

# VPM CONSULTANCY

## AHS/Department of Education – Case Review Committee

**Needs assessment of Residential Care for Children and Adolescents in Vermont**



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We would also like to thank the residential providers in the state who gave us time out of their very busy days to share their experiences and site-specific information in both the in-person interviews conducted and the more time consuming on-line surveys they were asked to fill out.

The Departments and Agencies that we work for deserve a special thank you for allowing us the time to do this work, as anyone who has been through VPM knows, the Consultancy takes up a lot of time and, while we spent many an evening and weekend on the work, we also were able to get the time to meet and work during the work day.

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## Summary

The State of Vermont's Case Review Committee (CRC), comprised of employees of the Agency of Human Services Department for Children and Families Division of Family Services, Department of Mental Health, and Department of Disabilities, Aging and Independent Living Division of Disability and Aging Services; the Department of Education and a parent representative from the Vermont Federation of Families for Children's Mental Health, determined that it could be advantageous to utilize the Vermont Public Manager Program's consulting project opportunity in order to ascertain existing gaps in services they suspect exist and hamper their ability to recommend appropriate residential placements for children in need within the boundaries of the state. As well, the CRC requested we evaluate their current system for approving placements.

The consulting team, comprised of four state employees, reviewed reams of data and statistics, and ultimately determined that in order to get the best sense of what the prevailing thinking was throughout Vermont residential homes specializing in working with emotionally disturbed children, as well as what was statistically factual with regard to specialization, waiting lists and diagnoses these facilities were unable to serve, we would need to do in-person interviews with each site as well as create a detailed survey for providers to take. Additionally, in order to get a sense of how well the current process was working, we designed a brief, confidential questionnaire that all CRC members and other interested stakeholders recommended by the CRC took.

Our findings support, in large part, existing beliefs relayed by the CRC when proposing this project and the strengths and challenges identified at the time the first DOE/AHS interagency agreement was established. Adolescent females are underserved, children in need are getting younger, aggression in children is greater, and that children with developmental disabilities, including Autism, are being identified in higher numbers, referred to CRC more frequently and are much more difficult to place and at risk of harm or long-delayed opportunities for appropriate care and support.

As for the CRC process, we discovered that for the most part, it is viewed as supportive, enlightened and appropriate. However, there is evidence that one existing shortfall relates to the challenge of determining placement for children upon release from either a short-term crisis stabilization facility or even a longer term facility. It's reasonable to conclude that many of these children ultimately end up regressing to their pre-placement condition when the "step down" placement isn't appropriate, thus causing a repetitive cycle of need.

We hope to, with this report, provide evidence and recommendations that will ultimately play a small part in the State of Vermont's efforts to ensure our citizen children with special needs are provided for in the most comprehensive, successful way possible. Too, we recognize that our report is a small part of a larger effort now underway to better understand the needs of emotionally disturbed children in Vermont and to provide them with a comprehensive system of care.

## Background and Context

The Case Review Committee is a critical function in the State of Vermont's System of Care for children and adolescents with severe emotional disturbances, disabilities, and behavior and/or delinquency problems. We cannot stress enough the enormity and importance of the task the committee is charged with in attempting to find the best solution for each case that crosses their table. None of these cases is simple, and there are few easy solutions to the issues that face these children and their families. At times, advocacy and opinion comes from all sides, including the child's local team, relatives, foster-care givers, treatment providers, educators, guardians ad litem /court representatives, and perhaps others, who may differ in what course of treatment may be the best option for the child.

Philosophically, the CRC, as documented in a July, 2005 Users Guide (see Appendix I for an excerpt), operates with the belief, in line with its parent organization, the State Interagency Team (SIT), that children "should be served within their own communities". The Department of Health's Mental Health Division too, has a published Residential Placement document (October, 2005) stating, in its opening paragraph, that "children should live with their families and within their own communities". Furthermore, this document notes the importance of a coordinated aftercare plan for children exiting a residential placement, in order to support any skills and successes gained during treatment. They state that this "can only be accomplished through collaboration between the community team and the residential program". According to the data provided us by the CRC, 66% of children referred to the CRC for residential treatment in the last two years are in DCF custody. That begs the question of what to do with children whose parents are themselves incapacitated in some way once residential treatment has ended. Are those families uninterested or unable, for whatever reason, to meet the challenges certain children present? How can the State of Vermont do better in terms of helping families achieve success as *families*? Will we always be wholly dependent on developing more quality foster care families? While these concerns are not addressed in either document cited, we feel certain that there is, to some degree, a correlation between those cases that aren't initially successful, and that of the degree of family interest and involvement during every step in the child's treatment. Too, we recognize that there is a serious gap in the ability to find an interim or "step down" placement for children who are stabilized, but whose needs will still not be served well if returned to their families.

As noted in the Summary page, the CRC tasked us with ascertaining what gaps in services exist in their ability to recommend in-state residential placements for children in need. They also stated that we would need to look at the clinical profiles of children that had been served effectively as well as those who had not. Additionally, we were to review profiles of children denied by programs and/or sent out of state. We were provided with vast amounts of data, including licensing reports of all in-state facilities, 52 relatively recent case profiles of children sent out of state, FY '06 utilization data, and two years of detailed numerical data related to 475 cases. We did not, however, end up receiving any actual case summaries that could help us determine what children had been served effectively or not, or what particular children were denied placement and why. That number, however, amounted to only a total of 10 cases, or 2.1% of total cases. What we can't tell though is how long approval for those that were placed took, or what community-based services and resources were tried first.

The CRC had hopes that we could also look at children who are being served successfully in community-based wraparounds in some areas as well as identify what services and supports made

such possible. This would have been a wonderful element to our report, but, unfortunately, our time frame for study was insufficient to even begin delving into this aspect, and would have required much more data than was made available to us.

What did we accomplish? We were able to visually map out where Vermont's facilities are located and categorize them in terms of what they do best and for whom they can serve. We identified gaps as related to what appears to be burgeoning changes in the population of children in need. Clearly, our findings suggest that Vermont will need to work quickly to catch up with these changes, and look further into identifying what enhancements and investments into early intervention services can and should be put into play in order to better address current and future needs.

Finally, we did feel that an important component of this project would need to include at least a cursory review of the CRC process, which, too, we were able to complete.

## Methodology

The VPM team felt that the best way to approach the question of needs gaps, in addition to studying whatever data was made available to us, was to probe residential service providers about the details of their particular program in hopes of gleaning from them, hard facts as well as anecdotal experience, about what was changing in our state. To that end we created a questionnaire (see Appendix II) and conducted in-person and a few telephone interviews with almost all in-state providers that currently have children referred to them by the CRC, as well as one of the out-of-state providers. (Two others did not return our calls).

In addition, we created a detailed online survey with hopes that most providers would find the time to participate. Ultimately, with a few reminders, the survey (see Appendix X) elicited a 50% response rate.

In order to address the CRC's request that we take a look at their current process, we devised a confidential questionnaire (see Appendix XII) and distributed it to all CRC members (100% return rate) and to approximately twenty other vested parties in the system. This questionnaire was aimed in particular at developing an understanding of how well the CRC referral process works and what its strengths and weaknesses are.

Finally, the CRC provided the VPM Team with extensive aggregated data on the number and type of referrals. This data was not immediately available in any one place and had to be created in its collated form (see results/findings).

The CRC also helped the VPM Team tremendously by introducing us to the providers by way of a letter. This was particularly useful because there were two other concurrent survey processes going on that were asking residential providers for information; both the Vermont Children's Forum and the Residential System of Care team (composed of VCORP, VFAFA, DCF, DMH, DOE) are currently looking at aspects of Vermont's System of Care. The VPM Team kept its review focused on the CRC and its process for placing children.

## Results/Findings

### Caseload Overview:

Who are the children and adolescents being considered for placement? We were provided with aggregated data culled from the single residential care referral application forms for 475 children/adolescents referred from July 1, 2004 thru June 30, 2006. After studying the data closely, we are able to provide a snapshot:

Below are the aggregated percentages of the 475 children and adolescents described by percentage in a single residential care referral application form:

**Male: 64 %    Female: 36 %**

Legal custody:            both parents 11%  
                                   mother 12 %  
                                   father 4%  
                                   DCF 66%  
                                   other 7%

IEP:                        for emotional disturbance 53%  
                                   for other reason 15%  
                                   IEP pending/ referred for IEP 5%  
                                   assessed and found ineligible 4%  
                                   no IEP 23%

Health insurance:        medicaid 95%  
                                   private insurance 2 %  
                                   none 2%

### Child's Living Situation

Type	Previous	Current	Proposed
independent	0.4%	0.6%	1.7%
parents	75.8%	21.3%	21.3%
relatives	20.0%	4.0%	2.5%
foster care	45.5%	17.1%	1.7%
therapeutic foster care	17.3%	7.2%	7.4%
group home	18.7%	10.9%	15.8%
residential school	10.7%	5.1%	45.1%
hosp/residential tx	21.7%	11.8%	34.9%
secure juvenile facility	22.1%	18.9%	5.9%
correctional facility	2.5%	0.6%	0.6%
homeless	2.1%	-----	-----
other	5.7%	5.7%	5.9%

Education

Kind of service	Previous	Current	Proposed
regular classroom	52.8%	12.8%	5.3%
regular w/ resource room	29.9%	6.1%	3.4%
regular w/ special education	28.8%	7.2%	5.7%
special education classroom	18.1%	8.0%	3.6%
day treatment/ day school	20.8%	21.9%	16.6%
residential school	10.7%	6.7%	56.4%
home or hospital instruction	5.9%	7.2%	5.3%
Other	9.1%	12.8%	5.9%

Children not in school:      GED 27.8%  
   dropped out 16.7%  
   expelled 56.6%

Risk factors

physical abuse 15.4%	developmental disability 6.9%
neglect 16.6%	physical disability 1.3%
sexual abuse 21.9%	serious physical illness 0.2%
emotional abuse 9.3%	other disabling condition 9%
sex offender 2.7%	

Services

Type	Previous	Current	Proposed
individual psychotherapy	69.5%	52.0%	74.3%
group counseling	33.7%	22.1%	57.1%
parent(s) in counseling	34.1%	20.2%	47.2%
family counseling	33.1%	13.9%	60.2%
substance abuse treatment	21.3%	10.1%	33.1%
skills training	17.9%	18.7%	50.1%
respite care	28.4%	20.8%	24.8%
vocational services	4.8%	3.4%	22.9%
after school program	15.6%	7.4%	18.9%
medication (psychiatric)	53.6%	53.5%	61.1%
behavior management	39.8%	42.9%	72.0%
case management	51.2%	59.6%	69.1%
other	3.4%	4.4%	7.6%

Behavioral issues

confused/ strange ideas 39.6%	suicidal thoughts 38.9%
inappropriate/ bizarre behavior 51.4%	suicidal behavior 17.9%
inappropriate emotional reactions 68%	stealing 36.6%
inappropriate attention 46.7%	animal cruelty 4.6%
hyperactivity 40.4%	eating disorder 0%
verbal aggression 73.5%	extreme sadness 40.6%

aggression towards people 63.4%  
aggression towards property 54.9%  
inappropriate sexual activity 37.7%  
extreme withdrawal from family 22.7%  
substance abuse 0%  
impulsive 74.5%  
runs away 47.4%  
anti-social acts 38.3%  
fire setting 8%  
refusal to accept limits 79.6%  
self-injurious behavior 37.5%

anxiety 59.6%  
maladaptive dependence 17.3%  
somatic complaints 19.8%  
bladder/ bowel difficulties 14.5%  
persistent school refusal 36.4%  
school suspension 44.4%  
avoidance of social contact 16.8%  
serious sleep disturbance 15.6%  
problems with the law 52.2%

### Approved for residential placement

By gender: 97% of boy referred were approved for residential placement  
98% of girls referred were approved for residential placement

By legal custody: 90.5% of children from two parent families  
93% of children who lived with their mother  
100% of children who lived with their father (only 18 total)  
99% of children in DCF custody  
100% of adopted children  
100% of children in other living situations

By IEP status: 98% of children on an IEP for emotional disturbance  
93% of children on an IEP for other reasons  
100% of children pending or referred for an IEP  
100% of children found ineligible for an IEP (only 17 total)  
100% of children NOT on an IEP (90 of 397)

By 504 status: 100% of children eligible for 504  
94% of children with eligibility to be determined  
100% of children receiving accommodations

### Referral sources

0.6% of approved placements were referred by the DOE  
89.3% of approved placements were referred by the DCF  
9.1% of approved placements were referred by the DMH  
1.1% of approved placements came from other sources

This data was culled from a CRC caseload analysis completed for the 7/1/04 thru 6/30/06 period. We condensed what we felt was relevant to our overall goal of discerning what children in need of residential services “look like”.

## **Out-of-State Placements:**

We were provided with 52 brief case summaries dated throughout all of 2005 and into early 2006. These case summaries represented children in placement on a particular day and afforded us a snapshot description of the presenting issues that led to out-of-state placements. Please note that the following data is not an all-inclusive list of clients sent. In addition to the case synopses, we were also provided with data listing the number of total placements made out-of-state from July 1, 2004, thru June 30, 2006, by facility. The following is a snapshot of the case summaries provided:

- Total cases reviewed: **52**
- Females: **22 – 42.3%**
- Males: **30 – 57.6%**
- Average age of females: **15**
- Average age of males: **15.86**
  
- Predominant issues with females:\*

  - 11** diagnosed as suicidal and/or self-harming and/or depressed
  - 8** known to have been sexually abused
  - 7** known to have abused substances
  - 6** diagnosed with ODD (Oppositional Defiance Disorder)
  - 5** diagnosed as bipolar
  - 5** diagnosed with PTSD (Post Traumatic Stress Disorder)
  - 5** that noted neglect of parent(s)

- Predominant issues with males:\*

  - 14** known to have inappropriate sexual behavior and/or sexual deviancy
  - 12** diagnosed with significant mental health disorders to include psychosis
  - 7** known to have been sexually abused
  - 7** diagnosed with ADHD (Attention Deficit Hyperactivity Disorder)
  - 6** known to have abused substances
  - 5** that noted neglect of parent(s)
  - 2** diagnosed with developmental disorders to include mild mental retardation and PDD (Pervasive Developmental Disorders such as Autism)
  - 1** diagnosed with co-occurring mental health disorders and developmental disorders

\*It should be noted that cases may describe certain tendencies, but not note a typical correlating diagnosis. For instance, a case may have referred to an adolescent as a sexual offender or one that has bizarre sexual behaviors, but with no mention of any history of possible or probable sexual victimization. Additionally, many are noted as “delinquent”, with associated crimes, but with little to no clinical or family history documented.

➤ **OOS Residential Sites utilized:**

<b>OOS Residential Program &amp; notes</b>	<b>Primary focus</b>	<b># Placed of the 52 case examples</b>	<b>Total # VT youth placed (7/1/04 – 6/30/06)</b>
Becket School (NH) 20 contracted VT beds	Unmanageable delinquents with behavioral issues (Female program ended in August, '06)	5 females 10 males	38
Brightside (MA) No longer using this site	Behavioral and psychiatric issues	1 female 1 male	2
Keystone (OH) No longer using; now using GA site	MH and psychiatric issues	2 females	4
Cottage Hill (MA)	Combination of psychiatric services for higher level intensive girls	4 females	4
Valley Head (MA)	Girls with low self-esteem, cognitive delays	4 females	4
NAFI (CT) No longer using	Secure behavioral services	4 females	4
Fall River (MA)	Behavioral, female sex offenders, extensive continuum of care	1 female	1
Emerson House (MA) No longer using	Female substance abuse residence	2 females	4
Stonington (CT)	Dually diagnosed substance abuse and MH issues	1 female	1
Lake Grove Maple Valley (MA)	Male sex offenders; can keep beyond age 18	7 males	7
Phal House (NY)	Male substance abuse residential program	2 males	6
Vision Quest (PA) Use suspended until supervision issues resolved	Outdoor wilderness program – high impact behavioral alternative to secure facility.	4 males	29
Presbyterian Children's Home (VA)	*Used only once for child who's family lived in the area	1 male	1
Eckerd Camp (NH) Is closer to 3 VT districts than Camp E-Wen-Akee	Similar to VT's Camp E-Wen-Akee: Treatment for unmanageable, conduct disorder	1 male	1
Whitney Academy (MA)	Low-functioning sex offender treatment	1 male	1
Hillcrest (MA)	Multiple programs: Intensive sex offenders, intensive treatment unit for out-of-control youth, latency program, adolescent girls intensive self-assaultive, intensive boy's behavioral	3 males	4

From numbers provided with regard to total referrals and placements from July '04 thru June '06, we found the following:

- 190 clients were “cleared” (not necessarily placed) for referral to an out-of-state treatment program.
- 188 clients, almost 99%, were referred by DCF.
- 2 clients, or 1%, were referred by DMH.
  
- 122 clients, or 64%, were actually placed at out-of-state treatment programs.
- 117 (96%) of those clients were referred by DCF
- 5 (4%) of those clients were referred by DMH\*

111, or 91%, of the total 122 clients listed were sent to one of the 16 programs described on the previous page, leaving 11 other sites used, likely for reasons such as placement close to family that live nearby.

We should also note that at least nine additional placements were made that are not accounted for in the data provided us, but are noted as placement sites in the case summaries we reviewed.

It is important to point out that according to CRC member Corey Shimko, whom we consulted when looking for brief descriptions about what many of the out-of-state facilities specialized in, children with the types of mental health issues that include mental retardation and pervasive developmental disorders (PDD) such as autism, are much more likely to be attended to in VT communities with a wrap around and are only referred to residential programs as a last resort if presenting as a danger to self or others. Yet, of the 52 out-of-state case notes reviewed, 50% of males showed diagnoses of significant mental health issues such as psychosis and/or developmentally delayed diagnoses to include mild mental retardation, and/or PDD at the average referral age of almost 16. We can't conclude decisively that this is an indicator that in-state community wraps are not successful, but we do feel that 50% is a significant number in terms of cases we did have an opportunity review. We should also note that few out-of-state facilities used actually specialize in treatment for males with severe mental health issues as described above.

Another observation lends to the collective belief that adolescent females are underserved in Vermont. While they only account for just over a third of all referrals, they are, disproportionately, being sent out-of-state for services that primarily do address psychiatric issues prevalent in this population: depression, self-harm and sexual abuse.

