System of Care Plan 2017-2018

Submitted by State Interagency Team January 2018

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Introduction and Executive Summary

This system of care report is in response to the statutory requirement as outlined in 33 VSA § 4302 which requires the State Interagency Team to *submit an annual report to the commissioners of developmental and mental health services, social and rehabilitation services and education on the status of programs for children and adolescents with a severe emotional disturbance which shall include a system of care plan. The system of care plan shall identify the characteristics and number of children and adolescents with a severe emotional disturbance in need of services, describe the educational, residential, mental health or other services needed, describe the programs and resources currently available, recommend a plan to meet the needs of such children and adolescents, and recommend priorities for the continuation or development of programs and resources.*

In 2005, an interagency agreement was established which expanded the scope of the statute in the following way: This interagency agreement outlines the provision of services to students who are eligible for both special education and services provided by AHS and its member departments and offices including Department of Health (VDH), Department for Children and Families (DCF), Department of Disability, Aging and Independent Living (DAIL), Department of Corrections (DOC), and Office of Vermont Health Access (OVHA). It is intended that the agreement will provide guidance to human services staff and school personnel in the coordination and provision of services for students with disabilities.

This System of Care Plan is based on the expansion of Act 264 through the 2005 Interagency Agreement. In preparing this report there was a great deal of discussion about what data would most accurately reflect the challenges facing Vermont's families, youth and children. The data in this report was collected from multiple sources as AHS and AOE have separate databases. As well, within AHS, there are many systems that collect data. Having data integrity and data that is accessible were some of the challenges faced when creating this report.

The following are the recommendations from the State Interagency Team after reviewing and analyzing the data provided in this report.

1. Support statewide integration of services through reinvigorating and resourcing Act 264 statutory mandates.
2. Focus on the number of children and youth in residential placements. A "Turn the Curve Initiative" began in June 2015 to look at increasing trend of not only more children and youth being placed in residential settings, but also the increased occurrence of very young children (4 and 5 years old) being placed in residential facilities. The goal of the Turn the Curve work is to: Increase the number of youth who are in family settings and increase family engagement for youth who are placed in residential care towards improving caregiver readiness.
3. Support payment reform efforts that move the System of Care away from fee-for-service and toward accountability focused on performance outcomes.
4. Support funding for family and youth partnership to be a shared responsibility of all AHS departments.

5. Increase collaboration with early childhood service providers and community supports due to trend of high rate of young children being placed into DCF custody (see Appendix M) and the fact that education begins for children in Vermont at age three.

Characteristics and the number of children and youth with eligible disabilities in need of services

What we know about Vermont's children and youth related to Adverse Family Experiences (AFE) and the Adverse Childhood Experiences (ACE) Study

Adverse Family Experiences[1] and Adverse Childhood Experiences[2] are phrases used to describe types of abuse, neglect, and traumatic experiences occurring to individuals during their childhood and within their families. We care about this information because research has shown a relationship between adverse childhood experiences and reduced health and well-being later in life.

Vermont AFE Data[3]

- The most prevalent AFEs among Vermont children and youth are (see Table 1):
    a. divorced/separated parents
    b. family income hardship
    c. having lived with someone who:
        i. had substance use problems
        ii. was mentally ill / suicidal / severely depressed

Table 1 shows the most common ACEs for children <1-17 years of age in Vermont. Table 2 shows the most common ACEs that Vermont adults age 18-44 years of age experienced when they were children. The adults are included as it is important to recognize this is of the age group that is often parenting and supporting our children. We want to support a system of care that is inclusive of whole families.

We also know that people have incredible resilience and the ability to overcome adversity. Therefore, Table 3 shows data about children in Vermont and the rate of children/youth who engage in resiliency-building dialogue/activities.

[1] Maternal and Child Health Bureau and United States Health Resources and Services Administration, 2011/12 National Survey of Children's Health, National Center for Health Statistics and Data Resource Center for Child and Adolescent Health, Editors. 2013.

[2] Felitti, V.J., et al., *Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study.* Am J Prev Med, 1998. **14**(4): p. 245-58.

[3] Kasehagen, L., *Characteristics of Vermont Children & Youth <1-17 years Who Have Experienced 3 or More Adverse Family Experiences,* Vermont Departments of Health & Mental Health, Senior MCH Epidemiologist/CDC Assignee to VDH & VDMH

Table 1: **Burden of Adverse Family Experiences among Vermont Children <1-17 years,**

2016 National Survey of Children's Health

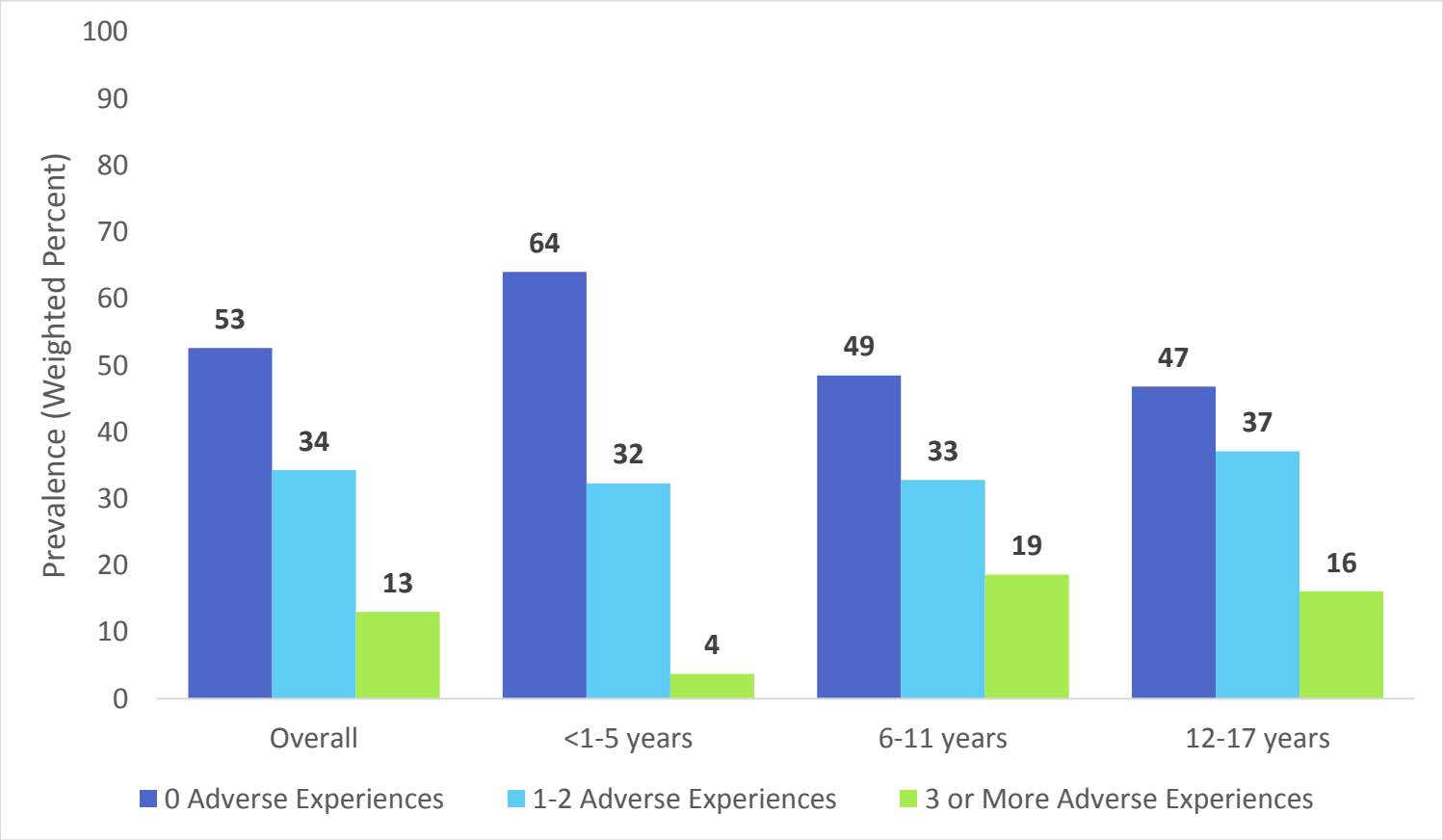


Table 2: **Burden of Adverse Childhood Experiences among Vermont Adults, 18-44 years,**
2011 BRFSS

