THE VIRGINIA BEACH BAR ASSOCIATION – JUVENILE AND DOMESTIC RELATIONS COMMITTEE 2017 ANNUAL CLE

9.21.2017 ~ ADVANCED TECHNOLOGY CENTER

TCC – VIRGINIA BEACH

8:30a-9a	Registration and Continental Breakfast
9a-11:00a	SPEAKING "MENTAL HEALTH": How to Assure the Court Has the Best Information from Mental Health Professionals to Make Decisions in Your Case -Dr. Weare Zwemer -Linda Ross, Esq. * 2.0
11:00-11:15a	Coffee Break
11:15a-12:15p	A Traumatology Primer for Judges and Court Officials -John Paradiso, LCSW, VBDHS C&Y -Jennifer Fudala, LCSW VBDHS C&Y *1.0
12:15p-1:00p	Lunch Provided
1:00p-2:00p	Autism Spectrum Disorders and Juvenile Cases -Dr. C. Rick Ellis -Bretta Lewis, Esq. -Paul Powers, Deputy Commonwealth Attorney *1.0
2:00-3:00p	Adolescent Development and Psychotherapy: Effects on Competency Evaluations Dr. Robert Archer Dr. Elizabeth Wheeler The Hon. Deborah V. Bryan, VBJDR Regis Rice, Esq. *1.0
3p-3:15p	Snack Break
3:15p-4:30p	The New Virginia "High Fidelity Wrapped Service Model and Its Effects on Court Service Unit Cases and DHS Cases" -Becky China, VBDHS, CSA Administrator -Rachel Evans, Associate City Attorney -Brandy Newton, Court Services Unit -Brian Hawkins, VBDHS - Parent Representative, Richmond, VA *1.5
4:30-5:15p	"Do I Have Capacity to be an Adult?" Reaching the Age of Majority with Severe Mental Health, Behavioral, or Developmental Delays/Children before the Court on Fostering Futures, Delinquency Matters, and CHINS - The Hon. Stephen C. Mahan, VBCC - Intake, Supervisor, Adult Services, VBDHS, BHDS - Lloyd Clemmons, Jewish Family Service of Tidewater, Inc. - Christianna Dougherty-Cunningham, Associate City Attorney - Kerriel Bailey, Esq. *1.0

7 Possible Credits
- 4 IDC (hopefully)
- 7 GAL
- 7 CLE

SPEAKING "MENTAL HEALTH": How to Assure the Court Has the Best Information from Mental Health Professionals to Make Decisions in Your Case

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-Dr. Weare Zwemer
-Linda Ross, Esq.

* 2.0

SPEAKING MENTAL HEALTH
How to Assure The Court Has the Best Information from Mental Health Professionals to Make Decisions in Your Case

OBJECTIVES

1. To sensitize attorneys and the court to the ethical and professional constraints of Mental Health Professionals in legal settings, depending on their roles.
2. To clearly define for bench, bar, and mental health professionals what legal authority allows the court to gather information from Mental Health Professionals and in which roles.
    a. When may the court compel mental health professionals to divulge otherwise protected information.
    b. Why a MHP may resist and require a court order rather than automatically complying with an SDT.
    c. When heightened standards of privacy apply.
3. To promote the development and publication of a lexicon for common use among both mental health and legal professionals in the Hampton Roads area.

I. Common Roles Mental Health Professionals Play in Court Cases and The Problems That Occur When Lawyers, Judges, And Mental Health Professionals Do Not Understand The Boundaries of The MHPs Role..
    a. Examiner Roles
    b. Therapeutic Roles
    c. Fundamental Differences between the two roles
    d. Conflicts
        i. Assignment of Incompatible Role
        ii. Unclear Expectations from Court
        iii. Proposal for A Local Court Lexicon When MHPs Are Involved In A Case.
            1. A common lexicon for the legal and mental health communities to use in court cases.
            2. A lexicon will help counsel, therapists, and the court understand what is needed and expected of mental health professionals in various roles.
            3. A lexicon will assist all involved assess the quality of the information they are receiving from the MHP.
            4. Some suggested terms to be defined.
        iv. Testimony outside of MHPs role
            1. Properly qualifying experts and their scope of testimony in a given case.
            2. Common ways in which attorneys try to use MHP testimony that do not provide good information to the court and may even provide bad information.

II. Professional and Ethical Conflicts Court Involvement Raises for Mental Health Professionals Working in A Therapist Role.

III. Procedures Under HIPAA and Virginia Law That Attorneys and The Court Must Follow in Order for A Mental Health Professional to Be Able to Provide PHI without Client Consent.

Specialty Guidelines for Forensic Psychology
American Psychological Association

January 2013 • American Psychologist

The goals of these Specialty Guidelines for Forensic Psychology ("the Guidelines") are to improve the quality of forensic psychological services; enhance the practice and facilitate the systematic development of forensic psychology; encourage a high level of quality in professional practice; and encourage forensic practitioners to acknowledge and respect the rights of those they serve. These Guidelines are intended for use by psychologists when engaged in the practice of forensic psychology as described below and may also provide guidance on professional conduct to the legal system and other organizations and professions. For the purposes of these Guidelines, forensic psychology refers to professional practice by any psychologist working within any subdiscipline of psychology (e.g., clinical, developmental, social, cognitive) when applying the scientific, technical, or specialized knowledge of psychology to the law to assist in addressing legal, contractual, and administrative matters.

1. Responsibilities

Guideline 1.01: Integrity
Guideline 1.02: Impartiality and Fairness
Guideline 1.03: Avoiding Conflicts of Interest

2. Competence

Guideline 2.01: Scope of Competence
When determining one's competence to provide services in a particular matter, forensic practitioners may consider a variety of factors including the relative complexity and specialized nature of the service, relevant training and experience, the preparation and study they are able to devote to the matter, and the opportunity for consultation with a professional of established competence in the subject matter in question. Even with regard to subjects in which they are expert, forensic practitioners may choose to consult with colleagues.
Guideline 2.04: Knowledge of the Legal System and the Legal Rights of Individuals
Forensic practitioners recognize the importance of obtaining a fundamental and reasonable level of knowledge and understanding of the legal and professional standards, laws, rules, and precedents that govern their participation in legal proceedings and that guide the impact of their services on service recipients.
Guideline 2.05: Knowledge of the Scientific Foundation for Opinions and Testimony
Forensic practitioners seek to provide opinions and testimony that are sufficiently based upon adequate scientific foundation, and reliable and valid principles and methods that have been applied appropriately to the facts of the case.
Guideline 2.07: Considering the Impact of Personal Beliefs and Experience
Forensic practitioners recognize that their own cultures, attitudes, values, beliefs, opinions, or biases may affect their ability to practice in a competent and impartial manner.

4. Relationships

Guideline 4.02: Multiple Relationships A multiple relationship occurs when a forensic practitioner is in a professional role with a person and, at the same time or at a subsequent time, is in a different role with the same person; is involved in a personal, fiscal, or other relationship with an adverse party; at the same time is in a relationship with a person closely associated with or related to the person with whom the forensic practitioner has the professional relationship; or offers or agrees to enter into another relationship in the future with the person or a person closely associated with or related to the person (EPPCC Standard 3.05).

Guideline 4.02.01: Therapeutic–Forensic Role Conflicts Providing forensic and therapeutic psychological services to the same individual or closely related individuals involves multiple relationships that may impair objectivity and/or cause exploitation or other harm. Therefore, when requested or ordered to provide either concurrent or sequential forensic and therapeutic services, forensic practitioners are encouraged to disclose the potential risk and make reasonable efforts to refer the request to another qualified provider. When providing both forensic and therapeutic services, forensic practitioners seek to minimize the potential negative effects of this circumstance (EPPCC Standard 3.05).

Guideline 4.02.02: Expert Testimony by Practitioners Providing Therapeutic Services Providing expert testimony about a patient who is a participant in a legal matter does not necessarily involve the practice of forensic psychology even when that testimony is relevant to a psycholegal issue before the decision maker. For example, providing testimony on matters such as a patient's reported history or other statements, mental status, diagnosis, progress, prognosis, and treatment would not ordinarily be considered forensic practice even when the testimony is related to a psycholegal issue before the decision maker.

Guideline 4.02.03: Provision of Forensic Therapeutic Services Although some therapeutic services can be considered forensic in nature, the fact that therapeutic services are ordered by the court does not necessarily make them forensic.

6. Informed Consent, Notification, and Assent

Because substantial rights, liberties, and properties are often at risk in forensic matters, and because the methods and procedures of forensic practitioners are complex and may not be accurately anticipated by the recipients of forensic services, forensic practitioners strive to inform service recipients about the nature and parameters of the services to be provided (EPPCC Standards 3.04, 3.10).

Staying in Your Own Lane

Lawyers argue. Experts opine. Therapists report.

Forensic Examiner

- Assessment serves to inform the trier of fact
- Examiners seek to identify and relate an objective or verifiable truth
- Examiners seek to access as many sources of information as possible
- Informed consent is relatively straight forward

Therapist

- Assessment serves to inform treatment
- Therapists rely on their patient's subjective truth as the only relevant truth
- Therapists depend upon their patient's report and perhaps a few others
- Informed consent can be complicated

Example of Reunification Counseling Letter to Attorneys

PSC Psychological Services of Chesapeake, PC

Father's Lawyer, Esquire
Lawyer & Lawyer, PLLC

Mother's Lawyer, Esquire
Lawyer & Lawyer, PLLC

December 31, 2016

Counsel

We understand that you are referring a young girl, who has expressed and been acting upon an extreme fear of her biological father. We further understand that you represent the mother and father in ongoing litigation and that there is or will be a Guardian *ad Litem* representing the child.

Whereas, members of our staff have both provided therapy to children, whose parents are in a custody dispute, and provided forensic evaluations on families before the Court, it is essential that all parties understand that we cannot fulfil both roles at once. Should we serve this child and family, it will be with the goal of lessening or resolving the fear or discomfort the girl is expressing and reestablishing some reasonable contact between father and daughter. By definition, it will be important to bring the father into that work. In the end, we could and would report to the GAL the extent of our therapeutic contacts, who had been in attendance, and whether we had been successful in achieving the goals outlined above. Please know that a treating therapist cannot validly or ethically inform the Court on the amount or nature of visitation to put into place, on whether the child's fear was justified by or proportionate to historical actions by the father, or on the relative contribution of each parent to the child's status. As a treatment provider to a Court-involved patient, we take our direction from the Court or joint agreement of parties and can relay only the extent, nature, and benefit of our therapy. To be able to assure the child's more candid participation, we accept this case on agreement that our primary clinical notes will not be subpoenaed by either party. Finally, while we define these sessions as family therapy, for which medical insurance can be billed, consultations, reports, or testimony necessitated by the family's court involvement will be billed at $000 an hour. We ask that you let us know who would be responsible for those fees, if incurred.

Please forgive the plodding and exacting nature of the conditions set above. It has been this practice's experience that ethically serving kids in custody disputes requires a statement of common expectations at the outset. We believe that our colleagues often flee from the task or give opinions to Court and counsel, which outstrip their role or data set.

As the above is acceptable, we will look forward to the family calling and scheduling an initial appointment.

Respectfully,

Weare A. Zwemer, Ph.D.
Licensed Clinical Psychologist

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516B Albemarle Drive, Chesapeake, Virginia 23322
(757) 548-8848 (fax) 549-1347 email: office@psc-va.com

PSC Psychological Services of Chesapeake, PC

Father's Lawyer, Esquire
Lawyer & Lawyer, PLLC

Mother's Lawyer, Esquire
Lawyer & Lawyer, PLLC

December 31, 2016

Counsel

We write to share the parameters and conditions of the Comprehensive Custody Evaluation, which we would be prepared to conduct with the Conflict family, should Court and counsel agree to our involvement.

Because of the exhausting and exhaustive nature of these evaluations, the assessment would be conducted jointly by Weare Zwemer, Ph.D. and Trusted Colleague, Ph.D. Whereas, we both have been conducting custody and parenting evaluations for over twenty years, we believe that we provide a more effective and comprehensive assessment as a team. Attached, please find copies of Dr. Zwemer's and Colleague's resumes.

We anticipate that this evaluation would cost approximately $00,000, not including fees for testimony, should that be requested. We bill at a rate of $000 an hour for all services immediately related to the assessment, including clinical interviews, record reviews, telephone consultations, team review, report writing, and testimony. Although we are both Licensed Clinical Psychologists, and much of our practice is reimbursable through medical insurance, the administration of a Custody Evaluation is not a medical procedure, but a legal one. As such, all fees for service are the responsibility of the parties involved.

Please know that the retainer fee would be $00,000. Of this sum, $0000 would be due at our initial meeting, and the remainder due before delivery of the final report or the sharing of our results with parents. On average, past assessments have spanned a three-month time period. Our total fee is unlikely to exceed the amount of the retainer, unless court testimony is required.

While parents often find it difficult to attend interviews conjointly, we ask that they meet with us together on initial conference to assure that we share the conditions and requirements of this process in a consistent fashion with both. In this first meeting, neither would be asked to share his/her report of the family history in the presence of the other parent. Rather, we would provide an overview of the process, schedule as many of the necessary interviews as possible, and have each sign releases of information to individuals, who they believe would provide useful information in this assessment.

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The assessment would include individual interviews with and psychological testing of the two parents, individual interviews and psychological assessment (as appropriate) with the both children, conjoint interviews of each parent with one and both children, and home visits to each parent's residence, at a time in which the children are present.

We recognize that divorce and the determination of custody represent extraordinary stressors for both parents and children. We seek to work with all members of the family in a sensitive, professional, and respectful manner.

As we can be of service to this family, please forward contact information for both parents (including mailing addresses) and for all counsel (including facsimile numbers). We are grateful for the Court and counsels' consideration.

Sincerely,

Weare A. Zwemer, Ph.D.
Licensed Clinical Psychologist

Trusted B. Colleague, Ph.D.
Licensed Clinical Psychologist

Example of Co-parenting Counseling Letter to Parents

PSC Psychological Services of Chesapeake, PC

Ms. Mother
Address

Mr. Father
Address

December 31, 2016

Dear Mr. Father and Ms. Mother

It is my understanding that you and your children were referred to me by your attorneys and the Guardian *ad Litem*. From my telephone consultation with (referring agent), I understand that you have found it difficult to co-parent effectively, that your case is set to be settled in the near future by the Norfolk JDR Court, and that co-parent counseling represents one condition of the settlement. I understand that our work together was recommended to improve cooperation and communication across households in the children's best interest.

As Co-parent Counselor, I would initially meet with you together, then each on individual consultation, in order to develop an appreciation for your past, your positions, and your respective perceptions of obstacles to co-parenting. Following that initial information gathering, I reserve the right to meet with one or both of your children to assess their perception of events leading to the present circumstance.

It is my and my practice's position that providing services either to inform the Court or as an alternative to Court involvement does not represent a medical expense, but a legal one. As such, I would charge you $000/hour for interviews. Should collateral work, e.g., record review, phone consultations, correspondence, prove to require extensive time, I would bill you for this effort at the same rate, but I do not foresee this to be of great expense. Unless otherwise agreed, I would expect each of you to pay $00 on each date of service.

I define my purpose as improving the effectiveness of your communication and helping you come to agreement around issues involving your children. Inevitably, agreements reached by both parents in consultation have the greatest likelihood of success. Whereas, I will be keeping notes on our consultations, I will proceed only on the condition that my notes and testimony not be available to future Court actions. If each of you were saddled with the knowledge that how you performed and what you said in this forum was subject to public review, I do not believe you could participate as openly and honestly as this effort requires.

Should information be sought, I will share with Court and counsel only the number of times we consulted, who was in attendance at each session, the nature and content of any agreement we reached, a recommendation as to whether our efforts should continue at that time, and a general statement about the relative success or failure of this process, assigning neither praise nor blame to either parent's respective participation. The only stretch to this confidentiality is that I would ask your permission to consult by phone with your own attorney about your participation and positions. This would not include providing opposing counsel with any information about you. At times, I have found it helpful to include a parent's own attorney in an effort to guide or reassure his/her participation.

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I recognize that the above may read as formal and off-putting. Please know that my sole purpose is to help you effectively and peaceably raise your children. I am less stilted in person. As indicated below, I have shared this missive with counsel, and I urge you to consult with your attorney around any concern or hesitation. Should you call this office and schedule to proceed, I will understand that you and your attorneys have accepted my conditions and our work as defined above.

Not knowing either of your schedules, I will not propose a time and date for our initial consult. If and when you call my office, please share with April, during the day, or Katherine, in the evening, what times and days of the week work better for you and any that would represent a hardship.

I thank you for your consideration and look forward to your response.

Sincerely,

Weare A. Zwemer, Ph.D.
Licensed Clinical Psychologist

Cc: Mother's attorney
Father's attorney
Guardian *ad Litem*

Would the Legal and Mental Health communities benefit from a shared lexicon?

Some Possible Terms for Inclusion in a Lexicon

Family Therapist
Family Assessment (CPS)
Psychological Evaluation
Parental Capacity Evaluation
Comprehensive Custody Evaluation
Parental Fitness
Parental Competence
Reunification Therapy
Coparent Counseling
Parent Coordination
Coparent Mediation
Guardian ad litem for Children
Guardian ad litem for Incapacitated Adults
Guardian ad litem reports
HIPAA-Compliant Medical and Mental Health Records Release Authorization
Qualified HIP AA Protective Order
Post-Adoption Contact Agreement
Mental Disorder
Medical Diagnosis
Psychiatric Diagnosis
Informed Consent

Ideally, developing this would be an inter-community project. What terms would you like to see defined for use in court settings?

Ideas for Possible Lexicon Entries

Comprehensive Custody Evaluation: an exhaustive assessment, which includes the Parental Capacity Evaluation of both parents/parties and of all involved children. The report should include not only the observations and conclusions cited above, but should also provide recommendations around the assignment of sole/joint legal custody, parenting schedule, and other issues, e.g., school enrollment, that have been put before the Court.

Parental Capacity Evaluation: an assessment administered to one or both parents/parties in a custody dispute. The process should include the psychological evaluation of the parent, often including measures of parenting knowledge and values, the psychological evaluation of the child(ren) centered on their functioning and perception of the parent, observations of parent/child interaction, and the gathering of information from a broad range of collateral sources (including other family members, family friends, school records, medical and mental health providers, et al.). The resulting report should describe the adult's capacity to parent the specific child(ren), whose custody is before the Court, at the time of evaluation and into the future. The conclusions should be relevant to, if not directly cite, the factors identified by statute to guide the judge's decision.

Parental Fitness Evaluation: an assessment of a parent, which generally includes a Psychological Evaluation, designed to determine whether that adult possesses a minimal degree of psychological stability, intelligence, and parenting knowledge to safely care for, supervise, and raise a child.

Psychological Evaluation: a generic term for the psychological assessment of an individual, in which clinical interviews, as well as standardized measures of intelligence, personality, psychopathology, cognitive processing, and/or other characteristics are employed. The nature of the assessment and scope of results are determined by the referral question.

OBTAINING PHI RECORDS UNDER HIPAA AND STATE LAW

WHOSE RECORDS ARE YOU SEEKING TO OBTAIN	STEPS TO FOLLOW UNDER FEDERAL AND STATE LAW
General Rule	• Your discovery requests and subpoena must comply fully with the requirements of Va. Code § 8,.01-413 and § 32.1-127.1:03 to be effective. • Mental Health Professionals who are in a therapeutic role in a case may be required by their own professional and ethical duties to force the issue to the point of obtaining a court order directing them to produce patient records. As far as HIPAA goes, 45 CFR 164.512(e)(1) and 45 CFR 164.514(h)(1)(i), specify what the MHP must have to assure that their disclosure of information will not result in a breach of HIPAA privacy provisions.
Your Client (Competent Adult)	1. Have client sign HIPAA-Compliant Medical and Mental Health Records Release Authorization Form.[i] 2. Provider has 30 days to comply, ask for more time, or notify of denial and the reason therefor. (Va. Code § 8.01-413 (B) and § 32.1-127.1:03 (E)) 3. If denied under either Va. Code § 8.01-413 (B) or § 32.1-127.1:03 (F), seek second opinion. 4. If second opinion provider agrees with first provider, request that a copy of the records be released to you instead of client. 5. If denied because you have not established your authority to receive such health records or proof of identity, establish the same in compliance with Va. Code. §8.01-413 B. 6. If denied for any other reason, issue subpoena duces tecum (SDT) allowing 15 days to comply (either by submitting records to you or to court under seal). (Va. Code § 8.01-413 (C)). 7. If treatment provider does not comply or file Motion to Quash within the allotted time, file a Motion to Compel to obtain an order granting you access to the records (Va. Code § 8.01-413 (C)). Obtain a Qualified HIPPA Protective Order prohibiting redistribution of records to your client if provider and second opinion expert

	have opined that it would be harmful for your client to have access to his/her records.[ii] 8. If provider has refused to provide the records to you or your client for 6 months, or has charged a fee in excess of the reasonable fees as set forth in Va. Code § 8.01-413 (B), seek damages as allowed by Va. Code § 8.01-413 (C).
Your Client (**CAC** or **GAL** for Incompetent Adult)	1. Regardless of reason for appointment, upon appointment, request that court enter order giving you access to your client's medical and mental health records, including but not limited to psychotherapy notes and substance abuse/alcohol abuse treatment records pursuant to § 8.01-413 (B). Argue that your client's incompetency (whether because he/she is incarcerated or has been deemed incompetent by the court) hampers your client's ability to aid in your representation of him/her and that medical/mental health records are essential to your representation of your client.[iii] 2. Have client sign HIPAA-Compliant Medical and Mental Health Records Release Authorization Form, if appropriate.[iv] Send written request to treatment provider with your court appointment order and release (if you have it). 3. Provider has 30 days to comply, ask for more time, or notify of denial (Va. Code § 8.01-413 (B) and § 32.1-127.1:03 (E)). 4. If denied under either Va. Code § 8.01-413 (B) or § 32.1-127.1:03 (F), seek second opinion. 5. If second opinion provider agrees with first provider, request that a copy of the records be released to you. 6. If court appointment order does not include a provision allowing you access to records w/out further order of court, follow steps 5 through 8 of "Your Client (Competent Adult)", above, to obtain an order compelling provider to turn over records to you. If necessary, draft a Qualified HIPPA Protective Order limiting redisclosure of records to client and request entry by court.[v] 7. If court appointment order contains provision allowing access without further order of the court, send letter to treatment provider highlighting that provision.[vi]

	8. If provider still does not comply, file Show Cause. Request attorney's fees.
Your Client Child who is the subject of a matter before the court for whom you have been appointed **GAL** (Custody/visitation, CHINS, CPS/TPR, criminal, etc.)	1. If you are appointed in circuit court, make sure court includes provision regarding your access to medical/mental health records pursuant to Va. Code § 32.1-127.1:03(D)(14) without further order of the court.[vii] 2. If you need the records in less than 60 days[viii], issue a SDT, which only requires 15 days' notice. If you need them in fewer than 15 days, you must obtain a court order that requires all documents be provided to you within the number of days you need them. (Ask for sufficient time to allow you to review the records before a report is due or a court date is scheduled—**ANY DEADLINE LESS THAN 15 DAYS REQUIRES A COURT ORDER STATING THE DEADLINE TO ACCOMPANY THE REQUEST**). (Va. Code §8.01-413 (C))[ix] 3. Send your request or SDT with order appointing you GAL to treatment provider. BE CERTAIN YOU INCLUDE THE PART THAT HAS THE COURT ORDERED ACCESS PROVISION IN IT. 4. Allow 30 days to receive records (up to 60 days if provider asks for more time) unless time is of the essence (i.e. need quick turn-around because you the circumstances required a quick court return date), then see #2. 5. If you have not received the records or any other response within 30 days, follow up with a firm but gracious letter drawing attention to the provision that no further court order is necessary for you to receive the records and requiring them to comply within 5 days. Let them know this is your attempt to resolve the matter without filing a show cause for contempt of court. 6. If still no response, file a Show Cause. If provider has failed to respond as required by Va. Code § 8.01-413 (B) and § 32.1-127.1:03 (E). Request attorney's fees.
Your Client Child who is the subject of a matter before the	1. Upon appointment, request that court enter an order pursuant to Va. Code § 32.1-127.1:03(D)(14), which allows you access to the child's medical and mental health records without further order of the court.[x]

court for whom you have been appointed **CAC** (Custody/visitation, CHINS, CPS/TPR, criminal, etc.)	2. Have client sign HIPAA-Compliant Medical and Mental Health Records Release Authorization Form, if 14 or older and appropriate[xi]. 3. Send written request to MHP with your court appointment order and release (if you have it). 4. Provider has 30 days to comply, ask for more time, or notify of denial (Va. Code § 8.01-413 (B) and § 32.1-127.1:03 (E)). 5. If denied under either Va. Code § 8.01-413 (B) or § 32.1-127.1:03 (F), seek second opinion at provider's expense, as allowed by both of the statutes cited. 6. If second opinion expert agrees with first treatment provider, request that a copy of the records be released to you with provision that you will not release to client. (Agree to have a Qualified HIPPA Protective Order entered stating the same, if necessary, to assure provider of their indemnification from prosecution under HIPAA and/or Virginia law.) 7. If court appointment order does not include provision allowing you access to records w/out further order of court, follow steps 5 through 8 of "Your Client (Competent Adult)" above. 8. If court appointment order contains provision ordering access without further order of the court, send letter to MHP highlighting that provision of court order.[xii] 9. If MHP still does not comply, file Show Cause. Request attorney's fees.
Opposing Party Custody/Visitation Matter	1. Send discovery request to party requesting medical and mental health records (including psychotherapy notes and substance abuse/alcohol abuse records). Include a HIPAA-compliant authorization form for opposing party to sign authorizing specified treatment provider(s) to release records to you. 2. If opposing party will not sign, attempt to negotiate with counsel to establish what information will be requested and produced. Both attorneys can protect their respective clients while obtaining what they agree is relevant material by agreeing to a Qualified HIPPA Protective Order.[xiii] By entering such an order by agreement, limit your client's exposure and you address most of the provider's liability concerns. 3. Send SDT to treatment provider with Notice to Health Care Entities (Va. Code § 32.1-127.1:03(H)(2)). Send

	copy of SDT to the pro se party or nonparty witness with a statement of their rights and remedies, including the Notice to Individual required by Va. Code § 32.1-127.1:03(H)(2). 4. If no Motion to Quash filed within 15 days, pursuant to Va. Code § 32.1-127.1:03(H)(5), send notice to provider stating that the time to file a Motion to Quash has passed and that the records must be delivered as specified in the SDT by the date required by the subpoena or within 5 days of the notice. 5. If Motion to Quash filed[xiv], after hearing on motion, provide notice to treatment provider of result of motion.[xv]
Opposing Party Not Custody/Visitation Matter (including but not limited to divorce not involving custody, spousal support, domestic violence)	1. Propound discovery request for mental health records, including psychotherapy notes and substance abuse/alcohol abuse treatment records. Include HIPAA-Compliant Authorization for Release of Records for opposing party to sign. 2. Send SDT to treatment provider with Notice to Health Care Entities (Va. Code § 32.1-127.1:03(H)(2)). Send copy of SDT to the pro se party or nonparty witness with a statement of their rights and remedies, including the Notice to Individual required by Va. Code § 32.1-127.1:03(H)(2). 3. If opposing party or their treatment provider files a Motion to Quash or fails to respond at all, you will need to file a motion to compel. As part of your argument, you will need to establish that: a. Your SDT fully complied with Va. Code § 32.1-127.1:03(H)(2). b. The mental health and/or substance/alcohol abuse problems of the party whose records you seek are at issue in the matter. c. The release of the PHI you seek is necessary for you to prepare for trial and to present for the trier of fact to make a just decision.
Someone Other than Opposing Party	1. If desired records are those of a party who is not necessarily an opposing party (i.e. parents in

(Nonparty Witness, other parent in CPS/TPR case, etc.)	CPS/TPR cases), try negotiating with counsel for exchange of records through releases.[xvi] 2. Issue SDT for nonparty witness' medical/mental health records with proper notices under Va. Code § 32.1-127.1:03(H)(2). 3. Be prepared for a Motion to Quash. 4. Be prepared to argue why the mental health of the person whose records have been subpoenaed is at issue in the case.

[i] See attached example.
[ii] See attached example.
[iii] Often treatment providers will not release records without a HIPAA-Compliant Medical Records Release Authorization form or a court order allowing the requester access, even if it is the patient's attorney. Getting an order at the time of appointment is far easier than coming back later.
[iv] See attached example.
[v] See attached example.
[vi] This is not a required step, but it documents your attempts to work with the treatment provider before taking court action; it increases civility in the practice of law; and it allows you to make a more compelling argument for monetary sanctions against the treatment provider for their refusal to comply with court orders even though you reassured them that the orders already in place protect them from penalty under HIPAA and state law.
[vii] See p. 2 of JDR GAL Appointment Order for the standard wording used in that context.
[viii] Va. Code § 8.01-413 (B) allows treatment provider 30 days to furnish requested records or to request additional time to provide records, in which case, the statute allows not more than 30 days from the date of the written notice to comply with the records request.
[ix] If you are present when appointed as GAL for a child, especially on an emergency case, if the court sets a quick return date and you must review medical/mental health records before the court date, request a specific order that any medical or mental health records requested must be provided to you in less than 15 days—specify the number of days, but if possible, give at least 5 days' turn-around time. Alternatively, you could explain the situation to the provider, request that they allow you to review the records at the their office within your timeframe, and that they provide a copy of the records for your file within the standard statutory time. If provider is unresponsive or uncooperative with you despite your attempts to find a solution to the short timeline, file an SDT returnable to the court on day of court, a witness subpoena for the provider to appear in court to testify, and a show cause for failure to comply with the GAL order allowing access to records and the requirement that MHP must make him/herself available within 72 hours after a request from the GAL to discuss the child's records.
[x] This is the same statute that allows GAL access to the same records. You can suggest that the court use the same wording as used on P. 2 of the standing JDR GAL order.
[xi] See attached example.
[xii] This is not a required step, but it documents your attempts to work with the treatment provider before taking court action; it increases civility in the practice of law; and it allows you to make a more compelling argument for monetary sanctions against the treatment provider for their refusal to comply with court orders even though you reassured them that the orders already in place protect them from penalty under HIPAA and state law.
[xiii] See attached example.
[xiv] If Motion to Quash is filed, keep in mind that HIPAA has a "minimum necessary" rule that requires treatment provider to release exactly that—the minimum amount of information that will comply with an agreement or court order. If opposing counsel will not agree to the terms of a HIPAA-Qualified-Protective Order, be prepared to argue

why the scope of the information you are seeking is necessary and not just a fishing expedition. The court has a duty to balance the privacy rights of the parties with the legitimate need for the trier of fact to have the relevant and necessary information to reach a just decision.

