



State of Vermont  
Department of Mental Health  
Office of the Commissioner  
Redstone Building  
Montpelier, VT 05609-1101  
[www.mentalhealth.vermont.gov](http://www.mentalhealth.vermont.gov)

[phone] 802-828-3824  
[Legal] 802-828-2385  
[fax] 802-828-3823  
[tty] 800-253-0191

Agency of Human Services

## MEMORANDUM

**TO:** Vermont's Community Mental Health Centers

- Executive Directors
- Program Directors in Child and Family Services,
- Community Rehabilitation and Treatment,
- Adult Outpatient Services,
- Emergency Services, and
- Psychiatry
- Staff of all programs

All Stakeholders in Mental Health Services in Vermont

**FROM:** Mary D. Moulton, Acting Commissioner

**SUBJECT:** System of Care Plan, Fiscal Years 2012-2014

**DATE:** February 4, 2013

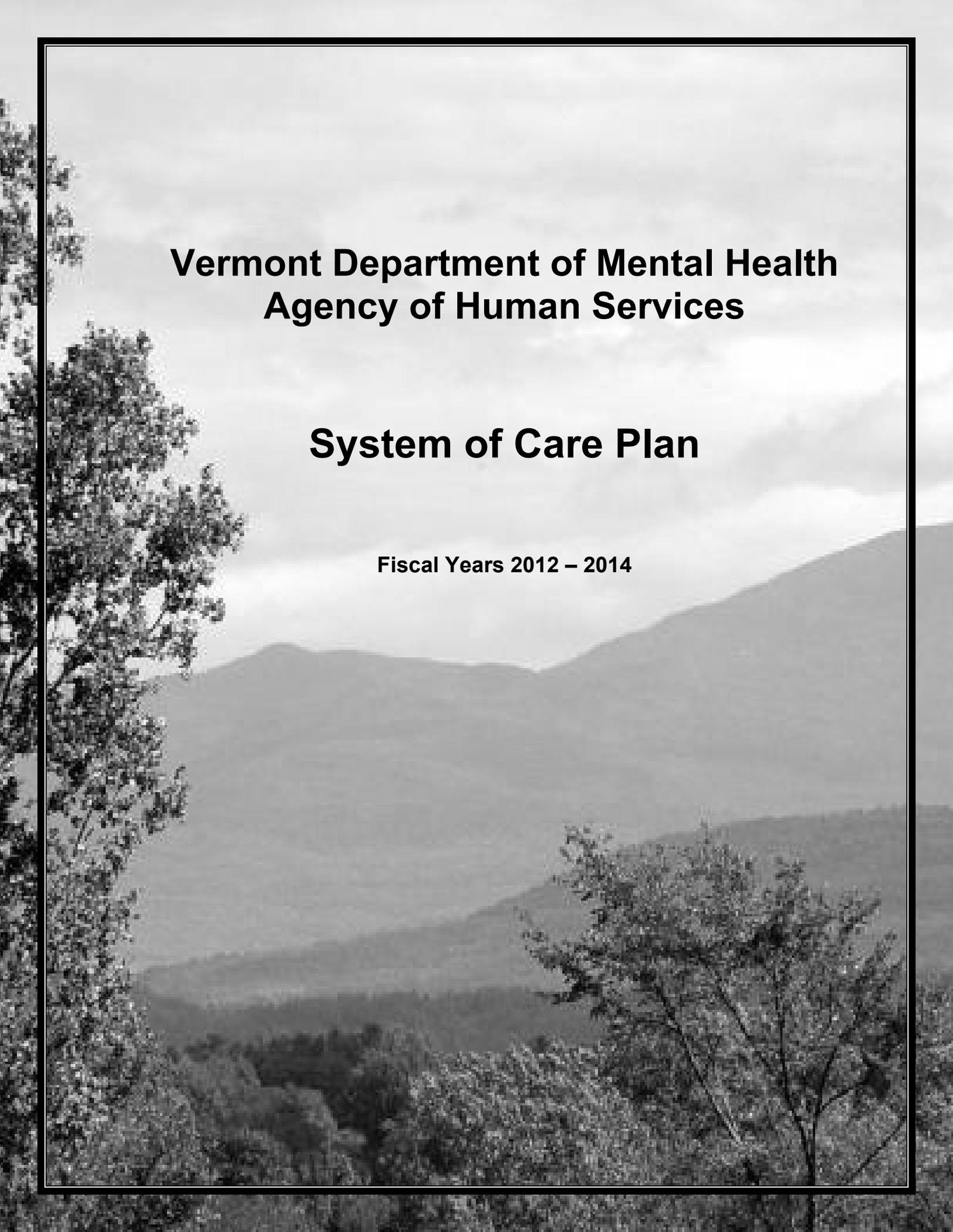
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I am pleased to present the Vermont Department of Mental Health's System of Care Plan for Fiscal Years 2012-2014. It is the first unified plan for services for children, adolescents, and families in emotional or behavioral distress and for adults with severe mental illness in addition to Adult Outpatient Services and Emergency Services. It is the most comprehensive and compact description currently available for the state's system of public mental health.

At the same time, readers will note the absence of information about huge efforts that have been going into system transformation on many levels after Tropical Storm Irene at the end of August 2011. DMH is already at work on an addendum that will encompass those developments and bring everyone up to date as soon as possible. In the meantime, please have a look at DMH's report to the legislature on the implementation of Act 79, *Reforming Vermont's Mental Health System*, January 15, 2013, on the Department of Mental Health's Website at:

[http://mentalhealth.vermont.gov/sites/dmh/files/legislative/2013/Legislative\\_Report\\_-\\_ACT\\_79\\_1-15-13.pdf](http://mentalhealth.vermont.gov/sites/dmh/files/legislative/2013/Legislative_Report_-_ACT_79_1-15-13.pdf)

Throughout this time of enormous change, it is important to take a deep breath, step back, and note that DMH has remained true to its vision that mental health will be a cornerstone of health in Vermont, with people living, working, learning, and participating fully in their communities. The mission is still to promote and improve the mental health of Vermonters.



**Vermont Department of Mental Health  
Agency of Human Services**

**System of Care Plan**

**Fiscal Years 2012 – 2014**



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## Purpose of Plan

This document is designed to provide all citizens a better understanding of:

- the vision, mission, and goals of the system of care;
- the components of the system of care;
- how the system serves Vermonters;
- how current resources from taxpayers and other sources are used;
- successful strategies meeting needs;
- unmet needs and strategies to address them; and
- indicators for system performance and outcomes for people served.

Readers will want to note that this three-year statewide *System of Care Plan* from the Department of Mental Health (DMH) is the first to combine Vermont's community-based programs for children and adolescents experiencing a severe emotional disturbance and their families with the state's community-based programs for adults (those with severe mental illnesses as well as those who are experiencing emotional or behavioral problems severe enough to warrant professional attention) and Emergency Services for individuals of any age in a mental-health crisis.

A copy of this document may be found at DMH's website:

[www.mentalhealth.vermont.gov](http://www.mentalhealth.vermont.gov).

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# Section I:

## The Vision:

### *Where We Want to Go*



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# Department of Mental Health

## **VISION**

Mental health will be a cornerstone of health in Vermont. People will live in caring communities with compassion for and a determination to respond effectively and respectfully to the mental-health needs of all citizens. Vermonters will have access to effective prevention, early intervention, and mental-health treatment and supports as needed to live, work, learn, and participate fully in their communities.

## **MISSION**

It is the mission of the Vermont Department of Mental Health to promote and improve the mental health of Vermonters.

## **VALUES**

We support and believe in the Agency of Human Services' values of respect, integrity, and commitment to excellence and express these as:

### **Excellence in Customer Service**

- People receiving mental-health services and their families should be informed and involved in planning at the individual and the system levels.
- Services must be accessible, of high quality, and reflect state-of-the-art practices.
- A continuum of community-based services is the foundation of our system.

### **Holistic Approach to Our Clients**

- We can promote resilience and recovery through effective prevention, treatment, and support services.
- Integration of mental health care with substance abuse and physical health care providers across public and private systems is essential for optimal outcomes.

### **Strengths-Based Relationships**

- It is important to foster the strengths of individuals, families, and communities.

### **Results Orientation**

- Strong leadership, active partnerships, and innovation are vital strategies to achieve our mission.
- We are accountable for results.

## DESIRED OUTCOMES IN FOUR QUALITY DOMAINS

### ☐ **Access**

Core services are available to individuals and families in need.

### ☐ **Practice Patterns**

Services provided are appropriate, of high quality, and reflect current best practices.

### ☐ **Outcomes/Results of Treatment**

The quality of life for consumers will improve.

### ☐ **Structure/Administration**

Designated Agencies will be fully functional and have strong working relationships with the Department, families, and other stakeholders.

The Department will forge new working relationships with public and private health care providers and insurers to build an integrated health care system for all Vermonters.





## Section II:

### The Reality:

### *Where We Are*



#### **A. Structure: Who We Are**

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## A. Structure: Who We Are

### 1. The Department of Mental Health

The Vermont Department of Health's (VDH) Division of Mental Health became a separate department of state government again on July 1, 2007. It remains within the Agency of Human Services. After returning to the department's original site in Waterbury in December 2009, the Child, Adolescent, and Family Unit relocated once again to temporary VDH offices in Burlington while most other central office staff went to the Redstone Building in Montpelier after Tropical Storm Irene struck and did extensive damage to the State Office Complex in Waterbury at the end of August 2011. The current Commissioner of the Department of Mental Health is Patrick Flood; the Deputy Commissioner is Mary Moulton.

As restored by Act 15, the Department of Mental Health (DMH) has a broader legislative mandate than it had when it was the Department of Developmental and Mental Health Services.

- DMH now has responsibility for coordinating services for mental health, physical health, and substance abuse across both public and private health-care delivery systems in Vermont.

DMH retains its previous responsibilities to:

- maintain and improve a system of care for children and youth experiencing a severe emotional disturbance and their families and for adults with severe mental illness;
- operate the Vermont State Hospital (VSH), but, with the evacuation of the State Hospital during Tropical Storm Irene on August 28-29, 2011, the system began to evolve in ways that could not have been foreseen before that cataclysmic event.
- provide leadership and direction for the public mental-health system; and
- conduct program and service monitoring and assessment to:
  - assure adherence to state and federal regulations and
  - manage the quality of mental-health services and supports delivered by the state's designated agencies (DAs), also known as community mental health centers, and the single Specialized Service Agency (SSA) for children and adolescents and their families.

Under Act 79, signed into law by Governor Peter Shumlin in April 2012, the General Assembly gave DMH broad new responsibilities for "offering a continuum of community and

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peer services, as well as a range of acute inpatient beds throughout the state” after the evacuation of the Vermont State Hospital as a consequence of the destruction of Tropical Storm Irene. The legislation sets forth principles to guide the reform of mental-health care in the state, requires a number of specific new and/or improved services and tools to implement them, and envisions coordination across mental and physical health care systems and among various state entities under the umbrella of the Agency of Human Services. Under broader health care reform in Vermont, greater collaboration and integration of mental health and other health services are envisioned.

## 2. Partnerships

Partnerships are an essential strategy if DMH is to achieve its mission and vision. The interagency system of care for children and adolescents has a robust history of partnership with families, education, child welfare, vocational rehabilitation, and juvenile justice. Adult mental health has been working with alcohol and drug abuse providers around treatment for co-occurring disorders of mental illness and substance abuse, with public and private entities around housing initiatives, and with the Division of Vocational Rehabilitation to provide Supported Employment.

Three areas in which partnerships have been operating and which could benefit from increased focus include: physical health care providers, private health insurers, and the Department of Corrections.

- Under federal health care reform, the Vermont Blueprint for Health, and DMH’s charge under Vermont Act 15, there are many opportunities as well as beneficial reasons to work with physical health care providers to create a more integrated and seamless system of health care for Vermonters of all ages.
- In this period of severe financial constraints, it is in everyone’s best interest to find new ways for the public mental health system to work with private insurers to maximize resources, create efficiencies in the health care system, and improve outcomes for individuals.
- Under Vermont’s Act 26 [April 2009], DMH and other AHS departments are working to improve the supports and services available to people with Severe Functional Impairment (SFI) returning to their communities after incarceration. The Department of Corrections may designate individuals as having SFI if conditions such as developmental disabilities, traumatic brain injury, dementia, autism, or certain severe

personality disorders create severe functional impairments within the prison environment. Many people with SFI need extra assistance if they are to avoid re-arrest and re-incarceration or to escape a cycle of criminal justice involvement. Depending upon each individual's needs, services and supports may include a combination of medical, mental health and/or case management services, assistance with activities of daily living and instrumental activity of daily living, medical and/or psychoeducational services, skill-building, housing and employment support and at times nursing-home services.

### 3. **Organizational Structure**

DMH is one of several departments that constitute the Agency of Human Services. At present, the Child, Adolescent, and Family Unit of DMH has statutory responsibility for seeing that mental health services are provided to Vermonters from birth to age 18 (or to age 22 if in a Special Education program). The Adult Unit has a similar charge for Vermonters 18 years of age and older.

Operating under *Administrative Rules for Agency Designation* (June 2003), DMH contracts with ten private nonprofit community mental health centers or Designated Agencies (DAs) to provide service coverage to all areas of the state and with one private nonprofit Specialized Service Agency (SSA). The Commissioner of DMH confers designated agency status when he confirms that an agency meets state and federal laws, regulations, and quality standards for the provision of mental health services. Each DA is responsible for providing core capacity services in a given region; the one SSA provides intensive services to adolescents from anywhere in the state. (See map in Appendix A, page 73.)

### 4. **Resources**

Ideally, a child's or adolescent's life is filled with the natural supports of a healthy family and friends, an excellent school, and a vibrant community. Adults also need these elements in addition to competitive employment. These natural supports are vital components of a person's mental health treatment plan. Examples might include mentoring by neighbors, participation in sports teams or in musical groups, or socializing in church group activities. When informal supports are not sufficient to meet a person's mental health needs, the use of other resources such as formal services may be in the best interest of the individual, family, and community.

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The greatest resource available from the public mental health system is the time of staff. Staff time is paid for by revenues from various sources, including federal Medicaid and its related state funds, private insurance, state and federal grants, direct payment by clients, and local or other sources.

Administrative costs at Vermont's community mental health agencies in FY2011 averaged 11% of allocated funds; 89% of the state's grant funding went directly into services for people who needed them. This level compares favorably with the widely used criterion of charitable commitment, expressed as a percentage, to assess how efficient individual charities are at directing contributions into the cause(s) to which they are given rather than into management, overhead, or fund-raising activities. In 2010, the average charitable commitment of the two hundred largest charities monitored by *Forbes* magazine was 86 percent. ([Forbes.com/2010/11/16](http://Forbes.com/2010/11/16))

In the fall of 2011, the United States continued to struggle to emerge from the severe economic downturn that officially ended in the summer of 2009. Vermont's state government also continues to operate within the severely limited resources imposed by the slower-than-anticipated economic recovery. Vermont and DMH are striving to keep focused on our desired outcomes, look for more effective and efficient ways to achieve those outcomes, and do both within budget and staff constraints.

In the late 1980s there were basically two types of services available for children: (1) an hour of therapy or (2) hospitalization. Although these are basic services, they did not meet many of the treatment and support needs of children and adolescents with significant mental health issues and their families. A continuum of services was needed. During the last three decades, DMH has worked with families and designated agencies to expand the types of services available. DMH has been able to expand services to meet these needs by successfully competing for and administering several major federal and private grants, working with the legislature, and by collaborating with other state departments, particularly the Department for Children and Families and the Department of Education as well as with Designated Agencies (DAs) and Local Education Agencies (LEAs). The total budget for children's mental health in FY2011 was \$72,672,505. This is an increase of \$53,145,780 since FY1994 and represents a 272% increase from the \$19,526,725 total budget in

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FY1994. Also during this time, the number of children served rose from 4,839 to 10,048, an increase of 5,209, or more than 100%.

**Figure 1. Numbers of Clients Served: 1994 and 2011**

<b>Age Range</b>	<b>Number Served FY 1994</b>	<b>Number Served FY 2010</b>
0 - 6	770	1,989
7 - 12	2,060	3,740
13 - 17	2,128	4,418
18 - 21	1,202	2,639
22 - 34	5,548	5,729
35 - 49	4,873	5,388
50 - 64	1,605	3,730
65+	832	1,065
Unknown	238	3,334
<b>Total</b>	<b>19,256</b>	<b>29,032</b>

In mental-health services for adults, dramatic reductions in the number and size of public psychiatric hospitals have been nationwide phenomena for more than half a century. Complex scientific, legal, political, social, and economic factors have all contributed to those reductions.

Among the most important are:

- ❖ The development and availability of psychotropic medications in the 1950s coupled with significant advances in the 1980s and 1990s that reduced the serious side effects of many of those medications
- ❖ Passage of the Community Mental Health Act in 1967: The federal law followed similar measures already passed by many state legislatures. Vermont's General Assembly passed a Community Mental Health Act in 1957.
- ❖ The subsequent growth of a system of community mental health centers offering a broad array of community-based services and supports
- ❖ A broad consensus statewide in favor of community over institutional care
- ❖ Greater protections for patients' rights, especially right to treatment in the least-restrictive settings possible

As the community system grew, the Vermont State Hospital (VSH) shrank in size from a maximum of 1,300 patients in 1954 to a capacity of 54 in 2011. Vermont's community-based public mental health system currently serves around 3,000 adults with severe mental illness in Community Rehabilitation and Treatment programs and another 6,500 adults with emotional and behavioral problems serious enough to need professional attention in Adult Outpatient programs.

## 5. Quality Management

### a. QM Overview

Quality Management (QM) is multifaceted and is not the responsibility of any single individual or entity. It is a shared responsibility among the individual/family receiving services, communities, designated agencies and providers, and the state and federal governments. DMH and the designated agencies share responsibility for providing or securing services for clients, assuring the quality of the services delivered, and monitoring and assessing the outcomes achieved for persons in each of the state's geographic areas. DMH has a clear role in assuring that all programs and services funded by the state are in compliance with state and federal laws and regulations and that they are achieving the desired outcomes through the provision of high-quality services and supports. Finally, the federal government has a need to assure that federal dollars are being used appropriately and effectively.

