1 BALDWIN STREET,
MONTPELIER, VT 05633-5701

PHONE: (802) 828-2295
FAX: (802) 828-2483

STATE OF VERMONT
JOINT FISCAL OFFICE

MEMORANDUM

To: James Reardon, Commissioner of Finance & Management

From: Nathan Lavery, Fiscal Analyst

Date: December 19, 2008

Subject: JFO #2352, #2353, #2354, #2355, #2356, #2357, #2360, #2361, #2362, #2363, #2364, #2365, #2366

At the December 19, 2008 meeting of the Joint Fiscal Committee, the following grant requests were approved:

JFO #2352 — $807,500 grant from the U.S. Department of Health and Human Services to the Vermont Agency of Human Services - Department of Health.

JFO #2353 — $9,000 grant from the U.S. Environmental Protection Agency to the Agency of Natural Resource – Environmental Conservation.

JFO #2354 — $161,407 grant from the U.S. Department of Justice to the Department of Corrections.

JFO #2355 — $20,000 grant from the State Justice Institute to the Judiciary – Vermont Supreme Court.

JFO #2356 — $333,002 grant from the U.S. Department of Justice to the Judiciary – Court Administrator's Office.

JFO #2357 — $212,408 grant from the U.S. Department of Justice to the Judiciary – Court Administrator's Office.

JFO #2360 — $2,000,000 grant from Substance Abuse and Mental Health Services Administration to the Agency of Human Services – Department of Mental Health.

JFO #2361 — $21,000 grant from the State Justice Institute to the Judiciary.

JFO #2362 — $32,125 grant from the U.S. Department of Education to the Vermont Department of Education.

JFO #2363 — $166,160 grant from the Center for Applied and Special Technology to the Vermont Department of Education.

JFO #2364 — $12,000 grant from the National Governor's Association to the Agency of Human Services – Department of Children and Families. **This grant was approved with the understanding that expenditure of the $9,885 in state funds, as originally proposed, was no longer considered necessary and would not occur.**

JFO #2365 — $19,140 donation from the Vermont Veterinary Medical Association (VVMA) to the Agency of Agriculture, Food and Markets.

JFO #2366 — $500,000 grant from the U.S. Department of Homeland Security to the Agency of Transportation – Department of Motor Vehicles.

In accordance with 32 V.S.A. §5, these grants were placed on the Joint Fiscal Committee agenda and subsequently approved by vote of the Committee. We ask that you inform the Secretary of Administration and your staff of this action.

cc: Robert Hofmann, Secretary
Wendy Davis, Commissioner
Michael Hartman, Commissioner
Stephen Dale, Commissioner
Andrew Pallito, Acting Commissioner
Armando Vilaseca, Commissioner
Lee Suskin, Court Administrator
Roger Allbee, Secretary
David Dill, Secretary
Bonnie Rutledge, Commissioner
George Crombie, Secretary
Laura Pelosi, Commissioner

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STATE OF VERMONT
JOINT FISCAL OFFICE

MEMORANDUM

To: Joint Fiscal Committee Members

From: Nathan Lavery, Fiscal Analyst

Date: December 17, 2008

Subject: Grant Requests

Attached please find seven (7) requests which the Joint Fiscal Office recently received from the Administration:

JFO #2360 — $2,000,000 grant from Substance Abuse and Mental Health Services Administration (SAMHSA) to the Agency of Human Services – Department of Mental Health. These grant funds will be used to improve access to mental health services for transition-aged (16-21 years) youth. The goal of this project is for these youth to have adequate preparation and the necessary supports to be productively engaged in the community and free from incarceration.
[*JFO received 12/15/08*]

JFO #2361 — $21,000 grant from the State Justice Institute (SJI) to the Judiciary. These grant funds will be used to contract for consultant services to develop an action plan for strengthening the state court system's foreign-language interpreter program, including meeting due process requirements and improving access to court-ordered programs and services.
[*JFO received 12/15/08*]

JFO #2362 — $32,125 grant from the U.S. Department of Education to the Vermont Department of Education. These grant funds will be used to assist local operation agencies in implementing the interstate electronic exchange of migrant children's records through the Migrant Student Information Exchange (MSIX). Implementation of MSIX is federally required.
[*JFO received 12/15/08*]

JFO #2363 — $166,160 grant from the Center for Applied and Special Technology to the Vermont Department of Education. These grant funds will be used to provide training and technical assistance for assistance technology services to students with disabilities.
[*JFO received 12/15/08*]

JFO #2364 — $12,000 grant from the National Governor's Association to the Agency of Human Services – Department of Children and Families. These grant funds will be used to host the Governor's Summit on Poverty and Economic Opportunity. This grant provides support for technical assistance, planning, holding, and follow-up activities associated with the April 20, 2009 meeting.
[*JFO received 12/15/08*]

JFO #2365 — $19,140 donation from the Vermont Veterinary Medical Association (VVMA) to the Agency of Agriculture, Food and Markets. VVMA is donating a Companion Animal Medical Emergency Trailer (CAMET) and associated supplies to house 50 dogs and cats in case their owners are relocated during an emergency. The value of this item represents the cumulative value of the vehicle and supplies, as well as the cost of transporting the CAMET to Vermont.
[*JFO received 12/15/08*]

JFO #2366 — $500,000 grant from the U.S. Department of Homeland Security to the Agency of Transportation – Department of Motor Vehicles. These grant funds will be used to fund enhancements to offset costs associated with implementation of the Enhanced Driver's License / Identification Card, including meeting Real ID requirements.
[*JFO received 12/15/08*]

The Joint Fiscal Office has reviewed these submissions and determined that all appropriate forms bearing the necessary approvals are in order.

Because the current Joint Fiscal Committee may not meet again prior to the onset of the legislative session, the Committee may wish to consider action on these items prior to the exhaustion of the 30 day review period.

JFO 2360

State of Vermont
Department of Finance & Management
109 State Street, Pavilion Building
Montpelier, VT 05620-0401

[phone] 802-828-2376
[fax] 802-828-2428

Agency of Administration

STATE OF VERMONT
FINANCE & MANAGEMENT GRANT REVIEW FORM

Grant Summary:	The Substance Abuse and Mental Health Services Administration awarded a grant to the Vermont State Dept. of Health for Mental Health Services for Transition-Aged Youth. This award is pursuant to the authority of Section 561 of the PHS Act. This grant does not use or request any new state money. The conditions of the grant allow the state to use expenditures that are already in our budget in other programs as allowable state funds upon which to draw federal match.
Date:	12/8/2008
Department:	Department of Health
Legal Title of Grant:	Child Mental Health Initiative
Federal Catalog #:	93.104
Grant/Donor Name and Address:	Substance Abuse and Mental Health Services Administration, Rockville, Maryland
Grant Period: From:	9/30/2008 **To:** 9/29/2014
Grant/Donation	1,990,526

	SFY 1	SFY 2	SFY 3	Comments
Grant Amount:	$490,526	$1,500,000	$2,000,000	

	# Positions	Explanation/Comments
Position Information:	0	

Additional Comments:

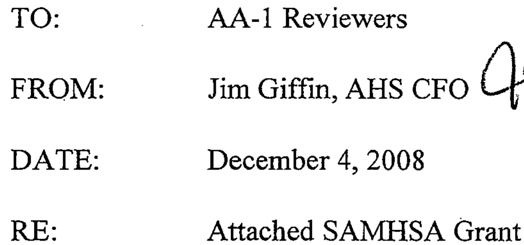
Department of Finance & Management	[initials] 12/10/08	(Initial)
Secretary of Administration	RPM 12/10/08	(Initial)
Sent To Joint Fiscal Office	12/11/08	Date

RECEIVED
DEC 15 2008
JOINT FISCAL OFFICE

VERMONT

Agency of Human Services
Business Office
103 South Main Street
Waterbury, VT 05671-0204
[phone] 802-241-2949
[fax] 802-241-1200

MEMORANDUM



TO: AA-1 Reviewers

FROM: Jim Giffin, AHS CFO

DATE: December 4, 2008

RE: Attached SAMHSA Grant

This federal grant's requirements differ from most other federal grants in that the 'match' does not have to be expended on grant activities. The State has to document the expenditure of State funds supporting certain activities that are list in the grant. VDH/DMH business office has created a sample form (attached) that they use to document the match expenses in the various departments each quarter.

The grant has increasing match over the years from 33% to 66% over the five years. However, the match SAMSHSA allows a cumulative calculation so any overmatch in the early years can count towards the later years.

SAMSHA has allowed the State to have the project director hired from a grantee and not a State employee. After acceptance, the State will need to secure approval from SAMSHA for the individual chosen for the project director.

STATE OF VERMONT REQUEST FOR GRANT ACCEPTANCE (Form AA-1)

BASIC GRANT INFORMATION

1. Agency:	Human Services
2. Department:	Mental Health
3. Program:	Mental Health Children
4. Legal Title of Grant:	Child Mental Health Initiative
5. Federal Catalog #:	93.104

6. Grant/Donor Name and Address:
Substance Abuse and Mental Health Services Administration, Rockville, Maryland

7. Grant Period: **From:** 9/30/2008 **To:** 9/29/2014

8. Purpose of Grant:
To improve access to mental health services for transition-aged youth. ✓

9. Impact on existing program if grant is not Accepted:
None

10. BUDGET INFORMATION

	SFY 1	SFY 2	SFY 3	Comments
Expenditures:	**FY 09**	**FY 10**	**FY 11**	
Personal Services	$24,526	$75,000	$100,000	
Operating Expenses	$0	$0	$0	
Grants	$466,000	$1,425,000	$1,900,000	
Total	$490,526	$1,500,000	$2,000,000	
Revenues:				
State Funds:	$0	$0	$0	
Cash	$163,509	$5,000,000	$6,666,670	not included in expenditure budget
In-Kind	$	$	$	
Federal Funds:	$490,526	$1,500,000	$2,000,000	
(Direct Costs)	$466,000	$1,425,000	$1,900,000	
(Statewide Indirect)	$	$	$	
(Departmental Indirect)	$24,526	$75,000	$100,000	
Other Funds:	$	$	$	
Grant (source)	$	$	$	
Total	$490,526	$1,500,000	$2,000,000	

Appropriation No:		**Amount:**	$
	22005/3150070000		$490,526
			$
			$
			$
			$
			$
		Total	$490,526

REC'D DEC 04 2008

STATE OF VERMONT REQUEST FOR GRANT ACCEPTANCE (Form AA-1)

PERSONAL SERVICE INFORMATION

11. Will monies from this grant be used to fund one or more Personal Service Contracts? ☒ Yes ☐ No
If "Yes", appointing authority must initial here to indicate intent to follow current competitive bidding

Appointing Authority Name: Beth Tanzman, Deputy Commissioner Agreed by: BHT (initial)

12. Limited Service Position Information:	**# Positions**	**Title**
	0	
Total Positions		

12a. Equipment and space for these positions: ☐ Is presently available. ☐ Can be obtained with available funds.

13. AUTHORIZATION AGENCY/DEPARTMENT

I certify that no funds have been expended or committed in anticipation of Joint Fiscal Committee Approval of this grant:	Signature: [signature]	Date: 12/3/08
	Title: Beth Tanzman, Deputy Commissioner of Mental Health	
	Signature: Patrick Flood	Date: 12/4/08
	Title: Deputy Secretary	

14. ACTION BY GOVERNOR

☑	Check One Box: Accepted	[signature]	12/10/08
☐	Rejected	(Governor's signature)	Date:

15. SECRETARY OF ADMINISTRATION

☐	Check One Box: Request to JFO	Linda P McIntire	12/10/08
☐	Information to JFO	(Secretary's signature or designee)	Date:

16. DOCUMENTATION REQUIRED

Required GRANT Documentation

☐ Request Memo ☐ Dept. project approval (if applicable) ☐ Notice of Award ☐ Grant Agreement ☐ Grant Budget	☐ Request Memo ☐ Dept. project approval (if applicable) ☐ Notice of Donation (if any) ☐ Grant (Project) Timeline (if applicable) ☐ Request for Extension (if applicable)

End Form AA-1

Vermont Department of Mental Health		
Supporting Schedule for SAMHSA Grant AA-1 dated 12/3/08		
Item	amount in application budget for year one	amount in AA1 budget for SFY09
salary, fringe and travel for project coordinator	$54,764 for three-quarters of a year	two-quarters of a year $36,510
VCHIP grant	$150,000 for three-quarters of a year	two-quarters of a year $100,000
Federation grant	$78,633 for three-quarters of a year	two-quarters of a year $52,422
Howard grant	$30,109 for three-quarters of a year	two-quarters of a year $20,073
training and technical assistance	$28,245 for one-quarter of a year	$28,245 for one-quarter of a year
social marketing	$12,500 for one-quarter of a year	$12,500 for one-quarter of a year
Regions	$595,749	$216,250 - one-quarter of annualized allocation of $865,000
total subgrants - direct costs	$950,000	$466,000
indirect costs	$50,000 at 5% of total Federal funds	$24,526 at 5% of total Federal funds
total costs	$1,000,000	$490,526

SAMPLE FOR AA-1

Vermont Department of Mental Health

New System of Care and Mental Health Treatment Investments for Transition-Aged Youth

Financial Match Reporting Statement for SFY 2009

Department: DCF (for example)

Programs	Cash Expenditures				
	Quarter Ended				YTD
	9/2008	12/2008	3/2008	6/2008	
Youth Aging Out of Foster Care					$ -
Restorative Justice and Street Checkers					$ -
Mentoring					$ -

The Department for Children and Families (for example) spent the above amount of State funds on the above programs for the quarters listed.

______________________________ ________________

Signature of Business Manager or Designee Date

____

Print Name and Title

Giffin, Jim

From: Biss, Charlie [cbiss@vdh.state.vt.us]
Sent: Friday, November 21, 2008 7:57 AM
To: Hartman, Michael; Clark, Leo; Johnson, Scott; Giffin, Jim
Subject: FW: Questions RE: 1U79SM058485-01

This is what I received from the feds. Does this answer the questions adequately enough?

-----Original Message-----
From: Simpson, Gwendolyn G. (SAMHSA/OPS) [mailto:Gwendolyn.Simpson@samhsa.hhs.gov]
Sent: Thursday, November 20, 2008 4:02 PM
To: Biss, Charlie
Subject: RE: Questions RE: 1U79SM058485-01

1. You will have an opportunity to change to the *Vermont Department of Mental Health instead of to the Vermont Department of Health when you apply for Yr. 2 continuation funding.*

2. In response to your match questions:

   (a) Match must be provided each budget year based on the minimum required match spelled out in the RFA. If you have overmatched in one year, you may apply the **unused** match in the next budget year.

   (b) The RFA spells out what the minimum required match is for each budget year of the six years of the project. You should use that as your documentation, or ask your Government Project Officer to provide you something in writing.

   (c) Consult with the financial officer there in your organization to find out the process for documenting the match on Federal grants. I am sure they are experienced at this.

   (d) If the Terms and Conditions indicate that the Project Director is a key staff position and needs prior approval, it does not matter whether the position is at the state level or contractor level, as soon as a candidate is identified, please submit a formal request in writing with the name of the person and that person's Resume that shows that this individual has the experience, along with a revised budget that shows the percentage of effort that this Project Director will work on the project and salary. The letter of request must come from the State. The letter, Resume and revised budget can be emailed as an attachment to both me and the Government Project Officer.

I hope I have addressed your questions sufficiently. If not, please email me again or call me.

Gwendolyn Simpson
Gwendolyn Simpson
Team Leader/Lead Grants Management Specialist
Division of Grants Management, SAMHSA
1 Choke Cherry Road, 7-1085
Rockville, MD 20857
240-276-1408
240-276-1430 (Fax No.)
gwendolyn.simpson@samhsa.hhs.gov

From: Biss, Charlie [mailto:cbiss@vdh.state.vt.us]

Notice of Award

Child Mental Health Initiative (CMHI) **Issue Date:** 08/30/2008
Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services

Grant Number: 1U79SM058485-01

Program Director:
Charles A Biss

Project Title: Mental Health Services for Transition-Aged Youth

Grantee Address	Business Address
VERMONT STATE DEPT OF HEALTH Heidi Hall Asst. Fiscal Operations Director 108 Cherry Street Burlington, VT 05402	Heidi Hall Asst. Financial Operations Director Vermont Department of Mental Health 108 Cherry Street Burlington, VT 05402

Budget Period: 09/30/2008 – 09/29/2009
Project Period: 09/30/2008 – 09/29/2014

Dear Grantee:

The Substance Abuse and Mental Health Services Administration hereby awards a grant in the amount of $1,000,000 (see "Award Calculation" in Section I and "Terms and Conditions" in Section III) to VERMONT STATE DEPT OF HEALTH in support of the above referenced project. This award is pursuant to the authority of Section 561 of the PHS Act, As amended and is subject to the requirements of this statute and regulation and of other referenced, incorporated or attached terms and conditions.

Award recipients may access the SAMHSA website at www.samhsa.gov (click on "Grants" then SAMHSA Grants Management), which provides information relating to the Division of Payment Management System, HHS Division of Cost Allocation and Postaward Administration Requirements. Please use your grant number for reference .

Acceptance of this award including the "Terms and Conditions" is acknowledged by the grantee when funds are drawn down or otherwise obtained from the grant payment system.

If you have any questions about this award, please contact your Grants Management Specialist and your Government Project Officer listed in your terms and conditions.

Sincerely yours,

Kathleen Sample
Grants Management Officer
Division of Grants Management, OPS
Substance Abuse and Mental Health Services Administration

See additional information below.

SECTION I – AWARD DATA – 1U79SM058485-01

Award Calculation (U.S. Dollars)

Salaries and Wages	$35,038
Fringe Benefits	$13,314
Personnel Costs (Subtotal)	$48,352
Consortium/Contractual Cost	$895,236
Travel Costs	$6,412
Direct Cost	$950,000
Indirect Cost	$50,000
Approved Budget	$2,942,726
Federal Share	$1,000,000
Non-Federal Share	$1,942,726
Cumulative Prior Awards for this Budget Period	$0
AMOUNT OF THIS ACTION (FEDERAL SHARE)	$1,000,000

SUMMARY TOTALS FOR ALL YEARS	
YR	**AMOUNT**
1	$1,000,000
2	$1,500,000
3	$2,000,000
4	$2,000,000
5	$1,500,000
6	$1,000,000

* Recommended future year total cost support, subject to the availability of funds and satisfactory progress of the project.

Fiscal Information:

CFDA Number:	93.104
EIN:	1036000274E7
Document Number:	U9SM58485A
Fiscal Year:	2008

IC	CAN	Amount
SM	C96C133	$1,000,000

SM Administrative Data:
PCC: CMHI / **OC:** 4145

SECTION II – PAYMENT/HOTLINE INFORMATION – 1U79SM058485-01

Payments under this award will be made available through the HHS Payment Management System (PMS). PMS is a centralized grants payment and cash management system, operated by the HHS Program Support Center (PSC), Division of Payment Management (DPM). Inquiries regarding payment should be directed to: The Division of Payment Management System, PO Box 6021, Rockville, MD 20852, Help Desk Support – Telephone Number: 1-877-614-5533.

The HHS Inspector General maintains a toll-free hotline for receiving information concerning fraud, waste, or abuse under grants and cooperative agreements. The telephone number is: 1-800-HHS-TIPS (1-800-447-8477). The mailing address is: Office of Inspector General, Department of Health and Human Services, Attn: HOTLINE, 330 Independence Ave., SW, Washington, DC 20201.

SECTION III – TERMS AND CONDITIONS – 1U79SM058485-01

ABSTRACT

The goal of this 6-year project is for Vermont's transition-aged youth (16 through 21 inclusive, with their families) with severe emotional disturbance (SED) to have adequate preparation and the necessary supports to be productively engaged in the community and free from incarceration. For this population, the necessary supports include access to health care (908 youth will receive treatment for mental health and co-occurring substance abuse challenges), also post-secondary education, employment, housing, and caring relationships (with adults who nurture positive youth development). The strategic planning and ongoing management of this project will be under the direction of Vermont's State Interagency Team (SIT), which was established by State law Act 264 in 1988 to oversee a system of care for children and youth with SED. Historically, most of the children and youth served by SIT have been in school and/or in the custody of the Department for Children and Families (DCF: *child welfare and juvenile justice*); for this project, SIT's reach will extend more systematically to youth who are out of school and/or in contact with the adult criminal justice system. Vermont Act 264 also established Local Interagency Teams (LITs), one in each of the 12 Agency of Human Services (AHS) service districts. The LITs support the creation of local systems of care and assure that staff are trained and supported in creating coordinated services plans. The SIT will issue an "Invitation to Communities" asking the 12 LITs to develop regional strategic and oversight plans to effectively address the goal of this project. The LITs will be asked to augment the existing system of care for children and adolescents with SED by intentionally reaching out to transition-aged youth at least through teen centers, recovery centers, homeless youth programs, and at critical intervention points with the juvenile and criminal justice systems. This will improve access to mental health services for the youth at most risk for poor outcomes and use the power of the courts to increase the likelihood of use of those services by the youth. The 12 LITs will also be asked to propose to the State specific mental health services to fund in addition to the required cross-system care management and individualized service plan development for each youth. The LITs will be required to use the Jump on Board for Success (JOBS) program as a logical foundation upon which to build the enhanced system of care. JOBS - which operates in accordance with the TIP Model and is an age-appropriate adaptation of the Evidence-Based Practice (EBP) of Supported Employment for adults with SMI - offers *available, accessible, and attractive* service delivery for transition-aged youth with SED. Each LIT must decide whether it is important for that region to establish and/or expand the JOBS program or to augment it with another EBP - such as for the treatment of co-occurring mental health and substance abuse disorders, the treatment of trauma, or for family or parenting education. Other 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, and mentoring.

BUDGET INFORMATION - Non- Construction Programs

SECTION A - BUDGET SUMMARY

Grant Program Function or Activity (a)	Catalog of Federal Domestic Assistance Number (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non- Federal (f)	Total (g)
1.		$	$	$	$	$
2.		$	$	$	$	$ 0.00
3.		$	$	$	$	$ 0.00
4.		$	$	$	$	$ 0.00
5. TOTALS		$ 0.00	$ 0.00		$	

SECTION B - BUDGET CATEGORIES

6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY				Total (5)
	(1)	(2)	(3)	(4)	
a. Personnel - Project Director ¾ yr	$ 35,038	$	$	$	$ 35,038
b. Fringe Benefits	$ 13,314	$	$	$	$ 13,314
c. Travel	$ 6,412	$	$	$	$ 6,412
d. Equipment	$	$	$	$	$
e. Supplies	$	$	$	$	$
f. Contractual	$ 895,236	$	$	$	$ 895,236
g. Construction	$	$	$	$	$ 0.00
h. Other	$	$	$	$	$ 0.00
i. Total Direct Charges *(sum of 6a -6h)*	$ 950,000	$ 0.00	$ 0.00	$ 0.00	$ 950,000
j. Indirect Charges	$ 50,000	$	$	$	$ 50,000
k. TOTALS *(sum of 6i and 6j)*	$ 1,000,000	$ 0.00	$ 0.00	$ 0.00	$ 1,000,000
7. Program Income	$	$	$	$	$ 0.00

SECTION C - NON- FEDERAL RESOURCES

(a) Grant Program	(b) Applicant	(c) State	(d) Other Sources	(e) TOTALS
8. CMHI – 93.104	$ in-kind DMH	$ 1,942,726	$	$ **1,942,726**
9.	$	$	$	$ 0.00
10.	$	$	$	$ 0.00
11.	$	$	$	$ 0.00
12. TOTALS *(sum of lines 8 and 11)*	$ in-kind DMH 0.00	$ **1,942,726**	$ 0.00	$ **1,942,726**

SECTION D - FORECASTED CASH NEEDS

	Total for 1st Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
13. Federal	$ 0.00	$	$	$	$
14. Non- Federal	$ 0.00	$	$	$	$
15. TOTAL *(sum of lines 13 and 14)*	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00

SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT

(a) Grant Program	FUTURE FUNDING PERIODS (Years)			
	(b) First	(c) Second	(d) Third	(e) Fourth
16. CMHI – 93.104 (also, fifth future year: **$1,000,000)**	$ 1,500,000	$ 2,000,000	$ 2,000,000	$ 1,500,000
17.	$	$	$	$
18.	$	$	$	$
19.	$	$	$	$
20. TOTALS *(sum of lines 16 -19)*	$ **1,500,000**	$ **2,000,000**	$ **2,000,000**	$ **1,500,000**

SECTION F - OTHER BUDGET INFORMATION

21. Direct Charges:	22. Indirect Charges: 5% for unspecified infrastructure charges; 15% allowed by RFA.

23. Remarks

PROJECT NARRATIVE

Section A: Understanding of the Project

Describe the population of children with serious mental health needs in the geographic area.

This is a proposal to bring hope to a subset of youth aged 16 through 21 (inclusive) and their families located in the State of Vermont. This is the subset of youth who are experiencing serious emotional disturbance (SED, especially but not exclusively with symptoms of depression and co-occurring substance abuse) as they make the high-stakes transition from childhood to adulthood. **The goal of this 6-year project is for these youth to have adequate preparation and the necessary supports to be productively engaged in the community and free from incarceration. For this population, the necessary supports include access to health care (908 youth [173 per each of 5.25 years] will receive treatment for mental health and co-occurring substance abuse challenges), also post-secondary education, employment, housing, and caring relationships (with adults who nurture positive youth development).**

"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 (1999)."[1] And the "federal Center for Mental Health Services estimates that ... about 12% of Vermont's children and youth may be experiencing serious or severe emotional disturbance each year."[2] **54,185 youth aged 16 through 21 reside in Vermont[3]; 6,502 are likely to be experiencing SED.**

At least 95% of these youth are White, and 1% of the Whites are Latino. About 4.6% of the youth are non-White, and within that percentage is the following distribution of races: 34.8% mixed, 26.2% Asian, 18.6% Black, 10.2% Native American, 9.3% other, and 0.9% Pacific Islander.[4] The Native Americans are likely to be associated with the Abenaki Self-Help Association in Swanton, Franklin County; Vermont does not have a federally-recognized tribe.

The racial data does not capture the full diversity of ethnicity in Vermont, which has historically been settled by French-Canadian, Italian, and Irish Catholics as well as the Scot and English Protestants/Puritans. Then there were the Germanic and Jewish people fleeing World War II. In more recent years the immigration has been heavily influenced by Vermont's Refugee Resettlement Program (VRRP), which since 1980 has brought in hundreds of Vietnamese, Bosnians, and Somalis as well as dozens of Meskhetian Turks, Sudanese, Congolese, and others from more than 20 additional countries. These refugees and asylees comprise less than one percent of the population and are most of the people in Vermont with Limited English Proficiency (LEP);[5] efforts are made to quickly enroll both the adults and their children in classes for English-language learners. The Vermont State Agency of Human Services (AHS) and many private non-profit service providers contract for interpreter and translation services to communicate with them.

Most of the non-White people are located in Vermont's only Standard Metropolitan Statistical Area (SMSA), which includes Chittenden, Franklin, and Grand Isle Counties and the northern part of Addison County, areas with prime real estate that border Lake Champlain. The

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[1] DMH. (2004). The Vermont State System of Care Plan for Child, Adolescent and Family Mental Health, State Fiscal Years 2005-2007, p.7.

[2] Ibid.

[3] VT Dept. of Health. (2006). Population Estimates, based on 2000 US Census.

[4] US Census Bureau. (2000). tables.

[5] Lamoureux, D. (2007). Summary of Vermont Refugee Arrivals.

SMSA houses about 1/4 of Vermont's 621,254 people.[6] Chittenden County has the most economic opportunity and the lowest rate of child poverty in the state (for 2002, 7.4% compared with 11.5% statewide).[7] However,

> nearly 20% of children in Burlington and Winooski [cities in Chittenden County] lived in poor families....Poverty rates are even higher for non-white Vermont children. The estimated child poverty rate for African American children under age 18 was 21.6% in 2000; the rate for non-white Hispanic children was 21.1%, and the rate for Native American children was 26.3%.[8]

Burlington is well served by a public bus transportation system, something mostly lacking in the rural cities and towns. "Limited or non-existent public transportation, a narrow employer base of mostly small businesses, and insufficient job development and job placement services"[9] are barriers to employment throughout much of Vermont. Most of the available jobs are in the service industry or retail settings, so "in 2000, only 39% of jobs in Vermont paid enough to meet basic needs."[10] People here have to work multiple jobs to pay their bills.

> Many families are one financial disaster away from homelessness – because of a job layoff, loss of health insurance, catastrophic medical costs, workplace injury, or loss of transportation to work....In 2006, nearly half of Vermont renters couldn't afford the fair market rent for a two-bedroom apartment of $797, which would require an hourly wage of $15.34. The average Vermont wage was only $9.87 per hour. The same apartment in Chittenden, Franklin and Grand Isle Counties would cost $983 per month, requiring an hourly wage of $18.90 per hour.[11]

The high rents are driven by the fact that "Vermont ranks second only to Maine as the state with the highest percentage of vacation homes....

> Of Vermont's 33,000 low-income households, about 27% live in substandard units. With housing stock ranked second oldest in the nation, Vermont homes and apartments have a greater likelihood of lead exposure, poor insulation, and need for repairs.[12]

"The limited resources and rural nature of the state means the service infrastructure is often weak or patchy. Services available in some of the state's larger towns are often unavailable in the more rural communities."[13]

> Vermont's rural places are those that retain the best elements of our Green Mountain State – its beauty, independence, and strong family ties. But rural places also may be home to isolation, fewer jobs, and limited affordable and quality child care, social services and medical care.[14]

"This particularly affects the quality of transition services for youth with disabilities, where so many different service systems need to be engaged and working together to be effective."[15]

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[6] The Times Argus. (December 27, 2007). Census information highlighted to go with story about "Louisiana population rebounds; Florida growth slows"
[7] The Vermont Children's Forum. (2005). The State of Our Children: 2005 Data Book: Kids Count in Vermont, p.7.
[8] The Vermont Children's Forum. (2003). Children and Poverty in Vermont, p. 2, 3.
[9] Kievit-Kylar, R. & Porter, A. (2007). Career Start Connections, p. 5.
[10] The Vermont Children's Forum. (2003). Children and Poverty in Vermont, p. 6, 11.
[11] Voices for Vermont's Children. (2007). Homeless in Vermont: Children, Youth and Families
[12] The Vermont Children's Forum. (2003). Children and Poverty in Vermont, p. 6, 11.
[13] Kievit-Kylar, R. & Porter, A. (2007). Career Start Connections, p. 5.
[14] The Vermont Children's Forum. (2003). Children and Poverty in Vermont, p. 3.
[15] Kievit-Kylar, R. & Porter, A. (2007). Career Start Connections, p. 5.

Of the youth in Vermont aged 16-21 (inclusive), 51.5% are male and 48.5% are female.[16] Most of them are successfully transitioning to adulthood, as can be seen by their rate of participation in the labor force.

> Based on 2000 Census Bureau data, 56% of 16-19 year olds were in the labor force and approximately 86% [of them] were actually employed. As one would assume, these percentages increased for 20-21 year olds. Approximately 69% were in the labor force and 88% [of them] were actually employed. The numbers were slightly higher for females compared to males. [17]

Furthermore, in Vermont

> the percent of young people aged 16-19 who are not working or in school declined between 1998 and 2002 from 8% to 6%...[and] a greater percent of Vermont students who enter 9th grade are completing school four years later. According to VT Department of Education [DOE] estimates, the completion rate for 2004 was 86%.[18]

However, a significant percentage of youth – particularly those with disabilities - lack the necessary skills and supports to succeed in today's economy. "Nationally, 14% of youth with disabilities enter college compared to 63% of the general youth population (Guideposts for Success, National Collaborative on Workforce and Disability – Youth)."[19]

Vermont has the highest percentage of students aged 6 to 17 with identified disabilities in the nation (16.6% compared with the US mean of 6.6%).[20] This is largely because of twenty years of State and local interagency efforts to better serve children and adolescents with SED. Despite significant attempts to serve them in regular classrooms with accommodations, "there was a substantial increase in the number of children and adolescents with an IEP [Individualized Education Plan] for ED [emotional disturbance] …from 1,614 in FY1999 to 2,207 in FY2004."[21] During FY2004, 47% of young people on an IEP for ED were also on the caseload of their local community mental health center (CMHC).[22]

In 2007 the number of children and adolescents who received children's mental health services from Vermont's ten publicly-funded, private non-profit CMHCs *[see map in Appendix 6]* was 9,609.[23] Of these children, 68% were covered by Medicaid, 18% were covered by other insurance, and 20% were uninsured.[24] It is likely that a high percentage of the transition-aged youth who were served were uninsured. The AHS has recently made increasing the enrollment in Medicaid a priority for youth aged 18 through 20 because "enrollment data indicated that only 44% of 18-, 19- and 20-year-olds who are eligible for some form of Medicaid are actually enrolled. This number is unacceptably low." [25]

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[16] US Census Bureau. (2000). tables.
[17] Smith, M.K. (2007). Report to the House Committee on Human Services and the Senate Committee on Health and Welfare about H.449 – Section 4. Study on Transitional Services for Youth, p. 5.
[18] The Vermont Children's Forum (2005). The State of Our Children: 2005 Data Book: Kids Count in Vermont, p.5.
[19] Smith, M.K. (2007). Report to the House Committee on Human Services and the Senate Committee on Health and Welfare about H.449 – Section 4. Study on Transitional Services for Youth, p. 4.
[20] Vermont State Department of Education. (200?). Vermont 2005 Child Count.
[21] Pandiani, J. & Mongeon, J. (2005). Use of Children's Services by Students with an Emotional/Behavioral Disability.
[22] Ibid.
[23] Pandiani, J, & Carroll, B. (2007). CMH Caseload: FY'85 –'07.
[24] VT Dept of Mental Health. (2007). Fiscal Year 2007 Statistical Report.
[25] LaWare, C. (2007). Clarifying Medicaid Eligibility for Youth in Vermont.