Finally, it appears that the majority (approximately 59%) of youth sent to out-of-state programs were placed in facilities focused primarily on working within the scope of unmanageable, delinquent and behavioral issues.

## **In-State Residential Program Data:**

Total VT programs utilized by CRC:

- Northern VT – 9
- Central VT – 7 (+1 in border town Haverhill, NH)
- Southern VT – 7

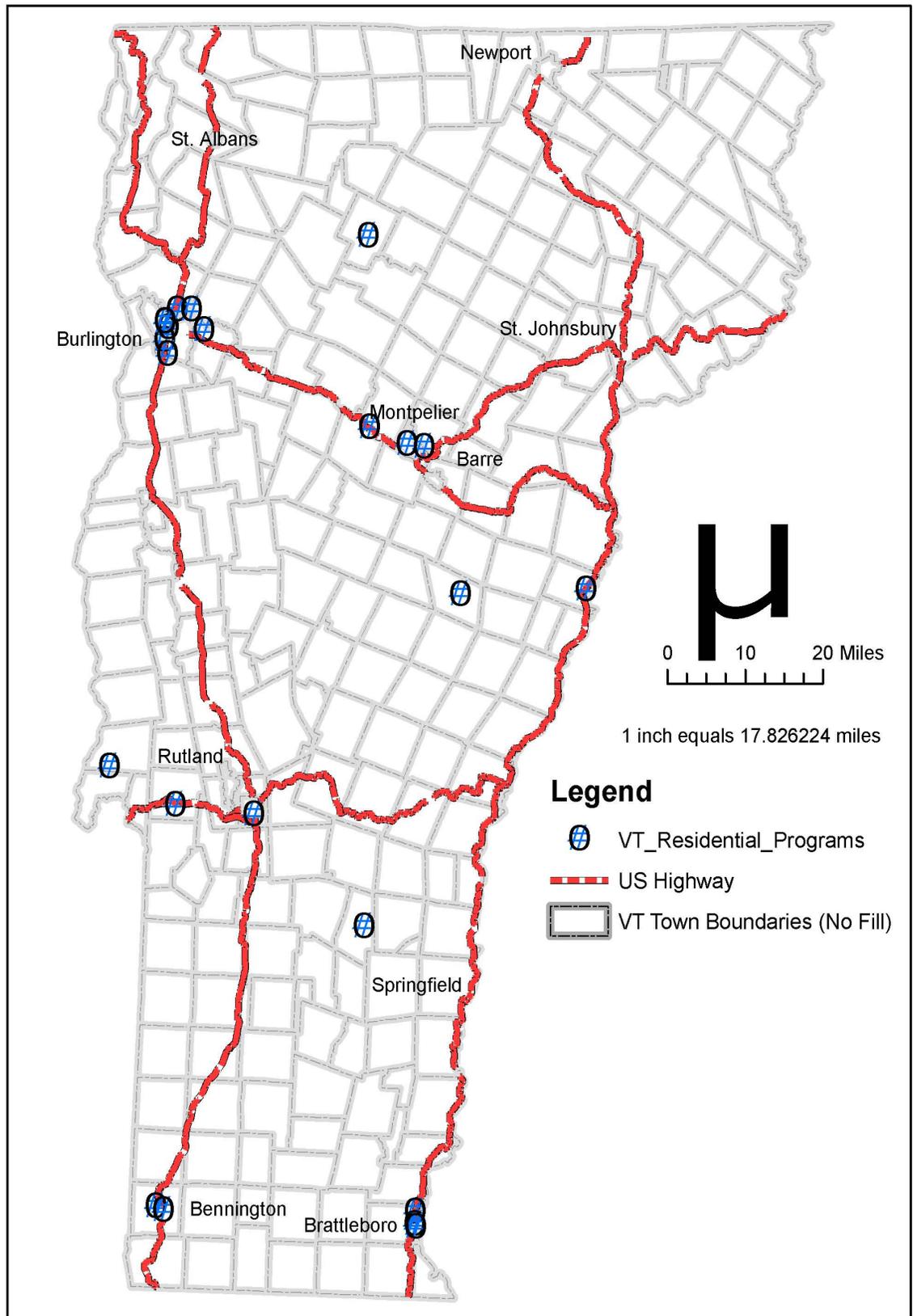
On the following page, we have created a map which provides a visual sense of where programs the CRC refers to exist in the state. One thing that stood out to us, was the lack of any utilized residential programs in the Northeast Kingdom, a population that including Newport and St. Johnsbury, had 161 children in DCF custody in 2006

([http://www.dcf.state.vt.us/fsd/statistics/table5\\_custodystatsbydistrict.html](http://www.dcf.state.vt.us/fsd/statistics/table5_custodystatsbydistrict.html)).

The St. Albans region is, too, without local programs. Early in the project, we discovered that a step-down program there, Griffin House, had been closed due to numerous licensing violations (Burlington Free Press, 10/15/06).

The one site (Laraway Youth and Family Services) north of Burlington that is plotted on the map isn't even, technically, a residential site; it's a foster care referral and support program which also educates at-risk youth.

# Vermont Residential Programs



## **Residential Program Interviews:**

Broadly speaking, the gaps, as seen by the residential programs, relate to funding limitations, funding formulas (the practice of paying per child causes significant hardship for some residential providers), staff availability, training and security.

Specific gaps in services for children and adolescents identified by the residential programs include a lack of transitional or step-down programs, particularly for older children and sex offenders. “We can put a child through our program successfully, but their family and their community have not been through the program.” They also report that there are not enough residential programs for girls, especially “high-end” girls (those in need of lots of services). Other concerns include a lack of programs that accept children with serious mental illness or developmental disabilities, a lack of programs which can provide secure supervision, insufficient substance abuse treatment, limited crisis bed capacity in the southern part of the state, a shortage of therapeutic foster homes, and no programs for very young children (4 to 5 years old).

Another issue raised by some of the residential programs involves a lack of communication and support from DCF caseworkers. DCF workers do not always attend treatment team meetings or collaborate on transition planning. Several programs spoke about DCF workers trying to bypass the CRC referral process to place children quickly in crisis situations. One crisis stabilization program described feeling that they are a “dumping ground” for DCF and that children are sometimes placed there who do not meet their criteria. Then, if things go badly in the middle of the night, there is no emergency support.

Related to us too, was that the referring caseworker doesn’t always provide complete background information on a child which makes choosing the appropriate placement difficult. There was a suggestion that some placements are more about where the beds are available than about how well a child will fit in a particular program.

One of the greatest strengths identified by the residential programs is their commitment to the children in their care. “We handle difficult kids through the worst and stick with them no matter what.” Almost every program talked about the connections and relationships that staff builds with the children. They really want to provide quality services and make a difference in these children’s lives.

In the appendices, we put together detailed tables reflective of our interviews (see Appendix II for all interview questions) for easy reference in the future. We hope they are helpful in the CRC’s efforts to identify what’s out there and what’s needed.

## **Residential Programs**

The first table, found under Appendix III, lists VT residential programs (and a NH border facility) by region and includes specific location, gender(s) served, ages served, the number of available beds, primary focus and services provided, though not necessarily all-inclusive.

### **Notable findings:**

- According to the residential programs interviewed, there are approximately 365 in-state beds, including Becket in NH, available to VT youth. CRC approves referrals of VT youth for 311 of those beds which are contracted thru DCF; remaining beds are accessed through other mechanisms such as ADAP or direct referral.
- There are no Northern Vermont residential facilities that focus solely on females other than Lund, which is specifically for pregnant females and their children.

### **Evaluation Process**

The next table, Appendix IV, details each facility's evaluation process, exclusions to acceptance in the program, typical length of stay, release criteria and what sort of waiting list, if any, exists.

### **Notable findings:**

- Approximately 35% of utilized programs have regular waiting lists that average (where noted - not all programs keep such data) around 7.75 weeks.
- The highest numbers of exclusionary criteria for acceptance into the program based on child's profile include those with serious developmental delays, those who are fire setters, those with serious mental illness, sexual offenders and those with a high risk for suicidal behavior. **NOTE:** We did not offer up exclusionary criteria for providers to choose from; all listings were those volunteered by the programs.
- By far, the most common denominator in determination for release is that treatment goals have been met.

### **Educational Services**

Appendix V is a table that notes, where possible, what educational services exist and the effectiveness of those services as described by the providers. Additionally, measurable outcomes of their programs are listed.

### **Notable findings:**

- 17 of the 26 programs provide on-site educational services.
- 4 programs mentioned being licensed as Independent Schools.
- 2 short-term stabilization programs do not typically provide educational services; there are concerns around clients being left there due to lack of "step down".
- As few as 3 - 4 programs track client progress post-release and can therefore gauge effectiveness of their program.

### **Staff Education/Experience**

Appendix VI is a table that documents residential program staff educational and/or experience requirements and the associated salary structure.

### **Notable findings:**

- The average starting hourly rate for line staff is approximately \$11.15/hour or \$23,192 annually.
- Most programs, particularly in northern and central VT, require at least a Bachelor's degree for all staff.

### **What works best?**

In addition to “hard” data collected during the interview process, we asked providers to tell us what they thought they were most successful with in their specific program. See Appendix VII for those responses.

### **Notable findings:**

- Staff teamwork is an important component to success in residential care.
- Family involvement is an important component to success with child's treatment
- Staff connections with the children are an important component to success with the child's treatment

### **What's lacking?**

As well we asked providers to give us a sense of what residential services they felt were lacking in our state. See Appendix VIII for the full list of responses.

### **Notable findings:**

- There is a lack of transitional or “step-down” programs, planning and support.
- There is a lack of programs for mentally ill and/or developmentally delayed children.
- There is a lack of programs that can address the needs of adolescent females.

### **Improvements**

Finally, we asked those we interviewed to speak freely and confidentially about what they thought could work better in terms of the referral and placement process as a whole. See Appendix XI for all responses.

### **Notable findings:**

- Inappropriate referrals are being made without CRC approval.
- DCF caseworkers are, at times, unable to provide needed background information in a timely manner.
- Better advance planning needed.

### **VPM Residential Provider On-line Survey:**

Another method utilized by the VPM team in the information gathering process involved development and deployment of an on-line survey as a follow-up to the in-person site visits the team made throughout the state in December of 2006, on into early '07. We determined that for the numerous and varied questions CRC members submitted in the interest of learning detailed information about each residential provider, an on-line survey would allow for providers to take any time needed in the gathering of pertinent facts and statistics.

Ultimately, we ended up getting about a 50% participation rate, but it can't be stated unequivocally that the other 50% ignored the survey. As with all things that are "free", it appears that some efforts may have been thwarted by the survey site itself, due to technical problems. You will notice as you read thru the results that a few of the providers did not appear to complete the survey in its entirety. This is in some part likely due to technical problems, as one provider specifically noted in a subsequent email to us that she was experiencing some site-driven technical difficulties.

While we were hopeful for close to 100% participation, and are disappointed in the evident unreliability of the site, particularly with the time invested in putting this survey together, we are of hopes that you will nevertheless find the information provided helpful. Without a doubt, some of the information gleaned again fully supports conclusions we have reached with regard to the gaps in Vermont's residential program and referral process.

The survey questions can be found in Appendix X; the full responses can be found in Appendix XI.

## **The CRC Process**

While the CRC/VPM team agreement charged us with focusing on the unmet needs of children referred by the CRC, it also asked us to take a look at the CRC process. Given time and resources this question could easily have been a full-scale project in and of itself. In order to get an understanding of how well the CRC process is working we sent confidential surveys to all CRC members and to approximately 20 other people and organizations involved in the CRC placement process.

### **What works best in the CRC placement process?**

Collaboration and communication, and the ability to share different agency perspectives and ideas, were clearly seen as the strengths of the current CRC process. The opportunity to bring the resources of the multiple departments together in one place and look at each case from multiple perspectives was seen by many people involved in the process as valuable and leading to better outcomes.

Aside from the benefit in terms of better placements, the collaboration and communication are seen as helpful in reducing competitiveness and turf issues between state agencies.

The CRC process is also perceived to be generally good at providing a level of oversight to ensure that other avenues have been exhausted before a residential placement is recommended.

Having said this, many of the respondents to our survey suggested ways that the CRC process could be improved.

### **Frustrations with the CRC process?**

Some respondents felt that cases are sometimes moved forward without consulting the CRC. This was seen to happen most often with crisis placements and in cases where a court order is involved. There seems to be a push-pull in these emergency situations where residential facilities insist on sign-off from the CRC before accepting a child, and the agency wanting to place the child wants to get the child placed quickly, so the quickest route to a CRC decision is used.

While having the different perspectives of multiple agencies was seen as a positive, having multiple agencies involved also has downsides. These include no centralized record keeping, different philosophies that can impact on fundamental decisions in a case, inadequate background information being shared across agencies in some cases; disagreements between agencies (i.e DCF and DOE).

As the CRC has grown in size the management of the group has also become more of a challenge. Meetings have to be tightly run. There were complaints that, in some instances, the CRC does not meet often enough, creating a log jam of cases before the CRC has a chance to review them – this too puts pressure on the system in emergency situations which come up without concern for the CRC meeting schedule.

There does not seem to be any systematic process for monitoring the outcome of placements, or to monitor and respond to the emerging trends issues, as a group.

In addition a number of residential facilities expressed frustration at multiple intake forms leading to a confusing process.

### **Are the right people at the table?**

There was broad, although not unanimous, consensus that the right people are sitting at the 'CRC table'. There were some comments that the group lacks a child advocate and conflicting comments about the role of DS in the CRC.

The greater concern expressed is that sometimes the applications sent to the CRC lack sufficient detail and residential facilities either receive children for whom they don't have enough background, or receive children who, upon investigation, do not fit the program. This is perhaps because the CRC didn't have enough information to make a better decision.

### **Does the CRC have the right amount of influence?**

The CRC process was generally seen as a reactive one; cases find their way to the CRC because most other avenues of support have failed. In this sense the CRC only has influence at a very late stage and its ability to 'control' the bigger picture is limited. On the other hand a number of respondents felt that there is strength in the collaboration at the CRC table and that this strength, while not leading to outright control, does give the CRC considerable influence within the system as a whole.

The other common response is that the real power and the real reason for the process is the treatment programs. CRC is good a mechanism for making placements, but making placements isn't the reason why the system exists. It exists to help Vermont children and families.

## Private Non-Medical Institutions Utilization Data (PNMI)

Finally, as requested, we studied data provided to us by the CRC and the Division of Rate Setting to build a snapshot of utilization rates and waiting lists.

What we did find, were that while the number of PNMI facilities utilized have basically remained the same since 2004, the number of projected beds have decreased since 2005.

Available projected beds in 2004 = 232  
2005 = 242  
2006 = 229

Combined *licensed capacity* for all the PNMI's in 2004 = 478  
2005 = 344  
2006 = 350

PNMI utilization data shows an actual decrease in the percentage of **actual utilization** over the last three years:

- 2004 showed 92% combined actual utilization.
- 2005 showed 91.5% combined actual utilization.
- 2006 showed 85% combined actual utilization.

Six residential sites interviewed stated that they have waiting lists. Four out of the six have license capacities greater than the projected number of beds.

Bennington School projected beds = 43 (down 8 from 2006). Licensed capacity = 123 (up 2 from '06).

Brattleboro ARCC projected beds = 15 (up 5 from 2006). Licensed capacity = 15

Brattleboro Osgood projected beds = 16 (up 3 from 2006). Licensed capacity = 24

Lund Family Center projected beds = 4. Licensed capacity = 18 (2006 data)

NFI Shelburne and Onion River's licensed capacity equaled their number of projected beds, so having a waiting list makes sense. Their waiting lists were from 1 week to 6 months.

Laraway, which is not, technically, a PNMI, sometimes has a waiting list of up to 3 months.

In 2006, the two Brattleboro PNMI's were the only sites that showed a significant increase in actual utilization, while Bennington School, Community House, NFI and Seal 206 showed less than a 2% increase in actual utilization for each. All of these PNMI's, with the exception of Seal 206, have shown a significant decrease in bed nights utilized so far in 2007.

Utilization by DCF is controlled by contracts with each program; the contract is often for fewer beds than the program has license capacity for. The program may have contracts with other entities, including other states. DMH does not contract with programs.

The Division of Rate Setting's chart (see Appendix XIV) shows the break down costs. Costs vary per PNMI based on location, facility (new/old), staffing, treatment programs, education. Several programs have a licensed educational component, which adds yet a third rate. Medicaid funds roughly 60% of the treatment allocated portion of the per diem rate. Medicaid will not fund room and board costs; the State has to allocate costs accordingly and come up with a treatment rate and a room and board rate, and depending on who the sending agency is, (DCF or DMH), will assume those costs. Combined is the "total" per diem rate that the program is reimbursed.

Questions that come to mind:

- Is there any relationship between these numbers and projected need?
- Is utilization decreasing due to decreasing funding or actual decrease in need for services?
- What happens to the kids who are on the waiting lists?
- Where are they placed while in abeyance?
- Some PNMI's are concerned about how the system is funded. Are their concerns valid?

We felt that there was a need to understand utilization rates better and have a recommendation on this issue.

## Conclusions and Recommendations

### *Changing Needs:*

Vermont's system of residential care for children and adolescents faces some significant challenges – not so much because we are seeing a dramatic increase in the number of children that need to be placed (although we do conclude that more females are coming into the system), or because we are seeing a significant lack of in-state facilities to place them – rather because of the apparent shift in the diagnoses of children who need to be placed in care and the profile of their needs.

More children are exhibiting behaviors that end up excluding them from in-state care. There are, for example, more females with issues that our current system is not prepared to address, except on a short-term basis. Disturbed children are observed to be getting younger and more aggressive. The most significant exclusionary criteria for acceptance into one of VT's programs include serious developmental delays, fire setters, sex offenders and those with a high suicidal risk. A compelling question, and one we recommend is deserving of a study all it's own, is this: how many children are unsuccessful in community wraps and/or in-state residential treatment, only to eventually end up in specialized out-of-state care? Most programs do not track client progress post-release and to our knowledge, DCF has no mechanism in place to gauge effectiveness of existing programs either.