[xv] See Va. Code § 32.1-127.1:03(H)(8) for specific wording for notice if Motion to Quash was filed and resolved resulting in the court's ordering records to be released and the conditions of that the release.

[xvi] The logic for disclosure between allied parties is that the parties may be able to form a more effective joint defense by sharing information on strengths and weaknesses. It is likely that neither party will be willing to give carte blanche to the other, but you may be able to negotiate limited release by the parties allowing disclosure of key information or redacted documents. Perhaps at least allowing each party's attorney to review the records in the possession of the other party's attorney would also be an acceptable outcome. The caution here is that parties who are allies at one point may not be allies at a later point in the litigation.

DRAFTING HIPAA COMPLIANT DISCOVERY DOCUMENTS

There are two ways to request documents of mental health professionals that will either produce results or give you authority to compel the MHP to respond:

1. Court Order or Court-Issued Subpoena. Under 45 CFR 164.512(e)(1)(i), obtaining an order or having your subpoena signed by a judge will automatically provide all the assurance a MHP needs to protect him/her from a HIPAA violation. Be certain you specify what you are seeking because the MHP still has a duty to follow the "minimum necessary" rule under HIPAA and only provide EXACTLY what is covered by order or court-issued subpoena.

2. Attorney-issued Subpoena Duces Tecum or Discovery Request. HIPAA requires the provider to verify your identity and authority to have access to the protected health information (PHI) and to have further assurance that the specific disclosure you are requesting is permissible under HIPAA (45 CFR 164.512(e)(ii) and 45 CFR 164.514(h)(1)(i)).

   To provide the required assurance follow one of the two tracks below:

   a. **Notice.** 45 CFR 154.512(e)(ii)(A). The notice requirement may be satisfied by proof of service of either 1) Notice to Individual form; or 2) Declaration.

      ☐ Proof of service showing that the individual (or his/her attorney) was served a copy of the subpoena or discovery request and a reasonable time to object. A Notice to Individual pursuant to Va. Code Sec. 32.1-127.1:03(H)(1) fulfills this requirement. "Reasonable time" to object is not defined by the HIPAA code, but Virginia Code deems 15 days to be reasonable time to object. Under Va. Code Sec. 32.10127/1:03, the party requesting the information must inform the mental health professional in writing upon the lapse of 15 days that the time has passed and that either no objection was raised or that a Motion to Quash was filed and affirming that the request is consistent with the court's ruling, or modifying the request to comport with it. Reassert the due date or, if the due date has passed, reset it 5 days out from the notice.

      ☐ Declaration 45 CFR 164.512(e)(iii). A declaration by the requesting party showing that reasonable efforts have been made by such party to ensure that the individual who is the subject of the protected health information that has been requested has been given notice of the request. The declaration must establish:

1. 45 CFR 154.512(e)(iii)(A) provides that if the party requesting the information has made a good-faith attempt to provide written notice to the individual (or, if the individual's location is unknown, to mail notice to the individual's last known address); AND

2. The notice contains sufficient information about the litigation or proceeding which in the protected health information is requested to permit the individual to raise an objection to the court or administrative tribunal (45 CFR 164.512(e)(1)(iii)(B)); AND

3. the time for the individual to raise objections to the court or administrative tribunal time have passed (45 CFR 164.512(e)1(iii)(B)); AND

4. **No objections** were filed; or all objections filed by the individual who is the subject of the discovery request or subpoena have been resolved in court by the court administrative tribunal and the disclosures being sought are consistent with such resolution.

b. **Qualified Protective Order.** 45 CFR 164.512(e)(1)(ii)(B) deems sufficient notice given if there is a Qualified Protective Order entered, or at least on the docket for entry.

HIPAA-COMPLIANT MEDICAL AND MENTAL HEALTH RECORDS RELEASE AUTHORIZATION

Patient's Name: _____

Health Care Provider: _____

Person, Agency, or Health Care Entity to whom disclosure is authorized:

_____

What information may be disclosed: _____

How or for what purpose may the information be used: _____

_____

As the person signing this authorization, I understand that I am giving my permission to the above-named health care provider for disclosure of confidential health records that contain protected health information. I understand that the health care provider may not condition treatment or payment on my willingness to sign this authorization unless the specific circumstances under which such condition is permitted by law are applicable and are set forth in this authorization. I also understand that I have the right to revoke this authorization at any time, but I that my revocation in not effective until it is delivered in writing to the person who is in possession of my health care records and it is not effective as to health records already disclosed under this authorization. A copy of this authorization and a notation concerning the person or agencies to whom disclosure was made shall be included with my original health records. I understand that health information disclosed under this authorization might be redisclosed by a recipient and may, because of such disclosure, no longer be protected to the same extent as such health information was protected by law while solely in the possession of the health care provider.

- ☐ I specifically authorize the release of psychotherapy notes.
- ☐ I specifically authorize the release of substance and/or alcohol abuse treatment notes and files.

This authorization expires on _____(date) or (event)

_____.

_____

Relationship or Authority of Legal Representative Signature of Individual or Individual's Legal Representative if Individual is unable to sign.

_____

Relationship or Authority of Legal Representative

_____

Date of signature

This document complies with HIPAA and Virginia Health Records Privacy Requirements as of 9/2017

EXAMPLE OF HIPAA-COMPLIANT QUALIFIED PROTECTIVE ORDER

VIRGINIA: IN THE CIRCUIT COURT OF THE CITY OF VIRGINIA BEACH

_____,
Plaintiff,

v. Civil Action No. _____

_____,
Defendant.

AGREED QUALIFIED HIPAA PROTECTIVE ORDER

On this day, came on for hearing the parties' Joint Motion to Enter Agreed Qualified Protective Order limiting the scope of discovery regarding medical and mental health records (the "Joint Motion") in the above referenced matter. After considering the Joint Motion, the pleadings on file with the Court, and the agreement of counsel, the Court is of the opinion that the Joint Motion should be GRANTED as follows:

WHEREAS, discovery in this matter, including Depositions, Interrogatories, Requests for Admissions, Requests for Production of Documents, and subpoenas, including those Requests for Production and subpoenas sent to third parties in connection with this matter (the "Discovery Material"), may require the disclosure of information deemed to be protected health information ("PHI") from any health care provider/covered entity ("covered entity") as provided for in the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. 1320d et seq. ("HIPAA") and 45 C.F.R. § 164.5 12(e) and/or other sensitive and private information which should otherwise remain confidential and the private property and information of the respective producing parties, third parties, and other witnesses

(collectively, such information appropriately designated as "Confidential" pursuant to the terms herein shall be referred to as "Confidential Information");

WHEREAS, the PHI and other private information of the parties, including documents produced by third parties in connection with this matter, should be given the protection of an Order of this Court to prevent injury to or an invasion of the confidential and private property of the parties and responding third parties and witnesses by reason of any disclosure; and

WHEREAS, the Court agrees that this Qualified HIPAA Protective Order ("Protective Order") is appropriate and advisable, pursuant to 45 C.F.R. § 164.512(e), it is hereby

ORDERED that access and dissemination of Discovery Material shall be governed by the following provisions:

1. Counsel for the responding party (i.e., Plaintiff, Defendants, Intervener, Third-Party Defendant, and/or any Third Party producing documents in connection with this Matter, or Witness) will specifically designate as "Confidential" any information which falls within the scope of confidential information recognized by the Court, including PHI.

(a) Confidential Information may include documents, information disclosed in an interrogatory answer or other discovery response, information revealed during a deposition and information otherwise disclosed in discovery, including documents produced by third parties in connection with this matter. Counsel shall have fifteen (15) days from receipt of any deposition transcript to designate any testimony as Confidential Information.

(b) Confidential Information shall bear the legend "Confidential Information – Subject to Protective Order" (or a substantial equivalent). Information or documents shall be

designated as Confidential Information only upon the good-faith belief that they fall within the scope of protection afforded by the Court.

(c) If counsel for any party believes that the "Confidential" designation has been improvidently applied, he/she shall so advise counsel for the producing party in writing. Should counsel for the producing party fail to withdraw the "Confidential" designation within fifteen (15) days after receipt of such notice, counsel for the objecting party may bring a motion before the Court to determine whether the information in question is, in fact, Confidential Information that should be protected under this Protective Order. Pending a ruling by the Court on the motion of the objecting party, all information designated as "Confidential Information" shall be governed by the limitations of this Order. Any Confidential Information that is attached to any document filed with the Court shall be filed under seal.

(d) If a party to this matter intends to include Confidential Information in any papers to be filed in court, that party shall give all other parties to this matter reasonable written notice under the circumstances, to be transmitted by facsimile (direct fax only) or email (via PDF and/or email), of such intent. Furthermore, the filing party shall attempt to confer with the attorney for the party who originally produced the information regarding the parties' rights and need to file a "Confidential" document with the court. If a "Confidential" document in this matter is filed with the court, the party filing the record shall be filed under seal and excluded from disclosure pursuant to Va. Code §2.2-3705.5 (1).

2. Access to Confidential Information shall be limited to the following designated persons:

(a) This Court or any other court to which this case may be transferred or any appeal to this matter that is taken;

(b) "Counsel," which is defined as counsel for the parties in this matter and those employees of counsel necessary to assist in this matter, mediators and/or special masters.

(c) The parties;

(d) Independent experts who are to testify (testifying experts) or whose expertise and training is required by the attorneys for the named parties in order to prepare for trial (consulting experts);

(e) Court and deposition reporters whose services are used in this action and other persons working for such reporters; and

(f) Witnesses and/or counsel for such witnesses, provided that Confidential Information is used solely for purposes of this matter and that any restrictions as to the use, dissemination, or review of Confidential Information agreed to in writing by the parties (which agreement need not necessarily be contained in this Protective Order) shall be strictly complied with at all times.

3. Persons described in subparagraphs (2)(d) and (2)(f) shall not be given access to Confidential Information unless and until such persons agree to abide by this Protective Order and sign a statement agreeing to be bound by this Protective Order or agree to be bound on the record regarding persons described in subparagraph 2(f). No party shall be required to reveal the identity of its testifying or consulting experts unless the Court determines that such revelation is required to enforce the provisions of this Protective Order and/or to impose sanctions upon any expert whom the Court determines may have violated

his or her attestation. The identity of testifying experts, however, will be provided pursuant to the requirements of the Rules of the Supreme Court of Virginia or other order of this Court.

4. Confidential Information may be used during any deposition taken in this action, subject to the following conditions: (a) only designated persons as defined in Paragraph 2 may be in attendance at the portions of the deposition in which Confidential Information is disclosed; (b) the witness is advised on record or in writing of the existence and contents of this Protective Order, and the witness agrees on the record or in writing to be bound by its terms. If a witness refuses to be bound by this Protective Order, the parties agree to immediately seek a judicial order directing compliance. If this is not feasible, the examination attorney may still ask questions concerning the documents, although they will not be produced to the witness and the deposition shall be designated under seal until further order of the Court.

5. All Confidential Information and documents or testimony designated as "Confidential" as well as duplicates, notes, memoranda and other documents that disclose, in whole or in part, the contents of confidential materials, shall be maintained in the strictest confidence by the parties and counsel and shall be used solely for purposes of this matter. Counsel shall keep a record of all copies of Confidential Information made and shall take appropriate precautions to avoid loss and/or inadvertent disclosure of Confidential Information. However, inadvertent disclosure by a party or any disclosure by any other person bound by this Protective Order of any document or other information during discovery in this action shall be without prejudice to any claims that such material is confidential, privileged or otherwise protected from discovery, and said party shall not be held to have waived any rights by such inadvertent disclosure.

6. At the conclusion of this Matter (including any and all appeals), Confidential Information, including originals, copies, abstracts or summaries thereof, shall, at the sole discretion of the responding party who produced or provided the Confidential information or his/her attorney, be returned to the attorney for the responding party producing or providing the Confidential Information or destroyed, and no copies thereof shall be retained by any other person or entity.

(a) In any case that Confidential Information is furnished to a testifying or consulting expert, the attorney for the party retaining such expert shall have the responsibility of ensuring that all such Confidential Information, including abstracts and summaries containing such Confidential Information, is shall, at the sole discretion of the responding party who produced or provided the Confidential information or his/her attorney, be returned to the attorney for the responding party producing or providing the Confidential Information or destroyed, and no copies thereof shall be retained by any other person or entity.

(b) Notwithstanding any other item of this Protective Order, counsel for a party may retain abstracts or summaries of Confidential Information which contain counsel's mental impressions or opinions. Such abstracts or summaries shall, however, remain subject to the terms of this Order.

7. Nothing herein shall be deemed to restrict in any manner the use by any party of (a) its own documents or materials or (b) documents or materials obtained by a party before this Protective Order was signed or without the specific use of this Protective Order.

8. The purpose of this Protective Order is to expedite the production of documents without resort to a court proceeding; however, the provisions hereof shall not

limit or be deemed to waive the right of any party to seek relief from or greater protection than any of the provisions herein.

9. The parties and their counsel are prohibited from using any Confidential Information obtained with this Protective Order for any purpose other than this matter and any appeals thereof.

10. Nothing in this Protective Order shall be construed as requiring the production of privileged or otherwise protected documents or information.

11. Any party may apply to the Court at any time, upon proper notice, for a modification of this Protective Order with respect to the handling of any document or other materials.

12. Any person or entity who receives Confidential Information pursuant to this Protective Order must shall, at the sole discretion of the responding party who produced or provided the Confidential information or his/her attorney, be returned to the attorney for the responding party producing or providing the Confidential Information or destroyed, at the conclusion of this matter (including any and all appeals) in accordance with paragraph 6 herein.

13. After final determination of this matter, the provisions of this Protective Order shall continue to be binding, and the Court shall retain jurisdiction over the parties and their counsel for enforcement of its provisions.

SIGNED this ____ day of _____, 20____.

_____
HONORABLE JUDGE PRESIDING

PARTY ENDORSEMENTS ON FOLLOWING PAGE

WE ASK FOR THIS:

_____
Attorney for Plaintiff
VSB #
Address
Address
Address
Phone
Fax
Email

_____
Attorney for Defendant
VSB #
Address
Address
Address
Phone
Fax
Email

_____
Guardian *ad litem* for the Minor Children
VSB #
Address
Address
Address
Phone
Fax
Email

Supplemental Resources

Guidelines for Releasing Patient Information to Law Enforcement, American Hospital Association, et al.,

HIPAA Violations and Enforcement, © 1995-2016, American Medical Association. Available online at http://ama-assn.org.

Substance Abuse Treatment and Domestic Violence, Treatment Improvement Protocol Series, No. 25. Revised 2012, 167 pages. U. S. Department of Health and Human Services, Public Health Service, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment, Rockville MD.

HIPAA Administrative Simplification: *Regulation Text 45 CFR Parts 160, 162, and 164*, Unofficial Version, as amended through March 26, 2013, 115 pages. U. S. Department of Health and Human Services, Office for Civil Rights.

"Reconciling the HIPAA Privacy Rule with State Laws Regulating Ex Parte Interviews of Plaintiffs' Treating Physicians: A Guide to Performing HIPAA Preemption Analysis," 40 *Hous. L. Rev.* 1091 2006-2007.

"HIPAA Facts: Parent and Minor Rights," Technical Assistance Support Center of the National Association for Rights Protection and Advocacy.

"Individual Access to Medical Records: 50 State Comaprison," on HealthInfoLaw.org

"Five Key Concepts Every Virginia Litigator Should Know," *Virginia Lawyer,* June/July 2004, pp. 24-27.

"Managing Protected Health Information (PHI) in Virginia," The Medical Society of Virginia.

"Court Orders and Subppoenas," U.S. Department of Health and Human Services, http://www.hhs.gov/hipaa/for-individuals/court-orders-subpoenas/index.html

"Principles of Cooperation for Physicians and Attorneys in the Commonwealth of Virginia," (Fourth Edition), Promulgated by The Medical Society of Virginia, The Virginia State Bar, and the Virginia Bar Association.

Regulations Governing the Practice of Psychology, Virginia Board of Psychology, 18 VAC 125-20-10 et seq., Statutory Authority §54.1-2400 and Chapter 36 of Title 54.1 of the *Code of Virginia*. See especially 18 VAC 125-20-150 and VAC 125-20-160 regarding Standards of Practice, Unprofessional Conduct, and Disciplinary Actions.

A Traumatology Primer for Judges and Court Officials

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-John Paradiso, LCSW, VBDHS C&Y
-Jennifer Fudala, LCSW VBDHS C&Y

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A Traumatology Primer for Judges and Court Officials

What you need to know for cases involving traumatized individuals

John M. Paradiso, LCSW
Crisis Intervention Services Supervisor
EMDRIA and TF-CBT Certified Therapist
Department of Human Services - CYBHS

Jessica Fudala, LCSW
Outpatient Clinician
EMDRIA Certified Therapist
Department of Human Services - CYBHS

Long Story Short

- Avoid ordering specific treatment modalities or terminology such as Trauma Focused Therapy.
- Do order a Behavioral Health Evaluation with attention to traumatic history and comply with treatment recommendations.

Short Story Long: Foundation

- Trauma loosely defined is an injury.
- The book says a trauma is an intense emotional or psychological event that threatens or causes harm to one's emotional or physical well-being.
- Can be a major 5 o'clock news Big "T" event.
- Can be a little "t" event that gets overlooked. Accumulated small t's can cause the most harm over time.
- The person defines the extent of the injury – Not Us.
- **26%** of children in the United States will witness or experience a traumatic event before they turn four.
- National Center for Mental Health Promotion and Youth Violence Prevention

Terminology is important

- You have Latin, we have alphabet soup

PTSD ADD DID DSM AD/HD ODD TF-CBT CBT GAD RAD Axis I MH MHSA SSRI MDD EMDR

- EMDR is a specialized evidence based therapy.
- TF-CBT is a specialized evidence based therapy.
- Trauma Focused Therapy is not a therapy.
- Trauma Informed Care is not a therapy.

Responses to Traumatic Events

- ACE's and ALE's. Adverse Childhood Experiences/ Adverse Life Experiences are accumulated small t events
- ACE's and ALE's interfere with the body's natural tendency to heal itself.
- PTS vs. PTSD vs. cPTSD vs. CPTSD vs. PTSG

Response Continued: Hyper or Hypo

Window of Tolerance

Hyperarousal Zone

2. Sympathetic "Fight or Flight" Response
Increased sensations, flooded
Emotional reactivity, hypervigilant
Intrusive imagery, Flashbacks
Disorganised cognitive processing

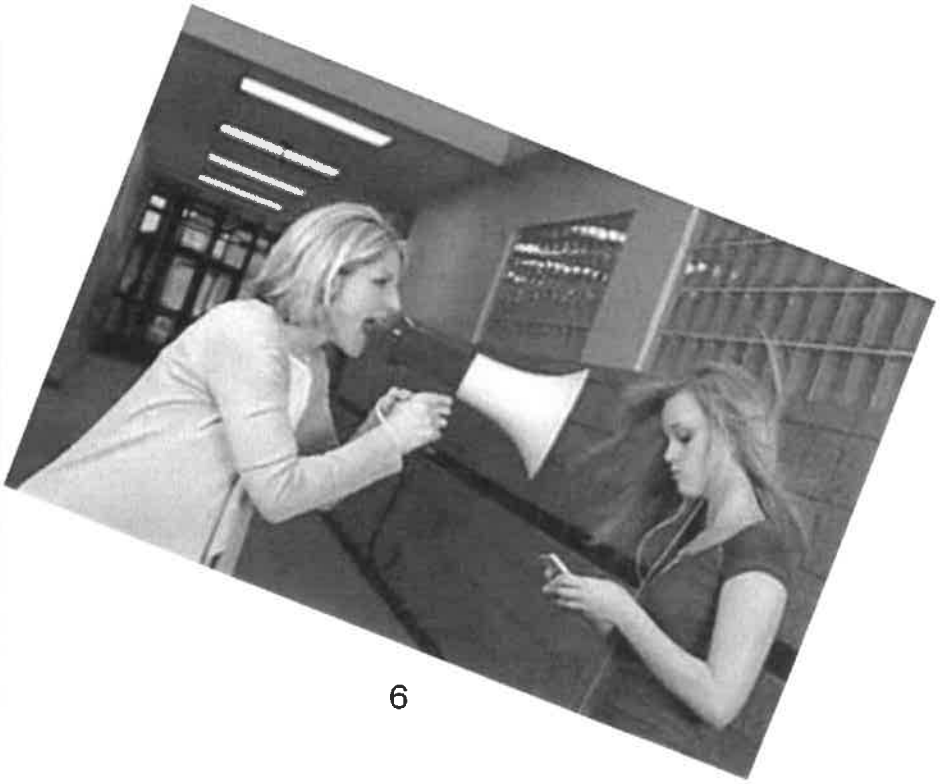
Window of Tolerance
Optimal Arousal Zone

1. Ventral Vagal "Social Engagement" Response
State where emotions can be tolerated and information integrated

Hypoarousal Zone

3. Dorsal Vagal "Immobilisation" Response
Relative absence of sensation
Numbing of emotions
Disabled cognitive processing
Reduced physical movement

Adapted from Ogden, Minton, & Pain, 2006, p. 27, 32; Corrigan, Fisher, & Nutt, 2010, p. 2



Effects of trauma over time

- Emotional Responses- vigilant, guarded, emotional numbing
- Dissociation- mentally separate themselves from the experience; can be used as a defense mechanism
- Behavior- unpredictable, oppositional, volatile, extreme (Wise Owl and Watch Dog)
- Cognition: Thinking and Learning – difficulty with reasoning and problem solving, hard to acquire new skills or information due to distraction of trauma reminders
- Self-Concept & Future Orientation- Their negative expectations interfere with positive problem-solving, and foreclose on opportunities to make a difference in their own lives; stuck in survival mode
- Long-Term Health Consequences- ACE

More effects

People who have experienced trauma are:

- **15 times** more likely to attempt suicide
- **4 times** more likely to become an alcoholic
- **4 times** more likely to develop a sexually transmitted disease
- **4 times** more likely to inject drugs
- **3 times** more likely to use antidepressant medication
- **3 times** more likely to be absent from work
- **3 times** more likely to experience depression
- **3 times** more likely to have serious job problems
- **2.5 times** more likely to smoke
- **2 times** more likely to develop chronic obstructive pulmonary disease
- **2 times** more likely to have a serious financial problem

Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services (http://www.samhsa.gov/children/social_media_apr2011.asp)

Now how do we treat trauma

- The slower you go the faster you get there
- Assessment, Preparation & Stabilization
- Therapeutic Rapport
- Evidence Based Therapy with Fidelity

Efficacy: Is one better than the other?

- Meta-analysis
- What needs to be addressed?
- Leave those decisions to the provider

EMDR or TF-CBT

- Major difference between EMDR and TF-CBT
- Comprehensive Treatment or Single Episode

How to find reputable provider

- Does the practice identify as a Trauma Informed Care Provider?
- Is the provider Certified or trained?
- Certified Clinical Trauma Professional

Policy Challenges

- Premise: Developmental imperative that children experience measured and increasing levels of frustration and failure. *Bruce Perry, MD, Ph.D.

Policy Challenges

- In the absence of those early childhood experiences, do we in the field provide a service by shielding traumatized persons from experiencing natural and logical consequences and risk exposing those in the community to being traumatized by the reactive person?

Questions?

- Thank you for your time and interest

Autism Spectrum Disorders and Juvenile Cases

** Points to Consider in Representing and Defending Juveniles

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-Dr. C. Rick Ellis
-Bretta Lewis, Esq.
-Paul Powers, Deputy Commonwealth Attorney

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Points to Consider in Defending/Representing a Juvenile Defendant with a Diagnoses Consistent with Autism Spectrum Disorder/Asperger's Syndrome

A. Characteristics of Children with ASD:

1. Deficits in back and forth communication, social cues and interactions
2. Differences in non-verbal communication - body language and affect
3. Difficulties in adjusting behaviors to suit social contexts…
4. Difficulty in the home – additional social/psychological stressors
5. Possible Development of Delusions or Psychotic Major Depression

B. Possible Impact on the Child's Case/Defense – Questions for Defense Attorney to Ask

1. Deficits in back and forth communication, social cues and interactions

a. Did the child misread a peer's intent (did the child mistakenly take someone's belongings, misunderstand a request, mistake the nature of the relationship?)?

b. Did the child misread the questions or instructions of a teacher, parent, or police officer?

c. Did the child respond to a question or direction in a way that gave the wrong impression and led an authority figure to infer a confession or admission of guilt?

d. Is the child capable of understanding a Miranda warning or his or her rights? Did tendency to say "yes" without understanding the question or statement lead to improper confession or admission?

e. Are you as counsel competent to interview and represent the child effectively/prepare him or her to testify? If not, is it wise to call in a counselor or psychologist with training to consult? If you are CAC, how do you make this happen within the system? Are there Motions you can file to get this paid for by the Commonwealth?

f. If there is a link between the alleged criminal behavior and the child's condition can be established, can alternative treatments be offered to the Court in lieu of more punitive measures (eg neurofeedback, other therapies)?

g. Was the child being manipulated/controlled/used by a group, gang, peer due to his or her ASD/Asperger's (*See* Dr Ellis notes on Roger)?

h. Does the child have a lack of empathy that could exaggerate the impact of the act? Can this be explained in the context of ASD/Asperger's to mitigate the impact?

2. Differences in non-verbal communication - body language and affect

a. Did an alleged victim misread the child's non-verbal cues and feel threatened when there was no intent?

b. Did an authority figure misunderstand the child's intent and infer a confession, a threat or disobedience/lack of cooperation?

c. Did the police when questioning the child understand and take into account the child's special needs?

d. Does the child have self-soothing or repetitive behaviors that can be misperceived as violent or aggressive? Grabbing, rocking, flailing arms etc.

e. How will the child's differences in affect or body language impact the Court's perception of his or her testimony? How can the attorney assist the court in understanding the child's behavior to avoid misunderstanding of the child's behavior at trial? Expert testimony? How to fund?

3. Difficulties in adjusting behaviors to suit social contexts…

a. Was the child's alleged criminal or inappropriate behavior an outcropping of the child's social and cognitive differences?

b. Can this be an affirmative defense?

c. Can a child on the spectrum formulate the requisite intent for some offenses?

d. Can an older teen defendant child be certified to Circuit Court or tried as an adult if ASD can be shown to have had a significant impact on the child's development or understanding of his or her behavior and its possible consequences?

4. Difficulty in the home – additional social/psychological stressors

a. Would a social history be helpful in understanding mitigating factors that may have contributed to the child's alleged criminal or inappropriate behavior?

b. Does the child qualify as a person with a disability and should the child have a GAL/mental health assessment/neuropsychological assessment to assist with Defense?

c. Do the parents understand the child's needs? Do the parents have the coping skills to assist the child effectively?

d. Could services to the child/parents be more beneficial than punitive measures?

e. Were there social factors at school or at home that contributed to the behavior – bullying, aggression between siblings/parents as a result of increased stress due to lack of ability to cope with ASD behaviors.

5. Possible Development of Delusions or Psychotic Major Depression

a. Is there a possible insanity defense?

b. Is the client competent to stand trial/assist with Defense?

c. Are there triggers in the defendant's disorder that caused the behavior? Are there routines to which the defendant is so attached that the disruption caused a psychotic reaction (see Dr Ellis notes on glasses/touching/irresistible impulse-type defense)?

C. GAL/CAC Concerns in Other (Non-Criminal) Cases Dealing with ASD Children or Parents

1. How does ASD impact a custody case?

a. Do the parents understand the child's needs?

b. Are the parents blaming each other for learning or behavioral issues that are actually a result of unaddressed/unrecognized ASD?

c. Do the parents agree on the diagnosis? Are they capable or working together to support treatments?

d. Could an eval or specialized therapy assist the child and help the parents understand that the child's issues are less environmental and not the other parent's fault?

e. If the child has ASD, is he or she capable of understanding the family dynamics?

f. Could a child with ASD mistakenly misrepresent facts to the GAL due to difficulty understanding social cues?

g. Do the parents/the GAL know how to read an IEP and understand the educational program if it is in dispute?

h. Is the GAL appropriately prepared to interview the child and understand his or her differences in formulating a recommendation for the Court?

i. Are there ways to make the child's experience more consistent and supportive across homes? (eg Diet, routines, rituals, objects, décor, comfort items)

2. How does ASD impact a DHS case

a. When a parent has ASD

Does the parent understand how to care for/nurture the child? What differences in parenting have resulted from issues with the parent's ability to connect and bond? How has the parent's differences in affect impacted his or her ability to parent effectively and meet the child's needs?

Can the parent work effectively with DHS ?

Can the parent benefit from services typically offered?

Can the parent testify and understand the proceedings?

b. When the child has ASD

Are behaviors being misunderstood?

Does the child engage in self-injurious behaviors that may be blamed on the parent or mistaken for abuse?

Has the child's issues with affect and social cues impacted development in ways that may be mistaken for signs of neglect?

Are there social and other stressors that DHS needs to address when formulating service plans?

Is the child capable of expressing a reasonable preference or understanding the proceedings?

Does the child's ASD impact his or her perceptions of the parents?

Does the child mistake everyday slights for abuse or something more sinister?

Does the foster parents/social worker/the GAL know how to read an IEP and understand the educational program to ensure the fewest gaps in the child's development?

Has the child misunderstood any portion of the interview or believed that there was a right/wrong answer?

Is the GAL appropriately prepared to interview the child and understand his or her differences in formulating a recommendation for the Court?

