ABSTRACT

The goal of this 6-year project is for Vermont's transition-aged youth (16 through 21 inclusive, with their families) with severe emotional disturbance (SED) to have adequate preparation and the necessary supports to be productively engaged in the community and free from incarceration. For this population, the necessary supports include access to health care (908 youth will receive treatment for mental health and co-occurring substance abuse challenges), also post-secondary education, employment, housing, and caring relationships (with adults who nurture positive youth development). The strategic planning and ongoing management of this project will be under the direction of Vermont's State Interagency Team (SIT), which was established by State law Act 264 in 1988 to oversee a system of care for children and youth with SED. Historically, most of the children and youth served by SIT have been in school and/or in the custody of the Department for Children and Families (DCF: *child welfare and juvenile justice*); for this project, SIT's reach will extend more systematically to youth who are out of school and/or in contact with the adult criminal justice system. Vermont Act 264 also established Local Interagency Teams (LITs), one in each of the 12 Agency of Human Services (AHS) service districts. The LITs support the creation of local systems of care and assure that staff are trained and supported in creating coordinated services plans. The SIT will issue an "Invitation to Communities" asking the 12 LITs to develop regional strategic and oversight plans to effectively address the goal of this project. The LITs will be asked to augment the existing system of care for children and adolescents with SED by intentionally reaching out to transition-aged youth at least through teen centers, recovery centers, homeless youth programs, and at critical intervention points with the juvenile and criminal justice systems. This will improve access to mental health services for the youth at most risk for poor outcomes and use the power of the courts to increase the likelihood of use of those services by the youth. The 12 LITs will also be asked to propose to the State specific mental health services to fund in addition to the required cross-system care management and individualized service plan development for each youth. The LITs will be required to use the Jump on Board for Success (JOBS) program as a logical foundation upon which to build the enhanced system of care. JOBS - which operates in accordance with the TIP Model and is an age-appropriate adaptation of the Evidence-Based Practice (EBP) of Supported Employment for adults with SMI - offers *available, accessible, and attractive* service delivery for transition-aged youth with SED. Each LIT must decide whether it is important for that region to establish and/or expand the JOBS program or to augment it with another EBP - such as for the treatment of co-occurring mental health and substance abuse disorders, the treatment of trauma, or for family or parenting education. Other opportunities exist for enhancing the JOBS experience for youth with SED by using culturally competent practices and linking the program more closely with existing community justice centers, resources for housing, Workforce Investment Boards, and mentoring.

TABLE OF CONTENTS

Sections	**Pages**
Face Page (SF 424 v2)	
Abstract	1
Table of Contents	2
Budget Form (SF 424A)	3
Project Narrative	5
• Section A: Understanding of the Project	5
• Section B: Implementation Plan	12
o Infrastructure Development	12
o Service Delivery	21
o Sustainability/Linkages with Statewide Transformation Efforts and Other Relevant Federally-Funded Programs	34
• Section C: Project Management and Staffing Plan	38
• Section D: Evaluation Plan	41
Supporting Documentation	45
• Section E: Literature Citations	45
• Section F: Budget Justification	51
• Section G: Biographical Sketches and Job Descriptions	55
• Section H: Confidentiality and SAMHSA Participant Protections/Human Subjects	67
Appendices	71
• Appendix 1: Letters of Commitment and Support and Memoranda of Understanding	71
• Appendix 2: Governor’s Assurance	86
• Appendix 3: Data Collection Procedures and Instruments	87
• Appendix 4: Sample Consent Forms	133
• Appendix 5: Non-Federal Match Certification(s)	141
• Appendix 6: Organizational Chart, Staffing Pattern, Timeline + Management Chart	149
Assurances (SF 424 B)	157
Certifications	160
Disclosure of Lobbying Activities (SF LLL)	163
Checklist (SF)	164

PROJECT NARRATIVE

Section A: Understanding of the Project

Describe the population of children with serious mental health needs in the geographic area.

This is a proposal to bring hope to a subset of youth aged 16 through 21 (inclusive) and their families located in the State of Vermont. This is the subset of youth who are experiencing serious emotional disturbance (SED, especially but not exclusively with symptoms of depression and co-occurring substance abuse) as they make the high-stakes transition from childhood to adulthood. **The goal of this 6-year project is for these youth to have adequate preparation and the necessary supports to be productively engaged in the community and free from incarceration. For this population, the necessary supports include access to health care (908 youth [173 per each of 5.25 years] will receive treatment for mental health and co-occurring substance abuse challenges), also post-secondary education, employment, housing, and caring relationships (with adults who nurture positive youth development).**

"Approximately one in five children and adolescents experience the signs and symptoms of a DSM-IV [mental health] disorder during the course of a year," according to the United States Surgeon General (1999)." [1] And the "federal Center for Mental Health Services estimates that … about 12% of Vermont's children and youth may be experiencing serious or severe emotional disturbance each year."[2] **54,185 youth aged 16 through 21 reside in Vermont[3]; 6,502 are likely to be experiencing SED**.

At least 95% of these youth are White, and 1% of the Whites are Latino. About 4.6% of the youth are non-White, and within that percentage is the following distribution of races: 34.8% mixed, 26.2% Asian, 18.6% Black, 10.2% Native American, 9.3% other, and 0.9% Pacific Islander.[4] The Native Americans are likely to be associated with the Abenaki Self-Help Association in Swanton, Franklin County; Vermont does not have a federally-recognized tribe.

The racial data does not capture the full diversity of ethnicity in Vermont, which has historically been settled by French-Canadian, Italian, and Irish Catholics as well as the Scot and English Protestants/Puritans. Then there were the Germanic and Jewish people fleeing World War II. In more recent years the immigration has been heavily influenced by Vermont's Refugee Resettlement Program (VRRP), which since 1980 has brought in hundreds of Vietnamese, Bosnians, and Somalis as well as dozens of Meskhetian Turks, Sudanese, Congolese, and others from more than 20 additional countries. These refugees and asylees comprise less than one percent of the population and are most of the people in Vermont with Limited English Proficiency (LEP);[5] efforts are made to quickly enroll both the adults and their children in classes for English-language learners. The Vermont State Agency of Human Services (AHS) and many private non-profit service providers contract for interpreter and translation services to communicate with them.

Most of the non-White people are located in Vermont's only Standard Metropolitan Statistical Area (SMSA), which includes Chittenden, Franklin, and Grand Isle Counties and the northern part of Addison County, areas with prime real estate that border Lake Champlain. The

[1] DMH. (2004). The Vermont State System of Care Plan for Child, Adolescent and Family Mental Health, State Fiscal Years 2005-2007, p.7.
[2] Ibid.
[3] VT Dept. of Health. (2006). Population Estimates, based on 2000 US Census.
[4] US Census Bureau. (2000). tables.
[5] Lamoureux, D. (2007). Summary of Vermont Refugee Arrivals.

SMSA houses about 1/4 of Vermont's 621,254 people.[6] Chittenden County has the most economic opportunity and the lowest rate of child poverty in the state (for 2002, 7.4% compared with 11.5% statewide).[7] However,

> nearly 20% of children in Burlington and Winooski [cities in Chittenden County] lived in poor families….Poverty rates are even higher for non-white Vermont children. The estimated child poverty rate for African American children under age 18 was 21.6% in 2000; the rate for non-white Hispanic children was 21.1%, and the rate for Native American children was 26.3%.[8]

Burlington is well served by a public bus transportation system, something mostly lacking in the rural cities and towns. "Limited or non-existent public transportation, a narrow employer base of mostly small businesses, and insufficient job development and job placement services"[9] are barriers to employment throughout much of Vermont. Most of the available jobs are in the service industry or retail settings, so "in 2000, only 39% of jobs in Vermont paid enough to meet basic needs."[10] People here have to work multiple jobs to pay their bills.

> Many families are one financial disaster away from homelessness – because of a job layoff, loss of health insurance, catastrophic medical costs, workplace injury, or loss of transportation to work….In 2006, nearly half of Vermont renters couldn't afford the fair market rent for a two-bedroom apartment of $797, which would require an hourly wage of $15.34. The average Vermont wage was only $9.87 per hour. The same apartment in Chittenden, Franklin and Grand Isle Counties would cost $983 per month, requiring an hourly wage of $18.90 per hour.[11]

The high rents are driven by the fact that "Vermont ranks second only to Maine as the state with the highest percentage of vacation homes….

> Of Vermont's 33,000 low-income households, about 27% live in substandard units. With housing stock ranked second oldest in the nation, Vermont homes and apartments have a greater likelihood of lead exposure, poor insulation, and need for repairs.[12]

"The limited resources and rural nature of the state means the service infrastructure is often weak or patchy. Services available in some of the state's larger towns are often unavailable in the more rural communities."[13]

> Vermont's rural places are those that retain the best elements of our Green Mountain State – its beauty, independence, and strong family ties. But rural places also may be home to isolation, fewer jobs, and limited affordable and quality child care, social services and medical care.[14]

"This particularly affects the quality of transition services for youth with disabilities, where so many different service systems need to be engaged and working together to be effective."[15]

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[6] The Times Argus. (December 27, 2007). Census information highlighted to go with story about "Louisiana population rebounds; Florida growth slows"
[7] The Vermont Children's Forum. (2005). The State of Our Children: 2005 Data Book: Kids Count in Vermont, p.7.
[8] The Vermont Children's Forum. (2003). Children and Poverty in Vermont, p. 2, 3.
[9] Kievit-Kylar, R. & Porter, A. (2007). Career Start Connections, p. 5.
[10] The Vermont Children's Forum. (2003). Children and Poverty in Vermont, p. 6, 11.
[11] Voices for Vermont's Children. (2007). Homeless in Vermont: Children, Youth and Families
[12] The Vermont Children's Forum. (2003). Children and Poverty in Vermont, p. 6, 11.
[13] Kievit-Kylar, R. & Porter, A. (2007). Career Start Connections, p. 5.
[14] The Vermont Children's Forum. (2003). Children and Poverty in Vermont, p. 3.
[15] Kievit-Kylar, R. & Porter, A. (2007). Career Start Connections, p. 5.

Of the youth in Vermont aged 16-21 (inclusive), 51.5% are male and 48.5% are female.[16] Most of them are successfully transitioning to adulthood, as can be seen by their rate of participation in the labor force.

> Based on 2000 Census Bureau data, 56% of 16-19 year olds were in the labor force and approximately 86% [of them] were actually employed. As one would assume, these percentages increased for 20-21 year olds. Approximately 69% were in the labor force and 88% [of them] were actually employed. The numbers were slightly higher for females compared to males. [17]

Furthermore, in Vermont

> the percent of young people aged 16-19 who are not working or in school declined between 1998 and 2002 from 8% to 6%...[and] a greater percent of Vermont students who enter 9th grade are completing school four years later. According to VT Department of Education [DOE] estimates, the completion rate for 2004 was 86%.[18]

However, a significant percentage of youth – particularly those with disabilities - lack the necessary skills and supports to succeed in today's economy. "Nationally, 14% of youth with disabilities enter college compared to 63% of the general youth population (Guideposts for Success, National Collaborative on Workforce and Disability – Youth)."[19]

Vermont has the highest percentage of students aged 6 to 17 with identified disabilities in the nation (16.6% compared with the US mean of 6.6%).[20] This is largely because of twenty years of State and local interagency efforts to better serve children and adolescents with SED. Despite significant attempts to serve them in regular classrooms with accommodations, "there was a substantial increase in the number of children and adolescents with an IEP [Individualized Education Plan] for ED [emotional disturbance] …from 1,614 in FY1999 to 2,207 in FY2004."[21] During FY2004, 47% of young people on an IEP for ED were also on the caseload of their local community mental health center (CMHC).[22]

In 2007 the number of children and adolescents who received children's mental health services from Vermont's ten publicly-funded, private non-profit CMHCs *[see map in Appendix 6]* was 9,609.[23] Of these children, 68% were covered by Medicaid, 18% were covered by other insurance, and 20% were uninsured.[24] It is likely that a high percentage of the transition-aged youth who were served were uninsured. The AHS has recently made increasing the enrollment in Medicaid a priority for youth aged 18 through 20 because "enrollment data indicated that only 44% of 18-, 19- and 20-year-olds who are eligible for some form of Medicaid are actually enrolled. This number is unacceptably low." [25]

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[16] US Census Bureau. (2000). tables.
[17] Smith, M.K. (2007). Report to the House Committee on Human Services and the Senate Committee on Health and Welfare about H.449 – Section 4. Study on Transitional Services for Youth, p. 5.
[18] The Vermont Children's Forum (2005). The State of Our Children: 2005 Data Book: Kids Count in Vermont, p.5.
[19] Smith, M.K. (2007). Report to the House Committee on Human Services and the Senate Committee on Health and Welfare about H.449 – Section 4. Study on Transitional Services for Youth, p. 4.
[20] Vermont State Department of Education. (200?). Vermont 2005 Child Count.
[21] Pandiani, J. & Mongeon, J. (2005). Use of Children's Services by Students with an Emotional/Behavioral Disability.
[22] Ibid.
[23] Pandiani, J, & Carroll, B. (2007). CMH Caseload: FY'85 –'07.
[24] VT Dept of Mental Health. (2007). Fiscal Year 2007 Statistical Report.
[25] LaWare, C. (2007). Clarifying Medicaid Eligibility for Youth in Vermont.

A study for the Vermont Legislature on Transitional Services for Youth[26] included data showing that in FY2006, CMHCs served 1,039 youth aged 16; 846 youth aged 17; 631 youth aged 18; 525 youth aged 19; 449 youth aged 20; and 413 youth aged 21. Most of these youth received children's community mental heath and/or substance abuse treatment services.[27] For the youth who received children's mental health services, the predominant diagnoses were affective disorder, non-psychotic disorders, anxiety disorder, adjustment disorder, and substance abuse.[28] Very few received either adult outpatient or Community Rehabilitation and Treatment (CRT) services for adults with serious and persistent mental illness.

> Only 10% of 15-17 year olds served by children's services programs in Vermont…also received services from an adult mental health program at the same CMHC when they were 21-23 years old. There was no difference between the genders in the likelihood of being served by adult outpatient programs after being served by children's services.[29]

Though the vast majority of the 3,903 youth aged 16-21 who were served by the CMHCs in 2006 will not make use of public mental health services after their eligibility for children's services ends, their need for care may not have ended.

Since children's mental health services clients are most likely to be referred by family and friends (28%) or educators (27%),[30] as transition-aged youth strive to establish independence from the caregivers and other adult authority figures in their lives it is not surprising to see the precipitous drop in the number of youth who choose to participate in these services after they turn 16 (the year they can choose to drop out of school), and even more after they become 18 (the year the State deems them to be adults). However, youth who distance themselves from social supports may have difficulty successfully transitioning to adulthood.

In Vermont in FY2000, special education students accounted for 20% of the dropouts; almost 50% of those special education dropouts were identified with ED.[31] Dropping out is often a precursor to ending up in jail. Of the 219 average daily population of youth aged 18-21 incarcerated in adult Correctional facilities in Vermont in 2007, 90% "have no high school diploma; 50% of these youth were eligible for special education services … in high school."[32]

> According to Dr. Ronald E. Dahl of the University of Pittsburgh Medical Center:
> Achieving adult status requires developing self-control of behavior & emotions:
> - Appropriately inhibit or modify behaviors to avoid negative future consequences
> - Initiate, persist, sequence steps toward goals
> - Navigate complex social situations despite strong affect
> - Skills in the self-regulation of affect and complex behavior [for] long-term goals
> - Involves neurobehavioral systems in PFC (Prefrontal Cortex) - *among the last regions of the brain to achieve full functional maturation.*[33]

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[26] Smith, M.K. (2007). Report to the House Committee on Human Services and the Senate Committee on Health and Welfare about H.449 – Section 4. Study on Transitional Services for Youth, Attachment E *(?)*
[27] VT Dept of Health, Div. of Mental Health. (2006). Fiscal Year 2006 Statistical Report.
[28] Vermont State Department of Mental Health. (2008). Management Information System for FY2007.
[29] Pandiani, J. & Kobel, O. (2007). Movement from Children's Services into Adult Services.
[30] Pandiani, J. & Simon, M. (2004). Source of Referral to Community Mental Health Programs.
[31] Vt. Dept. of Education. (2002). Vermont Self-Assessment Report.
[32] Smith, M.K. (2007). Report to the House Committee on Human Services and the Senate Committee on Health and Welfare about H.449 – Section 4. Study on Transitional Services for Youth, p. 4.
[33] Dahl, R.E. (undated). Adolescent Brain Development: A Framework for Understanding Unique Vulnerabilities and Opportunities.

Youth who do not have this self-control or adults to help them gain it are at great risk for poor outcomes. Davis and Stoep (1996) say

> The plight of youth with serious emotional disturbance in transition to adulthood is grave. As a group, these youth are undereducated, underemployed, and have limited social supports. Drug and alcohol abuse are common, and suicide risk is high. These youngsters remain largely "unclaimed"—falling through the cracks within and between the child and adult service systems.[34]

Nationally, according to Davis and Butler (2002),[35] "the transition from adolescence to adulthood is a major struggle for families of children with SED. Few parents found service systems to be helpful during this transition." Regarding child-service systems, "they rated only child vocational rehabilitation services as helpful on most transition-related issues. Overall, they rated child vocational rehabilitation services higher than mental health, education, special education, child welfare and juvenile justice services." They rated adult vocational rehabilitation and adult mental health systems lower than child-serving systems. "They rated colleges quite positively. The few parents who rated the substance abuse system tended to rate it as helpful."

The surveyed families were members of the National Federation of Families for Children's Mental Health. They observed that "the most common barrier to services is simply the stigma young people feel in accessing services that could label them as mentally ill."[36] And the parents felt the services did not address the issues most relevant to their youth ("such as getting a job or finding a place to live") or sufficiently or appropriately include the parents.

> Parents of 18-20 year-olds rated mental health services lower and parents of those under 18 rated mental health services higher than parents of those over 20….They rated child mental health and special education services neither good nor bad on most transition-related issues, but poor on preparing adolescents for adulthood. Overall, they gave negative ratings to regular education, child welfare, and juvenile justice.[37]

Youth without families who are meaningfully involved in their lives are at most risk. Some of those youth are in State custody. Of the 978 youth aged 13-17 in 2006 who were in the custody of the Department for Children and Families (DCF) for child abuse and neglect or unmanageable or delinquent behavior, 65% also received children's mental health services.[38]

Vermont's Juvenile Justice and Delinquency Prevention (JJDP) Program has documented that "black youth are 20% less likely to be referred to juvenile court for minor offenses than white youth, while they have nearly a 60% greater chance of being referred to adult court than white youth for similar offenses."[39]

A study of the incarceration rate for youth aged 18-21 who had previously received children's services compared with the incarceration rate for the general population for the five years from FY1998-2002 shows that:

> Young people who had been on the [DCF] caseload had the highest incarceration rates overall (18%, more than four times the general population rate). Young people who had been on the mental health caseload had the second highest incarceration rate (9%, more

[34] Davis, M. & Stoep, A.V. (1996). The Transition to Adulthood Among Adolescents Who Have Serious Emotional Disturbance, p. ii.
[35] Davis, M. & Butler, M. (2002). Service Systems Supports During the Transition from Adolescence to Adulthood: Parent Perspectives, p. vii-viii.
[36] Ibid.
[37] Ibid.
[38] Pandiani, J. & Martin, B. (2007). Children in DCF Custody Served by CMH Programs.
[39] Lay-Sleeper, T. (1/7/2008). Emailed communication from JJDP Specialist.

> than twice the general population rate). Young people who had been on the special education caseload had the lowest incarceration rates (7%). Incarceration rates for boys were substantially higher than the incarceration rates for girls in every service group. The elevated risk of incarceration (the incarceration rate for service recipients divided by the incarceration rate for the general population) among [DCF] service recipients, however, is greater for girls than for boys. There were no significant differences, however, between the elevated risk of incarceration for girls and boys on the mental health and special education caseloads.[40]

Looked at in a different way:

> On average, more than 1,000 young adults (18-21 years of age) were incarcerated, per year during FY1998-2002. These young adults were predominantly male (88% vs. 12% female). Overall, more than half (52%) had been on the caseload of at least one of these child-serving agencies. Incarcerated young women were much more likely than incarcerated young men to have been served by the children's agencies (64% vs. 50%).[41]

As part of an ongoing trend for African-American youth, during one year

> female minorities were over-represented among Woodside *[the DCF secure detention and treatment facility for juvenile delinquents]* admissions relative to white females…Minority females were primarily admitted to Woodside for running away and intoxication…Woodside likely served as a place to put an out of control or runaway youth until a crisis situation was resolved or another more suitable placement arranged.[42]

Vermont's JJDP Specialist says that "secure detention placements for youth with high needs and no other appropriate placements are common in VT as they are nationally. Youth with untreated mental health needs commonly end up in secure detention."[43] "Minority youth may have fewer placement options available to them than do white youth."[44]

Thus, there is a lot of room for Vermont to improve the outcomes of service for transition-aged youth, especially for those who have been removed from their families and particularly for black youth and young women. Service models have not been adequately tailored to meet different gender and cultural needs, though recent AHS attention to trauma-informed services may bring about changes.

Describe the current capacity to serve children and youth with SED and their families.

The State of Vermont Department of Mental Health (DMH) has been building its system of care for children with SED since receiving a Child and Adolescent Services Systems Planning (CASSP) grant in 1986. The number of children and adolescents served annually by children's mental health programs has more than tripled since 1985, when there were only 3,000. [45]

An additional way of assessing Vermont's success in building this system of care is to look at a measure of the Child and Adolescent Caseload Segregation/Integration or "the degree

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[40] Pandiani, J. & Ghosh, K. (2003). More on Incarcerated Youth: Incarceration Rates for Young Adults Previously Served by Child-serving Agencies.

[41] Pandiani, J. & Ghosh, K. (2003). Incarcerated Young Adults Previously Served by Child-Serving Agencies.

[42] Bellas, M. L. (2004). Disproportionate Minority Confinement at Woodside's Detention Program October 1, 2000 to September 30, 2002, p.1. Retrieved on 1/3/2008 from http://humanservices.vermont.gov/boards-committees/cfcpp/publications/disproportionate-...

[43] Lay-Sleeper, T. (1/7/2008). Emailed communication from JJDP Specialist.

[44] Bellas, M. L. (2004). Disproportionate Minority Confinement at Woodside's Detention Program October 1, 2000 to September 30, 2002, p.19-20. Retrieved on 1/3/2008 from http://humanservices.vermont.gov/boards-committees/cfcpp/publications/disproportionate-...

[45] Vermont State Department of Mental Health. (1/28/2008). Emailed MIS information.

to which child-serving agencies share responsibility for serving children and adolescents with emotional disorders."[46] The degree of caseload overlap between children's mental health, child welfare/juvenile justice, and special education has increased from the initial measurement of 21% statewide in 1993 to 37% statewide in 2006. (0% would show no caseload overlap while 100% would show no differentiation of service across agencies for individualized needs.)

