Medicaid-eligible children), timeliness of service approval and access; and,
- logistical difficulties such as transportation, and varied and restrictive service access across localities
- Funding issues noted across state agencies included Medicaid reimbursement, inadequate service arrays, service provision mandates, and narrow eligibility requirements.
- State agencies' reports indicated a need for a clear and consistent behavioral health services pathway that allows for individuals to access appropriate services through different access points in natural environments (i.e., schools, primary care).

Workforce emerged as a new priority during this time, and reports cited a general shortage of mental health professionals. Several agencies described workforce as being a significant barrier for behavioral health service utilization, and recommendations consistent across reports included:

- salary increases and competitive pay for behavioral health staff,

- increased reimbursement rates/incentives,
- family support staff as a key service need (i.e., community navigators, peer support staff, care coordinators, family support partners)

Specific service gaps named by more than one agency emerged for the following groups:

- adolescents (e.g., general mental health services, trauma focused services, school-based mental health services, substance use),
- caregivers abusing or misusing substances (both men and women),
- pregnant women and mothers of young children in need of multiple supports (mental and tangible)

Training needs remained present with reduced frequency of mention after 2017. Reports recommended moving away from a crisis-oriented approach to emphasize prevention and early intervention. Areas mentioned for improved or additional training:

- social and emotional and trauma- informed training,
- mental health training for primary care providers,
- case manager training for working with families
- ethical considerations when working with families and youth

III. Time Period: 2021 – 2023

All five themes remained with *workforce* and *training* rising to become the top priorities during this time, signifying an uptick in shared across all state partners after the start of the COVID-19 pandemic.

Workforce challenges commonly reported included difficulties retaining staff, inadequate workforce compensation, lack of diversity in the workforce, and shortages of licensed mental health workers (e.g., LCSW, LCP, LPC). Challenges were believed to relate to schooling (training), licensing requirements, administrative burden, and working conditions. Reports also called for improved funding and financial incentives for non-clinical workers such as court-appointed attorneys and teachers.

Echoing the other time periods, better and more consistent ***training*** was described as a significant need for both clinical mental health and non-clinical workers like teachers, court-appointed attorneys, law enforcement, and local agency case workers. Many reports described challenges with current training opportunities for their role including affordability, accessibility, and consistency of training. Training gaps were emphasized for CSBs and local DSS offices.

Infrastructure remained another key area for this period with shared recommendations:

- more consistent statewide implementation of initiatives such as substance use prevention,
- better inter-agency collaboration and communication,
- more efficient data collection and sharing platform (i.e., a standardized, unified method) for various types of information such as residential treatment bed availability, family Medicaid eligibility, and other family information.

Several reports noted difficulties with information sharing across various stakeholders across the state such as providers and agencies across the system of care struggling to receive timely, relevant and necessary information for quality treatment and repetitive reporting across agencies. For example, one report suggested that better alignment between the Independent Assessment, Certification, and Coordination Team (IACCT) and FAPT processes and the clarification of stakeholder roles would reduce redundancy of information sharing requirements for families and improve the coordination process, thus improving ***family service access challenges*****.** Additionally, another report suggested the potential benefits of partnerships between school divisions and community mental health providers.

Additionally, during this time period, reports more commonly listed ***specific service gaps:***

- children with multiple mental health diagnoses,
- individuals displaying sex offending/sexually reactive behaviors,
- school-age children with mental health difficulties such as anxiety/depression for whom these problems have worsened during the pandemic,
- victims and perpetrators of bullying, a population associated with mental health problems and self-harm behavior,
- substance abuse problems among youth and parents/caregivers,
- children and youth with autism and/or intellectual/developmental disabilities for whom there is a significant lack of Applied Behavior Analysis (ABA) service

PALS Study 1: SNAIL: Summary of Main Findings

Top 3 issues shared by state agencies since 2014:
1. Family service access problems 2. Infrastructure for better service coordination 3. Training needed across fields to enhance care

PALS Study 2: Policy Maps

The focus of the policy maps study was to examine the pathways to local services as determined by state authorities via policy, regulation, law, and other processes. That is, the study sought to make clear the steps families must take to access behavioral health services in their community as spelled out by state agency guidance and policy.

Method. To build our policy maps, guidance documents released by state agencies were downloaded from public websites. Policy manuals and worker reference guides were collected if the intended audience included state agencies' local workers or community-based agency representatives. Specifically, we gathered policy and other guidance documents from VDSS for LDSSs and their Family Service Specialists, Office of Children's Services (OCS) for CSA

Coordinators, DMAS for MCOs, DBHDS for CSBs, DJJ for Court Services Units, and DOE for respective frontline personnel. Policy related to residential and psychiatric inpatient services were excluded.

Policy Map I

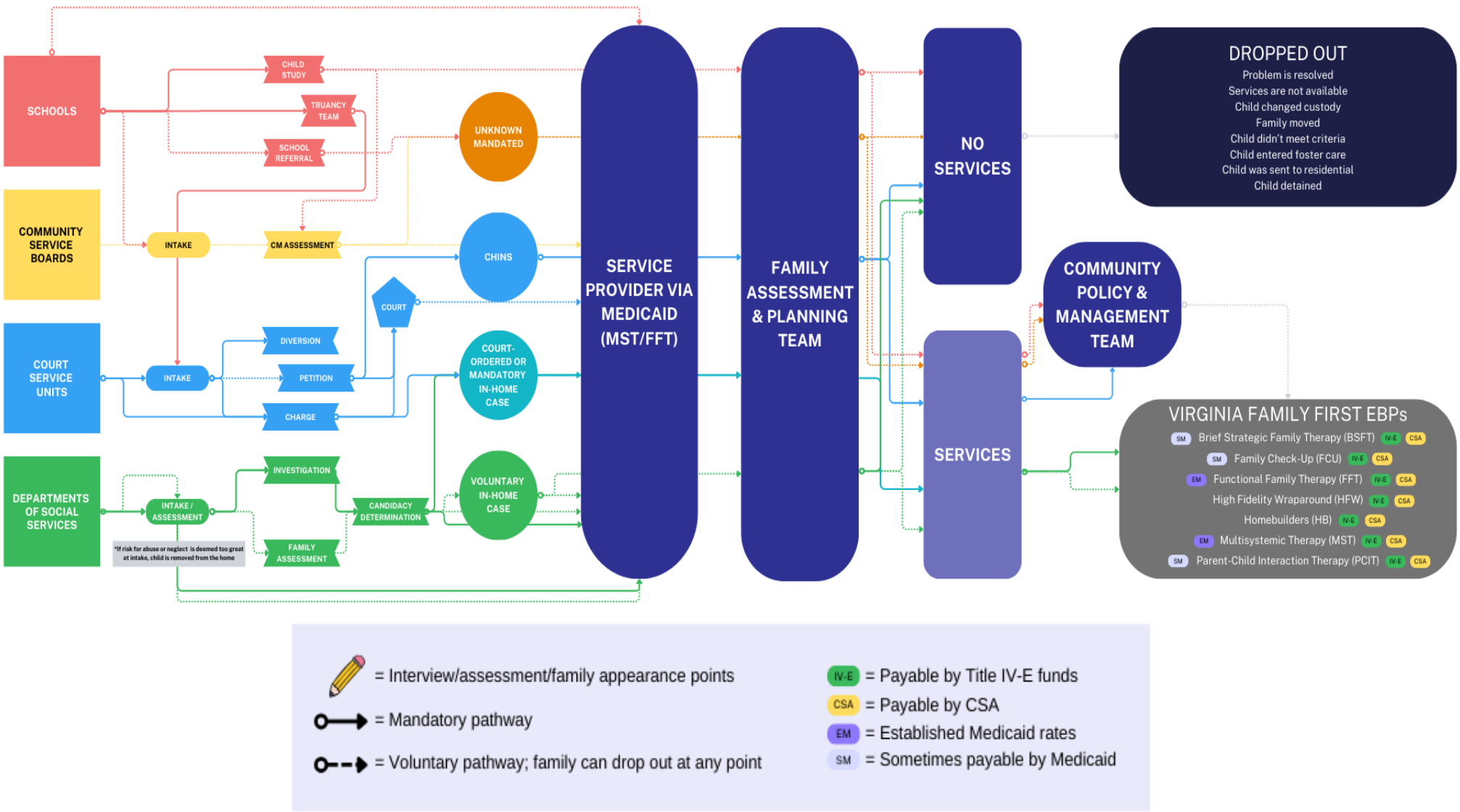
The primary access points for children and families to local community services are the public school system, CSBs, Court Service Units, and the LDSS. Typically, once families enter their first access point, they are sent through the next door based on their insurance. Children covered by Medicaid are linked directly to Medicaid reimbursable services, which could include an EBP (MST, FFT) if an EBP provider in their area accepts Medicaid.

Most families are likely to be referred to the CSB entry point, as the majority of children in Virginia are Medicaid-eligible. Families with private health insurance also present to CSBs but are more likely to pay out of pocket for out of network behavioral health services delivered by a licensed practitioner in a private practice setting. Arrival to a CSB initiates a series of intake appointments, an initial same-day assessment followed by a longer intake appointment weeks later. After intake, families are placed on waiting lists for each service determined as needed, which could include case management, medication management, and community-based services if available in their area.

CSA/FAPT was intended to service children with complex needs who could not readily be served by a single child-serving agency. Policy stipulates that children under *unknown* mandated status are assessed at the FAPT meeting for whether they meet eligibility for CSA dollars as a Child in Need of Services (CHINS). Children meet criteria if emotional or behavioral problems exceed a significant period or time or level of severity, are present in several community settings, and necessitate coordination of services or resources that have been unavailable or inaccessible (§2.2-5212). Potential CHINS cases referred to FAPT by courts must also attend FAPT to see whether they meet criteria.

Children determined to meet *mandated status* at FAPT meet the eligibility criteria for a) Child in Need of Services (CHINS), b) Candidate for Foster Care, or c) are currently in Foster Care (§2.2-5212). Children with an Individualized Education Program (IEP) are federally entitled to meet mandated status which means education in a private setting or transitional education services must be funded by CSA (§2.2-5211). Once a child is deemed *mandated*, all services recommended by FAPT and authorized by the Community Policy and Management Team are then *sum-sufficient*, i.e., paid for by the locality and reimbursed by the state using a pre-designated match rate that differs by locality. If children do not meet mandated status, they are referred to insurance-based services or another door (CSB, DSS, CSU), or may be served through “Protected Funds” if that CSA has any of that limited funding available to them.

Map I.


SCHOOLS
COMMUNITY SERVICE BOARDS
COURT SERVICE UNITS
DEPARTMENTS OF SOCIAL SERVICES
CHILD STUDY
TRUANCY TEAM
SCHOOL REFERRAL
INTAKE
CM ASSESSMENT
INTAKE
DIVERSION
PETITION
CHARGE
COURT
INTAKE / ASSESSMENT
INVESTIGATION
FAMILY ASSESSMENT
*If risk for abuse or neglect is deemed too great at intake, child is removed from the home
CANDIDACY DETERMINATION
UNKNOWN MANDATED
CHINS
COURT-ORDERED OR MANDATORY IN-HOME CASE
VOLUNTARY IN-HOME CASE
SERVICE PROVIDER VIA MEDICAID (MST/FFT)
FAMILY ASSESSMENT & PLANNING TEAM
NO SERVICES
SERVICES
DROPPED OUT
Problem is resolved
Services are not available
Child changed custody
Family moved
Child didn't meet criteria
Child entered foster care
Child was sent to residential
Child detained
COMMUNITY POLICY & MANAGEMENT TEAM
VIRGINIA FAMILY FIRST EBPs
SM Brief Strategic Family Therapy (BSFT) IV-E CSA
SM Family Check-Up (FCU) IV-E CSA
EM Functional Family Therapy (FFT) IV-E CSA
High Fidelity Wraparound (HFW) IV-E CSA
Homebuilders (HB) IV-E CSA
EM Multisystemic Therapy (MST) IV-E CSA
SM Parent-Child Interaction Therapy (PCIT) IV-E CSA
= Interview/assessment/family appearance points
= Mandatory pathway
= Voluntary pathway; family can drop out at any point
IV-E = Payable by Title IV-E funds
CSA = Payable by CSA
EM = Established Medicaid rates
SM = Sometimes payable by Medicaid

Note. Service providers via Medicaid, visualized as a long dark blue bar, are placed before the Family Assessment & Planning Team because children eligible for Medicaid are commonly referred to these providers before (and in some localities, instead of) FAPT regardless of the family's specific needs. Family First EBPs with a Medicaid rate include MST and FFT.

Policy Map II: Case Study

The second map shows an example of a family attempting to access the service that matches their needs. This hypothetical family struggles with both caregiver and child substance abuse in combination with child disruptive behavior, a profile for which Brief Strategic Family Therapy has been shown to be effective. Unavailable through Medicaid providers in their area, the family is instructed by a school counselor to present to their CSB for other potentially appropriate community-based services.

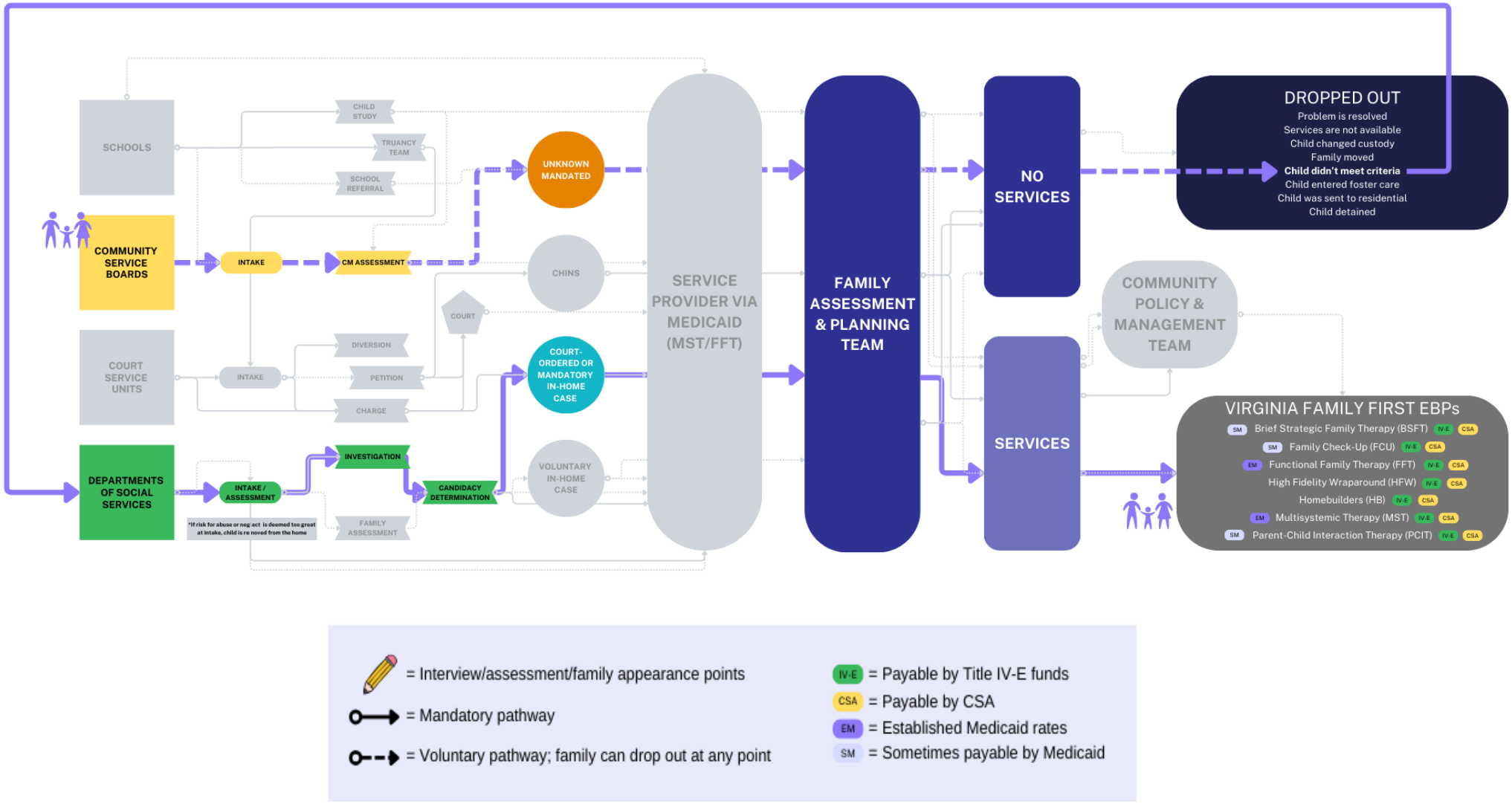
At the CSB point of entry, the child and caregiver become linked to a Mental Health Case Manager following individual Same Day Assessment intakes and then separate full intakes. Several weeks pass until an intervention begins for either family member.[4] At some point, the Mental Health Case Manager may offer to take the child and family to FAPT, with an unknown mandated status. The case manager knows of a private provider in the area that offers BSFT and believes the child could meet CHINS criteria.

Entering FAPT with an unknown mandated status suggests that the child does not have a current Foster Care case, Foster Care In-home case, Individualized Education Plan, or a CHINS petition from the court. In this example, the community in which the hypothetical child resides has either used up all of their Protected Funds through CSA or is a community that opts not to utilize the dollars for children outside of mandated status. At FAPT, the child is determined not to meet criteria for CSA funding and leaves the meeting without CSA funded services. The child is referred to Intensive In-home Services through a local Medicaid provider and is placed on a waitlist.

Services through the CSB, the family's original entry point, may come available. Monthly check-ins with the case manager determine that one of the caregiver's has increased their level of substance use; further, volatility at home has become worse, impacting the child's school attendance. As time passes and the family's needs become more significant, the family is forced back to FAPT pursuant to a CPS investigation. The child may now access BSFT through CSA, or IV-E as an open in-home case managed by LDSS.

[4] Wait times for any service may exceed 60 days (JLARC, 2022).

Map II.


SCHOOLS
CHILD STUDY
TRUANCY TEAM
SCHOOL REFERRAL
COMMUNITY SERVICE BOARDS
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NO SERVICES
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Problem is resolved
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PALS Study #2: Policy Maps: Summary of Main Findings

1. Policies are written for agency-specific *target populations*, or who state representatives have determined are the appropriate individuals for whom eligibility criteria is designed.
2. Current policies are likely to lead to duplication of effort for the family (e.g., repeating intake requirements across multiple agencies, being referred to a different agency due to narrow eligibility criteria). Such redundancy also increases the likelihood that a family will not receive services.
3. Policies, as currently written, may inadvertently exacerbate a child's initial presenting complaint due to their extending the time between the initial attempt to access services and the actual receipt of services.
4. Policies that define eligibility through multi-system involvement may inadvertently reinforce problem escalation when enforced within the context of an inaccessible service landscape.

Time spent attempting to access care without receiving care is dangerous for several reasons. Families presenting to a community clinic setting typically present with comorbidity, meaning more than one diagnostic concern (i.e., depression and substance abuse) potentially necessitating more than one service. Waiting weeks to months to begin services after a series of intakes has the potential to exacerbate presenting concerns. To an adolescent, an unresponsive environment sets into motion new patterns that with practice further distance them from a typical developmental sequence. Identifying needs becomes more difficult as problems grow and families transform into new target populations (e.g., academic failure to suspension to truancy).

PALS Study 3: Listening Sessions

Listening sessions were conducted with the local DSS and CSA workforce at the request of our VDSS partners who sought data on potential opportunities for earlier intervention and barriers of connecting families to services from workers in the field.

Targeted areas of inquiry included: (a) *Opportunities for intervention before a CPS report was made? If so, when, where. how?* (b) *Barriers for earlier intervention or prevention?* and (c) *aspects of services that are working well?*

Method. Three 90-minute listening sessions were conducted on Zoom across three dates in April 2024. CSA coordinators and LDSS workers (caseworkers, supervisors, and directors) were further divided into 13 total breakout sessions, ranging from 30-40 participants in each breakout room. Each breakout session was led by a representative from VDSS, a co-facilitator or support from CEP-Va, and at least one designated live transcriber. Attendees were able to participate verbally, through the Zoom chat and an anonymous Google form.

Attendees. Total Registered = 377; Total Attended = 207 (55% of those registered).

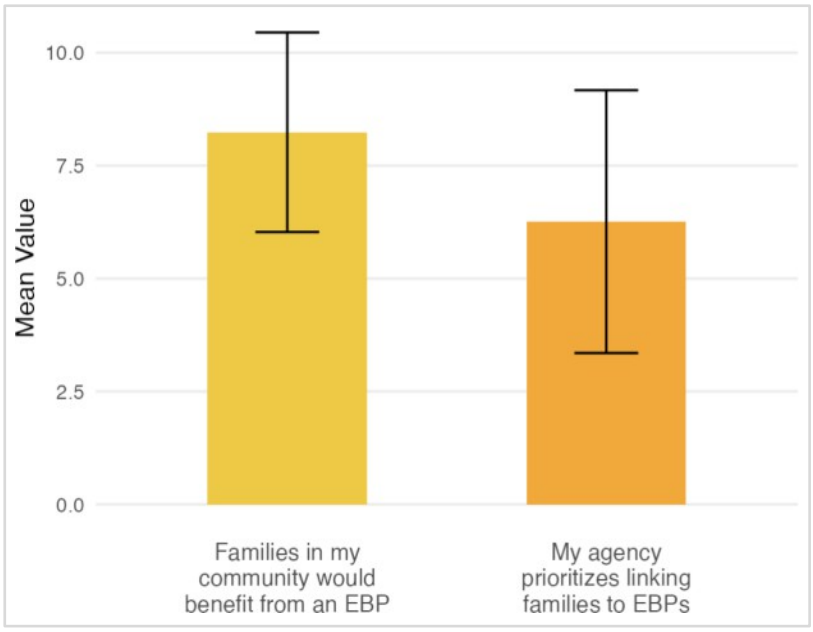
Highest turnout in terms of numbers of attendees came from the Eastern VDSS region followed by Northern, Piedmont, Central, and then Western. The number of attendees who contributed directly via verbal response or Zoom chat, was also tracked and found to reflect attendance. Before attendees entered breakout rooms, they were asked about Family First EBP availability and attitudes toward EBPs.

Poll Responses. Almost two-thirds of respondents (66.1%; *n* = 78) reported that an EBP was available in their area, 28.8% were unsure about EBP availability (*n* = 32), and 5.1% reported that no EBPs were available in their area (*n* = 6).

A second poll asked participants to indicate each respondent's level of agreement with two statements (10 = strong agreement, 0 = no agreement).

For the statement: "Families in my community would benefit from an EBP," those who contributed to the poll were on average in favor of EBPs (*M* = 8.24; *SD* = 2.21).

The following item "My agency prioritizes linking families to EBPs," noted less agreement (*M* = 6.26; *SD* = 2.91).



Such responses together may indicate positive attitudes from local DSS employees and CSA Coordinators for EBPs but that their work environment may be less oriented toward supporting their use.

Listening Session Primary Prompt:

What would have prevented local Department of Social Services involvement?

PALS Study #3: Listening Sessions: Summary of Main Findings

Central. Several themes emerged from the Central region, including the following:

Providers:

- Fewer providers available than before COVID, especially for outpatient services.

- Available providers seem undertrained and unprepared for the needs of the referred families.
- Some/many practitioners delivering services seem unaware of the local resources where they could be connecting families in the community.
- Waitlists are a major barrier.
- CSBs seem to be overwhelmed in general.

"Money could be spent to repair homes instead of removing children. Thousands of dollars are spent on removals to put band aids on problems instead of resolving the true issue."

Schools:

- Schools represent the best opportunity for preventing child welfare referrals.
- Improve mandated reporter training for school personnel, include emphasis connecting families directly to service providers or other resources vs. making reports to CPS.
- Problematic use of school suspension warrants attention.

Families:

- Families should be involved in the design of prevention programs
- Families were acknowledged as difficult to find and engage once they have already entered the DSS system.
- Community agency partners have few avenues or junctions to work together to help a family before FAPT.
- Attendees identified the need for a "community FAPT," some way to strengthen families through cross-agency support before FAPT referral.