**Are there ethical differences/concerns in representing a child in a case where one party or the child has ASD or related issues? How does this impact attorney/client relationships? How can the attorney/GAL gauge the client's level of understanding?

"Do I Have Capacity to be an Adult?"
Reaching the Age of Majority with Severe Mental Health, Behavioral, or Developmental Delays/Children before the Court on Fostering Futures, Delinquency Matters, and CHINS

****

- The Hon. Stephen C. Mahan, VBCC

- Intake, Supervisor, Adult Services, VBDHS, BHDS

- Lloyd Clemmons, Jewish Family Service of Tidewater, Inc.

- Christianna Dougherty-Cunningham, Associate City Attorney

- Kerriel Bailey, Esq.

"Do I Have Capacity to be an Adult?" Reaching the Age of Majority with Severe Mental Health/Behavioral Issues or Developmental Delays/Children before the Court on Fostering Futures, Delinquency Matters, and CHINS

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Materials:

A. The Fostering Futures Program
B. Incapacity is not the Same as Incompetency or Insanity
C. Adult Services through VBDHS

PART A:

The Fostering Futures Program

Fostering Futures enables LDSS to extend foster care financial and social support and services up to age 21 for two groups of young adults who reach age 18 on or after July 1, 2016:

• Youth who are in foster care when they reach age 18; and,

• Youth who were in foster care at the time of commitment to the Virginia Department of Juvenile Justice (DJJ) and are released from DJJ after age 18 and prior to turning 21.

In addition, adoption assistance may be extended for adopted youth who reach 18 on or after July 1, 2016 who were subject to an adoption assistance agreement that became effective after the youth reached age 16.

Eligibility

Youth who qualify for Fostering Futures are those who reach age 18 on or after July 1, 2016; and:

- Were in foster care in custody of a Virginia LDSS at the time they turned 18 years old but have not yet turned 21, including those who were in care under an entrustment and those who were in non-custodial foster care
- Were in Permanent Foster Care (PFC) when they turned 18. They will remain in PFC and concurrently qualify for Fostering Futures
- Were released from DJJ between ages 18 and 21 and who were in foster care in custody of a Virginia LDSS immediately prior to the commitment to DJJ

Alternative sources of eligibility either by current participation in criteria or by evidence of intent and planning to engage in the activity in the immediate future:

- Completing secondary education or a program leading to a General Education Diploma (GED).
- Enrolled full-time or part-time (at least half-time) in an institution that provides post-secondary or vocational education
- Participating in a program or activity designed to promote employment or remove barriers to employment.
- Employed at least 80 hours per month
- Incapable of engaging in any of the above activities due to a medical condition.

The Voluntary Continuing Services and Support Agreement (VCSSA) and participation in Fostering Futures are voluntary on the youth's part and may be terminated at any time by the youth by verbal or written notification to the service worker. The VCSSA shall be terminated by the LDSS if it is determined that the youth no longer meets the eligibility criteria and conditions.

Services

Maintenance payments are intended to cover the participant's costs for food, shelter, clothing, supplies and personal incidentals. The participant is eligible to receive the total maintenance payment rate and annual supplemental clothing allowance in effect for the age group 13 and over. Fostering Futures maintenance payments may be made directly to the youth with responsibility to pay for rent, groceries and other basic expenses

Housing

Supervised independent living (SIL) setting refers to the allowable living situations of a participant in Fostering Futures. Supervision includes, at a minimum, monthly visits by the service worker or contracted supervision.

Participants in Fostering Futures may reside in a variety of SIL settings. Supervision includes, at a minimum, monthly visits by the service worker or contracted supervision. SIL settings include but are not limited to independent living arrangements. The purpose of a SIL setting is to meet the needs of the youth for supervision and support as he or she moves toward independence.

Selection of a SIL setting should be based on availability, the participant's preference, and his or her skills and readiness to manage the chosen level of living independently (e.g. ability to budget and manage funds, etc.). The service worker does not have to approve an independent living arrangement.

- Foster family home placement in agency-approved or licensed child-placing agency home
- A licensed independent living apartment program.
- Independent living arrangements (adult foster home, college dormitory, rented room or apartment, home of a family member)

Legal Citation

** Fostering Futures does not have a specific code section in the Virginia Code.

Virginia implemented the program by the Appropriations Act of 2016, which incorporated by reference the Federal Statute and Regulations that govern the funding set aside for the states for this program. During the 2016 Legislative Session, HB 203 (Lingamfelter) Extended Foster Care Services and Support Program and SB 436 (Favola) Fostering Futures program were proposed to establish the Foster Futures program to provide services and support to individuals between the ages of 18 and 21 who were formerly in foster care as a minor and are transitioning to full adulthood and self-sufficiency. *Both of these bills failed to pass from the Appropriations committee.* However, language was included in the budget authorizing and funding the Fostering Futures program. Therefore, the correct legal citation to the Virginia Fostering Futures Program is the 2016 Appropriations Act.

PETITION FOR APPROVAL OF VOLUNTARY CONTINUING SERVICES AND SUPPORT AGREEMENT Commonwealth of Virginia VA. CODE § 16.1-242; 2016 Appropriations Act

Court Case No. .....

Agency Case No. .....

..... Juvenile and Domestic Relations District Court

In re: .....
NAME OF PARTICIPANT

....
AGE (YEARS/MONTHS) SEX DATE OF BIRTH

I, the undersigned Petitioner, state under oath to the best of my knowledge and belief that the following are true:

1. [ ] The above-named participant entered into a Voluntary Continuing Services and Support Agreement ("Agreement") with the ..... on ..... through the Fostering Futures program of the Virginia Department of Social Services.
   LOCAL DEPARTMENT OF SOCIAL SERVICES — DATE
2. [ ] The participant was in the custody of the local department of social services:
   [ ] prior to reaching 18 years of age and remained in foster care upon turning 18 years of age.
   OR
   [ ] immediately prior to commitment to the Department of Juvenile Justice and is transitioning from such commitment to self-sufficiency.
3. The following documents are attached and incorporated herein:
   [ ] The Agreement executed on ..... . [ ] Foster care plan.
   DATE

Wherefore, Petitioner requests that the Court:

1. Docket the case for a hearing as soon as practicable if a hearing has not already been scheduled.
2. Issue a summons and attach a copy of the petition to the following:

Participant	Petitioner, Local Department of Social Services
..... NAME	..... NAME
..... ADDRESS	..... ADDRESS
..... ADDRESS	..... ADDRESS

3. Provide notice of hearing to such other persons as the Court may direct.

..... NAME	..... NAME
..... ADDRESS	..... ADDRESS
..... ADDRESS	..... ADDRESS

4. Find that continuing to receive services and support through the Fostering Futures program is in the participant's best interest and approve the Agreement filed with a foster care plan.
5. [ ] Schedule a review hearing to be held within 6 months of the hearing on this Petition.
   OR
   [ ] No further review by this Court is requested.

..... LOCAL DEPARTMENT OF SOCIAL SERVICES

..... DATE

_____ PETITIONER

Subscribed and sworn to before me this ..... day of ..... 20, ...

_____ [ ] INTAKE OFFICER [ ] CLERK

FOR NOTARY PUBLIC'S USE ONLY:

State of ..... [ ] City [ ] County of .....

Acknowledged, subscribed and sworn to before me this ..... day of ....., 20 ..... .

..... NOTARY REGISTRATION NUMBER

_____ NOTARY PUBLIC
(My commission expires: .....)

YOUTH RIGHTS ACKNOWLEDGEMENT FORM

MY RIGHTS AND RESPONSIBILITIES

Directions: Please read the following information on your rights and responsibilities. If you do not understand, it is your service worker's responsibility to explain anything that is not clear to you. Some of these items may not apply to you. When you are sure you understand each statement, place a check mark beside each statement. At the end, you will be asked to sign the form. Your signature means you have reviewed and understand your rights and responsibilities.

☐ Safety - As a young person in foster care; you have the right to be in a safe home that is free of violence, abuse, neglect and mistreatment (exploitation).

☐ Education – You have the right to go to school and get an education that fits your age and any special needs you may have. You also have the right to stay in the same school you were enrolled in before coming into foster care if possible.

☐ Health – You have the right to be regularly taken to doctors and dentists, including eye doctors, for medical evaluation, medical care, and/or treatment as needed.

☐ Appeal – You have a right to appeal the suspension, reduction, termination, delay or denial of services in your transitional living plan for independent living services.

☐ Court Participation – You have a right to attend court hearings involving your care, be consulted in the development of and any revisions to your case and permanency plan. You also have the right to tell the judge what is happening to you and what you want regarding your plan for permanency. You can choose up to two individuals for your case and permanency planning team (subject to agency disapproval if not in the best interest of the youth).

☐ Sibling Visitation – You have a right to have regular contact and visitation with your siblings if you are separated. Your foster care plan shall take into account your wishes. The communication may include but are not limited to face-to-face visits, telephone calls, emails, and video conferencing.

☐ Credit Reports – Beginning at age 14 until age 17, you shall be entitled to an annual credit report free of charge. If there are any inaccuracies, the agency will help to resolve them.

☐ You understand that you may be asked to participate in a National Youth in Transition Database (NYTD) Survey asking questions of older youth and young adults who are or have been in foster care. The purpose of the survey is to learn how to better meet the needs of youth in foster care so they can be successful in life. You understand that if you are or was asked to participate in the survey at 17 years of age, you may be asked to complete the survey on or around your 19th and 21st birthdays.

☐ You understand that Virginia participates in a federal program called Education and Training Vouchers (ETV). The ETV Program is designed to help youth who were in foster care and those adopted from foster care after reaching the age of 16 with funding for qualified post-secondary school and vocation related expenses. For more information about ETV, you understand that you can ask your worker.

☐ You understand that local departments of social services and licensed child-placing agencies may, but are not required to, provide independent living services to persons between 18 and 21 years of age who are in the process of transitioning from foster care to self-sufficiency. Even though anyone over age 18 is an adult under Virginia law, young adults who were in foster care before the age of 18 may continue to receive services from LDSS between ages 18 and 21 under certain conditions. These conditions include:

1. You willingly agree to cooperate with all services and this is documented in your case record.
2. You are making progress in an educational, treatment, or training program; **or**
3. You are in permanent foster care and require continuing foster care to assist me in participating in an educational, training, or treatment program, and I wish to continue receiving services.

☐ At age 18, you shall be provided an official or certified copy of my (1) birth certificate; (2) social security card; (3) health insurance information; (4) medical records; (5) driver's license or state-issued identification card.

☐ You understand that during the 90 days before you turn age 18, you will finalize your plans for successfully transitioning from foster care to adulthood. This Plan for Successful Transition will include the names of adult(s) who have agreed to help you during this transition and in the future. It will also address your specific needs, including housing, health insurance, education, mentors, workforce supports, employment services, and any other needs.

☐ You understand that if you end Independent Living services after reaching age 18 but before your 21st birthday, you can ask that these services be started again. However, the request to resume services MUST BE MADE WITHIN 60 DAYS. You understand these services may not be available to you if you ask for them 61 days after you end services.

☐ You understand the importance of identifying someone to make health care treatment decisions on your behalf, if you become unable to make them and if you do not have or want a relative to make these decisions. You understand that you can identify a health care power of attorney using the form on the Virginia Department of Health's website, entitled "Virginia Advance Medical Directive."

☐ You understand that if you end Independent Living services after reaching the age of 18 and 60 days have passed (from the time you ended services) and you are not yet 21 years of age, then there may be limited funds to purchase needed services on your behalf. Those services may include financial, housing, counseling, employment, education, and other appropriate services to help with your own efforts to achieve self-sufficiency.

☐ You understand that if you are a man ages 18 through 25 and living in the U.S., then you must register with Selective Service. It's the law. According to law, a man must register with Selective Service within 30 days of his 18th birthday. You may be denied benefits or a job if you have not registered.

You can register at any U.S. Post Office or online at https://www.sss.gov/RegVer/wfRegistration.aspx

I have received a copy of the foster care plan dated _____ and that the rights contained therein have been explained in an age-appropriate manner.

Your signature means you have reviewed and understand your rights and responsibilities.

Youth's Signature:		Date:	
Social Worker's Name:			
Social Worker's Signature:		Date:	
Other (Please Print Name):			
Relationship to Youth:			
Signature of Other:		Date:	
Other (Please Print Name):			
Relationship to Youth:			
Signature of Other:		Date:	

ORDER APPROVING VOLUNTARY CONTINUING SERVICES AND SUPPORT AGREEMENT

Commonwealth of Virginia VA. CODE § 16.1-242; 2016 Appropriation Act

Court Case No. .....

..... HEARING DATE AND TIME

..... VIRGINIA BEACH ..... Juvenile and Domestic Relations District Court

In re: ..... NAME OF PARTICIPANT ..... DATE OF BIRTH

Present:

[ ] Participant ..... [ ] Attorney for Participant .....

[ ] Agency Representative ..... [ ] Agency Attorney .....

[ ] Other ..... [ ] Other .....

A PETITION FOR APPROVAL OF VOLUNTARY CONTINUING SERVICES AND SUPPORT AGREEMENT

was filed on ..... DATE . A hearing has been held pursuant to Acts 2016, ____, Item 346 #3c to review and approve the Voluntary Continuing Services and Support Agreement ("Agreement") filed with a foster care plan.

THE COURT FINDS THAT THE PARTICIPANT, WHO IS AT LEAST AGE 18 BUT IS NOT YET AGE 21, IS WITHIN THE JURISDICTION OF THIS COURT PURSUANT TO § 16.1-242 AND FINDS THE FOLLOWING:

1. [ ] The participant was in the custody of the local department of social services prior to reaching 18 years of age and remained in foster care upon turning 18 years of age.

   OR

   [ ] The participant was in the custody of the local department of social services immediately prior to commitment to the Department of Juvenile Justice and is transitioning from such commitment to self-sufficiency.

THE COURT FURTHER FINDS:

2. [ ] Continuing to receive services and support through the Fostering Futures program of the Virginia Department of Social Services in accordance with the Agreement [ ] is [ ] is not in the participant's best interest.

3. [ ] Other

.....

THE COURT ORDERS THE FOLLOWING:

4. [ ] The Agreement with foster care plan is [ ] approved [ ] disapproved.

5. [ ] This matter is set for review on ..... DATE at ..... TIME .

   If the participant enters into a new Agreement with the local department of social services, the local department of social services shall file a Petition for Approval of Voluntary Continuing Services and Support Agreement with a foster care plan no later than 30 days prior to the hearing date.

   OR

   [ ] No further review by this court is required at this time.

..... DATE

_____ JUDGE

PART B:

Incapacity is not the same as
Incompetency or Insanity

WHAT IS THE DIFFERENCE BETWEEN THE TERMS "NOT COMPETENT TO STAND TRIAL," "NOT CRIMINALLY RESPONSIBLE" AND "INCAPACITY" (I.E. IN GUARDIANSHIP PROCEEDINGS)?

3 CONCEPTS:

1- **MENTALLY COMPETENT TO STAND TRIAL**
2- **NOT CRIMINALLY RESPONSIBLE -NGRI**
3- **INCAPACITATED**

[Note: NGRI or "not guilty by reason of insanity" arises solely in the context of a criminal case; a guardianship proceeding is a purely civil matter. However, as discussed further below, there are instances where the concepts may become intertwined.]

MENTALLY COMPETENT TO STAND TRIAL V. NOT CRIMINALLY RESPONSIBLE

Whether a person charged with crime is mentally competent to stand trial is a discrete question, governed by different medical and legal standards from the question of mental responsibility.

To be *competent to stand trial* a defendant must have, at the time of his trial, sufficient present ability to consult with his lawyer with a reasonable degree of understanding-and a rational as well as factual understanding of the proceedings against him.

A claim that the defendant was *not criminally responsible*, on the other hand, is unconcerned with the defendant's understanding of his situation at the time of trial, but is directed entirely to his capacity to understand and to control his conduct at the time of the commission of the offense. This is also known as the "insanity defense"- a person successful in this defense is NGRI, or "not guilty by reason of insanity." For NGRI-the test is whether 'at the time of such conduct as a result of mental disease or defect he lacks substantial capacity either to appreciate the criminality of his conduct or to conform his conduct to the requirements of law. That a defendant may have exhibited such an absence of capacity to control his conduct as to indicate the possibility of a defense of insanity does not, of itself, answer the wholly different question of whether his understanding is presently so limited as to require that he not be tried at all. The one question may have little or no bearing upon the other, for many defendants who may not be held criminally responsible for their unlawful acts are clearly competent to stand trial.

INCAPACITY

The court does not equate legal competence-competence to stand trial-with medical competence-competence to make decisions concerning one's own medical care and/or other life choices. It is plain that these two capabilities are not the same. If a person can be declared incompetent based on disagreement with a medical choice he has made, the right to make personalized and individual decisions concerning one's own body would become a nullity.

"A person may be competent to make some decisions but not others."); Freedman, *Competence, Marginal and Otherwise: Concepts and Ethics,* 4 Intern.J. of L. & Psychiatry 53, 56 (1981) ("The test of competency varies from one context to another. In general to be considered competent an individual must be able to comprehend the nature of the *particular conduct* in question and to understand its quality and its consequences.") (quoting Roth, Meisel & Lidz, *Tests of Competency to Consent to Treatment,* 134 Am.J. Psychiatry 279 (1977)) (emphasis added); Hardisty, *Mental Illness: A Legal Fiction,* 48 Wash.L.Rev. 735 (1973) (a person may be considered competent for some legal purposes and not for others); Friedman, *Legal Regulation of Behavior Modification,* 17 Ariz.L.Rev. 39, 76 (1975) (capacity, like voluntariness, is a requirement of variable demands).

The very foundation of the doctrine of informed consent is every one's right to forego treatment or even cure if it entails what *for him* are intolerable consequences or risks, however warped or perverted his sense of values may be in the eyes of the medical profession, or even of the community, so long as any distortion falls short of what the law regards as incompetency. Individual freedom here is guaranteed only if people are given the right to make choices that would generally be regarded as foolish ones. 2 F. Harper, F. James, & O. Gray, *The Law of Torts* § 17.1 (2d ed 1986). G. Morris, *Dr. Szasz or Dr. Seuss: Whose Right to Refuse Mental Health Treatment,* 9 J. of Psychiatry & Law, 283, 290 (1981) (deciding whether a patient is competent by determining whether he agrees with the psychiatrist's proposed treatment undermines the concept of patient autonomy and abrogates the right to refuse treatment). There must be more on which to base a conclusion that a person is incompetent than the mere fact that the person has acted in a manner which to an outside observer appears less than advantageous.

Therefore, an **"incapacitated person"** means an adult who has been *found by a court* to be incapable of receiving and evaluating information effectively or responding to people, events, or environments to such an extent that the individual lacks the capacity to (i) meet the essential requirements for his health, care, safety, or therapeutic needs without the assistance or protection of a guardian or (ii) manage property or financial affairs or provide for his support or for the support of his legal dependents without the assistance or protection of a conservator. Thus- a finding that the individual displays poor judgment alone shall not be considered sufficient evidence that the individual is an incapacitated person within the meaning of this definition.

WHERE MIGHT THESE CONCEPTS INTERTWINE?

Often a criminal defendant is held in jail pending transfer to a psychiatric facility; it is usually at this time that they are seen as being somewhat in limbo. Typically, these individuals do not have a guardian, and may even have not yet been fully evaluated by a psychiatrist or other medical professional. Occasionally, a medical emergency with one of these individuals will arise that triggers the question of whether the individual is competent to give informed consent and/or to refuse treatment. Thus, it may be necessary for us to pursue guardianship, a judicial authorization for treatment, and/or an order for the provision of emergency adult protective services.

In the context of a delinquency proceeding or a foster care case (or even an on-going child protective services case), a youth before the court may be coming of age and lack capacity. It is important to establish *prior to the age of 18* whether the youth will need supportive services and to determine the extent to which he or she will be able to be self-sufficient. In many cases, lesser restrictive alternatives can suffice (powers of attorneys, representative payees, etc.). However, unfortunately, due to cognitive, developmental, behavioral, and mental health issues, many youth before the Court will be deemed unable to give informed consent and will require guardianship so that they can be effectively placed in supportive living programs and continue to receive treatment.

Virginia Code §64.2-2001 (C)

Where the petition is brought by a parent or guardian of a respondent who is under the age of 18, or by any other person and there is no living parent or guardian of a respondent who is under the age of 18, the petition may be filed no earlier than six months prior to the respondent's eighteenth birthday. Where such a petition is brought, a court may enter an order appointing the parent or guardian of the respondent, or other person if there is no living parent or guardian, as guardian or conservator prior to the respondent's eighteenth birthday. Such order shall specify whether it takes effect immediately upon entry or on the respondent's eighteenth birthday. Where the petition is brought by any other person and there is a living parent or guardian of a respondent who is under the age of 18, the petition may be filed no earlier than the respondent's eighteenth birthday.

§ 64.2-2005. Evaluation report

A. A report evaluating the condition of the respondent shall be filed, under seal, with the court and provided to the guardian ad litem, the respondent, and all adult individuals and all entities to whom notice is required under subsection C of § 64.2-2004 within a reasonable time prior to the hearing on the petition. The report shall be prepared by one or more licensed physicians or psychologists or licensed professionals skilled in the assessment and treatment of the physical or mental conditions of the respondent as alleged in the petition. If a report is not available, the court may proceed to hold the hearing without the report for good cause shown, absent any

objection by the guardian ad litem, or may order a report and delay the hearing until the report is prepared, filed, and provided.

B. The report shall evaluate the condition of the respondent and shall contain, to the best information and belief of its signatory:

1. A description of the nature, type, and extent of the respondent's incapacity, including the respondent's specific functional impairments;

2. A diagnosis or assessment of the respondent's mental and physical condition, including a statement as to whether the individual is on any medications that may affect his actions or demeanor, and, where appropriate and consistent with the scope of the evaluator's license, an evaluation of the respondent's ability to learn self-care skills, adaptive behavior, and social skills and a prognosis for improvement;

3. The date or dates of the examinations, evaluations, and assessments upon which the report is based; and

4. The signature of the person conducting the evaluation and the nature of the professional license held by that person.

C. In the absence of bad faith or malicious intent, a person performing the evaluation shall be immune from civil liability for any breach of patient confidentiality made in furtherance of his duties under this section.

D. A report prepared pursuant to this section shall be admissible as evidence in open court of the facts stated in the report and the results of the examination or evaluation referred to in the report, unless counsel for the respondent or the guardian ad litem objects.

Do I need a conservator too? Virginia Code §64.2-2009(D) A conservator need not be appointed for a person (i) who has appointed an agent under a durable power of attorney, unless the court determines pursuant to the Uniform Power of Attorney Act (§ 64.2-1600 et seq.) that the agent is not acting in the best interests of the principal or there is a need for decision making outside the purview of the durable power of attorney or (ii) whose only or major source of income is from the Social Security Administration or other government program and who has a representative payee.

PART C:
Adult Services through VBDHS

ADULT SERVICES OFFERED THROUGH VBDHS

Department of Social Services – ADULT SERVICES

Adult Protective Services (APS)

Adult Protective Services (APS) are provided, regardless of income, to persons 60 years or older and incapacitated adults age 18-59 who are abused, neglected and/or exploited. Investigations are conducted to determine the need for protective services and arrangements are made for the provision of these services.

The Social Services Division receives reports and conducts investigations to determine the need for protective services and provides or arranges for services needed. Reports may be made Monday through Friday, between 8:30 a.m. and 5 p.m. If calling after hours or on the weekends please use the Virginia state hotline at 1-888-83ADULT.

The Adult Protective Services Unit is located at the Witchduck Annex, 256/258 N. Witchduck Rd, Virginia Beach, 23462. **To make an APS report, please contact our hotline at (757) 385-3550.**

Adult Foster Care (AFC)

The Adult Foster Care Program is designed for individuals who require supportive services to live in the community. Persons placed in the Adult Foster Care homes have needs which range from geriatric, mental health, mental retardation, and young adults with lifelong disabilities who were former foster care children, all of whom desire a comfortable home environment with extra support for caring providers.

The Social Services Division of the Human Services Department is looking for providers who will supervise up to three adults in their home to provide meals, recreational activities, and a comfortable home environment. A representative from the Social Services Division is available to offer assistance to all adult foster care providers and the adults placed in each home.

To inquire about becoming an adult foster care provider, please contact our hotline at (757) 385-3550.

There are two specific programs designed to meet the needs of low income or disabled citizens of Virginia Beach who need either in-home or placement in a facility:

Companion Services
Services may be provided to adults who are unable to care for themselves due to physical or mental limitations. Supplemental Security Income (SSI) recipients and certain other low income persons may receive in-home care and light housekeeping services. These services are provided by a licensed agency, under a contractual arrangement with Virginia Department of Social Services. Recipients must live in Virginia Beach.

Facility Placement and Personal Care
For facility placement, an assessment must be completed to determine appropriate level of care. Determination is made by a screening team comprised of Adult & Family Services and Virginia Beach Department of Public Health Staff. If nursing home level of care is needed, an array of options may be available including day programs, personal care and nursing home placement.

Virginia Beach Department of Human Services-Behavioral Health and Developmental Services Division

CRISIS SERVICES

Emergency Services: Immediate telephone and in-person crisis assessment, intervention, and consultation is available 24-hours, seven days a week. Emergency services provide screening for psychiatric hospitalization and crisis stabilization.

Crisis Stabilization Program: The Community-Based Crisis Stabilization program provides direct Mental Health care to adult non-hospitalized individuals experiencing an acute psychiatric crisis that may jeopardize their current community living situations. The goals of the program are to do the following: Avert hospitalization or re-hospitalization through step-down or step-up services from acute care, intermediate care and Crisis Stabilization Units, provide a normative environment with a high assurance of safety and security, stabilize individuals in a psychiatric crisis, mobilize the resources of the community and natural support systems for ongoing maintenance and rehabilitation and symptom and behavior management through individual and group therapy.

Crisis Intervention Teams (CITs): Crisis Intervention Teams are designed to reduce negative interactions between individuals with serious mental illness and law enforcement officers, including incidents of violence, and to divert individuals from punitive incarceration to appropriate medical treatment. CITs are formed through the collaboration of mental health providers, law enforcement agencies, family members of individuals with mental illnesses, and the individuals themselves. This coalition develops plans to address systems issues, including the best way to transfer someone from law enforcement custody to mental health treatment; and crisis intervention situations, including teaching law enforcement officers how to recognize and de-escalate a psychiatric crisis to prevent injury or death.

Since its development in 1988 in Memphis, CIT has been implemented by hundreds of communities across the country and statewide in several states. Studies show that CIT trained officers identify individuals who need psychiatric care and are 25% more likely to transport an individual to a

psychiatric treatment facility than other officers. CIT training also reduces officer stigma and prejudice toward people with mental illness. Research also shows that police-based diversions in general and CIT in particular, significantly reduce arrests of people with serious mental illness. Individuals diverted through CIT and other programs receive more counseling, medication and other forms of treatment than individuals who are not diverted.

CIT is a community partnership that allows individuals with mental illnesses' to be redirected from the Judicial System to the Health Care System. It is a more educated, understandable and safer approach to mental health crisis events. It provides law enforcement-based crisis training for officers assisting citizens with mental illness. Officers are part of a specialized team which can respond to a mental health crisis at any time. CIT is now used in over 400 law enforcement agencies worldwide, including Australia, Israel, Canada, and Sweden.

HOUSING SUPPORT

Supportive Residential Services (SRS): SRS provides a continuum of supportive and supervised residential options for adults who have active cases with the Virginia Beach BHDS division to include transitional housing, adult foster care, assisted living facilities, co-occurring transitional housing, and subsidized housing with in-home support. The program also includes mental health skill building services that focus on the acquisition of skills in activities of daily living such as personal safety, nutrition, medication management. These services are person-centered and are committed to maximizing individual self-determination, personal choice and decision-making to enhance quality of life with full integration into the community. Services provided are determined by person-centered assessments, which become the basis for the specific goals, objectives and supports necessary for community success and personal fulfillment.

Projects for Assistance in Transition from Homelessness (PATH): The PATH program was authorized by the Stewart B. McKinney Homeless Assistance Amendments Act of 1990 and has been an active outreach service under the Virginia Beach Human Services umbrella in Virginia Beach for 20 years. PATH provides services to individuals with serious mental illness, including those with co-occurring substance use disorders, who are experiencing homelessness or are at imminent risk of becoming homeless. PATH can refer individuals to Mental Health Substance Abuse Services, primary health services and relevant housing services, such as the Virginia Beach Connection Point.

PATH provides training to the teams working in shelters, health clinics and to other organizations where homeless require services. PATH can provide presentations for any organization desiring more information on homelessness.

For more information, please contact Cheryl Molinet, Team Leader at (757) 636-3160.

CASE MANAGEMENT AND OTHER REHABILITATIVE AND SUPPORTIVE SERVICES

Adult Outpatient Services: Provides treatment for Virginia Beach residents age 18 and over with substance use, mental illness and co-occurring disorders. Services include individual, family and group therapy, psychiatric evaluations, and medication management. A wide variety of group topics are offered including cocaine addiction, recovery, substance dependence, and substance use influenced by trauma.

Adult outpatient services are staffed at two locations:

- Pembroke 6 - (757) 385-0511 - 297 Independence Blvd, Ste 126
- Magic Hollow I - (757) 385-8222 - 3143 Magic Hollow Blvd

Adult Day Treatment: Group therapy and education are provided for persons with moderate to severe levels of mental illness, substance use, or co-occurring disorders.

Beach House: Beach House is an empowering clubhouse community providing the highest quality psychiatric rehabilitation services, enhancing the quality of life and community integration of its members, and promoting personal dignity and independence. Utilization of Beach House is voluntary - members are free to come and go as they please, and to decide how they wish to utilize their time at the clubhouse. Members and staff members work side by side to complete the unit activities that keep the clubhouse running smoothly. Beach House focuses on developing employment and promoting the development of relationships through active involvement in the work ordered day activities of the clubhouse. Members need to be actively involved in the development of service plan goals, and continue to work on these goals throughout their time at Beach House.