A study for the Vermont Legislature on Transitional Services for Youth[26] included data showing that in FY2006, CMHCs served 1,039 youth aged 16; 846 youth aged 17; 631 youth aged 18; 525 youth aged 19; 449 youth aged 20; and 413 youth aged 21. Most of these youth received children's community mental heath and/or substance abuse treatment services.[27] For the youth who received children's mental health services, the predominant diagnoses were affective disorder, non-psychotic disorders, anxiety disorder, adjustment disorder, and substance abuse.[28] Very few received either adult outpatient or Community Rehabilitation and Treatment (CRT) services for adults with serious and persistent mental illness.

> Only 10% of 15-17 year olds served by children's services programs in Vermont…also received services from an adult mental health program at the same CMHC when they were 21-23 years old. There was no difference between the genders in the likelihood of being served by adult outpatient programs after being served by children's services.[29]

Though the vast majority of the 3,903 youth aged 16-21 who were served by the CMHCs in 2006 will not make use of public mental health services after their eligibility for children's services ends, their need for care may not have ended.

Since children's mental health services clients are most likely to be referred by family and friends (28%) or educators (27%),[30] as transition-aged youth strive to establish independence from the caregivers and other adult authority figures in their lives it is not surprising to see the precipitous drop in the number of youth who choose to participate in these services after they turn 16 (the year they can choose to drop out of school), and even more after they become 18 (the year the State deems them to be adults). However, youth who distance themselves from social supports may have difficulty successfully transitioning to adulthood.

In Vermont in FY2000, special education students accounted for 20% of the dropouts; almost 50% of those special education dropouts were identified with ED.[31] Dropping out is often a precursor to ending up in jail. Of the 219 average daily population of youth aged 18-21 incarcerated in adult Correctional facilities in Vermont in 2007, 90% "have no high school diploma; 50% of these youth were eligible for special education services … in high school."[32]

> According to Dr. Ronald E. Dahl of the University of Pittsburgh Medical Center:
> Achieving adult status requires developing self-control of behavior & emotions:
> - Appropriately inhibit or modify behaviors to avoid negative future consequences
> - Initiate, persist, sequence steps toward goals
> - Navigate complex social situations despite strong affect
> - Skills in the self-regulation of affect and complex behavior [for] long-term goals
> - Involves neurobehavioral systems in PFC (Prefrontal Cortex) - *among the last regions of the brain to achieve full functional maturation.*[33]

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[26] Smith, M.K. (2007). Report to the House Committee on Human Services and the Senate Committee on Health and Welfare about H.449 – Section 4. Study on Transitional Services for Youth, Attachment E *(?)*
[27] VT Dept of Health, Div. of Mental Health. (2006). Fiscal Year 2006 Statistical Report.
[28] Vermont State Department of Mental Health. (2008). Management Information System for FY2007.
[29] Pandiani, J. & Kobel, O. (2007). Movement from Children's Services into Adult Services.
[30] Pandiani, J. & Simon, M. (2004). Source of Referral to Community Mental Health Programs.
[31] Vt. Dept. of Education. (2002). Vermont Self-Assessment Report.
[32] Smith, M.K. (2007). Report to the House Committee on Human Services and the Senate Committee on Health and Welfare about H.449 – Section 4. Study on Transitional Services for Youth, p. 4.
[33] Dahl, R.E. (undated). Adolescent Brain Development: A Framework for Understanding Unique Vulnerabilities and Opportunities.

Youth who do not have this self-control or adults to help them gain it are at great risk for poor outcomes. Davis and Stoep (1996) say

> The plight of youth with serious emotional disturbance in transition to adulthood is grave. As a group, these youth are undereducated, underemployed, and have limited social supports. Drug and alcohol abuse are common, and suicide risk is high. These youngsters remain largely "unclaimed"—falling through the cracks within and between the child and adult service systems.[34]

Nationally, according to Davis and Butler (2002),[35] "the transition from adolescence to adulthood is a major struggle for families of children with SED. Few parents found service systems to be helpful during this transition." Regarding child-service systems, "they rated only child vocational rehabilitation services as helpful on most transition-related issues. Overall, they rated child vocational rehabilitation services higher than mental health, education, special education, child welfare and juvenile justice services." They rated adult vocational rehabilitation and adult mental health systems lower than child-serving systems. "They rated colleges quite positively. The few parents who rated the substance abuse system tended to rate it as helpful."

The surveyed families were members of the National Federation of Families for Children's Mental Health. They observed that "the most common barrier to services is simply the stigma young people feel in accessing services that could label them as mentally ill."[36] And the parents felt the services did not address the issues most relevant to their youth ("such as getting a job or finding a place to live") or sufficiently or appropriately include the parents.

> Parents of 18-20 year-olds rated mental health services lower and parents of those under 18 rated mental health services higher than parents of those over 20....They rated child mental health and special education services neither good nor bad on most transition-related issues, but poor on preparing adolescents for adulthood. Overall, they gave negative ratings to regular education, child welfare, and juvenile justice.[37]

Youth without families who are meaningfully involved in their lives are at most risk. Some of those youth are in State custody. Of the 978 youth aged 13-17 in 2006 who were in the custody of the Department for Children and Families (DCF) for child abuse and neglect or unmanageable or delinquent behavior, 65% also received children's mental health services.[38]

Vermont's Juvenile Justice and Delinquency Prevention (JJDP) Program has documented that "black youth are 20% less likely to be referred to juvenile court for minor offenses than white youth, while they have nearly a 60% greater chance of being referred to adult court than white youth for similar offenses."[39]

A study of the incarceration rate for youth aged 18-21 who had previously received children's services compared with the incarceration rate for the general population for the five years from FY1998-2002 shows that:

> Young people who had been on the [DCF] caseload had the highest incarceration rates overall (18%, more than four times the general population rate). Young people who had been on the mental health caseload had the second highest incarceration rate (9%, more

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[34] Davis, M. & Stoep, A.V. (1996). The Transition to Adulthood Among Adolescents Who Have Serious Emotional Disturbance, p. ii.

[35] Davis, M. & Butler, M. (2002). Service Systems Supports During the Transition from Adolescence to Adulthood: Parent Perspectives, p. vii-viii.

[36] Ibid.

[37] Ibid.

[38] Pandiani, J. & Martin, B. (2007). Children in DCF Custody Served by CMH Programs.

[39] Lay-Sleeper, T. (1/7/2008). Emailed communication from JJDP Specialist.

> than twice the general population rate). Young people who had been on the special education caseload had the lowest incarceration rates (7%). Incarceration rates for boys were substantially higher than the incarceration rates for girls in every service group. The elevated risk of incarceration (the incarceration rate for service recipients divided by the incarceration rate for the general population) among [DCF] service recipients, however, is greater for girls than for boys. There were no significant differences, however, between the elevated risk of incarceration for girls and boys on the mental health and special education caseloads.[40]

Looked at in a different way:

> On average, more than 1,000 young adults (18-21 years of age) were incarcerated, per year during FY1998-2002. These young adults were predominantly male (88% vs. 12% female). Overall, more than half (52%) had been on the caseload of at least one of these child-serving agencies. Incarcerated young women were much more likely than incarcerated young men to have been served by the children's agencies (64% vs. 50%).[41]

As part of an ongoing trend for African-American youth, during one year

> female minorities were over-represented among Woodside *[the DCF secure detention and treatment facility for juvenile delinquents]* admissions relative to white females...Minority females were primarily admitted to Woodside for running away and intoxication...Woodside likely served as a place to put an out of control or runaway youth until a crisis situation was resolved or another more suitable placement arranged.[42]

Vermont's JJDP Specialist says that "secure detention placements for youth with high needs and no other appropriate placements are common in VT as they are nationally. Youth with untreated mental health needs commonly end up in secure detention."[43] "Minority youth may have fewer placement options available to them than do white youth."[44]

Thus, there is a lot of room for Vermont to improve the outcomes of service for transition-aged youth, especially for those who have been removed from their families and particularly for black youth and young women. Service models have not been adequately tailored to meet different gender and cultural needs, though recent AHS attention to trauma-informed services may bring about changes.

Describe the current capacity to serve children and youth with SED and their families.

The State of Vermont Department of Mental Health (DMH) has been building its system of care for children with SED since receiving a Child and Adolescent Services Systems Planning (CASSP) grant in 1986. The number of children and adolescents served annually by children's mental health programs has more than tripled since 1985, when there were only 3,000.[45]

An additional way of assessing Vermont's success in building this system of care is to look at a measure of the Child and Adolescent Caseload Segregation/Integration or "the degree

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[40] Pandiani, J. & Ghosh, K. (2003). More on Incarcerated Youth: Incarceration Rates for Young Adults Previously Served by Child-serving Agencies.

[41] Pandiani, J. & Ghosh, K. (2003). Incarcerated Young Adults Previously Served by Child-Serving Agencies.

[42] Bellas, M. L. (2004). Disproportionate Minority Confinement at Woodside's Detention Program October 1, 2000 to September 30, 2002, p.1. Retrieved on 1/3/2008 from http://humanservices.vermont.gov/boards-committees/cfcpp/publications/disproportionate-...

[43] Lay-Sleeper, T. (1/7/2008). Emailed communication from JJDP Specialist.

[44] Bellas, M. L. (2004). Disproportionate Minority Confinement at Woodside's Detention Program October 1, 2000 to September 30, 2002, p.19-20. Retrieved on 1/3/2008 from http://humanservices.vermont.gov/boards-committees/cfcpp/publications/disproportionate-...

[45] Vermont State Department of Mental Health. (1/28/2008). Emailed MIS information.

to which child-serving agencies share responsibility for serving children and adolescents with emotional disorders."[46] The degree of caseload overlap between children's mental health, child welfare/juvenile justice, and special education has increased from the initial measurement of 21% statewide in 1993 to 37% statewide in 2006. (0% would show no caseload overlap while 100% would show no differentiation of service across agencies for individualized needs.)

This increased focus on the same children, youth, and families is designed to produce more comprehensive services with more consistency and clarity about performance expectations for all, providers and families alike. Yet surveys of key stakeholders (parents, youth, educators, and child welfare caseworkers) reveal continued differences of opinion about the role of children's mental health services. Vermont parents of children and youth aged up to 18 who were served by the CMHCs in 2005 "were very likely to rate their programs favorably."[47] A survey of youth aged 14-18 who received Medicaid reimbursed services from the CMHCs in 2006 showed that 75% evaluated the programs positively overall.[48]

> Young people and parents had high agreement in their ranking of programs for three of our four measures of program performance (staff, quality, and overall performance). Parents, however, did not have high agreement on any of these measures with either educators or [DCF] caseworkers. Youth had high agreement with educators on only one measure (outcomes) and did not have high agreement with [DCF] caseworkers on any of the measures....Educators and [DCF] caseworkers had high agreement in their rankings of all four measures of program performance. Educators, however, did not have high agreement on any of these measures with either youth or parents. [DCF] caseworkers had high agreement with youth on only one measure (outcomes) and did not have high agreement with parents on any of the measures.[49]

Because –or in spite – of these different and competing perspectives about public children's mental health services, providers have worked diligently with other departments and agencies to develop services that are meaningful for the children, adolescents, and their families. They have searched for effective approaches to help youth with SED learn self-control of behaviors and emotions so they can avoid future incarceration and other negative consequences. Talking therapies must be blended with skills training since

> how teens spend their time seems to be particularly crucial. If the 'Use it or Lose it" principle holds true, then the activities of the teen may help guide the hard-wiring, actual physical connection in their brains [which are pruning down cells in later adolescence).[50]

One hands-on approach for transition-aged youth with SED created by Washingtogn County Mental Health Services in 1993 is the JOBS (Jump on Board for Success) program, which has been replicated (though under-funded) in all but one of the State's 12 service districts.

Establish the significance of the proposed initiative.

Dr. Maryann Davis described the JOBS program in her 2001 report to the National Technical Assistance Center for State Mental Health Planning (NTAC) about "State Efforts to Expand Transition Supports for Adolescents Receiving Public Mental Health Services."

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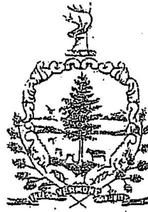
[46] Pandiani, J. & Carroll, B. (2006). Child and Adolescent Caseload Segregation/Integration in Vermont.
[47] Pandiani, J., Carroll, B. & Kobel, O. (2006). Parents' Evaluation of Children's Services Programs.
[48] Pandiani, J. & Carroll, B. (2007). Evaluation of Child and Adolescent Mental Health Programs By Young People Served in Vermont July – December, 2006: Technical Report, p.1.
[49] Pandiani, J. & Bramley, J. (2003). Survey Raters and Rankings: Children's Services Programs.
[50] Giedd, J. (undated). Inside the Teenage Brain. Interview with Frontline of PBS. Retrieved from internet 12/26/2007 from http://www.pbs.org/wgbh/pages/frontline/shows/teenbrain/interviews/giedd.html.

JAMES H. DOUGLAS
GOVERNOR



State of Vermont
OFFICE OF THE GOVERNOR

January 25, 2008

Ms. Crystal Saunders, Director of Grant Review
Office of Program Services
Substance Abuse and Mental Health Services Administration
Room 3-1044
1 Choke Cherry Road
Rockville, MD 20850

Re: Vermont's Application for RFA # CMHI – SM-08-004

Dear Ms. Saunders:

Please accept this application from the State of Vermont for a Children's Mental Health Initiative (CMHI) grant to expand the Vermont community capacity to serve transition-aged youth (16-21, inclusive) with serious emotional disturbance and their families. I have authorized Cynthia D. LaWare, Secretary of the Agency of Human Services, to submit this application on my behalf, and she in turn will designate Michael Hartman, Commissioner of the Department of Mental Health to administer the grant.

Ensuring that Vermont youth have access to supports and services that enable them to become self-sufficient, contributing members of society is of critical importance to my administration. I have championed legislation that supports new investments in career exploration and alternative education for the next generation, as well as enhanced college scholarships, mentoring, housing and other supports for youth transitioning out of the foster care system. Clearly, however, a great need for services remains.

Upon grant approval, the Department of Mental Health will propose to Vermont's Community Mental Health Block Grant Planning Council that the Mental Health Plan for Children and Adolescents with Serious Emotional Disturbance be amended to include these developments.

Additionally, this grant application is consistent with Vermont's SAMHSA-funded Co-occurring State Infrastructure Grant (COSIG), which is training mental health and substance abuse treatment staff to assess and treat co-occurring mental health and substance abuse issues.

I support this proposal and will assist the Agency of Human Services in cultivating the partnerships necessary to build and sustain this system of care for the next generation. Thank you for your consideration.

Sincerely,

James H. Douglas
Governor

JHD/rrs

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TELEPHONE: 802.828.3333 • FAX: 802.828.3339 • TDD: 802.828.3345

JFO 2360

VERMONT

State of Vermont
Department of Finance & Management
109 State Street, Pavilion Building
Montpelier, VT 05620-0401

[phone] 802-828-2376
[fax] 802-828-2428

Agency of Administration

STATE OF VERMONT
FINANCE & MANAGEMENT GRANT REVIEW FORM

Grant Summary:	The Substance Abuse and Mental Health Services Administration awarded a grant to the Vermont State Dept. of Health for Mental Health Services for Transition-Aged Youth. This award is pursuant to the authority of Section 561 of the PHS Act. This grant does not use or request any new state money. The conditions of the grant allow the state to use expenditures that are already in our budget in other programs as allowable state funds upon which to draw federal match.
Date:	12/8/2008
Department:	Department of Health
Legal Title of Grant:	Child Mental Health Initiative
Federal Catalog #:	93.104
Grant/Donor Name and Address:	Substance Abuse and Mental Health Services Administration, Rockville, Maryland
Grant Period: From:	9/30/2008 **To:** 9/29/2014
Grant/Donation	1,990,526

	SFY 1	SFY 2	SFY 3	Comments
Grant Amount:	$490,526	$1,500,000	$2,000,000	

	# Positions	Explanation/Comments
Position Information:	0	

Additional Comments:

Department of Finance & Management	JR 12/10/08	(Initial)
Secretary of Administration	RPM 12/10/08	(Initial)
Sent To Joint Fiscal Office	12/11/08	Date

RECEIVED
DEC 15 2008
JOINT FISCAL OFFICE

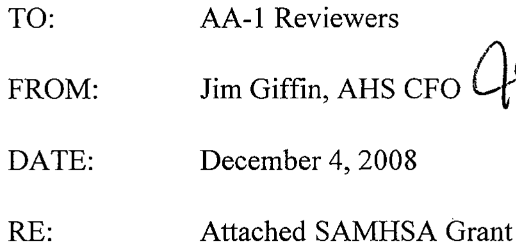
VERMONT

Agency of Human Services
Business Office
103 South Main Street
Waterbury, VT 05671-0204
[phone] 802-241-2949
[fax] 802-241-1200

MEMORANDUM

TO: AA-1 Reviewers

FROM: Jim Giffin, AHS CFO



DATE: December 4, 2008

RE: Attached SAMHSA Grant

This federal grant's requirements differ from most other federal grants in that the 'match' does not have to be expended on grant activities. The State has to document the expenditure of State funds supporting certain activities that are list in the grant. VDH/DMH business office has created a sample form (attached) that they use to document the match expenses in the various departments each quarter.

The grant has increasing match over the years from 33% to 66% over the five years. However, the match SAMSHSA allows a cumulative calculation so any overmatch in the early years can count towards the later years.

SAMSHA has allowed the State to have the project director hired from a grantee and not a State employee. After acceptance, the State will need to secure approval from SAMSHA for the individual chosen for the project director.

STATE OF VERMONT REQUEST FOR GRANT ACCEPTANCE (Form AA-1)

BASIC GRANT INFORMATION	
1. Agency:	Human Services
2. Department:	Mental Health
3. Program:	Mental Health Children
4. Legal Title of Grant:	Child Mental Health Initiative
5. Federal Catalog #:	93.104

6. Grant/Donor Name and Address:
Substance Abuse and Mental Health Services Administration, Rockville, Maryland

7. Grant Period:	**From:**	9/30/2008	**To:**	9/29/2014

8. Purpose of Grant:
To improve access to mental health services for transition-aged youth. ✓

9. Impact on existing program if grant is not Accepted:
None

10. BUDGET INFORMATION

	SFY 1	SFY 2	SFY 3	Comments
Expenditures:	**FY** 09	**FY** 10	**FY** 11	
Personal Services	$24,526	$75,000	$100,000	
Operating Expenses	$0	$0	$0	
Grants	$466,000	$1,425,000	$1,900,000	
Total	$490,526	$1,500,000	$2,000,000	
Revenues:				
State Funds:	$0	$0	$0	
Cash	$163,509	$5,000,000	$6,666,670	not included in expenditure budget
In-Kind	$	$	$	
Federal Funds:	$490,526	$1,500,000	$2,000,000	
(Direct Costs)	$466,000	$1,425,000	$1,900,000	
(Statewide Indirect)	$	$	$	
(Departmental Indirect)	$24,526	$75,000	$100,000	
Other Funds:	$	$	$	
Grant (source)	$	$	$	
Total	$490,526	$1,500,000	$2,000,000	

Appropriation No:		**Amount:**	$
	22005/3150070000		$490,526
			$
			$
			$
			$
			$
		Total	$490,526

REC'D DEC 0 4 2008

STATE OF VERMONT REQUEST FOR GRANT ACCEPTANCE (Form AA-1)

PERSONAL SERVICE INFORMATION

11. Will monies from this grant be used to fund one or more Personal Service Contracts? ☒ Yes ☐ No
If "Yes", appointing authority must initial here to indicate intent to follow current competitive bidding

Appointing Authority Name: Beth Tanzman, Deputy Commissioner Agreed by: BHT (initial)

12. Limited Service Position Information:	# Positions	Title
	0	
Total Positions		

12a. Equipment and space for these positions: ☐ Is presently available. ☐ Can be obtained with available funds.

13. AUTHORIZATION AGENCY/DEPARTMENT

I certify that no funds have been expended or committed in anticipation of Joint Fiscal Committee Approval of this grant:

Signature: [signature]	Date: 12/3/08
Title: Beth Tanzman, Deputy Commissioner of Mental Health	
Signature: Patrick Flood	Date: 12/4/08
Title: Deputy Secretary	

14. ACTION BY GOVERNOR

Check One Box:		
☑ Accepted	[signature]	12/10/08
☐ Rejected	(Governor's signature)	Date:

15. SECRETARY OF ADMINISTRATION

Check One Box:		
☐ Request to JFO	Linda P McIntire	12/10/08
☐ Information to JFO	(Secretary's signature or designee)	Date:

16. DOCUMENTATION REQUIRED

Required GRANT Documentation

☐ Request Memo	☐ Request Memo
☐ Dept. project approval (if applicable)	☐ Dept. project approval (if applicable)
☐ Notice of Award	☐ Notice of Donation (if any)
☐ Grant Agreement	☐ Grant (Project) Timeline (if applicable)
☐ Grant Budget	☐ Request for Extension (if applicable)

End Form AA-1

Vermont Department of Mental Health		
Supporting Schedule for SAMHSA Grant AA-1 dated 12/3/08		
Item	amount in application budget for year one	amount in AA1 budget for SFY09
salary, fringe and travel for project coordinator	$54,764 for three-quarters of a year	two-quarters of a year $36,510
VCHIP grant	$150,000 for three-quarters of a year	two-quarters of a year $100,000
Federation grant	$78,633 for three-quarters of a year	two-quarters of a year $52,422
Howard grant	$30,109 for three-quarters of a year	two-quarters of a year $20,073
training and technical assistance	$28,245 for one-quarter of a year	$28,245 for one-quarter of a year
social marketing	$12,500 for one-quarter of a year	$12,500 for one-quarter of a year
Regions	$595,749	$216,250 - one-quarter of annualized allocation of $865,000
total subgrants - direct costs	$950,000	$466,000
indirect costs	$50,000 at 5% of total Federal funds	$24,526 at 5% of total Federal funds
total costs	$1,000,000	$490,526

SAMPLE FOR AA-1

Vermont Department of Mental Health
New System of Care and Mental Health Treatment Investments for Transition-Aged Youth
Financial Match Reporting Statement for SFY 2009

Department: DCF (for example)

Programs	Cash Expenditures				
	Quarter Ended				YTD
	9/2008	12/2008	3/2008	6/2008	
Youth Aging Out of Foster Care					$ -
Restorative Justice and Street Checkers					$ -
Mentoring					$ -

The Department for Children and Families (for example) spent the above amount of State funds on the above programs for the quarters listed.

_______________________________________ Signature of Business Manager or Designee

_______________ Date

_______________________________________ Print Name and Title

\\Nessie\BusinessOffice\Program and Provider Oversight\Bill\Special Projects\Transition Grant\Transition Grant Match Data Collection Form

Giffin, Jim

From: Biss, Charlie [cbiss@vdh.state.vt.us]
Sent: Friday, November 21, 2008 7:57 AM
To: Hartman, Michael; Clark, Leo; Johnson, Scott; Giffin, Jim
Subject: FW: Questions RE: 1U79SM058485-01

This is what I received from the feds. Does this answer the questions adequately enough?

-----Original Message-----
From: Simpson, Gwendolyn G. (SAMHSA/OPS) [mailto:Gwendolyn.Simpson@samhsa.hhs.gov]
Sent: Thursday, November 20, 2008 4:02 PM
To: Biss, Charlie
Subject: RE: Questions RE: 1U79SM058485-01

1. You will have an opportunity to change to the *Vermont Department of Mental Health instead of to the Vermont Department of Health when you apply for Yr. 2 continuation funding.*

2. In response to your match questions:

   (a) Match must be provided each budget year based on the minimum required match spelled out in the RFA. If you have overmatched in one year, you may apply the **unused** match in the next budget year.

   (b) The RFA spells out what the minimum required match is for each budget year of the six years of the project. You should use that as your documentation, or ask your Government Project Officer to provide you something in writing.

   (c) Consult with the financial officer there in your organization to find out the process for documenting the match on Federal grants. I am sure they are experienced at this.

   (d) If the Terms and Conditions indicate that the Project Director is a key staff position and needs prior approval, it does not matter whether the position is at the state level or contractor level, as soon as a candidate is identified, please submit a formal request in writing with the name of the person and that person's Resume that shows that this individual has the experience, along with a revised budget that shows the percentage of effort that this Project Director will work on the project and salary. The letter of request must come from the State. The letter, Resume and revised budget can be emailed as an attachment to both me and the Government Project Officer.

I hope I have addressed your questions sufficiently. If not, please email me again **or call** me.

Gwendolyn Simpson
Gwendolyn Simpson
Team Leader/Lead Grants Management Specialist
Division of Grants Management, SAMHSA
1 Choke Cherry Road, 7-1085
Rockville, MD 20857
240-276-1408
240-276-1430 (Fax No.)
gwendolyn.simpson@samhsa.hhs.gov

From: Biss, Charlie [mailto:cbiss@vdh.state.vt.us]

Notice of Award

Child Mental Health Initiative (CMHI) **Issue Date:** 08/30/2008
Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services

Grant Number: 1U79SM058485-01

Program Director:
Charles A Biss

Project Title: Mental Health Services for Transition-Aged Youth

Grantee Address	Business Address
VERMONT STATE DEPT OF HEALTH Heidi Hall Asst. Fiscal Operations Director 108 Cherry Street Burlington, VT 05402	Heidi Hall Asst. Financial Operations Director Vermont Department of Mental Health 108 Cherry Street Burlington, VT 05402

Budget Period: 09/30/2008 – 09/29/2009
Project Period: 09/30/2008 – 09/29/2014

Dear Grantee:

The Substance Abuse and Mental Health Services Administration hereby awards a grant in the amount of $1,000,000 (see "Award Calculation" in Section I and "Terms and Conditions" in Section III) to VERMONT STATE DEPT OF HEALTH in support of the above referenced project. This award is pursuant to the authority of Section 561 of the PHS Act, As amended and is subject to the requirements of this statute and regulation and of other referenced, incorporated or attached terms and conditions.

Award recipients may access the SAMHSA website at www.samhsa.gov (click on "Grants" then SAMHSA Grants Management), which provides information relating to the Division of Payment Management System, HHS Division of Cost Allocation and Postaward Administration Requirements. Please use your grant number for reference .

Acceptance of this award including the "Terms and Conditions" is acknowledged by the grantee when funds are drawn down or otherwise obtained from the grant payment system.

If you have any questions about this award, please contact your Grants Management Specialist and your Government Project Officer listed in your terms and conditions.

Sincerely yours,

Kathleen Sample
Grants Management Officer
Division of Grants Management, OPS
Substance Abuse and Mental Health Services Administration

See additional information below

SECTION I – AWARD DATA – 1U79SM058485-01

Award Calculation (U.S. Dollars)

Salaries and Wages	$35,038
Fringe Benefits	$13,314
Personnel Costs (Subtotal)	$48,352
Consortium/Contractual Cost	$895,236
Travel Costs	$6,412
Direct Cost	$950,000
Indirect Cost	$50,000
Approved Budget	$2,942,726
Federal Share	$1,000,000
Non-Federal Share	$1,942,726
Cumulative Prior Awards for this Budget Period	$0
AMOUNT OF THIS ACTION (FEDERAL SHARE)	$1,000,000

SUMMARY TOTALS FOR ALL YEARS	
YR	**AMOUNT**
1	$1,000,000
2	$1,500,000
3	$2,000,000
4	$2,000,000
5	$1,500,000
6	$1,000,000

* Recommended future year total cost support, subject to the availability of funds and satisfactory progress of the project.

Fiscal Information:

CFDA Number:	93.104
EIN:	1036000274E7
Document Number:	U9SM58485A
Fiscal Year:	2008

IC	**CAN**	**Amount**
SM	C96C133	$1,000,000

SM Administrative Data:
PCC: CMHI / **OC:** 4145

SECTION II – PAYMENT/HOTLINE INFORMATION – 1U79SM058485-01

Payments under this award will be made available through the HHS Payment Management System (PMS). PMS is a centralized grants payment and cash management system, operated by the HHS Program Support Center (PSC), Division of Payment Management (DPM). Inquiries regarding payment should be directed to: The Division of Payment Management System, PO Box 6021, Rockville, MD 20852, Help Desk Support – Telephone Number: 1-877-614-5533.

The HHS Inspector General maintains a toll-free hotline for receiving information concerning fraud, waste, or abuse under grants and cooperative agreements. The telephone number is: 1-800-HHS-TIPS (1-800-447-8477). The mailing address is: Office of Inspector General, Department of Health and Human Services, Attn: HOTLINE, 330 Independence Ave., SW, Washington, DC 20201.

SECTION III – TERMS AND CONDITIONS – 1U79SM058485-01

ABSTRACT

The goal of this 6-year project is for Vermont's transition-aged youth (16 through 21 inclusive, with their families) with severe emotional disturbance (SED) to have adequate preparation and the necessary supports to be productively engaged in the community and free from incarceration. For this population, the necessary supports include access to health care (908 youth will receive treatment for mental health and co-occurring substance abuse challenges), also post-secondary education, employment, housing, and caring relationships (with adults who nurture positive youth development). The strategic planning and ongoing management of this project will be under the direction of Vermont's State Interagency Team (SIT), which was established by State law Act 264 in 1988 to oversee a system of care for children and youth with SED. Historically, most of the children and youth served by SIT have been in school and/or in the custody of the Department for Children and Families (DCF: *child welfare and juvenile justice*); for this project, SIT's reach will extend more systematically to youth who are out of school and/or in contact with the adult criminal justice system. Vermont Act 264 also established Local Interagency Teams (LITs), one in each of the 12 Agency of Human Services (AHS) service districts. The LITs support the creation of local systems of care and assure that staff are trained and supported in creating coordinated services plans. The SIT will issue an "Invitation to Communities" asking the 12 LITs to develop regional strategic and oversight plans to effectively address the goal of this project. The LITs will be asked to augment the existing system of care for children and adolescents with SED by intentionally reaching out to transition-aged youth at least through teen centers, recovery centers, homeless youth programs, and at critical intervention points with the juvenile and criminal justice systems. This will improve access to mental health services for the youth at most risk for poor outcomes and use the power of the courts to increase the likelihood of use of those services by the youth. The 12 LITs will also be asked to propose to the State specific mental health services to fund in addition to the required cross-system care management and individualized service plan development for each youth. The LITs will be required to use the Jump on Board for Success (JOBS) program as a logical foundation upon which to build the enhanced system of care. JOBS - which operates in accordance with the TIP Model and is an age-appropriate adaptation of the Evidence-Based Practice (EBP) of Supported Employment for adults with SMI - offers *available, accessible, and attractive* service delivery for transition-aged youth with SED. Each LIT must decide whether it is important for that region to establish and/or expand the JOBS program or to augment it with another EBP - such as for the treatment of co-occurring mental health and substance abuse disorders, the treatment of trauma, or for family or parenting education. Other 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, and mentoring.