DMH evaluates its ongoing work of quality assurance and quality improvement for the system of care within four domains:

**Access:**

Core capacity services will be available to people who need them.

**Practice Patterns:**

Services will be appropriate, of high quality, and reflect current best practices.

**Outcomes:**

The quality of life for consumers and families will improve.

**Agency Structure and Administration:**

Designated and specialized services agencies will be fully functional and have strong working relationships with DMH, consumers and families, and other stakeholders.

The Department will forge new working relationships with public and private health care providers and insurers to build an integrated health care system for all Vermonters.

**b. QM Activities**

**Agency Designation.** Commissioner designation is required for each community mental health center in Vermont every four years. The *Administrative Rules on Agency Designation* (effective June 2003) guide the findings presented in the designation report for each agency.

**Agency Review.** Agency reviews are conducted once every four years at each DA/SSA. In addition to the review for Child, Adolescent, and Family services, the adult reviews include Community Rehabilitation and Treatment, Adult Outpatient programs, and Emergency Services. Conducted by central office staff of DMH, reports are reviewed by the State Program Standing Committees for both adult mental health and for child and family mental health. Information from the agency review contributes to the designation report for each agency.

DMH has completed its evaluation of the components of agency reviews and of agency designation for all mental-health programs at DAs in comparison with requirements by JC (Joint Commission, formerly known as the Joint Commission on Accreditation of Hospital Organizations, or JCAHO) and CARF (Commission on Accreditation of Rehabilitation Facilities). Areas of overlap may be deemed during the agency reviews and designation if a DA is accredited by either the Joint Commission or CARF.

**Minimum Standards.** Minimum Standards reviews are conducted once every four years for both adult and children's mental health programs. They are conducted by central office staff. The site visit focuses on a representative sample of clinical care records and documentation requirements in the Children's Mental Health (CMH), Community Rehabilitation and Treatment (CRT), and Emergency Services programs and for services provided by DA/SSA medical staff and psychiatrists. Information from the reviews contributes to designation reports.

**Medicaid Fee-for-Service Reviews.** DMH is no longer responsible for Medicaid fee-for-service reviews. This activity is now managed by the Program Integrity Unit of the Department of Vermont Health Access (DVHA).

**Technical Assistance Site Visits.** As part of DMH's overall QM program, DMH staff are available for program and/or individual consultation, resource management, and planning purposes at the agency's request or DMH's discretion.

**Quality Management Staff.** The DMH QM team:

- ◆ plans and oversees the outcomes of quality-improvement activities,
- ◆ reviews key reports and service indicators,
- ◆ monitors and reports on provider and system resources,
- ◆ identifies unmet needs, and
- ◆ recommends system-improvement initiatives

**State Program Standing Committees.** State Program Standing Committees for Adult Mental Health and for Child and Family Mental Health are comprised of at least 51% disclosed consumers and family members. The committees are involved in the processes for re-designating agencies in each catchment area. The members receive key program information and advise the Commissioner on how well the service system is performing. In this way, the State Program Standing Committees have prominent roles in quality improvement as they examine how resources are being allocated in each region, how service priorities are being met, information on client satisfaction, and other outcome and performance data.

**Federal Block Grant Funding for Community-Based Mental Health Services.** DMH prepares annual plans for mental-health services for adults with severe and persistent mental illness and for children and adolescents experiencing a severe emotional disturbance and their families. The application plans are submitted to the Center for Mental Health Services (CMHS) in Rockville, Maryland, in order to obtain federal block grant funding under Public Law 99-660 and its several successors in federal statute up through Public Law 106-310 of 2000. In Fiscal Year 2011, the Community Mental-Health Services Block Grant contributed \$729,303 annually to community-based mental-health programs in Vermont for both adults and children. Annual reports also are

submitted to CMHS to account for actual expenditures and outcomes. CMHS conducts 3-day Congressionally mandated on-site monitoring visits to states and territories every five years; the most recent review in Vermont was in April 2011. Part of the federal block grant requirements includes reporting on National Outcome Measures (NOMS).

**Outcome Measures and Performance Indicators.** DMH's Managed Care Information System (MCIS) provides data on numerous indicators related to services and achievement of desired outcomes for consumers and agencies. The data available are used for several purposes: DMH oversight of agencies and agency internal management; informing the State Program Standing Committees about the designated agencies and their activities; recognition of good performance; and a wide range of reports to consumers, the legislature, and other key stakeholders in Vermont on various aspects of the public mental-health system.

**Evaluation Surveys.** DMH conducts annual statewide surveys to obtain evaluations from consumers of Community Rehabilitation and Treatment programs and of Child and Family programs. These surveys are one part of a larger effort to monitor community mental health program performance. DMH believes that people who participate in services have valuable insight into what makes quality health care. The combined results of these multiple evaluations provide a systematic comparison across the state and over time to support both the state and local programs in their ongoing quality improvement work. For CRT clients, the surveys cover mental health services, access, respect, autonomy, and outcomes. For children and their families, the surveys focus on mental health services, staff, outcomes, and overall quality. Analytical reports are available to the public in hard copy and on the DMH website (<http://mentalhealth.vermont.gov/report>).

**Treatment Guidelines.** DMH has issued treatment guidelines for bipolar illness, major depression, and schizophrenia. These guidelines are based on what is most effective in treatment for people who have these serious mental illnesses. The treatment guidelines are intended to encourage the use of effective treatments, to avoid treatments that are ineffective, and to allow clinical judgment to guide efforts to provide services and supports when the available outcomes literature is insufficient or lacking. Apart from the guidelines, DMH's Clinical Practices Advisory Panel (CPAP) has recognized six

evidence-based practices for adults with severe mental illnesses that designated agencies are encouraged to offer: Assertive Community Treatment, Supported Employment, Integrated Dual Diagnosis Treatment, Family Psychoeducation, Illness Management and Recovery, and Medication Algorithms, in addition to Dialectical Behavioral Therapy and the Social and Independent Living Skills modules as developed by Robert Liberman of the University of California at Los Angeles (UCLA). CPAP has also developed a set of general recommendations to guide implementation of all evidence-based practices in Vermont.

**Transformation Transfer Initiative Grant.** Vermont has received a federal Transformation Transfer Initiative grant from SAMHSA to fund the creation of an Evidence-Based Practices Cooperative. The cooperative will serve as an independent organization to promote practice improvement and workforce development, with a focus on the adoption of evidence-based, recovery-oriented practices within the state's community mental health system. Membership of the cooperative will include community and inpatient mental health providers, consumer and family-support organizations, higher education, and consumer and family members. Each stakeholder group will share responsibility for supporting the work of the cooperative to identify, implement, and sustain EBPs in Vermont.

The functions of the cooperative will be:

- 1) Performing systematic review, evaluation, and analysis of new evidence-based and promising practices for possible implementation in Vermont,
- 2) Operating as a state clearinghouse for resources and information on evidence-based practices (this will include specific information on EBPs for consumers and families to support informed consumer choice),
- 3) Developing in-state resources to support the implementation of evidence-based practices (e.g., training of trainers to establish in-state experts on specific EBPs, Web-based training, training materials, consumer and family panels),
- 4) Reviewing and initiating outreach, evaluations and fidelity assessments of mental health services to determine availability and quality of evidence-based practices in the state,
- 5) Coordinating training, case consultations, technical assistance, and other workforce- and program-development activities to support adoption of best practices,

6) Identification of state and local implementation barriers (e.g. policies, funding) and facilitating efforts to address barriers,

7) Supporting the use of data collection, outcomes-monitoring and community-based research to evaluate the effectiveness of practices being provided by the community mental health system.

Components of the cooperative will include:

- a program coordinator
- administrative support
- a steering committee that will oversee activities of the cooperative and perform regular reviews of new evidence-based/promising practices (the steering committee will take over this role from the panel described above)
- a cohort of Vermont clinicians who are available to provide training and consultation on various evidence-based practices
- flexible funding that can be used for the purchase of training and consultation.

**Audits of Emergency Examinations and Applications for Involuntary Treatment in Local General Hospitals.** Any care administered during the course of involuntary hospitalization must meet DMH standards.

**Hospital Designation.** Hospital designation is a review every other year to assess the capacity to provide involuntary emergency psychiatric care at designated community hospitals with psychiatric inpatient units. The review ensures adherence to Vermont statutes by reviewing administrative structures and clinical services as well as community collaboration and DMH reports associated with the hospital. Performance indicators are reviewed with each designated hospital at the time of each re-designation visit.

**Electroconvulsive Therapy (ECT) Reviews.** The standards for ECT are based on *The Practice of Electroconvulsive Therapy: Recommendations for Treatment, Training, and Privileging*, from the American Psychiatric Association (second edition, 2001). DMH collects data from Fletcher Allen Health Care and Central Vermont Medical Center, the two local general hospitals in Vermont designated to provide ECT.

**Safety and Accessibility Checks.** Physical safety and accessibility checks at DAs and the single SSA for compliance with state and federal statutes are incorporated into DMH's designation process.

**Grievances and Appeals.** The process and timelines for Medicaid beneficiaries receiving mental-health services from Vermont's designated agencies are laid out in accordance with grievance and appeals procedures as promulgated by the Department of Vermont Health Access under Vermont's Global Commitment to Health on July 1, 2007, and revised, with full guidance and collaboration by DVHA, by the Department of Mental Health in April 2010.

**c. Evidence-Based Practices**

Vermont's publicly funded mental health service system is committed to using all of the resources available to our system to provide state-of-the-arts services to consumers and families in order to promote their healthy development and resiliency, recovery from illness, and full participation in their community. The policy framework for evidence-based practices, values-based practices, and promising/emerging practices is a means by which providers, consumers, and family members can collaborate in identifying and implementing the best practices to achieve those goals.

**Evidence-Based Practices (EBPs).** EBPs are those treatment strategies for which consistent scientific evidence shows that they improve client outcomes. The scientific evidence is comprised of several randomized clinical trials (or quasi-experimental studies with comparison groups) in a variety of typical community mental-health settings, conducted by different researchers that produce consistently better results for consumers than alternative practices or no intervention.

The public system has a duty to learn about evidence-based practices and select models to pilot with high model fidelity in enough settings to provide meaningful experience with the practice. After evaluating the pilot for consumer outcomes, cost effectiveness, and compatibility with our system's values of resiliency, recovery, empowerment, and community integration, the state can choose one of the following options:

- ☒ *maintain high model fidelity* and make a commitment to widespread implementation of the evidence-based practice;
- ☒ *adapt* the practice and *measure* to ensure that expected outcomes are in fact achieved; or
- ☒ *decide not to use* the practice.

**Promising/Emerging Practices.** Promising or emerging practices are those strategies which have accrued some evidence of effectiveness but have not yet had sufficient funding or time to conduct several randomized clinical trials. The public system has an additional duty to pursue implementation of promising emerging practices by identifying gaps in current services and practice approaches that fail to address the needs of consumers and their families, searching for practice approaches or program models that show promise in addressing the need, and then learning about the practices and going through the same steps as for evidence-based practices.

**Values-Based Practices.** Finally, the public system shall pursue implementation of values-based practices through assessing the degree to which they promote resiliency, recovery, empowerment, and community integration.

## 1. Children, Adolescents, & Families in Emotional/ Behavioral Distress



### i. Access: The People Served

#### GOAL:

***The Core Capacity Services (pages 29-30) are available to children and families in need.***

#### ✧ Estimates of Prevalence of Need

“Approximately one in five children and adolescents experience the signs and symptoms of a DSM-IV [mental health] disorder during the course of a year,” according to the United States Surgeon General (*Mental Health: A Report of the Surgeon General*; 1999).

The number of people aged birth to 18 in Vermont was approximately 129,201 as of 2010. This means about 25,840 children and youth in Vermont (one in five, or 20%) may be in need of mental health treatment each year.

The federal Center for Mental Health Services (CMHS) estimates that approximately 16,000 in this group of Vermont’s children and youth (about 12% of the total youth population) may be experiencing serious or severe emotional disturbance each year. In fiscal year 2010, Vermont’s public mental health programs served 10,541 children, adolescents, and young adults; 57% were males and 43% were females. An unknown remainder of the 16,000 – 26,600 estimated to be in need of mental health treatment received service from private providers in either for-profit or non-profit organizations.

#### ✧ Description of the Population in Need

Research indicates that many factors may contribute to a child’s need for mental health treatment. These factors tend to come from the child’s environment and/or from the child’s biological make-up.

Factors from the child's environment may include: physical, sexual or emotional abuse; physical trauma; domestic violence and substance abuse in the family system; severe neglect; malnutrition; having a parent incarcerated; lack of caring adults; numerous transitions; unsafe or unsanitary living conditions; exposure to familial violence; harsh or inconsistent discipline; having one or two parents with a psychiatric disability.

Factors from the child's biological make-up may include: genetic, neurological and biochemical factors such as family history of depression, learning difficulties (especially reading), impulsivity, and temperament. These elements can contribute causative factors to a severe emotional disturbance or create a vulnerability for a disorder. In some situations medical conditions such as allergies, asthma, traumatic brain injury, seizure disorders, *etc.* can be the direct cause of emotional or behavioral difficulties. Additionally, exposure to toxins (environmental, chemical and nutritional) may affect the development and/or functioning of a child's brain and nervous system.

These risk factors – many of which are related to living in poverty – can be somewhat lessened and/or prevented by prenatal and perinatal medical care, childhood immunizations, home visiting and other forms of parenting support and training, high quality early care and education (especially to foster reading readiness, self-control, and social skills), and success in school. (*Ibid*). Children's public mental health services can offer parenting support and training and can help children learn self-control and social skills.

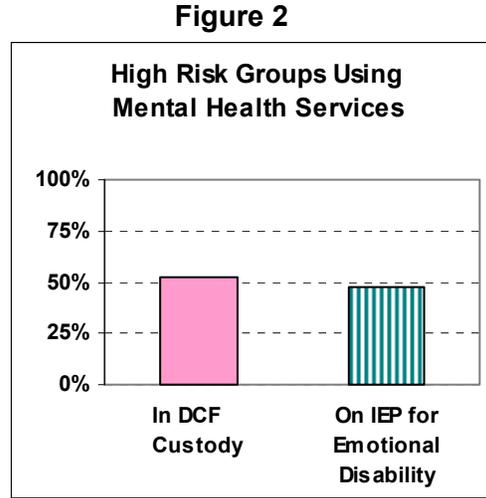
#### ✧ **Description of the Children and Families Served**

Because of the presence of significant risk factors in their lives, children from three special populations receive mental health treatment in higher proportions than the proportion of children in the general or overall population who receive treatment. These special populations of children are those who are:

1. enrolled in Medicaid due to poverty and/or disability,
2. in the custody of the State Department for Children and Families due to neglect and/or delinquency, and/or
3. on an Individualized Education Plan (IEP) in school due to an emotional disability (ED).



Figure 2 below shows data on service recipient percentages for the second and third of these populations; the table in Figure 3 provides data on the first.



Vermont’s public mental health system for children primarily – but not exclusively – serves children and families who are enrolled in Medicaid. In fiscal year 2010, at least 8,222 of the 10,541 children and youth served were enrolled in Medicaid. Some families have private insurance or other sources of health coverage in addition to Medicaid.

**Figure 3**

Responsibility for Fee	Medicaid	Medicare	Other Insurance	State Agency	Unknown
% of Children Served	78%	0%	18%	2%	11%

For the purpose of effective treatment planning, children and youth are assessed when seen by children’s mental health workers and are then assigned one or more diagnoses. In FY2010, children served had diagnoses that included adjustment disorder, anxiety disorder, affective disorder, substance abuse disorder, and schizophrenia/psychosis among others.

One way to illustrate what these diagnoses can mean in the lives of families is to tell stories. We have included three stories in Appendix A, which present composites of conditions and experiences of the children served. To assure confidentiality and protect privacy, none of the stories are about any one known person. However, they illustrate the diversity of diagnoses, severity of symptoms, and range of treatment options, as well as the complexity of situations faced when trying to meet the needs of children and adolescents experiencing mental health problems and their families.



## ii. Practice Patterns: What We Do

### GOAL:

***Services provided are appropriate, of high quality, and reflect current best practices.***

### A. Core Capacity Services

DMH contracts with its Designated Agencies to assure that its five Core Capacity Services are available in each region. (See map, page 72).

#### 1. Prevention, Screening, Referral and Community Consultation:

Each designated agency (DA) provides and/or has direct involvement in creating and/or maintaining community agreements that promote psychological health and resilience for families and youth.

- *Primary prevention/Health promotion*  
promotes healthy lifestyles and healthy communities for all youth and families.
- *Secondary prevention*  
reduces the effects of risk factors, minimizes trauma potential, and maximizes resiliency potential.
- *Tertiary prevention (i.e., treatment)*  
reduces any trauma and dysfunction that may be created by a difficult event or situation.

The prevention agreements with each designated agency may focus on one or more of the following elements:

- work with families, community groups, schools and health and child care providers to improve situations and environments for children and families and to provide education, consultation, and training;
- screening and referral; and
- educational activities about mental health for the public at large.

#### 2. Support:

Support services can be instrumental in reducing family stress and providing parents and caregivers with the guidance, support and skills to nurture a difficult-to-care-for child.

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Each designated agency provides and/or has direct community connections to a comprehensive array of support services for families and youth. These services are offered in partnership with parents and consumer advocates, and are provided as the family needs and desires:

- skills training and social support;
- peer support and advocacy;
- respite; and
- family and individual education, consultation, and training.

### **3. Outreach and Clinic-based Treatment:**

Each DA offers a comprehensive array of clinic-based and outreach treatment services for children and families. These services are available in the mental health center as well as the home, school, and general community settings. The intensity of the service is based on the clinical needs of the child and family and the family's request for one or more of the following elements:

- clinical assessment;
- group, individual, and family therapies;
- service planning and coordination (including residential case review);
- intensive in-home and out-of-home community services to child and family (including foster and adoptive families);
- medication services; and
- family and individual education, consultation, and training.

### **4. Immediate Response:**

Each DA provides access to an immediate response service and/or short-term intervention for children and adolescents who are experiencing a mental health crisis and their families. Crisis services are intensive, time-limited (usually 2-3 days) supports consisting of the following elements:

- telephone assessment, support, and referral;
- crisis assessment, outreach, and stabilization;
- family and individual education, consultation, and training;
- service planning and coordination;
- emergency/crisis bed ; and
- screening for inpatient psychiatric hospitalization.