Housing:

- Affordable housing is limited, and assistance for housing does not seem to be viewed as related to child welfare prevention by other local agencies.
- Families need tangible supports, like financial assistance and childcare.
- Guidance is needed from the state on how they can use Title IV-E dollars to respond to these types of needs.

TOP THREE PROBLEMS: CENTRAL REGION

1. Providers are needed.
2. Schools present the greatest opportunity for prevention.
3. Families are valuable contributors and they need tangible supports.

Eastern. Several themes emerged from the Eastern region, including the following.

Providers.

- Biggest concern: Lack of providers in the Eastern region as well as limited types of services available through the few providers that do exist.
- Providers that are available have limited hours and waitlists of 3-6 months.
- Providers willing to accept Medicaid-eligible families select certain MCOs but not all.
- Waitlists are especially cumbersome at CSBs, because of multiple waitlists for one individual to track, e.g., separate waitlists for case management, outpatient, and medication management was described by one attendee.
- Very few providers are trained to work with family systems
- Even fewer seem aware of how to connect families to local resources.

- Medical providers are not connecting families to services

> "All the agencies are so far behind in trying to get services in place for a child. Like a pediatrician, for months now, no follow-up… If you're not directing parents to the service or scheduling it for them, how is the child going to get the service?... but you'll call us, and report in for something that y'all probably could have helped if you just followed through with scheduling appointments and having the child seen."

Family support.

- Parents appear to have less community or family support than they did in the past.
- Services of any kind are not brought to a family's attention until DSS intervenes.

Schools.

- Children with behavior problems are
- often reported to CPS when the parent cannot come to school, to prevent truancy.
- Children are lagging in academics and supports (e.g., tutoring) are scarce.
- Trend for schools to believe services will happen quicker if a DSS referral is made.
- Trend for schools to suspend children who are struggling to learn, which turns into a vicious cycle for some.
- Tendency by schools to call CPS instead of talking with the family leading to broad mistrust of the system by the family.
- Local DSS offices with strong relationships with local schools report success stories and improvements in family relationships.

Housing.

- Housing needs are "off the charts" and "interfere with children receiving proper medical care, proper education, proper mental health services."
- Children are removed from homes because they are uninhabitable and logistic barriers exist for Section 8.
- Non DSS caseworkers have limited awareness of local resources related to economic support or affordable housing.
- FAPT timelines are too slow to address some concerns, leading to preventable removals.
- Training is needed for other professionals (e.g., law enforcement) on the potential damaging effect of threatening CPS referrals and child removal from the home.
- Families are less likely to accept prevention services when they arrive at local DSSs when referred in this way.

TOP THREE PROBLEMS: EASTERN REGION

1. Providers that accept Medicaid are desperately needed.
2. Schools and medical centers are overwhelmed.
3. Unstable housing drives CPS referrals and foster care entry.

Piedmont. Several themes emerged from the Piedmont region, including the following.

Schools.

- Many school personnel and teachers lack awareness of CSA or FAPT processes.
- Inconsistent reporting styles are present across schools; some overreport and some wait too long.
- Education for mandated reporters that includes how to find community resources and services is needed.

- Schools with higher report rates were described as forcing a CPS response through use of specific words that later have been found to be false
- In the cases where families are engaged by schools, DSS workers believe schools to be very helpful.

Earlier intervention.

- Attendees reported an uptick of relief of custody cases.
- Many opportunities where families could be educated about services.
- Especially for Medicaid-eligible families, very few local agencies or providers are aware of what Medicaid benefits can provide to families.
- Home visiting and other early intervention supports are needed to increase early access.
- More effort to help identify needs in kindergarten and elementary vs. high school.

> "If all community partners were prioritizing prevention then the first person a family comes to for help has the knowledge and skills to address the need."

Training.

- Hospitals have the greatest need for prevention-focused mandated reporter training.
- A pattern of inappropriate, duplicative reports on African American/Black families with very few reports on white families from hospitals was described.
- Poor relationships with schools and medical professionals were described.
- DSS attendees reported to be unaware of how to open an in-home case when families request in-home services.

Access.

- Insurance coverage appears to dictate waitlist time for providers in the Piedmont region. Six months is typical for Medicaid, 3 months for private.
- EBPs are consistently inaccessible because many counties share the same providers.
- Very few providers will service certain areas, and public transportation does not extend to large rural areas of counties.
- Medicaid transportation is unreliable.
- Too many providers not accepting new patients.

TOP THREE PROBLEMS: PIEDMONT REGION

1. Relationships amongst systems may require repair.
2. Earlier prevention is needed.
3. Medicaid families have few to zero options for timely care.

Northern. Several themes emerged from the Northern region, including the following.

Service availability.

- Lack of access to available services, including substance abuse services and EBPs.
- Waitlists running 3 to 6 months.
- Services not available during times outside of 9-5.

> "Not only are there staff shortages, there is no true continuum of care available."

Concrete needs.

- Lack of transportation for families to access services, despite the availability of some cab and bus services.
- Lack of adequate housing was also a major concern
- Job opportunities and available affordable daycare were also noted as concerns.

Cross-agency collaboration.

- Sheer number of schools in a locality creates a challenge for some workers.
- Although collaboration improved during the pandemic, afterward "everyone retreated to their silos, so we're not talking to each other as much as we should be."

TOP THREE PROBLEMS: NORTHERN REGION

1. Available services are inaccessible for many families.
2. Economic needs impact ability to access services.
3. Collaboration across systems has decreased.

Western. Several themes emerged from the Western region, including the following.

No providers.

- More so than in other regions, attendees described a dearth of providers that hold waitlists of 4-6 weeks at minimum and up to 6 months for evidence-based services.
- Providers willing to be flexible with where they are willing to travel and their hours of operation are needed.
- Services appear not to exist for children between 3 years of age and adolescence.

Schools.

- Collaborations with school have been fruitful for some.
- Need for schools to attend FAPT meetings.
- Need for schools to send fewer truancy cases to court.
- Some schools appear to have low awareness of the breadth of local services available.
- Opportunities were described to exist for CSBs to get more involved and to help DSS working with schools.
- Attendees noted greater need for interventions for elementary-age children more so than high school when parent buy-in is harder.

"We don't have much to offer them [teens]. In our community, there are no community-based programs we can offer. There's nothing long term to provide skills to take a different path. In the country, there's not much they can do beside smoke weed and get in trouble."

Economic and concrete needs.

- Need for home- or community-based (e.g., school) services given transportation challenges for some families.
- Need for more and more affordable housing options. Too many children are entering care due to lack of stable housing.

TOP THREE PROBLEMS: WESTERN REGION.

1. Large service gaps exist for elementary and middle school children.
2. CSBs are less engaged than is optimal.
3. Transportation and housing needs prevent access.

Strengths in Virginia's System

Attendees across all regions identified several notable strengths that could be leveraged by other localities, including:

★ Prevention-focused coalitions are able to be more successful when the county administrator is involved and part of leading the charge, engaging in real problem-solving with other programs and agencies that describe themselves as prevention-focused.

★ Digital platforms, like CarePortal mentioned by several attendees, have crowd-sourced resources for families. Churches and private businesses have largely responded to provide basic living items, like beds, dressers, and cleaning supplies, and resources, such as food and emergency rental assistance, to families without direct DSS involvement.

★ Good relationships among schools, law enforcement, and school resource officers have led to less truancy for some families.

★ Resource fairs and day-long in-person events have helped families become more aware of the resources that DSS can provide. Information should be displayed in visuals with clear (non-jargon) information for how to access them.

★ LDSSs that work directly with schools have seen a reduction in inappropriate referrals to their hotline.

★ Families already in receipt of services are the best people to ask when improving current processes or building something new.

★ EBPs like High Fidelity Wraparound and Multisystemic Therapy have reduced the need for residential placements in some communities.

★ Family partnership meetings improve relationships amongst families and CPS workers. Families are more likely to reach out before CPS if an LDSS director has a reputation for wanting to help prevent their own involvement

Brief Summary of Provider Opportunity

Regions have more in common than different when it comes to what is needed to prevent child welfare overinvolvement. Themes across all regions suggest that across Virginia, there are communities in varying states of crisis and instability, problems maintained in part by uncoordinated systems of care.

These findings also reveal **an enormous opportunity for providers to fil in gaps** with services that function to integrate systems and the multiple important adults in a child's life.

Providers likely to benefit substantially by filling a service gap are those who…

a. have been trained to work with families,
b. are knowledgeable of concrete supports in their area,
c. know how to connect families to supports as part of their treatment plan

Many Family First EBPs teach these skills; however, providers are most likely to be successful in serving families through an EBP if they are connected to schools and able to receive families in greatest need of care at time of referral.

Importantly, providers must match their service arrays to the needs of communities, which will require understanding how other stakeholders interpret behaviors of families they see. For instance, ABA therapy was named as a needed service in more than one region as well as through a recent OCS annual needs survey conducted with CSA Coordinators. Parent-Child Interaction Therapy is an evidence-based intervention for children on the autism spectrum that used to be more widely available in the state one year ago than it is today. Connecting what is available to what is being determined as needed is a critical bridge that deserves attention.

PALS Study 4: Focus Groups

As part of Juliet Wu's thesis project, she engaged in a qualitative study to learn about the barriers and facilitators of the success of FFPSA from relevant stakeholders.

Questions posed included, *"As a state agency staff member, what do you feel are major barriers to the delivery of Title IV-E services across Virginia?"* and *"What can be done to reduce some of the challenges and barriers that are making it difficult to roll out FFPSA services to Virginia families?"*

Method. A total of 4 focus groups were conducted with 13 total participants across local stakeholder groups (two localities) and state agency staff members (VDSS). These participants included local workers from two localities, providers from those localities, and state agency staff members from VDSS. Sixty-minute focus groups were conducted via Zoom, and each focus group had a facilitator and note-taker. Data were coded into five categories that included (a)

infrastructure, (b) workforce, (c) funding logistics, (d) family-specific factors, and (e) service-specific factors. Sample quotes are provided below.

Additionally, data was acquired from the Online Automated Services Information System (OASIS) through a data sharing agreement to examine the number of children who received a Family First EBP through Title IV-E between July 1st, 2021 and June 31st, 2023. After removing participants with missing information, a total of 7,469 participants remained. A final data reduction was conducted to remove all participants with missing candidacy status data, leading to a final sample of 110 participants. Figure 2 shows the distribution of these families by locality.

Infrastructure

"*I sometimes find myself having a hard time knowing what resources are really out there to help with these families. . . I think easier access to what's out there . . . would probably be helpful." [Providers]*

"There was a big opportunity and shift in Virginia to focus on evidence-based services . . . and so you're not only like implementing this funding source, you're also trying to implement this huge culture shift."
[VDSS]

Workforce

"There's some trepidation on their [workers] part, right? Like evidence-based services are expensive to be trained, ongoing, sustaining that training, is, can be expensive, can be perceived as expensive and I think we as an entire system, not just providers and not just the funding source, like we haven't figured out a good way to navigate that, to make sure that the cost for service will sustain not only the employee in a living wage who is providing a service, but also the company." [VDSS]

"When do you find the time of day to start this new thing? . . . we've got a million other things going on right now . . . there's no time to dig in right now unless it's easy to do, and that doesn't feel easy to do right now." [Local DSS]

Funding Logistics

"*To me, it's just been like 'here's the funds just figure it out' type thing. And then the more when I research it, I was like, I can't even use these because the only three that are on there are Medicaid funded…" [Local DSS]*

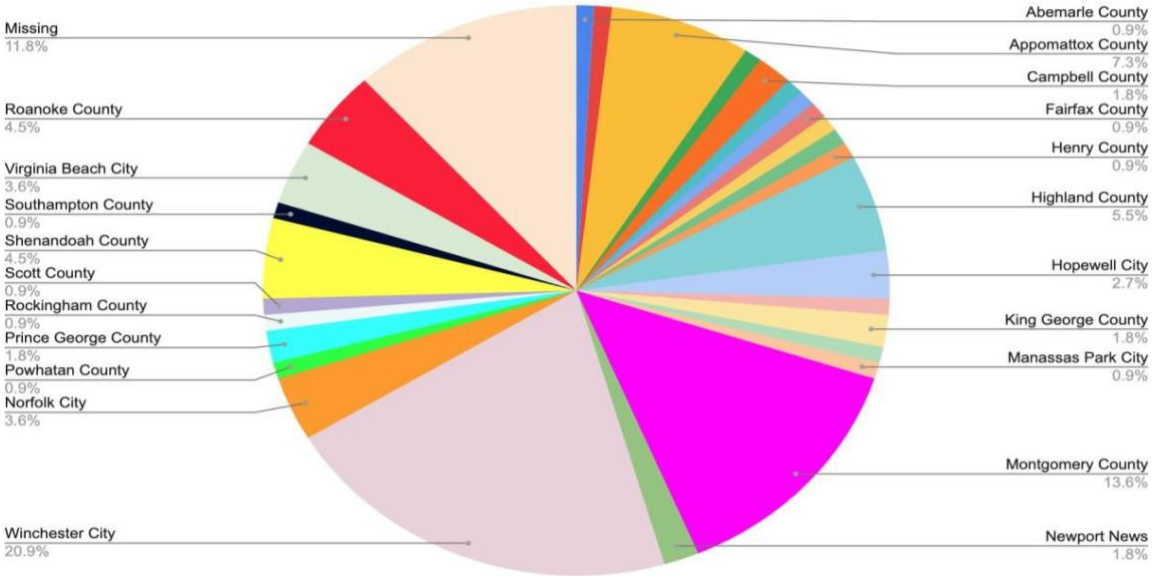
Family-Specific Factors

"With functional family therapy, training [is] out of the world. It's like a forever learning model and so I think that too helps with intervening with these families as well. But, and FFT guides you from the very beginning to the very end, when to let these families go, when are you noticing the progress, how are you going to communicate this." [Providers]

Service-Specific Factors

> *"Maybe the challenge is that, you know, working with in-home here, you come with working with social services. So sometimes there's a stigma with that, you know, like I don't want CPS in my life. . . so we have to kind of work through, like, 'we're here to help.'" [Local DSS]*

Figure 2. Locality distribution of families who accessed Title IV-E (*n* = 110)



PALS Study #4: Focus Groups: Summary of Main Findings

1. Infrastructure-related factors represent one of three prominent factors identified in our qualitative work. Examples of these factors included:
    a. Insufficient information dissemination and guidance to local DSSs from VDSS or the federal government
    b. Policy requirements (e.g., implementing new policy into OASIS, discrepancies between federal policy requirements and data system structure, incorporation of FFPSA policy increasing worker stress surrounding data documentation)
    c. Locality-specific factors (e.g., inconsistent knowledge and experience between DSS/CSA workers in each locality surrounding funding and policy, varying levels of collaboration with OCS)
    d. Lack of effective communication/collaboration between systems
2. Workforce factors were the second of three prominent themes from our qualitative work.
3. Examples from this theme included:
    a. A lack of knowledge of EBPs
    b. A lack of knowledge of how to leverage Title IV-E funding for families
    c. Lack of caseworker training for data entry and navigating Title IV-E funding

    d. High worker caseload
    e. High worker turnover
    f. Lack of providers
4. Funding-related factors were the third prominent factor. Examples:
    a. Lack of knowledge of how to utilize Title IV-E funding
    b. Title IV-E guidelines too specific and limited in scope
    c. Confusion and potential for interference from the multiple funding sources available (e.g., majority of families being served by Medicaid, difficulties coordinating Title IV-E with CSA funding)
5. Significant data challenges were apparent (e.g., the data set seemed to have a lot of missing data), suggesting that OASIS may not be adequate for Virginia to understand the progress of FFPSA in the state.

ADDITIONAL RELATED PROJECTS

In addition to the studies outlined in this report, CEP-Va is also engaged in multiple projects statewide, some of which are relevant to this needs assessment and gaps analysis. A brief summary of some of this work is presented here.

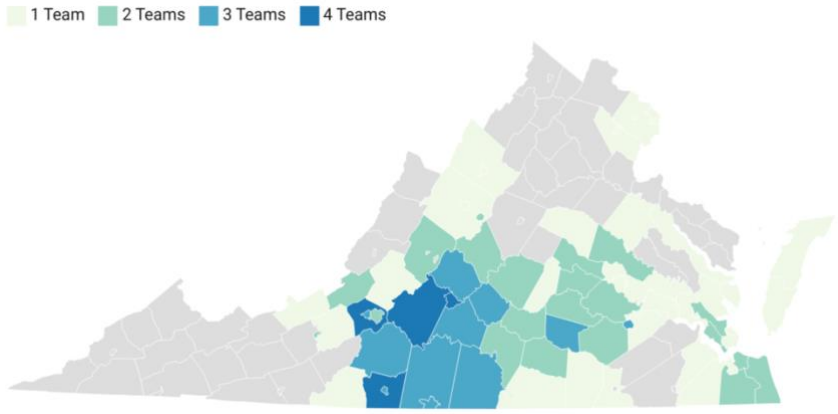
Title IV-E Training Updates

Since the launch of Title IV-E training awards in 2022, CEP-Va has facilitated funding to implement and sustain Family First EBPs for **20** different public and private providers in Virginia. A total of **96** practitioners have received training via a full or supplemental training award between September 1, 2022 and June 1, 2024.

- ***Seven (7)*** provider sites have received "full site" training awards to initiate a Family First EBP for the first time
- ***Ten (10)*** provider sites have received "supplemental" funding to train new practitioners in a Family First EBP already in place
- ***Three (3)*** provider sites were provided infrastructure support to sustain an EBP

CEP-Va tracks individual trainee progress and attrition for all providers who receive full-site training awards. This includes 72 trainees, only 24 of which are still active in model delivery. Of the seven that received full training, five sites remain active since initiating training. Two provider sites suspended their EBP teams during their second year of implementation due to lack of referrals.

Figure 3. Localities in receipt of EBP team training funds as of October 2024



The map details service coverage of 11 EBP teams across 10 provider companies who applied for and received a full or supplemental grant from CEP-Va to deliver a new EBP or support a pre-existing EBP in Virginia's Family First state prevention plan. EBPs include only BSFT, FCU, FFT, and MST. This map does not include support for PCIT, MI, HFW, or Homebuilders.

Qualified Mental Health Professional Study

In 2023, the CEP-Va team published a report reviewing states' approaches to unlicensed mental health staff without a master's degree, the largest growing sector of many states' behavioral health workforces. Only five states (including Virginia) have developed a certification or registration process for bachelor's level workers in fields outside of social work and substance abuse-related counseling.

At the time of the report, Virginia's requirements for the QMHP title were more stringent than other states (see NAGA 2.0 Regulation Study for a comprehensive description). Considering findings, CEP-Va made several recommendations to QMHP stakeholders, including (a) removal of the adult and child distinctions for the QMHP title; (b) consideration of an exam for registration; and (c) clarification or expansion of scope of QMHPs.

In the 2024 legislative session, Virginia's General Assembly enacted the two out of three of these recommendations in Senate Bill 403. Under the direction of a licensed or license-eligible practitioner, QMHPs can now provide collaborative behavioral services of "implementing interventions as assigned on individual plans of care and documenting the interventions for the purposes of recordkeeping; and, prevention of mental health and substance use disorders" (SB 403). CEP-Va maintains the position that QMHPs are an appropriate workforce for delivering those EBPs with embedded processes that ensure strict adherence to an individual treatment plan such as FFT, MST, and BSFT.

EBP Registry and Finder

As part of implementing Family First in Virginia, DBHDS contracted with CEP-Va to create the EBP Registry, an authoritative record of all mental health practitioners who are trained and certified to deliver the EBPs in Virginia's plan. These data inform the EBP Finder, a public tool that helps users identify and contact the providers of Family First EBPs in their locality.

As of April 2023, the EBP Registry has tracked the training status of 468 clinicians, 269 of whom are still practicing a Family First EBP. The EBP Finder provides contact information to the public for 63 active teams across 44 organizations. At the request of DBHDS, the Registry and Finder will begin recording two additional EBPs outside Family First in late 2024: Assertive Community Treatment and Coordinated Specialty Care.

Fidelity Reporting

One requirement of the FFPSA is that the state conducts ongoing fidelity monitoring of EBPs delivered to families that qualify for FFPSA funding. At the time of writing, CEP-Va aids in this process by providing quarterly reports on the fidelity and outcome data gathered by the purveyors of FFT and MST for all children in the state receiving these services. Other EBPs will be reported on as they reach the fidelity monitoring phases of implementation. All historical quarterly reports can be found on CEP-Va's website.

OVERALL SUMMARY OF FINDINGS AND RECOMMENDATIONS

The Virginia Department of Social Services is commended for their commitment to child safety by initiating Family First, legislation intended to transform the child welfare system. Such a decision catapulted the state agency from operating as a responsive system to a preventative one, moving VDSS to address family wellbeing in addition to child safety. For the first time in history, VDSS is tasked with contributing to the capacity of the behavioral health service landscape that in Virginia is unique compared to most other states.

The implementation of Family First Virginia as written in current policy remains a work in progress. Success can be identified; however, there is little question that more work remains to be done to realize the vision. The implementation of the plan has been challenged by multiple factors beyond the control of policy makers and state workers. A multi-year pandemic created a series of challenges for progress, including exacerbation of a workforce crisis. That workforce crisis has affected implementation across roles, including those tasked with managing the work at the state level as well as those implementing the plan at the local level.

Virginia's Family First plan is an ambitious one and few states in the United States have found much traction with implementation of FFPSA. That said, findings from this most recent Needs and Gaps Analysis report support directing leadership attention to several areas of concern. It is recommended that the following three issues be addressed in some fashion prior to defining a vision for Community Pathways. Project findings also spawned several additional recommendations that follow.

Recommendations listed with an asterisk are approved for implementation by VDSS as of 11/20/24.

These three recommendations are considered primary:

Recommendation 1: Expedite implementation of a new data system.

OASIS is insufficient for timely data monitoring and improvement cycles that are essential to Family First. Enhancing VDSS's data management and monitoring system is strongly encouraged to be prioritized above any other initiative.

Recommendation 2: Review and revise policy and guidance to clarify how local workers can facilitate access of Title IV-E funds. *

Hesitancy to participate in Family First was noted across stakeholders due to lack of clarity around policy related to Title IV-E reimbursement for Motivational Interviewing and provider-delivered EBPs. The greatest barrier to accessing Title IV-E included unknown applicability for Medicaid-eligible families. Also, the steps required for workers and families to access EBPs for any setting may work to escalate severity of symptoms from initial presentation at first point of contact.

Recommendation 3: Revisit and revise external CQI cycles and processes.

We recommend that VDSS invite partners at OCS (e.g., CPMT/SEC) to collaborate and rebuild **external CQI cycles** (e.g., between OCS and VDSS) and relink to internal cycles. We also recommend that **internal cycles** (i.e., between the state and local workers) are reassessed and recalibrated to ensure timely input from local workers to state workers to facilitate corrective action.

Several additional recommendations follow. The first few are actionable in the short term. The latter few will require a longer timeline and more sustained effort.

Recommendation 4: Support a community approach. *

To enhance EBP readiness of localities within CSB catchment areas, we recommend that VDSS garner state partner support for the implementation of a **Community Calibration** model to initiate engagement and action at the local level. Community Calibrations is a tiered prevention capacity-strengthening model in which CEP-Va supports grassroots efforts to organize powerbrokers to prioritize prevention services. Community Calibration is designed to engage the whole community using behavior change science. Relationship rebuilding, establishing shared understanding of prevention, and prioritizing local data ownership and monitoring will be the premise of the calibrations through three phases:

I. *Planning phase* where local data from multiple sources will be collected, aggregated, and then presented to a local core team to spark local interest in an upcoming in-person community event. The core team works with CEP-Va to plan and market the event, ensuring inclusion of key stakeholders (e.g., city council members).
II. *Integration phase* will involve an in-person full day event, Community Calibration Day, for cross-agency public stakeholders to learn about the trends in their community (target identification), provide feedback (stake declaration), and establish goals and objectives for moving forward (solution determination).
III. *Monitoring phase* following the integration phase event, structured coaching for tracking goals through an open monthly forum. Virtually, these forums will also include demonstrations of data benchmarking and equity-driven decision-making using data.

Importantly, the active ingredient in Community Calibration is **local data ownership**. Data from the state and local level have never been as accessible as today, but knowledge of how to set and monitor goals tends to concentrate in a few individuals. This recommendation, if selected, would entail the development of technical assistance, broad and locality-specific, by CEP-Va to supplement training provided by OCS for CSA Coordinators. Targeted audience would include all members of FAPT/CPMT as well as other local powerbrokers such as city council, city managers, and county administrators.