BUDGET INFORMATION - Non- Construction Programs

SECTION A - BUDGET SUMMARY

Grant Program Function or Activity (a)	Catalog of Federal Domestic Assistance Number (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non- Federal (f)	Total (g)
1.		$	$	$	$	$
2.		$	$	$	$	$ 0.00
3.		$	$	$	$	$ 0.00
4.		$	$	$	$	$ 0.00
5. TOTALS		$ 0.00	$ 0.00		$	

SECTION B - BUDGET CATEGORIES

6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY				Total (5)
	(1)	(2)	(3)	(4)	
a. Personnel - Project Director ¾ yr	$ 35,038	$	$	$	$ 35,038
b. Fringe Benefits	$ 13,314	$	$	$	$ 13,314
c. Travel	$ 6,412	$	$	$	$ 6,412
d. Equipment	$	$	$	$	$
e. Supplies	$	$	$	$	$
f. Contractual	$ 895,236	$	$	$	$ 895,236
g. Construction	$	$	$	$	$ 0.00
h. Other	$	$	$	$	$ 0.00
i. Total Direct Charges *(sum of 6a -6h)*	$ 950,000	$ 0.00	$ 0.00	$ 0.00	$ 950,000
j. Indirect Charges	$ 50,000	$	$	$	$ 50,000
k. TOTALS *(sum of 6i and 6j)*	$ 1,000,000	$ 0.00	$ 0.00	$ 0.00	$ 1,000,000
7. Program Income	$	$	$	$	$ 0.00

SECTION C - NON- FEDERAL RESOURCES

(a) Grant Program	(b) Applicant	(c) State	(d) Other Sources	(e) TOTALS
8. CMHI – 93.104	$ in-kind DMH	$ 1,942,726	$	$ **1,942,726**
9.	$	$	$	$ 0.00
10.	$	$	$	$ 0.00
11.	$	$	$	$ 0.00
12. TOTALS *(sum of lines 8 and 11)*	$ in-kind DMH 0.00	$ **1,942,726**	$ 0.00	$ **1,942,726**

SECTION D - FORECASTED CASH NEEDS

	Total for 1st Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
13. Federal	$ 0.00	$	$	$	$
14. Non- Federal	$ 0.00	$	$	$	$
15. TOTAL *(sum of lines 13 and 14)*	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00

SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT

(a) Grant Program	FUTURE FUNDING PERIODS (Years)			
	(b) First	(c) Second	(d) Third	(e) Fourth
16. CMHI – 93.104 (also, fifth future year: **$1,000,000)**	$ 1,500,000	$ 2,000,000	$ 2,000,000	$ 1,500,000
17.	$	$	$	$
18.	$	$	$	$
19.	$	$	$	$
20. TOTALS *(sum of lines 16 -19)*	$ **1,500,000**	$ **2,000,000**	$ **2,000,000**	$ **1,500,000**

SECTION F - OTHER BUDGET INFORMATION

21. Direct Charges:	22. Indirect Charges: 5% for unspecified infrastructure charges; 15% allowed by RFA.

23. Remarks

PROJECT NARRATIVE

Section A: Understanding of the Project

Describe the population of children with serious mental health needs in the geographic area.

This is a proposal to bring hope to a subset of youth aged 16 through 21 (inclusive) and their families located in the State of Vermont. This is the subset of youth who are experiencing serious emotional disturbance (SED, especially but not exclusively with symptoms of depression and co-occurring substance abuse) as they make the high-stakes transition from childhood to adulthood. **The goal of this 6-year project is for these youth to have adequate preparation and the necessary supports to be productively engaged in the community and free from incarceration. For this population, the necessary supports include access to health care (908 youth [173 per each of 5.25 years] will receive treatment for mental health and co-occurring substance abuse challenges), also post-secondary education, employment, housing, and caring relationships (with adults who nurture positive youth development).**

"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 (1999)."[1] And the "federal Center for Mental Health Services estimates that ... about 12% of Vermont's children and youth may be experiencing serious or severe emotional disturbance each year."[2] **54,185 youth aged 16 through 21 reside in Vermont[3]; 6,502 are likely to be experiencing SED.**

At least 95% of these youth are White, and 1% of the Whites are Latino. About 4.6% of the youth are non-White, and within that percentage is the following distribution of races: 34.8% mixed, 26.2% Asian, 18.6% Black, 10.2% Native American, 9.3% other, and 0.9% Pacific Islander.[4] The Native Americans are likely to be associated with the Abenaki Self-Help Association in Swanton, Franklin County; Vermont does not have a federally-recognized tribe.

The racial data does not capture the full diversity of ethnicity in Vermont, which has historically been settled by French-Canadian, Italian, and Irish Catholics as well as the Scot and English Protestants/Puritans. Then there were the Germanic and Jewish people fleeing World War II. In more recent years the immigration has been heavily influenced by Vermont's Refugee Resettlement Program (VRRP), which since 1980 has brought in hundreds of Vietnamese, Bosnians, and Somalis as well as dozens of Meskhetian Turks, Sudanese, Congolese, and others from more than 20 additional countries. These refugees and asylees comprise less than one percent of the population and are most of the people in Vermont with Limited English Proficiency (LEP);[5] efforts are made to quickly enroll both the adults and their children in classes for English-language learners. The Vermont State Agency of Human Services (AHS) and many private non-profit service providers contract for interpreter and translation services to communicate with them.

Most of the non-White people are located in Vermont's only Standard Metropolitan Statistical Area (SMSA), which includes Chittenden, Franklin, and Grand Isle Counties and the northern part of Addison County, areas with prime real estate that border Lake Champlain. The

[1] DMH. (2004). The Vermont State System of Care Plan for Child, Adolescent and Family Mental Health, State Fiscal Years 2005-2007, p.7.
[2] Ibid.
[3] VT Dept. of Health. (2006). Population Estimates, based on 2000 US Census.
[4] US Census Bureau. (2000). tables.
[5] Lamoureux, D. (2007). Summary of Vermont Refugee Arrivals.

SMSA houses about 1/4 of Vermont's 621,254 people.[6] Chittenden County has the most economic opportunity and the lowest rate of child poverty in the state (for 2002, 7.4% compared with 11.5% statewide).[7] However,

> nearly 20% of children in Burlington and Winooski [cities in Chittenden County] lived in poor families....Poverty rates are even higher for non-white Vermont children. The estimated child poverty rate for African American children under age 18 was 21.6% in 2000; the rate for non-white Hispanic children was 21.1%, and the rate for Native American children was 26.3%.[8]

Burlington is well served by a public bus transportation system, something mostly lacking in the rural cities and towns. "Limited or non-existent public transportation, a narrow employer base of mostly small businesses, and insufficient job development and job placement services"[9] are barriers to employment throughout much of Vermont. Most of the available jobs are in the service industry or retail settings, so "in 2000, only 39% of jobs in Vermont paid enough to meet basic needs."[10] People here have to work multiple jobs to pay their bills.

> Many families are one financial disaster away from homelessness – because of a job layoff, loss of health insurance, catastrophic medical costs, workplace injury, or loss of transportation to work....In 2006, nearly half of Vermont renters couldn't afford the fair market rent for a two-bedroom apartment of $797, which would require an hourly wage of $15.34. The average Vermont wage was only $9.87 per hour. The same apartment in Chittenden, Franklin and Grand Isle Counties would cost $983 per month, requiring an hourly wage of $18.90 per hour.[11]

The high rents are driven by the fact that "Vermont ranks second only to Maine as the state with the highest percentage of vacation homes....

> Of Vermont's 33,000 low-income households, about 27% live in substandard units. With housing stock ranked second oldest in the nation, Vermont homes and apartments have a greater likelihood of lead exposure, poor insulation, and need for repairs.[12]

"The limited resources and rural nature of the state means the service infrastructure is often weak or patchy. Services available in some of the state's larger towns are often unavailable in the more rural communities."[13]

> Vermont's rural places are those that retain the best elements of our Green Mountain State – its beauty, independence, and strong family ties. But rural places also may be home to isolation, fewer jobs, and limited affordable and quality child care, social services and medical care.[14]

"This particularly affects the quality of transition services for youth with disabilities, where so many different service systems need to be engaged and working together to be effective."[15]

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[6] The Times Argus. (December 27, 2007). Census information highlighted to go with story about "Louisiana population rebounds; Florida growth slows"

[7] The Vermont Children's Forum. (2005). The State of Our Children: 2005 Data Book: Kids Count in Vermont, p.7.

[8] The Vermont Children's Forum. (2003). Children and Poverty in Vermont, p. 2, 3.

[9] Kievit-Kylar, R. & Porter, A. (2007). Career Start Connections, p. 5.

[10] The Vermont Children's Forum. (2003). Children and Poverty in Vermont, p. 6, 11.

[11] Voices for Vermont's Children. (2007). Homeless in Vermont: Children, Youth and Families

[12] The Vermont Children's Forum. (2003). Children and Poverty in Vermont, p. 6, 11.

[13] Kievit-Kylar, R. & Porter, A. (2007). Career Start Connections, p. 5.

[14] The Vermont Children's Forum. (2003). Children and Poverty in Vermont, p. 3.

[15] Kievit-Kylar, R. & Porter, A. (2007). Career Start Connections, p. 5.

Of the youth in Vermont aged 16-21 (inclusive), 51.5% are male and 48.5% are female.[16] Most of them are successfully transitioning to adulthood, as can be seen by their rate of participation in the labor force.

> Based on 2000 Census Bureau data, 56% of 16-19 year olds were in the labor force and approximately 86% [of them] were actually employed. As one would assume, these percentages increased for 20-21 year olds. Approximately 69% were in the labor force and 88% [of them] were actually employed. The numbers were slightly higher for females compared to males. [17]

Furthermore, in Vermont

> the percent of young people aged 16-19 who are not working or in school declined between 1998 and 2002 from 8% to 6%...[and] a greater percent of Vermont students who enter 9th grade are completing school four years later. According to VT Department of Education [DOE] estimates, the completion rate for 2004 was 86%.[18]

However, a significant percentage of youth – particularly those with disabilities - lack the necessary skills and supports to succeed in today's economy. "Nationally, 14% of youth with disabilities enter college compared to 63% of the general youth population (Guideposts for Success, National Collaborative on Workforce and Disability – Youth)."[19]

Vermont has the highest percentage of students aged 6 to 17 with identified disabilities in the nation (16.6% compared with the US mean of 6.6%).[20] This is largely because of twenty years of State and local interagency efforts to better serve children and adolescents with SED. Despite significant attempts to serve them in regular classrooms with accommodations, "there was a substantial increase in the number of children and adolescents with an IEP [Individualized Education Plan] for ED [emotional disturbance] …from 1,614 in FY1999 to 2,207 in FY2004."[21] During FY2004, 47% of young people on an IEP for ED were also on the caseload of their local community mental health center (CMHC).[22]

In 2007 the number of children and adolescents who received children's mental health services from Vermont's ten publicly-funded, private non-profit CMHCs *[see map in Appendix 6]* was 9,609.[23] Of these children, 68% were covered by Medicaid, 18% were covered by other insurance, and 20% were uninsured.[24] It is likely that a high percentage of the transition-aged youth who were served were uninsured. The AHS has recently made increasing the enrollment in Medicaid a priority for youth aged 18 through 20 because "enrollment data indicated that only 44% of 18-, 19- and 20-year-olds who are eligible for some form of Medicaid are actually enrolled. This number is unacceptably low." [25]

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[16] US Census Bureau. (2000). tables.
[17] Smith, M.K. (2007). Report to the House Committee on Human Services and the Senate Committee on Health and Welfare about H.449 – Section 4. Study on Transitional Services for Youth, p. 5.
[18] The Vermont Children's Forum (2005). The State of Our Children: 2005 Data Book: Kids Count in Vermont, p.5.
[19] Smith, M.K. (2007). Report to the House Committee on Human Services and the Senate Committee on Health and Welfare about H.449 – Section 4. Study on Transitional Services for Youth, p. 4.
[20] Vermont State Department of Education. (200?). Vermont 2005 Child Count.
[21] Pandiani, J. & Mongeon, J. (2005). Use of Children's Services by Students with an Emotional/Behavioral Disability.
[22] Ibid.
[23] Pandiani, J, & Carroll, B. (2007). CMH Caseload: FY'85 –'07.
[24] VT Dept of Mental Health. (2007). Fiscal Year 2007 Statistical Report.
[25] LaWare, C. (2007). Clarifying Medicaid Eligibility for Youth in Vermont.

A study for the Vermont Legislature on Transitional Services for Youth[26] included data showing that in FY2006, CMHCs served 1,039 youth aged 16; 846 youth aged 17; 631 youth aged 18; 525 youth aged 19; 449 youth aged 20; and 413 youth aged 21. Most of these youth received children's community mental heath and/or substance abuse treatment services.[27] For the youth who received children's mental health services, the predominant diagnoses were affective disorder, non-psychotic disorders, anxiety disorder, adjustment disorder, and substance abuse.[28] Very few received either adult outpatient or Community Rehabilitation and Treatment (CRT) services for adults with serious and persistent mental illness.

> Only 10% of 15-17 year olds served by children's services programs in Vermont…also received services from an adult mental health program at the same CMHC when they were 21-23 years old. There was no difference between the genders in the likelihood of being served by adult outpatient programs after being served by children's services.[29]

Though the vast majority of the 3,903 youth aged 16-21 who were served by the CMHCs in 2006 will not make use of public mental health services after their eligibility for children's services ends, their need for care may not have ended.

Since children's mental health services clients are most likely to be referred by family and friends (28%) or educators (27%),[30] as transition-aged youth strive to establish independence from the caregivers and other adult authority figures in their lives it is not surprising to see the precipitous drop in the number of youth who choose to participate in these services after they turn 16 (the year they can choose to drop out of school), and even more after they become 18 (the year the State deems them to be adults). However, youth who distance themselves from social supports may have difficulty successfully transitioning to adulthood.

In Vermont in FY2000, special education students accounted for 20% of the dropouts; almost 50% of those special education dropouts were identified with ED.[31] Dropping out is often a precursor to ending up in jail. Of the 219 average daily population of youth aged 18-21 incarcerated in adult Correctional facilities in Vermont in 2007, 90% "have no high school diploma; 50% of these youth were eligible for special education services … in high school."[32]

According to Dr. Ronald E. Dahl of the University of Pittsburgh Medical Center:
Achieving adult status requires developing self-control of behavior & emotions:

- Appropriately inhibit or modify behaviors to avoid negative future consequences
- Initiate, persist, sequence steps toward goals
- Navigate complex social situations despite strong affect
- Skills in the self-regulation of affect and complex behavior [for] long-term goals
- Involves neurobehavioral systems in PFC (Prefrontal Cortex) - *among the last regions of the brain to achieve full functional maturation.*[33]

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[26] Smith, M.K. (2007). Report to the House Committee on Human Services and the Senate Committee on Health and Welfare about H.449 – Section 4. Study on Transitional Services for Youth, Attachment E *(?)*
[27] VT Dept of Health, Div. of Mental Health. (2006). Fiscal Year 2006 Statistical Report.
[28] Vermont State Department of Mental Health. (2008). Management Information System for FY2007.
[29] Pandiani, J. & Kobel, O. (2007). Movement from Children's Services into Adult Services.
[30] Pandiani, J. & Simon, M. (2004). Source of Referral to Community Mental Health Programs.
[31] Vt. Dept. of Education. (2002). Vermont Self-Assessment Report.
[32] Smith, M.K. (2007). Report to the House Committee on Human Services and the Senate Committee on Health and Welfare about H.449 – Section 4. Study on Transitional Services for Youth, p. 4.
[33] Dahl, R.E. (undated). Adolescent Brain Development: A Framework for Understanding Unique Vulnerabilities and Opportunities.

Youth who do not have this self-control or adults to help them gain it are at great risk for poor outcomes. Davis and Stoep (1996) say

> The plight of youth with serious emotional disturbance in transition to adulthood is grave. As a group, these youth are undereducated, underemployed, and have limited social supports. Drug and alcohol abuse are common, and suicide risk is high. These youngsters remain largely "unclaimed"—falling through the cracks within and between the child and adult service systems.[34]

Nationally, according to Davis and Butler (2002),[35] "the transition from adolescence to adulthood is a major struggle for families of children with SED. Few parents found service systems to be helpful during this transition." Regarding child-service systems, "they rated only child vocational rehabilitation services as helpful on most transition-related issues. Overall, they rated child vocational rehabilitation services higher than mental health, education, special education, child welfare and juvenile justice services." They rated adult vocational rehabilitation and adult mental health systems lower than child-serving systems. "They rated colleges quite positively. The few parents who rated the substance abuse system tended to rate it as helpful."

The surveyed families were members of the National Federation of Families for Children's Mental Health. They observed that "the most common barrier to services is simply the stigma young people feel in accessing services that could label them as mentally ill."[36] And the parents felt the services did not address the issues most relevant to their youth ("such as getting a job or finding a place to live") or sufficiently or appropriately include the parents.

> Parents of 18-20 year-olds rated mental health services lower and parents of those under 18 rated mental health services higher than parents of those over 20....They rated child mental health and special education services neither good nor bad on most transition-related issues, but poor on preparing adolescents for adulthood. Overall, they gave negative ratings to regular education, child welfare, and juvenile justice.[37]

Youth without families who are meaningfully involved in their lives are at most risk. Some of those youth are in State custody. Of the 978 youth aged 13-17 in 2006 who were in the custody of the Department for Children and Families (DCF) for child abuse and neglect or unmanageable or delinquent behavior, 65% also received children's mental health services.[38]

Vermont's Juvenile Justice and Delinquency Prevention (JJDP) Program has documented that "black youth are 20% less likely to be referred to juvenile court for minor offenses than white youth, while they have nearly a 60% greater chance of being referred to adult court than white youth for similar offenses."[39]

A study of the incarceration rate for youth aged 18-21 who had previously received children's services compared with the incarceration rate for the general population for the five years from FY1998-2002 shows that:

> Young people who had been on the [DCF] caseload had the highest incarceration rates overall (18%, more than four times the general population rate). Young people who had been on the mental health caseload had the second highest incarceration rate (9%, more

[34] Davis, M. & Stoep, A.V. (1996). The Transition to Adulthood Among Adolescents Who Have Serious Emotional Disturbance, p. ii.
[35] Davis, M. & Butler, M. (2002). Service Systems Supports During the Transition from Adolescence to Adulthood: Parent Perspectives, p. vii-viii.
[36] Ibid.
[37] Ibid.
[38] Pandiani, J. & Martin, B. (2007). Children in DCF Custody Served by CMH Programs.
[39] Lay-Sleeper, T. (1/7/2008). Emailed communication from JJDP Specialist.

> than twice the general population rate). Young people who had been on the special education caseload had the lowest incarceration rates (7%). Incarceration rates for boys were substantially higher than the incarceration rates for girls in every service group. The elevated risk of incarceration (the incarceration rate for service recipients divided by the incarceration rate for the general population) among [DCF] service recipients, however, is greater for girls than for boys. There were no significant differences, however, between the elevated risk of incarceration for girls and boys on the mental health and special education caseloads.[40]

Looked at in a different way:

> On average, more than 1,000 young adults (18-21 years of age) were incarcerated, per year during FY1998-2002. These young adults were predominantly male (88% vs. 12% female). Overall, more than half (52%) had been on the caseload of at least one of these child-serving agencies. Incarcerated young women were much more likely than incarcerated young men to have been served by the children's agencies (64% vs. 50%).[41]

As part of an ongoing trend for African-American youth, during one year

> female minorities were over-represented among Woodside *[the DCF secure detention and treatment facility for juvenile delinquents]* admissions relative to white females…Minority females were primarily admitted to Woodside for running away and intoxication…Woodside likely served as a place to put an out of control or runaway youth until a crisis situation was resolved or another more suitable placement arranged.[42]

Vermont's JJDP Specialist says that "secure detention placements for youth with high needs and no other appropriate placements are common in VT as they are nationally. Youth with untreated mental health needs commonly end up in secure detention."[43] "Minority youth may have fewer placement options available to them than do white youth."[44]

Thus, there is a lot of room for Vermont to improve the outcomes of service for transition-aged youth, especially for those who have been removed from their families and particularly for black youth and young women. Service models have not been adequately tailored to meet different gender and cultural needs, though recent AHS attention to trauma-informed services may bring about changes.

Describe the current capacity to serve children and youth with SED and their families.

The State of Vermont Department of Mental Health (DMH) has been building its system of care for children with SED since receiving a Child and Adolescent Services Systems Planning (CASSP) grant in 1986. The number of children and adolescents served annually by children's mental health programs has more than tripled since 1985, when there were only 3,000.[45]

An additional way of assessing Vermont's success in building this system of care is to look at a measure of the Child and Adolescent Caseload Segregation/Integration or "the degree

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[40] Pandiani, J. & Ghosh, K. (2003). More on Incarcerated Youth: Incarceration Rates for Young Adults Previously Served by Child-serving Agencies.

[41] Pandiani, J. & Ghosh, K. (2003). Incarcerated Young Adults Previously Served by Child-Serving Agencies.

[42] Bellas, M. L. (2004). Disproportionate Minority Confinement at Woodside's Detention Program October 1, 2000 to September 30, 2002, p.1. Retrieved on 1/3/2008 from http://humanservices.vermont.gov/boards-committees/cfcpp/publications/disproportionate-...

[43] Lay-Sleeper, T. (1/7/2008). Emailed communication from JJDP Specialist.

[44] Bellas, M. L. (2004). Disproportionate Minority Confinement at Woodside's Detention Program October 1, 2000 to September 30, 2002, p.19-20. Retrieved on 1/3/2008 from http://humanservices.vermont.gov/boards-committees/cfcpp/publications/disproportionate-...

[45] Vermont State Department of Mental Health. (1/28/2008). Emailed MIS information.

to which child-serving agencies share responsibility for serving children and adolescents with emotional disorders."[46] The degree of caseload overlap between children's mental health, child welfare/juvenile justice, and special education has increased from the initial measurement of 21% statewide in 1993 to 37% statewide in 2006. (0% would show no caseload overlap while 100% would show no differentiation of service across agencies for individualized needs.)

This increased focus on the same children, youth, and families is designed to produce more comprehensive services with more consistency and clarity about performance expectations for all, providers and families alike. Yet surveys of key stakeholders (parents, youth, educators, and child welfare caseworkers) reveal continued differences of opinion about the role of children's mental health services. Vermont parents of children and youth aged up to 18 who were served by the CMHCs in 2005 "were very likely to rate their programs favorably."[47] A survey of youth aged 14-18 who received Medicaid reimbursed services from the CMHCs in 2006 showed that 75% evaluated the programs positively overall.[48]

> Young people and parents had high agreement in their ranking of programs for three of our four measures of program performance (staff, quality, and overall performance). Parents, however, did not have high agreement on any of these measures with either educators or [DCF] caseworkers. Youth had high agreement with educators on only one measure (outcomes) and did not have high agreement with [DCF] caseworkers on any of the measures....Educators and [DCF] caseworkers had high agreement in their rankings of all four measures of program performance. Educators, however, did not have high agreement on any of these measures with either youth or parents. [DCF] caseworkers had high agreement with youth on only one measure (outcomes) and did not have high agreement with parents on any of the measures.[49]

Because –or in spite – of these different and competing perspectives about public children's mental health services, providers have worked diligently with other departments and agencies to develop services that are meaningful for the children, adolescents, and their families. They have searched for effective approaches to help youth with SED learn self-control of behaviors and emotions so they can avoid future incarceration and other negative consequences. Talking therapies must be blended with skills training since

> how teens spend their time seems to be particularly crucial. If the 'Use it or Lose it" principle holds true, then the activities of the teen may help guide the hard-wiring, actual physical connection in their brains [which are pruning down cells in later adolescence).[50]

One hands-on approach for transition-aged youth with SED created by Washingtogn County Mental Health Services in 1993 is the JOBS (Jump on Board for Success) program, which has been replicated (though under-funded) in all but one of the State's 12 service districts.

Establish the significance of the proposed initiative.

Dr. Maryann Davis described the JOBS program in her 2001 report to the National Technical Assistance Center for State Mental Health Planning (NTAC) about "State Efforts to Expand Transition Supports for Adolescents Receiving Public Mental Health Services."

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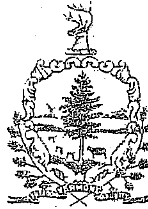
[46] Pandiani, J. & Carroll, B. (2006). Child and Adolescent Caseload Segregation/Integration in Vermont.
[47] Pandiani, J., Carroll, B. & Kobel, O. (2006). Parents' Evaluation of Children's Services Programs.
[48] Pandiani, J. & Carroll, B. (2007). Evaluation of Child and Adolescent Mental Health Programs By Young People Served in Vermont July – December, 2006: Technical Report, p.1.
[49] Pandiani, J. & Bramley, J. (2003). Survey Raters and Rankings: Children's Services Programs.
[50] Giedd, J. (undated). Inside the Teenage Brain. Interview with Frontline of PBS. Retrieved from internet 12/26/2007 from http://www.pbs.org/wgbh/pages/frontline/shows/teenbrain/interviews/giedd.html.

JAMES H. DOUGLAS
GOVERNOR



State of Vermont
OFFICE OF THE GOVERNOR

January 25, 2008

Ms. Crystal Saunders, Director of Grant Review
Office of Program Services
Substance Abuse and Mental Health Services Administration
Room 3-1044
1 Choke Cherry Road
Rockville, MD 20850

Re: Vermont's Application for RFA # CMHI – SM-08-004

Dear Ms. Saunders:

Please accept this application from the State of Vermont for a Children's Mental Health Initiative (CMHI) grant to expand the Vermont community capacity to serve transition-aged youth (16-21, inclusive) with serious emotional disturbance and their families. I have authorized Cynthia D. LaWare, Secretary of the Agency of Human Services, to submit this application on my behalf, and she in turn will designate Michael Hartman, Commissioner of the Department of Mental Health to administer the grant.

Ensuring that Vermont youth have access to supports and services that enable them to become self-sufficient, contributing members of society is of critical importance to my administration. I have championed legislation that supports new investments in career exploration and alternative education for the next generation, as well as enhanced college scholarships, mentoring, housing and other supports for youth transitioning out of the foster care system. Clearly, however, a great need for services remains.

Upon grant approval, the Department of Mental Health will propose to Vermont's Community Mental Health Block Grant Planning Council that the Mental Health Plan for Children and Adolescents with Serious Emotional Disturbance be amended to include these developments.

Additionally, this grant application is consistent with Vermont's SAMHSA-funded Co-occurring State Infrastructure Grant (COSIG), which is training mental health and substance abuse treatment staff to assess and treat co-occurring mental health and substance abuse issues.

I support this proposal and will assist the Agency of Human Services in cultivating the partnerships necessary to build and sustain this system of care for the next generation. Thank you for your consideration.

Sincerely,

James H. Douglas
Governor

JHD/rrs

109 STATE STREET • THE PAVILION • MONTPELIER, VT 05609-0101 • WWW.VERMONT.GOV
TELEPHONE: 802.828.3333 • FAX: 802.828.3339 • TDD: 802.828.3345

This award is based on the application submitted to, and as approved by, SAMHSA on the above-title project and is subject to the terms and conditions incorporated either directly or by reference in the following:

a. The grant program legislation and program regulation cited in this Notice of Award.
b. The restrictions on the expenditure of federal funds in appropriations acts to the extent those restrictions are pertinent to the award.
c. 45 CFR Part 74 or 45 CFR Part 92 as applicable.
d. The HHS Grants Policy Statement.
e. This award notice, INCLUDING THE TERMS AND CONDITIONS CITED BELOW.

Treatment of Program Income:
Additional Costs

SECTION IV – SM Special Terms and Condition – 1U79SM058485-01

STANDARD TERMS OF AWARD:

1. This grant is subject to the terms and conditions, included directly, or incorporated by reference on the Notice of Award (NoA). Refer to the order of precedence in Section III (Terms and Conditions) on the NoA.

2. The grantee organization is legally and financially responsible for all aspects of this grant, including funds provided to sub-recipients.

3. Grant funds cannot be used to supplant current funding of existing activities. Under the HHS Grants Policy Directives, 1.02 General – Definition: Supplant is to replace funding of a recipient's existing program with funds from a Federal grant.

4. The recommended future support as indicated on the NoA reflects TOTAL costs (direct plus indirect). Funding is subject to the availability of Federal funds, and that matching funds, (if applicable), is verifiable, progress of the grant is documented and acceptable.

5. By law, none of the funds awarded can be used to pay the salary of an individual at a rate in excess of the Executive Level I, which is **$191,300** annually.

6. "Confidentiality of Alcohol and Drug Abuse Patient Records" regulations (42 CFR 2) are applicable to any information about alcohol and other drug abuse patients obtained by a "program" (42 CFR 2.11), if the program is federally assisted in any manner (42 CFR 2.12b).

   Accordingly, all project patient records are confidential and may be disclosed and used only in accordance with (42 CFR 2). The grantee is responsible for assuring compliance with these regulations and principles, including responsibility for assuring the security and confidentiality of all electronically transmitted patient material.

7. Accounting Records and Disclosure - Awardees and sub-recipients must maintain records which adequately identify the source and application of funds provided for financially assisted activities. These records must contain information pertaining to grant or subgrant awards and authorizations, obligations, unobligated balances, assets, liabilities, outlays or expenditures, and income. The awardee, and all its sub-recipients, should expect that SAMHSA, or its designee, may conduct a financial compliance audit and on-site program review of grants with significant amounts of Federal funding.

8. Per (45 CFR 92.34) and the HHS Grants Policy Statement, any copyrighted or copyrightable works developed under this cooperative agreement/grant shall be subject to a royalty-free, nonexclusive and irrevocable license to the government to reproduce, publish, or otherwise use them and to authorize others to do so for Federal Government purposes. Income earned from any copyrightable work developed under this grant must be used a program income.

9. A notice in response to the President's Welfare-to-Work Initiative was published in the Federal Register on May 16, 1997. This initiative is designed to facilitate and encourage grantees and their sub-recipients to hire welfare recipients and to provide additional needed training and/or mentoring

as needed. The text of the notice is available electronically on the OMB home page at **http://www.whitehouse.gov/omb/fedreg/omb-not.html**.

10. Program Income accrued under the award must be accounted for in accordance with (45 CFR 74.24) or (45 CFR 92.25) as applicable. Program income must be reported on the Financial Status Report, Standard Form 269 (long form).

    Program income accrued under this award may be used in accordance with the additional costs alternative described in (45 CFR 74.24(b)(1)) or (45 CFR 92.25(g)(2)) as applicable. Program income must be used to further the grant objectives and shall only be used for allowable costs as set forth in the applicable OMB Circulars A-102 ("Grants and Cooperative Agreements with State and Local Governments") and A-110 ("Uniform Administrative Requirements for Grants and Agreements With Institutions of Higher Education, Hospitals, and Other Non-Profit Organizations").

11. Actions that require prior approval must be submitted in writing to the Grants Management Officer (GMO), SAMHSA. The request must bear the signature of an authorized business official of the grantee organization as well as the project director. Approval of the request may only be granted by the GMO and will be in writing. No other written or oral approval should be accepted and will not be binding on SAMHSA.

12. Any replacement of, or substantial reduction in effort of the Program Director (PD) or other key staff of the grantee or any of the sub-recipients requires the written prior approval of the GMO. The GMO must approve the selection of the PD or other key personnel, if the individual being nominated for the position had not been named in the approved application, or if a replacement is needed should the incumbent step down or be unable to execute the position's responsibilities. A resume for the individual(s) being nominated must be included with the request. Key staff (or key staff positions, if staff has not been selected) are listed below:

    Program Director

13. None of the Federal funds provided under this award shall be used to carry out any program for distributing sterile needles or syringes for the hypodermic injection of any illegal drug.

14. Refer to the NoA under Section II (Payment/Hotline Information) regarding the Payment Management System and the HHS Inspector General's Hotline concerning fraud, waste or abuse.

15. As the grantee organization, you acknowledge acceptance of the grant terms and conditions by drawing or otherwise obtaining funds from the Payment Management System. In doing so, your organization must ensure that you exercise prudent stewardship over Federal funds and that all costs are allowable, allocable and reasonable.

16. No HHS funds may be paid as profit (fees) per (45 CFR Parts 74.81 and 92.22(2)).

17. RESTRICTIONS ON GRANTEE LOBBYING (Appropriations Act Section 503).

    (a) No part of any appropriation contained in this Act shall be used, other than for normal and recognized executive-legislative relationships, for publicity or propaganda purposes, for the preparation, distribution, or use of any kit, pamphlet, booklet, publication, radio, television, or video presentation designed to support or defeat legislation pending before the Congress, except in presentation to the Congress itself or any State legislature.

    (b) No part of any appropriation contained in this Act shall be used to pay the salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence legislation or appropriations pending before the Congress or any State legislature.

18. Where a conference is funded by a grant or cooperative agreement the recipient must include the following statement on all conference materials (including promotional materials, agenda, and Internet sites):

    Funding for this conference was made possible (in part) by (insert grant or cooperative agreement award number) from SAMHSA. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.