From the data provided in our study, we can conclude that over half of those referred (53.6%), were taking psychiatric drugs prior to referral, yet few referrals came thru the DMH, who we assume would refer via Community Mental Health Centers. It is also suggested in the data provided, that 7.6% more children *should* be taking these drugs. Additionally, 52% of these children were in individual psychotherapy at the time of referral, and a whopping 22.3% increase of such was proposed for these cases. One possible conclusion we can draw from this is that as most referrals come thru DCF, there appears to be considerable resistance to treating children at the earliest possible time of diagnosis, thru specialized residential placement.

To further support this conclusion, we noted that of all the out-of-state cases reviewed, 50% of the males showed a diagnosis of a significant mental health issue to include Psychosis, and/or a developmental disorder such as mild Mental Retardation or a Pervasive Developmental Disorder, at the average referral age of almost 16. We are left with wondering why it takes so long to get these adolescents the needed treatment when they'll be "aging out" in just over 2 more years.

Finally, according to the PNMI utilization data, use of in-state programs has actually decreased by 7% over the last 3 years and appears to be trending toward a still growing percentage in '07. We view this as a possible indicator that in-state programs are not acclimating to Vermont's changing needs.

Specific recommendations include the following:

- Timely, comprehensive screening and assessment to include medical and psychiatric examinations for children in crisis.
- Movement from the SIT and the DMH toward acknowledging that specialized residential treatment may be a viable and appropriate option for *early intervention* in some situations.
- Development of in-state residential programs that work specifically with high end girls in need of long-term intensive treatment.
- Development of in-state residential programs that can intervene early, and work specifically with males who have psychiatric diagnoses and have typically been first labeled as “unmanageable”.
- Development of proposals with existing programs that are underutilized to revise their specialization(s).

*Transition, Family Reintegration and “Aging Out”:*

We recognize fully, that the ultimate goal shared by all is for eventual, even speedy, family reintegration once a child is stabilized. We heard a lot of concerns from providers about the lack of family involvement, some of which could be because of burn out or the belief that their input isn’t valued by the CRC or the treatment team. However, we also recognize that children may be returned to families prior to readiness and against recommendations of the residential site they’re leaving. Numerous providers shared their concern around the lack of appropriate planning for transition or step down, as well as the lack of transitional placements/programs. We also learned that high end adolescents reaching adulthood are particularly at risk if not supported during a transition period. To that end, we make the following recommendations:

- Work with DCF and DMH in the development of additional therapeutic foster families.
- Develop additional transitional programs for children and adolescents who aren’t yet ready for family reintegration and/or are lingering in short-term programs that don’t offer educational services.
- Identify and evaluate existing family support programs, trainings and respite opportunities available throughout the state and consider policy development around concurrent “treatment” and/or training for families as well as ensuring their inclusion with the child’s treatment.
- Where needed, increase the number of DCF social workers throughout Vermont to ensure manageable caseloads and opportunities for children to receive the most comprehensive and appropriately managed plan for success, to include transitional planning well in advance of release from residential care.
- Ensure transitional community services are in place for high end, aging-out young men and women.

### *Communications, Information and Process:*

We were commissioned to do this study, in part, because we were told that comprehensive information about what residential services exist in Vermont simply hasn't been readily available. We also learned that detailed historical data about the cases that cross the CRC's desk have, to date, not been easily accessible in order for interested parties to appropriately assess gaps in services on an ongoing basis. We also heard, more than once, that residential sites had to resist accepting referrals that were being made without the CRC's involvement; that referrals were often made with haste, without consideration for the facility's specialization and without a clear picture of the child's background, diagnoses and needs. Finally, we frequently heard about a lack of communication between residential programs and DCF in general. We consider the system the CRC employs as a "work in progress" as are most systems, and thus open to suggestions that make the process work better. Following, are recommendations related to these challenges:

- Work to improve communication and cooperation between residential program providers and DCF caseworkers. DCF should regularly attend treatment team meetings at the residential facilities and work with the providers and families on transition planning well in advance of anticipated discharge dates. Residential program staff should be included in any transition planning.
- Consider development of a training program for DCF and MH staff which addresses how to make appropriate referrals to the CRC and how to develop more comprehensive case plans, and ensure consistent practice throughout all district offices.
- Consider creating marketing materials to provide mental health and education professionals and perhaps even court personnel with better information on how the CRC process works.
- Agencies involved in CRC should have access to a single, centralized database of information so that it is possible to look at the 'big picture' in terms of how well the system is meeting the needs of Vermont children, families and communities. This would include development of a comprehensive database for documenting movement of referred children thru the DCF and CRC process.
- Look at streamlining the CRC referral application to avoid repetitiveness.
- The CRC should set up ground rules for meetings to include a weekly facilitator to keep the meeting moving.
- The CRC should consider adding a child advocate to the team.
- The CRC should plan a study on the utilization data available thru the Rate Setting division.
- The CRC should plan a study on the success rates, or lack thereof, of community-based wraparound initiatives.
- Work with DCF in promoting the excellent foster parent recruitment site they've sponsored with the Lund Family Center (<http://projectfamilyvt.org/contactUs.htm>)

In closing, we recognize that funding is a critical driver in government. As well, we realize that even if senior management agrees with some or all of our recommendations, much of what we are suggesting are “big picture” initiatives; long-term, difficult to attain goals. We envision a road map that can be followed by taking small steps, while working toward the larger goal of successfully meeting Vermont’s changing needs.

To that end, we hope you will all agree that most of the shorter-term steps focus on the CRC, DCF and DMH processes: improving communications, application simplicity, training development, marketing, database development and meeting enhancements.

We also believe that development of additional therapeutic foster families and identification of existing family support programs, trainings and respite opportunities can be had in the relative short-term.

Larger initiatives, to include more timely screening and assessment of children in crisis and increasing direct care staff may depend largely on AHS’s willingness and ability to reassess funding priorities.

Finally, the greatest challenges, but ones we feel strongly about, include development of in-state programs for females, and for males with serious psychological diagnoses beyond the “unmanageable” label; and the development of additional “step-down” programs and transitional community services for high end, aging-out young men and women.

We want to again, impress upon you how moved we are by what we’ve learned about the challenges faced in attempting to care for children with so many, often horrendous issues. We feel strongly, that by investing in our youth, we not only support them, we head off, potentially, a lifetime of financial drain on our system, to include our correctional system. We have a great deal of respect for all that you do; as well, a relative of one of us is a guardian ad litem with a number of very difficult cases, so we’ve had yet another window to peer thru, providing further anecdotal evidence of the myriad of challenges these children face in getting the care they so desperately need.

We hope you find this report of value and look forward to a future opportunity to learn of any changes implemented, or in the works, toward bettering the system as a whole. Thank you, CRC, for the opportunity to learn about a vital aspect of Vermont’s system of care.

## Appendix I

In 1988 the Vermont legislature passed Act 264 which requires the Agency of Human Services and the Department of Education to work together to coordinate their services for better outcomes for Vermont children and families. The bill was an attempt by the legislature to address the concern that there were many children with issues and needs that spanned more than one department who were either ‘falling through the cracks’ or were receiving only part of the help and support they needed, based on which government agency was the lead in their case.

Act 264 set out to accomplish the following:

- **Creates an interagency definition of severe emotional disturbance.** This unified definition allows a child or adolescent who is experiencing a severe emotional disturbance to be eligible for coordination of services and lessens the chance of “falling through the cracks” for not meeting a certain agency’s eligibility criteria for services.
- **Creates a coordinated services plan.** Children and adolescents experiencing a severe emotional disturbance who need services from multiple agencies are entitled to a coordinated services plan. The plan is a written addendum to each individual agency plan; it states a goal and outcomes that help measure progress toward the goal, as well as the services and supports to achieve it. The legal entitlement is to coordination of the plan; any entitlement to particular services identified in the plan may come through laws governing each of the involved agencies and providers. Permission of the child’s parent/guardian is a prerequisite for the development of a coordinated services plan.
- **Creates one Local Interagency Team in each of the State's twelve Agency of Human Services' districts.** The Local Interagency Teams (LITs) serve as a resource for interagency planning teams that are experiencing difficulty writing or implementing a child's coordinated service plan. The Local Interagency Teams are also a forum for understanding and addressing regional and statewide service system needs. These teams serve as a mechanism for feedback and advocacy within a complex human services and education network.
- **Creates a State Interagency Team.** The State Interagency Team (SIT) functions as a state level resource to the Local Interagency Teams. If a Local Interagency Team cannot help a child's treatment team to implement a coordinated services plan, the State Interagency Team works to resolve issues and overcome obstacles. The cases brought before the State Interagency Team alert state policy makers to problems in three broad areas: unmet service needs, policy difficulties, and funding issues.
- **Creates a governor appointed advisory board.** This nine-member board is composed of three parents, three advocates, and three professionals representing education, mental health and child welfare. One of their major statutory responsibilities is to advise the Department of Education and Agency of Human Services (AHS) on the annual priorities for developing the System of Care.
- **Maximizes parent involvement.** Act 264 requires the membership of a parent of a child or adolescent experiencing or having experienced a severe emotional disturbance on each Local

Interagency Team and the State Interagency Team; three parents are required on the Governor-appointed advisory board. It is fundamental to this law that parents have substantive input into the mechanisms to improve the System of Care.

• **Requires the submission to the state legislature of an annual system of care plan.**

This comprehensive plan, revised annually, gives guidance to policy makers in program development for children and adolescents experiencing a severe emotional disturbance. Through a collaborative planning process, program components are identified, defined and prioritized for Vermont's System of Care Plan. Three other important aspects of the report are: a yearly status report of programs that serve children and adolescents experiencing a severe emotional disturbance and their families; identifying values for the system of care; and articulating guiding principles for model programs.

An important component of the State Interagency Team (SIT) is the case Review Committee (CRC), created by the SIT to work with local teams to develop appropriate coordinated service plans for children.

The CRC reviews all requests for intensive residential placements and intensive wraparound services that provide 24 hour, seven days a week overnight staff for children with severe emotional disturbance. Representatives from all the departments on the committee review proposed placements together, funding decisions are made on a child-specific basis.

Referrals to the CRC may come for any of the following agencies:

- District office of the Department of Children and Families,
- Division of Mental Health Services,
- A community mental health center,
- Department of Education,
- A local education agency,
- Division of Disability and Aging Services,
- Or a any combination of these agencies.

In keeping with the intent of Act 264, the plan for each child referred to the Case review Committee will reflect a local interagency collaborative effort. To this end, each agency must adhere to its own rules and regulations surrounding intensive residential treatment placements. Referrals from local education agencies will go to the department of Education as required by state law. That department's Residential Review Team will then forward cases involving emotional disability or other disabilities as defined by the DOE/AHS Interagency Agreement to the CRC for consultation and technical assistance.

## **What Is The DOE/AHS Interagency Agreement?**

### **(From Agreement) Purpose:**

*This agreement promotes collaboration between the Agency of Human Services (AHS) and the Department of Education (DOE) in order to ensure that all **required** services are coordinated and provided to students with disabilities...The areas covered by this agreement include coordination of services, agency financial responsibility, conditions and terms of reimbursement, and resolution of interagency disputes.*

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

### **Mission/Guiding Principles:**

*The DOE, the local education agencies (LEA) and AHS work together to assure that children and youth with disabilities, ages 3-22, receive services for which they are eligible in a timely and coordinated manner. Ultimate responsibility to ensure a free and appropriate public education (FAPE) to students with disabilities lies with DOE and responsibility to provide a FAPE lies with the LEA. AHS is responsible for supporting students and their families toward successful outcomes in their broader functioning consistent with federal law including 34 CFR §300.1421 as well as state law. These agencies will work together to assure the needs of eligible students with disabilities are met, services are coordinated and integrated, funds are efficiently used, and a dispute resolution process is in place to resolve interagency policy and funding disputes when a conflict occurs.*

## **III. Who Is Served By Act 264 And The DOE/AHS Interagency Agreement?**

Following is the Act 264 definition of Severe Emotional Disturbance. Children and adolescents who meet the criteria defined below are eligible to coordination of services as defined in this law. **It is important to note that these individuals may or may not be eligible for special education services.**

**Act 264 Definition of Severe Emotional Disturbance:**\* - "Child or adolescent with a severe emotional disturbance" means a person who:

- 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:

1. 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.
2. Children and adolescents who are classified as management or conduct disorder because they manifest long-term behavior problems including developmentally inappropriate inattention, hyperactivity, impulsiveness, aggressiveness, anti-social acts, refusal to accept limits, suicidal behavior or substance abuse.
3. 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 non-familial social contact.

*\* As approved by the Vermont Legislature on June 17, 1988, with revisions stipulated in H.706 as passed by the House and Senate in April, 1990.*

### **Children Now Eligible for Coordination of Services According to the DOE/AHS Agreement:**

All students who meet eligibility requirements under special education, who also are eligible to receive disability-related service delivery and coordination by at least one AHS department now are entitled to coordination of services. This includes students who receive special education services within the following disability categories:

- A. learning impairment;
- B. specific learning disability of a perceptual, conceptual, or coordinative nature;
- C. visual impairment;
- D. deafness or hard of hearing;
- E. speech or language impairment;
- F. orthopedic impairment (result of congenital anomaly, disease or other condition);
- G. other health impairment;
- H. emotional disturbance;
- I. autism;
- J. traumatic brain injury;
- K. deaf-blindness;
- L. multiple-disabilities;
- M. developmental delay (applies to children ages 3 to 5 years 11 months).

NOTE: Students with the above documented disabilities may or may not be eligible for special education services based on criteria established for special education. For more information about eligibility for special education, visit the DOE Web site and view the Vermont State Board special education rules (sections 2361 and 2362) at [http://www.state.vt.us/educ/new/html/pgm\\_sped/laws.html#rules](http://www.state.vt.us/educ/new/html/pgm_sped/laws.html#rules).

In summary, children and adolescents who are **now** eligible for coordination of services as defined under Act 264 **and** the DOE/AHS Interagency Agreement are those individuals:

- A.** who meet the Act 264 definition of Severe Emotional Disturbance and who may or may not be eligible for special education services; and/or
- B.** who are eligible for special education services and are eligible for disability-related services and service coordination provided by AHS and its member departments and agencies. Within this target population, special attention must be made to assure that there is a focus on the particular needs of transition-age youth to support transition from school to adult life. Likewise, there must be a process for addressing the needs of children ages 3 to 6.

#### **IV. To What Are Eligible Children, Youth And Families Entitled?**

*Eligible children and youth are entitled to receive a coordinated services plan developed by a service coordination team including representatives of education, the appropriate departments of the Agency of Human Services, the parents or guardians, and natural supports connected to the family.*

A coordinated services plan outlines how services will be coordinated between agencies. The following is a framework for planning for eligible children. While the beginning steps in the process may occur for anyone who needs multi-agency supports, the development of coordinated services plans and referrals to the local and state teams are for eligible children and youth.

##### **Contacting an individual agency or school within the community**

Families may attempt to access appropriate services to address their child or adolescent's needs through the educational system, the child welfare system (if they are involved through the custody of their child), the local community mental health center or other agencies within or in partnership with the Agency of Human Services.

##### **Identifying a Case Manager**

Planning to meet outcomes may require developing and/or brokering for services and supports. Parents may be case managers even though we don't usually call them that name. But, if they are involved in identifying needs and finding and coordinating resources, they are most definitely playing the role of case manager. Children involved with special education will have an assigned case manager through special education. Children who are in the custody of the state will have an assigned social worker that is also in the role of case manager. Community Mental Health Centers and other AHS state and community agencies also have assigned case managers for their clients.

##### **Creating an Interagency Planning Team**

Generally 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 a plan.

### **Developing a Coordinated Services Plan**

With written permission of the parent/guardian, the interagency planning team may develop a coordinated services plan, which is an entitlement to coordination of services for families. The plan ensures that the child and family needs are considered holistically.

*(From Agreement) The coordinated services plan includes the Individual Education Plan (IEP) as well as human services treatment plans 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.*

While anyone can request the creation of a Coordinated Services Plan for an eligible child or youth, one agency has the responsibility for taking a lead role to ensure that existing services are coordinated. This agency assigns a lead service coordinator who assures that the plan is regularly reviewed and serves as the agreed upon contact person if the “coordinated services plan” needs to be adjusted. It should not be assumed however, that the agency with the lead role is also the agency responsible for the delivery or funding of services outlined in the coordinated services plan.

Act 264 legally defines lead agency as:

- Family Services – For all youth who are in state custody
- Education – For all youth not in state custody and who primarily have educational concerns
- Mental Health – For all youth who meet the Act 264 definition of severe emotional disturbance

With the expansion of the target population through the DOE/AHS Interagency Agreement, lead agency status may shift; a specific agency having the most expertise to understand the primary concerns of the child may take the lead in assuring that services are coordinated. Alternatively, the case manager with the strongest relationship to the family may take the lead role. These lead agency arrangements will likely facilitate more positive outcomes for children and families.

Until such time as the effects of the DOE/AHS Interagency Agreement are evaluated, and/or a change in Act 264 Law is requested, it is recommended that these agencies take the responsibility of lead coordination for particular children and families when the need arises.

### **Referral to a Local Interagency Team (LIT)**

*(From Agreement) 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.*

Each region has a Local Interagency Team (LIT) that meets regularly. The LIT is composed of representatives from the community mental health center (Children's Coordinator), local school districts (Special Education Administrator/s designated by the region), DCF Family Services district office (District Director), and family members. According to the DOE/AHS Interagency Agreement, AHS Field Directors as well as local leaders from developmental services and substance abuse, and a VR representative will now be officially included as regular members.

LITS must also work with the appropriate special education administrator when an issue involves a child within that school district. In addressing the specific needs of transition age youth, adult agency providers such as high-level leaders from adult mental health programs and the Department of Labor (DOL) are also included. Likewise, to assure an appropriate process to address the specific needs of children ages 3-6, special education administrators and/or essential early education coordinators as well as regional representatives of AHS and its partner agencies (members of regional early childhood resource teams) are included. Members of LIT must be those who are able to make programmatic, resource and/or funding decisions on behalf of their respective departments/agencies.

While not required by law or Agreement, it is recommended that regional representatives of the Vermont Adoption Consortium participate as active members of LITS when reviewing coordinated services plans for children who are in a pre or post adoptive process.

