

System of Care Plan

Submitted by State Interagency Team December 2016

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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 recommendation from the State Interagency Team after reviewing and analyzing the data provided in this report.

1. Support statewide integration of services as envisioned by IFS 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 towards improving caregiver readiness.
3. Identify and advocate for additional resources in community agencies.
4. Support payment reform efforts that move the System of Care away from fee for service and toward accountability focused on performance outcomes.
5. Support funding for family and youth partnership to be a shared responsibility of all AHS departments.

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 (see Appendix I) 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 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 Table 1):
 - a. divorced / separated parents
 - b. family income hardship (for children <18 years)
 - c. having lived with someone who:
 - i. had substance use problems
 - ii. was mentally ill / suicidal / severely depressed

- *One* out of every *eight* Vermont children and youth under the age of 18 has experienced three or more (3+) adverse family events. Among these children and youth with 3+ AFEs:
 - i. 1 in 7 has moved 4+ times since birth
 - ii. 4x as many have special health care needs
 - iii. 2x as many live in a household where the highest education level is high school or less
 - iv. 4x as many live in households below 300% of federal poverty level

- Children / youth (6-17 years) exposed to 3+ AFEs have higher odds of *failing to*:
 - i. engage in school
 - ii. exhibit resilience
 - iii. flourish

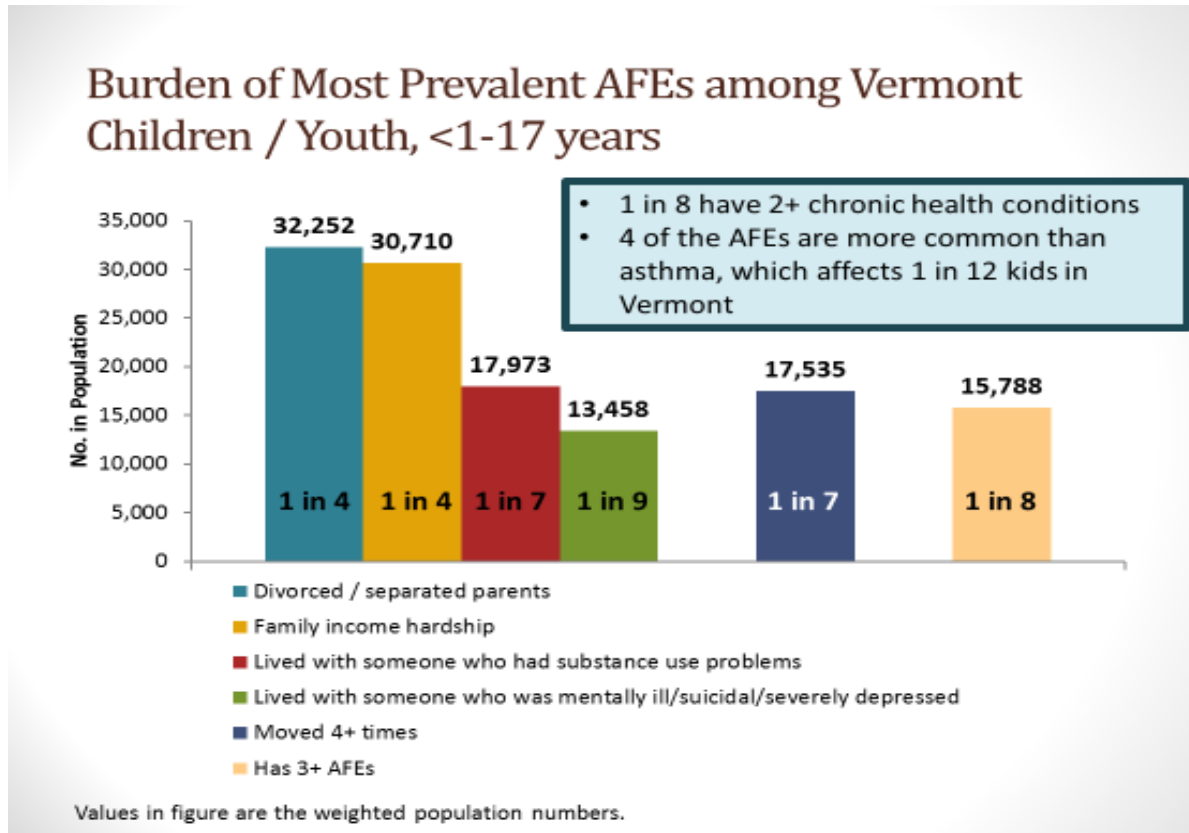
¹ Maternal and Child Health Bureau and United States Health Resources and Services Administration, 2011/12 National Survey of Children's Health, National Center for Health Statistics and Data Resource Center for Child and Adolescent Health, Editors. 2013.

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

- Families of Vermont children / youth with 3+ AFEs more commonly:
 - i. are contacted by schools about problems the child / youth is having with school
 - ii. have a child with an Individual Family Service Plan (IFSP) or Individualized Education Program (IEP)

Table 1. The most prevalent AFEs among Vermont children and youth⁴



Prevalence of children with an emotional disturbance in Vermont

The Vermont Department of Mental Health (DMH) reports data to SAMHSA on the number of children served through the Designated Agency (DA)/Specialized Service Agency (SSA) system who have severe emotional disturbance (SED), using the federal definition of SED identified by Global Assessment of Functioning (GAF) scores 50 and under. In 2015, of children ages 9-17 served in the DA/SSA system, 1,144 (19% of that population) met the definition of Severe Emotional Disturbance; 1,113 are projected for 2016⁵.

⁴ 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

⁵ 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.

Vermont has the highest rate of identifying students with emotional disturbance in the country. As a percentage of all students who received special education services in the 2014-15 school year in Vermont, about 16 percent were identified with an emotional disturbance, according to federal data⁶. That is more than twice the national average of 6.3 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 2015, total enrollment in Vermont's public schools dropped from 89,814 to 86,991, a decrease of a little more than 3 percent. During the same period, the number of students identified with emotional disturbance jumped from 1,870 to 2,021, an almost 7.5 percent increase. That growth occurred as the number of students receiving special education services in the state rose slightly from 13,914 to 13,991.

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 money to support mental health services in the schools. Under the Medicaid-supported formula, federal dollars cover about 60 percent of the costs for providing mental health services in the schools with local school districts paying about 40 percent. 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 2,021 (2.3% of the total student population), 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 2014, Success Beyond Six helped fund 778 full time equivalent mental health workers with about \$50 million in Medicaid and local dollars supporting the program.⁷

Vermont spends \$294 million a year for special education and identifies 16 percent of the state's students as needing services. A study of Vermont's spending during the 2014-2015 school year found the state could have saved \$140 million by changing the way it delivers special education.