This increased focus on the same children, youth, and families is designed to produce more comprehensive services with more consistency and clarity about performance expectations for all, providers and families alike. Yet surveys of key stakeholders (parents, youth, educators, and child welfare caseworkers) reveal continued differences of opinion about the role of children's mental health services. Vermont parents of children and youth aged up to 18 who were served by the CMHCs in 2005 "were very likely to rate their programs favorably."[47] A survey of youth aged 14-18 who received Medicaid reimbursed services from the CMHCs in 2006 showed that 75% evaluated the programs positively overall.[48]

> Young people and parents had high agreement in their ranking of programs for three of our four measures of program performance (staff, quality, and overall performance). Parents, however, did not have high agreement on any of these measures with either educators or [DCF] caseworkers. Youth had high agreement with educators on only one measure (outcomes) and did not have high agreement with [DCF] caseworkers on any of the measures….Educators and [DCF] caseworkers had high agreement in their rankings of all four measures of program performance. Educators, however, did not have high agreement on any of these measures with either youth or parents. [DCF] caseworkers had high agreement with youth on only one measure (outcomes) and did not have high agreement with parents on any of the measures.[49]

Because –or in spite – of these different and competing perspectives about public children's mental health services, providers have worked diligently with other departments and agencies to develop services that are meaningful for the children, adolescents, and their families. They have searched for effective approaches to help youth with SED learn self-control of behaviors and emotions so they can avoid future incarceration and other negative consequences. Talking therapies must be blended with skills training since

> how teens spend their time seems to be particularly crucial. If the 'Use it or Lose it" principle holds true, then the activities of the teen may help guide the hard-wiring, actual physical connection in their brains [which are pruning down cells in later adolescence).[50]

One hands-on approach for transition-aged youth with SED created by Washingtogn County Mental Health Services in 1993 is the JOBS (Jump on Board for Success) program, which has been replicated (though under-funded) in all but one of the State's 12 service districts.

Establish the significance of the proposed initiative.

Dr. Maryann Davis described the JOBS program in her 2001 report to the National Technical Assistance Center for State Mental Health Planning (NTAC) about "State Efforts to Expand Transition Supports for Adolescents Receiving Public Mental Health Services."

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[46] Pandiani, J. & Carroll, B. (2006). Child and Adolescent Caseload Segregation/Integration in Vermont.
[47] Pandiani, J., Carroll, B. & Kobel, O. (2006). Parents' Evaluation of Children's Services Programs.
[48] Pandiani, J. & Carroll, B. (2007). Evaluation of Child and Adolescent Mental Health Programs By Young People Served in Vermont July – December, 2006: Technical Report, p.1.
[49] Pandiani, J. & Bramley, J. (2003). Survey Raters and Rankings: Children's Services Programs.
[50] Giedd, J. (undated). Inside the Teenage Brain. Interview with Frontline of PBS. Retrieved from internet 12/26/2007 from http://www.pbs.org/wgbh/pages/frontline/shows/teenbrain/interviews/giedd.html.

> The JOBS program is based on a highly effective model of supported employment for adults with serious mental illness. Recognizing that children's mental health services might be more effective for transition-age youth if supportive counseling were linked with the motivator of employment, one community mental health center with a reputation for providing both leadership and effective wraparound services collaborated with the Vermont Department of [VR] to develop the JOBS model. Although comparison or control group data are not available, initial findings from the first site include high rates of employment and high school or GED completion, increases in stable housing, and reduced use of mental health services and corrections and justice involvement.[51]
> In FY2006, 243 youth with SED were served by the JOBS program.[52]

Clearly, more youth – including those who are not eligible for Medicaid - need access to the JOBS program. The JOBS program should be infused or linked with treatment for co-occurring substance abuse or with trauma-informed services. Other opportunities exist for enhancing the JOBS experience for youth with SED by using culturally competent practices and linking the program more closely with existing community justice centers, resources for housing, Workforce Investment Boards, mentoring organizations, substance abuse recovery centers, and parenting education (both for the parents of the youth and for the youth who are parents).

Describe how the initiative will collaborate with other Federal, State, and local programs.
Governor Jim Douglas

> has identified youth in transition as a focal point. The Governor is concerned that the demographics in Vermont indicate there will not be an adequate work force in the state within the next decade to fill necessary jobs…He has also been concerned that many young people are ending up under Corrections supervision.[53]

As a result, he and the Legislature have taken steps to expand mentoring and college scholarship opportunities, to invest in career exploration and alternative education like internships, to strengthen the system of foster care services (including housing) for transition-aged youth, and to set up drop-in centers for people recovering from substance abuse. The Legislature is also studying how to curtail growth in the costs of incarceration, perhaps by closing some older facilities and investing more in community-based justice, treatment and housing options for offenders.[54] The success of this project depends upon sustained state and local collaboration that includes all of these and other activities; the collaboration will be strategically planned during Year 1 of the grant and will build upon the infrastructure described below.

Section B: Implementation Plan

Infrastructure Development

Describe how the cross-agency infrastructure for the system of care will be developed.

The strategic planning and ongoing management of this project will be under the direction of Vermont's State Interagency Team (SIT). SIT was established by State Law Act 264 in

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[51] Davis, M. (2001). State Efforts to Expand Transition Supports for Adolescents Receiving Public Mental Health Services, p. 11-12.
[52] McClintock, G. (undated). Jump on Board for Success (JOBS) Program.
[53] Smith, M.K. (2007). Report to the House Committee on Human Services and the Senate Committee on Health and Welfare about H.449 – Section 4. Study on Transitional Services for Youth, p.2
[54] Hofmann, R. (2007). Plan to Reduce Correctional Costs and Achieve Savings for Reinvestment.

1988 to oversee a system of care for children and youth with severe emotional disturbance and their families. Since then, its mode of operation has been so influential in Vermont that in 2005 the SIT's responsibilities were expanded through an Interagency Agreement between the AHS and the DOE to include a broader population: any student who is eligible for special education (in any of its 14 disability categories) and for services under AHS (Department of Health (VDH *[which at that time included DMH, now – once again – a separate department]*), DCF, Department of Disability, Aging and Independent Living (DAIL), Department of Corrections (DOC), and Office of Vermont Health Access (OVHA [Medicaid]).

> 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….These services will be provided with the intent to increase the number of youth with disabilities entering employment, further education, and independent or supported living.[55]

A copy of the AHS/DOE Interagency Agreement is included in Appendix 1.

Describe the composition and responsibilities of the proposed governance body.

As required by the AHS/DOE Agreement,

> The SIT includes a high level manager from the following departments and divisions within state government: DOE,…DMH, Division of Disabilities and Aging Services (DDAS [in DAIL]), Division of Family Services (DFS [in DCF]), Division of Alcohol and Drug Abuse Programs (ADAP [in VDH]), …VR [from DAIL] and AHS Field Services as well as other units as determined by the Secretary of AHS. A family consumer representative will also be a core member of the SIT. The SIT is responsible for overseeing the development and maintenance of the system of care to address the needs of children with eligible disabilities, for assuring the consistent development of coordinated services plans, and to be part of the dispute resolution process.[56]

Historically, most of the children and youth served by SIT have been in school and/or in DCF custody; for this project, its reach will extend more systematically to youth who are out of school and/or in contact with the adult criminal justice system. One or more subcommittees of SIT will be established and report to it. One of the subcommittees will be a State Outreach Team that will take the lead in drafting the required strategic plan (including regional plans from each of the 12 AHS service districts) during Year 1 of this project and in overseeing its subsequent implementation. The State Outreach Team will include representation from the SIT State departments, statewide family organizations, and statewide youth organizations. Additional State departments that will be invited to participate on the State Outreach Team include at least Labor, Corrections, the Attorney General's Office (for Diversion), and the Courts. The statewide family organizations that will be invited to participate include at least the Vermont Federation of Families for Children's Mental Health and the Vermont Parent Information Center (which has now merged with Parent to Parent of Vermont). The statewide youth organizations that will be invited to participate include at least the DCF Youth Development Committee (with its staff liaison), the VR Youth and Family Advisory Committee (with its staff liaison), the Vermont Coalition of Runaway and Homeless Youth

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[55] Smith, M. & Cate, R. (2005). Interagency Agreement with Vermont Department of Education and Vermont Agency of Human Services Pursuant to Part B of the Individuals with Disabilities Education Act, p. 2.
[56] Ibid. p. 4

Programs [VCRHYP], the Vermont Coalition of Teen Centers, and Outright Vermont (serving gay, lesbian, and transgendered youth). All of the state-level staff required for this project will also participate on the State Outreach Team.

The representatives will be people who are knowledgeable about their agencies' resources, who can make funding commitments, and who are able to strategize and help with problem-solving. They will make at least annual site visits to the 12 regional in-state projects, prepare for and participate in federal program and evaluation site visits to Vermont, and attend the twice-yearly required grantee meetings out-of-state. See Appendix 1 and Appendix 5 for letters of commitment and support for this State Outreach Team.

Describe procedures for systems integration, interagency collaboration, etc.

The AHS/DOE Interagency Agreement describes the general process for coordination of services consistent with Act 264 as extended from children and youth with SED to the broader population of students with disabilities. Though the receipt of particular services is not guaranteed by the Act or Agreement, "eligible children are entitled to receive a coordinated services plan developed by a service coordination team including representatives of education, the appropriate departments of the (AHS), the parents or guardians, and natural supports connected to the family."[57]

The Agreement notes that "special consideration needs to be given to transition-aged youth. Specific transition planning must begin at the age required by federal and state law."[58] Four of the 14 pages of the Agreement describe the VR transition service coordination available for students with disabilities in Vermont's high schools, from the referral process to the use of specific resources and programs (like JOBS).

One of the current sub-committees of SIT is the Case Review Committee (CRC). "When a team believes that a child or youth requires highly intensive services in residential care or intensive wrap-around services, the [coordinated services] plan shall be reviewed and approved by the"[59] CRC.

> The CRC serves both as a control to assure the appropriateness of high cost placements in the least restrictive environment, and also as a consulting body for local teams, helping identify appropriate services and approaches for eligible children and youth with the highest level of need.[60]

Another 4 of the 14 pages of the Agreement clarify the financial responsibility of various AHS/DOE departments and programs for State-placed students, services provided to children residing in their homes and communities, and other funding obligations. According to this section, "local community mental health agencies provide mental health supports to children who would benefit from such services within available resources."[61] The lack of sufficient resources to provide services for transition-aged youth is why Vermont is applying.

Describe how you will replicate the local system of care in other communities.

Vermont Act 264 established, and the AHS-DOE Interagency Agreement expanded, the population served by Local Interagency Teams (LIT), one per each of the 12 AHS

[57] Ibid, p.3.
[58] Ibid, p.3.
[59] Ibid, p.3-4.
[60] Ibid, p.5.
[61] Ibid, p.10.

service districts. "The LIT supports the creation of a local system of care and assures that staff are trained and supported in creating coordinated services plans. They also play a key role in dispute resolution."[62] In addition, LITs

> assure that there is a structure to focus on the particular needs of transition-aged youth to support transition from school to adult life. Adult agency providers would be included as needed including high level local leaders from adult mental health programs (CRT) and the Department of [Labor].[63]…Each LIT includes a special education director selected by the districts in that region, the local children's mental health director, the Family Services director, a family consumer representative, high level local leaders from developmental services and substance abuse, and a VR representative. Other AHS programs are represented as needed. The AHS Field Director and a designated DOE staff person assure that the region has a highly functional team and [are] responsible for working with the team to solve funding issues. The Field Director is the key conduit to a High Risk Fund, managed through the Field Services Division.[64]

The SIT and LITs are well-versed in thinking about at least some transition-aged youth. "The first individual plan reviewed by the Act 264…SIT [in 1988] was for a transition-aged youth (VT Child and Adolescent Services System Plan [CASSP] grant application, 1993)."[65] By 1995 and the end of a three-year CASSP grant to DMH focused on transition-aged youth, the evaluator concluded that:

> On the local level, there has been improvement in capacity to assist youth in transition. The preliminary work of conducting needs assessment has been completed, identifying specific needs for each region. Important interagency collaborative relationships have been well established; each county approaches transition planning with all the key players at the table. Still, issues of categorical funding and eligibility criteria challenge providers to find needed resources to provide services to all youth in need (Livingston, 1995).[66]

As part of its strategic planning (including for sustainability), the SIT State Outreach Team will issue an "Invitation to Communities" asking the 12 LITS to develop regional strategic and oversight plans for this project. The State Outreach Team will sub-grant the federal funding based upon its review of the regional plans submitted by the LITs. The LITs might assign the initial planning to subcommittees or related groups already focused on the needs of transition-aged youth. Those subcommittees or groups might be Core Transition Teams or JOBS advisory boards or some other interagency entities active in the regions and knowledgeable about transition-aged youth with SED. Whatever the planning body, it will have or seek families and youth (among others) for ongoing membership and/or regular, frequent input. SIT will provide resources for the LITs to aid their planning processes and to effectively involve families and youth - including those who are non-white and/or not proficient in English - and the community organizations that represent them (such as local teen centers or member programs of the VCRHYP, or the Burlington-based Association of Africans Living in Vermont [AALV], etc.). SIT will instruct the LITs to seek input from youth and families who are served by each of the involved departments and agencies, including DCF, Corrections, CMHCs, etc.

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[62] Ibid, p.4.
[63] Ibid.
[64] Ibid, p.4.
[65] Delmasse, D. (2002). Partnership for Youth Initiative Grant Application, p. 2.
[66] Ibid, p.3.

Describe strategies for developing the structures of a system-of-care.

This project will make use of existing agencies and collaborative groups and does not require much new infrastructure beyond some additional key staff at the State and local levels. The ten CMHCs in Vermont that qualify as Designated Agencies (DAs) of the DMH will be involved in the delivery and oversight of clinical services, as may some other community agencies depending upon the regional plans that are developed. State statute gives the DAs responsibility for the delivery of mental health services in their regions; statute also requires that 51% of the Boards of Directors of the DAs be composed of consumers and family members. Every two years the DAs' programs are reviewed by DMH, and every four years they must pass a stringent Designation Review to maintain their status as preferred providers. The DAs follow strict internal auditing and corporate compliance standards and procedures, especially related to record-keeping and billing for the use of Medicaid. They track the services they provide by contributing data to the DMH statewide Management Information System (e.g., Dr. Pandiani).

The CMHCs do experience significant turn-over of staff due to low wages, high stress, and inadequate pre-service preparation for their system-of-care work; only 38% of the 1,175 children's mental health staff had greater than 2 years tenure in FY2006.[67] This greatly compromises continuity and quality of care. Therefore, **the most glaring infrastructure need related to this project is for high quality ongoing in-service training and mentoring for both clinicians (MA and BA-levels) and their supervisors.**

Describe the training, technical assistance and social marketing strategies.

In order to obtain the highest quality training and social marketing-communication assistance, the SIT State Outreach Team will issue competitive Requests for Proposals (RFP) in the second half of the Year 1 strategic planning process. Before doing so, the State Outreach Team will formally adopt a mission statement, goals, and logic model for this project. The State Outreach Team will also have approved the regional plans before awarding funds for the training and social marketing-communications assistance to carry them out. The RFPs will require the training and social marketing-communications providers (.5 FTE each) to design their delivery of services in a way that will involve the key stakeholders: the State Outreach Team, the regional LITs, families, youth, and community organizations that represent minorities in Vermont. The RFP for training will also require linkages with one or more institutions of higher education.

The selected Social Marketing-Communications Manager will produce a strategic marketing plan with input from a committee of the key stakeholders; their plan will be final only after approval by the State Outreach Team. Some of the social marketing will be linked with AHS efforts to inform transition-aged youth, their families and the broader public about the opportunity to enroll in Medicaid; some will help the Vermont Federation of Families for Children's Mental Health reach out to transition-aged youth with SED and their families to inform them about the existence of mental health problems and available help and hope for those problems. These efforts will be linked with the national Caring for Every Child's Mental Health Campaign goals and messages to reduce stigma related to mental illness and will annually include activities (in collaboration with the Federation) in honor of National Children's Mental Health Day. The Social Marketing-Communications Manager will determine the informational needs of priority audiences and develop messages and materials that are in compliance with relevant standards for cultural and linguistic appropriateness and sensitivity, including compliance with the Americans with Disabilities Act (ADA).

[67] Pandiani, J. & Kobel, O. (2007). Mental Health Staff Tenure and Turnover FY2006.

The selected Technical Assistance Coordinator provider will produce a strategic training and technical assistance plan with input and help from an ongoing interagency training team composed of key stakeholders. The plan will reflect the expectations of the national T/TA provider and will be final only after approval by the State Outreach Team. Much of the training and technical assistance will be offered to a cross-section of participants that includes youth, families, employers, and service providers from different agencies and youth-serving professions (mental health, health, education, child welfare, juvenile justice, criminal justice, etc.). This common training will be used to build common perceptions and expectations about services for transition-aged youth with mental health and/or co-occurring substance abuse challenges.

Describe plans to collaborate with the other child serving systems, including MOUs.

An AHS-sponsored study group formed in September, 2007 to respond to the Legislature's request for a report about youth in transition, including their use of foster care past age eighteen as allowed by the recently-passed H.449. The participants in the study group recommended that the AHS address the following eight goals for youth in transition:

- **Employment, Training and Post-Secondary Education:** Youth are competitively employed, enrolled in college or other post-secondary options, or have received a college degree.
- **Health Care:** Youth have health insurance and access to care.
- **High School Completion:** Youth earn a high school diploma or complete a training program.
- **Safe and Stable Housing:** Youth have safe, stable, & adequate housing.
- **Free from Incarceration:** Youth have adequate preparation and the necessary supports to be productively engaged in the community.
- **Caring Relationships:** Youth are meaningfully engaged in supportive and permanent relationships.
- **Future Planning:** Youth are engaged in planning for their future.
- **Skilled Workforce:** Youth are engaged by adults who have the knowledge, skills and abilities to support positive youth development.

The study group's attention to these areas of focus was the result of *[research reported by several national sources]* including: the National Governors' Association Center for Best Practices, the National Child Welfare Resource Center on Youth Development and the Jim Casey Youth Opportunities Initiative.[68]

The Secretary of Administration, who submitted the report to the Legislature, said:

The Agency *[of Human Services]* and its community partners already provide a variety of services and supports for youth in transition such as Jump on Board for Success (JOBS), Vermont Coalition for Runaway Youth Programs, mentoring, adult learning, personal care services, expanded services to youth aging out of foster care, transitional housing, and out-patient mental health. In recognition of the fact that expanding services comes with an enormous price tag, the Agency of Human Services is currently designing a comprehensive one agency approach to integrate all AHS efforts to meet the needs of

[68] Smith, M. K. (2007). Report to the House Committee on Human Services and the Senate Committee on Health and Welfare about H.449 – Section 4. Study on Transitional Services for Youth, p.7.

youth in transition that are currently served by the Agency. This is the recommended approach, rather than expanding the current system *[of separate services/providers]*.[69]

The members of the study group believe that **JOBS is a logical foundation upon which to build an integrated AHS approach to transition-aged youth with SED** because there is already a history of interdepartmental support within AHS for the program (see Letter of Agreement Between DMH, DOC, VR, and DCF for State FY2007 in Appendix 1). JOBS "serves high school drop-outs and those at risk for dropping out and engages youth in non-stigmatizing employment services while providing a bridge to more intensive mental health and case management services."[70] The JOBS program also works

> Closely with the Community High School of Vermont [*serving DOC clients]* and the…DOC to provide support to youth reintegrating in to the community. The JOBS Program costs an estimated $5,000 per client/per year. This compares favorably to the estimated annual cost of an inmate[71] at an in-state jail ($45,702).[72]

Explain how the initiative will increase the capacity and quality of services delivered.

In State FY2007, according to the DMH Management Information System, 2,346 youth aged 16-21 (inclusive) received the following children's mental health services from CMHCs:

- Community Supports 1,448 or 62%
- Clinical Interventions 1,353 or 58%
  - Service Planning and Coordination 1,233 or 53%
  - Individual, Family, and Group Therapy: 936 or 40%
  - Clinical Assessment Services 549 or 23%
  - Emergency/Crisis Assessment, Support and Referral 459 or 20%
  - Medication and Medical Support and Consult Services: 397 or 17%
- Housing and Home Supports 77 or 3%
- Respite 68 or 3%
- Emergency Crisis Beds 4 or 0%

Some of these services were delivered for youth involved with the JOBS program; others were delivered as part of individualized wrap-around plans for youth who were in State custody and perhaps not involved with JOBS; most were delivered for youth still in school.

The exact services to be implemented will be determined by the LITs with approval from the SIT State Outreach Team during the first year of the project. Building upon and consistent with the Act 264 system of care that has been in place in Vermont for 20 years, each LIT will be required to provide for each transition-aged youth who is served -- cross-system care management and individualized service plan development (consisting of, in Medicaid terms, targeted case management, or as it is now called by DMH, Service Planning and Coordination).

> **Service Planning and Coordination** assists individuals and their families in planning, developing, choosing, gaining access to, coordinating and monitoring the process of needed services and supports for a specific individual. Services and supports that are planned and coordinated may be formal (provided by the human services system) or

[69] Ibid, p.8.

[70] Smith, M. & Cate, R. (2005). Interagency Agreement with Vermont Department of Education and Vermont Agency of Human Services Pursuant to Part B of the Individuals with Disabilities Education Act, p. 8.

[71] AHS Youth in Transition Leadership Team. (2207). Draft #4: The JOBS Program Expansion – A Model Approach to Transition Services for Youth with Severe Emotional Disturbance, p.2.

[72] Hoffman, R. (2007). Plan to Reduce Correctional Costs and Achieve Savings for Reinvestment, p.26.

informal (available through the strengths and resources of the family or community). Services and supports include discharge planning, advocacy, monitoring the well-being of individuals (and their families), and supporting them to make and assess their own decisions.[73]

Community-based services such as (in Medicaid terms, specialized rehabilitation) Individual and Group Community Supports are also likely to be chosen for youth by the LITs.

Individual and Group Community Supports are specific, individualized, and goal oriented services that assist individuals (and families) in developing skills and social supports necessary to promote positive growth. These supports may include support in accessing and effectively utilizing community services and activities, advocacy and collateral contacts to build and sustain healthy personal and family relationships, supportive counseling, and assistance in managing and coping with daily living issues.[74]

Service Planning and Coordination and Individual and Group Community Supports are carefully tailored to the needs of the youth and family, including considerations about their race(s), ethnicity, and other cultural factors. The complexity and intensity of needs of the youth and families to be served will determine the number of units of Service Planning and Coordination or Individual or Group Community Supports delivered. Whenever possible, these services will be billed to Medicaid or private insurance, but for youth do not have this kind of coverage the grant funds will be used. The increased capacity for service will be due to the grant funds. Detailed regional planning will be needed before estimates can be made of the number of additional direct service staff who can be hired (est.1-2 FTE/region) or the number of additional youth and families who can be served with the grant funds (est.10-20/FTE/year).

Describe your relationship with and involvement of individuals in project development.

Subsequent to completion of their report about youth in transition for the Legislature, participants from the AHS study group and others advised the writing of this grant application. They included representatives from:

- *State child-serving agencies and leaders;*
  - The following AHS State departments: AHS Central Office Field Services Division, DMH, DCF (the Family Services, Economic Services, and Child Development Divisions), DAIL (VR and Developmental Disabilities), Corrections, VDH (Public Health and ADAP), OVHA
  - Other State departments: Education, Labor, Attorney General's Office (Diversion Programs), Court Administrator's Office
- *Local child-serving agencies and community leaders:*
  - DAs: public children's mental health programs (including JOBS)
  - VCRHYP: Vermont Coalition of Runaway and Homeless Youth Programs
- *Family members and family-run organizations and advocates:*
  - Vermont Federation of Families for Children's Mental Health
  - Vermont Parent Information Center
- *Youth:*
  - Staff liaison for DCF Family Services Youth Development Committee
  - Staff liaison for VR Youth and Family Advisory Committee

[73] DMH. (2005). Fee-For-Service Medicaid Reference Material for Mental Health Covered Services (Service Planning and Coordination and Community Supports) Under the State Medicaid Plan, p.6.
[74] Ibid, p.5.

- *Racial, ethnic and other cultural groups in the community.*
  - AHS State Refugee Coordinator.

