

System of Care Plan 2019

Submitted by State Interagency Team



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Table of Contents

Introduction and Executive Summary.....	3
Acuity of Need and the Hope Resiliency Brings.....	5
What we know about Vermont’s children and youth related to Adverse Family Experiences (AFE) and the Adverse Childhood Experiences (ACE) Study.....	5
Figure 1: Percent of Children by Age who have Experienced Adverse Childhood Experiences	6
Figure 2: Markers of Family Strengths among Vermont Children <1-17 years	7
Figure 3: Acuity of Need.....	8
Prevalence of children with an emotional disturbance in Vermont.....	9
Figure 4: Number of Children with SED in Vermont	9
Figure 5: Percent of Staff Trained in Trauma Informed Practices.....	10
Data specific to Coordinated Service Plans (CSP)	11
Figure 6: ESTIMATED Number of Coordinated Services Plans Reported by Region	11
Figure 7: Children’s Mental Health Services	13
Data and information specific to children with developmental disabilities.....	14
Figure 8: Developmental Disabilities Services Data	15
Act 264 Board: Recommendations on Priorities for the 2019 System of Care.....	17
APPENDICES	21
Appendix A: Act 264 Statutory Language	22
Appendix B: Act 264 Parent Representative Plan 2018.....	23
Appendix C: Children and Youth in Residential Care: Bed Days and Total Child Count	24
Appendix D: Children and Youth in Residential Care: By Funding Department	25
Appendix E: Children and Youth in Residential Care: In-State and Out-of-State	26
Appendix F: Specialized Child Care Caseloads Data from FY2014 through FY2018	27
Appendix G: Children/Youth involved with DCF	28
Appendix H: Number of Children/Youth in DCF Custody by Age Group	29
Appendix I: Act 204 (S. 261) and Response	30
Appendix J: References	31

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Introduction and Executive Summary

This system of care report is in response to the Act 264 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 Mental Health (DMH), Department of Disability, Aging and Independent Living (DAIL), Department of Corrections (DOC), Office of Vermont Health Access (now DVHA-Department of Vermont Health Access), and the Department of Education (now AOE-Agency of Education). 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.*

The priorities outlined in this report are the result of ongoing feedback and dialogue from a number of stakeholders including the 12 Local Interagency Teams, the Act 264 Advisory Board Annual System of Care recommendations, data analysis from the departments of the Agency of Human Services and the Agency of Education and discussion at monthly State Interagency Team meetings. Feedback and input about the Children’s System of Care comes in a variety of manners—through face-to-face meetings, annual LIT surveys, electronic communications and phone calls.

How wonderful it is that nobody need wait a single moment before starting to improve the world.

~Anne Frank

The following are the 2019 recommendations from the State Interagency Team

1. Support statewide integration of services to streamline and better coordinate the provision of services provided through Act 264 and as outlined in S.261 (passed by the Senate 2018, <https://legislature.vermont.gov/bill/status/2018/S.261>).
2. Increase the number of children, youth and families served in community settings by transferring resources from residential settings, investing in local regions, and focusing on mobile response efforts in Vermont.
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 and the Agency of Education.
5. Increase collaboration with early childhood service providers and community supports to address the high rate of young children being placed into DCF custody, young children being expelled from childcare, young children being placed in residential settings, and the impacts of trauma on child development.



System of Care Accomplishments During 2018

1. The Coordinated Services Plan was revised and launched statewide. The last revision occurred in 2009.
2. The State Interagency Team launched a family-friendly webpage www.act264.vt.gov for parents and caregivers and now have a guidance document for families should they be referred to the State Interagency Team including how they can be involved in the meeting.
3. The State Interagency Team hosted the 4th annual statewide gathering of Local Interagency Teams and celebrated the 30th anniversary of Act 264 with a Governor's Proclamation.
4. The Department of Mental Health (DMH) and the Department of Vermont Health Access (DVHA) spent 2017 & 2018 preparing for a payment reform launch that will begin January 1, 2019 to move all Children's Mental Health funding into case rates and out of fee-for-service for all of Vermont's Designated Agencies.
5. In June 2018, a statewide convening occurred focused on Mobile Response in Vermont to gather stakeholder feedback, review best practices from others states and think through how to move the current system of mobile supports forward to be more effective and supportive of families.
6. SIT has expanded membership over the past two years to include additional family voice, AHS Field Services Division, DVHA, and ADAP.
7. A communication tool has been launched, the Child and Adolescent Needs and Strengths (CANS) which focuses on creating a common language among families and providers.
8. An interagency Autism Workgroup has been meeting for over four years that brings together families, providers, hospital professionals, and state staff.
9. Over 2017-2018 SIT visited in person each LIT to provide information and technical assistance.
10. Vermont is rare in the groundbreaking legislation passed 30 years ago recognizing the importance of families being at the center of service coordination.

Acuity of Need and the Hope Resiliency Brings



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

Adverse Family Experiences¹ and Adverse Childhood Experiences² 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 Data³

- The most prevalent AFEs among Vermont children and youth are (see Figure 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

Figure 1 shows the most common ACEs for children <1-17 years of age in Vermont. We also know people have incredible resilience and the ability to overcome adversity. Therefore, Figure 2 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

Figure 1: Percent of Children by Age who have Experienced Adverse Childhood Experiences
2016-2017 National Survey of Children's Health