Recommendation 5: Clarify Medicaid/ Title IV-E intersection.

We request that VDSS works to **clarify the Medicaid and Title IV-E** issue further than they have in their policy manual (See excerpt from Section 2.4.3.1 below) and guidance to date.

2.4.3.1 Payer of last resort

Title IV-E funding is considered the payer of last resort for Family First prevention services that would have otherwise been paid from a public or private program (such as private insurance or Medicaid). Therefore, if public or private program providers would pay for a service allowable under the Title IV-E Family First prevention program, those providers have the responsibility to pay for these services before the Title IV-E agency would be required to pay. This requirement does not apply to CSA funding, since IV-E funding can be used prior to CSA funding.

VDSS Child and Family Services Manual, Title IV-E Prevention

Importantly, Family First EBPs are *programs* to be delivered as designed, and evidence-based *services* are what they become once they have been incorporated, thus adapted, into a pre-existing service milieu. MST and FFT are programs that have become Medicaid-reimbursable services. Given that the other Family First EBPs are functionally incongruent with existing Medicaid service categories, they should remain programs categorically outside of Medicaid. Attempting to fit Family First EBPs into the current Medicaid service categories reduces program potency and dilutes clinical impact. Thus, VDSS is strongly encouraged to work with DMAS to provide guidance that Family First EBPs, a) be made available to families covered by Medicaid, and b) be reimbursable through IV-E at an enhanced rate for providers, in- and out-of-network, delivering these programs to fidelity. If Family First EBPs cannot be billed outside of the Medicaid system (i.e., rationale provided herein is insufficient), then partners are requested to pursue the next recommendation.

The following recommendations are ones that will require a longer timeline and more sustained and coordinated effort.

Recommendation 6a: Partner to increase rates for Medicaid providers. *

We recommend that VDSS permit CEP-Va to engage with **DMAS** and other funding agencies (DJJ, OCS) to explore the technical aspects of billing for EBPs with the aim of **increasing reimbursement for these high-quality services.** Potential solutions that will require state authority include altered billing limits, possible avenues for supplementing Medicaid coverage with Title IV-E, and how the state defines network adequacy (42 CFR §438.68).

Regardless of how Virginia compares to other states, practitioners are not adequately reimbursed for the amount of time and labor required to deliver high-quality programs. Many model requirements are not adequately compensated, such as data collection and continued consultation with trainers that must occur in addition to state licensing supervision. Misalignment between Medicaid rates and EBP license requirements is amplified for Medicaid providers when an EBP does not have a Medicaid rate. This is because Medicaid providers are restricted to billing a Medicaid service category, such as outpatient therapy or intensive in home. This renders reimbursements that average less than one-fourth of the cost that it takes to deliver the EBP with integrity. Providers outside of the Medicaid system able to sustain an EBP are hesitant to accept children covered by Medicaid as they are expected to bill as an out of network provider. CSA also

stipulates rules that limit reimbursement for Medicaid children. furthering maintaining these children form services until they meet mandated criteria for CSA funding.

Conjointly, DMAS is encouraged to widen current practitioner requirements by increasing the number of QMHPs permitted to be on an MST/FFT team. This could mean updating policy to promote a higher rate for current teams with two licensed (or license-eligible) individuals, in tandem with releasing the restriction on QMHPs from one (i.e. 33% rule) to two members on a team. Such a decision has the potential to incentivize licensure without punishing providers for choosing to deliver MST or FFT. This recommendation aligns with 2024 legislation that defined the QMHP scope of practice, which includes, "implementing interventions as assigned on individual plans of care" amongst other supportive functions permitted under supervision (§ 54.1-3519). This decision has the potential to sustain providers that are small and embedded in their local community.

Recommendation 6b: Partner to increase rates for Medicaid providers.

Virginia needs a comprehensive system of care with multiple points of entry, a workforce equipped with differing and complementary scopes, and a tiered supervisory structure as support. Managed care organizations (MCOs) interested in behavioral innovation are presented with ample opportunity. CEP-Va encourages VDSS partners to engage MCO champions in regional efforts and events to spread awareness of their providers delivering EBPs. Family First grantees have included Medicaid providers trained to deliver MST, FFT, PCIT, BSFT, and FCU. These providers require additional support from MCOs to sustain these services, in ways like the following,

i. Help state partners discuss funding and compatibility of Medicaid and Title IV-E; aid in how guidance and fiscal policy could be messaged and disseminated on a schedule
ii. Ensure practitioners delivering EBPs receive greater compensation in proportion to enhanced reimbursement rate, or productivity credits; incentivize service quality by reimbursing supervision and required training time
iii. Integrate care coordination to FAPT/CPMT for in-home cases; adapt policies to OCS/CSA and LDSS needs
iv. Offer enhanced reimbursement rates for EBPs and remove administrative tasks like pre-authorization; acknowledge and begin to compensate for out of session labor (ex. 60 minutes of direct EBP treatment = 42 min. of out of session time[5])

Recommendation 7: Expand pre-existing community pathways.

VDSS is encouraged to take advantage of opportunities to fuse Family First into communities at pre-existing access points. Chapin Hall recommends expansion of pre-existing pathways to services across agencies to enable quicker care instead of designing a new route within an uncoordinated service system.

Many of the themes that arose in PALS revealed system struggles outside of child welfare that may be functioning to move a family closer to crisis. One example includes restricting youth with Medicaid to services only in the Medicaid benefit when an (uncovered) evidence-based service exists in their community even when the child is a candidate for foster care. A new service door

[5] Clinical Service Delivery Time Model (2022). North Carolina Child Treatment Program.

will not solve the funding eligibility issue (see Rec 4), nor will it incentivize more providers to serve Virginia's Medicaid population. A structural change is necessary because at this time families must wait until their child is further embedded into juvenile justice, child protection, or another federal entitlement category to reach services proven to be effective.

Tapping into pre-existing infrastructure (versus creating a new entry point outside of familiar places) also considers the severely limited number of mental health professionals available and willing to serve a primarily Medicaid population, as documented in past CEP-Va reports. CEP-Va strongly encourages VDSS to prioritize **cross-agency solutions and policy improvement specifically with DBHDS and DMAS** for improving access to Family First EBPs.

Examples:

a. Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) and/or housing infrastructure for supporting EBPs eligible under Title IV-E
b. Integrate access to Title IV-E funds into intake procedures of CSBs. Fortunately, most caseworkers outside of DSS prepare individual treatment plans that exceed the federal requirements for Title IV-E. Case managers in CSBs delivering MI to fidelity could initiate IV-E reimbursement by offering the Candidacy Form to a parent who consents to participate in an EBP. This form could then be added to the family's file and together maintained securely outside of the DSS database, mitigating the risk for DSS overinvolvement. Because CSB case managers are required to make contact with a family every 30 days, they are situated to catch problems before they progress to an appropriate child abuse report.
c. Regardless of junction, calibrate CQI cycles to be inclusive of pilot sites as well as the local FAPT and CPMT. Hold a regular forum to collect feedback and provide meaningful updates, bi-directionally, as infrastructure for routine outcome data monitoring is built. Investigate ways these meetings could satisfy the needs of groups designated as responsible for monitoring service gaps in their community such as CPMTs.

Recommendation 8: Reduce burden of entry into Family First EBPs.

The PALS project demonstrated that part of helping to create a pathway to services may be to **remove steps for families** that may not be necessary, **such as FAPT**. Since FAPT approval is not required for a family to *begin* an EBP, the requirement that the parent and child presents to FAPT after initiating services may be unnecessarily burdensome. For in-home cases, the worker could represent the family at FAPT and propose the family's service plan determined previously in a family partnership meeting. Alternatively, VDSS is strongly encouraged to promote an alternative MDT model where CPMT approval is all that is needed when CSA funds are not being requested.

This recommendation should not be interpreted to narrow the number of partners included in Family First planning. In fact, as is clear from earlier recommendations OCS and CSA Coordinators must be further integrated into VDSS's CQI cycles given the role they (and the SEC) have for ensuring an available and accessible service array. However, state and local-level

reports have long expressed concerns regarding varied FAPT implementation across the state and unintended consequences of delaying access to services.[6]

OCS/CSA has the largest stake in Family First in the state given its potential to save CSA state and local dollars through Title IV-E. CSA Coordinators are also the best point of contact for providers interested in delivering an EBP since CSA folks are most likely to be aware of service gaps in real time and the value of outcome monitoring. If the requirement that families attend FAPT remains, VDSS is strongly encouraged to partner with OCS to examine timeliness to care through employee and caregiver surveys to detect localities where focused technical assistance can be deployed.

Recommendation 9: Review and revise mandated reporter training.

Child wellbeing is a shared responsibility, and evidence continues to mount that reducing exposure to poverty reduces the need to separate families. The primary role of VDSS is child safety and not concrete supports, like housing. A few economic supports are available through social services, but families are likely to wait weeks to receive them and risk CPS investigation for poverty-related neglect. Children are not better off in foster care placements when poverty is the driver for removal, yet a majority of children in foster care came from families living in poverty. The individual making a report to Virginia's hotline is often in an optimal position to connect families to supports and services in their community.

Thus, we recommend a comprehensive review of **mandated reporter training** to assess alignment with Family First and the newer, trauma-informed way of serving families. Individuals already in contact with families must begin to connect families to concrete supports themselves. To accomplish this goal, there will need to be explicit training and changes in available VDSS guidance. VDSS and its training team are likely aware that information about what kind of concrete supports exist (like SNAP benefits), or do not exist (such as rent assistance), through LDSSs will involve a paradigm shift for some professionals in public safety, mental health, and medicine. Outreach should, at minimum, include:

- How connecting families to supports addresses root causes of abuse and neglect without CPS involvement
- How schools can help to strengthen protective factors in families, with and without local DSS involvement
- How practitioners could reduce exposure to poverty to prevent further trauma

Additionally, a shared taxonomy of commonly cited terms is seriously warranted to bridge mental health to child welfare regardless of what physical setting either is situated. Terms and topics recommended for inclusion in a taxonomy and for discussion with community agency partners, **both at the state and local level**:

- *Trauma-informed*: what this means and what is being inferred by its meaning
- *Concrete* and *economic supports*, including which ones local DSS can/cannot provide
- *Racial disproportionality*: what this means, where in the state is it happening, and how to reduce it

[6] JLARC (1999, 2006, 2019)

Recommendation 10: Integrate families into Family First. *

We recommend that VDSS expand the Parent Advisory Council and further **integrate birth parents** into the development of the next phase of Family First Virginia. We further recommend that VDSS explore opportunities to build out the concept of *family voice* into a continuum where community members with diverse types of exposure to social services are engaged more often for their feedback and ideas. This step is viewed as foundational by subject matter experts in that avenues to receive and integrate family voice must be established *prior* to planning any aspect of a new design, such as Community Pathways.

Appendices

Appendix A. Past NAGA Findings and Chosen Recommendations

NAGA 1.0 Summary

Needs across the state were captured via mixed methods, and the following themes were identified:

- Limited availability of quality services due to workforce turnover and limited training, especially in trauma-informed and family-centered care.
- Systemic barriers to service accessibility for families, including,
    - Insufficient communication across agencies and between state and local offices
    - Variance in the functioning of access points to services, namely CSBs and Family Assessment Planning Team (FAPT)

Three recommendations were selected by VDSS as a point of focus in the Center's work throughout 2022:

1. *Work to supplement CSB service arrays with Family First funding, especially CSBs within areas of high need.*

   CSBs represent the primary point of access for Medicaid-funded behavioral health services, so CEP-Va has prioritized these settings, especially those within localities with higher rates of foster care entry, when allocating Family First funding to implement evidence-based preventative services.

2. *Implement well-supported Evidence-Based Program (EBP) from Clearinghouse to provide service options for school age children.*

   Brief Strategic Family Therapy, which serves children ages 6-17, has been added to the array of EBPs in Virginia's Family First Prevention Plan to fill this gap.

3. *Strengthen LDSS engagement with families through frontline personnel training in Motivational interviewing (MI) (i.e., Train LDSS personnel in MI).*

   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. VDSS has been funding training in MI for LDSS workers throughout the state since August 2023.

NAGA 2.0 Summary

The second iteration of the Needs and Gaps Analysis (NAGA 2.0) report was published in February of 2023 and highlighted barriers identified after one year of training providers in Family First EBPs:

- Conflicting licensure requirements of practitioner-trainees. NAGA 2.0's Regulation study revealed inconsistencies in language and role clarity across agencies related to mental

- health service delivery, challenges that have impeded EBP sustainment in Virginia prior to Family First.
- Complexity related to who was allowed to train providers so that practitioners could be certified according to the standards set by the Title IV-E Prevention Services Clearinghouse
- Unconnected referral and reimbursement streams. Providers were interested in EBP training but lack of referrals and unsustainable reimbursement rates for Medicaid-eligible cases impeded program sustainability.

VDSS chose three recommendations as the point of focus in CEP-Va's NAGA work from June 2023 to July 2024. Updates sectioned by recommendation is the makeup of this current report.

1. *Continue to prioritize CSBs, as well as providers within the service coverage areas of CSBs identified as highest-need based on foster care entry rates, when allocating Family First training funds.*

2. *Set Parent-Child Interaction Therapy Training and Certification Standards in Virginia, to ensure all Parent-Child Interaction Therapy (PCIT) providers have received training that meets criteria cited in the Title IV-E Clearinghouse.*

3. *Conduct a service coordination study in tandem with continued allocation of Family First Training Funds, in order to improve guidance for localities surrounding how to access Title IV-E services and reimbursement.*

Appendix B. SNAIL Reports

- 2023 CSA Service Gap Survey, Office of Children's Services
- 2023 Survey for the DBHDS Combined Study Workgroup, Department of Behavioral Health and Developmental Services
- 2022 Virginia School Survey of Climate and Working Conditions: Executive Summary, Virginia Department of Criminal Justice Services / Virginia Department of Education
- 2022 Virginia School Survey of Climate and Working Conditions: Student Version – Grades 9 Through 12, Virginia Department of Criminal Justice Services
- 2022 Assessment of the Capacity of Virginia's Licensed Behavioral Health Workforce, Virginia Health Care Foundation
- 2022 CSA Service Gap Survey, Office of Children's Services
- 2022 CSB Behavioral Health Services, Joint Legislative Audit and Review Commission
- 2022 Pandemic Impact on Public K–12 Education, Joint Legislative Audit and Review Commission
- 2022 The Office of the Children's Ombudsman Annual Report, Office of the Children's Ombudsman
- 2022 VA Statewide Needs Assessment on Adolescent Substance Use, OMNI Institute
- 2022 Virginia Office for Substance Abuse Prevention: Annual Report, Virginia Office for Substance Use Prevention
- 2021 Virginia School Survey of Climate and Working Conditions: Student Version – Grades 6 through 8, Virginia Department of Criminal Justice Services
- 2021 CSA Service Gap Study, Office of Children's Services
- 2021 Needs Assessment for the Virginia Maternal, Infant, and Early Childhood Home Visiting Program, Virginia Department of Health
- 2021 Primary Care Needs Assessment, Virginia Department of Health
- 2021 Report on HB 728/SB 734: Children's Residential Workgroup Report, Magellan of Virginia
- 2021 The Virginia School Survey of Climate and Working Conditions: Executive Summary, Virginia Department of Criminal Justice Services / Virginia Department of Education
- 2021 Virginia's Juvenile Justice System, Joint Legislative Audit and Review Commission
- 2020 Children's Services Act & Private Special Education Day School Costs, Joint Legislative Audit and Review Commission
- 2020 Oversight of Mental Health Parity in Virginia, Joint Legislative Audit and Review Commission
- 2020 TITLE V Maternal and Child Health Block Grant Qualitative Needs Assessment, Virginia Department of Health
- 2019 Trends in Foster Care Entry Associated with Parental Drug Abuse, Virginia Department of Social Services
- 2018 Behavioral Health in Virginia: Alignment, Accountability, & Access, Farley Health Policy Center
- 2018 Listening Tour Report, Linking Systems of Care for Children and Youth
- 2018 Virginia Behavioral Health Redesign Stakeholder Report, The Farley Health Policy Center
- 2018 Virginia Medicaid Continuum of Behavioral Health Services, Department of Behavioral Health and Developmental Services / Department of Medical Assistance Services/The Farley Health Policy Center
- 2018 Virginia Statewide Substance Use and Behavioral Health Needs Assessment, OMNI Institute
- 2017 Child and Family Services Reviews: Virginia Final Report, Department of Family Services/Virginia Department of Social Services
- 2016 Juvenile and Criminal Justice Outcomes of Youth Completing Services through the Children's Services Act, Office of Children's Services/Department of Juvenile Justice
- 2015 Child and Youth Crime Victims Stakeholder Survey, Linking Systems of Care for Children and Youth
- 2014 Report of the Governor's Taskforce on Improving Mental Health Services and Crisis Response, Governor's Taskforce

Appendix C. Acronyms

CEP-Va – Center for Evidence-Based Partnerships in Virginia CHINS – Child in Need of Services
CPS – Child Protective Services CSA – Children's Services Act CSB – Community Service Board
DBHDS – Department of Behavioral Health and Developmental Services DJJ – Department of Juvenile Justice
DMAS – Department of Medical Assistance Services DSS – Department of Social Services
EBP – Evidence-Based Program
FAPT – Family Assessment Planning Team FCU – Family Check-Up
FFPSA – Family First Prevention Services Act FFT – Functional Family Therapy
IIHS – Intensive In-Home Services
LDSS – Local Department of Social Services M – Mean
MCO – Managed Care Organization MI – Motivational Interviewing
MST – Multisystemic Therapy
NAGA – Needs Assessment Gaps Analysis
OASIS – Online Automated Services Information System PALS – Pathways to Access Local Services
PCIT – Parent-Child Interaction Therapy QMHP – Qualified Mental Health Professional SD – Standard Deviation
SNAIL – State Needs Assessment Information Library SNAP – Supplemental Nutrition Assistance Program TANF – Temporary Assistance for Needy Families VDSS – Virginia Department of Social Services
WIC – Women, Infants, and Children

Appendix D. Family First Evidence-Based Programs

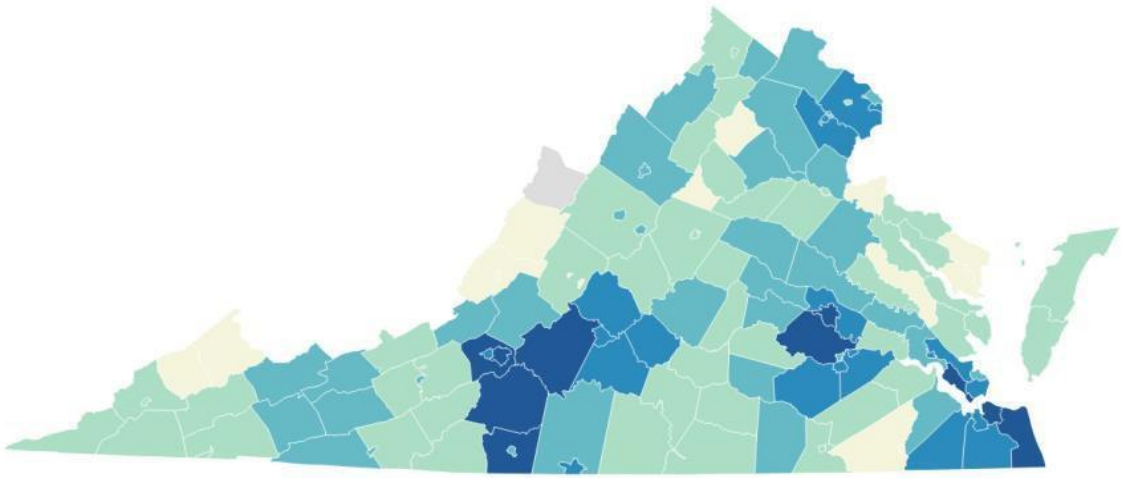
Evidence- Based Program	Population targeted	Delivery	Length	Outcomes
Brief Strategic Family Therapy	Youth (ages 6-18) with serious behavioral problems	Uses coaching to change negative family interaction patterns	60-90 weekly sessions lasting 12-16 weeks	Changes detrimental family interaction patterns
Family Check-Up	Children (ages 2-17) with disruptive behavior whose parents lack skills or engagement	A family assessment; can occur simultaneously with other supports	Limited to 15 sessions	Increases family engagement, healthy limit setting, and communication between family members
Functional Family Therapy	Youth (ages 11-18) at risk of court involvement due to acting out behaviors	Addresses internal and external cycles of the child	Typically 3-6 months	Reduces dysfunction in family system; strengthens child's relationships and other protective factors
High Fidelity Wraparound	Youth (ages 0-21) with complex mental health needs	Plan is coordinated by a team led by the family with assistance from a care coordinator	Varied; 4 phases	Goals are established by the family
Homebuilders	Children (ages 0- 17) who are at imminent risk of removal from home	Clinician is available to the family 24/7; delivered primarily in the family's home	Approximately 40 hours of direct care over the course of 4- 6 weeks	Prevents crisis and creates a thorough ongoing service plan
Motivational Interviewing	Wide range	Clinician helps the individual identify ambivalence for change	1-3 sessions	Promotes behavior change
Multisystemic Therapy	Children (ages 12-17) who are at risk of committing crimes	Involves intervening with family and community systems	3-5 months	Empowers youth and increases effective skills for children with difficult behaviors
Parent-Child Interaction Therapy	Young children (ages 2-7) with significant externalizing symptoms	Uses live coaching sessions; designed for office delivery, but can be delivered in homes	12-20 sessions	Teaches parenting skills that repair and strengthen the parent-child relationship

Appendix E. EBP Service Coverage Maps

Family First EBP Coverage in Virginia

The number of BSFT, FCU, FFT, HFW, or MST teams serving each locality as of June 2024

