SUMMARY OF REGIONAL STRATEGIES

FOR IMPLEMENTATION OF

VERMONT'S YOUTH IN TRANSITION GRANT

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SUMMARY OF REGIONAL YIT STRATEGIES

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SUMMARY OF REGIONAL YIT STRATEGIES

GENERAL EXPECTATIONS

Regional sub-grants to implement Projects for Young Adults in Transition are for strengthening the system of care and expanding behavioral health services for young adults of transition-age (16-21, inclusive, and their families/adult allies) who are experiencing serious emotional disturbance (SED). The Projects must:

1. Address Vermont State Outcome #7: "Youth Successfully Transition to Adulthood" and the following goal: **Vermont's young adults of transition-age with SED will have adequate preparation and the necessary supports to be productively engaged in the community and free from incarceration.**
2. Build consensus among different stakeholders in the systems of care about reasonable expectations for young adults of transition-age with mental health and/or co-occurring substance abuse challenges and services/supports to help them.
3. Reach out to young adults with SED who are out-of-school at least through teen centers, recovery centers, homeless youth programs, and by intercepting them at critical intervention points with the juvenile and criminal justice systems.
4. Improve access to mental health services for the young adults most at risk for poor outcomes and use the power of the courts to increase their likelihood of use of those services.
5. **Provide cross-system case management and individualized service plan development, ensuring that young adults are engaged in planning for their own futures.**
6. Link and/or provide young adults and their families/adult allies with:
   - Access to health care (including insurance and especially for co-occurring mental health and substance abuse treatment)
   - Post-secondary education (also training, and options for completing high school)
   - Employment
   - Housing (safe, stable, and adequate)[1], and
   - Caring relationships (with adults who nurture positive youth development).

   Making these linkages requires efforts to integrate AHS services for young adults of transition-age and to collaborate with other public and private service (including housing) providers, substance abuse prevention coalitions, Workforce Investment Boards, law enforcement, and criminal and juvenile justice officials.
7. **Adopt one or more evidence-based practices that are consistent with and build upon the JOBS program in the region.**
8. Respond competently to the cultures and languages of young adults and their families/adult allies.
9. Deliver in-service training and mentoring to assure a skilled workforce of front-line staff and supervisors.
10. Cooperate with the required National and State Evaluation Studies, including collect data for the Common Study.
11. Operate in accordance with continuing input from key stakeholders (including youth and family members) within the regional systems of care.

[1] Though the federal grant funds cannot be used to pay for housing per se, they can be used for the service coordination and community supports that may make it possible for youth to stay in housing.

ADDISON REGIONAL PLAN

The Addison County Project for Young Adults in Transition will meet these general expectations through use of the following strategies:

1. Hire a part-time **Peer Outreach Worker** to:
   a. be a voice and support for young adults throughout these implementation activities;
   b. coordinate and facilitate the Young Adult Advisory Board;
   c. be present in the community where young adults congregate to build relationships and offer information and referral;
   d. when requested, advocate at Act 264 and treatment team meetings to support and assist youth and young adults in the Coordinated Services Plan process;
   e. help organize leadership activities for/by young adults;
   f. represent the Young Adult Advisory Board on the Young Adult Services Council.

2. Identify, establish and utilize a **Young Adult Advisory Board.**
   a. Its primary role will be to work with the Addison County LIT and the Young Adult Services Council in order to further develop an appropriate System of Care for this population and to develop leadership among young adults.
   b. Stipends will be made available to support young adult participation on this Board.
   c. The mission of the Young Adult Advisory Board shall be authored by the participating young adults but may include guiding the LIT Team and the Young Adult Services Council in "Increasing Awareness and Reducing Stigma" by promoting and marketing young adult involvement, what it is, how to do it, and what the benefits of young adult involvement are for other young adults, service providers and the community.
   d. Responsibilities of the Board members shall include:
      - ❖ Consistently including the voice of young adults in defining the direction of service delivery.
      - ❖ Serving as trainers or presenters to teach students/service professionals what is important about engaging and serving young adults.

3. Collaborate with the current system of care by recruiting and hiring a dedicated **Young Adult Advocate** in order to provide a tangible, familiar connection and/or *case management service* for young adults. Primary job functions will include:
   a. Supervise and effectively utilize the Peer Outreach Worker;
   b. With Peer Outreach Worker, conduct outreach to and build leadership among young adults;
   c. Work with individual young adults to identify a "Team" and build a Coordinated Service Plan that addresses their expressed and revealed individualized needs.
   d. Schedule and facilitate, when appropriate, service provider team meetings, modeling the 264 process.
   e. Maintain a caseload of a minimum of 15 young adults for a period of not longer than one year per person.
   f. Complete required data collection and evaluation activities.
   g. Facilitate a community process to clarify the local system of care and develop corresponding MOU's, identify area resources and work towards service development for young adults in transition.

4. Form a **Young Adult Services Council** as a subcommittee of the LIT.
   a. The Young Adult Advocate will facilitate monthly meetings.

b. The Peer Outreach Worker will participate in the Council.
c. The Council will strengthen the system of care by:
    - ✓ Educating the community on the role and associated benefits of this project.
    - ✓ Strengthening coordination at key intercept points (Court system, etc.).
    - ✓ Offering county-wide training opportunities to service providers.

5. The Young Adult Services Council, with the help of the Young Adult Advisory Board, Young Adult Advocate, and Peer Outreach Worker will Infuse **cultural and linguistic competence** into the key human services systems and programs within Addison County as follows:
    a. Develop a partnership with the local Migrant Worker Coalition.
    b. Advocate for the design and delivery of services and supports to meet the needs of culturally and linguistically diverse groups (e.g., family-guided and community-based; flexible times, service hours; language access services; non- traditional therapeutic practice, culture-specific assessments, interventions and treatment)
    c. Conduct training on the use of appropriate strategies to address barriers to the design and delivery of culturally and linguistically competent interventions, services, and supports (e.g., staff attitude and manner, service hours, service location, language, insurance, lack of awareness about systems of care principles and practices including failure to consider family, lack of knowledge about diverse cultural groups, fear and distrust of the service system, stigma associated with social-emotional and behavioral disorders or mental illness)
    d. Utilize outreach to eliminate racial and ethnic disparities among other young adults experiencing social-emotional and behavioral disorders or mental illness
    e. Evaluate the quality of outreach, interventions, services, and supports by incorporating into the Coordinated Services Planning process the use of family and youth/young adult satisfaction surveys.

6. The Young Adult Advocate, in conjunction with the CSAC Youth and Family Director and with input from the Peer Outreach Worker, will manage a pool of available dollars to meet the needs of young adults that cannot be funded from other sources.
    a. Use of the funds will focus on addressing basic needs and barriers to accessing services.
    b. Young adults must request these **flexible funds** through an application process.

BENNINGTON REGIONAL PLAN

Implementation of the Bennington Youth in Transition (YIT) Plan will meet these general expectations through use of the following strategies:

Youth Outreach Program
Using the principles of Sequential Intercept Model and the TIPS Model, the Bennington Region will build upon the success of the UCS JOBS and Transitional Living Programs by creating a Youth Outreach Program.

The Youth Outreach Program will consist of one full time Youth Outreach Coordinator and two to three part time Youth Outreach Workers. The program will be housed with the JOBS and Transitional Living Program staff and supervised by the JOBS manager. This is a natural connection and will provide system continuity among services that are being provided.

