Report on Act 46 of 2015

Section 49. Coordination of Educational and Social Services

REPORT
January 2016

Report to the Senate Committees on Education and on Health and Welfare and the House Committees on Education and on Human Services

Submitted by

Secretary of Education, Rebecca Holcombe

and

Secretary of Human Services, Hal Cohen

VERMONT

AGENCY OF EDUCATION &
AGENCY OF HUMAN SERVICES

VERMONT

State of Vermont
Agency of Education
219 North Main Street, Suite 402
Barre, VT 05641
education.vermont.gov

[phone] 802-479-1030
[fax] 802-479-1835

RE: Act 46 of the 2015 Session of the Vermont Legislature

Act 46 requires that the "Secretaries of Education and of Human Services, in consultation with school districts, supervisory unions, social service providers, and other interested parties, shall develop a plan for maximizing collaboration and coordination between the Agencies in delivering social services to Vermont public school students and their families. The Secretaries shall present their plan and recommendations to the Senate Committees on Education and on Health and Welfare and the House Committees on Education and on Human Services."

This legislative report summarizes our work to date on the development of this plan, specifically as it relates to addressing Emotional Disturbance (ED) and mental health issues in school-age children. We elected to narrow the scope of the work to supports for students with emotional disturbances, as this is an identified priority statewide for our schools. Students with emotional disturbances often come from families with other needs for support services provided through AHS.

Within the area of special education, Vermont stands out nationally in terms of Emotional Disturbance (ED) designation; in fact, Vermont currently has the highest per capita ED incidence of all U.S. states. Not surprisingly, ED and associated features in schoolchildren such as trauma are presenting significant challenges to some supervisory unions and school districts across the state (personal communications, various superintendents and Vermont NEA; fall, 2015). ED is a special education disability category that is much more narrowly defined than the term "severe emotional disturbance" (ED) under Act 264. Since we do not currently have a data source for the number of youth with an ED we are using the more narrowly defined special education designation for data purposes. This means that the data represent a smaller subset of youth identified as Severely Emotionally Disturbed who also qualify for special education services. In other words, the population of youth who experience a Emotional Disturbance is *larger* than the special education data in this report reflect.

Included in the report is a description of the problem and associated challenges, including data brought to bear on the issue; a summary of existing collaborative efforts between the two Agencies; and an explicit set of action steps for moving forward. The Secretaries welcome this opportunity to further develop and strengthen working relationships between our Agencies, with the ultimate goal being to better serve Vermont's children and families.

The following individuals, listed in alphabetical order, contributed to the development of this Legislative Report:

Melissa Bailey, Deputy Commissioner
Department of Mental Health, AHS

Charlie Biss, Director of Child, Adolescent and Family Unit
Department of Mental Health, AHS

Heather Bouchey, Deputy Secretary
Agency of Education

Paul Dragon, Deputy Secretary
Agency of Human Services

Karin Edwards, Director
Integrated Support for Learning, AOE

Alicia Hanrahan, Education Programs Manager
Monitoring and Supervision, AOE

Breena Holmes, Director, Maternal and Child Health
Department of Health, AHS

Deborah Quackenbush, Director
Monitoring and Supervision, AOE

Melissa Reigl-Garrett, Prek Coordinator
Integrated Support for Learning, AOE

Lindsay Simpson, Student Health and Learning Team Leader
Integrated Support for Learning, AOE

Joellen Tarallo-Falk, Executive Director
Center for Health and Learning

Joanne Unruh, Executive Director
Vermont Council of Special Education Directors

Table of Contents

Current Challenges for Mental Health and Education 6
- Poverty 7
- Opiates 7
- Emotional Disturbance 8

Using Data to Better Target Resources 9

Existing Interagency Coordination 12

Current Activity 13
- Vermont Positive Behavior Intervention and Supports (VTPBiS) 13
- Success Beyond Six (SB6) 15
- School Health Collaborations 17
- Integrating Family Services 18

Next Steps and Opportunities 18

Conclusion 22

Appendix 23

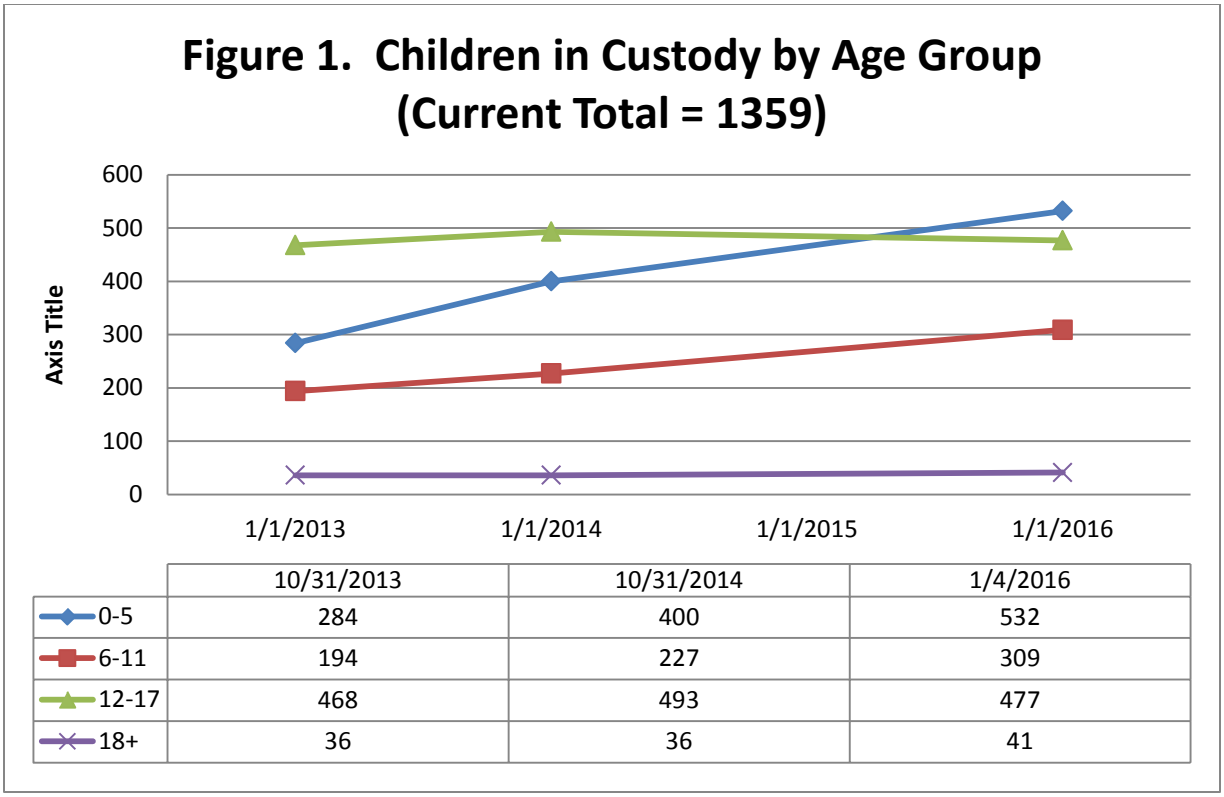
Current Challenges for Mental Health and Education

Vermont currently faces a number of problematic trends and deleterious individual outcomes that bode poorly for the state as a whole should we not address them. For instance, complex systemic and individual challenges such as poverty and opiate abuse have recently come to the forefront as areas that require immediate attention. [1, 2] Increasing poverty and opiate abuse, as well as their negative impact on individuals, families, and communities, intersect with both the social services and educational contexts; accordingly, trends for these two areas are of central concern to both the Agencies of Human Services and Education.