1 Team | 2-3 Teams | 4-5 Teams | 6-7 Teams | 8+ Teams



Family Check-Up in Virginia

FCU team coverage as of June 2024

1 Team

Brief Strategic Family Therapy in Virginia

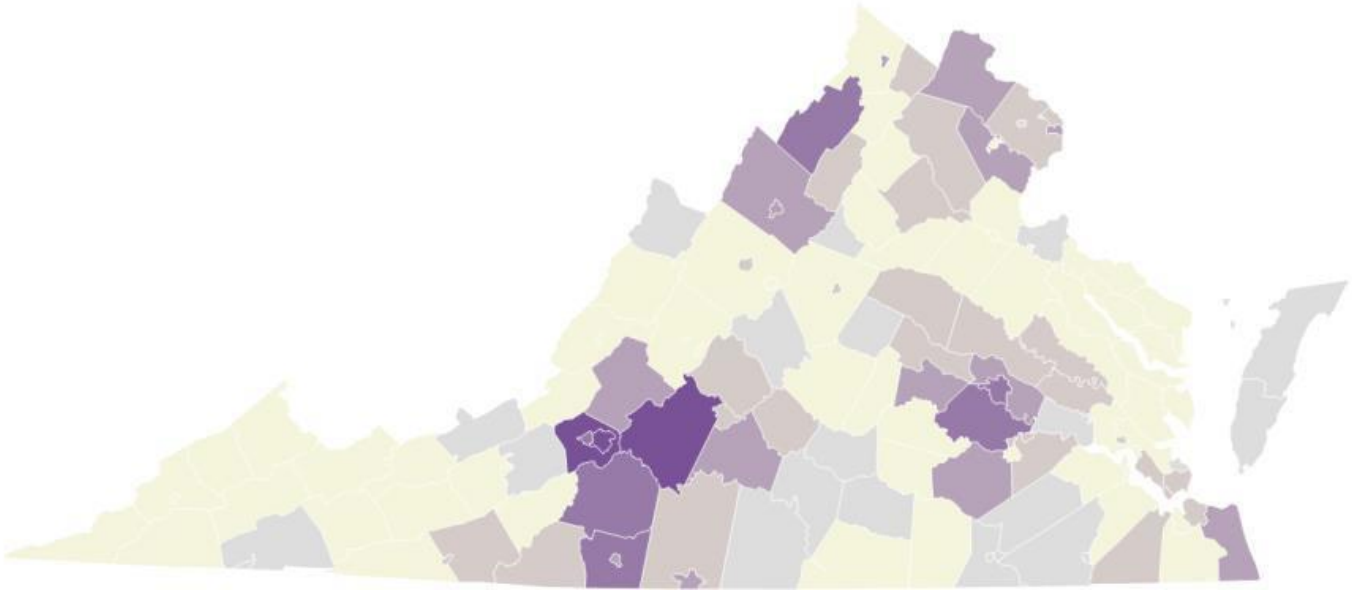
BSFT team coverage as of June 2024

1 Team 2 Teams

High Fidelity Wraparound in Virginia

HFW team coverage as of June 2024

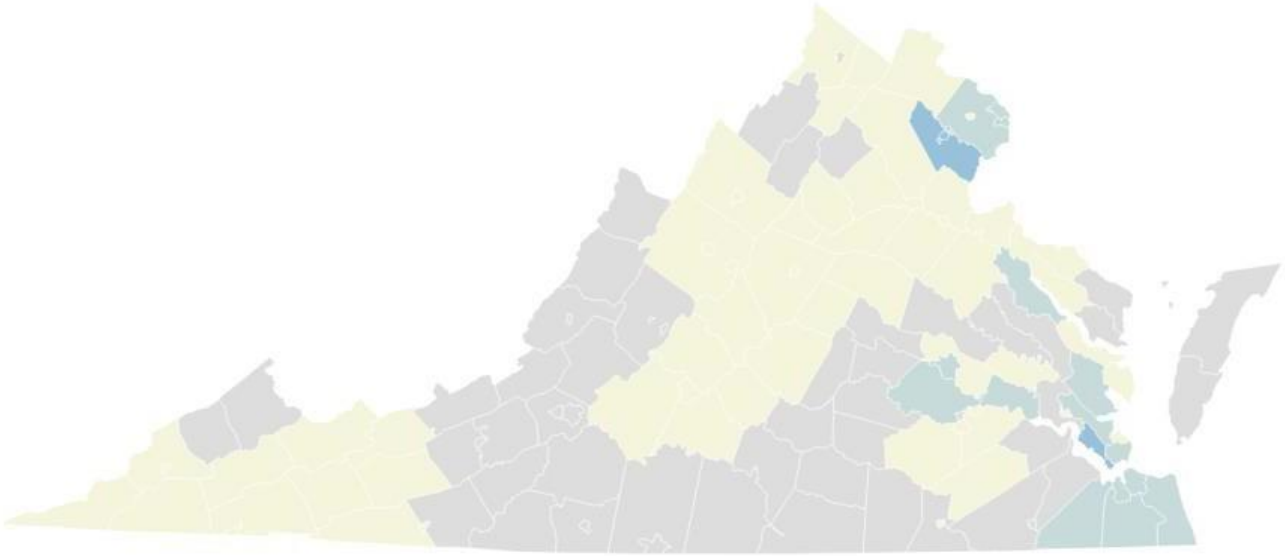
1 Team 2 Teams 3 Teams 4 Teams 5-7 Teams



Multisystemic Therapy in Virgina

MST team coverage as of June 2024

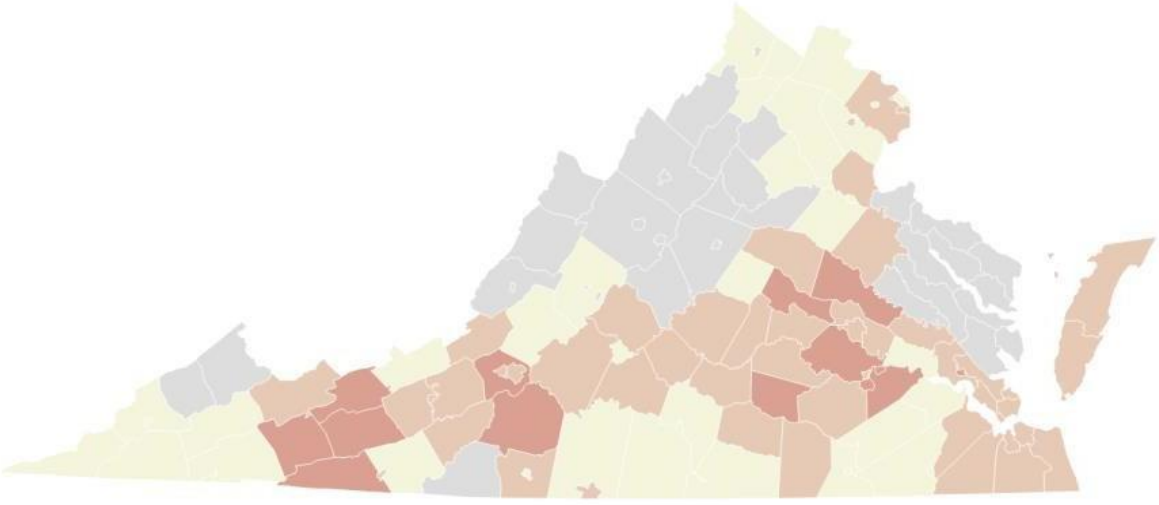
1 Team 2 Teams 3 Teams



Functional Family Therapy in Virginia

FFT team coverage as of June 2024

1 Team 2 Teams 3 Teams



Appendix F. Glossary

Concrete Supports	Government support which includes child care, housing, health care, flexible funds to prevent crises (e.g., rental assistance, car repair).
Economic Supports	Government support which includes tax credits, paid family leave, unemployment benefits, public transportation, and minimum wage.
Implementation	Multi-phasic process of integrating scientific findings into routine practice that emphasizes identification of factors that affect uptake of a novel practice or intervention.
Providers	Companies or agencies that deliver mental / behavioral health services, not individual “direct service providers” or therapists.
Practitioners	Individual therapists, clinicians, counselors delivering services directly to children and/or families in any setting; includes bachelor-level clinicians.
Public Assistance	Programs including TANF, SNAP, and WIC that aid families experiencing socio economic hardship and food insecurity.
Purveyors	Program developers, trainers, or vetted spokespeople who represent an evidence-based program, its developers, or certifying entity, and have a clear stake in how the program is delivered.
Workshop	A teaching strategy involving the presentation of new knowledge, and in some cases, experiential application to enhance learning.
Consultation	A style of teaching where information is provided by an external agent, or someone outside of a particular system.
Supervision	A regulatory component embedded within a system, typically for the purposes of quality assurance and patient safety.
Sustainment	The ultimate goal of implementation; the active maintenance of gains or defined outcomes related to an innovation.

Report to the Virginia Department of Social Services

Workforce and Other Factors Impeding Implementation and Sustainment of FFPSA Evidence-Based Programs: A Study of Obstacles and Opportunities

Report date: 02/27/2023

Suggested citation: Sale, R., Wu, J., Robinson, A., Finn, N., Aisenberg, G., Kaur, N., Riso, A., & Southam-Gerow, M. A. (2023). *Workforce and Other Factors Impeding Implementation and Sustainment of FFPSA Evidence-Based Programs: A Study of Obstacles and Opportunities.*

Section 1

Needs Assessment Gaps Analysis, Year 1 Review

The Center for Evidence-Based Partnerships in Virginia (hereafter, CEP-Va) set out to help address questions posed by our Virginia Department of Social Services (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, CEP-Va developed the Needs Assessment Gaps Analysis (NAGA) approach to assess and monitor mental health needs and service gaps within VDSS's five regions.

Approach

The NAGA approach is one tool used by CEP-Va to guide VDSS and the state in their effort to implement an optimal array of evidence-based services for families in Virginia's Family First Prevention Plan (FFPP). Needs assessments, in essence, aim to assess the needs of a community that remain unremedied by the services and systems currently in place. Needs assessments are typically conducted at one point in time, or predestined points in time, through use of survey and/or community partner interviews. The end goal is to introduce a new service that if implemented would fill a gap in the service landscape and theoretically ameliorate perceived needs shared by a community.

NAGA differs from the typical needs assessment approach in that it is designed as an ongoing process of data collection, serving both:

a. to fulfill specific VDSS requests (e.g., expand services)
b. to detect contextual barriers known to undermine such large-scale efforts

To accomplish these aims, CEP-Va has developed a developmental sequence of investigatory phases, where each phase provides data to inform the next. As such, the study sequence is not predetermined and fixed. This is because communities are dynamic and multifaceted, and the outward expressions of communities' needs change, as does collective interpretation. Therefore, CEP-Va approaches the needs assessment in an adaptive manner, shifting to real-time data to assess geographical and conceptual variation in addition to multilevel change over time.

Developmental Sequence

NAGA is referred to as an approach or system to study design and recommendation generation for Center partners. Each phase of NAGA contains a series of studies, projects, or products that share the common aim of supporting long term implementation success of evidence-based programs (EBP) in Virginia. NAGA phases and the studies they include represent a combination of partner requests, such as in the case of public-facing events and outreach, or Center generated lines of inquiry driven by evidence. All studies, regardless of phase, produce findings to assist state leaders in sustaining Family First EBPs years after their initial adoption.

NAGA 1.0. The first phase of NAGA included six individual projects, each designed to identify baseline behavioral health *needs* of families that prevent child safety in the home. Needs 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. Quantitative and qualitative data for analyses were collected from up to approximately 478 participants over eight months in 2021. Detailed findings led to the identification of several service gaps across VDSS regions, as well as crucial considerations for successful implementation of EBPs in Virginia.

A set of recommendations were formulated, consisting of potential areas for further investigation or evidence-informed actions to prepare the state for EBP training rollout. Our funding partners at VDSS chose which of the steps to pursue for the following year to support training efforts. Each recommendation was written to convey a goal of subsequent projects or initiatives to be developed and executed by CEP-Va. Progress updates of the work that followed, called *NAGA 2.0 Projects*, are also included in this report. Out of the ten NAGA 1.0 recommendations proposed, our VDSS partners selected:

1. Work to supplement Community Service Board (CSB) service arrays with Family First funding (i.e., Support System Transformation Excellence and Performance [STEP-VA] efforts)
2. Implement well-supported EBP from Clearinghouse to provide service options for school age children (i.e., Implement EBP for school-aged children)
3. Strengthen Local Department of Social Services (LDSS) engagement with families through frontline personnel training in Motivational interviewing (MI) (i.e., Train LDSS personnel in MI)

Projects vs. Studies. Each NAGA 1.0 recommendation spurred the design and execution of three separate projects that remain ongoing as of February 2023. Descriptions of these projects and updates on their progress are included in this report. See Table 1 for visual explanation of how a selected NAGA 1.0 recommendation initiated a project. Findings that emerge during the course of a project can spur an immediate study. A *NAGA-indicated Study* forms when a project finding detects a barrier that has been demonstrated historically and empirically to derail efforts similar to CEP-Va's contract deliverables. Initial findings of study produce their own set of recommendations, separate from the ones that follow a project.

Table 1. NAGA System

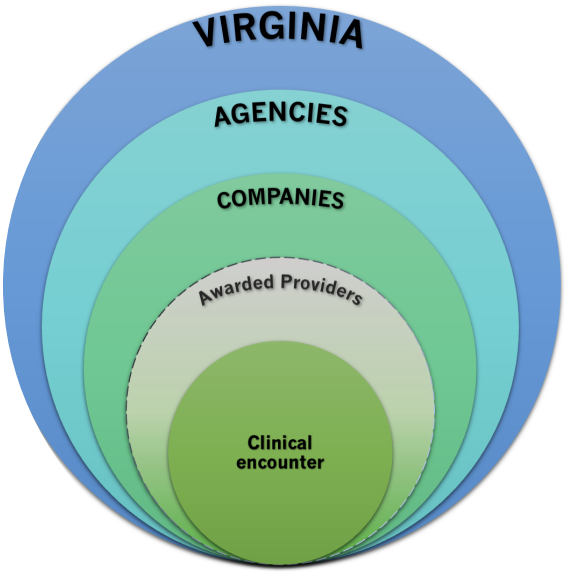
NAGA 1.0 Recommendation	NAGA 2.0 Projects	NAGA-Indicated Studies
Support STEP-VA efforts	Project 1: CSB Investment Initiative	PCIT-Va Pilot Study
Implement EBP for school-aged children	Project 2: Title IV-E Prevention Services Training Awards	Regulation Study, Phase I
Train LDSS personnel in MI	Project 3: MI Training Project	None indicated

Status as an official project requires input from our state partners. Whether CEP-Va continues down a line of inquiry indicated by a study will be determined by state leaders' selection decisions. The NAGA system was designed in this way because Center partners play an integral role in CEP-Va's work related to Family First. It is CEP-Va's responsibility to draw funders' attention to factors that have the potential to disrupt VDSS' vision for Family First and allotment of Title IV-E dollars. Such factors will require investigation outside of VDSS's immediate domain of child welfare. This is due to the nature of Family First, as it was designed to depend on the calibration of all child-serving, -facing, and -placing entities within one state context. **Attention to all contributing drivers of implementation success and failure is imperative to expect the type of outcomes any *one* agency attempts to reach.** Figure 1 illustrates this important aspect of interdependency that underlines NAGA's design to prevent misapplication of Family First funding.

Conceptual Model

Systems interdependency and the value of context was built into the NAGA model. Interrelated relationships exist amongst state and local governmental agencies, service provider companies, and the families they serve. This means that state *agencies*, such as VDSS, are impacted by Virginia law. Agencies contribute to the legal parameters in which provider companies are responsible for working within to serve families. *Awarded Providers*, public or private companies in receipt of Family First funding to deliver an EBP, live and are shaped within the context of fellow providers to hire and support practitioners to treat families. The clinical encounter represents the junction where an identified family and practitioner meet. What happens in a clinical encounter at any given time can be viewed as an end product of all of the circles depicted in Figure 1 and their impact compounded over time.

Figure 1. NAGA Conceptual Model



PROJECT 1: CSB INVESTMENT INITIATIVE

Rationale

CSBs represent the public service access point for many Virginians, including those with Medicaid or those without insurance coverage. VDSS chose to prioritize CSBs and their community partnerships with private providers in the allocation of Title IV-E funds as part of a cross-agency approach to service expansion. Many CSBs cover several localities within their service area (e.g., Horizon), and some CSBs are only responsible for servicing one locality (e.g., Norfolk). Applications from CSBs are also fast-tracked in CEP-Va's training recruitment efforts because they are mandated to serve families covered or eligible for coverage under Medicaid.

CSBs also provide a natural grouping variable for beginning to track potential service gaps and local coordination barriers. Successful adoption and implementation of any novel service is influenced by the way in which information is transmitted to and by local key players. How agency-specific funding is coordinated at the local level also depends upon general awareness of what services are available in an area. CSBs are tasked with offering a service to all of the localities within their coverage area, versus only to a partial selection of localities like many private providers, and positioned to communicate service availability to individuals in their community, which influences a family's accessibility to available services.

Method

CEP-Va sought to prioritize outreach to CSBs according to need, and where to begin required selection of some measure to guide Center efforts and outreach. *Benchmarking* is the practice of using a reference point by which data can be compared over time. Any relevant variable can be used as a reference point, or ***benchmark***, as the goal is not to prove cause and effect like in a research study but to guide outreach efforts when capacity is limited. In context of NAGA, outreach efforts were concentrated to CSBs and other providers in a CSB's catchment area.

In NAGA 1.0, ***foster care entry rate*** was used as a distal outcome variable due to its potential sensitivity to the roles that multiple agencies play in ensuring families receive timely care to prevent out-of-home placement. See Figure 2a-b for an updated heat map of this rate across the state.

Figure 2a. Foster care entry rate 2009-2019

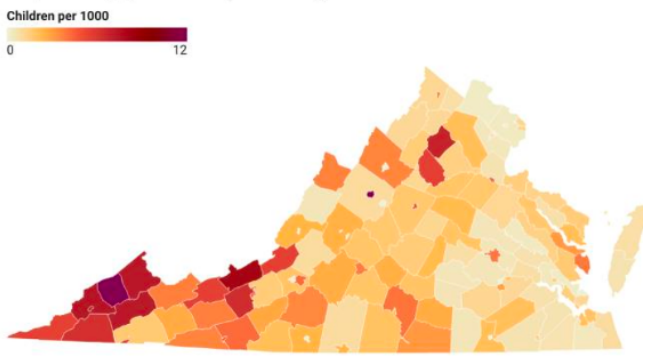
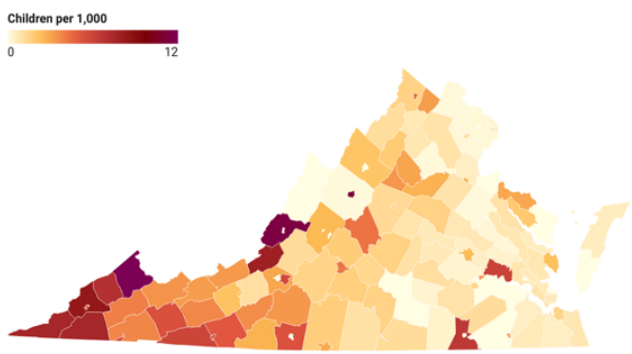


Figure 2b. Foster care entry rate 2021-2022



In alignment with the Family First prevention frame, multiple events are believed to occur before a family meets the threshold for maltreatment. Thus, every child-serving partner, public and private, can participate in preventing such events from happening. **Note:** Foster care entry rate is not a measure expected to change easily or quickly, nor should it ever be a measure used to diagnose the actions or intentions of a locality.

The CSBs presented in the NAGA 1.0 report can be found in Table 2. A 10-year average (2009-2019) of **2.56** was used in NAGA 1.0 as a threshold for detected CSBs that exhibited higher entry rates, accounting for **47%** of the total number of foster care entries in the state for that ten-year period.

Foster care entry: the rate in which children referred to Child Protective Services (CPS) enter the foster care system. To prevent localities with higher child population density from rising to the top of the 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.

Table 2. NAGA 1.0 Top Priority CSB List

CSB/Behavioral Health Authority (BHA)	2021-2022 Entry Rate	2021-2022 Child Count	Change from NAGA 1.0*	Change in Child Count from 1.0*
Dickenson	7.04	19	-4.91	-16
PD 1	7.05	125	+0.25	+12
Cumberland	6.52	90	+0.39	+8
Valley	5.67	56	+0.13	+14
New River Valley	2.50	57	-2.50	-52
Mount Rogers	4.90	106	+0.76	+21
Richmond	2.44	96	-1.52	-64
Highlands	4.86	57	+1.09	+19
Harrisonburg-Rock.	2.11	38	-1.53	-29
Rapp-Rapidan	1.54	48	-2.04	-41
Blue Ridge	4.51	198	+1.32	+53
Piedmont	3.79	95	+1.06	+25
Horizon	2.14	124	-0.46	-21

**NAGA 1.0 Benchmark = average annual rate of foster care entry from 2009-2019, to avoid atypical reporting during COVID-19.*

Project Review

As of December 2022, Family First funding was accepted by four Top Priority CSBs listed in Table 2. Two FFT teams and two PCIT programs were supported through Title IV-E. A fourth CSB is scheduled to commence Family Check-Up (FCU) training in early 2023.

Impact of Title IV-E investments into the EBP workforce may be better understood in terms of how many families could be served. One full FFT team would enable high-quality and effective care for approximately 20 to 30 families per year.[1] Two new PCIT clinicians typically maintain caseloads of 6 families during the first year in training,[2] and then increase based on referral needs of a given site. FCU clinicians serve 2 families during training when under the most extensive level of supervision and then a minimum of 5 once fully trained. Based on training timelines, FCU clinicians can see at least 15-20 families per year with the capacity to serve many more since treatment length is capped at 15 sessions.[3] Investments into programs that have already been established appear to *count* more in value as they prevent a provider from having wasted their own investments spent establishing the EBP, which is ubiquitously costly in terms of finances as well as staff turnover.

Project Findings

The CSB Reinvestment Initiative was CEP-Va's first formalized attempt to combine the interests of two child-facing agencies. Outreach via VDSS and CEP-Va led to a series of meetings with CSB leaders and program managers. CSBs have recently undergone several challenges and significant changes as part of the STEP-VA initiative and Medicaid expansion. Administrative burden has impacted time practitioners and CSB staff can spend with families. Many of the CSBs that reported to not have the staff eligible for training, and that much of their capacity had been shifted to crisis response.

Early in 2022, it became clear that most, if not all, CSBs were experiencing significant struggles with workforce recruitment and retention. Even before 2022, CSBs struggled to serve families in an expeditious and timely manner, as well as match children and their families with appropriate services. Regardless of what services are available, access to them is hampered by separate intake procedures for adult and child (versus whole family), convoluted referral procedures, and lengthy waiting lists (post-Same Day Access entry). A comprehensive review of the systemic issues experienced by Center researchers as disruptive to the CSB Investment Initiative was conducted by the Joint Legislative Audit and Review Commission (JLARC) and released in December 2022.

Furthermore, in NAGA 1.0, CEP-Va reported on the inefficient referral process for linking children and families to services in (CSBs), an observation further supported by findings from NAGA 2.0. Specifically, comprehensive information about where to find services is lacking. Many youth and families experience limited to no information about the process to access services or even which services are available. In addition, CSB leaders describe an unprecedented shortage of workforce capacity. Given extensive administrative demands, the staff shortages make it challenging for CSBs to meet the complex needs of their clients. In short, then, NAGA 2.0 findings continue to support a focus on CSBs.

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[1] Shared by FFT representative at the 2022 Open House series hosted by CEP-Va and VDSS

[2] Rosas, Y.G., Sigal, M., Park, A. et al. (2022). Predicting a rapid transition to telehealth-delivered parent–child interaction therapy amid COVID-19: A mixed methods study. *Global Implementation Research & Applications,* 2, 293–304. https://doi.org/10.1007/s43477-022-00057-0

[3] Shared by FCU purveyor at the 2022 Open House series hosted by CEP-Va and VDSS

Recommendation 1. Prioritize CSBs.

CSBs remain an important entry point into behavioral health services for Virginias who are uninsured. **CEP-Va recommends VDSS continue to prioritize CSBs and providers within the service coverage areas of those in the updated Top Priority CSB List with Title IV-E training funds** (see Table 3).

Entry rate between 2021-2022 was found to average **2.46** for the state (non-zero mean). CSBs found to exceed this new state rate threshold are listed in Table 3 and as a whole were found to account for **43%** of the total number of foster care entries between 2021-2022.

Table 3. Updated Top Priority CSB List

CSB/BHA	2021-2022 Entry Rate
Alleghany Highlands	11.44
PD 1	7.05
Dickenson	7.04
Cumberland	6.52
Valley	5.67
Mount Rogers	4.90
Highlands	4.86
Blue Ridge	4.51
Piedmont	3.79
District 19	2.74
New River Valley	2.50
Rockbridge Area	2.49

Family First funding to supplement CSB service arrays represented a clear step toward cross-agency collaboration in enhancing access to behavioral health services. However, the CSB Investment Initiative ran into several problems that necessitated a pivot toward a deeper examination. Important findings that arose during outreach raised the issue of CSBs as feasible implementation sites without further capacity-building. Another finding related to the quality of one preexisting EBP included in Virginia's Family First Plan.

NAGA-Indicated Study

Through CEP-Va's attempts to locate practitioners within CSB coverage areas, an issue related to one of the Family First EBPs, Parent-Child Interaction Therapy (PCIT) emerged. Specifically, a company unaffiliated and unsanctioned by PCIT's credentialing body, PCIT International, is accepting payment for training and certification in PCIT. As a result, some clinicians in the state have been trained (and supposedly certified) by the organization. Many of the clinicians have then advertised and delivered what they have called PCIT, despite the training they received not following the standards of PCIT International.

The company in question does not train according to PCIT International standards or eligibility specifications and appears to omit this important information to those who pay (and dedicate a substantial amount of their time over several months/years) to be trained. For instance, out of a group of 88 clinicians who reported to be certified in PCIT, approximately a quarter were not listed on PCIT International's directory of certified clinicians. It's possible this subgroup of clinicians did not complete full training or were trained by a purveyor unsanctioned by PCIT International. Regardless, the lack of clarity is felt at the local level by referral brokers searching for a Title IV-

E service to connect families but unsure whether an unlisted PCIT clinician has been trained adequately. The issue of practicing a model or treatment approach without adequate training is not a new topic, nor one isolated to Virginia. However, it is the specific EBP at hand that requires a clear response regarding who and who is not deemed certified to reimburse Title IV-E and Medicaid for their services.