⁶ Report on Act 46 of 2015; Section 49. Coordination of Educational and Social Services

⁷ Report on Act 46 of 2015; Section 49. Coordination of Educational and Social Services (with updated data from 2015)

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 Council, a consulting firm based in Massachusetts, will carry out the study.⁸

Data specific to coordinated service plans

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. **At this time, there is no database or way to track CSP’s that occur through the Designated Agencies (DA) or any other agencies.** DA’s, who resource LIT’s with children’s mental health staff yet do not receive additional financial resources to support this work, do not have a way to track this in their electronic health records. It is a possibility this could be added in the future; however, every change to an EHR is a cost and 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 (see Table 4). SIT will continue to work with and explore accurate data collection in collaboration with LIT’s and the Act 264 Board.

Table 2. ESTIMATED # Coordinated Services Plans Reported by Region

It is important to know these are estimates. There is no database that exists to track this information.

	2010	2011	2012	2013	2014
Barre	55	50	67	79	59
Bennington			25	20	
Brattleboro	90	76	60	41	50
Burlington	100		150-200	150-200	150-200
Hartford	54	81	73		
Middlebury	130	97	100	88	
Morrisville	25	35	39	43	51
Newport		25	25	25	
Rutland	30	52	65	65	63
St. Albans	39		150		
St. Johnsbury			25	25	
Springfield	36	21	12	8	42

Through Child Count data⁹, there is data about children/youth who had a CSP *and* are receiving special education services. The data follows and it should be noted these are not duplicated children; the primary disability is targeted.

500 Total

⁸ <https://vtdigger.org/2016/11/29/school-systems-set-for-study-of-special-education-costs-quality/> and Act 148

⁹ Child Count Data for children 3-21 as of 12/1/15

- 150 Females, 350 Males
- 33 in Kindergarten
- Early Essential Education (EEE) (number too small to report)
- 151 in grades 1-6
- 84 in grades 7 and 8
- 231 in grades 9-12+
- 38 with an intellectually disability
- 241 with an emotional disturbance
- 50 with another health impairment (this also includes students with Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD)
- speech/language impairment (number too small to report)
- 50 with developmental delays
- 56 with an autism spectrum disorder
- 34 with specific learning disabilities
- Traumatic Brain Injury (number too small to report)

Mental health services

In FY 2015, Vermont’s Designated and Special Services Agencies (DA/SSA) child, youth and family mental health programs served 10,585 children and youth (10,670 in 2016). The age and gender breakdown as well as general service data can be found in Table 3.¹⁰

Table 3. Children’s Mental Health Services

FY15	# of Children Served	Ages 0-6	Ages 7-12	Ages 13-19	Male	Female
Overall	10,585	20%	35%	41%	55%	45%

Services Received through DA/SSA	# children
Therapies	4,349
Medication & consultation	1,257
Clinical interventions	6,523
Service Planning & Coordination	7,343
Community Supports	8,685
Crisis assessment & supports	1,965
Respite	445
Enhanced Family Treatment (home & community based services; does not include IFS regions)	58 (5 DCF)
Individual Service Budgets (DCF)	99

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

¹⁰ DMH FY 2015 Statistical Report

years to survey parents and youth. The most recent survey data from parents (2014) showed that 82% of parents of children served by child and adolescent mental health programs in Vermont rated the programs favorably. In 2013, 84% of the surveyed youth evaluated the programs positively on the Overall measure of program performance.¹¹

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) “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 waivers 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

¹¹ DMH 2013 Consumer Evaluation of Children's Services Programs (1/17/14)

report, seventeen 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 4: Developmental services data from state fiscal Year 2015¹²

Program	Number of Children/Youth Served
Home and Community-Based Services	64 children up to age 18 194 transition-age youth (18-22)
BRIDGE program: Care Coordination	300 children/youth up to age 22
Flexible Family Funding	750 children/youth up to age 18 201 transition-age youth (18-22)
Family Managed Respite (FMR) (allocated to more families – the data only includes #s who used it)	323 children/families statewide <ul style="list-style-type: none"> • 165 ID/ASD dx • 123 MH dx • 35 co-occurring ID/ASD and MH dx
Vermont Crisis Intervention Network	95/525 total bed days were children, or 18% 7/34 individuals were children, or 20%

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.

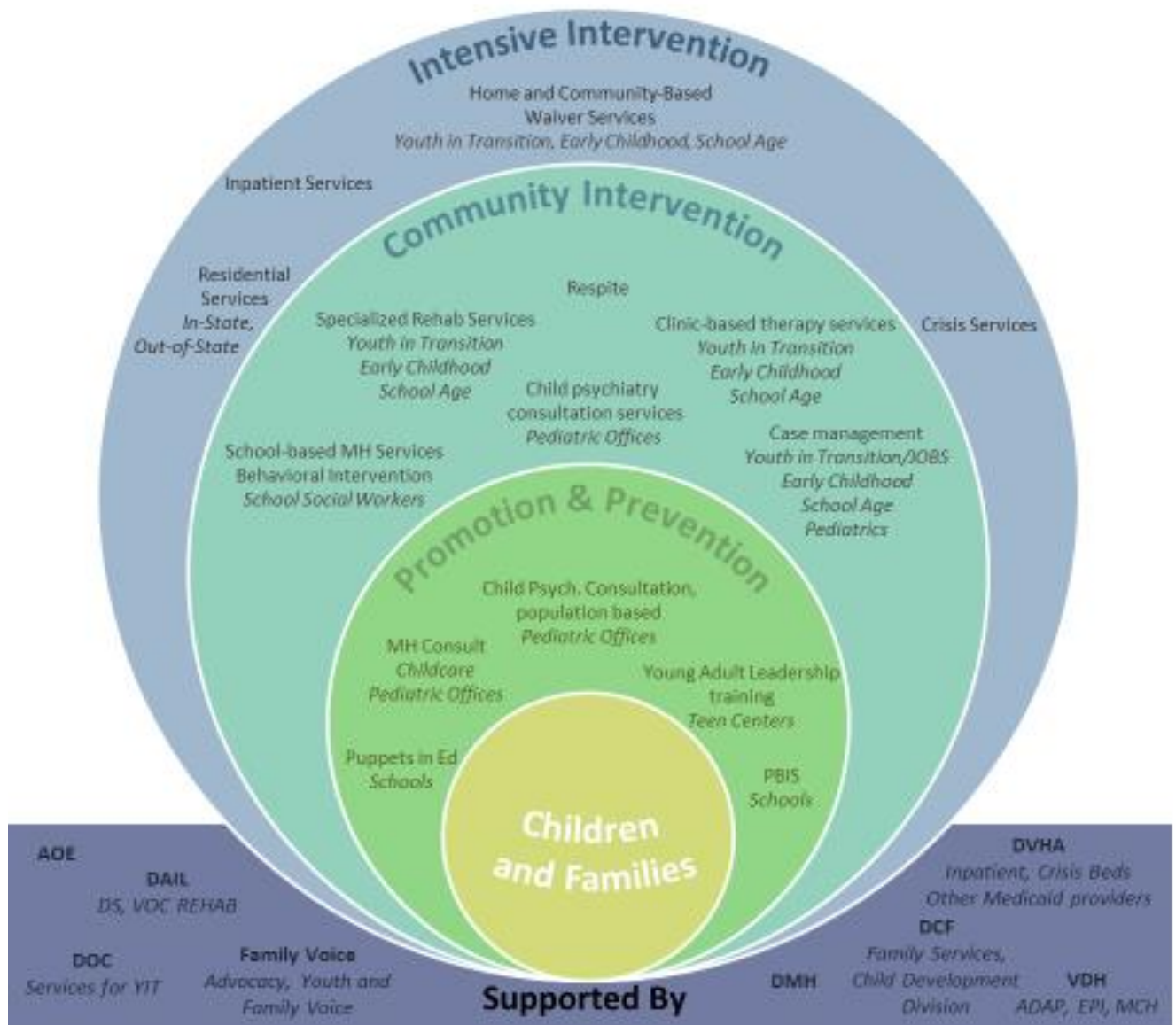
In Franklin/Grand Isle and Addison counties, services to children, regardless of disability type, are provided through Integrating Family Services. Children with DD have access to the same menu of services as children in the other counties of the state. In addition, the Howard Center