Additionally, these trends suggest children are experiencing more toxic stress and increased family neglect, which in turn are linked to poor educational and social outcomes. For example, Figure 1 shows a marked increase in Vermont DCF custody rates over the past four years. This upward trend has been particularly true for our youngest and most vulnerable children – in 2014, 284 children ages 0-5 were in state custody; that number has now risen to 532 at the start of 2016. These trends suggest that our youngest cohorts may experience more adversity on average and present more significant challenges than cohorts already in our school systems. Children in custody represent the most extreme need; beyond them, there are many other children in need who are still living with their families.

[1] State Launches New Treatment Program, *Vermont Public Radio,* December 1, 2015; Vermont Tackles Heroin, with Progress in Baby Steps, *New York Times,* February 25, 2015.

[2] Vermont Children's Economic Well-being, Today's 2014 Poverty Estimates. Voices for Vermont's Children, September 2015.



	10/31/2013	10/31/2014	1/4/2016
0-5	284	400	532
6-11	194	227	309
12-17	468	493	477
18+	36	36	41

Poverty

In 2014, approximately 15.8% of Vermont children lived in households with incomes below the Federal Poverty Level (FPL) threshold, an increase from 13% in 2008. This poverty is not spread evenly across the state; some towns and regions have relatively low poverty rates, whereas others are home to high proportions of children growing up in adversity.

Of the 15.8% VT children living in poverty, 7.6% live in deep poverty (Vermont Childhood Poverty report, 2015). The FPL threshold for 2014 for a family of two adults and two children was $24,008.00, and $16,317.00 for a family of one adult and one child. Vermont ranked fifth in the nation for overall child well-being, behind Minnesota, New Hampshire, Massachusetts and Iowa. Growing up in poverty can have tremendous negative consequences for children throughout their lives. Because strategies to reduce the impacts of poverty are most effective when assistance is offered to very young children and their families, it is important that the State continues to support poverty prevention efforts at schools, afterschool and summer school programs and in the community for those children not yet enrolled in formal k-12 school programs.

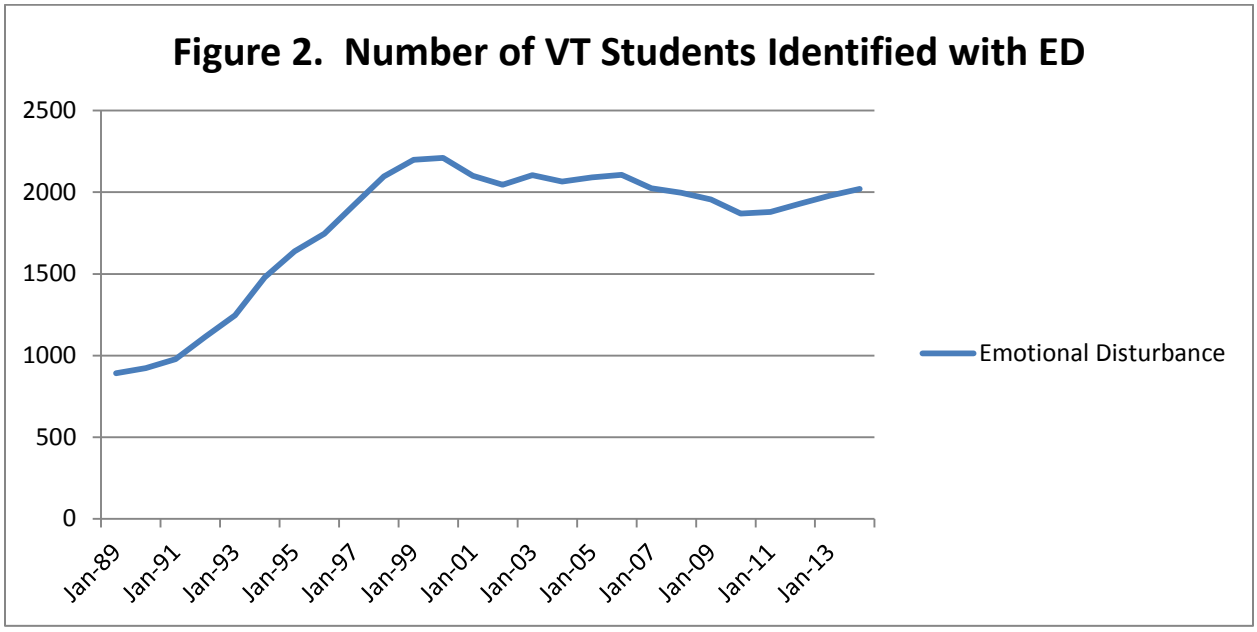
Opiates

Addiction is a lifelong chronic disease and addiction to opioids such as heroin and prescription pain relievers is a serious public health problem, with potentially devastating consequences. According to the Vermont Department of Health more than

50 Vermonters die from opioid poisoning every year and deaths from heroin doubled from 2012 to 2013. Vermonters age 18-25 have one of the highest rates for non-medical use of painkillers and more than one-quarter of the nearly 4,000 Vermonters in treatment for opioid abuse are young adults. Since addiction to opioids is a public health problem, Vermont has taken a public health approach by developing a comprehensive treatment system that responds specifically to opioid addiction. This Hub and Spoke System, for delivering Medication Assisted Therapy such as methadone and buprenorphine, emphasizes the care coordination and support including recovery services that is integral to addiction recovery.

Emotional Disturbance

Coinciding with these increasing trends of family poverty level and opiate abuse/death, the prevalence of children's behavioral challenges in school, specifically emotional disturbance (ED), has also increased (see Figure 2). In 1989, 891 students were identified as ED and this number increased to 2021 by 2014. And this trend occurred against a backdrop of overall decline in total student headcount within the state (PK-12 headcount, 2003-2004 = 95,526; 2014-2015 = 84,548).



At this point in time, we cannot *causally* tie high rates of poverty and opiate addiction to the increase of ED in Vermont. In fact, it may be that we have become better at *identifying* ED and other social/emotional issues in children and that is why we have higher rates. Alternatively, it may be that how we identify ED has changed over time, leading to a more lenient approach to identification in some regions or schools. Even if poverty and opiate addiction are not causal agents of ED per se, both such issues in the home further complicate treatment for and prevention of a variety of school-based difficulties, including ED. And we do know that toxic stress associated with opiate addiction and poverty leads to a host of negative short- and long-term educational,

social, and legal outcomes for children. In addition, we must pay closer attention, systemically, to those children who demonstrate challenging behaviors as a result of trauma or neglect but do not qualify for ED designation. Early intervention and prevention efforts provide opportunities to "bend the curve" sooner, perhaps changing life course trajectories for our most vulnerable.