Discuss the extent to which the nonfederal match dollars demonstrate interagency collaboration.

Appendix 5 includes letters with certification from different departments about the non-federal match they are pledging for the next six years for the public system of care for transition-aged youth. The certified match is summarized in a table (also in Appendix 5) that shows the new investments (above the average of expenditures for State FY06 and FY07) of State General Funds that the AHS and the Departments of Labor and the Attorney General's Office have already budgeted for FY08 and that they expect to budget for future years for this population. The State Outreach Team will monitor and report the budgeting and expenditures annually.

It is, of course, impossible to know what will happen several years in the future. Relying upon a track record from the past is the most reliable indicator of future performance. DMH was able to fully sustain the services initially funded by its two prior CMHI grants (1. Access Vermont, for children's crisis outreach services and 2. CUPS, for children aged 0-6) and expects to be able to do so again if it receives this grant. To do so, legislative approval will be required.

In 2006-2007 the Vermont Legislature studied and responded to the needs of transition-aged youth for improved access to Medicaid, scholarships for college, and extended foster care (past their 18th birthday), etc. In prior years legislators have studied and responded to the needs of adolescents for substance abuse treatment and for special status as youthful offenders rather than as adult criminals. *[In Appendix 1, see letters of support from legislators for this proposal.]*

In 2007 a larger concern about offenders was expressed by the Joint Corrections Oversight Committee and the Joint Fiscal Committee, which ordered a report from the DOC about "ways to curtail the growth in Corrections spending and Vermont's incarcerated population. The charge was: 1.) to reduce cost increases by $4 million, and 2.) to reduce the number of non-violent offenders in prison by 10%, or 100 beds."[75] One of the ideas generated by DOC in response to this charge is to

> place greater reliance on AHS capacities…A continuum of treatment approaches, ranging from intensive outpatient to secure treatment, could be provided in communities for non-violent offenders with either mental health or substance abuse disorders, or co-occurring disorders. AHS Field Directors are in a unique position to engage community leaders, rally advocates, and stand as local partners with DOC in support of community treatment for offenders.[76]

Another report requested by the Legislature this year says that

> For more than 25 years, Vermont has been developing and expanding a variety of community-based programs that are alternatives to the traditional criminal, juvenile justice, and correctional system. These include court diversion, restorative probation, street checker programs and community justice centers….Restorative justice is the common approach for all of these community justice programs…..Rather than solely imposing punishment, the focus is on repairing the harm caused by the offender to the victim and the community. A restorative justice approach creates opportunities for the people most directly affected by harmful behavior – the victim, the person who commits the act, families and the representatives of the community – to be actively involved in

[75] Hofmann, R. (2007). Plan to Reduce Correctional Costs and Achieve Savings for Reinvestment, p. i
[76] Ibid, p.71.

responding to and preventing further harm while also building capacity for the individual, family and community. [77]

The evidence is that this restorative justice approach has many benefits for crime victims; offenders; citizens, families, and community groups; the justice system; and human service providers.[78] Therefore, it seems quite possible that in future years the Legislature may divert some funds from incarceration to community-based justice programs and to community-based mental health treatment and substance abuse treatment for offenders, including transition-aged youth. Some of those treatments may well be in conjunction with the Drug and/or Mental Health Treatment Courts that are just beginning to emerge in Vermont as alternatives to incarceration:

- **Adult Drug/Treatment Court Projects in Rutland, Chittenden and Washington Counties** (best suited for high needs/high risk individuals and focuses on chronic behaviors for the purpose of reducing recidivism and substance abuse among nonviolent offenders and increasing their likelihood of success);
- **Juvenile Drug Court in Franklin County** (for youth who have been charged with delinquency and who are using drugs and/or alcohol);
- **Family Treatment Court Project in Chittenden County and one being planned for Caledonia County** (for parents with substantiated child abuse and neglect, who are dependent on drugs and/or alcohol and have admitted that their substance use has interfered with their ability to parent); and
- **Mental Health Court in Chittenden County** (for individuals aged 18 or over with severe and persistent mental illness and co-occurring disorders).[79]

Service Delivery

Specify eligibility criteria, referral sources and enrollment procedures.

The goal of this 6-year project is that youth aged 16-21 (inclusive) with SED have adequate preparation and the necessary supports to be productively engaged in the community and free from incarceration. For this population, the necessary supports include access to health care (908 youth [173 per each of 5.25 years] will receive treatment for mental health and co-occurring substance abuse challenges), post-secondary education, employment, housing, and caring relationships (with adults who nurture positive youth development. Providing all of these services and supports for individual youth and their families as needed – by a skilled workforce - addresses the AHS goals for youth in transition.

The Invitation to Communities will instruct the LITs that they must document to the satisfaction of the SIT State Outreach Team how they plan to structure and operate the regional system of care to effectively address the goal of the project. This will require efforts to integrate AHS services for transition-aged youth 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, some of whom will be new partners for the LITs.

The LITS will be asked to augment the existing system of care for children and adolescents with SED by intentionally reaching out to transition-aged youth at least through teen centers, substance abuse recovery centers, and homeless youth programs.

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[77] AHS and Attorney General's Office. (2007). Community-Based Alternatives for Criminal Justice Services: Report to the Legislature, p.1.
[78] Ibid, p.40.
[79] Gennette, K. (2007). State of Vermont Treatment Court Projects.

Also, the LITs must give systematic thought to how the region can intervene earlier with youth who might be headed for incarceration.

> The Sequential Intercept Model provides a conceptual framework for communities to use when considering the interface between the criminal justice and mental health systems…The model envisions a series of points of interception at which an intervention can be made to prevent individuals from entering or penetrating deeper into the criminal justice system. Ideally, most people will be intercepted at early points, with decreasing numbers at each subsequent point. The interception points are law enforcement and emergency services; initial detention and initial hearings; jail, courts, forensic evaluations, and forensic commitments; reentry from jails, state prisons, and forensic hospitalization; and community corrections and community support…Using the model, a community can develop targeted strategies that evolve over time to increase the diversion of people with mental illness from the criminal justice system and to link them with community treatment.[80]

An accessible mental health system using best clinical practices is considered “the ultimate intercept”.[81] Though this model was developed with help from the National GAINS Center for People with Co-occurring Disorders in the Justice System to address the needs of adults with serious mental illness (SMI), it is equally relevant to the situation of transition-aged youth with SED. For these youth in Vermont, the intersection points include the juvenile justice system as well as the criminal justice system because 16 and 17 year-olds here can be charged in either system at the discretion of the County State’s Attorney. A similar model with Critical Intervention Points was developed for the juvenile justice system by the National Center for Mental Health and Juvenile Justice (NCMHJJ). The Critical Intervention Points include: Initial Contact with Law Enforcement…Intake (Probation or Juvenile Court)…Detention…Judicial Processing…Dispositional Alternatives (Juvenile Correctional Placement or Probation).[82]

Both the Sequential Intercept Model and the framework with Critical Intervention Points highlight under-utilized sources of referral for mental health services for transition-aged youth with SED in Vermont. It is certainly preferable – and often in the heat of crisis more effective – to offer individuals treatment before they end up deep within the juvenile or criminal justice systems. The adult mental health system works closely with law enforcement and, in Burlington, HowardCenter adult mental health staff attend the Mental Health Court. Children’s mental health staff, however, have little interface with law enforcement (aside from some recent training about alternatives to transporting children in handcuffs), and there is virtually no children’s mental health presence at detention or other initial court hearings. While individuals with mental health expertise may (or may not) voluntarily serve on some of the growing number of community justice center and diversion boards, there is currently no systematic attention to making sure this happens. A simplified look at the Continuum of Justice Services here illustrates a number of pre-adjudicatory steps at which mental health referrals could be made.

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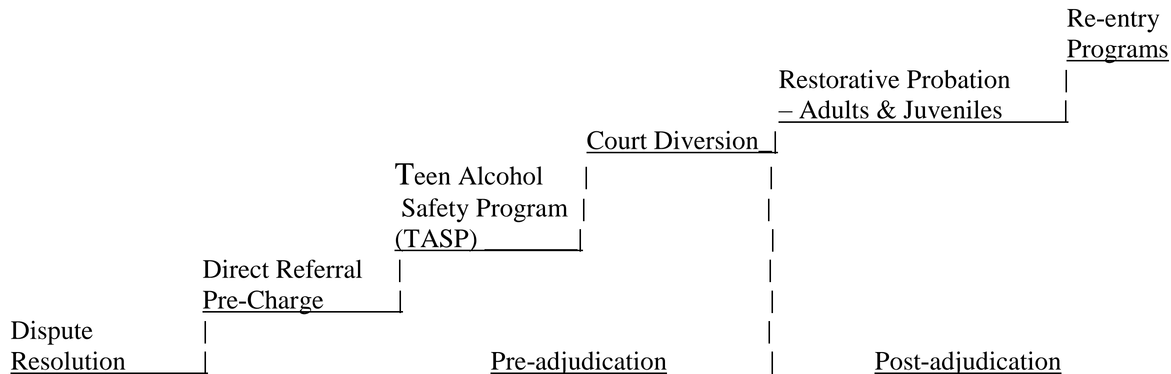
[80] Munetz, M. R. & Griffin, P. A. (2006). Use of the Sequential Intercept Model as an Approach to Decriminalization of People with Serious Mental Illness. *Psychiatric Services. ps.psychiatryonline.org.* 57(4), p. 544.

[81] Ibid, p. 545.

[82] Skowyra, K. R. & Cocozza, J. J. (2007). Blueprint for Change: A Comprehensive Model for the Identification and Treatment of Youth with Mental Health Needs in Contact with the Juvenile Justice System, p. ix.

A Continuum of Justice Services [83]



NCMHJJ recommends that

> every youth who comes in contact with the juvenile justice system should be systematically screened for mental health needs to identify conditions in need of immediate response, such as suicide risk, and to identify those youth who require further mental health assessment or evaluation.[84]

Furthermore, "given the high rates of co-occurring mental health and substance use disorders among this population, all screening and assessment instruments and procedures should target both mental health and substance use needs, preferably in an integrated manner."[85] The screening and assessment instruments may need to be adapted for "youth of color and girls".[86]

With this project, the LITs will be asked to strategically plan how to intercept transition-aged youth at critical intervention points with law enforcement and the criminal and juvenile justice systems. This will strengthen the existing linkages between children's mental health, law enforcement and the criminal and juvenile justice systems; improve access to children's mental health and co-occurring substance abuse treatment services for the youth at most risk for poor outcomes; and use the power of the courts to increase the likelihood of use of those services by the youth. As one such youth said when asked for advice about this proposal, "You have to make them go."

Most youth referred for mental health services – including screening and/or assessment for co-occurring problems – through this extension of the system of care will be eligible for either clinic-based or outreach-based services. To receive clinic-based services a person must simply be experiencing mental health symptoms as described in the DSM-IV-TR.[87] In order to receive outreach-based services, a child or adolescent must be experiencing or at risk of experiencing a severe emotional disturbance. Vermont's Act 264 defines a child or adolescent with a severe emotional disturbance as someone who:

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[83] AHS and Attorney General's Office. (2007). Community-Based Alternatives for Criminal Justice Services: Report to the Legislature, p. 5

[84] Skowyra, K. R. & Cocozza, J. J. (2007). Blueprint for Change: A Comprehensive Model for the Identification and Treatment of Youth with Mental Health Needs in Contact with the Juvenile Justice System, p.26.

[85] Ibid, p.29.

[86] Ibid.

[87] American Psychiatric Association. (2000). Diagnostic and Statistical Manual of Mental Disorders: Fourth Edition: Text Revision.

(A) exhibits a behavioral, emotional, or social impairment that disrupts his or her academic or developmental progress or family or interpersonal relationships;
(B) has impaired functioning that has continued for at least one year or has an impairment of short duration and high severity;
(C) is under 18 years of age, or is under 22 years of age and eligible for special education under state or federal law; and
(D) falls into one or more of the following categories, whether or not he or she is diagnosed with other serious disorders such as mental retardation, severe neurological dysfunction or sensory impairments:
   (i) Children and adolescents who exhibit seriously impaired contact with reality and severely impaired social, academic and self-care functioning whose thinking is frequently confused, whose behavior may be grossly inappropriate and bizarre and whose emotional reactions are frequently inappropriate to the situation.
   (ii) Children and adolescents who are classified as management or conduct disordered because they manifest long-term behavior problems including developmentally inappropriate attention, hyperactivity, impulsiveness, aggressiveness, anti-social acts, refusal to accept limits, suicidal behavior or substance abuse.
   (iii) Children and adolescents who suffer serious discomfort from anxiety, depression, irrational fears and concerns whose symptoms may be exhibited as serious eating and sleeping disturbances, extreme sadness of suicidal proportion, maladaptive dependence on parents, persistent refusal to attend school or avoidance of nonfamilial social contact.[88]

Act 264 also says that "the receipt of appropriate services…including out-of-home placement, shall not be conditioned on placement of the child or adolescent in the legal custody, protective supervision or protection of the [DCF]."[89]

While youth who are aged 18 or older can sign the necessary consent forms for treatment by a CMHC (see these forms in Appendix 4), adolescents under 18 can only be served once or twice unless their parents or guardians sign the forms. Therefore, family involvement with mental health treatment is assured for 16 and 17 year-olds; for older youth, to ensure the most lasting effects of treatment, every effort is made by clinical staff to involve each youth's nuclear and/or extended family and other informal community supports.

Explain how the service components will be developed, implemented… and sustained.

The CMHCs develop with the youth and their families individualized treatment plans that, as necessary and appropriate, make use of the full array of children's mental health and non-mental health services in their communities. In addition, for this project the CMHCs will address the critical needs of transition-aged youth for independent living skills as they continue their education and/or seek employment and housing with the complications of being under the jurisdiction of the juvenile and/or criminal justice systems.

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[88] V.S.A. (Vermont Statutes Annotated – Online) Title 33, Chapter 43, section 4301 (3). Retrieved 1/7/2008 from http://www.leg.state.vt.us/statutes/fullchapter.cfm?Title=33&Chapter=043, p.1-2.
[89] Ibid, p.6

Lessons learned by The National Center on Youth Transition for Behavioral Health, which has evaluated and provided technical assistance to the CMHS Partnerships for Youth Transition Initiative (PYT), are that

> continuity of care and developmentally appropriate services can improve outcomes for youth with SED/SMI. Developmentally appropriate services support their strengths, interests and goals, enhance their social and life skills, and connect them to responsible adults and other important people in their lives.[90]

Developmentally appropriate services "fit their time of life", helping youth with SED/SMI meet their priorities of finishing school and career training; finding a decent job; learning independent living skills; managing and living within a budget; finding an affordable, safe and comfortable home; and dealing with their family issues.[91]

The Director of the National Center on Youth Transition, Hewitt B. "Rusty" Clark, Ph.D., developed a Transition to Independence Process (TIP) Model for delivering developmentally appropriate services to youth. The TIP Model emphasizes the following principles:

1) **Engage** young people in a relationship with a caring, responsible adult to plan for their own future.
2) **Tailor** services and supports to be accessible, coordinated, developmentally appropriate and to build on strengths.
3) **Respect** young people's developmentally appropriate search for independence and social responsibility by acknowledging personal choice and their need to find their own way.
4) **Ensure** a safety net of support, including family, to reduce risks.
5) **Strengthen** young people's competencies to assist them in achieving greater self-sufficiency and confidence.
6) **Help** the young person maintain a focus on outcomes, and encourage programs and systems to do the same.
7) **Involve** young people, parents and other community partners in the TIP system at all stages and levels.[92]

> In a discussion of the theoretical and research underpinnings for TIP, Dr. Clark says he worked with colleagues in Washington County, Vermont as they were developing a transition system. He learned from them and they learned from him in those early days. Today, that program is operational in about nine communities in Vermont, and Clark had an opportunity to assist in an evaluation of the initiative, examining the effectiveness of this TIP-type program (Clark et al., 2004). This study provided an analysis of pre- to discharge progress that showed substantial improvements in the outcomes for young people with EBD (i.e,, increased percentages of young people being employed and completing educational goals – and decreased involvement in the criminal justice system, "intensive" mental health/substance abuse service use, and public assistance). The evaluators also conducted a cost avoidance analysis that showed substantial savings as a function of the community-based TIP-type program.[93]

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[90] National Center on Youth Transition..(2007). Seeking Effective Solutions: Partnerships for Youth Transition Initiative. Retrieved 1/7/2008 from http://ntacyt.fmhi.edu/index2.cfm , p.6.

[91] Ibid, p.3.

[92] Ibid, p.2.

[93] Transition to Independence Process (TIP) Project, Theoretical and Research Underpinnings. Retrieved 1/7/2008 at http:tip.fmhi.usf.edu . p.2.

That TIP-type program is the JOBS program, now in 11 of Vermont's 12 service districts. **JOBS includes an adaptation of Supported Employment, one of the six Evidence-Based Practices (EBPs) with Implementation Resource Kits introduced by SAMHSA and CMHS.** The other five kits are about Illness Management and Recovery, Medication Management Approaches in Psychiatry, Assertive Community Treatment, Family Psychoeducation, and Integrated Dual Diagnosis Treatment for Co-occurring Disorders.[94] These practices were primarily developed for use with adults with SMI; the basic ideas have been used by the adult mental health system in Vermont for years, with more recent attention to Co-occurring Disorders. The practices are – with adaptations to make them age-appropriate - also relevant for transition-aged youth with SED so are highlighted by the National Center on Youth Transition.

According to SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP), other EBPs that are appropriate for transition-aged youth are Multisystemic Therapy for Juvenile Offenders, Trauma Recovery and Empowerment for women with histories of exposure to sexual and physical abuse, Psychoeducational Multifamily Groups, and the Incredible Years (for teaching parenting skills). All have demonstrated effectiveness with diverse populations.[95]

With this project, the 12 Local Interagency Teams (LITS) will be asked to consider what mental health services (in addition to Service Planning and Coordination) to fund to best support youth aged 16-21 (inclusive) who are experiencing severe emotional disturbance so they can be productively engaged in the community and free from incarceration. The LITs will be required to use the JOBS program (which operates in accordance with the TIP Model) as a platform for integration of the services. Each LIT should also decide whether it is important for that region to establish (in one district) and/or expand the JOBS program (which uses the EBP of Supported Employment adapted to be age-appropriate) or augment it with another EBP - such as for the treatment of co-occurring mental health and substance abuse disorders, the treatment of trauma, or for family or parenting education.

For this strategic planning, they will be required to consider the input of at least youth, family members, community (including cultural) organizations, mental health staff from both child and adult services, VR representatives, Work Force Investment Board or other business representatives, substance abuse treatment providers, health care providers, educators, law enforcement, and juvenile and criminal justice (including but not limited to DCF and DOC) representatives. The LITS will also design a management team for the project. The management team will seek ongoing input from the key stakeholders and will contribute to the State's long-range planning (and activities) for sustainability. If the project achieves its goal, the key stakeholders and regional management teams will be helpful finding resources to continue.

Describe the strategies to implement key service activities including Delivery of Clinical Interventions and Care Coordination/Individual Service Plans.

The exact services to be implemented will be determined by the LITs with approval from the SIT State Outreach Team during the first year of the project. All will deliver Service Planning and Coordination, about which the following statements can be made.

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[94] National Center on Youth Transition. Evidence-Based Practice Implementation Resources. Retrieved 1/7/2008 at http://ntacyt.fmhi.usf.edu/events/evidence_based_kits.htm.
[95] SAMHSA. National Registry of Evidence-based Programs and Practices. Retrieved 12/17/2008 at http://www.nrepp.samhsa.gov/listofprograms.asp?textsearch=Optional+Search+Terms&S…

CMHC clinicians may meet with children, adolescents and their families up to three times within 30 days if necessary for clinical assessment before assigning a diagnosis and finalizing with them a preliminary set of treatment goals, preferably using the words of the youth and families. The resulting Individual Plan of Care (IPC) includes annual goals and objectives – with a prescription for the "Medicaid Modality" for the intervention and measureable steps for targeted outcomes. The clinicians write progress notes documenting the treatment and services provided and whether they help the youth and family meet the agreed-upon outcomes.[96] "The IPC is a working document that must be developed annually (total rewrite) and reviewed quarterly unless the individual's condition and/or treatment needs change, necessitating the addition, deletion, or modification of prescribed interventions."[97]

If the youth and family have many needs and/or many services that must be used to help them, they or the CMHC clinician or another case manager [perhaps from DCF, VR, DOC, etc.] in the community may, according to Act 264, request that an Interagency Planning Team be formed. The Act 264 and the DOE/AHS Interagency Agreement Users Guide (2006) says:

> A case manager helps to put together a (treatment or service coordination – interagency planning) team that includes the child, family, relevant professionals and community members and other natural supports. This team works together to develop a plan that is individualized, child-focused, family centered, and culturally competent. Teams are expected to create plans that build on the strengths and assets of the team, the family, and the community. Planning includes the selection of appropriate goals, development of high quality solutions to problems, and effective strategies for reaching desired outcomes. This interagency planning team approach is considered the most effective model for meeting complex, multi-agency needs of children and families. It is expected that teams will agree on a lead coordinator. This will likely be the assigned case manager. It is important to note that this lead coordinator is responsible for facilitating the planning process, not necessarily financially responsible for services defined in the plan.[98]

Through the composition and interactions of this individualized interagency team, a more complete picture emerges of the youth's presenting problems and symptoms of SED or other disabilities and health issues, as well as of his/her interests and natural supports. This may lead to changes in the initial diagnosis and/or treatment plan. The involvement of a youth's family and natural supports in the treatment planning is a key strategy for ensuring that the goals and services are meaningful for the youth based upon his/her choices, age, gender, race, culture, etc.

In addition to the CMHC IPC, the youth, family, and Interagency Planning Team may wish to develop a coordinated services plan.

> The coordinated services plan includes the …IEP as well as human services treatment plans *[such as the DCF Title IV-B individualized plans for children in foster care]* or individual plans of support, and is organized to assure that all components are working toward compatible goals, progress is monitored, and resources are being used effectively to achieve the desired result for the child and family. Funding for each element of the plan is identified.[99]

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[96] Ibid, p.7.
[97] Ibid, p.9.
[98] State Interagency Team and Interagency Agreement Support Committee. (2006). Act 264 and the DOE/AHS Interagency Agreement Users Guide, p.7.
[99] Smith, M. & Cate, R. (2005). Interagency Agreement with Vermont Department of Education and Vermont Agency of Human Services Pursuant to Part B of the Individuals with Disabilities Education Act, p. 3.

The coordinated services plan is appended to the treatment plans of the individual agencies serving the youth.[100] Under Act 264 this coordinated services plan is an entitlement for children and youth with SED, though the services associated with it are not. The services may be mental health services and non-mental health services depending upon the needs of the youth/family. (See Appendix 4 for a copy of the Coordinated Services Plan's Consent for Eligibility Determination & Coordinated Services Planning)

If youth and families are not satisfied with the mental health services they receive, they can make complaints and/or file formal grievances using the standard procedures of the CMHC and DMH. If they have a coordinated services plan, they may also make appeal to the Act 264 Local and perhaps State Interagency Team to review the situation.