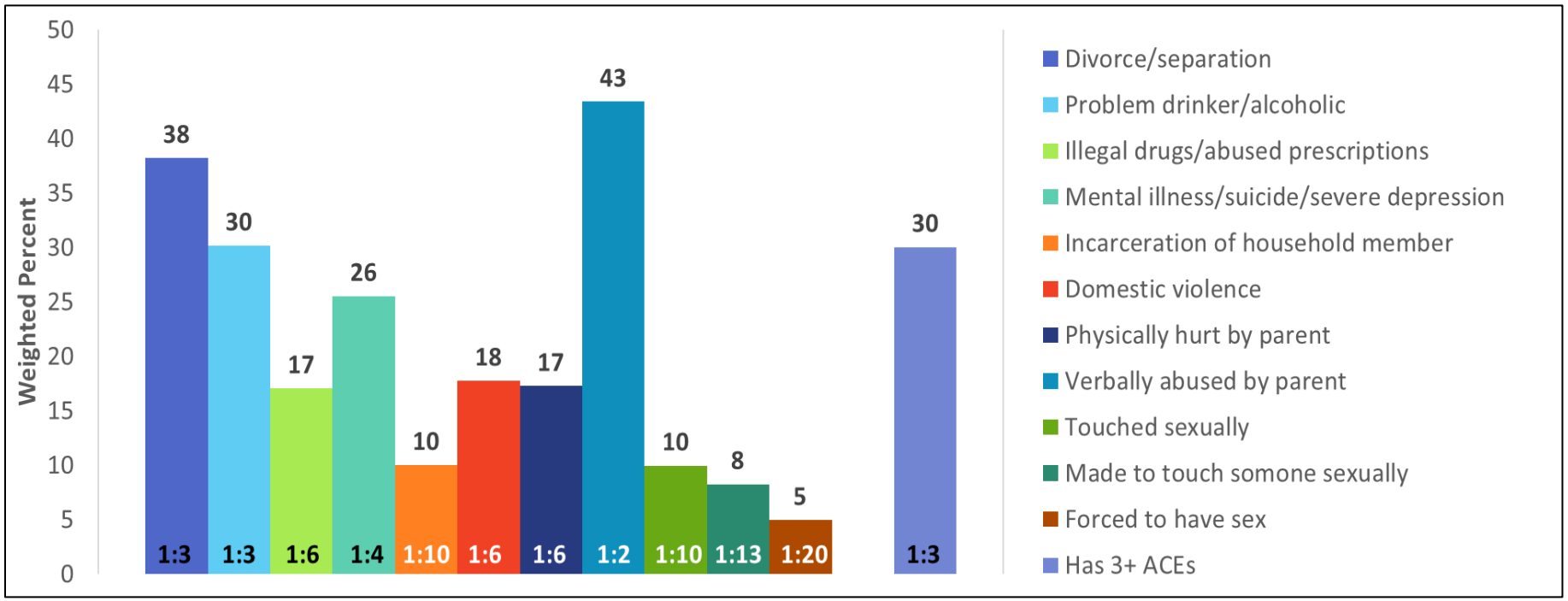
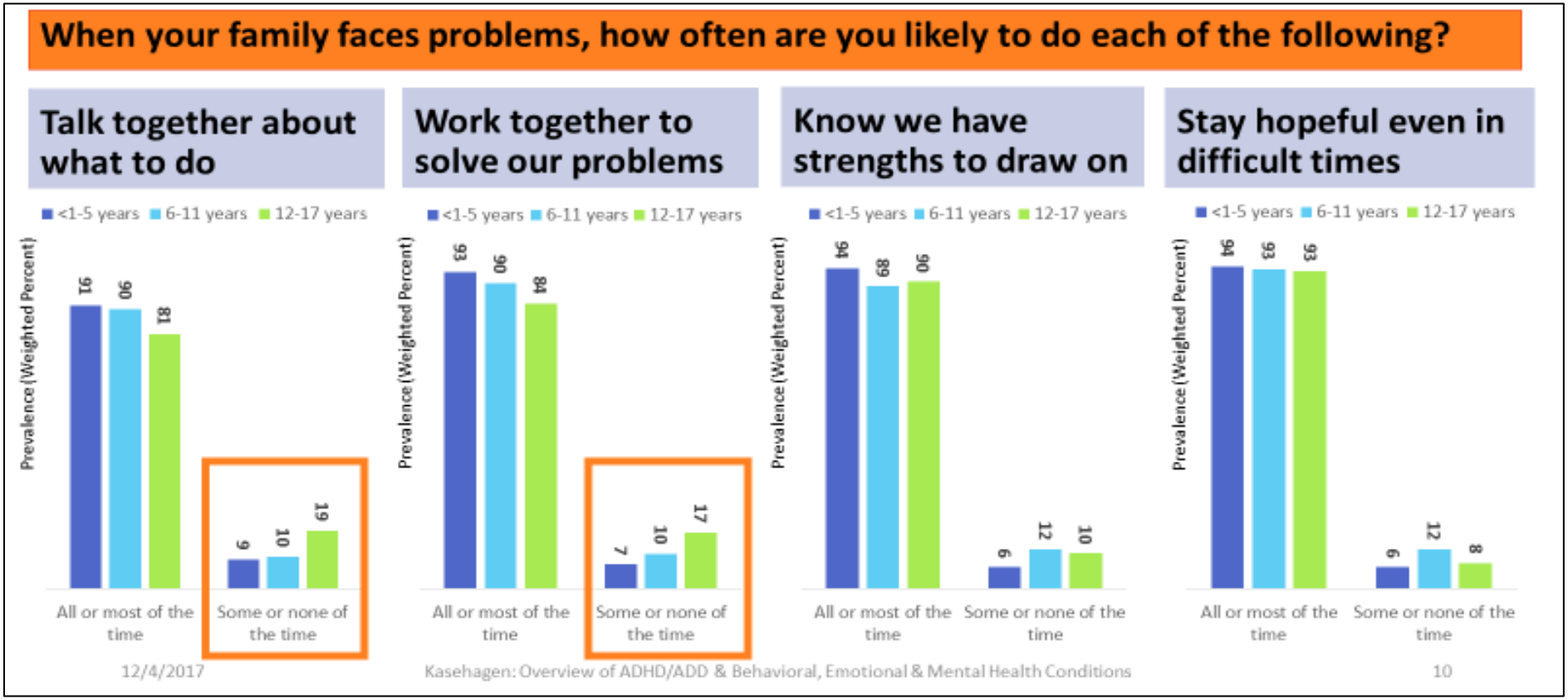


Table 3: **Markers of Family Strengths among Vermont Children <1-17 years,**

2016 National Survey of Children's Health



Prevalence of children with an emotional disturbance in Vermont

The Vermont Department of Mental Health (DMH) had been reporting data to SAMHSA on the number of children served through the Designated Agency (DA)/Specialized Service Agency (SSA) system with severe emotional disturbance (SED), using the federal definition of SED identified by Global Assessment of Functioning (GAF) scores 50 and under. However, the most recent version of the DSM-5 removed the GAF. Since provider agencies are expected to comply with the most current version of the DSM, they are no longer using GAF scores. Therefore, until a different tool to measure functioning or a different marker of SED is determined, trend analysis is being utilized to determine SED numbers.[4]

Table 4: **Number of Children/Youth with SED in Vermont**

Fiscal Year	Severe Emotional Disturbance (GAF <= 50)	
	Number	Percentage
FY17 Projected	1089	18.3%
FY16 Projected	1113	19.1%
FY 15	1144	19.1%
FY 14	1166	20.0%
FY 13	1184	20.6%
FY 12	1154	20.3%
FY 11	1243	21.4%
FY 10	1335	21.6%
FY 09	1252	21.0%
FY 08	1293	21.3%

Vermont has the highest rate of identifying students with emotional disturbance in the country. As a percentage of students (ages 6-21) who received special education services in the 2016-2017 school year in Vermont, about 14.4 percent were identified with an emotional disturbance, according to federal data[5]. That is more than twice the national average of 5.4 percent.

Vermont's growing number of children with emotional disturbance counters both state and national data on overall student counts and special education trends. Between 2010 and 2016, total enrollment in Vermont's public schools dropped from 89,814 to 87,171. During the same

[4] Analysis based on Monthly Service Report data submitted to the VT Department of Mental Health by the designated agencies. Includes youth aged 9 to 17 with a primary program assignment of Children's Programs.

[5] *Report on Act 46 of 2015; Section 49. Coordination of Educational and Social Services*

period, the number of students identified with emotional disturbance jumped from 1,870 to 2057. That growth occurred as the number of students receiving special education services in the state rose slightly from 13,914 to 14,242.

Nationally, the number of students identified with emotional disturbance grew from 1976 to 2005, but the number has been steadily going down since, both in the number of students served and as a percentage of total student enrollment.

In 1992, Vermont started Success Beyond Six, a funding mechanism run through the Agency of Human Services which allows school districts to use Medicaid match to support mental health services in the schools. Under the Medicaid-supported formula, federal dollars cover about 55% of the costs for providing mental health services in the schools with local school districts paying about 45%. Since the start of Success Beyond Six, the number of children identified with emotional disturbance has increased and so has the number of clinicians and behavior specialists working in the schools. There is no clear reason the number of students identified has increased – more trained individuals being aware could be a contributing factor.

Since 1991, the year before Success Beyond Six was introduced, the number of Vermont students identified with emotional disturbance has risen more than 200% from 978 to 2057 and this trend continues while the number of students in the state drops. By 2006, 556 full time equivalent mental health clinicians and behavior interventionists were working in Vermont schools at a cost of just more than $30 million. And in the 2016-2017 school year, Success Beyond Six helped fund 674 full time equivalent behavioral interventionists, as well as School Based Clinicians and Board Certified Behavioral Interventionists with about $54 million in Medicaid and local dollars supporting the program.[6] Vermont spends $300 million a year for special education and identifies 16.4 percent (2016-2017 school year) of the state's students as needing services.

Ten supervisory unions and districts were selected during the 2015-2016 legislative session for a study of special education that is intended to cut some costs and better serve students. The plan is to review current methods against proven best practices and provide advice to schools that can be shared across the state. The District Management Group, a consulting firm based in Massachusetts, completed the study.[7]

The results of the DMG report recommended the following:

1. Ensure elementary Tier 1 instruction (Universal Instruction) meets most needs of most students
2. Provide additional instructional time outside of core subjects to students who struggle, rather than providing interventions instead of core instruction
3. Ensure learners who struggle receive all instruction from highly skilled teachers
4. Create or strengthen a systems-wide approached to supporting student behaviors based on best practice and expert support

[6] Report on Act 46 of 2015; Section 49. Coordination of Educational and Social Services (with updated data from 2015)

[7] https://vtdigger.org/2016/11/29/school-systems-set-for-study-of-special-education-costs-quality/ and Act 148

5. Provide students with more intensive support needs specialized instruction from skilled and trained experts
6. Implications (including fiscal and operational)
7. Staffing Levels

Data specific to Coordinated Service Plans (CSP)

To organize information for this report, the State Interagency Team looked at several data factors all with the goal to better understand the level of need that exists and current challenges arising for children and families. Designated Agencies resource LITs with children's mental health staff (DAs do not receive additional financial resources to support this work) and they do not have a consistent way to track CSPs in their electronic health records. Some have worked hard to add this which comes with a financial cost, however, the efforts of Act 264 and Coordinated Service Planning does not come with fiscal support. LIT coordinators estimate the number of CSPs that occur and believe that it is likely an under-estimate since teams may use the tool at any time it may benefit planning. SIT continues to work with and explore accurate data collection in collaboration with LIT's and the Act 264 Board.