Work Ordered Day Activities through Beach House:

Clerical Services Unit: Clerical activities include; publishing a daily and monthly newsletter, photocopying of mail and maintaining the mail room, telephone reception, shredding, processing of travel vouchers, daily processing of attendance data, formulating a monthly attendance report, front desk reception, ordering and distributing office supplies for the house, maintaining personnel information, maintaining the Beach House Thrift Store Account, facilitating repairs for the house, checking courier mail daily, distributing faxes, updating and maintaining med sheets, maintaining the Beach House database, developing and disseminating reports monthly, researching community resources, ensuring network coordination and overseeing vehicle maintenance.

Retail Unit: Retail Unit activities include: procurement of donations for the Beach House Thrift Store, scheduling of donations pick up in the community, counting Thrift Store money, processing of thank you letters for donations, daily operation of the Thrift Store, Beach House custodial supplies inventory, overseeing of the Beach House Health and Safety training, tours of Beach House and coordination all visitors, intake and orientation for new members and coordination of Eastern State Hospital visits. If you are interested in making a donation, Please call 757-385-6946. Through these donations members are able to have clothing to wear to work and bicycles to get them there. If also provides furniture for their homes as well as electric appliances.

Food Services Unit: Providing a meaningful work-ordered day experience through the daily operation of the kitchen, snack bar and completion of other activities. We are dedicated to preparing and providing nutritious lunches in a timely manner, in an environment of unity and cooperation between staff and members of Beach House.

CORE unit (Community Opportunities through Recreation, Education and Employment): Activities include the coordination of recreational and social activities and transportation for evening and weekend programs, solicitation of complimentary tickets and volunteers for these recreational activities and coordination of the Beach House educational services. Coordination of Transitional Employment positions and the process of referrals and coordination with the Department of Rehabilitative Services for members also is the responsibility of this unit.

Transitionall Employment Program (TEP): TEP is a part-time, staff-supported employment program, which enables members to develop their work habits and build self-confidence in a normal

community work environment. Beach House staff provide members with onsite training, support, & back-up services.

Supported Employment (SEP): Members are assisted to get full or part time, independent employment in a field chosen by the member and without time limits. Beach House can refer members to the Department of Rehabilitative Services to obtain employment services. TEPs help members to get ready for independent or supported employment.

Educational Services-Beach House Tutoring Services: Beach House works with the Tidewater Literacy Council (TLC) to assist individuals who are interested in developing their literacy skills and obtaining their GED. Members help other members to achieve this through the coordination of the program and becoming tutors. Other tutors are sought through the general community. The Administrative Assistant coordinates the Educational Program with the assistance of the Educational Monitors.

Recreational Program Services: In an attempt to further enhance the member's quality of life and community integration; Beach House operates a comprehensive recreational program, which is primarily in the evenings on weekends. The recreational program will attempt to structure its program according to the needs and desires of the membership as a whole. Some activities will be free of charge, while others will have a cost to participate. All activities will focus on improving the member's quality of life, community integration, good mental and physical health, and diversity. Some activities have included: ballgames, movies, museums, putt-putt, etc.

Social Program Services: The Social Program provides members opportunities to socialize in the clubhouse after hours during the week & on Saturdays. This program encourages building better relationships between members and/or staff. The Social Program offers arts & crafts, board games, card tournaments, dancing, exercise, movies, and many other activities, which help members to explore talents and hobbies. Each month there is an evening Social Program activity.

Recovery is Possible Meetings: This meeting is on Wednesday evenings and for those members who need help conquering any type of addiction. Its' mission is to be clean, sober and addiction free through education and support from others in recovery.

The Harbour: The Harbour is an adult day support program that provides psycho-educational and skill development activities for consumers. These services help promote self-sufficiency and avoid hospitalization. Participation ranges from three to five days per week, four hours per day.

Located at 3160 Magic Hollow Blvd., Virginia Beach, VA; please4 call (757) 385-4010 for information.

The Pathways Center at Birdneck Circle: Facility operates 24 hours, seven days a week providing crisis stabilization for individuals with co-occurring disorders experiencing a psychiatric crisis, medical withdrawal from alcohol and other drugs, and serves as a link to continuing treatment and services.

Located at 409 Birdneck Circle, Virginia Beach, VA; please call (757) 385-6950 for information.

Senior Resource Center: Senior Resource Center is located at 912 Princess Anne Road in the Creeds area. It is a place for seniors and their families to go for information, assistance, activities, and socialization. Open five days a week and

staffed primarily by volunteers with one DHS Liaison, the Center provides a varying schedule of activities and lectures at no cost.

For information, please call 757-385-2175.

Senior Respite Care: Respite Care provides a temporary break from care-giving responsibilities allowing the family caregiver time to regroup, renew, recharge and restore balance in life and reduce stress. The in-home adult sitter provides supervision and socialization to individuals who live with their primary caregiver and who are not safe to be left alone due to illness or dementia. The respite receiver must reside with a caregiver and be 60 years of age or older; if 18-60 years old, must have a dementia diagnosis.

For information, please call 757-385-4135.

Supportive Living Program

The Supportive Living Program (SLP) serves residents of the City of Virginia Beach who have a diagnosis of Intellectual Disability. Services provided include person-centered planning to assist individuals to develop their abilities as much as possible while residing in community settings throughout the City of Virginia Beach. All components of this program are licensed by the Virginia Department of Behavioral Health and Developmental Services (DBHDS). Intermediate Care Facilities are also certified by the Virginia Department of Health.

All referrals to Supportive Living Program services are made through Developmental Services Case Management by calling (757) 385-0600.

Behavioral Consultation Services

Behavioral Consultation Services are offered by a certified Positive Behavioral Support Facilitator to assist individuals who have challenging behaviors lead more productive and successful lives. Activities of this service include interviewing and observing the individual, collecting data and developing a behavior plan that best suits the individuals' need. Intervention strategies are structured to identify areas of concern, to understand the meaning of the behavior, and to implement behavior plans designed to reduce problem behaviors and teach essential replacement skills. Persons who support individuals in the program are trained on replacement interventions to ensure success of the individual. All interventions are based on Positive Behavioral Supports and Person Centered

Thinking. Individuals are referred by their support coordinator and this service is provided Monday - Friday, 8:00 am - 5:00 pm.

Supported Residential Services

SLP individuals receive support, assistance and instruction on how to be safe and successful members of the community. Whether it is grocery shopping, managing money, or home safety, SLP will teach the skills necessary to achieve a better quality of life. The program also will coordinate doctor and dental appointments, and assist with medications.

Mental Health Support Services

Serves individuals with a diagnosis of intellectual disability and serious mental illness, who need support in major life activities. Individuals must be willing to reach agreement with staff in developing an Individual Service Plan (ISP). Services may include training or reinforcement of skills and appropriate behavior related to health and safety, personal care, activities of daily living, use of community resources. Other services may include monitoring of health, nutrition and physical condition, and assistance with medication management.

Psychosocial Rehabilitative Day Program - Rising Tides

This program is provided to adult residents eighteen years or older that reside in Virginia Beach, that have Medicaid, a diagnosis of intellectual or developmental disability and a diagnosis of serious mental illness. The mission of the program is to help promote self-sufficiency and avoid hospitalization. Activities include psycho-educational and skill development activities that focus on assisting the individual in developing skills and providing support in coping with the disability. The program provides a variety of groups and activities; treatment consists of participation in structured groups about mental illness, ways to cope with symptoms, prevent relapses, general health, exercise, nutrition, medication monitoring, skill building in activities of daily living as well as therapeutic and recreational opportunities. The program provides activities to individuals three (3) days a week at the SkillQuest services location.

Residential Services

Individuals receive services in group homes located in the City of Virginia Beach. Services are primarily funded via Medicaid Mental Retardation Waiver monies. Services may include support and assistance with money management, personal care, participation in recreational and social activities, and coordination of medical and dental care as needed. Meals are prepared on the premises according to a menu developed with assistance by a registered dietician. Overnight awake staffing is provided.

Skilled Nursing Services

Skilled Nursing services are provided as needed to any individual who is receiving Medicaid Waiver Residential Services from the Supportive Living Program. These individuals have chronic complex medical conditions that require long term nursing support to remain in a community based setting. Nursing staff provide ongoing training and oversight of non-licensed staff.

Intermediate Care Facilities

Intermediate Care Facilities serve persons age 21 or older with a diagnosis of intellectual disability, physical impairments, and chronic health issues, who are residents of Virginia Beach or Health Region V. Services include around the clock awake care, active treatment, leisure and community activities and available 24 hour nursing care. An interdisciplinary team of professionals, along with the individual and their authorized representative or legal guardian, develop a program plan designed to meet their health, safety, and skill needs, provide choice and assist them to engage in a fulfilling lifestyle.

Other Services

The Supportive Living Program employs nurses who educate and consult with individuals and staff on various health issues. Additionally, a registered dietician is available to assist the individual with nutritional needs and healthy meal planning. A Health and Wellness program is also offered that provides opportunities for exercise, and health and safety education.

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SkillQuest

Located at 400 Investors Place, Virginia Beach, VA 23452

SkillQuest provides training and support services to adults with primary diagnosis of intellectual disability, many with multi-handicapping conditions. Training and support is provided in the areas of communication, socialization, academics, independent living, gross and fine motor development, behavior management, leisure skills, and community exploration. SkillQuest is licensed through the state Department of Behavioral Health and Developmental Services (DBHDS).

Eligibility criteria must be met with regard to age, disability and Medicaid Waiver enrollment. Referrals must be age 18 upon entry to the program, must have a confirmed diagnosis of intellectual disability, and must be Medicaid Waiver recipients.

All referrals come through Virginia Beach Department of Human Services, Developmental Services Case Management. The program is funded primarily through Medicaid Waiver and must abide by all federal requirements and regulations.

SkillQuest operates two daily shifts Monday - Friday 9:30 am - 1:30 pm and 1:30 pm - 5:30 pm.

Center Based Site

This site provides a constellation of activities for adults who have challenges related to intellectual disabilities or other co-occurring developmental disabilities, including autism. The program provides continuous training and support in an atmosphere of encouragement, fun, and creativity. Primary activities include development and enhancement of independent living skills through activities such as art, technology, communication, socialization, special projects, and community integration.

Off-Site Locations

There are currently two offsite locations where training and support is provided with a focus on developing the skills required to be successful in employment. These sites operate as enclaves at contracted businesses. Supervision and training at the sites is provided by SkillQuest staff. Some of the vocational activities include assembly and mailing.

Other Services and Activities

All staff has experience working with individuals with intellectual disabilities. Upon employment, staff must complete a rigorous orientation and training regimen which includes CPR, first aid, and

medication management. Additionally, there are two nurses on staff, and an art therapist. Physical therapy, speech therapy, and occupational therapy may be provided as arranged by the case manager.

Community Employment Options

Community Employment Options exists to provide Virginia Beach citizens with intellectual disabilities with efficient effective employment services that will enhance the quality of their lives and increase their opportunities to participate in all aspects of the community.

Community Employment Options (CEO) helps Virginia Beach citizens diagnosed with Community Employment Options (CEO) helps Virginia Beach citizens diagnosed with intellectual and mental health disabilities find meaningful remunerative jobs. CEO services enhance community integration through placement in group or individual employment that increase their earning power, enhance their self-image, and create a sense of pride in their achievements. CEO also provides pre-vocational services that focus on developing basic work skills for individuals interested in future employment opportunities.

CEO Services

Supported Employment Services

CEO provides Supported Employment services, a highly individualized program aimed at matching the skills and interests of job applicants to positions in which they could be successful. Services include assessment, job development, on-the-job-training, and ongoing supports, such as further skills development, advocacy, and crisis intervention.

Assessment Services

Situational assessments allow the job candidate to try out different types of jobs and working environments before making a commitment to any one job. They also provide the employment specialists with a detailed picture of the job candidate's level of motivation, preferred learning style, understanding of work expectations, specific areas of work interests and strengths, and any accommodations needed to ensure success upon placement in a job.

Job Development Services

The job candidate is assisted by the employment specialist in identifying suitable positions, completing applications, interviewing, and completing any pre-employment activities required by the

employer. The employment specialist also coaches the job candidate in appropriate presentation, demeanor, and attire when applying for jobs.

On-Site Training

One-on-one training assistance may include helping with skill acquisition to perform the assigned tasks, setting up task schedules, facilitating the person's integration within the culture of the job (i.e., "learning the ropes"). The employment specialist also develops natural supports, which entails establishing relationships with co-workers that may be able to further guide, train and support the person in her new job after the employment specialist has decreased his or her presence to intermittent visits.

Advocacy, Crisis Intervention, and Career Progression

The follow along phase is designed to provide any supports needed by the individual to maintain his job over the long term. During follow along visits, employment specialists work with the employee and his employer on addressing any issues that may threaten his job. The employment specialist also advocates for more work hours, changing schedules, or additional responsibilities that will help him grow and progress on the job. Re-training and teaching new skills are also part of the services offered by the program during follow along. Based upon the individual's changing needs and interests, the employment specialist will also assist him in obtaining second job to supplement his income or different job if his job interests change.

Enclave Services

Individuals employed in CEO enclave's work in businesses in the community under the constant supervision of a program staff member. Individuals are employees of the company hosting the group and earn wages ranging from productivity-based to above minimum hourly wages. The group setting allows individuals to earn money while working on developing the basic work and social skills needed to move on to more independent jobs.

Work Incentives Specialist Advocate Services (WISA)

Work Incentives Programs (WIN) were developed by the Social Security Administration (SSA) to increase the number of Social Security and Supplemental Security Income (SSI) beneficiaries who wish to work but also want to preserve their benefits. CEO's Work Incentives Specialist Advocate services (WISA) provide individuals who receive SSI or SSDI with an in-depth benefits analysis using Work World, a specialized software that helps understand the impact of earned income on their benefits. Additionally, the WIS Advocate develops and helps access the work incentive program most appropriate to their situation. These services are available to persons who want to get a job or those who are already employed.

CEO's WISA:

- Works with the individual to help him or her realize income and work incentive potential through Work World Software demonstrations.
- Provides valuable information that helps the individual make informed decisions about work.
- Helps the individual understand the work incentive and what is required.
- Helps the individual gather, organize or write what is needed to apply.
- Helps submit the work incentive application and documentation.

What would you and your family member with a disability get from CEO services?

Supported Employment Services assist your family members to develop their potential as productive members of society. Through the assistance and support provided by employment specialists, persons with intellectual disabilities gain access to a variety of businesses that are in search of dependable employees and are willing to give opportunities to a labor pool of eager, motivated workers.

Employment specialists also assist families in many areas of concern, such as:

- Identifying transportation options for your family member
- Conducting a thorough written analysis of the impact of employment income on government benefits
- Assisting military families to obtain or regain military benefits for their dependent family member with a disability
- Providing the right level of support to maximize the potential for success of your family member

What would your business get from CEO services?

Across the United States, businesses that have hired persons with intellectual disabilities overwhelmingly report a high degree of satisfaction with their performance, dependability, and dedication to their jobs. One of the most attractive features of this mostly untapped labor pool is their excellent job retention rate. In a job market characterized by high worker mobility, businesses are often faced with the high cost of advertising, recruiting, and training new employees. Utilizing CEO services yields immediate benefits to a business by cutting down on recruitment costs, as we bring in qualified, pre-screened job candidates, matched to the positions the business needs to fill.

Business also benefit from:

- A thorough evaluation of the vacant positions to ensure we bring the most qualified candidates.
- A reduction in absenteeism, tardiness, and high turnover prominent in entry level positions.
- Increased productivity.
- A labor pool of conscientious, dedicated workers.

- Training for the new employee based on your specifications, at no cost to the business.
- Ongoing support to the employee hired through CEO to ensure satisfactory job performance, at no cost to the business.
- An enhanced company image through community involvement.
- The knowledge that the company has enabled persons with disabilities to become productive, tax paying members of their community.
- For qualified businesses, a federal tax credit of up to $2,400 during the first year of the worker's employment.
- Answers to ADA questions.

Our Developmental Services Community Employment Options program is CARF certified.

Adolescent Development and Psychotherapy: Effects on Competency Evaluations

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Dr. Robert Archer
Dr. Elizabeth Wheeler
The Hon. Deborah V. Bryan, VBJDR
Regis Rice, Esq.

*1.0

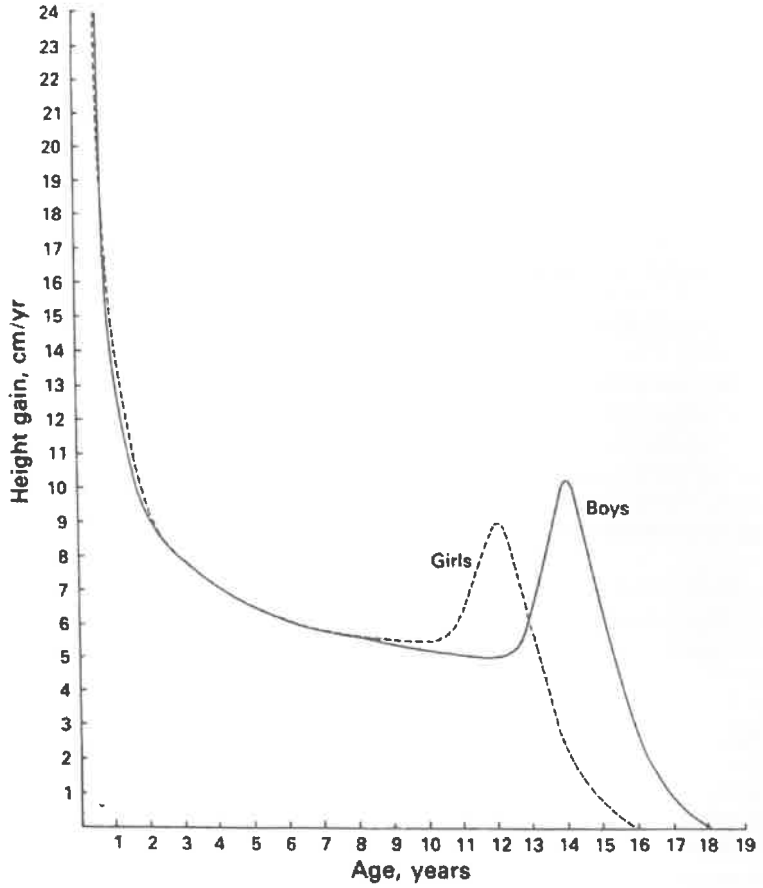
Adolescent Development and Psychopathology: Effects on competency Evaluation Findings

- Robert P. Archer Ph.D.
- *Bay Forensic Psychology*
- *And Eastern Virginia Medical School*

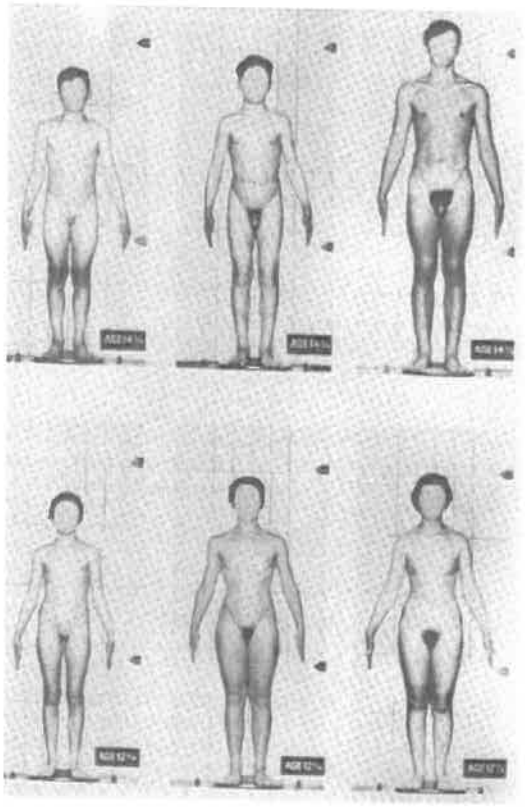
Adolescence is a unique developmental stage

- Physiological/Sexual Maturation
  - Gain of 25% in height and 100% in weight
  - Large variability in pace of development
  - Frontal lobe/prefrontal cortex development
- Cognitive Maturation
  - Piaget's Formal Operations
  - Requirements for valid self-report
  - important neurocognitive changes in frontal lobe

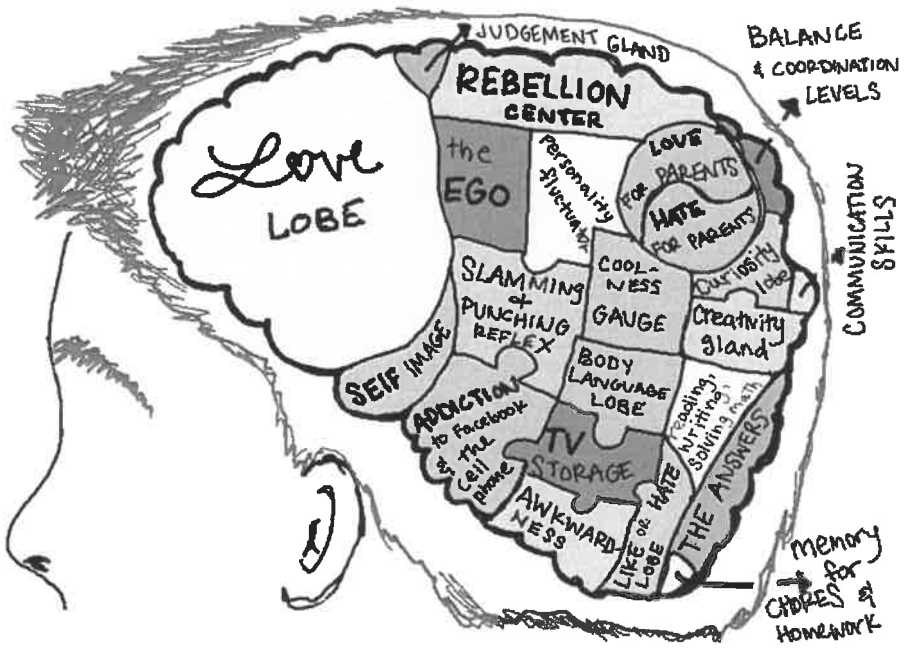
ADOLESCENT GROWTH SPURT



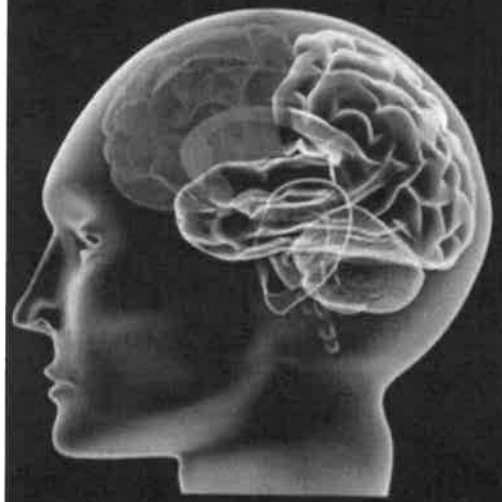
VARIATIONS IN SEXUAL MATURATION



Adolescent Brain



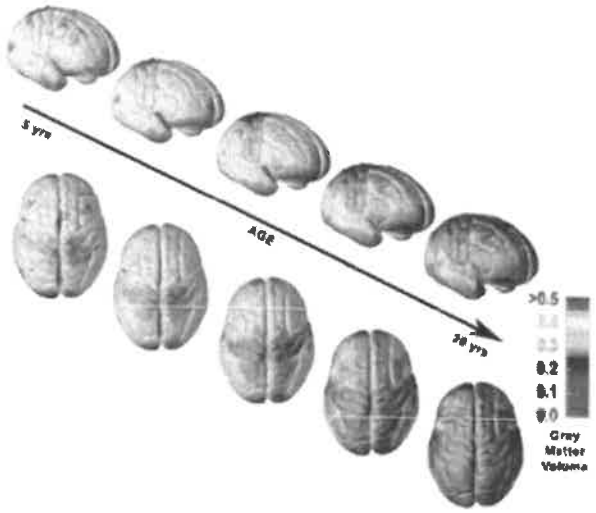
The Teenage Brain



- The neocortex not fully developed (responsible for language, planning, empathy, ex ecutive functions)
- Relies on a more reactive, gut-instinct part of the brain, the amygdala, (emotions and memories associated with emotion)
- Not good at reading emotion on others' faces

Engaging Teens &Tweens by Raleigh Philp

Proliferation: Grey Matter



Lenroot & Giedd (2006)

Grey matter develops quickly during childhood, but slows during adolescence.

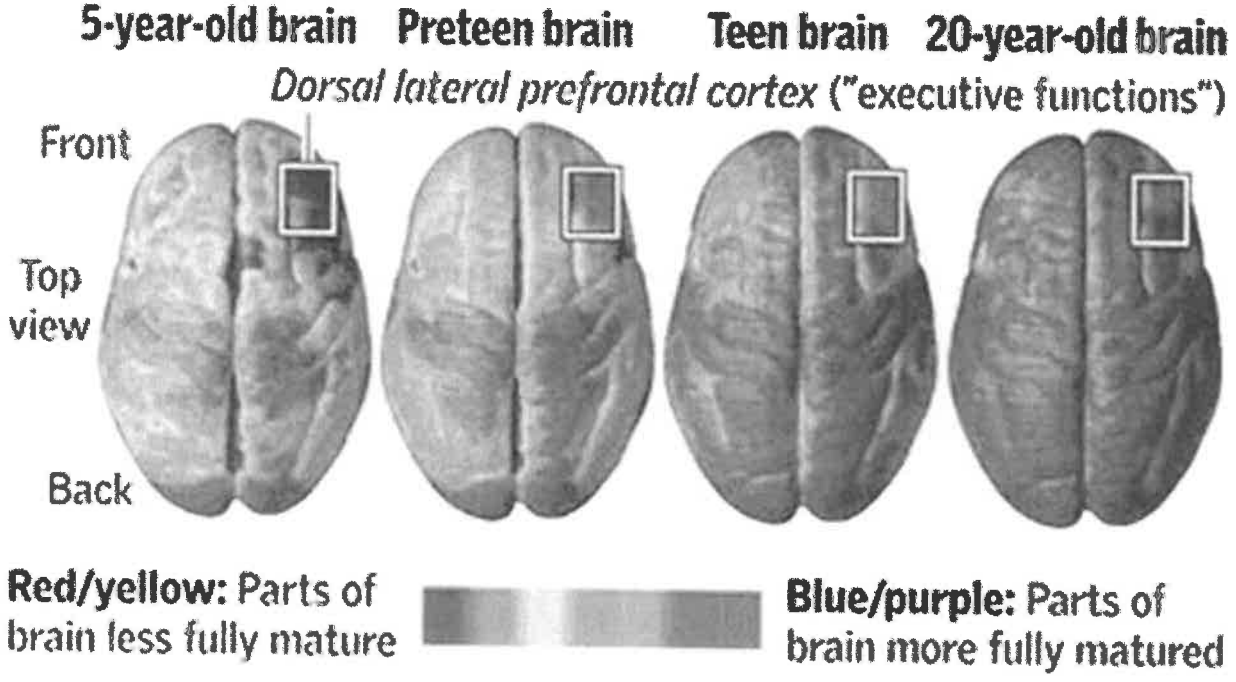
↓

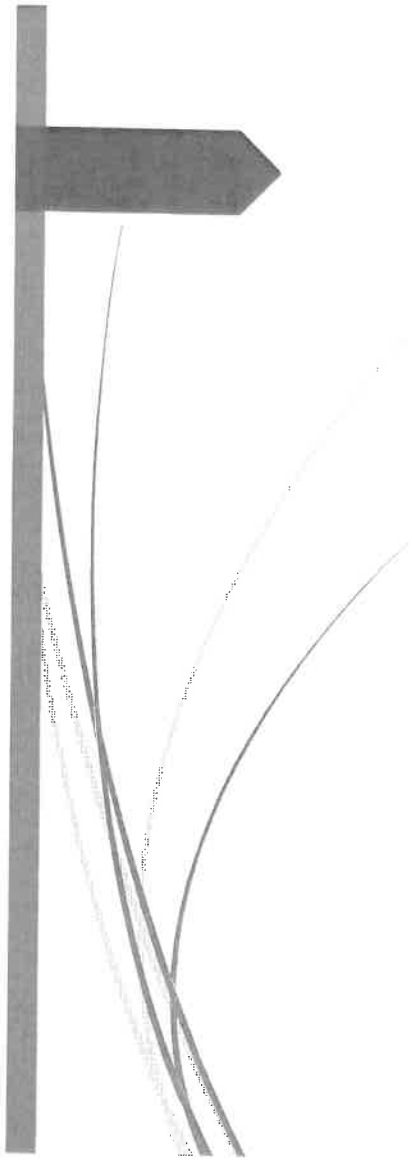
Grey matter volume peaks at age 11 in **girls** and at age 13 in **boys**.

↓

Then, the volume of grey matter begins to decline.

