



SERVING DESOTO, MANATEE, AND SARASOTA COUNTIES

Family Safety Alliance (FSA)
High Risk / High Need / High Utilizer Youth Workgroups
Executive Summary
November 2024

The mission of the Family Safety Alliance is to serve as a collaborative, prevention-focused, and transparent partner that provides community oversight, education, and advocacy in the achievement of systemic improvements in community-based child welfare services.

FSA Workgroups Executive Summary

The Problem

Background and Rationale

In 2021, our Community-Based Care (CBC) Lead Agency, the Safe Children Coalition (SCC), indicated that they were seeing a significant rise in children entering out of home care, not due to abuse or neglect, but due to a parent or caregiver's inability to cope or willful abandonment of a child (colloquially referred to as "Lockouts"). These children were almost exclusively adolescents and almost all of them had significant behavioral health challenges, ranging from debilitating mental health to violent and criminal behaviors. From 2015 – 2021, our Circuit averaged approximately 12 "Lockouts" per year; in FY 22-23, that rose to 32 Lockouts (a 250% Increase), and in FY 23-24 to 43 Lockouts (a 350% increase from 2021). A small workgroup formed to begin strategizing ways to address the increase. For lack of a better descriptor, we referred to these youth as "High Risk/High Need/High Utilizer."

Around the same time, our local School Districts were experiencing an increase in problematic behaviors among students that they believed were associated with unaddressed trauma. The districts were struggling to respond to the rising needs internally as some youth were beyond the capacity of the Multi-Tiered System of Support (MTSS) framework. The districts therefore were looking for external assistance from community providers.

As time passed, the problems only escalated. By the fall of 2023, our CBC was experiencing a crisis as this population continued to increase, resulting in significant negative outcomes for the youth themselves, the staff responsible for the youth, the finite budget, and the community. As such, the Family Safety Alliance (FSA) hosted community discussions in September and November of 2023. During these discussions, it was apparent that the Child & Family Well-Being System was not the only system impacted by these rising youth behavioral health issues, but that the issues extended across systems, including the education system, law enforcement, and the behavioral health crisis response system. At its January 2024 meeting, the FSA collectively decided to form two community workgroups to address these ongoing issues, one focused on those youth currently in out of home care, and the other focused on preventing families and youth from escalating to behavioral health crisis in the first place.



The Project

Work of the Workgroups

In February of 2024, an Orientation was held with community members interested in forming two workgroups to address this population of youth. The Orientation was intended to provide a more detailed overview of both the problem and the proposed workgroups. A total of 68 community members expressed interest in joining the Prevention Workgroup, while 41 community members expressed interest in joining the Intervention & Treatment Workgroup (see Appendix A for participants). Surveys were sent out to the workgroups in March of 2024 to generate the best meeting day and time for most and the cadence of the Workgroups. An Ad Hoc Data Workgroup also met in March to review existing and easily accessible data related to this population in order to inform our work.

Both Workgroups officially convened in April of 2024 and developed Issues and Priorities. Each Workgroup had agreed to meet monthly and collectively established a 6-month timeframe for the work to be completed. The Workgroups agreed to a Charter, or Strategic Plan, of sorts to guide our work. The ultimate goal of the Project was to collectively determine 5-7 Strategies from each Workgroup to address the Problem along the continuum from Prevention to Intervention to Treatment.

In May of 2024, each Workgroup began to define the Sequential Intercepts, or “Buckets,” that generally identified common areas for which strategies should be identified. A spreadsheet was developed to keep track of the ideas that were generated. Each workgroup then set out to collectively fill each “bucket”, using an approach that encouraged open dialogue and a “no idea is a bad idea” philosophy. This process of filling our “Buckets” with ideas continued in June and July of 2024. In total, approximately 150 ideas were generated in the Prevention Workgroup, while approximately 100 ideas were generated in the Intervention & Treatment Workgroup (see Appendix B & C for additional information). Two Small Ad Hoc Workgroups were created to roll all of these ideas into larger, general themes. The Prevention Workgroup generated 14 larger thematic strategies, while the Intervention & Treatment Workgroup generated 25 larger thematic strategies.