19. This award is subject to the requirements of Section 106 (g) of the Trafficking Victims Protection Act of 2000, as amended (22 U.S.C. 7104). For the full text of the award term, go to **http://samhsa.gov/grants/trafficking.aspx.**

20. Grantees must comply with the requirements of the National Historical Preservation Act and EO 13287, Preserve America. The HHS Grants Policy Statement provides clarification and uniform guidance regarding preservation issues and requirements (pages I-20, "Preservation of Cultural and Historical Resources"). Questions concerning historical preservation, please contact, Mike Daniels, SAMHSA Federal Preservation Coordinator, SAMHSA at **Mike.Daniels@samhsa.hhs.gov** or 240-276-0759.

REPORTING REQUIREMENTS:

1. Financial Status Report (FSR), Standard Form 269 (long form) is required on an annual basis and must be submitted for each budget period no later than 90 days after the close of the budget period. The FSR 269 is required for each 12 month period, regardless of the overall length of the approved extension period authorized by SAMHSA. In addition, a final FSR 269 is due within 90 days after the end of the extension. If applicable, include the required match on this form under Transactions (#10 a-d), Recipient's share of net outlays (#10 e-i) and Program Income (q-t) in order for SAMHSA to determine whether matching is being provided and the rate of expenditure is appropriate. Adjustments to the award amount, if necessary, will be made if the grantee fails to meet the match. The FSR must be prepared on a cumulative basis and all program income must be reported. Disbursements reported on the FSR must equal/or agree with the Final Payment Management System Report (PSC-272). The FSR may be accessed from the following website at **http://www.psc.gov/forms/sf/SF-269.pdf** and the data can be entered directly on the form and the system will calculate the figures and then print and mail to this office.

2. The grantee must provide quarterly, annual and final progress reports. The final progress report must summarize information from the annual reports, describe the accomplishments of the project and describe next steps for implementing plans developed during the grant period.

3. The grantee must comply with the GPRA requirements that include the collection and periodic reporting of performance data as specified in the RFA or by the Project Officer. This information is needed in order to comply with PL 102-62 which requires that SAMHSA report evaluation data to ensure the effectiveness and efficiency of its programs.

4. Submission of audit reports in accordance with the procedures established in OMB Circular A-133 is required by the Single Audit Act Amendments of 1966 (P.L. 104-156). An audit is required for all entities which expend $500,000 or more of Federal funds in each fiscal year and is due to the Clearinghouse within 30 days of receipt from the auditor or within nine (9) months of the fiscal year, whichever occurs first, to the following address:

   Federal Audit Clearinghouse

   Bureau of the Census

   1201 E. 10th Street

   Jeffersonvville, IN 47132

Failure to comply with the above stated terms and conditions may result in suspension, classification as High Risk status, termination of this award or denial of funding in the future.

INDIRECT COSTS:

Grantees that have not established an indirect cost rate agreement are required to submit an indirect cost rate proposal to the appropriate office within 90 days from the start date of the project period. If the grantee requests indirect cost reimbursement but does not have an approved rate agreement at the time of award, the grantee shall be limited to a provisional rate equaling one-half of the indirect costs requested up to a maximum of 10 percent of salaries and wages only whichever is less. If the recipient fails to provide a timely proposal, indirect costs paid in anticipation of establishment of a rate must be disallowed.

SAMHSA will not accept a research indirect cost rate. The grantee must use other-sponsored program rate or lowest rate available.

Please contact the appropriate office of the Division of Cost Allocation to begin the process for establishing an indirect cost rate. To find a list of HHS Division of Cost Allocation Regional Offices go to the SAMHSA website **www.samhsa.gov** then click on "grants"; then click on "Important offices".

All responses to special terms and conditions of award and postaward requests must be mailed to the Division of Grants Management, OPS, SAMHSA below:

For Regular Delivery:
Division of Grants Management,
OPS, SAMHSA
1 Choke Cherry Road,Room 7-1091
Rockville, MD 20857

For Overnight or Direct Delivery:
Division of Grants Management,
OPS, SAMHSA
1 Choke Cherry Road, Room 7-1091
Rockville, MD 20850

CONTACTS:

Bethanie R Parrish, Program Official
Phone: (240) 276-1782 **Email**: bethanie.parrish@samhsa.hhs.gov **Fax**: (240) 276-1930

Gwendolyn Simpson, Grants Specialist
Phone: 240-276-1408 **Email**: gwendolyn.simpson@samhsa.hhs.gov **Fax**: 240-276-1430

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424

Version 02

*1. Type of Submission:
- [ ] Preapplication
- [X] Application
- [ ] Changed/Corrected Application

*2. Type of Application:
- [X] New
- [ ] Continuation
- [ ] Revision

*If Revision, select appropriate letter(s):

*Other (Specify)

*3. Date Received:

4. Applicant Identifier:

5a. Federal Entity Identifier

*5b. Federal Award Identifier:

State Use Only:

6. Date Received by State:

7. State Application Identifier:

8. APPLICANT INFORMATION

*a. Legal Name: Vermont State Department of Mental Health

*b. Employer/Taxpayer Identification Number (EIN/TIN): 1-03-6000274-A8

*c. Organization DUNS: 80-937-6155

d. Address

*Street1: 108 Cherry Street, PO Box 70
Street2:
*City: Burlington
County: Chittenden
*State: Vermont
Province:
*Country: United States of America
*Zip/Postal Code: 05402

e. Organizational Unit

Department Name: Mental Health

Division Name: Child, Adolescent and Family Unit (CAFU)

f. Name and contact information of person to be contacted on matters involving this application:

Prefix: Mr. *First Name: Charles
Middle Name: Andrew
*Last Name: Biss
Suffix:

Title: Director, Child, Adolescent and Family Unit

Organizational Affiliation:

*Telephone Number: 802-652-2009 Fax Number: 802-652-2005

*Email: cbiss@vdh.state.vt.us

Application for Federal Assistance SF-424 — Version 02

9. Type of Applicant 1: Select Applicant Type:
State Government

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

* Other (specify)

10. Name of Federal Agency:

SAMHSA –CMHS

11. Catalog of Federal Domestic Assistance Number
93.104

CFDA Title:
Child Mental Health Initiative

*12. Funding Opportunity Number:
CMHI – SM – 08 - 004

*Title:
Cooperative Agreements for Comprehensive Community Mental Health Services and Their Families Program

13. Competition Identification Number:

Title:

14. Areas Affected by Project (Cities, Counties, States, etc.):
State of Vermont

15. Descriptive Title of Applicant's Project:
Mental Health Services for Transition-Aged Youth

Attach supporting documents as specified in agency instructions.

Application for Federal Assistance SF-424 — Version 02

16. Congressional Districts Of:

***a. Applicant** State of Vermont

b. Program/Project State of Vermont

Attach an additional list of Program/Project Congressional Districts if needed:

17. Proposed Project:

*a. Start Date: October 1, 2008 b. End Date: September 30, 2014

18. Estimated Funding($):

*a. Federal	$1,000,000
*b. Applicant	
*c. State	$1,942,726
*d. Local	
*e. Other	
*f. Program Income	
*g. TOTAL	

*** 19. Is Application Subject to Review By State Under Executive Order 12372 Process?**

☐ a. This application was made available to the State under the Executive Order 12372 Process for review on

X b. Program is subject to E.O. 12372 but has not been selected by the State for review.

☐ c. Program is not covered by E.O. 12372.

*20. Is the Applicant Delinquent on Any Federal Debt? (If "Yes", provide explanation.)

☐ Yes X No

21. ***By signing this application, I certify (1) to the statements contained in the list of certifications** and (2) that the statements herein are true, complete and accurate to the best of my knowledge. I also provide the required assurances** and agree to comply with any resulting terms if I accept an award. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties (U.S. Code, Title 218, Section 1001)**

X ** I AGREE

** The list of certifications and assurances, or an internet site where you may obtain this list, is contained in the announcement or agency specific instructions.

a. Authorized Representative

Prefix: Mr. *First Name: Michael

Middle Name:

Last Name: Hartman

Suffix:

*Title: Commissioner, Vermont State Department of Mental Health

*Telephone Number: 802-951-1258 Fax Number: 802-951-1275

*Email: mhartma@vdh.state.vt.us

*Signature of Authorized Representative: Date Signed: January 24 2008

Application for Federal Assistance SF-424 Version 02

*** Applicant Federal Debt Delinquency Explanation**

The following field should contain an explanation if the Applicant organization is delinquent on any Federal Debt. Maximum number of characters that can be entered is 4,000. Try and avoid extra spaces and carriage returns to maximize the availability of space.

INSTRUCTIONS FOR THE SF-424

Public reporting burden for this collection of information is estimated to average 45 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0043), Washington, DC 20503.

> The JOBS program is based on a highly effective model of supported employment for adults with serious mental illness. Recognizing that children's mental health services might be more effective for transition-age youth if supportive counseling were linked with the motivator of employment, one community mental health center with a reputation for providing both leadership and effective wraparound services collaborated with the Vermont Department of [VR] to develop the JOBS model. Although comparison or control group data are not available, initial findings from the first site include high rates of employment and high school or GED completion, increases in stable housing, and reduced use of mental health services and corrections and justice involvement.[51]
> In FY2006, 243 youth with SED were served by the JOBS program.[52]

Clearly, more youth – including those who are not eligible for Medicaid - need access to the JOBS program. The JOBS program should be infused or linked with treatment for co-occurring substance abuse or with trauma-informed services. Other 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, mentoring organizations, substance abuse recovery centers, and parenting education (both for the parents of the youth and for the youth who are parents).

Describe how the initiative will collaborate with other Federal, State, and local programs.
Governor Jim Douglas

> has identified youth in transition as a focal point. The Governor is concerned that the demographics in Vermont indicate there will not be an adequate work force in the state within the next decade to fill necessary jobs…He has also been concerned that many young people are ending up under Corrections supervision.[53]

As a result, he and the Legislature have taken steps to expand mentoring and college scholarship opportunities, to invest in career exploration and alternative education like internships, to strengthen the system of foster care services (including housing) for transition-aged youth, and to set up drop-in centers for people recovering from substance abuse. The Legislature is also studying how to curtail growth in the costs of incarceration, perhaps by closing some older facilities and investing more in community-based justice, treatment and housing options for offenders.[54] The success of this project depends upon sustained state and local collaboration that includes all of these and other activities; the collaboration will be strategically planned during Year 1 of the grant and will build upon the infrastructure described below.

Section B: Implementation Plan

Infrastructure Development

Describe how the cross-agency infrastructure for the system of care will be developed.
The strategic planning and ongoing management of this project will be under the direction of Vermont's State Interagency Team (SIT). SIT was established by State Law Act 264 in

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[51] Davis, M. (2001). State Efforts to Expand Transition Supports for Adolescents Receiving Public Mental Health Services, p. 11-12.
[52] McClintock, G. (undated). Jump on Board for Success (JOBS) Program.
[53] Smith, M.K. (2007). Report to the House Committee on Human Services and the Senate Committee on Health and Welfare about H.449 – Section 4. Study on Transitional Services for Youth, p.2
[54] Hofmann, R. (2007). Plan to Reduce Correctional Costs and Achieve Savings for Reinvestment.

1988 to oversee a system of care for children and youth with severe emotional disturbance and their families. Since then, its mode of operation has been so influential in Vermont that in 2005 the SIT's responsibilities were expanded through an Interagency Agreement between the AHS and the DOE to include a broader population: any student who is eligible for special education (in any of its 14 disability categories) and for services under AHS (Department of Health (VDH *[which at that time included DMH, now – once again – a separate department]*), DCF, Department of Disability, Aging and Independent Living (DAIL), Department of Corrections (DOC), and Office of Vermont Health Access (OVHA [Medicaid]).

> It is intended that the agreement will provide guidance to human services staff and school personnel in the coordination and provision of services for students with disabilities....These services will be provided with the intent to increase the number of youth with disabilities entering employment, further education, and independent or supported living.[55]

A copy of the AHS/DOE Interagency Agreement is included in Appendix 1.

Describe the composition and responsibilities of the proposed governance body.

As required by the AHS/DOE Agreement,

> The SIT includes a high level manager from the following departments and divisions within state government: DOE,...DMH, Division of Disabilities and Aging Services (DDAS [in DAIL]), Division of Family Services (DFS [in DCF]), Division of Alcohol and Drug Abuse Programs (ADAP [in VDH]), ...VR [from DAIL] and AHS Field Services as well as other units as determined by the Secretary of AHS. A family consumer representative will also be a core member of the SIT. The SIT is responsible for overseeing the development and maintenance of the system of care to address the needs of children with eligible disabilities, for assuring the consistent development of coordinated services plans, and to be part of the dispute resolution process.[56]

Historically, most of the children and youth served by SIT have been in school and/or in DCF custody; for this project, its reach will extend more systematically to youth who are out of school and/or in contact with the adult criminal justice system. One or more subcommittees of SIT will be established and report to it. One of the subcommittees will be a State Outreach Team that will take the lead in drafting the required strategic plan (including regional plans from each of the 12 AHS service districts) during Year 1 of this project and in overseeing its subsequent implementation. The State Outreach Team will include representation from the SIT State departments, statewide family organizations, and statewide youth organizations. Additional State departments that will be invited to participate on the State Outreach Team include at least Labor, Corrections, the Attorney General's Office (for Diversion), and the Courts. The statewide family organizations that will be invited to participate include at least the Vermont Federation of Families for Children's Mental Health and the Vermont Parent Information Center (which has now merged with Parent to Parent of Vermont). The statewide youth organizations that will be invited to participate include at least the DCF Youth Development Committee (with its staff liaison), the VR Youth and Family Advisory Committee (with its staff liaison), the Vermont Coalition of Runaway and Homeless Youth

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[55] Smith, M. & Cate, R. (2005). Interagency Agreement with Vermont Department of Education and Vermont Agency of Human Services Pursuant to Part B of the Individuals with Disabilities Education Act, p. 2.
[56] Ibid. p. 4

Programs [VCRHYP], the Vermont Coalition of Teen Centers, and Outright Vermont (serving gay, lesbian, and transgendered youth). All of the state-level staff required for this project will also participate on the State Outreach Team.

The representatives will be people who are knowledgeable about their agencies' resources, who can make funding commitments, and who are able to strategize and help with problem-solving. They will make at least annual site visits to the 12 regional in-state projects, prepare for and participate in federal program and evaluation site visits to Vermont, and attend the twice-yearly required grantee meetings out-of-state. See Appendix 1 and Appendix 5 for letters of commitment and support for this State Outreach Team.

Describe procedures for systems integration, interagency collaboration, etc.

The AHS/DOE Interagency Agreement describes the general process for coordination of services consistent with Act 264 as extended from children and youth with SED to the broader population of students with disabilities. Though the receipt of particular services is not guaranteed by the Act or Agreement, "eligible children are entitled to receive a coordinated services plan developed by a service coordination team including representatives of education, the appropriate departments of the (AHS), the parents or guardians, and natural supports connected to the family."[57]

The Agreement notes that "special consideration needs to be given to transition-aged youth. Specific transition planning must begin at the age required by federal and state law."[58] Four of the 14 pages of the Agreement describe the VR transition service coordination available for students with disabilities in Vermont's high schools, from the referral process to the use of specific resources and programs (like JOBS).

One of the current sub-committees of SIT is the Case Review Committee (CRC). "When a team believes that a child or youth requires highly intensive services in residential care or intensive wrap-around services, the [coordinated services] plan shall be reviewed and approved by the"[59] CRC.

> The CRC serves both as a control to assure the appropriateness of high cost placements in the least restrictive environment, and also as a consulting body for local teams, helping identify appropriate services and approaches for eligible children and youth with the highest level of need.[60]

Another 4 of the 14 pages of the Agreement clarify the financial responsibility of various AHS/DOE departments and programs for State-placed students, services provided to children residing in their homes and communities, and other funding obligations. According to this section, "local community mental health agencies provide mental health supports to children who would benefit from such services within available resources."[61] The lack of sufficient resources to provide services for transition-aged youth is why Vermont is applying.

Describe how you will replicate the local system of care in other communities.

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[57] Ibid, p.3.
[58] Ibid, p.3.
[59] Ibid, p.3-4.
[60] Ibid, p.5.
[61] Ibid, p.10.

Vermont Act 264 established, and the AHS-DOE Interagency Agreement expanded, the population served by Local Interagency Teams (LIT), one per each of the 12 AHS service districts. "The LIT supports the creation of a local system of care and assures that staff are trained and supported in creating coordinated services plans. They also play a key role in dispute resolution."[62] In addition, LITs

> assure that there is a structure to focus on the particular needs of transition-aged youth to support transition from school to adult life. Adult agency providers would be included as needed including high level local leaders from adult mental health programs (CRT) and the Department of [Labor].[63]...Each LIT includes a special education director selected by the districts in that region, the local children's mental health director, the Family Services director, a family consumer representative, high level local leaders from developmental services and substance abuse, and a VR representative. Other AHS programs are represented as needed. The AHS Field Director and a designated DOE staff person assure that the region has a highly functional team and [are] responsible for working with the team to solve funding issues. The Field Director is the key conduit to a High Risk Fund, managed through the Field Services Division.[64]

The SIT and LITs are well-versed in thinking about at least some transition-aged youth. "The first individual plan reviewed by the Act 264...SIT [in 1988] was for a transition-aged youth (VT Child and Adolescent Services System Plan [CASSP] grant application, 1993)."[65] By 1995 and the end of a three-year CASSP grant to DMH focused on transition-aged youth, the evaluator concluded that:

> On the local level, there has been improvement in capacity to assist youth in transition. The preliminary work of conducting needs assessment has been completed, identifying specific needs for each region. Important interagency collaborative relationships have been well established; each county approaches transition planning with all the key players at the table. Still, issues of categorical funding and eligibility criteria challenge providers to find needed resources to provide services to all youth in need (Livingston, 1995).[66]

As part of its strategic planning (including for sustainability), the SIT State Outreach Team will issue an "Invitation to Communities" asking the 12 LITS to develop regional strategic and oversight plans for this project. The State Outreach Team will sub-grant the federal funding based upon its review of the regional plans submitted by the LITs. The LITs might assign the initial planning to subcommittees or related groups already focused on the needs of transition-aged youth. Those subcommittees or groups might be Core Transition Teams or JOBS advisory boards or some other interagency entities active in the regions and knowledgeable about transition-aged youth with SED. Whatever the planning body, it will have or seek families and youth (among others) for ongoing membership and/or regular, frequent input. SIT will provide resources for the LITs to aid their planning processes and to effectively involve families and youth - including those who are non-white and/or not proficient in English - and the community organizations that represent them (such as local teen centers or member programs of the VCRHYP, or the Burlington-based Association of Africans Living in Vermont

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[62] Ibid, p.4.
[63] Ibid.
[64] Ibid, p.4.
[65] Delmasse, D. (2002). Partnership for Youth Initiative Grant Application, p. 2.
[66] Ibid, p.3.

[AALV], etc.). SIT will instruct the LITs to seek input from youth and families who are served by each of the involved departments and agencies, including DCF, Corrections, CMHCs, etc.

Describe strategies for developing the structures of a system-of-care.

This project will make use of existing agencies and collaborative groups and does not require much new infrastructure beyond some additional key staff at the State and local levels. The ten CMHCs in Vermont that qualify as Designated Agencies (DAs) of the DMH will be involved in the delivery and oversight of clinical services, as may some other community agencies depending upon the regional plans that are developed. State statute gives the DAs responsibility for the delivery of mental health services in their regions; statute also requires that 51% of the Boards of Directors of the DAs be composed of consumers and family members. Every two years the DAs' programs are reviewed by DMH, and every four years they must pass a stringent Designation Review to maintain their status as preferred providers. The DAs follow strict internal auditing and corporate compliance standards and procedures, especially related to record-keeping and billing for the use of Medicaid. They track the services they provide by contributing data to the DMH statewide Management Information System (e.g., Dr. Pandiani).

The CMHCs do experience significant turn-over of staff due to low wages, high stress, and inadequate pre-service preparation for their system-of-care work; only 38% of the 1,175 children's mental health staff had greater than 2 years tenure in FY2006.[67] This greatly compromises continuity and quality of care. Therefore, **the most glaring infrastructure need related to this project is for high quality ongoing in-service training and mentoring for both clinicians (MA and BA-levels) and their supervisors.**

Describe the training, technical assistance and social marketing strategies.

In order to obtain the highest quality training and social marketing-communication assistance, the SIT State Outreach Team will issue competitive Requests for Proposals (RFP) in the second half of the Year 1 strategic planning process. Before doing so, the State Outreach Team will formally adopt a mission statement, goals, and logic model for this project. The State Outreach Team will also have approved the regional plans before awarding funds for the training and social marketing-communications assistance to carry them out. The RFPs will require the training and social marketing-communications providers (.5 FTE each) to design their delivery of services in a way that will involve the key stakeholders: the State Outreach Team, the regional LITs, families, youth, and community organizations that represent minorities in Vermont. The RFP for training will also require linkages with one or more institutions of higher education.

The selected Social Marketing-Communications Manager will produce a strategic marketing plan with input from a committee of the key stakeholders; their plan will be final only after approval by the State Outreach Team. Some of the social marketing will be linked with AHS efforts to inform transition-aged youth, their families and the broader public about the opportunity to enroll in Medicaid; some will help the Vermont Federation of Families for Children's Mental Health reach out to transition-aged youth with SED and their families to inform them about the existence of mental health problems and available help and hope for those problems. These efforts will be linked with the national Caring for Every Child's Mental Health Campaign goals and messages to reduce stigma related to mental illness and will annually include activities (in collaboration with the Federation) in honor of National Children's Mental Health Day. The Social Marketing-Communications Manager will determine the informational

[67] Pandiani, J. & Kobel, O. (2007). Mental Health Staff Tenure and Turnover FY2006.

needs of priority audiences and develop messages and materials that are in compliance with relevant standards for cultural and linguistic appropriateness and sensitivity, including compliance with the Americans with Disabilities Act (ADA).

The selected Technical Assistance Coordinator provider will produce a strategic training and technical assistance plan with input and help from an ongoing interagency training team composed of key stakeholders. The plan will reflect the expectations of the national T/TA provider and will be final only after approval by the State Outreach Team. Much of the training and technical assistance will be offered to a cross-section of participants that includes youth, families, employers, and service providers from different agencies and youth-serving professions (mental health, health, education, child welfare, juvenile justice, criminal justice, etc.). This common training will be used to build common perceptions and expectations about services for transition-aged youth with mental health and/or co-occurring substance abuse challenges.

Describe plans to collaborate with the other child serving systems, including MOUs.

An AHS-sponsored study group formed in September, 2007 to respond to the Legislature's request for a report about youth in transition, including their use of foster care past age eighteen as allowed by the recently-passed H.449. The participants in the study group recommended that the AHS address the following eight goals for youth in transition:

- **Employment, Training and Post-Secondary Education:** Youth are competitively employed, enrolled in college or other post-secondary options, or have received a college degree.
- **Health Care:** Youth have health insurance and access to care.
- **High School Completion:** Youth earn a high school diploma or complete a training program.
- **Safe and Stable Housing:** Youth have safe, stable, & adequate housing.
- **Free from Incarceration:** Youth have adequate preparation and the necessary supports to be productively engaged in the community.
- **Caring Relationships:** Youth are meaningfully engaged in supportive and permanent relationships.
- **Future Planning:** Youth are engaged in planning for their future.
- **Skilled Workforce:** Youth are engaged by adults who have the knowledge, skills and abilities to support positive youth development.

The study group's attention to these areas of focus was the result of *[research reported by several national sources]* including: the National Governors' Association Center for Best Practices, the National Child Welfare Resource Center on Youth Development and the Jim Casey Youth Opportunities Initiative.[68]

The Secretary of Administration, who submitted the report to the Legislature, said:

The Agency *[of Human Services]* and its community partners already provide a variety of services and supports for youth in transition such as Jump on Board for Success (JOBS), Vermont Coalition for Runaway Youth Programs, mentoring, adult learning, personal care services, expanded services to youth aging out of foster care, transitional housing, and out-patient mental health. In recognition of the fact that expanding services comes with an enormous price tag, the Agency of Human Services is currently designing a

[68] Smith, M. K. (2007). Report to the House Committee on Human Services and the Senate Committee on Health and Welfare about H.449 – Section 4. Study on Transitional Services for Youth, p.7.

> comprehensive one agency approach to integrate all AHS efforts to meet the needs of youth in transition that are currently served by the Agency. This is the recommended approach, rather than expanding the current system *[of separate services/providers]*.[69]

The members of the study group believe that **JOBS is a logical foundation upon which to build an integrated AHS approach to transition-aged youth with SED** because there is already a history of interdepartmental support within AHS for the program (see Letter of Agreement Between DMH, DOC, VR, and DCF for State FY2007 in Appendix 1). JOBS "serves high school drop-outs and those at risk for dropping out and engages youth in non-stigmatizing employment services while providing a bridge to more intensive mental health and case management services."[70] The JOBS program also works

> Closely with the Community High School of Vermont *[serving DOC clients]* and the...DOC to provide support to youth reintegrating in to the community. The JOBS Program costs an estimated $5,000 per client/per year. This compares favorably to the estimated annual cost of an inmate[71] at an in-state jail ($45,702).[72]

Explain how the initiative will increase the capacity and quality of services delivered.

In State FY2007, according to the DMH Management Information System, 2,346 youth aged 16-21 (inclusive) received the following children's mental health services from CMHCs:

- Community Supports 1,448 or 62%
- Clinical Interventions 1,353 or 58%
  - Service Planning and Coordination 1,233 or 53%
  - Individual, Family, and Group Therapy: 936 or 40%
  - Clinical Assessment Services 549 or 23%
  - Emergency/Crisis Assessment, Support and Referral 459 or 20%
  - Medication and Medical Support and Consult Services: 397 or 17%
- Housing and Home Supports 77 or 3%
- Respite 68 or 3%
- Emergency Crisis Beds 4 or 0%

Some of these services were delivered for youth involved with the JOBS program; others were delivered as part of individualized wrap-around plans for youth who were in State custody and perhaps not involved with JOBS; most were delivered for youth still in school.

The exact services to be implemented will be determined by the LITs with approval from the SIT State Outreach Team during the first year of the project. Building upon and consistent with the Act 264 system of care that has been in place in Vermont for 20 years, each LIT will be required to provide for each transition-aged youth who is served -- cross-system care management and individualized service plan development (consisting of, in Medicaid terms, targeted case management, or as it is now called by DMH, Service Planning and Coordination).

> **Service Planning and Coordination** assists individuals and their families in planning, developing, choosing, gaining access to, coordinating and monitoring the process of needed services and supports for a specific individual. Services and supports that are

[69] Ibid, p.8.

[70] Smith, M. & Cate, R. (2005). Interagency Agreement with Vermont Department of Education and Vermont Agency of Human Services Pursuant to Part B of the Individuals with Disabilities Education Act, p. 8.

[71] AHS Youth in Transition Leadership Team. (2207). Draft #4: The JOBS Program Expansion – A Model Approach to Transition Services for Youth with Severe Emotional Disturbance, p.2.

[72] Hoffman, R. (2007). Plan to Reduce Correctional Costs and Achieve Savings for Reinvestment, p.26.

planned and coordinated may be formal (provided by the human services system) or informal (available through the strengths and resources of the family or community). Services and supports include discharge planning, advocacy, monitoring the well-being of individuals (and their families), and supporting them to make and assess their own decisions.[73]

Community-based services such as (in Medicaid terms, specialized rehabilitation) Individual and Group Community Supports are also likely to be chosen for youth by the LITs.

Individual and Group Community Supports are specific, individualized, and goal oriented services that assist individuals (and families) in developing skills and social supports necessary to promote positive growth. These supports may include support in accessing and effectively utilizing community services and activities, advocacy and collateral contacts to build and sustain healthy personal and family relationships, supportive counseling, and assistance in managing and coping with daily living issues.[74]

Service Planning and Coordination and Individual and Group Community Supports are carefully tailored to the needs of the youth and family, including considerations about their race(s), ethnicity, and other cultural factors. The complexity and intensity of needs of the youth and families to be served will determine the number of units of Service Planning and Coordination or Individual or Group Community Supports delivered. Whenever possible, these services will be billed to Medicaid or private insurance, but for youth do not have this kind of coverage the grant funds will be used. The increased capacity for service will be due to the grant funds. Detailed regional planning will be needed before estimates can be made of the number of additional direct service staff who can be hired (est.1-2 FTE/region) or the number of additional youth and families who can be served with the grant funds (est.10-20/FTE/year).

Describe your relationship with and involvement of individuals in project development.

Subsequent to completion of their report about youth in transition for the Legislature, participants from the AHS study group and others advised the writing of this grant application. They included representatives from:

- *State child-serving agencies and leaders;*
  - The following AHS State departments: AHS Central Office Field Services Division, DMH, DCF (the Family Services, Economic Services, and Child Development Divisions), DAIL (VR and Developmental Disabilities), Corrections, VDH (Public Health and ADAP), OVHA
  - Other State departments: Education, Labor, Attorney General's Office (Diversion Programs), Court Administrator's Office
- *Local child-serving agencies and community leaders:*
  - DAs: public children's mental health programs (including JOBS)
  - VCRHYP: Vermont Coalition of Runaway and Homeless Youth Programs
- *Family members and family-run organizations and advocates:*
  - Vermont Federation of Families for Children's Mental Health
  - Vermont Parent Information Center
- *Youth:*
  - Staff liaison for DCF Family Services Youth Development Committee

[73] DMH. (2005). Fee-For-Service Medicaid Reference Material for Mental Health Covered Services (Service Planning and Coordination and Community Supports) Under the State Medicaid Plan, p.6.
[74] Ibid, p.5.

    - Staff liaison for VR Youth and Family Advisory Committee
- *Racial, ethnic and other cultural groups in the community.*
    - AHS State Refugee Coordinator.

Discuss the extent to which the nonfederal match dollars demonstrate interagency collaboration.

Appendix 5 includes letters with certification from different departments about the non-federal match they are pledging for the next six years for the public system of care for transition-aged youth. The certified match is summarized in a table (also in Appendix 5) that shows the new investments (above the average of expenditures for State FY06 and FY07) of State General Funds that the AHS and the Departments of Labor and the Attorney General's Office have already budgeted for FY08 and that they expect to budget for future years for this population. The State Outreach Team will monitor and report the budgeting and expenditures annually.

It is, of course, impossible to know what will happen several years in the future. Relying upon a track record from the past is the most reliable indicator of future performance. DMH was able to fully sustain the services initially funded by its two prior CMHI grants (1. Access Vermont, for children's crisis outreach services and 2. CUPS, for children aged 0-6) and expects to be able to do so again if it receives this grant. To do so, legislative approval will be required.

In 2006-2007 the Vermont Legislature studied and responded to the needs of transition-aged youth for improved access to Medicaid, scholarships for college, and extended foster care (past their 18th birthday), etc. In prior years legislators have studied and responded to the needs of adolescents for substance abuse treatment and for special status as youthful offenders rather than as adult criminals. *[In Appendix 1, see letters of support from legislators for this proposal.]*

In 2007 a larger concern about offenders was expressed by the Joint Corrections Oversight Committee and the Joint Fiscal Committee, which ordered a report from the DOC about "ways to curtail the growth in Corrections spending and Vermont's incarcerated population. The charge was: 1.) to reduce cost increases by $4 million, and 2.) to reduce the number of non-violent offenders in prison by 10%, or 100 beds."[75] One of the ideas generated by DOC in response to this charge is to

> place greater reliance on AHS capacities...A continuum of treatment approaches, ranging from intensive outpatient to secure treatment, could be provided in communities for non-violent offenders with either mental health or substance abuse disorders, or co-occurring disorders. AHS Field Directors are in a unique position to engage community leaders, rally advocates, and stand as local partners with DOC in support of community treatment for offenders.[76]

Another report requested by the Legislature this year says that

> For more than 25 years, Vermont has been developing and expanding a variety of community-based programs that are alternatives to the traditional criminal, juvenile justice, and correctional system. These include court diversion, restorative probation, street checker programs and community justice centers....Restorative justice is the common approach for all of these community justice programs.....Rather than solely imposing punishment, the focus is on repairing the harm caused by the offender to the victim and the community. A restorative justice approach creates opportunities for the people most directly affected by harmful behavior – the victim, the person who commits the act, families and the representatives of the community – to be actively involved in

[75] Hofmann, R. (2007). Plan to Reduce Correctional Costs and Achieve Savings for Reinvestment, p. i
[76] Ibid, p.71.

responding to and preventing further harm while also building capacity for the individual, family and community.[77]

The evidence is that this restorative justice approach has many benefits for crime victims; offenders; citizens, families, and community groups; the justice system; and human service providers.[78] Therefore, it seems quite possible that in future years the Legislature may divert some funds from incarceration to community-based justice programs and to community-based mental health treatment and substance abuse treatment for offenders, including transition-aged youth. Some of those treatments may well be in conjunction with the Drug and/or Mental Health Treatment Courts that are just beginning to emerge in Vermont as alternatives to incarceration:

- **Adult Drug/Treatment Court Projects in Rutland, Chittenden and Washington Counties** (best suited for high needs/high risk individuals and focuses on chronic behaviors for the purpose of reducing recidivism and substance abuse among nonviolent offenders and increasing their likelihood of success);
- **Juvenile Drug Court in Franklin County** (for youth who have been charged with delinquency and who are using drugs and/or alcohol);
- **Family Treatment Court Project in Chittenden County and one being planned for Caledonia County** (for parents with substantiated child abuse and neglect, who are dependent on drugs and/or alcohol and have admitted that their substance use has interfered with their ability to parent); and
- **Mental Health Court in Chittenden County** (for individuals aged 18 or over with severe and persistent mental illness and co-occurring disorders).[79]

Service Delivery

Specify eligibility criteria, referral sources and enrollment procedures.