¹² Vermont State System of Care Plan for Developmental Disabilities Services FY15-FY17, other records

has developed a unique program called ARCh (**A**ccessing **R**esources for **C**hildren) which provides service coordination, skills work and clinical support to 200 children, many of whom have developmental disabilities.

Visual of Vermont's System of Care

The State Interagency Team has adapted the following visual from work done by the Department of Mental Health to show how the System of Care is considered in the state of Vermont.



Act 264 Board: Recommendations on priorities for the 2016 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 February 2016. The next portion of this report takes the recommendations from the Board with a response from the State Interagency Team.

1. Demonstrate strong commitment to develop and implement an Integrating Family Services (IFS) approach for child 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 “per patient” funding.
- 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 in Corrections.
- c. Require that information on all applicable resources and services be made available to families involved in kinship placements.
- d. 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.

SIT Response to Recommendations #1 and #2:

IFS propels individuals, organization, and systems to work together more collaboratively, use resources more flexibly, and make supports and services more family-friendly, so that children, youth, and families are better off as a result of their interaction with AHS and its community partners.

A priority of the Agency of Human Services is to create an Agency of One; a system in which Vermonters who need services can receive them with a complete and coordinated plan that

works for the entire family. This would mean AHS was functioning as one agency, not siloed, separate departments and divisions. Integrating Family Services (IFS) is how we describe the set of strategies being employed to achieve this goal. IFS is focused on promoting and sustaining collaborative leadership and decision making, among other areas of focus. These efforts are taking place both internally and in our AHS regions, and tie together AHS providers focused on the social determinants of health. It also supports the ongoing expansion of the use of coordinated service planning as a proactive tool to help teams work together with the family as the driver.

The goal of IFS from a service delivery and payment reform perspective, is to move from a “waiting until things were bad enough” to a more upstream and proactive approach. This is achievable with an upfront investment in prevention and promotion. However, the current fee-for-service structure as well as other existing payment models do not support achieving this shift. Due to the reality of the funding streams supporting treatment and intervention, IFS moved to creating a payment model that would provide some flexibility to be responsive to the continuum of needs existing within each region. Our hypothesis was that paying differently may create some funding room which would create that ability to slowly shift to more upfront services. There was no expectation or belief that IFS was going to provide all services for all needs or could solve the resource challenges. The pressure on the system had been growing for some time partly due to chronic underfunding and partly due to increased recognition of what children and families needed. The push to move forward with an IFS pilot was partly because the evidence and research direction (early childhood, ACE, social determinants) was telling us this was the right and because many of the reports commissioned by AHS or others told us this shift was necessary due to the frustration of families, providers and state workforce.

The initial IFS implementation site in Addison County started in July 2012 and the second pilot region in Franklin/ Grand Isle counties started in April 1, 2014. The initial pilot included consolidation of over 30 state and federal funding streams through one master grant agreement. The second pilot also included consolidation of multiple state and federal funding streams. This created a seamless system of care to help ensure there is no duplication of services for children and families.

The IFS model requires high levels of communication and collaboration. Several internal teams meet regularly to help assure the various divisions within the Agency work together to move the Agency’s integration agenda forward as it relates to children and families. These IFS teams are integral to the change process, as they represent the Agency’s diverse perspectives, and assure proposed integration efforts make sense, and take into consideration resource constraints, internal priorities, federal and state mandates, and other practicalities.

Several AHS regions are actively working toward becoming “IFS-ready” in FY17. These regions are creating formal collaborative relationships and decision making processes. Becoming an IFS region means that, as a group of state and community providers, the region:

- has an operating agreement that includes details such as who has a seat at the table, and how youth and family voice will be included in its decision making;*

- *commits its combined and collective resources through an annual work plan intended to bend the curve on the IFS population indicators, and reports annually to the state on its impact on those indicators;*
- *responds to state surveys on the functioning of the leadership team;*
- *creates a supportive and respectful environment for each member of the regional team to share performance level data on an annual basis; and*
- *demonstrates how resources are consolidated and shared to improve services for children and families.*

For the past two years, the State Interagency Team has hosted a state-wide event for all Local Interagency Teams to come together. At the 2nd annual event in November 2016, both the Secretary of Agency of Human Services and the Secretary of the Agency of Education opened the event by talking about their collaborations and priority areas for Vermont's children, youth and families. This event will continue to occur on an annual basis and be hosted by the SIT.

3. Urge the State Interagency Team (SIT) to create and publish a Statewide System of Care Plan, including attention to transition-age youth 18-22 years old by December 1, 2016.

SIT Response:

Report submitted in December 2016 in response to this request.