In August of 2024, each Workgroup participated in an exercise to map each of the larger thematic strategies based on their perceived Feasibility (i.e., cost, time, effort, complexity) and perceived Impact. Using the tool *Mural*, each Workgroup collectively placed these strategies in a matrix with four quadrants: Low Impact/Low Feasibility (Low Priority), Lower Impact/High Feasibility (Low-hanging Fruit), High Impact/Low Feasibility (Moonshots), and High Impact/High Feasibility (Best Bets) (see Appendix D & E for reference). Finally, In September of 2024, each Workgroup voted on its top 5-7 strategies. The final phase of the project included disseminating these strategies with as far a reach as possible, including to funders, policy makers, organizations, persons in positions of power, and the community.

In the following pages you will find a summary of these strategies that were developed by our community and represent our best ideas to prevent families and youth from escalating to crisis, and to address the High Risk/High Need/High Utilizer youth currently in out of home care, including the related issues that accompany the increase of this population in our Child & Family Well-Being System.

The Philosophy

Both workgroups determined it was critical to establish an overarching philosophy to approach this work, both during the workgroup discussion and in the implementation of the recommendations. The philosophy includes elements of Public Health, a Trauma-Informed & Resilience Oriented Approach, Wraparound, and System of Care.

Public Health is, according to CEA Winslow (1920), “the science and art of preventing *disease* (emphasis added), prolonging life, and promoting health through the organized efforts and informed choices of society, organizations, public and private communities, and individuals.” It is evident that the efforts of our workgroups and the implementation of our recommendations are a collective effort to create conditions in which children and families can be healthy.

A Trauma Informed Approach, according to SAMHSA (2023), is grounded in a core set of assumptions, principles, and domains. As such, we are committed to recognizing that trauma is widespread and there are paths to recovery, recognizing the signs and reactions of trauma in the people with which we work, responding by fully integrating knowledge about trauma into our work from policy to practice and from implementation to evaluation, and resisting re-traumatization. The six principles of a Trauma Informed Approach include: 1) Safety; 2) Trustworthiness & Transparency; 3) Peer Support; 4) Collaboration and Mutuality; 5) Empowerment, Voice, & Choice; and 6) Respecting Individual Perspectives (i.e. Social, Economic, Cultural, Demographic, etc.). Approaching our work with a Resilience Orientation means Authentic Inclusion, De-centralizing or Sharing Power, Promoting Hope & Optimism, and Reducing Risk Factors while Increasing Protective Factors at the Personal, Family, and Environmental Levels (North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services, 2011).

According to the National Wraparound Initiative (2008), Wraparound has 10 guiding principles: 1) Family Voice & Choice, 2) Team-Based, 3) Natural Supports, 4) Collaboration, 5) Community-Based, 6) Culturally Competent, 7) Individualized, 8) Strengths-Based, 9) Unconditional, and 10) Outcome-Based.

Finally, a System of Care (SOC) Approach includes core values and guiding principles that we believe should embody our work now and into the future. According to The Institute for Innovation & Implementation (2021), an SOC approach is Family & Youth Driven, Community-Based, and Culturally & Linguistically Competent (core values). The guiding principles of an SOC Approach include: a Comprehensive Array of Services and Supports; Individualized, Strengths-Based Services and Supports; Evidence-Based Practices and Practice-Based Evidence; Trauma-Informed; Least Restrictive Natural Environment; Partnerships with Families and Youth; Interagency Collaboration; Care Coordination; Health-Mental Health Integration; Developmentally Appropriate Services and Supports; Public Health Approach; Mental Health Equity; Data Driven and Accountability; and Rights Protection and Advocacy.

It should be evident that there are many shared values and principles in and between each of these approaches and, together, these form the philosophy of our work up to now and into the future. Research clearly shows these philosophies are essential to successfully addressing the needs of high-risk youth and their families by acknowledging the impact of trauma on individuals, promoting healing and empowerment, and fostering safer, more supportive environments for recovery and growth. Our workgroup participants and our community firmly believe that any strategy we pursue should align with this philosophy.