> If a team has not been formed or is not functioning, if a coordinated services plan is not satisfactory, if there is no lead service coordinator, or if a plan is not being implemented satisfactorily, the family or individual or another involved party may request a meeting of the Local Interagency Team to address the situation.[101]

Ultimately,

> where the SIT is unable to resolve a dispute among the various agencies, it shall inform all participating parties of the right to an appeal process. The Secretary of AHS and Commissioner of DOE may resolve the issues and render a written decision or may arrange for a hearing pursuant to Chapter 25 of Title 3.[102]

The clinicians who deliver the services chosen by the youth/family benefit from ongoing training and technical assistance. That is one reason the AHS/DOE have contracted with the University of Vermont's (UVM's) Center on Disability and Community Inclusion (CDCI) for support for implementation of the DOE/AHS Interagency Agreement Pursuant to Part B of IDEA. The Coordinator of the Implementation Committee served as training and technical assistance coordinator for Vermont's two prior CMHS Service Initiative grants. The Coordinator and Committee produce training events (including about effective teaming and treatment planning as part of Service Coordination), a quarterly "Interagency Matters!" newsletter, and various products like the User's Guide to help clinicians and administrators from multiple agencies understand and uphold Act 264 and the Interagency Agreement.

The SIT State Outreach Team's T/TA Plan for this project will ensure that training and technical assistance are made available to a wide variety of stakeholders (including clinicians, youth, families, and administrators from all involved agencies) about transition-aged youth with SED *[from Dr. Mary Ann Davis]* and about the TIP Model *[from Dr. Rusty Clark]*. There will be training about the intervention/intercept models [*from the NCMHJJ and the GAINS Center],* also about the EBPs (including Supportive Employment) chosen by one or more LIT. As needed, clinicians and their supervisors will receive in-depth initial and/or follow-up training about the EBPs to be delivered, including about the use of any associated screening or assessment tools and curricula.

Some clinicians and administrators will be familiar with the EBP chosen for their region and may be asked to help with delivery of the training there and in other regions in Vermont. For example, adult mental health staff are well versed in providing Supported Employment and,

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[100] State Interagency Team and Interagency Agreement Support Committee. (2006). Act 264 and the DOE/AHS Interagency Agreement Users Guide, p.12.

[101] Smith, M. & Cate, R. (2005). Interagency Agreement with Vermont Department of Education and Vermont Agency of Human Services Pursuant to Part B of the Individuals with Disabilities Education Act, p. 3.

[102] Ibid, p.13.

with assistance from VR, have helped children's mental health staff establish the JOBS programs in all but one of the 12 districts. In all ten CMHCs the adult mental health staff – and in two of them the children's mental health staff - have already been trained in delivery of Integrated Dual Disorders Treatment (IDDT) for Co-Occurring Disorders by the New Hampshire-Dartmouth Psychiatric Research Center in Lebanon, New Hampshire, whose Director, Dr. Robert E. Drake, has done much of the research establishing IDDT as an EBP. Perhaps staff from those CMHCs *(which, according to ADAP, are two of Vemont's six Centers of Excellence in Adolescent Substance Abuse Treatment)* could be funded to mentor staff in other regions about the use of IDDT with transition-aged youth.

Describe Family-Driven Care

The Vermont Federation of Families for Children's Mental Health has been in existence for over 15 years. It receives a CMHS Statewide Family Network grant as well as annual funding from the DMH and a sub-grant from the AHS (from its federal Family Support 360 grant). *[See the Sustainability/Linkages section below].* The Federation's mission is to:

> support families and children where a child or youth, age 0-22, is experiencing or at risk to experience emotional, behavioral, or mental health challenges. The Federation is committed to:
>
> - Providing families needed emotional and informational support.
> - Advocating for families and children to receive needed supports and services.
> - Promoti*[ng]* the creation of a full array of easily accessible, high quality, family-centered services needed on a state and local level.
>
> The Federation collaborates with schools, communities, governmental, and private agencies, and other advocacy organizations to achieve these ends.[103]

The Federation currently has a full-time Executive Director, a part-time Assistant Director (Cindy Marshall, who would work full-time if this grant is funded), and part-time field staff who function as Peer Navigators for parents with disabilities in 7 of the 12 districts. The Executive and Assistant Directors participate on State Boards such as the Governor's Act 264 Advisory Board, the Advisory Group for Vermont's CMHS federal Block Grant, the DMH State Program Standing Committee for Children's Mental Health, the SIT and its sub-committees, and related task forces. "The Vermont Federation's Executive and Assistant Directors have been a part of the ongoing discussion, planning and implementation of the expanded Act 264 process."[104] With the help of the Peer Navigators, the Federation also recruits parents of children and youth with SED to participate in the regions on CMHC Boards of Directors and Children's Mental Health Local Program Standing Committees as well as on the LITs, and to join or advocate when needed other administrative and legislative committees.

> An approach *[to recruiting]* that appears to be successful, so far, has been to co-host a free dinner for families. *[The Federation works]* collaboratively with the regional AHS Field Services Director and the local Children's Mental Health Director to sponsor and pay for this family dinner. Part of the evening has been dedicated to gather information from families via informal discussion groups of 8-10 people per table of what parents feel is needed for family support in their community. The questions we ask are: 1. What do families want/need? 2. What are the service gaps? 3. What can families/individuals do now to get things moving? 4. Are families/individuals willing to come to trainings to increase their skills; if so, what kind of trainings? 5. Do they want support groups,

[103] VFFCMH brochure
[104] Holsopple, K. (2007). Statewide Family Network Grant Application.

> activity groups, training or a combination?....Our next steps are to help families form regional family support groups and assist them to put identified supports in place with the help of our Peer Navigators. We also use this meeting time to encourage families and youth to get involved in the system of care, decision making bodies, and legislative advocacy. One of the first trainings we offer in each region is one on legislative advocacy in collaboration with the Vermont Association for Mental Health (VAMH)…. Training and technical assistance is needed to support the parents and youth/young adults to attain a level of comfort and confidence speaking to service providers, policy makers and legislators. Training also needs to happen within the system of care to create a family friendly atmosphere and to meaningfully include family members and youth. We see a real need in the system of care for providers to and families to understand the differences between family friendly, family involvement and family driven care.[105]

As part of its Statewide Family Network activities, the Vermont Federation is using the National "Federation of Families and SAMHSA *Ambassador's Guide to Family Driven Care* to present trainings for families and providers and to share the information in more informal settings as opportunities present themselves."[106] The Vermont Federation also continues to address barriers to family involvement such as

> family overload due to lack of services, providers not valuing the presence of families, childcare, transportation, living in poverty, and meeting times that don't work for families. Families are in need of mentoring and information to know the purpose of certain decision making bodies; receiving the leadership training needed to be full participants; and most importantly be able to receive compensation for their time just as their professional partners receive….We have been looking at the models of participant supports already in place in the system of care in Vermont. Currently the local children's mental health standing committees provide childcare, mileage, and food. State level mental health committees provide a stipend and mileage. Local interagency team provides a stipend. Regional Consumer Advisory Councils provide stipends and food. We continue to raise the issue of the need for supports such as: stipend/reimbursement, childcare, flexible meeting times, to insure family ability to become and stay involved.[107]

For this CHMI project, the current training and support practices will be extended to encourage parent and youth involvement in all aspects of planning, implementing and evaluating this project. (Financial incentives are not given to youth or families to encourage them to participate in mental health treatment.)

For 2008 the Federation adopted Legislative Priorities that include

> advancing the creation of a system of supports and services for transition age youth….This system needs to be defined in partnership with youth and former youth who can best define the supports and approaches that will be successful in assisting youth to move confidently into their future.[108]

Because the Vermont Federation is experienced with and committed to assisting transition-aged youth with SED and their families, and because it is interested in building a youth program like that of other chapters of the National Federation, it will house and supervise the required 1 FTE Youth Coordinator. Much of the time of the Executive and Assistant Directors is

[105] Ibid.
[106] Ibid.
[107] Ibid.
[108] VFFCMH statement of 2008 Legislative Priorities

spent strengthening the statewide system of care for transition-aged youth with SED, so the Federation will donate .5 FTE to this project; another .5 FTE will be added with these grant funds to increase the supervisory and family liaison capacity of the Federation and to meet the 1 FTE commitment to family-driven care required for this project.

Describe Youth Guided Care

As the service foundation for this project,

> The JOBS [program] remains committed to offering an *available, accessible, and attractive* service delivery for youth experiencing SED. Outreach is valued as the initial and most crucial step in connecting a youth experiencing SED to services. Work is used as the 'hook' to engage youth in relationships with project staff and additional services, such as intensive case management, substance abuse treatment and social skills training are added. Each JOBS program provides an accessible location – usually located on the bus line – in a welcoming environment that encourages youth to drop in and meet with project staff.[109]
>
> The success of [JOBS] is primarily due to its ability to meet youth **where they are at** – the JOBS Program is often co-located with other youth service providers in a non-stigmatizing, youth friendly environment. [110]

"JOBS staff and partners…are alert to the power of word-of-mouth referrals among youth and the benefits of street level outreach, positive relationships and the 'non-threatening' atmosphere of the program."[111] JOBS program staff "provide outreach to places youth congregate becoming an identified, trusted resource within the community and whenever possible, strive to incorporate youth input to its design, planning, implementation, and/or quality improvement strategy."[112]

Some JOBS programs are co-located with Runaway and Homeless Youth Programs. The statewide association of these programs, VCRHYP, is housed at Washington County Youth Services Bureau, a Boys and Girls Club that also houses the Association of Teen Centers in Vermont. Kreig Pinkham, Coordinator of VCRHYP, serves on the Act 264 Advisory Board and is Chair of Vermont's Juvenile Justice and Delinquency Prevention (JJDP) Advisory Group (called the Children and Family Council for Prevention Programs, or CFCPP) which oversees the planning for and use of federal JJDP Block Grant funds.

VCRHYP has 12 member agencies, one per AHS district, and together they serve about 1,000 youth per year, over 250 through their Transitional Living Programs that consist mostly of host homes and supervised scattered-site apartments plus five specialized short-term shelters. VCRHYP recently obtained a JJDP sub-grant from the CFCPP "to develop and implement a fund development strategy for the [VCRHYP] with the primary intent of increasing the capacity to serve homeless or at-risk youth aged 16-21."[113]

> The fund development strategy …will leverage the strength of a statewide Coalition to attract the attention of large private donors as well as Foundations and Corporate sponsors. VCRHYP will also create a youth employee position to work with the Fund

[109] Dalmasse, D. (2002). Partnership for Youth Initiative Grant Application, p.8.
[110] AHS Youth in Transition Leadership Team. (2007). Draft #4: The JOBS Program Expansion – A Model Approach to Transition Services for Youth with Severe Emotional Disturbance, p.1.
[111] Dalmasse, D. (2002). Partnership for Youth Initiative Grant Application, p.8-9
[112] AHS Youth in Transition Leadership Team. (2007). Draft #4: The JOBS Program Expansion – A Model Approach to Transition Services for Youth with Severe Emotional Disturbance, p.1.
[113] VCRHYP grant application to CFCPP, p.10.

Development Consultant to generate promotional materials expressing need from youth perspectives, and to assist in fund development efforts."[114]

As with CMHCs, the VCRHYP member agencies seek and make use of youth guidance related to their individual plans of care as well as to operation of the programs. In addition, DCF has a statewide network of Youth Development Programs, 12 Coordinators (one per district), and a Youth Development Committee (with website) for youth in foster care. "Through the Youth Development Program, [DCF] provides voluntary services and supports to ensure a successful transition to adulthood, including: housing assistance, transportation, case management services, assistance with obtaining and retaining health insurance or employment, and other services."[115] The Youth Development Committee has requested and received technical assistance from the National Resource Center for Youth Development "to empower all youth on [the] Committee to be their own leaders and learn…valuable and important leadership skills….[and] to receive assistance in developing a strategic…plan and schedule of activities for the coming year."[116] *[Letter of Support received for this CMHI project from the Youth Development Committee.]*

VR, too, has a Youth and Family Advisory Committee which includes 8-12 youth from around the state with a wide spectrum of disabilities and their family members. This committee meets bi-monthly with State transition staff to provide advice and direction about transition issues including VR practices and materials.[117] *[Letter of support received.]*

For this project, federal funds will be used to hire one FTE Youth Coordinator through the Vermont Federation of Families for Children's Mental Health. The youth will be of transition-age (more broadly defined, up to age 25) and have personal experience as either a consumer or family member of someone who is a consumer of public mental health services. The Youth Coordinator will be charged with reaching out to transition-aged youth with SED through networking with the DCF and VR Youth Committees, Outright Vermont, the ADAP recovery centers, the Vermont Coalition of Teen Centers, and other youth organizations. These connections and experiences will inform the Youth Coordinator as he/she seeks and supports youth with SED who are participating in JOBS, VCRHYP, or other programs to serve on the Local Program Standing Committees for Children's Mental Health Programs of the CMHCs and on various statewide committees for the Federation and for DMH and SIT for this project. The Youth Coordinator will also establish a Youth Program and Committee for the Federation.

Training is available for the Youth Coordinator, other youth workers in the system of care, and interested youth and families through an annual Youth Workers Conference organized by the VCRHYP. The conference teaches positive youth development. It also promotes for youth workers the development of such knowledge, skills, and abilities as those identified by the National Collaborative on Workforce and Disability (NCWD).[118] The VCRHYP is working with the Vermont Out-of-School Time Network, the Vermont School Age Care Network and others to adapt the national competencies and build a more skilled youth workforce here.

***Explain how cultural and linguistic competence and responsiveness will be addressed.*.**

The Vermont system of care for children and adolescents with severe emotional disturbance is accustomed to dealing with transition-aged youth and their families. Nearly all of these youth

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[114] Ibid, p.11-12.
[115] DCF. (2008). Draft Family Service Regulations for Services to Transition-Age Youth, p.16.
[116] Lawrence, D. (2007). Report on Youth Development Program (?)
[117] Kievit-Kyler, R. (2008). Emailed communication.
[118] NCWD. (2008). Professional Development: Knowledge, Skills & Abilities (KSA) Initiative. Retrieved 1/17/2008 from http:www.ncwd-youth.info/ksa/index.html.

and families are White and English speaking; most are poor. The AHS has conducted extensive training statewide for its staff and sub-grantees about effective ways for helping people who have grown up in a culture of poverty; the trainings are based on the book Bridges Out of Poverty.[119] The AHS is also, through its 360 Family Support Grant (described more fully below under Sustainability), in the midst of training DCF and other workers about how to assess and build on the strengths of parents with disabilities who are in danger of losing custody of their children to the State. This training is being led by Dr. Susan Yuan, co-director (with Scott Johnson, AHS Deputy Commissioner of the Field Services Division) of the 360 Grant, an employee of the University of Vermont's (UVM) Center on Disability and Community Inclusion (CDCI), and the parent of a man with developmental disabilities. Through her advocacy, the CDCI is hosting a Communications Project which has trained people throughout Vermont to help individuals with developmental disabilities understand what is happening and communicate their wishes when they are before the court. In addition, the AHS and its sub-grantees have and make use of contracts for the purchase of translation and interpreter services, including for the deaf and hard-of-hearing. These are just some of the measures Vermont already takes to be culturally and linguistically competent and responsive.

More activities have taken place in Chittenden County, where the Burlington school system must respond to students speaking over 20 different languages. The HowardCenter, the Chittenden County CMHC, has for several years employed a part-time Diversity Coordinator who works closely with a Multi-cultural Committee of the Board of Trustees and community members. The HowardCenter has adopted a vision with goals and objectives for being a culturally competent organization; the vision is described at http://www.howardcenter.org/about/diversity.php. This website "represents a good faith effort to comply with … the website accessibility standards of the Americans with Disabilities Act (ADA)."[120] The AHS State Refugee Coordinator has worked closely with the HowardCenter on diversity issues and recommends that the .5 FTE position required by this grant be placed there, to both respond to the needs of the CMHI project statewide and to supplement the cultural and linguistic competence resources of Chittenden County. The HowardCenter is "certainly interested in hosting the part-time cultural and linguistic competence coordinator…we have experience with recruiting for this type of work and have collaborative relationships with Vermont Refugee Resettlement and AALV (Association of Africans Living in Vermont)."[121] Therefore, DMH will sub-grant the work of this position to the HowardCenter.

The .5 FTE Cultural and Linguistic Coordinator will be responsible for producing and implementing – with broad, ongoing input from key stakeholders – a plan for cultural and linguistic competence for the CMHI project. The plan must "ensure that all of the services and strategies of the CMHI project are designed and implemented within the cultural and linguistic context of the youth and families to be served."[122] The plan will reflect the guidance of the national project/TA staff and will be final only after approval by the State Outreach Team.

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[119] Payne, R. K., Duvol, P., & Dreussi Smith, T. (2000). Bridges Out of Poverty: Strategies for Professionals and Communities.

[120] HowardCenter. Vision for a Culturally Competent Organization. Retrieved 1/23/2008 from http://www.howardcenter.org/about/diversity.php.

[121] Simonson, C. (1/18/2008). Emailed communication.

[122] Technical Assistance Partnership for Child and Family Mental Health. (2008). Sample Cultural and Linguistic Competence Plan for Advancing Cultural and Linguistic Competence in Systems of Care. Retrieved 1/28/2008 from http://www.tapartnership.org/cc/CLC_Plan_Template_FINAL.pdf

The Coordinator will assist the CMHI leadership with "infusing cultural and linguistic competence throughout the system of care"[123] in six domains when participating in the SIT State Outreach Team and the Chittenden County LIT. The six domains "are (1) governance and organizational infrastructure (2) services and supports (3) planning and continuous quality improvement (4) collaboration (5) communication and (6) workforce development."[124] The Coordinator will benefit from the detailed "Cultural and Linguistic Competence Implementation Guide"[125] now available from the National TA Partnership for Child and Family Mental Health.

Training is regularly available for children's mental health and DCF workers about effective teaming with families and building on family and child strengths and interests. Children's mental health clinicians are monitored on their use of child and family language in the Individualized Plan of Care (IPC). Some workers are bi- or multi-lingual and/or bi- or multi-cultural. However, national technical assistance about increasing Vermont's cultural and linguistic competence is likely to be of great help to all stakeholders in the system of care, particularly those like law enforcement and criminal justice representatives who have not partnered with SIT or LITs in the past. The Coordinator will arrange for the delivery of such technical assistance and training both statewide and in Chittenden County. The Coordinator will link this help with JJDP TA to address Disproportionate Minority Confinement of Black Youth.

Sustainability/Linkages with Statewide Transformation and Federally-Funded Programs
Indicate how this initiative links with transformation and Statewide reform efforts.

The goal of this 6-year project is for Vermont's transition-aged youth (16 through 21 inclusive, with their families) with SED to have adequate preparation and the necessary supports to be productively engaged in the community and free from incarceration. This goal is closely related to the interests of the Governor and Legislature in better meeting the needs of transition-aged youth. (For more detail about those interests, refer back to pages 18-20 and 22-23 and to the letters of commitment and chart showing match in Appendix 5.) The AHS recognizes that, for this population, the necessary supports include access to health care *[including Medicaid]*, post-secondary education, employment, housing, and caring relationships (with service providers and community members). This grant project will contribute to the Governor's "Next Generation" reform by increasing the number of transition-aged youth who have access to and receive treatment for mental health and co-occurring substance abuse challenges. 173 youth will be served per each of 5.25 years, for a total of 908 youth by the end of the six years. The proposed project is in full accord with the CMHI RFA goals to:

- expand community capacity to serve …adolescents with SED and their families;
- provide a broad array of accessible, clinically effective and fiscally-accountable services, treatments and supports;
- serve as a catalyst for broad-based, sustainable systemic change…;
- create a care management team with an individualized service plan for each *[youth]*;
- deliver culturally and linguistically competent services…; and

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[123] Ibid.
[124] Technical Assistance Partnership for Child and Family Mental Health. (2008). Sample Cultural and Linguistic Competence Plan for Advancing Cultural and Linguistic Competence in Systems of Care. Retrieved 1/28/2008 from http://www.tapartnership.org/cc/CLC_Plan_Template_FINAL.pdf
[125] Martinez, K. & Van Buren, E. (2008). Cultural and Linguistic Competence Implementation Guide.

- implement full participation of families and youth in service planning, in the development, evaluation and sustainability of local services and supports and in overall system transformation activities.[126]

The system – including policy and infrastructure - changes will emerge and evolve based on the strategic planning done in Year 1 and the implementation done in subsequent years by the statewide project personnel and committees, the SIT State Outreach Team, and the 12 regional LITs, with all their family, youth, State, and community partners.

Discuss strategies for ensuring project sustainability…and use of Medicaid.

The current plan for sustainability for this CMHI project is a Legislative appropriation to replace the federal funds as the grant ends. DMH has successfully sustained two prior CMHS Services Initiative Grants using the same plan. Because the first grant, Access Vermont, demonstrated that children's crisis outreach mental health services were effective in reducing new admissions of unmanageable youth (minors who are status offenders) to DCF, the Legislature approved new State General Funds for the program based on savings from the earlier-projected rate of growth in DCF custody. For the second grant, Children's UPstream Services (CUPS), which demonstrated effectiveness in improving the well-being of young children and their caregivers and in supporting child care providers, the Legislature invested in the early intervention approach by appropriating the amount of State General Funds needed to match Medicaid to maintain the same levels of service as provided by the grant. For this CMHI project, there may be less opportunity to sustain the same levels of service by relying on Medicaid for two reasons: 1) fewer transition-aged youth are enrolled in Medicaid, and 2) Vermont has capped its entire Medicaid program through a five-year 1115 Waiver. The Waiver, which the Governor calls a "Global Commitment",

> makes Vermont the only state in the nation facing a fixed dollar limit on the amount of federal funding for its Medicaid program. In exchange for taking on the risk of operating under a capped funding arrangement, the waiver allows Vermont to use federal Medicaid funds to refinance a broad array of its own, non-Medicaid health programs, creating a fiscal windfall for the state. It also gives Vermont new flexibility to reduce benefits, increase cost sharing, and cap enrollment for many Medicaid beneficiaries.[127]

To date, Vermont has maintained its level of benefits and expanded enrollment by using the "fiscal windfall" to create

> Green Mountain Care, the new name for our family of low-cost and no-cost health coverage programs offered by the State of Vermont and its partners. Green Mountain Care was created through Act 191, signed by Governor Douglas 18 months ago, and offers quality, comprehensive health coverage at a reasonable cost. The new Catamount Health Program is part of Green Mountain Care along with Medicaid, Vermont Health Access Plan (VHAP) and Dr. Dynasaur. Individuals may also receive help in paying for their monthly premiums depending upon income… The state …launch*[ed]* a major campaign to market Green Mountain Care on November 1st *[2007]* …feature*[ing]* television, radio, internet, and newspaper advertisements.[128]

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[126] SAMHSA. (2007). Cooperative Agreements for Comprehensive Community Mental Health Services for Children and Their Families Program, p. 7.

[127] Guyer, J. (2006). Vermont's Global Commitment Waiver: Implications for the Medicaid Program, p.1.

[128] LaWare, C. (2007). Statement from AHS Secretary Cynthia D. LaWare on the Launch of Green Mountain Care

This expansion of health coverage is crucial for transition-aged youth with SED, and it is expected to put Vermont at the ceiling of its Medicaid cap. Thus, if the Waiver continues, there may be no way to use Medicaid to sustain this CMHI project. However, DMH expects that the project will be able to demonstrate outcomes favorable to youth and families and to the State in terms of a reduction in the anticipated growth in the need for incarceration. If this happens to the satisfaction of the partners in this enhanced system of care, the likelihood increases of obtaining the necessary funding from the Legislature to sustain the project.

Explain how the initiative will coordinate with other relevant federally funded initiatives.