The goal of this 6-year project is that youth aged 16-21 (inclusive) with SED have adequate preparation and the necessary supports to be productively engaged in the community and free from incarceration. For this population, the necessary supports include access to health care (908 youth [173 per each of 5.25 years] will receive treatment for mental health and co-occurring substance abuse challenges), post-secondary education, employment, housing, and caring relationships (with adults who nurture positive youth development. Providing all of these services and supports for individual youth and their families as needed – by a skilled workforce - addresses the AHS goals for youth in transition.

The Invitation to Communities will instruct the LITs that they must document to the satisfaction of the SIT State Outreach Team how they plan to structure and operate the regional system of care to effectively address the goal of the project. This will require efforts to integrate AHS services for transition-aged youth and to collaborate with other public and private service (including housing) providers, substance abuse prevention coalitions, Workforce Investment Boards, law enforcement, and criminal and juvenile justice officials, some of whom will be new partners for the LITs.

The LITS will be asked to augment the existing system of care for children and adolescents with SED by intentionally reaching out to transition-aged youth at least through teen centers, substance abuse recovery centers, and homeless youth programs.

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[77] AHS and Attorney General's Office. (2007). Community-Based Alternatives for Criminal Justice Services: Report to the Legislature, p.1.

[78] Ibid, p.40.

[79] Gennette, K. (2007). State of Vermont Treatment Court Projects.

Also, the LITs must give systematic thought to how the region can intervene earlier with youth who might be headed for incarceration.

> The Sequential Intercept Model provides a conceptual framework for communities to use when considering the interface between the criminal justice and mental health systems...The model envisions a series of points of interception at which an intervention can be made to prevent individuals from entering or penetrating deeper into the criminal justice system. Ideally, most people will be intercepted at early points, with decreasing numbers at each subsequent point. The interception points are law enforcement and emergency services; initial detention and initial hearings; jail, courts, forensic evaluations, and forensic commitments; reentry from jails, state prisons, and forensic hospitalization; and community corrections and community support...Using the model, a community can develop targeted strategies that evolve over time to increase the diversion of people with mental illness from the criminal justice system and to link them with community treatment.[80]

An accessible mental health system using best clinical practices is considered "the ultimate intercept".[81] Though this model was developed with help from the National GAINS Center for People with Co-occurring Disorders in the Justice System to address the needs of adults with serious mental illness (SMI), it is equally relevant to the situation of transition-aged youth with SED. For these youth in Vermont, the intersection points include the juvenile justice system as well as the criminal justice system because 16 and 17 year-olds here can be charged in either system at the discretion of the County State's Attorney. A similar model with Critical Intervention Points was developed for the juvenile justice system by the National Center for Mental Health and Juvenile Justice (NCMHJJ). The Critical Intervention Points include: Initial Contact with Law Enforcement...Intake (Probation or Juvenile Court)...Detention...Judicial Processing...Dispositional Alternatives (Juvenile Correctional Placement or Probation).[82]

Both the Sequential Intercept Model and the framework with Critical Intervention Points highlight under-utilized sources of referral for mental health services for transition-aged youth with SED in Vermont. It is certainly preferable – and often in the heat of crisis more effective – to offer individuals treatment before they end up deep within the juvenile or criminal justice systems. The adult mental health system works closely with law enforcement and, in Burlington, HowardCenter adult mental health staff attend the Mental Health Court. Children's mental health staff, however, have little interface with law enforcement (aside from some recent training about alternatives to transporting children in handcuffs), and there is virtually no children's mental health presence at detention or other initial court hearings. While individuals with mental health expertise may (or may not) voluntarily serve on some of the growing number of community justice center and diversion boards, there is currently no systematic attention to making sure this happens. A simplified look at the Continuum of Justice Services here illustrates a number of pre-adjudicatory steps at which mental health referrals could be made.

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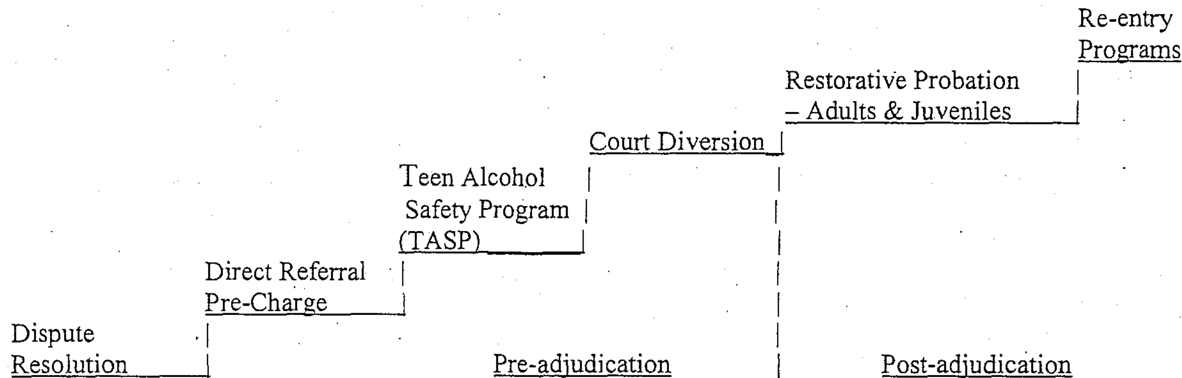
[80] Munetz, M. R. & Griffin, P. A. (2006). Use of the Sequential Intercept Model as an Approach to Decriminalization of People with Serious Mental Illness. *Psychiatric Services. ps.psychiatryonline.org.* 57(4), p. 544.

[81] Ibid, p. 545.

[82] Skowyra, K. R. & Cocozza, J. J. (2007). Blueprint for Change: A Comprehensive Model for the Identification and Treatment of Youth with Mental Health Needs in Contact with the Juvenile Justice System, p. ix.

A Continuum of Justice Services [83]



NCMHJJ recommends that

> every youth who comes in contact with the juvenile justice system should be systematically screened for mental health needs to identify conditions in need of immediate response, such as suicide risk, and to identify those youth who require further mental health assessment or evaluation.[84]

Furthermore, "given the high rates of co-occurring mental health and substance use disorders among this population, all screening and assessment instruments and procedures should target both mental health and substance use needs, preferably in an integrated manner."[85] The screening and assessment instruments may need to be adapted for "youth of color and girls".[86]

With this project, the LITs will be asked to strategically plan how to intercept transition-aged youth at critical intervention points with law enforcement and the criminal and juvenile justice systems. This will strengthen the existing linkages between children's mental health, law enforcement and the criminal and juvenile justice systems; improve access to children's mental health and co-occurring substance abuse treatment services for the youth at most risk for poor outcomes; and use the power of the courts to increase the likelihood of use of those services by the youth. As one such youth said when asked for advice about this proposal, "You have to make them go."

Most youth referred for mental health services – including screening and/or assessment for co-occurring problems – through this extension of the system of care will be eligible for either clinic-based or outreach-based services. To receive clinic-based services a person must simply be experiencing mental health symptoms as described in the DSM-IV-TR.[87] In order to receive outreach-based services, a child or adolescent must be experiencing or at risk of experiencing a severe emotional disturbance. Vermont's Act 264 defines a child or adolescent with a severe emotional disturbance as someone who:

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[83] AHS and Attorney General's Office. (2007). Community-Based Alternatives for Criminal Justice Services: Report to the Legislature, p. 5

[84] Skowyra, K. R. & Cocozza, J. J. (2007). Blueprint for Change: A Comprehensive Model for the Identification and Treatment of Youth with Mental Health Needs in Contact with the Juvenile Justice System, p.26.

[85] Ibid, p.29.

[86] Ibid.

[87] American Psychiatric Association. (2000). Diagnostic and Statistical Manual of Mental Disorders: Fourth Edition: Text Revision.

(A) exhibits a behavioral, emotional, or social impairment that disrupts his or her academic or developmental progress or family or interpersonal relationships;
(B) has impaired functioning that has continued for at least one year or has an impairment of short duration and high severity;
(C) is under 18 years of age, or is under 22 years of age and eligible for special education under state or federal law; and
(D) falls into one or more of the following categories, whether or not he or she is diagnosed with other serious disorders such as mental retardation, severe neurological dysfunction or sensory impairments:
   (i) Children and adolescents who exhibit seriously impaired contact with reality and severely impaired social, academic and self-care functioning whose thinking is frequently confused, whose behavior may be grossly inappropriate and bizarre and whose emotional reactions are frequently inappropriate to the situation.
   (ii) Children and adolescents who are classified as management or conduct disordered because they manifest long-term behavior problems including developmentally inappropriate attention, hyperactivity, impulsiveness, aggressiveness, anti-social acts, refusal to accept limits, suicidal behavior or substance abuse.
   (iii) Children and adolescents who suffer serious discomfort from anxiety, depression, irrational fears and concerns whose symptoms may be exhibited as serious eating and sleeping disturbances, extreme sadness of suicidal proportion, maladaptive dependence on parents, persistent refusal to attend school or avoidance of nonfamilial social contact.[88]

Act 264 also says that "the receipt of appropriate services…including out-of-home placement, shall not be conditioned on placement of the child or adolescent in the legal custody, protective supervision or protection of the [DCF]."[89]

While youth who are aged 18 or older can sign the necessary consent forms for treatment by a CMHC (see these forms in Appendix 4), adolescents under 18 can only be served once or twice unless their parents or guardians sign the forms. Therefore, family involvement with mental health treatment is assured for 16 and 17 year-olds; for older youth, to ensure the most lasting effects of treatment, every effort is made by clinical staff to involve each youth's nuclear and/or extended family and other informal community supports.

Explain how the service components will be developed, implemented… and sustained.

The CMHCs develop with the youth and their families individualized treatment plans that, as necessary and appropriate, make use of the full array of children's mental health and non-mental health services in their communities. In addition, for this project the CMHCs will address the critical needs of transition-aged youth for independent living skills as they continue their education and/or seek employment and housing with the complications of being under the jurisdiction of the juvenile and/or criminal justice systems.

[88] V.S.A. (Vermont Statutes Annotated – Online) Title 33, Chapter 43, section 4301 (3). Retrieved 1/7/2008 from http://www.leg.state.vt.us/statutes/fullchapter.cfm?Title=33&Chapter=043, p.1-2.
[89] Ibid, p.6

Lessons learned by The National Center on Youth Transition for Behavioral Health, which has evaluated and provided technical assistance to the CMHS Partnerships for Youth Transition Initiative (PYT), are that

> continuity of care and developmentally appropriate services can improve outcomes for youth with SED/SMI. Developmentally appropriate services support their strengths, interests and goals, enhance their social and life skills, and connect them to responsible adults and other important people in their lives.[90]

Developmentally appropriate services "fit their time of life", helping youth with SED/SMI meet their priorities of finishing school and career training; finding a decent job; learning independent living skills; managing and living within a budget; finding an affordable, safe and comfortable home; and dealing with their family issues.[91]

The Director of the National Center on Youth Transition, Hewitt B. "Rusty" Clark, Ph.D., developed a Transition to Independence Process (TIP) Model for delivering developmentally appropriate services to youth. The TIP Model emphasizes the following principles:

1) **Engage** young people in a relationship with a caring, responsible adult to plan for their own future.
2) **Tailor** services and supports to be accessible, coordinated, developmentally appropriate and to build on strengths.
3) **Respect** young people's developmentally appropriate search for independence and social responsibility by acknowledging personal choice and their need to find their own way.
4) **Ensure** a safety net of support, including family, to reduce risks.
5) **Strengthen** young people's competencies to assist them in achieving greater self-sufficiency and confidence.
6) **Help** the young person maintain a focus on outcomes, and encourage programs and systems to do the same.
7) **Involve** young people, parents and other community partners in the TIP system at all stages and levels.[92]

> In a discussion of the theoretical and research underpinnings for TIP, Dr. Clark says he worked with colleagues in Washington County, Vermont as they were developing a transition system. He learned from them and they learned from him in those early days. Today, that program is operational in about nine communities in Vermont, and Clark had an opportunity to assist in an evaluation of the initiative, examining the effectiveness of this TIP-type program (Clark et al., 2004). This study provided an analysis of pre- to discharge progress that showed substantial improvements in the outcomes for young people with EBD (i.e,, increased percentages of young people being employed and completing educational goals – and decreased involvement in the criminal justice system, "intensive" mental health/substance abuse service use, and public assistance). The evaluators also conducted a cost avoidance analysis that showed substantial savings as a function of the community-based TIP-type program.[93]

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[90] National Center on Youth Transition..(2007). Seeking Effective Solutions: Partnerships for Youth Transition Initiative. Retrieved 1/7/2008 from http://ntacyt.fmhi.edu/index2.cfm , p.6.
[91] Ibid, p.3.
[92] Ibid, p.2.
[93] Transition to Independence Process (TIP) Project, Theoretical and Research Underpinnings. Retrieved 1/7/2008 at http:tip.fmhi.usf.edu . p.2.

That TIP-type program is the JOBS program, now in 11 of Vermont's 12 service districts. **JOBS includes an adaptation of Supported Employment, one of the six Evidence-Based Practices (EBPs) with Implementation Resource Kits introduced by SAMHSA and CMHS.** The other five kits are about Illness Management and Recovery, Medication Management Approaches in Psychiatry, Assertive Community Treatment, Family Psychoeducation, and Integrated Dual Diagnosis Treatment for Co-occurring Disorders.[94] These practices were primarily developed for use with adults with SMI; the basic ideas have been used by the adult mental health system in Vermont for years, with more recent attention to Co-occurring Disorders. The practices are – with adaptations to make them age-appropriate - also relevant for transition-aged youth with SED so are highlighted by the National Center on Youth Transition.

According to SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP), other EBPs that are appropriate for transition-aged youth are Multisystemic Therapy for Juvenile Offenders, Trauma Recovery and Empowerment for women with histories of exposure to sexual and physical abuse, Psychoeducational Multifamily Groups, and the Incredible Years (for teaching parenting skills). All have demonstrated effectiveness with diverse populations.[95]

With this project, the 12 Local Interagency Teams (LITS) will be asked to consider what mental health services (in addition to Service Planning and Coordination) to fund to best support youth aged 16-21 (inclusive) who are experiencing severe emotional disturbance so they can be productively engaged in the community and free from incarceration. The LITs will be required to use the JOBS program (which operates in accordance with the TIP Model) as a platform for integration of the services. Each LIT should also decide whether it is important for that region to establish (in one district) and/or expand the JOBS program (which uses the EBP of Supported Employment adapted to be age-appropriate) or augment it with another EBP - such as for the treatment of co-occurring mental health and substance abuse disorders, the treatment of trauma, or for family or parenting education.

For this strategic planning, they will be required to consider the input of at least youth, family members, community (including cultural) organizations, mental health staff from both child and adult services, VR representatives, Work Force Investment Board or other business representatives, substance abuse treatment providers, health care providers, educators, law enforcement, and juvenile and criminal justice (including but not limited to DCF and DOC) representatives. The LITS will also design a management team for the project. The management team will seek ongoing input from the key stakeholders and will contribute to the State's long-range planning (and activities) for sustainability. If the project achieves its goal, the key stakeholders and regional management teams will be helpful finding resources to continue.

Describe the strategies to implement key service activities including Delivery of Clinical Interventions and Care Coordination/Individual Service Plans.

The exact services to be implemented will be determined by the LITs with approval from the SIT State Outreach Team during the first year of the project. All will deliver Service Planning and Coordination, about which the following statements can be made.

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[94] National Center on Youth Transition. Evidence-Based Practice Implementation Resources. Retrieved 1/7/2008 at http://ntacyt.fmhi.usf.edu/events/evidence_based_kits.htm.
[95] SAMHSA. National Registry of Evidence-based Programs and Practices. Retrieved 12/17/2008 at http://www.nrepp.samhsa.gov/listofprograms.asp?textsearch=Optional+Search+Terms&S...

CMHC clinicians may meet with children, adolescents and their families up to three times within 30 days if necessary for clinical assessment before assigning a diagnosis and finalizing with them a preliminary set of treatment goals, preferably using the words of the youth and families. The resulting Individual Plan of Care (IPC) includes annual goals and objectives – with a prescription for the "Medicaid Modality" for the intervention and measureable steps for targeted outcomes. The clinicians write progress notes documenting the treatment and services provided and whether they help the youth and family meet the agreed-upon outcomes.[96] "The IPC is a working document that must be developed annually (total rewrite) and reviewed quarterly unless the individual's condition and/or treatment needs change, necessitating the addition, deletion, or modification of prescribed interventions."[97]

If the youth and family have many needs and/or many services that must be used to help them, they or the CMHC clinician or another case manager [perhaps from DCF, VR, DOC, etc.] in the community may, according to Act 264, request that an Interagency Planning Team be formed. The Act 264 and the DOE/AHS Interagency Agreement Users Guide (2006) says:

> A case manager helps to put together a (treatment or service coordination – interagency planning) team that includes the child, family, relevant professionals and community members and other natural supports. This team works together to develop a plan that is individualized, child-focused, family centered, and culturally competent. Teams are expected to create plans that build on the strengths and assets of the team, the family, and the community. Planning includes the selection of appropriate goals, development of high quality solutions to problems, and effective strategies for reaching desired outcomes. This interagency planning team approach is considered the most effective model for meeting complex, multi-agency needs of children and families. It is expected that teams will agree on a lead coordinator. This will likely be the assigned case manager. It is important to note that this lead coordinator is responsible for facilitating the planning process, not necessarily financially responsible for services defined in the plan.[98]

Through the composition and interactions of this individualized interagency team, a more complete picture emerges of the youth's presenting problems and symptoms of SED or other disabilities and health issues, as well as of his/her interests and natural supports. This may lead to changes in the initial diagnosis and/or treatment plan. The involvement of a youth's family and natural supports in the treatment planning is a key strategy for ensuring that the goals and services are meaningful for the youth based upon his/her choices, age, gender, race, culture, etc.

In addition to the CMHC IPC, the youth, family, and Interagency Planning Team may wish to develop a coordinated services plan.

> The coordinated services plan includes the ...IEP as well as human services treatment plans *[such as the DCF Title IV-B individualized plans for children in foster care]* or individual plans of support, and is organized to assure that all components are working toward compatible goals, progress is monitored, and resources are being used effectively to achieve the desired result for the child and family. Funding for each element of the plan is identified.[99]

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[96] Ibid, p.7.
[97] Ibid, p.9.
[98] State Interagency Team and Interagency Agreement Support Committee. (2006). Act 264 and the DOE/AHS Interagency Agreement Users Guide, p.7.
[99] Smith, M. & Cate, R. (2005). Interagency Agreement with Vermont Department of Education and Vermont Agency of Human Services Pursuant to Part B of the Individuals with Disabilities Education Act, p. 3.

The coordinated services plan is appended to the treatment plans of the individual agencies serving the youth.[100] Under Act 264 this coordinated services plan is an entitlement for children and youth with SED, though the services associated with it are not. The services may be mental health services and non-mental health services depending upon the needs of the youth/family. (See Appendix 4 for a copy of the Coordinated Services Plan's Consent for Eligibility Determination & Coordinated Services Planning)

If youth and families are not satisfied with the mental health services they receive, they can make complaints and/or file formal grievances using the standard procedures of the CMHC and DMH. If they have a coordinated services plan, they may also make appeal to the Act 264 Local and perhaps State Interagency Team to review the situation.

> If a team has not been formed or is not functioning, if a coordinated services plan is not satisfactory, if there is no lead service coordinator, or if a plan is not being implemented satisfactorily, the family or individual or another involved party may request a meeting of the Local Interagency Team to address the situation.[101]

Ultimately,

> where the SIT is unable to resolve a dispute among the various agencies, it shall inform all participating parties of the right to an appeal process. The Secretary of AHS and Commissioner of DOE may resolve the issues and render a written decision or may arrange for a hearing pursuant to Chapter 25 of Title 3.[102]

The clinicians who deliver the services chosen by the youth/family benefit from ongoing training and technical assistance. That is one reason the AHS/DOE have contracted with the University of Vermont's (UVM's) Center on Disability and Community Inclusion (CDCI) for support for implementation of the DOE/AHS Interagency Agreement Pursuant to Part B of IDEA. The Coordinator of the Implementation Committee served as training and technical assistance coordinator for Vermont's two prior CMHS Service Initiative grants. The Coordinator and Committee produce training events (including about effective teaming and treatment planning as part of Service Coordination), a quarterly "Interagency Matters!" newsletter, and various products like the User's Guide to help clinicians and administrators from multiple agencies understand and uphold Act 264 and the Interagency Agreement.

The SIT State Outreach Team's T/TA Plan for this project will ensure that training and technical assistance are made available to a wide variety of stakeholders (including clinicians, youth, families, and administrators from all involved agencies) about transition-aged youth with SED *[from Dr. Mary Ann Davis]* and about the TIP Model *[from Dr. Rusty Clark]*. There will be training about the intervention/intercept models *[from the NCMHJJ and the GAINS Center]*, also about the EBPs (including Supportive Employment) chosen by one or more LIT. As needed, clinicians and their supervisors will receive in-depth initial and/or follow-up training about the EBPs to be delivered, including about the use of any associated screening or assessment tools and curricula.

Some clinicians and administrators will be familiar with the EBP chosen for their region and may be asked to help with delivery of the training there and in other regions in Vermont. For example, adult mental health staff are well versed in providing Supported Employment and,

[100] State Interagency Team and Interagency Agreement Support Committee. (2006). Act 264 and the DOE/AHS Interagency Agreement Users Guide, p.12.
[101] Smith, M. & Cate, R. (2005). Interagency Agreement with Vermont Department of Education and Vermont Agency of Human Services Pursuant to Part B of the Individuals with Disabilities Education Act, p. 3.
[102] Ibid, p.13.

with assistance from VR, have helped children's mental health staff establish the JOBS programs in all but one of the 12 districts. In all ten CMHCs the adult mental health staff – and in two of them the children's mental health staff - have already been trained in delivery of Integrated Dual Disorders Treatment (IDDT) for Co-Occurring Disorders by the New Hampshire-Dartmouth Psychiatric Research Center in Lebanon, New Hampshire, whose Director, Dr. Robert E. Drake, has done much of the research establishing IDDT as an EBP. Perhaps staff from those CMHCs *(which, according to ADAP, are two of Vemont's six Centers of Excellence in Adolescent Substance Abuse Treatment)* could be funded to mentor staff in other regions about the use of IDDT with transition-aged youth.

Describe Family-Driven Care

The Vermont Federation of Families for Children's Mental Health has been in existence for over 15 years. It receives a CMHS Statewide Family Network grant as well as annual funding from the DMH and a sub-grant from the AHS (from its federal Family Support 360 grant). *[See the Sustainability/Linkages section below]*. The Federation's mission is to:

> support families and children where a child or youth, age 0-22, is experiencing or at risk to experience emotional, behavioral, or mental health challenges. The Federation is committed to:
>
> - Providing families needed emotional and informational support.
> - Advocating for families and children to receive needed supports and services.
> - Promoti*[ng]* the creation of a full array of easily accessible, high quality, family-centered services needed on a state and local level.
>
> The Federation collaborates with schools, communities, governmental, and private agencies, and other advocacy organizations to achieve these ends.[103]

The Federation currently has a full-time Executive Director, a part-time Assistant Director (Cindy Marshall, who would work full-time if this grant is funded), and part-time field staff who function as Peer Navigators for parents with disabilities in 7 of the 12 districts. The Executive and Assistant Directors participate on State Boards such as the Governor's Act 264 Advisory Board, the Advisory Group for Vermont's CMHS federal Block Grant, the DMH State Program Standing Committee for Children's Mental Health, the SIT and its sub-committees, and related task forces. "The Vermont Federation's Executive and Assistant Directors have been a part of the ongoing discussion, planning and implementation of the expanded Act 264 process."[104] With the help of the Peer Navigators, the Federation also recruits parents of children and youth with SED to participate in the regions on CMHC Boards of Directors and Children's Mental Health Local Program Standing Committees as well as on the LITs, and to join or advocate when needed other administrative and legislative committees.

> An approach *[to recruiting]* that appears to be successful, so far, has been to co-host a free dinner for families. *[The Federation works]* collaboratively with the regional AHS Field Services Director and the local Children's Mental Health Director to sponsor and pay for this family dinner. Part of the evening has been dedicated to gather information from families via informal discussion groups of 8-10 people per table of what parents feel is needed for family support in their community. The questions we ask are: 1. What do families want/need? 2. What are the service gaps? 3. What can families/individuals do now to get things moving? 4. Are families/individuals willing to come to trainings to increase their skills; if so, what kind of trainings? 5. Do they want support groups,

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[103] VFFCMH brochure

[104] Holsopple, K. (2007). Statewide Family Network Grant Application.

activity groups, training or a combination?....Our next steps are to help families form regional family support groups and assist them to put identified supports in place with the help of our Peer Navigators. We also use this meeting time to encourage families and youth to get involved in the system of care, decision making bodies, and legislative advocacy. One of the first trainings we offer in each region is one on legislative advocacy in collaboration with the Vermont Association for Mental Health (VAMH).... Training and technical assistance is needed to support the parents and youth/young adults to attain a level of comfort and confidence speaking to service providers, policy makers and legislators. Training also needs to happen within the system of care to create a family friendly atmosphere and to meaningfully include family members and youth. We see a real need in the system of care for providers to and families to understand the differences between family friendly, family involvement and family driven care.[105]

As part of its Statewide Family Network activities, the Vermont Federation is using the National "Federation of Families and SAMHSA *Ambassador's Guide to Family Driven Care* to present trainings for families and providers and to share the information in more informal settings as opportunities present themselves."[106] The Vermont Federation also continues to address barriers to family involvement such as

family overload due to lack of services, providers not valuing the presence of families, childcare, transportation, living in poverty, and meeting times that don't work for families. Families are in need of mentoring and information to know the purpose of certain decision making bodies; receiving the leadership training needed to be full participants; and most importantly be able to receive compensation for their time just as their professional partners receive....We have been looking at the models of participant supports already in place in the system of care in Vermont. Currently the local children's mental health standing committees provide childcare, mileage, and food. State level mental health committees provide a stipend and mileage. Local interagency team provides a stipend. Regional Consumer Advisory Councils provide stipends and food. We continue to raise the issue of the need for supports such as: stipend/reimbursement, childcare, flexible meeting times, to insure family ability to become and stay involved.[107]

For this CHMI project, the current training and support practices will be extended to encourage parent and youth involvement in all aspects of planning, implementing and evaluating this project. (Financial incentives are not given to youth or families to encourage them to participate in mental health treatment.)

For 2008 the Federation adopted Legislative Priorities that include

advancing the creation of a system of supports and services for transition age youth....This system needs to be defined in partnership with youth and former youth who can best define the supports and approaches that will be successful in assisting youth to move confidently into their future.[108]

Because the Vermont Federation is experienced with and committed to assisting transition-aged youth with SED and their families, and because it is interested in building a youth program like that of other chapters of the National Federation, it will house and supervise the required 1 FTE Youth Coordinator. Much of the time of the Executive and Assistant Directors is

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[105] Ibid.
[106] Ibid.
[107] Ibid.
[108] VFFCMH statement of 2008 Legislative Priorities

spent strengthening the statewide system of care for transition-aged youth with SED, so the Federation will donate .5 FTE to this project; another .5 FTE will be added with these grant funds to increase the supervisory and family liaison capacity of the Federation and to meet the 1 FTE commitment to family-driven care required for this project.

Describe Youth Guided Care

As the service foundation for this project,

> The JOBS [program] remains committed to offering an *available, accessible, and attractive* service delivery for youth experiencing SED. Outreach is valued as the initial and most crucial step in connecting a youth experiencing SED to services. Work is used as the 'hook' to engage youth in relationships with project staff and additional services, such as intensive case management, substance abuse treatment and social skills training are added. Each JOBS program provides an accessible location – usually located on the bus line – in a welcoming environment that encourages youth to drop in and meet with project staff.[109]
>
> The success of [JOBS] is primarily due to its ability to meet youth **where they are at** – the JOBS Program is often co-located with other youth service providers in a non-stigmatizing, youth friendly environment. [110]

"JOBS staff and partners...are alert to the power of word-of-mouth referrals among youth and the benefits of street level outreach, positive relationships and the 'non-threatening' atmosphere of the program."[111] JOBS program staff "provide outreach to places youth congregate becoming an identified, trusted resource within the community and whenever possible, strive to incorporate youth input to its design, planning, implementation, and/or quality improvement strategy."[112]

Some JOBS programs are co-located with Runaway and Homeless Youth Programs. The statewide association of these programs, VCRHYP, is housed at Washington County Youth Services Bureau, a Boys and Girls Club that also houses the Association of Teen Centers in Vermont. Kreig Pinkham, Coordinator of VCRHYP, serves on the Act 264 Advisory Board and is Chair of Vermont's Juvenile Justice and Delinquency Prevention (JJDP) Advisory Group (called the Children and Family Council for Prevention Programs, or CFCPP) which oversees the planning for and use of federal JJDP Block Grant funds.

VCRHYP has 12 member agencies, one per AHS district, and together they serve about 1,000 youth per year, over 250 through their Transitional Living Programs that consist mostly of host homes and supervised scattered-site apartments plus five specialized short-term shelters. VCRHYP recently obtained a JJDP sub-grant from the CFCPP "to develop and implement a fund development strategy for the [VCRHYP] with the primary intent of increasing the capacity to serve homeless or at-risk youth aged 16-21."[113]

> The fund development strategy ...will leverage the strength of a statewide Coalition to attract the attention of large private donors as well as Foundations and Corporate sponsors. VCRHYP will also create a youth employee position to work with the Fund

[109] Dalmasse, D. (2002). Partnership for Youth Initiative Grant Application, p.8.
[110] AHS Youth in Transition Leadership Team. (2007). Draft #4: The JOBS Program Expansion – A Model Approach to Transition Services for Youth with Severe Emotional Disturbance, p.1.
[111] Dalmasse, D. (2002). Partnership for Youth Initiative Grant Application, p.8-9
[112] AHS Youth in Transition Leadership Team. (2007). Draft #4: The JOBS Program Expansion – A Model Approach to Transition Services for Youth with Severe Emotional Disturbance, p.1.
[113] VCRHYP grant application to CFCPP, p.10.

Development Consultant to generate promotional materials expressing need from youth perspectives, and to assist in fund development efforts."[114]

As with CMHCs, the VCRHYP member agencies seek and make use of youth guidance related to their individual plans of care as well as to operation of the programs. In addition, DCF has a statewide network of Youth Development Programs, 12 Coordinators (one per district), and a Youth Development Committee (with website) for youth in foster care. "Through the Youth Development Program, [DCF] provides voluntary services and supports to ensure a successful transition to adulthood, including: housing assistance, transportation, case management services, assistance with obtaining and retaining health insurance or employment, and other services."[115] The Youth Development Committee has requested and received technical assistance from the National Resource Center for Youth Development "to empower all youth on [the] Committee to be their own leaders and learn...valuable and important leadership skills....[and] to receive assistance in developing a strategic...plan and schedule of activities for the coming year."[116] *[Letter of Support received for this CMHI project from the Youth Development Committee.]*

VR, too, has a Youth and Family Advisory Committee which includes 8-12 youth from around the state with a wide spectrum of disabilities and their family members. This committee meets bi-monthly with State transition staff to provide advice and direction about transition issues including VR practices and materials.[117] *[Letter of support received.]*

For this project, federal funds will be used to hire one FTE Youth Coordinator through the Vermont Federation of Families for Children's Mental Health. The youth will be of transition-age (more broadly defined, up to age 25) and have personal experience as either a consumer or family member of someone who is a consumer of public mental health services. The Youth Coordinator will be charged with reaching out to transition-aged youth with SED through networking with the DCF and VR Youth Committees, Outright Vermont, the ADAP recovery centers, the Vermont Coalition of Teen Centers, and other youth organizations. These connections and experiences will inform the Youth Coordinator as he/she seeks and supports youth with SED who are participating in JOBS, VCRHYP, or other programs to serve on the Local Program Standing Committees for Children's Mental Health Programs of the CMHCs and on various statewide committees for the Federation and for DMH and SIT for this project. The Youth Coordinator will also establish a Youth Program and Committee for the Federation.

