VERMONT2008

Success Beyond Six

Report to the Legislature on **Act 35 2007 (ADJ) Session**
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TABLE OF CONTENTS

Success Beyond Six
Executive Summary

In May 2007, the Senate Appropriations Committee called for the creation of a study committee to examine Vermont's school-based mental health services with the following charge.

The secretary of the agency of human services and the commissioner of education shall convene a summer study group to ensure that expenditures in this area utilize best practices, yield positive outcomes, and are managed to a predictable rate of growth.

(1) This study will result in recommendations regarding:

(A) Mechanisms for managing Success Beyond Six services in a capped Medicaid environment to ensure the effective delivery of services to school-age children and controlled growth;

(B) Prioritizing Success Beyond Six populations and/or services for growth within the constraints of the waiver cap. This will include exploring whether prevention and mental health wellness programs can or should be funded within this model;

(C) Decreasing administrative burdens of service provision where ever possible.

In the beginning of his first term, President Bush commissioned a study on the state of mental health services nationally. The resulting *New Freedom Commission Report* calls for a transformation in the delivery of mental health services in this country and highlights the importance of providing mental health services through schools. School-based mental health services are widely recognized as improving students' access to care and improving educational achievement for students with special needs.

Vermont has been actively developing its partnerships between mental health, education, and students and their families under the Success Beyond Six (SBS) fiscal mechanism since its official start in December 1992. This voluntary development is driven by local needs and the desire to help students with an emotional disturbance succeed in school. In FY2007, fifty-four of Vermont's sixty Supervisory Unions had Success Beyond Six contracts with their region's community mental health center. Together they hired and supervised 556 full time equivalent staff to provide services to 3,855 students using 40% general funds from education to draw down 60% federal Medicaid funds. The total program expended $30,181, 957. Fifty-seven percent of these students, especially those covered by Part B of the 2005 IDEA Interagency Agreement between the Department of Education and the Agency of Human Services, also receive other non-school related services from the local mental health center funded by the Department of Mental Health and the Agency of Human Services. [See *Table 1*, page 4.]

We have learned much in the past 15 years about how community mental health agencies and school systems, despite their different cultures, can work collaboratively for the benefit of students and families in their communities. Research has demonstrated that bringing mental health services into the school environment reflects best practice as a service delivery model. This knowledge has informed the following recommendations on how to make Success Beyond Six programmatically and financially sound for the future.

Recommendations and Plan

Since the inception of Success Beyond Six, the Department of Mental Health has controlled growth by developing programs based on the amount of state general fund dollars that schools

invested. Going forward, growth will be controlled within the limits of the federal Medicaid cap in addition to a state general fund cap. While the specific parameters have changed, controlling growth is not a new role for the Department of Mental Health. As it always has, the Department will work within its allocation and not approve any contract above that amount.

Success Beyond Six programs and students served can be grouped into three major population areas. These three categories inform the structure of the full report as the implications for the numbers needing and receiving services, the types of services contracted for, the outcomes desired, and the average per pupil cost are significantly different in each category. Our four major recommendations below reflect these categorical differences.

Table 2.

In FY07 Success Beyond Six divided its resources among three populations:	**Actual # Served**	**Estimated Average Per Pupil Cost**
1. any students who have mental health issues	1,966	$4,100
2. students in Special Education who have an emotional disability	1,832	$10,300
3. students in Special Education who have intensive needs on the autism spectrum	57	$54,000 per year

In addition to working within the federal Medicaid cap, we have four recommendations outlined below. In 2008, the Agency of Human Services (AHS) and the Department of Education (DOE) will:

1. Capitalize on the Positive Behavioral Supports (PBS) model for all students

While the Vermont PBS implementation just began in the fall of 2007, over 50 schools are already demonstrating interest. National data from the 42 states in which PBS has been implemented show that this broad based prevention and early intervention approach creates significant improvements in school climate resulting in a marked reduction in disciplinary incidents and more effective use of intensive services such as those in Success Beyond Six. DOE has provided funding for schools to begin implementation with five trained and active coaches available statewide. DOE and DMH will vigorously study the Vermont schools applying the PBS model in relation to the kinds of SBS services needed to perform effective secondary and tertiary interventions. Based on national research findings, we expect that PBS will have a profound effect on the ability of schools to successfully work with students who exhibit problem behaviors and thus more clearly delineate what is needed from DMH for secondary and tertiary interventions. As this data on Vermont schools becomes available, we will take further steps toward providing standards and incentives for these practices.

2. Define quality standards for the behavior interventionist position used with students in special education who have an emotional disturbance

Establish an *ad hoc* group to define standards for the use, training, practice, supervision, and outcomes of Behavior Interventionists. As a key component of the SBS work with students in Special Education who have an emotional disability, it is important to assure schools and students, wherever they live in Vermont, are receiving a clearly defined, quality service capable of achieving desired outcomes in accordance with the 2005 Part B of the IDEA Interagency Agreement between DOE and AHS.

3. Promote Vermont's current evidence based practice (EBP) model to benefit students who have a diagnosis of autism spectrum disorder.

The EBP model in Vermont's four autism collaborative programs funded through Success Beyond Six is intensive and has a high per pupil cost. However, it achieves significant short-term results for students with very high needs and sets these students on the path to improved long-term outcomes. We recommend that Success Beyond Six continue to fund the four autism collaborative programs it currently funds. In order to control costs, we also recommend that Success Beyond Six suspend funding new programs without additional revenue sources.

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4. Improve administrative processes:

Develop Success Beyond Six from a local mechanism into a statewide program that will provide:

a. standards for contracts;
b. statewide outcomes;
c. more adequate financial mechanisms; and
d. standards for supervision and training.

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Table 1: **Services to Success Beyond Six (SBS) Clients In Vermont Children's Mental Health Programs FY2006**

Fifty-seven percent of students served through Success Beyond Six, especially those covered by Part B of the 2005 IDEA Interagency Agreement between the Department of Education and the Agency of Human Services, also receive other non-school related services from the local mental health center funded by the Department of Mental Health and the Agency of Human Services.

Success Beyond Six Services to SBS Clients		
Type of Service	**Students Served**	**% of Total Students Served**
Service Planning & Coordination	3,155	78%
Community Supports	3,441	85%
Clinical Interventions	1,680	42%
Consultation, Education, & Advocacy	623	15%
Total SBS Clients [unduplicated]	**4,037**	
Other Services to SBS Clients Funded by DMH/AHS		
Type of Service	**Students Served**	**% of Total Students Served**
Service Planning & Coordination	1,883	47%
Community Supports	1,499	37%
Clinical Interventions	297	7%
Consultation, Education, & Advocacy	170	4%
Total SBS Clients also receiving other services funded by DMH/AHS [unduplicated]	**2,309**	**57%**

INTRODUCTION AND CHARGE

The Senate Appropriations Committee called for the creation of a study committee to examine Vermont's school-based mental health services in May 2007. The study charge follows.

> *Success Beyond Six is a fiscal mechanism that allows local schools and local designated agencies for community mental health services to enter into contractual relationships for school-based service provision supported in part through state-approved Medicaid billing in the department of health – mental health division. This fiscal mechanism has reduced the schools' cost in providing these services by up to 60 percent. To date, however, these contracts have been approved conditioned on compliance with Medicaid rules and general fiscal management, not specifically on best practice, efficiency or outcome models. Under Vermont's Global Commitment for Health Waiver, Medicaid is no longer an unlimited funding stream; rather it must be managed to a fixed capped amount. The secretary of the agency of human services and the commissioner of education shall convene a summer study group to ensure that expenditures in this area utilize best practices, yield positive outcomes, and are managed to a predictable rate of growth.*
>
> *(1) This study will result in recommendations regarding:*
>
> *(A) Mechanisms for managing Success Beyond Six services in a capped Medicaid environment to ensure the effective delivery of services to school-age children and controlled growth;*
>
> *(B) Prioritizing Success Beyond Six populations and/or services for growth within the constraints of the waiver cap. This will include exploring whether prevention and mental health wellness programs can or should be funded within this model;*
>
> *(C) Decreasing administrative burdens of service provision where ever possible.*
>
> *(2) A report on the recommendations and a plan for implementation by the agency of human services and department of education will be presented to the house committees on education and on human services and the senate committees on education and on health and welfare no later than January 15, 2008.*

This report is presented by the Department of Education and the Agency of Human Services in response to this charge.

School-based mental health services are widely recognized as improving students' access to care and improving educational achievement for students with special needs. In the beginning of his first term, President Bush commissioned a study on the state of mental health services nationally. The resulting *New Freedom Commission Report* (1) calls for a transformation in the delivery of mental health services in this country and highlights the importance of bringing mental health services into school settings. School based mental health services are particularly cited in helping to achieve two of the six goals in the report: "disparities in mental health services are

eliminated" and "early mental health screening, assessment, and referral to services are common practice." To reach these goals, the commission recommends that we "improve access to quality care in rural and geographically remote areas" [3.2] and we "improve and expand school mental health programs" [4.2]. School mental health programs offer increased accessibility to students by reducing many of the barriers to seeking care in traditional mental health settings. Further, there is evidence that school mental health programs reduce any lingering historical stigma around mental health, provide additional opportunities for students to generalize and practice progress made in treatment, and support education and mental health staff in promoting mental health for all students (2). The commissioner and the secretary support this concept for delivering mental health services to students in school settings. The commissioner and the secretary are also committed to ensuring that Success Beyond Six provides effective services within a Medicaid environment with controlled growth and is consistent with federal and state legal mandates.

We have learned much in the past 15 years about how community mental health agencies and school systems, despite their different cultures, can work collaboratively for the benefit of students and families in their communities. Research has confirmed that bringing mental health services into the school environment reflects best practice as a service delivery model. This knowledge has informed our recommendations on how to make Success Beyond Six programmatically and financially sound for the future.

In preparing the report, a representative group of stakeholders from the state and local levels was created and met four times to assist in the review of the current situation and to offer suggestions on how to respond to the legislature's charge. We deeply appreciate the knowledge, experience, thought, and time they contributed to this process. The members of this group are noted in Appendix 1 [page 33].

II. CHALLENGES

This study responds to several concerns. These concerns can be summarized by the need to establish state-wide program parameters to control growth in a capped Medicaid environment. Thus this report describes how, moving forward, the state will define the population(s) to be served, establish the best practices for each, track the statewide outcomes, and utilize efficient and effective administrative practices to implement the goals. Some of the concerns that we heard in the advisory group included the following list.

1. **Impact of Medicaid cap**.
   Before the advent of Vermont's Global Commitment Medicaid Waiver with the federal government, the Department of Mental Health managed the growth of Success Beyond Six by limiting the amount of state general funds available as match to draw down the then unlimited Medicaid funds. Under the Global Commitment Waiver, there is now a cap on the Medicaid funds as well.

2. **Concerns about the rising cost of special education and its impact on the property tax.**
   As school taxes rise and property owners are asked to pay more, citizens are looking at ways to control costs in areas such as special education. As part of each Local Education Agency's (LEA) responsibility to provide a free and appropriate public education (FAPE) to students up to age 22 who are eligible for special education, it must provide related services that enable a student to access that special education. Because "related services" can be so broad, there may be an overlap between the types of services that a school may have to provide as part of an IEP entitlement and the types of services that may be provided by an Agency of Human Services' department or division to a child who is eligible and which is within the department's existing resources. Success Beyond Six has reduced some of these costs currently paid for by Special Education by using the Department of Mental Health's federal Medicaid to pay for 60% of such medically necessary services. Federal IDEA's Part B (34 CFR § 300.154) states that the financial responsibility of non-education agencies (including the State Medicaid Agency) precedes the financial responsibility of the school district or Department of Education. [See Appendix 2, page 35.] Due to the overlap under related services, the definition of non-educational services can be unclear. Mental Health does provide services to 57% of Success Beyond Six students in Special Education that are not funded by education. [See Appendix 3, ii, page 52.]