Table 5: **ESTIMATED Number of Coordinated Service Plans Reported by Region**

REGION	2010	2011	2012	2013	2014	2015	2016	2017
Barre	55	50	67	79	59	60	50	60-80
Bennington			25	20				25-30
Brattleboro	90	76	60	41	50	40	40	40
Burlington	100	150-200	150-200	150-200	150-200	150-200	83	180
Hartford	54	81	73					75-80
Middlebury	130	97	100	88				60
Morrisville	25	35	39	43	51	50	40-60	50-60
Newport		25	25	25				17
Rutland	30	52	65	65	63		66	70+
St. Albans	39		150				100	100
St. Johnsbury			25	25				11
Springfield	36	21	12	8	42	38	29	28

Through the Agency of Education's Special Education Child Count data[8], there is data identifying children/youth who had a CSP *and* are receiving special education services. The data follows, and it should be noted that: these are not duplicated children; the primary disability is identified; secondary and tertiary disabilities are not included. It is also important to note that not all students who access Coordinated Services Plans are eligible for special education. Some students have 504 Plans or Educational Support Team (EST) Plans.

Special Education Coordinated Services Plans as of December 1, 2016:

- 586 Total
- 181 Females, 405 Males

[8] Child Count Data for children 3-21 as of 12/1/15

- 13 in Kindergarten
- 34 Early Childhood Special Education (ECSE)
- 183 in grades 1-6
- 91 in grades 7 and 8
- 265 in grades 9-12+
- 41 with an Intellectual Disability
- 279 with an Emotional Disturbance
- 72 with Other Health Impairment (this includes students with Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD)
- 18 with a Speech/Language Impairment
- 68 with a Developmental Delay
- 54 with an Autism Spectrum Disorder
- 40 with a Specific Learning Disability
- 14 with an Orthopedic Impairment, Multiple Disability, Traumatic Brain Injury or Hearing Loss (numbers too small to report individually)

Mental health services

In FY 2016, Vermont's Designated and Special Services Agencies (DA/SSA) child, youth and family mental health programs served 10,670 children and youth (10,585 in 2015). The age and gender breakdown as well as general service data can be found in Table 3.[9]

***Table 6*. Children's Mental Health Services**

FY16	# of Children Served	Ages 0-6	Ages 7-12	Ages 13-19	Male	Female
Overall	10,670	21%	35%	40%	56%	44%

Services Received through DA/SSA	# children 2015	# children 2016
Therapies	4,349	4,003
Medication & consultation	1,257	1,344
Clinical interventions	6,523	6,322
Service Planning & Coordination	7,343	7,531
Community Supports	8,685	8,493
Crisis assessment & supports	1,965	1,558
Respite	445	302
Enhanced Family Treatment (Home & community based services * this does not include IFS regions)	58 (5 DCF)	34 (8 DCF)
Individual Service Budgets (DCF)	99	114

The Vermont DMH conducts annual perception of care surveys to monitor DA/SSA program performance from the perspective of service recipients and other stakeholders, alternating

[9] DMH FY 2016 Statistical Report

years to survey parents and youth. The most current available data from parents showed that 82% of parents of children served by child and adolescent mental health programs in Vermont rated the programs favorably. In addition, 84% of the surveyed youth evaluated the programs positively on the Overall measure of program performance.[10] Given these surveys alternate years, in next year's System of Care Plan updated information will be available.

Data and information specific to children with developmental disabilities

In 1996, the Vermont Developmental Disabilities Act (DD Act) required the Developmental Disabilities Services Division (DDSD) adopt a plan to provide services to Vermonters with developmental disabilities. The DDSD was required to develop a System of Care Plan which would outline eligibility, services, and funding priorities for Vermonters with Developmental Disabilities across the lifespan. When the DD Act went into effect, the Legislature made it clear that services would not be available to all Vermonters with Developmental Disabilities.

The System of Care Plan determined that a developmental disability is defined as having a diagnosis of intellectual disability OR an Autism Spectrum Disorder, AND significant deficits in adaptive functioning, AND onset of the disability prior to age 18.

The primary funding mechanism for services through the DDSD is the Home and Community Based Services (HCBS) individualized budget (formerly known as a DS waiver). Depending on the needs of the child/youth, HCBS funding can be used to provide service coordination, home supports, respite, clinical, crisis, and/or accessible transportation. In addition to having a developmental disability, a person must also have Vermont Medicaid and meet a funding priority outlined in the System of Care Plan.

At the time of the DD Act, and currently, HCBS individualized budgets are provided through the state's not-for-profit Designated Agencies and Specialized Services Agencies. There are also options for individuals and families to "self-manage" their services.

In 2001, because of budget constraints, DDSD had to restructure its funding priorities. The priority categories for children were reduced to two, making HCBS for children/youth under the age of 18 available only for those with the most intensive needs. These priorities are:

- Preventing Institutionalization – Nursing Facilities: Ongoing, direct supports and/or supervision needed to prevent or end institutionalization in nursing facilities when deemed appropriate by Pre-Admission Screening and Resident Review (PASRR). Services are legally mandated. [This priority applies to both children and adults.]
- Preventing Institutionalization – Psychiatric Hospitals and Intermediate Care Facilities (ICF/DD): Ongoing, direct supports and/or supervision needed to prevent, or end stays in inpatient public or private psychiatric hospitals or end institutionalization in an ICF/DD. [This priority applies to both children and adults.]

In addition, children with developmental disabilities who are in DCF custody may receive HCBS services if requested by DCF without needing to meet a funding priority. At the time of this

[10] DMH 2013 Consumer Evaluation of Children's Services Programs (1/17/14)

report, twelve children with developmental disabilities who are in custody are receiving HCBS and living in Developmental Services supported homes.

The following services are available to eligible children with Developmental Disabilities who do not receive HCBS:

- Flexible Family Funding – funding available for respite or goods which the family deems to be supportive of their child/youth with a Developmental Disability
- Family Managed Respite – respite funding for families of children/youth who have a MH and/or ID/DD diagnosis
- Bridge Case Management – care coordination for children with Developmental Disabilities
- VCIN - emergency placement in a safe, calm environment for individuals with ID/DD who are experiencing a psychiatric, emotional or behavioral crisis (on a limited basis for children).

Table 7: *Developmental Disabilities Services Data*

Program	Number of Children/Youth Served	
	FY2015	**FY2016**
Home and Community-Based Services	64 children up to age 18 194 transition-age youth (18-22)	62 children up to age 18 216 transition-age youth (18-22)
BRIDGE program: Care Coordination	300 children/youth up to age 22	323 children/youth up to age 22
Flexible Family Funding	750 children/youth up to age 18 201 transition-age youth (18-22)	725 children/youth up to age 18 220 transition-age youth (18-22)
Family Managed Respite (FMR) (allocated to more families – the data only includes number who used it)	323 children/families statewide • 165 ID/ASD diagnosis • 123 MH diagnosis • 35 co-occurring ID/ASD and MH diagnosis	384 children/families statewide • 197 ID/ASD diagnosis • 146 MH diagnosis • 41 co-occurring ID/ASD and MH diagnosis
Vermont Crisis Intervention Network	95 total bed days were children, or 18% 7 individuals were children, or 20%	74 total bed days were children, or 12% 4 individuals were children, or 9.5%

**The data in this table was produced by DAIL-DDSD*

Services provided with DDSD oversight are required to follow the rules and requirements of the Centers for Medicare & Medicaid Services (CMS), the Department of Labor, and the Collective Bargaining Agreement between the Agency of Human Services and Independent Direct Support Providers.

In Franklin/Grand Isle and Addison counties, services to children, regardless of disability type, are provided through an integrated approach and case rate. Children with DD have access to the same menu of services as children in the other counties of the state. In addition, the Howard Center has developed a unique program, also using a case rate, called ARCh (**A**ccessing **R**esources for **Ch**ildren) which provides service coordination, skills work and clinical support to 253 children in FY17, many of whom have developmental disabilities.

Act 264 Board: Recommendations on Priorities for the 2017 System of Care

A statutory requirement of the Act 264 Board is to: advise Education and Agency of Human Services (AHS) on the annual priorities for developing the System of Care. The following recommendations were submitted to AHS in March 2017.

RECOMMENDATIONS

1. Demonstrate strong commitment to develop and implement an Integrating Family Services (IFS) approach for Children and Family programs and services across the state.

a) Implement IFS long-term vision and goals.
b) Ramp up efforts to transition communities to an IFS funding model.
c) Support health care payment reform efforts to move away from 'fee for service' payment frameworks to accountability funding based on performance outcomes.
d) Communicate and coordinate with the Department of Vermont Health Access (DVHA) to support prevention services and reimbursement rates sufficient to ensure statewide availability of needed services.

2. Ensure all Agency of Human Services and Agency of Education Departments are coordinating and implementing system-wide changes that advance an IFS approach; explore and align areas of service overlap within and beyond AHS and AOE.

a) Continue work to develop clear, written guidelines and expectations for the State Interagency Team (SIT) and Local Interagency Teams (LITs), including roles, accountability, authority, management, deliverables, and interactions with the Act 264 Advisory Board.
b) Establish guidelines across all agencies and departments to assist linking children and families to needed basic services (e.g., housing, food, skills training, etc.), especially for children whose parents are involved with Corrections.
c) Require that information on all applicable resources and services be made available to families involved in kinship placements.
d) Ongoing training for families and employees regarding Act 264 entitlement and process.
e) Support court decision makers with a goal of identifying the training, consultation, and coordination process with AHS departments to improve outcomes of court decisions that recognize current best-practice child development thinking and principles, including trauma informed issues and services.
f) Provide links to the Act 264 Advisory Board on the DCF and AOE, VDH, Corrections, DAIL websites.