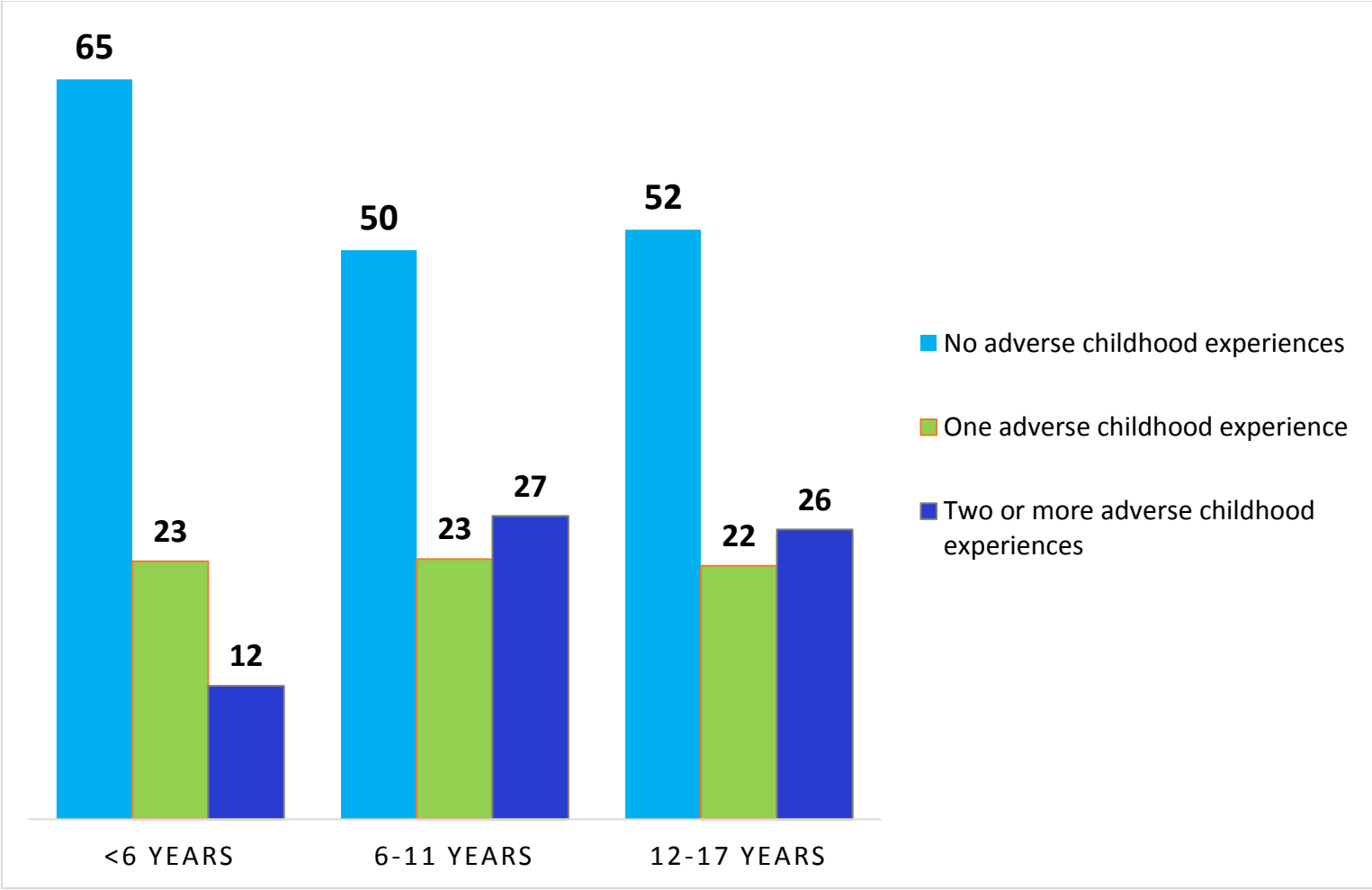
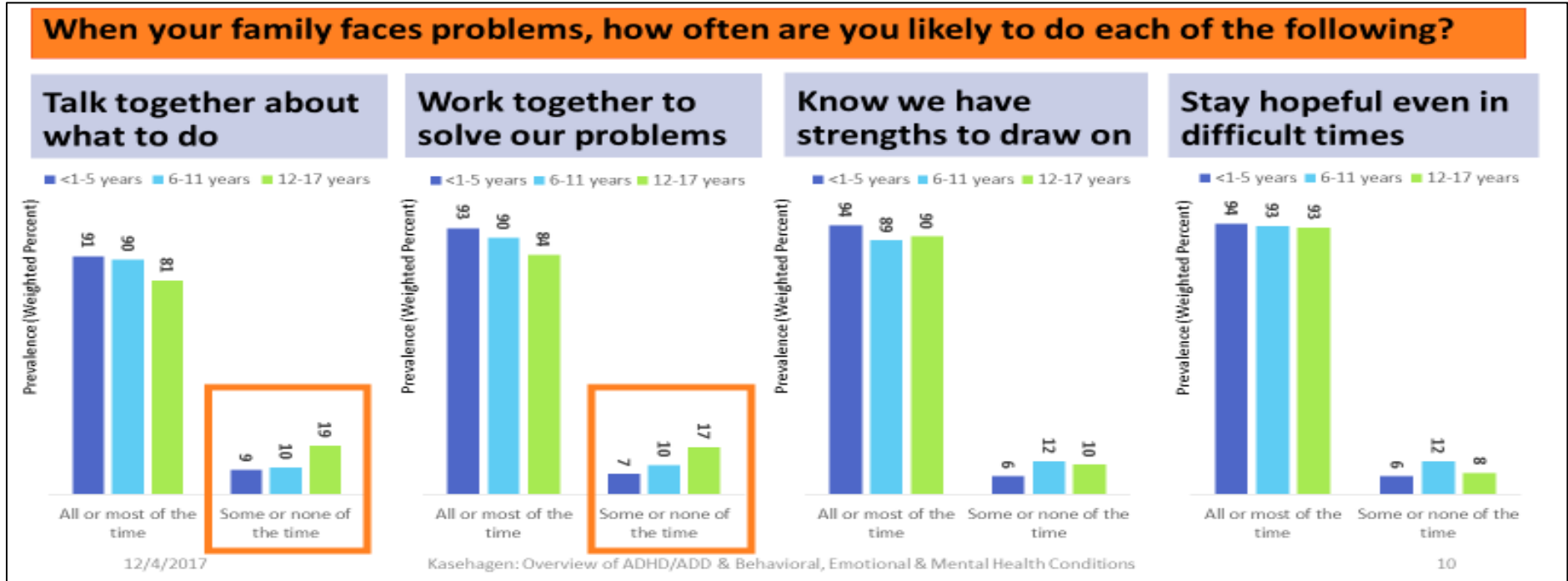


Figure 2: Markers of Family Strengths among Vermont Children <1-17 years
2016 National Survey of Children's Health



From the 2017 Youth Risk Behavior Survey:

MIDDLE SCHOOL:

- **Family engagement:** Most students ate dinner with a parent at least four times in the last week (88%).
- **School engagement:** Three quarters of middle school students had at least one teacher or other adult in their school that they could talk to if they have a problem. One in seven (14%) were not sure if they did. Seven in ten middle school students (71%) agreed or strongly agreed that their school has clear rules and consequences for behavior. One in eight (13%) did not believe (strongly disagreed or disagreed) it does.

HIGH SCHOOL:

- **Family engagement:** In the past week, 77% ate dinner at home with at least one parent on four or more days.
- **School engagement:** 80% of students had at least one teacher or adult in their school that they could talk to if they had a problem; 65% of students agreed or strongly agreed that their school has clear rules and consequences for behavior; one in five were not sure if their school's rules and consequences were clear.

Population of Children 0-18 in Vermont

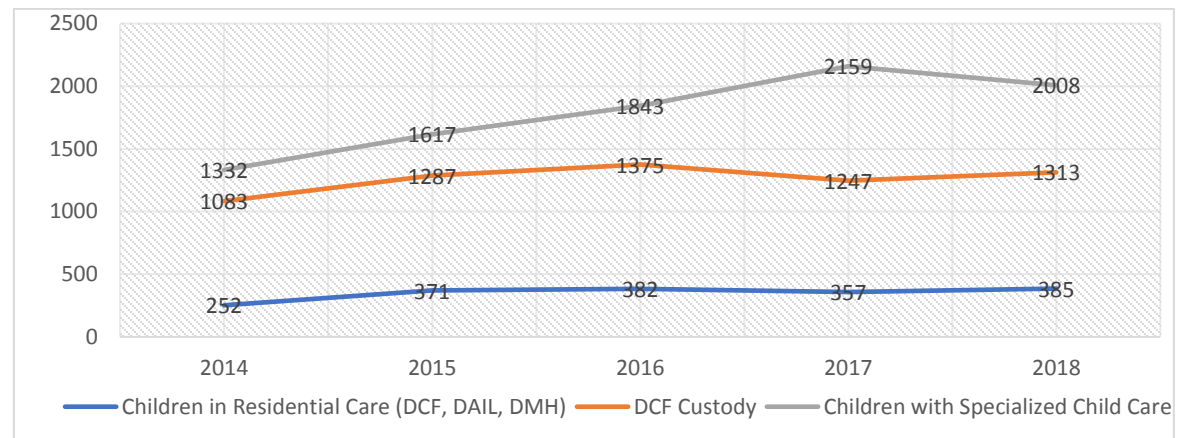
2010: 139,094
 2011: 136,451
 2012: 134,023
 2013: 132,714
 2014: 131,199
 2015: 129,512
 2016: 128,060