3. **What are statewide outcomes of Success Beyond Six?**
   The contracts for Success Beyond Six are written locally by schools and community mental health centers in response to their changing needs in any given year. The Department of Mental Health authorizes these contracts to assure that they are financially sound and follow Medicaid regulations. Traditionally the contract's outcomes are established locally. A next step is to establish statewide outcomes for the program as a whole.

4. **Are we using best practices statewide?**
   In the past 15 years, the research on school-based mental health services has expanded both in Vermont and nationally. We now have more evidence about what works. A next step is to write standards, to endorse these practices throughout the state, and to design a process that keeps Vermont's standards current with emerging practices and research results.

5. **Are the services and supports dispersed equitably around the state?**
   Since all the services and contracts are driven by changing local needs and local working relationships, the types of services available in any geographic region at any point in time vary. The next step is to develop and implement a standard program of basic services that each community mental health center can offer to local schools.

6. **Possible impact of further federal threats on Medicaid in school and community agencies.**
   All states are faced with the possibility of significant revisions to the federal Medicaid program. The Centers for Medicare and Medicaid Services (CMMS) may decide to reduce the number of children eligible for Title XIX Medicaid (SCHIP), eliminate administrative Medicaid in schools, and/or restrict the use of funds for rehabilitation services. The impact of these proposed changes could be significant for Vermont. At the time of this report, the outcome is uncertain and Vermont needs to monitor these threats closely.

7. **Should we be doing more work on prevention, school climate, and teacher training?**
   Best practice literature on school-based mental health indicates that these activities are cost effective and positively impact the larger school population. We have not been able to deliver them to the fullest because of limitations on fee-for-service Medicaid regulations.

8. **What about those students not on Medicaid for whatever reason?**
   Success Beyond Six funding is based on Medicaid. Students who are not eligible for **and** who are not currently enrolled in Medicaid do not benefit from the 60% Medicaid financial subsidy for services. The cost of services for these students is 100% state education funds.

9. **Are we using the most efficient funding mechanism?**
   Vermont has always used a fee for service funding mechanism to pay for Success Beyond Six services. This means that funding is generated by each unit of service delivered. Each unit of service must be "medically necessary" and prescribed in an Individual Plan of Care for a Medicaid enrolled student. Progress notes must meet federal Medicaid standards. The mechanism has been cumbersome and inefficient in schools because of the classroom setting and the pace of a school day. It also does not pay for needed services such as training and consultation to groups of teachers and other services focused on addressing issues in or generally improving the school environment.

10. **Are contracts standardized enough?**
    The local contracts between individual schools and local mental health centers demonstrate variability regarding the types of services, the cost of services, the use of best practices, and expected outcomes. This is a natural result of changing local needs, availability of differing community resources, and the local history of the working relationship between the school and the community mental health center. Contracts historically have been written at the local level and approved at the state level only to assure that they conform to Medicaid financial requirements and to the overall objectives of Success Beyond Six. The next step is to develop a contract template that will address Success Beyond Six standards and still allow for changing local needs and creativity in meeting them.

III. BACKGROUND

History

Since the passage of Vermont's Act 264 in 1988, the Department of Education and the Agency of Human Services' Department of Mental Health and Department for Children and Families [formerly SRS] have been attempting to build an interagency system of care with each other and with families. Act 264 was in part a response to the frustrations experienced by families and these three major service providers. Under the legal mandates of special education and of child welfare and protection at the federal and state levels, any eligible child was (and is) **entitled** to receive all necessary services regardless of the agency's budget status. There is no comparable entitlement for children with mental health needs, and the Department of Mental Health has a small budget of general fund. Act 264 was originally drafted as a similar entitlement to services for a defined eligible population to make Mental Health an equal support to Vermont's children and adolescents. However, it quickly became clear that the bill would not pass the legislature due to cost implications. Therefore, the entitlement to services was deleted and the entitlement to coordination of care was kept.

Success Beyond Six was later developed to help reduce the cost burden to education and the state by tapping into the one significant financial resource mental health possessed: access to federal Medicaid funding to eligible Medicaid-enrolled students for medically necessary services. While this is distinct from giving mental health the general fund to serve all children who are eligible for mental health services and who are enrolled it Medicaid, it provided obvious benefits:

- students received improved access to needed mental health services; and
- the state used federal Medicaid funds for the remaining 60% of the cost.

Success Beyond Six was officially defined in a December 1992 policy memo by Governor Howard Dean and began official implementation in early 1993. It was *"intended to solidify and expand local partnerships among Vermont's 60 supervisory unions, local human service agencies, parents and community members in order to improve learning and behavioral outcomes for students" (3).*

Supervisory unions were first authorized to use funds to participate in the Success Beyond Six initiative in Section 166 of Act 60 of 1993, the state appropriate act. That section permitted each supervisory union to use up to $16,000 of funds eligible for matching federal funds or a great amount if agreed to by individual supervisory unions, the commissioner of education, and the secretary of human services. The section also required the services to be provided through a contract with community-based Medicaid providers. The form and substance of the contract was to be established as part of an overall agreement for the implementation of the program and executed between the commissioner of education and the secretary of human services.

The text of the authorization was repeated in each subsequent state budget bill through 1996. Beginning in 1997, the language was changed by removing the $16,600 limit. The language appeared that way in all subsequent budget bills through 2004. Subsequent budget bills have not included language on the subject.

In 1993 the articulated goals of Success Beyond Six were:

1. Enhance the capability of schools and communities to meet the needs of at risk students. This will ultimately help <u>all</u> students so they can be successful in the regular classroom.

2. Build and solidify a partnership between the local human service system and the 60 supervisory unions, making it easier for human services and school personnel to coordinate resources in better serving children and families.
3. Increase, coordinate, and focus all resources from all sources in order to best meet the prevention and treatment needs of children and families. (4)

In 1993 Success Beyond Six provided "state and federal resources to each supervisory union in collaboration with their respective Mental Health agency to:

- Enhance communities' capacity to support families through earlier identification and treatment of children;
- Provide staff and/or services to address the needs of children with emotional and behavioral problems who are experiencing difficulty in school;
- Assist with systemic change efforts for school improvement;
- Provide training and support for teachers and other school personnel to address the emotional and behavioral needs of these children; and
- Develop school prevention programs which reduce problem behavior in the classroom" (4).

In FY94, the initial spending authority for Success Beyond Six was $1.4 million. Today it is $30 million. The intent of the original collaboration allowed the parties to purchase whatever mental health service were deemed necessary and Medicaid eligible. This might be a fulltime professional who could provide a specific type of service for a number of students with similar issues (*e.g.*, anger management, social skills), or part-time services for a specific student who needed services to be able to access and benefit from the education being offered by the school (*e.g.*, counseling, intensive family based services).

At the same time there was an expansion of federal funding to children in Vermont as a result of EPSDT administration. The Vermont Department of Health administers the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Medicaid program. School districts are able to access federal Medicaid reimbursement for some of the administrative time of school nurses and guidance counselors. Participation in the billing of administrative services to EPSDT is an optional program for Vermont school districts and the state match rate is higher than in fee-for-service Medicaid. The EPSDT administrative program generates $3 million in federal revenue per year. The Vermont Department of Health retains 15% of the federal revenue to cover the costs of public health nurses in its district offices. The school districts may use these funds for a variety of preventative health services which may include the match for Success Beyond Six contracts (5).

The original guidance for contracts between local schools and mental health services (4) required the following:

1. a description of how the three goals of Success Beyond Six would be achieved;
2. a listing of the major activities and projected outcomes;
3. a description of the role and tasks of personnel or services;
4. how Success Beyond Six would enhance school improvement efforts;
5. a self-evaluation process to assess progress throughout the year;
6. an explanation of linkage with Success By Six efforts; and
7. a budget.

The evaluation for Success beyond Six was to be based on two outcomes:

- teachers report they are receiving more assistance in addressing the needs of children with behavioral problems in the classroom, and
- evidence indicates that human service providers and schools have developed a better system of care to support children and their families.

Today in 2008 (15 years later), we have exceeded the initial goals. In FY2007, local partnerships included fifty-four of Vermont's sixty supervisory unions (90%) and helped to improve the learning and behavioral outcomes for over 4,000 students. Statewide we have blended $30 million of state and federal revenue between schools and mental health centers. We have provided staff (556 Full Time Equivalents) and services to address the needs of children who have or are at risk of emotional and behavioral problems who are experiencing difficulty in school. [See Appendix 3, i, page 48.]

In summary, Vermont has exceeded its 1993 goals of enhancing the ability of schools and communities to meet the needs of at risk students; of solidifying a partnership between human services and schools; and of increasing, coordinating, and focusing all resources on the needs of students and their families. The influx of EPSDT and IEP Medicaid partnerships with schools has increased the growth of Success Beyond Six. The contracts continue to use the original format, and the two major outcomes continue to be achieved.

At the same time, the world has continued to change for students, families, and agencies. The signing of Vermont's 2005 Interagency Agreement under the IDEA's Part B [Appendix 2, page 35] has highlighted again the original structural difference between education and child welfare/protection and their partners in the interagency system of care. Special education and AHS child welfare and child protection are funded to provide entitled services to children in need (*i.e.*, to children in special education and in state custody). Mental health, developmental services, and alcohol and substance abuse do not share this legal mandate and, therefore, define children's eligibility based in part on available resources.

Current Process

There are sixty-nine different contracts with fifty-four (90%) of the sixty supervisory unions throughout the state. [See Appendix 3, i, page 48.] All contracts are established on the local level between a school district and its community mental health center. The process involves the following general steps.

1. The school district describes a behavioral health need in the school and collaborates with its community mental health center to define a position or program to address the need.
2. The school then transfers about 40% of the cost of the position or program to the mental health center in non-federal funds.
3. The mental health center sends the contract and the school district's state education fund money to the Department of Mental Health.
4. The Department of Mental Health uses these education funds as state match to draw down federal Medicaid funds as services are delivered.
5. Additional state education funds are necessary to serve students who are not enrolled in Medicaid.
6. The mental health center hires and supervises the Success Beyond Six staff and program in collaboration with the school.

7. The Department of Mental Health controls the growth of the program by monitoring the state's share to the federal authority. Each year the Department of Mental Health reviews all contract/grant applications and allocations to assure financial feasibility.
8. Program outcomes are evaluated locally by each school district and community mental health center.

IV. SERVICES PURCHASED AND STUDENTS SERVED

Services delivered with Success Beyond Six funds and students served can be grouped into three major population areas; these categories inform the structure of this report.

1. Services designed to assist all students and support a healthy school environment.
2. Services targeted to those students in Special Education with an Individualized Education Plan (IEP) for an emotional disability.
3. Services targeted to students in Special Education with an IEP for autism spectrum disorders.

The types of mental health services for which schools contracted with their community mental health center under Success Beyond Six in FY2007 for all students with mental health issues are grouped under the following broad headings.

Table 3

Service Type *[See Appendix 3 for description of service types.]*	**% of Total SBS Services**
Service planning and coordination	23%
Community supports: individual	52%
Community supports: group	4%
CERT [Concurrent with Education: Mental Health Rehabilitation and Treatment]	11%
Clinical assessment	1%
Individual therapy	5%
Consultation, education, and advocacy	3%
Alcohol and substance abuse: diagnosis and evaluation	1%

The following description of each program area shows how the services vary and how they also correspond to the original goals of the Success Beyond Six program.

1) Services designed to assist all students and support a healthy school environment

Since the early days of Success Beyond Six, schools have purchased Master's level trained clinicians to perform the role of *home school coordinator*. These clinicians provide individual group and family therapeutic supports in the school, home, and community. They serve any eligible at risk student and special financial arrangements are made for students not enrolled in Medicaid. Schools and students benefit from these arrangements in the following ways.