Training is available for the Youth Coordinator, other youth workers in the system of care, and interested youth and families through an annual Youth Workers Conference organized by the VCRHYP. The conference teaches positive youth development. It also promotes for youth workers the development of such knowledge, skills, and abilities as those identified by the National Collaborative on Workforce and Disability (NCWD).[118] The VCRHYP is working with the Vermont Out-of-School Time Network, the Vermont School Age Care Network and others to adapt the national competencies and build a more skilled youth workforce here.

Explain how cultural and linguistic competence and responsiveness will be addressed.

The Vermont system of care for children and adolescents with severe emotional disturbance is accustomed to dealing with transition-aged youth and their families. Nearly all of these youth

[114] Ibid, p.11-12.

[115] DCF. (2008). Draft Family Service Regulations for Services to Transition-Age Youth, p.16.

[116] Lawrence, D. (2007). Report on Youth Development Program (?)

[117] Kievit-Kyler, R. (2008). Emailed communication.

[118] NCWD. (2008). Professional Development: Knowledge, Skills & Abilities (KSA) Initiative. Retrieved 1/17/2008 from http:www.ncwd-youth.info/ksa/index.html.

and families are White and English speaking; most are poor. The AHS has conducted extensive training statewide for its staff and sub-grantees about effective ways for helping people who have grown up in a culture of poverty; the trainings are based on the book Bridges Out of Poverty.[119] The AHS is also, through its 360 Family Support Grant (described more fully below under Sustainability), in the midst of training DCF and other workers about how to assess and build on the strengths of parents with disabilities who are in danger of losing custody of their children to the State. This training is being led by Dr. Susan Yuan, co-director (with Scott Johnson, AHS Deputy Commissioner of the Field Services Division) of the 360 Grant, an employee of the University of Vermont's (UVM) Center on Disability and Community Inclusion (CDCI), and the parent of a man with developmental disabilities. Through her advocacy, the CDCI is hosting a Communications Project which has trained people throughout Vermont to help individuals with developmental disabilities understand what is happening and communicate their wishes when they are before the court. In addition, the AHS and its sub-grantees have and make use of contracts for the purchase of translation and interpreter services, including for the deaf and hard-of-hearing. These are just some of the measures Vermont already takes to be culturally and linguistically competent and responsive.

More activities have taken place in Chittenden County, where the Burlington school system must respond to students speaking over 20 different languages. The HowardCenter, the Chittenden County CMHC, has for several years employed a part-time Diversity Coordinator who works closely with a Multi-cultural Committee of the Board of Trustees and community members. The HowardCenter has adopted a vision with goals and objectives for being a culturally competent organization; the vision is described at http://www.howardcenter.org/about/diversity.php. This website "represents a good faith effort to comply with ... the website accessibility standards of the Americans with Disabilities Act (ADA)."[120] The AHS State Refugee Coordinator has worked closely with the HowardCenter on diversity issues and recommends that the .5 FTE position required by this grant be placed there, to both respond to the needs of the CMHI project statewide and to supplement the cultural and linguistic competence resources of Chittenden County. The HowardCenter is "certainly interested in hosting the part-time cultural and linguistic competence coordinator...we have experience with recruiting for this type of work and have collaborative relationships with Vermont Refugee Resettlement and AALV (Association of Africans Living in Vermont)."[121] Therefore, DMH will sub-grant the work of this position to the HowardCenter.

The .5 FTE Cultural and Linguistic Coordinator will be responsible for producing and implementing – with broad, ongoing input from key stakeholders – a plan for cultural and linguistic competence for the CMHI project. The plan must "ensure that all of the services and strategies of the CMHI project are designed and implemented within the cultural and linguistic context of the youth and families to be served."[122] The plan will reflect the guidance of the national project/TA staff and will be final only after approval by the State Outreach Team.

[119] Payne, R. K., Duvol, P., & Dreussi Smith, T. (2000). Bridges Out of Poverty: Strategies for Professionals and Communities.
[120] HowardCenter. Vision for a Culturally Competent Organization. Retrieved 1/23/2008 from http://www.howardcenter.org/about/diversity.php.
[121] Simonson, C. (1/18/2008). Emailed communication.
[122] Technical Assistance Partnership for Child and Family Mental Health. (2008). Sample Cultural and Linguistic Competence Plan for Advancing Cultural and Linguistic Competence in Systems of Care. Retrieved 1/28/2008 from http://www.tapartnership.org/cc/CLC_Plan_Template_FINAL.pdf

The Coordinator will assist the CMHI leadership with "infusing cultural and linguistic competence throughout the system of care"[123] in six domains when participating in the SIT State Outreach Team and the Chittenden County LIT. The six domains "are (1) governance and organizational infrastructure (2) services and supports (3) planning and continuous quality improvement (4) collaboration (5) communication and (6) workforce development."[124] The Coordinator will benefit from the detailed "Cultural and Linguistic Competence Implementation Guide"[125] now available from the National TA Partnership for Child and Family Mental Health.

Training is regularly available for children's mental health and DCF workers about effective teaming with families and building on family and child strengths and interests. Children's mental health clinicians are monitored on their use of child and family language in the Individualized Plan of Care (IPC). Some workers are bi- or multi-lingual and/or bi- or multi-cultural. However, national technical assistance about increasing Vermont's cultural and linguistic competence is likely to be of great help to all stakeholders in the system of care, particularly those like law enforcement and criminal justice representatives who have not partnered with SIT or LITs in the past. The Coordinator will arrange for the delivery of such technical assistance and training both statewide and in Chittenden County. The Coordinator will link this help with JJDP TA to address Disproportionate Minority Confinement of Black Youth.

Sustainability/Linkages with Statewide Transformation and Federally-Funded Programs
Indicate how this initiative links with transformation and Statewide reform efforts.

The goal of this 6-year project is for Vermont's transition-aged youth (16 through 21 inclusive, with their families) with SED to have adequate preparation and the necessary supports to be productively engaged in the community and free from incarceration. This goal is closely related to the interests of the Governor and Legislature in better meeting the needs of transition-aged youth. (For more detail about those interests, refer back to pages 18-20 and 22-23 and to the letters of commitment and chart showing match in Appendix 5.) The AHS recognizes that, for this population, the necessary supports include access to health care *[including Medicaid]*, post-secondary education, employment, housing, and caring relationships (with service providers and community members). This grant project will contribute to the Governor's "Next Generation" reform by increasing the number of transition-aged youth who have access to and receive treatment for mental health and co-occurring substance abuse challenges. 173 youth will be served per each of 5.25 years, for a total of 908 youth by the end of the six years. The proposed project is in full accord with the CMHI RFA goals to:

- expand community capacity to serve ...adolescents with SED and their families;
- provide a broad array of accessible, clinically effective and fiscally-accountable services, treatments and supports;
- serve as a catalyst for broad-based, sustainable systemic change...;
- create a care management team with an individualized service plan for each *[youth]*;
- deliver culturally and linguistically competent services...; and

[123] Ibid.
[124] Technical Assistance Partnership for Child and Family Mental Health. (2008). Sample Cultural and Linguistic Competence Plan for Advancing Cultural and Linguistic Competence in Systems of Care. Retrieved1/28/2008 from http://www.tapartnership.org/cc/CLC_Plan_Template_FINAL.pdf
[125] Martinez, K. & Van Buren, E. (2008). Cultural and Linguistic Competence Implementation Guide.

- implement full participation of families and youth in service planning, in the development, evaluation and sustainability of local services and supports and in overall system transformation activities.[126]

The system – including policy and infrastructure - changes will emerge and evolve based on the strategic planning done in Year 1 and the implementation done in subsequent years by the statewide project personnel and committees, the SIT State Outreach Team, and the 12 regional LITs, with all their family, youth, State, and community partners.

Discuss strategies for ensuring project sustainability...and use of Medicaid.

The current plan for sustainability for this CMHI project is a Legislative appropriation to replace the federal funds as the grant ends. DMH has successfully sustained two prior CMHS Services Initiative Grants using the same plan. Because the first grant, Access Vermont, demonstrated that children's crisis outreach mental health services were effective in reducing new admissions of unmanageable youth (minors who are status offenders) to DCF, the Legislature approved new State General Funds for the program based on savings from the earlier-projected rate of growth in DCF custody. For the second grant, Children's UPstream Services (CUPS), which demonstrated effectiveness in improving the well-being of young children and their caregivers and in supporting child care providers, the Legislature invested in the early intervention approach by appropriating the amount of State General Funds needed to match Medicaid to maintain the same levels of service as provided by the grant. For this CMHI project, there may be less opportunity to sustain the same levels of service by relying on Medicaid for two reasons: 1) fewer transition-aged youth are enrolled in Medicaid, and 2) Vermont has capped its entire Medicaid program through a five-year 1115 Waiver. The Waiver, which the Governor calls a "Global Commitment",

> makes Vermont the only state in the nation facing a fixed dollar limit on the amount of federal funding for its Medicaid program. In exchange for taking on the risk of operating under a capped funding arrangement, the waiver allows Vermont to use federal Medicaid funds to refinance a broad array of its own, non-Medicaid health programs, creating a fiscal windfall for the state. It also gives Vermont new flexibility to reduce benefits, increase cost sharing, and cap enrollment for many Medicaid beneficiaries.[127]

To date, Vermont has maintained its level of benefits and expanded enrollment by using the "fiscal windfall" to create

> Green Mountain Care, the new name for our family of low-cost and no-cost health coverage programs offered by the State of Vermont and its partners. Green Mountain Care was created through Act 191, signed by Governor Douglas 18 months ago, and offers quality, comprehensive health coverage at a reasonable cost. The new Catamount Health Program is part of Green Mountain Care along with Medicaid, Vermont Health Access Plan (VHAP) and Dr. Dynasaur. Individuals may also receive help in paying for their monthly premiums depending upon income... The state ...launch*[ed]* a major campaign to market Green Mountain Care on November 1st *[2007]* ...feature*[ing]* television, radio, internet, and newspaper advertisements.[128]

[126] SAMHSA. (2007). Cooperative Agreements for Comprehensive Community Mental Health Services for Children and Their Families Program, p. 7.
[127] Guyer, J. (2006). Vermont's Global Commitment Waiver: Implications for the Medicaid Program, p.1.
[128] LaWare, C. (2007). Statement from AHS Secretary Cynthia D. LaWare on the Launch of Green Mountain Care

This expansion of health coverage is crucial for transition-aged youth with SED, and it is expected to put Vermont at the ceiling of its Medicaid cap. Thus, if the Waiver continues, there may be no way to use Medicaid to sustain this CMHI project. However, DMH expects that the project will be able to demonstrate outcomes favorable to youth and families and to the State in terms of a reduction in the anticipated growth in the need for incarceration. If this happens to the satisfaction of the partners in this enhanced system of care, the likelihood increases of obtaining the necessary funding from the Legislature to sustain the project.

Explain how the initiative will coordinate with other relevant federally funded initiatives.

1. The Vermont Integrated Services Initiative (VISI) is a five-year Co-occurring State Infrastructure Grant (COSIG) from the federal CMHS to the Office of the Governor. It is a collaborative project between DMH and VDH and

> is the fourth in a series of federal grants to Vermont that has focused on co-occurring conditions....There are 26 agencies participating in the VISI Initiative. They include all the community mental health agencies, several substance use providers, three primary care facilities, two treatment courts and seven homeless service providers.[129]

Teams are active in identifying opportunities for improving the infrastructure related to clinical practices, financial planning, information systems, and workforce development. The grant is half completed. More service providers are now screening clients for mental health and substance abuse disorders and performing integrated assessments and treatment. While the COSIG grant and the earlier related co-occurring work have established a level of readiness and expertise in the mental health system for serving adults with co-occurring disorders, this has not yet permeated many of the children's mental health programs or other youth-serving agencies. One or more of the regions may choose this CMHI project as an opportunity for gaining expertise in the EBP related to co-occurring disorders.

2. Certain federal CMHS discretionary grants to the mental health system in Vermont have been frequently renewed, such as the Statewide Family Network Grant to the Vermont Federation of Families for Children's Mental Health, the Data Infrastructure Grant to the DMH (thus, the research reports by Dr. John Pandiani), and the Statewide Consumer Network Grant to Vermont Psychiatric Survivors (which operates Safe Haven, one of the homeless programs that just received HUD funding). This discretionary funding typically exceeds the small amount of funding available through Vermont's Community Mental Health Services Block Grant ($786,193 in FFY 2006).[130] All of these resources are important to the operation of the mental health system in Vermont, with its family and consumer partners and attention to planning and quality improvement; this CMHI project is dependent upon the functioning of that system.

3. The Vermont Strategic Prevention Framework (SPF) is a Center for Substance Abuse Prevention (CSAP) State Incentive Grant (SIG) to the VDH–ADAP

> to advance community based programs for substance abuse prevention, mental health promotion, and mental illness prevention. The SPF-SIG *[which is half completed]* implements a five-step process known to promote youth development, reduce risk-taking behaviors, build on assets, and prevent problem behaviors. The five steps are: (1) conduct needs assessments; (2) build state and local capacity; (3) develop a comprehensive strategic plan; (4) implement evidence-based prevention policies,

[129] DMH and VDH. (2007). Vermont Integrated Services Initiative, p.1.

[130] SAMHSA. Grant Awards by State – Summaries FY 2006/2007. Retrieved on 1/26/2008 from http://www.samhsa.gov/statesummaries/StateSummaries.aspx?state=vt , p.1.

> programs and practices; and (5) monitor and evaluate program effectiveness, sustaining what has worked well.[131]

In addition to this statewide grant, CSAP has awarded at least 11 Drug Free Communities grants that will still be current at the time of award of this CMHI project. The grantees are in 9 of the 12 AHS districts in Vermont. In regions with this resource, the LITs will factor it into their planning for the enhanced system of care and services for this CMHI project. The SIT State Outreach Team will also factor the activities of the SPF into its planning for this CMHI project.

4. Vermont is currently in year four of a five-year 360 Family Support Grant from the federal Administration on Developmental Disabilities to the AHS, which sub-grants the funds to one mental health agency and to two statewide family support organizations (the Federation and VPIC). The Federation uses its funds to provide Peer Navigation to parents with developmental (and other) disabilities in 7 of the 12 regions in the state. VPIC provides Peer Navigation in 4 districts, and Rutland Mental Health provides this service in 1 district. The goals of the grant are to increase family input to AHS reorganization (in earlier years) and to assist parents with disabilities in obtaining the help they need to successfully raise their children, thus avoiding the loss of custody that is too common for parents with disabilities. Many of the parents being served have mental illness, a known risk factor for SED in children.

> For the AHS and its 360 sub-grantees, the Family Support Grant has created unprecedented opportunities to work together and support families in ways new to *[all]* entities. The AHS has contributed office space, which includes phone and computer, for each Peer Navigator...In each region, the Peer Navigator has been working closely with the AHS Field Service Director to create and establish regional consumer advisory groups to advise the Field Service Director and continue to identify gaps and problems as the AHS reorganization, now called transformation, efforts move forward....The consumer advisory groups are comprised of people who receive services from AHS. The Peer Navigator's further role is to support parents to also be a part of this advisory role....Peer Navigators' speaks to the fact that all *[these staff]* are family members who have experienced receiving services within our system of care, and can help other family members navigate the service system.[132]

This deeper and broader connection between the Federation and the AHS Field Services Division and Directors will help to bolster the youth and family involvement with the state and regional systems planning and to more easily address the inevitable problems of individual youth and families served through the system of care enhanced by this CMHI project.

5. The VCRHYP has two Transitional Living Program (TLP) grants of $200,000 apiece from the federal Family and Youth Services Bureau that will allow 8 of its 12 member agencies to, over the next five years, annually provide about 160 youth with core support services and 70 of those youth with shelter. The housing resource is critical for stabilizing youth in transition so they can more effectively attend to their health, mental health, substance abuse, employment, education, family, and other daily living issues.[133] In the regions with this resource, the LITs will factor it into their planning for the system of care and services for this CMHI project.

6. Governor Jim Douglas announced on January 15, 2008 that

> more than $1.7 million in federal funding has been awarded to Vermont to support 16 homeless programs....The funding...is provided under HUD's Continuum of Care

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[131] Ibid, p.3.
[132] Holsopple, K. (2007). Statewide Family Network Grant Application.
[133] Pinkham, K. (2008) phone and emailed communication including copy of TLP grant.

program, which supports the full spectrum for homeless individuals and families – from street outreach and emergency shelter to transitional and permanent housing. In addition, the funding provides for critically needed services including job training, child care, substance abuse treatment and mental health counseling.[134]

CMHCs operate programs for homeless adults with severe and persistent mental illness and captured 22% of this statewide HUD funding. Also, the HowardCenter (a CMHC) captured 50% of an additional $765,755 in HUD Continuum of Care funding awarded for Burlington and Chittenden County. Some of the homeless programs funded by HUD will be used by transition-aged youth with SED so are a resource for the LITs to consider in their planning.

Section C.: Project Management and Staffing Plan

Discuss the capability and experience of the applicant organization.

The applicant for this grant, the Department of Mental Health (DMH), is one of six departments and offices within the AHS *[see organizational charts in Appendix 6]*, which was created by the Vermont Legislature in 1969 to serve as the umbrella organization for all human service activities within state government. The Agency is led by the Secretary, who is appointed by the Governor, and the Deputy Secretary *[and Commissioners]* who is appointed by the Secretary with the Governor's approval.[135]

These AHS departments and offices are responsible for administering a very broad range of federal and state programs, block grants, and entitlements, including at least the following:

- Office of Vermont Health Access (OVHA)
  - Title XIX of the Social Security Act – Medicaid
  - Title XXI – State Children's Health Improvement Program (S-CHIP)
- Department for Children and Families (DCF)
  - Child Development Division
    - Head Start Program (Head Start – State Collaboration Office)
    - Part C (formerly Part H) of the Individuals with Disabilities Education Act (IDEA), administered jointly with the Department of Education (not in AHS), which is responsible for Part B of IDEA
  - Economic Services Division
    - Title IV-A – Temporary Assistance for Needy Families (TANF) Program
  - Family Services Division
    - Child Welfare Services: Title IV-B, Subpart 1 of the Social Security Act – Preventive intervention, alternative placements and reunification efforts to keep families together
    - Promoting Safe and Stable Families: Title IV-B, Subpart 2 of the Social Security Act – Family support, family preservation and support, time-limited family reunification services, and services to support adoptions
    - Title II of Keeping Families and Children Safe Act
    - Title IV-E-Foster Care, Adoption and Independent Living
    - John H. Chaffee Foster Care Independence Program (Part of Title IV-E
- Department of Health (VDH)
  - Community Public Health Division

[134] Douglas, J. (2008). Press Release. Governor's Office, forwarded by email

[135] LaWare, C. (2008). Welcome to the Vermont Agency of Human Services. Retrieved 1/23/2008 from http://www.ahs.state.vt.us

        - Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
- Department of Mental Health (DMH)
    - CMHS Mental Health Block Grant.

Memoranda of understanding (MOU) between programs and departments (including Corrections and Disabilities, Aging and Independent Living [DAIL]) are not usually required to carry out operations within AHS because the departments and offices are considered to comprise one legal entity. However, when the budgeting across departments is very complex – as with JOBS – an MOU is helpful to keep track of interdepartmental transfers. The Department of Education is separate from AHS.

DMH oversees a network of independent, private, non-profit organizations that comply with stringent state and federal laws, regulations and quality standards for delivering community-based mental health services, especially when using Medicaid. DMH designates these agencies to provide core services to all eligible individuals and families in their catchment areas (10, preceding the 12 AHS districts). The Designated Agencies (DAs) screen children and adults for psychiatric hospitalization. DMH provides psychiatric hospitalization for adults through the Vermont State Hospital and contracts with community hospitals that can hold patients involuntarily if necessary for up to 72 hours. If children or youth need hospitalization, they are referred to one of three private hospitals in or near Vermont or to hospital diversion placements. DMH also contracts with several small intensive residential treatment programs for children and youth whose needs cannot be met in their home or communities.

The DAs - community mental health centers (CMHCs) - have been in existence since the 1960s and serve adults with serious and persistent mental illness, children with serious emotional disturbance (both groups through oversight from DMH), and people with developmental disabilities (through oversight from DAIL). Most of them also serve adults and adolescents with substance abuse problems (through oversight from ADAP, in VDH). For children with serious emotional disturbance, the CMHCs maintain core service capacities in immediate response; outreach treatment; clinic-based treatment; support; and prevention, screening, referral and community consultation.[136]

Within DMH, the Child, Adolescent and Family Unit (CAFU) has the mission "to assure timely delivery of effective prevention, early intervention, and behavioral/emotional health treatment and supports through a family-centered system of care for all children and families in Vermont."[137] It does this by paying attention to the following desired outcomes for four domains of quality service: access, practice patterns, outcomes/results of treatment, and structure/administration. To achieve these outcomes, the CAFU engages in priority strategies of: Family Involvement, Participation and Empowerment, Partnerships, Effective Management of Care, Expansion of Attitudes, Knowledge and Skills, and Effective Working Relationships.[138]

Charles A. Biss, Principal Director for this project and Director of the CAFU for the past 15 years, is very experienced and skilled in carrying out these strategies *[see his biographical sketch in Section G]* with the SIT and LITs, with the CMHC Children's Mental Health Directors, with the CAFU sub-grantees like the Federation of Families for Children's Mental Health., and with his staff of 9 FTEs. Six of the staff function as an Operations Team that provides clinical

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[136] DMH. (2004). The Vermont State System of Care Plan for Child, Adolescent and Family Mental Health, State Fiscal Years 2005-2007, p.11-12

[137] Ibid, p.3

[138] Ibid, p.3

consultation and oversight to CMHCs and LITs statewide as they manage the care of about 200 children and youth who have Individualized Service or Wraparound Budgets and Plans of Care as an alternative to psychiatric hospitalization, in accordance with a 1915 (c) Home and Community-Based Medicaid Waiver. One staff member oversees other quality improvement efforts. The CAFU staff, particularly the Operations Team, meet and consult regularly with the DMH Medical Director, a Child Psychiatrist.

Under the leadership of Charlie Biss, the DMH has successfully applied for, received, implemented and sustained two prior CMHS Service Initiative Grants: 1). In 1993, Access Vermont for children's crisis outreach services, primarily for school-aged children with SED, and 2). In 1997, Children's UPstream Services, or CUPS, for children aged 0-6 with SED. Both of these system-of-care grants were carried out with essentially the same strategic process planned for this project but with different target populations and a different blend of partners.

For this CMHI project, DMH has the added support of the AHS Field Services Division and the AHS District Field Services Directors. The Division and its Directors did not exist prior to the AHS Reorganization of 2005 but are now based in the AHS Secretary's Central Office; this gives the Field Services roles with the DOE-AHS Interagency Agreement, Act 264 SIT and LITs, and Youth in Transition planning added influence. Scott Johnson is the Deputy Secretary of the AHS Field Services Division *[see his biographical sketch in Section G]*, the co-director (with a family member) of the 360 Family Support Grant, and a former member of the board of the Federation of Families for Children's Mental Health. Because of the scope of the Field Services Division activities on behalf of AHS, Scott and the 12 District Field Services Directors have very close relationships with a wide variety of public and private service providers, as demonstrated by the many letters of support *(in Appendix 1 and Appendix 5)* for this grant proposal. Scott will serve as the required State-Local Liaison.

Provide a complete list of staff positions for the project.

Charlie Biss will donate his time as Principal Investigator for the project. Scott Johnson and all other current State and community SIT, LIT or other partners will donate their time, too. Charlie, Scott, and their partners (individually and collectively) have many years of experience delivering services – and creating policies to better serve – youth with SED and their families.

The federal funds for this grant will be used by DMH to hire one FTE Project Director *[see job description in Section G]* and to sub-grant out the rest of the statewide and regional services needed for implementation, evaluation, and technical assistance. The sub-grants will go to:

- The Vermont Child Health Improvement Project (VCHIP) for evaluation: 2 FTEs *[see Section G for biographical sketch for Dr. Thomas Delaney and the job description for a Research Analyst still to be assigned or hired for the work]* plus graduate student(s) for interviewing and support staff for data entry.
- The Vermont Federation of Families for Children's Mental Health for the family liaison and youth coordinator positions: 1 FTE family liaison, with .5 FTE to be donated by the Federation *[see Section G for biographical sketch for Cindy Marshall, currently part-time Assistant Director for the Federation; she will work full-time if this grant is funded]* and 1 FTE youth coordinator to be hired *[see Section G for the job description]*
- HowardCenter for the cultural and linquistic competency coordinator: .5 FTE *[see Section G for the job description]*

- Not yet determined: RFPs will be created to seek organizations willing to provide the training and technical assistant coordinator (.5 FTE) and/or the social marketing-communications manager (.5 FTE) *[see Section G for these job descriptions]*.
- Fiscal agents (perhaps the CMHCs but not necessarily) chosen for each of the 12 regions to pay for Evidence-Based Practices built on the foundation of the Jump on Board for Success (JOBS) program and integrated with other community-based services: approximately 14.42 FTE clinical positions. The jobs will be described by the regions during their strategic planning.

The main function of the regional positions will be to serve transition-aged youth (16-21) with SED and their families. The main functions of the statewide positions will be to advise and support regional staff, administrators, and community partners in their development of this enhanced system of care and delivery of service, and to prepare for sustainability of the project. The sub-grantees have been or will be chosen based upon their experience functioning in similar ways with the same or similar populations. VCHIP's prior experience is described below in Section D; the Federation's prior experience is described above in Section B under Family-Driven Care; the HowardCenter's prior experience is described above in Section B under Cultural and Linguistic Competence.

Describe the resources available for the proposed project.

The Project Director will be part of the CAFU in DMH and have use of all DMH facilities: space, desk, phone, computer, copying machines, parking, etc. DMH is co-located with the VDH in downtown Burlington in a relatively new State office building that is on a main bus route, across the street from the U.S. Post Office, beside a big shopping mall, and a couple of blocks from a VCRHYP shelter. It is easily accessible and compliant with the American with Disabilities Act. The Federation has an adequate and handicapped-accessible office; a youth Board member who uses a wheelchair and an adult Board member who relies on a cane are both able to attend the Board meetings. All the CMHCs (including the HowardCenter) also have easily accessible, ADA-compliant offices, though much of their work is done on an outreach basis in communities. The SIT "Invitation to Communities" will instruct the LITs to plan for delivery of their chosen services in adequate, accessible, ADA-compliant locations that will appeal to transition-aged youth with SED and their families.

<u>*Section D: Evaluation Plan*</u>

Describe the evaluation activities and procedures.

Overview of the Vermont CMHI evaluation

The Vermont Department of Mental Health has selected the Vermont Child Health Improvement Program (VCHIP) to conduct the evaluation of the Vermont CMHI project. Founded in 1999, VCHIP is a research and quality improvement organization based in the Department of Pediatrics of the UVM College of Medicine. VCHIP has a track record of successful evaluations of large scale (including statewide) projects targeting mental health and healthcare services for children and youth. These evaluations have involved coordinating activities with a wide range of partner organizations including government agencies, providers of direct mental health and healthcare services for children, hospitals, insurance carriers, and local and statewide child-serving agencies. VCHIP has considerable resources relating to the collection, analysis and reporting of quantitative and qualitative data, including three fulltime equivalent PhD and masters level data analysts, an experienced data support staff, and the

support of research and clinical faculty drawn from a broad array of disciplines represented at the University of Vermont. VCHIP will obtain University of Vermont Institutional Review Board (IRB) approval for all Vermont CMHI evaluation activities.

VCHIP will develop an evaluation of the Vermont CMHI project that is comprehensive and rigorous, has multiple levels of analysis, and assesses the impact of project activities across both local and statewide systems. VCHIP will coordinate its evaluation activities closely with the Vermont CMHI project, SAMHSA personnel, and the national evaluation contractor. The VCHIP evaluation activities will fully comply with the SAMHSA requirements for the national evaluation, the national outcome measures (NOMs), and Government Performance and Results Act (GPRA) data collection and reporting. VCHIP will also work with the Vermont AHS and the State Interagency Team (SIT) to develop a state-level evaluation that will be valuable in assessing the implementation of the Vermont CMHI project and that will also be used to guide continuous quality improvement.

The VCHIP evaluation will demonstrate a high level of cultural competence. This will be accomplished by forming an Evaluation Committee to get input on the initial evaluation design from families, youth, cultural consultants, and service providers, also by ongoing collaboration with the Vermont CMHI project staff (including the CMHI Lead Family Contact, Youth Coordinator, and Cultural and Linguistic Competency Coordinator) to ensure that all data collection instruments and reporting systems meet the standards for cultural competence that the project adopts and that they continue to be appropriate for the population being served.. The data collection instruments proposed for the Vermont-specific evaluation have been used in a wide variety of studies that occurred in different cultural settings; VCHIP anticipates they will be effective tools for assessing the functioning/outcomes for VT youth with SED and caregivers.

VCHIP plans to have the clinicians describe the purpose of the evaluation to transition-aged youth enrolling in services and their caregivers. The clinicians will obtain the necessary signatures from the youth and caregivers on the assent and consent forms *[see Appendix 4]* for participating in the VCHIP evaluation. VCHIP staff will then contact youth and caregivers who have signed the forms and arrange to conduct the evaluation interviews either in person or by telephone. All youth and caregivers will be offered a $20.00 cash incentive each time they are asked to participate in an interview.

Collecting and reporting data for the CMHS National Outcome Measures (NOMs)

Vermont is committed to collecting the NOMS data through using TRAC as specified in the CMHI RFA. The VCHIP evaluation team will receive training on how to collect and report data for the CMHS NOMs and then work with the SIT and the LITs to develop a system by which this data will be collected. The resulting system will support the collection and transmission of data obtained using the CMHS NOMS Child Consumer Outcome Measures for Discretionary Programs: Child and Adolescent Respondent Version to the TRAC system. The NOMS data will be collected at three month intervals for all youth receiving services through the Vermont CMHI project, up until the time a youth is clinically discharged from the service he or she is receiving. NOMs data will be collected primarily by the Vermont CMHI clinicians, transmitted to VCHIP, and then entered by VCHIP staff into the TRAC system within seven days of having been collected.

VCHIP anticipates that data collected for the CMHS NOMs will be valuable additions to the VCHIP evaluation and quality improvement work with the Vermont CMHI project, and will provide a window into how youth with SED are progressing in the domains of: Functioning, Stability in housing, Employment and education, Crime and criminal justice status, Perception of

care, Social connectedness. These and the NOMs that measure Access/capacity, Retention, Cost effectiveness, and Use of evidence-based practices closely align with the goal for the Vermont CMHI project, and in combination with other measures will be the basis for assessing the overall impact of the project on youth, their caregivers, and on the enhanced system of care.

Collecting and reporting of GPRA measures

The Vermont evaluation will collect GPRA measures as specified by the CMHI. VCHIP will work with the SIT, LITs, the national evaluator, and SAMHSA personnel to develop a data collection and reporting system for the GPRA required measures.

Participating in the required National Evaluation:

VCHIP will participate in and support all components of the National Evaluation. The data collection and reporting system that VCHIP develops will include data collected from youth receiving services and their families, child-serving clinicians, LIT and SIT personnel, multiple child-serving agencies and project directors. VCHIP anticipates that this system will build upon existing data collection and reporting systems that it has developed in support of other evaluation and quality improvement work, such as:

- the Vermont Youth Health Improvement Initiative, which established a system for obtaining and summarizing administrative data from a variety of mental health and healthcare agencies, including approximately 60 primary care practices that serve youth;
- the Vermont Preventive Services Initiative, which established protocols for data collection from all pediatrics practices in Vermont);
- the Children's Metal Health Project, which established a statewide network for the collection, submission and processing of data from the Achenbach System for Empirically Based Assessment (ASEBA, used by healthcare and educational institutions throughout the state (The ASEBA measures a broad range of behaviors and generates DSM-IV based symptom profiles.)); and
- the Vermont Blueprint for Health chronic illness care project, which collects questionnaire, interview and healthcare information in child-serving agencies, medical practices and hospital settings in more than one half of Vermont.

