

**Respite Program Guidelines
Child and Adolescent Mental Health
Department of Mental Health**

I. Mission

Respite services offer short-term support and relief to the families of children and adolescents with significant mental health issues. Services are intended to help maintain family stability and to enhance mental health within the family, which may help prevent out-of-home placements, de-escalate crisis situations, and/or assist a youth to transition back into the home and community.

II. Definition¹

Respite services are a planned break for parents who are caring for a child experiencing a serious emotional disturbance. Respite gives the child a positive social experience apart from the family with an individual who is trained and can offer safe, stimulating activities.

Respite care may be provided in the home or in a variety of community settings. Respite workers receive on-going supervision from the Community Mental Health Center or Specialized Service Agency (both referred to below as the “Agency”).

Respite (hourly): In-home or community based care for the purpose of providing a planned break for parents/guardians.

Respite (overnight): Care for the purpose of providing a planned overnight break for parents/guardians. It is a supportive service for non-custody children/youth that are living in their own home/residence, be it a biological, adoptive, or kin-care home. This is not a service for children/youth in DCF custody living in their own home, or for any child/youth living in a foster home (therapeutic foster care or DCF foster care).

III. Eligibility

Children and adolescents receiving respite services shall meet the definition of severe emotional disturbance in Vermont’s Act 264 or be at risk of developing such a disturbance and living with their natural or adoptive family.

As defined by Act 264, “A child or adolescent with a severe emotional disturbance is 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.
 - Children and adolescents who exhibit seriously impaired contact with reality and severely impaired social, academic and self-care functioning whose thinking is frequently

¹ These definitions are relevant to respite services funded by the Department of Mental Health only for children not in State custody. Please refer to the Enhanced Family Treatment manual for information about respite services provided through that funding mechanism.

confused, whose behavior may be grossly inappropriate and bizarre, and whose emotional reactions are frequently inappropriate to the situation.

- Children and adolescents who are classified as management or conduct disordered 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;
- 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.”

IV. Program

In operating the respite program, the Agency shall:

- A. designate a Respite Coordinator who shall:
 - i. have overall responsibility for the coordination of respite services;
 - ii. serve as the agency’s contact with the staff of the Department of Mental Health; and
 - iii. attend, or send a representative, to the annual statewide meeting of the state’s Respite Coordinators and to any other required meetings;
- B. recruit, screen, train, and supervise workers to provide respite services to the eligible population;
- C. review applications for respite services and prioritize recipients based on eligibility, level of need, and funding parameters;
- D. match families and workers based on the child’s individual strengths and needs and the identified skills of the respite worker; and
- E. evaluate the access to, quality, and outcomes of the program.

Consumer feedback is the heart of quality improvement efforts. Each program will ask at least these 4 questions beginning in January 2006 of parents whose child has received respite over the course of six months and will report the results to DMH staff.

<i>Strongly</i>					<i>Strongly</i>
<i>Disagree</i>	<i>Disagree</i>	<i>Neutral</i>	<i>Agree</i>	<i>Agree</i>	
1	2	3	4	5	

- i. I can depend on respite services to happen as scheduled.
- ii. My respite workers provide service of high quality.
- iii. My life is better because of respite services.
- iv. My child’s life is better because of respite services.

V. Reporting

A. The Agency shall submit monthly client, service, and financial data reports as follows.

- MSR clients through monthly batch submissions and items noted below (i).
- Non-MSR clients through form supplied by DMH and e-mailed to DMH respite contact person no later than 30 days after the first of each month. [See [Respite Report Form](#)]

i. Client data

- 1. All types of respite
 - a. # of individuals on waiting list due to:

- i. lack of worker
 - ii. lack of funding
 - b. average length of time on list for those currently waiting
- 2. Family/staff specific request respite
 - a. # of families served

ii. Service data

- 1. MSR and non-MSR clients receiving family/staff specific request respite
 - a. \$ spent
 - b. type of units provided
 - c. # of units provided

iii. Financial data

- 1. For MSR clients, the agency shall utilize the **Respite Cost Center (#7)** to report all costs associated with the program. The only exception is for ISBs and Enhanced Family Treatment (formerly called Waiver) at WCMH, NKHS, and NFI which may report respite to the ISB cost center (#22) as appropriate.
 - a. report **Direct Service Costs**
 - i. respite workers' wages, benefits, and travel
 - ii. activities fund for respite recipients. This does not include activity funds for respite workers.
 - b. report **Administrative Costs**
 - i. % of allocation determined by DMH to cover rent, heat, etc.
 - c. report **Operating Costs**
 - i. respite Coordinator's salary, benefits, and travel
 - ii. respite workers' recruitment and training costs
- 2. For non-MSR clients receiving family/staff specific request respite funds, expenditures are reported on monthly report form supplied by DMH and e-mailed to DMH respite contact person no later than 30 days after the first of each month. [See [Respite Report Form](#)]

VI. Suggested Best Practices

- A. Agencies provide respite workers with a manual on the program. Respite Coordinators, Directors of Children's Services, and staff from the Child, Adolescent, and Family Unit supply a manual which may be used as is or adapted by each agency.