1. The Vermont Integrated Services Initiative (VISI) is a five-year Co-occurring State Infrastructure Grant (COSIG) from the federal CMHS to the Office of the Governor. It is a collaborative project between DMH and VDH and

> is the fourth in a series of federal grants to Vermont that has focused on co-occurring conditions….There are 26 agencies participating in the VISI Initiative. They include all the community mental health agencies, several substance use providers, three primary care facilities, two treatment courts and seven homeless service providers.[129]

Teams are active in identifying opportunities for improving the infrastructure related to clinical practices, financial planning, information systems, and workforce development. The grant is half completed. More service providers are now screening clients for mental health and substance abuse disorders and performing integrated assessments and treatment. While the COSIG grant and the earlier related co-occurring work have established a level of readiness and expertise in the mental health system for serving adults with co-occurring disorders, this has not yet permeated many of the children's mental health programs or other youth-serving agencies. One or more of the regions may choose this CMHI project as an opportunity for gaining expertise in the EBP related to co-occurring disorders.

2. Certain federal CMHS discretionary grants to the mental health system in Vermont have been frequently renewed, such as the Statewide Family Network Grant to the Vermont Federation of Families for Children's Mental Health, the Data Infrastructure Grant to the DMH (thus, the research reports by Dr. John Pandiani), and the Statewide Consumer Network Grant to Vermont Psychiatric Survivors (which operates Safe Haven, one of the homeless programs that just received HUD funding). This discretionary funding typically exceeds the small amount of funding available through Vermont's Community Mental Health Services Block Grant ($786,193 in FFY 2006).[130] All of these resources are important to the operation of the mental health system in Vermont, with its family and consumer partners and attention to planning and quality improvement; this CMHI project is dependent upon the functioning of that system.

3. The Vermont Strategic Prevention Framework (SPF) is a Center for Substance Abuse Prevention (CSAP) State Incentive Grant (SIG) to the VDH–ADAP

> to advance community based programs for substance abuse prevention, mental health promotion, and mental illness prevention. The SPF-SIG *[which is half completed]* implements a five-step process known to promote youth development, reduce risk-taking behaviors, build on assets, and prevent problem behaviors. The five steps are: (1) conduct needs assessments; (2) build state and local capacity; (3) develop a comprehensive strategic plan; (4) implement evidence-based prevention policies,

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[129] DMH and VDH. (2007). Vermont Integrated Services Initiative, p.1.

[130] SAMHSA. Grant Awards by State – Summaries FY 2006/2007. Retrieved on 1/26/2008 from http://www.samhsa.gov/statesummaries/StateSummaries.aspx?state=vt , p.1.

> programs and practices; and (5) monitor and evaluate program effectiveness, sustaining what has worked well.[131]

In addition to this statewide grant, CSAP has awarded at least 11 Drug Free Communities grants that will still be current at the time of award of this CMHI project. The grantees are in 9 of the 12 AHS districts in Vermont. In regions with this resource, the LITs will factor it into their planning for the enhanced system of care and services for this CMHI project. The SIT State Outreach Team will also factor the activities of the SPF into its planning for this CMHI project.

4. Vermont is currently in year four of a five-year 360 Family Support Grant from the federal Administration on Developmental Disabilities to the AHS, which sub-grants the funds to one mental health agency and to two statewide family support organizations (the Federation and VPIC). The Federation uses its funds to provide Peer Navigation to parents with developmental (and other) disabilities in 7 of the 12 regions in the state. VPIC provides Peer Navigation in 4 districts, and Rutland Mental Health provides this service in 1 district. The goals of the grant are to increase family input to AHS reorganization (in earlier years) and to assist parents with disabilities in obtaining the help they need to successfully raise their children, thus avoiding the loss of custody that is too common for parents with disabilities. Many of the parents being served have mental illness, a known risk factor for SED in children.

For the AHS and its 360 sub-grantees, the Family Support Grant

> has created unprecedented opportunities to work together and support families in ways new to *[all]* entities. The AHS has contributed office space, which includes phone and computer, for each Peer Navigator…In each region, the Peer Navigator has been working closely with the AHS Field Service Director to create and establish regional consumer advisory groups to advise the Field Service Director and continue to identify gaps and problems as the AHS reorganization, now called transformation, efforts move forward….The consumer advisory groups are comprised of people who receive services from AHS. The Peer Navigator's further role is to support parents to also be a part of this advisory role….Peer Navigators' speaks to the fact that all *[these staff]* are family members who have experienced receiving services within our system of care, and can help other family members navigate the service system.[132]

This deeper and broader connection between the Federation and the AHS Field Services Division and Directors will help to bolster the youth and family involvement with the state and regional systems planning and to more easily address the inevitable problems of individual youth and families served through the system of care enhanced by this CMHI project.

5. The VCRHYP has two Transitional Living Program (TLP) grants of $200,000 apiece from the federal Family and Youth Services Bureau that will allow 8 of its 12 member agencies to, over the next five years, annually provide about 160 youth with core support services and 70 of those youth with shelter. The housing resource is critical for stabilizing youth in transition so they can more effectively attend to their health, mental health, substance abuse, employment, education, family, and other daily living issues.[133] In the regions with this resource, the LITs will factor it into their planning for the system of care and services for this CMHI project.

6. Governor Jim Douglas announced on January 15, 2008 that

> more than $1.7 million in federal funding has been awarded to Vermont to support 16 homeless programs….The funding…is provided under HUD's Continuum of Care

[131] Ibid, p.3.
[132] Holsopple, K. (2007). Statewide Family Network Grant Application.
[133] Pinkham, K. (2008) phone and emailed communication including copy of TLP grant.

program, which supports the full spectrum for homeless individuals and families – from street outreach and emergency shelter to transitional and permanent housing. In addition, the funding provides for critically needed services including job training, child care, substance abuse treatment and mental health counseling.[134]

CMHCs operate programs for homeless adults with severe and persistent mental illness and captured 22% of this statewide HUD funding. Also, the HowardCenter (a CMHC) captured 50% of an additional $765,755 in HUD Continuum of Care funding awarded for Burlington and Chittenden County. Some of the homeless programs funded by HUD will be used by transition-aged youth with SED so are a resource for the LITs to consider in their planning.

Section C.: Project Management and Staffing Plan

Discuss the capability and experience of the applicant organization.

The applicant for this grant, the Department of Mental Health (DMH), is one of six departments and offices within the AHS *[see organizational charts in Appendix 6]*, which was created by the Vermont Legislature in 1969 to serve as the umbrella organization for all human service activities within state government. The Agency is led by the Secretary, who is appointed by the Governor, and the Deputy Secretary *[and Commissioners]* who is appointed by the Secretary with the Governor's approval.[135]

These AHS departments and offices are responsible for administering a very broad range of federal and state programs, block grants, and entitlements, including at least the following:

- Office of Vermont Health Access (OVHA)
    - Title XIX of the Social Security Act – Medicaid
    - Title XXI – State Children's Health Improvement Program (S-CHIP)
- Department for Children and Families (DCF)
    - Child Development Division
        - Head Start Program (Head Start – State Collaboration Office)
        - Part C (formerly Part H) of the Individuals with Disabilities Education Act (IDEA), administered jointly with the Department of Education (not in AHS), which is responsible for Part B of IDEA
    - Economic Services Division
        - Title IV-A – Temporary Assistance for Needy Families (TANF) Program
    - Family Services Division
        - Child Welfare Services: Title IV-B, Subpart 1 of the Social Security Act – Preventive intervention, alternative placements and reunification efforts to keep families together
        - Promoting Safe and Stable Families: Title IV-B, Subpart 2 of the Social Security Act – Family support, family preservation and support, time-limited family reunification services, and services to support adoptions
        - Title II of Keeping Families and Children Safe Act
        - Title IV-E-Foster Care, Adoption and Independent Living
        - John H. Chaffee Foster Care Independence Program (Part of Title IV-E
- Department of Health (VDH)
    - Community Public Health Division

[134] Douglas, J. (2008). Press Release. Governor's Office, forwarded by email

[135] LaWare, C. (2008). Welcome to the Vermont Agency of Human Services. Retrieved 1/23/2008 from http://www.ahs.state.vt.us

- Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
- Department of Mental Health (DMH)
  - CMHS Mental Health Block Grant.

Memoranda of understanding (MOU) between programs and departments (including Corrections and Disabilities, Aging and Independent Living [DAIL]) are not usually required to carry out operations within AHS because the departments and offices are considered to comprise one legal entity. However, when the budgeting across departments is very complex – as with JOBS – an MOU is helpful to keep track of interdepartmental transfers. The Department of Education is separate from AHS.

DMH oversees a network of independent, private, non-profit organizations that comply with stringent state and federal laws, regulations and quality standards for delivering community-based mental health services, especially when using Medicaid. DMH designates these agencies to provide core services to all eligible individuals and families in their catchment areas (10, preceding the 12 AHS districts). The Designated Agencies (DAs) screen children and adults for psychiatric hospitalization. DMH provides psychiatric hospitalization for adults through the Vermont State Hospital and contracts with community hospitals that can hold patients involuntarily if necessary for up to 72 hours. If children or youth need hospitalization, they are referred to one of three private hospitals in or near Vermont or to hospital diversion placements. DMH also contracts with several small intensive residential treatment programs for children and youth whose needs cannot be met in their home or communities.

The DAs - community mental health centers (CMHCs) - have been in existence since the 1960s and serve adults with serious and persistent mental illness, children with serious emotional disturbance (both groups through oversight from DMH), and people with developmental disabilities (through oversight from DAIL). Most of them also serve adults and adolescents with substance abuse problems (through oversight from ADAP, in VDH). For children with serious emotional disturbance, the CMHCs maintain core service capacities in immediate response; outreach treatment; clinic-based treatment; support; and prevention, screening, referral and community consultation.[136]

Within DMH, the Child, Adolescent and Family Unit (CAFU) has the mission "to assure timely delivery of effective prevention, early intervention, and behavioral/emotional health treatment and supports through a family-centered system of care for all children and families in Vermont."[137] It does this by paying attention to the following desired outcomes for four domains of quality service: access, practice patterns, outcomes/results of treatment, and structure/administration. To achieve these outcomes, the CAFU engages in priority strategies of: Family Involvement, Participation and Empowerment, Partnerships, Effective Management of Care, Expansion of Attitudes, Knowledge and Skills, and Effective Working Relationships.[138]

Charles A. Biss, Principal Director for this project and Director of the CAFU for the past 15 years, is very experienced and skilled in carrying out these strategies *[see his biographical sketch in Section G]* with the SIT and LITs, with the CMHC Children's Mental Health Directors, with the CAFU sub-grantees like the Federation of Families for Children's Mental Health., and with his staff of 9 FTEs. Six of the staff function as an Operations Team that provides clinical

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[136] DMH. (2004). The Vermont State System of Care Plan for Child, Adolescent and Family Mental Health, State Fiscal Years 2005-2007, p.11-12
[137] Ibid, p.3
[138] Ibid, p.3

consultation and oversight to CMHCs and LITs statewide as they manage the care of about 200 children and youth who have Individualized Service or Wraparound Budgets and Plans of Care as an alternative to psychiatric hospitalization, in accordance with a 1915 (c) Home and Community-Based Medicaid Waiver. One staff member oversees other quality improvement efforts. The CAFU staff, particularly the Operations Team, meet and consult regularly with the DMH Medical Director, a Child Psychiatrist.

Under the leadership of Charlie Biss, the DMH has successfully applied for, received, implemented and sustained two prior CMHS Service Initiative Grants: 1). In 1993, Access Vermont for children's crisis outreach services, primarily for school-aged children with SED, and 2). In 1997, Children's UPstream Services, or CUPS, for children aged 0-6 with SED. Both of these system-of-care grants were carried out with essentially the same strategic process planned for this project but with different target populations and a different blend of partners.

For this CMHI project, DMH has the added support of the AHS Field Services Division and the AHS District Field Services Directors. The Division and its Directors did not exist prior to the AHS Reorganization of 2005 but are now based in the AHS Secretary's Central Office; this gives the Field Services roles with the DOE-AHS Interagency Agreement, Act 264 SIT and LITs, and Youth in Transition planning added influence. Scott Johnson is the Deputy Secretary of the AHS Field Services Division *[see his biographical sketch in Section G],* the co-director (with a family member) of the 360 Family Support Grant, and a former member of the board of the Federation of Families for Children's Mental Health. Because of the scope of the Field Services Division activities on behalf of AHS, Scott and the 12 District Field Services Directors have very close relationships with a wide variety of public and private service providers, as demonstrated by the many letters of support *(in Appendix 1 and Appendix 5)* for this grant proposal. Scott will serve as the required State-Local Liaison.

Provide a complete list of staff positions for the project.

Charlie Biss will donate his time as Principal Investigator for the project. Scott Johnson and all other current State and community SIT, LIT or other partners will donate their time, too. Charlie, Scott, and their partners (individually and collectively) have many years of experience delivering services – and creating policies to better serve – youth with SED and their families.

The federal funds for this grant will be used by DMH to hire one FTE Project Director *[see job description in Section G]* and to sub-grant out the rest of the statewide and regional services needed for implementation, evaluation, and technical assistance. The sub-grants will go to:

- The Vermont Child Health Improvement Project (VCHIP) for evaluation: 2 FTEs *[see Section G for biographical sketch for Dr. Thomas Delaney and the job description for a Research Analyst still to be assigned or hired for the work]* plus graduate student(s) for interviewing and support staff for data entry.
- The Vermont Federation of Families for Children's Mental Health for the family liaison and youth coordinator positions: 1 FTE family liaison, with .5 FTE to be donated by the Federation *[see Section G for biographical sketch for Cindy Marshall, currently part-time Assistant Director for the Federation; she will work full-time if this grant is funded]* and 1 FTE youth coordinator to be hired *[see Section G for the job description]*
- HowardCenter for the cultural and linquistic competency coordinator: .5 FTE *[see Section G for the job description]*

- Not yet determined: RFPs will be created to seek organizations willing to provide the training and technical assistant coordinator (.5 FTE) and/or the social marketing-communications manager (.5 FTE) *[see Section G for these job descriptions]*.
- Fiscal agents (perhaps the CMHCs but not necessarily) chosen for each of the 12 regions to pay for Evidence-Based Practices built on the foundation of the Jump on Board for Success (JOBS) program and integrated with other community-based services: approximately 14.42 FTE clinical positions. The jobs will be described by the regions during their strategic planning.

The main function of the regional positions will be to serve transition-aged youth (16-21) with SED and their families. The main functions of the statewide positions will be to advise and support regional staff, administrators, and community partners in their development of this enhanced system of care and delivery of service, and to prepare for sustainability of the project. The sub-grantees have been or will be chosen based upon their experience functioning in similar ways with the same or similar populations. VCHIP's prior experience is described below in Section D; the Federation's prior experience is described above in Section B under Family-Driven Care; the HowardCenter's prior experience is described above in Section B under Cultural and Linguistic Competence.

Describe the resources available for the proposed project.

The Project Director will be part of the CAFU in DMH and have use of all DMH facilities: space, desk, phone, computer, copying machines, parking, etc. DMH is co-located with the VDH in downtown Burlington in a relatively new State office building that is on a main bus route, across the street from the U.S. Post Office, beside a big shopping mall, and a couple of blocks from a VCRHYP shelter. It is easily accessible and compliant with the American with Disabilities Act. The Federation has an adequate and handicapped-accessible office; a youth Board member who uses a wheelchair and an adult Board member who relies on a cane are both able to attend the Board meetings. All the CMHCs (including the HowardCenter) also have easily accessible, ADA-compliant offices, though much of their work is done on an outreach basis in communities. The SIT "Invitation to Communities" will instruct the LITs to plan for delivery of their chosen services in adequate, accessible, ADA-compliant locations that will appeal to transition-aged youth with SED and their families.

Section D: Evaluation Plan

Describe the evaluation activities and procedures.

Overview of the Vermont CMHI evaluation

The Vermont Department of Mental Health has selected the Vermont Child Health Improvement Program (VCHIP) to conduct the evaluation of the Vermont CMHI project. Founded in 1999, VCHIP is a research and quality improvement organization based in the Department of Pediatrics of the UVM College of Medicine. VCHIP has a track record of successful evaluations of large scale (including statewide) projects targeting mental health and healthcare services for children and youth. These evaluations have involved coordinating activities with a wide range of partner organizations including government agencies, providers of direct mental health and healthcare services for children, hospitals, insurance carriers, and local and statewide child-serving agencies. VCHIP has considerable resources relating to the collection, analysis and reporting of quantitative and qualitative data, including three fulltime equivalent PhD and masters level data analysts, an experienced data support staff, and the

support of research and clinical faculty drawn from a broad array of disciplines represented at the University of Vermont. VCHIP will obtain University of Vermont Institutional Review Board (IRB) approval for all Vermont CMHI evaluation activities.

VCHIP will develop an evaluation of the Vermont CMHI project that is comprehensive and rigorous, has multiple levels of analysis, and assesses the impact of project activities across both local and statewide systems. VCHIP will coordinate its evaluation activities closely with the Vermont CMHI project, SAMHSA personnel, and the national evaluation contractor. The VCHIP evaluation activities will fully comply with the SAMHSA requirements for the national evaluation, the national outcome measures (NOMs), and Government Performance and Results Act (GPRA) data collection and reporting. VCHIP will also work with the Vermont AHS and the State Interagency Team (SIT) to develop a state-level evaluation that will be valuable in assessing the implementation of the Vermont CMHI project and that will also be used to guide continuous quality improvement.

The VCHIP evaluation will demonstrate a high level of cultural competence. This will be accomplished by forming an Evaluation Committee to get input on the initial evaluation design from families, youth, cultural consultants, and service providers, also by ongoing collaboration with the Vermont CMHI project staff (including the CMHI Lead Family Contact, Youth Coordinator, and Cultural and Linguistic Competency Coordinator) to ensure that all data collection instruments and reporting systems meet the standards for cultural competence that the project adopts and that they continue to be appropriate for the population being served.. The data collection instruments proposed for the Vermont-specific evaluation have been used in a wide variety of studies that occurred in different cultural settings; VCHIP anticipates they will be effective tools for assessing the functioning/outcomes for VT youth with SED and caregivers.

VCHIP plans to have the clinicians describe the purpose of the evaluation to transition-aged youth enrolling in services and their caregivers. The clinicians will obtain the necessary signatures from the youth and caregivers on the assent and consent forms *[see Appendix 4]* for participating in the VCHIP evaluation. VCHIP staff will then contact youth and caregivers who have signed the forms and arrange to conduct the evaluation interviews either in person or by telephone. All youth and caregivers will be offered a $20.00 cash incentive each time they are asked to participate in an interview.

Collecting and reporting data for the CMHS National Outcome Measures (NOMs)

Vermont is committed to collecting the NOMS data through using TRAC as specified in the CMHI RFA. The VCHIP evaluation team will receive training on how to collect and report data for the CMHS NOMs and then work with the SIT and the LITs to develop a system by which this data will be collected. The resulting system will support the collection and transmission of data obtained using the CMHS NOMS Child Consumer Outcome Measures for Discretionary Programs: Child and Adolescent Respondent Version to the TRAC system. The NOMS data will be collected at three month intervals for all youth receiving services through the Vermont CMHI project, up until the time a youth is clinically discharged from the service he or she is receiving. NOMs data will be collected primarily by the Vermont CMHI clinicians, transmitted to VCHIP, and then entered by VCHIP staff into the TRAC system within seven days of having been collected.

VCHIP anticipates that data collected for the CMHS NOMs will be valuable additions to the VCHIP evaluation and quality improvement work with the Vermont CMHI project, and will provide a window into how youth with SED are progressing in the domains of: Functioning, Stability in housing, Employment and education, Crime and criminal justice status, Perception of

care, Social connectedness. These and the NOMs that measure Access/capacity, Retention, Cost effectiveness, and Use of evidence-based practices closely align with the goal for the Vermont CMHI project, and in combination with other measures will be the basis for assessing the overall impact of the project on youth, their caregivers, and on the enhanced system of care.

Collecting and reporting of GPRA measures

The Vermont evaluation will collect GPRA measures as specified by the CMHI. VCHIP will work with the SIT, LITs, the national evaluator, and SAMHSA personnel to develop a data collection and reporting system for the GPRA required measures.

Participating in the required National Evaluation:

VCHIP will participate in and support all components of the National Evaluation. The data collection and reporting system that VCHIP develops will include data collected from youth receiving services and their families, child-serving clinicians, LIT and SIT personnel, multiple child-serving agencies and project directors. VCHIP anticipates that this system will build upon existing data collection and reporting systems that it has developed in support of other evaluation and quality improvement work, such as:

- the Vermont Youth Health Improvement Initiative, which established a system for obtaining and summarizing administrative data from a variety of mental health and healthcare agencies, including approximately 60 primary care practices that serve youth;
- the Vermont Preventive Services Initiative, which established protocols for data collection from all pediatrics practices in Vermont);
- the Children's Metal Health Project, which established a statewide network for the collection, submission and processing of data from the Achenbach System for Empirically Based Assessment (ASEBA, used by healthcare and educational institutions throughout the state (The ASEBA measures a broad range of behaviors and generates DSM-IV based symptom profiles.)); and
- the Vermont Blueprint for Health chronic illness care project, which collects questionnaire, interview and healthcare information in child-serving agencies, medical practices and hospital settings in more than one half of Vermont.

Developing and implementing the Vermont-specific CMHI evaluation

In addition to participating in the NOMs, GPRA, and required National Evaluation activities, VCHIP is developing a state-specific evaluation to assess the impact of changes in the system of care on key process and outcome measures. We anticipate that this component of the evaluation will be important for ensuring both that the Vermont CMHI is an effective project in how it supports youth with SED and their families as well as for sustaining the project beyond the period funded by the SAMHSA grant.

Vermont CMHI process measures

VCHIP will monitor and report on key process measures that reflect the degree of success of the Vermont CMHI project interventions. The measures will be derived from a mix of interviews with clinical providers, Vermont CMHI project staff, SIT and LIT members, and youth with SED and their families. In addition, CMHI clinicians and LITs will collect tracking measures. VCHIP will access available administrative databases in order to assess progress towards the Vermont CMHI goal. All these measures will enable the VCHIP evaluation team to answer the questions suggested in the RFA regarding the effectiveness of the implementation of the Vermont CMHI interventions.

VCHIP will use the data collected to gauge progress towards the project goal, for writing progress reports and also as a means to guide project activities by communicating VCHIP's

findings with the statewide and local AHS area project leadership on at least a quarterly basis (see *Using evaluation data for Quality Improvement* section below.)

Monitoring and reporting outcomes measures for persons receiving services

The key outcome measures that VCHIP will use as indicators of whether the Vermont CMHI is achieving its goal will be collected through a combination of mechanisms and will supplement the required GPRA, NOMs and National Evaluation measures. These measures (some of which may be required by the National Evaluation) are detailed in Appendix 3: Data Collection Procedures and Instruments. Based on prior evaluation and research projects conducted by VCHIP and its partner agencies, the state-level evaluation will use 3 assessment tools: 1) the Youth Self Report (YSR, or depending on age, the Adult Self Report (ASR)) component of the ASEBA, 2) the Young Adult Health Care Survey (YAHCS) and 3) the Stress Index for Parents of Adolescents (SIPA). Both the YSR and YAHCS tools have been used in recent Vermont projects and have proved invaluable in understanding changes in youth's functioning across multiple domains (the YSR) and experiences within the healthcare system (the YAHCS) - important indicators of whether the project goal is being met. In addition, we have identified the SIPA as a reliable and validated tool to assess the extent to which project interventions are associated with changes in parents' or caregivers' perceptions of their relationships with the youth receiving services through the Vermont CMHI. In total the NOMs, GPRA and Vermont-specific measures will allow for answering four key assessment questions:

- What was the effect of the Vermont CMHI interventions on participants?
- What program/contextual factors were associated with youth/family/system outcomes?
- What individual factors were associated with outcomes?
- How durable were the effects, both for youth/family and system level change?