The two primary focus areas of the Youth Outreach Program are **outreach** to young people and **enhancing the existing system of care**:

1. Outreach

Target population: The program will outreach to young people who are SED, dropped out of school (or at significant risk of dropping out) and at risk of moving deeper into the criminal justice systems. Initially the program will focus on transition age youth residing in the towns that are part of the Southwest Vermont Supervisory Union (SVSU) (The SVSU consists of towns with the greatest number of youth who did not graduate from high school, highest teen pregnancy rate, highest incarceration rate, and highest rate of youth living in poverty. Over the course of the grant, the Youth Outreach Coordinator will make a concerted effort to reach out to the North Shire community.)

Goals: The goals of the outreach component of the program are twofold: Skill development and the feeling of belonging for both the youth outreach worker and the program participant. It is anticipated that program participants will develop the knowledge, skills and attitudes that will allow some of them to successfully move into a Youth Outreach Worker position.

a) Youth Outreach Coordinator

The Youth Outreach Program will employ a Youth Outreach Coordinator who will seek out transition age youth and young adults who have been identified by the community as at risk, develop a supportive relationship, build a strength based plan, connect them with services as needed, and connect them with a positive peer group or mentor either through a Youth Outreach Worker or the Youth Advisory Council. The Youth Outreach Coordinator will also:

- Develop positive connections with community partners
- Create a Youth Services Council.
- Develop a training program for the Youth Outreach Workers. The training program will include information on community resources, mediation skills, and ethics.
- Provide on-going supervision to the Youth Outreach Workers.
- Work directly with youth and young adults to assure positive connections with services and community.
- Work to develop a mentor program to increase positive peer supports
- Develop a protocol to ensure that there is a strategy to engage new youth workers after a specified period of service.
- Will support the Youth Advisory Council.

b) Youth Advisory Council

The Youth Advisory Council will be made up of a group of young people who are in the process of transitioning or have transitioned to adulthood who have worked or who are working with Mental Health, Substance Abuse, and/or Criminal Justice systems. The Youth Advisory Council will act as a consultation team to the Outreach Program, create social and recreational opportunities for young people in the community, and work to increase the youth voice within the Bennington County community and local civic organizations. The Youth Advisory Council will work to develop its own system and protocol with guidance from the Youth Outreach Coordinator.

c) Youth Outreach Workers

The Youth Outreach Coordinator will work with the Council to identify 2-3 part time Youth Outreach Workers who have worked within the system of care and are in recovery. The Youth Outreach Workers (YOW's) will be hired on a part-time short-term basis and paid a stipend for their work. The goal is to train the YOW's as paid peer mentors, work with young people for up

to a year at which time other young people on the council will be identified as YOW's and trained as paid supports. This rotation will continue throughout the grant cycle.

Youth Outreach Workers will develop a productive relationship with an at-risk youth and use their own experiences to support them by building a positive peer relationship and work toward identified goals. They will work to ensure appropriate community supports (like health insurance, a medical and dental home, etc.) are identified and in place for the young adult. They will provide a positive peer group for program participants both individually and in group and social situations.

The graduating Youth Outreach Worker will develop the appropriate knowledge, skills, and attitudes to successfully attain their own stated personal goals. The "graduating" YOW will mentor the new Youth Outreach Worker during a transition period as they move out of the position and the new worker moves into the position.

2. Enhance the Existing System of Care

The Youth Coordinator will identify and interface with the current youth systems such as School, Family Services, Center for Restorative Justice, Sunrise, Department of Labor, Adult Education, DOC, Police, the Juvenile Justice Team, and other youth serving entities to continue the process of developing a more coordinated system of care. This coordinated effort will result in the development of the Youth Services Council (YSC).

a) Youth Services Council (YSC)

The primary goal and mission of the Youth Services Council is to develop a coordinated system of care for transition age youth and young adults paying particular attention to those who are SED. The Youth Services Council will work with the Youth in Transition Regional Plan developed by the community to help build on the strengths of the plan and identify ways of filling the service gaps. The Youth Outreach Coordinator or his or her designee and a Youth Outreach Worker will co-facilitate the YSC. The YSC may become an extension of the Local Interagency Team (LIT) as a way to better incorporate various systems (the Local Interagency Team will oversee the Youth in Transition Grant).

b) Youth Summits

The Youth Outreach Coordinator will plan and facilitate additional summits on youth during the grant period. The summits will work to identify and deal with larger community issues affecting successful transition to adulthood. The summits will enhance a community system of care and work toward identifying situations that impact youth. The focus will be to develop a collaborative method of addressing the identified issues; particularly those acknowledged in the community plan and enhance the work of the YSC.

c) System Efficiency

It is in the identification of service redundancy and the realization that services are often disjointed that the planning team feels it can make the most difference in developing a more cohesive, efficient system of care for transitioning young adults. For instance, one area of overlap identified was that of the skills development groups offered by the various independent living programs, for example, Transitional Living, Youth Development, Teen Housing Options programs and others. Each program offers transitional living skills development groups that are required as part of their programs. It is suggested that the facilitators of the groups work together to identify a common curriculum and divide up the facilitation process in order to make the system more efficient and share limited resources. The YIT funding will allow this type of system work to begin.

CALEDONIA/SO. ESSEX (CSE) REGIONAL PLAN

The Caledonia/So. Essex (CSE) Plan for Young Adults in Transition will meet these general expectations. The CSE LIT vision is to better meet the individual needs of youth and young adults through open and thoughtful dialogue in collaboration with them, significant people in their lives and potential service providers. The LIT will use the following strategies to accomplish two general objectives:

- To reduce the number of young adults entering the criminal justice system in conjunction with the Sequential Intercept Model's (SIM) 5 Intercepts; and
- To increase the number of young adults who successfully gain skills, knowledge, and the ability to live successful, independent lives through an Independent Life Plan designed by them with help from the Transition Facilitator.

1. Transition Facilitator

Youth and young adults will be engaged by a Transition Facilitator who will work out of the Northeast Kingdom Youth Services (NEKYS) Living Room on Bagley Street in St. Johnsbury. Free to all youth age 15 through 21, NEKYS Living Room provides a safe place for youth to meet, talk and participate in positive and healthy recreational activities. Youth/young adults who frequent the Living Room serve as recruiters for others. The Living Room provides a peer to peer environment that will allow both the youth/young adults and the Transition Facilitator to develop their relationships slowly and at the comfort level of the youth/young adults. The Transition Facilitator will not be limited to this one center. In time he or she will travel to the Lunenburg and Gilman areas to further develop a location there to serve youth/young adults from Southern Essex County.

The evidence-supported Transition to Independence Process (TIP) System will be used to guide the work of the Transition Facilitator and as a checklist for the Local Interagency Team (LIT).

TIP Step 1. Engage young people through relationship development, person-centered planning, and a focus on their futures.
TIP Step 2. Tailor services and supports to be accessible, coordinated, appealing, developmentally-appropriate, and build on strengths to enable the young people to pursue their goals across all transition domains.
TIP Step 3. Acknowledge and develop personal choice and social responsibility with young people.
TIP Step 4. Ensure a safety-net of support by involving a young person's parents, family members, and other informal and formal key players.
TIP Step 5. Enhance young persons' competencies to assist them in achieving greater self-sufficiency and confidence.
TIP Step 6. Maintain an outcome focus in the TIP system at the young person, program, and community levels.
TIP Step 7. Involve young people, parents, and other community partners in the TIP system at the practice, program, and community levels.

