VENTURA COUNTY
BEHAVIORAL HEALTH

Ventura County MHSA Innovative Project Proposal
Children's Accelerated Access to Treatment and Services (CAATS)

Purpose: Innovation projects are novel, creative and/or ingenious mental health practices/approaches that contribute to learning. An INN project is defined, as one that contributes to learning rather than a primary focus on providing a service. By providing the opportunity to 'try out' new approaches that can inform current and future mental health practices/ approaches in communities. Merely addressing an unmet need is not sufficient to receive INN funding.

I. Description of Proposed Innovative Project

"Innovative Project": This is a project that the county designs, implements, and evaluates in order to develop new best practices in mental health. An Innovative Project must be defined by one of the following criteria:	**Select One**
1. Introduces a new practice or approach to the overall mental health system, including, but not limited to, prevention and early intervention.	☐
2. Make a change to an existing practice in the field of mental health, including but not limited to, application to a different population	☒
3. Apply a promising community driven practice or approach that has been successful in a non-mental health context or setting to the mental health system.	☐
❖ **A mental health practice that has already demonstrated its effectiveness is not eligible for funding as an Innovative Project unless it is changed in a way that contributes to learning.**	

a. Describe the proposed project, include answers to the following questions in the description. Based on the selection above, how does the proposed project meet criteria for Innovation Funding? Include how the proposed project expects to contribute to the development of a new or changed practice within the mental health field?

Ventura County Behavioral Health (VCBH) is proposing to make several significant changes in the way that mental health services are provided to foster youth. VCBH will provide a comprehensive intake process that includes mental health assessments, coordinated interagency service linkages, medication support, and clinical intervention for all youth entering the child welfare system. VCBH perceives that these proposed changes will produce better outcomes for the youth and their families by reducing symptoms of traumatic stress, preventing the onset of mental illness through early intervention, improving medication monitoring of youth in treatment and medication education for caregivers, and reducing the overall recidivism rates of youth.

Under the current system, foster youth are screened for mental health issues by their child welfare worker and, if deemed appropriate, referred for a clinical mental health screening. Even post referral additional criteria must be met for a full mental health assessment to occur for these youth. Given the

realities of caseloads and the many diverse responsibilities of clinicians, this process can be slow and lacking in comprehensiveness even for those youth who are deemed in need of services by their caseworker. The result may be a delay in the provision of services and appropriate placements, thus having a potentially negative impact on long-term outcomes and increasing the chances for recidivating.

Another critically important issue facing foster youth who are already in treatment is psychotropic medication administration, education, and compliance. In spite of best efforts to closely monitor compliance to prescribed medications and provide important education to youth and caregivers, gaps can occur due to shortage of medical staff and the potential lack of the oversight and interagency communication needed to serve this special needs population.

In response to these existing gaps in services, Ventura county proposes to, in part, remodel its provision of mental health services to foster youth and families so as to improve quality, access, and, ultimately, overall outcomes. Three process improvements are central to this proposal; the employment of an expedited trauma-informed assessment process performed by a team of clinicians that are specially trained to speak to all county-based services, universal mental health services for foster youth, and the employment of a Licensed Vocational Nurse (LVN) that can support the efforts to meet the psychotropic medication needs of foster youth.

First, rather than relying on case workers or a screening tool when referred, all foster youth will receive a comprehensive mental health assessment as a part of the child welfare intake process. The assessment will include the trauma-informed Children and Adolescent Needs and Strengths (CANS) -Trauma Comprehensive, a reliable and valid tool with flexible capabilities. The assessment will be conducted by clinicians specially trained to be knowledgeable in all county and community-based services and resources, streamlining the many difficulties inherent in successful interagency collaboration. When necessary, assessments will take place where the youth resides to promote access, expedite the process and create a more casual, non-clinical feel that contributes to open dialogue. Further, and perhaps most significant, this assessment will adhere to an aggressive expedited model with assessment completion and recommendations occurring within 10 days of receiving the referral from Child and Family Services. This will allow for timely linkage to the appropriate services and supports for the youth and caregiver(s) thus promoting better long-term outcomes. The assessment recommendations will be available to the Family Team Meeting (FTM) that will be held within 30 days of the referral – again promoting expedited responses from FTM members to best serve the needs of the youth and caregiver(s).

A second, significant change being proposed is that all foster youth will receive some level of mental health services when they enter the system. VCBH has adopted the perspective based on the Adverse Childhood Experiences research that being removed from the home is a traumatic experience that should be addressed. Accordingly, youth will be offered professional assistance in processing that loss. The modality, intensity and

duration will depend on acuity and need, but even youth identified as having only mild or moderate issues will be offered services.