Using Data to Better Target Resources

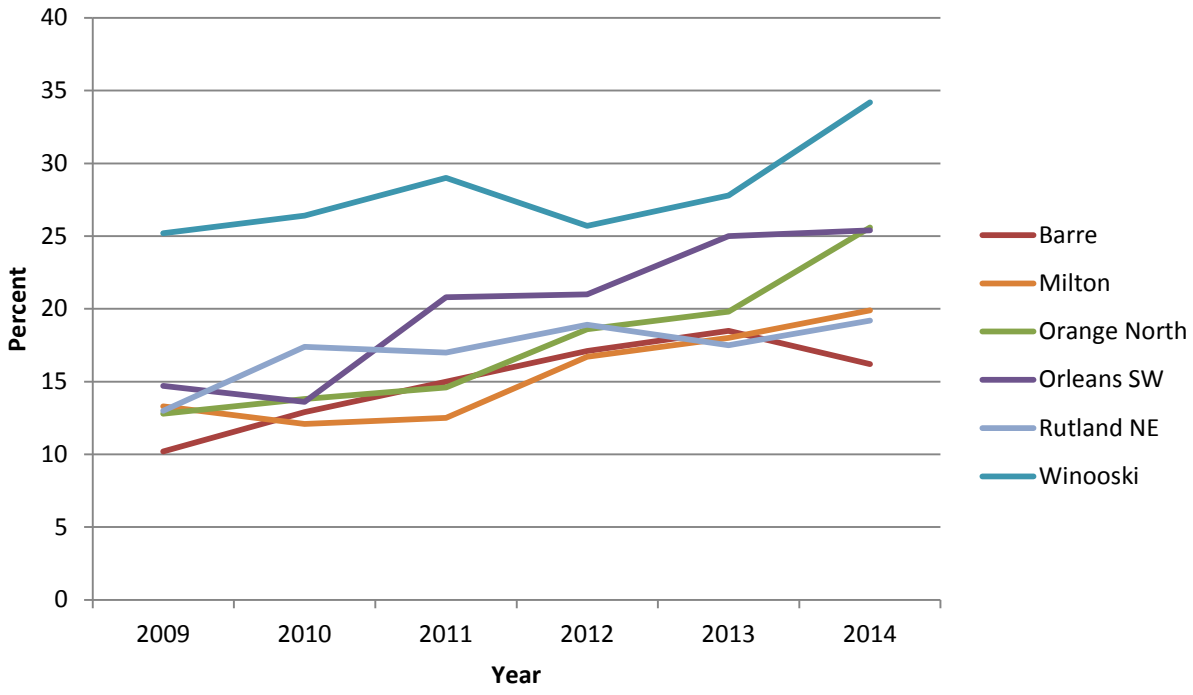
One question that the AOE has begun to investigate recently is whether we can identify particular supervisory unions or districts that appear to have higher than average numbers of students with ED designation, and whether this designation is related in any systematic way to the availability of services.

In an effort to best target resources toward those children, schools, and systems that most need them, we set out to identify potential areas of the state that seem to be foci where high rates of ED incidence occur. We also looked at this issue from a couple of different perspectives. First, we wondered which SUs or districts have the highest rate of *increase* over time in ED designation. In other words, which areas have shown the strongest upward trends in the proportion of students who are identified as having ED?

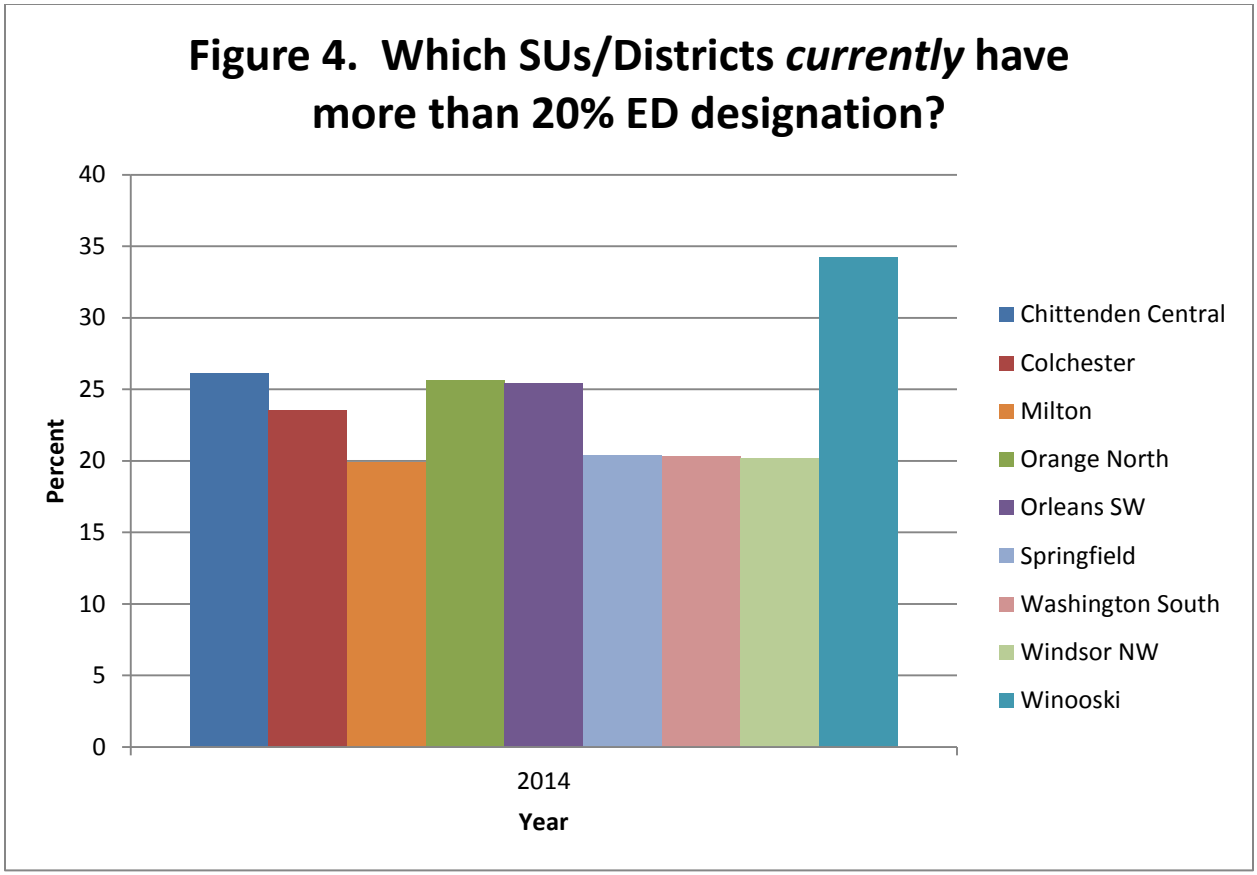
As shown below, Figure 3 provides the five-year trends for those SUs/districts that have the highest rates of increase. In Winooski, the proportion of students receiving special education services who were designated as ED rose from right around 25% in 2009 to just over 34% in 2014. ED identification rates in the Orange North supervisory union doubled in five years, with 12.8% in 2009 and 25.6% in 2014.[3]

[3] Note: To aid in interpretation of the chart, only the top six SUs/districts with the highest rate of increase in ED designation are shown; the full data set is available upon request.

Figure 3. Which SUs/Districts have the greatest increase in ED designation?