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

- Promote participation on state and regional IFS advisory groups and work groups.
- Ensure all state Agencies and Departments carry out practices for capturing and incorporating family and youth voice.
- Include a Family Representative on the Medicaid Advisory Committee by October 1, 2016.

In an effort to increase collaboration and communication, the IFS Director attends monthly Act 264 Board meetings and coordinates SIT. These responsibilities enable IFS to get input from family voice, provide updates to the Act 264 Board and to collaborate on efforts for data collection from LIT's and analysis of the strengths and challenges present in Vermont's System of Care.

An IFS workgroup was launched in November 2016 to focus on Partnering with Youth and Families. This group is being co-chaired by Cindy Tabor, Vermont Federation of Families for Children's Mental Health (VFFCMH) and Cheryle Bilodeau, IFS Director. This workgroup will focus on developing an AHS framework for partnering with youth and families. There are two components to this issue of partnering:

- how service providers and staff work with children, youth and families, for example, what it means to put families at the center of our work using a two-generation approach; and
- how we embed youth and family voice in our central and regional decision making processes.

The expectation is that this workgroup will emerge from its process at the end of February 2017, with some significant recommendations about how as an Agency we support and sustain parent and youth voice in our processes.

Additional support occurring at the state and local level to promote family inclusion:

- Both IFS regions (Franklin/Grand Isle and Addison) have continued to support family voice under Act 264/LIT. The commitment to authentic family voice being part of their IFS Regional Core Teams is evident by them providing financial support to the Federation to hire parent representatives to ensure they have family voice at their planning tables and family representatives available to parents in LIT meetings.
- Agency of Education: Every two years since 1993, the Department of Health and the Agency of Education's Coordinated School Health Programs have sponsored the Vermont Youth Risk Behavior Survey (YRBS) to measure the prevalence of behaviors that contribute to the leading causes of death, disease and injury among youth.
- Fall 2016: The Department of Health, Alcohol and Drug Abuse Programs (ADAP) conducted a study in Lamoille County to assess what systems of care were available for youth in their community needing substance abuse treatment. One part of the study included conducting a focus group with adolescents in Lamoille County to get their feedback about substance abuse treatment in their community. ADAP is using the information gathered in this process to assess the needs of adolescents and to take into account their experiences. ADAP will continue to engage youth in the development of substance use education, prevention and treatment programs.
- During the winter of 2016/2017, the Vermont Federation of Families for Children's Mental Health will be calling family members who have a child/youth placed in a residential placement to help inform statewide planning on how best to build up community-based services so children, youth and families have access to the supports and services they need close to home.

The Medicaid Advisory Committee has made steps to ensure family voice is present as well by:

- VFFCMH has been an informal member on this committee and is working towards becoming a formal full-time member.
- Vermont Family Network is represented and brings a policy lens to this group.

5. 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.

SIT Response:

The Vermont Federation of Families for Children's Mental Health (VFFCMH) will provide ongoing training and technical assistance regarding the role of Parent Representatives on Local Interagency Teams. Goals for VFFCMH:

- 1. enhance the role of Local Interagency Team (LIT) Parent Representatives; and*
- 2. offer support for Local Interagency Teams around their needs of the Parent Representative role.*

This will include the following actions:

- VFFCMH will provide technical assistance to the Parent Representatives and LITs to help with implementation of the parent representative role.*
- VFFCMH will assist those regions that do not have a Parent Representative to find one for the LIT team. This will involve recruitment, assessment of competencies, collaboration with LIT leadership for approval of the position, and consultation with SIT to address barriers to securing Parent Representatives for all regions.*
- VFFCMH will hold a training day for Parent Representatives up to two times in the fiscal year.*
- VFFCMH will explore new opportunities to promoting sharing of challenges and solutions among Parent Representatives.*
- VFFCMH will continue to provide outreach and technical assistance to other parent and family advocacy organizations around Coordinated Service Plans.*
- VFFCMH will partner on development of Integrating Family Services (IFS) implementation and products to share a parent and family perspective and "voice" with this initiative.*
- VFFCMH will collaborate with related statewide initiatives to ensure effective coordination of services for children, youth, and families.*
- VFFCMH brochure was updated and given to LIT's for distribution for outreach.*

IFS has articulated a commitment to family and youth engagement as one of the core practice principles. This commitment has not yet made its way into AHS budgets in any substantive and sustainable way as DMH is the only department providing funding. A workgroup was launched in September 2016 co-chaired by IFS and the VFFCMH to define the state's approach to family and youth engagement and a plan for how we will sustain it. This workgroup will conclude in February 2017 and will have at that time a completed framework that includes the philosophy and values of family/youth partnership, language that identifies the commitments agencies

have made to family/youth partnership and identified outcomes for ensuring there is a consistent approach and performance measures to ensure continuous quality improvement.

VT had a statewide Peer Navigation grant 2004-2010 with Navigators in every region. VFFCMH supervised 7 navigators, VFN supervised 4 and Rutland Health supervised 1. A new consortium, VT Coalition for Family Empowerment applied for the NDLR grant that would cover much of the state with part time Parent Support Providers. VFFCMH took the lead as the applying organization. If funded this work begins October 2016. VFFCMH is committed to look for sustainability by seeking out Medicaid reimbursement for youth & family peer supports.

UPDATE: VFFCMH did not receive this grant.

System of Care Priorities for FY17 and FY18

The following are the recommendation from the State Interagency Team after reviewing the data provided in this report. **As well, 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
1	<p>Support statewide integration of services as envisioned by IFS through reinvigorating and resourcing Act 264 statutory mandates.</p>	<ul style="list-style-type: none"> 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 development issues at DA's and SSA's. Currently, several within the state are struggling with work force issues related to the hiring of direct care workers. h. Discuss and explore ways to support the Act 264 Board more fully.
2	<p>Focus on the number of children and youth in residential placements.</p> <p><i>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</i></p>	<ul style="list-style-type: none"> 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. e. Develop funding streams that support flexibility in the delivery and intensity of supports and services.

	<i>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 towards improving caregiver readiness.</i>	f. Analyze data related to trend lines in residential care to identify policy and practice shifts that need to occur to support vision.
3	Identify and advocate for additional resources in community agencies.	<ul style="list-style-type: none"> 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 H) 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 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.	<ul style="list-style-type: none"> a. Continue to work with broader system reform (Medicaid Pathway; All Payer Model; Accountable Health Communities)
5	Support funding for family and youth partnership to be a shared responsibility of all AHS Departments.	<ul style="list-style-type: none"> a. Define the Family/youth partnership framework: <ul style="list-style-type: none"> i. 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; ii. Define outcomes; and iii. 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 (see Appendix I) and the fact that education begins for children in Vermont at age three.	<ul style="list-style-type: none"> 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.