Suggested Priority Strategies

Prevention Workgroup

“How do we prevent youth and families from escalating to crisis in the first place?”

Strategy 1: Implement High Fidelity Wraparound.

- Specialized High Fidelity Wraparound Team(s).
- Increase Caregiver participation in youth services.
- Build Flexible Funding Capacity.

Strategy 2: Increase availability of peer supporters throughout the system that emphasize building on family strengths, active engagement of parent, youth, and kin, and improved systems navigation. This includes ensuring adequate resources are available for training, organizational support, and certification of peers.

- Increase family support programs to decrease formal system involvement.
- Peers in more front-end capacity (initial hospitalization, initial arrest, etc.).
- Parent Support/Advocacy – Parent as partner (parent voice), advocate engaged before discharge from CSU/JAC and before YAR staffing (i.e. any point a child touches the BH system).

Strategy 3: Dedicated physical spaces for community respite and care services for youth and caregivers on a planned basis, or in times of crisis or emergency situations.

- Partial Hospitalization Program (PHP)/Day Program.
- Family Resource Center(s)/Drop-in Center(s).
- In-Home Day Support.

Strategy 4: Universal behavioral health screening for children, starting early.

- For Fetal Alcohol Spectrum Disorder (FASD), Developmental Delays, Substance Exposure, etc.
- Training for identification & screenings across systems (i.e. Pediatricians, Early Learning, etc.).
- Education to Community & Providers on importance and impact of early screening.

Strategy 5: No wrong door to access continuum of care including immediate and interim access to services while waiting for additional resources (i.e. wait list) by building capacity, warm referrals and handoffs between providers and organizations, and a universal road map/decision tree to assist with navigating services at varying levels of intensity.

- Once Identified, immediate case management/family navigation, preferable with capacity for in-home.
- Increase Array and therefore options of services, including Non-Clinical Services.
- Enhancement of Community Action Treatment (CAT) Teams and Youth at Risk (YAR) Staffings.

Suggested Priority Strategies

Intervention/Treatment Workgroup

“What do we do with and for the youth already in out of home care, their families, and the staff working with them?”

Strategy 1: Implement High Fidelity Wraparound approach specifically for high acuity youth in out of home care. Foster a youth-centric approach to decision-making by incorporating youth voice, choice, and perspective, encouraging strengths-based individualized case discussions, and cultivating natural supports for the youth. This approach includes working with cross-systems community partners to establish points of contact and facilitate communication on co-involved children, meeting routinely to discuss specific cases, and collaboration across disciplines to streamline processes and remove barriers to receiving timely, necessary services and supports for children, youth, and families.

- Include Youth in decision making and in Multi-Disciplinary Team (Nothing About us Without Us).
- Individualized Case Discussions that explore all options, including informal, non-traditional & natural supports; address socio-economic supports.
- Enhance Youth’s feeling of belonging with family.

Strategy 2: Expand peer support capacity across diverse age groups and lived experiences, including addressing background check barriers to hiring peers, fostering innovative peer approaches, and facilitating community connections and natural supports.

- Youth/Young Adult Peers.
- Family Peers for permanency families and Out of Home Care peers Foster Parents and Relatives.
- On site Peer Support for staff.

Strategy 3: Create one or multiple dedicated physical spaces for youth to connect and receive compassionate, empathetic support such as community crisis/respice beds and/or a drop-in center/day program for youth.

- Extra-Curricular Connections in Community.
- Location for youth to convene and connect with each other that includes formal/informal peer support and formal/informal services; Extra-Curricular Connections in Community.
- Changing the setting of the healing space (i.e., not institutional).
- Provide opportunity for youth to convene as a group – part advocacy, part support (Leadership or Advocacy “Board”).

Strategy 4: Develop a policy and procedure to address physical safety concerns of caregivers that may involve providing security items or training in de-escalation and highly individualized safety planning with caregivers specific to the needs of the family to return children safely to the community, either to their parents or another caregiver.