A final proposed change in service delivery is the employment of a licensed medical professional to support county child psychiatrists in their difficult task of medication monitoring and support for foster youth. The licensed medical professional, with support from VCBH administration, will provide education regarding medication, better monitoring of adherence to medication, and overall improved collaboration with interagency partners. Again, the ultimate goal is improved outcomes for foster youth and families.

VCBH, along with our agency partners, feel strongly that these proposed changes in the way services are currently accessed and provided will have a significantly positive impact on the foster youth and caregiver(s) to avoid congregate care, hospitalizations, school failure, adjudication, and promote reunification / family stabilization. If the proposed changes demonstrate positive effects on the above-mentioned indicators, the field of mental health would have a tested change model for how to improve service quality and outcomes for children entering the child welfare system.

b. Describe the target population to be served relevant to the proposed project. Include demographic information such as age, gender, race, ethnicity, and language if applicable. Describe the expected number of clients to be served/enrolled/trained annually.

Program Target Population: All entering the foster care system youth between the ages of 0 -17.

Below is the specific rates of age and race/ethnicity of children entering foster care in Ventura County according to kidsdata.org a program of the Lucile Packard Foundation.

Total number of Children in Foster Care in 2014 by Race/Ethnicity	Number
African American/Black	**46**
American Indian/Alaska Native	**0**
Asian/Pacific Islander	**11**
Hispanic/Latino	**645**
White	**256**
Total Children in Foster Care	**961**

Rate of Children Entering Foster Care by Race/Ethnicity 2012-2014	Rate per 1,000
African American/Black	**6.1**
American Indian/Alaska Native	**LNE***
Asian/Pacific Islander	**LNE***
Hispanic/Latino	**2.9**
White	**1.7**

*LNE (Low Number Event) refers to data that have been suppressed because there were fewer than 20 first entries.

Rate of Children Entering Foster Care by Age 2012-2014	Rate per 1,000
Under 1	**11.1**
Ages 1-2	**3.6**
Ages 3-5	**2.6**
Ages 6-10	**1.7**
Ages 11-15	**1.2**
Ages 16-17	**0.6**

c. Outline a total timeline of the proposed project, note the start and end date for this project that does not exceed three years. Include in the timeline specific key milestones for the project such as; development, implementation, decision making, on-going assessment, and final evaluation of the Innovative project.

TIMELINE
Proposed Start: July 1, 2017
Proposed End: June 30, 2020

Quarter 1 year 1: Hiring and Training

a. Recruit and hire four clinicians to be trained in CANS-Trauma Comprehensive Assessment and trauma informed Cognitive Behavioral Therapy.
b. Recruit and hire one LVN for medication education and oversight.
c. General employee hiring and training process for Ventura County takes 3-6 months.
d. Clinicians will train at various county public service sites and relevant community service organizations in order to become familiar with services and programs eligibility that are relevant to foster youth and their caregivers.
e. Performance measurement tracking system created through Avatar, the county's database.
f. Develop the policy and protocols training manual for use in Ventura County to implement rapid assessment and mental health care for foster youth.
g. Evaluation plan, forms, timeline, and training will also be developed.

Quarter 2-3 Year 1 Program Roll Out

h. Improved rapid comprehensive intake process roll out county wide
i. Evaluation process and protocols will be implemented.

j. Clinicians trained in CANS-Trauma offer ongoing trainings in the assessment for VCBH youth and family clinicians.
k. CANS-Trauma will be administered at intake and every 3-6 months after intake in order to assess improvements from the changes made to the child welfare process.
l. Ongoing performance measurements tracked in Avatar system.

Quarters 1-4 Years 2 and Quarter 1-3 Year 3 Program Services

m. All youth entering the child welfare system receive CAATS
n. CANS-Trauma will be administered at intake and every 3-6 months after intake in order to assess improvements from the changes made to the child welfare process.
o. Ongoing performance measurements tracked in Avatar system.

Quarter 4 Year 3: Wrap Up

p. Final review for follow-up and evaluation
q. Summation report on findings presented to Behavioral Health Advisory Board and the Board of Supervisors.
r. The dissemination of results will take place through the annual community planning process, stakeholder meetings, and formal report.
s. Decision to expand the program for permanent procedure.