In addition to looking at the rate of increase in ED designation by district/SU, we also examined overall rates. This analysis gets at a slightly different question: what areas of the state have the *highest levels* of ED designation, at any one point in time? This is different than looking at which areas show the largest increase over time. Results show some interesting patterns (see Figure 4). First, there seems to be a natural "break" in the 2014 data at about 20% or more proportional ED designation; thus, we set this as the "high mark" for statewide levels. Nine supervisory unions or districts met the criteria of having at least 20% of their students who were receiving special education services identified as ED. However, not all of these SUs/districts are the *same* as those with the biggest increase in ED identification over time. In fact, we have some SUs/districts (e.g., Colchester, Springfield) that have quite high levels of ED designation but these high levels have remained stable during the past five years.



In sum, we are using these trends in both rate of ED identification change over time and overall incidence (high versus low) to better target resource allocation and service coordination moving forward. Appendix A includes a set of maps that collectively identify regions where both concentrations of and changes in proportions of ED are occurring. As a result of these preliminary data analyses and inspection of prevalence maps, we recommend that four identified regions (i.e., Winooski SD, Orleans SW SU, Milton SD, and Orange North SU) be among our first regional areas of outreach and targeted systemic support for turning the curve on ED. *It is critical to note that the goal of these analyses is not to "point the finger" at particular districts/SUs, but to have AOE and AHS work together to ensure necessary supports in place for these communities so that high-quality education can continue without disruption. These districts are working hard; by coordinating state-level support, we hope to bolster on-going local efforts to make sure all children are safe, healthy, engaged and appropriately challenged.*

Moving forward, we will also look at the areas in Vermont where ED identification levels and rates of growth are very *low*. This will provide deeper insight into whether rates at both ends of the continuum are related to service ability, best practice implementation, or other factors that may have an impact on identification and delivery of appropriate services.

How do our two agencies plan to jointly address ED and other mental health challenges moving forward? The subsequent sections of the report highlight our existing inter-

agency history and work together, followed by what programming seems to be working or appears particularly promising with respect to more fully addressing ED challenges in Vermont. The report concludes with a set of specific action steps, a timeline and projected outcomes, and themes or issues that must guide our work as we move into 2016.

Existing Interagency Coordination

The Agencies of Education (AOE) and Human Services (AHS) have a fairly long history of working together to maximize efficient, effective service provision to Vermont public school students and their families. In 1988 the state enacted legislation referred to as Act 264. This legislation set up an expectation of coordination between mental health, education, child welfare and families in order to assure children with mental health issues a Coordinated Service Plan (CSP). In June 2005, consistent with Vermont's Act 264 requirements and federal IDEA legislation (Part B), AOE and AHS updated the established formal interagency agreement to lay out the shared mission and guiding principles of both agencies with respect to serving students with disabilities under IDEA. This agreement stipulated special emphasis on those individuals transitioning out of the K-12 system and also expanded the CSP-eligible population to include all children who were eligible for an IEP and were receiving some kind of service from AHS.

Both Act 264 and the Interagency Agreement continue to be in effect today. Students eligible for special education services and disability related service coordination from AHS are entitled to a Coordinated Service Plan. The CSP coordinates and streamlines all services, including social, emotional, behavioral and educational, as well as other services needed through AHS departments, so students are assured effective, non-redundant services and, as a result, successful outcomes. This process also requires the identification of a lead service coordinator to assure the plan is implemented to the degree possible. One policy weakness of Act 264 is that it affords children the right to coordination but not necessarily to the services outlined in the plan. The requirements of Medicaid, state and federal law and resource allocation all play a role in the delivery of services.

As a result of Act 264, the AOE and AHS also formed a State Interagency Team (SIT), Local Interagency Teams (LIT) and the statewide Case Review Committee (CRC) as a subcommittee of SIT. These entities are active today in reviewing each student's CSP to make decisions about students who require high-level services, as well as helping to resolve CSP conflicts or resource issues. Service coordination involves a lead case manager who assists the child and family to obtain available community services, resources, and entitlement programs and has oversight of the implementation of the CSP. Case managers can act as brokers of services and advocate for access to programs and services with the support of the family and assessments by service providers.

Act 264 established the creation of Local Interagency Teams (LIT) in each of the 12 AHS designation areas (Das) across the state. Each LIT includes a special education director selected by the districts in that region, the local Children's Mental Health Director, the Family Services Director, a Family Consumer representative, high level local leaders from Developmental Services and Substance Abuse, and a Vocational Rehabilitation representative. Other AHS programs, such as early childhood, are represented as needed. The LIT supports the creation of a local system of care and assures that staff are trained and supported in creating and implementing coordinated services plans. The LITs can also play a key role in dispute resolution at the local level. The Child Development Division of DCF is also included as a core part of the System of Care in relevant cases (as indicated above).

Under Act 264, all Vermont children who meet the statewide definition of Emotional Disturbance are entitled to services coordination. These students may or may not be eligible for special education. Under the DOE/AHS Interagency Agreement of 2005, students with disabilities who are eligible for special education, and who are also receiving services (including service coordination) from an AHS agency are also eligible for a CSP. This is to ensure ALL services delivered either through AHS agency, AOE school district or other community services are coordinated and the family is aware of who is identified as lead service coordinator. The interagency agreement was an expansion of Act 264 requirements (by agreement rather than legislation) to include all disabilities under IDEA and not just be limited to ED. As a System of Care, locally and at the state level, we have adopted CSP as best practice, meaning this process is used more broadly than just the defined population and as determined by each local region. (See the following link for an on-line summary of Act 264 provisions: http://mentalhealth.vermont.gov/cafu/act264/description).

Current Activity

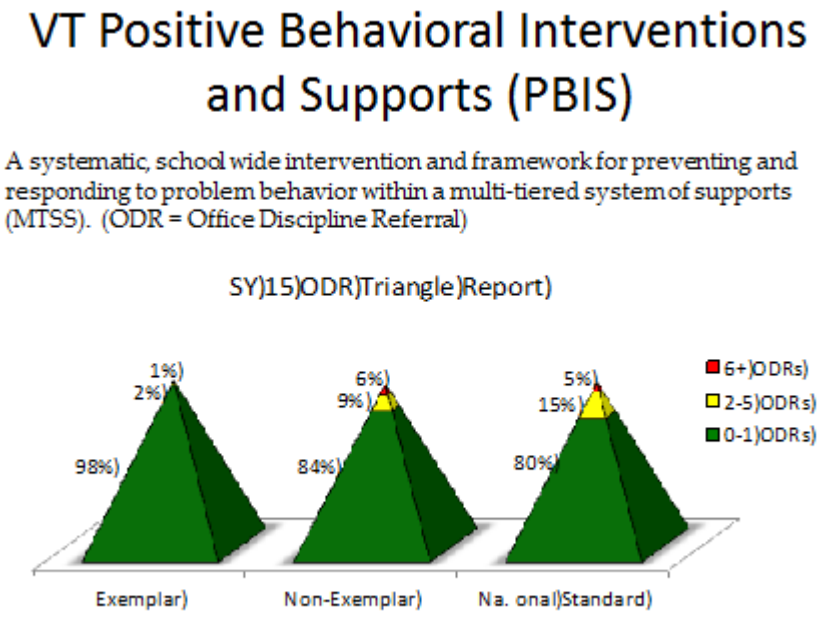
Both AOE and AHS have provided research-informed programming during the past several years that either directly or indirectly should address ED designation and amelioration moving forward, provided a more targeted approach is undertaken. In particular, we argue that both the Positive Behavior Intervention and Supports (PBIS) framework and the Success Beyond Six (SBS) program can be better utilized to meet the needs of children with ED and other mental health challenges, effectively easing the burden on traditional school personnel and local school budgets.