2. Independent Life Plan (ILP)

With the LIT's Act 264 Coordinated Services Plans, the lead agency is the agency with the assigned case manager who assures that the plan is regularly reviewed and who serves as the agreed upon contact person if the Coordinated Services Plan needs to be adjusted. With this initiative, the lead agency will maintain this status but will also have the Transition Facilitator to

help build a positive life experience for youth/young adults that will help sustain outcomes from the services provided. And youth/young adults who are not already served by a lead agency may want to develop an Individual Life Plan (ILP), which will address domains similar to those of the LIT's Coordinated Services Plan. As youth/young adults are identified for services, they will receive information and be asked to sign a basic contract in which they agree to actively participate in the program and create their ILP. He/she will then work to design and complete the ILP with the assistance of the Transition Facilitator. The parent/guardian and/or other family members or adult allies will be asked to participate in the process if a youth/young adult agrees. Service providers who might be helpful will also be invited to participate in this process.

3. Youth/Young Adult Advisory Committee
The CSE LIT will create an advisory group comprised of youth/young adults who have successfully navigated the system, are familiar with services offered in the community, and/or who have had experience with educational programs. The group will, with technical assistance, develop its own guidelines and structure. The advisory group will be asked by the LIT to assist with advocating for system development, expansion, and evaluation -- and for reform of funding and policy to support a responsive, effective service system for young people in transition and their families. These activities will inform service providers and other community resources, also build leadership and a sense of community investment in youth/young adults.

4. Regional Training
The LIT will supplement the technical assistance and training provided at the State level about the Sequential Intercept and TIP Models. Some trainings being considered are about the Search Institute's 40 Developmental Assets and the Circle of Courage Model.

5. LIT Oversight
The CSE LIT will guide this regional plan, meeting monthly with the Transition Facilitator and quarterly with the young adult advisory board. With the help of the advisory board, the LIT will develop an 11th principle to guide its actions and encourage the creation of Individual Life Plans (ILPs) for youth/young adults served through this initiative. Northeast Kingdom Youth Services, the employer and the fiscal agent for this plan, is a member of the LIT.

CHITTENDEN REGIONAL PLAN

The Chittenden County Youth in Transition (YIT) Regional Plan will meet these general expectations through use of the following strategies:

Use of the TIP System
Chittenden County providers believe many of the programs and services available to transition-aged young adults with emotional or behavioral challenges currently reflect many of the values embodied by the TIP System. The providers also acknowledge there is much room for growth in developing a more fully operational TIP system. In developing and implementing each outcome and strategy, the following TIP guidelines will continue to focus and direct the work:

1. Person-centered planning is driven by the young person's interests, strengths, and cultural and familial values.
2. Services and supports must be tailored for each youth individually and must encompass all transition domains.
3. Services and supports need to be coordinated to provide continuity from the young person's perspective.
4. A safety net of support is provided by the young person's team.

5. Achieving greater independence requires the enhancement of the young person's competencies.
6. The TIP System must be outcome driven.

(TIP System Guidelines taken from "Transition to Adulthood: A Resource for Assisting Young People with Emotional or Behavioral Difficulties" by Hewitt B. Clark and Maryann Davis).

Outcome I: To improve the life skills of Chittenden County transition-age young adults, with a special focus on employment.

The plan includes a strategic expansion of key community services.

1. Strategy: Increase the capacity of the JOBS (Jump On Board for Success) Program, so more JOBS staff can be hired and more young adults can be served. (This strategy also relates to Outcome III).

Outcome II: To improve knowledge of, access to, and collaboration among, community resources: for young adults, parents/caregivers, and providers.

The plan builds greater access to services and supports in and beyond the immediate Burlington area.

1. Strategy: Develop an On-line Resource Center that is user friendly and accessible to people regardless of their ability to access transportation, to assist parents, young adults ages 16 to 21 years old, caregivers/parents, and community service providers to find out what existing community services and resources are available and how to access them.

Collaborative teams are working parallel to one another, and we need to join together, to creatively problem-solve on a systems level, as well as look at individual needs and challenges, for an improved system of care.

2. Strategy: Improve collaboration with existing housing and housing support programs to increase housing options for transition-age young adults.

3. Strategy: The YIT Leadership team will provide oversight and management for the Chittenden County YIT Plan.

Key components to successfully expanding access to services and supports for young adults and their families in Chittenden County will include more fully involving young people and their families in the implementation of Chittenden County's YIT Regional Plan. T hough our collaborative circles have increased and widened, we must create more room at these tables for young adults, parents, and for community providers and members.

4. Strategy: Young Adult Navigator positions will be created to provide assistance to young adults ages 16 to 21, within the target population, to secure information and connect to existing community services and resources, to ensure an informed and successful transition to adulthood.

5. Strategy: A Parent Navigator position will be created to provide assistance to parents/caregivers of transition-age young adults within the target population, to secure information and connect to existing community resources and services to receive support for themselves and to ensure their child's informed and successful transition to adulthood.

Outcome III: To improve and expand service delivery and service coordination for youth and families.

1. Strategy: All young people, ages 15 and older, who meet the criteria for a Coordinated Services Plan, will have a Transition Plan.

FRANKLIN/GRAND ISLE REGIONAL PLAN

The Franklin/Grand Isle Plan for Young Adults in Transition will meet these general expectations through use of the following strategies:

1. **Expand Interagency and Community Collaboration**

The Regional YIT Steering Committee envisions this grant as the beginning of a long-term collaboration between several local agencies to support youth in transition. The Committee will work with professionals and community members to form high functioning interdisciplinary teams and coordinated plans to meet youth in transitions' needs and achieve better outcomes. Three priorities to be addressed through this collaboration are:

a) a lack of knowledge of services (consumers and professionals didn't know about many existing resources),
b) inadequate transportation to reach transitional activities, and
c) a lack of housing for transition aged youth.

a) Knowledge of Services

Goal: Youth in transition will have knowledge of and understand the mental health services available to them in Franklin and Grand Isle counties. In addition, they will know how to access these services and will make referrals to their peers. An indicator for this outcome will be an increased number of referrals, and ultimately case loads, at the above listed local service agencies.

The Steering Committee will hold meetings at various locations and forums in the region to present pertinent information to youth in need of support and knowledge about services or connections to services. To do this, the Committee will interface with the J.O.B.S. program, NFI, Court Diversion, alternative schools, DCF, Franklin County Sheriff's Department, teen centers, Northwestern Medical Center, health care facilities, social service agencies, and alternative school programs.

Also, the Steering Committee will explore creating a drop-in center by forging agreements with the various public agencies and private businesses/citizens for in-kind donations of equipment, space, etc. Youth from across the region frequent downtown St. Albans, making it the most strategic place to establish a drop- in center. A drop-in center would allow the Youth in Transition Manager (see below) and J.O.B.S. Case Managers to reach youth who congregate in the downtown vicinity. The drop-in center will be a friendly environment where youth can come to talk, have a snack, and establish a connection with NCSS Adolescent Services staff. The center will serve as a place to inform possible clients about the available services. The drop-in center will be a site where professionals from various agencies can connect with youth.

b) Transportation

Goal: Youth in transition will have access to reliable, safe, accessible, and affordable transportation in all areas of Franklin and Grand Isle counties. Indicators for this outcome will be evidence that youth are missing fewer appointments at local service agencies and are able to retain jobs for longer periods of time.