II. Identify Primary Problem and Purpose of Proposed Innovative Project

Primary Purpose: The county shall select one of the following purposes for developing and evaluating a new or changed mental health practice**:**	**Select One**
1. Increases access to mental health services to underserved groups	☐
2. Increases the quality of mental health services, including measured outcomes	☒
3. Promote interagency and community collaboration related to Mental Health Services or supports or outcomes.	☐
4. Increase access to mental health services	☐
❖ **Focus on Mental Health:** An Innovative Project may affect virtually any aspect of mental health practice or assess a new or changed application of a promising approach to solve persistent mental health challenges, including but not limited to administrative, organizational policies, advocacy, education, training, non-traditional mental health practices, outreach, capacity building, community development, system development, public education, research , services: interventions, prevention, early intervention, and treatment.	

a. What challenge does the proposed Innovative Project seek to address? Why was this challenge chosen? How is this challenge consistent with the Primary Purpose selected above?

County and state governments have been trying to resolve the disproportionate rates that foster youth have for developing or experiencing mental health disorders for almost as long as child welfare systems have been in their purviews. Reports from the National Institute of Mental health find that 47.9% of youth in foster care have clinically significant emotional or behavioral problems. (Burns et al., 2004). Several studies have documented increased prevalence of emotional and behavioral disorders in foster care youth (Stahmer et al,. 2005; Dos Reis, Zito, Safer, & Soken, 2001). Similarly, Pecora et al. (2009) found that up to 80% of the children in foster care require intervention for serious behavioral or mental health problems. Even more profound was the long-term findings that Pecora observed; three of five children were found to have a lifetime mental health diagnosis and one in five had a three or more lifetime diagnosis (2009). These studies strongly indicate that untreated children in today's child welfare system are at a high risk of developing significant mental health issues in adulthood. Other outcomes for foster youth aging out of the system find they are more likely to become homeless, pregnant, or involved in the criminal justice system and less likely to have a job or go to college than their peers (The Midwest Study, 2011).

Considering these significant findings, children entering the child welfare system should have their mental health needs prioritized along with access to services. However, youth currently in foster care regularly face long delays in receiving clinical services despite legislation that mandates their right to treatment. In 2016, according to the California's Children Report card, only 65 percent of California's foster youth with serious emotional challenges receive the mental health services they need. The National Study of Child and Adolescent Well-Being (NSCAW) also found that three of four children who came to the

attention of the child welfare systems because of a child abuse and neglect investigation and who had clear clinical impairment had not received any mental health care within 12 months after the investigation (Stahmer et al. 2005). Much of this issue can be contributed to long waits for assessment and service openings, but additional contributing factors identified included racial bias, child's age, and the type of placement (Stahmer et al. 2005). To expand on racial bias issue, Garland, Landsverk, and Lau (2003), found bias in assessment and referral patterns as well as less effective engagement and retention of African American children in care. On the issue of age, it was noted that children under the age of 5 did not receive mental health services because the impact of the trauma was not recognized for this age group.

Given the high needs of these youth it may be assumed that these youth are receiving comprehensive services once they enter treatment. The research does not support this. Research indicates that youth who enter the foster care system are not receiving the intensive treatment required to meet their mental health needs. Rather, these youth are frequently overprescribed medication in place of therapy and rarely receive the appropriate psychiatric follow-up according to the California State Auditor Report (2015). This is alarming given that youth with psychotropic prescriptions require consistent clinical assessments, education, and supportive oversight in addition to traditional mental health therapy

The aforementioned concerns and issues pertaining to the access of mental health treatment exclude one prominent group of foster youth, children who are coping well at the time of intake. Current county systems are designed to screen children for mental health service eligibility at the point of entry, a process that often prevents youth from being referred for services that they need. This is in spite of the research that indicates that close to 90% of children have experienced one or more trauma exposures including physical or sexual abuse, neglect, exposure to domestic violence, community violence, or the violent death of a loved one (Doresey et al., 2012. p.816). Children who experience trauma in the form of adverse childhood experiences, which include entering foster care, have a well-established high risk of developing both mental health and physical health problems (Pritchett, Hockaday, Anderson, Davidson, Gillberg, and Minnis, 2016). Hence, an explanation for the exceedingly high rates of mental health problems may be, at least in part, due to a flawed child welfare system. Current practices often deny mental health services for well-functioning youth. These children, because of their effective coping skills, may have the greatest chance for success in reunification, permanency placement, education achievement, and maintaining mental health if they receive intervention early.

Research indicates that a timely comprehensive mental health assessment at the point of intake for all child welfare youth would address the majority of these issues (American Academy of Child and Adolescent Psychiatry and Child Welfare League of America, 2002). Of course, this narrow approach would not resolve the many challenges discussed, only significant system changes could begin to resolve all of these issues. VCBH is proposing to make those changes by providing universal mental health care access, expedited and comprehensive assessments and adjunct support by a medical professional for

youth that receive psychotropic medication. Youth that would normally not have immediate and supportive access to mental health treatment will now have the opportunity to address the traumatic experience of removal, build resilience, and potentially, prevent the onset of mental illness. It is the assertion of VCBH that this model of expedited access, assessment and medication support will result in the provision of appropriate mental health services early on, thus avoiding service delays and placement changes that only add to the trauma typically experienced by the youth and parent/ caregiver as they enter the child welfare system.