The LIT assists interagency planning teams to identify ways to implement a child's coordinated services plan when they need extra support. The LIT may review a plan and make recommendations on the content of the plan; suggest possible additional resources of support to implement the plan; recommend that an agency waive or modify a policy; or, if necessary, refer the situation to the State Interagency Team for further consideration. Each LIT has a designated LIT Coordinator who accepts the referrals to LIT and assures that the correct forms are completed and that the request for guidance from LIT is clearly articulated. Typically, the LIT Coordinator has been the Children's Director of the Community Mental Health Center. With the expansion of LIT membership and the expansion of the target population, regions may consider redirecting some responsibilities of the LIT Coordinator to other LIT members as appropriate.

A LIT may also make a referral to the Case Review Committee (CRC) to determine the clinical appropriateness of a residential placement or high-end wrap-around plan. See below – **Referral to the CRC** - for detail on CRC referrals.

At any time in the planning process, LIT members may seek consultation from their state-level agency counterparts to discuss possible resolutions to coordinated services plan issues that arise at the local level. LIT members will always consult with their specific state-level counterparts when considering a residential placement or high cost individualized wraparound plan, and a referral to the CRC. (See below - **Referral to the CRC.**) **Referral to the State Interagency Team (SIT)**

The State Interagency Team (SIT) is an interagency forum designed to assist in problem solving at the state level. If a LIT is unable to resolve the problems or resource needs

outlined in a coordinated services plan, the State Interagency Team attempts to provide assistance. This may include reviewing a plan and making recommendations on content; suggesting possible additional resources to help implement the plan; and/or recommending that an agency waive or modify a policy. Members of the State Interagency Team include a high level manager from the following departments and divisions within state government: DOE, Division of Mental Health (DMH), Division of Disability and Aging Services (DDAS), Division of Family Services (DFS), Division of Alcohol and Drug Abuse Programs (ADAP), Division of Vocational Rehabilitation (VR), AHS Field Services and other units as determined by the Secretary of AHS. A family consumer representative will also be a core member of the SIT. All referrals from LITS to the SIT are facilitated by the LIT Coordinator at the request of any LIT member. The LIT Coordinator assures that the correct forms are completed and that the request for guidance from SIT is clearly articulated. Referrals are sent to the State Interagency Team Coordinator who then reviews the referral with designated representatives of SIT prior to presenting the referral at SIT. The State Interagency Team Coordinator assures that the LIT receives recommendations from SIT.

### **Referral to the Case Review Committee (CRC)**

When interagency planning teams or LITS are recommending residential care or high-end wraparound plans a referral must be made to the Case Review Committee (CRC). (High-end wraparound plans include 24 hour, awake overnight staffing, and individualized residential programming. If not for this level of service, the child would be in a residential setting **but** can't function in a group setting). The CRC is a committee of SIT, and includes representatives of the Family Services Division, DMH, DDAS, DOE, and a parent representative. Other units of AHS are included as appropriate. They meet regularly to review the recommendations of interagency planning teams to determine if a child's needs require the proposed level of service. Before a child is reviewed at CRC for residential placement or a high-end wrap-around plan, there must be consensus at a local level about the proposed level of care. Referrals to CRC will only be accepted from local interagency planning teams if they have first developed a CSP. Coordinated services plans recommending residential placement may also be reviewed by LIT prior to referral to CRC. The referral package will include the Individualized Education Plan (IEP) along with a cover letter describing the needs of the child. The referral to CRC should go through the appropriate CRC member depending on the child's "lead agency" status. If a child is in custody, Family Services is always the lead in bringing the referral to CRC. Alternatively, if the child is receiving services through the mental health agency, the referral will be presented to CRC by the Division of Mental Health CRC member. Other agencies may present referrals to the CRC depending on the presenting issues. Details about referrals to the Case Review Committee can be found in the Case Review Committee Policies and Procedures document (04/06) located on the Division of Mental Health Web site – <http://www.healthyvermonters.info/ddmhs>. CRC members are knowledgeable about different residential programs and can provide consultation to local planning teams and/or LITS upon consideration of a referral to CRC. The designated CRC representatives can also be helpful in determining what other options are available. If the CRC has agreed that the clinical needs of a child warrant an intensive, individual wraparound plan or residential placement and dollars have not been identified to fund the placement, the CRC will refer to the SIT for review.

**Appeals Process**

*(From Agreement) If the State Interagency Team is unable to resolve a dispute concerning coordination 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. If a hearing is held, it shall be conducted by a hearing officer appointed by the Secretary of the AHS and the Commissioner of Education. The Secretary and the Commissioner may affirm, reverse, or modify the proposals of the hearing officer. Nothing in the DOE/AHS Interagency agreement shall be construed to limit any existing substantive or procedural protections of state or federal law or regulation.*

## Appendix II

### RESIDENTIAL PROVIDER INTERVIEW QUESTIONNAIRE

Introduction: To reiterate what was sent to you recently by the State's Case Review Committee, the purpose for my visit, as well as the subsequent internet survey I'm of hopes you'll take the time to fill out, is to support the CRC's interest in identifying in-state treatment shortfalls for Vermont's children and finding ways to adapt to the shifting needs that have emerged. Thank you in advance for taking the time to meet with me!

Residential Home: \_\_\_\_\_ Location: \_\_\_\_\_

Email address: \_\_\_\_\_

Population served: M F CoEd Age range: \_\_\_\_\_

Number of beds: \_\_\_ VT child only beds \_\_\_ Staff to child ratio: \_\_\_\_\_

Handicapped accessible? Y N If yes, describe \_\_\_\_\_

This is a:

- a) Group home with shared rooms
- b) Group home with private rooms
- c) Dormitory-style
- d) Other \_\_\_\_\_

1. What is the primary program focus at this facility?
2. What specific services are offered?
3. How is a service evaluation done in order to determine what services are rendered to each child?
4. Is there a subset of exclusionary criteria in the referral process? If so, what? In other words, please explain what might typically be a rationale for turning down a new admission?
5. What are the minimum and maximum lengths of stay? Is there an average?
6. How do you determine when a child is ready for release from your care? Is it through stay length, goals having been met, behavioral changes, funding stream, or any combination thereof?
7. Do you have an existing waiting list? Do you maintain historical data around wait lists and average length?

8. What format of educational services do you provide? What are its strengths and weaknesses?
9. Do you maintain a record of measurable outcomes for clients you have served?
10. What do you think works best in your specific program?
11. What do you feel could work better in terms of the entire referral and placement process?
12. Do you have any sense of what residential services for children might be lacking in the State of Vermont at this time? If so, how do you come this conclusion?
13. What educational and/or experiential requirements are required of staff?
14. What is the salary range for employees?
  - a) line staff:
  - b) clinical staff:
  - c) education staff:
15. Do you have an in-depth written program description that speaks to your treatment modality? If so, may I please have a copy?
16. Is there anything we haven't asked about your program that you feel might add value to our findings?

### Appendix III

The following table lists VT residential programs (and a NH border facility) by region and was put together from our interviews. Services provided are not necessarily all-inclusive:

Program	Location	M or F	Ages	# of beds	Primary focus	Service Abbv.
<b>Northern VT</b>						
Howard Ctr.- Baird	Burlington	Co-ed	6 - 14	18	mental health tx	CM, IT, GT, Psy, SR, RA, OD
Lund Family Ctr.	Burlington	F +kids	12 - 28	18	MH/ SA tx	PE, SA, FT, CT, HS, LS, Dev, TH
NFI Group Home	Burlington	Co-ed	13 -18	6	Family therapy	CM, CR, Psych
Spectrum Youth	Burlington	M	15 -18	6	Preparation for independent living	IT, SA, FT, Med, PhBM, SS, Job, Leisure skills
Woodside Tx	Essex	M	13 - 17	12	Intensive tx MH/SA	GT, MT, CM, SO,SA, IT, BM, FT
Woodside Detention	Essex	Co-ed	10 - 17	16	DCF/court detention	GT, MT, CM, SO SA, IT, BM, FT
Allenbrook	S Burlington	Co-ed	12 - 17	14	Teaching Family Home	GT, MS
NFI Hosp Diversion	Winooski	Co-ed	10 - 18	6	Crisis stabilization	GT, IT, CM, FT, Psych
NFI Shelburne	Williston	M	13 - 18	3	Intensive treatment for emotional problems	IT, CM, FT, GT, DBT, GL, SS
Laraway	Johnson	Co-ed	7 - 19	27	Child placement	FH, CM, CR, M
<b>Central VT</b>						
Onion River Crossroad	Montpelier	F	13 - 18	8	guide girls w/ family or behavioral problems	BM, Psych, SA
Washington Cty MH	Barre	M F	9 - 12 14 - 18	12	Anger, sex, self-harm, anti-social behavior	IT, structure
Camp E-Wen-Akee	Benson	Co-ed	12 - 17	30 26 VT	unmanageable/ conduct disorder	MT, Psych, FT, LS, AC, SO
Valley Vista	Bradford	Co-ed	13 - 17	18 16 VT	chemical dependency tx	Med, Psych, CM, Rec, IT, GT, FT
Brookhaven	Chelsea	M	6 - 14	10	therapeutic tx for behavior	MT, IT, GT, CM, PhBM, TR, FT, TH
Baird - Park St.	Rutland	M	12 - 17	16	sex offender tx	IT, GT, FT, SO, EMDR initiative
Becket School	Haverhill, NH	M	11 - 20	104 20 VT	Adolescent boys with acting out behavior	SO, IT, GT
Spectrum Sandhill	Castleton	F	12 - 17	7	Crisis stabilization for unmanageable girls	GT, LS
<b>Southern VT</b>						
NFI South	Brattleboro	M F	8 - 12 13 - 18	8 4 VT	Attachment (boys) DBT (girls)	IT, GT, FT, SS, CR, FH, CM (med)

<b>Program</b>	<b>Location</b>	<b>M or F</b>	<b>Ages</b>	<b># of beds</b>	<b>Primary focus</b>	<b>Service Abbv.</b>
Brattleboro Retreat	Brattleboro	Co-ed	6 - 18	39 24 VT	Psychiatric treatment ( axis 1 diagnosis)	IT, FT, GT, SA Psych, nursing
Bratt Retreat ARC	Brattleboro	Co-ed	6 – 14	15	Behavior and emotional disorders	FT, IT, GT Psych, OD, peer relations
Community House	Brattleboro	Co-ed	6 - 13	8	Assessment/stabilization	MT, ED, Rec, Assessment eval
Mountainside House transitional	Ludlow	Co-ed	13 - 18 16 - 22	12 4	Short-term stabilization	FT, IT, CM, GT, licensed tutorial
204 Depot St.	Bennington	M	13 - 18	14	Delinquent behavior	IT, GT, Voc, SA, LS, AM
206 Depot St.	Bennington	M	13 - 17	5	De-escalate/ Stabilize	SS, Assessment
Bennington School	Bennington	Co-ed	10 - 18	41	Academic, social, behavioral, therapeutic	ED, OD, Voc, Rec, Med

### **SERVICES PROVIDED ABBV list**

AC = after-care/ support  
 AM = anger management  
 BM = behavior management  
 CM = case management  
 CR = crisis support  
 CT = couples therapy  
 DBT = dialectical behavior therapy  
 Dev = developmental assessments  
 ED = education  
 FH = foster homes  
 FT = family therapy  
 GL = grief and Loss  
 GT = group therapy  
 HS = high school credit  
 IT = individual therapy  
 Job = job support  
 LS = life skills training  
 M = mentoring

MS = motivational system  
 MT = milieu treatment  
 Med = medical services  
 OD = outdoor experiences  
 PE = parenting education  
 PhBM = psychopharmacological behavior mgmt.  
 Psych = psychiatric treatment  
 Ratx = reactive attachment treatment  
 Rec = recreational therapy  
 SA = substance abuse treatment  
 SO = sex offender treatment (relapse prevention)  
 SRBtx = treatment for sexually reactive behavior  
 SS = social skills  
 TH = transitional housing  
 TR = transportation to medical, programs, court  
 Voc = vocational education

## Appendix IV

The following table details what sort of evaluation process takes place, what exclusions there are in the application process, length of stay and waiting list information:

Program	Evaluation	Exclusions	Stay Length	Release	Waiting List
<b>Northern VT</b>					
Howard Ctr.- Baird	intake information, comprehensive eval., psychiatrist evaluates medications	Sex, MI, DD, SR, HR, Med, V	1 - 2 yrs.	MG, DPB, TR	Not usually, but have had up to 4-5
Lund Family Ctr.	SA screening, mental status exam, intake information	DD, MI, Sex, SR, V	3 mo.- 1 yr.	MG	yes (avg 10)
NFI Group Home	Treatment team process	FS, Sex, DD	12-18 mo.	MG	rarely
Spectrum Youth	GAIN, intake information, plan developed w/client	MI (psychotic), SR, HR, Detox	avg: 1 yr.	MG	no
Woodside TX	comprehensive psych/ed evaluation	DD, MI	15 - 18 mo. avg.	MG (80%)	no
Woodside Detention	behavioral screening	none	15 days avg.	MG, DPB	sometimes
Allenbrook	team meetings, weekly clinical supervision	FS, extreme sexual Reactivity	min: school yr., no maximum	LM, Fam, TR	no
NFI Hosp Diversion	objective testing, questionnaire	V, MI, Fit, Sex (at times)	7-10 days	TR	triage if full
NFI Shelburne	referral evaluations, pre-admission evaluation	NC, Fam, AP, ED	min: 1 yr. max: 2 yrs.	MG	yes (2)
Laraway	assessment of needs questionnaire	Sex, SR	min: 6 - 9 mo. avg: 2-3 yrs.	MG	yes, 2-3 months
<b>Central VT</b>					
Onion River Crossroad	treatment team with DCF worker, family, others	Sex, RA, MI	Avg. 1-1/2 yrs.	MG, progress through levels	2-5 girls, one week to 6 mo.
Washington Cty MH	intake information	Fit, safety	min: 30 days; max: 12-18 mos.	DPB, TR, team decision	no
Camp E-Wen-Akee	intake information, YASI, Woodcock-Johnson, 3 week assessment	Detox, DD, FS, SR	1 yr. SOT 1-1/2 y yrs.	MG	no

<b>Program</b>	<b>Evaluation</b>	<b>Exclusions</b>	<b>Stay Length</b>	<b>Release</b>	<b>Waiting List</b>
Valley Vista	medical eval, psych assessment, GAIN, personal interview, Ed and rec assessment	FS, SR, HR, Med, V	30 to 90 days	MG (per ASAM criteria)	Not for past year
Brookhaven	pre-screening, intake interview, initial plan in 7 days, treatment plan within 30 days	Sex, DD, SR	9 - 12 mo.	MG	no
Baird - Park St.	psycho-sexual eval Educ/psych eval (IEP) 60 day assessment	DD, V, Vic, Age	18 mo. avg.	MG, DPB, IS	no
Becket School	30 day assessment	SR, MI (with weapons), RA	min: 9-12 mo., max: 18 mo.	MG, DPB	no
Spectrum Sandhill	MH screening, ASAM, LOCUS, interview	MI (psychotic), SR, HR, Detox	up to 10 days, but often longer	LS, S, TR	no
<b>Southern VT</b>					
NFI South	referral process (set program)	M - FS, Sex F - FS, SR	min: 6 mo. max: 18 mo	SDP, family therapy	no, CSM system
Brattleboro Retreat	initial assessment, weekly/monthly treatment planning, multi-disciplinary	FS, Sex, V	min: 30 days, max: 18-24 mo	MG, S	3.5 weeks 2 to 8 weeks
Bratt Retreat ARC	determined by the sending team	DD, Fit	min: 6 mo. avg: 1 yr.	community ready, MG	yes
Community House	evaluation, records	Med	avg: 90-120 days, max: 6 mo.	MG, E, SDP	sometimes
Mountainside House	initial assessment, referral questions, case management review, collaboration with MH	MI, HR,FS, Detox, Sex,	1 - 60 days avg:14 days	TR	no
204 Depot St.	individualized treatment plan	FS	45 day eval max: 24 mo avg: 12-15 days	MG	no
206 Depot St.	(not a treatment program)	heinous crimes	max: 20 days	TR, LS	no
Bennington School	intake information, 30 day evaluation	CH, FS	min:12 mo. max:36 mo.	MG, DPB	yes

## **EXCLUSIONARY CRITERIA**

AP= aftercare plan not in place  
Age = will be 18 before completing program  
CH = significant criminal history  
DD = serious developmental delays  
Detox = detoxing  
ED = school placement not available  
FS = fire setter  
Fam = family not willing to work with them  
Fit = child not a good fit w/milieu, existing dynamic  
HR = homicide risk  
Med = serious medical issues  
MI = serious mental illness  
RA = significant history of running away  
Sex = sexual offense  
SR = suicide risk  
V = violence  
Vic = victim issues

## **RELEASE DECISION**

DPB = decreased problem behavior  
E = evaluation completed  
Fam = progress with family  
IS = implementation of skills  
LM = levels of motivation system  
LS = length of stay  
MG = met treatment goals  
SDP = solid discharge plan  
S = stabilization  
TR = somewhere to transition to

## Appendix V

The following table details what format of education services residential sites provide, comments about strengths and/or weaknesses and if/how records of measurable outcomes are maintained for the clients they work with.