Vermont Positive Behavior Intervention and Supports (VTPBiS)

VTPBiS can best be described as a systems approach to academic achievement and social competence for all children. It is a framework for employing research-based practices, interventions and an implementation system designed to improve the

educational experience of all students, including those with disabilities. The framework includes systems at three to four different levels or "tiers" of intensity and duration. For instance, a Tier 1 intervention might be acknowledging and praising students' positive behaviors (e.g., waiting patiently, avoiding physical contact with others, being quiet, etc.) in the classroom or during hallway transitions. A more intense, Tier III intervention might be providing a particular student with more one-on-one daily support and guidance through a daily behavior form.

So far, the positive effects of VTPBiS look promising. Those VTPBiS schools using student behavior data for decision making (i.e., SWIS implementation) demonstrate fewer Office Discipline Referrals. Those schools implementing PBIS with fidelity exceed the national standard set for minimal frequency of behavioral referrals (see Figure 5, below). Further, the overall rates for Out-of-School Suspensions (OSS) in VTPBiS schools are less than those for schools not implementing PBIS. Exemplar schools show an even lower rate of OSS and also demonstrate improving educational outcomes.



As more VTPBiS schools become successful in implementing the universal level, they begin implementation at the Targeted and Intensive levels. Thus, more students are gaining access to targeted group and individual supports. One example of these individual supports is Check-In Check-Out (CICO). This is a simple Tier II (Targeted) intervention for students who need support beyond classroom instruction in order to be successful. Through CICO, students set and monitor progress towards individual goals. During the 2014-15 school year, 78% of students enrolled in CICO met their individual goal. With scale-up in mind, the VTPBiS State Team has evolved from

supporting three schools in 2007 to 133 schools in 53 supervisory unions/districts in 2015. Over this time, 97% of VTPBiS schools continue to sustain PBiS implementation.

The VTPBiS System of Supports that promotes the enduring sustainability of PBiS consists of:

• A State Team that provides training as well as regional technical assistance and coaching;
• SU/SD Coordinators that provide resources and support to their PBiS schools;
• School-based Coordinators that facilitate, communicate and share PBiS knowledge with school leadership teams and staff; and
• Building administrators and school leadership teams that support staff to implement PBIS practices with fidelity

Success Beyond Six (SB6)

Success beyond Six (SB6) was developed when then Secretary of the Agency of Human Services, Con Hogan, wanted to find a way to collaborate with schools to address children's mental health needs. Sometime later, a Special Education Director and a Children's Mental Health Director decided to figure out a new way to collaborate regarding students with Autism whose parents were on the verge of either having to leave the district to access education for their children or were about to engage in due process because of struggles in the school. Both these initiatives built on the concept of using local school dollars as match to draw down federal Medicaid share in order to enhance the provision of services and to keep children in their local school. The initial program created School Based Clinicians who are Master Level clinicians. These clinicians worked with children identified by the school. Most of these children were "Medicaid only" because Medicaid covered this service array and private insurance only covered mental health individual, group or family therapy, medication management and psychiatric hospitalization. Vermont's Medicaid State Plan includes additional services that better match the needs of children and their families in a school setting such as service coordination, skill building and supportive counseling. This model grew quickly and there are now about 200 school-based clinicians state-wide.

The largest single category of growth in Success beyond Six is the provision of individual behavior intervention services. We use the term Behavior Interventionist to describe mental health staff that provide 1:1 or small group assistance to students struggling with an emotional disability in a classroom or school setting. This position of behavior interventionist has been endorsed in practice by many schools choosing to contract for it even in the face of tight school budgets.

The role of behavior interventionist is not an evidenced-based practice *per se* but it uses evidence-based and best practice strategies such as Applied Behavior Analysis (ABA).

The BIs are part of a larger team and are supervisedby Master level clinicians, receive regular training and supervision and participate in team meetings. In 2009, the Vermont Department of Mental Health (DMH) developed minimum training credentials and characteristics for Vermont's Behavior Interventionists. This was an effort to strategically "even the playing field" in terms of ensuring high-quality, accessible mental health supports for all Vermont students.

In Vermont, the roles have been developed in variable ways depending on the needs of the students, the local school conditions, and the orientation of the community mental health center/DA. While behavior interventionist services are highly valused by Vermont's schools and families and follow the BI Minimum Standards, the service itself may vary from setting to setting in terms of expertise of the staff hired, turnover rate, and application of the Minimum Standards.

Importantly, both School-Based Clinicians and behavior interventionists can be integrated into the over-arching framework of VTPBiS. Specifically, School-Based Clinicians can offer the student specific interventions by a highly trained mental health professional (Tier III) and participate in whole-school interventions (Tier I). Tiers II and III PBiS supports are critically dependent on the presence of well-trained, adequately staffed professional educational and mental health teams in high-risk schools and populations.

Behavior interventionists may work with students who have an emotional disability in Special Education within a mainstream education program or in an alternative education program. Also, they may work with students not in special education who have a Section 504 Accommodation Plan. The educational background of behavior interventionists may be an Associate's level degree or a Bachelor's level degree. Some school contracts use behavior interventionists to provide one to one supports to individual students in classrooms; others use a behavior interventionist to support a small group of students (up to four students at one time). Complicating the picture is that schools also use other types of professional staff, educational assistants, and other paraprofessionals to provide supports to students in the classroom. The decision about when to use a behavior interventionist or another type of professional staff member is made locally and is not based on consistent criteria. Similarly, there are no standard criteria to guide the decision about when to decrease or cease using a behavior interventionist on behalf of a student or students. Finally, as schools contract with each community mental health agency on a per student basis, there is not a mechanism in place at the state level to collect systematic outcome data. Any collaborative interagency models moving forward must address these existing challenges.

Recently, the DMH created a new payment methodology for SB6 to bring more mental health support to the entire school population for those schools engaged in VT PBiS. This payment reform model focuses on a case load minimum that then allows for

population-based health work. This flexible funding mechanism, using Medicaid dollars to bring mental health services to those students with Emotional Disturbance as well as school-based support/assistance, builds on providing services to mitigate the development of more intense and/or long term disabilities.

School Health Collaborations

The Vermont Department of Health (VDH) and AOE jointly provide support and input around collection and use of both Youth Risk Behavior Survey and School Health Profiles data. AOE and VDH staff members also work across agencies to implement tobacco use prevention and education, sexuality education, and chronic disease prevention programs, resources and funding. Both the Vermont Department of Health VDH and AOE are committed to promoting use of the Whole School, Whole Community, Whole Child model by their school and community partners to improve population health and academic achievement outcomes. The VDH and AOE recommend using the WSCC model to achieve goals outlined in school continuous improvement plans and school wellness policies, and integrating it into a multi-tiered system of supports (MTSS). As updated or new tools become available from the CDC and ASCD, they will be promoted and distributed to schools in a consistent and coordinated manner by the Health Department and AOE.