Difference 2010 to 2016: -11,034

Source: Vermont Department of Health, Population of Vermont Counties,
<http://www.healthvermont.gov/health-statistics-vital-records/vital-records-population-data/vermont-population-estimates>

Figure 3: Acuity of Need

There is no question there is a clear decline in the population of children 0-18 in Vermont (see sidebar), however, this does not correlate to a decline in acuity of need. In fact, the line graph below shows there continues to be a rise in the need for supports and interventions to combat the growing social and economic needs of families in Vermont. Families are facing poverty, struggles with opiate addiction, limited employment opportunities, and the impacts Adverse Family Experiences have on children.



From the 2017 Youth Risk Behavior Survey:

MIDDLE SCHOOL: Compared to 2015 for middle school students:

- suicidality and feelings of sadness or hopelessness among middle school students did not change. In 2017:
- 19% of middle school students felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities, during the past 12 months.
- 18% of middle school students have seriously thought about killing themselves; 12% have ever made a plan about how they would kill themselves; and 6% have ever tried to kill themselves.

HIGH SCHOOL: Compared with 2015 for high school students:

- were significantly LESS likely to report self-harm and suicidality; however, rates are higher than a decade ago.
- hurt themselves on purpose without wanting to die, such as by cutting or burning during the past 12 months (16% vs 17%).
- made a plan about how they would attempt suicide (11% vs 12%) or attempted suicide (5% vs 6%).

During the same time period, high school students were significantly MORE likely to:

- feel so sad or hopeless almost every day for at least two weeks during the past 12 months that they stopped doing some usual activities (25% vs 24%).

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 beginning in 2016.⁴

Figure 4: Number of Children with SED in Vermont

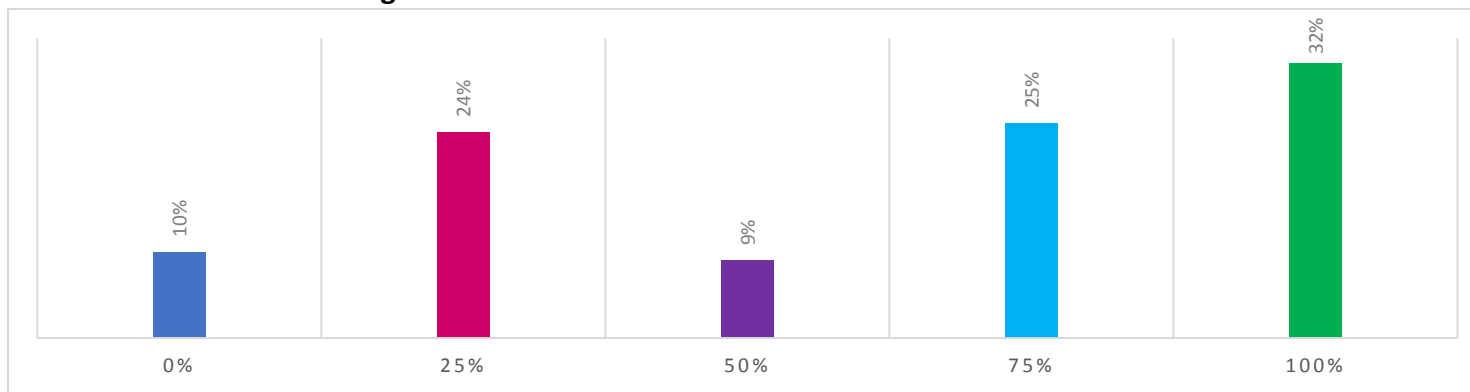
Fiscal Year	Severe Emotional Disturbance (GAF <= 50)	
	Number	Percentage
FY17 Projected	1089	18.3%
FY16 Projected	1113	19.1%
FY 15	1144	19.1%
FY 14	1166	20.0%
FY 13	1184	20.6%
FY 12	1154	20.3%
FY 11	1243	21.4%
FY 10	1335	21.6%
FY 09	1252	21.0%
FY 08	1293	21.3%

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.

In Vermont, about 14.4 percent of children are identified with an emotional disturbance, according to federal data⁵. That is more than twice the national average of 5.4 percent, however, due to the current use of trend analyses to determine SED rates, this is likely an underrepresentation. To support children/youth experiencing challenges, Vermont started Success Beyond Six in 1992, which is an Agency of Human Services funding mechanism. This allows school districts to use Medicaid match to support mental health services in schools. Under this Medicaid-supported formula, federal dollars cover about 54% of mental health costs while local school districts pay about 46%. The mental health services provided through the Designated Agencies in schools have become more varied and individualized over the years based on the identified needs of the children/youth. The collaboration of Local Education Agencies and Designated Mental Health Agencies has created opportunities for a spectrum of services including prevention and early intervention all the way to intensive individualized services. In the 2017-2018 school year, Success Beyond Six helped fund 585 full time equivalent behavioral interventionists, as well as 175 School Based Clinicians and 25 Board Certified Behavioral Interventionists with about \$69 million in Medicaid and local dollars supporting the program.⁶

In addition to mental health supports being available in schools, there has been a focus on increasing staff knowledge about trauma. Below is a graph which shows the data from the Multi-Tiered Systems of Support Survey Summary.⁷ Thirty-two percent of schools reported that 100 percent of staff are trained in Trauma Informed Practices. Twenty-five percent reported 75 percent of staff are trained, and nine percent indicated 50 percent of staff are trained, twenty-four percent indicated 25 percent of staff are trained, and ten percent indicated 0 percent of staff are trained in Trauma Informed Practices.

Figure 5: Percent of Staff Trained in Trauma Informed Practices



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

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

⁷ Multi-tiered System of Supports (MTSS) Survey Summary 2017-2018, Response to Title 16 V.S.A. §2904, November 12, 2018

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. LIT coordinators estimate the number of CSPs that occur and believe it is likely an underestimate 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 LITs and the Act 264 Board.