Program	Education Services-Effectiveness	Measurable Outcomes
<b>Northern VT</b>		
Howard Ctr.- Baird	High staff ratio/Residential and community kids together/Combines therapeutic & education. Fantastic!	Program effectiveness, efficiency, consumer satisfaction, accessibility, Time on waiting list, timely discharge.
Lund Family Ctr.	Classroom w/ 2 teachers/Special Ed. Available/Good outcomes w/ at risk students. Funding difficulties.	Clients and treatment team rate progress; track recidivism, child Permanency, education, self-sufficiency, SA recovery
NFI Group Home	Attend public or alternative school in Burlington school district.	Yes, mostly during stay (level and points system); follow-up w/ aftercare for 3months, hold yearly summer reunions
Spectrum Youth	Burlington school district, some kids attend Spectrum alternative school.	Length of stay, school, counseling, jobs, savings program.
Woodside TX	More structured/HS credit/Small group instruction. Adolescent relevant.	Tracks completion of HS diploma, work history, Criminal behavior.
Woodside Detention	Resource room/Small group instruction.	Yes, through follow-up interviews with kids.
Allenbrook	Attend public or alternative. Great relationship w/ So. Burlington district.	Yes, through daily logs, points, self-recognition, and motivation system.
NFI Hospital Diversion	None and school not attended. If there longer we try to develop a school plan.	Satisfaction survey done; internal rating at beginning and end.
NFI Shelburne House	Attend private alternative schools, primary is Stepping Stones, Winooski - Very good program, 1:1 staffing.	Records maintained at administrative office in So. Burlington.
Laraway	Alternative program licensed by DOE: HS credits, school to work option, 25 Students, 5-6 in class, grades 4-12	Success defined differently for each individual, based on abilities/ needs.
<b>Central VT</b>		
Onion River Crossroad	Attend Montpelier public H.S.	Constant evaluation while in program, measure progress toward target skills.
Washington Cty MH	Most in public school and on an IEP w/ individual interventionist.	"Don't spend a lot of time tracking Outcomes, it would take time and money away from work".
Camp E-Wen-Akee	Theme-based/Combo of experiential and traditional/Differentiated/ Non-graded/Generate interest, not Focus on failures. Difficult transition	Track educational progress, restraints/ incident reports, productivity, where they are living. (weekly, monthly, quarterly)
Valley Vista	Instruction 2 hrs a day, 5 days a wk./ Licensed as Independent School/ Part-time coordinator and 5 teachers.	Follow-up surveys, but no clinical follow-up, working towards clinical Outcome measures by end of 2007

<b>Program</b>	<b>Education Services-Effectiveness</b>	<b>Measurable Outcomes</b>
Brookhaven	Licensed Independent School/24 student capacity (14 from community)/ Special ed, therapeutic groups, Adventure learning, summer program.	Follow-up surveys. Staff visits at 1, 3, 6, 12 months. They want to develop formal outcome measurements.
Baird – Park St.	Full academic program w/ HS credit, year round, small classes. Conflicts btw treatment philosophy And education at transition.	Treatment plan reviews, satisfaction Surveys, follow-up surveys, check records for new sexual offenses.
Becket School	Regular education classes, vocational every other day, special education.	Yes
Spectrum Sandhill	Teacher on site Monday – Friday, works with home school to keep child On track.	They report the number that return to the program.
<b>Southern VT</b>		
NFI South	None, but work w/ supervisory union.	Track target behavior only.
Brattleboro Retreat	Core academic instruction, 5 in class, reading, speech and language, Occupational and speech therapy.	Treatment plan, daily and weekly notes, no surveys.
Bratt Retreat ARC	Accredited school thru 12th grade. Strengths: communication w/parents, team mtgs., goals, art teacher and speech therapists on site. Weakness: need longer days (group therapy in afternoons).	Working on it. Send out questionnaires. Need to do more. Keep track of restraints.
Community House	Access approved Independent Special Ed. School. Strengths: individualized, behavior education, small number kids.	Yes, goals met and monthly evaluations.
Mountainside House	Tutorial program. Strengths: good collaboration w/schools, strong teachers. Weakness: no vocational or labs.	Not measured very well.
204 Depot St.	Approved tutorial, can get credit from sending school, select few attend off-campus school/ college	No.
206 Depot St.	No educational services provided.	No.
Bennington School	Multi-media presentations and Instruction/Collaborative groups/ Interactive settings - very effective. Weakness: ever changing dynamic.	Yes.

## Appendix VI

The next table documents residential program staff educational and/or experience requirements and the associated salary structure. Please note: this list represents the best information we could elicit during the interview process. Salaries listed here may not be entirely accurate as a number of programs guessed the approximate salaries of their staff.

Program	Staff Education/Experience	Salaries
<b>Northern VT</b>		
Howard Ctr. - Baird	line staff - BA, exp preferred team leaders - clinicians - MA, 1-2 years exp.	\$11.02/ hour \$28,000 \$30,000
Lund Family Ctr.	line staff - BA, 1-2 years exp clinicians - license required education -	\$25,600-32,000 \$33,600-42,000 \$29,600-37,000
NFI Group Home	line staff - minimum is Associates in Human Svcs., usually hire BA in SW or Psych and exp in care for kids	line: \$20-26,000 clinical: \$30,000 education: n/a
Spectrum Youth	line staff - BA clinical - MA	start at \$26,000
Woodside TX/detention	line staff - HS diploma, experience preferred	temps - \$9-12/ hr perm - \$17-21/ hr super - \$21-25/ hr educ - \$20-24/ hr
Allenbrook	line staff - BA, exp working with kids house manager - 5 yrs. Exp clinical -	\$10.25/ hr \$32-40,000/yr \$75.00/ hr.
NFI Hospital Diversion	residential counselors - BA in SW, HS, Psych preferred plus some exp working w/ kids. clinicians - MA	line staff: \$11/ hr clinical:\$30-45,000
NFI Shelburne House	line staff - BA in SW, HS, Psych; prefer exp in MH field, clean record check	line: start \$25,000 clinical: \$38-40k education: n/a
Laraway	case manager - MA preferred or BA w/exp and commitment to get MA Mentor - emotional maturity, life experience, awareness of clinical needs.	Did not get salaries - Interviewed w/ group of staff.
<b>Central VT</b>		
Onion River Crossroad	No information	No information
Washington Cty MH	most staff have BA, but will train people w/right experience	line: \$12.33/ hr. managers: \$16.74
Camp E-Wen-Akee	line staff - BA, no exp required clinical - education -	\$23,600-30,000 \$30,000-40,000 \$30,000-40,000
Valley Vista	line staff - HS diploma clinical - BA (work for MA) education -	\$10-11/ hour \$31,000-44,000 part-time
Brookhaven	line staff - BA, exp preferred clinical - MA education -	\$25,000-29,000 low to mid 30's \$27,000-30,000

<b>Program</b>	<b>Staff Education/Experience</b>	<b>Salaries</b>
Baird - Park St.	line staff - BA, no exp required clinical - MA, 3 yrs. exp	\$11.02/ hour
Becket School	line staff - BA clinical - MA education -	\$20-26,000/yr \$32-40,000/yr \$26-32,000/yr
Spectrum Sandhill	line staff - BA clinical - MA	start at \$26,000
<b>Southern VT</b>		
NFI South	intensive training in attachment, DBT training, ongoing clinical supervision	milieu staff:\$25/hr case managers: \$28-30/ hr.
Brattleboro Retreat	direct care – BA and prior exp in residential setting clinical - licensed medical mgmt - licensed w/ exp.	line: BA \$11.50/hr clinical: \$17.18/hr
Bratt Retreat ARC	mental health BA, ongoing training social workers need Master's	line: \$13.00/hr clinical: \$25.00/hr education;\$25/hr Ed. aides:\$13/hr
Community House	ranges from BA to experience in related field	line:\$25-30,000 clinical: \$50,000 educ:\$35-40k +
Mountainside House	line staff - HS education clinical & teachers - BA, licensed	line: \$10.25/hr clinical: educ:\$10.75/hr
204 Depot St.	depends on position, ranges from GED to Master's	line: \$20,000/yr clinical: \$30-40k education: \$40k +
206 Depot St.	line staff - HS diploma: open-minded, willing to work w/ troubled kids in fair, firm, consistent manner para-educators: HS or equivalent	line: \$10-11/hr
Bennington School	teachers: Bachelor's degree special ed: Master's degree clinical: MSW residential: HS or equivalent	Ed: \$20,800 - 53,025 Clinical: \$35 -56,600 Line: \$18,720-33,000

## Appendix VII

The following tables provide synopses of responses to the question of what providers feel work best in their program:

Program	What works best in your specific program?
<b>Northern VT</b>	
Howard Ctr - Baird	Behavioral system, family style milieu tx, outdoor challenge
Lund Family Center	Gender responsive, meet all the woman's needs, individualized treatment
NFI Group Home	Focus on family therapy, normative model - empowerment of resident's voices, focus on relationships
Spectrum Youth	Committed to working with kids - even when they are resistant, relationships that build bridges, when kids experience success, holistic care - offer full range of services
Woodside Tx/Detention	Empowered line staff, role-modeling and counseling, staff training and clinical supervision
Allenbrook	Having kids establish their own goals, helping them get there through motivation, "family"
NFI Hospital Diversion	Crisis stabilization program and very thorough discharge planning
NFI Shelburne	1-on-1 attention/ supervision, treatment specifically tailored to individual, adult feedback vs. peer feedback
Laraway	Relationships built w/ kids, development of a variety of resources, finding the child's strengths
<b>Central VT</b>	
Onion River	Boys Town model, everyone on same level, individual responsibility for behavior and outcomes
Crossroads	
Washington Cty MH	Program, school, DCF, and family collaborate closely, everyone knows what the next step is
Camp E-Wen-Akee	Commitment to kids, work through whatever, 24 hour living w/ students (5 days), consistency of staff
Valley Vista	"Interpersonal connectiveness", nurturing and caring, environment of unconditional acceptance, committed to ongoing staff training
Brookhaven	Therapeutic crisis intervention model, teamwork/ team oriented approach, communication btw line staff and clinical/ management staff
Baird - Park St.	Teamwork, staff are supported in tough work - allows them to be therapeutic w/ kid, high staff ratio, staff secure, intensive family work
Becket School	Group therapy and VOC classes
Spectrum Sandhill	Successful when they get appropriate referrals, when girls are ready to look for next steps
<b>Southern VT</b>	
NFI South	Specialization of programs for particular age groups
Brattleboro Retreat	Direct care staff reaching families, range of services offered, on-site doctor & nurse, spectrum of services
Bratt Retreat ARC	Handle difficult kids - structure, location, handle kids through the worst and stick with them
Community House	Able to evaluate and stabilize kids with a wide array of services
Mountainside House	Short term stabilization
204 Depot St.	Ability to connect with kids, safe and trusting environment
206 Depot St.	Kids accept responsibility for why they got there
Bennington School	Strength based service planning, family-centered collaborative team approach

## Appendix VIII

Program	Do you have a sense of what is lacking in VT for services?
<b>Northern VT</b>	
Howard Ctr - Baird	Residential for Developmentally Delayed kids, young children with serious sexual acting out behaviors; programs for 4-5 yr. olds
Lund Family Ctr.	Services for "high-end" girls; need more women's treatment programs
NFI Group Home	Program for young women in crisis AND in need of family work
Spectrum Youth	Transitional housing for 18-22 year olds; step-down programs/community re-integration for sex offenders
Woodside Tx/Detention	Small involuntary program for girls (separate from boys), transitional living situations for older children (16-17)
Allenbrook	Needs for older kids-getting to adulthood successfully; lack of developed families for younger kids to go to; need better foster families; kids getting sent back home and regressing; need more variety and accessibility
NFI Hosp Diversion	"It's 60-40 girls out there, and not many girl's programs"
NFI Shelburne	Lots of girls out there whose needs are not getting addressed - we see this through NFI intake mtgs.
Laraway	IEP not being current - need a better way to award kids credit; need way to bridge foster families and residential programs; transitional support needed
<b>Central VT</b>	
Onion River Crossroads	More programs that offer holistic, long-term approach; high quality services lacking in VT
Washington Cty MH	Distinct lack of post-residential transition plans; "while we are working with the kids, who's working with the family?" We end up keeping kids longer because they have no place to go.
Camp E-Wen-Akee	Transitional homes, wrap-around services programs for girls w/ sex offenses; limited secure supervision, short-term crisis intervention
Valley Vista	Step-down/ transitional housing
Brookhaven	Adequate after-care planning across systems; need funds for additional services; concern about steering away from residential programs
Baird - Park St.	Therapeutic foster homes (not in all districts - none in Burlington); residential tx for DD sex offenders
Becket School	N/A
Spectrum Sandhill	Comprehensive screening/ assessment by DCF - kids just labeled "unmanageable"; long-term treatment for girls with high needs
<b>Southern VT</b>	
NFI South	Crisis bed capacity down south; housing transitional youths; aging-out, sex offender community based programs
Brattleboro Retreat	Profile of self-harming, aggressive females - do they really need higher level of care? Step-down programs non-existent
Bratt Retreat ARC	Step-down programs - we need them! Programs that deal with younger kids
Community House	Specialized populations not being provided for - not enough resources for every child
Mountainside House	High needs individuals, teenagers who age out - no transitional programs for those leaving
204 Depot St.	Substance abuse support for teens - not enough programs in this area
206 Depot St.	Kids that have mental health issues -not enough programs to handle them
Bennington School	Transitional services, discharge planning not very successful; less restrictive yet structured programs for students leaving residential

## Appendix IX

**Confidential question: *What do you feel could work better in terms of the entire referral and placement process? (Responses are in no particular order).***

Reduce multiple intake forms, process is confusing, disagree with approving specific programs.

Not much involved w/ CRC – difficult that children don't count, even though they get lots of services.

More timely receipt of paperwork, make sure DCF worker is directly involved in process. On the other hand, the process can move quickly.

Match kids more closely to program; kids are coming into the program with no place to transition to afterwards.

There's a lack of understanding of clinical parameters for substance abuse treatment.

Residential programs should be part of process. DCF workers need to stay more involved. Low funding for long-term intensive tx. per child; payment makes it difficult to maintain program.

Works fairly for treatment program; detention could benefit from improved communication with DCF.

Need more thoughtful planning about what kids need – to be appropriately placed. There's a wide range of skill of the evaluators. We're not being solicited for feedback.

Need more CSP (coordinated service plans) generated by team already working with the child.

Referrals sent even if no opening; send multiple referrals so there can be a choice. CRC should ensure local DCF/DMH worker gets educational assessment updated early in the referral process.

Need more foster homes, wider range of residential group homes, more options. Not knowing who's in charge, team approach a strength and weakness – too convoluted.

Aftercare, educational and competency issues need to get addressed within the referral.

No complaints, work well with everyone.

The process would work better if family members and social workers didn't try to make exceptions in the program. People don't get behavioral intervention – it's all about consistency.

Communication with child's school takes a while and delays their education. Behavior issues for kids under 16 trump everything – including education.

Problems getting all the information on the child – even though they accept kids in crisis, background information should be provided.

Educate referral sources on what type of kids are successful in their program.

Need more updated psychological and psychiatric evaluations and better follow-up by agencies regarding placement after interview process.

Regarding the referral source - try to sort through whether the referral is appropriate or not – need better communication. Otherwise, no real concerns.

Process too vague, haphazard. Needs to be more systematic; they talk to people on top - others are too reactive. No information on kid – we try not to take kids until CRC approved.

A good step for CRC would be more complete applications; don't wait until there's a log jam of kids before meeting. Need freer communication to get kids in quickly.

People who make referrals should visit sites; sometimes choice is made because there is an open bed – history and what child needs not taken into consideration. Referrals inconsistent, lack complete information, a lot of miscommunication, “dumping ground”, no emergency support from DCF.

Concern about retribution if we don't accept kids; we resist pressure to move quickly and insist on CRC referral.

We're not familiar with the process.

## Appendix X

### VT Coalition of Residential Providers Survey

Thank you for participating in our survey. Your feedback is important.



### VT Coalition of Residential Providers Survey

1

Please fill in the following data:

Name:	<input type="text"/>
Company:	<input type="text"/>
Address 1:	<input type="text"/>
Address 2:	<input type="text"/>
City/Town:	<input type="text"/>
State/Province:	<input type="text"/>
Zip/Postal Code:	<input type="text"/>
Country:	<input type="text"/>
Email Address:	<input type="text"/>

2

We will begin with questions related to the referral and admission process.

Clients often come with a variety of challenges and needs. In your experience, which clients are you most successful with? Which clients present the most challenges?

3

For out-of-state facilities: Why do you think the State of Vermont sends children and/or adolescents to your facility, specifically?

4

Now, we will move on to questions related to clinical/treatment protocols, policies and procedures.

Please list the clinical treatment modalities your program uses and note whether each modality is a specialty of your program or only that of an individual providing the services.

5

What are your safety/crisis intervention program protocols/procedures?

6

This is a two-part question: What is the frequency of harrassment and/or bullying among residents at your facility and how do you manage it?

7

In the past five years, what are your average annual incidents of restraints use?

- None
- 1-5 per year
- 6-10 per year
- 11-15 per year
- 16-20 per year
- Other, please specify

8

In the last five years, what are your average annual incidents of runaways (off site)?

- None
- 1-5 per year
- 6-10 per year
- 11-15 per year
- 16-20 per year
- Other, please specify

9

This is a two-part question: What is your policy on restraint if a client runs away? What restraint model do you use?

10

This is a two-part question: What types of individual therapy do you provide, if any? Do you have the ability to provide intensive 1:1 treatment?

11

Please choose all that apply:

- Family therapy is provided on an as-needed basis, with a licensed therapist.
- Family therapy is routinely provided to all residents, with a licensed therapist.
- Family therapy is provided on an as-needed basis by an on-site facilitator.
- Family therapy is provided to all residents by an on-site facilitator.
- Occasionally, it is difficult to get family members to attend arranged sessions.
- Frequently, it is difficult to get family members to attend arranged sessions.
- Family therapy is not one of our treatment modalities.
- Other, please specify:

12

As a follow-up to the last two questions, if individual and/or family therapy is utilized, what are the qualifications of the designated therapist or facilitator?

13

Do you offer clinical supervision? If yes, please specify for whom and please note the job title, degree(s) held and frequency of visits to your site.

Additional Information about clinician:

14

Do you have nursing staff on site? If yes, please note the typical schedule below.

Nursing staff on-site schedule:

15

Is your facility affiliated with any hospital? If so, please note which hospital in the comment box below.

Hospital affiliated with:

16

What is your program's level of comfort/expertise in addressing the following issues:

1                      2                      3                      4  
No expertise      Minimal expertise      Some expertise      High expertise

Substance abuse

Sexual reactivity

Sexual offending

Adoption issue

Severe allergies

Fire setting

Cognitive limitations

Autism spectrum

---

Sexual abuse

1

2

3

4

---

Emotional disturbance

1

2

3

4

---

Trauma

1

2

3

4

---

Domestic violence

1

2

3

4

---

Physical abuse

1

2

3

4

---

Traumatic Brain Injury/brain damage

1

2

3

4

---

Hearing impairment

1

2

3

4

---

Medical fragility

1

2

3

4

---

Multiple disabilities

1

2

3

4

---

Non-verbal learning disability

1

2

3

4

---

Language disability

1

2

3

4

---

Language impairment

1

2

3

4

---

Visual impairment

1

2

3

4

Attachment disorder

1

2

3

4

Self-injury behaviors

1

2

3

4

Assaultive behavior

1

2

3

4

Psychosis

1

2

3

4

Severe medical issues

1

2

3

4

17

This is a two-part question: How often do your staff meet as a team regarding each client? How often do you meet with the local team regarding each client?