The Steering Committee will work with Green Mountain Transit Agency (GMTA), Champlain Islanders Developing Essential Resources (CIDER), Department of Labor, and the United Way to explore establishing a new system of transportation for this population or increasing accessibility to existing resources. Options may include the purchase and staffing of a van to transport YIT to and from scheduled appointments and jobs, improved use of a volunteer driver system, or providing vouchers for and increasing access to existing bus services.

c) Housing

Goal: Youth in transition are better able to access temporary shelter on short notice or to secure and maintain permanent housing. An indicator that this is happening will be fewer calls to crisis hotlines, fewer youth sleeping in cars, fewer young people at Samaritan House shelter (staying for shorter periods of time) and possibly a reduced crime rate in this population.

The Steering Committee will work with the Franklin and Grand Isle Housing Solutions/Continuum of Care to explore a more comprehensive approach to solving the housing gap. Ideally, transitional housing will be available for participants to learn necessary skills and receive stabilization services so they become ready for a more permanent living situation.

2. **Network of Youth and Young Adults**

The Steering Committee will establish a network of youth and young adults throughout the region to inform the Committee what is and is not working. The Steering Committee will tap into the established Youth Council at Project Soar (a local alternative school) and speak with the staffs of teen centers, service providers and community members to recruit youth who would make strong advocates. Special attention will be paid to building a Network with the full range of diversity in the Franklin-Grand Island region, including participants from the Abenaki and Champlain Island communities. Youth and young adults will receive incentives and/or stipends for participating in the Steering Committee

3. Youth in Transition Manager, 1 FTE

A YIT Manager will be hired to carry out the decisions of the YIT Steering Committee. He/she will be overseen and managed by the existing Steering Committee and will:

- reach out to youth and young adults, disseminating information to them about services and opportunities throughout the community.
- spearhead the creation of the Youth and Young Adult Advisory Network.
- provide cross system case management for some young adults and refer others to the J.O.B.S. Case Managers.
- serve as liaison to and provide data for the required YIT Evaluation.
- make greater connections and collaborate with agencies, businesses and citizens.
- write a white paper about the resources allocated to transportation and housing for transition aged youth in the region.

LAMOILLE VALLEY REGIONAL PLAN

The Lamoille Valley Plan for Young Adults in Transition will meet these general expectations through use of the following strategies:

1). Lamoille Valley YIT Steering Committee: While the Local Interagency Team (LIT) will maintain general oversight for the YIT Plan, a Steering Committee of youth/young adults, family members and providers will be developed to ensure that collaborative activities occur as planned to progress toward the desired outcomes (see General Expectations above, page 3).

2). Grant Manager: The Lamoille Valley YIT Steering Committee will be supported by a 1-day per week grant manager who will organize and facilitate committee meetings, implement systems strategies and manage reporting and evaluation requirements. The grant manager will ensure that social marketing materials and training opportunities are culturally and linguistically competent and create an overall message about – and for - youth and young adults in transition. The grant manager will be LIT's liaison with the State YIT Operations Team and ensure local efforts follow the best State strategies as they emerge over the life of the grant. The grant manager will facilitate dialogue among LIT and Steering Committee members about how efficiently the Lamoille area is using existing funds. This may prevent duplication of services and generate ways to sustain the strategies of the YIT Plan beyond the grant period.

3). Criminal Justice Social Worker (CJSW): A 3-day per week Criminal Justice Social Worker will be hired to manage a caseload of youth/young adults who intersect with the criminal justice system and are at risk for going deeper into the system. The overall responsibilities of the CJSW – who will serve on the Steering Committee - are to:

- intervene at any sequential intercept point with an emphasis on prevention and intercepts #1 and #2 (law enforcement intercept and arraignment/initial hearings), and
- provide wrap around case management services that help to divert the individual from going deeper into the criminal justice system.

The CJSW will establish a care coordination model to:

- coordinate interdisciplinary services and supports already being provided,
- develop one coordinated services plan,
- ensure that screening and assessment utilize current best practice, and
- implement a holistic approach to care.

The goal for average duration of service with a client will be six months.

The CJSW will be actively engaged with the court and the local police and sheriff's offices. Key referral sources will be the Public Defender, State's Attorney, the Judge, Probation & Parole, AHS, Lamoille Family Center, Court Diversion, Copley Hospital, Copley Behavioral Health & Wellness (CBH&W), and LCC.

Local law enforcement (including Morristown PD and the Lamoille County Sheriff) have already committed to integrating this position into their operations, including participating in staff meetings, conducting trainings, and going out on calls when clients being served by the CJSW are requiring law enforcement interventions. The CJSW will be trained in restorative justice practices and will facilitate restorative processes when appropriate to assist the youth/young adult with taking responsibility for his/her actions while avoiding further criminal charges.

2). Youth/Peer Outreach Worker: A 1-day per week YIT Peer Outreach Worker will be hired to reach out to youth/young adults who intersect with the criminal justice system and are at risk of going deeper into the system. The peer outreach worker will be actively engaged with the court and the local police and sheriff's offices. Key referral sources will be the Public Defender, State's Attorney, the Judge, Probation & Parole, AHS, Lamoille Family Center, Court Diversion, Copley Hospital, Copley Behavioral Health & Wellness (CBH&W), and LCC.

The peer outreach worker will provide information, referral and assistance to those seeking to access services. He/she will offer support and advocacy for youth/young adults at coordinated care meetings. Finally, the peer outreach worker will be an active member of the YIT steering committee, representing youth interests and reporting issues, barriers, and gaps for youth in transition to the committee. S/he will be a liaison to engage other youth/young adults interested in having voice and involvement in the system of care.

ORANGE-NO. WINDSOR REGIONAL PLAN

The Orange-No. Windsor region will provide services for young adults in transition and meet these general expectations through the Clara Martin Center's (CMC's) Transition Age Youth (TAY) program by using the following strategies:

1). A full-time **Young Adult Services Navigator/**case manager will:

a. identity young adults and or/receive referrals from regional youth-serving facilities and professionals;
b. help the young adults identify their individual needs;
c. guide them so they are able to effectively access needed services;
d. function as a mentor, an emotional support, a role model, a skills trainer, and an advocate;
e. network and collaborate with the service providers in the region;
f. be well-informed regarding all current and potential regional resources and resource persons (including families) for young adults of transition-age.

2). The Young Adult Services Navigator will be assisted by three part-time **Peer Mentors:**

a. One Peer Mentor position will be created for each of the three service hubs: Randolph, Bradford, and White River Junction.
b. Each Peer Mentor will work approximately 4 hours per week.
c. They will provide peer support, mentoring, and related functions to individuals who attend alternative and/or public schools and/or receive Transitional Age Youth (TAY) or Jump or Board for Success (JOBS) services.
d. They and the Young Adult Services Navigator will meet as much as possible where the young adults are located, viz., in their homes, at the schools, at The Junction teen center, etc.

3). **Administration**: The program will be administered under the aegis of the CMC's Transition Age Youth Services (TAY) program, whose applied best practices and philosophical approach are based on the JOBS model (which is close in ideology to the TIP model) and Bonnie Benard's Resiliency Model, both of which are very compatible with the youth-centered values, ideology, and goals of this regional plan, as well as the spirit and letter of the overall mission goal as described in "An Invitation to Communities." The TAY Program will oversee and supervise the Young Adult Services Navigator and the Peer Mentors, including their:

a. training,
b. collection of data for the required evaluation,
c. outreach to the public, and
d. collaboration with service providers and community organizations, including representatives of the criminal and juvenile justice systems.