3. Promote inclusion of family members and youth as full partners in the development and implementation of policies and programs that affect them.

a) Promote participation on state and regional IFS advisory groups and work groups.
b) Ensure all state Agencies and Departments carry out practices for capturing and incorporating family and youth voice.

4. Ensure appropriate peer support is available for families and youth.

a) Ensure there is a Parent Representative on every LIT, and families have knowledge of and access to Parent Representatives' services. Also, ensure Parent Representatives have access to technical support and orientation for their role.
b) Make a financial commitment to a Peer Support and Peer Navigation statewide system to help families and youth access and participate in services.

System of Care Priorities for 2017 and 2018

The following are the recommendations from the State Interagency Team after reviewing the data provided in this report. It is important to note that the priorities identified in this System of Care Plan support the AHS 2015-2018 Strategic Plan goal specific to: Strengthening and supporting families with complex needs.

#	Goal	Action Steps	Progress in 2017
1	**Support statewide integration of services through reinvigorating and resourcing Act 264 statutory mandates.**	a. Continue providing statewide, annual LIT gatherings. b. Provide ongoing communication to LIT Coordinators. c. SIT Coordinator will continue to attend monthly Act 264 Board Meetings d. Collaborate closely with Act 264 Board to continue collecting data from LIT's regarding key indicators. e. Provide the SOC Plan to all Local Interagency Teams and ensure there is commitment to move the plan forward at the local and state level. f. Work with AOE, AHS staff and stakeholders to provide technical assistance in using CSPs and LITs to improve community collaboration on a case basis and system basis. This includes offering multiple modality educational opportunities (webinars, in-person technical assistance, learning community calls, etc.) g. Focus on workforce recruitment and professional development issues at DA's and SSA's. Currently, several within the state are struggling with work force issues related	The 3rd Annual LIT Extravaganza occurred on October 20, 2017 and was attended by over 70 people from all areas of the state. During this calendar year, members from SIT and the Act 264 Board traveled to each LIT in the state and met with them to find out what was working well, what challenges they were facing and to ensure there was a mechanism for dialogue between SIT and LITs. This information was used to inform this System of Care Plan. The Agency of Human Services and communities have been integrating, collaborating and supporting the coordination of services for children, youth and families for decades. Started in 2008, as an AHS initiative, Integrating Family Services began in earnest with a position created in the Agency of Human Services Secretary's Office in 2010. From the beginning, the intent of integrating services for children and their families revolved around providing services, supports and treatment earlier to *prevent more intense needs, to achieve better outcomes and spend funding more efficiently*. AHS was able to test the model in two regions while several other important reform efforts began to take shape such as Accountable Care Organizations, an All Payer Model, the State Innovation grant and other important health care and human services reform efforts. It has become clear that the lessons learned through IFS need to shift from "testing a model" to the way we do business. This would include more attention on how we operate internally at

#	Goal	Action Steps	Progress in 2017
		to the hiring of direct care workers. h. Discuss and explore ways to support the Act 264 Board more fully.	AHS, so our community partners can achieve positive outcomes for children and their families. IFS was ahead of the times in this reform effort. IFS made huge strides in the right direction. IFS is now how we need to do business within AHS and in support of community partners, children and their families. The efforts of IFS have now been absorbed into the departments and will continue; however, the unique identification of an "IFS effort" will end. IFS Collaborative Leadership efforts in communities will continue with an increased focus on Local Interagency Teams and Children's Integrated Services teams as the forums to work together on the children's system of care. AHS Field Directors will continue to play a lead role in the function of the LITs in their regions via the AHS/AOE Interagency Agreement. Quarterly meetings with the Commissioners of DCF, DAIL and DMH as the "executive managers" of children and family services will begin to cohesively improve a child and family system of care. Support will continue to the two IFS regions in partnership with the DCF, DAIL and DMH to fine tune current payment methodology, continue work on integrated outcomes, helping the three departments agree on priorities for the system and work with DMH on other payment reform activities. The Agency of Human Services is committed to maintaining the gains that have been made in the IFS regions and within AHS and would like to improve the current model. The Agency of Human Services and its departments that focus on children and families are excited about this next phase in the work.

#	Goal	Action Steps	Progress in 2017
2	**Focus on the number of children and youth in residential placements.** ***A "Turn the Curve Initiative" began in June 2015 to look at increasing trend of not only more children and youth being placed in residential settings, but also the increased occurrence of very young children (4 and 5 years old) being placed in residential facilities. The goal of the Turn the Curve work is to: Increase the number of youth who are in family settings and increase family engagement for youth who are placed in residential care***	a. Convene focus groups and/or conduct interviews to ensure the voice of families, youth, staff and stakeholders inform this process. b. Adequate and consistent reimbursement for foster parents providing specialized foster care. c. Increase capacity for project management to coordinate this statewide effort by hiring a dedicated position as project manager. d. Customize strategies for reductions in the use of residential placements and increases in community-based supports and services. Develop funding streams that support flexibility in the delivery and intensity of supports and services. e. Analyze data related to trend lines in residential care to identify policy and practice shifts that need to occur to support vision.	In June 2015, the Agency of Human Services held a dialogue to discuss the increased concern about the number of children and youth in residential placements. During this meeting, the group reviewed the trend lines for residential placements, looked at the current system of care in Vermont and held small group discussions to understand opportunities to turn the curve by addressing the issue at all levels in the system of care. This report and the work being undertaken by AHS is focused on children in the custody of the Department for Children and Families (DCF) and those children placed in residential care by the Department of Mental Health (DMH) and the Department of Disabilities, Aging and Independent Living. Three main points were agreed upon during this meeting: 1. There is a shared concern about the increasing number of Vermont children and youth who are placed in residential programs, including out-of-state placements. 2. A problem was identified that needs resolution: our trend lines for residential and out-of-state residential are going in the wrong direction. 3. There is commitment to create more community-based treatment options. Since that meeting, an AHS and Agency of Education (AOE) interagency team was created to move forward with the goal of increasing the number of children, youth and families served in community settings by transferring resources from residential settings and investing in local regions. This interagency team (Turn the Curve Advisory Team) is comprised of staff from the Department for Children and Families, the Department of Mental Health, the Department of Disabilities, Aging and Independent Living, and

#	Goal	Action Steps	Progress in 2017
	towards improving caregiver readiness.		the Agency of Education. To embark on this work, the Turn the Curve Advisory Team obtained consultation from Casey Family Programs and reviewed research about the use of residential care. One such document was the Elements of Effective Practice for Children and Youth Served by Therapeutic Residential Care (March 2016) which speaks to the importance of residential treatment with the "right size" lengths of stay, involving family members more extensively in treatment, helping youth learn skills for managing their emotions and behaviors that they can use in the community, and conducting more extensive evaluation studies. The Turn the Curve Interagency Team has been looking at the number of children/youth in residential care and the lengths of stay they are there. Appendices F, G, H and I at the end of this report show the data the Agency is using and analyzing to inform the effort to turn the curve on the number of children and youth in residential placements. As well, more data and information on these efforts can be found in the 2017 Legislative Report on the IFS website.
3	**Identify and advocate for additional resources in community agencies.**	a. There has been an increase in Family Services Social Workers to address the issue of opiate addiction and the increased number of children in DCF custody (See Appendix L & M) and parallel support is needed for local community partners as they are supporting these families as well. b. Due to the nature of this goal which speaks to a gap in resources, action steps for this goal will be created in	During the 2017 Legislative session an appropriation of over $8 million dollars was allocated to support DA/SSAs being able to increase hourly wages to $14/hour for staff. This financial increase is just one part of the workforce development issue facing Vermont. As the aging population in Vermont grows there are often not enough younger professionals available for open positions.

#	Goal	Action Steps	Progress in 2017
		close collaboration with AHS leadership.	
4	**Support payment reform efforts that move the System of Care away from the fee-for-service model and toward accountability focused on performance outcomes.**	Continue to work with broader system reform (All Payer Model; Accountable Health Communities)	The Department of Mental Health is working with the DVHA Payment Reform team and in coordination with the Director of Health Care Reform to develop a new payment model for reforming children's mental health reimbursement. The new payment structure under development is in alignment with alternative and value based purchasing approaches. The goal is to create a model that may include other AHS Departments over time, that will align with payment approaches through the APM, and that will support providers to have the flexibility they need to implement effective service delivery approaches. The target for implementation is FY19, recognizing that it is more desired to accomplish reform for the identified scope rather than reduce scope to meet a fixed timeframe. This work is occurring through multiple workgroups which are focused on operational considerations, payment structure and outcomes. All workgroups are facilitated and supported by DVHA's Payment Reform team, with representation from DMH (including the former Integrating Family Services Director), the Designated Agencies, and Vermont Care Partners. Depending on scope and capacity, other Departments may join the effort over time.
5	**Support funding for family and youth partnership to be a shared responsibility of all AHS Departments.**	Define the Family/youth partnership framework: a. Explain how service providers and staff can work with children, youth and families – i.e., what it means to put families at the center of our work using a two- generation approach; b. Define outcomes; and	For FY17, DMH continued their funding of the VFFCMH for supporting Act 264 mandates. As well, five departments of AHS (VDH-Maternal Child Health, VDH-ADAP, DCF-FSD, DCF-CDD and DAIL) provided an increase in funding for the training and education of parent representatives. The Family and Youth Partnership Framework was shared with LITs and is posted on the IFS website.