Figure 6: ESTIMATED Number of Coordinated Services Plans Reported by Region

REGION	2015	2016	2017	2018
Barre	60	50	60-80	75
Bennington			25-30	25
Brattleboro	40	40	40	75
Burlington	150-200	83	180	227
Hartford			75-80	★
Middlebury			60	63
Morrisville	50	40-60	50-60	50-70
Newport			17	★
Rutland		66	70+	60
St. Albans		100	100	125
St. Johnsbury			11	12
Springfield	38	29	28	28
TOTALS*	338	408	716	680

**When a range was identified the lower end was utilized for this calculation*

★ Data not reported by region

Through the Agency of Education's Special Education Child Count data⁸, there is data identifying children/youth who had a CSP **and** are receiving special education services. The data in the sidebar are unduplicated 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.



⁸ Child Count Data for children 3-21 as of 12/1/17

Children/Youth Receiving Special Education Services who also had a Coordinated Services Plans as of December 1, 2017:

536 Total

- 153 Females, 383 Males
- 11 in Kindergarten
- 30 Early Childhood Special Education (ECSE)
- 173 in grades 1-6
- 88 in grades 7 and 8
- 234 in grades 9-12+
- 22 with an Intellectual Disability
- 277 with an Emotional Disturbance
- 65 with Other Health Impairment (this includes students with Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD))
- 17 with a Speech/Language Impairment
- 59 with a Developmental Delay
- 52 with an Autism Spectrum Disorder
- 32 with a Specific Learning Disability
- 12 with an Orthopedic Impairment, Multiple Disability, Traumatic Brain Injury or Hearing Loss (numbers too small to report individually)

Mental health services

In FY 2017, Vermont's Designated and Special Services Agencies (DA/SSA) child, youth and family mental health programs served 10,661 children and youth. ⁹

Figure 7: Children's Mental Health Services

FY17	# of Children Served	Ages 0-6	Ages 7-12	Ages 13-19	Ages 20-34	Male	Female
Overall	10,661	20%	36%	41%	3%	56%	44%
Services Received through DA/SSA				# children			
				FY2015	FY2016	FY2017	
Therapies				4,349	4,003	3,839	
Medication & consultation				1,257	1,344	1,337	
Clinical interventions				6,523	6,322	6,291	
Service Planning & Coordination				7,343	7,531	7,138	
Community Supports				8,685	8,493	8,333	
Crisis assessment & supports				1,965	1,558	1,170	
Respite				445	302	215	
Enhanced Family Treatment (Home & community-based services /This does not include IFS regions)				58	34	57	
Individualized Service Budgets (DCF)				99	114	206	

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 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 DA/SSA 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

⁹ DMH FY2017 Statistical Report

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

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) to 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 DAIL System of Care Plan determined 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 DAIL System of Care Plan. 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:

1. 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.]
2. 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 report, 17 children with developmental disabilities who are in DCF custody receive HCBS.

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)

Figure 8: Developmental Disabilities Services Data

Program	Number of Children/Youth Served		
	FY2015	FY2016	FY2017
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)	58 children up to age 18 221 Transition-age youth (18-22)
BRIDGE program: Care Coordination	300 children/youth up to age 22	323 children/youth up to age 22	391 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)	729 children/youth up to age 18 211 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 <ul style="list-style-type: none"> • 165 ID/ASD diagnosis • 123 MH diagnosis • 35 co-occurring ID/ASD and MH diagnosis 	384 children/families statewide <ul style="list-style-type: none"> • 197 ID/ASD diagnosis • 146 MH diagnosis • 41 co-occurring ID/ASD and MH diagnosis 	523 children/families statewide <ul style="list-style-type: none"> • 256 ID/ASD diagnosis • 226 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%	91 total bed days were children (under 18) = 15.6% 5 individuals were children under 18 = 15.6%

**The data in this figure 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. In addition, the Howard Center has developed a unique program, also using a case rate with funds included from DAIL and DMH, called ARCh (**A**ccessing **R**esources for **C**hildren) which provides service coordination, skills work and clinical support to 277 children in FY18, the majority of whom have developmental disabilities.



Act 264 Board: Recommendations on Priorities for the 2019 System of Care

A statutory requirement of the Act 264 Board is to: advise the Agency of 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 December 2018.

1. **Demonstrate strong commitment to develop and implement an integrated approach for child and family programs and services across the state.**

- a) Support the efforts of Building Flourishing Communities and statewide coordination across agencies with a focus on resiliency and trauma-informed services.
- b) Support health care payment reform efforts away from 'fee for service' payment frameworks and towards accountability funding based on program performance measures and client outcomes.
- c) Create a state database across AHS and AOE to track all in-state and out-of-state residential placements, including length of stay, performance measures, and client 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.
- e) AHS and the Act 264 Advisory Board will work together to provide state and local police officers brochures about contacts for Coordinated Service Plans to share with relevant Vermont families they encounter in their work.

2. **Strengthen direct and indirect strategies to improve staff recruitment and retention to assure timely access to needed quality services, particularly in Designated Agencies and in the Department for Children and Families' Division of Family Services.**

- a) Continue to try to increase salary levels for line staff.
- b) Try various methods to enhance the work culture and climate with non-monetary incentives.
- c) Consider hiring family members with appropriate life experience equivalents for educational requirements.

3. **Expand and align areas of service overlap within and beyond the Agency of Human Services (AHS) and the Agency of Education (AOE).**

- a) Adjust services and funding within Success Beyond Six budget cap to promote better geographic accessibility.
- b) Work across public and private entities to offer engaging, affordable activities to all ages of children and adolescents, especially between 3:00 and 6:00 pm which is a critical time for substance abuse prevention.
- c) Increase collaboration between the Department of Health (VDH) and education to:
 - 1) enhance school-based curriculum for substance abuse prevention;
 - 2) promote oral health in schools; and
 - 3) protect children's brain development by testing water in schools for lead and other contaminants.

4. Ensure all Agency of Human Services' departments, the Agency of Education, and families coordinate and implement system-wide changes that advance an integrated approach.

- a) The State Interagency Team (SIT) will produce a 50-minute training video, to be available on the web, on the basics of Act 264 for distribution to the Local Interagency Teams (LITs) and their communities by December 31, 2019.
- b) Provide links to the Act 264 Advisory Board on the websites of the Department for Children and Families (DCF), the Department of Health (VDH), the Department of Corrections (DOC), the Department of Disabilities, Aging, and Independent Living (DAIL), and the Agency of Education (AOE).
- c) Continue work to develop clear, written guidelines and expectations for the State Interagency Team and Local Interagency Teams (see page 2 for statutory requirements), including roles, accountability, authority, management, deliverables, and interactions with the Act 264 Advisory Board.
- d) Ensure there is a Parent Representative on every Local Interagency Team, 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.
- e) Establish guidelines across all agencies and departments to assist linking children and families to needed basic services (e.g., housing, food, skills training, etc.), particularly for pregnant women and for children whose parents are involved with Corrections.
- f) Require that information on all applicable resources and services be made available to families involved in kinship placements.
- g) 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.