PCIT is an intensive treatment designed for children with severe disruptive behavior problems and is particularly effective for children who have experienced serious and complex trauma. Implemented in naturalistic play settings, PCIT involves a one-way mirror and use of a hidden ear device worn by the parent while guided through a series of behavior management techniques. PCIT is highly structured; each client session has a predetermined agenda, recommended script, and complex command sequences the clinician is required to follow and coach the parent to perform in real time. The intervention works through strengthening the caregiver-child bond and significantly improving caregiver mental health.[4] Program length depends on child progress, meaning PCIT does not end until the family recovers and can prove their new parenting skills to the clinician. When applied as intended and tested, PCIT has been shown to surpass similar interventions that target symptoms of disruptive behavior disorders (e.g., oppositional defiant disorder) and ADHD in young children.

Increasing access to high-quality interventions like PCIT is an important goal; however, such interventions have been rated high-quality in part because of the rigorous training procedures that create a high threshold for competency to be certified in the EBP. The Family First Prevention Services Act requires a certain level of evidence determined through an independent, systematic review process for a program to be labeled *well-supported* and, in turn, eligible for enhanced federal funding. Studies that measure an intervention's effect are only included in the Title IV-E Prevention Services Clearinghouse if the intervention has been standardized and tested multiple times. Standardized programs include specific instructions for how it should be delivered, and by whom. Only when the same program has been tested more than once, and under certain conditions, can researchers begin to believe the program could be effective and whether it is worth further investment.

Program specifics are determined by the program developer or sanctioned purveyor and include factors related to training intensity, duration, and frequency of didactics and supervision. The developer stipulates training and practice requirements to ensure demonstrated outcomes. Therefore, only individuals judged to have received the type of training and educational background required by program developers should be permitted to deliver the treatment, regardless of whether they are licensed to provide services independently. For most EBPs, certification is the only way developers can ensure competency standards have been met and the treatment is being delivered as it was intended. Without such assurance, the robust outcomes proven in research cannot be reasonably expected.

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[4] Warren, J. M., Halpin, S. A., Hanstock, T. L., Hood, C., & Hunt, S. A. (2022). Outcomes of parent-child interaction therapy (PCIT) for families presenting with child maltreatment: A systematic review. *Child Abuse & Neglect*, *134*, 105942.

Recommendation 2. PCIT Training and Certification Standard for Virginia.

PCIT International was founded by the developer of PCIT and is the only organization that offers therapist and trainer certification procedures approved by the developer of the intervention. The training offered by PCIT International mirrors that used in the research studies that serve as the evidence base for the approach and are the reason for its inclusion in the Clearinghouse. Additionally, PCIT International is the sole purveyor listed in the Title IV-E Clearinghouse to provide PCIT training.

For these reasons, state agencies with a stake in PCIT in Virginia are recommended to require all individuals that bill for PCIT services or provide PCIT training meet standards set PCIT International and be enrolled in the EBP Practitioner Registry, the authoritative database of EBP-trained practitioners in Virginia. Licensed or license-eligible practitioners who have been trained by any organization or company unaffiliated with the certifying body are encouraged to be referred to CEP-Va. If the recommendations here are approved, CEP-Va will work with PCIT International to develop a remediation pathway to attain PCIT certification via Title IV-E training funds.

Recommendation 3. Improved Reimbursement Rate for PCIT.

To sustain PCIT and enhance access to this intensive service, **CEP-Va urges an increase in reimbursement for practitioners with verifiable training through PCIT International and who are listed in the EBP Practitioner Registry**. This recommendation spans all funding streams and child-facing agencies oriented toward prevention of out of home placement (e.g., Office of Children's Services [OCS], VDSS). Medicaid reimbursement for all licensed clinicians is particularly encouraged to be increased, given the impact such a service has demonstrated for prevention of later juvenile justice involvement. See Table 4 for a rates comparison across funding streams.

Recommendation 4. Site Certification Model for PCIT.

Given the high rate of practitioner departure from provider site post-training, **CEP-Va recommends that future investment of Title IV-E training funds be allocated toward building competency of provider sites, versus solely investing in individual practitioners**, to create an environment that facilitates PCIT training and effective delivery of the program. VDSS (and other state agencies) is encouraged to permit CEP-Va to examine whether certifying at the site level aids in retention of PCIT International trained clinicians (i.e., PCIT-Va Pilot Study).

Table 4. EBP Reimbursement Schedules by Funder

EBP	DMAS / Medicaid (Obtained 8/22)				OCS / CSA (Obtained 9/22)			VDSS / Title IV-E (Obtained 11/22)		
	Rate	Note	Unit	Code	Rate	Note	Unit	Title IV-E Rate	Note	Unit
FFT	$38.37	33% BA QMHP*	15 min	H0036	$73.60	NoVa	Daily	$73.60	NoVa	Daily
	$41.94	33% MA QMHP*	15 min	H0036						
	$45.82	33% BA QMHP**	15 min	H0036	$64.00	All other areas	Daily	$64.00	All other areas	Daily
	$49.69	33% MA QMHP**	15 min	H0036						
MST	$51.78	33% BA QMHP*	15 min	H2033	$116.00	NoVa	Daily	$116.00	NoVa	Daily
	$56.21	33% MA QMHP*	15 min	H2033						
	$57.38	33% BA QMHP**	15 min	H2033	$101.25	All other areas	Daily	$101.25	All other areas	Daily
	$61.91	33% MA QMHP**	15 min	H2033						
PCIT	$101.93	MD***	50 min	90847	$124.00	-	60 min	$124.00	-	60 min
	$91.74	Psychologist ***	50 min	90847	$149.00	For nationally certified practitioners	60 min			
	$68.80	LCSW, LPC, LMHP***	50 min	90847						
BSFT	$101.93	MD***	50 min	90847	No rate			$300.00	-	Daily
	$91.74	Psychologist ***	50 min	90847						
	$68.80	LCSW, LPC, LMHP***	50 min	90847						

Note. Information obtained through Zoom and email exchanges with agency leaders.

*These rates are set for established teams enrolled with Medicaid MCO or FFS contractor 18+ months

**These enhanced rates are set for new teams in months 0-18 of being enrolled with Medicaid MCO or FFS contractors

***Rates are DMAS recommended service categories, not modality-specific

PROJECT 2: TITLE IV-E PREVENTION SERVICES TRAINING AWARDS

Rationale

A key VDSS strategy to meet the mission of the Family First Prevention Services Act (FFPSA) has been to build workforce capacity through targeted EBP training. VDSS has tasked CEP-Va with the bulk of the work selecting EBPs for implementation, recruiting and vetting appropriate provider companies for training, organizing training events, and ensuring ongoing quality monitoring of each implementation. In brief, CEP-Va: (a) recruited recipients of EBP training; (b) verified EBP purveyor and trainer credentials; and (c) designed, implemented, and adjusted a phased training model for VDSS-funded EBP rollouts.

Standard Center Training Model

The CSB Investment Initiative and initial rollouts of BSFT illuminated a series of challenges and barriers embedded within the preexisting service landscape. Namely, the issue of a missing comprehensive provider or service directory. Through a different contract agreement, CEP-Va is building an EBP registry to fill in that knowledge gap of where high-quality services are available. The CSB Investment Initiative (Project 1) was impacted by several of the issues captured in NAGA 1.0, but most problematic was the inability of Center staff to delineate whether services advertised through CSBs were accessible since private companies are not bound to cover an entire CSB catchment area. Inconsistencies obfuscated any attempt to map service arrays that did not expire before distribution.

In response, CEP-Va developed a standard training model for all EBP training coordinated by CEP-Va staff beginning in 2023. In an effort to protect Family First expenditures, CEP-Va prioritized capacity building and the development of self-sustaining training hubs at provider sites granted a Title IV-E Prevention Services Training Award. Components of the Standard Center Training Model are consistent with recommended best practices and intend to sustain a service past the first year of implementation. The CEP-Va site certification process involves:

a. An initial Request for Applications and subsequent formal review process that includes state partner input
b. At least one informal meeting between CEP-Va staff and the provider to further assess EBP fit and site readiness (these are termed *EBP Funding Meetings*)
c. Development of a *Training Plan and Payment Agreement*, a living document that outlines the responsibilities of the provider agency, trainer, state agencies, and CEP-Va
d. A *Training Plan Finalization Meeting* where all parties listed above will discuss the Training Plan, make changes to adapt the plan to implementation site, and set a tentative date for training to begin
e. A kick-off organizational workshop that precedes practitioner training that centers referral brokers and their understanding of an appropriate referral and the enhanced reimbursement rate
f. A series of meetings to assess and document the first year of initial implementation that will indicate site viability and determine additional funding
g. Onboard of all trained practitioners into Virginia's EBP Practitioner Registry and collection of any required fidelity monitoring data.

Training Phases and Implementation Support

Phase I: Fit Assessment. To accomplish provider recruitment, a Request for Applications (RFA) process for Title IV-E Prevention Services Training Awards was developed. The process was initially designed to gauge provider interest in specific EBPs and pilot CEP-Va's fit assessment approach. Mid-way through 2022, the RFA portal transitioned to an ongoing submission portal for allocating training funds through individual awards to providers based on a set of criteria. Funding was also allocated through supplemental awards designated to strengthening a preexisting EBP team, if the EBP was included in Virginia's FFPP (see Table 5).

Table 5. EBPs eligible for a Title IV-Prevention Services Training Award

EBP	Description
MST	Multisystemic Therapy (MST) is an intervention for children 12-17. MST is intended for youth with conduct issues, truancy, law involvement, and poor parent mental health. Length of treatment averages 3-5 months.
FFT	Functional Family Therapy (FFT) is an intervention for children 11-18. FFT is intended for youth with substance use, disruptive behavior and conduct issues, depression, and family conflict. Length of treatment averages 4-8 months.
PCIT	Parent-Child Interaction Therapy (PCIT) is an intervention for children 2-7. PCIT is intended for youth experiencing defiance, aggression, extreme mood swings, ineffective social skills, and safety concerns. Length of treatment averages 6 months but depends on family progress.
BSFT	Brief Strategic Family Therapy (BSFT) is an intervention for children 6-17 and their family. BSFT is intended for families with dysfunctional family patterns and poor parent mental health. Length of treatment averages 3-5 months.
FCU	Family Check-Up (FCU) is an intervention for children 2-17. Family Check-Up is intended for any presenting problems where there is a lack of motivation for treatment and/or disengaged family members. Length of treatment averages 1-4 months.
HB	Homebuilders (HB) is an intervention for children 0-18. Homebuilders is intended for youth and families in crisis and/or unstable living conditions. Length of treatment averages 4-6 weeks.

An information session in February 2022 and a series of program-specific open house series in the following March were held to inform providers about the RFA process to apply for a Title IV-E Prevention Services Training Award. Awards were first granted to providers who were willing to be the initial Brief Strategic Family Therapy (BSFT) implementation sites for the state.

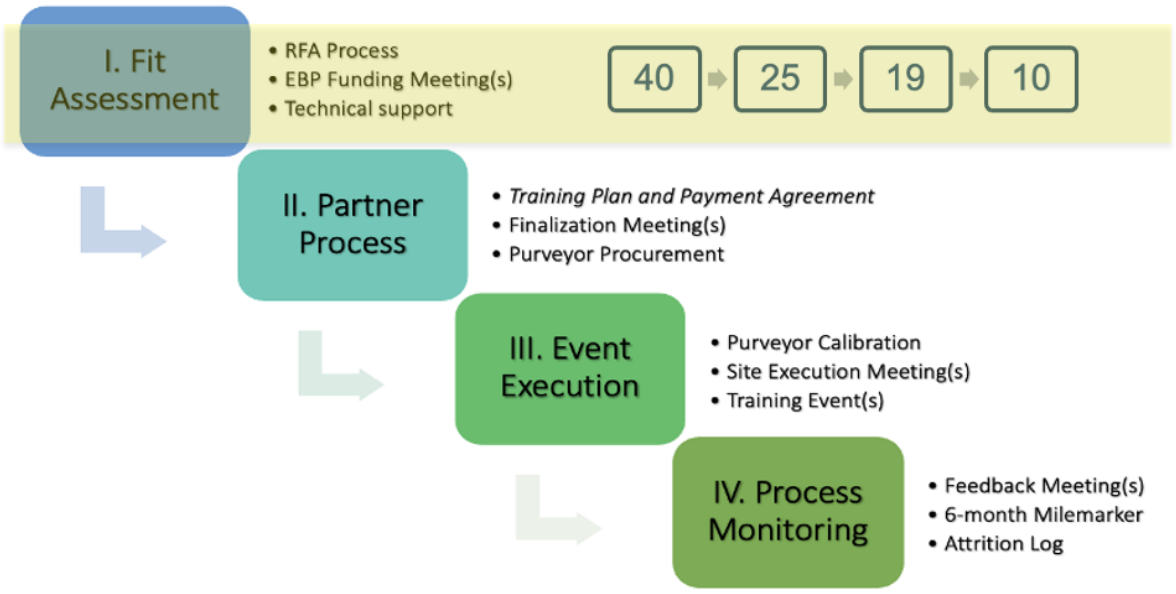
CEP-Va recommended BSFT as the first EBP in Virginia's plan to implement statewide to fill an age-based gap in the EBP array for the state–i.e., school-age children (6-18). BSFT has also been found to decrease caregiver substance abuse, which was found through NAGA 1.0 to be a substantial driver to foster care entry. The intervention has been found to be effective when delivered in multiple settings, most especially schools and in homes.

To access training funds, providers were required to demonstrate key factors associated with EBP readiness and implementation success, such as community need and capacity for the organization to support the new practice. Providers were also required to furnish a letter of support from their local DSS and/or Children's Services Act (CSA) Coordinator. A review panel of Center and VDSS staff reviewed all applications monthly. Once notified, successful applicants were required to attend at least one *EBP Funding Meeting* with Center staff to confirm components of

their application and assess fit of their selected EBP. Rapid turnover of staff eligible for training greatly protracted this phase.

As of December 2022, approximately 40 submissions were collected through the online RFA portal. Of these, 25 submissions were complete, or had all components that were requested to complete a submission packet. Nineteen providers accepted the opportunity to move forward into the next phase to verify practitioner eligibility and discuss funding and fidelity reporting requirements. Ten providers were able to secure the staff for full model implementation and training. Figure 3 depicts the provider procurement process, highlighted, within context of all Training Phases of the Center Standard Training Model.

Figure 3. CEP-Va Standard Training Model.



Phase II: Partnering Process. Once an EBP is selected, CEP-Va drafts a site- and EBP-specific Training Plan, a document designed to provide technical information as well as serve as a tangible representation of the planned, research-supported implementation strategy. Awards allotted to new implementation sites differ substantially from smaller supplemental pre-existing team awards, requiring a complex sequence of planning events and on-site implementation support; therefore, multiphasic training plans are only written for full implementation sites.

The CSB Investment Initiative (Project 1) helped Center researchers begin to understand the difficulty likely experienced by local referral brokers in search of providers. Regardless of whether a provider works closely with a given CSB, they are unlikely to be bound to the service coverage area of the CSB. CSBs are mandated to cover specific groupings of localities but the private providers with whom they contract are not. In an effort to enhance consistency and, in turn, community awareness of a service, Training Plans included formal requests to private providers

to expand their coverage area to an entire CSB catchment area. A provider's decision to do so increased their likelihood of receiving additional funding from VDSS post Y1.

Each Training Plan is designed to be a *working* compendium of information expected to evolve as implementation progresses. At minimum, all plans include training format, structure, and estimated timeline to reach competence in an EBP, reimbursement rate and training cost coverage, and important expectations of the provider to maintain certification. Most importantly, plans include individual roles and responsibilities of all parties (VDSS, Center, Provider, EBP Purveyor) before, during, and after initiation of training. The entire training process is discussed during the *Training Plan Finalization Meeting.* Once the Training Plan individualization is complete, approvals from all parties are collected and planning for training execution begins.

Over the course of 2022, a total of 10 training plans for 10 providers were drafted and individualized for full site training of a Family First EBP: BSFT (5), FCU (3), and PCIT (2). Total number of practitioners to be trained across all sites and EBPs was estimated to be 82. The number of plans that were able to be finalized, agreed upon and issued for execution was 8 by December 2022, with 51 practitioners available for training. As of January 2023, 3 providers paused plans for training indefinitely due to staff turnover and concerns around reimbursement.

Phase III: Event Execution. Training requirements, or what training specifically entails, differ across EBP models. EBP training typically includes two components: a workshop series and a consultation period that looks like intensive supervision + progress monitoring with outcome data. Initial training is followed by the EBP's purveyor version of a train-the-trainer site development phase, so that provider sites established through Family First transition into self-sustaining training sites. EBP purveyors remain connected to the sites they've trained indefinitely.

The first full site training event occurred in September 2022 for BSFT, followed by the second BSFT training that occurred in November 2022. As of December 2022, 14 practitioners initiated training. The third BSFT site began training in February 2023. Two full site trainings in FCU are scheduled to begin in March 2023. The first implementation site for FCU will be Horizon CSB which intends to train 25 clinicians and supervisors to work towards becoming a self-sustaining EBP training hub.

Phase IV: Process Monitoring. Implementing EBPs is complex given the many changing dynamics in provider companies. Evidence suggests that sustainment of EBPs is improved with prolonged engagement. Accordingly, CEP-Va remains engaged with providers with trained staff in several ways, through regularly scheduled check-ins and calibration meetings with trainers. A formal meeting six months after training begins is held with the provider, Center, VDSS, and EBP purveyor to review progress and discuss contingent allocation of additional funding post Y1.

As of early 2023, BSFT training began at three sites, across the Piedmont Eastern VDSS regions. All sites combined, 21 clinicians initiated workshop training beginning in September of 2022. As of February 2023, a total of 11 clinicians remain on track to complete training, equating to an

attrition rate of almost 50%. The following explanations were provided by provider and BSFT consultants as reasons for practitioner-employee departures:

- Competing job offer
- Outpatient therapy without having to adhere to an EBP protocol was more lucrative and less time-intensive
- EBP training requirements reduced time for reportable clinical hours needed for licensure
- BSFT supervision hours could not be counted toward supervision hours required for licensure
- BSFT supervision requirements were too intensive (i.e., trainees felt uncomfortable with heavy session monitoring from BSFT consultants (See *Terms Glossary* in Appendix 4 for definition of training terms)

Concerns for Sustainment

First, additional findings of pilot BSFT sites involved systems barriers that prevented provider sites from receiving appropriate referrals in a timely manner. The BSFT training model requires each practitioner-trainee carry a full caseload of families to learn and deliver BSFT with fidelity. All training sites experienced immense interest from referral brokers at initiation of implementation; however, referrals lagged substantially due to local-level contracting issues that appeared to differ across sites. Feedback reports from site leaders included the following commonalities:

- Arduous contracting procedures that differed across localities and FAPTs
- Insufficient and unreliable Medicaid reimbursements
- Inability to access enhanced Title IV-E rate (i.e., eligible families from local DSSs must be detected and caseworkers must undergo a new set of paperwork requirements associated with new 'in-home' model)
- Lack of CSA funding to support Title IV-E EBPs

Recommendation 5. Service Coordination Study.

CEP-Va recommends continued disbursement of EBP training funds through the phases described herein and in accordance with the Standard Center Training Model, with one caveat. **Further investment into EBP training should occur only within the context of an in-depth study into service coordination and referral processes at the local level.**

CEP-Va proposes a study on the service coordination teams in charge of making referrals at the local level, i.e., a *Service Coordination Study*. The unique intricacies related to how a family arrives at an EBP provider vary by funding stream as well as locality. A deeper analysis into the coordinating structures that involve all child-facing agencies in the state is strongly recommended, as these systems impact a family's path and ability to take advantage of an effective service. Results from this type of contextual roots analysis would permit CEP-Va and its funders to begin to organize localities and regions by the characteristics of their respective coordination procedures and develop guidance to improve assimilation of Title IV-E funding. If approved, CEP-Va would engage in the study in 2023, with results presented in early 2024.

Second, NAGA 2.0 initiation of Title IV-E funding for Family First EBP rollout was significantly impacted by staff turnover, or lack of capacity due to losing and then being unable to hire licensed

staff. Importantly, a pattern emerged for those practitioners who did not complete training and provider companies that decided not to move forward after applying and subsequently being offered training funds. Licensed clinicians, who have already received training in many of the principles and concepts embedded in EBPs, were torn between donating their time to the EBP and delivering outpatient services that earned them greater pay without having to change their practice. Even with the enhanced reimbursement rate and free training, many providers were unable to find a way to make the time investment worth the loss in billable outpatient hours.

Recommendation 6. Continued Regulation Study.

The Center's initial efforts to support the state's training goals necessitated an immediate closer look into trainee attrition and workforce supply. This was a driver for the focus of the Regulation Study, as initiated through the NAGA model of immediate response to an implementation barrier. The first phase of the Regulation Study began to explore the actual structures in place that influence the state's ability to leverage an entirely new funding stream to establish child welfare's stake in behavioral health service expansion.

The preliminary findings of this report as they relate to the regulatory context of the state are presented in Section 2. **The Center requests approval from VDSS to continue the Regulation Study past its initial phase by selecting areas for further examination as they are presented and described within the study's narration of findings.**

SEE SECTION 2 for NAGA-Indicated Regulation Study.

PROJECT 3: MOTIVATIONAL INTERVIEWING TRAINING

Project Activity

CEP-Va coordinated a process to select a company appropriate for large scale training of the VDSS workforce in Motivational Interviewing (MI). A Request for Applications announcement for an MI trainer was sent to all MINT (Motivational Interviewing Network Trainers) trainers and members. The application required that companies: (a) describe their training approach, (b) present a plan for sustainability, (c) use a fidelity measurement model, and (d) have experience with the child welfare system. The submission window was open from September 19th, 2022 to October 14th, 2022. Twenty-three applications from MINT trainers and members from various states across the US and Canada were received. Two workgroups were formed including VDSS and Center staff to review and score applications. Interviews were hosted by Center staff with each of the final four applicants with VDSS representatives present. The final selection was made in a meeting of VDSS leaders and Center staff in December 2022.

Next Steps

CEP-Va is working closely with VDSS and Sage to build out: (a) a phased training plan for all in-home workers, (b) a fidelity monitoring program to be implemented during the training phase and post training, and (c) intentional data collection before, during, and after training to gauge the effects of the training with the workforce. Furthermore, CEP-Va will work with VDSS to consider expansion of the MI training for other members of the VDSS workforce.

Section 2

REGULATION STUDY: Initial Phase

In October 2022 at the VACSB Public Policy conference, an executive-level behavioral health stakeholder shared their insight when they stated, “Regulations are a problem. They are inconsistent and confusing to most.” Much of the audience made up of Virginia behavioral health providers, CSBs, researchers, and additional state stakeholders nodded in agreement. Similarly, Center staff were experiencing challenges related to regulations in real time during the initial rollout of Family First EBP service expansion. Although several barriers have impeded the early stages of Family First implementation, regulations represented one of the most vexing.

The goals of the Regulation Study were to,

a. to examine existing regulations fueling the structure of Virginia’s workforce design
b. to illuminate barriers to effective EBP implementation and service delivery

This investigation into Virginia’s behavioral health workforce regulations was geared towards providing perspective for purveyors and state regulatory entities. CEP-Va was interested in understanding the state’s available workforce and their capacity to improve accessibility of services within the current regulatory environment. The recommendations that are proposed from this initial phase of study are based on preliminary data collected and presented herein. Feedback from our state partners will dictate the scope of further investigation in 2023 (see Recommendation 2.2).

Method

1. National and state-specific needs assessments and workforce reports were collected and contextualized with the reports in CEP-Va’s needs assessment library (see *Workforce Trends*)
2. Guidance disseminated by all regulatory bodies were reviewed, as well as other state equivalents (see *Regulatory Guidance*)
3. A series of interviews (n = 34) were conducted with individuals from the following groups,
    a. State employees,
    b. Providers with experience in EBP implementation,
    c. Local government employees,
    d. Individual practitioners with experience in EBP training and delivery

Procedure. State agency needs assessments and workforce reports from 2013-2022 were reviewed to detect recurring themes shared by more than one agency. Regulations related to licensing and scope of practice were examined and then cross-walked with other stakeholder state agencies that impact workforce and Medicaid reimbursement. Interviewees were recruited through snowball referral, and interviews ranged from approximately 20-90 minutes each. Given the sensitivity of content discussed, all interview notes were recorded without identifying

information (demographic information was not collected) and processed by the two doctoral-level research scientists at CEP-Va.