## ***B. Intensive Statewide Services***

In addition to core capacity services provided by designated agencies for each region, there are intensive residential services, emergency/hospital diversion beds, and hospital inpatient services available to the entire state of Vermont.

### **1. Intensive Residential Services:**

DMH contracts with three residential treatment programs to provide intensive mental health residential treatment for children and youth in Vermont:

- (a) HowardCenter,
- (b) Northeastern Family Institute (NFI), and
- (c) Retreat Healthcare.

These programs have around-the-clock awake staff, medical/psychiatric backup services, and an in-house array of psychological assessment and treatment services.

### **2. Emergency/Hospital Diversion Beds:**

Emergency or hospital diversion beds are community-based programs that provide a very high level of care and have the ability to divert youth from in-patient hospitalization. Typically, youth who do not require around-the-clock medical monitoring can be stabilized in a smaller, less institutional treatment setting. Like the Intensive Residential Services, Hospital Diversion programs have 24-hour awake night staff, 24-hour psychiatric and in-house crisis back up, and the ability to conduct psychological, neurological and other specialized testing as needed. The typical length of stay in these services is one to ten days.

### **3. Hospital Inpatient Services:**

Inpatient hospitalization may be required for youth with a mental illness who:

- require around-the-clock medical monitoring for such things as drug overdoses, suicide attempts, or other complicating medical conditions;
- have complex and uncontrollable behaviors such as causing or threatening harm to themselves and/or others;
- cannot be stabilized in a smaller and more individualized hospital diversion treatment setting; and/or
- meet the criteria for an emergency exam (EE).

Three hospitals provide psychiatric inpatient services for Vermont youth:

- (1) Retreat Healthcare in Brattleboro, Vermont;
- (2) Cheshire Medical Center in Keene, New Hampshire; and
- (3) Champlain Valley Psychiatric Hospital in Plattsburgh, New York.

A child meeting the criteria for an emergency exam may be placed only at Retreat Healthcare.

### **C. Guiding Principles**

The following are **guiding principles** for the Vermont system of care for children and adolescents who are experiencing or at risk for experiencing mental health challenges and their families. They inform both the types of services we strive to provide and how we provide them.

1. The system works from a strengths-based and holistic approach to the child and family.
2. Communities support families to raise healthy children by providing opportunities to build each child's strengths or assets and to reduce exposure to risks.
3. Early identification, assessment, and intervention services should be available to families to enhance the likelihood of positive outcomes.
4. Child-centered, family-focused treatment and support can best be delivered through an individualized treatment plan developed with child and family input.
5. Children and adolescents should receive services within their family home or the most family-like environment appropriate to meet their needs.
6. Respectful services should foster enduring family relationships regardless of where children are living.
7. Children and adolescents have the right to receive appropriate services without having parents relinquish custody to the State. Children who are in the custody of the State have a right to family involvement that is safe and appropriate.
8. All children and adolescents, regardless of parental involvement, should have access to all core services and supports within their local community.

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9. The system of care functions best when there is coordinated administrative and financial planning, and collaborative service delivery among all involved parties. Families and the general public must be well informed about available options and procedures for using the system of care.
10. Children, adolescents, and their families should be assured smooth transition into and through the system of care, including transition into adult life.
11. The rights of children, adolescents, and their families should be protected. Effective advocacy efforts and assistance in becoming their own advocates should be promoted for all children, adolescents, and their families.
12. Children, adolescents, and their families should receive services without regard to their race, religion, national origin, gender, sexual orientation, disability, or socio-economic status. Service policies and practices should be sensitive and responsive to cultural differences and special needs.
13. Services and supports are best provided by people who are competent, well trained, and well supported.
14. The system of care must be based upon the latest research available and ongoing evaluation about what is effective. Program evaluation should incorporate information from program recipients as well as service providers.

## ii. Outcomes: What's Working or Not



### **GOAL:**

***The quality of life for consumers will improve.***

It is the intent of the Department that Vermont's public mental health system will be effective, efficient, and have families who are satisfied that they have the supports and services they need to help their children thrive in their own home, school, and community.

### **↪ Effective**

There are two basic methods used to measure whether or not the mental health system is effective: analysis of subjective and of objective data.

The primary source of subjective data is the DMH annual consumer survey. [See reports at <http://mentalhealth.vermont.gov/report/survey#cafu>.] Child and family mental health within DMH alternates its surveys between two populations: (1) parents of any child who received a minimum of five Medicaid reimbursed services within a four-month window, and (2) any adolescent aged 14 through 17 who received a minimum of five Medicaid reimbursed services within a four-month window. Although adolescents and parents frequently do not view life the same way, there was a high degree of agreement between the two recent surveys (2008 for parents and 2009 for adolescents). Within a range of 61-70%, both groups agreed that, as a result of the mental health services received, the adolescent:

- is better at handling daily life;
- is doing better in school and/or at work;
- is getting along better with friends and other people; and
- is getting along better with his/her family.

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DMH uses two types of objective data in its analysis of effectiveness of services. The first is the Achenbach System of Empirically Based Assessment (ASEBA). It offers a comprehensive approach to assessing adaptive and maladaptive functioning. It provides multi-informant, multi-cultural scoring for ages 1½-18 and is supported by extensive research on service needs and outcomes, diagnosis, prevalence of problems, and treatment efficacy. DMH currently requires its use with the following five population groups of children and adolescents: those:

1. with a history of complex trauma;
2. being considered for or in residential treatment;
3. receiving Enhanced Family Treatment;
4. receiving psychiatric services; and
5. receiving Success Beyond Six Behavior Interventionist services.

The second type of objective data involves a combination of data reported to DMH on clients served with data from other existing sources. Because all agencies are required to protect client confidentiality, DMH uses a mathematical method called Probabilistic Population Estimation (PPE) to determine client overlap between agencies. PPE is a statistical tool that uses anonymous data sets to produce quantitative measures of access to care, practice patterns, and treatment outcomes in complex systems of care. [For more information on PPE, see <http://thebristolobservatory.com/probabilisticestimation.html>.] With PPE, DMH is able to determine how the mental health clients served by the Designated Agencies as a group compare to non-clients as a group in various areas. For example, are they more or less apt to be employed, be hospitalized, or be arrested or incarcerated. DMH routinely conducts such analyses and posts results to its website. [For reports, see <http://mentalhealth.vermont.gov/report/pip/service>.]

In addition to monitoring whether or not services are effective, DMH also works to assure effectiveness by promoting evidence-based and promising practices. As an example, a major focus within children's mental health is on increasing providers' clinical skills to treat clients with a history of complex and severe trauma. Because such trauma affects the biological functioning of the brain, victims of trauma will not respond to subsequent life events or to treatment methods in the same way as clients without this experience. Therefore, it is important to screen all clients and to adjust treatment methods for those with such a history. DMH competed for and won a grant to provide training to sixty clinicians, including 24 clinical supervisors, around

the state in the ARC model (Attachment, Self-Regulation, and Competency); that grant is coming to a successful conclusion. We will soon have data to help us gauge its effectiveness.

Vermont also has become a member of The National Child Traumatic Stress Network. Through this SAMHSA-sponsored network, we are learning about the methods used by other states and connecting with the latest research findings. For example, the *Adverse Childhood Experiences (ACE) Study* is an important epidemiological study; it shows that the number of traumatic events experienced by a child has a direct correlation to the health outcomes of that person as an adult. The higher the number of traumatic experiences, the poorer their adult health outcomes are likely to be, including mental health and substance abuse outcomes. Clearly our system of care must address this need if our children are to thrive.

### ↳ **Efficient**

With limited resources of time, energy, and finance at both the individual family and the system of care levels, it is vital that we coordinate those resources to avoid duplication and to maximize potential benefits. Three strategies are fundamental to Vermont's efforts in child and family mental health.

#### 1. *Act 264 and Integrated Family Services*

Act 264 was passed by the Vermont legislature in 1988 and signed into law by then-Governor Madeline Kunin. It required a partnership between families, the departments for education, mental health, child welfare, and juvenile justice to create an interagency system of care and to provide a *Coordinated Service Plan* to each eligible child who was experiencing a severe emotional disturbance (SED) and needed services across agencies. It also created a unified definition of SED and a system of regional Local Interagency Teams and a State Interagency Team to oversee the system's development and to help resolve difficulties in implementing Coordinated Service Plans. A Governor-appointed Advisory Board was created and charged to advise the various commissioners on the interagency system of care's development and results. A great amount of progress has been made through the efforts of many people. Services and supports to children and their families have been created and coordination has become the expectation.

We are now ready to take the next steps under the Integrated Family Services Initiative (IFS), which includes the five departments of the Vermont Agency of Human Services, the Department of Vermont Health Access, and the Vermont Department of Education. The

intent of IFS is to integrate screening and intake, create one service plan for the family (rather than individual plans for each person), meld funding, and create outcome-based grants and contracts with providers. The Addison County region volunteered to act as a pilot site and has begun grappling with the numerous issues that must be defined and working with the state to develop and implement solutions to these issues in order to build a more integrated system of care for children and families. It is not anticipated that everything developed in the pilot will work exactly the same way everywhere else in the state. However, much fundamental groundwork will be laid, providing a quicker launch to subsequent regions.

## 2. *Success Beyond Six*

Success Beyond Six is a program which exemplifies efficiency on several levels. Children and adolescents spend a great deal of time in school. Schools can be a source of great excitement and satisfaction and/or a great source of frustration and anxiety. Children may lack the social skills necessary to learn in a regular school classroom. Mental health counseling, home/school coordination, and case management services may all help a student to more fully participate in and benefit from his/her educational environment. Transportation to such services can be a major barrier for families in which both parents work outside the home and for whom public transportation for children is non-existent. Under Success Beyond Six, services can be provided in the school. Further, when a Local Education Agency (LEA) contracts with its Designated Mental Health Agency, it can provide Success Beyond Six services to any Medicaid eligible student at roughly one-third the cost; it pays the state's match rate and mental health draws down the remaining two-thirds of the cost in federal Medicaid funds. In FY10, 37% of all children served in mental health Designated Agencies were served through this program.

## 3. *Vermont's Blueprint*

Vermont's Blueprint for Health, headed by the Department of Vermont Health Access (DVHA), is the state's plan to realize the Institute of Medicine's call for "The right care at the right price, efficiently delivered and resulting in lives saved, health gained, and people satisfied." Exciting possibilities are emerging around the integration of all physical and behavioral health care with the advent of the Electronic Health Record (EHR) and with new partnerships between mental health, alcohol and substance abuse, pediatric and family health medical practices, and Federally Qualified Health Centers (FQHCs). All Vermont's

Designated Agencies are on track to implement EHR as required by federal law. We already have several partnerships between Designated Agencies and pediatric practices, and several Designated Agencies are exploring collaboration with their regional FQHCs, especially in the areas of psychiatric services and the purchase of psychotropic medication, which is considerably less expensive for clients through a FQHC.

### ↳ **Satisfied**

In terms of whether or not consumers are satisfied that they are receiving the supports and services needed to thrive in their home, school, and community, there is a basic agreement that they are. In the DMH's annual perception of care surveys by adolescents and by parents, there was a fairly narrow range of response from 86% to 77% to the following questions.

- The services I received from [specific DA] were helpful to me...(86% parents; 80% adolescents)
- Overall, I am satisfied with the services I received....(82%; 77%)
- If I needed mental health services in the future, I would use this mental health center again....(85%; 78%)

Although these results are good, work remains to improve the system of care and its desired outcomes. DMH competed for and won grants for three important development projects: helping youth transition to adult life, improving community suicide prevention strategies, and increasing service system capacity to provide effective services to victims of complex trauma.

- The Youth in Transition (YIT) grant is a 6-year project for Vermont's transition-aged youth (ages 16 through 21 inclusive) with severe emotional disturbance (SED) and their families. Its goal is to have adequate preparation and the necessary supports for these young adults to be productively engaged in the community and free from incarceration. For this population, the necessary supports include access to health care, post-secondary education, employment, housing, and caring relationships with adults who nurture positive youth development.
- The Suicide Prevention Grant has been administered for DMH by the Center for Health and Learning in Brattleboro. It focused on three primary strategies: (1) building a Vermont Youth Suicide Prevention Coalition; (2) offering school and community-based trainings utilizing the Life Line curriculum; and (3) developing and implementing a statewide public awareness campaign on youth suicide prevention known as **Umatter**. The campaign emphasizes:
  - the importance of de-stigmatizing mental health problems,

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- asset-building for youth, and
- letting young people know where they can turn for help.
- The Vermont Child Trauma Collaborative, with the Vermont Department of Mental Health as lead, has administered a three-year grant from SAMHSA's Center for Mental Health Services' National Child Traumatic Stress Initiative (NCTSI). It has allowed Vermont to fully implement and sustain the Attachment, Self-Regulation and Competency (ARC) Framework in Vermont's community mental health system to change the standard of practice so that:
  - children in Vermont have access to trauma-informed services in the system of care;
  - children who screen positively for trauma receive a standardized trauma assessment; and
  - children with complex trauma and their families are referred for and receive empirically-based trauma treatment services.

Outcomes will include reduced trauma symptoms, increased child competency, reduced parenting stress, and reduced need for intensive services.



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## 2. Adults with Severe Mental Illness



### i. Access: The People Served

#### GOAL:

***The Core Capacity Services (pages 44-47) are available to adults with major mental illnesses.***

#### ❖ Number of Clients Served

Community Rehabilitation and Treatment (CRT) programs provide services and supports for adults with the most severe course of illness. Approximately 3,000 adults with diagnoses of major mental illness are currently served by CRT programs around the state.

Schizophrenia, bipolar disorder, major depression, and certain other serious thought or mood disorders are all major mental illnesses. They may be relatively mild or substantially disabling—and everything in between—for long periods of time. Episodic relapses mean that any individual person's need for services may vary greatly over the years. Recovery is possible.

#### ❖ Prevalence and Need Met

National incidence and prevalence estimates from the Center for Mental Health Services (CMHS) of the federal Substance Abuse and Mental Health Services Administration (SAMHSA) indicate that 2.6% of adults might be expected to show symptoms of a major

mental illness in any given year.<sup>1</sup> In Vermont, then, out of an adult population of approximately 490,000, approximately 12,740 might exhibit some kinds of symptoms. Thus, the 3,000 adults served in CRT programs statewide are 24% of the estimated need. Over a five-year period, the estimated need met by the public mental-health system is higher: 36%.

### ❖ **Challenges of Living in the Community**

Living with long-term disabilities often means living in poverty. Supplemental Security Income (SSI) from the federal government, supplemented by an additional sum from the state of Vermont, may be the only source of income for someone with a disabling major mental illness. A monthly SSI check in 2011, including both federal and state portions, for an individual is \$726, for an annual income of \$8,712. A single individual with an annual income of \$10,890 is living in poverty, according to the federal government's poverty guidelines.<sup>2</sup> That is \$2,178 higher than SSI annual income. CRT clients living solely on SSI thus fall significantly below the federal poverty level and frequently have to rely on their spouses, partners, parents, friends, and others in the community for additional resources and supports of all kinds that are necessary to sustain them.

In contrast, someone working full-time and making the minimum wage of \$8.15 an hour in Vermont in 2011 would have an annual income of \$16,952. Per capita annual income in Vermont in 2005-2009, the most recent years for which the Census Bureau publishes data, was \$27,036. For the United States as a whole, per capita annual income in those years was \$27,041.<sup>3</sup>

People whose only coverage for health care is the federal Medicaid or Medicare program (or both) must largely rely upon the public system for the services they receive. Eighty percent of CRT clients in Vermont are enrolled in Medicaid, while 55% of them have Medicare (many clients have coverage from both programs). Only 11% of CRT clients have other insurance,

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<sup>1</sup>*Federal Register*, Vol. 64, No. 121, June 24, 1999, pp. 33890-33897. The estimates are based on the Epidemiologic Catchment Area and the National Comorbidity Survey studies. State-by-state and county-by-county estimates are available.

<sup>2</sup> *Federal Register* Vol. 76, No. 13, January 20, 2011, pp. 3637-3638.

<sup>3</sup>U.S. Census Bureau, [quickfacts.census.gov/qfd/states/50000.html](http://quickfacts.census.gov/qfd/states/50000.html).

another 6% have coverage through a state agency, and 2% are reported as having no insurance or unknown coverage.

Low incomes and limited options for CRT clients are major reasons behind DMH's priority on improving employment outcomes. Housing is another reason that adults with severe mental illnesses need higher incomes. A place for CRT clients to live is problematic not only because of the stigma that frequently attaches to having a mental illness but also because their incomes are so low and rents are so high. For someone living on \$726 a month, housing that would be considered affordable—that is, housing that would cost no more than 30% of a person's income for rent and utilities—would be a place with a monthly rental of \$218 at most, utilities included. The fair market rent for a two-bedroom apartment in Vermont in 2011 is \$990, significantly more than a monthly SSI check and 4.5 times the affordable rent for someone on that income.<sup>4</sup> In general, low-income housing development in the state tends to be directed toward low-income people who nevertheless have higher incomes than many CRT clients have. (See additional information about housing options developed by DMH for CRT clients under Comprehensive CRT Services and Supports, pp. 46-47.)

### ❖ **Involuntary Community Commitments**

In Vermont Fiscal Year 2011, 210 (or 7%) of the 2,952 CRT clients served by the public mental-health system that year were on court-ordered community commitments, or orders of nonhospitalization. Adults on community commitments often need intensive support services, since they may have done harm to themselves or others in the past or may have been at risk for doing so. Some of them may have had other legal complications, or they may be returning to the community after a prolonged hospitalization. Even though their needs may be higher or more complex than most, they are often clients who are the least willing to accept the supports and services they need to live independently in the community.




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<sup>4</sup>Vermont Housing Awareness Campaign: Between a Rock and a Hard Place. Housing and Wages in Vermont, 2011 Update. <http://www.housingawareness.org/>.