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

<p>Barre District Amy Lincoln Moore PO Box 181 East Montpelier, VT 05651 (c) 802-233-6197 Amylm1965@gmail.com</p>	<p>Bennington District Vacant</p>
<p>Burlington District Connie Simendinger VFN 600 Blair Park Road, Suite 240 Williston, VT 05495 800-800-4005 x211 Connie.Simendinger@vtfn.org</p>	<p>Burlington District Janice Sabett VFN 600 Blair Park Road, Suite 240 Williston, VT 05494 800-800-4005 x218 Janice.Sabett@vtfn.org</p>
<p>Brattleboro District Vacant</p>	<p>Hartford Vacant</p>
<p>Middlebury District Vacant</p>	<p>Morrisville District Donna Sherlaw PO Box 938 Morrisville, VT 05661 (c) 802-498-3071 lamoillenavigator@yahoo.com</p>
<p>Newport District Vacant</p>	<p>Rutland District Cinn Smith 711 West Street Fair Haven, VT 05743 (h)802-265-2014 (c)802-353-6817 cinna@together.net</p>
<p>St. Albans District Nina Ward 802-524-0886 meandmy5boysomg@myfairpoint.net</p>	<p>St. Johnsbury District Donna Conley P.O. Box 687 North Concord, VT 05858-0687 (c) 802-461-6984 Conleygd89@charter.net</p>
<p>Springfield District Linda Batchelder 6 Hillside Road Springfield, VT 05156 (h) 802-886-2485 (c) 802-376-8787 Linbatch@yahoo.com</p>	<p>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</p>

Appendix C: State Interagency Team

<p>Cheryle Bilodeau, SIT Coordinator Integrating Family Services AHS Secretary's Office Cheryle.Bilodeau@vermont.gov (802) 760-9171</p>	<p>Alicia Hanrahan Agency of Education Alicia.hanrahan@vermont.gov (802) 479-1206</p>
<p>Charlie Biss Laurel Omland Child, Adolescent & Family Unit Department of Mental Health charlie.biss@vermont.gov (802) 241-0152 laurel.omland@vermont.gov (802) 241-0162</p>	<p>Barb Joyal Melanie D'Amico Family Services Division Department for Children and Families Barbara.Joyal@vermont.gov (802) 760-0599 Melanie.DAmico@vermont.gov (802) -793-2416</p>
<p>Diane Bugbee Clare McFadden Developmental Disabilities Services Division Department of Disabilities, Aging & Independent Living Diane.Bugbee@vermont.gov (802) 871-3367 Clare.McFadden@vermont.gov 802-871-3062 office/802-585-5396 cell</p>	<p>Kathy Holsopple Cindy Tabor Amy Lincoln Moore VT Federation of Families for Children's Mental Health kholsoption@vffcmh.org ctabor@vffcmh.org almoore@vffcmh.org (802) 876-7021</p>
<p>Pam McCarthy VT Family Network Family Support Consultants pam.mccarthy@vtfn.org (802) 782-1495</p>	<p>Amy Danielson Division of Alcohol and Drug Abuse Department of Health Amy.Danielson@vermont.gov (802) 651-1557</p>
<p>Monica Ogelby Maternal Child Health Department of Health Monica.ogelby@vermont.gov (802) 658-1329</p>	<p>Will Eberle Agency of Human Services, Central Office Field Director Will.Eberle@vermont.gov (802) 760-8741</p>
Members for Specific Discussions	
<p>Division of Vocational Rehabilitation Dept. of Disabilities, Aging & Independent Living</p>	
<p>Reeva Murphy Child Development Division Department for Children and Families Reeva.murphy@vermont.gov (802) 769-6420</p>	

Appendix D: Statewide Act 264 Parent Representative Plan 2016

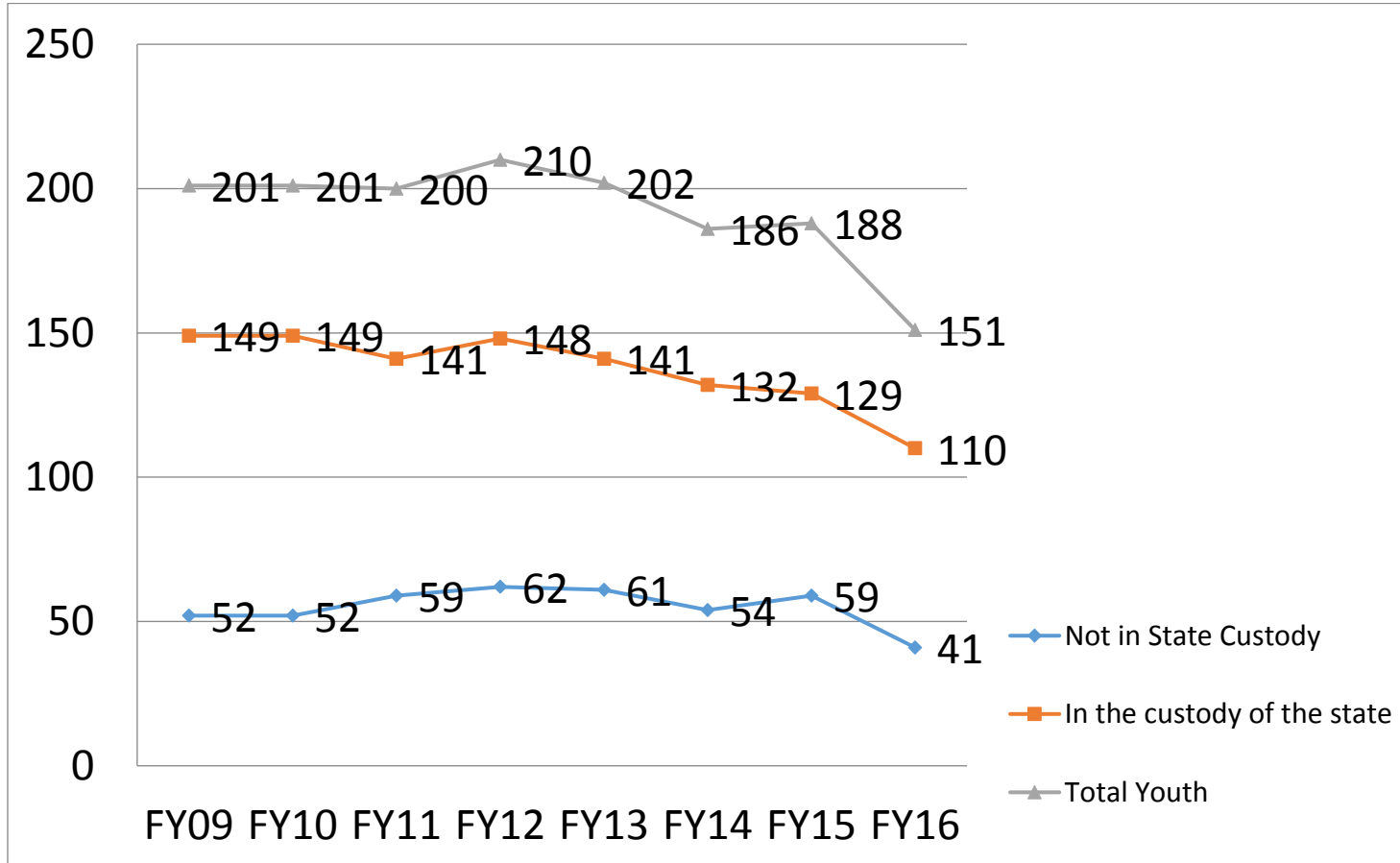
- Goal 1 – Provide two parent representative trainings per year
- Goal 2 – Increase # of stipend payments to parent representatives
- Goal 3- Formalize a structured orientation and training for new parent representatives
- Goal 4 – Increase parent representative to all 12 AHS Regions.
- Goal 5 – Increase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