#	Goal	Action Steps	Progress in 2017
		c. Ensure consistent and full funding of family voice that is shared by all of AHS.	
6	**Increase collaboration with early childhood service providers and community supports due to trend of high rate of young children being placed into DCF custody and the fact that education begins for children in Vermont at age three.**	a. Include permanent SIT membership from the Child Development Division. b. Engage in dialogue and planning to address the high needs of the young children coming into DCF custody who have experienced high rates of trauma from abuse, neglect and parental substance abuse. c. Continue to grow access to early childhood and family evidence based mental health services.	During calendar year 2017, the Children's Integrated Services Director joined SIT. She retired in September. A new CIS Director starts in January 2018 and will join SIT at that time. The SIT Coordinator will become a member of the Building Bright Futures Advisory Council in January 2018.

APPENDICES

Appendix A: Act 264 Statutory Language

Per 33 VSA § 4302: *The State Interagency Team shall have the following powers and duties:*

1. Submit an annual report to the commissioners of developmental and mental health services, social and rehabilitation services and education on the status of programs for children and adolescents with a severe emotional disturbance which shall include a system of care plan. The system of care plan shall identify the characteristics and number of children and adolescents with a severe emotional disturbance in need of services, describe the educational, residential, mental health or other services needed, describe the programs and resources currently available, recommend a plan to meet the needs of such children and adolescents, and recommend priorities for the continuation or development of programs and resources.

2. Develop and coordinate the provision of services to children and adolescents with a severe emotional disturbance.

3. Make recommendations to the local interagency team for resolution of any case of a child or adolescent with a severe emotional disturbance referred by a local interagency team under subsection 4303(f) of this chapter.

4. Recommend to the Secretaries of Human Services and of Education and the Commissioners of Mental Health and for Children and Families any fiscal, policy, or programmatic change at the local, regional, or State level necessary to enhance the State's system of care for children and adolescents with a severe emotional disturbance and their families. (Added 1987, No. 264 (Adj. Sess.), § 2; amended 1989, No. 187 (Adj. Sess.), § 5; 1995, No. 174 (Adj. Sess.), § 3; 2013, No. 92 (Adj. Sess.), § 295, eff. Feb. 14, 2014; 2013, No. 131 (Adj. Sess.), § 69, eff. May 20, 2014.)

Appendix B: Local Interagency Team Parent Representatives

Barre District Judy S. Patterson Tremont St. Barre, VT 05641 802-476-3066 judy3265@hotmail.com	**Bennington District** Vacant
Burlington District Cathleen Francis VFN 600 Blair Park Road, Suite 240 Williston, VT 05494 800-800-4005 x211 Cathleen.Francis@vtfn.org	Janice Sabett, Vermont Family Network 600 Blair Park Road, Suite 240 Williston, VT 05494 800-800-4005 x218 Janice.Sabett@vtfn.org
Brattleboro District Marlene Wein PO Box 365 Wilmington, VT 05363 802-464-3579 mwpond@weinv.com	**Hartford** Vacant
Middlebury District Trisha Smith 1621 VT RT 17 Bristol, VT 05443 802-377-5483 tsmith@csac-vt.org Lorraine Sylvan 4614 Case Street Middlebury, VT 05753 802-777-7983 lorrainehsylvain@comcast.net	**Morrisville District** Donna Sherlaw PO Box 938 Morrisville, VT 05661 802-498-3071 lamoillenavigator@yahoo.com
Newport District Vacant	**Rutland District** Cinn Smith 711 West Street Fair Haven, VT 05743 (h)802-265-2014 (c)802-353-6817 cinna@together.net
St. Albans District Vacant	**St. Johnsbury District** Vacant
Springfield District Vacant	**STATE Parent Representative (SIT, CRC)** Amy Lincoln Moore VFFCMH PO Box 1577 Williston, VT 05495 (o) 800-639-6071 (c) 802-595-5147 almoore@vffcmh.org

Appendix C: State Interagency Team

Cheryle Bilodeau-Wilcox, SIT Coordinator **Laurel Omland** AHS-Department of Mental Health Cheryle.Bilodeau@vermont.gov (802) 760-9171 Laurel.Omland@vermont.gov (802) 241-0090	**Alicia Hanrahan** **Jennifer Gresham** Agency of Education Alicia.Hanrahan@vermont.gov (802) 479-1206 Jennifer.Gresham@vermont.gov (802) 479-1191
Morgan Cole Child Development Division Department for Children and Families Morgan.cole@vermont.gov (802) 241-0827	**Barb Joyal** **Melanie D'Amico** Family Services Division Department for Children and Families Barbara.Joyal@vermont.gov (802) 241-9002 Melanie.DAmico@vermont.gov (802) 793-2416
Diane Bugbee **Amy Roth** Developmental Disabilities Services Division Department of Disabilities, Aging & Independent Living Diane.Bugbee@vermont.gov (802) 241-0154 Amy.Roth@vermont.gov 802) 241-0306	**Amy Lincoln Moore** **Cindy Tabor** VT Federation of Families for Children's Mental Health almoore@vffcmh.org (802) 876-7021 ctabor@vffcmh.org (802) 876-7021
Pam McCarthy **Karen Price** VT Family Network Family Support Consultants Pam.Mccarthy@vtfn.org (802) 238-1106 Karen.Price@vtfn.org (802) 876-5315 Ext. 220	**Amy Danielson** Division of Alcohol and Drug Abuse Department of Health Amy.Danielson@vermont.gov (802) 651-1557
Monica Ogelby, Clinical Director Maternal Child Health Department of Health Monica.Ogelby@vermont.gov (802) 658-1329	**Suzanne Legare Belcher** Agency of Human Services, Central Office Field Director Suzanne.legarebelcher@vermont.gov (802) 585-5488

Appendix D: Act 264 Advisory Board Members

Name	Email	Term exp.	Town	Position Type
Doug Norford	dnorford@rmhsccn.org	3/31/2018	Pittsford	Provider
Tiffiny Moore	TiffinyM@WCMHS.ORG	3/31/2018	Williston	Provider
Joanne Wells	wellsj@fcsuvt.org	3/31/2019	Fairfax	Provider
Cinn Smith (Chair)	cinna@together.net	3/31/2019	Fair Haven	Parent
Kristin Holsman-Francoeur	kholsman-francoeur@acsu.org	3/31/2020	Leicester	Parent
Vacant				Parent
Matt Wolf (Co-Chair)	mwolf@vffcmh.org	3/31/2020	Springfield	Advocate
Cindy Tabor	ctabor@vffcmh.org	Pending		Advocate
Alice Maynard	a_maynard@comcast.net	3/31/2019	Underhill	Advocate

Appendix E: Act 264 Parent Representative Plan 2017

Goal 1: Provide two parent representative trainings per year
Goal 2: Increase # of stipend payments to parent representatives
Goal 3: Formalize a structured orientation and training for new parent representatives
Goal 4: Increase parent representative to all 12 AHS Regions.
Goal 5: Increase parent representative expanded role to all 12 AHS Regions

Amount of CSP's per fiscal Year attended by LIT Parent Rep						
	FY 14/15		FY 15/16		FY 16/17	
	#'s	Cost	#'s	Cost	#'s	Cost
REGION						
Barre	34	$1,621.91	98	$4,248.14	116	$5,050.96
Bennington	3	$254.63	0	$113.80	0	
Burlington	16	$-	20	$-	18	$-
Brattleboro			1	$-	1	$223.30
Hartford	0	$365.71	2	$-	0	
Middlebury	18	$858.45	23	$1,768.17	0	
Morrisville	25	$1,681.30	39	$2,705.98	26	$2,129.63
Newport				$-	0	
Rutland	18	$1,058.87	60	$3,514.27	117	$5,268.31
St Albans				$-	0	
St Johnsbury			0	$145.20	0	$145.20
Springfield	0	$110.92	0	$463.06	6	$463.06
Totals	**114**	**$5,951.79**	**243**	**$12,958.62**	**284**	**$13,280.46**
Notes:						
*** FY 14/15 is only half the year data**						
*** If a region has no CSP's listed but there is a cost, that means PR is attending LITS only and not CSPS**						

Appendix F: Children and Youth in Residential Care: Bed Days and Total Child Count

**Data compiled by Department of Mental Health*

The following charts represents the *total bed days* (Figure 1) and *total number of children placed in residential* (Figure 2) by State fiscal year. Total Bed Days is the total number of days a child/youth stays overnight in a residential program. For the Total Bed Days chart, children who were placed in more than one program during the fiscal year are represented more than once so that all bed days are calculated. For the Total Child Count in Residential by State fiscal year, the number of children is unduplicated within the fiscal year, such that if a child was placed in more than one residential program during the fiscal year, the child is only counted once.