18

Now we are moving on to questions specific to Educational Services.

What is your process for developing IEP and 504 meetings with the Local Education Authority (LEA)?

19

This is a two-part question: How do you include the educational surrogate parent and VT DCF worker in IEP and 504 meetings? How do you determine who else to invite to these meetings?

20

Is there an academic credit agreement with the Local Educational Authority (LEA)?

Additional Comment

21

This is a two-part question: How do you obtain school records and what type of student records do you maintain?

22

Do you send the LEA, surrogate parent and DCF worker student progress reports? If so, how often?

Additional Comment

23

Do you make written educational recommendations when engaging in discharge planning for students?

Additional Comment

24

How do clients participate in educational assessments?

25

What type of career planning and/or vocational training does your program offer?

26

For out-of-state programs only: What disability categories are you approved for?

27

Almost done! Finally, we're moving on to discharge and general closing questions.

This is a two-part question: What types of discharge planning/aftercare services do you provide? What problems do you run into with discharge planning, if any?

28

Do you regularly solicit customer satisfaction information? If yes, from whom?

Additional Comment

29

Do you feel that the needs of VT youth have shifted in any way in the last year or two? Please elaborate.

30

If you do feel that the needs of Vermont's youth have evolved, please explain how your program has had to adapt to these changing needs.

## Appendix XI

### RESIDENTIAL PROVIDER ONLINE SURVEY RESULTS January, 2007

#### *We are most successful with clients who...*

**Brattleboro Retreat:** Are depressed, anxious profiles; psychotic, pervasive developmental disorders.

**Lund Family Center:** Have a supportive community team and motivation in own treatment.

**Windsor County Youth Services:** Are short term, able to participate in school and in groups around behavior changes needed to be successful.

**NFI Winooski:** Are adolescents in a mental health crisis.

**Community House:** Aren't severely cognitively delayed or have physical handicaps.

**Woodside Juvenile Rehab Ctr:** Have anger/aggression problems, acting out, emotional dysregulation.

**The Howard Center:** Are latency age children.

**Valleyhead, Inc (Lenox, MA):** Are highly traumatized girls, who are very challenging.

**Washington County MH:** Are 16 yr. olds and up who want to participate and have a investment in the services.

**NFI Group Home:** Can or have capacity to exercise some degree of self control over behaviors that are significantly unsafe toward themselves or others; those who have some family connections.

**SEALL, Inc. (204 Depot):** Are diagnosed as Conduct Disordered.

**Park Street Program:** Have average cognitive ability, moderate trauma history, typical offender patterns, those w/ family involvement.

**Hillcrest Educational Centers (Pittsfield, MA):** Are very difficult children with significant psychiatric disturbances and very high risk behaviors incl. self harm, aggression, firesetting & sexual abuse.

**Eckerd Youth Alternatives:** Have appropriate permanency plans.

**Laraway Youth & Family Services:** Are transitioning from out-of-state programs or who have exhausted in-state foster and residential placements.

#### *Clients who present the most challenges are.....*

**Brattleboro Retreat:** Aggressive, have self harming behaviors and conduct disorders.

**Lund Family Center:**

**Windsor County Youth Services:** Teens with mental health issues who need one on one care.

**NFI Winooski:** Children w/ no families, not in custody but not able to go home, those with cognitive challenges that prevent them from participating in a meaningful way, those with significant acting out behaviors.

**Community House:** Severely cognitively delayed children or children with physical handicaps.

**Woodside Juvenile Rehab Ctr:** Those with cognitive impairments, spectrum disorders.

**The Howard Center:** Those with cognitive impairments, spectrum disorders.

**Valleyhead, Inc (Lenox, MA):**

**Washington County MH:**

**NFI Group Home:** Clients who require physical containment.

**SEALL, Inc. (204 Depot):** Those whose motivation/behavior is more attention seeking.

**Park Street Program:** Clients who have cognitive limitations, extreme trauma histories and those who have obsessive sexual offender patterns.

**Hillcrest Educational Centers (Pittsfield, MA):** Delinquent conduct disordered population.

**Eckerd Youth Alternatives:** Clients who do not have appropriate permanence plans.

**Laraway Youth & Family Services:** Clients with highly sexualized behaviors.

***Out of State facilities only: the State of Vermont sends clients to you because...***

**Valleyhead, Inc (Lenox, MA):** Our school has the ability to offer intensive therapeutic treatment, a full time school and quality residential care.

**Hillcrest Educational Centers (Pittsfield, MA):** We have a proven track record of success with their children and a good working relationship.

***Clinical treatment modalities include.....***

**Brattleboro Retreat:** Milieu based approach: individual, group and family therapy. Program offerings include therapeutic recreation- adventured based services.

**Lund Family Center:** 12 step, Covington's Model, Gain Assessment tool, psychotherapy model for individual, group, family & couples counseling.

**Windsor County Youth Services:** Case management and group, individual community support – programmatic.

**NFI Winooski:** Children Normative approach within a group milieu setting. Group counseling (both process oriented and expressive), family sessions, supported individual treatment, clinical observations and assessments.

**Community House:** Behavior system, Individual therapy, Group Therapeutic Recreational Therapy, Therapeutic Milieu.

**Woodside Juvenile Rehab Ctr:** Crisis, individual, family support, group counseling, positive milieu, behavior management, interpersonal relationship work – all staff trained to do work.

**The Howard Center:** Most treatment in the milieu. We've begun using the ARC model. Behavior modification systems such as POINTS AND PICS. Providers who specialize in treating attachment disorders, sexually reactive children and a variety of behavioral disorders. Recently have acquired a curriculum for addressing firesetting behaviors – 2 staff trained.

**Valleyhead, Inc (Lenox, MA):** Intensive individual therapy, groups and a behavioral program based on natural rewards and consequences.

**Washington County MH:** Behavior management and Trauma informed serves. Other clinical services provided to meet each child's individual need.

**NFI Group Home:** Family therapy, Family systems frameworks, attachment, complex developmental trauma (including attachment & PTSD frameworks), DBT, CBT, normative model, group therapy, individual therapy  
**SEALL, Inc. (204 Depot):** Our milieu borrows from Reality Therapy, Guided Group Interaction and other behavior modification models. Substance Abuse treatment component relies heavily on the 12 steps NA/AA and Motivational Interviewing techniques.

**Park Street Program:** Cognitive behavioral model, therapeutic crisis intervention, relapse prevention model and beginning to use ARC and EMDR, all provided in house. Also- psychiatric, individual, group and family therapy.

**Hillcrest Educational Centers (Pittsfield, MA):**

**Eckerd Youth Alternatives:**

**Laraway Youth & Family Services:** Not sure – would need to get information from Clinical Director or Program Coordinator.

### ***Safety/crisis intervention program protocols/procedures include....***

**Brattleboro Retreat:** A license to utilize the MANDT system.

**Lund Family Center:** A clinical on call system within the agency, and community supports such as First Call, the local police and adult crisis.

**Windsor County Youth Services:** CPI agency and in house protocols including adult supervision at all times.

**NFI Winooski:** No access to “sharps”, no 2 clients ever alone together, individualized safety plan for each client - reviewed daily, awake supervision at night.

**Community House:** CPI restraint protocols that include de-escalation strategies prior to physical restraint.

**Woodside Juvenile Rehab Ctr:** Individual room check procedure, suicidality assessment and monitoring, intake and monitoring protocols, annual staff training in de-escalation and physical restraint, and in 1<sup>st</sup> aid/CPR/defib, etc. Units locked w/ 24 hr. awake staff.

**The Howard Center:** Worker safety protocol, physical intervention policy and procedure, medication incident policy/procedure, critical incident policy/procedure. Each client has a tailored Crisis Management Plan. Also a 3 tiered clinical back-up system. Psychiatrist available by pager 24/7.

**Valleyhead, Inc (Lenox, MA):** One on one intervention using talking and reviewing coping skills. If a continued crisis, a therapeutic restraint may be implemented – they follow the TCI method and are always 2 or 2 man. Hospital intervention for evaluation if downward spiral continues.

**Washington County MH:** Each client has a crisis plan and there are on-call svcs. And the agency has an emergency crisis service 24/7.

**NFI Group Home:** We focus on prevention (thru teaching skills and developing trusting relationships), intervention (thru accountability combined with validation & compassion) & crisis intervention using the DBT approach.

**SEALL, Inc. (204 Depot):** All staff trained in 1<sup>st</sup> aid/CPR. Also in TCI (Therapeutic Crisis Intervention).

**Park Street Program:** All staff trained in TCI – trainer on site w/ oversight of daily implementation of such. 24/7 on call staff available. Cell phones while in community w/ clients, positive relations w/ local police for interventions/immediate response when needed, monthly fire drills, all staff certified in 1<sup>st</sup> aid and CPR. Alarms on all doors/windows.

**Hillcrest Educational Centers (Pittsfield, MA):**

**Eckerd Youth Alternatives:**

**Laraway Youth & Family Services:** Crisis plan development after thorough review of client file, updated after crises as necessary. Crisis support available 24/7 to all staff, foster parents and clients. Proactive approach to crises, averting before happening when possible.

***Frequency of harassment & how managed...***

**Brattleboro Retreat:** Periodic. Managed by limit setting, community meeting, individual coaching and counseling.

**Lund Family Center:** Not uncommon as groups of young women target other young women. Addressed thru staff intervention & frequently a facilitated mediation.

**Windsor County Youth Services:** Addressed thru adult intervention at first sign of problem. (Frequency not noted).

**NFI Winooski:** Extremely low. Managed by 1:2 staff client ratio; discouraged from making negative statements against peers. Leading by example – all staff speak respectfully at all times to each other and residents.

**Community House:** Very little of this as densely staffed and all interactions observed. Inappropriate behavior dealt with immediately.

**Woodside Juvenile Rehab Ctr:** Immediate feedback and intervention provided. Consequence as related to situation via asking resident to think through what happened and to provide an alternative, appropriate way to handle the situation, including an apology. (Frequency not noted).

**The Howard Center:** Picking on each other is often a part of behavior problem. Youth are closely supervised at all times, and bullying is addressed immediately, both sides of story are relayed. The child who bullies has a consequence and is asked to make restitution and is part of the planning of such. Many groups that are run focus on “how to be a good friend”.

**Valleyhead, Inc (Lenox, MA):** Very little due to small campus as detected quickly. Managed by addressing privately w/ clinician to resolve problem and determine underlying reason for such behavior. Often a coping mechanism due to reaction of a letter, phone call or family visit that didn't go as expected or produced stress. Alternative coping strategies are used to deal w/ disappointment or stress. Harassed recipient is also seen by therapist to address feelings, fears, reactions. These behaviors not tolerated and if continued after interventions, consequences are put in place.

**Washington County MH:** Daily. Managed thru specific group and individual interventions around unlawful harassment. 24/7.

**NFI Group Home:** Disrespect occurs on avg. once a day; any such action is dealt with in the least restrictive way possible.

**SEALL, Inc. (204 Depot):** Program has a strong “peer group” component and such behavior is typically not tolerated by the group. (Frequency not noted).

**Park Street Program:**

**Hillcrest Educational Centers (Pittsfield, MA):**

**Eckerd Youth Alternatives:**

**Laraway Youth & Family Services:** Very rare. Clients are in foster homes and have consistent supervisor.

***Average annual incidents of restraints use in past 5 years:***

**Brattleboro Retreat:** Approximately 30  
**Lund Family Center:**  
**Windsor County Youth Services:**  
**NFI Winooski:** 1-5  
**Community House:**  
**Woodside Juvenile Rehab Ctr:** 24  
**The Howard Center:** 15 – 25 – check w/ facility – they noted 150-250!  
**Valleyhead, Inc (Lenox, MA):**  
**Washington County MH:** 1-5  
**NFI Group Home:**  
**SEALL, Inc. (204 Depot):** Had one restraint four years ago  
**Park Street Program:** 6-10  
**Hillcrest Educational Centers (Pittsfield, MA):**  
**Eckerd Youth Alternatives:**  
**Laraway Youth & Family Services:** Estimate 6-10

*Average annual incidents of runaways off site:*

**Brattleboro Retreat:** Unknown  
**Lund Family Center:**  
**Windsor County Youth Services:**  
**NFI Winooski:** 6-10  
**Community House:**  
**Woodside Juvenile Rehab Ctr:** 1  
**The Howard Center:** 6-10  
  
**Valleyhead, Inc (Lenox, MA):**  
**Washington County MH:** 6-10  
**NFI Group Home:**  
**SEALL, Inc. (204 Depot):** 6-10  
**Park Street Program:** Total of 5 (not annualized)  
**Hillcrest Educational Centers (Pittsfield, MA):**  
**Eckerd Youth Alternatives:**  
**Laraway Youth & Family Services:** 1-5

***Policy on restraint use if client runs away/Restraint model used...***

**Brattleboro Retreat:** If safety an issue, client will be restrained from leaving, otherwise, they're followed until leaving grounds, then law enforcement called. Model: MANDT

**Lund Family Center:** We do not restrain.

**Windsor County Youth Services:** We do not restrain runners.

**NFI Winooski:** Clients only restrained if risk for harming selves. Model: 3 person, face up restraint.

**Community House:** CPI restraint or physical escort.

**Woodside Juvenile Rehab Ctr:** At lockdown, so running not an option. Model: Advance Control Technique (ACT).

**The Howard Center:** Clients only restrained if risk for harming self or others. Model: TCI

**Valleyhead, Inc (Lenox, MA):** No restraint if in greater community; may restrain if runaway still on property. Model: TCI method.

**Washington County MH:** Only restrain clients under 12. Model: Handle With Care.

**NFI Group Home:** No restraint unless client creating a dire risk of harm and if assessment is such that physical intervention will lead to safer outcome. We typically follow with a cell phone and call police as necessary.

**SEALL, Inc. (204 Depot):** Policy is NOT to restrain.

**Park Street Program:** Only restrained if safety issue. Informed from the beginning that police will be called if they run. Model: not noted.

**Hillcrest Educational Centers (Pittsfield, MA):**

**Eckerd Youth Alternatives:**

**Laraway Youth & Family Services:** Only when a serious risk of harm to self or others. Model: Handle With Care.

***Types of individual therapy provided. Is 1:1 intensive treatment available?***

**Brattleboro Retreat:** Range of individual therapy approaches employed depending on individual worker's training & orientation.

**Lund Family Center:** We do provide intensive 1:1 treatment.

**Windsor County Youth Services:** Supportive counseling.

**NFI Winooski:** Individual therapy not provided. Clients have access to 1:1 time with either a residential counselor or clinician on a daily basis for "check-ins".

**Community House:** Cognitive behavioral, sand tray, play therapy, EMDR.

**Woodside Juvenile Rehab Ctr:** No individual therapy in Detention, but crisis counseling always available. Individual therapy provided by Case Teams in Treatment program and then by community providers as clients move into transitional community living.

**The Howard Center:** Each client receives 1 hr. of individual therapy/wk. Daily 1:1 time w/ residential counselor.

**Valleyhead, Inc (Lenox, MA):** Play therapy, role playing, 1:1 individual sessions, art forms used. Has ability to provide intensive 1:1 treatment.

**Washington County MH:** Any treatment needed would include individual, family, group.

**NFI Group Home:**

**SEALL, Inc. (204 Depot):** Contract with local MH agency for licensed therapists.

**Park Street Program:** Minimum 1 hr./wk of individual therapy as well as family therapy when appropriate. At least 1 hr./wk with assigned residential counselor. 1:1 intensive treatment available as needed.

**Hillcrest Educational Centers (Pittsfield, MA):**

**Eckerd Youth Alternatives:**

**Laraway Youth & Family Services:** Individual psychotherapy in all treatment plans. Work w/ consultants outside of program. Clinical coordinator on staff does provide some 1:1 therapy.

### *With regard to family therapy and family involvement....*

**Brattleboro Retreat:** Provided as needed, to all residents with a licensed therapist or an on-site facilitator. It is occasionally and frequently difficult to get family members to attend arranged sessions.

**Lund Family Center:**

**Windsor County Youth Services:**

**NFI Winooski:** Provided on an as-needed basis to all residents with a licensed therapist or an on-site facilitator.

**Community House:** Family therapy is not one of the treatment modalities.

**Woodside Juvenile Rehab Ctr:** Family support counseling in treatment programs.

**The Howard Center:** Provided routinely to all residents with a licensed therapist. It is occasionally difficult to get family members to attend arranged sessions.

**Valleyhead, Inc (Lenox, MA):** Provided to all residents with an on-site facilitator. It is frequently difficult to get family members to attend arranged sessions.

**Washington County MH:** Provided on an as-needed basis to all residents with a licensed therapist.

**NFI Group Home:**

**SEALL, Inc. (204 Depot):** Provided on an as-needed basis to all residents with a licensed therapist. It is occasionally difficult to get family members to attend arranged sessions. A family worker sees families.

**Park Street Program:** Provided routinely to all residents with a licensed therapist. It is occasionally difficult to get family members to attend arranged sessions.

**Hillcrest Educational Centers (Pittsfield, MA):**

**Eckerd Youth Alternatives:**

**Laraway Youth & Family Services:** Provided on an as-needed basis to all residents with a licensed therapist.

***Qualifications of individual or family therapist:***

**Brattleboro Retreat:** Licensure or license eligibility in a clinical discipline.

**Lund Family Center:** Licensed social worker/mental health clinician.

**Windsor County Youth Services:** Bachelor level with experience.

**NFI Winooski:** Licensed clinical MH counselor or a clinical SW.

**Community House:** Licensed Psychologist/Master and Doctoral.

**Woodside Juvenile Rehab Ctr:** Ph.D. psychologist supervises counseling staff & is also involved in family support counseling (in treatment program).