The evaluation data that will be collected will reflect the several types of data that are crucial for understanding the effects of the Vermont CMHI, including:

- Number and proportion of youth with SED who are employed,
- Number and proportion of youth with SED who are free from incarceration,
- Number and proportion of youth who are in school or have graduated,
- Number and proportion of youth with access to, and utilization of healthcare,
- Number and proportion on youth accessing mental health services, and
- Number and proportion of youth with stable housing situations.

Using evaluation data for Quality Improvement (QI)

Collecting data for the national (cross site) evaluation (including GPRA), the NOMs, and the Vermont specific evaluation will allow VCHIP significant opportunities to track the effectiveness of the SAMHSA-funded work in Vermont, both in terms of outcomes data and monitoring the implementation of the project interventions. In order to facilitate the use of these data for quality improvement during the project, VCHIP will conduct monthly reviews of progress towards the grant goal using all available data, develop recommendations for improving the implementation of project activities, and then provide these data and recommendations to the SIT and LITs on at least a quarterly basis. This feedback will be provided whenever possible in face-to-face meetings. Brief (less than two page) written summaries will also be distributed by mail and electronically, depending on the availability and preference of the teams. Thus, the Vermont DMH, SIT and LITs will receive timely, important feedback that can be used to guide the implementation of project interventions in order to better serve transition-aged youth participating in grant funded activities.

SUPPORTING DOCUMENTATION

Section E: Literature Citations

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Section F: Budget Detail

Expenses	**FFYear 1 - 09**	**FFYear 2 – 10**	**FFYear 3 - 11**	**FFYear 4 - 12**	**FFYear 5 - 13**	**FFYear 6 - 14**
Personnel:						
Project Director:1 FTE *Salary (State pay-grade 24) + fringe (38%)*	(3/4 year) $48,352	$66,403	$68,395	$70,447	$72,560	$74,737
Travel for Principal Investigator and/or Project Director: 2 required CMHS trips per year, 3 visits to each DA per year, and 2 X week trips between DMH and AHS	(3/4 year) $6,412	$8,550	$8,550	$8,550	$8,550	$8,550
Contractual:						
VCHIP: 2 FTE Evaluators, data entry, materials, participant incentives, and expenses, including 2/yr CMHS trips	(3/4 year) $150,000 (3/4 of 20% of federal funds as allowed)	$300,000 (20% of federal funds as allowed)	$400,000 (20% of federal funds as allowed)	$400,000 (20% of federal funds as allowed)	$300,000 (20% of federal funds as allowed)	$200,000 (20% of federal funds as allowed)
VT Federation of Families for Children's	(3/4 year) $78,633	$104,844	$104,844	$104,844	$104,844	$104,844

Mental Health: .5 FTE for Family Liaison, *with other .5 FTE donated*; also 1 FTE Youth Coordinator, with operating expenses and mileage, including 2 required CMHS trips per year for each person						
HowardCenter: .5 FTE Cultural and Linguistic Coordinator, with operating expenses and mileage, including 2/yr CMHS t rips	(3/4 year) $30,109	$40,145	$40,145	$40,145	$40,145	$40,145
Bid for Training and Technical Assistance: .5 FTE Coordinator plus materials, event costs, and expenses incl.	(1/4 year) $28,245	$112,980	$112,980	$112,980	$112,980	$105,852

2/yr CMHS trip						
Bid for Social Marketing: Estimated cost of $80 per hour plus materials and expenses, including 2/yr CMHS trips	(1/4 year) $12,500	$50,000	$50,000	$50,000	$50,000	$50,000
Regional Services – 12 regions ($865,000 average per 5.25 years of service)	$595,749: $120,000 ($10,000 for each region) for planning and accommodations like translations and interpreters; rest for services	$742,078	$1,115,086	$1,113,034	$735,921	$365,872
Subtotal of Contractual	$895,236	$1,350,047	$1,823,055	$1,821,003	$1,343,890	$866,713
Sub-total of Direct Costs	$950,000	$1,425,000	$1,900,000	$1,900,000	$1,425,000	$950,000
Indirect (5% unallocated infrastructure) Costs	*$50,000*	*$75,000*	*$100,000*	*$100,000*	*$75,0000*	*$50,000*
Total Federal	**$1,000,000**	**$1,500,000**	**$2,000,000**	**$2,000,000**	**$1,500,000**	**$1,000,000**
System of Care Match (See Appendix 5)	*$1,942,726*	*$2,437,809*	*$2,893,851*	*$2,945,390*	*$3,000,000*	*$3,853,068*
Required Match	$333,333	$500,000	$666,667	$2,000,000	$3,000,000	$2,000,000

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

*At $5,000 per youth, 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.

Section G: Biographical Sketches and Job Descriptions

Principal Investigator - *CHARLES A. BISS*

86 Mayapple Lane
Middlebury, VT 05753
(802) 388-3508(home)
(802) 652- 2009 (work)

VT Department Mental Health
P.O. Box 70 108 Cherry Street
Burlington, Vermont 05402-0070
email: cbiss@vdh.state.vt.us

EMPLOYMENT HISTORY

1987 – Present, with Vermont Department of Mental Health, Burlington, VT

1993 – Present: Child, Adolescent and Family Unit Director; directs statewide system of Mental Health Care for children and their families

- Serves 10,000 children a year
- Manages a budget of $60 million per year
- Directs a workforce of 800 FTE's employed by 11 designated non-profit provider agencies
- Develops, implements and sustains several grants, both federal and private
  -Robert Wood Johnson
  -2 Federal Community Mental Health Services Comprehensive Grants-Children's Upstream Services, CUPS, and Access
  -3 Respite Grants
- Develops new services using existing state dollars in creative ways
  →Success Beyond Six, School Based Mental Health Services,
  →Individualized Service Budgets (ISB) development Individualized Wraparound Plans,
  →Hospital Diversion Services -Community-Based Intensive Services
  →JOBS Program -Transition Program
  →Crisis Response Services -Access
  →Consult Services to Children 0-6 -Children's Upstream Services (CUPS)
  →Pediatric Collaborative -Pediatric-Based Mental Health Services
  →Child Psychiatric Consult Service
- Works collaboratively with all child-serving and youth and adult-serving systems in Vermont.

1987 – 1993: Regionalization Project Director; directed a Robert Wood Johnson Grant to create community-based services for adults with serious mental illness. Grant was a bridge fund to transfer dollars from state hospital ward closings to community-based services. In 6 years, census at the Vermont State Hospital (VSH) went from 200 to 60 and in excess of 6^+ million dollars was transferred to community services from the hospital. The project was guided by consumers, families, providers and other interested stakeholders.

Other Employment/Consultation

1996 – Present Southern New Hampshire University, Manchester, N.H. – Instructor for the Program in Community Mental Health

1995 – Present Technical Assistance Consultant with Georgetown Child Development Clinic, Washington DC. Co-authored chapter of the book *Social and Emotional Health in Early Childhood, 2007*
1996 – 2005 Technical Assistance Consultant with the National Federation of Families for Children's Mental Health, Alexandria, Virginia. Co-authored *Learning From Colleagues: Family/Professional Partnerships Moving Forward Together, 1999*
1999 – 2004 Peer Mentor Technical Assistance Partnership, Washington DC
1982- Present Consulted with and presented to, many groups and organizations regarding

- Community-based services that work for consumers (Children and Adult)
- Family and consumer partnerships with providers (Children and Adult)
- Funding opportunities as result of partnership with other child serving agencies
- Mental health services for children (0-6) and their families.

1980-1987: Howard Center for Human Services, Burlington, VT; Director of Mental Health Residential and Acute Care Program. Planned, developed and implemented a comprehensive Community Support Program for persons with serious mental illness. Program included housing, assertive community outreach, community emergency beds and substance abuse detox, community group homes, and club house/supported employment
1982-1987: Developed and implemented the 20-week family education course for Families of the Mentally Ill. These courses led to the founding of National Alliance for the Mentally Ill, VT.
1979-1980: Baird Center for Children and Families, Burlington, VT; Social Worker for Life Skills Program. Upon closing the Juvenile Detention Facility (Weeks School), this group home was developed to serve the children with severe emotional disturbance.
1977-1979: Parsons Child and Family Center, Albany, NY; Social Worker for Institutional Care Prevention Project. Worked with Juvenile Court and Child Welfare to provide community-based services to children and their families at imminent risk of being removed from home/community.
1973-1975: St John's Home for Boys, Rockaway, NY; Apartment Supervisor-12 juv. offenders

EDUCATION

- Certified Social Worker, License #107, State of Vermont, 1987
- Master of Social Work, State University of New York at Albany, 1977
- Bachelor of Science, English, State University of New York at Oneonta, 1973

CIVIC INVOLVEMENT

2000 - 2004 Kids on the Block, VT – Chair of the Board of Directors
1993 – 1999 Burlington Parks and Recreation – Youth Soccer, Baseball, Basketball Coach
1985 – 1993 Vermont Association of Mental Health – Board Member
1981 – 1993 Committee on Temporary Shelter – Founding Board Member

HONORS AND AWARDS

1996 & 1997 Finisher – New York City Marathon and Vermont City Marathon
1992 The First Vermont Family Service Award, Alliance for the Mentally Ill of Vermont: For pioneering efforts in family education…and more….

State –Local Liaison

Scott Johnson, 245 Maxfield Road, Waterville, Vermont 05492. (802) 644-5683
scott.johnson@ahs.state.vt.us

EDUCATION

M.S. Counseling, University of Vermont, 1990.
B.S. Education, Central Connecticut State College, 1975.

EMPLOYMENT

2005 – present	**AHS Field Services Deputy Commissioner**	Agency of Human Services Waterbury, VT
2004 – 2005	**AHS Field Director**	Agency of Human Services Morrisville District Office
1998 – 2004	**Statewide Coordinator**	VT Regional Partnerships
1994 – 2004	**Regional Coordinator**	People in Partnership Morrisville, VT.
1986 - 1993	**Executive Director**	Laraway School, Inc. Johnson, VT.
1984 - 1986	**Landscaper/Designer/Builder**	Earthscapes Underhill, Vermont
1979 - 1984	**Executive Director/Principal**	Laraway School, Inc.
1975 - 1979	**Assistant Director, Teacher**	

BOARD AFFILIATIONS AND VOLUNTEER PROGRAMS

State Team for Children, Families and Individuals. Interagency team represented by Vermont State agency and department personnel, and community partners to oversee coordination of policy, resources, supports and services to improve the well being of Vermont's children and families. 1994 - present. Co-chair 2003 – 2005.

Vermont Federation of Families for Children's Mental Health. Statewide parent advocacy organization promoting coordinated service systems to support children and youth with a severe emotional disturbance and their families. 1995 - 2005.

United Way of Lamoille County. Member of Board of Directors responsible for county fundraising campaign to support non-profit human service agencies.
1993 - 2001, Chairman 1999 – 2001, Allocations Committee 1998 - 2001.

Vermont Association of Mental Health. Advocacy organization to promote policy and legislation supportive of individuals that are challenged by mental health issues.
Runs Camp Daybreak summer program for children. 1993 - 1999.

Vermont Advisory Board for Children and Youth with Special Mental Health Needs (Act 264 Advisory Board). Governor appointed board to oversee the Vermont "System of Care" for children and youth with a severe emotional disturbance and their families. 1989 - 1999, Chairman 1991 - 1993.

Lamoille Court Diversion. Statewide program for first offenders to enter community restitution program. 1979 - 1993 Community Review Board, 1983 - 1993 Advisory Board, Chairman of Advisory Board 1987 - 1991.

CMHI Program Director Job Description

Definition: Policy and program development and coordination work at a professional level for the Department of Mental Health involving development and implementation of community-based mental health programs for youth in transition. Duties include implementation of Department grants and sub-grants. Significant interaction and coordination is required with other state agencies, federal officials, service providers, and local school districts. Work is performed under the direction of the Department's Child, Adolescent and Family Unit Director.

Examples of Work: Assists in the development, implementation, coordination, monitoring and promotion of community-based mental health programs for youth in transition. Collaborates with local service providers, other Department staff, and other state agencies to solve program problems and enhance services. Participates in the development of policies and procedures for coordinated services. Coordinates use of data from operational and financial reports, site visits, client tracking, and other program review and monitoring activities for program evaluation and management purposes. Negotiates and administers contracts and grant agreements with providers of services and/or technical assistance (including for family and youth involvement, evaluation, T/TA, cultural and linguistic competence, and social marketing-communications). Provides consultation to grantees and communities in the development of local plans for mental health services to youth in transition. Identifies opportunities for resource development; writes grant proposals, monitors funding, and ensures compliance with guidelines. Meets with funding agencies to review project status, accomplishments, and expenditures.

Environmental Factors: Duties are performed primarily in a standard office setting. Frequent travel to attend provider and public meetings requires that private means of transportation be available and may entail some work outside of normal office hours. Interactions with public and private service providers, youth and families may involve conflict and strong feelings.

Minimum Qualifications:
Knowledge, Skills and Abilities:

- Considerable knowledge of the principles and practices of public administration
- Considerable knowledge of program planning principles and practices
- Considerable knowledge of emotional and mental disturbances among youth in transition and of their treatment
- Working knowledge of the principles and practices of grant writing and implementation
- Ability to collect and analyze data, evaluate program performance, identify strengths and problem areas, and recommend viable changes
- Ability to communicate effectively, both orally and in writing
- Ability to establish and maintain effective working relationships among a variety of agencies and publics, including family and youth groups

Education: Bachelor's degree, preferably in a human services field
Experience: Four years at a professional level in a program dealing with children and adolescents with serious emotional disturbance, including at least two years in an administrative, planning and evaluation, or program development role.
Note: Graduate work in a human services field or in special education may be substituted for the two years of general experience on a semester for six months basis.

<u>Lead Family Contact</u>: Cynthia A. Marshall
260 Codling Road
East Montpelier, VT 05651
802-223-0496

Work Experience

Assistant Director – July 2006 – Currently part-time
VT Federation of Families for Children's Mental Health, PO Box 507, Waterbury, VT

- ❖ Assist the Executive Director in all aspects of running a family support nonprofit organization
- ❖ Participate in and facilitate training activities, legislative awareness and education events, and other public speaking opportunities.
- ❖ Assist in contract/grant oversight and monitoring
- ❖ Oversee program implementation which includes monitoring all data collection and program evaluation.
- ❖ Participate in program and training development for staff which includes orientation, supervision, and evaluation of staff

Executive Director / Office Manager – June 1, 2005 to June 30, 2006
ARC of Vermont, 27 Granite Street #1, Barre, VT 05641

- ❖ Administered all aspects of a nonprofit agency, oversaw funding and fundraising
- ❖ Supervised employees and volunteers
- ❖ Provided testimony and information to policy makers
- ❖ Provided public outreach and education (included preparing a quarterly membership publication)
- ❖ Coordinated communication between state departments, agencies, and families
- ❖ Supported individuals and families in crisis including advocacy, research, and information and referrals

Administrative Assistant – March 2003 to May 2005
Court Administrator's Office, Vermont Judiciary, 109 State Street, Montpelier, VT 05602

- ❖ Organized and facilitated all Employee Educational workshops/conferences
- ❖ Created and maintained all budget tallying for the Employee Education Division
- ❖ Provided various administrative support services for the Employee Education Division

Education

Vermont Community College, Morrisville, VT
1996 – Business and Professional Writing

Holyoke Community College, Holyoke, MA
1988 – 1990 3 semesters Business Administration

Ludlow High School, Ludlow, MA
1984 – 1988

Vermont Federation of Families for Children's Mental Health
Youth Coordinator *(1 FTE)*
Job Description

Supervisor:
VFF Executive Director/ Assistant Director

Purpose:
The Youth Coordinator will assist the Executive Director in these activities: oversight, monitoring, evaluation, and administration of VFF youth program and public relations. The Youth Coordinator will also perform related duties as requested by the Executive Director.

Skills, Knowledge, and Experience

- Have experience as a member, recent member or family member associated with the target population of youth aged 16-21 with Severe Emotional Disturbance(SED)
- Leadership skills
- Strong oral and written communication skills
- Competence in working as a team member
- Ability to facilitate meetings
- Ability to provide phone support to families and youth
- Computer skills

Activities/Responsibilities

Advocacy/outreach:

- Participate in training activities, legislative awareness and education events, VFF and other public speaking opportunities as requested by VFF Executive Director
- Organize youth engagement activities
- Support youth to participate on decision making boards

Grants and Contracts:

- Submit documentation and reports for contract and grant oversight and monitoring

Human Resources:

- Participate in the interview and hiring process for all new youth program staff.
- Assist in ensuring all youth program staff have an up to date personnel file
- Develop a plan of orientation and training for all new youth program staff
- Assist in providing ongoing supervision and support to all youth program staff according to VFF policies, procedures and program manuals. Document all supervision interactions with tasks to be achieved, outcomes and personal development needs.
- Assist in completing annual evaluation of all VFF youth program staff

Programs: In partnership with VFF Executive Director:

- Develop annual program plan with action steps for implementing VFF youth programs as they are related to the overall strategic plan of VFF.
- Oversee and monitor progress of VFF Youth Programs Plan.
- Write and submit to VFF Executive Director quarterly reports outlining achievement of goals and deliverables within the VFF Youth Program Plan.
- Maintain multiculturalism values and principles within the VFF environment and in delivery of services and activities.
- Provide ongoing training and technical assistance to youth staff and volunteers.

Evaluation/Quality Assurance:

- Provide oversight and monitoring of all youth program data collection and evaluation
- Submit quarterly quality assurance reports to Executive Director

Cultural and Linguistic Competence Coordinator

Definition: This position is responsible for producing and implementing – with broad, ongoing input from key stakeholders – a plan for cultural and linguistic competence for the CMHI project. The plan must "ensure that all of the services and strategies of the CMHI project are designed and implemented within the cultural and linguistic context of the youth and families to be served."[139] The plan will reflect the guidance of the national project and technical assistance staff and will be final only after approval by the State Outreach Team.

Major Duties: Assist the CMHI leadership with "infusing cultural and linguistic competence throughout the system of care"[140] in accordance with the plan when participating in the SIT State Outreach Team and the Chittenden County LIT. Deliver and /or arrange for delivery of related training and technical assistance statewide and in Chittenden County, linked with JJDP TA. He/she is responsible for operating within the budget for cultural and linguistic competence.

Environmental Factors:
Work will be performed in standard office settings and at frequent meetings throughout Vermont, some beyond normal office hours. Meetings may involve the expression of strong feelings and conflicting opinions. The Coordinator must have private transportation available.

Knowledge, Skills and Abilities:
- Ability to be respectful and to listen carefully
- Ability to express self clearly orally and in writing
- Ability to use standard office equipment including word-processing and email
- Ability to establish objectives and design strategies for achieving them
- Skills in collaboration and teamwork
- Knowledge of diverse populations and cultures (including one or more of the following: youth, people living in poverty, people who are gay or lesbian or transgendered, people who are deaf or hard-of-hearing, people who are blind, people who are learning impaired, refugees, immigrants, etc.)
- Knowledge of principles for effective planning and/or organizational development
- Knowledge of state and regional resources for improving the access of people with disabilities and/or Limited English Proficiency to the existing service systems and informal community supports

Minimum Qualifications:
Education: Bachelor's degree, preferably in human services or education
Experience: Four years experience serving vulnerable populations including at least two years experience with planning and/or organizational development for those populations
Note: Graduate work in human services, education, or organizational development may be substituted for the two years of general experience on a semester for six months basis.
Preference will be given to applicants who are bi- or multi-lingual and/or bi- or multi-cultural.

[139] Technical Assistance Partnership for Child and Family Mental Health. (2008). Sample Cultural and Linguistic Competence Plan for Advancing Cultural and Linguistic Competence in Systems of Care. Retrieved1/28/2008 from http://www.tapartnership.org/cc/CLC_Plan_Template_FINAL.pdf
[140] Ibid.

Evaluator
CURRICULUM VITAE

Name: Thomas V. Delaney
Address: 40 Village Green, Burlington, VT 05408
Date of Birth: May 28, 1971
Place of Birth: Montclair, NJ

Education:
1995 B.A. Rutgers Newark College of Arts and Sciences, Newark, NJ
1999 M.A. University of Denver, Denver, CO
2004 Ph.D. University of Denver, Denver CO

Awards and Honors:
2001 Elected to Sigma Xi, the National Science Honor Society
2000 Lawrence Miller Graduate Research Fellowship ($1200)
1996-2000 Colorado Graduate Fellowship ($20,000)
1999 Graduate Students of the Three Faculties Research Award ($400)
1994-1995 President, Rutgers Chapter of Psi Chi (Psychology Honor Society)
1993-1995 College Honors Program, Rutgers Newark College of Arts & Science
1994 Dean's Campus Service Award
1993 Elected to Psi Chi, the National Honor Society in Psychology

Memberships in Professional Societies:
1995-2002 American Psychological Society
2006- American Public Health Association

Grant/Contract Support:
2007 "Educational Interventions for Preventing Head Injuries in Winter Sports (continuation funding)," -- The Vermont Health Foundation, **Lead Grant Writer** ($10,000)
2007 "Educational Interventions for Preventing Head Injuries in Winter Sports," -- The Vermont Health Foundation, **Lead Grant Writer** ($19,000)
2006 "Improving Mental Health in Primary Care Project." – The American Academy of Child and Adolescent Psychiatry, **Grant Co-writer** ($25,000)

Publications in Peer Review Journals
1. Miller S, *Delaney T,* Tallal P. Speech and other central auditory processes: Insights from cognitive neuroscience. *Current Opinion in Neurobiology* 1995: 198-204.

2. Bishop D, Bishop S, Bright P, James C, *Delaney T,* Tallal P. Different origin of auditory and phonological processing problems in children with language impairment: Evidence from a twin study. *Journal of Speech, Language, & Hearing Research* 1998; 42: 155-168.

3. Shaw J, Wasserman R, Barry S, *Delaney T,* Duncan P, Davis W, Berry P. Statewide quality improvement outreach improves preventive services for young children. *Pediatrics* 2006; 118: e1039-e1047.

4. Frankowski B, Keating K, Rexroad A, *Delaney T*, McEwing S, Wasko N, Lynn S, Shaw J. The Community Collaboration Model - bringing it all together: Communicating the plan, empowering to educate. *Journal of School Nursing* 2006; 76: 303-306.

5. Mercier C, Barry S, Paul K, *Delaney T*, Horbar J, Wasserman R, Berry P, Shaw J. Improving newborn preventive services at the birth hospitalization: a collaborative hospital-based quality improvement project. *Pediatrics* 2007; 120: 481-488.

6. Williams R, *Delaney T*, Heath B, Nelson E, Gratton J, Laurent J. Speeds associated with skiing and snowboarding. *Wilderness and Environmental Medicine* 2007; 18: 102–105.