Further VCBH proposes that youth and their families who enter the system under this new model will experience better overall mental health outcomes, which will promote stability and family reunification and reduce the risk of recidivism.

b. What Has Been Done Elsewhere To Address Your Primary Problem? Describe the efforts you have made to investigate existing models or approaches close to what you're proposing (e.g., literature reviews, internet searches, or direct inquiries to/with other counties). Have you identified gaps in the literature or existing practice that your project would seek to address?

A literature review performed by VCBH found a significant amount of research addressing foster youth's ability to access needed mental health services. Primary areas of concern include: the lack of comprehensive mental health screening / assessment upon entering out-of-home care, the need to improve identification of youth with emotional and behavioral disorders, and the insufficient access to appropriate mental health services (Pecora et al., 2012 paragraph 3).

Barriers to access include: fragmentation of responsibility and funding for services; failure to provide adequate information to foster care and/or social workers; inability to recognize problems and make appropriate referrals; and in over-reliance of case workers on foster parents judgment in identifying mental health problems of children in their care. (Halfon et al. 2002) Notably, African American and Hispanic children are least likely to be referred for services until they display major behavioral problems (Polihronakis 2008). These findings support VCBH's position that a radical shift in how foster youth access mental health services is a worthy investment.

There have been a number of initiatives and strategies aimed at addressing these gaps in services to foster youth. The most common of these include: in-school services, education, intensive treatment, and prevention.

In-school services: It was found that many schools across the nation provided group services exclusive for foster youth or for youth with trauma exposure designed to be facilitated by community organizations or school-based mental health professionals. Other school interventions provided prevention and

early intervention strategies. Of these several had programs that targeted children in kindergarten through fifth grade. The groups focused on enhancing the social and emotional development of young children and preventing the development of serious mental health problems, substance abuse, academic failure, and delinquent behavior.

Parent and Caregiver Education**:** All counties are required to provide voluntary or mandated parent training classes for parents who have been involved in child protective services. Topics generally included child development, communication skills, anger management, alternatives to corporal punishment, and positive reinforcement. Several programs in Los Angeles (Children's Institute Incorporated and the Children's Bureau of Southern California), provided additional targeted support services that focused on fathers whose children are in or at risk of placement in the child welfare system.

Intensive Treatment or Therapeutic Foster Care Services: Also pervasive from county to county is intensive and supportive foster care placements for children and youth with serious emotional and/or behavioral problems. Therapeutic placements with specially trained foster families or staff are provided in conjunction with intensive counseling, case management, and support services.

Prevention: Another common strategy was the prevention of youth removal through supportive services. At-risk families are provided in-home counseling, peer partners, educational groups, and other services to protect children, prevent foster care placement, and promote family preservation

Several states have responded to issues with ambitious, large-scale efforts to integrate a wide range of community services for families at risk or involved in child welfare. A report by the Urban Institute summarized several initiatives such as alternative response systems, structured decision making, and family group decision making as efforts to respond to ongoing concerns about the quality of the child welfare system (2001). Many of these efforts have focused largely on the better use of existing resources through collaborative planning, pooled funding, and interagency agreements. Some examples include the creation of family centers piloted in Colorado, now in use by 15 states (The Urban Institute, 1999). Family centers are located in churches, schools, community centers, and shopping malls. These centers provide a range of services including advocacy, child care, maternal and child health services, parent education, family literacy, substance abuse and juvenile delinquency prevention services, and information and referral services. Alternatively the Alabama Multiple Needs Child (MNC) Act allows juvenile judges to designate children with multiple problems to a Multidisciplinary staff team funded by several state agencies that provide continuous support and oversight of interagency services. Washington, Michigan, and Florida implemented some variation on the Alternative Response System which provides a wide range of voluntary prevention support services to families

screened out of the child welfare system without a formal investigation, unsubstantiated, or closed (The Urban Institute, 2001).

Exploratory and evidence base programs demonstrating positive outcomes were prevalent but, as of yet, have not been incorporated as a state or county policy. This is likely due to very strict funding sources. The field as a whole is coming around to include family decision-making processes and to mandate mental health screenings, but not to provide mental health intervention. Literature has recommended better access and improved quality of mental health services but does not provide successful examples of counties or states that have implemented these recommendations. A child welfare system that offers access to mental health intervention regardless of the child's level of symptomology has not yet been tried by any of the counties that were contacted nor from a preliminary review of programs performed through an internet search.

c. How have stakeholders been involved in the identification of the priority issue to be addressed by the implementation of the proposed Innovative Project?