Importantly, a number of state regulatory and guidance changes happened to occur during the time interviews were conducted and, as such, vastly contrasting opinions of how these changes applied dominated and obfuscated interview content. Inconsistencies in interpretation of state regulations were so varied both across and within groups of interviewees that determination of a set of clear themes (such as those visualized in NAGA 1.0) was unattainable. Thus, information gleaned during interviews was used to provide historical context for which archival records were reviewed and were integrated into the preliminary hypotheses presented in the *Interpretation of Initial Findings* section. Direct quotes from these conversations have been included without identifying information.

Workforce Trends. The State Needs Assessment Information Library (SNAIL) was developed as a way for CEP-Va to synthesize various reports released by the child-serving agencies in the state. As an internal project, SNAIL is a knowledge bank used to build an understanding of context into Center activities. SNAIL is updated on an ongoing basis by Center doctoral students and include the following:

- 2022 CSB Behavioral Health Services Commission Draft, JLARC
- 2022 Assessment of the Capacity of Virginia's Licensed Behavioral Health Workforce, Virginia Health Care Foundation
- 2022 Service Gap Survey (2021 Follow-up), OCS
- 2021 Service Gap Survey, OCS
- 2021 Report on HB 728/SB 734 Children's Residential Workgroup, DBHDS
- 2020 Virginia Behavioral Health System Needs Assessment Final Report, DBHDS
- 2020 Review of the Children's Services Act and Private Special Education Day School Costs, JLARC
- 2019 Listening Tour Report, Virginia HEALS project / Linking Systems of Care
- 2018 Virginia Behavioral Health Redesign Stakeholder Report, DMAS/DBHDS
- 2018 Virginia Statewide Substance Abuse and Behavioral Health Needs Assessment, OMNI Institute/DBHDS
- 2016 Juvenile and Criminal Justice Outcomes of Youth Completing Services through the Children's Services Act, OCS
- 2015 Child and Youth Crime Victims Stakeholder Survey, Virginia HEALS
- 2013-2022 Virginia's Licensed Clinical Social Worker Workforce Reports, DHP
- 2013-2022 Virginia's Licensed Clinical Psychologists Workforce Reports, DHP
- 2013-2022 Virginia's Licensed Professional Counselors Workforce Reports, DHP

Regulatory Guidance. A number of public regulatory documents issued by several state-level bodies were reviewed for the purposes of the Regulation Study. Agencies most involved in behavioral health service provision and payment for youth and families were included in this initial phase of CEP-Va's review, and comprise of:

a. DHP
b. DBHDS
c. DMAS

These entities absolutely shape the service landscape for families most likely to experience public systems involvement and present for essential services at CSBs. State laws for health professions contain scopes of practice, establish requirements for licensure, and grant authority to regulatory boards that then have the power to write regulations for how to implement those laws. Health regulatory boards also determine the administrative procedures for implementing regulations and laws, such as license applications and renewals.

Department of Health Professions. DHP, is an Executive Branch agency located in the Health and Human Resources Secretariat. DHP licenses and regulates over 500,000 healthcare practitioners across 62 professions in the state of Virginia. Their mission is to, "ensure safe and competent patient care by licensing health professionals, enforcing standards of practice, and providing information to health care practitioners and the public."[5] DHP is responsible for 13 regulatory boards, including the Board of Counseling, the Board of Psychology, and the Board of Social Work.

The Board of Counseling houses existing laws and regulations for six licenses (Licensed Marriage and Family Therapists [LMFT], Licensed Professional Counselors [LPC], Licensed Substance Abuse Treatment Practitioners [LSATP], Resident in Counseling, Resident in Marriage and Family Therapist, and Resident in Substance Use Treatment), three certifications (Rehabilitation Providers [CRP], Substance Abuse Counselors [CSAC], and Substance Abuse Counseling Assistants), and two registrations (Qualified Mental Health Professional [QMHP], Registered Peer Recovery Specialist [RPRS]). The Board of Psychology oversees five licenses (Applied Psychologist, Clinical Psychologist, School Psychologist, School Psychologist-Limited, and Sex Offender Treatment Provider) and the Board of Social Work oversees three licenses (Clinical Social Worker, Baccalaureate Social Worker, and Master's Social Worker) and two registrations (Associate Social Worker and Registered Social Worker).

Department of Behavioral Health and Developmental Services. DBHDS, is the governing body for behavioral health and developmental services in the Commonwealth of Virginia. At the state level, DBHDS oversees and funds the 40 CSBs designated to serve as the single point of entry for publicly-funded behavioral health services. In 2017, legislation associated with STEP-VA enacted a new requirement for CSBs to provide nine new services when before only emergency services were mandated by law. Then in 2019, a new state law required CSBs to provide same-day access to screening services.

A key relevant function of DBHDS for this study is the agency's role in licensing providers for each numerous service type (see here and here). DBHDS licenses companies/organizations such as CSBs and private providers, and not individuals, who provide an array of services in the behavioral health space. Regulations clearly state that they do not include in their definition of provider *any individual practitioner who holds a license issued by DHP*. DBHDS license types include outpatient, intensive-in home, residential treatment, case management, day treatment, inpatient

[5] Virginia Department of Health Professions - Licensing Health Professionals. (n.d.). Retrieved February 24, 2023, from http://dhp.virginia.gov/index.html

psychiatric, substance abuse outpatient, mental health community support, and more than a dozen more.

Department of Medical Assistance Services. DMAS regulates reimbursement of services covered by Medicaid. A critical role played by DMAS is in its definitions of service types and their billing rates, a process largely governed by federal law and regulations through Centers for Medicare and Medicaid Services (CMS). Although DMAS is not the only payer of behavioral health services in Virginia, it did account for more than $1.3B of expenditures in FY2022. Nationally, Medicaid accounts for almost 25% of behavioral health and substance use treatment expenditures. As a result, DMAS is a key economic driver of behavioral health services in the state. The basic process established by DMAS for billing for behavioral health services is as follows:

1. Appropriate licenses must be in place (from DHP and from DBHDS)
2. Provider must be an enrolled Medicaid provider
3. For most (if not all) behavioral health services, a service authorization is required from the Managed Care Organization (MCO)

Prior authorization for a service is a requirement to obtain approval from a MCO, and the *consumer* cannot receive care until the request is approved. DMAS has contracted six MCOs to provide access to care for Medicaid patients across Virginia. Each of the state's 40 CSBs must individually deal with the paperwork of as many as six MCO, when before they only had to claim through DMAS. See JLARC (2022) Chapter 5: Medicaid Funding for CSB Behavioral Health Services.[6]

Preliminary Findings

Common challenges shared by past needs assessments that include mention of workforce ***and*** shared by more than one agency include:

- Lack of funding to offer competitive pay
- Increased practitioner credentialing requirements and burdensome licensure process, lack of regulation alignment across agencies
- Lack of consistent, sufficient, and affordable resources, training, and education for behavioral health professionals throughout the Commonwealth
- Aging workforce and high percentage of professionals set to retire soon with insufficient number of replacements
- Need for more care navigator or peer/family support roles to help families navigate through services
- Increase in burdensome, redundant, and inconsistent documentation needs for clinicians, prescribers, and support staff, most especially for CSBs

[6] *CSB Behavioral Health Services Commission Draft*

National data provide additional context for understanding state and local concerns. According to the most recent (2021) large-scale surveillance report on mental health care access, Virginia ranks **39th** among US states for mental health worker availability,[7] This ranking is based on the number of psychiatrists, psychologists, Licensed Clinical Social Workers (LCSW), LPCs, MFTs and advanced nurse practitioners physically present in the state during 2021. The term *availability*, versus accessibility, is important here, given that we do not know whether these practitioners were actively seeing patients and, if so, accepting insurance during that time. In Virginia, the individual patient to practitioner ratio is 480:1, compared to the national average of 350:1. For 2020 and 2021, Virginia ranked **48th** out of all US states for overall accessibility to care for youth, indicating that youth in Virginia exhibited a higher rate of mental illness during that time paired with greater difficulty accessing care for their symptoms.

The Healthcare Workforce Data Center (HWDC) is part of the DHP, to collect and analyze data on the supply and demand of the health professions workforce. The HWDC profession reports provide profession-by-profession information collected via survey of the licensed workforce and are published each year. Interestingly, HWDC workforce reports indicate a steady *increase* in the number of licensed behavioral health professionals in Virginia. Within the past decade, the number of licensed clinical psychologists (LCP) has increased by 25%, LPCs by 66%, and LCSWs by 39%. However, it is important to note an increase in volume of professionals does not indicate an increase in workforce capacity. Growth must be examined within the context of population growth, and national data tell us that the patient to practitioner ratio in Virginia indicates less capacity than the national average.[7]

HWDC profession workforce reports also show that there are notable regional and workplace type differences in the licensed workforce. Consistent among LCPs, LPCs, and LCSWs, there has been negligible growth of the workforce outside of urban areas of the state. That is, growth in the licensed workforce has been only observed in the most urban and populated regions of the commonwealth. Further, the large majority of licensed professionals in the state across all three professions work in group or solo private practice settings instead of CSBs, outpatient mental health facilities, or governmental agencies. Departure to the private sector has been a growing trend, as documented by DHP data. **As of 2022, approximately 60% of Virginia's licensed workforce reported to provide services out-of-pocket (i.e., cash or self-pay), 45% accept private insurance, and fewer than 30% accept Medicaid.**

[7] Reinert, M, Fritze, D., & Nguyen, T. (October, 2022). *The State of Mental Health in America.* 2023 Mental Health America, Alexandria, VA.

Study Pivot Point
The behavioral health practitioner workforce in the state of Virginia includes both licensed (or *license-eligible*) and unlicensed (*license-ineligible*) professionals. The data tell us that the licensed workforce is experiencing an unprecedented explosion of opportunity and latitude in their roles. Some of this has to do with emergency orders due to COVID, but the exit from positions that require a clinician to treat families in their homes had been occurring long before 2020. **The licensed workforce has been for several years transitioning away from serving the Medicaid population as the demand for behavioral health as well as the number of families willing to pay out of pocket has increased.** This trend is not one that can be corrected nor reset without significant structural changes to how we train, compensate, and maintain these workers in positions outside of the comfort of their homes and the freedom that not having to claim for reimbursement allows. If this level of transformation cannot happen expeditiously, then alternative options should be explored.

Because of these findings, regulation review was narrowed to those individuals most likely to serve the population of Virginians unable to access private practice or pay out-of-pocket for care: QMHPs.

State Regulatory Environment and QMHPs
For the first phase of the Regulation Study, we focused on the roles and perceptions of three state agencies: DHP, DBHDS, and DMAS, with an emphasis on their involvement in overseeing the QMHP workforce. QMHPs in Virginia are required to abide by sets of regulations authored by DBHDS, DHP, and DMAS to render services, maintain their QMHP designation, and reimburse for services. QMHPs do not represent the only workforce providing services reimbursed through Medicaid; however, their title and registration status originated in DMAS.

The following sections detail each agency's regulatory role with regard to QMHPs. Subsequently, the section titled Interpretation of Initial Findings dives deeper into how these different sets of rules combine to impact the overall mental health workforce.

DHP. DHP's Board of Counseling provides regulatory oversight for Licensed Mental Health Professionals (LMHP) and QMHPs. The oversight of the QMHP workforce transferred from DMAS to DHP and the Board of Counseling in 2019 with the stated goals of quality control and public safety. Current regulations provide guidance for the practice, certification, or registration of practitioners whose services fall under the definition of *counseling*.

The Board defines counseling as,

…the application of principles, standards, and methods of the counseling profession in (i) conducting assessments and diagnoses for the purpose of establishing treatment goals and objectives and (ii) planning, implementing, and evaluating treatment plans using treatment interventions to facilitate human development and to identify and remediate mental, emotional, or behavioral disorders and associated distresses that interfere with mental health.

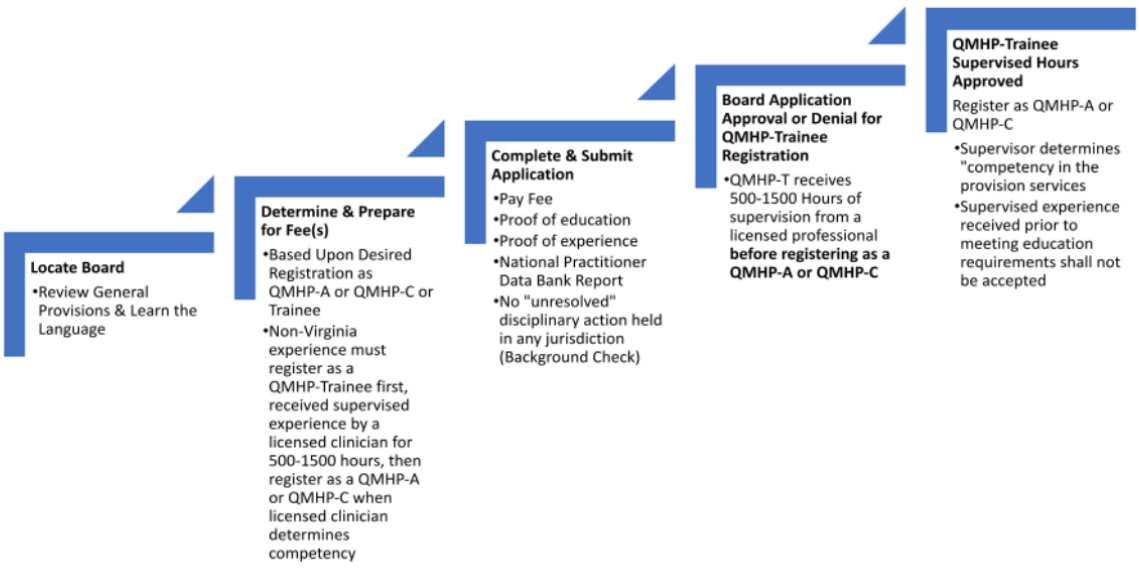
DHP via the Board restricts counseling practice to licensed or licensed-eligible practitioners. The Board defines a QMHP's scope of practice to consist solely of ***collaborative mental health services*** [emphasis added], further described to mean,

…those rehabilitative supportive services that are provided by a qualified mental health professional, as set forth in a service plan under the direction of and in collaboration with either a mental health professional licensed in Virginia or a person under supervision that has been approved by the Board of Counseling, Board of Psychology, or Board of Social Work as a prerequisite for licensure. 18 Va. Admin. Code § 115-80-50

Both masters-level and bachelors-level professionals register as QMHPs. MA-level QMHPs must have a graduate degree in psychology, social work, counseling, marriage and family therapy, special education, or an adjacent human services field. BA-level QMHPs are allowed to have a greater range of degree disciplines if accompanied by 15 hours in a human service field. Licensed RNs and OTs qualify for QMHP registration. Full registration status requires a number of supervision hours that ranges from 1,500 to 3,000 depending on degree and must occur within a 5 year period. Applicants with a master-degree in psychology, social work, and aligned fields can waive the supervision requirement with proof of "500 hours of experience with persons with mental illness." Supervision "shall consist of face-to-face training in the services of a QMHP until the supervisor determines competency in the provision of such services, after which supervision may be indirect in which the supervisor is either onsite or immediately available for consultation."

QMHPs register as either a QMHP-C, for *child*, or a QMHP-A, for *adult*. Before reaching full QMHP registration status, applicants must collect supervision hours as a registered QMHP-Trainee. These applicants are referred to as QMHP-Trainees (QMHP-T) by DHP, but as QMHP-Eligible (QMHP-E) by DBHDS and DMAS. Supervision hours, regardless of whether multiple family members are present or the family system as a whole is being treated, can only be counted toward one registration designation or patient category: Adult or Child. If a person is required to have both A and C designations for their work, they must complete the registration process for each in full. Despite the two designations, QMHPs who are both QMHP-A and QMHP-C are only required to satisfy the continuing education requirements for one per year, which is 8 CEs.

Figure 4. QMHP Registration Path (18 Va. Admin. Code § 115-80-10)



DBHDS. QMHPs are relegated to specific locations, as regulations state QMHPs "shall provide such services as an employee or independent contractor of the [DBHDS] or the Department of Corrections, or as a provider licensed by [DBHDS]." DBHDS provides the oversight for mental health services while DHP issues the designation of QMHP to persons who complete the application process and are approved to register with the Board of Counseling as a QMHP-A, QMHP-C, or QMHP-T.

Beginning in 2019, DBHDS regulations caution providers of the potential for citations if a provider fails to verify employees' QMHP designation through DHP's registry. According to 18 Va. Admin. Code § 115-80, a QMHP's purpose is to provide *collaborative mental health services* for adults and children. DBHDS is involved because DHP allocates QMHPs to service categories that their employer is licensed by DBDHS to provide. A person with the QMHP designation is not permitted to render service autonomously or practice independently (i.e., without supervision), regardless employer DBHDS licensure status.

Out of the service categories licensed through DBHDS, QMHPs are allowed to render services within specific delineated service categories according to their -A/C classification. QMHP-As are allocated to Mental Health Skill Building, Partial Hospitalization or Day Treatment, Crisis Stabilization, and Psychosocial Rehabilitation. QMHP-Cs are allocated to provide Intensive In-Home and Therapeutic Day Treatment.

DBHDS also embeds supervision requirements into licensed service categories for QMHPs, LMHPs, and Supervisees/Residents, in addition to those set by DHP. QMHP-T/Es are allowed to provide any of the aforementioned services under supervision while working towards registration as a QMHP-A or QMHP-C, and QMHP-As are included in the group of permitted supervisors for

QMHP-Ts. According to DBHDS guidance titled *Licensing Intensive In-home Services*: “A QMHP who is not a LMHP or Supervisee/Resident can provide administrative supervision only. They cannot provide clinical supervision.” Additional information that delineates these two types of supervision could not be found within the timeline of this initial study phase, but it may not matter given the great latitude supervisors are granted by DHP/BoC to discontinue regular supervision once they determine QMHP-supervisee competency.

It may also be important to note that QMHPs can supervise QPPMHs, or Qualified Paraprofessional(s) in Mental Health. QPPMH is a practitioner category monitored by DBHDS only, as they are not included within DHP’s list of health professionals for oversight. QPPMHs must have an associate’s degree in a mental health related field and “a minimum of 90 hours classroom training and 12 weeks of experience under the direct supervision of a QMHP-A providing services to individuals with mental illness.” (12VAC35-105-20) DBHDS also monitors Peer Recovery Specialists (PRSs), who *are* included in DHP’s purview and requirement for registration. In contrast to QMHPs, PRSs are not required to have any type of formal education degree but must undergo 60 hours of direct instruction provided by a PRS authorized by DBHDS to train. PRSs and QMHPs share a similar scope of practice to provide collaborative services to assist individuals with mental illness.

DMAS. Beginning in 2019, DMAS began to require QMHPs to be registered with the Board of Counseling to be reimbursed for services. DMAS sets the policies and parameters on the circumstances in which services can be billed for, making the agency’s role a critical one in understanding the workforce landscape because these policies guide how behavioral health companies design their business models and practices. Specifically, state-set reimbursement should include consideration for

- Overall system goals and strategies to promote cost-effective care
- Intended delivery and desired outcomes of the service
- Ensuring payment rates are sufficient to enlist enough providers and are not excessive to incentivize over- or under-utilization of other services

If services are rendered by a QMHP but are required to be conducted by a licensed professional, then the service will not be reimbursed; however, QMHPs can claim and be reimbursed for services they are allowed to deliver. As previously mentioned, DBHDS sets which services, or service categories, QMHPs can deliver, such as Intensive In-home, for instance. DMAS has its own set of specifications for how activities within a DBHDS service category can be administered, and by whom, in addition to DBHDS. For the Intensive In-Home service, counseling is named as an essential component of the service, but counseling can only be conducted by a licensed or licensed-eligible individual according to DHP and to be reimbursed through Medicaid according to DMAS.

Interpretation of Initial Findings

One resulting and critical challenge of the complexity of regulations for behavioral health service delivery is that without excellent cross-agency communication, there is room for considerable confusion for all involved participants in the system. Our review of regulations related to QMHPs

is a prime example; confusion about who is permitted to provide and bill for specific services is a pain point in the system. Because there are multiple ways services can be labeled across agencies, some of which are open to interpretation, the need for cross-agency coordination and revision is high. However, state agencies are often not able to be as nimble as would be ideal, resulting in challenges for behavioral health providers and their clients. In the following sections, we highlight areas in need of additional clarity; these have been organized by a recommendation as section header for each.

Finding 1: QMHPs are a poorly understood workforce.

Although introduced in DHP in 2017 as a formal role, Qualified Mental Health Professionals (QMHPs) have been a plentiful and critical part of Virginia's behavioral health workforce. Although registration has provided some data on QMHPs in the state, data about them remains scarce. In this section, a few findings related to QMHPs are reviewed.

1. QMHPs have been estimated to tally approximately 19,000 in the state; however, this number is virtually unknown as it relates to licensed practitioners. This is because many licensed practitioners also hold a QMHP registration, and the extent of that overlap is unclear. CEP-Va maintains a practitioner database for a project outside of the NAGA umbrella. Of a sample of 70 licensed practitioners in the EBP Directory, 44% also held an active or expired QMHP registration. Residents of counseling were most likely to have both registration and licensure statuses.
2. If QMHPs do not represent a distinct group of individuals, then it's possible QMHP registration operates as a step that clinicians under supervision for licensure go through in order to bill for certain services when in training. For instance, MSWs in particular appear to have a clear QMHP path built into their degree. Further, CSBs remain the staple training hubs where practitioner-supervisees gain experience and hours toward licensure, as well as the entry point for uninsured community members—many of whom under emergency provisions newly qualify for Medicaid coverage—for services reimbursable by QMHPs. The evidence is too preliminary to say with confidence, but **QMHPs and LMHPs are unlikely to constitute discrete groupings of *unlicensed*, *license-eligible*, or *license-eligible* individuals.** More likely, they represent developmental phases within an individual's professional trajectory to independent practice.
3. What is known for certain is that QMHPs largely represent the workforce entering families' homes and were described as likely to do so widely outside of the CSB setting. Interview content included certainty that QMHPs make up the primary practitioners employed by private companies who may not be licensed by DBHDS, or are licensed but also provide services outside of the DBHDS service category structure. These providers functioning outside of the DBHDS licensing arena may believe to provide oversight to contracted QMHPs under the coverage of their DHP license. Interviewees at the local level were more likely than those at the state level to be aware of this reality, as many state-level representatives reported to believe QMHPs are restricted to CSBs and large providers of intensive services covered by Medicaid. It's possible that private companies that employ QMHPs without a DBHDS license are within their right to do so, as regulations are unclear (see Finding 2.1).

4. The BoC does not track supervisors of QMHPs over time; only at certain points in the registration process. This level of oversight seems insufficient given that QMHPs are allowed to supervise other professionals, such as QPPMHs and QMHP-Es. For QMHP's own supervision, DHP permits relaxation of oversight once a supervisor determines competency, after which supervision is downgraded to being available for consultation.