- Schools pay only 40 - 50% of the cost of the home school coordinator position.
- This lower cost allows the school to serve a greater number of students.
- The position allows for early intervention and prevention services for at risk students.
- Schools are able to tailor the types of services they need, changing it over time as the needs of students change.

- The home school coordinator provides a school-based mental health specialist who is knowledgeable about referrals to community resources and easily accessible to students and teachers.
- The home school coordinator can focus attention on strengthening the connection between the home and the school, fostering better communication and unified support strategies for the student.
- It is a position that can help to address issues of school climate.

The Medicaid funding stream imposes limits on the program. A significant limitation is the need to focus on Medicaid enrolled students. In addition, Medicaid does not reimburse for other valued services, such as teacher training, general consultation to school staff (*e.g.*, trauma-informed understanding of student behavior), prevention activities (*e.g.*, suicide prevention), and efforts to address school climate issues (*e.g.*, bullying, safety).

Even with these Medicaid funding limitations, **this program served 51% of students in Success Beyond Six in FY2007 at an average per pupil cost of $4,100.**

Currently the Department of Education is promoting an initiative called Positive Behavioral Supports (PBS). PBS is an evidence-based practice in education that a growing number of Vermont schools are choosing to implement because of its proven ability to prevent problems for students and schools. This study will propose how Success Beyond Six can be used to enhance these efforts. During the initial phases of implementation, the costs of PBS are covered by the Department of Education and the Local Education Agency (LEA). Services provided to students with more intensive needs may be funded through multiple sources including the LEA and Success Beyond Six.

2) Services targeted to students on an IEP for emotional disturbance.

A second important use of the Success Beyond Six funding stream has been to support children on an Individualized Education Plan (IEP) for emotional disturbance so that they can participate more fully in the classroom. The Interagency Agreement describes the overlapping responsibilities of education and the Department of Mental Health for providing these services. A variety of services are available from community mental health centers to schools for this population of students. [See Table 3, page 13]. Among these service options, a key element involves behavior support plans and behavioral intervention strategies.

Behavioral Interventionists in Vermont typically are specially trained mental health staff who offer services focused on helping students learn how to cope with their behavioral disability so the students can access and successfully complete their education. Different types of staff are credentialed at various levels including at an Associate's level, a Bachelor's level, a Master's level integration specialist, and a Master's level family worker. These positions are integrated on school teams working on issues of community supports, behavioral interventions, and family supports as part of each child's IEP. The behavior interventionist model also supports the intensive therapeutic staffing in alternative school programs for children with IEPs for emotional disturbance.

The next developmental task for this group of services is to standardize the best practices for the use of Behavioral Interventionists within the state. Vermont is known to be a leader in developing promising practices in this area. Because this service involves a high per student cost, it should be used in concert with the best practices in the general education environment. The Department of Mental Health and the Department of Education will convene a standards and best practice group to develop the training, professional, procedural, and policy standards for Behavior Interventionists.

This program for students in Special Education served 47.5% of students in Success Beyond Six in FY2007 at an average per pupil cost of $10,300.

One way to limit the growth in costs to this population is to reduce the need for specialized behavior intervention services. Data from other states show that the successful implementation of the evidence based educational practice of Positive Behavioral Supports in schools has the potential to reduce the number of students who need more intensive services to 20% or less (11, 12).

3) Services available exclusively to students on an IEP for Autism Spectrum Disorder.

In 1998, based on the demonstrated advantages of the Success Beyond Six partnerships, the Department of Education's Director of Special Education requested an exception to the original intent of Success Beyond Six which was to serve children with emotional disturbance. The request was to establish a service for several students with autism using the Success Beyond Six funding mechanism so that Medicaid funding would be available to help subsidize the cost of services to this new target group. Because of this expansion of the Success Beyond Six funding parameter, mental health is providing services to children with developmental disabilities.

Upon development of this agreement, a highly specialized, very intensive, evidenced based practice was implemented in Washington County; the program is called the Autism Collaborative. Later the model and the funding mechanism expanded to Chittenden County and Addison County and a program is just beginning in Franklin and Grand Isle Counties. Each child is provided one specially trained bachelor's level interventionist and a clinical autism specialist who develop and supervise the individualized plan. Most clinical specialists in this program are Board Certified Applied Behavioral Analysts.

Challenges in running this program include:

- finding and training highly specialized staff;
- paying for the very high per pupil cost;
- consistently providing the level of service intensity needed to produce the desired outcomes; and
- working with the current cumbersome billing mechanism.

These four Autism Collaboratives served 1.5% of students in Success Beyond Six in FY2007; the average per pupil cost per year was $54,000.

V. BEST PRACTICES FOR POPULATIONS SERVED

In order to assure the best outcomes for Vermont students and to assist in the cost effective allocation of AHS and education funds, the Success Beyond Six Summer Study Group worked to identify those practices with the strongest evidence of efficacy and feasibility targeted at each of the program and population categories of the Success Beyond Six school-mental health partnerships.

1. All Students

Positive Behavior Supports

Current Context

Fifty-one percent of students served in Success Beyond Six do not meet eligibility requirements for Special Education. Some of these students may have an identified emotional disability and receive accommodations according to a Section 504 plan. Schools under Section 504 operate much as mental health does. Both define students who are eligible for services, but both are constrained in providing services within available resources as they are not legally mandated to pay for them. In FY2007, the average per pupil cost for these 1,966 students was $4,100. Prevention, early intervention and supports for all students help to build resilience in individual students and good learning environments for all.

Vermont schools face many challenges today.

- There are continued reports of bullying, hazing, and harassment. For example, the *2007 Combined Incident Reporting Survey* indicates 1,849 reported incidents of this type.
- Vermont's high incidence of childhood poverty (6) contributes to educational achievement gaps among students with economic disadvantage and/or emotional/behavioral challenges (7);
- Vermont's rate of identification of students with emotional disabilities has increased over the last 10 years and, when reported in relation to other disability categories and general student population, is very high compared to other states (8).
- Based on national studies including the US Surgeon General's *Report on Mental Health (*9), it is estimated that during any given year:
  - as many as one in five (20%) children and adolescents (28,875 Vermont youth) will have a diagnosable mental-health or addictive disorder that has a negative effect on their well-being and/or ability to function in daily life;
  - 15,125 of these 28,875 Vermont youth will experience a significant functional impairment due to their disorder; and
  - 6,875 of these 28,875 Vermont youth will experience extreme functional impairment due to their disorder.
- In FY07, Vermont's public mental health system served 9,609 youth; 4,037 of these youth were served with Success Beyond Six funding. [See Appendix 3, ii, page 52.] Vermont data reveal these conditions include severe forms of illness such as schizophrenia, bi-polar, and major depression, as well as other conditions such as trauma, grief reaction, obsessive-compulsive disorder, panic attacks, childhood adjustment disorders, and attention deficit/hyperactivity disorder. Sometimes these disorders are observed in conjunction with alcohol and substance abuse.

- The rates at which Vermont schools include students with disabilities in mainstream school settings as reported by schools in *State Performance Plan Indicators* have been declining in recent years although inclusion remains a strong Vermont value and helps all students learn and practice important social skills.
- Vermont state education data for special education students shows the use of paraprofessionals as the primary solution for meeting the needs of students who are behaviorally challenged has increased over the last ten years with increasing costs to schools and the Agency of Human Services.

Recommended Priority Solution

Considerable emphasis has been placed in recent years on the importance of integrating mental health into the educational environment and in defining known best practice in the area of school mental health (1, 2). The evaluation of practices indicates that the following components and characteristics are positively correlated with good educational outcomes.

- *Coordinated service planning*:
  Students and their families benefit from coordinated service planning between professionals such as educators and mental health staff. One clear plan with strategies that work together toward common goals is much more likely to succeed than multiple plans unknown to other service providers listing a multitude of goals and potentially conflicting strategies to achieve them. The Act 264 process in Vermont is an example of coordinated service planning.

- *Comprehensive systems of support*
  Such a system promotes resilience, early identification and intervention, and provides more intensive services if needed.

- *Tiered models of prevention and early intervention as adapted from the public health model*
  This approach provides universal services to everyone in the community, more targeted services for those who are at risk, and intensive services to those who need them. There is an inverse relationship between the number of people targeted and the cost per person as the tiers climb from the entire population at a low per person cost to the treatment subgroup at a higher per person cost.

The Centers for Disease Control (CDC) define a coordinated school health model as the most effective for holistically addressing the needs of all students (19). A coordinated school health approach includes:

1. improved access to health, mental health, and substance abuse services for students and families,
2. greater ability to identify those students who are at risk (for suicide for instance) whether or not they exhibit outward signs of disturbance,
3. diverse opportunities to observe students for educational needs,
4. reduced inappropriate referrals to special education, and
5. a resulting positive impact on students' social, emotional, and academic experience.

School-wide positive behavior supports (PBS) continues to gain national and international recognition as a model known to effectively incorporate the key elements defined above. PBS has been in existence for nearly 20 years and clearly supports three of the six goals in the *New*

Freedom Commission Report (1). Currently, 42 states are engaged in a State-wide effort for implementing PBS and over 6,600 schools nationwide are known to have implemented PBS with fidelity to the model. Additionally, the U.S. Department of Education sponsors national PBS centers in Oregon and Connecticut, and the May Institute is a National Center Partner (10).

The outcomes of successful PBS implementation include significant reduction in discipline referrals including suspensions, expulsions, and drop-outs and a corresponding increase in levels of academic achievement. In addition, PBS strategies result in improved measures of school safety, positive culture, and positive school climate. These changes create related cost savings and the realization of increased instructional time. Within 1-2 years of implementing PBS, research has shown that most schools see a 25-60% reduction in office discipline referrals, in and out of school suspensions, expulsions, and drop-outs. Using a conservative measure, national estimates equate each referral to 45 minutes of student time out of class, 10 minutes of teacher instructional time to process, 20 minutes of administrator time to process. As an example, in a data analysis of 44 schools implementing in New Hampshire, recovered time after implementing PBS equaled 2,823 days for learning, 591 days for teaching, and 1,263 days for leadership/administration (11).

Additionally, the reduction in students who are identified as needing intensive interventions for emotional and behavioral problems helps reduce the demand for special education and mental health professionals. Specific school data varies, but it is not uncommon to see schools over a 1-3 year period go from having 30-40% of students needing targeted and individualized planning and interventions to having 15-20% of students in need of that level of support. Additionally, there is research to support a resultant reduction in out-of-district placements for students with intensive emotional and behavioral needs. The potential cost savings in these areas is considerable when taking into consideration the high cost of services at those levels (12, 13).

Description of the Model: Positive Behavior Supports

The principles of PBS emphasize prevention, providing a continuum of behavior support for all students, understanding human behavior, application in real school environments, continuous improvement, and systemic organizational change (14, 15). PBS can best be characterized as a problem solving and action planning framework through which school leadership teams:

1. review information or data about their school,
2. develop measurable and realistic short and long-term objectives and outcomes,
3. select practices that have demonstrated efficacy in achieving those outcomes, and
4. establish systems to enable adaptation of practices and preparation of implementers for the most effective, efficient, and relevant use of those practices (15).

Much of the success of PBS is predicated on the formation of a school leadership team that represents the students' entire support team including teachers, administrators, mental health practitioners, parents, support staff, community members, and of course, students themselves and on gaining school-wide support for this systems change effort prior to implementation (7). Success Beyond Six workers are already involved in similar teams and would be logical members of these new teams.

In short, PBS changes the way schools respond to all students. This positive school environment:

- improves student behavior by actively teaching and reinforcing desired behaviors,

- reduces triggers,
- eliminates inadvertent reinforcements for problem behavior,
- increases the presence of actively engaged adults,
- proactively defines expectations for adults and children, and
- provides frequent instances of recognition and positive reinforcement.