Figure 1

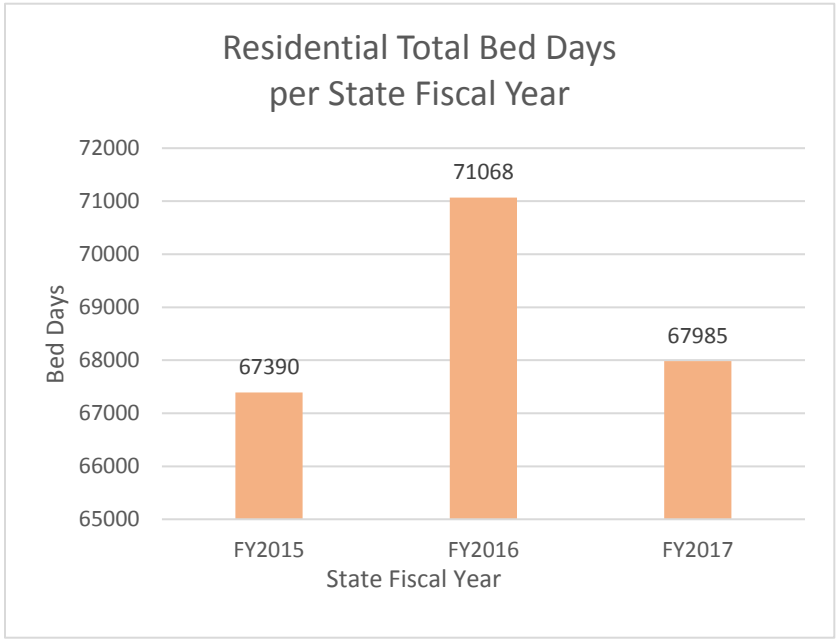
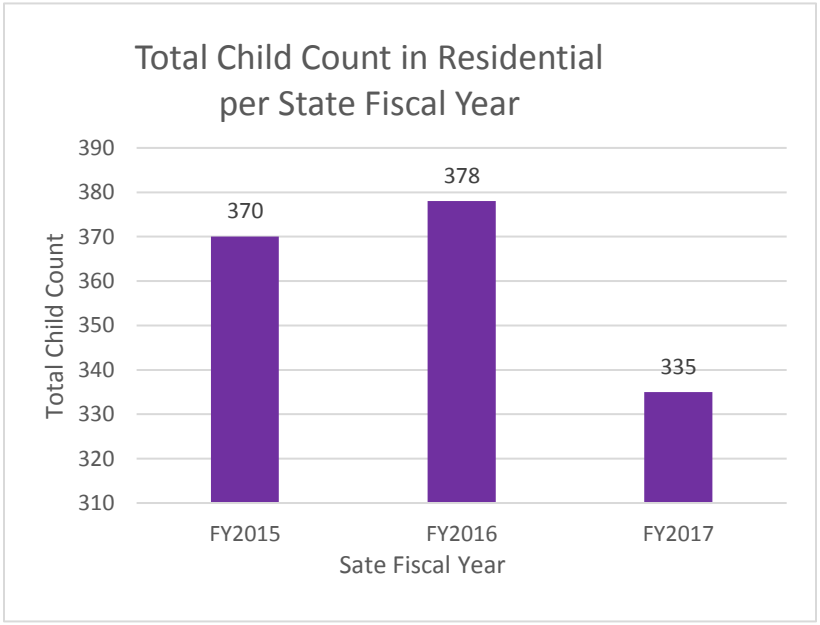


Figure 2

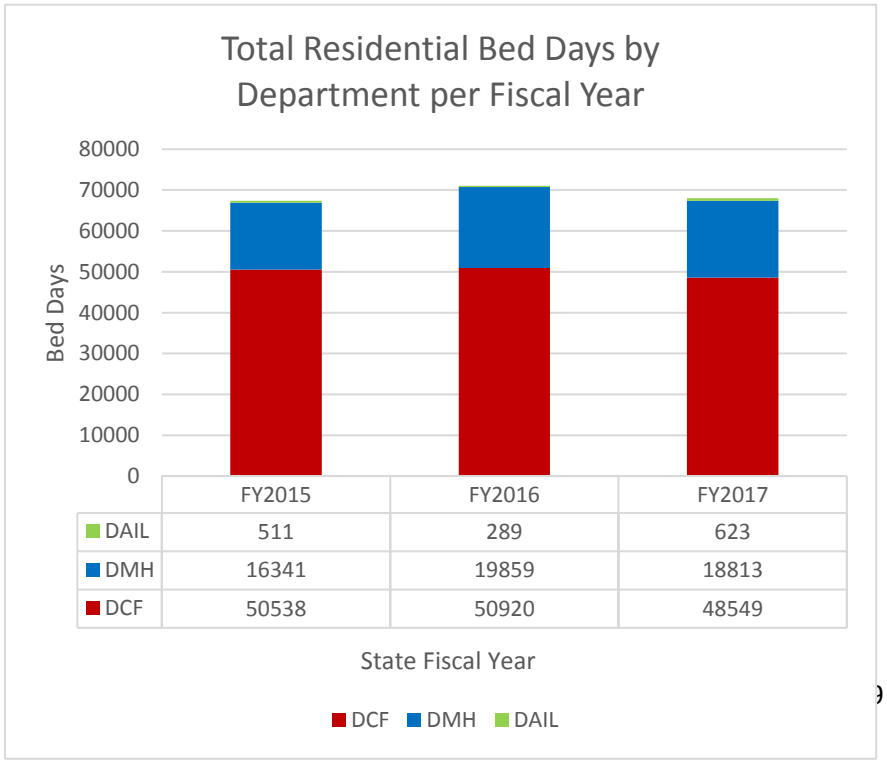


Appendix G: Children and Youth in Residential Care: By Funding Department

**Data compiled by Department of Mental Health*

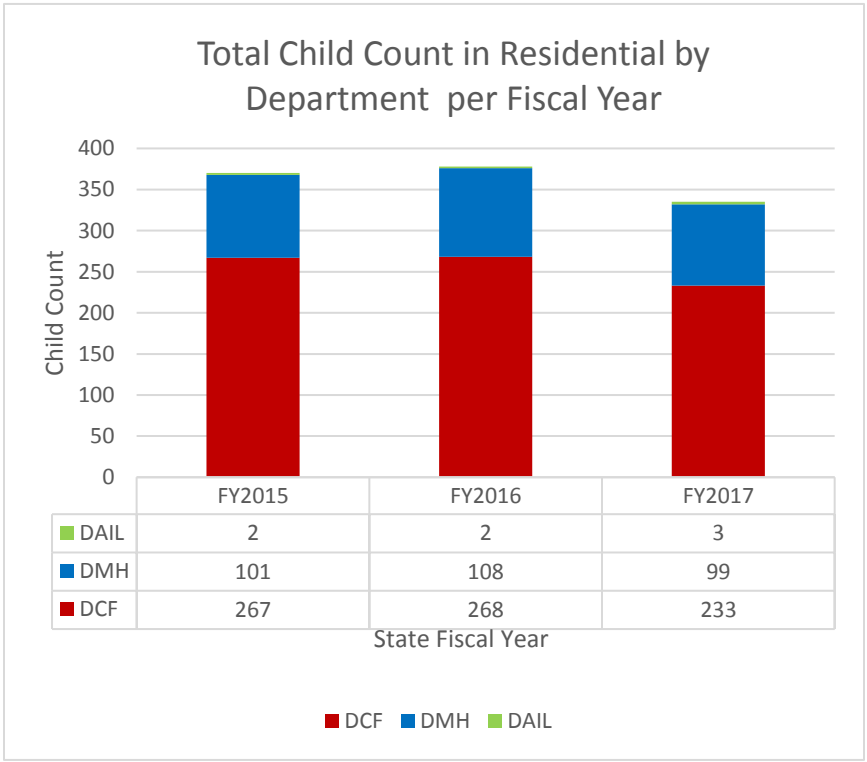
The following charts (Figures 3-4) are duplicates of the previous two charts, broken down by funding department. As noted previously, if a child is state-placed by an AHS department in a residential program which has an affiliated school, the Agency of Education is responsible for the education costs. The charts below represent the primary placing department. If a child changed custody status within a fiscal year (i.e. child in DCF custody returned to parent's custody but remained in residential program), the child is counted under both Departments in the Total Child Count chart; the actual bed days are attributed to the respective department in Total Residential Bed Days. Due to the low number of placements by DAIL not visibly standing out in the chart, the numbers are presented in the table below the chart.

Figure 3



	FY2015	FY2016	FY2017
DAIL	511	289	623
DMH	16341	19859	18813
DCF	50538	50920	48549

Figure 4



	FY2015	FY2016	FY2017
DAIL	2	2	3
DMH	101	108	99
DCF	267	268	233

Appendix H: Children and Youth in Residential Care: In-State and Out-of-State

**Data compiled by Department of Mental Health*

The following pie charts (Figures 5-7) represent the breakdown of in-state placements compared to out-of-state placements by fiscal year. If a child was placed in more than one program in a fiscal year, they are represented more than once.

Figure 5

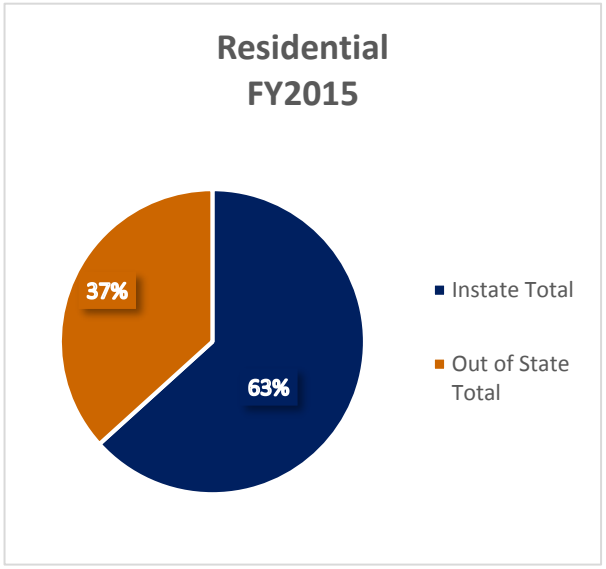


Figure 6

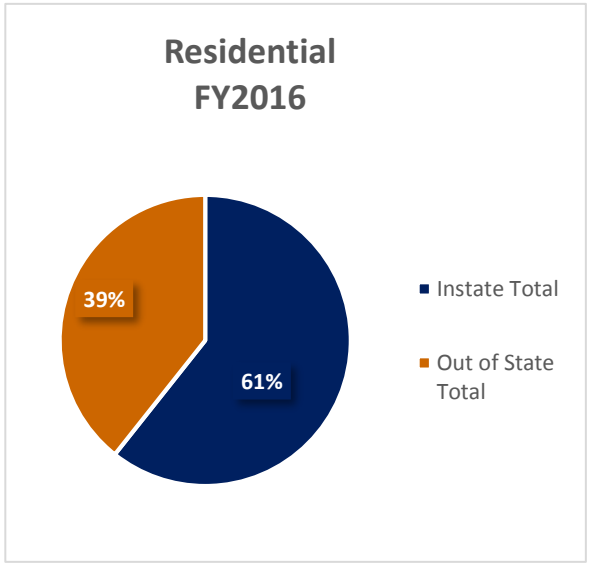
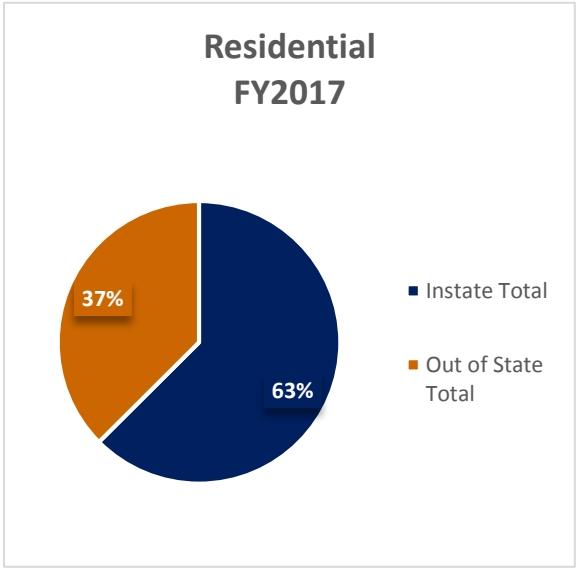