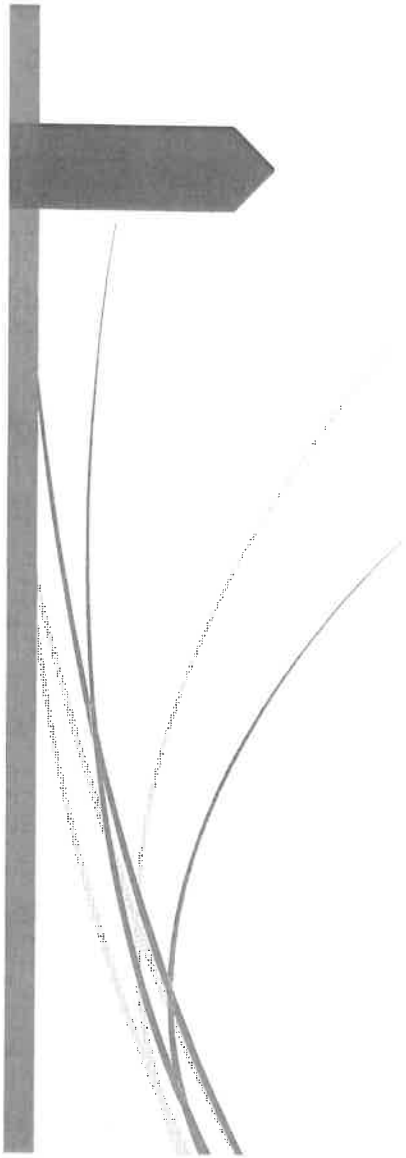
Frontal Lobe Development





Loevinger's Ego Development Stages

- Pre-conformist Stage (IMM Scale)
  - Superficial presentation of self-confidence
  - Externalization of blame
  - Lack of insight and introspection
  - Hypersensitivity to criticism
  - Inability to work constructively with others
  - Cognitive rigidity and inflexibility
- Not all individuals progressed beyond pre-conformist functioning

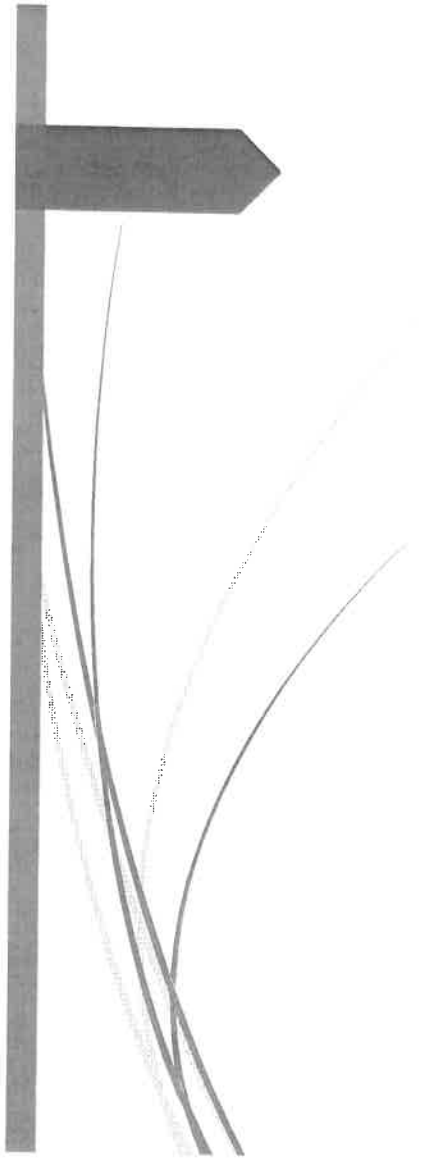


Psychopathology During Adolescence

- **Prevalence findings**
  - 10% to 20% meet DSM-IV-TR criteria
  - Girls more likely to receive dx of depression, anxiety, eating disorders, and adjustment disorder
  - Boys more likely to meet criteria for disruptive behavior disorders including conduct disorder
  - First appearance of anorexia, bipolar disorder, bulimia, obsessive–compulsive disorder, schizophrenia, and substance abuse
  - Results are dependent on who is interviewed: Parent, teacher, or adolescent

Discerning normal from abnormal psychological functioning is more challenging with juveniles than with adults

- Psychopathology and personality Structure are much more fluid than in Adulthood
- Psychopathology data from Juvenile Justice samples looks like clinical sample data



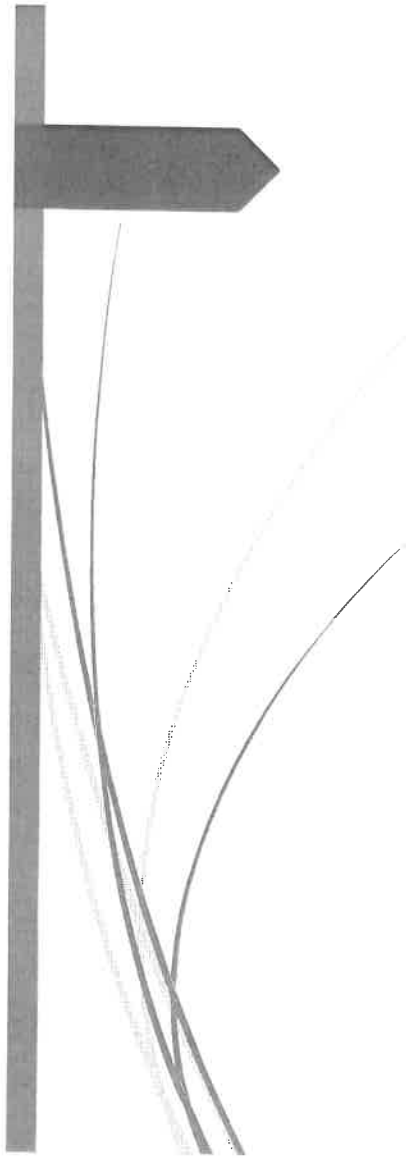
Item Endorsement Differences: Men versus Teenage Boys

- "I have very few quarrels with members of my family"
  - 79% (men) versus 46% (boys)
- "At times I feel like picking a fist fight with someone"
  - 16% (men) versus 48% (boys)

ITEM ENDORSEMENT DIFFERENCES: MALES

- "I have strange and peculiar thoughts"
  - 15% (men) versus 45% (boys)

- "Bad words, often terrible words, come into my mind and I cannot get rid of them"
  - 12% (men) versus 42% (boys)

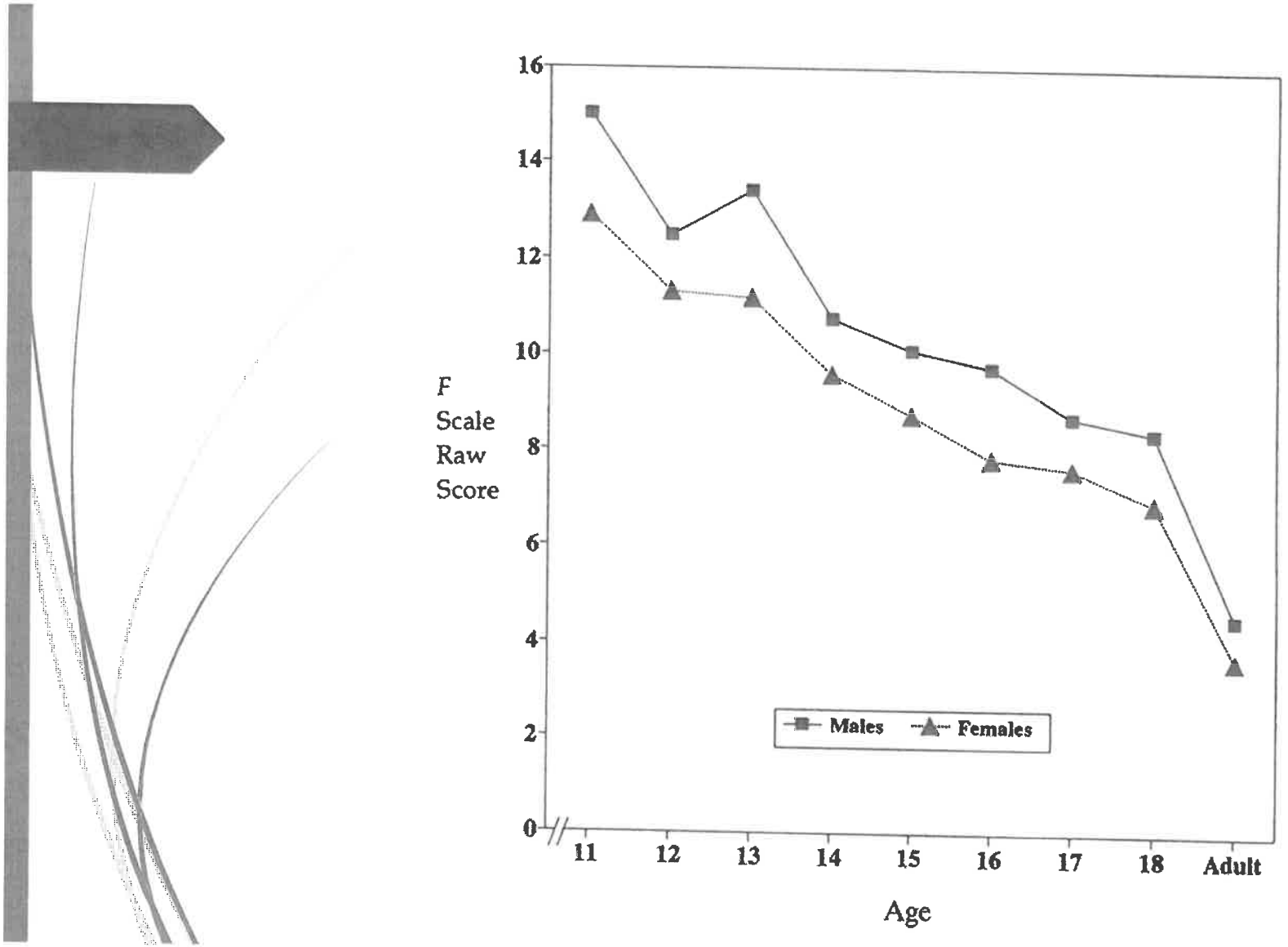


ITEM ENDORSEMENT DIFFERENCES: FEMALES

- "My conduct is mostly controlled by the behavior of those around me"
  - 26% (women) versus 62% (girls)
- "When I get bored I like to stir up some excitement"
  - 8% (women) versus 43% (girls)
- "I have strange and peculiar experiences"
  - 10% (women) versus 46% (girls)

Item Endorsement Differences: Women versus Teenage Girls

- "At times I have fits of laughing and crying that I cannot control"
  - 18% (women) versus 64% (girls)
- "At times I have a strong urge to do something harmful"
  - 16% (women) versus 53% (girls)

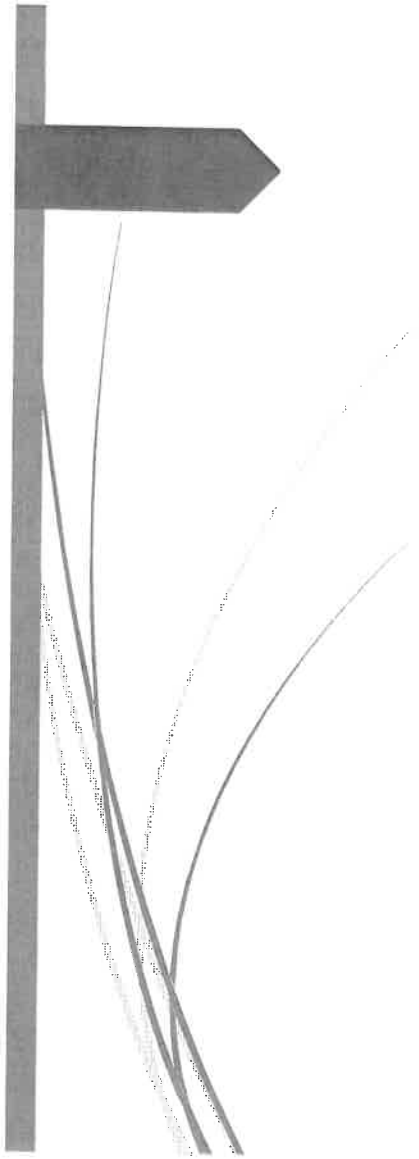

16
14
12
10
8
6
4
2
0
F Scale Raw Score
Males
Females
11
12
13
14
15
16
17
18
Adult
Age

Evidence of growing issue

- Recent survey: Two-thirds of juvenile courts report that referrals are continuing to increase
- Most research studies developed only in past 10 years

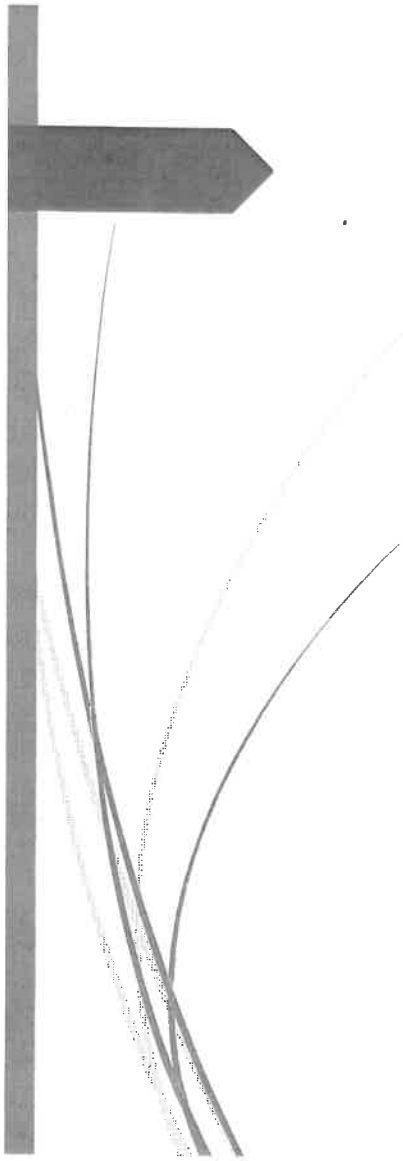
Juvenile CST articles		
	before 1990	2
	1991 to 1995	5
	1996 to 2000	12
	2001 to now	25

- Stimulated development of MacArthur research initiative



How CST Became an Issue in Juvenile Court

- CST not necessary in early (civil) juvenile court
- In re Gault (1967) to 1990
  - Introduced due process in juvenile courts
  - But did not produce attention to CST for juveniles
- 1990s reform of juvenile law after wave of juvenile homicides in late 1980s
  - Changes in use of criminal court
  - Changes in sanctions in juvenile court
- Defense bar began raising the issue of juveniles' CST in mid- to late-1990s



Developmental perspective (cont'd)

Immaturity in cognitive or psychosocial abilities does not automatically mean "incompetent"

- Functional abilities: What actually can't the youth do related to competence?
  - Understanding
  - Appreciation
  - Decision Making
- Cause: Are those inabilities related to immaturity? (Or something else?)
- Context: Can the inabilities be dealt with by simple instruction or accommodation?

The MacArthur Juvenile Adjudicative Competence Study (2000-2003)

- Philadelphia, Gainesville, Los Angeles, and North/East Virginia (Coordinating site, Univ of Mass. Medical School)

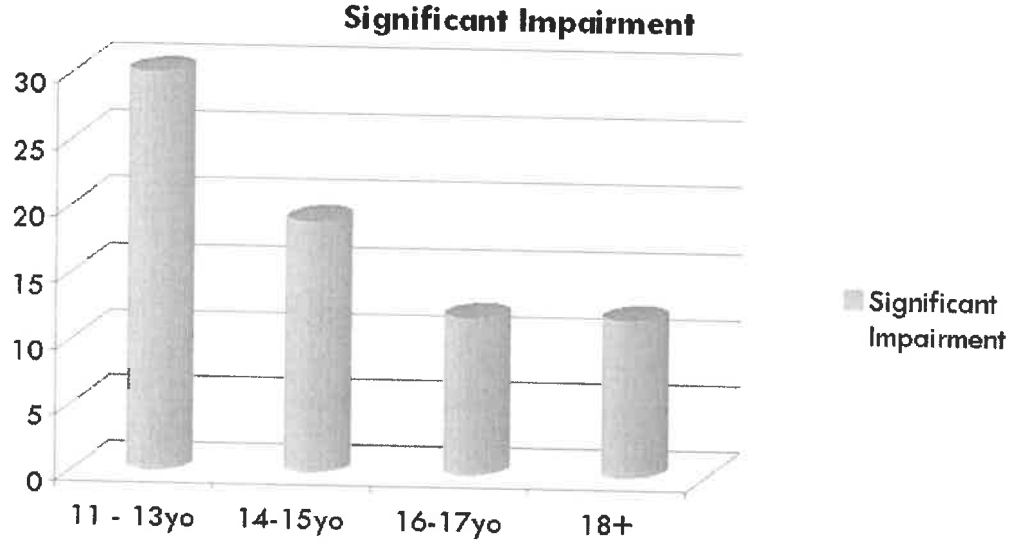
- Youths and adults in detention centers and jails, and in communities in targeted neighborhoods

Juveniles' Competence to Stand Trial: A Comparison of Adolescents' and Adults' Capacities as Trial Defendants

	Detained Sample	Community sample
11–13	74	116
14–15	186	159
16–17	193	199
18–24	233	233
Total	518	707

"The MacArthur Study"

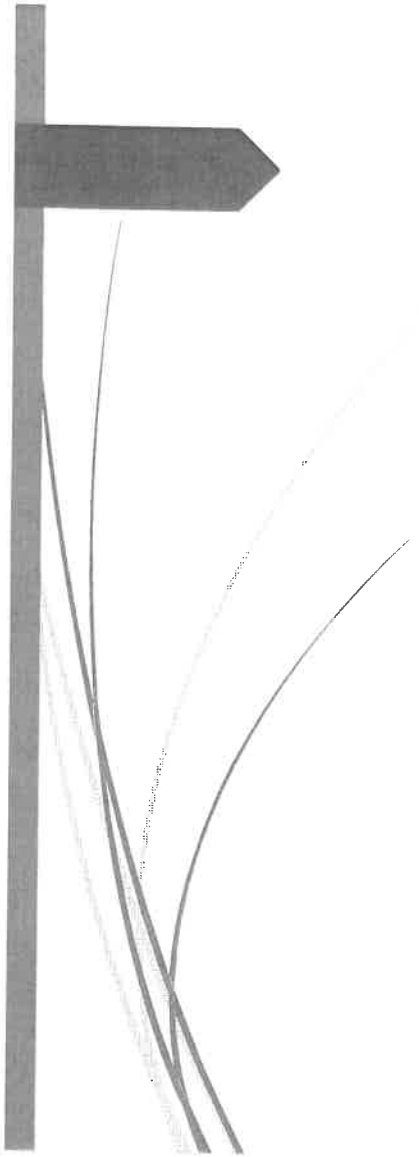
Overall Impairment in COMPETENCE TO PROCEED
(i.e., one or more scales)



Proportion of individuals at different ages who are significantly impaired with respect to either cst Understanding and/or Reasoning.

- 11 to 13 Years Old 30%
- 14 to 15 years old 19%
- 16 to 17 years old 12%
- 18 and older 12%

Averaged across detained and community samples



Conclusions/Recommendations

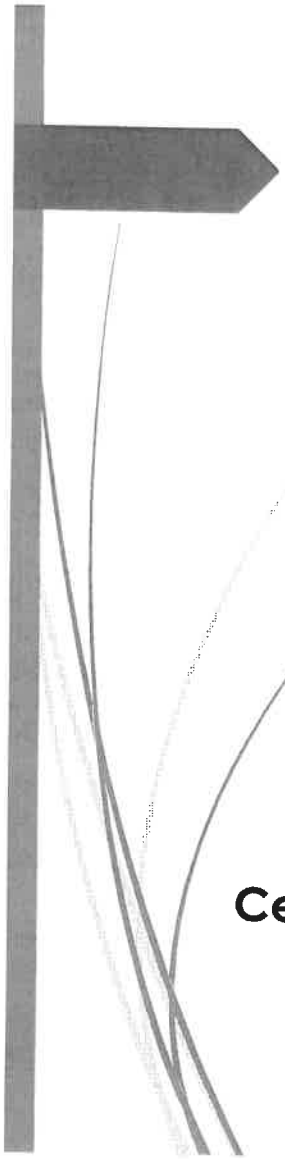
- Proper training and experience working with children and adolescents.
- a significantly greater proportion of who are 15 and younger are probably not competent to stand trial in a criminal proceeding due to immaturity
- Discerning normal from Abnormal Psychological functioning is more challenging than with adults (Sanity evaluations)
- Restoration of competency in children and adolescents is often more of the remediation process

References

- Archer, R. P. & Wheeler, E.M. (Eds.)(2015). *Using clinical assessment instruments in forensic settings: Uses and limitations.* New York: Routledge Press.

- Roper V. Simmons, 543 u.s. 551 (2005)

- Grisso, T. (2203). Juveniles' competence to stand trial : a comparison of adolescents' and adults' capacities as trial defendants. *Law and human behavior, 27, 333-363.*



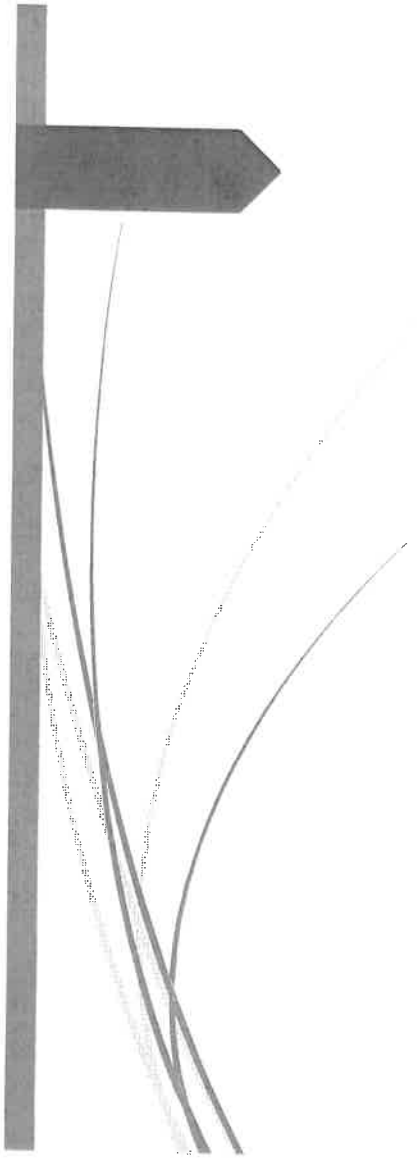
Juvenile Competency To Stand Trial

Elizabeth Wheeler, Ph.D.

Bay Forensic Psychology

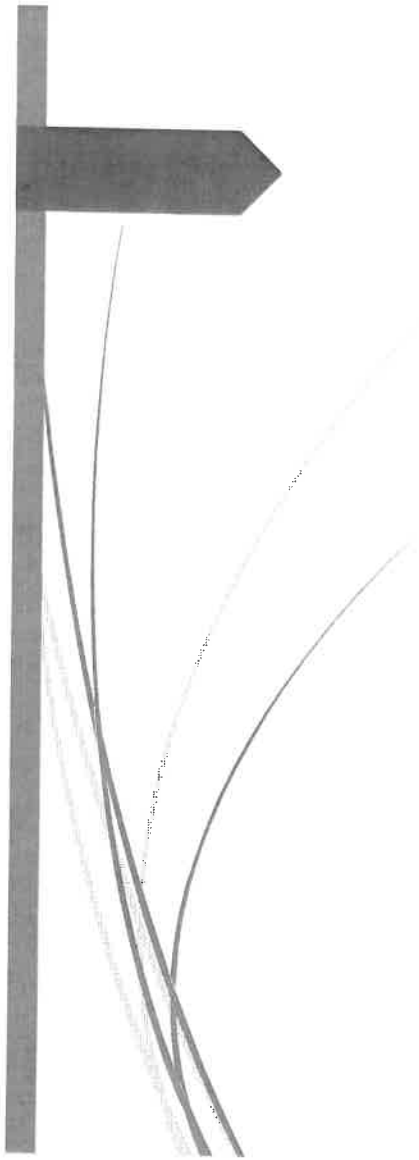
&

Central State Hospital (Director of the Forensic Evaluation Department)



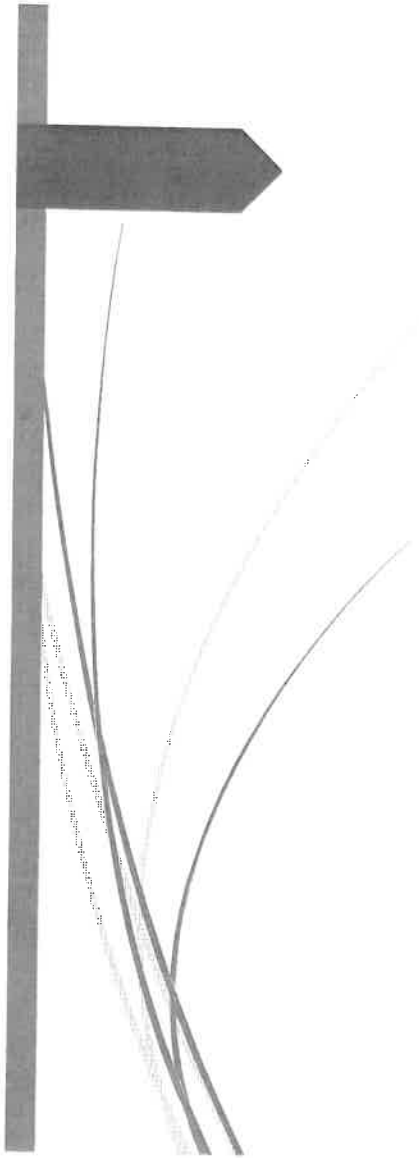
Prevalence

- **Juveniles provided with competency restoration by fiscal year**
  - **2002 – 92**
  - **2003 – 91**
  - **2004 – 111**
  - **2005 – 90**
  - **2006 – 121**
  - **2007 – 161**
  - **2008 – 208**
  - **2009 - 192**



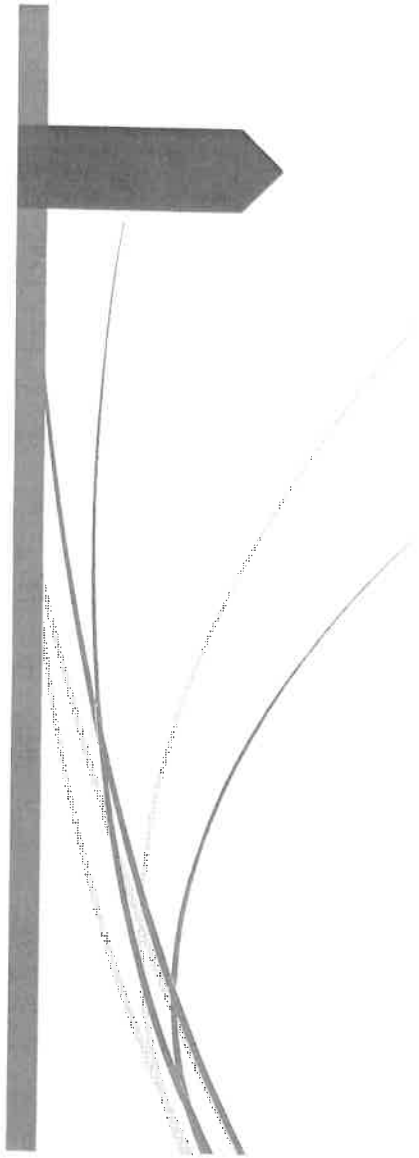
Statute

- Guided by 16.1-356
  - Shall be performed on an outpatient basis unless the results of the outpatient evaluation are not adequate or the juvenile is currently hospitalized
  - If hospitalized, it cannot be for more than 10 days (in contrast to 30 days for adults)
- Most evaluations take place on an outpatient basis
- Same basic standards as an adult competency evaluation
  - Capacity to understand the proceedings against him
  - His ability to assist his attorney
  - His need for services in the event he is found incompetent



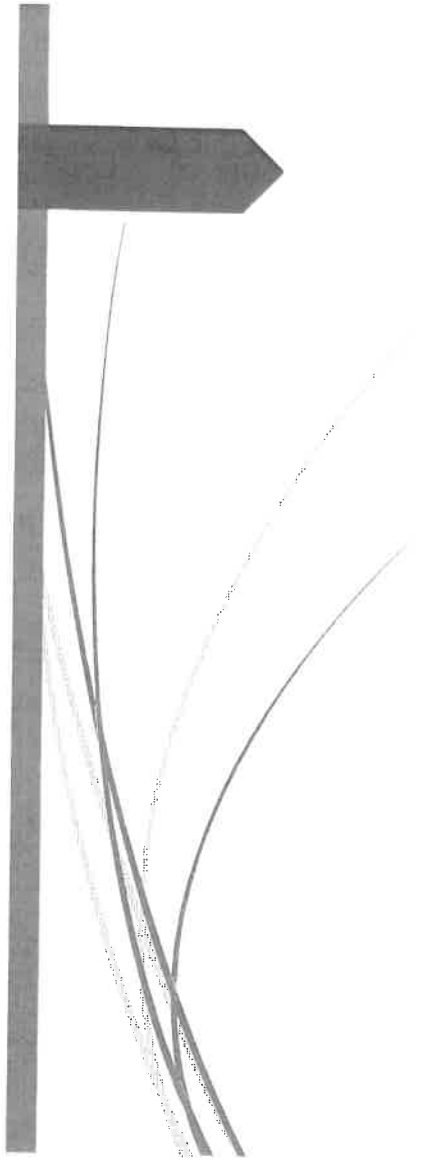
Raising the Question

- **If there is concern, make the request**
- **Age is often a factor that appears to be related to the request**
- **It is *possible* to be both young and competent but certainly very young age raises questions**



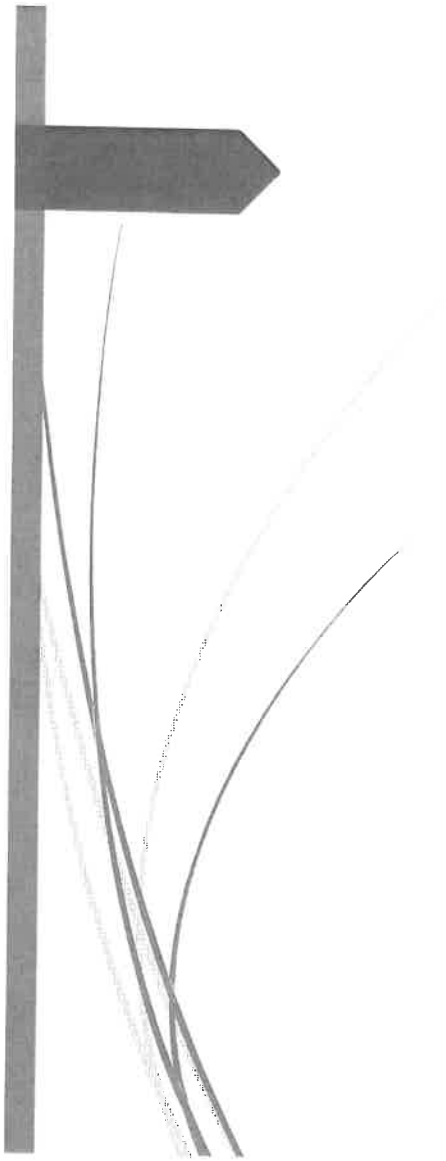
Within 96 Hours…

- The evaluator should be provided with
  - Copy of the warrant or petitions
  - Names and addresses of the attorney for the parties
  - Information about the alleged offense
  - Psychiatric records and other relevant information
  - Summary of the reasons for the request