Information, outreach, and feedback opportunities were held with foster youth, parent partners, and foster families as a part of the community planning process. These community information presentations took place as a part of a larger Community Program Improvement Mapping process held on the following dates: May 4th, 5th, and June 14th.

Initial information was also given to the Behavioral Health Advisory Board about the intention to form an innovative project on the topic of foster care access to mental health on June 13th 2016. A presentation was also given at a Citizen Review Panel on November 29th. All meetings took place in this past year, 2016.

From this point the program was developed in further detail and a final version of the program was presented February 27th, 2017 to the BHAB. At this meeting the proposal was also set for a 30-day review. A public hearing is scheduled for April 17th 2017. If approved by the BHAB the proposal will be presented to the Board of Supervisors on April 25th.

d. Describe the proposed plan for how to continue the Innovative Project or the project elements beyond Innovation funding if the project is successful. Be sure to address how individuals and families receiving services through the proposed project be protected and continuity be provided after the end of Innovation Funding if applicable.

Should the proposed changes to create an expedited comprehensive assessment and intake process lead to improved mental health outcomes for foster youth, the county is prepared to fund the four positions that are being requested for full time and maintain the alterations. Evaluation data that would inform the County about the program's effects will be reported to decision makers in an ongoing process to plan for budget transition possibilities.

III. Evaluation of Proposed Innovative Project

Evaluation: If funded, the County shall assist with further design and methodology for evaluating the effectiveness and feasibility of the Innovative Project and shall conduct the evaluation according to the method designed.

a. Describe the intended mental health outcomes of the proposed project in relation to the primary purpose (section II) in a Logic Model. How will the selected primary purpose be evaluated for the proposed Innovative Project and what are the outcomes and indicators? For example the primary purpose is to increase access to mental health services the evaluation must include a measurement of access.

The primary purpose of the proposed program is to improve the access and quality of mental health services through universal access, prescription medication support, and comprehensive assessments of all foster youth entering the child welfare system. Outcomes will be evaluated primarily through improvements on the CANS-Trauma assessment completed by a clinician. Additional program outcomes and impact will be measured through the county's Avatar tracking system, client feedback surveys, and yearly Child Welfare Indicators Project reports.

Outcomes from attached Logic Model.

Outcomes	Indicators
• Decreased levels of traumatic stress symptoms	• Lower levels in trauma symptoms section on CANS-Trauma Assessment
• Improvement of youth's resilience	• Improvement in child strengths section on CANS-Trauma Assessment
• Lower levels of risk taking behaviors	• Lower levels in risk-taking behaviors section on CANS-Trauma Assessment
• Improvement in foster youth's overall functioning	• Improvement in life domain function section on CANS-Trauma Assessment
• Improved mental health outcomes for parents and caregivers referred to and receiving treatment	• Improvement on the VCOS Assessment

b. Measurement: What measurement tools will be used and what is the plan for how the data be collected? How will the evaluation assess the effectiveness of the elements of the project that are new or changed? Specify the evaluation methods to determine which elements of the project contributed to successful outcomes.

A mixed method design will be used to evaluate each of the following learning goals. Focus groups, client surveys, and assessments will all be collected in order to evaluate outcomes. Evalcorp, a third party contractor with the county, will be brought on to lead the evaluation.

All youth will be assessed with the CANS Trauma Comprehensive at intake, every 3-6 months and at discharge. Surveys will be given to youth and caregivers who received education and support from the LVN and are prescribed psychotropic medication. Ventura County adults are assessed with the VCOS Assessment, outcomes for caregivers who are referred for services will also be tracked. The Child Welfare Indicators Project releases reentry rates for youth within 12 months of reunification annually. Reports on reentry rates therefore will always lag a year behind. Focus groups to take place annually with clinicians treating foster youth to discuss qualitative results of early treatment intervention.

Research Questions/Learning Goals being considered:

1. What is the level of trauma status for foster youth in the county?
2. Does an expedited assessment and service linkage process improve mental health outcomes for foster youth and caregiver(s)?
3. Does providing mental health intervention to all foster youth improve mental heal outcomes? What is the level of improvement for youth experiencing mild to moderate symptoms if any?
4. Does providing a comprehensive intake assessment lead to lower rates of reentr within 12 months of reunification?
5. Does providing support, education, and oversight from an LVN lead to more accurate prescriptions and adherence of psychotropic medication?