In a positive school environment, typically 80% of the students can be successful 100% of the time. This makes it clearer to school leadership teams which students are in need of additional support. A comprehensive planning effort can then be engaged around the needs of those students while maintaining the universally positive and proactive school culture for all.

Consistent with the Centers for Disease Control framework of a tiered approach to coordinated school health the national center for PBS (16) is designed with three levels of implementation:

- ***primary*****:** *prevention for all students*
  (reduce new cases of problem behavior),
- ***secondary****: targeted intervention for students needing more support*
  (reduce current cases of problem behavior), and
- ***tertiary***: *more intensive intervention for students with higher needs*
  (reduce complications, intensity and severity of current cases).

<u>Primary Prevention/Universal/School-wide Application for All Students</u>

"Primary Prevention involves system-wide efforts to prevent new cases of a condition or disorder. As a system-wide Primary Prevention effort in schools, positive behavior support consists of rules, routines, and physical arrangements that are developed and taught by school staff to prevent initial occurrences of problem behavior. We want to prevent the major 'behavioral earthquakes' that we hear about in the news: violent acts against teachers or other students, theft, bullying behavior, drug use, and the like. However, research has taught us that efforts to prevent these serious problems are more successful if the 'host environment'—the school as a whole—supports the adoption and use of evidence-based practices. Practices that meet these criteria include teaching and rewarding students for complying with a small set of basic rules for conduct, such as 'be safe,' 'be responsible,' and 'be respectful.' Some parents and educators believe that students come to school knowing these rules of conduct, and that those who don't follow them simply should be punished. However, research and experience has taught us that systematically teaching behavioral expectations and rewarding students for following them is a much more positive approach than waiting for misbehavior to occur before responding. Finally, the use of Primary Prevention strategies has been shown to result in dramatic reductions in the number of students being sent to the office for discipline in elementary and middle schools across the United States and Canada. In effect, by teaching and encouraging positive student behavior (*i.e.*, positive behavior support), we reduce the 'white noise' of common but constant student disruption that distracts us from focusing intervention expertise on the more serious problems mentioned above." (16)

<u>Secondary/Targeted Interventions for Youth Needing More Support</u>

"Secondary Prevention is designed to provide intensive or targeted interventions to support students who are not responding to Primary Prevention efforts. Common Secondary Prevention practices involve small groups of students or simple individualized intervention strategies. Secondary Prevention is designed for use in schools where there are more students needing

behavior support and for students who are at risk of chronic problem behavior, but for whom high intensity interventions are not essential. Secondary Prevention often involves targeted group interventions with ten or more students participating. There is a growing literature documenting that targeted interventions can be implemented by typical school personnel, with positive effects on up to 67% of referred students. Targeted interventions also are recommended as an approach for identifying students in need of more intensive, individualized interventions. Specific Secondary Prevention interventions include practices such as 'social skills club,' 'check in/check out' and the Behavior Education Plan" (16).

Tertiary Interventions/Individualized Behavior Support

"Tertiary Intervention was originally designed to focus on the needs of individuals who exhibited patterns of problem behavior. Research has demonstrated the effectiveness of PBS in addressing the challenges of behaviors that are dangerous, highly disruptive, and/or impede learning and result in social or educational exclusion. Tertiary Prevention is most effective when there are positive primary (school-wide) and secondary (classroom) systems in place. In addition, the design and implementation of individualized supports are best executed when they are conducted in a comprehensive and collaborative manner and, in Vermont, would usually be provided to students in Special Education. The process should include the individual with behavioral challenges and people who know him/her best all working together to promote positive change, all working as a behavioral support team (BST). Support should be tailored to people's specific needs and circumstances. It should involve a comprehensive approach to understanding and intervening with the behavior, and should use multi-element interventions. The goal of Tertiary Prevention is to diminish problem behavior and, also, to increase the student's adaptive skills and opportunities for an enhanced quality of life."

"Tertiary Intervention is focused on individual students and involves a structured assessment of their functional behavioral and learning needs followed by the development of a support plan comprised of individualized, intervention strategies based on the assessment's results. Possible strategies include:

- guidance or instruction for the student to use new skills as a replacement for problem behaviors;
- changes to the environment so that problems can be prevented and desirable behaviors can be encouraged; and
- procedures for monitoring, evaluating, and reassessing the plan as necessary.

In some cases, the plan may also include emergency procedures to ensure safety and rapid de-escalation of severe episodes (required when the target behavior is dangerous to the student or others), or changes in school placements in cases where more substantive environmental changes are needed" (16).

The PBS tiered prevention/intervention approach offers an evidence based framework for schools in which mental health and other specialty support services (health, substance abuse prevention and treatment) can be linked and coordinated across the broader school environment. It offers a framework for implementing effective prevention strategies and services targeted to individual students. The process of individualized assessment, treatment planning, interventions, and monitoring progress is consistent with medical and mental health approaches to individual care.

Current Status and Next Steps

Vermont schools began implementing PBS in February 2007. The Department of Education established the Assistant Division Director for the Student Support Team as the State PBS Coordinator. This individual collaborates directly with the National PBS Center directors, formed the Statewide PBS Leadership Team, and is responsible for coordinating the leadership effort and a management team of implementation coaches who have been trained to assist leaders in Vermont schools in implementing PBS.

There are 11 schools in the process of implementing PBS, 34 schools preparing to implement, and another 47 schools that have expressed interest in PBS with the possibility of implementing in their schools in 2008. The Department of Education considers statewide implementation of PBS a priority for Vermont's schools and has made BEST and Act 230 funds available to support this initiative. However, it is important to note that this is not a legal mandate.

A status report on implementation progress will be made to the Department of Education, the Agency of Human Services, and the Department of Mental Health in January 2009.

2. Students in Special Education with an Emotional Disability:

Behavior Interventionists

The majority of resources in Success Beyond Six are targeted to students who are in special education with a disability of emotional disturbance and who have an Individual Education Plan (IEP) with overlapping eligibility under mental health.

Current Context

In FY2007, Vermont had:

- 13,657 students in Special Education.
- 2,116 of the students in Special Education were in the category of emotional disability.
- 1,832 of this subset of students were served in Success Beyond Six with a variety of services.
- The average per pupil cost was $10,300.

Emotional disabilities can significantly impact a student's ability to access a free, appropriate, public education (FAPE) and as a result that student may need specialized education services. Some of these students will also meet eligibility under mental health. In many situations, mental health services can help support a student to learn in the classroom. Therefore, Individualized Education Plans often call for mental health services.

Schools may contract for a variety of services offered by designated agencies. [See Table 3, page 13.] Some of the services offered have an evidence base regarding their effectiveness (*e.g.*, clinical assessment, individual and group counseling, home/school coordination). Not all services have such a base, partly because children's mental health is a rapidly developing field and a limited number of practices have received the funding and focused attention necessary to earn the title of evidence based practice.

Recommended Priority Solution

The largest single category of growth in Success Beyond Six is the provision of individual behavior intervention services which, in the Vermont Department of Mental Health's Medicaid plan is called "individual community supports." We use the term *Behavior Interventionist* to describe mental health staff who provide 1:1 or small group assistance to students struggling with an emotional disability in a classroom or school setting. This position of behavior interventionist has been endorsed in practice by many schools choosing to contract for it even in the face of tight school budgets.

The role of behavior interventionist is not an evidenced-based practice. In Vermont, the role has been developed in variable ways depending on the needs of the students, the local school conditions, and the orientation of the community mental health center. While behavior interventionist services are highly valued by Vermont's schools and families, the service itself is variable from setting to setting in terms of training, credentials, supervision, and the activities performed.

The role of behavior interventionist can be integrated into the over-arching approach of PBS as described in the previous section of this report. Due to the significance of the position in

Vermont's current system of care and due to the degree of variability found in the training and expectations for this category of mental health staff, we recommend the application of a quality improvement process to the position of Behavior Interventionist.

Description of the Model: Current Practice for Behavior Interventionist

As an emerging practice at the grassroots level, variability is still a dominant feature of behavior interventionist services across Vermont's community mental health agencies and schools. Behavior interventionists may work with students with an emotional disability in Special Education in a mainstream education program or an alternative education program. Also, they may work with students not in special education who have a Section 504 Accommodation Plan.

The educational background of behavior interventionists may be an Associate's level degree or a Bachelor's level degree. Most are supervised by Master's level mental health staff who themselves have various levels of training in Applied Behavioral Analysis.

Some school contracts use behavior interventionists to provide one-to-one supports to individual students in classrooms; others use a behavior interventionist to support a small group of students (up to four students at one time). Complicating the picture is that schools also use other types of teacher's aides and paraprofessionals to provide supports to students in the classroom. The decision about when to use a *behavior interventionist* is made locally and is not based on consistent criteria. Similarly, there are no standard criteria to guide the decision about when to stop using a behavior interventionist on behalf of a student or students. Finally, because schools contract with each community mental health agency on a per student basis, no service specific outcome data has been collected state-wide.

Current Status and Next Steps

Success Beyond Six was not originally developed as a program, but rather as a funding mechanism. Over the fifteen years since its inception, it has developed in response to local needs, local leadership, and local resources. Now that it is to become a program responsible for ensuring the use of best practices and controlling growth, key elements need to be reviewed to assure standards of quality are defined and met. For the population of students with a special education disability of emotional disturbance, the emerging position of Behavior Interventionist has become a significant service choice and cost to schools. It is the logical place to begin this process.

We recommend the formation of a representative stakeholder group to define quality standards for the use of Behavior Interventionists. The workgroup should include representatives from the state departments of mental health and of education, local providers of mental health and education services, family organizations, and higher education.

The group will be charged with developing guidelines for statewide use in the following areas.

1. For whom, and under what circumstances, should a behavior interventionist be used (versus a para-educator, class room aide)
2. Define the linkage between behavior interventionists and those schools implementing PBS and those schools which are not.

3. Define the core competencies for Behavior Interventionists.
4. Define standards for training and experience in supervisors of Behavior Interventionists.
5. Define standards for the amount and type of supervision given to Behavior Interventionists.
6. Establish guidelines for student - provider ratios and other key practice elements.
7. Recommend standardized assessment protocols to guide the activities of behavior interventionists working with students and to evaluate the effectiveness of the interventions.
8. Define standardized evaluation processes to help determine when a student no longer needs intensive behavioral support.
9. Define what data on outcomes should be tracked at the local and state levels.

A report from the workgroup will be due to the Agency of Human Services, the Department of Mental Health, and the Department of Education by December 31, 2008.

3. Students in Special Education with Autism Spectrum Disorders

School-Based Treatment with Applied Behavior Analysis

Current Context

In Vermont and nationally, the number of children diagnosed with pervasive developmental and autism spectrum disorders is increasing dramatically. In 1990, Vermont community mental health centers served 26 students in mental health and developmental services programs with these diagnoses; by 2007, the number had climbed to 526 students. Because these are spectrum disorders, there is variability in the degree of severity individuals experience and, therefore, in intensity of need. However, for many of these students and their families, the therapeutic and support needs are intense. At this time, the responsibility for meeting these needs lies with Vermont LEAs and several divisions within AHS with the Department of Disabilities, Aging, and Independent Living (DAIL) as the lead AHS agency.

Vermont's school-based programs for students with pervasive developmental disorders funded by Success Beyond Six served 57 students in FY2007 or 1.5% of the students in Success Beyond Six. The average per pupil cost was $54,000 per year.

Recommended Priority Solution

Although the recent rapid increase in these diagnoses marks this category as an emerging population, autism has been studied for some time. There is an emerging body of research identifying evidence-based practices that yield positive outcomes (17). Vermont has developed four autism collaborative programs which have produced markedly positive short-term outcomes and potential significant long-term gains (18). Vermont's Higher Education Collaborative has been instrumental in developing the skilled workforce that these programs require. Because the practices used by these Autism Collaboratives have an evidence base and produce demonstrable positive outcomes, we recommended that any expansion of school-based autism programs use these practices.