- Safety Planning with youth & family to safely return youth home.
- Ensuring that the family has adequate training and support around the youth's behaviors.
- Trauma and Resilience focused team approach.

The Value of the Project & Strategies

The FSA serves as Circuit 12's Community Alliance as required by Florida Statute 20.19(5). Community Alliances were established as part of the Community-Based Care Initiative for child welfare by Florida Statute in 2000 under Title IV, Chapter 20.19 which governs the Department of Children and Families (DCF). Per Section 20.19 (5)(a), under "Community Alliance:"

"The department shall, in consultation with local communities, establish a community alliance or similar group of the stakeholders, community leaders, client representatives and funders of human services in each county to provide a focal point for community participation and governance of community-based services. An alliance may cover more than one county when such arrangement is determined to provide for more effective representation. The community alliance shall represent the diversity of the community."

Community-Based Care was a comprehensive redesign of Florida's Child Welfare System. It combines the outsourcing of foster care and related services to competent service agencies with an increased local community ownership of service delivery and design.

Per Section 20.19 (5)(b), the duties of the community alliance include, but are not limited to:

1. Joint planning/or resource utilization in the community, including resources appropriated to the department and any funds that local funding sources choose to provide.
2. Needs assessment and establishment of community priorities for service delivery.
3. Determining community outcome goals to supplement state-required outcomes.
4. Serving as a catalyst for community resource development, including, but not limited to, identifying existing programs and services delivered by and assistance available from community-based and faith-based organizations, and encouraging the development and availability of such programs, services, and assistance by such organizations. The community alliance shall ensure that the community-based care lead agency is aware of such programs, services, and assistance and work to facilitate the lead agency's appropriate use of these resources.
5. Providing for community education and advocacy on issues related to delivery of services.
6. Promoting prevention and early intervention services.

FSA Vision: Cultivate a collaborative, prevention-focused, and trauma-informed community that continually seeks to improve the well-being of children and families living in Sarasota, Manatee, and DeSoto counties.

FSA Mission: Serve as a collaborative, prevention-focused, and transparent partner that provides community oversight, education, and advocacy in the achievement of systemic improvements in community-based child and family well-being services. The FSA serves as advocate, assessor, collaborator, educator, identifier of needs, inspirer, ombudsman, overseer, policy driver, and sounding board.

FSA Guiding Principles: Offering solutions that are data-driven and evidence-based, fostering a collaborative environment in which all child and family well-being needs are considered, and keeping the needs and voices of the community, children, and families at the forefront of all decisions.

The workgroups were formed under the structure of the FSA and, as such, embody the intent of the Community Alliance legislation and the vision, mission, and guiding principles of the FSA. The value of this work cannot be understated in that it has been community driven, inclusive, and rooted in evidence. Therefore, the priorities and strategies produced were developed democratically in a public meeting format where all voices and ideas were welcome.

Proposed Next Steps

A series of presentations will be provided at existing or specially curated public meetings, beginning in late 2024. Concurrently, exploratory discussion and stakeholder engagement will take place at the same time.

Implementation ideally would begin no later than January 2025 and will likely be staggered as different strategies are pursued by different stakeholders.

It is important to plan for an evaluation component from the beginning, therefore at the March 2025 FSA Meeting, we will collectively establish community goals related to prevention, intervention, and treatment for our target population. Evaluation of meeting those goals would take place throughout the following year and be reported on at FSA meetings.

Conclusion

As mentioned previously, this work was undertaken to achieve better outcomes for youth and families in our community. We cannot think of a more impactful reason to collectively consider priorities and strategies to meet this goal. It is a testament to the collaboration and commitment of our community that so many agencies and individuals came together for six months to develop these priorities. Most importantly, however, the work is just beginning, and we hope you will join us.