Number of CSP's per Fiscal Year attended by LIT Parent Representative

REGION	FY 14/15		FY 15/16	
	#'s	Cost	#'s	Cost
Barre	34	\$ 1,621.91	98	\$ 4,248.14
Bennington	3	\$ 254.63	0	\$ 113.80
Burlington	16	\$ -	20	\$ -
Brattleboro			1	\$ -
Hartford	0	\$ 365.71	2	\$ -
Middlebury	18	\$ 858.45	23	\$ 1,768.17
Morrisville	25	\$ 1,681.30	39	\$ 2,705.98
Newport				
Rutland	18	\$ 1,058.87	60	\$ 3,514.27
St Albans				
St Johnsbury			0	\$ 175.28
Springfield	0	\$ 110.92	0	\$ 143.20
Totals	114	\$ 5,951.79	243	\$ 12,668.84

** FY 14/15 is only half the year data
 **Burlington gives data for CSP's , although is not reimbursed as she is a VFN staff
 ** If a region has no CSP's listed but there is a cost, that means PR is attending LITS only and not CSPS
 ** If a region has CSP's Listed, with no cost, that means another PR went to that region to do it

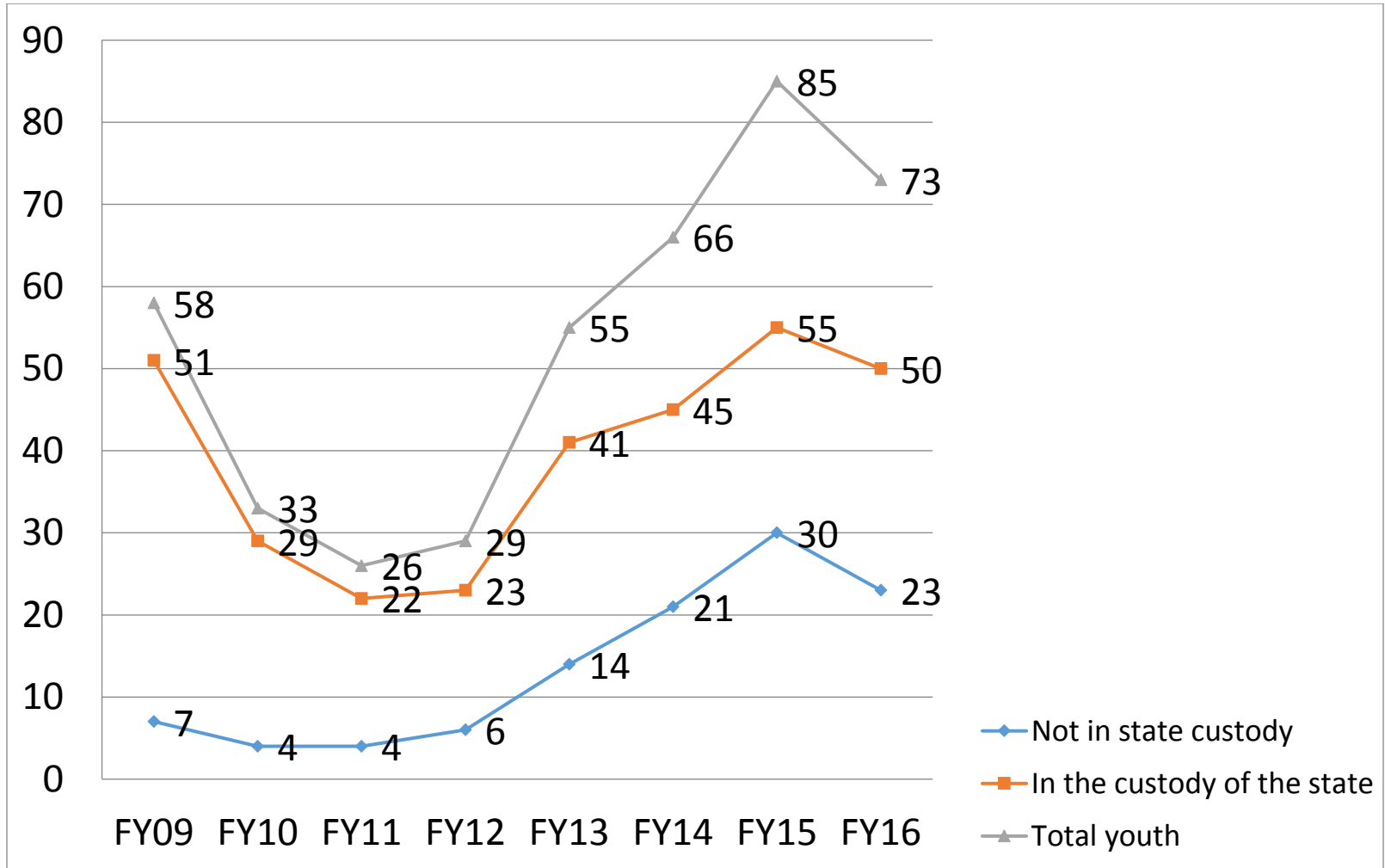
Appendix E: Children and Youth in Residential Care—In VERMONT