The charge of the legislature is to control growth within the Success Beyond Six program. We believe that the current use of the Success Beyond Six program, even with modest increases in the number of students served can be supported within existing resources provided that:

- Vermont schools employ PBS for the general education population because evidence indicates that this will reduce the overall rise in the need for specific treatment services, including the need for *behavior interventionists* in special education;
- Vermont establishes a systematic framework for use of behavior interventionists based on best practice evidence available nationally and in Vermont; and
- funding for any new population or new programs (such as additional autism collaboratives) be found outside the existing Success Beyond Six funds.

It is hoped that the autism plan and proposal developed for the legislature will be a first step in comprehensive planning to meet the needs of this population.

Any emerging population will have an unexpected and rapid growth rate and potentially significant cost impact. Since such growth cannot be controlled in the short term, different funding sources will need to be found.

Description of the Model

Each of Vermont's autism collaborative programs funded under Success Beyond Six provides staff trained in the fields of Developmental Disability, Applied Behavioral Analysis, and Autism. Each program is coordinated by either a Master's or a Doctoral level clinician with mid-level graduate or near-graduate level clinicians. Treatments based upon Applied Behavioral Analysis focus on providing structured teaching experiences using positive reinforcement and pro-social skill development to support children in their home, educational, vocational, and community environments (18). As such, Vermont's autism model is clearly in harmony with the PBS model.

Each child's program could include the following elements:

- structured teaching experiences (*e.g*., discrete trial learning, verbal behavior training, independent work schedules, TEACCH models, picture exchange communication)
- an individualized behavioral plan to reduce maladaptive behaviors and increase pro-social behaviors;
- planning for generalization of skills;
- development of social skills, and
- development of vocational and independent livings skills for older children.

Each Autism Collaborative program includes the following components:

1. one to one support in home, school, community, and/or vocational environments by highly trained interventionists;
2. rotation of staff to promote generalization of skills across adults;
3. coordination of treatment with families in conjunction with their early childhood and school teams;
4. in-home family behavioral consultation and coordination if desired;
5. training for school personnel and families;
6. treatment components developed collaboratively with behavioral clinicians, autism spectrum disorder consultants, and others on each child's team;
7. monthly treatment team review of progress based upon behavioral and curricular data;
8. data-based decision making about treatment;
9. case management of the family's needs; and
10. consultation to teams supporting children with these diagnoses around the state.

Some variations to this basic model have evolved in each region to tailor services and supports to expressed unmet needs. However, consensus has developed that a program needs to become comfortable with the basic model before adding components.

At this point in time, approximately half of the 93 children who have been enrolled in an Autism Collaborative over the past ten years have been reintegrated into their schools or graduated. A recently completed evaluation (18) found that length of time in programs averaged 3 years, with younger children spending considerably longer periods of time in programming compared to older children. Upon discharge, 85% of the children returned to school with an individual assistant and consultation to support continuity of programming.

Positive outcomes were also evident within one year of programming:

- 64% of children demonstrated at least a 50% improvement in maladaptive behaviors;
- 41% of children demonstrated at least a 50% improvement in pro-social behaviors;
- 82% of families and 79% of school teams demonstrated improvement in their ability to support the identified children in the home and school; and
- 81% of children demonstrated generalization of skills to other environments.

Current Status and Next Steps

While we are building the evidence base for effective practices for students with an autism spectrum disorder, the level of unmet need for such services continues to increase. The legislature charged the Agency of Human Services and the Department of Education to explore several critical areas for system development. The Success Beyond Six Summer Study Committee included representation from the Act 35 committees and is looking forward to their findings.

Specific next steps for the Department of Education, the Agency of Human Services, and the Department of Mental Health include:

- coordination with Act 35 committee's findings;
- promotion of the community-based model that is currently working well in Vermont;
- continued funding at current levels of the 4 programs operating in FY2007; and
- suspension of additional Success Beyond Six funds for intensely specialized and high cost programs coupled with exploration of possible sources to fund and sustain effective models.

VI. ADMINISTRATIVE PROCESSES

In considering methods to effectively transform Success Beyond Six into a program from its original function as a funding mechanism, Vermont should develop common administrative standards and practices. In addressing the legislative charge to decrease administrative burdens of service provision where possible, the Study Group noted there are several areas that could benefit from focused attention and action. These include the following.

1. Develop an approach to assure service continuity even while a student may move on and off the Medicaid program. (This may happen if a family was not able to pay the premium.)
2. The Medicaid fee-for-service billing process does not cover all types of mental health services needed by schools.
3. The current Medicaid fee-for-service billing process does not fit well within the education culture and milieu and has administrative inefficiencies.
4. Support the need for the time required for clinical supervision and training for mental health staff in a manner consistent with the education culture and milieu.
5. Reduce variability statewide in students' access to school based mental health services and in the types of mental health services offered in schools.
6. Reduce variability statewide of the costs for services.
7. Develop a standard evaluation process to assure achievement of outcomes at the local and state levels.
8. Increase transparency regarding the contracting process for schools.

The next step is to convene a group of stakeholders to develop the Success Beyond Six program's:

1. standards for contracts;
2. statewide outcomes;
3. efficient financial mechanisms that match service needs within the school milieu; and
4. standards for quality supervision and training for mental health staff.

These common administrative standards and practices should also support creativity and flexibility between the local level partners as schools and community mental health centers focus on meeting the various needs of their students.

1. Standards for contracts

For a state-wide program, all parties should be assured of a common contract template that:

- encourages the use of evidence based and best practices,
- assures transparency of types and cost of services offered for purchase,
- lists the desired outcomes,
- describes the funding mechanisms and process to be used, including ensuring that non-educational agencies pay as required, and
- includes a standard evaluation feedback loop to assure program quality.

2. Statewide outcomes

As a state-wide program, Success Beyond Six units around the state need to share a limited number of outcomes beyond their locally determined outcomes. These state-

wide outcomes should be able to demonstrate that the program is effective and efficient and has satisfied customers in four areas:

- access to care,
- practice patterns within care,
- results of care, and
- program administration.

3. ***Efficient financial mechanisms***

Medicaid fee-for-service has provided the financial framework for Success Beyond Six historically. The committee needs to explore all aspects of funding going forward. For example,

- with the advent of Global Commitment Waiver, Vermont has the opportunity to explore funding mechanisms that fit the education milieu and the services needed; and
- explore possible expansion of bundled funding as used in CERT.

4. ***Standards for quality supervision and training of staff***

Quality supervision of mental health clinical staff is an essential component of quality care and good outcomes. Although clinical supervision reduces the amount of direct service time a mental health staff person can spend with students, only well trained and supervised clinicians can deliver evidence based practices. At this time, there is still a high degree of variability around the state about the professional training and experience for such supervisors, the number of staff per supervisor, and the type of supervision provided. Standards and core competencies need to be developed.

VII. SUMMARY OF RECOMMENDATIONS AND PLAN

Since the inception of Success Beyond Six, the Department of Mental Health has controlled growth by developing programs based on the amount of state general fund dollars that schools invested. Going forward, growth will be controlled within the limits of the federal Medicaid cap in addition to a state general fund cap. While the specific parameters have changed, controlling growth is not a new role for the Department of Mental Health. As it always has, the Department of Mental Health will work within its allocation and not approve any contract above that amount.

Success Beyond Six programs and students served can be grouped into three major population areas. These three categories inform the structure of the full report as the implications for the numbers needing and receiving services, the types of services contracted for, the outcomes desired, and the average per pupil cost are significantly different in each category. Our four major recommendations below reflect these categorical differences.

Table 1

In FY07 Success Beyond Six divided its resources among three populations:	**# Served**	**Average Per Pupil Cost**
➢ any students who have mental health issues	1,966	$4,100
➢ students in Special Education who have an emotional disability	1,832	$10,300
➢ students in Special Education who have intensive needs on the autism spectrum	57	$54,000 per year

In addition to working within the federal Medicaid cap, we have four recommendations outlined below. In 2008, the Agency of Human Services (AHS) and the Department of Education (DOE) will:

1. Capitalize on the Positive Behavioral Supports model for all students.
While the Vermont PBS implementation just began in the fall of 2007, over 50 schools are already demonstrating interest. National data from the 40 states in which PBS has been implemented show that this broad based prevention and early intervention approach will reduce the need for more intensive services such as those in Success Beyond Six. DOE has provided funding for schools to begin implementation with five trained and active coaches available statewide. DOE and DMH will vigorously study the Vermont schools applying the PBS model in relation to the kinds of SBS services needed to perform effective secondary and tertiary interventions. Based on national research findings, we expect that PBS will have a profound effect on the ability of schools to successfully work with students who exhibit problem behaviors and thus more clearly delineate what is needed from DMH for secondary and tertiary interventions. As this data on Vermont schools becomes available, we will take further steps toward providing standards and incentives for these practices.

2. Define quality standards for the behavior interventionist position used with students in special education who have an emotional disturbance.

Establish an *ad hoc* group to define standards for the use, training, practice, supervision, and outcomes of Behavior Interventionists. As a key component of the Success Beyond Six work with students in Special Education who have an emotional disability, it is important to assure that schools and students are receiving a clearly defined, quality service capable of achieving desired outcomes wherever they live in Vermont.

3. Promote Vermont's current evidence based practice (EBP) model to benefit students who have a diagnosis of autism spectrum disorder.

The EBP model in Vermont's four autism collaborative programs funded through Success Beyond Six is intensive and has a high per pupil cost. However, it achieves significant short-term results for students with very high needs and sets these students on the path to much improved long-term outcomes. We recommend that Success Beyond Six continue to fund the four autism collaborative programs it currently funds. In order to control costs, we also recommend that Success Beyond Six suspend funding new programs without additional revenue sources.

4. Improve administrative processes:

Develop Success Beyond Six from a local mechanism into a statewide program that will provide:

a. standards for contracts;
b. statewide outcomes;
c. more adequate financial mechanisms; and
d. standards for supervision and training.

VIII. APPENDICES

Appendix 1: Advisory Committee Members and Affiliations

Name	Affiliation
Biss, Charlie	Department of Mental Health Director, Child, Adolescent, and Family Unit
Quackenbush, Deb	Department of Education Interagency Coordinator, Student Support Team
Barker, Elizabeth	Hartford School District Special Education Director
Barrett, Stephanie	Legislature Associate Fiscal Officer, Joint Fiscal Office
Bauman, Todd	Northwestern Counseling and Support Services Director for Children's Mental Health
Bean, Brenda	Department for Children and Families Program Director, Child Development Division
Bruno, Claire	Department of Education Autism Consultant
Cimaglio, Barbara	Department of Health Deputy Commissioner, Alcohol and Substance Abuse
Collins, Jeanne	Burlington School District Superintendent
Curtin, Connie	Vermont Parent Information Center Executive Director
Hall, Heidi	Department of Health and Department of Mental Health Assistant Fiscal Operations Manager
Hartman, Michael	Department of Mental Health Commissioner
Haskins, Deb	Student Assistance Professionals Executive Director
Holsopple, Kathy	Vermont Federation of Families Executive Director
Johnson, Scott/ Hutt, Monica	Agency of Human Services Deputy for Field Services/Senior Field Services Manager
Knopf, Rae Ann	Department of Education Assistant Director, Student Support Team

Lutz, Carrie	Colchester School District Special Education Director
Maynard, Alice	Department of Mental Health Quality Management Chief for Children's Mental Health
McFadden, Clare	Department of Disabilities, Aging, and Independent Living Autism Specialist
McMains, Bill	Department of Mental Health Medical Director
Santarcangelo, Suzanne	Agency of Human Services Principal Assistant, Secretary's Office
Schelley, Margaret	Department of Education Assistant Director for Special Education Finance
Simonson, Catherine	HowardCenter Director for Child, Youth, and Family Services
Tanzman, Beth	Department of Mental Health Deputy Commissioner
Teitelbaum, Jeff	Fletcher Elementary School Principal
Thomas, Nancy	Washington Central Supervisory Union Assistant Superintendent/Director of Special Services
Wheeler, Carol	South Burlington School District School Counselor, Orchard Elementary School

Interagency Agreement with
Vermont Department of Education and
Vermont Agency of Human Services
Pursuant to Part B of the Individuals with Disabilities Education Act
June 2005

Errata Sheet available at
http://education.vermont.gov/new/pdfdoc.pgm_interagency/interagency_agreement_05.pdf.