Consequences of these findings include:

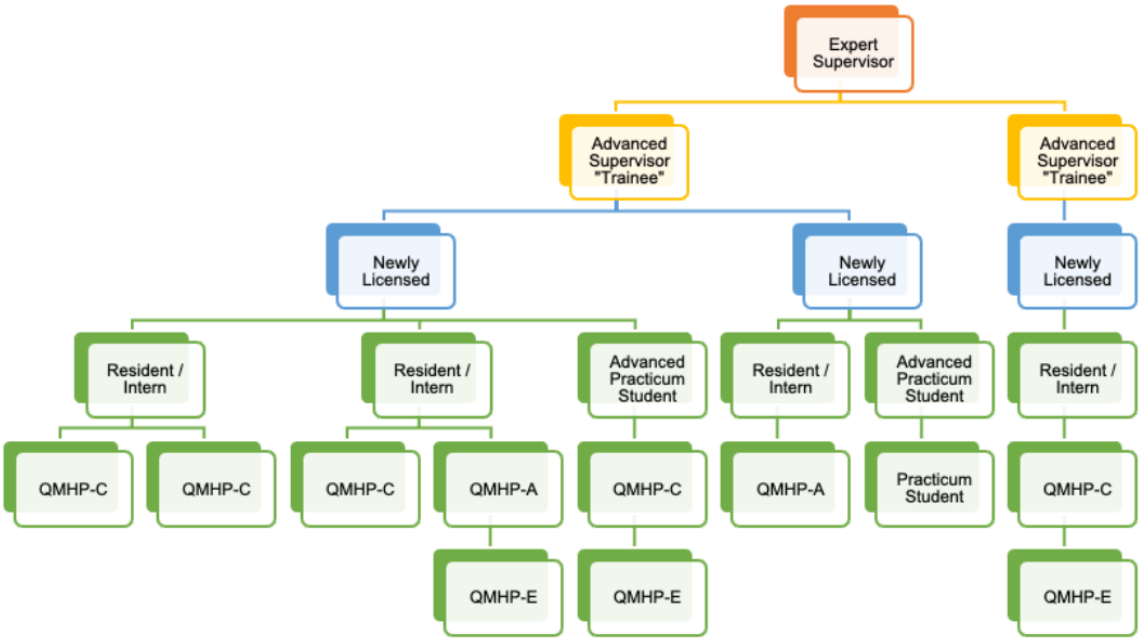
1. There's potential that the pre-registration step of QMHP-E, the dual registration procedures of QMHP-C and QMHP-A, in combination with the additional set of supervision requirements for licensure creates a slog in the workforce pipeline. Despite the protracted process, supervision practices are not required to differ or adapt to the developmental level of any supervisee, license-eligible or not. Without evidence to support such requirements, the path to licensure may include unnecessary steps unknown to state regulatory bodies within an already steep requirement schedule for pre-licensure post-graduate training.
2. DBHDS has a heavy role in setting the supervision parameters of QMHPs (as well as QPPMHs and PRSs). These requirements in conjunction with DHP's define the type and quality of supervision received (hence, learned) and, in turn, delivered to others. DHP regulations delegate the power of determining competency to individual supervisors, to the extent of permitting QMHPs essentially to practice without oversight. DMAS regulations allow unlicensed supervisees to make this determination. Within context of other regulations, DHP may be inadvertently delegating significant authority to the QMHP, as their supervisory protocol includes two underlying assumptions:
    a. QMHPs are able to attain competency, and therefore practice without routine oversight, because LMHPs share a common understanding of competency
    b. QMHPs are able to assess properly when it is time to reach out for consultation. In other words, QMHPs are expected to self-regulate (and ensure public safety from themselves).
3. Because of the supervisory roles permitted by DBHDS, the trust allotted to supervisors by DHP, and the leniency allowed by DMAS toward license-eligible (but not yet licensed) supervisees, it is possible that several individuals are providing behavioral health services across a variety of settings without structured oversight.

Recommendation 7. QMHP Study.

CEP-Va recommends an in-depth study on the QMHP workforce with the aim to improve applicability and impact of BoC regulations. If permitted by governance committee partners, CEP-Va could collaborate with DHP/BoC in such a project. Also, the project could be folded into the work of other initiatives underway dedicated to workforce. Study activities with the objective of characterizing the QMHP workforce include the following,

- Conduct a survey with the QMHP workforce that collects demographics, educational and experience background, in addition to any other information to help begin to characterize the overall group
- Perform follow-up interviews to confirm emerging group characteristics
- Collect any additional data necessary to begin to determine whether sets of characteristics are present within the population as a whole
- Determine number of subgroups based on relationships among and between group characteristics
- Reexamine potential for reclassification of QMHP workforce, or clarification of existing delineations, based on emergent subgroups (i.e., is the -A/-C dichotomy warranted?), with the goal of removing unnecessary paperwork and extra steps to full licensure

Figure 5. Example Supervision Cascade to Enhance Capacity of Licensed Workforce



Recommendation 8. QMHP Supervision Capacity Building.
CEP-Va encourages DHP and DBHDS to work together to enhance supervision capacity, possibly in partnership with CEP-Va. The work is recommended to begin with CSBs or private providers affiliated with CSBs. Supervision expectations must first be determined and then standardized for each level of the workforce regardless of a licensure or discipline's guild. For instance, LCSWs appear to have more stringent requirements than all other professions at a commensurate level, with QMHPs having the least. Potential areas to explore include, but are not limited to the following:

- Develop a multi-tiered supervisory structure, or supervision cascade (e.g., more experienced supervising less experienced practitioners in chains of 3-4, creating multiple layers of supervisory oversight for cases seen by unlicensed practitioners); See Example below
- Develop guidance for agencies that support supervision best practices in combination with incentives for "proof of use"
- Develop guidance for Board applicants on their rights to competent supervision, decision-trees for when to request supervision/consultation, and supervisory contracts
- Develop a supervisory directory for individuals to seek out supervisors based on areas of expertise for case consultation
- Develop a path that allows expert consultation (i.e., external supervision) hours to be counted toward licensure/registration requirements to supplement regular supervision
- For DHP/BoC in particular, raise minimum supervision requirements of unlicensed workforce to routine supervisor contact and remove option for "on call" supervision (or stepped path that requires regular proof of competency)

Finding 2: Inconsistencies in language across agencies creates confusion related to mental health service delivery.

Language used across agencies is at times inconsistent, resulting in confusion for multiple stakeholder groups (e.g., public, provider companies, state regulators). Examples of confusion are listed in abridged form below. See Appendix 2 for a preliminary content analysis.

1. Use of the term *provider* to refer to a company (e.g., DBHDS) and a person (e.g., DBHDS, DMAS).
2. Use of the phrase Mental Health Professional by DHP to refer to any licensed person despite the existence of the QMHP role, which references an unlicensed person.
3. Lack of clear guidance on the roles permitted to QMHPs given potentially conflicting language about their scope across agencies. Per DBHDS, QMHPs can provide treatment and therapeutic interventions. Per DHP, QMHPs may NOT engage in counseling practice. However, DHP includes treatment interventions in their definition of counseling. DMAS guidance reflects similar incongruence with DHP terms.

Consequences of these inconsistencies include:

1. Possible loophole for provider companies to avoid DBHDS licensure.

2. Confusion among the public, who may view the QMHP title as meaning something different from what the regulations state.
3. Confusion among provider companies about the appropriate role for QMHPs.

Recommendation 9: Ontological Alignment.

DHP and the BoC are encouraged to clarify further their definition of *counseling* in addition to the components used in the definition of that word. Reaching consensus of common terms such as *assessment*, *diagnosis*, *therapy*, *treatment,* and *intervention* is also strongly recommended. All state agencies are strongly encouraged to use the same language and definitions for protected terms, to compile one standard glossary that is hierarchical – also referred to as an *ontology*.[a]

Ontologies are arranged from general to specific terms that create a foundational touch point for understanding what is being requested, expected, and eventually reimbursed. For example, *activity scheduling* is a *practice element*, or skill, used by a practitioner. Its parent term, in accordance with the current evidence, is behavioral activation. Below is an example that could become an excerpt in a complete ontology:

Counseling:
1. *Treatment intervention*
    a. *Behavioral activation*
        i. *Activity scheduling*

Recommendation 10: Regulation Audit.

A comprehensive investigation or audit of all behavioral health profession regulations governed by all three boards to determine inconsistencies and whether each licensed, certified, or registered class of professions meets the criteria set by the Board of Health Professions for guiding regulation decisions readopted in 2019.[b] The following areas are proposed for additional inspection and/or clarification within context of the current workforce crisis and the evidence to date that supports their continuation:

- Bachelor-level professionals who are license-eligible, and other exceptions to the practice status categories of licensure, certification, and registration
- How scopes of practice are defined and whether clear delineations across the professional guilds are warranted (e.g., who can provide supervision)
- Limits related to time and expiration of supervisory hours, or other resource intensive requirements (i.e., exams)

a. Michie, S., West, R., Finnerty, A. N., Norris, E., Wright, A. J., Marques, M. M., ... & Hastings, J. (2020). Representation of behavior change interventions and their evaluation: Development of the Upper Level of the Behaviour Change Intervention Ontology. *Welcome Open Research*, *5*(123), 123.

b. 75-2 *Policies and Procedures for the Evaluation of the Need to Regulate Health Occupations and Professions*, revised February 25, 2019 (begin at p. 6)

Study Pivot Point
In addition to state regulatory bodies, interview findings necessitated including EBP purveyors as another main contributor to the state's regulatory environment.

Finding 3: State initiatives and federal programs designed to increase EBPs highlight key regulation-related workforce challenges for Virginia

In the late 2010s and early 2020s, the commonwealth embarked on several initiatives related to widespread implementation of EBPs, including the Behavioral Health Redesign for Access Value & Outcomes (Project BRAVO). Further, the 2018 federal law called the FFPSA has prompted Virginia (and all states) to build out EBPs in the child welfare space. Many of the EBPs to be implemented have been studied for decades and have long-standing training models, models that provide yet another set of guidelines for the qualification of a practitioner to deliver a particular service. In many cases, the empirical literature has demonstrated that when properly supervised, practitioners delivering an EBP need not be licensed to achieve the same results as licensed individuals.[8]

EBP Purveyors. Program developers, trainers, or vetted spokespeople who represent an evidence-based program, its developers, or certifying entity, and have a clear stake in how the program is delivered. Because purveyors typically operate across state and country lines, they build their own set of policies governing who is eligible to be trained and deliver the services contained in their programs. To the extent that these policies are less restrictive than state (and federal) regulations related to licensure or billing, problematic questions emerge for provider companies and state policy makers. As one example, if Program X states that one need not be licensed to be trained in (and thereby deliver) the program but the state regulations require a license, a challenging bind emerges. An expert treatment model developer that has studied the model extensively in controlled studies has determined the level of experience needed to deliver the treatment but the state regulation prevents some forms of that delivery based on unclear evidence.

Some details on EBPs are relevant. First, for this report, the focus is on EBPs–that is programs with a considerable evidence base recognized by one or more clearinghouses of such treatments. It would be obviously problematic to change state policy or regulations based on a company's policy in the absence of strong evidence to do so.

Although EBPs vary across many dimensions (e.g., theoretical model, treatment delivery approach), they share in common a rigorous and often phased training approach used to ensure fidelity to the model. Training often involves both didactic and rehearsal components and is often spread across multiple days. Most EBPs also involve ongoing (and costly) supervision and consultation throughout a training period of six to twelve months. In many EBPs, the consultation

[8] *Ex.* Lau, A. S., Lind, T., Motamedi, M., Lui, J. H., Kuckertz, M., Innes-Gomberg, D., ... & Brookman-Frazee, L. (2021). Prospective predictors of sustainment of multiple EBPs in a system-driven implementation context: Examining sustained delivery based on administrative claims. *Implementation Research and Practice*, *2*, 26334895211057884.

period continues indefinitely. For most of the EBPs, there is also ongoing fidelity measurement that is used as immediate and developmental feedback for the practitioners who are being trained. The fidelity measurement feedback system is an ongoing process for many EBPs even after the initial training period. Last, many EBPs require a site or individual license or certification to be considered an official provider of the EBP. Further, these licenses or certifications must be renewed annually, often requiring demonstration that service quality standards are being maintained.

As such, most EBPs possess intensive quality assurance procedures designed to keep each practitioner faithful to the model. As a result, practitioners delivering EBPs are under a level of supervised scrutiny not found in most other practice settings (e.g., intensive in-home services). See Table 6. For this reason, many EBP purveyors have set their minimum training and experience thresholds for practitioners at lower levels than many states have established for providing services like those found in the EBP. In this way, the data used by EBP purveyors to support their policies about experience and training level needed to deliver the program serve as *potential justification for states to consider relaxing their own regulations requiring practitioner licensure to provide certain EBPs*, a point we return to in our recommendations.

Table 6. Most common supervisory components embedded into EBPs

Evidence-based supervisory component(s)	Definition
Live supervision + immediate feedback	Supervisor observes session live and provides immediate feedback to supervisee
Video recording review + in real time feedback	Supervisee records video of the session and supervisor provides feedback to supervisee while they review the recording together
Video recording review + delayed feedback	Supervisee records video of the session and supervisor reviews at a later time and provides feedback
Audio recording review	Supervisee records the audio of a session and supervisor reviews at a later time
Skills practice: Role-play	Supervisor and supervisee engage in a role-play so that supervisee can rehearse specific skills
Skills practice: Modeling	Supervisor shows supervisee how to deliver specific skills by modeling them first
Assessment data review / progress monitoring	Supervisee collects assessment data from clients and supervisor reviews this data over time to track client progress
Case notes review	Supervisee writes notes about the session or case and supervisor reviews these notes

Note. Listed in rank order from most to least intensive.

Virginia Case Study. Evidence-based programs are not new to Virginia. Reportedly, MST has been accessible to CSB-referred families for decades. In 2016, availability of these high-quality services increased when the Department of Juvenile Justice (DJJ) invested in their youth population and set up a coordinated system of certified MST and FFT teams across the state. Primarily QMHPs staffed these teams under a multi-layered supervision structure. EBP expert-consultants trained administrative staff and organization leaders through a parallel program development process (4-6 months to complete). Once providers and their staff made it past initial training, sites became licensed and their teams certified. Ongoing support and monitoring were provided through a highly structured quality assurance process and a booster workshop schedule that all QMHPs were required to attend quarterly. Measurement outcome data reflected good outcomes and these data were fed back to licensed sites through regional consultants and team supervisors.

In 2021, as part of the rollout of Project BRAVO, DMAS issued a new requirement for MST and FFT teams to be reimbursable through Medicaid. The other option for these families was and still is intensive in-home programming, a broad service category without baseline practice sequences, training or documented supervision procedures, treatment principles or basic standards of care. Since both EBPs were delivered through a traditional in-home model and team-based, QMHPs filled these positions prior to DMAS's announcement. Regardless of whether providers had met all of the EBP purveyors' requirements, QMHPs were newly restricted to one position on EBP teams of 3, or 33% of any team makeup. At least two team members were then required to be licensed (i.e., LMHPs). Almost immediately after the 33% rule was announced, many teams disbanded and care was reportedly disrupted for families before treatment completed. One interviewee estimated that "for every QMHP that left, 10 families were left hanging."

EBP team-based models typically require practitioners to be designated to the EBP full-time, and this is the case with MST. Fully salaried practitioners on certified teams were blocked from practicing any other modality than the EBP. Purveyors also require teams to be fully staffed to deliver the model with fidelity; therefore, members of incomplete teams were required to wait for their employers to hire licensed clinicians. Providers reported unprecedented difficulty securing licensed staff, and the licensed practitioners they could secure were barred from providing any other service. Further, providers with understaffed and inactive teams were not exempt from annual licensing and consultant fees required to maintain their EBP site license.

Mid-way into 2022, MST and FFT expert consultations reported more than half of EBPs teams were understaffed. Incomplete teams impacted service utilization rates, despite extensive waitlists. A timeline of reports collected from provider updates estimated that over the course of one year, at least 8 MST and FFT teams closed in total. Hiring issues required providers to consolidate staff into fewer teams, while providers continued to struggle with the Medicaid billing structure and managed care authorizations. MST cases were reported to require several hours of additional work each week, some of which to be adherent to the EBP model, that go uncompensated. In total, four provider companies were estimated to discontinue their MST or FFT service by early 2023. See *Appendix 3* for maps of teams.

Implications. EBP Purveyors are included in the regulatory context because they contribute to the rigidity that providers and practitioners are charged with navigating. Unintended outcome is that they, too, may be **working against EBP sustainment in the state**.

As presented in the key summary of findings above, it is possible that most regulations set by states reflect continued allegiance to the traditional model of psychotherapy, which designates the clinician as the sole responsible power in charge of drawing out change from the identified patient. Evidence-based medicine ushered in a new concept of *team-based care*, through evidence that *multiple individuals each with their own individual skill sets work together to improve outcomes for the identified patient*. In this model, the patient may continue to see only one clinician when they present for care, when in actuality an entire team of professionals and a tiered quality assurance system with data monitoring are present but invisible. Many EBPs require full video recording of an entire session to be reviewed by multiple consultants and experts. Whether by design or not, **evidence-based programs remove and redistribute the power inherent to a clinician's role, and the clinician is reassigned as a conduit.**

The current regulatory context appears to prevent EBPs from being applied with fidelity, or like how they were designed, developed, and tested to be effective. In Virginia, restrictions enforced from multiple state-level entities, in addition to the EBP purveyors themselves, ***have functioned to move practitioners and providers away from the evidence base***. Providers and practitioners are caught in a double-bind situation, where adherence to one set of rules automatically identifies them as practicing outside the scope of another. Proven outcomes of EBPs such as lessened court involvement, improved family functioning, and fewer out-of-home placements in residential treatment facilities and congregate group homes, apply to all of the regulatory bodies' interests.

Other States. A cursory look into EBP delivery by unlicensed practitioners in other states has returned some preliminary leads that could be further studied by CEP-Va in a future study. For instance, Pennsylvania, a commonwealth and a county-administered state similar to Virginia. According to PA's regulations, to provide any form of counseling, social work, or therapy, a person must be licensed. However, if working through an EBP team-based model, unlicensed clinicians are permitted to be on the team and only the team supervisor is required to be licensed. This is an allowance the state has granted to EBP purveyors according to EBP purveyors, but this allowance has not yet been made clear within state regulations or state guidance materials.

In Louisiana, the Department of Health includes an official allowance for bachelor-level clinicians to deliver EBPs specifically. The state's Medicaid program includes flexibility with hiring in light of their workforce shortage and history of staff turnover. Providers are allowed to hire bachelor-level therapists if the applicant is "clearly better qualified than the master's-level applicants" and if the bachelor's degree is in a human services field.[9] All other team-based EBP models covered by Medicaid have received the same regulatory relief in Louisiana, through state-mandated provider

[9] Louisiana Behavioral Health Services Provider Manual (2022). Chapter 2: Medicaid Services, Appendix E-2.

agreements that require the EBP purveyor to conduct all hiring processes, including vetting educational requirements and interviewing candidates.

New Mexico has gone a step further, integrating at least one EBP purveyor and their authority to license EBP sites into their state code, perhaps similar to how DBHDS licenses service categories. Unlicensed bachelor-level practitioners are permitted to be a part of EBP teams and claim for therapeutic interventions, assessments, case management, and crisis stabilization under strict supervision (§ 8.321.2.28). Similar to DMAS in Virginia, New Mexico's Human Services Department Medical Assistance Division only permits one member of a three-person team to be unlicensed bachelor-level. The other two practitioners must be master-level *and* licensed. Supervision (e.g., two hours per week) and other training requirements (such as quarterly workshop training) mandated by the EBP purveyor company are included in the state code.

Medicaid programs across states have leveraged the non-licensed workforce for substance use disorder treatment for many years. A comprehensive review conducted by the National Academy for State Health Policy (2019) found that unlicensed workers allowed to bill for Medicaid were typically categorized as peers, counselors, or other qualified staff. Counselors, the category that most aligns with QMHPs in Virginia, were not required to have more than a bachelor's degree in 31 states, and 28 of these states reimburse these individuals for delivery of counseling services under supervision. Requirements and restrictions varied across states, but the following themes shared by the majority emerged:

- Unlicensed staff are only permitted to deliver services in licensed behavioral health agencies, and most commonly as part of a team.
- A variety of licensed health professionals could provide state-approved supervision of unlicensed, bachelor-level practitioners, such as advanced addiction specialists, nurse practitioners, and others with expertise relevant to where the unlicensed individual delivered services.
- Most states define the frequency and nature of supervision, which was typically ongoing and more intensive for unlicensed practitioners.

In short, many EBP training companies successfully train practitioners to fidelity whose training is akin to Virginia's QMHPs. These EBPs have an extensive and ongoing consultation requirement, meaning that the practitioners are trained and have ongoing contact with experts in the EBP (in addition to their local supervisor). EBP training company guidelines are thus, at times, inconsistent with Virginia regulations, with Virginia regulations being stricter (see Table 7 and corresponding key). Although Virginia has to this point maintained its more stringent guidelines, the conflict between them and EBP training company guidelines poses risk for successful implementation of the EBPs.

Table 7. EBP Purveyor v. State Regulations for Eligibility to Practice

EBP / Service	Diploma / GED	has BA (*QMHP*)	has MA (*QMHP*)	License Eligible	Licensed
Purveyor Rules for Service Provision					
MST		*1 max.*			
FFT					
PCIT					
BSFT					
FCU					
MI					
HB					
Virginia-specific Laws/Regulations for Service Provision					
IIH*					
IIH - MST**		*1 max.*			
OP*					
OP - FFT**		*1 max.*			

*Practitioner requirements are set by DHP within DBHDS service categories of IIH = Intensive In-Home and OP = Outpatient.

**Practitioner requirements are set by both DHP and DMAS within DBHDS service categories adapted to EBP(s).

Table 1 CELL KEY:

Light green = Practitioner status of cell column can ***deliver*** the EBP/service.

Dark green = Practitioner status of cell column can ***supervise delivery*** of the EBP/service.

Red = DMAS's reinforcement of DHP regulations for QMHPs within the context of two team-based EBPs presents a scenario where two sets of regulations appear to contradict each other. DHP restricts counseling and marriage and family therapy to licensed individuals only.

Gray = "Gray area"; DBHDS defines IIH service category as including "individual and family counseling," which are practice elements named to be outside of the QMHP scope of practice. IIH also includes "life, parenting, and communication skills; and case management and coordination with other services," which appear to align with DHP's only designation for QMHPs: collaborative mental health services, without further description. Therefore, only a portion of IIH can be delivered by a QMHP. (12VAC35-105-20)

Recommendation 11*: *QMHP Scope Expansion.

CEP-Va proposes to work with DHP, DBHDS, DMAS, and other agencies to identify a path that permits QMHPs to deliver specific federally-funded EBPs that include a scope of practice not usually permitted for (but not unknown to) QMHPs–that is, counseling practice. CEP-Va would propose specific EBPs to the state, those with high levels of structure, ongoing consultative oversight and fidelity measurement, and with governance committee approval, those EBPs would be considered special cases, and CEP-Va would recommend that all such exceptions would be documented in the state's EBP Registry. The recommendation would improve or strengthen current oversight procedures for QMHPs, in addition to installing structure and therapeutic scripts that transform their work into effective practice.

Finding 4: Regulations have worked to de-incentivize delivery of higher quality services and most especially to the Medicaid population.

A few key regulatory and procedural impediments threaten implementation of FFPSA EBPs such as FFT, MST, BSFT, and FCU. These challenges include:

1. DBHDS licensable services and CSB intake procedures have an individual versus family focus (i.e., separation of child and adult services). QMHP-As and -Cs are allotted to different services, including those conducted in a child's home in the presence of family members. Every Family First EBP requires participation of family members in addition to the traditionally-identified patient.
2. CMS and DMAS rate structures have not kept pace with scientific evidence[10] and do not have clear ways to account for intensive, system-oriented, and family-engaged treatment approaches. As one example, many EBPs involve extensive contacts with multiple members of a family's system (e.g., teacher, probation officer); many of these contacts are not billable. EBPs also require continuous feedback and communication with other agencies and stakeholders involved in a family's case, such as local DSSs initiating referrals. Rate structures do not take into account these interactions that can be resource-intensive and time consuming but predictive of EBP sustainment.
3. Beginning mid-2022, some providers began to limit or stop accepting Medicaid referrals altogether. Inability to claim essential components of EBP models was one problem. In addition, MCO procedures and inconsistent reimbursement coverage led to an unfavorable cost-benefit analysis for providers.

Taken together, EBP models contain practice uncompensated by Medicaid, and what can be compensated is insufficient in proportion to the level of effort necessary to attain reimbursement. Interviewees provided the following additional reasons for reducing or discontinuing services to the Medicaid population:

- Six different sets of paperwork in addition to any required EBP paperwork

[10] Fraher, E., Spero, J., Thomas, S., Galloway, E., & Wilson, H. (December, 2019). *How data and evidence can (and should!) inform scope of practice.* North Carolina Institute of Medicine Policy Fellows.

- High rate of adverse authorization determinations
- MCOs failing to recognize other credentialed sites providing services in a different location than the main licensed provider location
- Lack of responsivity of MCOs when peer reviews have been requested
- Slow authorizations disrupt EBP models with a crisis component, providers must access other funding streams first then transition to Medicaid once the MCO responds

Notable consequences of these findings include:

1. Disincentive for providers to invest in family-based EBPs
2. Some providers that choose to invest in such EBPs are eschewing Medicaid

Recommendation 12*: *Funding Alignment.