### ✧ **Eligibility Criteria for CRT Programs**

Staff at local agencies determine eligibility for their CRT program based on an individual's

- ☑ diagnosis of major mental illness,
- ☑ long-term disability (as evidenced by social isolation or poor social functioning, a poor work history, or SSI income),
- ☑ recent history of intensive and ongoing mental-health treatment (multiple psychiatric hospitalizations, for example, or six consecutive months of outpatient treatment), and
- ☑ significant functional impairments

Some adults who do not meet the criteria but nevertheless have a high level of need may be enrolled in CRT programs if a DA waives the formal enrollment criteria.

## ii. Practice Patterns: What We Do

### GOAL:

**Services provided are appropriate, of high quality, and reflect current best practices.**



Core capacity services for adults enrolled in Community Rehabilitation and Treatment programs are available in each region through Vermont's ten designated agencies. (See map, page 72.)

### ❖ **Comprehensive CRT Services and Supports**

Community-based CRT programs are designed to provide comprehensive supports and services tailored to the needs and goals of individual clients. For any particular client, the individualized plan of care (IPC) may include any of the following in any number of combinations:

- ❖ A needs assessment (initial and ongoing as a person's needs change),
- ❖ Finding out the goals that adults with severe and persistent mental illness want to achieve and jointly planning services and supports to work toward those goals,
- ❖ Consultation with team members and other professionals,
- ❖ Coordination of mental-health treatment with other services or supports,
- ❖ Advocacy with other agencies or service systems or in the community at large,
- ❖ Education on the need for medications, medication monitoring, information about side effects and drug interactions, and assessment of medication risks and benefits,
- ❖ Education about the importance of physical health and support for a healthy lifestyle,
- ❖ Assistance in managing a budget and other day-to-day activities,
- ❖ Learning about available community resources and how to use them,
- ❖ Housing supports either to stay at home or to find a place that is livable and affordable,
- ❖ Help in finding and keeping a job,
- ❖ Individual, family, and group counseling,

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- ❖ Help with transportation,
- ❖ Other supports as necessary to allow people maximum opportunities to make friends and feel at home in their communities.

In the fall of 2011, in addition to offering every-day community-based services and supports, Vermont's designated agencies operated seven residential crisis-stabilization programs (in Springfield, Rutland, St Johnsbury, Barre, Burlington, Bennington, and St. Albans). These 25 crisis beds are available 24 hours a day, seven days a week, for individuals with acute psychiatric symptoms who require a safe, supervised setting but who do not meet criteria for hospitalization. These beds are used for both diversion from hospitalization and step-down from inpatient treatment. Funding for these beds is primarily from CRT case rates and Futures funds and is not part of the funding shown for Emergency Services programs. An additional two crisis alternative beds became available with the opening of Alyssum, a unique peer-operated program in Rochester, Vermont, in October 2011.

#### ❖ **Recovery in Vermont**

DMH has promoted dissemination of the principles and skills of recovery for adults with severe and persistent mental illness for a number of years. Two primary models of Recovery Education are available in Vermont:

- ⊗ Recovery Education as taught by Vermont Psychiatric Survivors (VPS), with emphasis on consumer empowerment, Wellness Recovery Action Plans (WRAP), and other principles and tools worked out originally by Vermonter Mary Ellen Copeland, and
- ⊗ Illness Management and Recovery (IMR), along the lines of the Toolkit Model for an Evidence-Based Practice developed by the New Hampshire-Dartmouth Psychiatric Research Center.

A minimum of 1,000-1,500 consumers and their friends and family members, providers, advocates, and others are estimated to have received some form of Recovery Education in Vermont. Vermont's Clinical Practices Advisory Panel (CPAP) has endorsed both models, recommending that at least one of the models be available for CRT clients in all catchment areas.

In reality, recovery as a way of coping with mental illness probably has as many definitions as the number of people one might ask. In general, recovery emphasizes hope, personal responsibility, knowledge about mental illness, self-advocacy, and support networks to enable consumers to set their own goals and work toward them on their own terms—in short, to reclaim their lives in the community.<sup>5</sup>

### ✧ **Housing**

The Department of Mental Health has spent many years developing a wide range of housing options and assistance for adults with severe and persistent illness receiving services from the public mental-health system. Federal assistance is also available. Prominent among these possibilities are:

- ✧ **Housing Contingency Funds.** These funds were created about twenty years ago to assure temporary rental assistance and start-up support to individuals discharged from the Vermont State Hospital. In addition, the contingency funds assist Community Rehabilitation and Treatment clients who spend more than 50% of their income on rent while they are waiting for federal Section 8 or other affordable/subsidized housing supports. In Fiscal Year 2007, the original state appropriation of \$300,000 per year was increased for the first time to \$390,000. An additional appropriation of \$460,000 was made in Fiscal Year 2008 for individuals at risk of hospitalization at VSH and for those in need of housing assistance upon discharge from the State Hospital.
- ✧ **Array of Housing Options.** Support from the State of Vermont Housing and Conservation Trust, Vermont State Housing Authority, smaller public housing authorities, and DMH funding provides an array of housing options tailored to suit local needs across the state. These developments/options have a mix of funding from the Department of Housing and Urban Development, SAMHSA, state general fund, the Federal Home Loan Bank, and in some instances tax-credit support. Most of these housing options have been developed with not-for-profit housing developers. Options include:
  - ◆ Subsidized independent living (statewide)

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<sup>5</sup>On reclaiming lives in the community, see the Connecticut Department of Mental Health and Addiction Services' *Practice Guidelines for Recovery-Oriented Behavioral Health Care*, prepared by the Yale University Program for Recovery and Community Health (Tondora & Davidson, 2006), p. 6.

- ◆ PATHWAYS to Housing “Housing First” demonstration grant (three locations)
  - ◆ Transitional housing (five locations)
  - ◆ Shelter Plus Care homeless assistance (now in excess of 120 subsidies)
  - ◆ Safe Havens (two locations)
- ∞ **Conservation Trust and DMH Collaboration.** Vermont has an array of housing options tailored to suit local needs across the state. These developments have a mix of funding from the Department of Housing and Urban Development, state general fund, the Federal Home Loan Bank, and in some instances tax-credit support. Most of these housing options have been developed with not-for-profit housing developers. Options include:
- ◆ Subsidized independent living (statewide)
  - ◆ Transitional housing (five)
  - ◆ Shelter Plus Care homeless assistance (now in excess of 100 subsidies)
  - ◆ Safe Havens (two)
- All of these living arrangements complement statewide housing with treatment options.
- ∞ **Private-Sector Residential Care Providers.** These are a significant statewide resource and housing partnership. They house and care for Vermonters who are elderly and disabled.
- ∞ **Health and Human Services/Program to Assist in the Transition from Homelessness (HHS/PATH).** Vermont receives \$300,000 annually in federal PATH funds for outreach and engagement to treatment-resistant individuals who have both mental-health and substance-abuse issues. These funds now go to nine providers in seven of Vermont's ten catchment areas. Three of the providers are in Chittenden County.
- ∞ **McKinney-Vento Homeless Projects.** These projects, serving adults with severe mental illness or co-occurring disorders of mental illness and substance abuse, began in 1992. The funding from HUD has become highly competitive since its introduction. Total federal funds secured for these projects in Vermont exceed \$1.2 million annually. A Homeless Management Information System (HMIS) is mandated by Congress to monitor and track these HUD-funded homeless projects.

✧ **Implementation of Evidence-Based Practices**

See description of Transformation Transfer Initiative and Vermont's Evidence-Based Practices Cooperative, pp. 21-22.

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### iii. Outcomes: What's Working or Not

#### GOAL:

The quality of life for consumers will improve.

- ✧ **Priority Outcome for CRT Consumers:**  
**Employment**



Employment is a key measure of well-being and successful integration of CRT consumers into their communities. Because of the numerous benefits associated with employment, it is one of the most valuable services that mental-health agencies can offer consumers. Some of the benefits of employment include, but are not limited to, a decreased involvement with corrections, better health outcomes, reduced substance use, increased income, increased opportunities for decent independent housing, a chance to meet new people, increased self-esteem, a growing sense of independence and dignity, added structure to the day, and community integration. Not only is employment beneficial, it is an important aspect of recovery for many individuals with a mental illness. Our goal is to ensure that all Vermonters with a severe mental illness who want to go to work have access to high-quality, evidence-based supported employment services and reach their employment goals. Meaningful employment is achievable, beneficial, and a successful approach to mental-health treatment. All consumers should be given encouragement and opportunities to find and keep employment of their choice.

Supported Employment services with high model fidelity for adults with severe mental-health conditions are available in all ten of Vermont's catchment areas. In Fiscal Year 2012, the Department of Mental Health moved toward outcomes-based contracting through the Agency of Human Services' Master Grant with designated agencies. The FY 2012 Master Grant offered incentive payments to designated agencies for higher employment rates, earnings per client, and new placements in employment.

**Employment Rate.** The target employment rate for CRT programs is 35 % for the grant term. The statewide employment rate in Fiscal Year 2010 was 20%.<sup>6</sup> Each DA is required to make progress toward achieving that target rate in order to receive an incentive payment. Since employment rates can vary widely from agency to agency, CRT programs that have lower employment rates are required to demonstrate greater progress toward achieving the target rate than programs that are closer to that rate. Figure 4, below, sets forth the varying percentages and rewards that are possible.

**Figure 4**

<b>FY 2011 Annual Employment Rate</b>	<b>Minimum Increase by End of FY 2012</b>	<b>Minimum Increase to Generate Incentive Payment for FY 2012</b>
15% or less	3%	10%
16-24%	2%	6%
25-34%	1%	4%
35%	Maintain	2%

**Earnings.** The goal is for employed CRT consumers to maintain average quarterly earnings at 80% of the statewide average of all employed CRT consumers served, or \$1,800 per quarter, whichever is greater. For the DA to be eligible to receive performance incentive payments, the employed CRT consumers must maintain average quarterly earnings at 100% of the statewide average of all employed CRT consumers served, or \$2,283 per quarter, whichever is greater.

**New Placements.** Designated agencies are required to achieve the state's Vocational Rehabilitation (VR) target for consumers who work for ninety days in stable employment. The state's VR goals are proportional to the state/VR grant funds. Goals vary from agency to agency. Based on historical data, the Agency of Human Services and the Division of Vocational Rehabilitation have established a standard of \$5,800 in costs per consumer who achieves the 90-day stability in employment.

✧ **System Performance Indicator: Access to Services**

Vermont's Community Rehabilitation and Treatment programs currently provide services and supports for approximately 3,000 adults with severe mental illness on an annual basis. DMH anticipates that statewide capacity will remain roughly the same over the next three years.

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<sup>6</sup>Vermont Mental Health Performance Indicator Project, "Employment of CRT Clients from FY2000 through FY2010," March 25, 2011.

### **3. Adults in Emotional or Behavioral Distress Severe Enough to Disrupt Their Lives**



#### **i. Access: The People Served**

**GOAL: *Mental Health Services* (pages 44-47) are available to adults who need them.**

Adult Outpatient programs (AOP) are also known as “family” programs because so many of the adults in AOP services have children who are receiving services from other programs or departments under the umbrella of Vermont’s Agency of Human Services. The best estimate is that around 107,600 Vermonters 18 and older, out of an adult population of 496,000 in 2011, might be affected by a range of mental disorders in any given year.<sup>7</sup> The public system served 6,541 of them in Adult Outpatient services in Fiscal Year 2011.

There are no “typical” Adult Outpatient clients. People in AOP programs have a wide range of problems that are nearly always disrupting, and sometimes temporarily disabling. Many have attempted suicide within the past year, or are afraid that they will do so. Many adults receiving these outpatient services have histories of psychological trauma, with lingering impairments to their ability to cope with everyday living. Those with disabling depression may have trouble with such basic activities as eating, bathing, and dressing daily, for example. Alcohol and drug abuse is common. Additional common difficulties include maintaining a household, managing money, getting around the community, and taking prescribed medications.

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<sup>7</sup>Prevalence estimate of 21.3 percent based on the Epidemiologic Catchment Area study of the early 1980s and the National Comorbidity Survey of the early 1990s. See the *Federal Register*, Vol. 64, No. 121, June 24, 1999, pp. 33890-33897; see also *Mental Health: A Report of the Surgeon General*, pp. 45-46.

The most common diagnoses of individuals served in Adult Outpatient programs are mood disorders (55%) and anxiety disorders (35%). Twenty percent of AOP clients have adjustment disorders, and 15% have substance-abuse issues.<sup>8</sup> More than three-quarters have Medicaid or Medicare coverage (or both). Other illustrative facts about individuals in AOP programs include:

- ❖ **63%** have annual incomes of less than \$20,000,
- ❖ **62%** are women,
- ❖ **67%** are between the ages of 20 and 50
- ❖ **49%** have problems in daily living,
- ❖ **42%** have marital and family problems—living in abusive situations, perhaps, or having children in state custody or in trouble with the law,
- ❖ **37%** have other social and interpersonal difficulties, and
- ❖ **30%** have medical-somatic issues in addition to mental-health difficulties.
- ❖ **Other problems** commonly encountered among clients of AOP programs include victimization (19%), suicidal tendencies (12%), alcohol abuse (13%), criminal behavior (10%) and thought disorders and eating disorders (9% each)

Because adults in AOP programs usually do not have long-term disability arising from major mental illnesses, they are not eligible for CRT services. At the same time, they frequently lack health insurance or have insurance policies that do not fully cover services they need. Private mental-health practitioners provide only limited (if any) services to these individuals. Approximately 15% of AOP clients have no insurance or their coverage is unknown; 23% of them have insurance other than Medicaid and/or Medicare. The community programs at DAs often become the only recourse most AOP clients have for access to mental-health services.




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<sup>8</sup>As many as four diagnoses may be reported for AOP clients, thus diagnostic groups do not represent an unduplicated count of clients served.

### **Eligibility Criteria**

Adult Outpatient services do not have set eligibility criteria of the same sort as Community Rehabilitation and Treatment programs or admission to an inpatient facility. Admission to AOP services is determined much more by the level of the client's needs and the availability of funds. The persistence and patience of the people seeking the services can often be determining factors as well. They must frequently try to cope on their own through sometimes long periods of waiting until a mental-health professional can see them. In trying to cope on their own, they can easily end up in other, more expensive systems—hospitals, Emergency Services, correctional facilities, or other human-services agencies. Those other systems may or may not offer the kinds of services that are appropriate for their needs.

### **ii. Practice Patterns: What We Do**

#### **GOAL:**

***Services provided are appropriate, of high quality, and reflect current best practices.***

Adult Outpatient services are not as intensive or comprehensive as CRT services. The first step is for clinicians to make an **assessment** of a new client's problems and need for treatment. Ninety percent (7,128) of clients receiving AOP services in Fiscal Year 2010 received clinical interventions after that initial assessment. Of those 7,128 clients, 59% (4,649) received **individual, family and group therapy. Medication, medical support and consultation services** may also be required to meet more intensive needs, but fewer adult outpatients receive these services. Medical support and consultation were delivered to 33% (2,658) of clients in the same time period. Twenty-five percent (1,979) of clients in AOP services received **community supports**. Complex issues involving more than one family member often require a team approach with both **psychiatric and emergency back-up services** that are not usually available outside of comprehensive community mental health agencies. Emergency/crisis services were delivered to 592 clients (7%) by AOP programs in the same fiscal year.

**iii. Outcomes: What's Working or Not****GOAL:**

*The quality of life for consumers will improve.*

**SYSTEM PERFORMANCE INDICATOR:****Access to Services**

The number of clients assigned to AOP programs at designated agencies was in decline during Fiscal Years 2004-2009, from 7,120 in FY 2004 to 6,448 in FY 2009. Their number grew to 7,015 in FY 2010 then fell back to 6,541 in FY 2011.

**CLIENT OUTCOME:****Improvement**

Among the 1,857 clients discharged from Adult Outpatient programs in Fiscal Year 2011, 1,250 (or 67%) filled out a questionnaire about their condition upon discharge. Forty-nine percent, or 615 of them, said that they were better after treatment than before. DMH and DAs need to work on ways to improve the data from AOP clients about their condition upon discharge.



#### **4. Anyone in a Mental-Health Crisis**



##### **i. Access: The People Served**

###### **GOAL:**

***Mental Health Services*** (pages 44-47) ***are available to anyone who needs them.***

Anyone experiencing mental-health distress has access to public mental-health Emergency Services from designated agencies 24 hours a day, seven days a week. In addition, communities or organizations trying to cope with events that have a collective impact can also rely on Emergency Services not only for help for the many but also for help to individuals reacting to such traumatic events.

A mental-health crisis can happen to anyone without respect to age, income, occupation, mental-health status, or any number of other circumstances. Individuals who turn to Emergency Services do so for quite a broad range of reasons. Often they are depressed (a mood disorder is the most frequent diagnosis given to people who receive Emergency Services). They may be thinking about suicide, or they may be grieving for someone they loved who died recently. They may be under severe stress at home, at school, or at the office. Sometimes people are afraid of doing dangerous things, or of hurting themselves or others, and they call Emergency Services; they also call because they are afraid that others intend to do harm to them. Family violence is an all-too-common factor in situations that provoke calls to Emergency Services. Exacerbations

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of the symptoms of mental illnesses can cause situations in which Emergency Services clinicians will be called upon for intervention or advice in a crisis.

Approximately 10,200 individuals in Vermont received 70,000 units of crisis assistance through designated agencies during Fiscal Year 2011. These figures come from data that include Emergency Services as program of service as well as the cost centers for Crisis Services and Emergency/Crisis Beds and type of service code. Emergency/Crisis Assessment, Support and Referral, and Emergency/Crisis Beds.

### **Eligibility Criteria**

Anyone who thinks that he or she needs emergency help for mental-health issues may call Emergency Services in any area of the state. There are no eligibility requirements. Because of the very nature of the services, it would be inappropriate to try to establish any criteria for receiving them.

Most recipients of Emergency Services are self-referred. Sometimes family members may place a call seeking help for their loved ones. In a community crisis, any number of agencies or individuals looking for help in managing the crisis may be the ones to call for help.

## ii. Practice Patterns: What We Do

DMH requires designated agencies to provide basic crisis services 24 hours a day, seven days a week. The basic services include:

- ❖ **Telephone support**, and
- ❖ **Assessment and referral**

**Consultation** is also an important part of what Emergency Services and other DA personnel provide in crisis situations. **Crisis stabilization** or **resolution** is the goal of crisis interventions but is not possible in all situations.