Developing and implementing the Vermont-specific CMHI evaluation

In addition to participating in the NOMs, GPRA, and required National Evaluation activities, VCHIP is developing a state-specific evaluation to assess the impact of changes in the system of care on key process and outcome measures. We anticipate that this component of the evaluation will be important for ensuring both that the Vermont CMHI is an effective project in how it supports youth with SED and their families as well as for sustaining the project beyond the period funded by the SAMHSA grant.

Vermont CMHI process measures

VCHIP will monitor and report on key process measures that reflect the degree of success of the Vermont CMHI project interventions. The measures will be derived from a mix of interviews with clinical providers, Vermont CMHI project staff, SIT and LIT members, and youth with SED and their families. In addition, CMHI clinicians and LITs will collect tracking measures. VCHIP will access available administrative databases in order to assess progress towards the Vermont CMHI goal. All these measures will enable the VCHIP evaluation team to answer the questions suggested in the RFA regarding the effectiveness of the implementation of the Vermont CMHI interventions.

VCHIP will use the data collected to gauge progress towards the project goal, for writing progress reports and also as a means to guide project activities by communicating VCHIP's

findings with the statewide and local AHS area project leadership on at least a quarterly basis (see *Using evaluation data for Quality Improvement* section below.)

Monitoring and reporting outcomes measures for persons receiving services

The key outcome measures that VCHIP will use as indicators of whether the Vermont CMHI is achieving its goal will be collected through a combination of mechanisms and will supplement the required GPRA, NOMs and National Evaluation measures. These measures (some of which may be required by the National Evaluation) are detailed in Appendix 3: Data Collection Procedures and Instruments. Based on prior evaluation and research projects conducted by VCHIP and its partner agencies, the state-level evaluation will use 3 assessment tools: 1) the Youth Self Report (YSR, or depending on age, the Adult Self Report (ASR)) component of the ASEBA, 2) the Young Adult Health Care Survey (YAHCS) and 3) the Stress Index for Parents of Adolescents (SIPA). Both the YSR and YAHCS tools have been used in recent Vermont projects and have proved invaluable in understanding changes in youth's functioning across multiple domains (the YSR) and experiences within the healthcare system (the YAHCS) - important indicators of whether the project goal is being met. In addition, we have identified the SIPA as a reliable and validated tool to assess the extent to which project interventions are associated with changes in parents' or caregivers' perceptions of their relationships with the youth receiving services through the Vermont CMHI. In total the NOMs, GPRA and Vermont-specific measures will allow for answering four key assessment questions:

- What was the effect of the Vermont CMHI interventions on participants?
- What program/contextual factors were associated with youth/family/system outcomes?
- What individual factors were associated with outcomes?
- How durable were the effects, both for youth/family and system level change?

The evaluation data that will be collected will reflect the several types of data that are crucial for understanding the effects of the Vermont CMHI, including:

- Number and proportion of youth with SED who are employed,
- Number and proportion of youth with SED who are free from incarceration,
- Number and proportion of youth who are in school or have graduated,
- Number and proportion of youth with access to, and utilization of healthcare,
- Number and proportion on youth accessing mental health services, and
- Number and proportion of youth with stable housing situations.

Using evaluation data for Quality Improvement (QI)

Collecting data for the national (cross site) evaluation (including GPRA), the NOMs, and the Vermont specific evaluation will allow VCHIP significant opportunities to track the effectiveness of the SAMHSA-funded work in Vermont, both in terms of outcomes data and monitoring the implementation of the project interventions. In order to facilitate the use of these data for quality improvement during the project, VCHIP will conduct monthly reviews of progress towards the grant goal using all available data, develop recommendations for improving the implementation of project activities, and then provide these data and recommendations to the SIT and LITs on at least a quarterly basis. This feedback will be provided whenever possible in face-to-face meetings. Brief (less than two page) written summaries will also be distributed by mail and electronically, depending on the availability and preference of the teams. Thus, the Vermont DMH, SIT and LITs will receive timely, important feedback that can be used to guide the implementation of project interventions in order to better serve transition-aged youth participating in grant funded activities.

SUPPORTING DOCUMENTATION

Section E: Literature Citations

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Section F: Budget Detail

Expenses	**FFYear 1 - 09**	**FFYear 2 – 10**	**FFYear 3 - 11**	**FFYear 4 - 12**	**FFYear 5 - 13**	**FFYear 6 - 14**
Personnel:						
Project Director:1 FTE *Salary (State pay-grade 24) + fringe (38%)*	(3/4 year) $48,352	$66,403	$68,395	$70,447	$72,560	$74,737
Travel for Principal Investigator and/or Project Director: 2 required CMHS trips per year, 3 visits to each DA per year, and 2 X week trips between DMH and AHS	(3/4 year) $6,412	$8,550	$8,550	$8,550	$8,550	$8,550
Contractual:						
VCHIP: 2 FTE Evaluators, data entry, materials, participant incentives, and expenses, including 2/yr CMHS trips	(3/4 year) $150,000 (3/4 of 20% of federal funds as allowed)	$300,000 (20% of federal funds as allowed)	$400,000 (20% of federal funds as allowed)	$400,000 (20% of federal funds as allowed)	$300,000 (20% of federal funds as allowed)	$200,000 (20% of federal funds as allowed)
VT Federation of Families for Children's	(3/4 year) $78,633	$104,844	$104,844	$104,844	$104,844	$104,844

Mental Health: .5 FTE for Family Liaison, *with other .5 FTE donated*; also 1 FTE Youth Coordinator, with operating expenses and mileage, including 2 required CMHS trips per year for each person						
HowardCenter: .5 FTE Cultural and Linguistic Coordinator, with operating expenses and mileage, including 2/yr CMHS t rips	(3/4 year) $30,109	$40,145	$40,145	$40,145	$40,145	$40,145
Bid for Training and Technical Assistance: .5 FTE Coordinator plus materials, event costs, and expenses incl.	(1/4 year) $28,245	$112,980	$112,980	$112,980	$112,980	$105,852

2/yr CMHS trip						
Bid for Social Marketing: Estimated cost of $80 per hour plus materials and expenses, including 2/yr CMHS trips	(1/4 year) $12,500	$50,000	$50,000	$50,000	$50,000	$50,000
Regional Services – 12 regions ($865,000 average per 5.25 years of service)	$595,749: $120,000 ($10,000 for each region) for planning and accommodations like translations and interpreters; rest for services	$742,078	$1,115,086	$1,113,034	$735,921	$365,872
Subtotal of Contractual	$895,236	$1,350,047	$1,823,055	$1,821,003	$1,343,890	$866,713
Sub-total of Direct Costs	$950,000	$1,425,000	$1,900,000	$1,900,000	$1,425,000	$950,000
Indirect (5% unallocated infrastructure) Costs	*$50,000*	*$75,000*	*$100,000*	*$100,000*	*$75,0000*	*$50,000*
Total Federal	**$1,000,000**	**$1,500,000**	**$2,000,000**	**$2,000,000**	**$1,500,000**	**$1,000,000**
System of Care Match (See Appendix 5)	*$1,942,726*	*$2,437,809*	*$2,893,851*	*$2,945,390*	*$3,000,000*	*$3,853,068*
Required Match	$333,333	$500,000	$666,667	$2,000,000	$3,000,000	$2,000,000

Funding Formula for Regional Services through LITs

	Estimated 2006 Population	**A.** Percentage of Population	**B.** Basic Operating Allowance (1/12)	Percentage Distribution Regional $	Dollars Per 5.25 Years of Regional Services at Average $865,000*
AHS Districts	Aged 16-21	Aged 16-21		**(A + B)/(C + D)**	
Barre	5,541	10.2261%	8.3333%	9.2797%	$80,269.40
Bennington	2,959	5.4609%	8.3333%	6.8971%	$59,659.92
Brattleboro	2,795	5.1583%	8.3333%	6.7458%	$58,351.17
Burlington	15,107	27.8804%	8.3333%	18.1069%	$156,624.68
Hartford	3,946	7.2825%	8.3333%	7.8079%	$67,538.34
Middlebury	4,100	7.5666%	8.3333%	7.9500%	$68,767.50
Morrisville	2,635	4.8630%	8.3333%	6.5982%	$57,074.43
Newport	2,226	4.1081%	8.3333%	6.2207%	$53,809.06
Rutland	5,296	9.7739%	8.3333%	9.0536%	$78,313.64
Springfield	2,442	4.5068%	8.3333%	6.4201%	$55,533.86
St. Albans	4,236	7.8177%	8.3333%	8.0755%	$69,853.08
St. Johnsbury	2,902	5.3557%	8.3333%	6.8445%	$59,204.92
Total	54,185	**C.** 100%	**D.** 99.9996%	100%	$865,000

*At $5,000 per youth, 173 youth to be served per each of 5.25 years, for 908 total. At an estimated DA cost of $60,000 per 1 FTE clinician, this budget "buys" 14.42 FTEs, each with a caseload of 12 youth, all estimated to stay in program for 1 year.

Section G: Biographical Sketches and Job Descriptions

Principal Investigator - *CHARLES A. BISS*

86 Mayapple Lane
Middlebury, VT 05753
(802) 388-3508(home)
(802) 652- 2009 (work)

VT Department Mental Health
P.O. Box 70 108 Cherry Street
Burlington, Vermont 05402-0070
email: cbiss@vdh.state.vt.us

EMPLOYMENT HISTORY

1987 – Present, with Vermont Department of Mental Health, Burlington, VT

1993 – Present: Child, Adolescent and Family Unit Director; directs statewide system of Mental Health Care for children and their families

- Serves 10,000 children a year
- Manages a budget of $60 million per year
- Directs a workforce of 800 FTE's employed by 11 designated non-profit provider agencies
- Develops, implements and sustains several grants, both federal and private
  -Robert Wood Johnson
  -2 Federal Community Mental Health Services Comprehensive Grants-Children's Upstream Services, CUPS, and Access
  -3 Respite Grants
- Develops new services using existing state dollars in creative ways
  →Success Beyond Six, School Based Mental Health Services,
  →Individualized Service Budgets (ISB) development Individualized Wraparound Plans,
  →Hospital Diversion Services -Community-Based Intensive Services
  →JOBS Program -Transition Program
  →Crisis Response Services -Access
  →Consult Services to Children 0-6 -Children's Upstream Services (CUPS)
  →Pediatric Collaborative -Pediatric-Based Mental Health Services
  →Child Psychiatric Consult Service
- Works collaboratively with all child-serving and youth and adult-serving systems in Vermont.

1987 – 1993: Regionalization Project Director; directed a Robert Wood Johnson Grant to create community-based services for adults with serious mental illness. Grant was a bridge fund to transfer dollars from state hospital ward closings to community-based services. In 6 years, census at the Vermont State Hospital (VSH) went from 200 to 60 and in excess of 6^+ million dollars was transferred to community services from the hospital. The project was guided by consumers, families, providers and other interested stakeholders.

Other Employment/Consultation

1996 – Present Southern New Hampshire University, Manchester, N.H. – Instructor for the Program in Community Mental Health

1995 – Present Technical Assistance Consultant with Georgetown Child Development Clinic, Washington DC. Co-authored chapter of the book *Social and Emotional Health in Early Childhood, 2007*
1996 – 2005 Technical Assistance Consultant with the National Federation of Families for Children's Mental Health, Alexandria, Virginia. Co-authored *Learning From Colleagues: Family/Professional Partnerships Moving Forward Together, 1999*
1999 – 2004 Peer Mentor Technical Assistance Partnership, Washington DC
1982- Present Consulted with and presented to, many groups and organizations regarding

- Community-based services that work for consumers (Children and Adult)
- Family and consumer partnerships with providers (Children and Adult)
- Funding opportunities as result of partnership with other child serving agencies
- Mental health services for children (0-6) and their families.

1980-1987: Howard Center for Human Services, Burlington, VT; Director of Mental Health Residential and Acute Care Program. Planned, developed and implemented a comprehensive Community Support Program for persons with serious mental illness. Program included housing, assertive community outreach, community emergency beds and substance abuse detox, community group homes, and club house/supported employment
1982-1987: Developed and implemented the 20-week family education course for Families of the Mentally Ill. These courses led to the founding of National Alliance for the Mentally Ill, VT.
1979-1980: Baird Center for Children and Families, Burlington, VT; Social Worker for Life Skills Program. Upon closing the Juvenile Detention Facility (Weeks School), this group home was developed to serve the children with severe emotional disturbance.
1977-1979: Parsons Child and Family Center, Albany, NY; Social Worker for Institutional Care Prevention Project. Worked with Juvenile Court and Child Welfare to provide community-based services to children and their families at imminent risk of being removed from home/community.
1973-1975: St John's Home for Boys, Rockaway, NY; Apartment Supervisor-12 juv. offenders

EDUCATION

- Certified Social Worker, License #107, State of Vermont, 1987
- Master of Social Work, State University of New York at Albany, 1977
- Bachelor of Science, English, State University of New York at Oneonta, 1973

CIVIC INVOLVEMENT

2000 - 2004	Kids on the Block, VT – Chair of the Board of Directors
1993 – 1999	Burlington Parks and Recreation – Youth Soccer, Baseball, Basketball Coach
1985 – 1993	Vermont Association of Mental Health – Board Member
1981 – 1993	Committee on Temporary Shelter – Founding Board Member

HONORS AND AWARDS

1996 & 1997	Finisher – New York City Marathon and Vermont City Marathon
1992	The First Vermont Family Service Award, Alliance for the Mentally Ill of Vermont: For pioneering efforts in family education…and more….

State –Local Liaison

Scott Johnson, 245 Maxfield Road, Waterville, Vermont 05492. (802) 644-5683
scott.johnson@ahs.state.vt.us

EDUCATION

M.S. Counseling, University of Vermont, 1990.
B.S. Education, Central Connecticut State College, 1975.

EMPLOYMENT

2005 – present	**AHS Field Services Deputy Commissioner**	Agency of Human Services Waterbury, VT
2004 – 2005	**AHS Field Director**	Agency of Human Services Morrisville District Office
1998 – 2004	**Statewide Coordinator**	VT Regional Partnerships
1994 – 2004	**Regional Coordinator**	People in Partnership Morrisville, VT.
1986 - 1993	**Executive Director**	Laraway School, Inc. Johnson, VT.
1984 - 1986	**Landscaper/Designer/Builder**	Earthscapes Underhill, Vermont
1979 - 1984	**Executive Director/Principal**	Laraway School, Inc.
1975 - 1979	**Assistant Director, Teacher**	

BOARD AFFILIATIONS AND VOLUNTEER PROGRAMS

State Team for Children, Families and Individuals. Interagency team represented by Vermont State agency and department personnel, and community partners to oversee coordination of policy, resources, supports and services to improve the well being of Vermont's children and families. 1994 - present. Co-chair 2003 – 2005.

Vermont Federation of Families for Children's Mental Health. Statewide parent advocacy organization promoting coordinated service systems to support children and youth with a severe emotional disturbance and their families. 1995 - 2005.

United Way of Lamoille County. Member of Board of Directors responsible for county fundraising campaign to support non-profit human service agencies.
1993 - 2001, Chairman 1999 – 2001, Allocations Committee 1998 - 2001.

Vermont Association of Mental Health. Advocacy organization to promote policy and legislation supportive of individuals that are challenged by mental health issues.
Runs Camp Daybreak summer program for children. 1993 - 1999.

Vermont Advisory Board for Children and Youth with Special Mental Health Needs (Act 264 Advisory Board). Governor appointed board to oversee the Vermont "System of Care" for children and youth with a severe emotional disturbance and their families. 1989 - 1999, Chairman 1991 - 1993.

Lamoille Court Diversion. Statewide program for first offenders to enter community restitution program. 1979 - 1993 Community Review Board, 1983 - 1993 Advisory Board, Chairman of Advisory Board 1987 - 1991.

CMHI Program Director Job Description

Definition: Policy and program development and coordination work at a professional level for the Department of Mental Health involving development and implementation of community-based mental health programs for youth in transition. Duties include implementation of Department grants and sub-grants. Significant interaction and coordination is required with other state agencies, federal officials, service providers, and local school districts. Work is performed under the direction of the Department's Child, Adolescent and Family Unit Director.

Examples of Work: Assists in the development, implementation, coordination, monitoring and promotion of community-based mental health programs for youth in transition. Collaborates with local service providers, other Department staff, and other state agencies to solve program problems and enhance services. Participates in the development of policies and procedures for coordinated services. Coordinates use of data from operational and financial reports, site visits, client tracking, and other program review and monitoring activities for program evaluation and management purposes. Negotiates and administers contracts and grant agreements with providers of services and/or technical assistance (including for family and youth involvement, evaluation, T/TA, cultural and linguistic competence, and social marketing-communications). Provides consultation to grantees and communities in the development of local plans for mental health services to youth in transition. Identifies opportunities for resource development; writes grant proposals, monitors funding, and ensures compliance with guidelines. Meets with funding agencies to review project status, accomplishments, and expenditures.

Environmental Factors: Duties are performed primarily in a standard office setting. Frequent travel to attend provider and public meetings requires that private means of transportation be available and may entail some work outside of normal office hours. Interactions with public and private service providers, youth and families may involve conflict and strong feelings.

Minimum Qualifications:
Knowledge, Skills and Abilities:
- Considerable knowledge of the principles and practices of public administration
- Considerable knowledge of program planning principles and practices
- Considerable knowledge of emotional and mental disturbances among youth in transition and of their treatment
- Working knowledge of the principles and practices of grant writing and implementation
- Ability to collect and analyze data, evaluate program performance, identify strengths and problem areas, and recommend viable changes
- Ability to communicate effectively, both orally and in writing
- Ability to establish and maintain effective working relationships among a variety of agencies and publics, including family and youth groups

Education: Bachelor's degree, preferably in a human services field
Experience: Four years at a professional level in a program dealing with children and adolescents with serious emotional disturbance, including at least two years in an administrative, planning and evaluation, or program development role.
Note: Graduate work in a human services field or in special education may be substituted for the two years of general experience on a semester for six months basis.

Lead Family Contact: Cynthia A. Marshall
260 Codling Road
East Montpelier, VT 05651
802-223-0496

Work Experience

Assistant Director – July 2006 – Currently part-time
VT Federation of Families for Children's Mental Health, PO Box 507, Waterbury, VT

- Assist the Executive Director in all aspects of running a family support nonprofit organization
- Participate in and facilitate training activities, legislative awareness and education events, and other public speaking opportunities.
- Assist in contract/grant oversight and monitoring
- Oversee program implementation which includes monitoring all data collection and program evaluation.
- Participate in program and training development for staff which includes orientation, supervision, and evaluation of staff

Executive Director / Office Manager – June 1, 2005 to June 30, 2006
ARC of Vermont, 27 Granite Street #1, Barre, VT 05641

- Administered all aspects of a nonprofit agency, oversaw funding and fundraising
- Supervised employees and volunteers
- Provided testimony and information to policy makers
- Provided public outreach and education (included preparing a quarterly membership publication)
- Coordinated communication between state departments, agencies, and families
- Supported individuals and families in crisis including advocacy, research, and information and referrals

Administrative Assistant – March 2003 to May 2005
Court Administrator's Office, Vermont Judiciary, 109 State Street, Montpelier, VT 05602

- Organized and facilitated all Employee Educational workshops/conferences
- Created and maintained all budget tallying for the Employee Education Division
- Provided various administrative support services for the Employee Education Division

Education

Vermont Community College, Morrisville, VT
1996 – Business and Professional Writing

Holyoke Community College, Holyoke, MA
1988 – 1990 3 semesters Business Administration

Ludlow High School, Ludlow, MA
1984 – 1988

Vermont Federation of Families for Children's Mental Health
Youth Coordinator *(1 FTE)*
Job Description

Supervisor:
VFF Executive Director/ Assistant Director

Purpose:
The Youth Coordinator will assist the Executive Director in these activities: oversight, monitoring, evaluation, and administration of VFF youth program and public relations. The Youth Coordinator will also perform related duties as requested by the Executive Director.

Skills, Knowledge, and Experience
- Have experience as a member, recent member or family member associated with the target population of youth aged 16-21 with Severe Emotional Disturbance(SED)
- Leadership skills
- Strong oral and written communication skills
- Competence in working as a team member
- Ability to facilitate meetings
- Ability to provide phone support to families and youth
- Computer skills

Activities/Responsibilities

Advocacy/outreach:
- Participate in training activities, legislative awareness and education events, VFF and other public speaking opportunities as requested by VFF Executive Director
- Organize youth engagement activities
- Support youth to participate on decision making boards

Grants and Contracts:
- Submit documentation and reports for contract and grant oversight and monitoring

Human Resources:
- Participate in the interview and hiring process for all new youth program staff.
- Assist in ensuring all youth program staff have an up to date personnel file
- Develop a plan of orientation and training for all new youth program staff
- Assist in providing ongoing supervision and support to all youth program staff according to VFF policies, procedures and program manuals. Document all supervision interactions with tasks to be achieved, outcomes and personal development needs.
- Assist in completing annual evaluation of all VFF youth program staff

Programs: In partnership with VFF Executive Director:
- Develop annual program plan with action steps for implementing VFF youth programs as they are related to the overall strategic plan of VFF.
- Oversee and monitor progress of VFF Youth Programs Plan.
- Write and submit to VFF Executive Director quarterly reports outlining achievement of goals and deliverables within the VFF Youth Program Plan.
- Maintain multiculturalism values and principles within the VFF environment and in delivery of services and activities.
- Provide ongoing training and technical assistance to youth staff and volunteers.

Evaluation/Quality Assurance:
- Provide oversight and monitoring of all youth program data collection and evaluation
- Submit quarterly quality assurance reports to Executive Director

Cultural and Linguistic Competence Coordinator

Definition: This position is responsible for producing and implementing – with broad, ongoing input from key stakeholders – a plan for cultural and linguistic competence for the CMHI project. The plan must "ensure that all of the services and strategies of the CMHI project are designed and implemented within the cultural and linguistic context of the youth and families to be served."[139] The plan will reflect the guidance of the national project and technical assistance staff and will be final only after approval by the State Outreach Team.

Major Duties: Assist the CMHI leadership with "infusing cultural and linguistic competence throughout the system of care"[140] in accordance with the plan when participating in the SIT State Outreach Team and the Chittenden County LIT. Deliver and /or arrange for delivery of related training and technical assistance statewide and in Chittenden County, linked with JJDP TA. He/she is responsible for operating within the budget for cultural and linguistic competence.

Environmental Factors:
Work will be performed in standard office settings and at frequent meetings throughout Vermont, some beyond normal office hours. Meetings may involve the expression of strong feelings and conflicting opinions. The Coordinator must have private transportation available.

Knowledge, Skills and Abilities:
- Ability to be respectful and to listen carefully
- Ability to express self clearly orally and in writing
- Ability to use standard office equipment including word-processing and email
- Ability to establish objectives and design strategies for achieving them
- Skills in collaboration and teamwork
- Knowledge of diverse populations and cultures (including one or more of the following: youth, people living in poverty, people who are gay or lesbian or transgendered, people who are deaf or hard-of-hearing, people who are blind, people who are learning impaired, refugees, immigrants, etc.)
- Knowledge of principles for effective planning and/or organizational development
- Knowledge of state and regional resources for improving the access of people with disabilities and/or Limited English Proficiency to the existing service systems and informal community supports

Minimum Qualifications:
Education: Bachelor's degree, preferably in human services or education
Experience: Four years experience serving vulnerable populations including at least two years experience with planning and/or organizational development for those populations
Note: Graduate work in human services, education, or organizational development may be substituted for the two years of general experience on a semester for six months basis.
Preference will be given to applicants who are bi- or multi-lingual and/or bi- or multi-cultural.

[139] Technical Assistance Partnership for Child and Family Mental Health. (2008). Sample Cultural and Linguistic Competence Plan for Advancing Cultural and Linguistic Competence in Systems of Care. Retrieved1/28/2008 from http://www.tapartnership.org/cc/CLC_Plan_Template_FINAL.pdf
[140] Ibid.

Evaluator
CURRICULUM VITAE

Name: Thomas V. Delaney
Address: 40 Village Green, Burlington, VT 05408
Date of Birth: May 28, 1971
Place of Birth: Montclair, NJ

Education:

1995	B.A. Rutgers Newark College of Arts and Sciences, Newark, NJ
1999	M.A. University of Denver, Denver, CO
2004	Ph.D. University of Denver, Denver CO

Awards and Honors:

2001	Elected to Sigma Xi, the National Science Honor Society
2000	Lawrence Miller Graduate Research Fellowship ($1200)
1996-2000	Colorado Graduate Fellowship ($20,000)
1999	Graduate Students of the Three Faculties Research Award ($400)
1994-1995	President, Rutgers Chapter of Psi Chi (Psychology Honor Society)
1993-1995	College Honors Program, Rutgers Newark College of Arts & Science
1994	Dean's Campus Service Award
1993	Elected to Psi Chi, the National Honor Society in Psychology

Memberships in Professional Societies:

1995-2002	American Psychological Society
2006-	American Public Health Association

Grant/Contract Support:

2007	"Educational Interventions for Preventing Head Injuries in Winter Sports (continuation funding)," -- The Vermont Health Foundation, **Lead Grant Writer** ($10,000)
2007	"Educational Interventions for Preventing Head Injuries in Winter Sports," -- The Vermont Health Foundation, **Lead Grant Writer** ($19,000)
2006	"Improving Mental Health in Primary Care Project." – The American Academy of Child and Adolescent Psychiatry, **Grant Co-writer** ($25,000)

Publications in Peer Review Journals

1. Miller S, *Delaney T,* Tallal P. Speech and other central auditory processes: Insights from cognitive neuroscience. *Current Opinion in Neurobiology* 1995: 198-204.

2. Bishop D, Bishop S, Bright P, James C, *Delaney T,* Tallal P. Different origin of auditory and phonological processing problems in children with language impairment: Evidence from a twin study. *Journal of Speech, Language, & Hearing Research* 1998; 42: 155-168.

3. Shaw J, Wasserman R, Barry S, *Delaney T,* Duncan P, Davis W, Berry P. Statewide quality improvement outreach improves preventive services for young children. *Pediatrics* 2006; 118: e1039-e1047.

4. Frankowski B, Keating K, Rexroad A, *Delaney T*, McEwing S, Wasko N, Lynn S, Shaw J. The Community Collaboration Model - bringing it all together: Communicating the plan, empowering to educate. *Journal of School Nursing* 2006; 76: 303-306.

5. Mercier C, Barry S, Paul K, *Delaney T*, Horbar J, Wasserman R, Berry P, Shaw J. Improving newborn preventive services at the birth hospitalization: a collaborative hospital-based quality improvement project. *Pediatrics* 2007; 120: 481-488.

6. Williams R, *Delaney T*, Heath B, Nelson E, Gratton J, Laurent J. Speeds associated with skiing and snowboarding. *Wilderness and Environmental Medicine* 2007; 18: 102–105.

Recent Presentations at National and International Meetings (2006-2007)

1. Duncan P, Kallock E, Frankowski B, Carey P, Philibert D, *Delaney T*, Shaw J. Will primary care providers incorporate a strengths assessment into well-child care for the 11 -18 year old? (Presented at the Pediatric Academic Societies meeting, San Francisco, May 2006)

2. Duncan P, Frankowski B, Carey P, *Delaney T*, Barry S, Philibert D, Kallock E, Shaw J. A modified quality improvement initiative for youth risk behavior screening (Presented at the Pediatric Academic Societies meeting, San Francisco, May 2006)

3. Brakeley J, Greenblatt J, Delaney T, Kallock E, Davis W, & Shaw J. Improving Pediatric Primary Care for Children with Symptoms of ADHD. (Presented at the American Academy of Pediatrics Division 21 Conference: Connecting for Children's Sake, Washington, D.C., October 2006)

4. *Delaney T*, Williams R. Injury Prevention and Preparedness among Backcountry Skiers & Snowboarders in a Northeastern State. (Presented at the American Public Health Association meeting, Boston, November 2006)

5. Nelson E, Keating K, *Delaney T*, McEwing S, Hunt E, Munene E, Shaw J. Risky Behaviors in Teenage Motor Vehicle Occupants. (Presented at the Pediatric Academic Societies meeting, San Francisco, May 2007)

6. Frankowski B, Duncan P, Kallock E, *Delaney T*, Philibert D, Shaw J. Implementing a communication and tracking system for the health needs of children entering state custody. (Presented at the Pediatric Academic Societies meeting, San Francisco, May 2007)

7. Nelson E, Hunt E, Keating K, *Delaney T*, McEwing S, Jewiss J, Munene E, Shaw J. How Are Primary Care Clinicians Addressing Teen Risky Driving? (Presented at the American Academy of Pediatrics National Conference and Exhibition, Washington D.C., October, 2007)

...and more......

Evaluator Position (2nd FTE)

BASIC FUNCTION: The Research Analyst will direct community, agency and statewide research and data collection activities for a large statewide project to include developing research plans and protocols, designing quantitative and qualitative data collection instruments, implementing summative and process evaluation procedures, data analysis, presenting results and co-authoring reports, grants, and manuscripts.

ESSENTIAL FUNCTIONS:

Develop research strategies, protocols, and evaluation plans for a large, federally funded mental health services project; develop summative, process, and outcomes evaluation plans based on available data from primary (survey, interviews, validated data collection instruments) and secondary sources (state & national data sets); design both qualitative and quantitative instruments to support data collection activities of the project; provide consultation on instrument design during project conception and implementation phases; evaluate project progress and results.

Provide consultation on quality improvement (QI) methods and strategies in the context of the federally funded evaluation work; make recommendations on appropriate QI methods for specific project interventions/circumstances; review local and state level reports and continually assess progress and needs; recommend interventions to achieve goals; and work with project participants and staff in a variety of professional, government agency and local clinical provider settings.

Conduct complex analyses and interpret research data; recommend sampling strategies for a variety of data collection methods; oversee all data safety and monitoring activities for the IRB-approved evaluation; develop protocols and amendments related to data collection instruments and methods; ensure integrity of all data collected; pilot test data collection instruments; conduct validity and reliability testing of instruments; oversee data entry and cleaning; design analysis plans and analyze data using specialized software; develop presentations of results (tables, graphs, narrative descriptions of results); maintain knowledge of relevant biostatistical tools and techniques. Present results of data analysis and monitoring activities to staff, state and federal officials and contractors; write technical reports documenting project methodology; and collaborate in the writing of scientific manuscripts describing the data analysis and results.

Provide functional supervision of graduate research assistants or similar employees.

MINIMUM QUALIFICATIONS: PhD in biostatistics, epidemiology, public health or related field with 3-5 years of experience required in program evaluation, preferably in a clinical research or health care setting. Knowledge of statistical methods for design and analysis of health care programs and clinical trials. Previous work involving applied health care or mental health care research and/or quality improvement activities highly desirable. Must possess competent writing and editing skills, including sound grammar, spelling, and punctuation. Working knowledge of Microsoft Windows (i.e., Outlook, Excel, Word, & Access) required. Statistical software (e.g., SPSS, SAS) experience required.

Technical Assistance Coordinator (.5 FTE)

Definition: This position is responsible for producing and implementing – with broad, ongoing input from key stakeholders and institutions of higher education – a plan for training and technical assistance for the CMHI project. The plan must include a variety of learning opportunities for youth, families, and youth-service providers from different agencies and professions (mental health, health, education, child welfare, juvenile justice, criminal justice). The plan will reflect the expectations of the national T/TA provider and will be final only after approval by the State Outreach Team.

Major Duties: The Technical Assistance Coordinator must arrange for the delivery of training about transition-aged youth with SED *[from Dr. Mary Ann Davis]*, the TIP Model *[from Dr. Rusty Clark]*, the intervention/intercept models *[from the NCMHJJ and the GAINS Center]*, and the EBPs (including Supportive Employment) chosen by one or more LIT. He/she must arrange, as needed, for clinicians and their supervisors to receive in-depth initial and/or follow-up training about the EBPs to be delivered, including about the use of any associated screening or assessment tools and curricula. The Coordinator must also respond to other needs for learning that are identified (by state and regional needs assessments) throughout the six years of the project. The Coordinator will find national, state, and local experts to provide the desired training and technical assistance. She/he is responsible for operating within the budget for training and technical assistance.

Environmental Factors:
Work will be performed in standard office settings and at frequent meetings throughout Vermont, some beyond normal office hours. Meetings may involve the expression of strong feelings and conflicting opinions. Because extensive in-state travel is expected, the Coordinator must have private transportation available.