4).**Steering Committee Activities**:
The CMC and the regional steering committee are geared to working on both a micro and a macro level for this project. The steering committee recognizes that it serves a pivotal role in

the regional plan through its collective resource-sharing, networking, and coordination of services. The steering committee will:

a. assist the CMC in fostering collaboration and networking with the other regional agencies and resources (with *families* to be treated as essential “resources” as well) to promote the goals of the regional plan;
b. function as an *activist* body that will review individual cases (similar to what the LIT does) with the intent of seeking to remove barriers to needed services and providing problem-solving and resource-sharing, also to review progress and share information;
c. meet at least once a month with CMC representatives to go over data as it is gathered, as well as data-gathering outcomes for state and federal program evaluations.
d. continue to act as a *team* to keep watch over the needs of the region’s young adults and to assertively use its collective voice to advocate for filling in the various identified gaps in services that limit the welfare, growth, and future of these young adults.
e. recruit young adults and their parents, as well as other members of the community (such as cultural organizations) - besides representatives from social services, mental health, and the schools - for committee membership to help steer the plan.

ORLEANS/NO. ESSEX (ONE) REGIONAL PLAN

The Orleans/No. Essex (ONE) Plan for Young Adults in Transition has program objectives to reduce the number of young adults entering the criminal justice system by applying the Sequential Intercept Model’s (SIM) 5 Intercepts and to increase the number of young adults who successfully gain skills, knowledge, and the ability to live successful independent lives. The region will use the following strategies to achieve these objectives and meet the general expectations of this grant:

1. Transition Facilitator

Youth and young adults will be engaged by a Transition Facilitator who will work out of the Northeast Kingdom Community Action’s (NEKCA’s) Teen Drop-in-Center on Main Street in Newport. The Teen Center provides a safe place for youth to meet, talk and participate in positive and healthy recreational activities. Youth and young adults who frequent the Newport Teen Center serve as recruiters for others. The Teen Center provides a peer-to-peer environment allowing both the young adult and the transition facilitator to develop their relationship slowly and at the comfort level of the young adult. The transition facilitator will not be a mental health employee or mental health licensed but will be a liaison assuring that the youth/young adult has access to all needed services. The Transition Facilitator will offer support to the NECKA teen center in Canaan VT and overtime will expand services in Essex County.

The evidence-supported Transition to Independence Process (TIP) System will be used to guide the work of the Transition Facilitator and as a checklist for the Local Interagency Team (LIT).

TIP Step 1. Engage young people through relationship development, person-centered planning, and a focus on their futures.
TIP Step 2. Tailor services and supports to be accessible, coordinated, appealing, developmentally-appropriate, and build on strengths to enable the young people to pursue their goals across all transition domains.
TIP Step 3. Acknowledge and develop personal choice and social responsibility with young people.
TIP Step 4. Ensure a safety-net of support by involving a young person’s parents, family members, and other informal and formal key players.

TIP Step 5. Enhance young persons' competencies to assist them in achieving greater self-sufficiency and confidence.
TIP Step 6. Maintain an outcome focus in the TIP system at the young person, program, and community levels.
TIP Step 7. Involve young people, parents, and other community partners in the TIP system at the practice, program, and community levels.

2. Individual Life Plan (ILP)
For the ONE LIT, when responding to the needs of a youth or young adult, his or her most critical need will determine the lead case manager. With the LIT's Act 264 Coordinated Services Plan (CSP), the lead agency is the agency with the assigned case manager who assures that the plan is regularly reviewed and who serves as the agreed upon contact person if the CSP needs to be adjusted. The lead case manager helps to identify other service team members who can help the youth/ young adult access all needed services. With this initiative, for CSPs, the lead agency will maintain this status but will also have the Transition Facilitator to help build positive life experiences for youth/young adults that will help sustain outcomes from the services provided.

Youth/young adults who are not in need of a CSP may want to develop an Individual Life Plan (ILP), which will address similar domains. As youth/young adults are identified for services, they will receive information and be asked to sign a basic contract in which they agree to actively participate in the program and create their ILP. He/she will then work to design and complete the ILP with the assistance of the Transition Facilitator. The parent/guardian and/or other family members or adult allies will be asked to participate in the process if a youth/young adult agrees. Service providers who might be helpful will also be invited to participate in this process.

3. Behavioral Health Specialist
The ONE LIT plans to imbed a behavioral health specialist at the Newport Teen Center a minimum of 4 hours per week for the purpose of building relationships with the young adults. There would be an additional 2 hours per week for supervision meetings and reports for the ONE LIT. The objective of this service is two-fold, first to combat the assumption young adults often make that "counseling" or "therapy" is not going to help, and second to guide youth through the health care application process to get them the services they may need. *(This strategy is being funded through the Global Commitment of Northeast Kingdom Mental Health Services, not through this sub-grant, but is a part of the ONE regional plan.)*

4. Peer Outreach Worker
A peer support person will work 10 hours per week reaching out to peers and under-served youth, also building caring relationships and bringing them to the transition facilitator.

3. Youth/Young Adult Advisory Committee
The ONE LIT will create an advisory group comprised of youth/young adults who have some experience navigating the system and, if possible, some post-secondary education. Encouragement will be given to teen or recent teen parents to participate. Parents/families identified by youth as caring, families working with reunification, and parents working through the Runaway Program may be asked to participate if/as the youth direct.

The purpose of this committee is for youth/young adults to be given opportunities to develop leadership roles and to become skilled collaborators, team players and advocates for transition-aged youth and the system of care. Youth/young adult members on the board will be trained to

help themselves and others design and receive the services needed for Individual Life Plans (ILP) for success. Members will be offered leadership training that will include conflict resolution and communication skills-building.

With guidance from the transition facilitator, the advisory board will develop meeting protocols to determine structure, voting procedures and frequency and times of meetings. They will be asked to suggest strategies for improving relationships between young adults and all service providers, also to advise agencies about programs that meet the needs of the young adults in the community. The youth/young adult advisory board will play an important role in ensuring that services and supports are accessible, appealing and developmentally appropriate.

4. Regional Training
The ONE LIT will work toward strengthening relationships for all students, families, and participating partners or collaborators through the development of a common language of trust, respect, responsibility, and support. To do this, monthly or more frequent focus group style gatherings will be conducted throughout the community to continue hearing and validating the voice of our youth and young adults. Also, the ONE LIT will provide trainings in the Search Institute's 40 Developmental Assets the Communities that Care Model, and the Circle of Courage Model. These trainings will supplement technical assistance and trainings provided at the State level about the Sequential Intercept and TIP Models. A seamless, coordinated, comprehensive system of care will emerge as each provider is trained in the TIP System.

5. LIT Oversight
The ONE LIT will expand its membership to include the transition facilitator, who will represent the youth/young adult advisory board. The ONE LIT will receive monthly reports from the transition facilitator and provide oversight to this project. The ONE LIT has added an 11th Principle to its Procedures and Protocols to guide its actions and encourage the creation of Individual Life Plans (ILPs) for youth/young adults served through this initiative. The Northeast Kingdom Community Action (NEKCA), a member of the LIT, will be the employer of record.