TABLE OF CONTENTS

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, in accordance with applicable state and federal laws and policies. As required by the Individuals with Disabilities Education Act (IDEA), the agreement delineates the provision and funding of services required by federal or state law or assigned by state policy. 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 Disability, Aging and Independent Living (DAIL), Department of Corrections (DOC), and Office of Vermont Health Access (OVHA). It is intended that the agreement will provide guidance to human services staff and school personnel in the coordination and provision of services for students with disabilities.

MISSION/GUIDING PRINCIPLES

The DOE, the local education agencies (LEA) and AHS work together to assure that children and yo uth 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 §300.142[1] 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 whe n a conflict occurs.

In recognition of the importance of providing a smooth transition from education to adult life, transition services for eligible students will be community-driven, involve a comprehensive system including AHS, DOE, employers, the workforce system and youth and their families. These services will be provided with the intent to increase the number of youth with disabilities entering employment, further education, and independent or supported living.

[1] All statutory and regulatory citations in this agreement are to those in effect at the date of execution of the agreement and as amended thereafter from time to time. The statutory and regulatory citations in this agreement will be updated to reflect the IDEIA of 2005 and its implementing regulations.

AREAS OF AGREEMENT

I. COORDINATION OF SERVICES

A. General

The Department of Education and the Agency of Human Services and its member departments are committed to assuring that students with disabilities, ages 3-22, receive integrated services which allow them to receive a free and appropriate education and to grow and develop and reach their goals. The intent of this section is to extend, by agreement and by procedure, the provisions of 33 V.S.A. §§ 4301-4303 and 4305, to all children and youth who meet eligibility requirements under IDEA, who also are eligible for disability-related service delivery and coordination by at least one AHS department.

1. Coordinated Services Plan

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. The coordinated services plan includes the Individual Education Plans (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.

Special consideration needs to be given to transition-age youth. Specific transition planning must begin at the age required by federal and state law. (See page 4 for definition of transition services.) The LEA is responsible for identifying each child or youth in need of a transition plan and

arranging for appropriate team meetings. Also, the LEAs will collaborate with AHS on the annual survey which identifies students who will be graduating and may be in need of long-term supports.
Each child or youth and family has 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.
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 (see below) to address the situation.

When a team believes that a child or youth requires highly intensive services in residential care or intensive wrap-around services, the plan

shall be reviewed and approved by the Case Review Committee (see below), except as otherwise required by federal or state law.

2. Infrastructure

a. State Interagency Team

The DOE and the AHS commit to the existence and ongoing support of a State Interagency Team (SIT). The SIT includes a high level manager from the following departments and divisions within state government: DOE, Division of Mental Health(DMH), Division of Disabilities and Aging Services (DDAS), Division of Family Services (DFS), Division of Alcohol and Drug Abuse Programs (ADAP), Division of Vocational Rehabilitation (VR) and AHS Field Services as well as other units as determined by the Secretary of AHS. A family consumer representative will also be a core member of the SIT. The SIT is responsible for overseeing the development and maintenance of the system of care to address the needs of children with eligible disabilities, for assuring the consistent development of coordinated services plans, and to be part of the dispute resolution process outlined below.

b. Local Interagency Team

The DOE and the AHS commit to the existence and support of a system of Local Interagency Teams (LIT) in each of the 12 AHS regions in Vermont. Each LIT includes a special education director selected by the districts in that region, the local children's mental health director, the Family Services director, a family consumer representative, high level local leaders from developmental services and substance abuse, and a VR representative. Other AHS programs are represented as needed. The LIT supports the creation of a local system of care and assures that staff are trained and supported in creating coordinated services plans. They also play a role in dispute resolution as outlined below. The AHS Field Director and a designated

DOE staff person assure that the region has a highly functional team and is responsible for working with the team to solve funding issues. The Field Director is the key conduit to a High Risk Fund, managed through the Field Services Division.

LITs will assure that there is a structure to focus on the particular needs of transition-age youth to support transition from school to adult life. Adult agency providers would be included as needed including high level local leaders from adult mental health programs (CRT) and the Department of Employment and Training (DET).

Likewise, special attention must be taken to assure an appropriate process to address the needs of children ages 3 to 6. Such a process must include the Child Development Division.

5 of 14

c. Case Review Committee (CRC)
The SIT shall establish a Case Review Committee that will include representatives of the Family Services Division, DMH, DDAS, DOE, and a parent representative. Other units of AHS will be included as appropriate. The CRC meets regularly to review the recommendations of service coordination teams for intensive services including residential care and high- level wrap-around services. The purpose of the review is to determine if a child's needs require the proposed level of service. The CRC serves both as a control to assure the appropriateness of high cost placements in the least restrictive environment, and also as a consulting body for local teams, helping identify appropriate services and approaches for eligible children and youth with the highest level of need.

B. VR Transition Service Coordination for Students with Disabilities in Vermont's High Schools

1. VR Services for Students with Disabilities
VR is committed to the successful transition of young adults with disabilities from school to work or further education or training. VR is required under the Rehabilitation Act of 1973, as amended by the Workforce Investment Act of 1998, see 29 U.S.C. §720 et seq. and pertinent federal regulation, see 34 CFR §361.22; the IDEA, and pertinent federal regulation, see 34 CFR §§300.347 (b) and 300.348; and the Assistive Technology Act of 2004, see 29 U.S.C. §3001 et seq., to coordinate policies and procedures with education officials that facilitate the transition of students with disabilities from the receipt of educational services in school to the receipt of vocational rehabilitation services from the VR agency.

"Transition services" are defined as a coordinated set of activities for a child with a disability that (a) is designed to be within a results-oriented

process, that is focused on improving the academic and functional achievement of the child with a disability to facilitate the child's movement from school to post-school activities, including post-secondary education, vocational education, integrated employment (including supported employment), continuing and adult education, adult services, independent living, or community participation; b) is based on the individual child's needs, taking into account the child's strengths, preferences, and interests; and (c) includes instruction, related services, community experiences, the development of employment and other postschool adult living objectives, and, when appropriate, acquisition of daily living skills and functional vocational evaluation.

2. Early Identification and Follow-Along

A VR staff member will maintain at least annual contact with school personnel in each area school to ensure early identification of students in special education who may be eligible for vocational rehabilitation services. This early identification occurs at the age required by federal and state law and includes formal VR involvement in IEP/Transition Team meetings. VR will provide brochures to schools to be shared with students with disabilities and their families. Additionally, local Core Transition Teams will provide the VR Counselor with a forum to discuss projections of numbers of students who will need transition services from VR. Outreach activities by VR, such as visits with guidance counselors, will include ways to identify out-of-school youth and students at risk for dropping out of school. Outreach activities may also include meeting with families and students at their homes (or other settings at the choice of families and students).

The VR Counselor's role in this early identification is primarily counseling, guidance and assistance during the IEP/transition planning process. The Counselor may assist the individual, family members, and school transition team members in long-term planning for adult life. This planning may focus on post-secondary education, a job, a place to live after graduation and participation in the community.
Although VR's primary focus is to assist with vocational preparation, VR staff also serves as a resource for area schools regarding local community services and long-term supports.

3. Referrals to VR

Consultation should intensify when a student is four years from graduation. VR should initiate formal intake at least 18 months before the student is scheduled to graduate or exit from high school. Students at risk for dropping out or students with complex needs may be considered for earlier intake.

VR will not serve persons under age 18 without the permission of a parent, guardian, or legal representative unless they are emancipated.

Services may include counseling and consultation around the development of the Individual Plan for Employment (IPE) that is coordinated with the IEP. Services also may include assessment, job development, training and other paid services.

The IPE must be developed and written before the student leaves school.

4. Purchased Services

The VR Counselor shall make the IEP/Transition Team aware of the scope of VR services available, including financial assistance for post-secondary education.

As determined on an individual basis, VR may provide for assistive technology, (AT), services and devices for a VR-eligible student within 12 months of exiting school. The AT services must meet the following criteria: a) they are part of an IEP with coordinated transition goals, b) they are part of an approved IPE, and c) they are necessary to accomplish a successful transition to employment, post-secondary education or training.

During the student's Transition Year (nine months before exiting school), VR may support Employment Specialist services on a job site, which is expected to continue post-graduation. VR may pay for an Employment Specialist for up to twelve (12) months if ongoing supports have been negotiated with a long-term services provider (e.g., mental health agency, DDAS, private provider, or through the use of natural supports).

As determined by the Counselor and the VR Regional Manager, services may be provided prior to the last year in school if essential to the IPE goals and/or their development and there are no other funding options. As determined by the Counselor and the VR Regional Manager, other timelimited services may be purchased consistent with the comparable services and benefits requirement of 34 CFR §361.53. Examples include on-site job assessments, driver education evaluations or physical restoration services.

5. VR Transition Counselors

VR Transition Specialty Counselors work with many high schools in Vermont. At least one counselor is based on-site, serving one of the large st high schools in the state and the remaining counselors are on-site in schools multiple times per month. General VR Counselors serve adults as well as young adults in transition in the remaining high schools. VR school counselors who exclusively serve youth in transition provide a higher level of service and offer a higher level of expertise on transition issues and requirements.

6. Bridges to Self Sufficiency – Youth Benefits Counseling Program
It is often the accepted wisdom of high school special education staff, transition professionals and family members that youth with disabilities put their cash benefits and healthcare at risk by working. What is generally not well understood, is that there are some excellent work incentives built into these public benefit programs for youth who want to work and attend post-secondary education.

The Bridges Project makes benefits planning and other assistance available to every student with a disability of transition age in Vermont and provides accurate information to youth and their families on the impact of employment on all the federal and state benefits they receive. Benefits Counselors, located in each of the AHS district offices, are in the schools in their district on a regular basis, work with Special Education staff and attend transition planning/IEP meetings at the request of the student, family or school personnel. They conduct training for educators, students and families on benefits and work incentives. About half of Vermont's high schools routinely use the benefits counselors' expertise to assist students and their families. Benefits Counselors receive referrals from VR, community mental health agencies, community developmental services agencies, family services agencies, consumer advocates and families.

7. JOBS Program
The JOBS Program offers vocational services and intensive case management to high-risk youth with emotional behavioral disabilities in 11 of 12 AHS districts through a partnership between VR and the Division of Mental Health, the Division of Family Services and the Department of Corrections. The program serves high school drop-outs and those at high risk of dropping out and engages youth in non-stigmatizing employment services while providing a bridge to more intensive mental health and case management services.

8. Vermont Assistive Technology (AT) Project
The AT Project provides services to schools and students through the Assistive Technology Act of 2004 and through a formula grant from the Vermont DOE. Two certified staff provide the following AT services across the state as requested by school personnel: a) assistive technology evaluations, consultation and technical assistance to children with disabilities, enrolled in public schools; b) additional children's AT services are provided on a case-by-case basis, depending on level and need and intervention required; c) outreach, information and referral and tryout of equipment; and d) training and technical assistance to students, educators, other service providers and family members as teams.