State Interagency Team: System of Care Priorities for 2019

#	Goal	Action Steps
1	<p>Support statewide integration of services to streamline and better coordinate the provision of services provided through Act 264 and as outlined in S.261 (passed by the Senate 2018, https://legislature.vermont.gov/bill/status/2018/S.261).</p>	<ul style="list-style-type: none"> a. Continue providing statewide, annual LIT gatherings. b. SIT Coordinator will continue to attend monthly Act 264 Board Meetings. c. Collaborate closely with Act 264 Board to continue collecting data from LITs regarding key indicators. d. Provide the SOC Plan on an annual basis to all Local Interagency Teams and ensure there is commitment to move the plan forward at the local and state level. e. 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.) f. Focus on the boundary lines of supervisory unions, designated agencies, and state offices to identify where these delineations impede integrated service delivery.
2	<p>Increase the number of children, youth and families served in community settings by transferring resources from residential settings, investing in local regions, and focusing on mobile response efforts in Vermont.</p>	<ul style="list-style-type: none"> a. Continue to provide regional and statewide data on a quarterly basis to maintain a focus on the trend lines in residential care. b. An interagency team is attending a learning summit in New Jersey in mid-December 2018 to learn more about best practices of mobile response in other states and bring back the information to Vermont. c. Convene an ongoing workgroup that includes community partners to focus on mobile response efforts in Vermont which is often seen as a way to support children, youth and families earlier on to prevent higher levels of care from being needed. d. Continue to analyze data regarding children and youth waiting in hospital Emergency departments and length of psychiatric hospitalizations to evaluate possible correlations to crisis response, residential placements, and access to services.

#	Goal	Action Steps
3	Support payment reform efforts that move the System of Care away from the fee-for-service model and toward accountability focused on performance outcomes.	<ul style="list-style-type: none"> a. The Department of Mental Health has spent the past year and a half working with the DVHA Payment Reform team to develop a new payment model for reforming children’s mental health reimbursement. The new payment structure will begin on January 1, 2019 and may include other AHS Departments over time. b. DMH and DAIL representatives have been meeting for over a year and continue to do so to work towards exploration of incorporating Developmental Services funding for children in a future case rate for Designated and Specialized Service Agencies.
4	Support funding for family and youth partnership to be a shared responsibility of all AHS Departments and the Agency of Education.	<ul style="list-style-type: none"> a. In FY18, DMH continued their funding of the VFFCMH for supporting Act 264 mandates. As well, six departments of AHS (VDH-Maternal Child Health, VDH-ADAP, DCF-FSD, DCF-CDD, DVHA and DAIL-DDSD) all provided an increase in funding to VFFCMH to support the training and education of parent representatives. b. At the writing of this report, AOE was working on a funding mechanism to provide financial support for this effort as well. c. In FY19, the goal is to create an ongoing, consistent mechanism to fund this work.
5	Increase collaboration with early childhood service providers and community supports to address the high rate of young children being placed into DCF custody, young children being expelled from childcare, young children being placed in residential settings, and the impacts of trauma on child development.	<ul style="list-style-type: none"> a. 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 use. b. Continue to grow access to early childhood and family evidence-based mental health services, including analyzing the funding streams supporting these services. c. The Children’s Integrated Services Director will continue to be a member of SIT (as of January 2018). d. The SIT Coordinator continues to be a member of the Building Bright Futures State Advisory Council (as of 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: Act 264 Parent Representative Plan 2018

Annual Goals

- 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						
REGION	FY 16		FY 17		FY18	
	#'s	Cost	#'s	Cost	#'s	Cost
Barre	98	\$4,248.14	116	\$5,050.96	60	\$2563.93
Bennington	0	\$113.80	0		0	
Burlington	20	\$-	18	\$-	14	\$-
Brattleboro	1	\$-	1	\$223.30	8	\$771
Hartford	2	\$	0		0	\$26.36
Middlebury	23	\$1,768.17	0		3	\$554.87
Morrisville	39	\$2,705.98	26	\$2,129.63	44	\$3485.31
Newport		\$-	0		1	\$364.13
Rutland	60	\$3,514.27	117	\$5,268.31	135	\$6286.29
St Albans		\$-	0		1	\$-
St Johnsbury	0	\$145.20	0	\$145.20	2	\$70.48
Springfield	0	\$463.06	6	\$463.06	0	\$-
Totals	243	\$12,958.62	284	\$13,280.46	268	\$14,122.37

* If a region has no CSPs listed but there is a cost, that means PR is attending LITS only and not CSPs

HIGHLIGHTS FOR 2018

Outcomes:

- Provided 3 parent representative trainings
- Increased the AHS Division Contribution from 12,500.00 to 15,000.00. Also have a commitment from AOE.
- Two new Parent Reps were identified in Burlington & Bennington
- Have made four LIT PR candidate recommendations to four LITs
- All seven LIT PR's are attending LIT and doing CSPs

Strengths:

- Fully funded to have all 12 LIT PRs in 12 Regions; currently recruiting for 5 regions.
- As of this writing, close to having nine parent representatives.
- 680 CSPs were reported by LIT and 268 has a LIT PR attending, which is 39% of the entitlement.

Challenges:

- Despite being fully funded, continue to have challenges in finding parents with lived experience who are interested in this role.
- The role is extremely flexible, although a qualified candidate must have lived experience, advocacy skills, strong communication and teaming skills, and ability to make strong relationships in the community.
- A major barrier to recruitment of PRs is the stipend reimbursement (on average \$350 - \$600 per month, for 5-10 CSP s per month) which is not fiscally feasible for most families.

Appendix C: 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

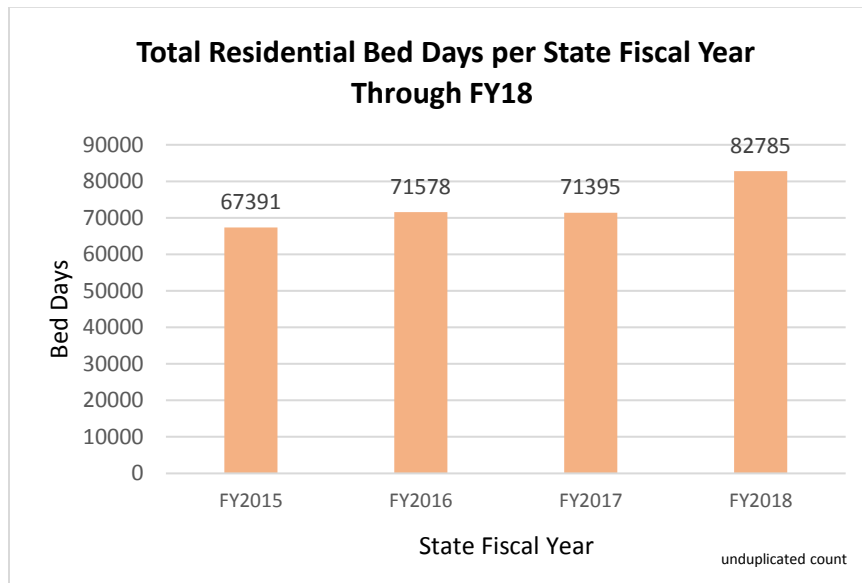
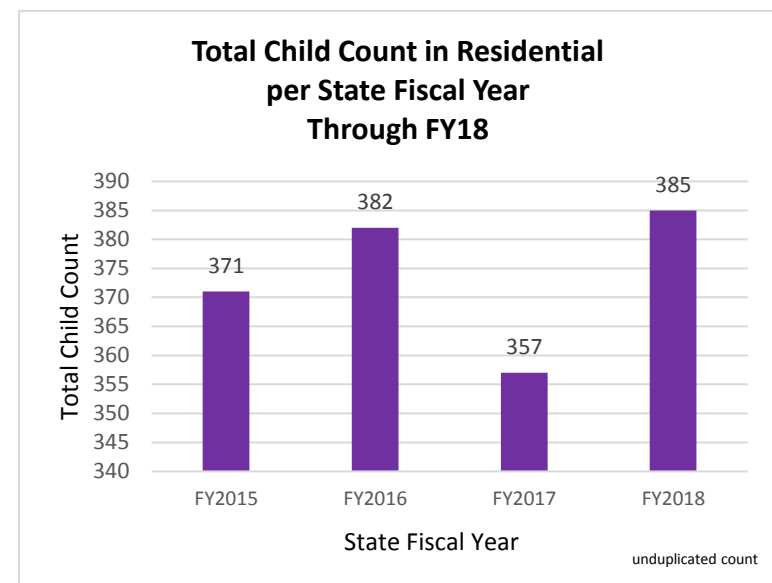