Align rate structures and reimbursement totals across funding streams to reduce confusion and potential of over incentivizing providers to discontinue EBPs for more lucrative services, such as the intensive in-home when billed at a high weekly dosage by QMHPs. Example solutions to try would include increasing Medicaid funding or building easy-to-access braided funding models (e.g., Title-IVE, Medicaid, CSA) approaches.

Recommendation 13: Tiered EBP Rates.

CEP-Va strongly recommends discontinuing the practice of setting reimbursement rates for individual EBPs, such as FFT and MST, and to instead work with CEP-Va and contracted expert consultants to determine a set of tiered rates for EBPs. For example, it may be most sensible to establish the highest rates for the most intensive, family-involved, team-based, consultation intensive, EBP models and the lowest rates for more traditional, individual practitioner driven, office-based models.

In Closing

NAGA yielded a lot of actionable steps for the state and highlighted many of the challenges facing the state as it embarks on the ambitious implementation of a slew of EBPs in the context of FFPSA. The state can take heart that Virginia is not alone in these struggles. All states are experiencing similar challenges in their FFPSA efforts. Fortunately, CEP-Va sees multiple ways that VDSS and other state agencies could take direct actions to improve chances for EBP sustainment in the commonwealth.

A few other final considerations are warranted. First, protections in place have been referred to as regulations throughout this report. This is because protections convey a purpose to protect the public from the unskilled practitioners. What does not easily come to mind is the harm we do to the public when we neglect to serve a vulnerable population. Balancing these two protections is a challenge the state should acknowledge and meet head on. As has been detailed in the Regulation Study, within the context of many EBPs the former risks (i.e., unskilled practitioners causing harm) are mitigated to a great extent. Thus, CEP-Va sees an opportunity to reduce the latter risk–that is, lack of access to services despite the potential for workforce expansion.

Integrated behavioral health and acknowledgement of behavioral health in primary care is leading to new team structures and new roles for LMHPs. Science is telling us that people get better and do so faster through strategies and formats that are not yet acknowledged on a large scale or built into state regulatory structures. Virginia may be unprepared for, and even structured to reject, evidence-based solutions and EBP sustainment. Fortunately, there is ample time to solve this problem and good evidence to bring to bear in that effort.

Because states can define license requirements and regulate behavioral health professional scopes of practice, Virginia has agency to address the challenges. However, unless changes are made, Virginia remains a state for which many EBPs are a bad fit for long-term sustainment. That need not remain the case. The first phase of the Regulation Study highlighted the state's challenges; the findings also foreshadow the state's chance to become a national leader in EBP implementation.

Appendices

Appendix 1: Summary of Recommendations

Recommendation 1. Prioritize CSBs.
CSBs remain an important entry point into behavioral health services for Virginias who are uninsured. CEP-Va recommends VDSS continue to prioritize CSBs and providers within the service coverage areas of an updated Top Priority CSB List (presented in Table 3) with Title IV-E funds.

Recommendation 2. PCIT Training and Certification Standard for Virginia.
State agencies with a stake in PCIT in Virginia are recommended to require all individuals that bill for PCIT services or provide PCIT training meet standards set by PCIT International and be enrolled in the EBP Practitioner Registry, the authoritative database of EBP-trained practitioners in Virginia. Licensed or license-eligible practitioners who have been trained by any organization or company unaffiliated with the certifying body are encouraged to be referred to CEP-Va. If the recommendations here are approved, CEP-Va will work with PCIT International to develop a remediation pathway to attain PCIT certification via Title IV-E training funds.

Recommendation 3. Improved Reimbursement Rate for PCIT.
To sustain PCIT and enhance access to this intensive service, CEP-Va urges an increase in reimbursement for practitioners with verifiable training through PCIT International and who are listed in the EBP Practitioner Registry. This recommendation spans all funding streams and child-facing agencies oriented toward prevention of out of home placement (e.g., Office of Children's Services [OCS], VDSS). Medicaid reimbursement for all licensed clinicians is particularly encouraged to be increased, given the impact such a service has demonstrated for prevention of later juvenile justice involvement.

Recommendation 4. Site Certification Model for PCIT.
Given the high rate of practitioner departure from provider sites post-training, CEP-Va recommends that future investment of Title IV-E training funds be allocated toward building competency of provider sites, versus solely investing in individual practitioners, to create an environment that facilitates PCIT training and effective delivery of the program. VDSS (and other state agencies) is encouraged to permit CEP-Va to examine whether certifying at the site level aids in retention of PCIT International trained clinicians (i.e., PCIT-Va Pilot Study).

Recommendation 5. Service Coordination Study.
CEP-Va proposes a study on the service coordination teams in charge of making referrals at the local level, i.e., a Service Coordination Study. The unique intricacies related to how a family arrives at an EBP provider vary by funding stream as well as locality. A deeper analysis into the coordinating structures that involve all child-facing agencies in the state is strongly recommended, as these systems impact a family's path and ability to take advantage of an effective service. Results from this type of contextual roots analysis would permit CEP-Va and its funders to begin to organize localities and regions by the characteristics of their respective coordination

procedures and develop guidance to improve assimilation of Title IV-E funding. If approved, CEP-Va would engage in the study in 2023, with results presented in early 2024.

Recommendation 6. Continued Regulation Study.

The Center's initial efforts to support the state's training goals necessitated an immediate closer look into trainee attrition and workforce supply. This was a driver for the focus of the Regulation Study, as initiated through the NAGA model of immediate response to an implementation barrier. The first phase of the Regulation Study began to explore the actual structures in place that influence the state's ability to leverage an entirely new funding stream to establish child welfare's stake in behavioral health service expansion. The preliminary findings of this report as they relate to the regulatory context of the state are presented herein. The Center requests approval from VDSS to continue the Regulation Study past its initial phase introduced below by selecting areas for further examination as they are presented and described within the study's narration of findings.

Recommendation 7. QMHP Study.

CEP-Va recommends an in-depth study on the QMHP workforce with the aim to improve applicability and impact of BoC regulations. If permitted by governance committee partners, CEP-Va could collaborate with DHP/BoC in such a project. Also, the project could be folded into the work of other initiatives underway dedicated to workforce. Study activities with the objective of characterizing the QMHP workforce include the following,

- Conduct a survey with the QMHP workforce that collects demographics, educational and experience background, in addition to any other information to help begin to characterize the overall group
- Perform follow-up interviews to confirm emerging group characteristics
- Collect any additional data necessary to begin to determine whether sets of characteristics are present within the population as a whole
- Determine number of subgroups based on relationships among and between group characteristics
- Reexamine potential for reclassification of QMHP workforce, or clarification of existing delineations, based on emergent subgroups (i.e., is the -A/-C dichotomy warranted?), with the goal of removing unnecessary paperwork and extra steps to full licensure

Recommendation 8. QMHP Supervision Capacity Building.

CEP-Va encourages DHP and DBHDS to work together to enhance supervision capacity, possibly in partnership with CEP-Va. The work is recommended to begin with CSBs or private providers affiliated with CSBs. Supervision expectations must first be determined and then standardized for each level of the workforce regardless of a licensure or discipline's guild. For instance, LCSWs appear to have more stringent requirements than all other professions at a commensurate level, with QMHPs having the least. Potential areas to explore include, but are not limited to the following:

- Develop a multi-tiered supervisory structure, or supervision cascade (e.g., more experienced supervising less experienced practitioners in chains of 3-4, creating multiple layers of supervisory oversight for cases seen by unlicensed practitioners); See Example below

- Develop guidance for agencies that support supervision best practices in combination with incentives for “proof of use”
- Develop guidance for Board applicants on their rights to competent supervision, decision-trees for when to request supervision/consultation, and supervisory contracts
- Develop a supervisory directory for individuals to seek out supervisors based on areas of expertise for case consultation
- Develop a path that allows expert consultation (i.e., external supervision) hours to be counted toward licensure/registration requirements to supplement regular supervision
- For DHP/BoC in particular, raise minimum supervision requirements of unlicensed workforce to routine supervisor contact and remove option for “on call” supervision (or stepped path that requires regular proof of competency)

Recommendation 9. Ontological Alignment.

DHP and the BoC are encouraged to clarify further their definition of *counseling* in addition to the components used in the definition of that word. Reaching consensus of common terms such as *assessment*, *diagnosis*, *therapy*, *treatment,* and *intervention* is also strongly recommended. All state agencies are strongly encouraged to use the same language and definitions for protected terms, to compile one standard glossary that is hierarchical – also referred to as an *ontology*.

Ontologies are arranged from general to specific terms that create a foundational touch point for understanding what is being requested, expected, and eventually reimbursed. For example, *activity scheduling* is a *practice element*, or skill, used by a practitioner. Its parent term, in accordance with the current evidence, is behavioral activation. Below is an example that could become an excerpt in a complete ontology:

Counseling:

1. *Treatment intervention*
    a. *Behavioral activation*
        i. *Activity scheduling*

Recommendation 10. Regulation Audit.

A comprehensive investigation or audit of all behavioral health profession regulations governed by all three boards to determine inconsistencies and whether each licensed, certified, or registered class of professions meets the criteria set by the Board of Health Professions for guiding regulation decisions readopted in 2019.[1] The following areas are proposed for additional inspection and/or clarification within context of the current workforce crisis and the evidence to date that supports their continuation:

- Bachelor-level professionals who are license-eligible, and other exceptions to the practice status categories of licensure, certification, and registration
- How scopes of practice are defined and whether clear delineations across the professional guilds are warranted (e.g., who can provide supervision)
- Limits related to time and expiration of supervisory hours, or other resource intensive requirements (i.e., exams)

Recommendation 11. QMHP Scope Expansion.
CEP-Va proposes to work with DHP, DBHDS, DMAS, and other agencies to identify a path that permits QMHPs to deliver specific federally-funded EBPs that include a scope of practice not usually permitted for (but not unknown to) QMHPs–that is, counseling practice. CEP-Va would propose specific EBPs to the state, those with high levels of structure, ongoing consultative oversight and fidelity measurement, and with governance committee approval, those EBPs would be considered special cases, and CEP-Va would recommend that all such exceptions would be documented in the state's EBP Registry. The recommendation would improve or strengthen current oversight procedures for QMHPs, in addition to installing structure and therapeutic scripts that transform their work into effective practice.

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Recommendation 13. Tiered EBP Rates.
CEP-Va strongly recommends discontinuing the practice of setting reimbursement rates for individual EBPs, such as FFT and MST, and to instead work with CEP-Va and contracted expert consultants to determine a set of tiered rates for EBPs. For example, it may be most sensible to establish the highest rates for the most intensive, family-involved, team-based, consultation intensive, EBP models and the lowest rates for more traditional, individual practitioner driven, office-based models.

Appendix 2: Preliminary Content Analysis (Section 2, Finding 2)

1. Provider as entity vs. Provider as a person

Commonly heard in interviews included variations of "DBHDS licenses places, DHP licenses people." However, contrary to the meaning the mantra conveys, DBHDS uses the term provider to inhabit two meanings: the provider as a *person*, and the provider as an *entity*, such an organization. The definition, indeed, includes both:

"Provider means any person, entity, or organization, excluding an agency of the federal government by whatever name or designation, that delivers services to individuals with mental illness, developmental disabilities, or substance abuse… It shall ***not*** *include any individual practitioner who holds a license issued by a health regulatory board of the Department of Health Professions…"*

That the dual use of the term may be a cause of confusion was reflected through differences that emerged between governmental employee interpretations of the law and provider or practitioner interpretations. Preliminary findings suggest it is likely that many QMHPs are employed by private companies unlicensed by DBHDS, and that state regulations do allow many privately owned organizations to bypass the burden of DBHDS oversight and licensing. DBHDS regulations do include a provision that contracting QMHPs to provide services is acceptable when services are supervised under an individual's DHP license. However, it is possible that state agency officials are unaware of the full extent of how many private companies are able to take advantage of this allowance for individual licensed practitioners. Companies headed or managed by individuals licensed by DHP may be presumed to negate the need to abide by the DBHDS licensure requirement to license regardless of whether QMHPs deliver the bulk of a company's services.

DBHDS may wish to clarify when a private company owned by a licensed practitioner becomes the type of *provider* that would require a DBHDS license. A standard language across all agencies would help clarify where QMHPs are allowed to practice further. For instance, DHP's Board of Counseling appears to follow DBHDS dual-use without noting the transition from defining a professional as an individual to defining the same professional as a company (i.e., provider as an entity), in their definition of a QMHP:

A qualified mental health professional… shall provide such services as an employee or independent contractor of the Department of Behavioral Health and Developmental Services or the Department of Corrections, or as a provider licensed by the Department of Behavioral Health and Developmental Services.

Similarly, DMAS uses both definitions but does so inconsistently across guidance. For example, the DMAS Member Handbook includes both of the following excerpts from different sections.

'Provider' is the general term we use for doctors, nurses, and other people who give you services and care. The term also includes hospitals, home health agencies, clinics, and other places that provide your health care services, medical equipment, and long-term services and supports…

'Provider: A person who is authorized to provide your health care or services. Many kinds of providers participate with [Plan], including doctors, nurses, behavioral health providers and specialists.'

2. MHP definition v. QMHP title

Another point of confusion may be evident in the title of QMHP. The Board of Counseling uses the words *qualified* and *licensed* to define the basic foundation of a mental health professional:

*'Mental health professional' means a person who by education and experience is professionally qualified and **licensed** in Virginia to provide counseling interventions designed to facilitate an individual's achievement of human development goals and remediate mental, emotional, or behavioral disorders and associated distresses that interfere with mental health and development.*

More than likely, DHP's definition of mental health professional was established prior to QMHP's transfer over from DMAS. This is because a QMHP would not be included in this definition despite that the phrase MHP is in their title with the word Qualified in front.

3. Conflicting guidance for QMHPs

Interviewees believed that the issue of whether a QMHP could perform a service or not, i.e., *was it in their scope of practice?,* was directly related to whether it contained a certain word. Several interviewees disclosed the protected word to be *therapy.* In actuality, the BoC protected word is *counseling*.

According to DBHDS service category guidance, QMHPs can provide ***treatment*** and ***therapeutic interventions.*** DBHDS defines the IIH service category as including "individual and family counseling,.. life, parenting, and ***communication skills***; and case management and coordination with other services."

In contrast, QMHPs are not legally permitted to classify themselves as a *counselor* nor engage in ***counseling*** practice according to DHP. The BoC does acknowledges that the term is not a special service distinct from other tasks shared by behavioral health professions, and this sentiment may be reflected in the BoC's multifaceted **definition of counseling**:

*…application of principles, standards, and methods of the counseling profession in (i) conducting assessments and diagnoses for the purpose of establishing treatment goals and objectives and (ii) planning, implementing, and evaluating treatment plans using **treatment interventions** to facilitate human development and to identify and remediate mental, emotional, or behavioral disorders and associated distresses that interfere with mental health.*

DHP's definition of a protected term, counseling, includes activities that DBHDS allows QMHPs to do in accordance with their designated service category. **This means DBHDS may relegate QMHPs to service elements that are included in the BoC's definition of counseling, which is outside of a QMHP's scope of practice.**

Further, according to DMAS guidance:

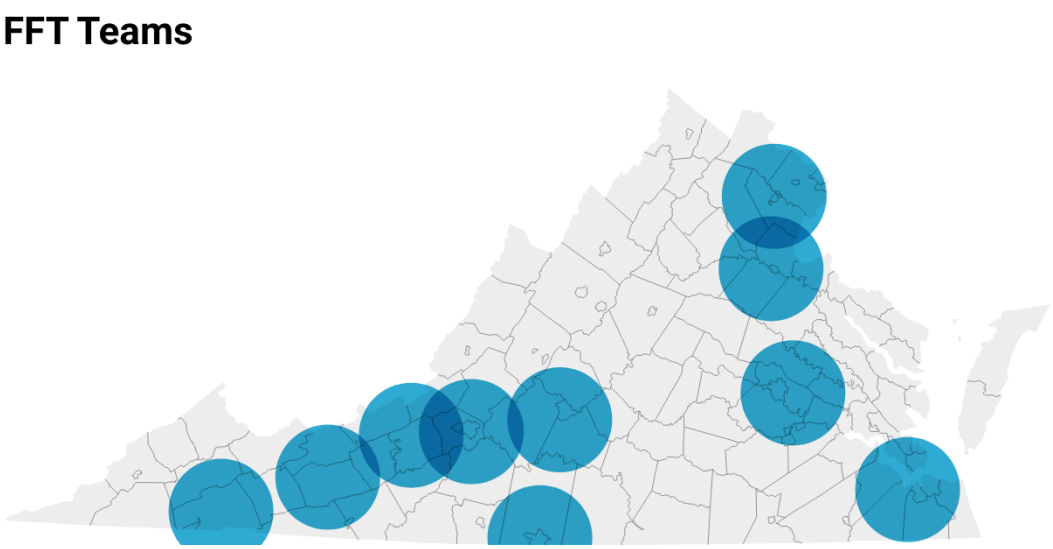
*Intensive in-home services (IIH)... are intensive **therapeutic interventions** provided in the youth's residence (or other community settings as medically necessary… to improve family functioning, and significant functional impairments in major life activities that have occurred due to the youth's mental, behavioral or emotional illness… **All IIH services** shall be designed to specifically improve family dynamics, provide modeling, and include **clinically necessary interventions** that increase functional and therapeutic interpersonal relations between family*

members in the home… [Service requirements:] ***…****Training to increase appropriate* ***communication skills*** *(e.g.,* ***counseling*** *to assist the youth and his parents or guardians…)...* ***Therapeutic interventions****, crisis intervention and care coordination must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S,* ***QMHP-E,*** *QMHPC, CSAC or CSAC-supervisee who meets the qualifications of this section.*

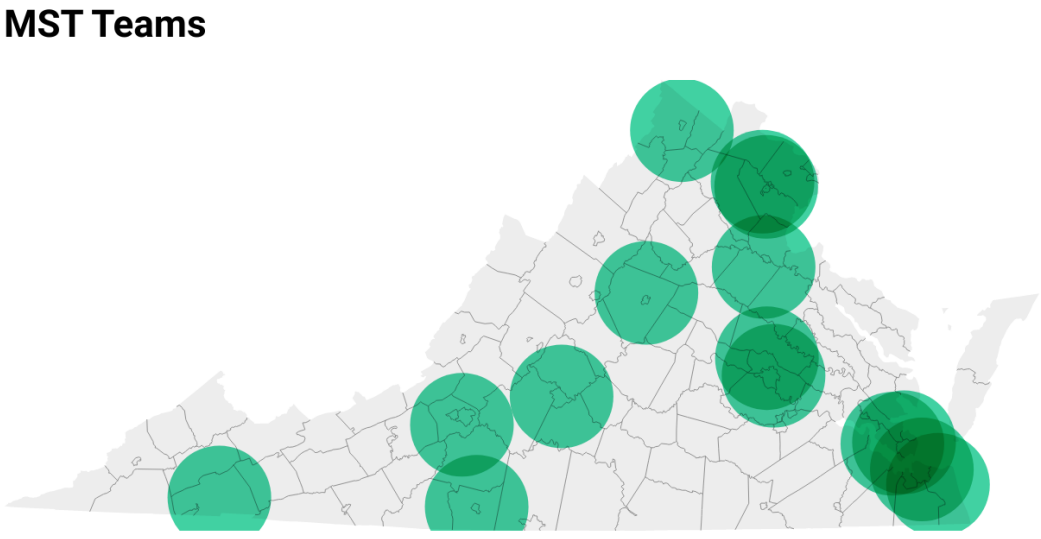
Similar to DBHDS, DMAS includes therapeutic interventions to be within the purview of QMHPs within the service category of IIH. Additionally, DMAS includes the term **counseling** to further describe the service requirement of *communication skills training*, which is not permitted to be delivered by QMHPs according to DHP.

Appendix 3: Maps of MST and FFT as of February 2023

MST and FFT services are delivered in the state by multiple service providers. Maps are provided below to display location of these services and are based on information available from FFT LLC and MST Services website directories. Teams are expected to provide coverage within a 90 minute driving radius of their location and the circles on the maps very broadly estimate this driving radius catchment area.



FFT map includes 10 FFT teams coordinated by 9 providers.



MST map includes 15 MST teams coordinated by 7 providers.

Appendix 4: Terms Glossary

Implementation	Multi-phasic process of integrating scientific findings into routine practice that emphasizes identification of factors that affect uptake of a novel practice or intervention
Providers	Companies or agencies that deliver mental / behavioral health services, not individual “direct service providers” or therapists
Practitioners	Individual therapists, clinicians, counselors delivering services directly to children and/or families in any setting; includes bachelor-level clinicians
Purveyors	Program developers, trainers, or vetted spokespeople who represent an evidence-based program, its developers, or certifying entity, and have a clear stake in how the program is delivered
Workshop	A teaching strategy involving the presentation of new knowledge, and in some cases, experiential application to enhance learning
Cohort	A group of individuals who move through a sequence of milestone events with each other to reach a common goal
Consultation	A style of teaching where information is provided by an external agent, or someone outside of a particular system
Supervision	A regulatory component embedded within a system, typically for the purposes of quality assurance and patient safety
Sustainment	The ultimate goal of implementation; the active maintenance of gains or defined outcomes related to an innovation

Appendix 5: Acronyms

ADHD – Attention Deficit Hyperactivity Disorder
BA – Bachelor of Arts
BHA – Behavioral Health Authority
BoC – Board of Counseling
BRAVO – Behavioral Health Redesign for Access Value & Outcomes
BSFT – Brief Strategic Family Therapy
CE – Continuing Education
CEP-Va – Center for Evidence-Based Partnerships in Virginia
CMS – Centers for Medicare and Medicaid Services
CPS – Child Protective Services
CRP – Certified Rehabilitation Provider
CSA – Children's Services Act
CSAC – Certified Substance Abuse Counselor
CSB – Community Services Board
DBHDS – Department of Behavioral Health and Developmental Services
DHP – Department of Health Professions
DJJ – Department of Juvenile Justice
DMAS – Department of Medical Assistance Services
EBP – Evidence-based program
FCU – Family Check-Up
FF – Family First
FFPP – Family First Prevention Plan
FFPSA – Family First Prevention Services Act
FFT – Functional Family Therapy
FSP – Family Support Partner
GED – General Education Development
HWDC – Healthcare Workforce Data Center
ISP – Individual Service Plan
JLARC – Joint Legislative Audit and Review Commission
LBSW – Licensed Baccalaureate Social Worker
LCP – Licensed Clinical Psychologist
LCSW – Licensed Clinical Social Worker
LDSS – Local Department of Social Services
LLC – Limited Liability Company
LMFT – Licensed Marriage and Family Therapist
LMHP – Licensed Mental Health Professional
LMHP-R – Licensed Mental Health Professional-Resident
LMHP-RP – Licensed Mental Health Professional-Resident in Psychology
LMHP-S – Licensed Mental Health Professional-Supervisee
LPC – Licensed Professional Counselor
LSATP – Licensed Substance Abuse Treatment Practitioners
MA – Master of Arts
MCO – Managed Care Organization
MFT – Marriage and Family Therapist
MI – Motivational Interviewing
MINT – Motivational Interviewing Network Trainers
MST – Multisystemic Therapy
NAGA – Needs Assessment Gaps Analysis
OCS – Office of Children's Services
OP – Outpatient
PCIT – Parent-Child Interaction Therapy
PO – Probation Officer
PRS – Peer Recovery Specialist
QMHP – Qualified Mental Health Professional
QMHP-A – Qualified Mental Health Professional-Adult
QMHP-C – Qualified Mental Health Professional-Child
QMHP-E – Qualified Mental Health Professional-Eligible
QMHP-T – Qualified Mental Health Professional-Trainee
QPPMH- Qualified Paraprofessional in Mental Health
RFA – Request for Applications
RPRS – Registered Peer Recovery Specialist
SNAIL – State Needs Assessment Information Library
STEP-VA – System Transformation Excellence and Performance
VAC – Virginia Administrative Code
VDSS – Virginia Department of Social Services
Virginia HEALS – Helping Everyone Access Linked Systems