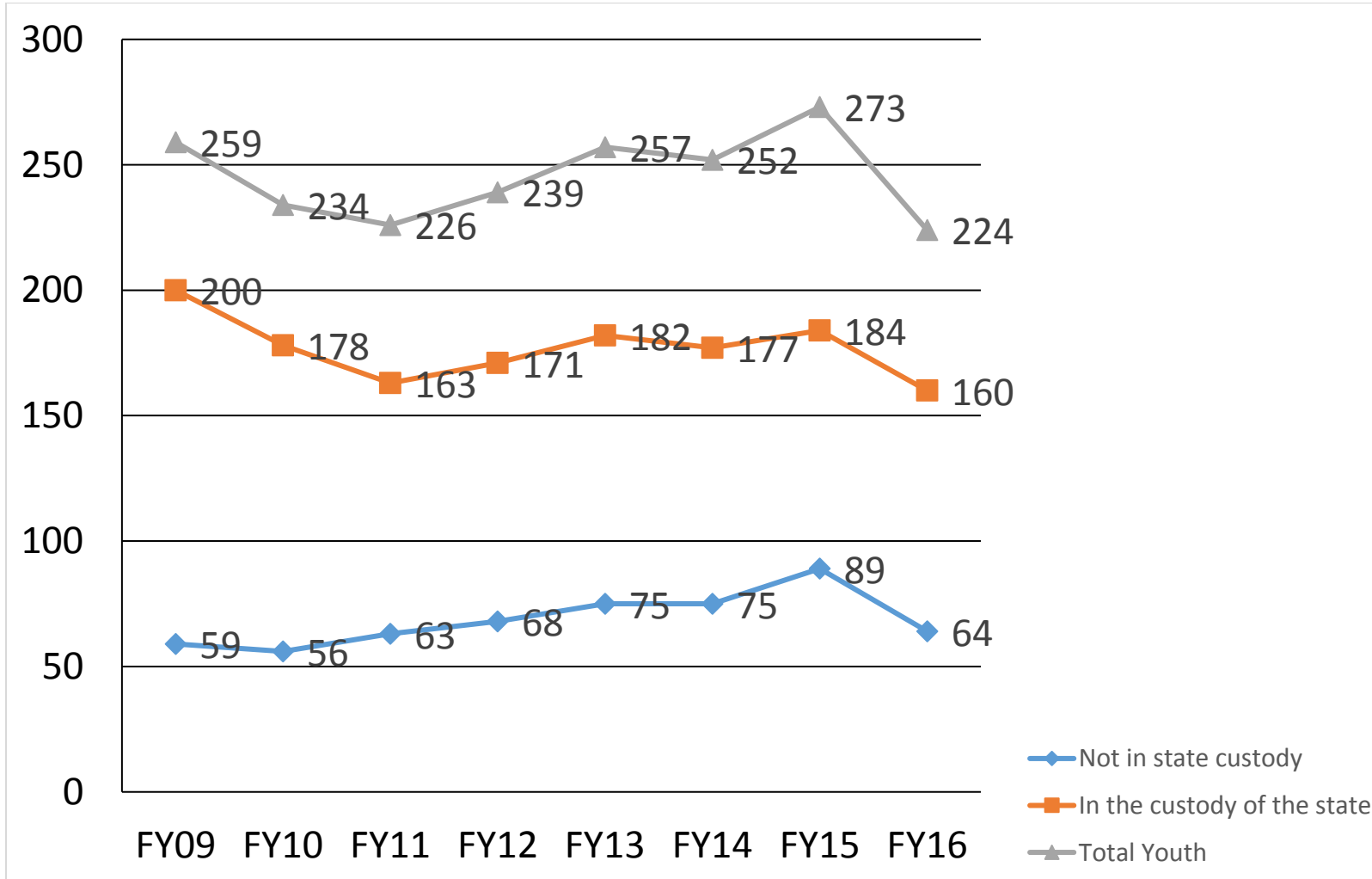
In the custody of the state is the number of **youth in residential placement as of the last day of the fiscal year.*

Not in state's custody is the number of **placements during the entire FY which means a youth may be counted more than once if they were admitted and discharged to a program(s).*