Figure 2

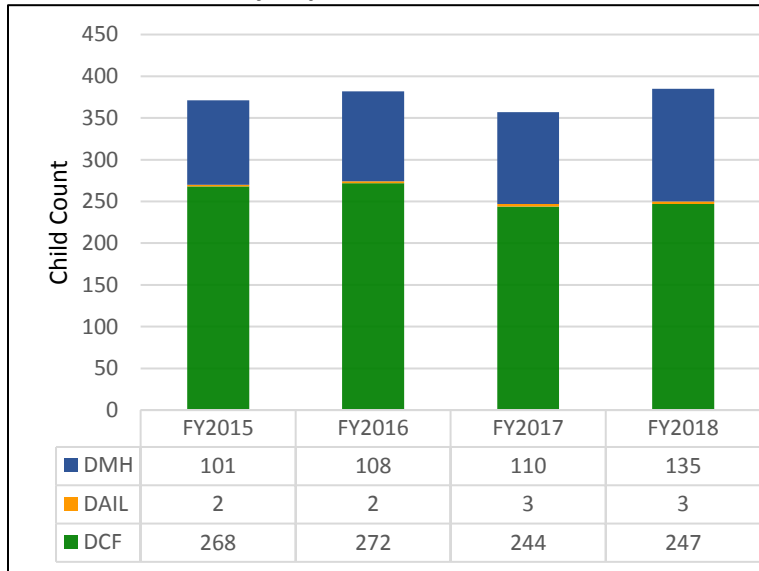


Appendix D: Children and Youth in Residential Care: By Funding Department

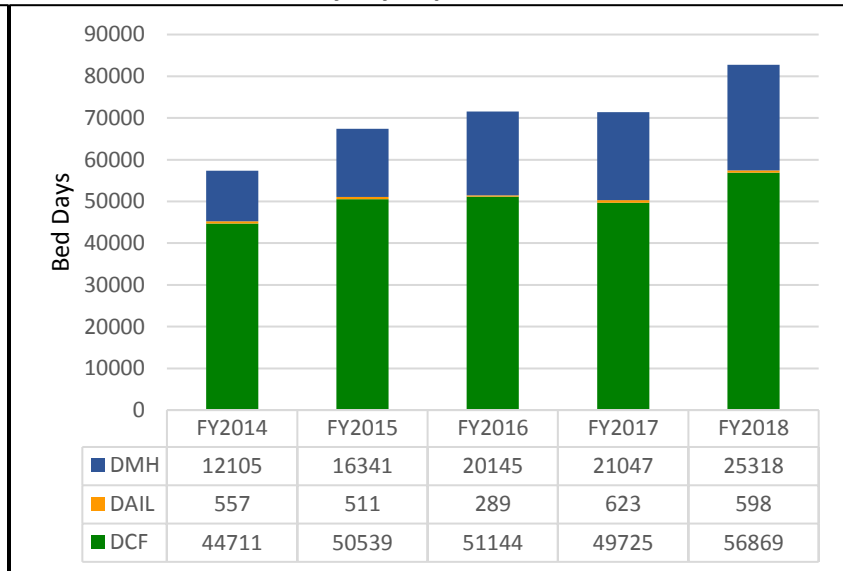
**Data compiled by Department of Mental Health*

The following charts 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 a 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.

Total Child Count by Department



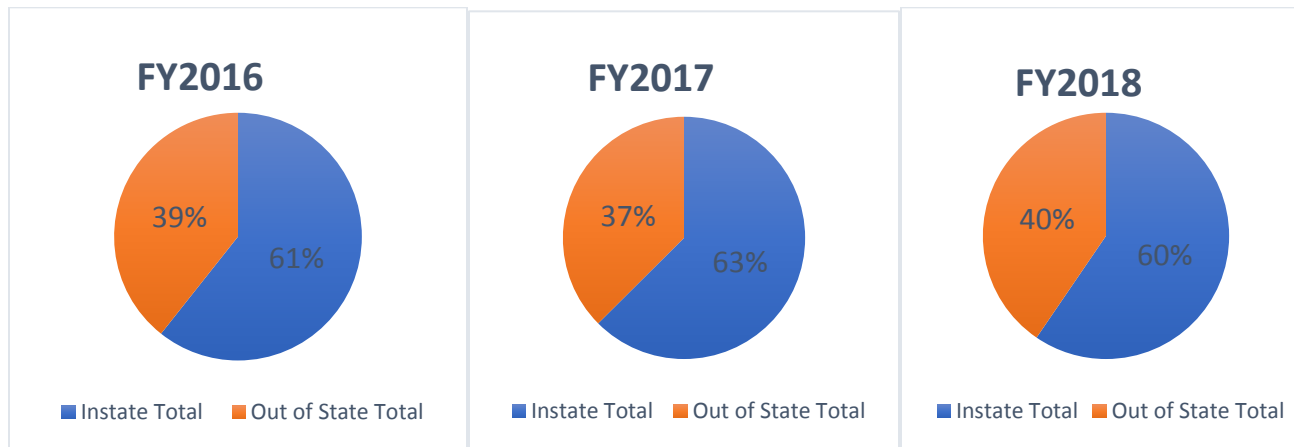
Total Residential Bed Days by Department