Mobile crisis teams can offer on-the-spot assistance where the crisis occurs—home, school, business, or other community locations—but the capacity for outreach of this kind varies in different areas of the state. At times, communities expect Emergency Services to go beyond the essential services and provide follow-up in the form of short-term support and care coordination, but limited funding inhibits this capacity in most places most of the time. Enhancements to emergency services around the state are an important part of DMH’s system planning after the evacuation of the Vermont State Hospital as a result of Tropical Storm Irene’s destructiveness in Waterbury.

Emergency Services can be the gateway to other mental-health services. Emergency Services must be available any time of the day or night. By design, they are intensive and comprehensive but short-term. Their main functions are:

- ⌘ responding to individuals in acute distress,
- ⌘ responding to individuals, communities and organizations in community crisis situations,
- ⌘ assisting, coordinating, or collaborating with other agencies (police and courts, for example, as well as schools, businesses, community action agencies, and the list goes on), and
- ⌘ screening for admissions to psychiatric facilities in emergency situations.

The goals of Emergency Services in responding to an individual are to offer help to resolve the crisis or at least to stabilize the situation so that it is not dangerous or threatening anymore and the person feels capable of dealing with it. Referrals to other services may be necessary, and

then the clinician's job becomes one of figuring out which services from which agencies can help and assuring the person's access to those services as soon as possible.

In community crisis situations, Emergency Services goals are fairly similar to those in responding to an individual, except that they are in larger and more complex circumstances. Emergency Services clinicians have to determine what people need individually or collectively and bring everyone through a community crisis to a point at which they can better cope on their own.

Goals in assisting, coordinating, or collaborating with other agencies may be as varied as the responsibilities of those agencies, but generally involve making determinations about the mental-health status of others—often with little background information for guidance. For example, police officers might call an Emergency Services clinician to accompany them to someone's home in case of a domestic disturbance or to a park to offer assistance if a person is in obvious distress in a public place. An Area Agency on Aging might call a crisis clinician if an older person appears disoriented, is neglecting basic self-care, or is not eating regularly or properly to meet nutritional needs. In all of these situations, the goals become variants of basic assessment and referral: to determine people's needs and see that those needs are appropriately met as soon as possible.



### iii. Outcomes: What's Working or Not

#### GOAL:

*The quality of life for consumers will improve.*

#### SYSTEM PERFORMANCE INDICATOR:

##### System Responsiveness

By definition, Emergency Services must respond quickly. Staff response times at all ten designated agencies have been shown to be within the standard of five minutes for a telephone call from an individual and, on average, within thirty minutes when face-to-face assessments are needed.

#### CLIENT OUTCOME:

##### To Be Developed

Given the lack of capacity in most Emergency Services programs for even short-term follow-up of people served during a mental-health crisis, DMH has still not developed a client outcome that can be consistently and accurately measured for these programs. Conditional upon more capacity in Emergency Services and full implementation of enhanced data-collection capabilities, we have given consideration to measuring some of the following potential indicators when resources become available in the future:

- ☒ Client satisfaction with services
- ☒ Community safety
- ☒ Successful crisis resolution (or other outcomes)
- ☒ Getting people into the right services for their problems
- ☒ Improvement of situation (or condition) after Emergency Services
- ☒ Enhanced/lengthened community tenure for mental-health clients

## Section III:

### Next Steps: How to Get from Where We Are to Where We Want to Go



A.	Public Health Model	60
B.	Successful Strategies and New Initiatives	62

## A. Public Health Model



**Public health is what we, as a society, do collectively to assure the conditions in which people can be healthy.**

**Institute of Medicine, 1988**

In order to accomplish its vision and mission, DMH must increase its focus and strategies to embrace the concept of public health.

Given current and trend data on the incidence and the human and financial cost of mental health issues, it is clear that the state needs to focus on the public health approach at this time. The numbers of Vermont's children whose families ask for treatment continue to rise and the children are often younger and have more complex presentations than ever before. Historically, children in special education with a serious emotional disability have been the most likely of all the 14 disability groups to drop out of school. Prospects for employment and a life above the poverty level for those without a high school diploma or a GED are discouraging. Further, research has shown an inverse correlation between funding for mental health services and funding for incarceration. Those states that pay more for mental health services typically pay less for jails and prisons and vice versa.

In order to slow the rate of incidence of poor mental health and the cost of services to individuals, we must balance the current intense focus on a medical care model of treating individuals who already have a diagnosis with increased focus on a public health model of promoting health and preventing problems for the entire population.

There are four main elements to a strong public health model:

1. Focus on the entire population.
2. Promote methods to optimize everyone's good health and prevent problems through public policy based on accurate data and solid research.
3. Determine risk and protective factors as well as social determinants for subpopulations at higher risk.
4. Follow a process with three core functions and ten essential elements:
  - a. Assess the situation
    - i. Monitor health
    - ii. Diagnose problems and investigate causes
  - b. Intervene through policy development
    - i. Inform, educate, and empower everyone
    - ii. Mobilize community partnerships
    - iii. Develop policies
  - c. Assure access to quality care
    - i. Enforce laws
    - ii. Link people to and provide care as needed
    - iii. Assure competent workforce
    - iv. Evaluate

*(A Public Health Approach to Intervention: A New Framework for Strengthening Children's Mental Health and Well-Being. National TA Center for Children's Mental Health. June 19, 2008.)*

The following section highlights some of the current initiatives on which the system of care is focused within a public health framework.

## B. Successful Strategies and New Initiatives

Vermont continues to benefit from the creativity of its citizens and their passionate commitment to helping their neighbors. Even with limited resources, such creativity and commitment have been hallmarks of the state's culture and history. Below is a partial list of the many successful strategies and new initiatives that have been created so that all "Vermonters will have access to effective prevention, early intervention, and mental-health treatment and supports as needed to live, work, learn, and participate fully in their communities."

### ↪ **Affordable Care Act:**

Although this is the federal health care reform law passed by Congress in March 2010, implementing many of its components is a function of each state. Major elements include:

- expanding the number of people with health care insurance;
- moving toward an Electronic Health Record (EHR);
- elimination of the exclusion for "previously existing condition" by insurers; and
- potential to maintain children on parents' policy until age 26.

### ↪ **Vermont's Act 48 of 2011:**

Vermont's Act 48, signed by Governor Peter Shumlin in May 2011, created Green Mountain Care, a publicly financed health care program designed to contain costs and to provide comprehensive, affordable, high-quality health care coverage for all Vermont residents. The act sets out 14 principles as a framework for reforming health care in Vermont and expands the list of Vermont's ongoing health care reform efforts, with a view to eventual transition to a publicly financed single-payer system to be known as Green Mountain Care. The statute was designed to be implemented in coordination with the federal Affordable Care Act.<sup>9</sup>

### ↪ **Act 264, the 2005 Interagency Agreement, and Integrated Family Services:**

DMH continues to work on the continued improvement to Vermont's interagency system of care for all youth with a disability in need of services. Signed in 1988, Vermont's Act 264 mandated coordination among child-serving agencies and partnering with families for one disability population, children and adolescents experiencing a severe emotional disturbance (SED). In 2005, the AHS/DOE Interagency Agreement expanded the scope of the act to all

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<sup>9</sup> State of Vermont, Office of the Legislative Council, *Summary of the Acts and Resolves of the 2011 Vermont General Assembly*, at [http://www.leg.state.vt.us/REPORTS/2011Legislative Reports/](http://www.leg.state.vt.us/REPORTS/2011Legislative%20Reports/)

14 disability populations under special education law. Recently, the Coordinated Services Plan form has been updated to increase clarity for users and free trainings have been offered around the state on the entitlements of the law, its structures (e.g., Coordinated Services Plans, Local Interagency Teams, State Interagency Team, Advisory Board), and the interagency system of care.

Now the Integrated Family Services (IFS) Initiative seeks to bring all children, youth and family services together in an integrated and consistent continuum of services for families. The premise is that giving families early support, education and interventions will produce more favorable outcomes at a lower cost than the current practice of waiting until circumstances are bad enough to access high-end funding streams which may result in out-of-home or out-of-state placement. The goal is to fully integrate human service efforts to create a continuum of services from which families choose and base service delivery on diagnostic and functional needs of the child, youth and family. Best practices will be promoted in clinical service, early intervention, and family support. Using the flexibility granted under Vermont's Global Commitment Waiver for federal Medicaid funding, a single Family Plan will be possible for the first time. The system will monitor outcomes and integrate AHS funding across programs to assure effective and efficient results. Integrated Family Services is the overarching "umbrella" under which other initiatives and program changes fall. Examples include but are not limited to: Enhanced Family Services (EFS), Children's Integrated Services (CIS) ages 0-6, Children's Health and Support Services (CHASS), Best Practices in Psychotropic Medication Use, and Administrative Streamlining.



#### **Chronic Care Management and Care Coordination Programs:**

DMH is collaborating with the Department of Vermont Health Access (DVHA) in coordinating care through these two programs for Medicaid beneficiaries with the greatest need for managing one or more chronic mental and physical conditions. The less intensive **Chronic Care Management Program** serves approximately 25,000 Vermonters by:

- identifying beneficiaries with chronic conditions and helping them obtain access to clinically appropriate health care information and services,
- coordinating efficient delivery of health care by removing barriers, bridging gaps, and avoiding duplication of services, and
- educating, encouraging and empowering this population in the appropriate self-management of their chronic conditions.

The more intensive **Care Coordination Program** is directed toward beneficiaries with the most complex and expensive conditions to treat. It serves approximately 1,200 Vermonters. Registered Nurses and Social Workers provide intensive case management to clients between visits to the doctor so that plans of care will have the best chance of success in maintaining or improving their health.

#### ↳ **ElderCare Clinician Program (ECCP):**

In addition to the usual mix of services accessible to older clients through CRT and AOP programs, Vermont's designated agencies partner with Area Agencies on Aging to offer an ElderCare Clinician Program to Vermont residents sixty years of age and older. The goal of the program is to improve or maintain the quality of life and maximize independence among this population of at-risk Vermonters. Because many of the people in need of these types of services have difficulty traveling to outpatient services or would resist seeking mental-health services because of possible stigma, the program was designed as an outreach model. DMH and the Department of Disabilities, Aging, and Independent Living (DAIL) jointly administer the ECCP at the state level; locally the program is administered by the five Area Agencies on Aging and the ten mental-health DAs. The ElderCare Program served 434 clients in Vermont Fiscal Year 2011.

#### ↳ **Mental Health Promotion:**

As part of DMH's public health mission, the department will continue the development of its statewide plan to inform, educate, and empower all Vermonters on proven methods to nurture mental health. Through health promotional messages in various media, DMH will describe ways to build individual, family, and community assets or protective factors and to limit exposure to risk factors.

#### ↳ **Peer-based Early Intervention for At-Risk Young Adults:**

In the fall of 2011, DMH received a Mental Health Transformation Grant from the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services (CMHS). This grant is intended to foster adoption and implementation of permanent transformative changes in how public mental health services are organized, managed and delivered so that they are consumer-driven, recovery-oriented, and supported through evidence-based and best practices.

Under this grant, DMH plans an expansion of services for young adults (18-34) with or at risk of serious mental illness who are not currently receiving Community Rehabilitation and

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Treatment (CRT) services at their local designated community mental health agency (DA). This population often falls through the cracks of our service systems because they are not eligible for CRT services and/or they choose not to seek the services that are available. This initiative will create an effective early intervention system to deliver peer-based, evidence-based interventions for this population. In partnership with consumer, family and professional stakeholders, the state will pilot the use of peer services to engage with this population and provide wellness-promotion, recovery self-management and supported employment.

The grant will also develop a state interagency team to focus on the identification of state-level barriers to treatment and support of this population and strategies to address those barriers.

#### ↪ **Planning with Private Providers:**

Ten thousand or more individuals with DVHA/Medicaid health insurance coverage regularly go to private providers for mental health services. Under the Affordable Care Act, DMH is expanding its exploration of ways of bringing these providers into statewide planning for a system of care with improved coordination between the public and private sectors.

#### ↪ **Positive Behavioral Intervention and Supports:**

Positive Behavioral Intervention and Supports (PBIS, also known as PBS) is an educational evidence-based practice. It is a proactive, school-wide, systems approach to improving social and academic competence for all students. As such, it is an example of a public health approach. Implementing it is a voluntary decision by each school. At the end of FY2011, 33% of Vermont schools were implementing PBIS and 66% of Vermont's supervisory unions/school districts had at least one school implementing it; interest is strong and continues to grow. DMH and DAs/SSA will work closely with these schools to modify the types of services and the training of staff offered under Success Beyond Six contracts between Designated Agencies and schools to maximize the benefits from PBIS.

#### ↪ **Smoking Prevention and Cessation:**

DMH is teaming up with the Department of Education's (DOE) and the Vermont Department of Health's (VDH) School Health Team to help prevent young Vermonters from starting to smoke and with VDH's Tobacco Cessation Program to help promote smoking cessation among clients in the CRT program. The increased mortality rate for smokers and for non-smokers exposed to second-hand smoke is well-documented. Adults with severe mental

illness on average die 25 years sooner than adults who do not have it. These deaths are in large part related to potentially preventable conditions such as obesity, hypertension, cardiovascular disease, diabetes, and tobacco-related illnesses such as lung cancer and emphysema. Schools have worked diligently to assure information is taught in health curriculum. Many youth are not focused on long-term consequences such as these, however; they are more focused on short-term needs. Some may turn to smoking as a method of coping with anxiety or as a strategy to assure social belonging with a group. More effective and less damaging methods to reduce anxiety and to improve socialization skills need to be provided.



**Transition:**

Vermont's transition-aged youth (16 through 21 inclusive, with their families) with severe emotional disturbance (SED) need to have adequate preparation and supports to become adults who are productively engaged in the community and free from incarceration. For this population, the necessary supports include access to health care, post-secondary education, employment, housing, and caring relationships with adults who nurture positive youth development. Access to health care includes treatment, if needed, for mental health and co-occurring substance abuse challenges, the effects of trauma, and for family or parenting education. Vermont is reaching out to transition-aged youth through their families and high schools, teen centers, recovery centers, homeless youth programs, and at critical intervention points with the juvenile and criminal justice systems. Youth with more intensive needs benefit from cross-system care management and individualized service plan development. The Jump on Board for Success (JOBS) program is a critical component of Vermont's system of care. Opportunities exist for enhancing the JOBS experience for youth with SED by using culturally competent practices and linking the program more closely with existing community justice centers, resources for housing, Workforce Investment Boards (WIBs), and mentoring. All regions are also incorporating the evidence-supported practice Transition to Independence Process (TIPS), a system to assist young people with emotional and/or behavioral difficulties in making a successful transition to adult life with all young persons achieving, within their potential, their goals in the transition domains of education, employment, living situation, and community life.

### ↳ **Trauma:**

DMH applied for and won a competitive federal Community Treatment and Services Centers grant from SAMHSA's Center for Mental Health Services, National Child Traumatic Stress Initiative (NCTSI). Under it, the Vermont Child Trauma Collaborative, with the Vermont Department of Mental Health as lead, is fully implementing and will sustain the Attachment, Self-Regulation and Competency (ARC) Framework in Vermont's community mental health system to change the standard of practice so that: 1) children in Vermont have access to trauma-informed services in the system of care; 2) children who screen positively for trauma receive a standardized trauma assessment; and 3) children with complex trauma and their families are referred for and receive empirically-based trauma treatment services. This promising/emerging practice is expected to produce outcomes that include reduced trauma symptoms, increased child competency, reduced parenting stress, and reduced need for intensive services.

### ↳ **The Vermont Blueprint for Health:**

The Vermont Blueprint for Health is a vision, a plan, and a statewide partnership to improve health and the health care system for Vermonters. The Blueprint provides the information, tools, and support that Vermonters with chronic conditions need to manage their own health – and that doctors need to keep their patients healthy. [See <http://healthvermont.gov/blueprint.aspx>.]

The Blueprint is also working with the public health model to enable health care systems to focus on preventing illness and complications, rather than waiting for and reacting to illness and health emergencies. An increasing number of young Vermonters, as well as more than 50% of adults, have one or more chronic conditions with significant lifelong implications (e.g., depression, asthma, obesity, diabetes). People with chronic physical conditions are more likely to have depression. Left untreated, depression becomes more debilitating and complicates other chronic health conditions. DMH and VDH are collaborating on better integration of the service delivery systems of health and mental health to treat chronic physical ailments as well as depression.

### ↳ **Vermont Disaster Planning, an Integrated Mental-Health Response:**

For a number of years, a grant from the Centers for Disease Control and Prevention (CDC) has supported VDH/DMH collaboration in designing disaster-response plans as they relate

to health and mental-health needs. Washington County Mental Health (WCMH) organizes and trains DA and private mental-health providers as well as school, pastoral, and other human-services staff to respond to disasters. Over 300 persons have received this training, and Vermont has received high marks for disaster preparedness.

↪ **The Vermont Integrated Services Initiative (VISI):**

VISI was funded by an infrastructure planning grant from the federal Substance Abuse and Mental Health Services Administration (SAMHSA). The project's two broad goals sought: (1) to restructure administrative and funding practices of the Office of Alcohol and Drug Abuse Programs (ADAP) and of DMH to support integrated treatment for individuals with co-occurring mental-health and substance-use disorders, and (2) to provide training and technical assistance to a wide group of service providers to increase their programmatic and clinical capacity to deliver effective treatment for clients with co-occurring disorders. Twenty-six different service provider agencies in Vermont participated in the project. The participants included DAs, federally qualified health centers, housing and homeless service providers, and specialty residential providers.