II. FINANCIAL RESPONSIBILITY

A. General Statement

The Vermont DOE and AHS are committed to meeting financial responsibilities as required by law. The secretary of AHS and the commissioner of DOE will periodic ally review the financial responsibilities enumerated below, identify areas for improved programmatic and financial efficiencies, and develop strategies to meet financial responsibilities, including joint appropriations requests from the state legislature and negotiations with federal agencies.

1. Specific Funding Provisions for State-placed Students

In the circumstances listed below, financial responsibility for services otherwise considered special education and related services shall be as set forth in federal law, Vermont law, and/or existing memorandum of understanding as described below:

a) Services provided to state-placed students in residential facilities with approved schools or tutorial program, as defined in 16 V.S.A. § 11(28), with payment as described:

i. DCF, Family Services – Pursuant to 16 V.S.A. § 2950(b)(1) and 33 V.S.A. § 310, when a child is in the custody of the DCF, and DCF has agreed to the child's placement in a 24-hour residential facility with an approved educational program, the Commissioner of Education shall pay the education costs and the Commissioner of DCF shall arrange for the payment of the remainder of the costs. Except for short-term emergency or evaluation placements, prior approval of payment must be provided by authorized representatives of DCF and DOE for its respective portions.

ii. VDH, DMH, Child, Adolescent and Family Unit – Pursuant to 16 V.S.A. § 2950(b)(2), when a child is placed in a 24-hour residential facility by a designated community mental health agency and that placement has been approved by the Division, the Commissioner of DOE shall pay the education costs and DMH shall arrange for payment of the remainder of the costs. Except for short-term emergency or evaluation placements, prior approval of payment must be provided by authorized representatives of DMH and DOE for its respective portions.

iii. VDH, ADAP – For individuals placed by a licensed alcohol and drug counselor of a designated community mental health agency or substance abuse agency in an approved 24-hour residential substance abuse treatment facility located within Vermont, and who meet the DSM-IV criteria or its successor for substance abuse/dependence and the American Society of Addiction

Medicine Level III criteria for residential treatment, DOE will pay

for both general and special education tutorial services; ADAP, or its sub- grantee will pay for treatment, room and board. (Note: Substance abuse is not an IDEA-covered disability; this provision pertains to students otherwise IDEA-eligible who enter a substance abuse treatment residential program.)

b) Services provided to children residing in their homes and communities with payment as described:

i. DAIL, DDAS– DAIL, DDAS, serves children with developmental disabilities as defined in 18 V.S.A. §8722 and provides services pursuant to 18 V.S.A. §8725. DAIL, DDAS, pays for the developmental home or shared parenting placement for children who:

(a) are under 18 years of age and "grandfathered, following a regulatory change in 2001, and
(b) are at risk of entering a psychiatric institution and in which case, DAIL pays the state share.
In these instances where the child is receiving educational services in a district other than the district of the parent's residence, the costs for those services will be paid by the DOE pursuant to VSBE Rule 2366.7.2(1).
Prior approval of payment must be provided by authorized representatives of DAIL for its respective portion.

ii. VDH, DMH, Child, Adolescent and Family Unit
Local community mental health agencies provide mental health supports to children who would benefit from such services within available resources. Community mental health agencies receive funding on an annual basis from the DMH which pays for a portion of the costs associated with the provision of care to children with mental health disabilities. Depending on the type of service, the community mental health agency may fund the appropriate and necessary mental health services; to the extent that such services may also be considered "related services" pursuant to 34 C.F.R. §300.24, such services shall be provided consistent with 34 C.F.R. §300.142(b)(ii).

iii. VDH, Children with Special Health Needs (CSHN) program
Eligible children who meet program requirements may receive medically necessary services provided at the CSHN Clinic consistent with 42 U.S.C. § 1396b(c). Upon enrollment in CSHN, a CSHN team evaluates the child and issues a report that is sent to the child's family who in turn may send the report to the child's

11 of 14

school. The report may also be used at the LIT and SIT meetings. Pursuant to Vt. Code Rules 13 140 CVR 048, Cost-Share for Patients of AHS/VDH/CSHN Programs, all families with children

enrolled in the CSHN program are subject to cost sharing, as specified in the rule. For any service specified in an IEP, the school district may not require parents to incur an out-of-pocket expense such as the payment of a deductible or co-pay amount incurred in filing a claim for services specified in an IEP pursuant to 34 C.F.R. 300.142(e) and (g)(2).

a) Vocational Rehabilitation - For eligible students, VR will pay for
services to the extent that funds are available at the time the services
are needed, including assistive technology services and devices, that
are identified in an approved IPE in keeping with VR's order of selection for services that:[2]

i. are consistent with the Rehabilitation Act of 1973 and implementing regulations including but not limited to 34 C.F.R.§361.53; the IDEA, including but not limited to 34 C.F.R. §§300.5, 300.6, 300.347(b), and 300.348; the Assistive Technology Act of 2004, PL 108-364; and Vermont State Plan; and

ii. promote or facilitate the accomplishment of vocational rehabilitation goals and any intermediate rehabilitation objectives identified in the student's IPE to ensure the student's successful transition to employment, post-secondary education, or training within 12 months of the student's exit from school.

b) Medicaid – School-based Program – Financial responsibility for the School-based Medicaid program will be consistent with the "Interagency Agreement between AHS and DOE for School-Based Health Services" of November 2004 or any subsequent agreements replacing it. Pursuant to the IDEA, related services do not include services that must be performed by a physician, other than services for diagnostic and evaluation purposes.

c) Medicaid – OVHA – OVHA will pay for Medicaid-covered services to eligible individuals consistent with 42 U.S.C. §1396b(c) of the Public Health and Welfare law, and 34 C.F.R. §300.142(b)(1)(ii) of the IDEA. However, for the purposes of a 42 U.S.C. §1396n waiver, "habilitation services" shall not include special education and related services. For any service specified in an IEP, the school district may not require parents to incur an out-of-pocket expense such as the payment of a deductible or co-pay amount incurred in filing a claim

[2] Order of selection does not consider whether a student is on an IEP or not.

for services specified in an IEP pursuant to 34 C.F.R. 300.142(e) and (g)(2). Pursuant to the IDEA, related services do not include services that must be performed by a physician, other than services for diagnostic and evaluation purposes.

d) Community High School of Vermont (CHSVT), DOC – For students enrolled in CHSVT, the Department of Corrections' and the DOE's financial responsibility shall be assigned in accordance with 28 V.S.A. §120 and other relevant state and federal laws. A separate memorandum of understanding for CHSVT will be developed and signed by the commissioners of corrections and education to be incorporated into this agreement.

e) Woodside – For students who are in DCF custody and placed at the Woodside Juvenile Rehabilitation Center, DCF will pay for all costs of treatment, room and board, and education, including services required in an IEP, as required by 16 V.S.A. § 2948(n).

2. Other Funding Obligations

For all other services that may be considered special education and related services, financial responsibility will be assigned consistent with federal law including 34 C.F.R. § 300.142, state law and the following understanding:

a) DOE shall be responsible to ensure a FAPE to students with disabilities and LEAs shall be responsible to provide a FAPE.

b) The DOE will work with LEAs to maximize receipt of federal Medicaid dollars available for reimbursement of medically related services provided to Medicaid-eligible students.

c) The DOE will identify best practices concerning cost containment and
the provision of FAPE consistent with 16 V.S.A. §2959b. DOE will provide technical assistance in this area to LEAs.

d) The IDEA does not limit the responsibility of non-educational agencies from providing or paying for some or all of the costs of FAPE to children with disabilities. However, this shall not be construed to expand or otherwise alter state and/or federal law requirements imposed on any non-education agency.

3. Conditions and Terms of Reimbursement

If a non-educational agency fails to provide or pay for services for which they are responsible and which are also considered special education and related services, the LEA (or state agency responsible for developing the child's IEP) shall provide or pay for these services to the child in a timely manner. The LEA or state agency may then claim reimbursement for the services from the non-educational agency that was responsible for the

provision of the services and failed to provide or pay for these services and that agency shall reimburse the LEA or state agency in accordance with the terms of this agreement.

Pursuant to this provision, the AHS and DOE will develop joint procedures for reimbursement.

III. DISPUTE RESOLUTION RELATIVE TO THE IMPLEMENTATION OF THE INTERAGENCY AGREEMENT

Where the LIT is unable to resolve any of the issues pursuant to this agreement, a referral may be made to the SIT for resolution.

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

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 this agreement shall be construed to limit any existing substantive or procedural protections of state or federal law or regulations.

IV. QUARTERLY REVIEW

The Commissioner of DOE and the Secretary of AHS or their designees will meet at least quarterly to review existing data and evaluate the implementation of this agreement in order to improve the results for eligible children with disabilities and the operations of local and regional teams of educators and human services providers. Local and/or state teams may be asked to assist state agencies through provision of data on coordinated services plans and financial resources. The input of parents and other stakeholders may be solicited and considered. DOE and AHS will develop a plan for coordinated data sharing. This evaluation will be used to improve policies, procedures and planning and development activities.

V. NON-DISCRIMINATION

The parties shall comply with all applicable state and federal non-discrimination laws and regulations including the Americans with Disabilities Act, Section 504 of the Rehabilitation Act of 1973 and Vermont’s Public Accommodations Act.

VI. AMENDMENTS OR MODIFICATIONS

Any provision in this agreement may be rendered null and void by changes in federal or state law that prevent either or both parties from fulfilling the terms of the agreement. If

this circumstance should arise, each party agrees to notify the other as soon as reasonably possible.

14 of 14

During the term of the agreement, either party that is a signatory to this agreement may submit a written request to amend or modify this memorandum. When such a request is made, the parties shall meet without unnecessary delay to consider the proposed amendment.

VII. TERM

This agreement in its present form or as modified shall be effective as of the date of signing and shall remain in effect for five years. The agreement shall be reviewed annually by the parties and may be extended by the mutual written agreement of the parties. Prior to the expiration of the agreement the parties shall meet to negotiate and execute a successor agreement. In the event a successor agreement is not in place when this agreement is due to expire, this agreement will remain in effect until a successor agreement is concluded.