The VDH has invited an AOE representative to sit on their department-wide school health team, to help our different school health programs with messaging, feedback, and valuable insight as we develop goals and resources to help ensure we are maximizing our opportunities to engage schools in a way that makes sense to the school communities. This is also an opportunity to identify common priorities and work towards achieving desired outcomes that may impact both the health and academic achievement of students, as well as improve overall health for the school community.

The AOE representatives focusing on both PBiS and continuous school improvement have met with public health nursing staff that work closely with schools throughout Vermont in order to increase our knowledge and understanding about these efforts, and the potential opportunities to engage in these activities in a relevant way.

In addition, Vermont Act 63, E.313 required a restructuring of the grant opportunity that previously funded the Student Assistance Professionals Program. Consistent with this requirement, in July 2012, 21 supervisory unions (SUs) were awarded a 4 year grant (FY13-FY14) to support school-based substance abuse prevention and early intervention services through the Vermont Department of Health Division of Alcohol and Drug Abuse Programs (ADAP). A primary goal of this grant is to optimize the coordination of school based health services and use of resources. This grant increases the capacity of schools to coordinate substance use prevention and early intervention strategies within the overall school health framework. These services are called School-Based Substance

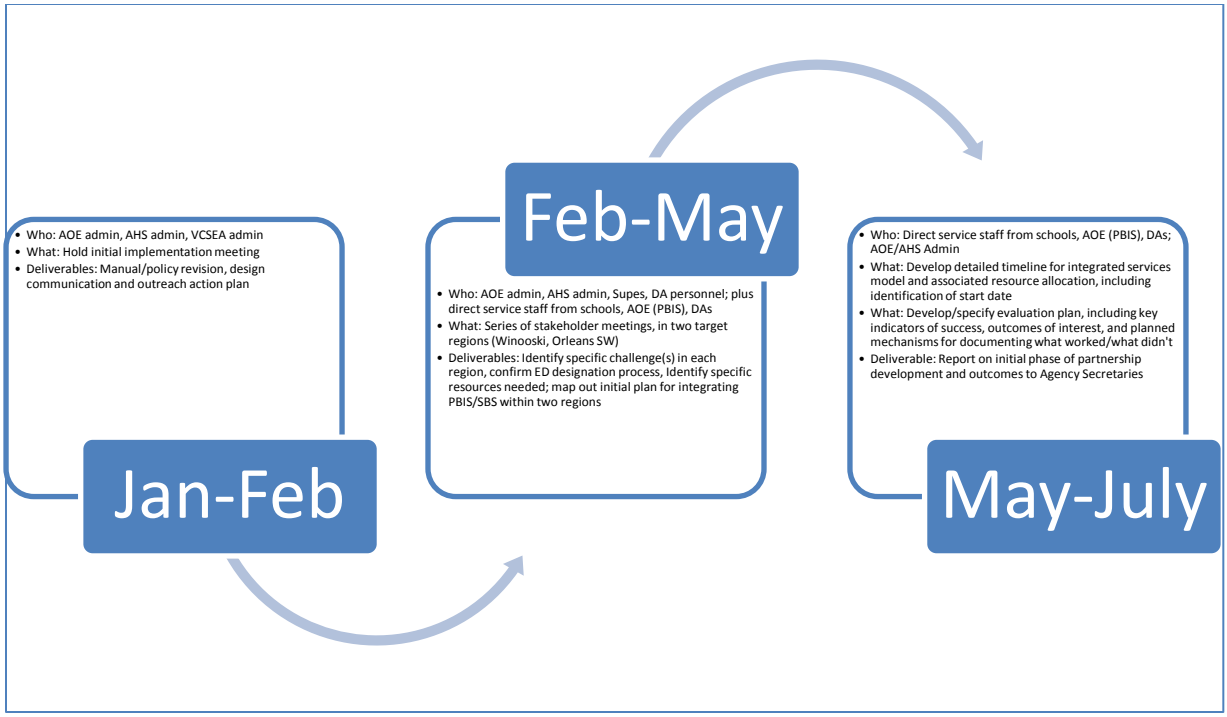
Abuse Services (SBSAS). A new Request for Proposals for FY17 was released in January 2015. Where applicable, the joint activity framework established between VDH and AOE personnel will be incorporated into the statewide plan for addressing ED and mental health issues.

Integrating Family Services

The AHS embarked in a systems change for their child and family services across the agency. The AHS decided to bring together the funding and service delivery across the Agency under one organizing umbrella called Integrating Family Services (IFS). In July 2012, Counseling Services of Addison County (CSAC) and the Addison (A-PCC) Parent Child Center entered into a different contract structure with AHS. This was the pilot to create a more integrated service delivery system, streamline outcomes and engage in payment reform to create flexibility and more efficient use of funding. In May 2014, Northwest Counseling and Support Services (NCSS), which also houses the Franklin/Grand Isle Parent Child Center, entered into the same type of agreement. At this point it remains in pilot status but there is considerable work happening with a goal to expand IFS services statewide by 2020. This expansion work should include the AOE and school partners both at the local and state level.

Next Steps and Opportunities

Due to staff reductions, starting in 2008 AHS and AOE agreed to pull back on the number of local trainings and technical assistance provided regarding Act 264, Coordinated Service Planning, Local Interagency Teams and the State Interagency Team, the framework for our system of care. Due to this change there has been a significant decrease in educators' and parents' knowledge regarding the coordinated service planning process and the values and application of the system of care. In addition, as mentioned previously, the quality of and consistency in service options both within and out of the school setting varies across regions of Vermont. As such, the AOE and AHS are firmly committed to reinvigorating the important work established initially with Act 264. We are currently in the process of developing a clear, transparent, well-communicated work plan to increase knowledge and skills regarding coordinated service planning. In addition, we believe that by integrating and fine-tuning existing supports, strategically targeting resources at high need areas and strengthening collaboration, we can significantly reduce the deleterious effects of ED on children, schools, and families. This action plan will include all parties outlined in the 2005 AHS/AOE Interagency Agreement. We anticipate the following timeline of work, staffing plan, and indicated outcomes/key products during the next several months.



Below are highlights from the initial planning meetings that have occurred to date, identifying both current challenges or gaps and potential solutions. Each of these issues will be discussed and/or will guide the activities presented in the timeline above.

Identified Needs or Gaps	**Specifics**	**Potential Solutions**
System of Care Understanding	• Lack or reduced knowledge of the Act 264 and its components. • Lack or reduced knowledge of Success Beyond 6 funding and application and PBiS application, as well as the partnership between these efforts.	• Bring local community leadership together to re-educate and provide technical assistance regarding: o Act 264 service provision o System of Care values o Success Beyond 6 and VT PBiS overview o Plan for better integrating SB6 and VTPBiS • Share what is working in areas with positive outcomes • Disseminate information regarding working partnership at the state level between AOE and AHS.