# SECTION IV:

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## Appendix A:

### Designated Agencies by Region

#### Barre

##### ***Washington County Mental Health***

P.O. Box 647; Montpelier, VT 05601-0647

Phone: (802) 229-0591; <http://www.wcmhs.org/>

#### Bellows Falls

##### ***Health Care and Rehabilitation Services of Southeastern VT***

1 Hospital Court, Suite 410; Bellows Falls, VT 05101

Phone: (802) 463-3947; <http://www.hcrs.org/>

#### Bennington

##### ***United Counseling Services of Bennington County***

1 Ledge Hill Drive; Bennington, VT 05201

Phone: (802) 442-5491; <http://www.ucsvt.org/>

#### Bradford

##### ***Clara Martin Center***

Route 5, Box 278; Bradford, Vermont 05033

Phone: (802) 222-4477; <http://www.claramartin.org/>

#### Brattleboro

##### ***Health Care and Rehabilitation Services of Southeastern VT***

51 Fairview Street; Brattleboro, VT 05301

Phone: (802) 254-6028; <http://www.hcrs.org/>

#### Burlington

##### ***HowardCenter***

300 Flynn Avenue; Burlington, VT 05401

Phone: (802) 660-3678; <http://www.howardcenter.org/>

#### Hartford

##### ***Health Care and Rehabilitation Services of Southeastern VT***

20 School Street; Hartford, VT 05047

Phone: (802) 2959-3031; <http://www.hcrs.org/>

#### Manchester

##### ***Northshire UCS***

Stephen C. Lundy Building; 5312 Main Street; Manchester, VT 05255

Phone: (802) 362-3950; <http://www.ucsvt.org/>

**Middlebury*****Counseling Services of Addison County***

89 Main Street; Middlebury, VT 05753

Phone: (802) 388-6751; <http://www.csac-vt.org/>**Morrisville*****Lamoille Community Connections***

72 Harrel Street; Morrisville, VT 05661

Phone: (802) 888-5026

**Newport*****Northeast Kingdom Human Services***

154 Duchess Street; Newport, VT 05855-0724

Phone: (802) 334-6744; <http://www.nkhs.net/>**Randolph*****Clara Martin Center***

11 Main Street, Box G; Randolph, VT 05060

Phone: (802) 728-4466; <http://www.claramartin.org/>**Rutland*****Rutland Mental Health Services***

78 South Main Street; Rutland, VT 05701

Phone: (802) 775-2381; <http://www.rmhsccn.org/>**St. Albans*****Northwest Counseling and Support Services***

107 Fisher Pond Road; St. Albans, VT 05478

Phone: (802) 524-6554; <http://www.ncssinc.org/>**St. Johnsbury*****Northeast Kingdom Human Services***

560 Railroad Street; St. Johnsbury, VT 05819

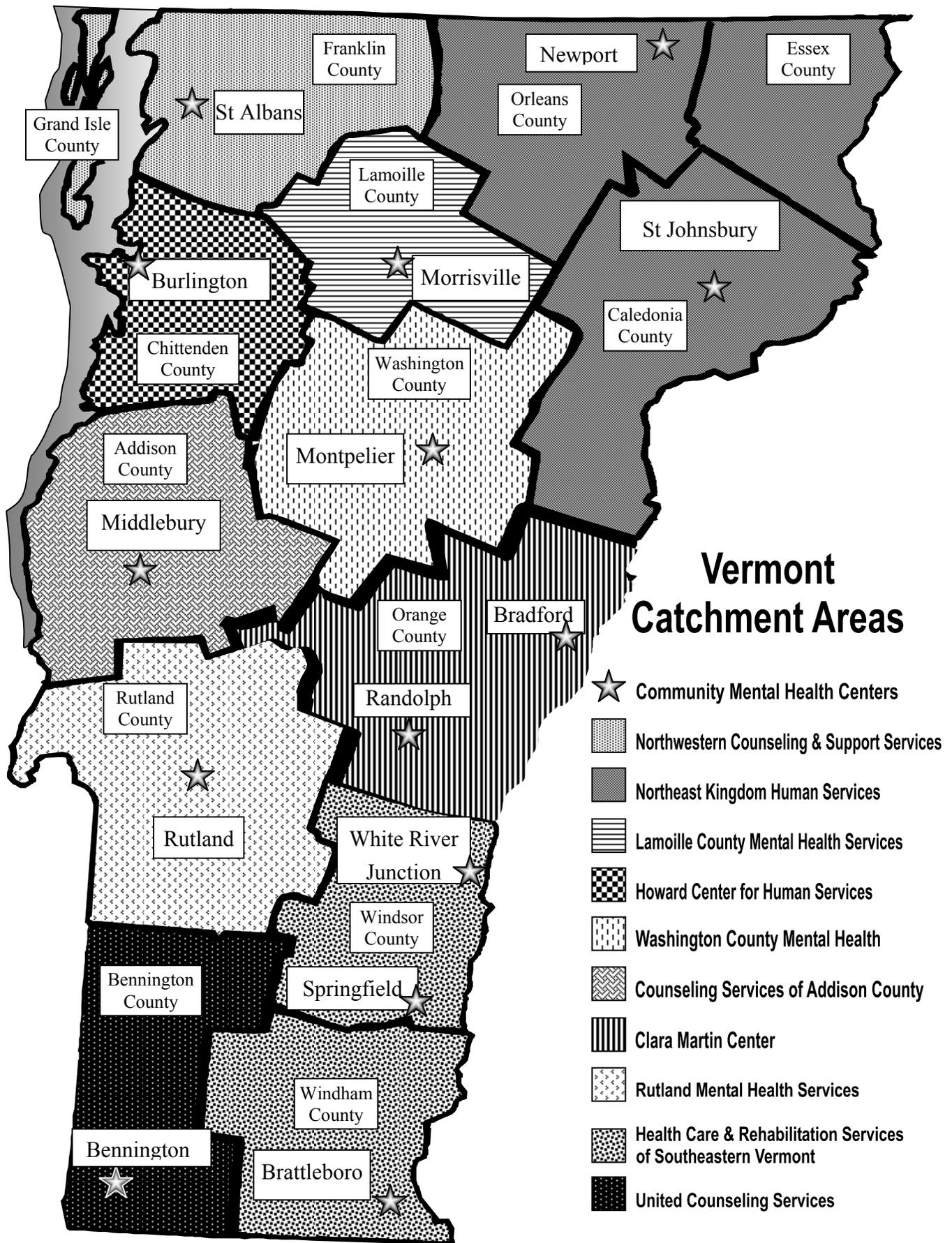
Phone: (802) 748-3181; <http://www.nkhs.net/>**Springfield*****Health Care and Rehabilitation Services of Southeastern VT***

390 River Street; Springfield, VT 05156

Phone: (802) 886-4500; <http://www.hcrs.org/>**Windsor*****Health Care and Rehabilitation Services of Southeastern VT***

14 River Road; Windsor, VT 05089

Phone (802) 674-5419; <http://www.hcrs.org/>



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## Appendix B:

### Strategic Initiatives from Substance Abuse and Mental Health Services Administrative (SAMHSA)

#### SAMHSA Strategic Initiatives

*[Excerpts from]*

#### Executive Summary

Behavioral health is essential for the Nation's health – for individuals, families, and communities, as well as for the Nation's health delivery systems. SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities. SAMHSA, together with many partners, has demonstrated that prevention works, treatment is effective, and people recover from mental and substance use disorders.

Substance use disorders, poor emotional health and mental illnesses take a toll on individuals, families, and communities. Like physical illnesses, they cost money and lives if they are not prevented, left untreated, or poorly managed. Their presence exacerbates the cost of treating co-morbid physical diseases and results in some of the highest disability burden in the world for individuals, families, businesses and governments. SAMHSA has a unique responsibility to focus the Nation's health care and social agendas on these preventable and treatable problems stemming from disease, trauma, inadequate access to appropriate care, and insufficient community and family supports. Our country can make a difference in its health, justice, social services, educational, and economic systems by addressing the prevention and treatment of mental and substance use disorders and related problems.

America's people are central to SAMHSA's values and mission. While systems, services, and programs are the means, people's lives matter most. SAMHSA's goal is a high-quality, self-directed, satisfying life in the community for everyone in America. This life in the community includes:

- a) A physically and emotionally health lifestyle (**health**);
- b) A stable, safe and supportive place to live (a **home**);

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- c) Meaningful daily activities such as a job, school, volunteerism, family caretaking, or creative endeavors and the independence, income, and resources to participate in society (a **purpose**); and
- d) Relationships and social networks that provide support, friendship, love, and hope (a **community**).

....To guide its work through at least 2012, SAMHSA identified eight Strategic Initiatives. In the years ahead, budgetary pressures mean that SAMHSA and the behavioral health field will face serious financial constraints. These initiatives will focus SAMHSA's efforts and maximize the impact of our resources on areas of urgency and opportunity. ...

### **1. Prevention of Substance Abuse and Mental Illness**

Create Prevention Prepared Communities where individuals, families, schools, faith-based organizations, workplaces, and communities take action to promote emotional health and reduce the likelihood of mental illness, substance abuse including tobacco, and suicide....

### **2. Trauma and Justice**

Reduce the pervasive, harmful, and costly health impact of violence and trauma by integrating trauma-informed approaches throughout health and behavioral health care systems and by diverting people with substance use and mental disorders from criminal and juvenile justice systems into trauma-informed treatment and recovery....

### **3. Military Families**

Support America's service men and women – Active Duty, National Guard, Reserve, and Veterans – together with their families and communities by leading efforts to ensure needed behavioral health services are accessible and outcomes are successful....

### **4. Health Care Reform Implementation**

Broaden health coverage to increase access to appropriate high quality care, and to reduce disparities that currently exist between the availability of services for substance abuse, mental disorders, and other medical conditions....

### **5. Housing and Homelessness**

Provide housing and reduce barriers to accessing effective programs that sustain recovery for individuals with mental and substance use disorders who are homeless....

### **6. Health Information Technology**

Ensure the behavioral health provider network, including prevention specialists and consumer providers, fully participates with the general health care delivery system in the adoption of Health Information Technology (HIT)....

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**7. Data, Outcomes, and Quality**

Realize an integrated data strategy that informs policy and measures program impact leading to improved quality of services and outcomes for individuals, families, and communities....

**8. Public Awareness and Support**

Increase understanding of mental and substance use disorder prevention and treatment services and activities to achieve the full potential of prevention and assist people in accessing/getting help for these conditions with the same urgency as any other health condition....



## Appendix C

### Three Stories of Children and Their Families

One way to illustrate what different mental health diagnoses can mean in the lives of families is to tell stories. We have included three stories which present composites of conditions and experiences of children and families served. To assure confidentiality and protect privacy, none of the stories are about any one known person. However, they illustrate the diversity of diagnoses, severity of symptoms, and range of treatment options, as well as the complexity of situations faced when trying to meet the needs of children and adolescents experiencing mental health problems and their families.

#### Composite Stories about Children's Mental Health:

- **The Picture**
- **Action**
- **Results**

↵ **Sasha**

↵ **Kevin**

↵ **Dan**



## **Sasha's Story**

### **THE PICTURE**

**Sasha** is a 10-year old girl who lives with her single mom and 2 younger brothers, aged seven and four. Her mother works full time to support her family and her father lives in the next town. He sees his children on a weekly basis, but works two jobs and doesn't have a lot of free time, so visits are limited to one afternoon on the weekend.

Sasha's parents divorced shortly after the birth of her youngest brother, just as Sasha was entering kindergarten. When she started school, she was anxious and acted out between project times, especially after lunch while returning to the classroom. At first the school team, along with her parents, decided to explore learning disabilities thinking her most difficult time was during math. Sasha's evaluation showed she was learning at a normal pace and did not have a learning disability. As her behavior kept swinging between anxious and acting out, her parents and the school staff became more concerned. They did not want her to keep to this pattern because it would impact her learning and pro-social skills development. The parents and school decided a different approach was needed, and the school made a referral to the mental health clinician who worked in the school.

### ***Help at School***

Because many students need help, the school had a Success Beyond Six contract with the region's community mental health agency to hire a school-based clinician. This clinician could provide:

- assessment
- diagnosis
- case management
- social skill development and
- supportive counseling to children and their families.

The clinician was also able to talk with the school's staff about many types of mental health issues. For example, talk with teachers about ways to:

- help students with Attention Deficit Hyperactivity Disorder (ADHD) succeed in a classroom;
- organize the classroom to help students control impulsive and aggressive behavior; or
- build lessons about improving self-esteem and empathy.

**ACTION**

The school-based clinician first met with the school team and parents to hear about Sasha, what her challenges were, and what had been tried. Following that meeting, the clinician and Sasha met to get to know each other. The clinician also went to the family's house to meet the family as a whole and see how they interacted in their own environment.

This information gathering helped the clinician to understand Sasha's problems and how her actions were a part of her response to those problems. Then the clinician could start to figure out what Sasha needed to do well in school. The clinician knew that dealing with Sasha's anxiety would help her learn and maintain healthy peer relationships. This clinical understanding also drove the design of an individual plan of care. This plan of care allowed the team, Sasha's parents, and Sasha to focus upon specific goals so that she could succeed in school. The plan had measurable objectives or stepping stones on the path to those goals so everyone could gauge Sasha's progress and celebrate her successes.

The school-based clinician provided ongoing coordination with the team and family; if there was miscommunication, it was addressed immediately. Sasha began to develop skills needed to manage her anxiety and deal with changes in her day. Sasha's parents recognized their role in her behavior. For example, sudden changes in her weekend schedule also produced the same reaction they were seeing at school. It became clear that in order to help Sasha manage her anxiety, she needed explanations as to the changes about to occur. The school-based clinician then began to work with Sasha on developing internal management techniques.

**RESULTS**

Sasha's anxiety did not completely disappear, but she learned how to cope and her school team was now aware of the function of her behavior. She was not a child who was acting out to get attention, but rather a child trying to control her anxiety. Now the adults in her life could understand what her behavior was saying. Now they could respond more effectively by giving her reminders of the skills she had practiced to reduce her anxiety symptoms and by changing their own actions to reduce the cause of her anxiety.

## **Kevin's Story**

### **THE PICTURE**

**Kevin** is a fourteen year-year old boy who has many personal strengths. Kevin loves the outdoors, preferring nature and outdoor play to most other adolescent activities. He adores animals and uses their company to calm himself during transitions and periods of distress at home and in therapy. In addition, Kevin values the relationships in his life and has a number of people who enjoy spending time with him and are committed to supporting his growth and success.

During the pregnancy and Kevin's childhood, his home was marked by neglect, abuse, chaos, drug abuse and instability. It was typical for him and his siblings to be exposed to domestic abuse, adult drug use and distribution, sexual behaviors and abuse. Family stressors included the commonly correlated struggles of substance abuse, domestic violence, unemployment, housing and financial instability with significant impact on the family. Kevin's family history of domestic and childhood abuses date back at least three generations, and multiple family members are identified as sexual perpetrators. Secrecy, family loyalty, oppression and fear are ever present, as is a wariness of service providers.

Kevin has a history of aggressive and explosive behaviors for which he received services from the community mental health center for many years. His verbally and physically aggressive behaviors appeared to mimic the domestic violence he witnessed in his home from a very young age. He is easily frustrated and angry and has difficulty regulating his emotions. He is hyper-vigilant and anxious and can be easily overwhelmed in over-stimulating environments. Previous diagnoses included Mood Disorder Not Otherwise Specified, Attention Deficit Hyperactivity Disorder (ADHD), Oppositional Defiant Disorder (ODD) and concerns about possible Bipolar Disorder.

### **ACTION**

At age 10, Kevin moved into a therapeutic foster home with an intensive "wraparound" of mental health services due to unmanageable behaviors in his home and school settings. Kevin stated that he felt safe with the foster parent and that he liked the home because "it is calm and quiet."

Since then, Kevin has made slow, but significant progress. Kevin has a treatment team that is made up of his parents, foster parent, mental health workers, school staff, and other relevant community providers. The intensive community-based services included a thorough assessment. This allowed the team to rule out Bipolar Disorder and to recognize that trauma was the primary concern. The diagnosis of Post-Traumatic Stress Disorder was accepted as the best description for Kevin's history, current symptoms and behavior. His diagnosis, and thus his treatment approach, has been clarified with an understanding of the role of trauma and its impact on his early development (see sidebar for more information on trauma in children).

When he becomes escalated, Kevin can either look like an out of control toddler (consistent with delayed development due to his trauma history) or a battering adult (consistent with his exposure to violence in the home). The challenge for his team is to understand how to respond to these two very different presentations. The hyper-vigilance affects Kevin in profound ways including somatic (body-based) complaints, cardiovascular issues, night terrors, and self-regulation difficulties.

Kevin's unmet mental health and sensory needs often leave him exhausted and overwhelmed by the high stimulation in his home, school, and community. His team recognized these difficulties as they related to the early trauma and referred Kevin for evaluation of his sensory integration system. This helped to determine if one or more senses are either over- or under-reactive to stimulation and whether the sensory inputs are properly interpreted by the brain. Kevin's mental health workers began a sensory-specific, trauma-informed treatment approach to address these deficits. Immediate results were observed, including a dramatic reduction in sleep disturbances and lowered blood pressure. His treatment team has also noticed improvements in his ability to manage his anger, fewer and less intense violent outbursts, and he has begun to heal his relationships with both adults and peers.

Kevin is very loyal to his family, and his ability to do well is often a reflection of the stability of his family, even when he is not living with them. The provider system has recognized this and offered services for his family to receive the support that they need. Despite this, Kevin's father was incarcerated while Kevin was in foster care and there is no contact. Kevin entered the custody of the State Department for Children and Families (DCF), Family Services Division due to the continued risk of harm in the biological home; he continues to reside with his therapeutic foster parent and receive the wraparound mental health services. Kevin continues to struggle

with his identity formation and understanding who he is in the context of his family and what life choices he will face. Kevin's treatment team is partnering with DCF to address Kevin's permanency needs while continuing his intensive mental health treatment. Kevin and his mother participate in family treatment to build a healthier foundation for their relationship despite significant changes in Kevin's permanency plan. This family treatment focuses on basic parenting skills, practicing attuning (recognizing and responding) to Kevin's emotional and behavioral needs, and setting boundaries to protect his emotional and physical safety.

## **RESULTS**

Kevin is living and going to school in the community due to a committed treatment team and comprehensive treatment plan including therapeutic case management, community skills work, crisis supports, a stable therapeutic foster home, therapeutic school placement and a number of supportive relationships in the community. However, there are significant concerns that Kevin continues to need this level of care after many years of treatment and that as he gets older his foster home placement could be in jeopardy if he continues to be unsafe.