RUTLAND REGIONAL PLAN

The Rutland County Plan for Young Adults in Transition will meet these general expectations via a coordinated network of programs and services that offer a single point of entry with synchronized and efficient follow-up and ongoing support for youth and young adults identified as in transition. The following strategies will be used to engage and serve these young people:

A. Street Outreach Team – *to improve outreach to youth and young adults in transition:*

The project will create a Street Outreach Team consisting of two professionals and one trained youth outreach worker. The involvement of a peer-aged outreach worker is critical in attracting and engaging youth in transition by providing a "bridge" from the street to the Center, in providing a positive and relevant role-model, and in the creation of a "success story" where a youth in transition is employed and on his/her own path to becoming a productive member of society. The two adult outreach workers will be responsible for data collection for all aspects of the grant on a monthly basis, as well as case management, daily outreach responsibilities, and the daily running of the Life Skills Center.

The Street Outreach Team members will work in collaboration with Rutland Mental Health and the other mental health providers in the community to identify youth with serious emotional

disturbance and provide ongoing case management and follow-up to assist the youth in committing to and following a treatment plan.

The Team will focus on the areas, organizations and outlets where the target population naturally gathers in order to engage and relate to them. Once a relationship is formed, the targeted youth will be invited to the Life Skills Center. Each targeted youth will be encouraged to form relationships with the caring adults who are a part of the project as well as with other trained peer mentors.

B. Life Skills Center – *to increase access to resources, coordinated care/case management and other services, and caring relationships:*

The Life Skills Center - a youth-centered site with food, multiple activities, services and opportunities to form positive peer relationships -.will operate out of the Boys & Girls Club of Rutland County. To build credibility, resources and collaborative relationships, the initial emphasis will be on engaging youth in a positive, attractive environment that creates a comfort level so the Center becomes known as a gathering place that provides safety, healthy choices and coordinated services. It will be staffed by the Street Outreach Team, who will bring youth and young adults into the Center and work with them to develop short and long term goals and objectives to support them in securing a path to a stable and productive adulthood. With each young person, the Team will map out and document strategies to achieve his/her goals.

C. Guidance from Young Adults – *to collaborate with a youth-led committee to assist the Street Outreach Team and the Life Skills Center staff in engaging and retaining Youth in Transition participants:*

The YIT Project will be guided as it grows by a Youth and Young Adult Development Committee. The Committee will review the results of formal and informal surveys of young people using the Life Skills Center. The Committee will provide input about day-to-day activities in the Life Skills Center as well as about special events and field trips for YIT. The Committee will establish Life Skills Center rules and recommend which agencies and organizations make visits to the Center (e.g., VSAC, the Thresholds decision making program, career exploration, money matters, and other guest speakers and workshop facilitators). Committee meetings will include discussions of progress and barriers to achieving Plan goals and objectives and strategizing ways to overcome these barriers.

D. Relationships with Partner Agencies – *to establish and expand relationships with partner organizations in the local system of care:*

To achieve this, the Outreach and Life Skills Center staff and Executive Director of the Boys and Girls Club of Rutland County will work closely with the area service providers and community resources that are partners with the project through Memorandums of Understanding (MOUs). These include:

- Rutland Mental Health to provide mental and behavioral health services to participants in the project and to maximize available funding (i.e., through Medicaid and other sources) to sustain these services.
- Evergreen and Turning Point to engage youth with substance abuse issues in treatment and support services.
- Rutland Free Clinic to facilitate youth in receiving regular health care and track their usage.

- The JOBS program to provide supportive employment and case management services.
- Community High School in providing lunches to attract and sustain involvement of youth in transition
- Vermont Achievement Center's "Cooking for Life" classes, to educate young adults in transition about cooking, nutrition, budgeting and shopping to encourage independence and healthy lifestyle choices.

Ongoing collaboration and consistent communication with community partners through the Local Interagency Team (LIT) will facilitate referrals to educational and job training resources for out of school youth, referrals to Medicaid and other health insurance programs for eligible youth, housing and shelter programs for youth without stable housing, and employment services for youth able to seek and sustain employment.

It will also facilitate knowledge - and maximize use - of available and appropriate funding for education and training, which may include Next Generation funds, financial aid, work study programs, scholarships, etc. as well as of Drug Treatment Court services and other resources to minimize the amount of YIT funds that will be needed to provide mental health and substance abuse treatment services, and to ensure the sustainability of the Rutland County YIT Project.

SO. WINDHAM REGIONAL PLAN

The So. Windham Project for Young Adults in Transition will meet these general expectations through some strategies funded by this sub-grant and other strategies not funded through this sub-grant. The funded strategies are:

1. **Services:** Case management and individualized planning to support young adults in obtaining and maintaining *housing (see program description below)*.

2. **System Improvement:**
   a) Convening and managing an ongoing **Oversight Committee** of the Southern Windham County CORE Transition Team to accept and screen referrals to the Transitional Housing Toward Independence (THTI) Program.
   b) The program Oversight Committee will have links to the Local Interagency Team, the CORE Team, and the Homeless Outreach Team, and will be composed of representatives from human services agencies in the area.

The Southern Windham County CORE Transition Team is a cooperative group including schools and agencies who all work with transition-age youth. This Team is willing to oversee implementation of the Youth in Transition regional plan and will expand its membership in the process.

The strategies of the regional plan not funded through this sub-grant include goals and activities of the expanded Southern Windham County CORE Transition Team to address the following needs of young adults in transition:
1. Post Secondary Education – Help getting diploma, GED, skills development.
2. Youth Employment – Connecting youth in community: jobs, housing, and training. One person assigned to each youth who helps them connect.
3. Caring Relationships – Collaborating with and involving family members and/or caregivers in the development of decisions and plans.

The TIPS model has been selected as the evidenced based practice for the entire regional plan and, in particular, guides the design of the Youth in Transition Housing Coordinator position, which involves the delivery of case management not only for supported housing, but also relating closely to the other unfunded sections of the regional plan as relevant for particular young adults in the program.

Housing Program – The strategy funded through this sub-grant is to support a **housing coordinator/case manager** position for the Transitional Housing Towards Independence (THTI) Program for youth and young adults.

Outcome: Youth have safe, stable and adequate housing
Objective: 1. By December 1, 2009 fill a Youth In Transition Housing Coordinator position. The Youth In Transition Housing Coordinator will assist ten young people at a time to learn the independent living skills necessary to acquire and maintain an apartment or room; this position will also oversee the transitional housing program. 2. By March 30, 2010 provide a transitional housing program for six young adults.

Indicators of Success

Population Indicators:

Six young adults <u>at a time</u> who are in need of safe, stable, adequate housing will live in transitional housing under the guidance of a Youth In Transition Housing Coordinator.

Eight young people <u>at a time</u> (including the youth in the transitional housing program) who need safe, stable, adequate housing, will be - under the guidance of the Youth In Transition Housing Coordinator -given supports and case management directed toward preparing them to live independently.

Program Performance Indicators:

A Transitional Housing Program providing up to six beds for young adults will be established in Windham County.

The Transitional Housing Toward Independence (THTI) Program will serve young people who are out of school and those at risk of dropping out of school due to homelessness or who are precariously housed. Participants will range in age from 16-21 (*Minors may participate in the program with parental consent.*) and will be experiencing or at risk for experiencing serious emotional disturbance.

The obstacles to securing an apartment or room of one's own vary by individual. In some cases, the main obstacle is absence of a rental history and absence of a rental deposit. For others, deficits in interpersonal skills, lack of employment, probation status, or unstable mental status may be the major obstacles. Participants might require help negotiating living with others, with budgeting and career planning, finding a job, or satisfying probation conditions.