		• Create an AOE/AHS leadership team to oversee the system of care; explore developing an Executive Committee of the existing Statewide Interagency Team • Identify areas of fiscal or resource pressures and their impact on other parts of the system. There are combined pressures.
Data	• Increased number of children on IEPs for Emotional Disturbance (both school age and young children and which may include other developmental disabilities). • Increased number of children in state's custody • Lack of data at a local level to monitor trends and develop focus areas. • Clarity around priority areas for targeting services	• Map state-wide data regarding SU/Districts that have PBiS, Success Beyond 6, IEP rates and IFS implementation to identify areas of focus [note: already begun]. • Identify specific mental health and educational trends to monitor • Prioritize regions for locating services
System of Care services	• Access to school based mental health and population based supports • Varying degrees of mental health services and educational services – depends on region	• Identify common goals between AOE and AHS for focus and monitoring. • Create an addendum or MOU update to the AOE/AHS Interagency Agreement. • Increase PBiS schools and schools implementing with

	(identify priority regions for support).	fidelity • Increase Success Beyond 6 contracts, especially in PBiS schools • Look for opportunities in Health Care Reform to include services in schools • Explore Full Service schools or the elements of Full Service schools and determine if, when and how to implement. • Ensure schools are trauma informed, understand toxic stress and have access to appropriate services to address; consider offering statewide conference on trauma informed best practice, in order to beef up training statewide • Explore alternatives to residential and out of state treatment to ensure children are served in their school district whenever possible • Engage in conversations with adult system of care to assure parents are receiving necessary services

Conclusion

This report reviewed Vermont's existing challenges for serving children with severe emotional disturbance, a critical area of concern for both educators and mental health professionals. Using a data-based approach and capitalizing on successful evidence-based work to date, we propose an initial plan that relies largely on re-calibrating and/or re-focusing existing Agency resources, instead of moving in a completely novel direction. We believe this represents the smartest, most strategic approach for interagency collaboration at this time. We are energized to collaboratively "get to work" on this issue. Indeed, engaging in multiple rounds of interagency conversation and debate, as well as generating the report, has been instrumental in helping us collectively identify and target an issue that needs our immediate attention. This process also models how our two agencies should function together as we tackle additional challenges of statewide interest in the future. We believe this was an explicit intent of the legislation and are pleased to share with you our progress so far.

Appendix

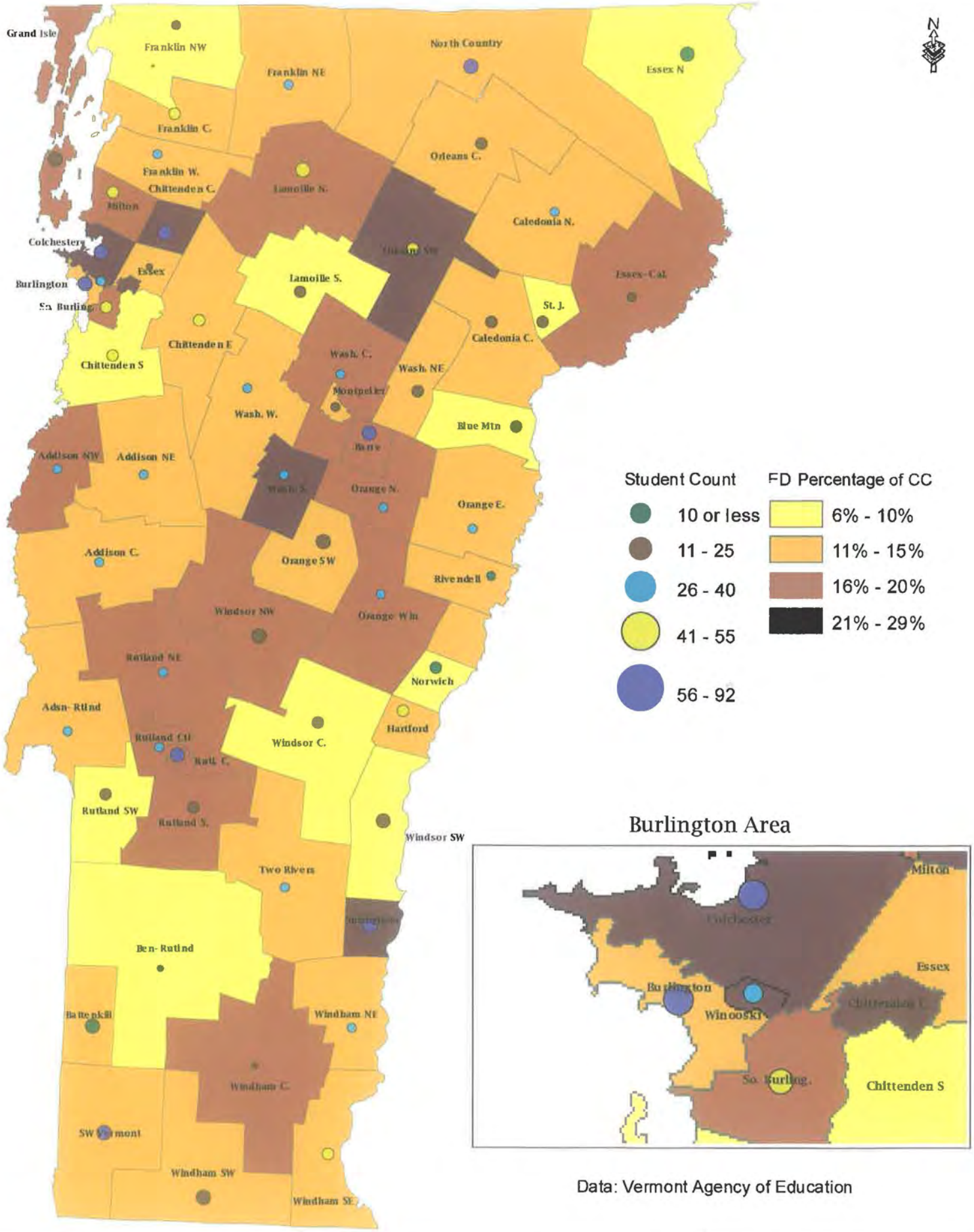
Maps containing data reflective of:

I. Students with Emotional Disturbances

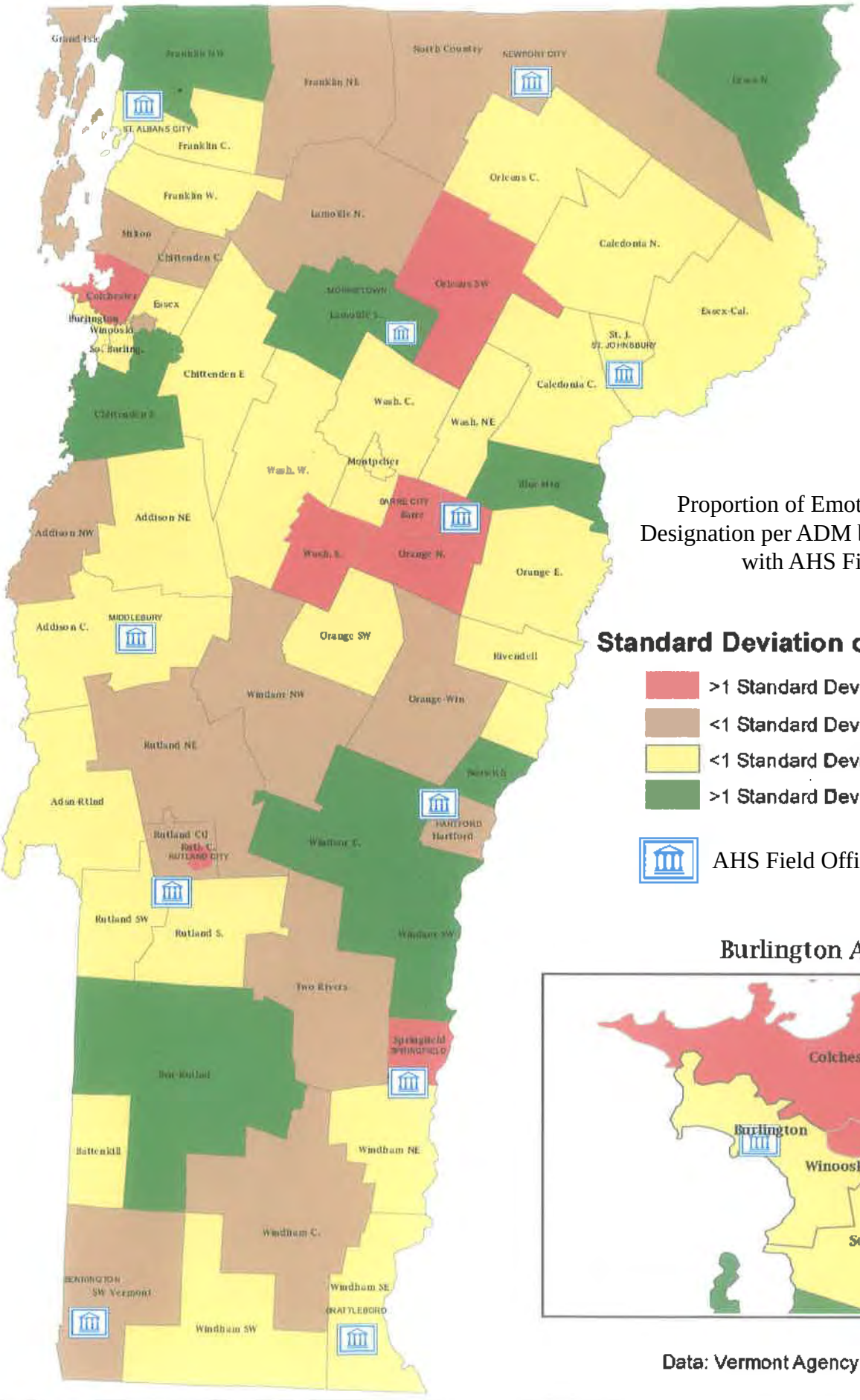
II. Proportion of Emotional Disturbance Designation per ADM by Supervisory Union

III. Percent of Students with Emotional Disturbances (of Active IEPs) with PBIS Schools

Students with Emotional Disturbance - School Year 2014



Data: Vermont Agency of Education



Proportion of Emotional Disturbance Designation per ADM by Supervisory Union with AHS Field Offices

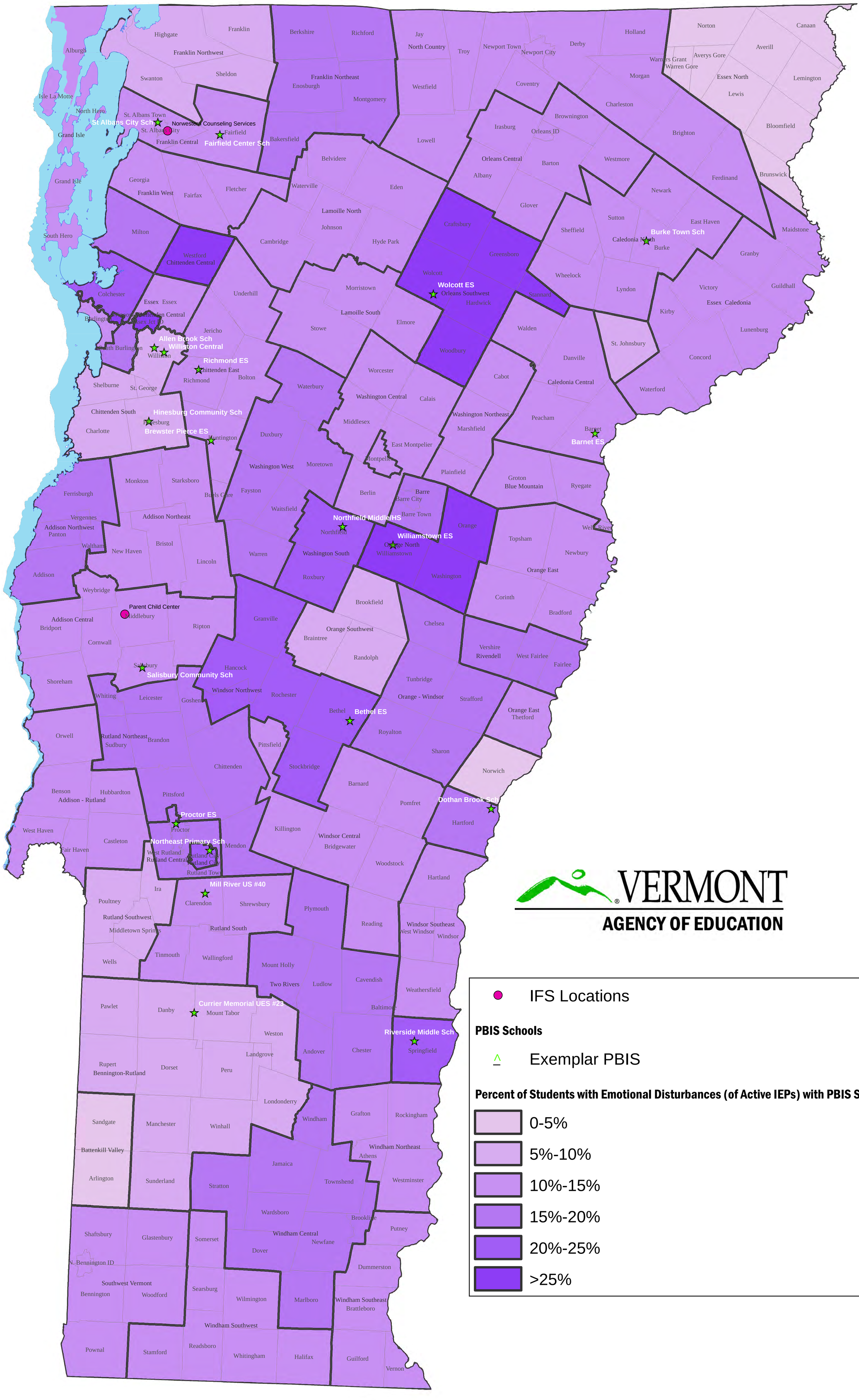
Standard Deviation of ED Percentage

- >1 Standard Deviation Above Mean
- <1 Standard Deviation Above Mean
- <1 Standard Deviation Below Mean
- >1 Standard Deviation Below Mean

AHS Field Offices

Burlington Area

Data: Vermont Agency of Education



VERMONT
AGENCY OF EDUCATION

- IFS Locations

PBIS Schools

- Exemplar PBIS

Percent of Students with Emotional Disturbances (of Active IEPs) with PBIS Schools

- 0-5%
- 5%-10%
- 10%-15%
- 15%-20%
- 20%-25%
- >25%

Updated: 12/18/2015