Figure 7

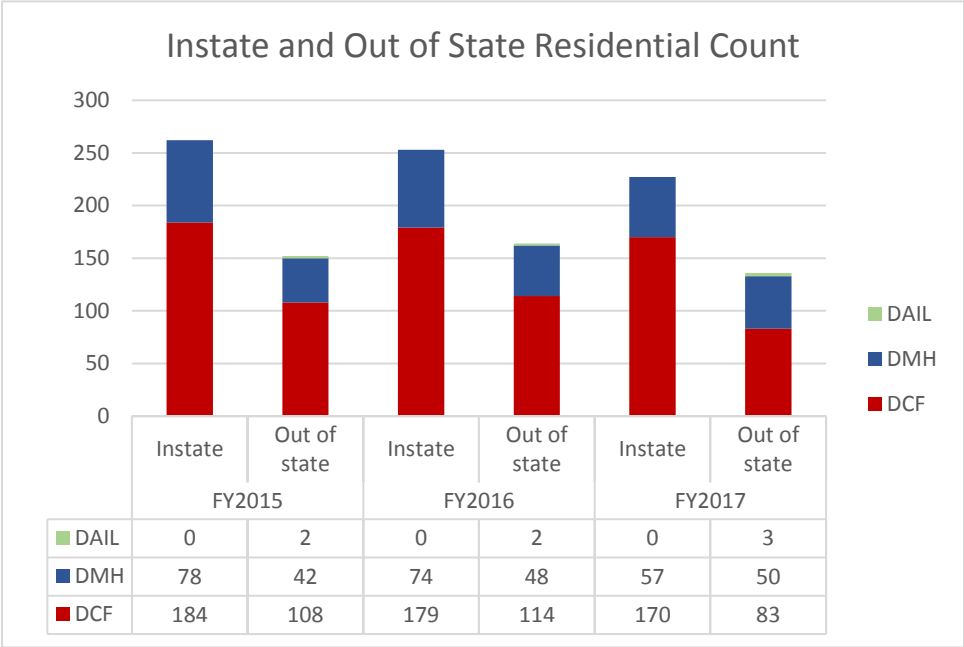


Appendix I: Children and Youth in Residential Care: In-State and Out-of-State by Funding Department

**Data compiled by Department of Mental Health*

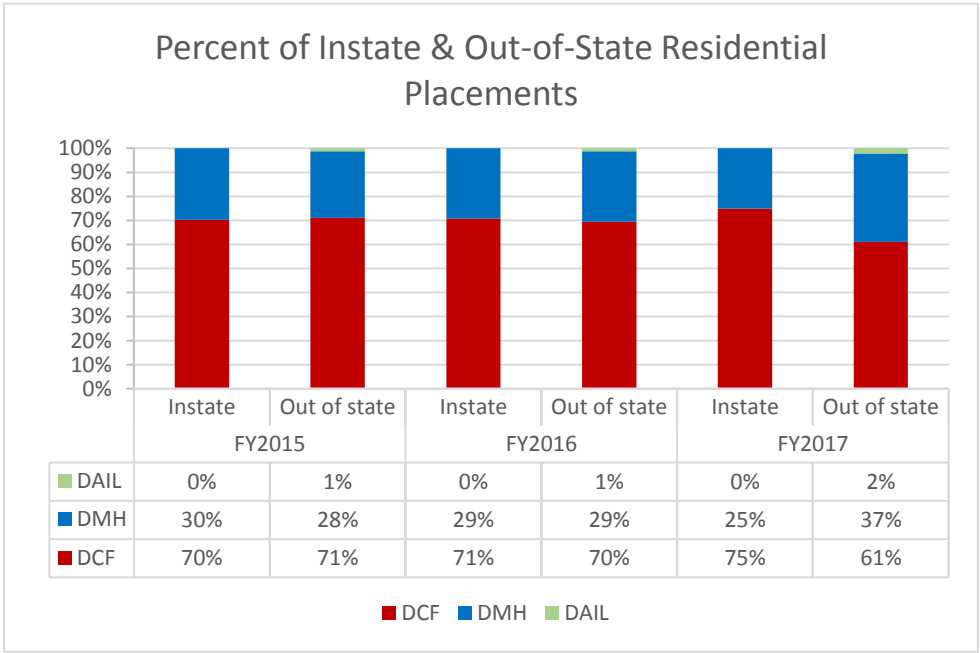
The following charts represent the *total number* and *percent of placements in-state and out-of-state* by funding department and by fiscal year. Children who were placed in more than one facility or had a custody change in a fiscal year are duplicated in the numbers below. Figure 9 provides a percentage breakdown by department of in-state and out-of-state placements in each fiscal year. Again, due to the low number of placements by DAIL not visibly standing out in the chart, the numbers are presented in the table below the chart.

Figure 8



	Instate	Out of state	Instate	Out of state	Instate	Out of state
	FY2015		FY2016		FY2017	
DAIL	0	2	0	2	0	3
DMH	78	42	74	48	57	50
DCF	184	108	179	114	170	83

Figure 9

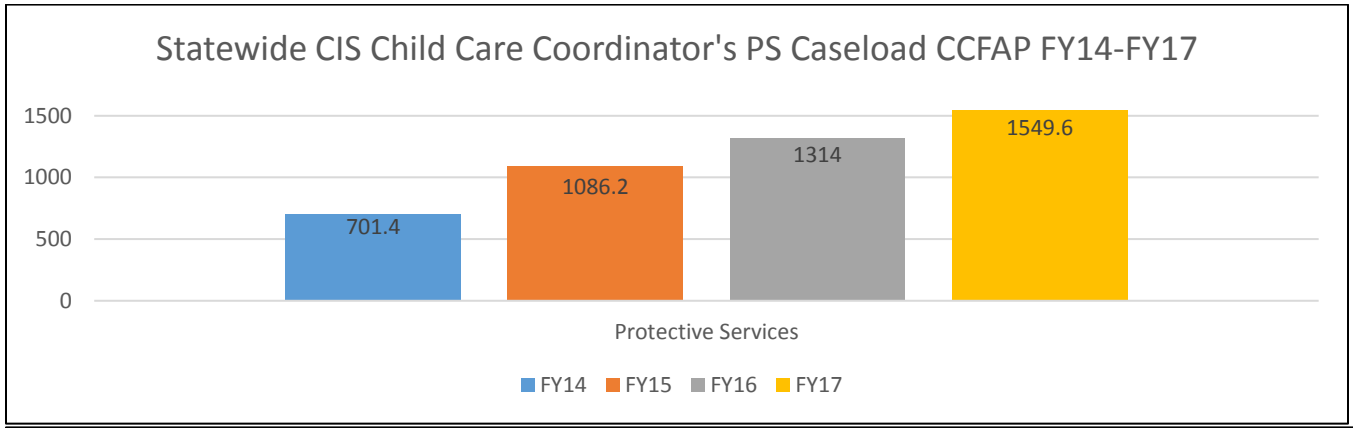


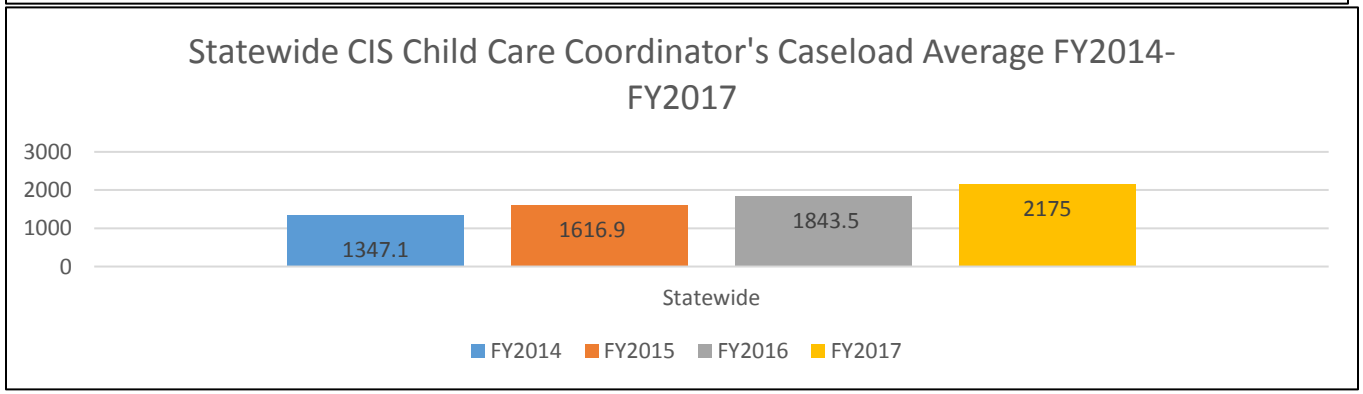
	Instate	Out of state	Instate	Out of state	Instate	Out of state
	FY2015		FY2016		FY2017	
DAIL	0%	1%	0%	1%	0%	2%
DMH	30%	28%	29%	29%	25%	37%
DCF	70%	71%	71%	70%	75%	61%

Appendix J: Early Childhood Data

**Data provided by DCF-Child Development Division*

Between FY2014 and FY2017, there has been a 62% increase in the number of average Children's Integrated Services Coordinators caseloads statewide. As well, there has been a 45% increase Statewide in Protective Services Child Care Financial Assistance Program (CCFAP) cases over the last four years.