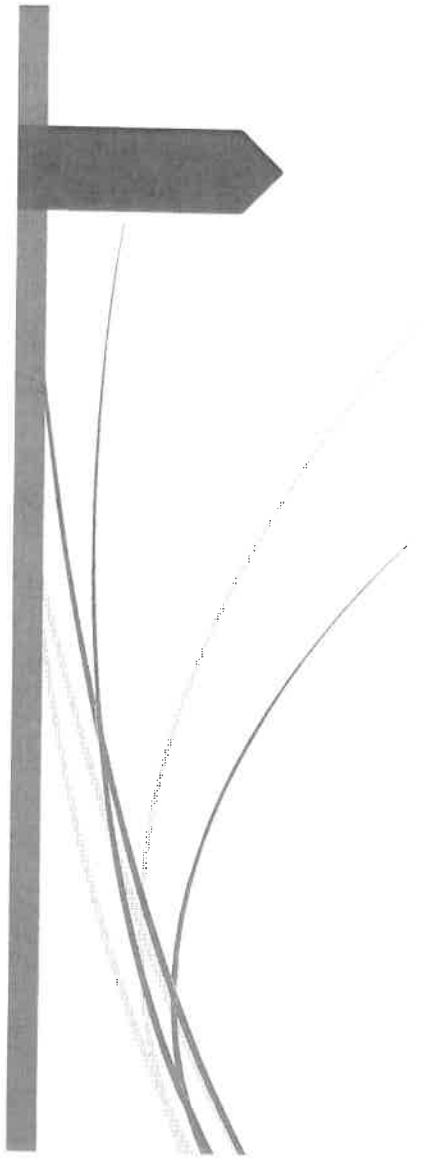
Evaluation

- Factual understanding
  - What are your charges?
  - Who decides if you are guilty or not guilty?
  - Review plea options
- Rational
  - How do you want to plead and why?
  - Hypothetical plea bargains scenarios
  - What do you think will happen in your case
- Ability to assist counsel
  - Do you trust your attorney?
  - Using the relationship between evaluator and juvenile as a proxy
- Reports should address all of these areas



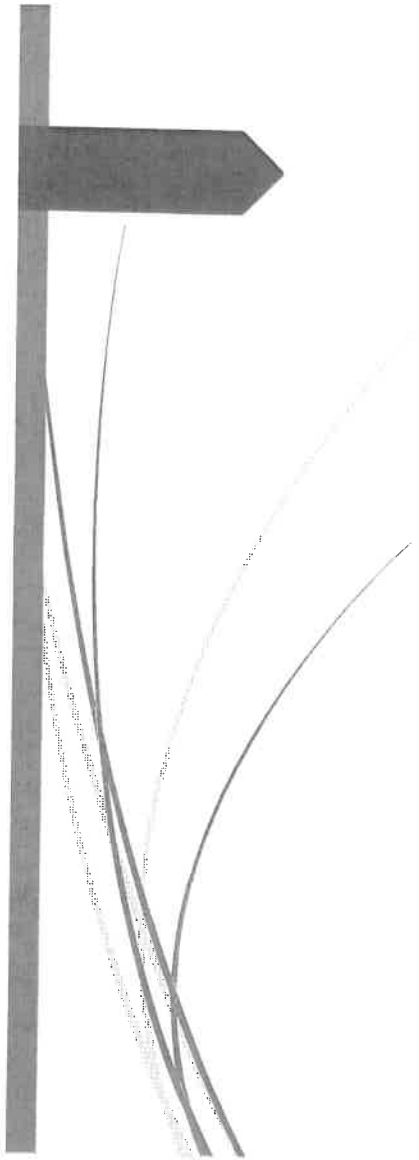
Specific issues with juveniles

- **Unlikely to be acutely mentally ill**
- **More likely to be uneducated regarding court**
- **More likely to have deficits in rational understanding**
- **More likely to automatically defer to attorney on issues**



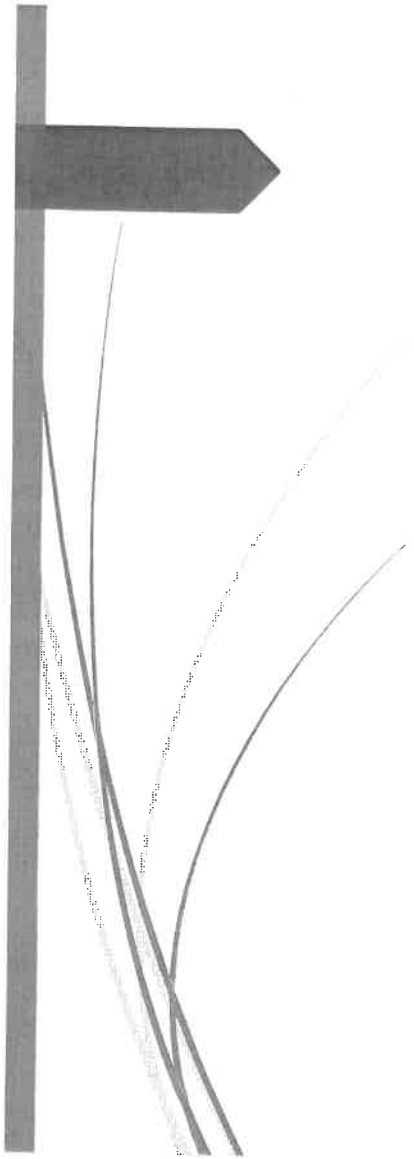
If Incompetent

- Statute 16.1-357
- Three month restoration orders
- Either outpatient or in a "secure facility"
- Services typically provided through DBHDS and the local CSBs
- Education and training services as well as case management services
- At the end of three months can:
  - Find competent
  - Find incompetent but likely to be restorable
  - Find URIST



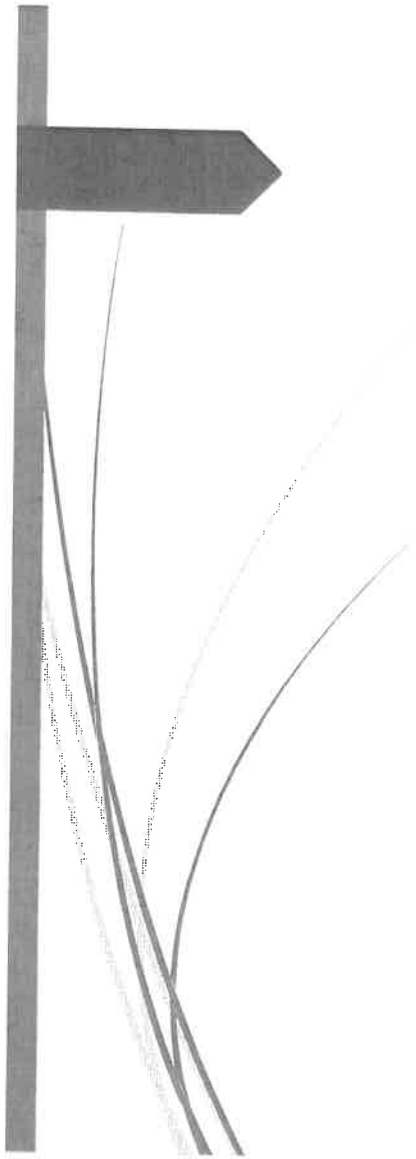
If URIST

- If the youth is found to be URIST
  - Committed pursuant to Article 16
  - Certified (not really an option anymore)
  - Have a CHINS petition filed
  - Released



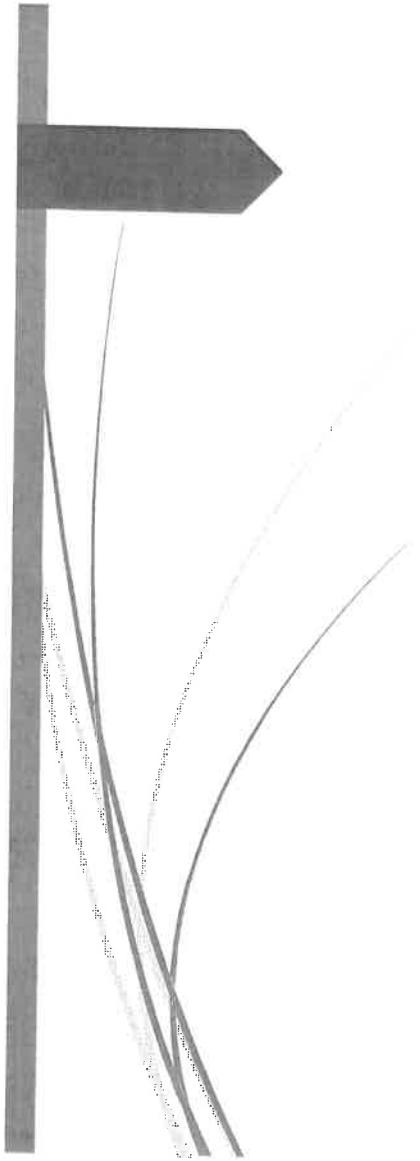
Disclosures

- **Just like with adults:**
  - **No statement or disclosure made during evaluation or restoration can be used against the juvenile**
- **This matters….**



"Battle" of the experts

- **Uncommon**
- **Result in a hearing**
- **Want to determine how the evaluator came to their conclusions that the trier of fact can be clear on the appropriate determination**



Other issues

- **How to determine if something is a "good report"**
- **Resources:**
  - **Central office at DBHDS**
  - **Other evaluators**

Questions?

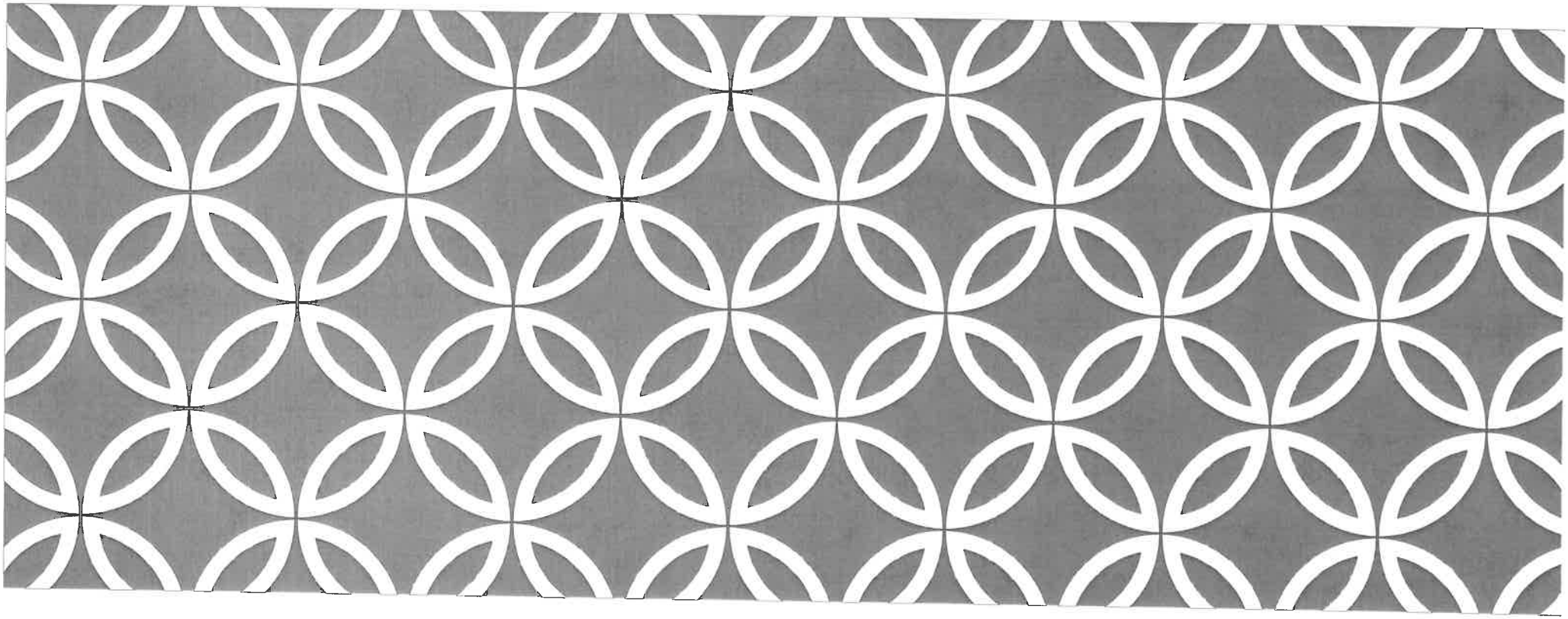
- 757-408-2266
- ewheeler@bayforensicpsychology
  or
  elizabeth.wheeler@dbhds.virginia.gov

The New Virginia "High Fidelity Wrapped Service Model" and Its Effects on Court Service Unit Cases and DHS Cases

-Becky China, VBDHS, CSA Administrator
-Rachel Evans, Associate City Attorney
-Brandy Newton, Court Services Unit
-Brian Hawkins, VBDHS
- Parent Representative, Richmond, VA

*1.5

POWERPOINT



VIRGINIA BEACH CSA: HIGH FIDELITY WRAPAROUND

CHILDREN'S SERVICES ACT (CSA)
VA CODE § 2.2-5200

~ Created in 1992, renamed in 2015 – formerly known as the Comprehensive Services Act for At-Risk Youth and Families

~ Law that governs a state pool of funds set aside for services for children/families

~ State funds are combined with local funds and managed by LOCAL, INTERAGENCY teams

~ The State Executive Council (SEC) is the supervisory body that oversees CSA (VA Code § 2.2-2648)

~ The Office of Children's Services (OCS) is the administrative entity that implements the policies/decisions of the SEC (VA Code §2.2-2649)

COMMUNITY POLICY AND MANAGEMENT TEAM (CPMT)
VA CODE § 2.2-5204-5206

Each locality has a CPMT to receive and manage CSA money.

Mandatory members are:

1) an elected or appointed official from the governing body of the locality,

2) a representative from a private Virginia Beach service provider,

3) a parent representative,

the local agency head from five agencies:

4) CSB,
5) CSU,
6) Health Department,
7) DHS, and
8) the school division.

FAMILY ASSESSMENT AND PLANNING TEAM (FAPT) VA CODE § 2.2-5208

Each CPMT appoints one or more teams.

Members include a representative from:

1) CSB,

2) CSU,

3) DHS,

4) the local school division,

5) a parent representative,

6) the Health Department (if CPMT so elects), and

7) a representative from a local service provider (if CPMT so elects).

[*SOME OF*] CPMT'S DUTIES

1) "Develop interagency policies and procedures to govern the provision of services to children and families in its community" (VA Code § 2.2-5206(1));

2) "Coordinate long-range, community-wide planning that ensures the development of resources and services needed by children and families in its community including consultation on the development of a community-based system of services" (VA Code § 2.2-5206(4));

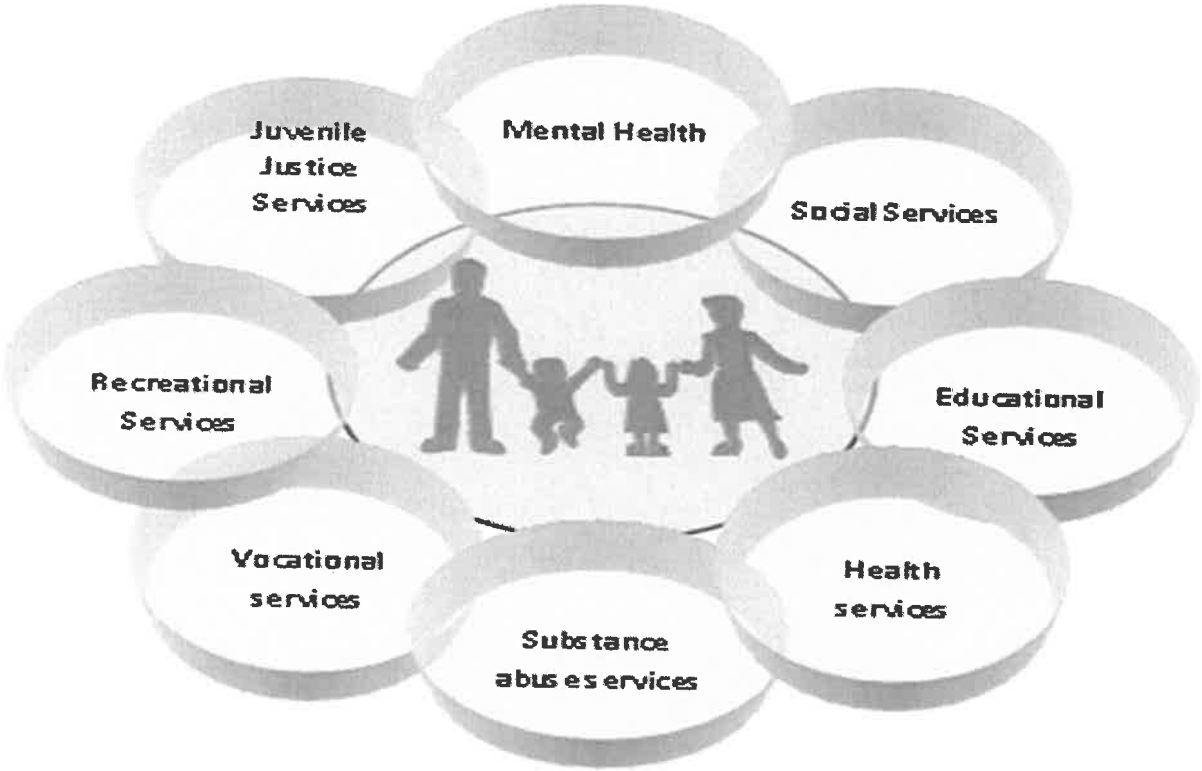
3) "Submit grant proposals that benefit its community to the state trust fund and enter into contracts for the provision or operation of services upon approval of the participating governing bodies" (VA Code § 2.2-5206(10));

4) "Establish policies for providing intensive care coordination services for children who are at risk of entering, or are placed in, residential care through the CSA program" (VA Code § 2.2-5206(17)).

SYSTEMS OF CARE (SOC)

(AS DEFINED BY THE VA DEPT. OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES/STROUL, B. BLAU & FRIEDMAN, SYSTEMS OF CARE IN VA, 2010)

"A spectrum of effective, community-based services and supports for children and youth with or at-risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs in order to help them function better at home, school, in the community, and throughout life."



System of Care Framework

System of care Framework (From Stroul, B. & Friedman, R. (1986 rev ed)

VIRGINIA'S SOC VALUES:

~ Individualized, family/youth driven services

~ Strength-based practices

~ Reliance on natural supports and creating self-efficacy

~ Team-based

~ Outcome-based

~ Culturally and linguistically competent

ONE COMPONENT OF SOC IS THE HIGH FIDELITY WRAPAROUND MODEL (HFW)

HFW is how VA DBHDS intends to implement SOC at the family level.

Our region -

1) Received a $880,000 grant from DBHDS to commence HFW this year,
2) Includes Virginia Beach, Chesapeake, James City County, Poquoson, and Williamsburg,
3) Obtained the highest award.

46 other localities already use HFW. As it is a national model, many other states already use it. UMFS is the regional coordinator/facilitator.

WHAT IS HFW?

It is not ----

~ a clinical service

~ group therapy or case management

~ an FPM (although group meetings are a key component)

WHAT IS HFW?

It's a MODEL whereby ownership and voice are given back to the youth and families who are in the best position to know what will work best for them.

The model empowers families to use their voices to express their needs, strengths, preferences, and assists them in making informed decisions about mental health care.

It's a team-based, collaborative process for developing and implementing individualized care plans for children with behavioral health challenges and their families.

The youth and family are integral – they select a team, develop the plan, and receive services in accordance with the plan.

WHAT ARE THE GOALS OF HFW?

1) To meet the stated needs as prioritized by the youth and family,

2) To improve the youth/family's ability and confidence to manage their own services and supports,

3) To develop and strengthen the youth/family's natural support system over time, and

4) To integrate the work of all the child-serving systems and natural supports into one streamlined plan.

WHAT IS INTENSIVE CARE COORDINATION (ICC) AND HOW DOES IT INTERPLAY WITH HFW?

~ ICC is characterized by activities that extend beyond regular case management services that are within the normal scope of public child serving systems and that are beyond the scope of services defined by DMAS as mental health case management

~ Both CSB workers and private providers may provide ICC

~ All ICC providers are trained in HFW

~ ICC is a licensed service under DBHDS

~ ICC is implemented <u>THROUGH</u> HFW

WHO IS PART OF THE HFW TEAM?

1) the youth and the family

2) an ICC worker serves as the Facilitator

3) a Family Support Partner (FSP)

4) professional partners (no more than 50% of the team can be professionals)

5) natural supports identified by the family who continue to assist long after formal HFW ends

6) eventually, Youth Support Partners

WHAT FAMILIES WILL RECEIVE HFW?

~ families that have needs that have traditionally been addressed by more than one service system (schools, mental health, juvenile justice, human services)

~ mandated and non-mandated clients are eligible

~ families that have a child out of the home or at-risk of being out of the home due to mental health challenges

WHAT ARE FAMILY SUPPORT PARTNERS (FSP)?

~ they're formal members of the HFW team and equal workforce partners

~ they're graduates of HFW – capable of engaging with the family at a deeper level because they've 'been there'

~ they ensure that the family is truly heard

~ they serve as a partner to the facilitator

~ they receive training and are paid for their services

~ they're objective – they don't do whatever the family wants

WHAT DOES THE FACILITATOR DO?

~ provides youth and families with options

~ coordinates between agencies

~ reframes negative comments but honors all input

~ permits the family to brainstorm to find their own solutions

~ delegates tasks to all members

~ creates a plan that builds upon successes

~ creates tasks that are measurable and includes deadlines

~ follows up in between meetings so that the plan advances

~ writes all documents in accordance with timelines

WHAT ARE THE PHASES OF THE MODEL?

1) Engagement/Preparation,
2) Planning,
3) Implementation, and
4) Transition.

*Upfront, a crisis-stabilization plan is created if needed.

WHAT ASSESSMENT TOOL IS USED?

The Strengths, Needs, Cultural Discovery (SNCD) is utilized.

The family tells their unique story.

The family and youth shares strengths, family culture, defines their needs and goals, and ultimately creates a clear family vision.

PHASE ONE: ENGAGEMENT

~ this occurs over time and not in one single meeting

~ the Facilitator and the FSP meet with the family, youth, and potential team members to orient them to the process

~ information is gathered for the SNCD and the family's vision is defined

~ the Facilitator prepares everyone for an Initial Team Meeting (phase 2)

~ roles are defined and a tone of collaboration is established

~ the entire engagement process lasts throughout the process (on average, 12 months)

~ this takes time as some families have had poor past experiences

Documents Created: Crisis Stabilization Plan, SNCD (called Discovery)

PHASE TWO: PLANNING

~ the Team convenes for the first time and the Initial HFW Plan is created

~ the Facilitator helps the team define a shared mission

~ the family and youth voices are heard

Documents: Initial Action Plan (developed at the first meeting), Crisis Prevention Plan

PHASE THREE: IMPLEMENTATION

~ this is the longest phase – 3 to 9 months

~ the Team meets regularly to develop, implement, and update the Action Plan to meet the prioritized needs of the family

~ the Facilitator follows up with members before, after, and between meetings to ensure all action steps are completed

~ the Facilitator is responsible to maintain team engagement and monitors progress

~ successes are celebrated

Documentation: Ongoing Action Plans are developed at each meeting (no less than monthly)

PHASE FOUR: TRANSITION

~ at this point, the team should have a strong mix of natural and formal supports

~ the family is approaching the vision they defined and the team is completing the mission

~ formal HFW is wrapping up

~ the family is equipped with new skills to manage crisis and problem solve

Documentation: Final Action Plan, Transition Plan, Final Version of SNDC

PARTNERING ORGANIZATIONS:

~ Children's Mental Health Resource Center

~ National Alliance on Mental Illness (NAMI)

~ Virginia Family Network (VFN)

~ United Methodist Family Services (UMFS)

ANOTHER COMPONENT OF SOC/HFW IS YOUTH ENGAGEMENT

~ through the grant, a local chapter of Youth MOVE (Youth Motivating Others Through Voices of Experience) is being created

~ this will be accomplished through a partnership with UMFS, Project Life, and NAMI

~ the youth council will include minority youth, LGBTQ, youth who have experienced early onset of serious mental illness, youth currently or formerly received mental health services, and non-mandated youth

~ by year 3 of the grant, youth will be trained as Youth Support Partners and will participate in HFW as Team members

HFW MOTTO:

"DO FOR,
DO WITH,
CHEER ON!!"

FILL – IN THE BLANK??!!!!

Virginia Beach CSA: High Fidelity Wraparound

1) Children's Services Act (CSA) VA Code § 2.2-5200

~ Created in 1992, renamed in 2015 – formerly known as the Comprehensive Services Act for At-Risk Youth and Families

~ Law that governs a state pool of funds set aside for _____ for children/families

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4) [*Some of*] CPMT's Duties

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5) Systems of Care (SOC) (as defined by the VA Dept. of Behavioral Health and Developmental Services/Stroul, B. Blau & Friedman, systems of care in Va, 2010)

"A _____ of effective, community-based services and supports for children and youth with or at-risk for mental health or other challenges and

their families, that is organized into a _____, builds _____ with families and youth, and addresses their cultural and linguistic needs in order to help them function better at home, school, in the community, and _____."

6) Virginia's SOC Values:

~ Individualized, _____ driven services

~ _____-based practices

~ Reliance on _____ and creating self-efficacy

~ _____-based

~ _____-based

~ _____ and linguistically competent

7) One Component of SOC is the High Fidelity Wraparound Model (HFW)

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~ It's a team-based, _____ process for developing and implementing _____ care plans for children with behavioral health challenges and their families.

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10) What Are The Goals of HFW?

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~ mandated and non-mandated clients are eligible

~ families that have a child out of the home or at-risk of being out of the home due to mental health challenges

14) What Are Family Support Partners (FSP)?

~ they're formal members of the HFW Team and _____ workforce partners

~ they're _____ of HFW – capable of engaging with the family at a deeper level because they've 'been there'

~ they ensure that the family is truly _____

~ they serve as a _____ to the Facilitator

~ they receive training and are paid for their services

~ they're _____ – they don't do whatever the family wants

15) What Does The Facilitator Do?

~ provides youth and families with _____

~ _____ between agencies

~ reframes negative comments but honors all input

~ permits the family to brainstorm to find their _____ solutions

~ delegates tasks to all members

~ creates a plan that builds upon successes

~ creates tasks that are _____ and includes deadlines

~ follows up in between meetings so that the plan advances

~ writes all documents in accordance with timelines

16) What Are The Phases Of The Model?

1) _____,

2) _____,

3) _____, and

4) _____.

*Upfront, a crisis-stabilization plan is created if needed.

17) What Assessment Tool Is Used?

The Strengths, Needs, Cultural Discovery (SNCD) is utilized.

The family tells their _____ story.

The family and youth shares strengths, family culture, defines their needs and goals, and ultimately creates a clear _____.

18) Phase One: Engagement

- this occurs over time and not in one single meeting

- the Facilitator and the FSP meet with the family, youth, and potential team members to orient them to the process

- information is gathered for the SNCD and the family's vision is defined

- the Facilitator prepares everyone for an Initial Team Meeting (phase 2)

- roles are defined and a tone of _____ is established

- the entire engagement process lasts throughout the process (on average, 12 months)

- this takes time as some families have had poor past experiences

Documents Created: Crisis Stabilization Plan, SNCD (called Discovery)

19) Phase Two: Planning

- the Team convenes for the first time and the Initial HFW Plan is created

- the Facilitator helps the Team define a shared _____

- the family and youth voices are _____

Documents: Initial Action Plan (developed at the first meeting), Crisis Prevention Plan

20) Phase Three: Implementation

- this is the longest phase – 3 to 9 months

- the Team meets regularly to _____, _____, and _____ the Action Plan to meet the prioritized needs of the family

- the Facilitator follows up with members before, after, and between meetings to ensure all action steps are completed

- the Facilitator is responsible to maintain Team engagement and monitors progress

- successes are celebrated

Documentation: Ongoing Action Plans are developed at each meeting (no less than monthly)

21)Phase Four: Transition

- at this point, the Team should have a strong mix of natural and formal supports

- the family is approaching the vision they defined and the Team is completing the mission

- formal HFW is wrapping up

- the family is equipped with new skills to _____ and problem solve

Documentation: Final Action Plan, Transition Plan, Final Version of SNDC

22)Partnering Organizations:

~ Children's Mental Health Resource Center

~ National Alliance on Mental Illness (NAMI)

~ Virginia Family Network (VFN)

~ United Methodist Family Services (UMFS)

23)Another component of SOC/HFW is youth engagement

~ through the grant, a local chapter of Youth MOVE (Youth Motivating Others Through Voices of Experience) is being created

~ this will be accomplished through a partnership with UMFS, Project Life, and NAMI

~ the youth council will include minority youth, LGBTQ, youth who have experienced early onset of serious mental illness, youth currently or formerly received mental health services, and non-mandated youth

~ by year 3 of the grant, youth will be trained as Youth Support Partners and will participate in HFW as Team members

24)HFW motto:

"DO _____,
DO _____,
_____!!"

RESOURCE AND REFERENCE MATERIALS

Code of Virginia
Title 2.2. Administration of Government
Chapter 52. Children's Services Act

§ 2.2-5200. Intent and purpose; definitions.

A. It is the intention of this law to create a collaborative system of services and funding that is child-centered, family-focused and community-based when addressing the strengths and needs of troubled and at-risk youths and their families in the Commonwealth.