Methodology/Data Collection:

Outcome Measurements Tools:

- For foster youth MH outcomes: comparison of the CANS Trauma Comprehensive Assessment; intake, exit, and every 3-6 months.
- For youth who would not typically get immediate intervention: focus groups with mental health providers to discuss results of early treatment intervention model.
- For caregivers MH outcomes who are referred to treatment: comparison of Ventura County Outcomes Survey; intake, exit, and mid-year.
- Systems impact measured by comparison of county foster care data from 2005, 2010, and 2013 and every year during the project (one year lag time).
- Health data (psychiatric appointment tracking and medication adherence) mini-assessment by LVN and pre/post survey administered to families prescribed medications

Research Question	Indicator	Measures being considered
Question 1.	Clinical Profile	CANS –Trauma and MHSA demographics form
Question 2.	Timely Access	Tracking of service delivery through Avatar

Question 3.	Mental Health Status overall and subsection for mild to moderate youth	CANS –Trauma and psychosocial assessment. Two focus groups one with mental health providers and one with parents/caregivers of mild to moderate youth.
Question 4.	Reentry rates within 12 months of reunification	Child Welfare Indicators Project
Question 5.	Psychiatry attendance rates and reported adherence.	Surveys given to caregivers and youth. Tracking of psychiatry appointment attendance in Avatar.

c. How would the results of this evaluation support data-driven decisions about incorporating new and or revised mental health practices into the counties existing systems, services, and in disseminating successful practices?

Should the rapid assessment and mental health treatment process indicate successful outcomes, dissemination of the information will be presented during the community program planning process, the BHAB's public general meeting, and the Board of Supervisors so that all levels of decision making will be informed of the improved program strategy.

d. How does the project intend to ensure the evaluation of the Innovative Project is culturally appropriate and inclusive meaningful involvement by diverse community stakeholders?

The comprehensive intake and assessment process is specifically focused for youth, trauma experience, language, and culture. Foster youth and their caregivers were involved in the planning process and will be included in the evaluation. All VCBH clinicians are trained in cultural competence and required to attend additional trainings annually. Three of the four clinicians to be hired under this proposal are slated to be bilingual and all program processes and documents will be offered in Spanish, Ventura County's threshold language.

Providing universal assessments and referrals for treatment will also ensure that the County eliminates the racial bias identified by Pecora et al. (2009). The standardization of referral processes and coordination will help to reduce disparity in services that may otherwise be subject to implicit biases.

IV. Projected Cost of Innovative Project

a. **Please provide the projected cost of the proposed Innovative Project in a Budget Narrative Format and a yearly annual breakdown. Include a separate breakdown for any leveraged funding sources if applicable:**

Project Budget Narrative*

PERSONEL COSTS

1 Behavioral Health Clinician IV, Licensed, Clinical Supervision (TBD) – Provides staff oversight and clinical supervision, works with BH manager to develop program policies, procedures, protocols; liaise with program partners; oversee program and assessment compliance; ensure performance measures are met; attend and help facilitate training for the CANS-Trauma Comprehensive, trauma informed biopsychosocial assessments, and with all available county resources for other staff; additional responsibilities as listed for the BHC III below.
Time to Project: 36 Months; 100% FTE; Annual Salary $78,800 Project Salary= $248,417

3 Behavioral Health Clinician III, Licensed, (TBD) – Attend training for the CANS-Trauma Comprehensive, trauma informed biopsychosocial assessments, and with all available county resources relevant for families involved in the child welfare system; comprehensive assessment of all youth entering child welfare within 10 days of referral, attend Family Team Meetings, liaise with other agencies for coordinated referrals, enter results in data tracking system (Avatar), provide recommendations for mental health services and other needs for you and caregiver based on assessment results to assist with case plan for family entering child welfare, connect families to LVN if child has prescription for psychotropic medication.
Time to Project: 36 Months; 100% FTE; Annual Salary $75,100 Project Salary= $236,752.66 Total Project Salaries= $710,258

Licensed Vocational Nurse, Mental Health, (TBD)- Creates educational training for all youth and caregivers who are receiving psychotropic medication, provides training to caregivers any time a youth has change of caregiver, provides outreach and creates close partnerships with county psychiatrists and other agencies working with youth in order to provide accurate oversight, advocates for youth if follow-up psychiatric assessments or appointments are not attended, provides on-site support as necessary to ensure proper medication organization and storage, enters pre and post surveys for all families receiving educational trainings, enters all data into performance measurement tracking system.
Time to Project: 36 Months; 100% FTE; Annual Salary $100,886 Project Salary= $318,042