Appendix K: Specialized Child Care Caseloads Data from FY2014 through FY2017

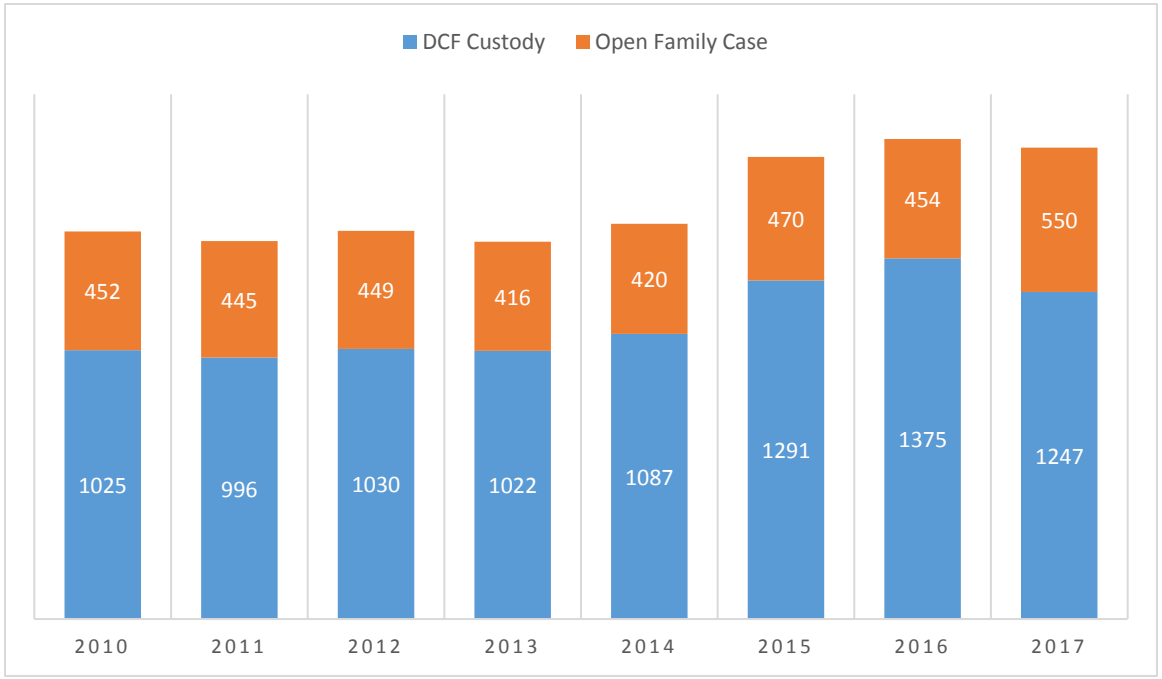
**Data provided by DCF-Child Development Division*

	Bennington	Hartford	Burlington	Barre	Morrisville	Middlebury	Newport	Springfield	St. Albans	St. Johnsbury	Rutland	Brattleboro
FY2014	115.6	81.3	274.6	112.5	89.1	150.9	21	55.2	111.1	75.4	173.8	71.5
FY2015	172	97	330.9	146.3	94.1	135	25.1	63.9	143.8	106.9	197	105.4
FY2016	207.8	108.6	400.9	172.2	86.9	121.6	39.2	75.4	170.3	126.9	240.8	93
FY2017	229.2	100	498.4	185.6	114.6	156.4	37.2	103	166.8	162.6	285.4	120.2

Appendix L: Children and Youth in DCF Custody and Open Family Support Cases

As of June 30th, of each year

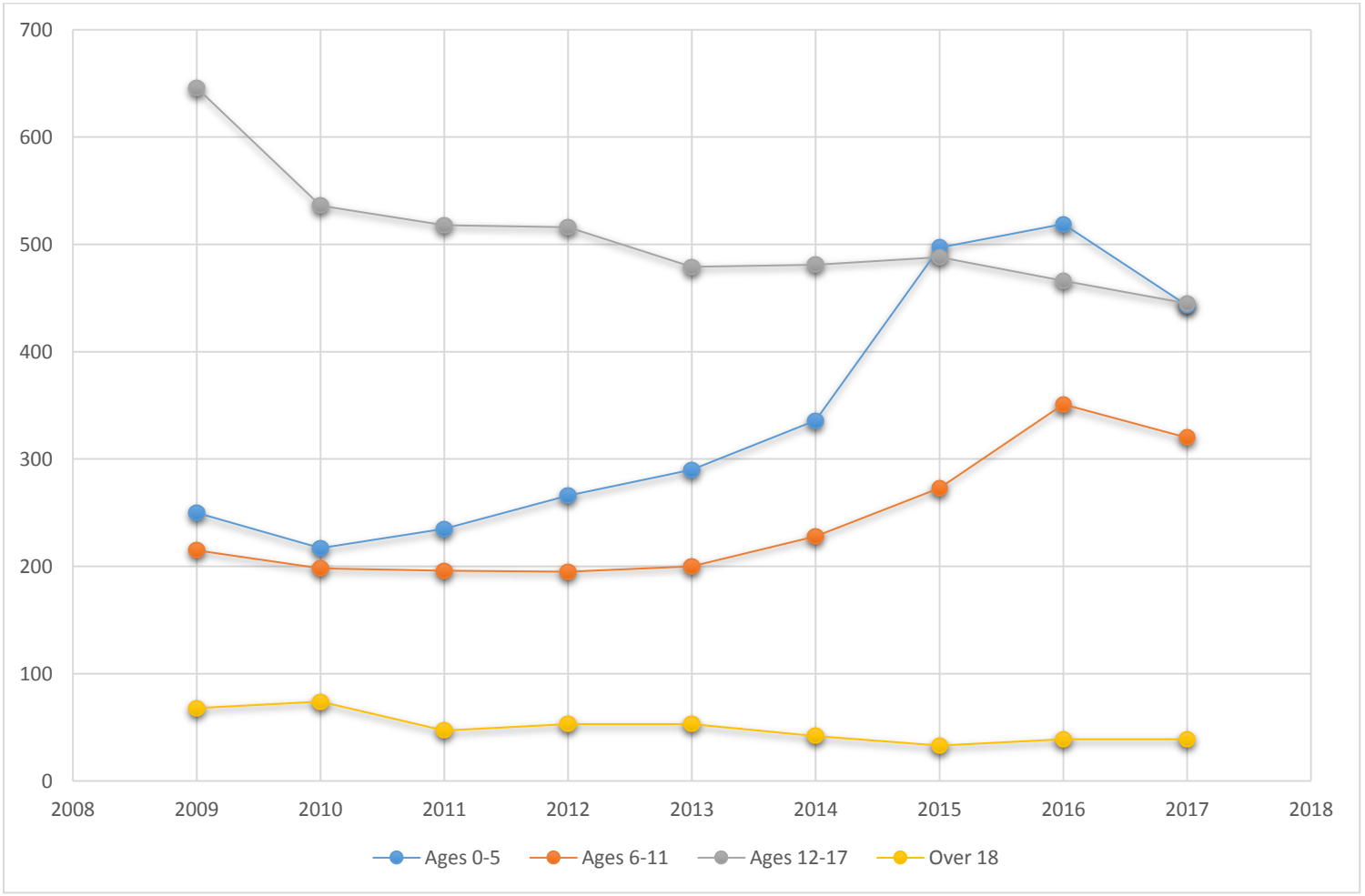
**Data provided by DCF-Family Services Division Quality Team*



Appendix M: Children in DCF Custody by Age Group

As of June 30th, of each year

**Data provided by DCF-Family Services Division Quality Team*



Appendix N: References

ACE Survey Source: https://acestoohigh.com/

Agency of Education, Act 46 Report: http://education.vermont.gov/documents/legislative-report-act46-sec46-special-education-funding

Agency of Education, Study of Vermont State Funding for Special Education: https://legislature.vermont.gov/assets/Legislative-Reports/edu-legislative-report-special-education-funding-study-executive-summary-and-full-report.pdf

Vermont Agency of Education, Expanding and Strengthening Best-Practice Supports for Students Who Struggle: https://legislature.vermont.gov/assets/Legislative-Reports/edu-legislative-report-dmg-expanding-and-strengthening-best-practice-supports-for-students-who-struggle.pdf

Act 264 Statutory Reference: http://legislature.vermont.gov/statutes/section/33/043/04302

Act 264 Information and materials: http://ifs.vermont.gov/docs/sit

AFE Survey Source: http://www.childtrends.org/indicators/adverse-experiences/

DCF, Family Services Performance Measures Dashboard: http://dcf.vermont.gov/scorecard

DCF, 2016 Report on Child Protection in Vermont, http://dcf.vermont.gov/pubs

DAIL Draft System of Care Plan for DS Services FY18-20: http://dail.vermont.gov/draft-care-plan-DS-services-FY18-20

Developmental Disabilities Services State Fiscal Year 2016 Annual Report: http://dail.vermont.gov/resources/documents-reports/annual-reports

DMH Stats Report, FY2016: http://mentalhealth.vermont.gov/sites/dmh/files/documents/reports/DMH-2016_Statistical_Report.pdf

Vermont Family Network: http://www.vermontfamilynetwork.org/

Vermont Federation of Families for Children's Mental Health: http://www.vffcmh.org/