_____	_____
Michael Smith, Secretary	Richard H. Cate, Commissioner
Agency of Human Services	Department of Education
Date_____	Date_____

Approved as to Form:

_____
Assistant Attorney General

Appendix 3: Data

i. Success Beyond Six Contracts in FY2007

State FY 2007					
Success Beyond Six Contracts					
CMHC	**SCHOOL SUPERVISORY UNION**	**FTE**	**FY 2007 GROSS MEDICAID**		
Counseling Service of Addison County	Addison Central	6.00	$ 571,428.00		
	Addison Northeast	5.00	$ 297,523.00		
	Addison Northwest	7.50	$ 928,343.00		
	Neshobe	1.50	$ 87,509.00		
	Regional Collaborative	4.00	$ 206,510.00		
Subtotal CSAC		24.00	$ 2,091,313.00		
United Counseling Service	Southwest Vermont	1.00	$ 47,805.00		
(Bennington County)	Bennington Rutland	3.80	$ 171,578.00		
Subtotal USC		4.80	$ 219,383.00		
Howard Center for Howard Services	Baird School	26.61	$ 843,433.00		
(Chittenden County)	Inclusion Program	27.88	$ 1,672,395.00		
	Garvin School/Best Consortium	10.31	$ 429,736.00		
	Autism Spectrum Disorders Program	30.68	$ 1,659,387.00		
	Centerpoint School	9.39	$ 376,218.00		
	Stepping Stones	20.39	$ 1,082,900.00		
	School Services	48.16	$ 2,294,591.00		
Subtotal HCHS		173.42	$ 8,358,660.00		

Northwestern Counseling/Support	Franklin Northwest	3.00	$ 180,306.00		
(Franklin and Grand Isle Counties)	Franklin Northeast	2.30	$ 138,235.00		
	Franklin Central	1.20	$ 72,122.00		
	Grand Isle	1.00	$ 60,102.00		
	Franklin West	2.20	$ 132,224.00		
	Collaborative Achievement Team (CAT)	18.00	$ 972,997.00		
	Project Soar	15.00	$ 978,212.00		
	Project SOAR High School	6.00	$ 482,525.00		
Subtotal NCSS		48.70	$ 3,016,723.00		
Lamoille County Mental Health	Lamoille South	15.27	$ 732,243.00		
(Lamoille County)	Lamoille North	17.20	$ 1,164,580.00		
	Orleans Southwest	7.53	$ 453,177.00		
Subtotal LCMHS		40.00	$ 2,350,000.00		
Northeast Kingdom Human Services	Caledonia Central (Walden/Barnet)	0.18	$ 9,476.00		
(Caledonia, Essex, & Orleans Countries)	Caledonia North (Sutton/Lydon/Burke/Newark)	0.27	$ 9,855.00		
	Essex North (Canaan)	1.00	$ 57,283.00		
	Lyndon Institute	1.00	$ 42,496.00		
	NFI/Turning Points and Cornerstone	9.00	$ 410,807.00		
	Orleans Central	2.20	$ 72,435.00		
	Orleans Essex North	6.03	$ 341,956.00		
	Project High School	1.05	$ 41,702.00		
	St. Johnsbury	2.15	$ 72,516.00		
	Sutton	0.53	$ 17,881.00		
Subtotal NKHS		23.41	$ 1,076,407.00		

Clara Martin Center	EVA	14.00	$ 750,000.00		
(Orange County)	Orange East	1.00	$ 49,203.00		
	Orange Windsor	2.20	$ 93,485.00		
	OSSU	2.00	$ 98,407.00		
	RAP Wilder School	4.50	$ 260,000.00		
	Rivendell School District	2.00	$ 98,407.00		
	Windsor Northwest	4.80	$ 147,610.00		
Subtotal CMC		30.50	$ 1,497,112.00		
Rutland County Mental Healt	Addison/Rutland SU (Castleton)	1.00	$ 60,784.00		
(Rutland County)	Autism Program	4.00	$ 262,263.00		
	Benson	0.50	$ 29,471.00		
	Bowse Tapestry	1.00	$ 50,000.00		
	Danby	1.00	$ 66,309.00		
	Lothrup	0.75	$ 63,013.00		
	Neshobe	1.50	$ 126,026.00		
	Otter Valley	1.50	$ 124,269.00		
	Rutland Central SU (Proctor)	1.50	$ 126,026.00		
	Rutland City (CERT-Success Program)	12.00	$ 694,516.00		
	Rutland City Elementary	1.00	$ 60,784.00		
	Rutland City Summer Program	5.00	$ 58,123.00		
	Rutland Town Elementary	0.75	$ 63,013.00		
	Wallingford	1.00	$ 66,309.00		
Subtotal RMHS		32.50	$ 1,850,906.00		

Health Care & Rehabilitation Services	Brattleboro Area	28.00	$ 1,502,000.00		
(Windham & Windsor County)	Springfield Area	20.00	$ 1,084,000.00		
	White River Area	25.00	$ 1,298,000.00		
Subtotal HCRS		73.00	$ 3,884,000.00		
Washington County Mental Health	Barre City Schools	4.00	$ 373,323.00		
(Washington County)	Waterbury-Duxbury Schools	2.20	$ 110,442.00		
	Washington West	3.00	$ 110,442.00		
	Washington Central	12.00	$ 477,153.00		
	Washington Northeast	1.20	$ 163,459.00		
	Laraway School	18.50	$ 968,000.00		
	CHOICE Academy	17.00	$ 661,368.00		
	ACES Prograns	14.00	$ 844,596.00		
	Central VT. Collaborative Austism/PDD	17.40	$ 1,214,430.00		
	TAPAS Program	17.00	$ 776,217.00		
Subtotal WCMHS		106.30	$ 5,699,430.00		
Total		556.63	$ 30,043,934.00		

Appendix 3: Data

ii. Services to Success Beyond Six (SBS) Clients in Vermont Children's Mental Health Programs FY2006

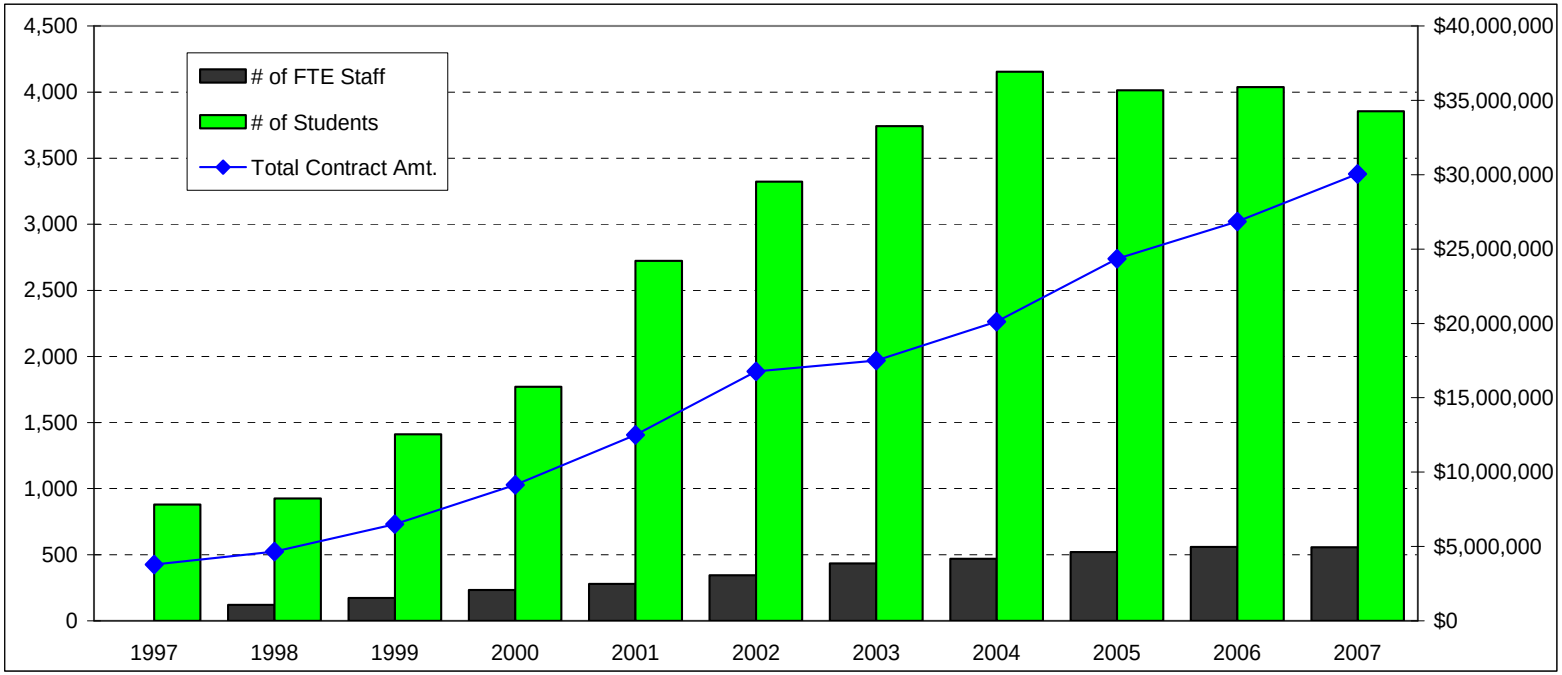
Fifty-seven percent of students served through Success Beyond Six, especially those covered by Part B of the 2005 IDEA Interagency Agreement between the Department of Education and the Agency of Human Services, also receive other non-school related services from the local mental health center funded by the Department of Mental Health and the Agency of Human Services.

Success Beyond Six Services to SBS Clients		
Type of Service	**Students Served**	**% of Total Students Served**
Service Planning & Coordination	3,155	78%
Community Supports	3,441	85%
Clinical Interventions	1,680	42%
Consultation, Education, & Advocacy	623	15%
Total SBS Clients	**4,037**	
Other Services to SBS Clients Funded by DMH/AHS		
Type of Service	**Students Served**	**% of Total Students Served**
Service Planning & Coordination	1,883	47%
Community Supports	1,499	37%
Clinical Interventions	297	7%
Consultation, Education, & Advocacy	170	4%
Total SBS Clients also receiving other services funded by DMH/AHS	**2,309**	**57%**

Appendix 3: Data

iii. Dollars, Number of Clients, and Number of FTEs: 1997 – 2007

Success Beyond Six
Staff, Students Served and Dollars Invested: 1997-2007



	Fiscal Year										
Number	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**
FTEs	0.0	120.1	173.1	233.4	278.7	345.5	433.9	469.6	521.0	559.1	556.6
Students Served	880	926	1,410	1,771	2,724	3,322	3,743	4,154	4,013	4,037	3,855
Total Contract Amount	$3,781,230	$4,670,589	$6,506,311	$9,142,183	$12,513,962	$16,770,880	$17,499,683	$20,118,737	$24,351,122	$26,851,625	$30,043,930

Appendix 4. Mental Health Service Definitions

Department of Mental Health

Definitions of Services Available through Success Beyond Six in 2007

Service Planning and Coordination

- **Service Planning and Coordination** assists individuals and their families in planning, developing, choosing, gaining access to, coordinating and monitoring the provision of needed services and supports for a specific individual. Services and supports that are planned and coordinated may be formal (provided by the human services system) or informal (available through the strengths and resources of the family or community). Services and supports include discharge planning, advocacy and monitoring the well being of individuals (and their families), and supporting them to make and assess their own decisions.

Community Supports

- **Community Supports (1)** are specific, individualized and goal oriented services which assist individuals (and families) in developing skills and social supports necessary to promote positive growth. These supports may include assistance in daily living, supportive counseling, support to participate in community activities, collateral contacts, and building and sustaining healthy personal, family and community relationships.

- **Community Supports (2)** are the same as (1) but are provided in a group setting.

- **Family Education** is education, consultation and training services provided to family members, significant others, home providers and foster families with knowledge, skills and basic understanding necessary to promote positive change.

- **CERT (Concurrent with Education: Mental Health Rehabilitation and Treatment)** is therapeutic behavior services concurrent to education (community support in a school setting). It assists individuals, their families, and educators in planning, developing, choosing, coordinating and monitoring the provision of needed mental health services and supports for a specific individual in conjunction with a structured educational setting.

Clinical Interventions are assessment, therapeutic, medication or medical services provided by clinical or medical staff, including a qualified clinician, therapist, psychiatrist or nurse.

- **Clinical Assessment** services evaluate individuals' and families' strengths, needs, existence and severity of disability(s), and functioning, across environments. Assessment services may include evaluation of the support system's and community's strengths and availability to the individual and family.

- **Individual Therapy** is a method of treatment that uses the interaction between a therapist and the individual to facilitate emotional or psychological change and to alleviate distress.

- **Family Therapy** is a method of treatment that uses the interaction between a therapist, the individual, and family members to facilitate emotional or psychological change and to alleviate distress.

- **Group Therapy** is a method of treatment that uses the interaction between a therapist, the individual, and peers to facilitate emotional or psychological change and to alleviate distress.

- **Medication and Medical Support and Consultation Services** include evaluating the need for, prescribing and monitoring medication, and providing medical observation, support and consultation for an individual's health care.

Consultation, Education & Advocacy

- **Consultation, Education & Advocacy** services are system-based work done with family and community groups to improve circumstances and environments for targeted DMH populations. These services may include community resource development. They are not provided in relation to a specific individual receiving services funded by DMH and are <u>not</u> funded through Medicaid.

Appendix 5: References

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