### **Trauma in Childhood**

*Dr. Bruce Perry is an internationally recognized authority on child trauma and the effects of child maltreatment. Dr. Perry is the Senior Fellow of the Child Trauma Academy ([www.ChildTraumaAcademy.com](http://www.ChildTraumaAcademy.com); [www.ChildTraumaAcademy.org](http://www.ChildTraumaAcademy.org)). The following is excerpted from his articles.*

Healthy development in children is made possible through positive, healthy, repetitive relationships where their primary needs for safety are met. A child's potential for healthy development is determined by his or her early experiences. "You don't become human just because you're born into the species, but because someone was kind with you, held you, and shared." "Traumatic experiences can have a devastating impact on the child, altering their physical, emotional, cognitive and social development. In turn, the impact on the child has profound implications for their family, community and, ultimately, us all." (*Living and Working with Traumatized Children*, B. Perry, 2004)

The human "brain systems which allow us to think, feel, and act are shaped by experience. Furthermore,...the experiences of childhood act as primary architects of the brain's capabilities throughout the rest of life. These organizing childhood experiences can be consistent, nurturing, structured and enriched - resulting in flexible, responsible, empathic and intelligent contributors to society. Or, all too often, childhood experiences can be neglectful, chaotic, violent and abusive – resulting in impulsive, aggressive, remorseless, and intellectually-impoverished members of society." (*The Power of Early Childhood*, B. Perry, 2005)

Children who experienced early neglect or trauma need external, organized, repetitive activities (not just medications) to reverse this brain structure. Good physical practices for sleeping, eating, and exercise help the brain to get organized around these systems. They, in turn, help the child to manage his or her emotions, to develop social skills, and to solve problems. If the child didn't receive this help in the early years, there can still be positive growth if given a structured nurturing environment, self-care, and caring relationships; the earlier the better.

## **Dan's Story**

### **THE PICTURE**

Danny was diagnosed with Shaken Baby Syndrome when he was six months old. He had been roughly handled and shaken on a number of occasions by his mother's boyfriend, who became angry when Danny would not stop crying. This man was sent to jail for this abuse and for domestic abuse toward Danny's mother. The whereabouts of Danny's father were unknown. Ongoing concerns about Danny's safety in his mother's home led to the termination of parental rights by his first birthday. He entered state's custody and was adopted on his second birthday by a family with a previously adopted five year old son.

Danny settled in with his new family, but struggled to meet milestones of cognitive and motor development. Danny's new parents worried about his almost constant hyperactive behavior and lack of impulse control. These traits caused Danny problems in getting along with other children his age and with his older brother. They worked with him and hoped he would grow out of the hyperactive behavior and grow into the ability to think about consequences before he acted.

### **ACTION**

Danny had not outgrown these traits by the time he was old enough to enter kindergarten, and his parents worried about the possible impact on his success in school. They spoke with the school's guidance counselor and decided to have a mental health assessment at the region's community mental health center. Danny was assessed and diagnosed with Attention Deficit Hyperactivity Disorder (ADHD). After talking with the clinician, the school guidance counselor, and Danny's pediatrician, his parents decided that Danny's best interest was to follow the assessment's advice. This included Danny taking medication for the hyperactivity to allow him to focus more easily and Danny taking part in individual and family therapy. The mental health clinician set up the family therapy so everyone in the family could understand how their actions could affect their life together. Methods to deal with different types of problems at home and school were explained and tried. If a method worked well, it was kept as part of the family's "toolkit." If it worked somewhat, it was changed and the new version tried. If a method did not work, it was dropped. The clinician also worked with Danny's parents on ways to build his assets, such as connections with sports and music, as well as ways to keep a balance of

attention with Danny's older brother. At school, Danny was found eligible for Special Education for Emotional Disturbance and for Learning Disability and was placed on an Individualized Education Plan (IEP). The IEP designed teaching methods and supports to help Danny succeed in school.

There were rough patches and good times during elementary and middle school years. In the fifth grade, Danny's family was able to buy him a dirt-bike motorcycle, and he became a very good rider. This was an interest that he shared with his older brother, and they often raced against each other. Even with supports, though, there were some difficult times, often marked by anger and tears both at school and at home. Danny liked and had no trouble meeting new people, but his swings in emotions and lack of impulse control made it hard to keep friends. As he entered adolescence, the few friendships that he did have faded away, increasing Danny's levels of frustration and unhappiness. His parents and teachers saw acts of oppositional behavior toward adults and unprovoked aggression toward his peers and his brother. In ninth grade, he was hospitalized twice when his actions became a danger to himself and others. It was decided that it would help to develop a Coordinated Service Plan (CSP) for Danny to assure collaboration between the family, school, mental health, and the hospital and to provide an increased level of support. The CSP also included a pro-active crisis plan. This laid out what might trigger a mental health crisis for Danny and what everyone could do (and should not do) to de-escalate a situation and avoid a crisis.

It became clearer in high school that Dan was falling behind his peers educationally as well as socially. As time went on, his learning disability, combined with his emotional disability, had created larger distances from his age peers. But Dan, his family, school team, therapist, and case manager refused to give up and continued to struggle to understand him diagnostically to plan for his needs. He had more psychological and neurological tests which further refined everyone's understanding of the interactive impacts of Dan's post traumatic stress disorder, reactive attachment disorder, learning disorder, and expressive language disorder. The traumatic brain injury caused by Shaken Baby Syndrome further complicated the mental health diagnoses. Brain damage such as Dan received as an infant can require specific treatment, which may be different than that for people who have not suffered such damage even though on the surface the symptoms look very similar.

In the tenth grade, Dan was placed in a special school and mental health residential treatment program. Dan's school team worked with the residential school staff to keep him on track with his home school's curriculum. Dan and his family worked with the treatment staff to learn more about his condition and to practice methods that would help them all to cope with his handicapping conditions. There were good parts and hard parts to this placement. On the plus side, Dan met peers who shared his challenges and were working on similar methods with the program's staff. For the first time in a long time, Dan did not feel quite so different. On the minus side, Dan was far from his family, and it was difficult for them to make the 2-hour trip to the program to see him and work with the staff.

Dan returned to his family and school at the end of the tenth grade. It was not easy to apply the skills learned in the controlled setting of the residential school and treatment program to the much more changeable settings of a family and public high school. But everyone kept working at it and making adjustments to increase Dan's level of success in these settings. Dan discovered that he liked running to use up some of his energy and to work off frustrations. With the encouragement of his gym teacher, he joined the track team.

An added stress for everyone at this point became thoughts about Dan's life after high school. On extra hard days, Dan just wanted to drop out of school. This was a particular worry for his parents and school team because they knew that, without a high school diploma or a GED, Dan's chances would drop for a job with a livable wage and his chances would increase for alcohol and substance abuse, unemployment, becoming homeless, and perhaps ending up in jail.

The school team referred Dan to the region's JOBS program. This program was designed to help youth with mental health issues transition to adult life by combining vocational skills and community work experiences with mental health supports. After working with his JOBS case manager, Dan discovered that, although he had trouble using language, he had no trouble figuring out why small engines in motorcycles, lawn mowers, and chain saws broke down and how to fix them. Dan enrolled in a class in his region's technical education center and, with the help of his JOBS case manager, found a part-time after-school job in a small business that did this type of work. The JOBS case manager worked with the employer to set up the time, place, and skills Dan would use and worked with Dan on methods to handle job-related frustrations. The technical problems Dan could not easily solve on his job gave him a reason to go back to

his technical center class and ask questions. His education and his life felt connected. This real work gave Dan a sense of self-esteem, of normalcy, and of a possible future, all of which are vitally important to adolescents moving into adult life.

## **RESULTS**

Dan could not be cured from the brain damage he suffered as a baby. His adoptive family provided much love and support and reached out for additional help when more was needed. Dan will always have specific learning disabilities; however, his school team helped him to see that he learns best when the basic approach is hands-on rather than verbal. He will always be vulnerable to specific emotional triggers; however, his mental health workers helped him to learn ways to limit exposure to potential triggers and to control those that cannot be avoided. Together they shared love, knowledge, skills, encouragement, stability, and a sense of hope for the future. Because of his enduring disabilities, Dan may always need some supports. However, he has been loved and learned how to love others in his family, has stayed in school and benefited from his education, has acquired valuable job experience, has learned how to reach out for help when he needs it, and has a reasonable expectation of life as a contributing member of his community.

## Appendix D:

### Glossary

#### **Glossary:**

**Act 15:** Vermont law passed in 2007 which separated the Division of Mental Health from the Department of Health, restored its departmental status, and expanded its responsibilities. A copy of the law can be found at <http://www.leg.state.vt.us/docs/legdoc.cfm?URL=/docs/2008/acts/ACT015.HTM>.

**Act 264:** Vermont law passed in 1988, adding Chapter 2 to Title 3 V.S.A. and sections to related titles in order to develop and implement a coordinated system of care for children and adolescents with a severe emotional disturbance and their families. Act 264 defines severe emotional disturbance and creates an Advisory Board and State and Local Interagency Teams to assist in the provision of care through the use of a Coordinated Service Plan for children served by more than one agency. A copy of the law can be found at [http://mentalhealth.vermont.gov/sites/dmh/files/legislative/DMH-Act\\_264\\_Advisory\\_Creation\\_1988.pdf](http://mentalhealth.vermont.gov/sites/dmh/files/legislative/DMH-Act_264_Advisory_Creation_1988.pdf).

**Adjustment Disorder:** Defined in DSM-IV-TR (code #309 range) as the development of emotional or behavioral symptoms in response to an identifiable stressor(s) occurring within 3 months of the onset of the stressor(s).

**Administrative Rules on Agency Designation:** Formally adopted regulations for implementing Vermont mental health law (18 V.S.A., chapter 207) designating community mental health agencies. These rules were most recently revised effective June 1, 2003. A copy can be found at [http://mentalhealth.vermont.gov/sites/dmh/files/policies/ADMINISTRATIVE\\_RULES\\_AGENCY\\_DESIGNATION\\_2003.pdf](http://mentalhealth.vermont.gov/sites/dmh/files/policies/ADMINISTRATIVE_RULES_AGENCY_DESIGNATION_2003.pdf).

**Agency of Human Services (AHS):** The largest unit within the Executive Branch of Vermont State government, the AHS includes the Departments of: Disabilities, Aging, and Independent Living (DAIL); Corrections (DOC); Mental Health (DMH); Health (VDH); Vermont Health Access (DVHA); and the Department for Children and Families (DCF).

**Agency Review:** The Department of Mental Health's (DMH) Agency Review evaluates the performance of mental health programs offered by Vermont's designated agencies (DAs). DMH is responsible for conducting and reporting on the results of the reviews every four years. The reviews offer opportunities to focus on the system of care's ability to achieve desired outcomes, to recognize program accomplishments and challenges, and to identify

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areas for quality improvement. Agency Review reports concentrate on four quality domains: Access, Practice Patterns, Outcomes of Care, and Administrative Structures. Findings from Agency Reviews feed into DMH's process for re-designation of agencies, also every four years.

Alcohol and Drug Abuse Programs (ADAP): The Division of ADAP is part of the Vermont Department of Health and has responsibility for preventing and treating substance abuse by Vermonters.

Appropriation: Funding approved by the legislature for a department, program, or particular expense.

Attention Deficit Hyperactivity Disorder (ADHD): Defined in DSM-IV-TR (code #314 range) as a persistent pattern of inattention and/or hyperactivity that is more frequently displayed and more severe than is typically observed in individuals at comparable levels of development. Some symptoms must have been present before 7 years of age.

Autistic Disorder: Defined in DSM-IV-TR (code #299.00) as the presence of markedly abnormal or impaired development in social interaction and communication and a markedly restricted repertoire of activity and interests.

Child, Adolescent and Family Unit (CAFU): This Unit is one of the units of the Department of Mental Health (DMH). CAFU staff oversees Vermont's mental health system of care for children described in this plan.

Caseload integration: A measure of caseload overlap of clients of the public mental health system (Department of Mental Health), the Department for Children and Families, and the Agency of Education.

Caseload overlap: This condition exists when different departments share the same client on their caseloads.

Causative factors: Agents that cause other things to happen.

Collaborative: Together, jointly with others.

Competencies: Skills, abilities.

Composite: A fictional person based on various aspects of real people and their lives.

Continuous Quality Improvement (CQI): A comprehensive approach to quality control and management that grew out of work by Dr. W. Edward Deming who said to give customer concerns top priority, and to study and constantly improve every work process so that the final product or service exceeds customer expectation.

Coordinated Service Plan (CSP): Defined by Act 264, this is an interagency tool for identifying the goals, strengths, services and funding needed for a child with severe emotional disturbance, and also the unmet service needs. This Plan is a written addendum to the service plan developed for the child by each agency serving him/her.

Core Capacity Services: This is the minimum range of children's mental health services for which DMH contracts with each DA.

Cultural diversity: The variety of behavior patterns, arts, beliefs, institutions and other characteristics expressed in a community by different populations.

Department of Disabilities, Aging, and Independent Living (DAIL): The Department is part of the Agency of Human Services and provides a variety of services to Vermonters who are over the age of 60 or who have a disability. Its website is at <http://dail.vermont.gov>. Its divisions include:

- Blind and Visually Impaired
- Disabilities and Aging Services
- Licensing and Protection
- Vocational Rehabilitation

The department also includes services for Vermonters who are deaf and hard of hearing

Department for Children and Families (DCF): The Department for Children and Families, as part of an integrated Agency of Human Services, fosters the healthy development, safety, well-being, and self-sufficiency of Vermonters. Its website is at <http://dcf.vermont.gov>. Its divisions include:

- Child Development
- Disability Determination
- Economic Services
- Family Services
- Office of Child Support
- Office of Economic Opportunity.

Department of Education (DOE): This free-standing State Department licenses teachers, approves funds, and provides technical assistance for schools to educate children from pre-kindergarten through high school graduation and oversees Adult Basic Education programs. Its website is at <http://education.vermont.gov>.

Department of Vermont Health Access (DVHA): The Department of Vermont Health Access is responsible for the management of Vermont's publicly funded health insurance programs. Its website is [www.ovha.vermont.gov](http://www.ovha.vermont.gov). Its mission is to:

- assist beneficiaries in accessing clinically appropriate health services;
- administer Vermont's public health insurance system efficiently and effectively; and
- collaborate with other health care system entities in bringing evidence based practices to Vermont's Medicaid beneficiaries.

Department of Mental Health (DMH): This AHS Department designates, funds, monitors and provides technical assistance for community non-profit agencies (designated agencies and specialized service agencies) to deliver services to Vermonters with serious and persistent mental illness, severe emotional disturbance, and/or mental health crises. Its website is at <http://mentalhealth.vermont.gov>. Its major areas of service oversight include:

- Child, Adolescent, and Family Services
- Adult Outpatient Programs
- Community Rehabilitation and Treatment
- Emergency/Crisis Services
- Vermont State Hospital

Developmental Disabilities: This term is defined by Vermont's Developmental Disabilities Act of 1996 (adding 18 V.S.A., chapter 204A) and the related regulations of 5/15/97. Services for people with developmental disabilities are described in the *Vermont State System of Care Plan for Developmental Services*.

Designated Agency (DA): As specified in the *Administrative Rules on Agency Designation*, the Commissioner of DMH shall designate one agency in each geographic area of the state to assure that people in local communities receive services and support that are consistent with available funding, the State System of Care Plan, the local System of Care Plans, outcome requirements, *etc.*

Designation Review: As specified in the *Administrative Rules on Agency Designation*, the process for initial and re-designation of an agency by the DMH consists of multiple steps and levels of review that must occur at least once every four years to assure the contracted agency meets or exceeds required levels of quality.

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Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR): Produced by the American Psychiatric Association, this manual reflects research and the consensus of experts about how to classify and describe mental disorders.

Domains of Quality Service: The items chosen for ongoing measurement to guide management of DMH have been grouped as follows for easy reference: (1) access to care, (2) practice patterns of care, (3) outcomes/results of treatment, and (4) structure/administration.

Dysthymic Disorder: Defined in DSM-IV-TR (code #300.4) as a chronically depressed mood that occurs for most of the day for more days than not for at least 2 years. For children and adolescents, instead, there may be a chronically irritable mood that occurs for most of the day for more days than not for at least 1 year.

Emotional Disability (ED): Generally, a problem involving a person's emotions and/or behaviors.

Technically, as defined in federal IDEA legislation (Individuals with Disabilities Education Act), an emotional disturbance exhibited over a long time and to a marked degree may be documented as a disability allowing school accommodations under a 504 Plan. If the disability has an adverse effect on educational performance and there is a need for special education that cannot be met by existing school services, a student may be eligible for special education and an IEP (Individual Education Plan).

Early Periodic Screening, Diagnosis, and Treatment (EPSDT): EPSDT was enacted by Congress to reduce infant mortality and improve access to child health services. It mandates that a comprehensive set of services be available to children enrolled in Medicaid. An individual child may use a particular service if it is prescribed by a licensed practitioner as medically necessary.

Families First (Access Vermont/Family Preservation Initiative): Initially a five-year grant from the federal Center for Mental Health Services, this initiative has been sustained with a mix of state general funds and Medicaid to provide crisis outreach services for families whose children are at risk of removal from their homes and/or communities.

Family Support Child Care: The cost of child care is paid for families assessed to be at risk of abusing and/or neglecting their children. Funding is provided if the family participates in a plan for services to reduce its stress.

Federally Qualified Health Center (FQHC): A federally qualified health center (FQHC) is a type of provider defined by the Medicare and Medicaid statutes. FQHCs include all public or non-profit organizations

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receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. Benefits of being an FQHC include PHS 330 grant funding; enhanced Medicare and Medicaid reimbursement; medical malpractice coverage through the Federal Tort Claims Act; eligibility to purchase prescription and non-prescription medications for outpatients at reduced cost through the [340B Drug Pricing Program](#); access to [National Health Service Corps](#); access to the [Vaccine for Children](#) program; and eligibility for various other federal grants and programs. FQHCs must provide primary care services for all age groups. FQHCs must provide on site or by arrangement with another provider preventive health services, dental services, mental health and substance abuse services, transportation services necessary for adequate patient care, hospital and specialty care. FQHCs must use a sliding fee scale with discounts based on patient family size and income in accordance with federal poverty guidelines. FQHCs must be open to all, regardless of their ability to pay.

**Full-Time Equivalent (FTE):** A full-time employee for a DA works 37.5 hours per week. Employees' time is often pro-rated across different positions (*e.g.*, clinician and supervisor), and multiple part-time employees may fill one position (*e.g.*, 4 respite workers may work a total 37.5 hours in a week between them).