Recent Presentations at National and International Meetings (2006-2007)

1. Duncan P, Kallock E, Frankowski B, Carey P, Philibert D, *Delaney T*, Shaw J. Will primary care providers incorporate a strengths assessment into well-child care for the 11 -18 year old? (Presented at the Pediatric Academic Societies meeting, San Francisco, May 2006)

2. Duncan P, Frankowski B, Carey P, *Delaney T*, Barry S, Philibert D, Kallock E, Shaw J. A modified quality improvement initiative for youth risk behavior screening (Presented at the Pediatric Academic Societies meeting, San Francisco, May 2006)

3. Brakeley J, Greenblatt J, Delaney T, Kallock E, Davis W, & Shaw J. Improving Pediatric Primary Care for Children with Symptoms of ADHD. (Presented at the American Academy of Pediatrics Division 21 Conference: Connecting for Children's Sake, Washington, D.C., October 2006)

4. *Delaney T*, Williams R. Injury Prevention and Preparedness among Backcountry Skiers & Snowboarders in a Northeastern State. (Presented at the American Public Health Association meeting, Boston, November 2006)

5. Nelson E, Keating K, *Delaney T*, McEwing S, Hunt E, Munene E, Shaw J. Risky Behaviors in Teenage Motor Vehicle Occupants. (Presented at the Pediatric Academic Societies meeting, San Francisco, May 2007)

6. Frankowski B, Duncan P, Kallock E, *Delaney T*, Philibert D, Shaw J. Implementing a communication and tracking system for the health needs of children entering state custody. (Presented at the Pediatric Academic Societies meeting, San Francisco, May 2007)

7. Nelson E, Hunt E, Keating K, *Delaney T*, McEwing S, Jewiss J, Munene E, Shaw J. How Are Primary Care Clinicians Addressing Teen Risky Driving? (Presented at the American Academy of Pediatrics National Conference and Exhibition, Washington D.C., October, 2007)

…and more……

Evaluator Position (2nd FTE)

BASIC FUNCTION: The Research Analyst will direct community, agency and statewide research and data collection activities for a large statewide project to include developing research plans and protocols, designing quantitative and qualitative data collection instruments, implementing summative and process evaluation procedures, data analysis, presenting results and co-authoring reports, grants, and manuscripts.

ESSENTIAL FUNCTIONS:

Develop research strategies, protocols, and evaluation plans for a large, federally funded mental health services project; develop summative, process, and outcomes evaluation plans based on available data from primary (survey, interviews, validated data collection instruments) and secondary sources (state & national data sets); design both qualitative and quantitative instruments to support data collection activities of the project; provide consultation on instrument design during project conception and implementation phases; evaluate project progress and results.

Provide consultation on quality improvement (QI) methods and strategies in the context of the federally funded evaluation work; make recommendations on appropriate QI methods for specific project interventions/circumstances; review local and state level reports and continually assess progress and needs; recommend interventions to achieve goals; and work with project participants and staff in a variety of professional, government agency and local clinical provider settings.

Conduct complex analyses and interpret research data; recommend sampling strategies for a variety of data collection methods; oversee all data safety and monitoring activities for the IRB-approved evaluation; develop protocols and amendments related to data collection instruments and methods; ensure integrity of all data collected; pilot test data collection instruments; conduct validity and reliability testing of instruments; oversee data entry and cleaning; design analysis plans and analyze data using specialized software; develop presentations of results (tables, graphs, narrative descriptions of results); maintain knowledge of relevant biostatistical tools and techniques. Present results of data analysis and monitoring activities to staff, state and federal officials and contractors; write technical reports documenting project methodology; and collaborate in the writing of scientific manuscripts describing the data analysis and results.

Provide functional supervision of graduate research assistants or similar employees.

MINIMUM QUALIFICATIONS: PhD in biostatistics, epidemiology, public health or related field with 3-5 years of experience required in program evaluation, preferably in a clinical research or health care setting. Knowledge of statistical methods for design and analysis of health care programs and clinical trials. Previous work involving applied health care or mental health care research and/or quality improvement activities highly desirable. Must possess competent writing and editing skills, including sound grammar, spelling, and punctuation. Working knowledge of Microsoft Windows (i.e., Outlook, Excel, Word, & Access) required. Statistical software (e.g., SPSS, SAS) experience required.

Technical Assistance Coordinator (.5 FTE)

Definition: This position is responsible for producing and implementing – with broad, ongoing input from key stakeholders and institutions of higher education – a plan for training and technical assistance for the CMHI project. The plan must include a variety of learning opportunities for youth, families, and youth-service providers from different agencies and professions (mental health, health, education, child welfare, juvenile justice, criminal justice). The plan will reflect the expectations of the national T/TA provider and will be final only after approval by the State Outreach Team.

Major Duties: The Technical Assistance Coordinator must arrange for the delivery of training about transition-aged youth with SED *[from Dr. Mary Ann Davis],* the TIP Model *[from Dr. Rusty Clark],* the intervention/intercept models [*from the NCMHJJ and the GAINS Center],* and the EBPs (including Supportive Employment) chosen by one or more LIT. He/she must arrange, as needed, for clinicians and their supervisors to receive in-depth initial and/or follow-up training about the EBPs to be delivered, including about the use of any associated screening or assessment tools and curricula. The Coordinator must also respond to other needs for learning that are identified (by state and regional needs assessments) throughout the six years of the project. The Coordinator will find national, state, and local experts to provide the desired training and technical assistance. She/he is responsible for operating within the budget for training and technical assistance.

Environmental Factors:
Work will be performed in standard office settings and at frequent meetings throughout Vermont, some beyond normal office hours. Meetings may involve the expression of strong feelings and conflicting opinions. Because extensive in-state travel is expected, the Coordinator must have private transportation available.

Knowledge, Skills and Abilities:
- Ability to be respectful and to listen carefully
- Ability to express self clearly orally and in writing
- Ability to use standard office equipment including word-processing and email
- Ability to establish objectives and design strategies for achieving them
- Ability to produce training events
- Skills in collaboration and teamwork, also team-building
- Knowledge about adult learning styles and group process
- Knowledge about family-driven and youth-guided service delivery
- Knowledge about adolescent and family growth and development
- Knowledge of existing State/community resources

Minimum Qualifications for Position:
Education: Bachelor's degree, preferably in a human services field or education
Experience: Four years experience serving children and adolescents with SED including at least two years coordinating training and technical assistance for their service providers
Note: Graduate work in a human services field or in education may be substituted for the two years of general experience on a semester for six months basis.

Social Marketing-Communications Manager (.5 FTE)

Definition: This position is responsible for producing and implementing – with broad, ongoing input from key stakeholders – a plan for social marketing and communications for the CMHI project. The plan will be linked with the national Caring for Every Child's Mental Health Campaign goals and messages to reduce stigma related to mental illness and will annually include activities (in collaboration with the Vermont Federation of Families for Children's Mental Health) in honor of National Children's Mental Health Day. The plan must be linked with AHS efforts to inform transition-aged youth, their families, and the broader public about the opportunity to enroll in Medicaid. The plan must also help the Federation reach out to transition-aged youth with SED and their families to inform them about the existence of mental health problems and available help and hope for those problems. The plan will be final only after approval by the State Outreach Team.

Major Duties:
The Social Marketing-Communications Manager will determine the informational needs of priority audiences and develop messages and materials that are in compliance with relevant standards for cultural and linguistic appropriateness and sensitivity, including compliance with the Americans with Disabilities Act (ADA). She/he is responsible for operating within the budget for social marketing-communications.

Environmental Factors:
Work will be performed in standard office settings and at frequent meetings throughout Vermont, some beyond normal office hours. Meetings may involve the expression of strong feelings and conflicting opinions. Because extensive in-state travel is expected, the Manager must have private transportation available.

Knowledge, Skills and Abilities:
- Ability to be respectful and to listen carefully
- Ability to express self clearly orally and in writing
- Ability to use standard office equipment including word-processing and email
- Ability to establish objectives and design strategies for achieving them
- Skills in collaboration and teamwork
- Skills for assessing needs and desires of diverse audiences for social messages
- Skills for producing social marketing-communications materials
- Knowledge of social marketing-communications procedures, practices, and resources

Minimum Qualifications:
Education: Bachelor's degree, preferably in human services or marketing/communications
Experience: Four years experience working for human service or education agencies including at least two years producing social marketing-communications materials
Note: Graduate work in human services or marketing/communications may be substituted for the two years of general experience on a semester for six months basis.

Section H: Confidentiality and SAMHSA Participant Protections/Human Subjects

Protection of Human Subjects Regulations

VCHIP will develop - and gain UVM Institutional Review Board (IRB) approval for - the Vermont CMHI project evaluation prior to any participants being enrolled. At the start of the planning phase (9 months) of the Vermont CMHI project, the VCHIP team will begin to develop an IRB protocol that accurately and completely reflects the project evaluation activities. This protocol will be submitted to the UVM IRB at least three months prior to the beginning of enrollment of project participants, as we anticipate that it will require a full IRB committee review. VCHIP will make any and all changes to the protocol required by the UVM IRB. VCHIP will, with DMH, document for the federal CMHS that IRB approval has been obtained and file the required Assurance of Compliance with the federal Office of Human Research Protection (OHRP) before enrolling participants.

If any changes to the evaluation methodology are needed after initial approval has been obtained, the appropriate protocol amendments will be submitted and no methods changes will be implemented prior to IRB approval of the amendments. The VCHIP team will seek annual renewal of the approved IRB protocol until all data collection, processing, analysis and reporting has been completed. Deviations from the approved evaluation protocol will be promptly reported per the UVM IRB regulations.

Confidentiality and Participant Protection

Identify foreseeable risks or adverse effects due to participation in the project and/or in the data collection (performance assessment) activities (including physical, medical, psychological, social, legal, and confidentiality) and provide your procedures for minimizing or protecting participants from these risks.

This CMHI project includes mental health treatment (and related supports) and evaluation; the risks and consents are different for treatment and evaluation. Because the project is focused on improving treatment through implementation of evidence-based practices, there are few foreseeable physical, medical, psychological, social, or legal risks or potential adverse effects as a result of the project itself or any data collection activity.

Risks related to treatment: The foreseeable risks associated with participating in community-based mental health treatment are the psychological and social discomforts of facing challenging life issues and having to deal with such consequences of those issues as legal actions. For example, youth and/or their caregivers may be challenged to address neurological dysfunctions, substance abuse, domestic violence, child abuse/neglect, suicidal or homicidal ideation. The treating clinicians have related duties to protect and warn all potential victims by reporting to the appropriate officials threats or actions by the youth and/or their caregivers.

Vermont state law mandates that a mental health professional who has a reasonable cause to believe that any child, disabled or elderly person has been abused or neglected, must report such abuse or neglect to the Department *[for Children and Families]*. Also by Vermont law (Peck vs. Counseling Service of Addison County), if a clinical staff member has reason to believe that a client will commit a serious crime against either property or another person, that staff is required to warn the intended victim to take reasonable steps to protect him or

her. If the client is so impaired as to pose a threat to society in general (e.g., intoxicated and driving) the law is interpreted as requiring the staff to take steps to protect the public by rendering the client harmless (e.g., taking his or her keys) and/or informing the proper authorities. If the client is both mentally ill and a danger to him/herself or others, then the staff should institute commitment proceedings.[141]

All of these risks are fully explained to youth and their caregivers at the time of – and in the process of – obtaining their signatures indicating informed consent for treatment. Furthermore, the Notice of Privacy Practices provided by mental health centers at the start of treatment informs clients that their health information may be disclosed "to prevent a serious threat to your health and safety or to the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat"[142] or to report public health risks like abuse or neglect.

There is no absolute protection from life's challenges and consequences, which must eventually be faced with or without mental health treatment. However, through the support of a consistent, trusting relationship with a mental health or other community-based service provider, youth and their caregivers may feel less vulnerable and more comfortable and able to make the next decisions/steps in their lives. The treatment goal in this situation might be for youth to recognize the possible adverse effects of their decisions and actions and, with encouragement from their workers, report themselves for abuse or neglect or voluntarily admit themselves for psychiatric hospitalization.

The treating clinicians are trained and closely supervised to inform youth ahead of time (if possible, or immediately afterwards) whenever an instance has arisen requiring the clinicians to submit a mandated report. They are routinely trained in de-escalation and other techniques (such as the use of cell phones to call 9-1-1) to maintain their own and client safety during all encounters.

Transition-aged youth will be recipients of enhanced screening, assessment and treatment using nationally recognized evidence-based models/treatment, and there are no known risks associated with receiving these types of treatment vs. standard treatment. Individuals receiving enhanced services funded through this grant will likely benefit from improved treatment since clinicians will receive supervision and training in evidence-based practices so they are as effective as possible in their work with youth and caregivers. Implementation of enhanced treatment will be overseen by clinical experts, which will help to ensure treatments are developed and provided correctly without posing any risk to participants resulting from incorrect application of a treatment intervention.

Risks related to evaluation: The main foreseeable risk associated with participating in the evaluation of the proposed project is loss of confidentiality. To minimize risk, identifying information collected from project participants will be coded, and the key to the code will be kept in a separate location (electronic file). Electronic data files will be maintained on secure servers and accessed only by VCHIP CMHI project personnel. Hard copies of data will be kept in a locked file cabinet with access restricted to VCHIP CMHI project personnel.

- *Identify plans to provide guidance and assistance in the event there are adverse effects to participants.*

[141] WCMHS Records Information Form
[142] WCMHS Notice of Privacy Practices, p. 2

For treatment, in the event of a crisis, the clinicians will involve emergency mental health staff or police or others (like shelter providers) as needed to help youth and their caregivers and the public remain safe.

For evaluation, in the event of a loss of confidentiality, VCHIP will notify the University of Vermont IRB immediately and consult with them about how to proceed. VCHIP will comply with the requirements of the IRB regarding any adverse events.

- *Describe the target population and explain why you are including or excluding certain subgroups. Explain how and who will recruit and select participants.*

The target population for mental health treatment through this CMHI project is transition-aged youth (16-21, inclusive) in Vermont who are experiencing SED and their families. As explained in Section A of this proposal, about 95% of these youth are White and about 99% are likely to speak English. The project will reach out to youth through teen centers, substance abuse recovery centers, runaway and homeless youth programs, Outright Vermont, etc. All youth who seek services will be enrolled in treatment.

Enrollment in CMHI services will automatically entail collection of the NOMs data from all youth and their caregivers. This data collection will be required from youth and their caregivers regardless of their agreement to participate (or not) in the more in-depth data collection for the Vermont and national evaluation. Participation in the evaluation is not required for youth receiving services or their caregivers.

Recruitment into the comprehensive evaluation will be done initially by the clinicians who will provide information about the evaluation to the youth and caregiver and, with their written assent and consent, notify the VCHIP evaluation team that a youth has been enrolled in the evaluation. VCHIP will work with the national evaluator to identify the optimal methodology for obtaining and retaining the needed sample.

- *State whether participation in the project is voluntary or required. If you plan to provide incentives/compensate participants, specify the type (e.g., money, gifts, coupons) and the value of any such incentives. Provide justification that the use of incentives is appropriate, judicious and conservative and that incentives do not provide an "undue inducement" which removes the voluntary nature of participation. Incentives should be the minimum amount necessary to meet the programmatic and performance assessment goals of the grant. Applicants should determine the minimum amount that is proven to be effective by consulting with existing local programs and reviewing the relevant literature. In no case may the value of an incentive paid for with SAMHSA discretionary grant funds exceed $20. (See Appendix G, Funding Restrictions.)*

Participation in treatment is completely voluntary. No cash or token incentives are offered to encourage participation, though assistance with transportation may be provided if necessary for the youth to receive treatment.

Participation in the CMHI project evaluation activities will be completely voluntary. A monetary incentive of $20.00 to each participant will be provided at the time of the youth and their caregivers participating in the baseline and follow-up interviews. Based on previous VCHIP interview and qualitative studies involving youth and family participants, we believe that the $20.00 amount is the smallest amount that can be used that is not an undue inducement to either youth or caregivers, but that will also encourage participation in the project evaluation activities.

- *Describe data collection procedures, including sources (e.g., participants, school records) and the data collecting setting (e.g., clinic, school). Provide copies of proposed data collection instruments and interview protocols in **Appendix 3** of your application, "Data Collection Instruments/Interview Protocols." State whether specimens such as urine and/or blood will be obtained and the purpose for collecting the specimens. If applicable, describe how the specimens and process will be monitored to ensure both the safety of participants and the integrity of the specimens.*

The treatment will be conducted without specimens such as blood or urine collected. With the exception of administrative data from the AHS MIS databases, all data will be collected directly from the youth, their caregiver, or the youth's mental health clinician. Baseline NOMs measures and other instruments requiring a baseline for the longitudinal components of the evaluation will be collected as soon as possible after youth's entry into the CMHI project. Subsequent to the initial data collection, the data will be collected regularly at three to six month intervals during the time the youth is receiving services through the project (for all youth, for NOMs) and beyond (only for a sample, for the evaluation). The NOMs data will be collected by the clinician and entered into TRAC by VCHIP. The Vermont and national evaluation data will be collected by the VCHIP evaluation team; see some of the data collection tools, Appendix 3.

- *Explain how you will ensure privacy and confidentiality of participants' records, data collected, interviews and group discussions. Describe where the data will be stored, safeguards (e.g., locked, coding systems, storing identifiers separate from data) and who will have access to the information.*

Community mental health centers have extensive safeguards for protecting client records and the use of private health information. The Vermont Council of Developmental and Mental Health Services, Inc. – an association of the CMHCs and other specialized agencies – has developed an extensive set of standardized forms and privacy practices for its member agencies to use with clients in order to comply with HIPAA and related state and federal laws.

For the evaluation, at the time of initial data collection, the youth and caregiver will be assigned a unique non-identifying code that will be the only link to the youth and caregiver. The codes will be stored in a password-protected "key" file. No other identifying information will be collected. The unique ID code will be used for all data processing and analysis. The key to the identifying code will be kept separate from the data files, and will only be accessible by the VCHIP evaluation team. Electronic data files will be maintained in a password protected files on the UVM secure server. Hard copy data will be kept in a locked filing cabinet in the VCHIP office and will only be accessible to VCHIP evaluation team members.

- *Describe the process for obtaining and documenting consent from adult participants and assent from minors along with consent from their parents or legal guardians. Provide copies of all consent forms in **Appendix 4** of your application, "Sample Consent Forms." If needed, give English translations.*

The CMHC's "Consent and Agreement to the Use and Disclosure of Health Information For Treatment, Payment or Healthcare Operations" (see Appendix 4) is the standard form used to obtain consent from adults for their own or their dependent's mental health treatment. This form will be provided to adult clients and to the parents or guardians of child clients at the time the Vermont CMHI services begin. At the time the CMHC consent form for treatment is provided to the client (or parent/guardian), the clinician will ask the client to review the form as well as ask if

the client would like the form read out-loud to him/her. The clinician will allow adequate time for review of the form prior to the youth or parent/guardian choosing to sign or not sign the form. Clinicians will also offer to answer any questions that youth or their parents or guardians may have about the form. The CMHCs do not have a written form for minor's assent to treatment, though obtaining their verbal assent and cooperation is a critical first step in engaging children and adolescents in their own treatment.

Consent and/or assent forms for the evaluation component of the CMHI project will be provided to adult clients and to the parents or guardians of child clients separately from – and subsequent to - the CMHC consent for treatment form. Consent or assent to participate in the evaluation will be obtained by the youth's clinician prior to any evaluation data being collected (see assent and consent forms in Appendix 4). Youth and their parents or guardians (if applicable) will be told that participation in the CMHI evaluation is voluntary and they will still receive services even if they choose to not sign the evaluation consent or assent forms. As with the CMHC consent to treatment forms, the clinician will ask the youth and parent/guardian to review the consent and assent forms for evaluation. The clinician will offer to read the forms out-loud. The clinician will then allow the youth and parent/guardian time to review the form before choosing to sign or not sign them. The clinician will also offer to answer any questions that youth or their parents or guardians may have about the forms.

For both consent/assent processes, if a youth or parent or guardian requests language interpretation or the clinician observes that language interpretation is needed, the clinician will arrange to provide a translated version of the forms.

Signed copies of the CMHC consent to treatment form and of the CMHI evaluation consent and assent forms will be provided to the youth and their parents or guardians. The signed, original CMHC treatment consent forms will be retained by the clinicians in accordance with their agencies' HIPAA and other rules. The signed, original CMHI evaluation consent/assent forms will be sent to the VCHIP evaluation team for safe-keeping as described above.

- ❑ *Discuss why the risks are reasonable compared to expected benefits from the project.*

Engaging in treatment takes courage, but facing life's challenges with the support of a trusted clinician is much easier and more effective than doing so without that help. The benefits are likely to include better decisions made and steps taken by the youth and their caregivers.

The risks associated with participating in the Vermont CMHI evaluation are minimal (an individual's loss of confidentiality) while the potential benefits include helping to determine and guide (through action research) the efficacy of a project that is designed to help over 900 youth and families in Vermont over six years. In addition, the research results will inform the conduct of future projects nationally.

Appendix 3: Data Collection Procedures and Instruments

The Vermont-specific component of the VCHIP CMHI evaluation will use 3 data collection instruments to compliment the assessment tools being using for the national evaluation. These tools will be: 1) the Youth Self Report (YSR; or for youth over 18 years of age, the Adult Self Report (ASR)) tools from the Achenbach System for Empirically Based Assessment, a self report assessment of a wide range of behaviors that has been extensively tested and validated, 2) the Young Adult Health Care Survey (YAHCS) version 2.0, developed by the Foundation for Accountability and that is used to assess adolescents' and young adults' perceptions and experiences of health care and that also assesses specific health-related behaviors, and 3) the Stress Index for Parents of Adolescents (SIPA) developed by P. Sheras and colleagues, a parent self report instrument filled out by parents of youth aged 11-19 years and that assesses adolescent and parent stress-related characteristics.

All youth and caregivers receiving services through the CMHI project will be invited to participate in the Vermont CMHI evaluation, across all years of the project. Following obtaining informed consent, youth with SED and their caregivers will be contacted by the VCHIP CMHI evaluation team and asked to schedule an appointment at which a baseline interview will be conducted. This interview will be scheduled at the same time for both the youth and the caregiver, but these individuals will be interviewed and fill out questionnaires in separate rooms. In cases where youth and caregivers cannot be present at the same time, VCHIP will make arrangements for separate interviews. Interviews are anticipated to last between 1.5 and 2 hours, and $20 stipend will be paid the each individual participant.

All 3 data collection instruments, the YSR (or ASR), YAHCS and SIPA will be collected at baseline and follow-up interviews. Interviews will be conducted by the 2 VCHIP CMHI PhD-level evaluators and by graduate student supervisees from the University of Vermont Department of Psychology PhD program. Interviewers will have conducted practice interviews and will be trained on use the interview and questionnaire tool prior to the baseline interviews being conducted. All data will be collected on hard copy, and subsequently entered and scored using the appropriate software by the VCHIP CMHI evaluation team.

While all 3 instruments are typically administered as self report questionnaires, the VCHIP CMHI evaluation team anticipates that in many cases they will be administered by one of the evaluators as an interview, or at least with the evaluator providing assistance (in the form of helping with reading, answering process questions, etc.) as the tools are being filled out. VCHIP will develop and adhere to a protocol for the evaluators that will specify the order for the instruments to be administered as well as the specific wording to be used during the interviews.

Follow up interviews will be conducted with the youth and caregivers approximately 12 months after entry into the CMHI project, or sooner for individuals who exit the program prior to 12 months. Procedures for scheduling the interviews and collecting the data will be essentially identical to those used at the baseline assessment.

See attached copies of the YSR, ASR, YAHCS and SIPA.

Statement of Informed Consent

Title of Research Project: Evaluation of the Vermont CMHI
Principal Investigator: Judy Shaw, RN., MPH., Ed.D.
Sponsor: Department of Pediatrics, University of Vermont

Throughout this document "you" refers to "you and your child." You are being invited to take part in an evaluation of the Vermont CMHI project because you are the caregiver of a young person who is receiving services through the CMHI project. This evaluation is being conducted by Dr. Judy Shaw (PI), Research Associate Professor of Pediatrics at the University of Vermont. We encourage you to ask questions and take the opportunity to discuss the study with anybody you think can help you make this decision.

Why is this Evaluation Being Conducted?

- It is very important that we assess how well the CMHI project is working, in order to understand the impact the project is having on youth peoples' lives and the lives of their caregivers.
- The results of this evaluation should go far in understanding which aspects of the CMHI project are associated with improved outcome for young people receiving CMHI services and their caregivers, and to help us improve the CMHI project.