Benefits for all 5 positions = $574,523

Total Personnel Costs = $1,851,240

OPERATING COSTS

Service and Supplies- Communication services cell phones and plans, liability insurance; office/janitorial/other supplies software purchase and licensing. Total= $94,533
Occupancy- facility lease, maintenance/supplies, utilities, improvements. Total= $96,658
Vehicle- County car fuel/maintenance, private vehicle mileage. Total= $46,574
Total Operating Costs: **$237,765**

NON RECURRING COSTS

Computer Tablets- Tablets ($3,000) and data cards ($500), PC Computers ($5,124) Total=$130,622
Vehicles- Four vehicles for clinical staff to perform in home assessments ($25,000)
Total= $102,788
Total Non-Recurring Costs=**$233,410**

OTHER EXPENDETURES

Administration Allocation (15%) – County standard administration cost allocation percentage
Total Other= **$348,362**

*A 5% increase for cost of living, inflation, etc. has been applied to each line item for each fiscal year.

Annual Budget by Fiscal Year

New Innovative Project Budget By FISCAL YEAR (FY)*					
EXPENDITURES					
PERSONNEL COSTs (salaries, wages, benefits)		**FY 17-18**	**FY 18-19**	**FY 19-20**	**Total**
1.	Salaries	**587,229**	**616,591**	**647,420**	**1,851,240**
2.	Direct Costs				
3.	Indirect Costs				
4.	Total Personnel Costs	**587,229**	**616,591**	**647,420**	**1,851,240**
OPERATING COSTs		**FY 16-17**	**FY 17-18**	**FY 18-19**	**Total**
5.	Direct Costs	**75,421**	**79,192**	**83,152**	**237,765**
6.	Indirect Costs				
7.	Total Operating Costs				

NONRECURRING COSTS (equipment, technology)		FY 16-17	FY 17-18	FY 18-19	Total
8.	Tablets, Computers	130,622			130,622
9.	Vehicles	50,000	25,750	27,038	102,788
10.	Total Non-recurring costs	**180,622**	**25,750**	**27,038**	**233,410**
CONSULTANT COSTS/CONTRACTS (clinical, training, facilitator, evaluation)		**FY 16-17**	**FY 17-18**	**FY 18-19**	**Total**
11.	Direct Costs				
12.	Indirect Costs				
13.	Total Operating Costs				

OTHER EXPENDITURES (please explain in budget narrative)	FY 16-17	FY 17-18	FY 18-19	Total
14. Administrative Overhead (15%)	126,491	108,230	113,641	348,362
15.				
16. Total Other expenditures	126,491	108,230	113,641	348,362

BUDGET TOTALS	FY 16-17	FY 17-18	FY 18-19	
Personnel	**587,229**	**616,591**	**647,420**	**1,851,240**
Direct Costs (add lines 2, 5 and 11 from above)	**75,421**	**79,192**	**83,152**	**237,765**
Indirect Costs (add lines 3, 6 and 12 from above)				
Non-recurring costs (line 10)	**180,622**	**25,750**	**27,038**	**233,410**
Other Expenditures (line 16)	**126,491**	**108,230**	**113,641**	**348,362**
TOTAL INNOVATION BUDGET	**969,763**	**829,763**	**871,251**	**2,670,777**

Expenditures By Funding Source and FISCAL YEAR (FY) Leveraged Funding					
Administration:					
A.	Estimated total mental health expenditures <u>for ADMINISTRATION</u> for the entire duration of this INN Project by FY & the following funding sources:	**FY 17-18**	**FY 18-19**	**FY 19-20**	**Total**
1.	Innovative MHSA Funds	83,035	71,048	74,599	228,682
2.	Federal Financial Participation	43,456	37,182	39,042	119,680
3.	1991 Realignment				
4.	Behavioral Health Subaccount				
5.	Other funding*				

6.	**Total Proposed Administration**	**126,491**	**108,230**	**113,641**	**348,362**
Evaluation:					
B.	Estimated total mental health expenditures <u>for EVALUATION</u> for the entire duration of this INN Project by FY & the following funding sources:	**FY 17-18**	**FY 18-19**	**FY 19-20**	**Total**
1.	Innovative MHSA Funds				
2.	Federal Financial Participation				
3.	1991 Realignment				
4.	Behavioral Health Subaccount				
5.	Other funding*				
6.	Total Proposed Evaluation				
TOTAL:					
C.	Estimated TOTAL mental health expenditures (this sum to total funding requested) for the entire duration of this INN Project by FY & the following funding sources:	**FY 17-18**	**FY 18-19**	**FY 19-20**	**Total**
1.	Innovative MHSA Funds	534,365	457,221	480,082	1,471,668
2.	Federal Financial Participation	435,398	372,542	391,169	1,199,109
3.	1991 Realignment				
4.	Behavioral Health Subaccount				
5.	Other funding*				
6.	**Total Proposed Expenditures**	**969,763**	**829,763**	**871,251**	**2,670,777**
***If "Other funding" is included, please explain.**					

b. Provide a preliminary plan for funding the Innovative Project past three years if funds are available and evaluation outcomes warrant the continuation of the program:

The program changes will become new policies and protocols for all children entering child welfare and the staff will be brought in-house as permanent positions.