**Fiscal Year (FY):** For business purposes, the State of Vermont claims July 1-June 30 to be its fiscal year.

**Generalized Anxiety Disorder (with or without Panic Attacks):** Defined in DSM-IV-TR (code #300.02) as excessive anxiety and worry (apprehensive expectation) occurring more days than not for a period of at least 6 months, about a number of events or activities.

**Global Commitment (GC):** Vermont's title for a five-year agreement with the federal government on the use of Medicaid funding. In exchange for accepting a limit on a previously uncapped source of federal funding, Vermont is granted greater flexibility on how it may spend its Medicaid dollars to achieve better outcomes for its service recipients.

**Grants:** Funds bestowed on a formula or competitive basis to organizations for specific purposes as agreed between the funder and the grantee.

**Health Department:** This AHS Department plans and implements primary prevention programs (such as smoking cessation) targeted to improve the health of whole communities and populations in Vermont, as well as programs targeted to special groups such as low-income mothers with babies or people with AIDS. Its website is <http://healthvermont.gov>.

**Holistic:** Emphasizing the importance of the whole and the interdependence of its parts.

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Ibid: Note indicating that the quoted material can be found in the book, article or paper cited in the previous footnote. From the Latin word *ibidem* meaning “the same.”

Individualized Education Plan (IEP): Federal and state laws entitle all students, including those with disabilities, to receive a free, appropriate public education (FAPE). An IEP is an important tool for ensuring the appropriateness of that special education for qualified students. An IEP identifies and monitors progress toward learning goals and objectives for the student, based upon a comprehensive assessment and input from the student’s team, which includes at least parents and teachers.

Individualized Services Plan (ISP): This mechanism is used by DMH in collaboration with one or more other departments (usually DCF) to plan and budget for the multiple services required by particular youth with intensive needs. DMH approves the related Medicaid expenditures in accordance with the state general funds provided as match by the other department.

Jump on Board for Success (JOBS): This is a partnership among Vocational Rehabilitation, DMH, Corrections, and DCF, to expand services and employment outcomes for youth with SED who are transitioning to adulthood. JOBS was developed by Vermont’s Washington County Mental Health Services in 1992 and has since been replicated in each region of the state.

MAPS: The McGill Action Planning System for helping a team identify with a student his/her history, dreams, fears, strengths and needs in order to develop a plan for action.

Match: State general fund dollars needed to access or draw down federal Medicaid dollars. The exact ratio is adjusted periodically by an economic formula, but Vermont’s ratio is roughly 1:2. For every \$1.00 of general funds Vermont pays as match, DMH can draw down approximately \$2.00 additional in federal Medicaid to help pay for medically necessary services.

Medicaid: Title XIX of the federal Social Security Act creates Medicaid as an entitlement to medical care for people who are aged, blind or disabled or who have low-incomes and children. This entitlement is funded partly (about 50-60%) by the federal government and partly (about 40-50%) by the states. Each state decides what services to cover and for whom, based upon projected expenses and social priorities. All services must be determined by appropriately licensed professionals to be “medically necessary.”

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Oppositional Defiant Disorder (ODD): Defined in DSM-IV-TR (code #313.81) as a recurrent pattern of negativistic, defiant, disobedient and hostile behavior toward authority figures that persists for at least 6 months.

Paraprofessionals: Assistants to professionals.

Partnership: An association of organizations or people cooperating with each other in an activity of common interest.

Perinatal: The period of time ranging from 28 weeks after conception to 28 weeks after birth.

Postpartum depression: Defined in DSM-IV-TR as a mood disorder with onset within 4 weeks after childbirth.

Prenatal: Before birth.

Pervasive Developmental Disorder (PDD): Defined in DSM-IV-TR (code #299 range) as a group of disorders characterized by severe and pervasive impairment in several areas of development: reciprocal social interaction skills, communication skills, or the presence of stereotyped behavior, interest and activities. PDD includes Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder, and PDD Not Otherwise Specified.

Preferred provider system: A method for managing the quality and cost of care by paying only certain providers to deliver services. According to Vermont law, DMH must use such a system. For DMH, the preferred providers are the DAs and SSAs.

Prevalence: Generally, the rate of occurrence of a condition. The federal estimate of the prevalence of serious emotional disturbance among Vermont's children and youth is conveyed in the Federal Register for July 17, 1998.

Program in Community Mental Health (PCMH): This is a certificate and Master's Degree program now administered by Southern New Hampshire University, formerly by Trinity College. PCMH was created with extensive involvement and support from the DMH and the DAs, which have a continuing need for staff educated about effective approaches to community-based public mental health care.

Psychiatric nurse practitioner: A Registered Nurse with a Master's Degree in Nursing who is allowed in Vermont to prescribe medications if s/he works in consultation with a licensed physician. Some nurse practitioners are also nationally certified to work with patients with psychiatric conditions.

Psychological testing: The use of valid and reliable ways of examining the mind or emotions.

Qualified Mental Health Professional (QMHP): A QMHP is designated by the Commissioner of DMH to screen people for voluntary admission and to serve as the applicant for involuntary admission to the Vermont State Hospital and designated general hospitals. Designation as a QMHP depends upon qualification, demonstrated knowledge and training, and completion of a DMH application.

Quality Improvement (QI) Plan: *The Administrative Rules on Agency Designation* require an annually updated QI Plan from each DA, reporting on the DA's use of agency data and outcomes, changes in objectives, timelines, and scope of planned projects for the year.

Reactive Attachment Disorder of Infancy and Early Childhood: Defined in DSM-IV-TR (code #313.89) as markedly disturbed and developmentally inappropriate social relatedness in most contexts that begins before age 5 years and is associated with grossly pathological care.

Residential case review: The process of determining whether or not a child's best treatment interests would be met in a residential placement involves application for such a placement through the Central Review Committee (CRC) of the Act 264 State Interagency Team. DCF, DOE, CAFU, DAIL, VDH and the Vermont Federation of Families for Children's Mental Health are represented on the CRC. CRC considers applications from state departments and the DAs on behalf of the Act 264 Local Interagency Teams and/or treatment teams for individual children, youth, and their families.

Resiliency: The capacity to bounce back from misfortune or illness, to be restored to an earlier condition or shape.

Respite: Temporary rest or reprieve from the stress of care-giving.

Separation Anxiety Disorder: Defined in DSM-IV-TR (code #309.21) as developmentally inappropriate and excessive anxiety concerning separation from home or from those to whom the individual is attached.

Serious Emotional Disturbance: The federal definition for serious emotional disturbance is conveyed in the Federal Register for May 20, 1993.

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**Severe Emotional Disturbance (SED)**: Act 264 embeds into Vermont law a definition for severe emotional disturbance that is essentially (with slight changes) the federal definition for SED. The definition includes diagnostic and functional elements relevant for children and youth aged 0-22 in Vermont. Children with SED experience mental health symptoms that seriously impair their functioning and comfort. A copy of the law and its definition may be found at [http://mentalhealth.vermont.gov/sites/dmh/files/legislative/DMH-Act\\_264\\_Advisory\\_Creation\\_1988.pdf](http://mentalhealth.vermont.gov/sites/dmh/files/legislative/DMH-Act_264_Advisory_Creation_1988.pdf).

**Severe Functional Impairment (SFI)**: (A) a disorder of thought, mood, perception, orientation, or memory, as diagnosed by a qualified mental health professional, which substantially impairs judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life and which substantially impairs the ability to function within the correctional setting; or (B) a developmental disability, traumatic brain injury or other organic brain disorder, or various forms of dementia or other neurological disorders, as diagnosed by a qualified mental health professional, which substantially impairs the ability to function in the correctional setting.

**Socialization Skills**: Abilities (like communicating, sharing, waiting and understanding behaviors of others) needed to take part in social situations.

**Specialized Service Agency (SSA)**: As specified in the *Administrative Rules on Agency Designation*, if a needed service is not available through a DA, the DMH may contract with another organization to provide it if the agency meets the requirements of a Specialized Service Agency. Such an Agency must offer services that meet distinctive individual needs or take a distinctive approach to service delivery and/or coordination.

**Stakeholders**: People with legal, financial or other interests in the outcome of a program or undertaking.

**Step-down**: To gradually reduce the intensity of service by moving from a hospital to a structured residential placement before moving home.

**Strengths-based**: This treatment principle asserts the benefits of building on the strengths of a child or family, rather than focusing solely on their “deficits” or problems.

**Success Beyond Six**: This is a funding partnership between DAs and schools whereby schools provide the state general funds to match Medicaid, the DAs provide access to Medicaid, and the schools and DAs jointly hire children’s mental health staff for a variety of programs which serve children referred by the schools. It is currently being reviewed to develop program parameters and to complement the educational evidence-based practice of Positive Behavioral Supports (PBS).

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System of Care: A set of ideas, principles, rules, procedures, services and supports that are interrelated and that interact as a whole to ensure that children and adolescents with an emotional disturbance and their families receive services and supports needed to help them grow into caring, competent and responsible citizens.

Temporary Assistance for Needy Families (TANF): This is cash assistance available on a short-term basis for families with children that have low incomes and meet work and/or other requirements.

Trauma: A wound or emotional shock that produces substantial and lasting psychological/physical damage.

Unconditional care: Absolute, unrestricted commitment to protection, supervision and treatment for eligible children and their families.

Vocational Rehabilitation (VR) Division: This Division is part of the AHS Department of Disabilities, Aging and Independent Living (DAIL). VR helps adults and transition-aged youth with disabilities prepare for and obtain employment suited to their interests, knowledge, and skills.

Waiver: The Home and Community-based Waiver is a federal release from (or waiving of) the usual rules governing fee-for-service Medicaid. The Waiver allows more flexibility in the definition and delivery of services for people at risk of institutionalization under the condition that the cost of services provided under the Waiver does not exceed the cost of institutionalization.

## Appendix E:

### Acronyms and Abbreviations

ACT	Assertive Community Treatment (a.k.a. PACT, Program in Assertive Community Treatment)
ACT	Application for Continued Treatment
ADAP	(Division of) Alcohol and Drug Abuse Programs, Vermont Department of Health
ADD	Attention Deficit Disorder
ADHD	Attention Deficit Hyperactivity Disorder
AHS	Agency of Human Services
AOP	Adult Outpatient Programs
APA	American Psychiatric Association
APA	American Psychological Association
APSE	Association for Persons in Supported Employment
ARC	Attachment, Self-Regulation, and Competency model
AS	Autism Spectrum
ASEBA	Achenbach System of Empirically Based Assessment ( <i>cf.</i> CBCL)
ASI	Addiction Severity Index
BGS	(Department of) Buildings and General Services
BISHCA	Now the Department of Financial Regulation (formerly the Department of Banking, Insurance, Securities, and Health Care Administration)
BPD	Borderline Personality Disorder
BRFSS	Behavioral Risk Factor Surveillance System
CARF	Commission on Accreditation of Rehabilitation Facilities
CAFU	Child, Adolescent, and Family Unit
CARE	Community Aid and Recovery Effort
CBCL	Child Behavior Checklist (a.k.a. “the Achenbach”)
CBT	Cognitive Behavior Therapy
CCISC	Comprehensive, Continuous, Integrated System of Care
CCON	Conceptual Certificate of Need
CDC	Centers for Disease Control and Prevention

CDD	Child Development Division
CHASS	Children's Health and Support Services
CMC	Clara Martin Center
CMHC	Community Mental Health Center
CMHS	Center for Mental Health Services
CMS	Centers for Medicare and Medicaid Services
COA	Certificate of Approval
COD	Co-occurring Disorders (e.g., mental illness and substance abuse)
CON	Certificate of Need
CPAP	Clinical Practices Advisory Panel
CQI	Continuous Quality Improvement
CRC	Case Review Committee
CRT	Community Rehabilitation and Treatment
CSAC	Counseling Service of Addison County
CSID	Crisis Stabilization Inpatient Diversion (program)
C-SIR	Caseload Segregation Integration Ratio
CSP	Coordinated Service Plan
CSP	Community Support Program
CVMC	Central Vermont Medical Center, a designated hospital in Berlin
DA	Designated Agency
DAIL	Department of Disabilities, Aging, and Independent Living
DBT	Dialectical Behavioral Therapy
DCF	Department for Children and Families
DDCAT	Dual Diagnosis Capability in Addiction Treatment
DFR	Department of Financial Regulation
DHHS	U.S. Department of Health and Human Services
DH	Designated Hospital
DIG	Data Infrastructure Grant
DMH	Department of Mental Health
DOE	Department of Education (now Agency of Education)
DOJ	U.S. Department of Justice
DRVT	Disability Rights Vermont
DSM-IV R	<i>Diagnostic and Statistical Manual of Mental Disorders</i> (4 <sup>th</sup> Edition Revised)
DVHA	Department of Vermont Health Access

EBD	Emotional/Behavioral Disorder
EBP	Evidence-based Practices
ECT	Electroconvulsive Therapy
ED	Emotional Disability
EDO	Emergency Detention Disorder for child custody
EE	Emergency Exam for psychiatric disorder
EEE	Essential Early Education
EHR	Electronic Health Record
EMDR	Eye Movement Desensitization and Reprocessing
EMR	Electronic Medical Record
ES	Emergency Services
FAHC	Fletcher Allen Health Care, a designated hospital in Burlington
FCC	Federal Communications Commission
FEMA	Federal Emergency Management Agency
FFF	Flexible Family Funding
FFY	Federal Fiscal Year
FPE	Family Psychoeducation
FQHC	Federally Qualified Health Center
FTE	Full-time equivalent (used in reference to personnel)
FY	Fiscal year
GAF	Global Assessment of Functioning
GAIN	Global Assessment of Individual Need
GAS	Goal Attainment Scale
GC	Global Commitment to Health
GF	General Funds
HC	HowardCenter
HCRS	Health Care and Rehabilitation Services of Southeastern Vermont
HEDIS	Healthcare Effectiveness Data and Information Set
HIPAA	Health Insurance Portability and Accountability Act (1996)
HMIS	Homeless Management Information System
HRD	Human Resource Development
HUD	U.S. Housing and Urban Development
IDDT	Integrated Treatment for Individuals with Dual Diagnoses of Mental Illness and Substance Abuse

IDEA	Individuals with Disabilities Education Act
IEP	Individualized Education Plan
IFS	Integrated Family Services
IGA	Intergovernmental Agreement
IMR	Illness Management and Recovery
IOA	Inpatient Options Analysis
IPC	Individual Plan of Care
IPS	Individual Placement and Support, or evidence-based Supported Employment
IT	Information Technology
JOBS	Jump on Board for Success
LCC	Lamoille Community Connections
LIT	Local Interagency Team
LOCUS	Level of Care Utilization of Services
LOS	Length of Stay
MCE	Managed Care Entity
MCIS	Managed Care Information System
MCO	Managed Care Organization
MOU	Memorandum of Understanding
MSR	Monthly Service Report
MSW	Master's degree in Social Work
NAMI—VT	National Alliance on Mental Illness of Vermont
NAPPI	Non-Abusive Physical and Psychological Intervention
NASMHPD	National Association of State Mental Health Program Directors
NCSS	Northwestern Counseling and Support Services
NCQA	National Committee for Quality Assurance
NETC	New England Telehealth Consortium
NFI	Northeastern Family Institute
NKHS	Northeast Kingdom Human Services
NIH	National Institute of Health
NIMBY	Not in My Backyard!
NIMH	National Institute of Mental Health
NOMS	National Outcome Measures
NTAC	National Technical Assistance Center (for Children's Mental Health)
OBS	Observation

PASARR	Preadmission Screening and Annual Resident Review (for nursing homes)
PATH	Program to Assist in the Transition from Homelessness
PIP	Performance Indicator Project
PORT	(Schizophrenia) Patient Outcomes Research Team
PRC	Psychiatric Research Center (Dartmouth)
PTSD	Post-Traumatic Stress Disorder
QA	Quality Assurance
QAPI	Quality Assurance/Performance Improvement
QI	Quality Improvement
QM	Quality Management
QMHP	Qualified Mental Health Professional
RAISE	Recovery After an Initial Schizophrenia Episode
RHC	Retreat Health Care, a designated hospital (Brattleboro Retreat)
RMHS	Rutland Mental Health Services
RRMC	Rutland Regional Medical Center, a designated hospital
SAMHSA	Substance Abuse and Mental Health Services Administration
SBS	Success Beyond Six
SCHIP	State Children's Health Insurance Program
SE	Supported Employment
SED	Severe Emotional Disturbance
SFI	Severe Functional Impairment
SIT	State Interagency Team
SMHA	State Mental Health Authority
SOC	System of Care
SPSC	State Program Standing Committee
SSA	Specialized Service Agency
SSA	Social Security Administration
SSDI	Social Security Disability Income
SSI	Supplemental Security Income
SRR	Secure residential recovery (facility)
SUD	Substance Use Disorder
TBI	Traumatic Brain Injury
TCR	Therapeutic Community Residence
TIP	Transition to Independence Process

TTW	Ticket to Work
TX	Treatment
UCS	United Counseling Service of Bennington County
VAMHAR	Vermont Association for Mental Health and Addiction Recovery (formerly VAMH, Vermont Association for Mental Health)
VCDMHS	Vermont Council of Developmental and Mental Health Services
VCDR	Vermont Coalition for Disability Rights
VCHIP	Vermont Child Health Improvement Program
VCRHYP	Vermont Coalition of Runaway and Homeless Youth Programs
VCTC	Vermont Child Trauma Collaborative
VDH	Vermont Department of Health
VFFCMH	Vermont Federation of Families for Children's Mental Health
VFN	Vermont Family Network
VISI	Vermont Integrated Services Initiative
VPA (1)	Vermont Psychiatric Association
VPA (2)	Vermont Psychological Association
VPS	Vermont Psychiatric Survivors
VPQHC	Vermont Program for Quality in Health Care
VR	Vocational Rehabilitation
VSA	Vermont Statutes Annotated
VSH	Vermont State Hospital
WC	Windham Center, unit of Springfield Hospital offering inpatient psychiatric care
WCMHS	Washington County Mental Health Services
WRAP	Wellness Recovery Action Plan
YIT	Youth in Transition grant