Participants must help develop a plan for independence and work collaboratively with service providers to implement, revise and achieve the goals of the plan. Plans will address job, career, education, interpersonal skills, emotional and mental health needs, and other issues, depending on the individual. Continuation in the program will depend on compliance with the individualized case plan; "slips" are anticipated and will not necessarily lead to immediate expulsion from the program. The emphasis of the program will be on transition to self-sufficiency in housing. Full independence means that the young person will be able to support him or herself, afford an

apartment or a room of his or her own, and possess the skills to manage life with minimal agency support.

The program will provide housing for a period of 6 – 9 months. Young participants will reside in a single room occupancy building. The program is intended to duplicate, as much as possible, the kind of shared-housing that is common to young renters and college students. Though participants must abide by house rules, the rules will be modeled after the kinds of rules routinely imposed on young people living together in off-campus housing – e.g., respecting housemates, neighbors, and the property itself. There will be no "house parent" and no mandatory group meetings. A building manager will live on-site to provide supervision (*This position is not funded through this sub-grant.*).

Each resident admitted to the program will be co-case-managed by the referring agency and the Youth in Transition Housing Coordinator. The Youth in Transition Housing Coordinator will be a member of the participant's planning team, as will the young person's workers from other service agencies. The emphasis of this team will be on integrated, seamless service. In most cases, the agencies supporting the youth will continue to provide help to the participants as they move into their own apartments, thus assuring that gains made are preserved. In cases where the referring agency is able to provide only minimal case management, the Youth in Transition Housing Coordinator will be the primary case manager and the referring case manager will be secondary.

While addressing the needs of homeless and precariously housed young people, the YIT Housing Coordinator will engage with minority youth who need housing and enlist the active involvement of agencies serving minority youth.

A variety of agencies have agreed to subsidize the rent for individual young adults, depending on their affiliation (some will be aligned with Probation and Parole, others with HCRS, others with Youth Services, VR, or NFI).

The cost of staffing the program will be offset by assigning the Youth in Transition Housing Coordinator the role of overseeing the project. The Youth in Transition Housing coordinator's duties will initially include: supported housing case management and leading the initiative to create this transitional housing program. When the transitional housing program is up and running, the Housing Coordinator's duties will include oversight of the housing program, including admissions, coordinating development of the case plans, data collection for the required evaluation for the Youth in Transition grant, periodic case reviews, and discharge planning.

SO. WINDSOR REGIONAL PLAN

The So. Windsor Plan for Young Adults in Transition will meet these general expectations through use of strategies to identify and locate youth with severe emotional/behavioral needs or at risk to be so who are not visible in current systems and to create a means to link and connect youth with existing services accessible from/in their homes and communities. During this first 6 months of the project, the focus will be on setting up the systems, establishing awareness and good connections to the schools and community groups, and creating a Project Board to help guide and direct the project's use of the following regional strategies:

1). A Transition Facilitator will be hired to facilitate referrals of young adults and will serve as a recruiter and bridge from the community and young adults to the Youth in Transition Team.

This will be done through networking with young adults as well as by regularly being in contact with organizations that have contact with them, such as the Department of Corrections, the police, supportive housing, Court Diversion, the Restorative Justice Center, a newly- opened music venue for youth, etc..

a) The Transition Facilitator will work with all grades in the high school and with the young adults at risk for involvement in the criminal justice system.
b) He/she will engage young adults in pre-contemplative and contemplative stages of readiness to change.
c) For those who do not meet the criteria for other programs, such as JOBS, the Transition Facilitator will provide case management and service planning and coordination.
d) He/she is likely to have a caseload of 15-20 young adults, aged 16 to 22, with emotional and behavioral difficulties.
e) The Transition Facilitator will "do what has to be done" including conduct a needs assessment, develop a TIP plan, and provide direct services wherever the young adult is most comfortable and willing to receive services.

2). A Youth in Transition (YIT) Team will be created of representatives from Vocational Rehabilitation, Department of Labor, Department for Children and Families, Department of Corrections, Windsor County Youth Services, HCRS (the clinician who has completed any clinical assessment, the JOBS case manager, and the JOBS Coordinator), also the Youth Development Coordinator and the Transition Facilitator. This Team will focus on young adults who are out of the school system, have a severe emotional disturbance and/or are displaying high risk behavior, and are clearly in need of intervention in order to be able to complete their education, gain employment, and live safely in their communities.

a) Identified cases will only be reviewed by members of the Team (or individuals who represent an agency or group) when a signed release from the parent or young adult is in place.
b) For such referrals, the YIT Team will strategize on how best to provide the supports and services the young adults need to be educated, employed, healthy, and free from incarceration.
c) The Team will determine which programs will meet the needs of the young adult and for which programs the young adult meets the eligibility requirements.
d) This collaborative approach will allow all providers to coordinate services between systems, pool resources and information, and avoid duplication, including in their communications with the young adult.
e) Besides handling new referrals, the YIT Team will review existing cases to determine whether their plans are effective. *(YIT cases can be brought to the Local Interagency Team [LIT] if needed. Members of the Youth in Transition Team who are members of the LIT will serve as liaisons between the two oversight bodies.)*

4. Outreach: Together, the Youth in Transition Team members will conduct a comprehensive outreach strategy which includes informing the community, young adults, their families, and adult allies regarding the role of the Team and the referral process.

a) Included in these outreach efforts will be a young adult who can serve as a bridge between the 'system' and the world of the youth.
b) The 45 individuals and organizations involved in the YIT planning process, as well as local schools, the restorative justice program, and the courts, will be the target of the first outreach efforts by the YIT Team.
c) Outreach to the Springfield and Bellows Falls Police will be done in collaboration with the Transition Facilitator and the Police Social Worker, both HCRS employees.

d) In addition, the YIT Team will develop a brochure and distribute it throughout the community to organizations and businesses (including the medical community) that intersect with youth.
e) These efforts will be coupled with a more global outreach effort that will include articles placed in local newspapers.

<u>3). TIP Model Training and Plan:</u>

a) Soon after the Transition Facilitator is hired, the Youth in Transition Team will participate in TIP training so that there is a shared approach to working with youth in a strength-based manner.
b) The Team, in turn, will provide training to schools, organizations who work with youth, and the community at large on using a strength-based approach to working with youth.
c) The JOBS, Springfield School Alternative, and Transition programs have all agreed to create plans with young adults using the Transition to Independence Process (TIP) system.
d) The young adult will have one plan that will be used across systems and programs.

<u>4). Project Board:</u>

a) HCRS will work with the membership of the Springfield LIT and the YIT Steering (e.g. Planning) Committee to establish an ongoing Project Board to monitor and advise on both the JOBS program and the YIT program.
b) This Project Board will be briefed on the progress and outcomes of these two young adult transition assistance programs.
c) Many members of the YIT Steering Committee will continue to provide on-going program advice to ensure that the original intent of the program is adhered to as outlined in the plan.
d) The Project Board will not have any specific case review functions, though they will have access to data and de-identified situations that illustrate what is happening.
e) Membership of the Project Board will include young adults, parents and adult allies, LIT and CORE members, and business and community leaders.
f) The Project Board will explore the possibility of establishing a broad-based group of young adults with a diversity of cultures, ages, lifestyles and opinions to also advise this grant.