**The Howard Center:** Licensed clinical MH counselor.

**Valleyhead, Inc (Lenox, MA):** All therapists have advanced degrees.

**Washington County MH:** Licensed MSW or licensed MH worker or licensed psychologist.

**NFI Group Home:** MSW, LCSW.

**SEALL, Inc. (204 Depot):** Usually a licensed therapist (one staff in process of pursuing license).

**Park Street Program:** Master's level clinicians.

**Hillcrest Educational Centers (Pittsfield, MA):**

**Eckerd Youth Alternatives:**

**Laraway Youth & Family Services:** Licensed therapist.

***Clinical supervision offered? For whom? Job title, degree(s) held and frequency of visits?***

**Brattleboro Retreat:** Yes, by department managers.

**Lund Family Center:** Yes, by a clinical psychologist, licensed drug and alcohol counselor and licensed clinical social workers. (For whom not noted).

**Windsor County Youth Services:** Yes, by licensed psychologist/doctoral, weekly, for the Clinical Director and any other staff in need of that services on an as needed basis.

**NFI Winooski:** Yes, only to employees of the program, by the program director and assistant director who are a LCMHC and MSW.

**Community House:** Yes, by doctoral psychologist, once a week, for Clinical Director and any other staff in need of that service on an as needed basis.

**Woodside Juvenile Rehab Ctr:** Yes, by Judith Christens, Ph.D. in psychology, daily as needed and more formally once a week. (For whom not noted).

**The Howard Center:** Yes, everyone in the program receives one hour of individual supervision a week. All clinical staff and supervisors are supervised by a LCMHC.

**Valleyhead, Inc (Lenox, MA):** No.

**Washington County MH:** Yes, weekly, by an MSW. (For whom not noted).

**NFI Group Home:** Yes, for all staff, by the director, an MSW and assistant director, an MSW. Visited biweekly by the regional director, an MA level Psychologist and the medical director, a Psychiatrist.

**SEALL, Inc. (204 Depot):** Yes, by Tom Simek, MA, licensed substance abuse therapist, who meets with clinical staff weekly. Dr. Doris Russel, licensed therapist meets with clinical staff monthly.

**Park Street Program:** Yes, some individual and family therapists receive clinical supervision from a Ph.D who specialized in the field of work with sexual offenders.

**Hillcrest Educational Centers (Pittsfield, MA):**

**Eckerd Youth Alternatives:**

**Laraway Youth & Family Services:** Yes, by a clinical coordinator on a weekly-monthly basis.

*Nursing staff on site? Note typical schedule:*

**Brattleboro Retreat:** Yes, M-F, 7-11 (am/pm not noted). Weekends on call. Onsite nurse for hospital overnights.

**Lund Family Center:** Yes, two nurses, one works days, the other overlaps in afternoon and works into evenings.

**Windsor County Youth Services:**

**NFI Winooski:** Yes, a psychiatric nurse on site twice a week.

**Community House:** No.

**Woodside Juvenile Rehab Ctr:** Yes. 5 days/week, 7:45 am – 4:30 pm and on call.

**The Howard Center:** Yes, a school nurse working M-F, 8:30 am – 4:30 pm. Too, a psychiatric nurse working M-F, 8 am – 4 pm.

**Valleyhead, Inc (Lenox, MA):** Yes. M-F, 6 am – 8 pm; modified weekend schedule but on call.

**Washington County MH:** Yes, on call as needed.

**NFI Group Home:**

**SEALL, Inc. (204 Depot):** No.

**Park Street Program:** Yes. 15 hrs./wk which includes attending to resident ongoing medical needs, oversight of meds via consult with the program psychiatrist, training of staff, etc.

**Hillcrest Educational Centers (Pittsfield, MA):**

**Eckerd Youth Alternatives:**

**Laraway Youth & Family Services:** Yes, a Nurse Practitioner 2x/mth.

*Facility associated with any hospital? Which?*

**Brattleboro Retreat:** Yes, Brattleboro Retreat.

**Lund Family Center:** We work closely with Fletcher Allen Hospital.

**Windsor County Youth Services:**

**NFI Winooski:** No.

**Community House:** No.

**Woodside Juvenile Rehab Ctr:** No, however Director holds an appointment as Assistant Professor of Psychiatry at Dartmouth Medical School.

**The Howard Center:** No.

**Valleyhead, Inc (Lenox, MA):** No.

**Washington County MH:** No.

**NFI Group Home:**

**SEALL, Inc. (204 Depot):** No.

**Park Street Program:** No.

**Hillcrest Educational Centers (Pittsfield, MA):**

**Eckerd Youth Alternatives:**

**Laraway Youth & Family Services:** No.

***Your program's level of comfort/expertise is addressing issues.....***

**Brattleboro Retreat:**

*High expertise with:* Substance Abuse, Emotional Disturbance, Trauma, Assaultive Behavior, Psychosis

*Some expertise with:* Sexual Reactivity, Adoption Issues, Severe Allergies, Cognitive Limitations, Autism Spectrum, Sexual Abuse, Domestic Violence, Physical Abuse, Non-verbal Learning Disability, Attachment Disorder, Self-injury Behaviors

*No expertise with:* Sexual Offending, Fire Setting, Traumatic Brain Injury (TBI), Hearing Impairment, Medical Fragility, Multiple Disabilities, Language Disability/Impairment, Visual Impairment, Severe Medical Issues.

**Lund Family Center:**

**Windsor County Youth Services:**

**NFI Winooski:**

*High expertise with:* Adoption Issues, Sexual Abuse, Emotional Disturbance, Trauma, Physical Abuse, Attachment Disorder, Self-injury Behaviors, Assaultive Behavior, Psychosis

*Some expertise with:* Substance Abuse, Fire Setting, Autism Spectrum, Domestic Violence, Non-verbal Learning Disability

*Minimal expertise with:* Sexual Reactivity, Sexual Offending, Cognitive Limitations, TBI, Language Disability/Impairment

*No expertise with:* Severe Allergies, Medical Fragility, Multiple Disabilities, Visual Impairment, Hearing Impairment, Severe Medical Issues.

**Community House:**

*High expertise with:* Sexual Reactivity, Sexual Offending, Adoption Issues, Autism Spectrum, Emotional Disturbance, Trauma, Domestic Violence, Physical Abuse, Attachment Disorder, Self-injury Behaviors, Assaultive Behavior

*Some expertise with:* Fire Setting, Cognitive Limitations, , Sexual Abuse, TBI, Hearing Impairment, Non-verbal Learning Disability, Language Disability/Impairment, , Psychosis

*Minimal expertise with:* : Substance Abuse, Severe Allergies, Medical Fragility, Multiple Disabilities, Visual Impairment, Severe Medical Issues

**Woodside Juvenile Rehab Ctr:**

*High expertise with:* Substance Abuse, Sexual Reactivity, Sexual Offending, Fire Setting, Sexual Abuse, Emotional Disturbance, Trauma, Domestic Violence, Physical Abuse, TBI, Attachment Disorder, Self-injury Behaviors, Assaultive Behaviors

*Some expertise with:* Severe Allergies, Cognitive Limitations, Medical Fragility, Non-verbal Learning Disability, Language Disability/Impairment, Visual Impairment

*Minimal expertise with:* Adoption Issues, Autism Spectrum, Multiple Disabilities, Psychosis, Severe Medical Issues

**The Howard Center:**

*High expertise with:* Sexual Reactivity, Sexual Offending, Adoption Issues, Sexual Abuse, Emotional Disturbance, Trauma, Domestic Violence, Physical Abuse, Attachment Disorder, Assaultive Behavior, Psychosis

*Some expertise with:* Severe Allergies, Fire Setting, Multiple Disabilities, Non-verbal Learning Disability, Language Disability/Impairment, Self-injury Behaviors

*Minimal expertise with:* Substance Abuse, Autism Spectrum, TBI, Hearing Impairment, Medical Fragility, Visual Impairment, Severe Medical Issues  
*No expertise with:* Cognitive Limitations

**Valleyhead, Inc (Lenox, MA):**

*High expertise with:* Sexual Reactivity, Adoptions Issues, Cognitive Limitations, Sexual Abuse, Emotional Disturbance, Trauma, Domestic Violence, Physical Abuse, Attachment Disorder, Self-injury Behaviors

*Some expertise with:* Substance Abuse, Severe Allergies, Non-verbal Learning Disabilities, Assaultive Behavior, Psychosis

*Minimal expertise with:* Sexual Offending, Fire Setting, Autism Spectrum, TBI, Hearing impairment, Language Disability/Impairment, Visual Impairment

*No expertise with:* Medical Fragility, Severe Medical Issues

**Washington County MH:**

*High expertise with:* Sexual Reactivity, Sexual Offending, Emotional Disturbance, Trauma, Physical Abuse, Self-injury Behaviors, Assaultive Behavior, Psychosis

*Some expertise with:* Substance Abuse, Adoption Issues, Severe Allergies, Fire Setting, Cognitive Limitations, Sexual Abuse, Domestic Violence, TBI, Hearing Impairment, Attachment Disorder

*Minimal expertise with:* Autism Spectrum, Medical Fragility, Multiple Disabilities, Non-verbal Learning Disability, Language Disability/Impairment, Visual Impairment, Severe Medical Issues

**NFI Group Home:**

**SEALL, Inc. (204 Depot):**

*High expertise with:* Substance Abuse, Assaultive Behavior

*Some expertise with:* Sexual Reactivity, Self-injury Behaviors

*Minimal expertise with:* Sexual Offending, Sexual Abuse, Trauma, Domestic Violence, Non-verbal Learning Disability, Language Disability, Attachment Disorder

*No expertise with:* Adoptions Issues, Severe Allergies, Fire Setting, Cognitive Limitations, Autism Spectrum, Emotional Disturbance, TBI, Hearing impairment, Medical Fragility, Multiple Disabilities, Language Impairment, Visual Impairment, Psychosis, Severe Medical Issues

**Park Street Program:**

*High expertise with:* Sexual Reactivity, Sexual Offending, Sexual Abuse, Emotional Disturbance, Domestic Violence, Physical Abuse

*Some expertise with:* Cognitive Limitations, Trauma, Attachment Disorder, Self-injury Behaviors, Assaultive Behavior

*Minimal expertise with:* Substance Abuse, Severe Allergies, Hearing Impairment, Multiple Disabilities, Language Disability/Impairment, Psychosis, Severe Medical Issues

*No expertise with:* Adoptions Issues, Fire Setting, Autism Spectrum, TBI, Medical Fragility, Non-verbal Learning Disability, Visual Impairment

**Hillcrest Educational Centers (Pittsfield, MA):**

**Eckerd Youth Alternatives:**

**Laraway Youth & Family Services:**

*High expertise with:* Emotional Disturbance, Trauma, Multiple Disabilities, Self-injury Behaviors, Assaultive Behavior

*Some expertise with:* : Sexual Reactivity, Sexual Offending, Adoptions Issues, Sexual Abuse, Physical Abuse, Medical Fragility, Language Disability, Psychosis

*Minimal expertise with:* Substance Abuse, Severe Allergies, Fire Setting, : Cognitive Limitations, Autism Spectrum, Domestic Violence, TBI, Non-verbal Learning Disability, Language Impairment

*No expertise with:* Hearing Impairment, Visual Impairment

***How often do staff meet as a team regarding each client? How often with the local team?***

**Brattleboro Retreat:** Weekly.

**Lund Family Center:** 2x/week as a team; minimum 1x/month with local team.

**Windsor County Youth Services:** Weekly or more often as needed; local team meeting are not often.

**NFI Winooski:** Multiple check-ins per day; with local team, at least once during the course of a week (typical) stay.

**Community House:** 1x/week.

**Woodside Juvenile Rehab Ctr:** Case teams meet weekly and treatment teams meet once every three months on each client.

**The Howard Center:** Internal teams meet at least 2x/week; supervisory staff meet more often; for long term kids, the whole treatment team meets every six weeks; shorter term kids – more often.

**Valleyhead, Inc (Lenox, MA):** 2x/monthly unless more needed. We work with 7 states – team members from each state are always invited to attend.

**Washington County MH:** Staff meet weekly. Teams meet monthly or weekly if needed.

**NFI Group Home:** The entire team meets weekly covering each client; local teams meet monthly or more frequently as needed.

**SEALL, Inc. (204 Depot):** Staff meet weekly for 3-4 residents so all residents get staffed at least 1x/month. Treatment team meetings are supposed to happen every three months, but they sometimes happen more frequently, sometimes less.. Some social workers are more “on top of things” in this department than others.

**Park Street Program:** We meet every week informally about clients and then we meet every three months formally where the client’s local team is invited to attend.

**Hillcrest Educational Centers (Pittsfield, MA):**

**Eckerd Youth Alternatives:**

**Laraway Youth & Family Services:** Staff – 1x/wk; local team – 1x/month.

***Process for developing IEP and 504 meetings with LEA?***

**Brattleboro Retreat:** Referring school district handles. We handle updates as needed.

**Lund Family Center:** We have an approved educational program and work with a consultant related to IEP’s and 504 meetings.

**Windsor County Youth Services:** Short term placement here – not usually involved in IEP meetings.

**NFI Winooski:** We might recommend that a team have one of these meetings, but we do not plan or attend these meetings.

**Community House:** Our teachers works with the sending school/district/LEA to amend the child’s education plan as needed. We work together to complete annual reviews and re-evaluations that occur during the child’s placement. LEA’s and other pertinent school personnel are also included in treatment team meetings throughout the child’s assessment as appropriate. They also participate in discharge and placement planning as appropriate.

**Woodside Juvenile Rehab Ctr:** We have a specific protocol covering both programs which has been reviewed/approved by the DOE.

**The Howard Center:**

**Valleyhead, Inc (Lenox, MA):** Upon admission conversations begin with the LEA in regards to current IEP's and services needed.

**Washington County MH:** Teams meet with the LEA.

**NFI Group Home:** Prior to intake we inform the LEA of potential new clients. We ask referring teams to have all necessary assessments for IEP and 504 plans updated prior to admission. We then follow the LEA's lead on actual placement. The LEA is then a participant at all ongoing treatment team meetings.

**SEALL, Inc. (204 Depot):** We will travel to the LEA, or sometimes the LEA will travel to us, so that we can together develop a comprehensive plan.

**Park Street Program:** Our special educator contacts the LEA to coordinate meetings.

**Hillcrest Educational Centers (Pittsfield, MA):**

**Eckerd Youth Alternatives:**

**Laraway Youth & Family Services:** Contact LEA prior to placement.

***How are educational surrogate parents and DCF workers included in IEP/504 meetings?  
How is it determined who else should be invited to such meetings?***

**Brattleboro Retreat:** Invitation is extended based upon report of referring district.

**Lund Family Center:** These are done primarily by the sending school.

**Windsor County Youth Services:** N/A

**NFI Winooski:** N/A

**Community House:** These individuals are usually already a part of a resident's treatment team and are therefore invited to meetings. For children who are in DCF custody, the DCF worker lets us know other school personnel who should be invited.

**Woodside Juvenile Rehab Ctr:** Both are included in all education meetings. The LEA, the educational surrogate and the DCF worker coordinate with each other to determine who will be invited.

**The Howard Center:**

**Valleyhead, Inc (Lenox, MA):** The educational surrogate and VT DCF worker are invited to attend the meetings. Who else is invited is often determined by the LEA or the VT DCF.

**Washington County MH:** They are invited to team meetings, as are anyone who has an interest or investment in the child.

**NFI Group Home:** We always invite the parent, ed surrogate, DCF worker and/or local mental health case manager to all treatment team meetings including IEP/504 meetings.

**SEALL, Inc. (204 Depot):** We let them know of the meetings and hope they show up.

**Park Street Program:** They are invited to attend the meetings through the invite sent out by the LEA. If there are additional people to invite specific to a client's individual needs, the special educator will advocate on behalf of the client with the LEA to make sure they are added to the meeting list.

**Hillcrest Educational Centers (Pittsfield, MA):**

**Eckerd Youth Alternatives:**

**Laraway Youth & Family Services:** Public school calls these for our kids.

***Is there an academic credit agreement with the LEA?***

**Brattleboro Retreat:** Yes. We meet educational requirements of the referring district.

**Lund Family Center:** As a licensed tutorial program contact is made upon entry into the program with the LEA.

**Windsor County Youth Services:**

**NFI Winooski:** No. Children are only with us for 7 -10 days.

**Community House:** Yes.

**Woodside Juvenile Rehab Ctr:** Yes. The Woodside School provides academic transcripts of credit for students in the Treatment Program. LEA's can also get a curriculum summary for Detention Program students upon request, but they assign the credit.

**The Howard Center:** Yes.

**Valleyhead, Inc (Lenox, MA):** Yes.

**Washington County MH:** Not sure.

**NFI Group Home:** We do not have a school onsite. Residents earn Burlington Credit if they are placed at a specialized school.

**SEALL, Inc. (204 Depot):** Yes. It depends on the LEA district. Some(most) are very agreeable to given credit, and can be very creative in assigning credit. A few districts vcan be VERY difficult to deal with, and do not seem to have the child's best interest considered.

**Park Street Program:** Yes.

**Hillcrest Educational Centers (Pittsfield, MA):**

**Eckerd Youth Alternatives:**

**Laraway Youth & Family Services:** No.

***How are school records obtained and what type of student records are maintained?***

**Brattleboro Retreat:** Request from referring district. Provide updates, maintain attendance and performance records.

**Lund Family Center:** We request records from the sending school and maintain our educational records within each client file.

**Windsor County Youth Services:** Contact and request for IEP's and current school work is done by phone and follow up letter with current school. Attendance record and initial reading/math assessment are kept on file. Work goes to the school when client is discharged or as ready, by mail.

**NFI Winooski:** N/A

**Community House:** Once we have a signed release of information, it is sent to the sending school. The teacher then speaks with personnel from that school and obtains copies of pertinent education plans, evaluations, records, etc. We do not receive originals or the child's permanent school file. During the child's placement we keep records of attendance and academic/behavioral progress. Copies of this information is provided to the DCF worker and is also available to the sending school or the child's new school.

**Woodside Juvenile Rehab Ctr:** As a program operated by DCF, we cannot legally possess an original school record. The original school record remains with the LEA. We maintain copies of special education eligibility assessments and current IEP's for working purposes.

**The Howard Center:** With a signed release, the sending school sends school records to the Baird School, where our residential kids attend school while they are with us. Educational records are kept separately from the residential records because FERPA applies.