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

**Data compiled by Department of Mental Health*

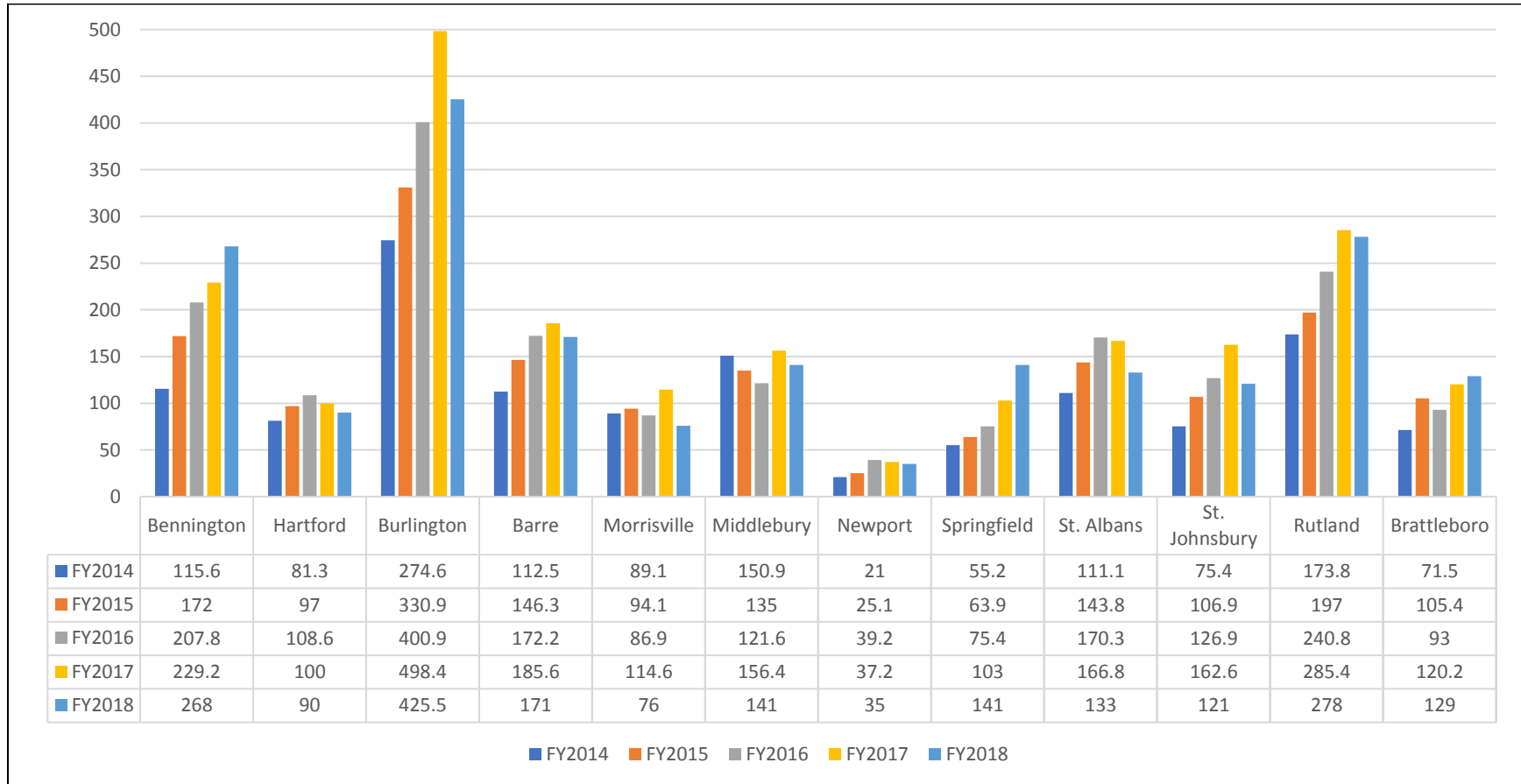
The following pie charts represent the breakdown of in-state placements compared to out-of-state placements. If a child was placed in more than one program in a fiscal year, they are represented more than once.



Appendix F: Specialized Child Care Caseloads Data from FY2014 through FY2018

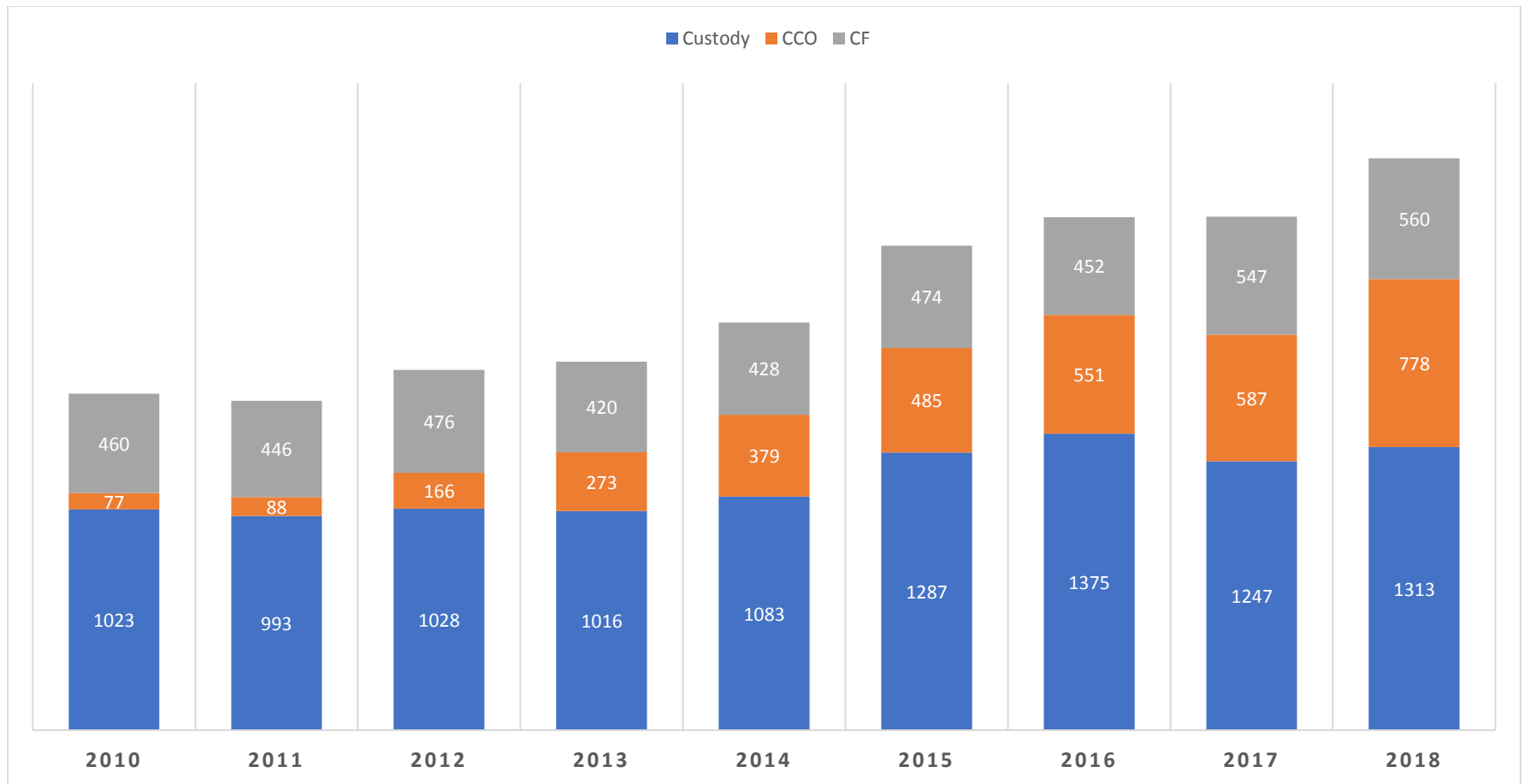
Specialized Child Care provides vulnerable children and high-risk families with quality child care and specific supports that help meet their needs, strengthen their families, and promote their children's development.