WASHINGTON REGIONAL PLAN

The Central Vermont Implementation Project for Young Adults in Transition will meet these general expectations through use of the following strategies:

1. **<u>A System of Care Team Leader and Evaluation Liaison:</u>**
   a) Create and manage youth and family advisory group(s)
   b) Provide staff support to the Youth in Transition management and intake teams
   c) Inform the Youth in Transition management team (e.g., System of Care Team) about the progress of this project and receive input from the team on a monthly basis.
   d) Manage the Youth in Transition funds respecting the rules and limits provided by the state team and as outlined in the federal grant
   e) Exercise expenditure authority for local Youth in Transition intake team to disburse Youth in Transition Support Funds
   f) Pursue further development of the local system of care to increase the engagement and integration of Youth in Transition.

g) Liaison with State Evaluation Team and local organizations involved in the individual youth evaluation component.
h) Serve as lead in any process or program evaluation requested by key stakeholders.

2. **A Youth Advisor:**
   a) will assist the System of Care Team Leader (SOCTL) to fulfill the work of the YIT Grant by promoting and providing authentic youth voice. Assistance could include but is not limited to:
      i. developing youth advisory capacity, and
      ii. developing valuation documentation.

3. **Youth & Family Advisory Team:**
   a) Will be created and staffed by the System of Care Team Leader
   b) Will assist in all aspects of the further development of the local System of Care with an emphasis on the training and professional development plan

4. **Housing Opportunities for Transition Aged Youth:** Work with a System of Care consultant to lead collaboration in Washington County around development by January, 2011 of 10-12 additional transitional apartments for young adults ages 18-22 (which may include families with young adults aged 18-22 who are heads of household) who will receive mental health treatment as part of the residential program:
   a) 5 to 6 scattered site apartments with private landlords
   b) 5-6 transitional apartments within one or more buildings as part of a group housing model of no more than 10 beds.

4. **Youth in Transition Intake Team:** The existing Youth in Transition Team (with representatives from Washington County Mental Health, Washington County Youth Service Bureau, JOBS Program who are involved in housing for youth in transition) will serve as the gateway/screening for intake to the supervised apartments.
   a) Review current operations.
   b) Make recommendations needed to meet the challenge of using the existing team as the gate for Youth in Transition to obtain housing.
   c) All young adults without housing or a plan for obtaining it will be staffed through this Youth in Transition Intake Team.
   d) Staff will be skilled in engaging young adults in a competent, safe and respectful manner.
   e) The young adults who are referred will be involved in making their own plans.
   f) The individualized plans for the young adults will include but not be limited to:
      - A contract with the youth
      - Individual paid mentors or other appropriate support such as existing case managers
      - High school completion
      - Training and employment
      - Transportation
      - Recreation and pro-social activities
      - Child care
      - Mental health services.
      - Housing.

5. **A Youth in Transition Support Fund**
   a) Is in place and

b) Distributing funding.
   - Develop clear funding parameters (for whom, by whom, for what, for how much)

6. Interagency Professional Development Plan

a) Is in place and
b) Used by the youth-serving agencies.
c) Develop training outcomes.
d) Offer youth/adult training.
e) Support travel to training and professional development activities

CHART OF REGIONAL YOUTH IN TRANSITION (YIT) STRATEGIES and Federally-Funded FTEs

Regions	AHS Districts	Fiscal Agents	Service Coord/ Case Manager	Individual Service Plans	Interagency or Inter-department Intake Team	Peer Worker	Young Adult Advisory Board	Council of Service Providers	Flexible Funds For young adults	Supportive Housing Treatment	Supportive Employment Treatment (JOBS expansion)	Other: -training -outreach -system coordinator -life skills classes -parenting education -misc.	Total FTEs
Addison	Middlebury	Counseling Service of Addison County (CSAC)	.8 FTE	X		.16 FTE	X	X	X			X	.96 FTE
Bennington	Bennington	United Counseling Services of Bennington County	1.0 FTE	X	X	.53 FTE	X	X				X	1.53 FTE
Caledonia/ No. Essex	St. Johnsbury	Northeast Kingdom Youth Services	1.1 FTE	X			X	X				X	1.1 FTE
Chittenden	Burlington	Howard Center	X (See Support-ive Employ-ment)	X	X	.8 FTE	X	X			1.67 FTE	.5 FTE	2.97 FTE
Franklin-Grand Isle	St. Albans	Northwest Counseling and Support	1.12 FTE	X				X				X	1.12 FTE

		Services											
Lamoille	Morrisville	Lamoille Community Connections	.6 FTE	X	X	.2 FTE	X	X				.16 FTE (est)	.96 FTE
Orange-No. Windsor	Hartford	Clara Martin Center	1.0 FTE	X	X	.32 FTE	X	X				X	1.32 FTE
Orleans-No. Essex	Newport	Northeast Kingdom Community Action	.8 FTE	X	X	.25 FTE	X					X	1.05 FTE
Rutland	Rutland	Boys and Girls Club of Rutland County	.5 FTE	X		.375 FTE	X	X			.375 FTE	X	1.25 FTE
So. Windham	Brattleboro	Youth Services	X (see Support-ive Housing)	X	X	X (Success Beyond Six $ - ?)		X		1.0 FTE		X	1.0 FTE
So. Windsor	Springfield	Health Care and Rehabilitation Services (HCRS)	.8 FTE	X	X		X	X				X	.8 FTE
Washington	Barre	Washington County Mental Health Services	X (in-kind)	X	X	X – stipend	X	X	X	.1 FTE (est)		1.0 FTE	1.1 FTE
Total Units	12	12	11	11	8	9	9	11	2	2	2	11	
Total FTEs			7.72 FTE			+ 2.635 FTE				1.1 FTE	2.045 FTE	1.66 FTE	15.16 FTE

Shaded rows = regions which mentioned TIP model as their “evidence-supported” practice

Funding Formula for Regional Services through LITs

	Estimated 2006 Population	**A.** Percentage of Population	**B.** Basic Operating Allowance (1/12)	Percentage Distribution Regional $	Dollars Per 5.25 Years of Regional Services at Average $865,000*
AHS Districts	Aged 16-21	Aged 16-21		**(A + B)/(C + D)**	
Barre	5,541	10.2261%	8.3333%	9.2797%	$80,269.40
Bennington	2,959	5.4609%	8.3333%	6.8971%	$59,659.92
Brattleboro	2,795	5.1583%	8.3333%	6.7458%	$58,351.17
Burlington	15,107	27.8804%	8.3333%	18.1069%	$156,624.68
Hartford	3,946	7.2825%	8.3333%	7.8079%	$67,538.34
Middlebury	4,100	7.5666%	8.3333%	7.9500%	$68,767.50
Morrisville	2,635	4.8630%	8.3333%	6.5982%	$57,074.43
Newport	2,226	4.1081%	8.3333%	6.2207%	$53,809.06
Rutland	5,296	9.7739%	8.3333%	9.0536%	$78,313.64
Springfield	2,442	4.5068%	8.3333%	6.4201%	$55,533.86
St. Albans	4,236	7.8177%	8.3333%	8.0755%	$69,853.08
St. Johnsbury	2,902	5.3557%	8.3333%	6.8445%	$59,204.92
Total	54,185	**C.** 100%	**D.** 99.9996%	100%	$865,000

*Average figured for original grant application as follows:

At $5,000 cost per youth (as in JOBS),173 youth to be served per each of 5.25 years, for 908 total. At an estimated DA cost of $60,000 per 1 FTE clinician, this budget "buys" 14.42 FTEs, each with a caseload of 12 youth, all estimated to stay in program for 1 year.