**Valleyhead, Inc (Lenox, MA):** We ask for school records in our admissions packet. We like to have current IEP, past schools attended and any history of legal involvement that may have incurred for student at any particular school.

**Washington County MH:** The guardian requests records from the sending school.

**NFI Group Home:** Prior to intake we require all assessments, IEP/504 plans and permanent records be sent to the Burlington LEA.

**SEALL, Inc. (204 Depot):** School records are difficult to obtain, usually we just get a transcript. We maintain records of hours put in to specific subjects.

**Park Street Program:** Our special educator will contact the last school attended to have records sent to us. We maintain a record that includes a copy of an IEP, educational evaluations, program assessment report, monthly progress summaries, report cards, transcripts, discharge reports, etc.

**Hillcrest Educational Centers (Pittsfield, MA):**

**Eckerd Youth Alternatives:**

**Laraway Youth & Family Services:** Thru DCF social worker.

***Are the LEA, surrogate parent and DCF worker sent student progress reports? Is so, how often?***

**Brattleboro Retreat:** Yes, quarterly.

**Lund Family Center:** Yes, quarterly.

**Windsor County Youth Services:** Summer program has a progress report sent out to school for each child. Other reports as requested or needed.

**NFI Winooski:** No.

**Community House:** Yes. DCF workers get monthly updates on behavioral and academic progress. Copies are sent directly or via the DCF worker to other appropriate individuals on a case by case basis.

**Woodside Juvenile Rehab Ctr:** Yes, quarterly.

**The Howard Center:** Yes.

**Valleyhead, Inc (Lenox, MA):** Yes, each marking period.

**Washington County MH:** Yes. Most often these folks are at regular meetings.

**NFI Group Home:**

**SEALL, Inc. (204 Depot):** No. We communicate frequently with these parties and meet occasionally to go over progress. There is no official progress report. When the resident leaves the program, we work with the LEA to determine how much credit the resident gets for all the things accomplished in the program, academic and other areas.

**Park Street Program:** Yes. Parents also get copies of reports if permitted by the DCF worker.

**Hillcrest Educational Centers (Pittsfield, MA):**

**Eckerd Youth Alternatives:**

**Laraway Youth & Family Services:** No.

***Are written educational recommendations made during discharge planning?***

**Brattleboro Retreat:** Yes.

**Lund Family Center:**

**Windsor County Youth Services:**

**NFI Winooski:** Yes. We do not make specific educational recommendations, but we often address educational issues in our discharge summaries – suggesting that a child be evaluated or receive tutoring, etc.

**Community House:** Yes. These may be included in monthly updates during assessment, but there is also an educational summary and recommendations report written at discharge.

**Woodside Juvenile Rehab Ctr:** Yes, as a part of transition plans for students in the treatment program.

**The Howard Center:** Yes.

**Valleyhead, Inc (Lenox, MA):** Yes.

**Washington County MH:** No.

**NFI Group Home:**

**SEALL, Inc. (204 Depot):** Occasionally, but not a majority of the time.

**Park Street Program:** Yes.

**Hillcrest Educational Centers (Pittsfield, MA):**

**Eckerd Youth Alternatives:**

**Laraway Youth & Family Services:** Yes.

***How do clients participate in educational assessments?***

**Brattleboro Retreat:** In testing, if recommended.

**Lund Family Center:** Written and orally with our teacher.

**Windsor County Youth Services:**

**NFI Winooski:** N/A

**Community House:** Our students are almost exclusively elementary aged. Informal assessments are done at intake. Our consulting psychologist may include some cognitive assessments as part of the overall assessment. Sending schools sometimes arrange for other academic testing during placement as part of a special education evaluation. Students participate in statewide standardized testing as a scheduled and dictated by their IEP.

**Woodside Juvenile Rehab Ctr:** They are involved in every aspect of the assessment – including administration of formal assessments such as Woodcock Johnson Tests of Cognition and Achievement, curriculum-based assessments, interviews, meetings, etc.

**The Howard Center:** There are tri-annual assessments done on each child.

**Valleyhead, Inc (Lenox, MA):**

**Washington County MH:** Not sure of the question.

**NFI Group Home:** Clients are a part of ongoing treatment team meetings, including IEP meetings.

**SEALL, Inc. (204 Depot):** ???

**Park Street Program:** They participate via testing, meeting with the special educator and attending the assessment meeting where the results of this information is shared with the client's local team.

**Hillcrest Educational Centers (Pittsfield, MA):**

**Eckerd Youth Alternatives:**

**Laraway Youth & Family Services:** Not sure.

***What type(s) of career planning and/or vocational training does your program offer?***

**Brattleboro Retreat:** Limited.

**Lund Family Center:** We offer life skill classes and each resident works with a transition specialist on financial management , housing, and other basic life skills.

**Windsor County Youth Services:** Living skills groups have a component. Transitional living clients often connected with the JOBS program.

**NFI Winooski:** N/A

**Community House:** Not applicable to our population.

**Woodside Juvenile Rehab Ctr:** Transition Coordinator works with students in the Treatment Program on job-seeking and employability skills, and works with students in job placements.

**The Howard Center:** Minimal since our school is only licensed thru the 8<sup>th</sup> grade.

**Valleyhead, Inc (Lenox, MA):** We offer job placement in the community when the client is eligible. We accommodate any testing for placements in public schools or colleges that are needed or required either by testing on campus or by providing transportation to the nearest school offering the testing.

**Washington County MH:** Life skills.

**NFI Group Home:** As needed for older clients. Usually through direct mentoring, support of summer or after school jobs.

**SEALL, Inc. (204 Depot):** We offer a work component. Initially, residents are part of our work program. In time, they can transition to a job in the community.

**Park Street Program:** We have a life skills teacher in the school who works with students to prepare them for this. We also have a wood working shop on site that helps kids learn a carpentry trade.

**Hillcrest Educational Centers (Pittsfield, MA):**

**Eckerd Youth Alternatives:**

**Laraway Youth & Family Services:** We develop individualized plans based on client's permanency plan.

***For out-of-state facilities only – what disability categories are you approved for?***

**Valleyhead, Inc (Lenox, MA):** Learning.

**Hillcrest Educational Centers (Pittsfield, MA):**

***What types of discharge planning/aftercare services are provided.... and what problems do you run into with discharge planning, if any?***

**Brattleboro Retreat:** Discharge planning begins upon admission....Availability of recommended discharge services.

**Lund Family Center:** We begin discharge planning at admission. The most frequent problem is housing and debt load.

**Windsor County Youth Services:** Short term program which often helps with discharge planning. When we are doing family reunification, we are available for follow-up as needed to support the contract which is developed for success.

**NFI Winooski:** We begin discharge planning at admission. We always hold a team discharge meeting. We provide a written summary and list of recommendations upon discharge – frequently containing 10 to 20 specific recommendations. Problems usually involve not being able to identify specific providers with actual appointments for clients. Another major problem is if there is no clear plan for where a child will be residing next.

**Community House:** We work closely with the treatment team of the child, having meetings and sharing our findings as well as our recommendations. We also at times work with the families that the children are returning to in an attempt to give recommendations and assist in a smooth transition. We are not able to provide any aftercare services at this time as we are only a short term stabilization program. The only big problem is a lack of placement options for the children to transition into. They end up remaining in our facility longer than necessary because they have nowhere to go.

**Woodside Juvenile Rehab Ctr:** In the Treatment Program, we provide and arrange for all community-based services until the 18<sup>th</sup> birthday and after that is the client is willing. Other kids need services past their 18<sup>th</sup> birthday and there are significant barriers to this.

**The Howard Center:** We begin discharge planning the moment a child arrives in our program. After we assess what the needs are and what services might already be in place, we begin making calls to secure additional needed services for when the child is discharged. We make sure everything is set up before the child leaves. From our assessment and long-term programs, we gradually transition the child back home (weekend visits, etc.). We do home visits with the child too. Problems – sometimes it is unclear where a child will be going after they leave (maybe DCF is thinking of TPRing the parents, or they are looking for an adoptive home but haven't found one yet). Sometimes these kids get "stuck" at Residential.

**Valleyhead, Inc (Lenox, MA):** We do not provide any aftercare services. We recommend services we think would be beneficial to the client and her family. Problems with discharge planning mainly stem from receiving very short notice of a discharge which makes the transition work difficult for some clients.

**Washington County MH:** Lots of energy goes into discharge planning. Often the sending communities are not prepared for the child's return.

**NFI Group Home:** We discuss discharge planning throughout treatment. We offer intensive case management to pull together the team members necessary to facilitate discharge recommendations. We offer extensive written discharge summaries, including assessments and recommendations. We attend team meetings for three months following discharge. We attend family/individual therapy as necessary to transition work to new therapists. The most significant problems have either been when a DCF district decides to offer fewer support services than we have recommended or when local teams agree with recommendations but do not have the services necessary in the community.

**SEALL, Inc. (204 Depot):** We provide a lengthily transition process, which involves the resident spending a lot of time to where the resident is transitioning to. Resident must present a plan at discharge outlining living situation, work/education, and community supports (therapy, 12 step meetings, etc.). We offer aftercare services for 5 months to our residents and families. However, many residents and families do NOT take advantage of these services and there is not much to motivate them to do so.

**Park Street Program:** We provide a discharge meeting to discuss recommendations followed by a discharge report. We also provide clients with opportunities to do some transition visits to their future placement if this can be arranged, depending on funding availability to make this happen. We schedule a time for the client to meet his future therapist, tour of new school, etc. The challenges we have with discharging clients is there is not enough placement options in the state for the clients to transition to. There needs to be specialized foster care

available in each district for this specific population and it does not exist. We would love to provide more formal aftercare services, but this is not currently built into our budget. However, informally, we make ourselves available at anytime a community team asks for our input or assistance with a case. We also track clients after discharge to assess our level of success with them.

**Hillcrest Educational Centers (Pittsfield, MA):**

**Eckerd Youth Alternatives:**

**Laraway Youth & Family Services:** No formal aftercare.... Need more crossover between programs and individuals when clients move.

***Do you regularly solicit customer satisfaction information? If yes, from whom?***

**Brattleboro Retreat:** Yes.

**Lund Family Center:** Yes, from the resident.

**Windsor County Youth Services:** Yes, using a discharge survey and sometimes a consumer survey to DCF and parents, but not as much as we should or would like to.

**NFI Winooski:** Yes. Survey from parents and residents on last day in program.

**Community House:** Yes. Parents and social workers.

**Woodside Juvenile Rehab Ctr:** No.

**The Howard Center:** Yes, from families, DCF, other referring parties.

**Valleyhead, Inc (Lenox, MA):** Yes. The Admissions Director will follow up every discharge with a phone call, visit or letter to the placing agency inquiring about what they liked about our program and what they did not like or would like to see change or improve.

**Washington County MH:** No.

**NFI Group Home:** Yes, from parents and clients.

**SEALL, Inc. (204 Depot):** Yes. Informal conversations with social workers, ex-residents and families.

**Park Street Program:** Yes, from clients, families and referral agencies.

**Hillcrest Educational Centers (Pittsfield, MA):**

**Eckerd Youth Alternatives:**

**Laraway Youth & Family Services:** No.

***Do you feel that the needs of VT youth have shifted in any way in the last year or two, and in what ways?***

**Brattleboro Retreat:** Yes: increased substance abuse, aggressive self-harm, aggression towards others.

**Lund Family Center:** Yes.

**Windsor County Youth Services:** Yes: higher incidents of drug and alcohol issues.

**NFI Winooski:** We see more complicated cases – children who’s challenges are so extreme that there is not a “right” place for them to go. Kids caught between the DMH and DCF catchment areas. Older teens (17+) who are about to “age out” of services.

**Community House:** The children that are referred to us appear to be getting a little younger and perhaps more emotionally disturbed.

**Woodside Juvenile Rehab Ctr:** Yes: more intense aggression.

**The Howard Center:** Yes: more need for beds for younger kids, DD kids, serious sexually offending youth under age of 12.

**Valleyhead, Inc (Lenox, MA):** If anything, the clients we serve are presenting with more trauma than in the past. More abuse, sexual and physical, and a greater incidence of ongoing subtle traumas.

**Washington County MH:** I'm a Vermonter and my agency cares about kids. Not sure of the shift you're talking about.

**NFI Group Home:** Not necessarily. It will be interesting, though, to see how peak oil and climate change issues impact all of us.

**SEALL, Inc. (204 Depot):** No.

**Park Street Program:** Yes, the mental health issues of clients being referred are greater and create more of a challenge. We have also seen a need for services for a much younger group of boys and more cognitively limited.

**Hillcrest Educational Centers (Pittsfield, MA):**

**Eckerd Youth Alternatives:**

**Laraway Youth & Family Services:** Yes: many kids on adoption track experiencing disruptions.

***If you do feel that the needs of VT's youth have evolved, please explain how your program has had to adapt to these changing needs.***

**Brattleboro Retreat:** Exploration of increased levels of care.

**Lund Family Center:** There has been a real need for increased substance abuse services for women and we have stepped up to fill that need with the support of our SAMHSA grant.

**Windsor County Youth Services:**

**NFI Winooski:** We have recently admitted some 18 yr. old clients, as this seemed more appropriate than having them served by the adult system. This means altering a number of things, especially around confidentiality and house privileges. Longer stays for kids caught between DMH and DCF as there is no clear plan where they will live next.

**Community House:** There seems to be a need for a placement option that is somewhere between long term residential and therapeutic foster care for children whose needs fall in-between the two. Often, attachment disorder children are very easy to maintain in some type of structured and staffed group home but really have problems when placed in a family setting. This is one population that seems to be growing.

**Woodside Juvenile Rehab Ctr:**

**The Howard Center:** We've had to "staff up" for some of these kids which is a problem because we don't have extra money in our budget for this!!

**Valleyhead, Inc (Lenox, MA):** We have to remain mindful of the underlying subtle traumas that may be driving the present behaviors and focus treatment on encouraging the girls to come to terms with these traumas and to learn skills to overcome the residual effects of them.

**Washington County MH:** We have become more trauma-informed.

**NFI Group Home:**

**SEALL, Inc. (204 Depot):**

**Park Street Program:** We have had to adapt by working to learn more about ways to serve the cognitively limited kids and getting clinicians trained to address the trauma related histories.

**Hillcrest Educational Centers (Pittsfield, MA):**

**Eckerd Youth Alternatives:**

**Laraway Youth & Family Services:** We are working with adoptive and bio families and supporting youth in their homes.



## **Appendix XIII**

### **VPM Consultancy Contract**

The following is an agreement between the VPM consulting team (“the team”) made up of:

Julie Anderson, Agency of Human Services  
Donna Pratt, Department of Corrections  
Scott Smith, Department of Public Safety (Primary Contact)  
Justin Johnson, Department of Environmental Conservation

And the AHS/Department of Education Case Review Committee (CRC) represented by:

Danielle Grise, Division of Mental Health (Primary contact)  
Dana Robson, Division of Mental Health  
Deb Quackenbush, Department of Education  
Cori Shimko, Department of Children and Families

### **Project Summary**

The team will carry out a needs assessment to identify the gaps in service provided to children who are referred through the Case Review Committee for residential programs within and outside the state of Vermont.

The team will provide the CRC with an analysis of the gaps between the needs of children being referred to residential programs, and the services that those programs currently offer. The methodology will be made available as a part of the final report to ensure that the CRC will be able to continue the analysis in future years.

### **Background**

Since the passage of Act 264 in 1988 the state has required that human services and public education work together to provide coordinated services to children and families. The Act crested a state interagency team which, in turn, created a sub committee called the Case Review Committee that reviews referrals for residential placement from local interagency teams. Generally referrals will only be approved if all reasonable and appropriate community-based options have been exhausted.

The interagency agreement between AHS and the DOE lays out the process by which decisions will be made, which agency takes the lead in individual cases, and how cases will be reviewed and approved for residential placement.

The CRC has noticed, particularly in the past year, increasing waiting lists for eligible children to get into appropriate residential facilities/programs. The Committee has also developed an anecdotal sense that there are:

- Not enough assessment programs for adolescents

- Limited treatment for children with cognitive delays and/or autism spectrum disorders and sex offending behaviors
- No treatment for girls with sex offending behaviors
- Too few treatment options for children with highly specialized treatment issues
- No facilities for girls who need a high level of security
- Too few short-term programs to fill the need for interim placements.

The VPM team will attempt to quantify and define some of these needs and the gaps that exist in meeting the needs.

### **Access to Information**

In order to carry out the needs assessment the VPM team will need timely access to aggregated information about the needs of children being referred for residential placement; the current services available to these children and how well these existing services are serving the children.

While the team understands that information about what programs are available is relatively easy to gather, for privacy and confidentiality reasons the CRC is going to need to provide much of the children's data in aggregated form.

In addition to the aggregated numeric data that will be made available the VPM team will conduct interviews with CRC members and other state agency staff, with program managers responsible for running the residential facilities and with advocates for children who have been admitted to residential care.

The VPM team will complete its information gathering phase between mid November and the end of January 2007.

### **Final Product**

The VPM team will produce a report that combines a narrative description of the current available services and the current needs of children being referred for residential care. This report will include, but not be limited to such information as the number of beds available in each residential facility and the average waiting time for those beds, the types of services provided by each facility and the geographic location of the facilities (overlaid, if the information is available) with the geographic spread of the children being referred to the facilities; their age, sex, diagnosis, and any exclusionary criteria. In addition the report will highlight areas where there is an identified need, but no in-state facilities currently addressing that need. In defining the unmet needs we will look at the number of children whose needs are not being met and the specific type of program that would meet their needs.

The final report will be completed no later than mid April 2007.

**The team will not**

- Use any information that hasn't been aggregated to ensure that no individuals can be identified.
- Provide any clinical analysis as to the appropriateness of any referrals, treatment methods, or any decisions made by the CRC or other professionals with the State's system of care for children and families.

**Other Issues**

- Both teams agree to renegotiate parts of the contract if it becomes necessary (such as the inability to get necessary data in a certain area).
- Both teams accept the responsibility to discuss any concerns openly and fully and commit to finding solutions as necessary to keep the project on track.
- Scott Smith will be the lead contact for the VPM team, Danielle Grise will be the lead contact for the CRC team.

Signed:

VPM Team:

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