Appendix A: Workgroup Rosters

Prevention Workgroup

All Star Children's Foundation
Bridge a Life
Charles & Margery Barancik Foundation
Centerplace Health
Centerstone
Central Florida Behavioral Health Network
Manatee County Government
Community Foundation of Sarasota County
Department of Children & Families
Doctor's Hospital
Department of Health
Early Learning Coalition of Sarasota County
Family Initiative
Foster & Adoptive Parent Association
First 1000 Days Suncoast
Florida Center for Early Childhood
Family Network on Disabilities
Forty Carrots
Growing OAKS
Guardian ad Litem Office
Gulf Coast Community Foundation
Harbor 58
Isaiah 117 House
Jewish Family & Children Services
Lightshare
Manatee Community Foundation
Manatee County School District
NAMI Sarasota & Manatee Counties
Parents for Parents
Parents
Samaritan Counseling
Sarasota County School District
Safe Children Coalition
Sarasota County Government
Sarasota Memorial Hospital
SRQ Strong
Sunshine Health
Teen Court of Sarasota
The Twig
Truly Valued
William G. & Marie Selby Foundation
Youth MOVE Suncoast

Intervention & Treatment Workgroup

All Star Children's Foundation
Bridge a Life
Community Assisted Supportive Living (CASL)
Centerstone
Central Florida Behavioral Health Network
Children's Legal Services
Manatee County Government
Community Foundation of Sarasota County
Department of Children & Families
Doctor's Hospital
Department of Health
Department of Juvenile Justice
Family Initiative
Foster & Adoptive Parent Association
Growing OAKS
Guardian ad Litem Office
Gulf Coast Community Foundation
Jewish Family & Children Services
Lightshare
Manatee County School District
Sarasota County School District
Safe Children Coalition
Sarasota Memorial Hospital
Solve Maternity Homes
SRQ Strong
Sunshine Health
The Twig

Appendix B: Prevention Workgroup Additional Strategies

Education and Resource sharing between providers and community partners, particularly cultivating cross-system connections

- o Involvement of Universities – Community University Partnerships

Advocacy opportunities and collaborations at state and local levels for policies and resources that can positively impact prevention efforts

- o Increase Funding for Prevention

- o Flexible Funding

- o Engaging AHCA/Medicaid/HMOs – Coverage Issues, Service Structure, Risk, Access, Restrictive Treatment Planning, etc.

- o Enhance Post-Adoption Services & Post-PG Services

- o Family Arrangements – Enhance Concrete Supports, Funding, Benefits, etc.

- o Background Checks for Peers

- o Cross-systems Advocacy

Emphasize the importance of and improving access to pre-natal and post-partum care for the mother, baby, and father to achieve optimal outcomes for the family

- o Plan of Safe Care Enhancement

- o Expansion & Support of First 1000 Days

- o Cross-Systems Collaboration – From OBGYN to Social Services

Increase access to care including reducing stigma and assisting families in overcoming barriers

- o Family Centered Treatment – Substance Abuse, “Family Residential Treatment”

- o Reduce resistance to services after case closure; Develop post-Reunification services (after case closure)

- o Increase asking for help behaviors

- o Engage families who withdraw their children from school

- o Immigrant Services

Appendix C: Intervention/Treatment Workgroup Additional Strategies

Review and revise existing policy frameworks across systems that create barriers to services (financial, judicial, access, etc.).

- o No Contact Orders
- o Accountability for Crimes; DRAI
- o Peer to Peer Consults between Psychiatrists to avoid multiple changes in Psych Meds
- o Providers who can confirm Autism Diagnoses
- o Cross System Collaboration between DCF/DJJ/APD, especially DJJ Prevention
- o Identification of who is the client & focus of intervention – individual <-> family
- o Engaging post-TPR parents as possible support/placement for youth

Develop a policy for when virtual services are permitted to be used that ensures maximum benefit from services while considering the youth's needs, the families' resources, and the effectiveness of treatment. LOW HANGING FRUIT

- o Possibility for parent coaching virtually

CAT teams be expanded and have dedicated staff to serve OHC youth.

Explore establishing group homes specifically designed for juvenile sex offenders and provide a structured and supervised environment. These homes can offer therapy, education, and life skills training while ensuring community safety.