This law shall be interpreted and construed so as to effectuate the following purposes:

1. Ensure that services and funding are consistent with the Commonwealth's policies of preserving families and providing appropriate services in the least restrictive environment, while protecting the welfare of children and maintaining the safety of the public;

2. Identify and intervene early with young children and their families who are at risk of developing emotional or behavioral problems, or both, due to environmental, physical or psychological stress;

3. Design and provide services that are responsive to the unique and diverse strengths and needs of troubled youths and families;

4. Increase interagency collaboration and family involvement in service delivery and management;

5. Encourage a public and private partnership in the delivery of services to troubled and at-risk youths and their families; and

6. Provide communities flexibility in the use of funds and to authorize communities to make decisions and be accountable for providing services in concert with these purposes.

B. As used in this chapter, unless the context requires a different meaning:

"CSA" means the Children's Services Act.

"Council" means the State Executive Council for Children's Services created pursuant to § 2.2-2648.

1992, cc. 837, 880, § 2.1-745; 2001, c. 844; 2015, c. 366.

Code of Virginia
Title 2.2. Administration of Government
Chapter 26. Councils

§ 2.2-2649. Office of Children's Services established; powers and duties.

A. The Office of Children's Services is hereby established to serve as the administrative entity of the Council and to ensure that the decisions of the council are implemented. The director shall be hired by and subject to the direction and supervision of the Council pursuant to § 2.2-2648.

B. The director of the Office of Children's Services shall:

1. Develop and recommend to the state executive council programs and fiscal policies that promote and support cooperation and collaboration in the provision of services to troubled and at-risk youths and their families at the state and local levels;

2. Develop and recommend to the Council state interagency policies governing the use, distribution and monitoring of moneys in the state pool of funds and the state trust fund;

3. Develop and provide for the consistent oversight for program administration and compliance with state policies and procedures;

4. Provide for training and technical assistance to localities in the provision of efficient and effective services that are responsive to the strengths and needs of troubled and at-risk youths and their families;

5. Serve as liaison to the participating state agencies that administratively support the Office and that provide other necessary services;

6. Provide an informal review and negotiation process pursuant to subdivision D 19 of § 2.2-2648;

7. Implement, in collaboration with participating state agencies, policies, guidelines and procedures adopted by the State Executive Council;

8. Consult regularly with the Virginia Municipal League, the Virginia Coalition of Private Provider Associations, and the Virginia Association of Counties about implementation and operation of the Children's Services Act (§ 2.2-5200 et seq.);

9. Hire appropriate staff as approved by the Council;

10. Identify, disseminate, and provide annual training for CSA staff and other interested parties on best practices and evidence-based practices related to the Children's Services Act Program;

11. Perform such other duties as may be assigned by the State Executive Council;

12. Develop and implement uniform data collection standards and collect data, utilizing a secure electronic database for CSA-funded services, in accordance with subdivision D 16 of § 2.2-2648;

13. Develop and implement a uniform set of performance measures for the Children's Services Act program in accordance with subdivision D 17 of § 2.2-2648;

14. Develop, implement, and distribute management reports in accordance with subdivision D 18 of § 2.2-2648;

15. Report to the Council all expenditures associated with serving children who receive pool-funded services. The report shall include expenditures for (i) all services purchased with pool funding; (ii) treatment, foster care case management, community-based mental health services, and residential care funded by Medicaid; and (iii) child-specific payments made through the Title IV-E program;

16. Report to the Council on the nature and cost of all services provided to the population of at-risk and troubled children identified by the State Executive Council as within the scope of the CSA program;

17. Develop and distribute model job descriptions for the position of Children's Services Act Coordinator and provide technical assistance to localities and their coordinators to help them to guide localities in prioritizing coordinator's responsibilities toward activities to maximize program effectiveness and minimize spending; and

18. Develop and distribute guidelines, approved by the State Executive Council, regarding the development and use of multidisciplinary teams, in order to encourage utilization of multidisciplinary teams in service planning and to reduce Family Assessment and Planning Team caseloads to allow Family Assessment and Planning Teams to devote additional time to more complex and potentially costly cases.

C. The director of the Office of Children's Services, in order to provide support and assistance to the Children's Policy and Management Teams (CPMTs) and Family Assessment and Planning Teams (FAPTs) established pursuant to the Children's Services Act (§ 2.2-5200 et seq.), shall:

1. Develop and maintain a web-based statewide automated database, with support from the Department of Information Technology or its successor agency, of the authorized vendors of the Children's Services Act (CSA) services to include verification of a vendor's licensure status, a listing of each discrete CSA service offered by the vendor, and the discrete CSA service's rate determined in accordance with § 2.2-5214; and

2. Develop, in consultation with the Department of General Services, CPMTs, and vendors, a standardized purchase of services contract, which in addition to general contract provisions when utilizing state pool funds will enable localities to specify the discrete service or services they are purchasing for the specified client, the required reporting of the client's service data, including types and numbers of disabilities, mental health and intellectual disability diagnoses, or delinquent behaviors for which the purchased services are intended to address, the expected outcomes resulting from these services and the performance timeframes mutually agreed to when the services are purchased.

2000, c. 937, § 2.1-746.1; 2001, c. 844; 2002, c. 410; 2003, c. 485; 2008, cc. 38, 277; 2009, c. 275; 2012, cc. 476, 507; 2013, c. 1; 2015, c. 366.

Code of Virginia
Title 2.2. Administration of Government
Chapter 52. Children's Services Act

§ 2.2-5204. Community policy and management team; appointment; fiscal agent.

Every county, city, or combination of counties, cities, or counties and cities shall establish a community policy and management team in order to receive funds pursuant to this chapter. Each such team shall be appointed by the governing body of the participating local political subdivision establishing the team. In making such appointments, the governing body shall ensure that the membership is appropriately balanced among the representatives required to serve on the team in accordance with § 2.2-5205. When any combination of counties, cities or counties and cities establishes a community policy and management team, the board of supervisors of each participating county or the council in the case of each participating city shall jointly establish the size of the team and the type of representatives to be selected from each locality in accordance with § 2.2-5205. The governing bodies of each participating county and city served by the team shall appoint the designated representatives from their localities. The participating governing bodies shall jointly designate an official of one member city or county to act as fiscal agent for the team.

The county or city that comprises a single team and the county or city whose designated official serves as the fiscal agent for the team in the case of joint teams shall annually audit the total revenues of the team and its programs. The county or city that comprises a single team and any combination of counties or cities establishing a team shall arrange for the provision of legal services to the team.

1992, cc. 837, 880, § 2.1-750; 2001, c. 844.

Code of Virginia
Title 2.2. Administration of Government
Chapter 52. Children's Services Act

§ 2.2-5205. Community policy and management teams; membership; immunity from liability.

The community policy and management team to be appointed by the local governing body shall include, at a minimum, at least one elected official or appointed official or his designee from the governing body of a locality that is a member of the team, and the local agency heads or their designees of the following community agencies: community services board established pursuant to § 37.2-501, juvenile court services unit, department of health, department of social services and the local school division. The team shall also include a representative of a private organization or association of providers for children's or family services if such organizations or associations are located within the locality, and a parent representative. Parent representatives who are employed by a public or private program that receives funds pursuant to this chapter or agencies represented on a community policy and management team may serve as a parent representative provided that they do not, as a part of their employment, interact directly on a regular and daily basis with children or supervise employees who interact directly on a daily basis with children. Notwithstanding this provision, foster parents may serve as parent representatives. Those persons appointed to represent community agencies shall be authorized to make policy and funding decisions for their agencies.

The local governing body may appoint other members to the team including, but not limited to, a local government official, a local law-enforcement official and representatives of other public agencies.

When any combination of counties, cities or counties, and cities establishes a community policy and management team, the membership requirements previously set out shall be adhered to by the team as a whole.

Persons who serve on the team shall be immune from any civil liability for decisions made about the appropriate services for a family or the proper placement or treatment of a child who comes before the team, unless it is proven that such person acted with malicious intent. Any person serving on such team who does not represent a public agency shall file a statement of economic interests as set out in § 2.2-3117 of the State and Local Government Conflict of Interests Act (§ 2.2-3100 et seq.). Persons representing public agencies shall file such statements if required to do so pursuant to the State and Local Government Conflict of Interests Act.

Persons serving on the team who are parent representatives or who represent private organizations or associations of providers for children's or family services shall abstain from decision-making involving individual cases or agencies in which they have either a personal interest, as defined in § 2.2-3101 of the State and Local Government Conflict of Interests Act, or a fiduciary interest.

1992, cc. 837, 880, § 2.1-751; 1995, c. 190; 1999, cc. 644, 669; 2001, c. 844.

Code of Virginia
Title 2.2. Administration of Government
Chapter 52. Children's Services Act

§ 2.2-5206. Community policy and management teams; powers and duties.

The community policy and management team shall manage the cooperative effort in each community to better serve the needs of troubled and at-risk youths and their families and to maximize the use of state and community resources. Every such team shall:

1. Develop interagency policies and procedures to govern the provision of services to children and families in its community;

2. Develop interagency fiscal policies governing access to the state pool of funds by the eligible populations including immediate access to funds for emergency services and shelter care;

3. Establish policies to assess the ability of parents or legal guardians to contribute financially to the cost of services to be provided and, when not specifically prohibited by federal or state law or regulation, provide for appropriate parental or legal guardian financial contribution, utilizing a standard sliding fee scale based upon ability to pay;

4. Coordinate long-range, community-wide planning that ensures the development of resources and services needed by children and families in its community including consultation on the development of a community-based system of services established under § 16.1-309.3;

5. Establish policies governing referrals and reviews of children and families to the family assessment and planning teams or a collaborative, multidisciplinary team process approved by the Council, including a process for parents and persons who have primary physical custody of a child to refer children in their care to the teams, and a process to review the teams' recommendations and requests for funding;

6. Establish quality assurance and accountability procedures for program utilization and funds management;

7. Establish procedures for obtaining bids on the development of new services;

8. Manage funds in the interagency budget allocated to the community from the state pool of funds, the trust fund, and any other source;

9. Authorize and monitor the expenditure of funds by each family assessment and planning team or a collaborative, multidisciplinary team process approved by the Council;

10. Submit grant proposals that benefit its community to the state trust fund and enter into contracts for the provision or operation of services upon approval of the participating governing bodies;

11. Serve as its community's liaison to the Office of Children's Services, reporting on its programmatic and fiscal operations and on its recommendations for improving the service system, including consideration of realignment of geographical boundaries for providing human services;

12. Collect and provide uniform data to the Council as requested by the Office of Children's Services in accordance with subdivision D 16 of § 2.2-2648;

13. Review and analyze data in management reports provided by the Office of Children's Services in accordance with subdivision D 18 of § 2.2-2648 to help evaluate child and family outcomes and public and private provider performance in the provision of services to children and families through the Children's Services Act program. Every team shall also review local and statewide data provided in the management reports on the number of children served, children placed out of state, demographics, types of services provided, duration of services, service expenditures, child and family outcomes, and performance measures. Additionally, teams shall track the utilization and performance of residential placements using data and management reports to develop and implement strategies for returning children placed outside of the Commonwealth, preventing placements, and reducing lengths of stay in residential programs for children who can appropriately and effectively be served in their home, relative's homes, family-like setting, or their community;

14. Administer funds pursuant to § 16.1-309.3;

15. Have authority, upon approval of the participating governing bodies, to enter into a contract with another community policy and management team to purchase coordination services provided that funds described as the state pool of funds under § 2.2-5211 are not used;

16. Submit to the Department of Behavioral Health and Developmental Services information on children under the age of 14 and adolescents ages 14 through 17 for whom an admission to an acute care psychiatric or residential treatment facility licensed pursuant to Article 2 (§ 37.2-403 et seq.) of Chapter 4 of Title 37.2, exclusive of group homes, was sought but was unable to be obtained by the reporting entities. Such information shall be gathered from the family assessment and planning team or participating community agencies authorized in § 2.2-5207. Information to be submitted shall include:

a. The child or adolescent's date of birth;

b. Date admission was attempted; and

c. Reason the patient could not be admitted into the hospital or facility;

17. Establish policies for providing intensive care coordination services for children who are at risk of entering, or are placed in, residential care through the Children's Services Act program, consistent with guidelines developed pursuant to subdivision D 22 of § 2.2-2648; and

18. Establish policies and procedures for appeals by youth and their families of decisions made by local family assessment and planning teams regarding services to be provided to the youth and family pursuant to an individual family services plan developed by the local family assessment

and planning team. Such policies and procedures shall not apply to appeals made pursuant to § 63.2-915 or in accordance with the Individuals with Disabilities Education Act or federal or state laws or regulations governing the provision of medical assistance pursuant to Title XIX of the Social Security Act.

1992, cc. 837, 880; 1995, cc. 396, 696, 699, § 2.1-752; 1997, c. 347; 1999, c. 669; 2000, c. 937; 2001, cc. 190, 206, 844; 2002, cc. 585, 619; 2003, c. 483; 2008, cc. 39, 170, 277; 2009, cc. 813, 840; 2014, c. 407; 2015, cc. 88, 305, 366.

Code of Virginia
Title 2.2. Administration of Government
Chapter 52. Children's Services Act

§ 2.2-5208. Family assessment and planning team; powers and duties.

The family assessment and planning team, in accordance with § 2.2-2648, shall assess the strengths and needs of troubled youths and families who are approved for referral to the team and identify and determine the complement of services required to meet these unique needs.

Every such team, in accordance with policies developed by the community policy and management team, shall:

1. Review referrals of youths and families to the team;

2. Provide for family participation in all aspects of assessment, planning and implementation of services;

3. Provide for the participation of foster parents in the assessment, planning and implementation of services when a child has a program goal of permanent foster care or is in a long-term foster care placement. The case manager shall notify the foster parents of a troubled youth of the time and place of all assessment and planning meetings related to such youth. Such foster parents shall be given the opportunity to speak at the meeting or submit written testimony if the foster parents are unable to attend. The opinions of the foster parents shall be considered by the family assessment and planning team in its deliberations;

4. Develop an individual family services plan for youths and families reviewed by the team that provides for appropriate and cost-effective services;

5. Identify children who are at risk of entering, or are placed in, residential care through the Children's Services Act program who can be appropriately and effectively served in their homes, relatives' homes, family-like settings, and communities. For each child entering or in residential care, in accordance with the policies of the community policy and management team developed pursuant to subdivision 17 of § 2.2-5206, the family assessment and planning team or approved alternative multidisciplinary team, in collaboration with the family, shall (i) identify the strengths and needs of the child and his family through conducting or reviewing comprehensive assessments, including but not limited to information gathered through the mandatory uniform assessment instrument, (ii) identify specific services and supports necessary to meet the identified needs of the child and his family, building upon the identified strengths, (iii) implement a plan for returning the youth to his home, relative's home, family-like setting, or community at the earliest appropriate time that addresses his needs, including identification of public or private community-based services to support the youth and his family during transition to community-based care, and (iv) provide regular monitoring and utilization review of the services and residential placement for the child to determine whether the services and placement continue to provide the most appropriate and effective services for the child and his family;

6. Where parental or legal guardian financial contribution is not specifically prohibited by federal or state law or regulation, or has not been ordered by the court or by the Division of Child Support Enforcement, assess the ability of parents or legal guardians, utilizing a standard sliding fee scale, based upon ability to pay, to contribute financially to the cost of services to be provided and provide for appropriate financial contribution from parents or legal guardians in the individual family services plan;

7. Refer the youth and family to community agencies and resources in accordance with the individual family services plan;

8. Recommend to the community policy and management team expenditures from the local allocation of the state pool of funds; and

9. Designate a person who is responsible for monitoring and reporting, as appropriate, on the progress being made in fulfilling the individual family services plan developed for each youth and family, such reports to be made to the team or the responsible local agencies.

1992, cc. 837, 880, § 2.1-754; 1995, c. 396; 1999, c. 669; 2001, cc. 437, 844; 2008, cc. 39, 170; 2015, c. 366.

STATE EXECUTIVE COUNCIL MEMBERSHIP

Name	Agency/Organization	Term
The Honorable William A. (Bill) Hazel, Jr. M.D, Chairman	Secretary of Health and Human Resources	n/a
Margaret Schultze, Commissioner	Virginia Dept. of Social Services	n/a
John Eisenberg, Assistant Superintendent for Special Education	Virginia Dept. of Education	Designee for Steven Staples, Ed.D
Andrew K. Block, Jr., Director	Dept. of Juvenile Justice	n/a
Sandra Karison , Director of Court Improvement Program	Office of the Executive Secretary Supreme Court of Virginia	Designee for Karl Hade
Cynthia B. Jones,	Director Dept. of Medical Assistance Services	n/a
Robert Hicks , Deputy Commissioner	Virginia Dept. of Health	Designee for Marissa Levine, MD., MPH
Jack Barber, MD, Interim Commissioner	Virginia Dept. of Behavioral Health and Developmental Services	n/a

PRIVATE PROVIDER REPRESENTATIVES

Courtney Gaskins , Ph.D., Services	Youth For Tomorrow	July 1, 2015 – June 30, 2018
Greg Peters, President, CEO	UMFS	July 1, 2015 – June 30, 2018

PARENT/SERVICE RECIPIENT REPRESENTATIVES

Jeanette Troyer	n/a	July 1, 2016 – June 30, 2019
Sophia Booker	n/a	July 1, 2016 – June 30, 2019
Elizabeth O'Shea	n/a	*Filling an un-expired term ending June 30, 2019*

LOCAL GOVERNMENT REPRESENTATIVES

The Honorable Mary Biggs, Member, Board of Supervisors	Montgomery County	July 1, 2015 – June 30, 2018
Maurice Jones, City Manager	City of Charlottesville	July 1, 2015 – June 30, 2018
R. Morgan Quicke,County Administrator	Richmond County	*Filling an un-expired term ending June 30, 2018*
The Honorable Catherine Hudgins, Member, Board of Supervisors	Fairfax County	July 1, 2015 - June 30, 2018
The Honorable Sheila Olem Council Member, Town of Herndon	Herndon	*Filling an un-expired term ending June 30, 2018*

LEGISLATIVE REPRESENTATIVES

The Honorable Richard P. "Dickie" Bell, Member	Virginia House of Delegates	Coincident with term of office
The Honorable Jennifer T. Wexton, Member	Virginia Senate	Coincident with term of office

JUVENILE AND DOMESTIC RELATIONS DISTRICT COURT JUDGES

The Honorable Frank Somerville Presiding Judge Culpeper/Orange JDRC	16th Judicial District	Filling an un-expired term ending June 30, 2017

STATE AND LOCAL ADVISORY TEAM

Tamara Temoney, Ph.D. Chair	State and Local Advisory Team	n/a

Virginia Beach Community Policy Management Team (CPMT)

FY2017

CPMT VOTING MEMBERS

MEMBER'S NAME	EMAIL	PHONE	ALTERNATE	EMAIL	PHONE	AGENCY/DIVISION REPRESENTED
Debbie Batakis	Deborah.Batakis@vdh.virginia.gov	518-2682				Health Dept
Pamela Hamrick	pkh1978@aol.com	563-9056	N/A			Parent Representative
Bob Matthias	rmatthia@vbgov.com	385-8267	Vice-Chair fills role			City Manager's Office
Olymphia Perkins	olymphia.perkins@djj.virginia.gov	385-8020	Gloria Bartley	gloria.bartley@djj.virginia.gov	757-385-8260	Court Services Unit
Ginger Ploeger	gploeger@tyscommission.org	488-9161	Shawn Sawyer	SSawyer@tyscommission.org		Tidewater Youth Services Commission
Aileen Smith	alsmith@vbgov.com	385-0504	James Thornton	JThornto@vbgov.com	757-385-0842	HSD/CSB
Dannette Smith	drsmith@vbgov.com	385-3613	Gailyn Thomas	GThomas@vbgov.com	757-385-3262	HSD/Admin/SSD
Ronald Taylor	rrtphy@aol.com	385-1250	N/A			Community Represenative
Veleka Gatling, Ph.D.	Veleka.Gatling@vbschools.com	263-2405	Tania Sotomayor	Tania.Sotomayor@vbschools.com	757-263-2400	Schools/Special

OFFICERS: Elected May 23, 2016
Chair: Robert Matthias
Term: July 1, 2016 - June 30, 2018

Vice-Chair: Olymphia Perkins
Term: July 1, 2016 - June 30, 2018

Last update: October 24, 2016

Virginia Beach Community Policy Management Team (CPMT)
FY2017

NON-VOTING ATTENDEES

NAME	EMAIL	PHONE	TITLE
Donald Barnett	dbarnett@vbgov.com	x4588	CVB/Comptroller
Rachel Evans	revans@vbgov.com	x4539	CVB Attorney's Office
Stacy Hershberger	shershbe@vbgov.com	x8389	CVB/Management Services
Dawn Rykheart	DRykhear@vbgov.com	x3204	HSD/Bus Admin/CPMT Fiscal Agent
Gailyn Thomas	Gthomas@vbgov.com	x3262	HSD/SSD
Carolyn Wood	cwood@vbgov.com	x0802	HSD/Consumer & Family Affairs
Miryam Woodson	mwoodson@vbgov.com	x4048	Comptroller - Don's staff
Becky China	bchina@vbgov.com	x3341	CSA Administrator/Staff Liaison

FY2017

VB Family Assessment and Planning Team (FAPT)

NAME	EMAIL	PHONE	Division
Lorelei Jones	Ljones@vbgov.com	x3435	HSD/DSS/FC
Maclovia Butler	MMButler@vbgov.com	x0855	CSB/ C&Y/MHSA
Kelly Doolan	KDoolan@vbgov.com	x0840	CSB/ C&Y/MHSA
John Paradiso	JParadis@vbgov.com	x0835	CSB/ C&Y/MHSA
Mary Ellen Patton	mpatton@vbgov.com	x0846	HSD/C&Y/MHSA
Brenda King	brenda.king2@vbschools.com	263-2300	Schools/Special
Karen Hatfield	karen.hatfield@vbschools.com	263-2300	Schools/Special
Damion Wilson	Damion.Wilson@VBSchools.com	263-2300	Schools/Special
Angela Perrotta	angela.perrotta@djj.virginia.gov	x5662	Court Services
Brandy Newton	brandy.newton@djj.virginia.gov	x8399	Court Services
John Zamora	john.zamora@djj.virginia.gov	x6335	Court Services
Nina Joyner	nina.joyner@djj.virginia.gov	x8351	Court Services
Katie McCurdy	katie.McCurdy@djj.virginia.gov	x8398	Court Services
Karen Roundtree	KARountr@vbgov.com	x3539	HSD/ DSS/ Adoptions
Lisa Wall	LWall@vbgov.com	x3465	HSD/DSS/CPS
Lacey Holman	LHolman@vbgov.com	x3298	HSD/DSS/CPS
Emily Lowe	ELowe@vbgov.com	x3292	HSD/DSS/FC
Connie Johnson	COJohnso@vbgov.com	x3540	HSD/DSS/Adoptions
Dorothy Simpkins	DSimpkin@vbgov.com	x3289	HSD/DSS/FC
Dana Faulkner	DFaulkne@vbgov.com	x3588	HSD/DSS/CPS
Yolanda Murrell	YMurrell@vbgov.com	x3712	HSD/DSS/CPS
Marisha Griffith	'marisha.griffith@djj.virginia.gov'	x5611	Court Services
Marie Gustafson	MGustafs@vbgov.com	x3346	HSD/DSS/FC
Joy Slight	JSlight@vbgov.com	x3276	HSD/DSS/CPS
Ninah Pearson	NPearson@vbgov.com	x3284	HSD/DSS
Linda Brooks	LBrooks@vbgov.com	x3290	HSD/DSS/Placement
Matthew Donovan	MDonovan@vbgov.com	x3552	HSD/DSS/School Liason
Brian Hawkins	BHawkins@vbgov.com	x3490	HSD/DSS/ FIT
Nadia Howell	NHowell@vbgov.com	x3527	HSD/DSS/CPS
Jennifer Bond	JBond@vbgov.com	x3248	HSD/DSS/FC
Raylethea Dillard	RSDillard@vbgov.com	x3288	HSD/DSS/CPS

As of May 15, 2015

VIRGINIA BEACH FAPT MEMBERS - 2017

ROTATION SCHEDULE
FAPT Meets Every Tuesday and Thursday 9:00 a.m. – 5:00 p.m.

CSB – Mental Health

Tuesdays		Thursdays
Kelly Doolan	Feb	Mary Ellen Patton
John Paradiso	March	Kelly Doolan (covering for Mac)
Kelly Doolan	April	Mary Ellen Patton
John Paradiso	May	Maclovia Butler
Kelly Doolan	June	Mary Ellen Patton
John Paradiso	July	Maclovia Butler
Kelly Doolan	August	Mary Ellen Patton
John Paradiso	Sept	Maclovia Butler
Kelly Doolan	Oct	Mary Ellen Patton
John Paradiso	Nov	Maclovia Butler
Kelly Doolan	Dec	Mary Ellen Patton

CSU – Courts

Tuesdays	Thursdays
Brandy Newton- Jan	Marisha Griffith
Angela Perotta- Feb	
Nina Joyner- March/Aug	
Katie McCurdy- April/Sept	
John Zamora- May/Oct	
Brandy Newton- June/Nov	
Angela Perotta- July/Dec	

Schools

Tuesdays	Thursdays
Karen Hatfield	Brenda King
Damion Wilson- Backup	

VIRGINIA BEACH FAPT MEMBERS - 2017

ROTATION SCHEDULE

Social Services

Tuesdays		Thursdays
Karen Roundtree	June	Connie Johnson
Lisa Wall	July	Lacey Holman
Jennifer Bond?	August	Dorothy Simpkins
Lacey Holman	September	Dana Faulkner
Emily Lowe	October	Lorelei Jones
Joy Slight	November	Yolanda Murrell
Ninah Pearson	December	Brian Hawkins
Lorelei/Dana Faulkner	January -2017	Yolanda Murrell
Marie Gustafson	February	~~Matthew Donovan~~
Lorelei Jones	March	Dana Faulkner
Linda Brooks	April	Connie Johnson
Lisa Wall	May	Joy Slight

Members on Team however not in SS rotation

Nadia Howell, Raylethea Dillard, Robin Guenthner (never attended training)

FAPT Members email address

Katie McCurdy <Katie.McCurdy@djj.virginia.gov>; John Zamora <John.Zamora@djj.virginia.gov>; Damion T. Wilson <Damion.Wilson@VBSchools.com>; Marie Gustafson <MGustafs@vbgov.com>; Karen E. Hatfield <Karen.Hatfield@VBSchools.com>; Maclovia M. Butler <MMButler@vbgov.com>; John M. Paradiso <JParadis@vbgov.com>; Mary E. Patton <MPatton@vbgov.com>; Kelly J. Doolan <KDoolan@vbgov.com>; Angela Perrotta <APerrott@vbgov.com>; Angela W. Perotta <angela.perrotta@djj.virginia.gov>; Nina Joyner <nina.joyner@djj.virginia.gov>; Brandy.Newton@djj.virginia.gov; 'marisha.griffith@djj.virginia.gov'; Lacey M. Holman <LHolman@vbgov.com>; Joy Slight <JSlight@vbgov.com>; Emily Lowe <ELowe@vbgov.com>; Jennifer Bond <JBond@vbgov.com>; Karen Rountree <KARountr@vbgov.com>; Ninah Pearson <NPearson@vbgov.com>; Linda Brooks <LBrooks@vbgov.com>; Matthew P. Donovan <MDonovan@vbgov.com>; Brian Hawkins <BHawkins@vbgov.com>; Connie Johnson <COJohnso@vbgov.com>; Dorothy Simpkins <DSimpkin@vbgov.com>; Yolanda M. Murrell <YMurrell@vbgov.com>; Dana Faulkner <DFaulkne@vbgov.com>; Lisa Wall <LWall@vbgov.com>; Griffith, Marisha A. (DJJ) <Marisha.Griffith@djj.virginia.gov>; Lorelei Jones LJones@vbgov.com; Brenda King <Brenda.King2@vbschools.com>; Starquitta Dickey <SDickey@vbgov.com>;

OFFICE OF COMPREHENSIVE SERVICES

ADMINISTERING THE COMPREHENSIVE SERVICES ACT FOR AT-RISK YOUTH AND FAMILIES

Intensive Care Coordination (ICC) FAQ

September 2014

- What Is ICC and Who Can Provide ICC?

Intensive Care Coordination shall include facilitating necessary services provided to a youth and his/her family designed for the specific purpose of maintaining the youth in, or transitioning the youth to, a family-based or community-based setting. Intensive Care Coordination is characterized by activities that extend beyond regular case management services that are within the normal scope of responsibilities of the public child serving systems and that are beyond the scope of services defined by the Department of Medical Assistance Services as "Mental Health Case Management."

The provision of ICC is open to both CSB's and private providers. In accordance with the State Executive Council (SEC) Policy, effective July 1, 2014, all ICC providers must be trained in the High Fidelity Wraparound (HFW) model. All educational, training, and supervision requirements for ICC can be found in the 2013 SEC ICC Policy. A list of all agencies with providers who have completed the required training can be found on the CSA website at: http://www.csa.virginia.gov/COE/coe.cfm.

- I am a new staff and have not yet been trained in HFW; can I still provide the service?

Yes, new staff can serve in the ICC role provided that they complete the next available HFW facilitator training and are supervised by someone who has completed the required HFW training.

- What is High Fidelity Wraparound (HFW)?

High Fidelity Wraparound is an evidenced-informed practice that is firmly grounded in System of Care values such as individualized, family and youth driven services, strengths-based practice, reliance on natural supports and building of self-efficacy, team-based practice, outcomes-based service planning, and cultural and linguistic competence. The HFW approach is a process of care management that holistically addresses the behavioral and social needs of a youth and family in order to develop self-efficacy. HFW provides the family with voice and ownership of their plan of care and service delivery. With the help and support of the facilitator as well as youth and family supports, the youth and family develop their team. The team will consist of system partners and those important to the family (natural supports). The youth and family are integral to the process, sharing their voice and choice as it relates to their plan, and eventually the youth and family will lead the meetings. This team works together to identify the family's vision, goals and needs and then develops specific measureable plans to accomplish those outcomes making certain to honor the family culture. The HFW model follows a "structured" series of four phases (Engagement and Team Preparation, Planning, Implementation, Transition) with associated activities and hallmarks.