How Many People Will Take Part in this Evaluation?

- All youth and their caregivers who receive services through the CMHI project are being asked to participate in the evaluation.

What is Involved in this Study?

- The main part of the evaluation will involve paper-and-pencil surveys that youth and their caregivers will fill out during a meeting with the project evaluator. Only youth who assent (agree) to be in the evaluation and whose caregivers also agree to be in the evaluation will fill out the surveys. It is expected to take approximately one and one half hour to complete the surveys, and we will try to schedule a time to do them soon after the youth starts receiving services through the CMHI project.
- Approximately one year later, we will contact you to schedule a time to do another round of the same surveys.

What are the Risks and Discomforts of the Study?

- The only possible risk is a breach of confidentiality. VCHIP will use only trained interviewers to minimize this risk. In addition, VCHIP will store all data in a locked cabinet and on a secure, password-protected network. Furthermore, all identifying information about you (name, age, etc.) will be kept separate from the actual data we collect.

What are the Benefits of Participating in this Evaluation?

- This evaluation will help us understand which aspects of the CMHI project are working well, and which aspects may need to be improved, and we will then work to improve how the project is working with the aim of all people who receive services benefitting.

What is the Compensation?

- You will a $20 payment for each interview; each youth will also receive $20 for participating in each interview.

Can You Withdraw from the Evaluation?

- Yes, you can stop participating or skip any questions that you do not want to answer, without penalty.
- Participating in the first interview does not obligate you to participate in any future interviews.

What about Confidentiality?

- All surveys and questionnaires will be coded with a number that protects youths' and caregivers' identity and keeps their responses confidential.
- The master list of youth and caregiver identities will be kept separately from the data, in a locked laboratory at UVM.
- The surveys will be kept in a locked filing cabinet in a locked suite (PI's laboratory).
- The electronic data will be kept on a secure network, with password access. Only members of the PI's evaluation team will have access to these data.
- The results of this study may eventually be published and information may be exchanged between researchers; however, your confidentiality will be maintained.

Contact Information

You may contact Dr. Judy Shaw, the Investigator in charge of this study, at (802) 656-8210 for more information about this study. If you have any questions about your rights as a participant in a research project or for more information on how to proceed should you believe that you may have been injured as a result of your participation in this study you should contact Nancy Stalnaker, the Institutional Review Board Administrator at the University of Vermont at (802) 656-5040.

Statement of Consent

You have been given and have read or have had read to you a summary of this evaluation. Should you have any further questions about the evaluation, you may contact the person conducting the study at the address and telephone number given below. Your participation is voluntary and you may refuse to participate or withdraw at any time without penalty or prejudice to your present and/or future care.

You agree to participate in this study and you understand that you will receive a signed copy of this form.

____ Yes, I agree to participate.

____ No, I do not agree to participate.

(go to next page)

Signature of Legal Guardian or Legally Authorized Representative **Date**

Printed Name of Legal Guardian or Legally Authorized Representative

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Signature of Minor Providing Assent **Date**

Printed Name of Legal Minor Providing Assent

Signature of Principal Investigator or Designee **Date**

Printed Name of Principal Investigator or Designee

Name of Principal Investigator: Judy Shaw, RN., MPH, Ed.D.
Address: UVM VCHIP, UHC St. Joseph 7, University of Vermont, Burlington, VT 05401
Telephone Number: (802) 656-8210 **Email Address:** **Judith.Shaw@uvm.edu**

Documentation of Informed Consent/Assent Process Form

Protocol: Adolescents' Beliefs about School Study

Participant ID:

Participant Initials:

Date of Participation:

PI/Designee:

Participant, ____________________________, assented to the above named protocol after
(participant's name)
researchers obtained parent/guardian permission form indicating that the participant was

able to be invited to participate in the above named research study.

Prior to signing the assent form the participant:

- Read the information sheet and assent form
- Discussed the protocol participation with researcher including:
  - Purpose of the study
  - Risks/benefits
  - Alternatives
  - Who to contact with questions
  - Withdrawal rights
- Asked questions; and
- *Consulted with family or other physicians*.

Informed assent was conducted prior to any research-related procedures.

The subject was provided with a fully executed copy of the information sheet and assent form.

Other Comments:

PI/Designee Signature: ___________________________ Date:___________________

Note: Parental permission form and participant assent form should be attached to this form.

ASSENT DOCUMENT FOR PARTICIPATION IN THE CMHI EVALUATION

Title of Research Project: Evaluation of the Vermont CMHI
Principal Investigator: Judy Shaw, RN., MPH., Ed.D.
Sponsor: Department of Pediatrics, University of Vermont

This assent form may contain words that you do not understand. Please ask the interviewer or your case worker to explain any words or information that you do not clearly understand before signing this document.

1. A team of researchers from University of Vermont (UVM) are inviting you to take part in their evaluation of the CMHI project. Why is this being done?
We want to find out how well the CMHI project is working for all the young people who are receiving services as part of the CMHI project. We are asking all the people receiving CMHI services to be part of this evaluation.

2. What will happen?
First you will be interviewed by a member of the UVM team. The interview will take about one half hour. We will also ask you to fill out two surveys, which should take a total of about 45 minutes. We will also collect some information about you such as your age, year in school, job status among others. All of your answers on the surveys and interviews will be kept confidential. We do not plan to share your survey responses or your interviews with anyone outside of the research team and no one will be able to look at them except the UVM evaluation team unless we have to share them by law. Also, the answers to your survey and interview questions will be marked with an identification number assigned to you. Your name will not be on any of this information. Your name will be kept in a safe place away from any of the information we collect so we can protect your privacy. After about 6 months we will ask you to do another round of interviews and surveys, and again at about 12 months from now. We will also ask your caregiver (this might be a parent or a foster parent) to fill out surveys several times.

3. What does it cost and how much does it pay?
You do not have to pay to take part in this study. At the first interview, you will receive $20 from UVM to reward you for the time you spent completing the survey. You can keep this money even you decide to not participate in any more of the interviews and surveys.

4. There are very few risks in taking part in this research, but the following could happen:
Probably: Nothing bad would happen.
Maybe: Your survey and interview answers would be seen by somebody not involved in this study. We will do our absolute best to keep all of your answers private. Your answers will be kept locked up. Your name will not appear on your survey or interview forms; we will use a code number instead. The people who work on the UVM evaluation team are very well trained and understand the importance of confidentiality. But, if the researchers learn that you or someone else is in serious danger they would have to tell an appropriate person, such as your case worker, or the appropriate officials to protect you and other people.

Very unusual: You could be upset or embarrassed by a few of the questions. If this should occur, remember that you don't have to answer any questions you don't want to and you can stop taking the survey at any time.

5. Are there any benefits that you or others will get out of being in this study?
All research must have some potential benefit either directly to those who take part in it or potentially to others through the knowledge gained. You may benefit from answering questions about your experiences as part of the Vermont CMHI project. The knowledge gained through this study may allow us to help the CMHI project improve how it works for yourself and other young people.

6. It is completely up to you!
Both you and your caregiver have to agree to allow you to take part in this study. If you choose not to take part in this study, we will honor that choice. You may agree to take part in this study now and change your mind later, which is OK too. It's always your choice.

7. CONFIDENTIALITY: We will do everything possible to protect your confidentiality.
If we write professional articles about this research, they will never say your name or anything that could give away who you are. We will do a good job at keeping all our records secret by following the rules that the US government has made for researchers.

8. Do you have any questions? If you have any questions or worries about this study, of if any problems come up, you may ask a member of the UVM evaluation team or you can contact the principal investigator, Dr. Judy Shaw, at (802) 656-8210 or Judith.Shaw@uvm.edu. You can also ask questions or talk about any worries with Nancy Stalnaker, the Institutional Review Board Program Director at the University of Vermont at (802) 656-5040

9. The University of Vermont evaluation team appreciates very much your taking part in this study. What if you think something bad happens just because of this study or that people from the University of Vermont are pushing you too much to make you be in the study? Call Nancy Stalnaker, the Institutional Review Board Program Director at the University of Vermont at (802) 656-5040. We will do our best to help and make things right for you.

I assent (that means I agree) to participate in this study called: Evaluation of the Vermont CMHI.

____
Signature Date

____
Name (Please Print)

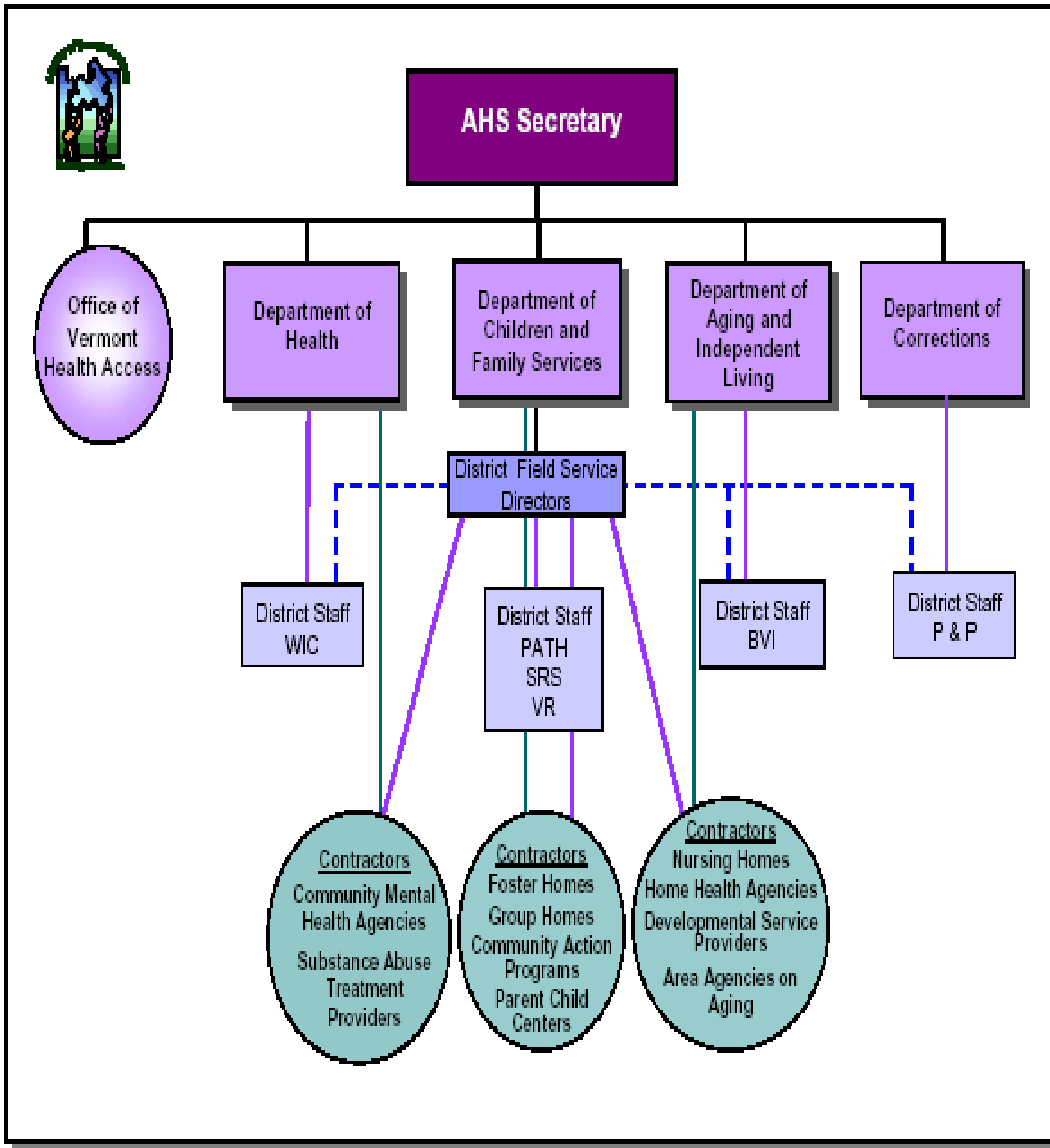
____
Signature of Principal Investigator or Designee Date

____
Printed Name of Principal Investigator or Designee

New System of Care and Mental Health Treatment Investments for Transition-Aged Youth (in therapeutic community or residential programs with fewer than 10 beds)

Expected [*Replace with Actual*] New State General or Private Funds Counted as Match							
Source of $ - Cash or In-kind	FFY Year #1 – SFY 2009	FFY Year #2 – SFY 2010	FFY Year #3 – SFY 2011	FFY Year #4 – SFY 2012	FFY Year #5 – SFY 2013	FFY Year #6 – SFY 2014	FFY Year #7 – SFY 2015
DCF - Family Services	Youth Aging Out of Foster Care (Housing Supports) $967,575	Youth Aging Out of Foster Care (Housing Supports) $1,448,944	Youth Aging Out of Foster Care (Housing Supports) $1,891,272	Youth Aging Out of Foster Care (Housing Supports) $1,929,097	Youth Aging Out of Foster Care (Housing Supports) $1,967,679	Youth Aging Out of Foster Care (Housing Supports) $2,007,033	Youth Aging Out of Foster Care (Housing Supports) $2,047,174
	Restorative Justice + Street Checkers $33,233	Restorative Justice + Street Checkers $33,233	Restorative Justice + Street Checkers $33,233	Restorative Justice + Street Checkers $33,233	Restorative Justice + Street Checkers $33,233	Restorative Justice + Street Checkers $33,233	Restorative Justice + Street Checkers $33,233
	Mentoring $25,000	Mentoring $25,000	Mentoring $25,000	Mentoring $25,000	Mentoring $25,000	Mentoring $25,000	Mentoring $25,000
DCF Family Services Sub-total	*$1,025,808*	*$1,507,177*	*$1,949,505*	*$1,987,330*	*$2,025,912*	*$2,065,266*	*2,105,407*
DCF - Economic Services	Reach-up – Solely State-funded Share $65,539	Reach-up – Solely State-funded Share $79,253	Reach-up – Solely State-funded Share $92,967	Reach-up – Solely State-funded Share $106,681	Reach-up – Solely State-funded Share $122,709	Reach-up – Solely State-funded Share $136,423	Reach-up – Solely State-funded Share $147,823
DCF Sub-total	***$1,091,3478***	***$1,586,430***	***$2,042,472***	***$2,094,011***	***$2,148,621***	***$2,201,689***	***$2,253,230***
VDH - Alcohol and Drug Abuse	Recovery Centers ***$46,500***	Recovery Centers ***$46,500***	Recovery Centers ***$46,500***	Recovery Centers ***$46,500***	Recovery Centers ***$46,500***	Recovery Centers ***$46,500***	Recovery Centers ***$46,500***
Corrections	Transitional Housing $125,000 Return House	Transitional Housing $125,000 Return House	Transitional Housing $125,000 Return House	Transitional Housing $125,000 Return House	Transitional Housing $125,000 Return House	Transitional Housing $125,000 Return House	Transitional Housing $125,000 Return House
Corrections	Community Justice Centers $60,000	Community Justice Centers $60,000	Community Justice Centers $60,000	Community Justice Centers $60,000	Community Justice Centers $60,000	Community Justice Centers $60,000	Community Justice Centers $60,000
Corrections Sub-total	***$185,000***	***$185,000***	***$185,000***	***$185,000***	***$185,000***	***$185,000***	***$185,000***

Attorney General	***$19,879*** for Diversion	***$19,879*** for Diversion	***$19,879*** for Diversion	***$19,879*** for Diversion	***$19,879*** for Diversion	***$19,879*** for Diversion	***$19,879*** for Diversion
Labor	Career Exploration and Alternative Education $400,00	Career Exploration and Alternative Education $400,00	Career Exploration and Alternative Education $400,00	Career Exploration and Alternative Education $400,00	Career Exploration and Alternative Education $400,00	Career Exploration and Alternative Education $400,00	Career Exploration and Alternative Education $400,00
Labor	Secondary School Internship Grants $200,000	Secondary School Internship Grants $200,000	Secondary School Internship Grants $200,000	Secondary School Internship Grants $200,000	Secondary School Internship Grants $200,000	Secondary School Internship Grants $200,000	Secondary School Internship Grants $200,000
Labor Sub-total	***$600,000***	***$600,000***	***$600,000***	***$600,000***	***$600,000***	***$600,000***	***$600,000***
Mental Health						***$800,000***; replace fed CMHI $	***$1,500,000*** replace fed CMHI $
Total Match for SOC	***$1,942,726***	***$2,437,809***	***$2,893,851***	***$2,945,390***	***$3,000,000***	***$3,853,068***	***$4,604,609***
Match Required	$333,333	$500,000	$666,667	$2,000,000	$3,000,000	$2,000,000	Depends on carry-forward $



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Management, Staffing, and Timeline Chart
Year 1

TASKS	STAFFING	TIMELINE IN MONTHS
STATE-LEVEL		
Apply to Joint Fiscal Committee of Legislature to accept grant	DMH Principal Investigator	Upon notice of grant award; no funds can be spent until Joint Fiscal approval given
Negotiate final terms for Cooperative Agreement with CMHS	DMH Principal Investigator	Upon notice of grant award or as soon afterwards as possible
Convene State Outreach Team* of Act 264 SIT	DMH Principal Investigator	Upon notice of grant award
Begin strategic planning for statewide sustainability, including adopting a logic model	DMH Principal Investigator and State Outreach Team	1st -3rd month
Hire Project Director	DMH Principal Investigator with State Outreach Team input	1st -3rd month
Issue Invitation to Act 264 LITs for regional planning, including for management and sustainability of services	Principal Investigator and/or Project Director, and State Outreach Team	3rd month
Award planning grants ($10,000) to each of 12 regions	Project Director	3rd month
Award sub-grants to VCHIP for evaluation, Vermont Federation of Families for Children's Mental Health for family and youth liaisons, and HowardCenter for cultural and linguistic competence	Project Director	3rd month
2nd Evaluator hired/assigned	VCHIP	3rd – 4th month
Family Liaison hired/assigned	Federation	3rd – 4th month
Youth Coordinator hired	Federation	4th month
Cultural and Linguistic Competence Coordinator hired/assigned	HowardCenter	3rd – 4th month
Form Evaluation Committee to get input to evaluation design from families, youth, cultural consultants, and service providers	VCHIP	5th – 6th month

Form Cultural and Linguistic Competence Committee to begin statewide planning for cultural and linguistic competence, with particular focus on Chittenden County	Cultural and Linguistic Competence Coordinator	5th – 6th month
Provide on-site TA to regions as they plan	Principal Investigator, Project Director, and State Outreach Team	4th -6th month
Application for IRB approval for evaluation submitted to University of Vermont	VCHIP	7th month
Issue Requests for Bids for Training and Technical Assistance and for Social Marketing expertise	Principal Investigator, Project Director, and State Outreach Team	7th month
Review and approve or seek revisions to regional plans	Principal Investigator, Project Director, and State Outreach Team	8th month
Award service grants to regions	Project Director	9th month
IRB approval obtained from University of Vermont for evaluation design	VCHIP	9th month
Review and approve or seek revisions to bids for T/TA and Social Marketing	Principal Investigator, Project Director, and State Outreach Team	9th month
Award sub-grants for Training and Technical Assistance and for Social Marketing expertise	Project Director	9th month
Hire/assign T/TA Coordinator	Successful bidder for T/TA	9th – 10th month
Hire/assign Social Marketing-Communications Manager	Successful bidder for Social Marketing	9th – 10th month
Form T/TA Committee to begin statewide planning for technical assistance	T/TA Coordinator	11th – 12th month
Form Social Marketing Committee to begin statewide planning for social marketing-communications	Social Marketing-Communications Manager	11th – 12th month
Provide on-site TA to regions as they start-up services	Principal Investigator, Project Director, and State Outreach Team	10th -12th month
Support to regions as needed	Project Director	Ongoing

Meet National CMHS expectations for quarterly and annual progress reports and annual financial reports	Project Director and VDH/DMH Business Office	Quarterly and annually
Attend required CMHS sub-grantee meetings	Principal Investigator, Project Director, and State Outreach Team	Twice a year
REGIONAL-LEVEL		
Convene local planning group* and decide how to best use planning resources (including for translation and interpreters)	AHS Field Services Directors with LITs	4th month
Conduct local assessment and planning for services	Assigned local planning group, including families, youth, mental health, and key community stakeholders	4th -7th months
Submit to State Outreach Team the regional plan and request for funds for services, with designation of fiscal agent and ongoing management group	LITs	8th month
Hire service staff	CMHC and/or other regionally-chosen providers	10th -12th months
Start providing services	CMHC and/or other regionally-chosen providers	10th -12th months
Participate in evaluation	CMHC and/or other regionally-chosen providers	10th -12th months
Provide quarterly progress report and monthly financial reports to DMH	Regional fiscal agent, with information from providers	12th month, and ongoing
Attend State-level and National meetings as required	CMHC and/or other regionally-chosen providers and members of regional management group	Ongoing

*State Outreach Team includes State-level staff required for project (including evaluators, youth coordinator, family liaison, cultural competence coordinator, T/TA coordinator, and social marketing-communications manager) and representatives from the State departments and organizations which have pledged match for the system of care, as well as interested others. Local planning teams include similar representation from the regions.

Management, Staffing, and Timeline Chart
Years 2-6

TASKS	STAFFING	TIMELINE PER YEAR
STATE-LEVEL		
State Outreach Team meetings, with continued development of strategic sustainability plan	DMH Principal Investigator and Project Director, with SIT	Quarterly
Inform State Outreach Team of evaluation findings and recommendations	VCHIP	Quarterly
Inform regions of evaluation findings and recommendations	VCHIP	Annually
State Outreach Team site visits to regions	DMH Principal Investigator, Project Director, and State Outreach Team	Annually, in spring before refunding regional service sub-grants
Award regional service sub-grants	Project Director	June (for next State FY, 7/1 – 6/30)
Award sub-grants for evaluation, family liaison and youth coordination, cultural and linguistic competence, T/TA, and social marketing-communications	Project Director	June (for next State FY)
Cultural and Linguistic Competence Committee meetings, with continued development of cultural and linguistic competence plan and activities	Cultural and Linguistic Competence Coordinator	Monthly
T/TA Committee meetings, with continued development of technical assistance plan and activities	T/TA Coordinator	Monthly
Social Marketing Committee meetings, with continued development of social marketing-communications plan	Social Marketing-Communications Manager	Monthly
Support to regions and Committees as needed	Project Director and all other key staff	Ongoing

Submit data for National Evaluation and TRAC as required	VCHIP	Ongoing
Meet National CMHS expectations for quarterly and annual progress and financial reports	Project Director and VDH/DMH Business Office	Quarterly and Annually
Attend required CMHS sub-grantee meetings	Principal Investigator, Project Director, and State Outreach Team	Twice a year
Host National site visits (program, evaluation, etc.) to Vermont	Principal Investigator, Project Director, and all other key staff	At least years 2 and 4 for National CMHS site visits
REGIONAL LEVEL		
Local management group meetings, with continued development of strategic sustainability plans	AHS Field Services Directors, with LITs	Quarterly
Provide regional services	CMHC and/or other regionally-chosen provides	Ongoing
Participate in evaluation	CMHC and/or other regionally-chosen providers	Ongoing
Participate in TA activities and state-level committees as requested	CMHC and/or other regionally-chosen providers	Ongoing
Provide quarterly and annual progress reports and monthly financial reports to DMH	Regional fiscal agent, with information from service providers	Quarterly, Annually, and Ongoing
Attend State-level and National meetings as required, including National site visits to Vermont	CMHC and/or other regionally-chosen providers and members of regional management group	Ongoing, including at least years 2 and 4 for National CMHS site visits