Explore various program models like TARGET, or Thompson and Alia that require lower caseloads and specialized training for case managers working with this population.

- o Lower caseloads; specialized team; multi-disciplinary team (CM, Therapist, Peer, Family Navigator, etc.)

Implement a multi-faceted strategy to address missed diagnoses of trauma by universally administering screening tools and providing behavioral health consultations. Determine what points can we build these assessment/tools/screenings into the system of care the way it is currently structured. Identify what evidenced based assessments/tools/screeners meet the needs of the population identified.

Develop a comprehensive strategy encompassing, but not limited to, education on problematic sexual behaviors, cross-training for professionals, communication strategies, behavioral consequences, school-based YMHFA training enhancement, and fact-based drug prevention education.

- o Helping youth understand consequences of behavior
- o Enhance school-based Youth MH First Aid
- o Facts based prevention
- o Include a Caregiver Component for support and managing youth behaviors
- o In-Home Support
- o Specialized provider/modality for violent/disruptive behavior

Appendix C: Intervention/Treatment Workgroup Additional Strategies (Continued)

Identify evidenced based approaches to use to educate parents, youth, professionals, and other community members involved in child welfare on needs identified in the community. Determine which agencies would be responsible for training each identified problem as it relates to their area of expertise.

Identify funding if insurance does not cover recommended assessments/tools/screenings.

- o Utilization of EPSDT & Unrestricted Flex Funding

Explore expanding School districts screening capacity outside of educational impact.

Revamping the CBHA process and what diagnostic screening tools they use. Expand on basic recommendations currently made to include items like, but not limited to, Gene-sight testing.

Expand those who can screen and diagnose as it relates to developmental disorders (i.e. ASD). This would require changes in current statutes and agreements of multiple government agencies.

Create a formal process for internal Group supervision/consultation within organizations or peer to peer to ensure fidelity in information sharing and identifying and meeting the need of children and families.

- o Expanding de-escalation strategies for case managers & controlling our own response

- o CCERT Self Care Model Training/Time Management "Workshop"

- o Contracted MH professional available for group or 1:1 for staff

- o Therapy Dogs in Office

- o Retired professionals as possible resources for staff

Appendix D: Prevention Workgroup Mural

Trauma & Resilience responsive care and culture

Place youth and family voice at the center of services and use best practices to enhance participation

Community respite and care services for youth and caregivers on a planned basis, or in times of crisis or emergency situations

Immediate and interim access to services while waiting for additional resources by building capacity

Place youth and family voice at the center of services and use best practices to enhance participation

Increase availability of peer supporters throughout the system that emphasize building on family strengths, active engagement of parent, youth, and kin, and improved systems navigation. Ensure adequate resources are available for training, organizational support, and certification of peers

Implement High-Fidelity Wraparound model throughout System Of Care

Utilizing technology to maximize data collection and sharing

No wrong door to access continuum of care including a universal road map/ decision tree to assist with navigating services at varying levels of intensity

Warm referrals and handoffs between providers and organizations

Moonshots
High impact, but not as feasible

Universal behavioral health screening for children, starting early

Best bets
High impact and feasible

Trauma & Resilience responsive care and culture

Emphasize the importance of and improving access to pre-natal and post-partum care for the mother, baby, and father in order to achieve optimal outcomes for the family

Increase access to care including reducing stigma and assisting families in overcoming barriers

Education and Resource sharing between providers and community partners, particularly cultivating cross-system connections

Advocacy opportunities and collaborations at state and local levels for policies and resources that can positively impact prevention efforts

Impact
Ignoring feasibility, how impactful would it be to implement each idea?