- ## What Restrictions Exist for the Provision of ICC and Other Services?

Virginia DMAS (in accordance with Federal Guidelines) categorizes ICC as a Case Management Service. As a result, regulations regarding non-duplication apply; meaning that other billed Case Management services (e.g., Treatment Foster Care – Case Management, Mental Health Case Management) cannot occur while ICC is in place. This also applies to Intensive In-Home (IIH) Services. Once currently proposed regulations to unbundle case management from IIH are signed (these are currently at the final stage pending signature by the Governor), then IIH will be allowable as a service concurrent with ICC.

- ## Can ICC Be Provided To a Youth In Residential Placement?

Virginia DMAS (in accordance with Federal Guidelines) allows for a three month, pre-discharge period for the concurrent provision of ICC while a youth is in Residential Placement. This allowance falls under the Transition Coordination Model (part of the Children's Mental Health Program) in the DMAS Provider Manual. During the overlap period, the ICC can begin engagement activities as well as the development of a High Fidelity Wrap (HFW) Plan related to discharge planning and other HFW Team identified needs.

- ## Can the ICC Serve as the Lead Agency Case Manager for FAPT?

The ICC cannot be the lead agency case manager for FAPT. The Office of Comprehensive Services provided guidance on this issue in November 2013 (November 2013 ASK OCS Question, ICC as Lead Agency Case Manager). If the ICC is a CSB employee, the lead agency case manager must be a separate individual from a child serving agency (schools, DSS, DJJ, or CSB).

Local CSA may purchase the FAPT case oversight function from the CSB by using the Case Support service (Standardized Service Name Definitions).

- ## Is ICC a Separately Licensed Service?

Yes, effective 10/31/2014, ICC is a licensed service under the Department of Behavioral Health and Development Services (DBHDS). Programs currently licensed by DBHDS will need to complete a Service Modification Application in order to add ICC to the list of services currently provided. Please see the ICC Licensing Guidance for details regarding Licensing Requirements.

Please note that in accordance with State Executive Council policy, state pool funds may only be used to purchase ICC from a licensed provider.

OFFICE OF COMPREHENSIVE SERVICES

ADMINISTERING THE COMPREHENSIVE SERVICES ACT FOR AT-RISK YOUTH AND FAMILIES

The Comprehensive Services Act (CSA, §2.2-2648 et seq) was enacted in 1993 to create a collaborative system of services and funding for at-risk youth and families.

The CSA establishes local multidisciplinary teams responsible to work with families to plan services according to each child's unique strengths and needs and to administer the community's CSA activities.

The Office of Comprehensive Services (OCS) is the administrative entity responsible for ensuring effective and efficient implementation of the CSA across the Commonwealth.

Guiding principles for OCS include:

- Child and family directed care,
- Equitable access to quality services,
- Responsible and effective use of public funds,
- Support for effective, evidence-based practices, and
- Collaborative partnerships in implementation of the Comprehensive Services Act.

Office of Comprehensive Services
Empowering communities to serve youth

What is Intensive Care Coordination in a High Fidelity Wraparound Model?

Why Should ICC in a High Fidelity Wraparound Model be an Important Component of a System of Care Service Continuum?

(August 2014)

Intensive Care Coordination (ICC) in the High Fidelity Wraparound (HFW) Model provides a structured approach to care coordination that is designed for youth and families where the youth is in, or at risk of, an out-of-home placement. These are youth with complex, challenging behavioral health issues who typically represent the upper 10 – 20% of a "severity pyramid".

HFW is an evidence-informed practice that is firmly grounded in system of care values including:

- Individualized and family and youth driven services
- Strengths-based practice
- Reliance on natural supports and building self-efficacy
- Team-based practice
- Outcomes-based service planning
- Cultural and linguistic competence

Emerging evidence indicates superior outcomes for youth receiving HFW as compared to those who receive traditional services. Examples include a comparison study completed on youth in child welfare (comparing youth receiving HFW with those receiving "mental health services as usual") finding that after 18 months, 82% of youth who received wraparound moved to less restrictive, less costly environments, compared with 38% of the comparison group (*Return on Investment in Systems of Care, National Technical Assistance Center for Children's Mental Health, April 2014*).

Additional evidence is found in state-wide initiatives such as Wraparound Maine which found a 28% reduction in total net Medicaid spending for youth served through HFW, even as home and community based services increased. These cost reductions occurred as a result of a 43% drop in the use of psychiatric inpatient treatment, and a 29% decrease in the use of residential treatment (*ICC using High Quality Wraparound: State and Community Profiles, Center for Health Strategies, July 2014*).

Evidence in support of HFW also lies in follow-up outcomes noted in Los Angeles County that over a 12 month follow-up period, 77% of HFW graduates were in less restrictive placements, while 70% of the comparison group (non-HFW recipients) were in more restrictive placements. Additionally at follow up, the mean service costs for youth following completion of HFW were 60% lower than the costs of the comparison group (*Return on Investment in Systems of Care, National Technical Assistance Center for Children's Mental Health, April 2014*).

ICC using the HFW approach is a process of care management that holistically addresses the behavioral and social needs of a youth and family in order to develop self-efficacy. The youth and family are integral to the HFW process which provides them with voice and choice in the selection of their "team", development of the plan and delivery of services. The youth and family are supported in this team process by the ICC (team facilitator), trained youth and family support partners, the professional system partners and those natural supports identified as important by the family. This team works together to identify the family's vision, goals and needs and then develops specific measureable plans to accomplish those outcomes making certain to honor the family culture. The HFW model follows a "structured" series of four phases (Engagement and Team Preparation, Planning, Implementation, Transition) with associated activities and hallmarks. These include:

- Specific youth/family orientation and engagement practices
- Development of a short-term Crisis Stabilization Plan which targets pressing needs identified by the family. The development of this plan is done by collaborating with system partners (who may already have a crisis plan in place) and utilizing family and youth voice.
- Completion of a unique form of assessment called a Strengths, Needs and Culture Discovery (SNCD) which is distinct from traditional clinical assessments as its purpose is to tell the family story, does not emphasize diagnosis and avoids a problem-oriented focus. In the Discovery, the youth and family tell their story, share their unique strengths and family culture, define their needs and goals, and come up with a family vision. The Discovery process is informed by system-requirements and mandates if they exist, and the facilitator is responsible for communicating with system partners to understand these mandates.
- The formation of a youth and family team to identify and carry out action plans that are different from traditional service plans by being frequently revised, driven by youth and family preference, with a focus on needs as opposed to services, and the significant reliance on natural supports to accomplish desired outcomes.
- Completion of a Functional Assessment on the team-defined potential crisis behaviors in order to better understand the function/purpose of the behaviors as well as what is reinforcing the behaviors.
- Development of a Crisis Prevention Plan incorporating the Functional Assessment, as well as youth and family voice regarding what the results of the Crisis Prevention Plan should be, and use of a measurement strategy that will determine if the Crisis Prevention Plan is accomplishing what the team wants it to achieve.
- Development of a purposeful transition plan that incorporates formal and natural supports in the community.

The HFW model embraces a specific Theory of Change which centers on increasing youth and family self-efficacy by prioritizing youth and family needs, developing natural supports, and integrating planning. As a result of the Theory of Change, and the structured phases and activities, ICC in a HFW Model is distinct from other clinical and case management approaches.

While ICC in a HFW Model is *not a traditional clinical service*, skilled ICC workers will require and utilize many clinical skills including relationship building/engagement, soliciting and empowering client voice, conflict management, facilitating group process, understanding and management of group dynamics, assessing group themes and needs, knowledge of various clinical and related community services, development of case plans, crisis intervention planning and skills, and monitoring progress. While ICC in a HFW Model is *not traditional case management*, many traditional case management activities (e.g., assessment, case planning, service linkages, advocating for the family and youth, and monitoring progress) are accomplished through the guidance and activities of the team (while reducing the prominence of the case manager as the central figure). Specific case management activities assigned to the ICC Facilitator **by the team** are appropriate (e.g., maintaining communications between team members, assisting the youth/family with referrals and service linkages, advocating for youth/family when needed and desired) and as a result the ICC Facilitator does more than "simply facilitate the team". It is through an understanding of the family culture that the team is able to successfully develop plans and complete case management activities. Ownership and voice is given back to families who know best what works for them. Emphasis on the HFW Theory of Change which develops youth and family self-efficacy, and following the specific phases and activities of the evidence-informed HFW model also sets ICC in a HFW model apart from traditional case management.

OFFICE OF COMPREHENSIVE SERVICES

ADMINISTERING THE COMPREHENSIVE SERVICES ACT FOR AT-RISK YOUTH AND FAMILIES

Family Support Partners in the High Fidelity Wraparound Process

September 2014

High Fidelity Wraparound (HFW) is a team driven process for developing and implementing individualized care plans for at-risk youth and families. HFW is grounded in Systems of Care principles and strives to meet the prioritized needs identified by the youth and family, to increase and strengthen the family's natural supports, to improve the family's level of self-efficacy, and to integrate the work of child-serving agencies and service providers. The use of Family Support Partners (FSP) as workforce partners enhances the team's ability to honor the ten guiding principles of HFW (Family Voice and Choice, Team Based, Natural Support, Collaboration and Integration, Community Based, Culturally Competent, Individualized, Strengths Based, Unconditional Care, and Outcome-Based and Cost Responsible).

Family Support Partners (FSP) are an integral part of the HFW process. Because of their lived experience, FSP's are able to deeply engage with families; earning their respect and developing a trusting relationship. The lived experience of FSP's also makes them excellent keepers of information regarding resources and supports in the community; a vital trait for the mission of increasing a family's natural supports. FSP's are formal members of the HFW team, and are equal workforce partners.

The primary role of a FSP is to be sure that the needs of the family are addressed, and to ensure that the family is heard. This is done by partnering with the HFW facilitator (which assists in assuring that the HFW process is successful for the youth and family), and by providing peer support to the family. Peer support is the process by which FSP's provide education, modeling, active listening, and the disclosure of personal experiences. This process empowers families to use their voice to express their needs, strengths, and preferences and assists them in making informed decisions regarding their care plan. Throughout the four phases of HFW (Engagement, Initial Plan Development, Engagement, and Transition), there are distinct skill sets for the FSP as well unique opportunities to align with the family and natural supports; thus supporting the needs of the family, and at times, serving as a bridge between system agencies and the family.

There is a growing body of literature that supports the role of family support when serving at-risk youth and families. A review of this literature by the Center for Health Care Strategies (Family and Youth Peer Support Literature Review) finds that the use of family support can improve the "self-efficacy and empowerment of families" and has been "associated with improved outcomes such as service initiation and completion; increased knowledge about the youth's condition and relevant services", and improvement in "youth functioning at discharge". The above mentioned review also notes that the use of FSP's is connected to an increase in hopefulness, reduction in stress, improved mental health, increased self-efficacy, and increased engagement in treatment by the parents and caregivers. Parents who receive FSP services report tremendous satisfaction with their experience; stating that their FSP relayed information, connected them to resources, was a good listener and was caring.

Office of Children's Services
Empowering communities to serve youth

High Fidelity Wraparound (HFW) Activities and Documentation Timeline

I. Engagement Phase:

Engagement is a phase in HFW, and occurs over time, not in a single meeting. During this phase the Facilitator and Family Support Partner (FSP) are meeting with the youth, family, and potential team members (natural supports and system partners) to explain and orient them to HFW, to understand the prioritized needs of the youth, family, and team members, to gather the information for the Strengths Needs and Culture Discovery and to understand the family's vision for the HFW process. The facilitator is preparing the family, youth, and team members for the initial team meeting (which occurs in the 2nd phase of the process). Successful engagement ensures that the youth and family as well as all team members have clarity regarding their role, establishes a tone of collaboration for the HFW team, and ensures that families are central to the planning process (entire process averages 12 months).

Documentation:

- Crisis Stabilization ("Band Aid") Plan) - Completed during initial meeting with youth/family and as needed throughout the HFW Process.
- Strengths, Needs, and Culture Discovery- Completed 30-45 Days after initiating HFW (ICC). This document is written by the Facilitator (FSP helps to collect the information). The purpose of the Discovery is to educate the HFW team on who the family is and as a result the Discovery is shared with all team members and guides the HFW Planning Process. The Discovery is updated throughout HFW to reflect new information learned.

II. Planning Phase:

The Planning Phase begins when the HFW team convenes for the first time and the Initial HFW Plan (based upon the prioritized needs of the youth and family) is developed. During this meeting, the facilitator models the principles of HFW, helps the team develop a shared team mission, and ensures that the youth and family voice is heard (Family Support Partners are essential for this as well). In the Planning Phase, a Crisis Prevention Plan (CPP) is also created by the team. The Planning Phase typically ends once the Initial HFW Plan and the CPP are developed.

Documentation:

- Initial Action Plan (developed at first team meeting)
- Crisis Prevention Plan (developed by the team)

III. Implementation Phase:

The Implementation Phase is the longest phase of the HFW Process, typically lasting 3-9 months. During this phase the HFW team is meeting regularly to develop, implement, and update Action Plans to meet the prioritized needs of the youth family (while incorporating and honoring system mandates). The Facilitator is following up with team members before, after, and between meetings to ensure action steps will be completed. The Facilitator is responsible for maintaining engagement with the youth, family, and all team members and for ensuring the success of the team. Success and progress are continuously monitored (through measurable strategies, the team mission, and the family vision) and successes are celebrated by the Facilitator and the team.

Documentation:

- Ongoing Action Plans (developed at each Team Meeting; occurring as needed and decided by the team; at least monthly)

IV. Transition Phase:

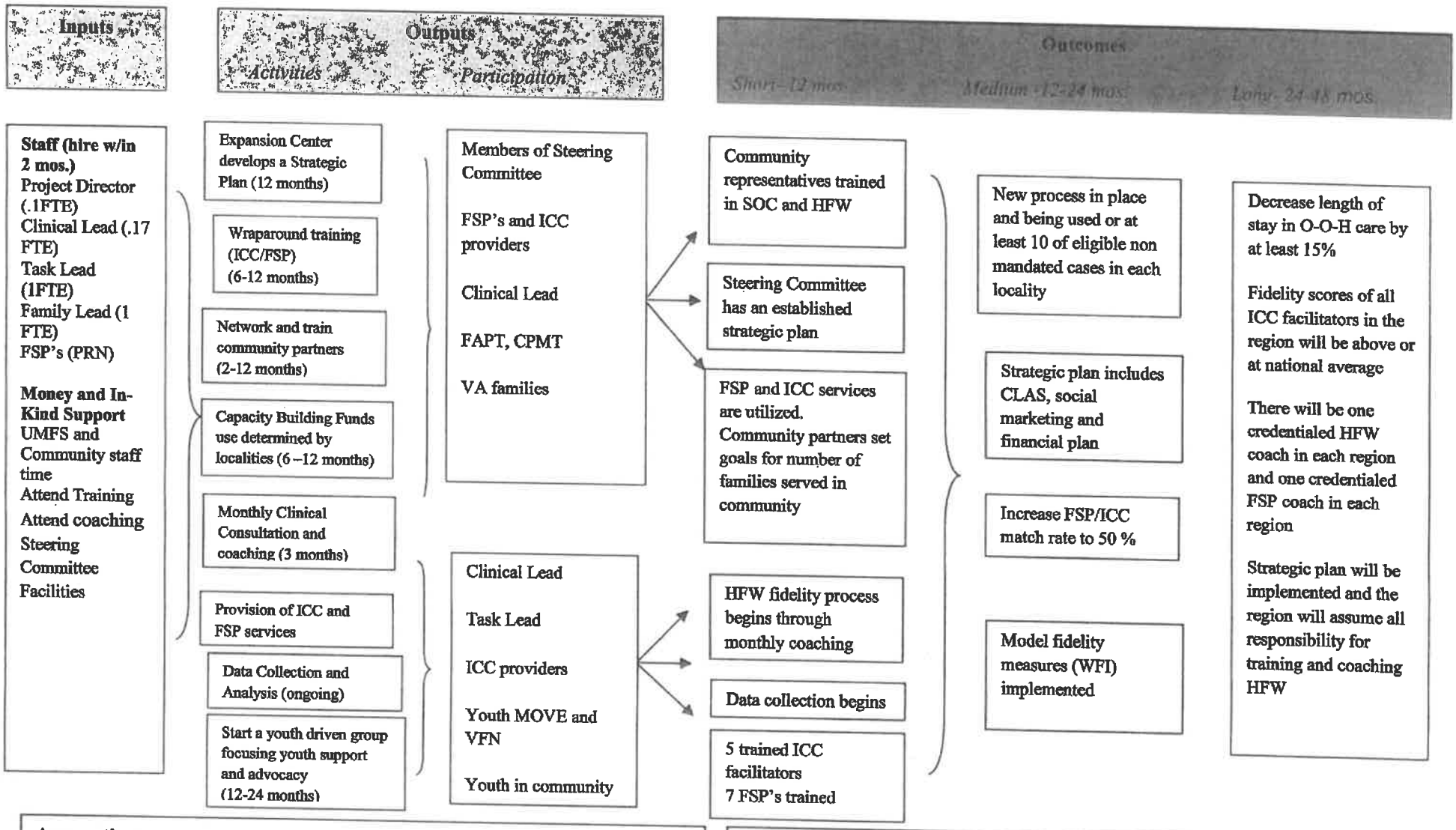
Transition is the final phase in HFW. During this phase, the HFW team should have a strong mix of natural and formal supports. This phase begins when the family and team believe that the family is approaching their vision, the team is approaching their mission, the family and youth have the skills to meet their needs, and the appropriate ongoing formal and informal supports are in place. By engaging natural supports, understanding the family vision, building upon strengths and transferring skills, preparation for Transition begins at Engagement. However, during the Transition Phase plans are made for the formal end to HFW. The team ensures that the essential professional and natural supports are in place, that the family is equipped with the skills to manage crises and to meet/problem-solve around their needs. The progress of the youth, family, and team are celebrated, lessons learned are shared, and a graduation celebration occurs.

Documentation:

- Final Action Plans (team is meeting less frequently now)
- Transition Plan
- Completed/Updated Strengths, Needs, and Culture Discovery

High Fidelity Wraparound Motto: "Do For, Do With, Cheer On...!!!"

Program: Tidewater Region Initiative Bringing SOC to Scale



Assumptions

- Localities believe community and natural supports are necessary
- Parents want to be partners
- HFW is supported by the community

External Factors

- OCS will work with statewide coach to provide a statewide coaching program

PROJECT SUMMARY

The Tidewater regional Expansion Center aims to expand the Systems of Care (SOC) initiative through establishing a regional SOC Expansion Center, as well as a regional Steering Committee. Additionally, a Regional Task Lead and Regional Family Lead, hired by UMFS, will facilitate Expansion Center activities. The activities provided by the Expansion Center will include HFW expansion, peer support provision, youth engagement, community engagement and education, and capacity building funds.

HFW Expansion.

HFW will be expanded through increased integration of ICC and Family Support Partners (FSP's). Fidelity to the HFW model will be ensured through monthly coaching with the Task Lead and with consultation from the Clinical Lead.

This project will support and broaden the use of ICC in partner localities by ensuring that ICC is available for families requesting services. Intensive Care Coordinators will help families access a broad spectrum of mental health services as identified by the HFW team. Non-mandated clients will be made a priority through this project and will have access to all of these services. Intensive Care Coordinators will also collaborate to develop cross-system family teams in the HFW process. Additional resources for training, education, and technical assistance include the following statewide organizations: the Children's Mental Health Resource Center, National Alliance on Mental Illness (NAMI) and the Virginia Family Network (VFN). To further encourage family driven care, community trainings and education will be provided through a partnership with VFN. All of these resources are available to Intensive Care Coordinators, and as appropriate, to their families served.

Peer Support Provision.

The Family Support Partner (FSP) program will implement peer support provision, and will be led by the Regional Family Lead. The Family Lead will also be a full time FSP, and accordingly will provide their family perspective to the Steering Committee. Family Lead will supervise part time FSP's. Family Lead will develop an outreach and recruitment strategy through the Expansion Center and associated relationships, which may include schools, doctor's offices, clinics, and other community resources. These resources will support recruitment of FSP's as well as linking families to the local system of care as needed for services. To support the social marketing and cultural and linguistic plan, as created by the Steering Committee, Family Lead will identify a diverse pool of part time FSP's to include bilingual staff, mothers and fathers, and family members that are representative of the communities they serve. Partner agencies will identify potential FSP's from the pool of parents whose children have previously received their services. FSP's will be trained in HFW as well as complete Peer Recovery Specialist training and certification. FSP and HFW credentialed coach Cristy Corbin will consult with Family Lead regarding monthly coaching groups to be held for FSP's. Additionally, Ms. Corbin is a trainer in the peer recovery model and will facilitate this FSP training as well. Coaching groups will provide FSP's the opportunity to practice HFW skills. FSP's will be incorporated into ICC service provision to ensure the roles of youth and family are present in service planning, and to further the mission of bringing SOC to scale. FSP's will also be an integral part in the evaluation of Expansion Center programs, including ICC and FSP.

Youth Engagement.

Youth will be engaged through establishing a youth led, youth guided, and youth attended group. Task Lead and Family Lead will partner with local youth resources to recruit a youth leader. This youth will have the opportunity to go through the NAMI advanced youth leadership training to be an official youth leader for the group. Once the group is established, the group may apply to become an official chapter of Youth MOVE (Youth Motivating Others through Voices of Experience). Through a partnership with UMFS, Project Life, and NAMI, the central region youth group is a nationally recognized Youth MOVE chapter and is part of Youth MOVE VA. Youth involved will also receive opportunities to represent youth voice on regional committees and governance boards, including the Steering Committee. Currently Sophia Booker, Youth MOVE leader in the central region, sits on the State Executive Council. The group will be comprised of youth representative of their community, and is expected to include minority youth, LGBTQ youth, youth experiencing early onset of Serious Emotional Disturbance or Serious Mental Illness, and youth currently receiving or former recipients of services, including non-mandated youth. The group will be able to consult and network with various organizations, to include Youth MOVE VA, Virginia Family Network (VFN), Project Life, and local NAMI affiliate if applicable. Through a partnership with VDSS and UMFS, Project LIFE has a youth advisory board called Speak Out, and VFN has both parent and youth advisory boards. The Expansion Center will collaborate with both of these programs to allow for insight and consultation on youth and family voice on boards. The youth group will be established within the first year of the grant and fully implemented within the first two years. In the third year, the region will explore a youth support partner program by recruiting from the youth led group. Youth support partners will be trained in HFW and become certified peer support providers.

Community Engagement and Education.

The Expansion Center will provide training and consultation to systems within the community to include case managers, schools, Family Assessment and Planning Teams (FAPT's), and Community Policy and Management Teams (CPMT's). Moreover, FSP's will promote family voice on governance boards such as FAPT and CPMT, and will collaborate with Community Services Boards. Currently UMFS has two FSP's serving on two separate CPMT's, and one of these FSP's was also invited to address the State Executive Council. To further embed SOC and HFW culture, FSP's will also continue to be involved in work groups with DBHDS and Magellan, as well as advocate to the General Assembly (in partnership with NAMI) on behalf of families and children with mental health issues.

To further engage the community in the wraparound model, the Expansion Center will develop a social marketing strategy. Each region will send at least one representative to a social marketing training, and utilize technical assistance to help with developing the social marketing plan. Goals of the plan will include engaging youth in the system of care, as well as further imbedding HFW into the community. Some options for implementation include development of a smartphone application such as the Community Care App that was created during the 2014-2016 Central Region grant, development of a social media strategy, and development of a training program that each community can utilize.

Capacity Building Funds

In the prior SOC project, UMFS found that providing localities with capacity building funds greatly assisted with the development of innovative practices in support of SOC principles, and

in expanding the use of flex funds. Use of flex funds has been shown to facilitate the transition to a fully integrated system of care. These funds will receive oversight by the Steering Committee. These funds can be used to support a variety of innovative ways to build capacity, such as social marketing, ICC, and the provision of other services not typically included in traditional service delivery. Each locality will create a plan on how they will use capacity funds as related to their needs assessment and strategic plan. Additionally, partner localities will identify individuals to become trainers in the HFW and FSP models to build the state's capacity to provide ongoing access to training. With Steering Committee support, localities will create a long-term flex fund sustainability plan that will meet the needs of youth, families, and their localities.

The Expansion Center will develop and implement a cultural and linguistic strategic plan that will include receiving consultation and technical assistance. The Expansion Center will have at least one person in the community become a cultural broker and receive the training that is offered through DBHDS. This person will assist the region with developing a strategic plan that will meet the cultural and linguistic needs in the community.

Virginia Mandatory Continuing Legal Education

Virginia State Bar
1111 East Main Street, Suite 700
Richmond, VA 23219-0026
Phone: (804) 775-0577
Web site: www.vsb.org

September 7, 2017

Via E-mail

Christopher Jacobs
Virginia Beach Bar Association
VA

RE: VIEE007

Dear Mr. Jacobs:

The course titled "Juvenile Domestic Relations Committee Annual CLE" has been approved for 7.0 credit hours including (0.0) credit hours for Ethics by the Virginia Mandatory Continuing Legal Education Board.

Accreditation of this program is approved through October 31, 2017. Enclosed are the applicable certification forms for your course. Virginia attorneys may certify their attendance at our website **upon receipt of this form** and the course ID# may **not** be provided without it. Course attendance lists are not processed as certification of attendance.

Any recording of this program for future presentation by any delivery means requires a separate application.

Please contact the MCLE Department if you have any questions.

Sincerely,

Gale M. Cartwright

Gale M. Cartwright
Director of MCLE

Virginia MCLE Board

CERTIFICATION OF ATTENDANCE (FORM 2)

MCLE requirement pursuant to Paragraph 17, of Section IV, Part Six, Rules of the Supreme Court of Virginia and the MCLE Board Regulations.

INSTRUCTIONS

Certify Your Attendance Online at www.vsb.org see Member Login

Complete this Certification. Retain for two years.

MCLE Compliance Deadline - October 31. MCLE Reporting Deadline - December 15.

A $100 fee will be assessed for failure to comply with either deadline.

Member Name: _____ **VSB Member Number:** _____

Address: _____ **Daytime Phone:** _____

_____ **E-mail Address:** _____

_____

City **State** **Zip**

Course ID Number: **VIEE007**

Sponsor: **Virginia Beach Bar Association**

Course/Program Title: **Juvenile Domestic Relations Committee Annual CLE**

Live Interactive * **CLE Credits (Ethics Credits):** **7.0** **(0.0)**

Date Completed:_____ **Location:** _____

By my signature below I certify

___ I attended a total of _____ (hrs/mins) of **approved CLE**, of which (_____) (hrs/mins) were in **approved Ethics**. Credit is awarded for actual time in attendance (0.5 hr. minimum) rounded to the nearest half hour. (Example: 1hr 15min = 1.5hr)

___ The sessions I am claiming had written instructional materials to cover the subject.

___ I participated in this program in a setting physically suitable to the course.

___ I was given the opportunity to participate in discussions with other attendees and/or the presenter.

___ I understand I may not receive credit for any course/segment which is not materially different in substance than a course/segment for which credit has been previously given during the same completion period or the completion period immediately prior.

___ I understand that a materially false statement shall be subject to appropriate disciplinary action.

* NOTE: A maximum of 8.0 hours from pre-recorded courses may be applied to meet your yearly MCLE requirement. Minimum of 4.0 hours from live interactive courses required.

_____ _____

Date Signature

Questions? Contact the MCLE Department at (804) 775-0577

If not certified online, this form may be mailed

Virginia MCLE Board
Virginia State Bar
1111 East Main Street, Suite 700
Richmond, VA 23219-0026
Web site: www.vsb.org

[Office Use Only: Live]

Virginia MCLE Board

CERTIFICATION OF TEACHING (FORM 3)

MCLE requirement pursuant to Paragraph 17, of Section IV, Part Six, Rules of the Supreme Court of Virginia and the MCLE Board Regulations.

INSTRUCTIONS

E-mail this form to mymcle@vsb.org

Follow Form 1 Instructions after 10/31 Compliance Deadline

Complete this Certification to Include Both Teaching and Attendance hours. Retain copy for two years.

MCLE Compliance Deadline - October 31. MCLE Reporting Deadline - December 15.

A $100 fee will be assessed for failure to comply with either deadline.

Member Name: _____ **VSB Member Number:** _____

Address: _____ **Daytime Phone:** _____

_____ **E-mail Address:** _____

_____

City **State** **Zip**

Course ID Number: **VIEE007**

Sponsor: **Virginia Beach Bar Association**

Course/Program Title: **Juvenile Domestic Relations Committee Annual CLE**

Live Interactive * **CLE Credits (Ethics Credits):** **7.0** **(0.0)**

Date(s) of Teaching: _____ Location(s): _____

ONLY SESSIONS WITH WRITTEN INSTRUCTIONAL MATERIALS ARE APPROVABLE FOR CREDIT

- My teaching segment was _____ (hrs/mins) of CLE, of which (_____) (hrs/mins) were in Ethics.
- In addition, I attended *other* segments totaling _____ (hrs/mins) of CLE, of which (_____) (hrs/mins) were in Ethics.
- I spent _____ hours preparing for teaching my segment of the course.
- No more than four (4) hours of preparation credit may be claimed per one hour of instructional time in your presentation, and no more than eight (8) hours total for any one course. Total credit is awarded for actual time spent teaching, attendance and preparation rounded to the nearest half hour. (Example: 1hr 15min = 1.5hr)
- A materially false statement shall be subject to appropriate disciplinary action.

* NOTE: A maximum of 8.0 hours from pre-recorded courses may be applied to meet your yearly MCLE requirement. Minimum of 4.0 hours from live interactive courses required.

_____ _____

Date **Signature**

Questions? Contact the MCLE Department at (804) 775-0577

If not e-mailed, this form may be mailed to:

Virginia MCLE Board
Virginia State Bar
1111 East Main Street, Suite 700
Richmond, VA 23219-0026
Web site: www.vsb.org

[Office Use Only: Live]