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Logic Model

Program Goal: To improve the access and quality of mental health services though universal access, prescription medication support, and comprehensive assessments of all foster youth entering the child welfare system.

Assumptions of Program Approach: By providing a comprehensive intake process that includes mental health assessments, coordinated service linkages, medication support, and clinical intervention for all foster youth, VCBH perceives that the youth and their families will experience better mental health outcomes- by reducing symptoms of traumatic stress, preventing the onset of mental illness through early intervention, improving the medication monitoring of youth, and reducing their chances of recidivating in to the system.

Resources	Activities	Outputs	Outcomes	Impact
Key Staff VCBH Program Staff 4 Generalist Clinicians Masters Level (3 bilingual) 1 Licensed Vocational Nurse or Psych-Tech (referred to in this document as LVN) **Collaborative Partners** - VC Public Health - VC Alcohol and Drug - VC Human services Agency - Probation - Contracted Providers **Target Population** All youth entering into court appointed care ages 0-17 and their families and caregivers - A majority (70%) of these families are Latino **Budget** $819,217 per year and $2,457,825 total of MHSA-Innovations funding	**Key Intervention** Provide expedited comprehensive intake assessment for coordinated access to treatment and services **Program Activities** • Intake to include the Children and Adolescent Needs and Strengths-Trauma Comprehensive and psychosocial assessments • Assessments performed by a trained clinician • Full assessment process takes place in 15 days • All youth receive coordinated access to some level of mental health care intervention • Clinicians participate in all Family Team Meetings • Foster youth and their family receive coordinated referrals • Expedited (15 day) assessment for parents/caregivers for appropriate mental health services • LVN facilitates interagency collaboration regarding medication needs of foster youth. • LVN provides support and education about prescribed medication to foster youth and their caregivers • CANS-Trauma Comprehensive given at intake, exit, and follow up intervals of every 3-6 months • Ongoing performance measurement and data collection	**Training Received by Staff:** • Comprehensive psychosocial assessment • CANS-Trauma Comprehensive Assessment Tool training • Trauma Informed Cognitive Behavioral Therapy • County wide services and eligibility applicable to address foster youth/family's needs **Program Process Objectifies** - Comprehensive assessment period cut from 60 to15 days from referral - Performance measurement system created to track all services **Planned Targets for percentage of youth served Per year (Process Objectives):** • 100% of youth receive psychosocial assessment including CANS Trauma Comprehensive • 100% Foster youth receive some level of mental health treatment • 80% participate in mental health services • 100% of foster youth prescribed psychotropic medication receive education and support	**Perceived Programmatic (Outcome Objectives)** ▪ Increased participation in services for foster youth and their families ▪ More accurate placements in appropriate level of care ▪ Greater adherence and ability to track medication needs for foster youth ▪ Improved attendance of follow up appointments with prescribing professional **Perceived Clinical (Outcome Objectives)** • Decreased levels of traumatic stress symptoms • Improvement of youth's resilience • Lower levels of risk taking behaviors • Improvement in foster youth's overall functioning • Improved mental health outcomes for parents and caregivers referred to and receiving treatment	**Perceived Systemic Outcomes** *Short Term Outcomes:* • Increased services and support for foster youth and their families • Improved overall mental health outcomes for foster youth • Improved tracking, agency collaboration, and follow up for foster youth who have medication needs • Reduced numbers of system reentries • Integrated and simultaneous services for foster youth and their families *Long Term Outcomes:* • Greater number of youth placed back in home or other permanency placements • Shorter duration of stay in foster care • Reduced rates of Mental Illness in foster youth alumni • Better physical health of foster youth alumni

Outcome Measurements Tools:

- For foster youth MH outcomes: comparison of the CANS Trauma Comprehensive Assessment; intake, exit, and every 3-6 months.
- For youth who would not typically get immediate intervention: focus groups with mental health providers to discuss results of early treatment intervention model.
- For caregivers MH outcomes who are referred to treatment: comparison of Ventura County Outcomes Survey; intake, exit, and mid-year.
- Systems impact measured by comparison of county foster care data from 2005, 2010, and 2013 and every year during the project (one year lag time).
- Health data (psychiatric appointment tracking and medication adherence) mini assessment by LVN and pre/post survey administered to families prescribed medications.