Low priority
Low impact and low feasibility

Low-hanging fruit
Lower impact, but feasible

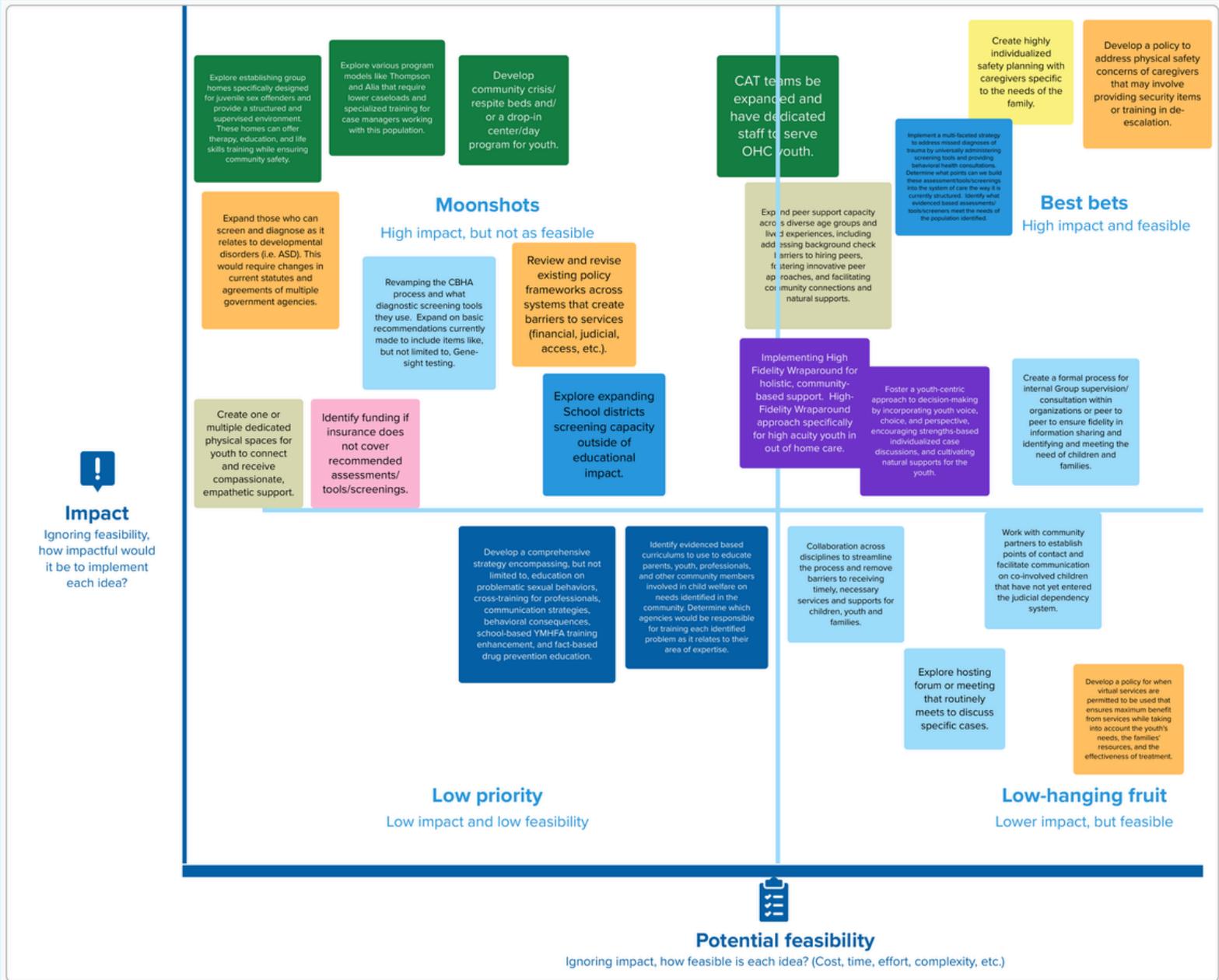


Potential feasibility

Ignoring impact, how feasible is each idea? (Cost, time, effort, complexity, etc.)