**Data provided by DCF-Child Development Division*



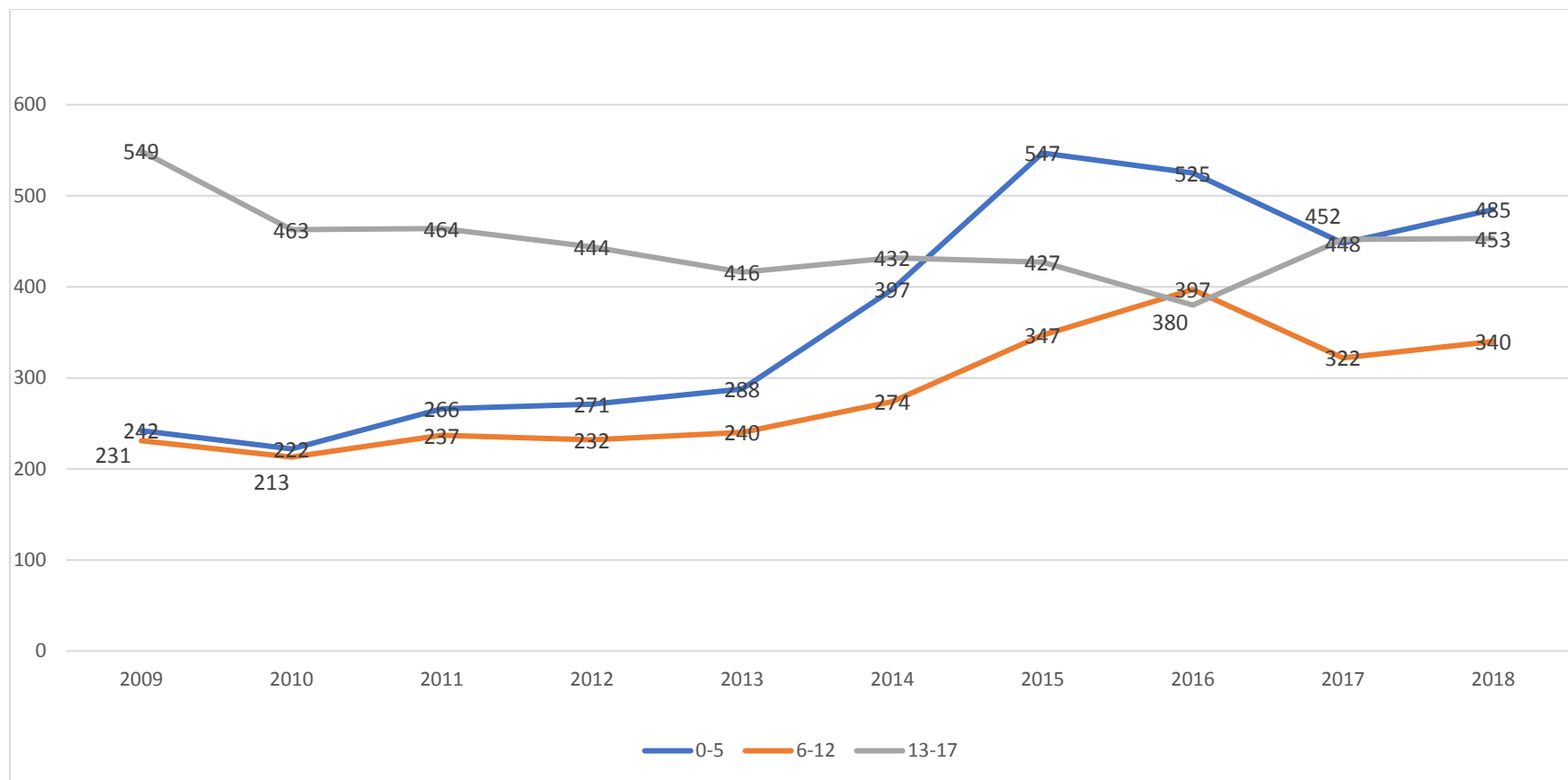
Appendix G: Children/Youth involved with DCF Custody, Conditional Custody (CCO) and Family Support Cases (CF)

Data Source: FSD Quarterly Management Reports-last day of Q2 for Custody; FSD Report Catalog-Full Caseload & CCO Reports for Non-Custody



Appendix H: Number of Children/Youth in DCF Custody by Age Group

Data Source: FSD Quarterly Management Reports-last day of Q3.






Appendix I: Act 204 (S. 261) and Response

Sec. 7a. COORDINATION OF ACT 264 SERVICES

The Agency of Human Services, in collaboration with Vermont Care Partners, shall identify opportunities to streamline and better coordinate the provision of services provided pursuant to 1988 Acts and Resolves No. 264. On or before January 15, 2019, the Secretary shall present the findings and recommendations for legislative action to the House Committee on Human Services and to the Senate Committee on Health and Welfare.

Response from Vermont Care Partners



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(802) 223-1773 
Contact@vermontcarepartners.org 

December 18, 2018

To Whom It May Concern:

In Act 204 of the 2018 legislative session, the Agency of Human Services was asked to collaborate with Vermont Care Partners to identify opportunities to streamline and integrate services to better meet the goals of 1988's Act 264.

Vermont Care Partners recognizes that children and families can experience unnecessary hurdles and disruptions in services when the geographical catchment areas for education, mental health, and protective services are misaligned. We have reviewed the System of Care Plan for 2019, developed by the State Interagency Team. We support the goals identified in this plan, including Goal #1: "Support statewide integration of services to streamline and better coordinate the provision of services provided through Act 264 as outlined in S. 26." We believe that the action step defined as "focus on the boundary lines of supervisory unions, designated agencies, and state offices to identify where these delineations impede integrated service delivery" is an important start, and we will continue to collaborate with AHS to make logical and family-centered changes.

Cara Capparelli, Chair
Children, Youth, and Family Services Directors' Group
Vermont Care Partners

Appendix J: References

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

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/>

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>

DAIL System of Care Plan for DS Services FY18-20:
https://ddsd.vermont.gov/sites/ddsd/files/documents/Vermont_DS_State_System_of_Care_Plan_0.pdf

DAIL-Developmental Disabilities Services State Fiscal Year 2017 Annual Report:
https://ddsd.vermont.gov/sites/ddsd/files/documents/DAIL_DDS_Annual_Report.pdf

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

DCF, 2017 Report on Child Protection in Vermont:
<https://dcf.vermont.gov/sites/dcf/files/Protection/docs/2017-CP-Report.pdf>

DMH Stats Report, FY2017:
https://mentalhealth.vermont.gov/sites/dmh/files/documents/reports/DMH-2017_Statistical_Report.pdf

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

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

Youth Risk Behavior Executive Summary, 2017:
http://www.healthvermont.gov/sites/default/files/documents/pdf/CHS_YRBS_ExecutiveSummary.pdf