Appendix F: Children and Youth in Residential Care—OUT OF STATE PLACEMENTS

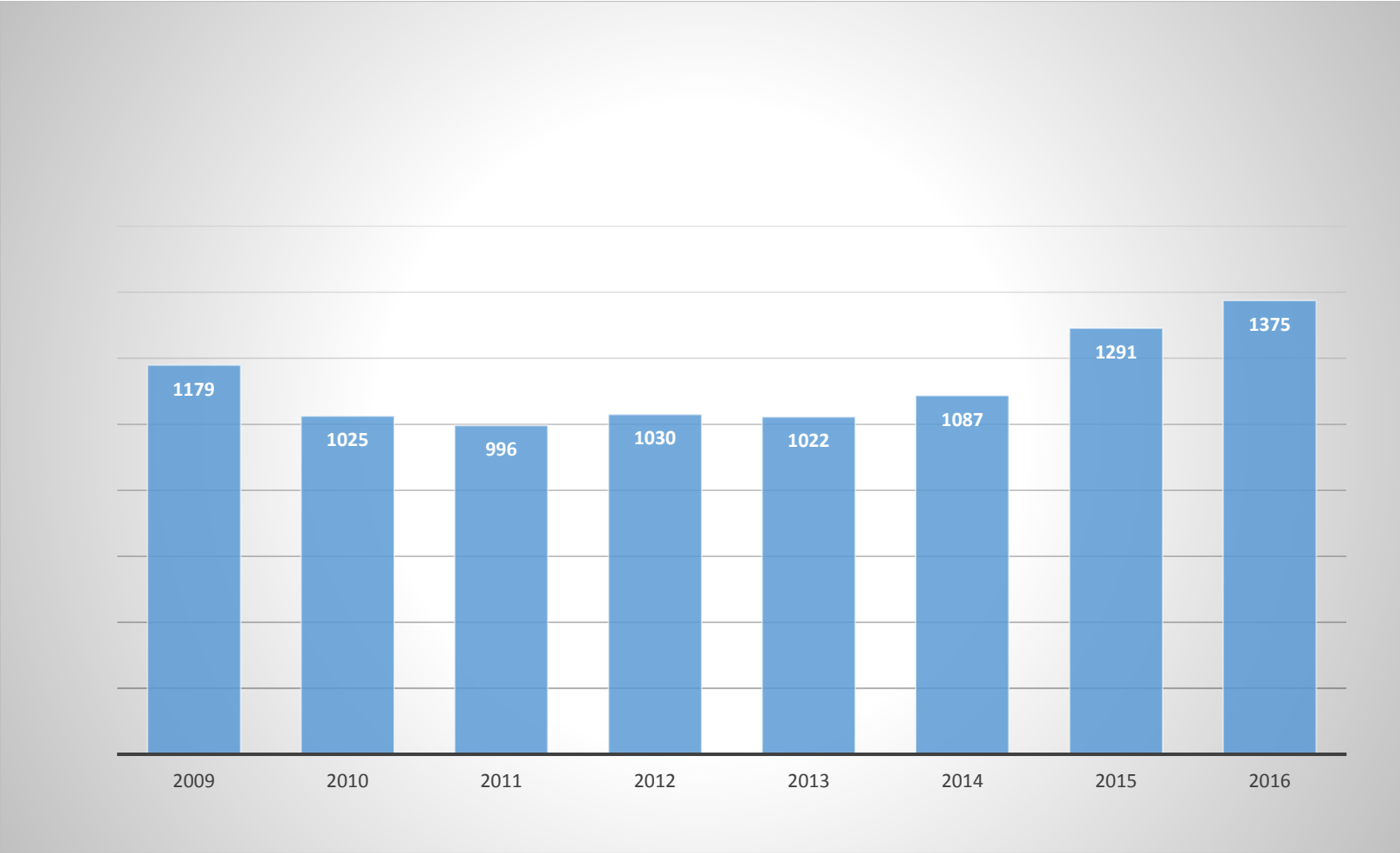


Appendix G: Total Children and Youth in Residential Placements



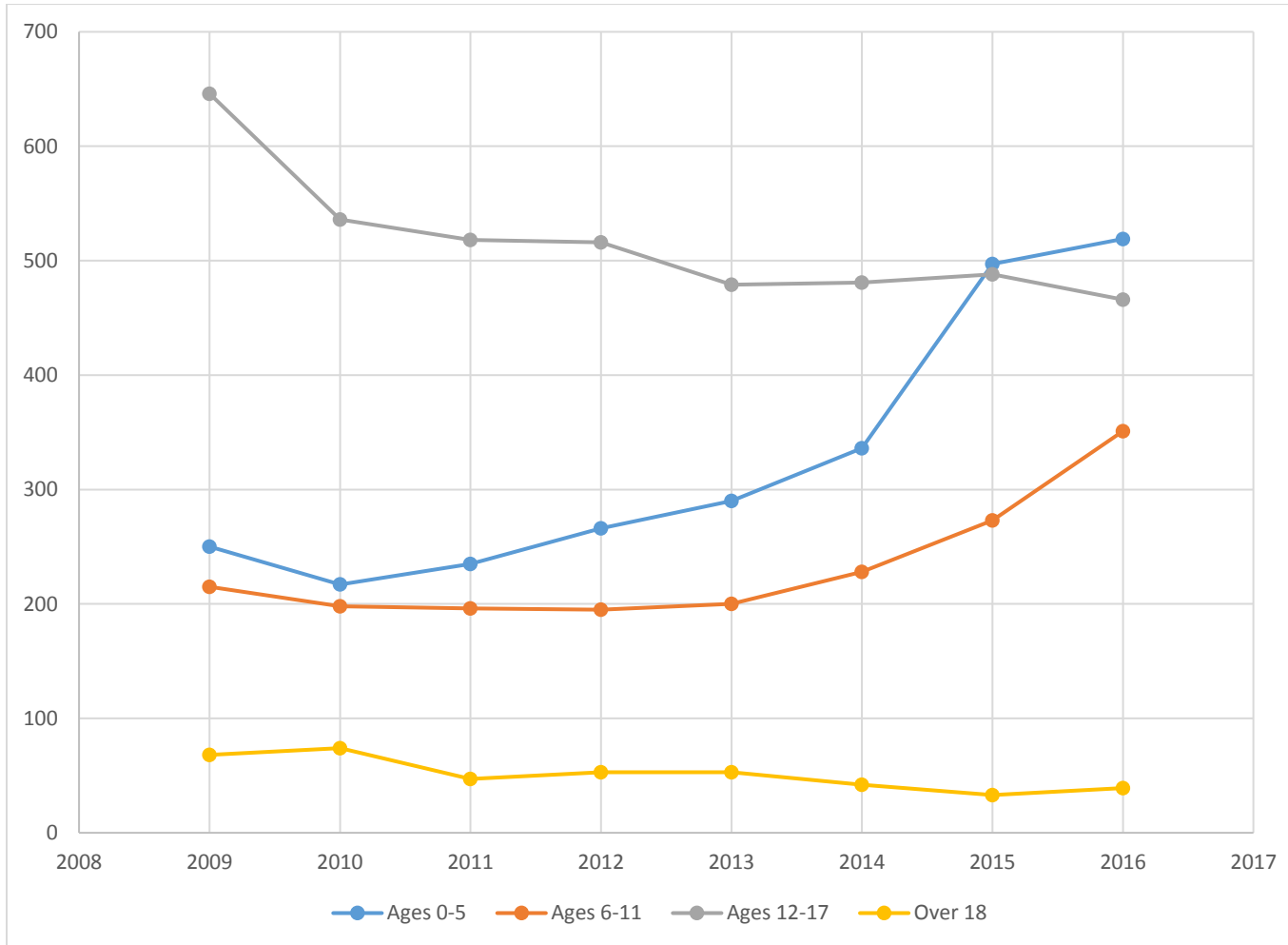
Appendix H: Children and Youth in DCF Custody

As of June 30th of each year



Appendix I: Children in DCF Custody by Age Group

As of June 30th of each year



Appendix J: 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 Human Services, Strategic Plan:

<http://humanservices.vermont.gov/strategic-plan/one-agency-strategic-plan-january-2016-january-2019/view>

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>

DAIL System of Care Plan: Vermont State System of Care Plan for Developmental Disabilities Services FY 2015-FY 2017: <http://www.ddas.vermont.gov/ddas-policies/policies-dds/policies-dds-documents/policies-dds-documents-soc-plans/socp-fy-15-17>

Developmental Disabilities Services State Fiscal Year 2015 Annual

Report: <http://dail.vermont.gov/dail-statutes/legislative-testimony-2016/dev-disabilities-services-divison-annual-report-fy15>

DMH Stats Report, FY2015:

http://mentalhealth.vermont.gov/sites/dmh/files/documents/oversight/DMH-2015_Statistical_Report.pdf

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

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