[See an example](#)

Appendix E: Intervention/Treatment Workgroup Mural



Appendix F: Prevention Workgroup Priority Selection Surveys

Emphasize the importance of and improving access to pre-natal and post-partum care for the mother, baby, and father in order to achieve optimal outcomes for the family

7/25 (28%)

Universal behavioral health screening for children, starting early

14/25 (56%)

Utilizing technology to maximize data collection and sharing

3/25 (12%)

Warm referrals and handoffs between providers and organizations

6/25 (24%)

Education and Resource sharing between providers and community partners, particularly cultivating cross-system connections

7/25 (28%)

Advocacy opportunities and collaborations at state and local levels for policies and resources that can positively impact prevention efforts

6/25 (24%)

Increase access to care including reducing stigma and assisting families in overcoming barriers

10/25 (40%)

Increase availability of peer supporters throughout the system that emphasize building on family strengths, active engagement of parent, youth, and kin, and improved systems navigation. Ensure adequate resources are available for training, support, etc

15/25 (60%)

Place youth and family voice at the center of services and use best practices to enhance participation

13/25 (52%)

Community respite and care services for youth and caregivers on a planned basis, or in times of crisis or emergency situations

12/25 (48%)

Immediate and interim access to services while waiting for additional resources by building capacity

12/25 (48%)

Implement High-Fidelity Wraparound model throughout System Of Care

15/25 (60%)

No wrong door to access continuum of care including a universal road map/decision tree to assist with navigating services at varying levels of intensity

6/25 (24%)

Appendix G: Intervention/Treatment Workgroup Priority Selection Survey

Foster a youth-centric approach to decision-making by incorporating youth voice, choice, and perspective, encouraging strengths-based individualized case discussions, and cultivating natural supports for the youth.

8/20 (40%)

Expand peer support capacity across diverse age groups and lived experiences, including addressing background check barriers to hiring peers, fostering innovative peer approaches, and facilitating community connections and natural supports.

11/20 (55%)

Create one or multiple dedicated physical spaces for youth to connect and receive compassionate, empathetic support.

8/20 (40%)

Review and revise existing policy frameworks across systems that create barriers to services (financial, judicial, access, etc.).

3/20 (15%)

Develop a policy for when virtual services are permitted to be used that ensures maximum benefit from services while considering the youth's needs, the families' resources, and the effectiveness of treatment.

1/20 (5%)

Develop a policy to address physical safety concerns of caregivers that may involve providing security items or training in de-escalation.

9/20 (45%)

Work with community partners to establish points of contact and facilitate communication on co-involved children that have not yet entered the judicial dependency system.

4/20 (20%)

Explore hosting forum or meeting that routinely meets to discuss specific cases.

0/20 (0%)

Create highly individualized safety planning with caregivers specific to the needs of the family.

6/20 (30%)

Develop community crisis/respice beds and/or a drop-in center/day program for youth.

9/20 (45%)

CAT teams be expanded and have dedicated staff to serve OHC youth.

6/20 (30%)

Appendix G: Intervention/Treatment Workgroup Priority Selection Survey (Continued)

Explore establishing group homes specifically designed for juvenile sex offenders and provide a structured and supervised environment. These homes can offer therapy, education, and life skills training while ensuring community safety.

2/20 (10%)

Explore various program models like TARGET, or Thompson and Alia that require lower caseloads and specialized training for case managers working with this population.

5/20 (25%)

Implement a multi-faceted strategy to address missed diagnoses of trauma by universally administering screening tools and providing behavioral health consultations.

2/20 (10%)

Collaboration across disciplines to streamline the process and remove barriers to receiving timely, necessary services and supports for children, youth, and families

3/20 (15%)

High-Fidelity Wraparound approach specifically for high acuity youth in out of home care.

11/20 (55%)

Identify funding if insurance does not cover recommended assessments/tools/screenings.

3/20 (15%)

Explore expanding School districts screening capacity outside of educational impact.

2/20 (10%)

Revamping the CBHA process and what diagnostic screening tools they use. Expand on basic recommendations currently made to include items like, but not limited to, Gene-sight testing.

1/20 (5%)

Expand those who can screen and diagnose as it relates to developmental disorders (i.e. ASD). This would require changes in current statutes and agreements of multiple government agencies.

1/20 (5%)

Create a formal process for internal Group supervision/consultation within organizations or peer to peer to ensure fidelity in information sharing and identifying and meeting the need of children and families.

2/20 (10%)