Knowledge, Skills and Abilities:
- Ability to be respectful and to listen carefully
- Ability to express self clearly orally and in writing
- Ability to use standard office equipment including word-processing and email
- Ability to establish objectives and design strategies for achieving them
- Ability to produce training events
- Skills in collaboration and teamwork, also team-building
- Knowledge about adult learning styles and group process
- Knowledge about family-driven and youth-guided service delivery
- Knowledge about adolescent and family growth and development
- Knowledge of existing State/community resources

Minimum Qualifications for Position:
Education: Bachelor's degree, preferably in a human services field or education
Experience: Four years experience serving children and adolescents with SED including at least two years coordinating training and technical assistance for their service providers
Note: Graduate work in a human services field or in education may be substituted for the two years of general experience on a semester for six months basis.

Social Marketing-Communications Manager (.5 FTE)

Definition: This position is responsible for producing and implementing – with broad, ongoing input from key stakeholders – a plan for social marketing and communications for the CMHI project. The plan will be linked with the national Caring for Every Child's Mental Health Campaign goals and messages to reduce stigma related to mental illness and will annually include activities (in collaboration with the Vermont Federation of Families for Children's Mental Health) in honor of National Children's Mental Health Day. The plan must be linked with AHS efforts to inform transition-aged youth, their families, and the broader public about the opportunity to enroll in Medicaid. The plan must also help the Federation reach out to transition-aged youth with SED and their families to inform them about the existence of mental health problems and available help and hope for those problems. The plan will be final only after approval by the State Outreach Team.

Major Duties:
The Social Marketing-Communications Manager will determine the informational needs of priority audiences and develop messages and materials that are in compliance with relevant standards for cultural and linguistic appropriateness and sensitivity, including compliance with the Americans with Disabilities Act (ADA). She/he is responsible for operating within the budget for social marketing-communications.

Environmental Factors:
Work will be performed in standard office settings and at frequent meetings throughout Vermont, some beyond normal office hours. Meetings may involve the expression of strong feelings and conflicting opinions. Because extensive in-state travel is expected, the Manager must have private transportation available.

Knowledge, Skills and Abilities:
- Ability to be respectful and to listen carefully
- Ability to express self clearly orally and in writing
- Ability to use standard office equipment including word-processing and email
- Ability to establish objectives and design strategies for achieving them
- Skills in collaboration and teamwork
- Skills for assessing needs and desires of diverse audiences for social messages
- Skills for producing social marketing-communications materials
- Knowledge of social marketing-communications procedures, practices, and resources

Minimum Qualifications:
Education: Bachelor's degree, preferably in human services or marketing/communications
Experience: Four years experience working for human service or education agencies including at least two years producing social marketing-communications materials
Note: Graduate work in human services or marketing/communications may be substituted for the two years of general experience on a semester for six months basis.

Section H: Confidentiality and SAMHSA Participant Protections/Human Subjects

Protection of Human Subjects Regulations

VCHIP will develop - and gain UVM Institutional Review Board (IRB) approval for - the Vermont CMHI project evaluation prior to any participants being enrolled. At the start of the planning phase (9 months) of the Vermont CMHI project, the VCHIP team will begin to develop an IRB protocol that accurately and completely reflects the project evaluation activities. This protocol will be submitted to the UVM IRB at least three months prior to the beginning of enrollment of project participants, as we anticipate that it will require a full IRB committee review. VCHIP will make any and all changes to the protocol required by the UVM IRB. VCHIP will, with DMH, document for the federal CMHS that IRB approval has been obtained and file the required Assurance of Compliance with the federal Office of Human Research Protection (OHRP) before enrolling participants.

If any changes to the evaluation methodology are needed after initial approval has been obtained, the appropriate protocol amendments will be submitted and no methods changes will be implemented prior to IRB approval of the amendments. The VCHIP team will seek annual renewal of the approved IRB protocol until all data collection, processing, analysis and reporting has been completed. Deviations from the approved evaluation protocol will be promptly reported per the UVM IRB regulations.

Confidentiality and Participant Protection

- *Identify foreseeable risks or adverse effects due to participation in the project and/or in the data collection (performance assessment) activities (including physical, medical, psychological, social, legal, and confidentiality) and provide your procedures for minimizing or protecting participants from these risks.*

This CMHI project includes mental health treatment (and related supports) and evaluation; the risks and consents are different for treatment and evaluation. The foreseeable risks associated with participating in community-based mental health treatment are the psychological and social discomforts of facing challenging life issues and having to deal with such consequences of those issues as legal actions. For example, youth and/or their caregivers may be challenged to address neurological dysfunctions, substance abuse, domestic violence, child abuse/neglect, suicidal or homicidal ideation, etc. The treating clinicians have related duties to protect and warn all potential victims by reporting to the appropriate officials threats or actions by the youth and/or their caregivers. These risks are fully explained to youth and their caregivers when they enter treatment.

There is no absolute protection from life's challenges and consequences, which must eventually be faced with or without mental health treatment. However, through the support of a consistent, trusting relationship with a mental health or other community-based service provider, youth and their caregivers may feel less vulnerable and more comfortable and able to make the next decisions/steps in their lives. The treating clinicians will help youth and their caregivers identify possible adverse effects of their decisions and actions. The clinicians will also receive supervision and training in Evidence-Based Practices so they are as effective as possible in their work with youth and caregivers.

The main foreseeable risk associated with participating in the evaluation of the proposed project is loss of confidentiality. To minimize risk, identifying information collected from project participants will be coded, and the key to the code will be kept in a separate location (electronic file). Electronic data files will be maintained on secure servers and accessed only by VCHIP CMHI project personnel. Hard copies of data will be kept in a locked file cabinet with access restricted to VCHIP CMHI project personnel.

- *Identify plans to provide guidance and assistance in the event there are adverse effects to participants.*

For treatment, in the event of a crisis, the clinicians will involve emergency mental health staff or police or others (like shelter providers) as needed to help youth and their caregivers and the public remain safe.

For evaluation, in the event of a loss of confidentiality, VCHIP will notify the University of Vermont IRB immediately and consult with them about how to proceed. VCHIP will comply with the requirements of the IRB regarding any adverse events.

- *Describe the target population and explain why you are including or excluding certain subgroups. Explain how and who will recruit and select participants.*

The target population for mental health treatment through this CMHI project is transition-aged youth (16-21, inclusive) in Vermont who are experiencing SED and their families. As explained in Section A of this proposal, about 95% of these youth are White and about 99% are likely to speak English. The project will reach out to youth through teen centers, substance abuse recovery centers, runaway and homeless youth programs, Outright Vermont, etc. All youth who seek services will be enrolled in treatment.

Enrollment in CMHI services will automatically entail collection of the NOMs data from all youth and their caregivers. This data collection will be required from youth and their caregivers regardless of their agreement to participate (or not) in the more in-depth data collection for the Vermont and national evaluation. Participation in the evaluation is not required for youth receiving services or their caregivers.

Recruitment into the comprehensive evaluation will be done initially by the clinicians who will provide information about the evaluation to the youth and caregiver and, with their written assent and consent, notify the VCHIP evaluation team that a youth has been enrolled in the evaluation. VCHIP will work with the national evaluator to identify the optimal methodology for obtaining and retaining the needed sample.

- *State whether participation in the project is voluntary or required. If you plan to provide incentives/compensate participants, specify the type (e.g., money, gifts, coupons) and the value of any such incentives. Provide justification that the use of incentives is appropriate, judicious and conservative and that incentives do not provide an "undue inducement" which removes the voluntary nature of participation. Incentives should be the minimum amount necessary to meet the programmatic and performance assessment goals of the grant. Applicants should determine the minimum amount that is proven to be effective by consulting with existing local programs and reviewing the relevant literature. In no case may the value of an incentive paid for with SAMHSA discretionary grant funds exceed $20. (See Appendix G, Funding Restrictions.)*

Participation in treatment is completely voluntary. No cash or token incentives are offered to encourage participation, though assistance with transportation may be provided if necessary for the youth to receive treatment.

Participation in the CMHI project evaluation activities will be completely voluntary. A monetary incentive of $20.00 to each participant will be provided at the time of the youth and their caregivers participating in the baseline and follow-up interviews. Based on previous VCHIP interview and qualitative studies involving youth and family participants, we believe that the $20.00 amount is the smallest amount that can be used that is not an undue inducement to either youth or caregivers, but that will also encourage participation in the project evaluation activities.

- *Describe data collection procedures, including sources (e.g., participants, school records) and the data collecting setting (e.g., clinic, school). Provide copies of proposed data collection instruments and interview protocols in* ***Appendix*** *3 of your application, "Data Collection Instruments/Interview Protocols." State whether specimens such as urine and/or blood will be obtained and the purpose for collecting the specimens. If applicable, describe how the specimens and process will be monitored to ensure both the safety of participants and the integrity of the specimens.*

The treatment will be conducted without specimens such as blood or urine collected. With the exception of administrative data from the AHS MIS databases, all data will be collected directly from the youth, their caregiver, or the youth's mental health clinician. Baseline NOMs measures and other instruments requiring a baseline for the longitudinal components of the evaluation will be collected as soon as possible after youth's entry into the CMHI project. Subsequent to the initial data collection, the data will be collected regularly at three to six month intervals during the time the youth is receiving services through the project (for all youth, for NOMs) and beyond (only for a sample, for the evaluation). The NOMs data will be collected by the clinician and entered into TRAC by VCHIP. The Vermont and national evaluation data will be collected by the VCHIP evaluation team; see some of the data collection tools, Appendix 3.

- *Explain how you will ensure privacy and confidentiality of participants' records, data collected, interviews and group discussions. Describe where the data will be stored, safeguards (e.g., locked, coding systems, storing identifiers separate from data) and who will have access to the information.*

Community mental health centers have extensive safeguards for protecting client records and the use of private health information. The Vermont Council of Developmental and Mental Health Services, Inc. – an association of the CMHCs and other specialized agencies – has developed an extensive set of standardized forms and privacy practices for its member agencies to use with clients in order to comply with HIPPA and related state and federal laws.

For the evaluation, at the time of initial data collection, the youth and caregiver will be assigned a unique non-identifying code that will be the only link to the youth and caregiver. The codes will be stored in a password-protected "key" file. No other identifying information will be collected. The unique ID code will be used for all data processing and analysis. The key to the identifying code will be kept separate from the data files, and will only be accessible by the VCHIP evaluation team. Electronic data files will be maintained in a password protected files on the UVM secure server. Hard copy data will be kept in a locked filing cabinet in the VCHIP office and will only be accessible to VCHIP evaluation team members.

- *Describe the process for obtaining and documenting consent from adult participants and assent from minors along with consent from their parents or legal guardians. Provide copies of all consent forms in **Appendix 4** of your application, "Sample Consent Forms." If needed, give English translations.*

The CMHC's "Consent and Agreement to the Use and Disclosure of Health Information For Treatment, Payment or Healthcare Operations" (see Appendix 4) is the standard form used to obtain consent from adults for their own or their dependent's mental health treatment. The CMHCs do not have a written form for minor's assent to treatment, though obtaining their verbal assent and cooperation is a critical first step in engaging children and adolescents in their own treatment.

Consent and assent for the evaluation will be obtained will be obtained by the youth's clinician prior to any data being collected (see assent and consent forms in Appendix 4).

- *Discuss why the risks are reasonable compared to expected benefits from the project.*

Engaging in treatment takes courage, but facing life's challenges with the support of a trusted clinician is much easier and more effective than doing so without that help. The benefits are likely to include better decisions made and steps taken by the youth and their caregivers.

The risks associated with participating in the Vermont CMHI evaluation are minimal (an individual's loss of confidentiality) while the potential benefits include helping to determine and guide (through action research) the efficacy of a project that is designed to help over 900 youth and families in Vermont over six years. In addition, the research results will inform the conduct of future projects nationally.

Appendix 1

Contents:

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

Jump on Board for Success (JOBS) Letter of Agreement

Letters of Support:

1) Cynthia LaWare, Secretary, Agency of Human Services (**letter included**)
2) Julie Tessler, Executive Director, Vermont Council of Developmental and Mental Health Services (**included**)
3) Diane Dalmasse, Director, VocRehab Vermont (**included**)
4) Judy Shaw, Executive Director, UVM Department of Pediatrics (**included**) (VCHIP)
5) Kathleen Holsopple, Executive Director, Vermont Federation of Families for Children's Mental Health (**included**)
6) Senator Dick Sears & Representative William Lippert Chairpersons of the Vermont Senate Judiciary Committee and the Vermont House Judiciary Committee (**included**)
7) Senator Doug Racine & Representative Ann Pugh Chairpersons of the Vermont Senate Health and Welfare Committee and the Vermont House Human Services Committee (**included**)
8) Maryann Davis, Ph.D., Associate Research Professor University of Massachusetts Medical School (**included**)
9) Catherine Simonson, Director - Child Youth and Family Services, HowardCenter (**letter on file**)
10) Jo-Anne Unruh, Ph.D., Act 264 Advisory Board for Children and Adolescents with Severe Emotional Disturbances (**on file**)
11) Wendy Davis, MD, Director, Vermont Division of Maternal and Child Health (**on file**)
12) Lee Suskin, Esq., Court Administrator, Vermont Supreme Court (**on file**)
13) Karin Edwards, Director - Student Support Team, Vermont Department of Education (**on file**)
14) Kreig Pinkham, Coordinator, Vermont Coalition of Runaway and Homeless Youth Programs (**on file**)
15) Kellie Coakley, President, DCF Family Services Youth Development Committee (**on file**)
16) Connie Curtin, Executive Director, Vermont Parent Information Center (**on file**)
17) Seven members, Youth and Family Advisory Council for VR (on file)

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

PURPOSE

This agreement promotes collaboration between the Agency of Human Services (AHS) and the Department of Education (DOE) in order to ensure that all required services are coordinated and provided to students with disabilities, in accordance with applicable state and federal laws and policies. As required by the Individuals with Disabilities Education Act (IDEA), the agreement delineates the provision and funding of services required by federal or state law or assigned by state policy. The areas covered by this agreement include coordination of services, agency financial responsibility, conditions and terms of reimbursement, and resolution of interagency disputes.

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

MISSION/GUIDING PRINCIPLES

The DOE, the local education agencies (LEA) and AHS work together to assure that children and youth with disabilities, ages 3-22, receive services for which they are eligible in a timely and coordinated manner. Ultimate responsibility to ensure a free and appropriate public education (FAPE) to students with disabilities lies with DOE and responsibility to provide a FAPE lies with the LEA. AHS is responsible for supporting students and their families toward successful outcomes in their broader functioning consistent with federal law including 32 CFR §300.142[1] as well as state law. These agencies will work together to assure the needs of eligible students with disabilities are met, services are coordinated and integrated, funds are efficiently used, and a dispute resolution process is in place to resolve interagency policy and funding disputes when a conflict occurs.

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

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

AREAS OF AGREEMENT

I. COORDINATION OF SERVICES

A. General

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

1. Coordinated Services Plan

Eligible children and youth are entitled to receive a coordinated services plan developed by a service coordination team including representatives of education, the appropriate departments of the Agency of Human Services, the parents or guardians, and natural supports connected to the family. The coordinated services plan includes the Individual Education Plans (IEP) as well as human services treatment plans or individual plans of support; and is organized to assure that all components are working toward compatible goals, progress is monitored, and resources are being used effectively to achieve the desired result for the child and family. Funding for each element of the plan is identified.

Special consideration needs to be given to transition-age youth. Specific transition planning must begin at the age required by federal and state law. (See page 4 for definition of transition services.) The LEA is responsible for identifying each child or youth in need of a transition plan and arranging for appropriate team meetings. Also, the LEAs will collaborate with AHS on the annual survey which identifies students who will be graduating and may be in need of long-term supports.

Each child or youth and family has a lead service coordinator who assures that the plan is regularly reviewed and serves as the agreed upon contact person if the "coordinated services plan" needs to be adjusted.

If a team has not been formed or is not functioning, if a coordinated services plan is not satisfactory, if there is no lead service coordinator, or if a plan is not being implemented satisfactorily, the family or individual or another involved party may request a meeting of the Local Interagency Team (see below) to address the situation.

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

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

2. *Infrastructure*

   a. **State Interagency Team**

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

   b. **Local Interagency Team**

   The DOE and the AHS commit to the existence and support of a system of Local Interagency Teams (LIT) in each of the 12 AHS regions in Vermont. Each LIT includes a special education director selected by the districts in that region, the local children's mental health director, the Family Services director, a family consumer representative, high level local leaders from developmental services and substance abuse, and a VR representative. Other AHS programs are represented as needed. The LIT supports the creation of a local system of care and assures that staff are trained and supported in creating coordinated services plans. They also play a role in dispute resolution as outlined below. The AHS Field Director and a designated DOE staff person assure that the region has a highly functional team and is responsible for working with the team to solve funding issues. The Field Director is the key conduit to a High Risk Fund, managed through the Field Services Division.

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

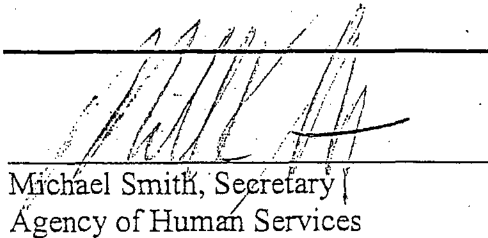
   Likewise, special attention must be taken to assure an appropriate process to address the needs of children ages 3 to 6. Such a process must include the Child Development Division.

. . . . more . . . .

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

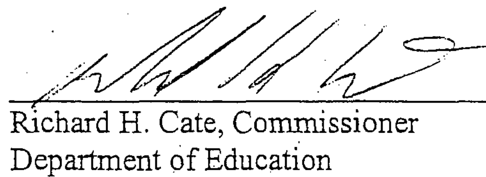
VII. TERM

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



Michael Smith, Secretary
Agency of Human Services

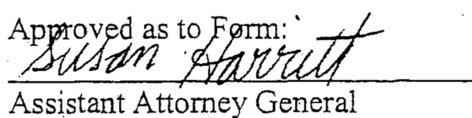
Date 6/21/05



Richard H. Cate, Commissioner
Department of Education

Date 6/15/05

Approved as to Form:



Assistant Attorney General

LETTER OF AGREEMENT BETWEEN

The Department of Health/Division of Mental Health Services (DMHS)
And
The Department of Corrections (DOC)
And
The Department of Disabilities, Aging and Independent Living/Division of Vocational Rehabilitation (DVR)
And
The Department of Children and Family Services/Division of Family Services (DCFS)

JOBS Program

July 1, 2006 through June 30, 2007

The purpose of this agreement is to delineate the understanding of the parties regarding the operation and funding of the JOBS (Jump on Board for Success) programs. This agreement delineates the funding of ten JOBS program sites throughout the State: Burlington, Bennington, Barre, Morrisville, Newport & St. Johnsbury, Rutland, Middlebury, Brattleboro, Springfield, and St. Albans. The long-term goal is to implement the JOBS program statewide. The purpose of JOBS is to improve the community functioning and employment outcomes of "at risk" transition aged youth with emotional and behavioral disabilities (EBD). Specifically, the program strives to: (1) secure paid employment for youth with EBD; (2) increase community integration for youth with EBD; (3) provide a natural continuum of transitional support to individuals who are "aging out" of the children's mental health/or DCFS systems; (4) increase productive collaboration among schools, youth, and adult service agencies; (5) prevent or reduce the involvement in the juvenile or adult criminal justice systems of youth with EBD; (6) involve employers in a visible and rewarding way in addressing the needs of EBD youth.

STANDARDS FOR DMHS, DOC, DCFS, AND DVR COLLABORATION

1. DMHS, DOC, DCFS, and DVR will work together to promote the replication of the JOBS program model for "at risk" youth with EBD.

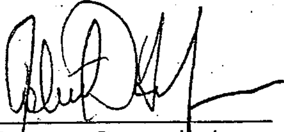
2. DMHS, DOC, DCFS, and DVR will encourage and support local collaboration between Corrections staff, DMHS Designated Agencies, DVR staff, schools, DET staff, youth services and DCFS field staff to ensure appropriate referrals to the JOBS programs.

3. A minimum of 20% of the youth served across sites will have been, or are currently involved with, the juvenile justice or adult correctional systems (e.g. probation and parole, house arrest, or incarceration).

4. The goal of the Vermont JOBS Initiative is to establish JOBS programs in twelve sites throughout the state. Over time, state partners anticipate the following funding breakdown in order to fund all sites statewide: $40,000 VR grant and $50,000 general fund match to Medicaid.

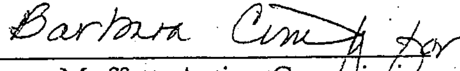
....more...

JOBS Letter of Agreement FY'07



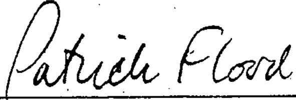
Robert Hofmann, Commissioner
Department of Corrections

Date: 10/24/06



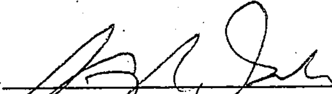
Sharon Moffatt, Acting Commissioner
Department of Health/Division of Mental Health Services

Date: 11-7-06



Patrick Flood, Commissioner
Department of Aging and Independent Living

Date: 6/1/07



Steve Dale, Commissioner
Department of Children and Family Services

Date: 5/31/07

CC William (Butch) Alexander, LCMH
Carol Boucher, NKHS
Michael Curtis, WCMH
Susan Grady, NCSS
Eric Grims, NKHS
Cheryl Huntley, CSAC
Lorna Maki, UCS
Jeff McKee, RMHS
William Shakespeare, HCRS
Catherine Simonson, HCHS

State of Vermont
Agency of Human Services
Office of the Secretary
103 South Main Street
Waterbury, VT 05671-0204
www.ahs.state.vt.us

[phone] 802-241-2220
[fax] 802-241-2979

Cynthia D. LaWare, Secretary

January 25, 2008

Ms. Crystal Saunders, Director of Grant Review
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 3-1044
Rockville, MD 20850

Re: Vermont's application for RFA # CMHI – SM – 08- 004
Appendix 1: Letters of Commitment and Support

Dear Ms. Saunders:

I am writing to express my strong support for this grant to expand the community capacity in Vermont to serve transition-aged youth, age 16 to 22, with serious emotional disturbances. This opportunity will enable Vermont to enhance our current system of care, and offer transitioning youth the necessary holistic supports to become self-sufficient and successful members of their larger communities.

Governor Douglas and the Agency of Human Services have made the needs of transition-aged youth a high priority, have actively championed legislation that supports these individuals, and the Agency continues to take advantage of opportunities to rethink, reform and revitalize how we serve this population.

The proposal from the Department of Mental Health is designed to maximize existing and effective local and state resources to promote these important efforts, and aspires to build upon our most successful program models. It is critical that we recognize the importance of this transition time for our youth experiencing serious emotional disturbance, and assist them in identifying and building upon their strengths. The Department of Mental Health and the Agency of Human Services are well positioned to create these opportunities and ensure these youth become successful, contributing members of their communities.

I fully support this grant proposal and continue to work with my staff to build and sustain an enhanced system of care for Vermont's transitioning youth. Both the Governor and I are deeply committed to this effort, and to moving this agenda forward for the state of Vermont.

Thank you for your consideration.

Sincerely,

Cynthia D. LaWare

Cynthia D. LaWare, Secretary
Agency of Human Services

VERMONT

Staff

Julie Tessler
Executive Director

Erin Campos
Administrative
Coordinator

Marlys Waller
Developmental Services
Coordinator

Nick Emlen
Mental Health
Services Coordinator

Council Members

Champlain Community Services

Clara Martin Center

Counseling Service of Addison County

Families First in Southern Vermont

Health Care and Rehabilition Services of Southeastern Vermont

HowardCenter

Lamoille County Mental Health Services

Lincoln Street, Inc.

Northeast Kingdom Human Services

Northwestern Counseling and Support Services

Northeastern Family Institute

Rutland Mental Health Services

Sterling Area Services

United Counseling Services of Bennington County

Upper Valley Services

Washington County Mental Health Services

National Memberships

National Council for Community Behavioral Healthcare

American Network of Community Options and Resources

The National Association for Rural Mental Health

January 17, 2008

Crystal Saunders, Director of Grant Review
Substance Abuse and Mental Health Services Administration
Room 3-1044
1 Choke Cherry Road
Rockville, MD 20850

Re: Vermont's application for RFA # CMHI – SM – 08- 004
Appendix 1: Letters of Commitment and Support

Dear Ms. Saunders:

The Vermont Council of Developmental and Mental Health Services promotes a statewide, nonprofit system of developmental and behavioral healthcare for people with developmental disabilities; serious and persistent mental illness; substance abuse; and children experiencing severe emotional disturbance, as well as their families. The Council, through its sixteen member agencies, works toward ensuring access to a high-quality continuum of health care and support services in every community throughout the state. The Council also strives to improve the health and safety of our communities through socially responsible alliances and partnerships, information sharing, education and advocacy at the national, state and local levels.

I am writing to whole-heartedly support this grant application to expand the community capacity in Vermont to serve transition-aged youth (aged 16-21) with serious emotional disturbance so that they have adequate preparation and the necessary supports to be productively engaged and free from incarceration.

This proposal from the Department of Mental Health to use the existing State and Local Interagency Teams and to build upon the existing JOBS program makes good use of our proven infrastructure and serves as a platform for more systematically extending that system of care to youth who are in contact with the adult criminal or juvenile justice systems, either pre-adjudication or post-adjudication. This proposal also offers opportunities for enhancing the JOBS program with additional evidence-based practices like treatment for co-occurring substance abuse and mental health problems and treatment for trauma.

The Vermont Council of Developmental and Mental Health Services and our members will actively participate in the strategic planning for this project during Year 1 through both the Local Interagency Teams and will continue to advise it in subsequent years.

I hope you will give this proposal careful consideration.

Sincerely,

Julie B. Tessler
Executive Director

137 Elm Street, Montpelier, Vermont 05602 Telephone: 802-223-1773
Fax: 802-223-5523 Website: www.vtcouncil.org

VERMONT

State of Vermont
VocRehab Vermont
Department of Disabilities, Aging and Independent Living
103 South Main Street, Weeks IA
Waterbury VT 05671-2303
www.vocrehab.vermont.gov

Phone or TTY: 802-241-2186
Toll Free: 866-879-6757
Fax: 802-241-3359

Agency of Human Services

January 24, 2008

Crystal Saunders, Director of Grant Review
Substance Abuse and Mental Health Services Administration
Room 3-1044
1 Choke Cherry Road
Rockville, MD 20850

Dear Ms. Saunders:

I am writing to strongly support this proposal from the Department of Mental Health to create a community driven, comprehensive system of care in Vermont to serve transition-aged youth (aged 16-21) with serious emotional disturbance (SED).

The Department of Mental Health's proposed model uses the existing State and Local Interagency Teams and builds upon the existing JOBS program. The plan makes good use of our proven infrastructure and serves as a platform for more systematically extending that system of care to youth who are in contact with the adult criminal or juvenile justice systems. This proposal would expand the scope and effectiveness of the JOBS program with additional evidence-based practices like treatment for co-occurring substance abuse and mental health problems and treatment for trauma.

In the early 90s, Voc Rehab pulled together a group of stakeholders to focus on the needs of youth with severe emotional disturbance (SED). Through a cross agency partnership, the JOBS program was replicated across the state to begin to meet the unique needs of this population. This grant presents an incredible opportunity to build on the existing infrastructure to truly create a system of care for youth with SED.

Voc Rehab is deeply committed to the needs of youth in transition to adult life. We have built a statewide system of VR Transition Counselors who serve young adults with disabilities and provide VR supports to the JOBS programs. We will actively participate in the strategic planning for this project during Year 1 through both the State and Local Interagency Teams, will continue to advise it in subsequent years and will commit additional funding to support the system of care over the life of the grant.

I urge the reviewers to fund this proposal.

Sincerely,

Diane P. Dalmasse
Director

THE UNIVERSITY OF VERMONT
Department of Pediatrics
St Joseph 7, UHC Campus
One South Prospect Street, Burlington, VT 05401
Phone: (802) 656-8210 Fax: (802) 656-8368

RECEIVED
JAN 29 2008
CHILD DEVELOPMENT DIVISION

January 25, 2008

CMHI-SM-08-004: VT Appendix 1

Dear Mr. Biss,

This letter is written in strong support of the application from the Vermont Department of Mental Health (DMH) for the Substance Abuse and Mental Health Administration Child Mental Health Initiative (CMHI) cooperative agreement. Receiving this award will allow the Vermont DMH and the Vermont Agency of Human Services (AHS) to strengthen and expand their statewide efforts assisting youth with Serious Emotional Disabilities. The Vermont Child Health Improvement Program (VCHIP) has entered into an agreement with DMH that will enable VCHIP to work with DMH, AHS and the CMHI National Evaluator to develop, implement and document a comprehensive evaluation of the Vermont CMHI work.

VCHIP is a research and quality improvement program based in the Department of Pediatrics in the University of Vermont, College of Medicine. VCHIP's mission is to optimize the health of Vermont children and youth by initiating and supporting measurement-based efforts to enhance public and private child health (including mental health) practice. Since its inception in 1999, VCHIP has focused on improving the health of Vermont's children and families by conducting applied research and evaluation studies and quality improvement projects on a variety of topics (e.g. preventive services, prenatal care, asthma, attention deficit hyperactivity disorder, immunizations, adolescent substance abuse, teen safe driving). VCHIP faculty and staff have extensive experience in designing, implementing and reporting on multi-site, multi-year quality improvement and research projects. VCHIP has conducted evaluations of statewide initiatives that targeted specific mental health quality improvement initiatives (e.g., the Vermont ADHD Practice Improvement Project) as well as evaluating projects that involve multiple agencies and partners working together to meet the needs of a specific group (e.g., the Vermont Youth Health Improvement Initiative).

Three years ago VCHIP received funding to work with states interested in developing VCHIP-like programs. Currently, 12 states are developing Improvement Partnerships based on the VCHIP program. VCHIP offers a solid foundation in Vermont for collaboration and support of state activities to improve child health outcomes. It is this foundation and the history of strong partnerships among VCHIP, DMH and AHS that will assure the success of this initiative and develop a model for replication in other states.

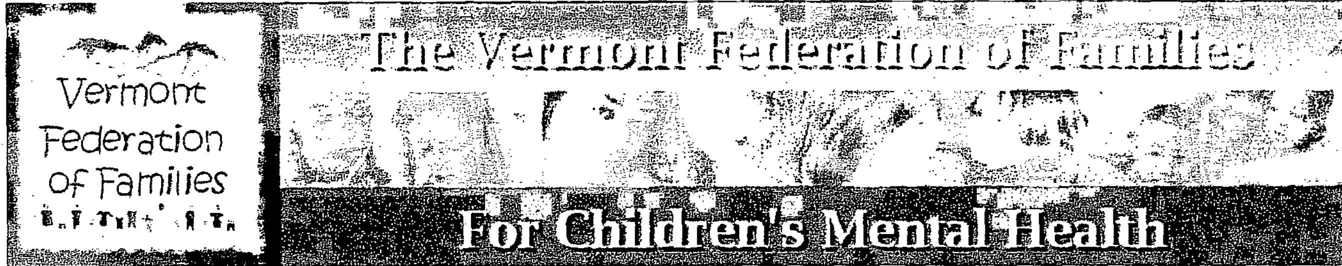
The VCHIP evaluation of the Vermont CMHI project activities will conform to all of the evaluation requirements set forth in the SAMHSA CMHI cooperative agreement announcement. Specifically, VCHIP will conduct data and performance measurements to satisfy the requirements of the Government Performance and Results Act of 1993, to participate in the cross site National Evaluation (including the CMHS National Outcome Measures) and will conduct an evaluation that is specific to the Vermont CMHI implementation. VCHIP will also develop a Quality Improvement plan that uses key indicators from the evaluation data to continuously monitor the implementation of the Vermont CMHI activities and provide regular feedback to the state and local interagency teams.

We look forward to collaborating with the Vermont DMH and the National Evaluator in developing and implementing an evaluation of the effectiveness of the Vermont CMHI project.

Sincerely,

Judy Shaw

Judy Shaw, Executive Director



Crystal Saunders, Director of Grant Review
Substance Abuse and Mental Health Services Administration
Room 3-1044
1 Choke Cherry Road
Rockville, MD 20850

January 22, 2008

Re: Vermont's application for RFA # CMHI – SM – 08- 004

Dear Ms. Saunders:

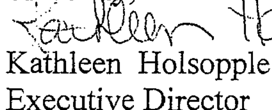
I am writing to give our full support to this grant application to expand the community capacity in Vermont to serve transition-aged youth (aged 16-21) with serious emotional disturbance (SED). The focus of this grant is to assure that youth with SED have adequate preparation and the necessary supports to be productively engaged and free from incarceration.

This proposal from the Department of Mental Health to use the existing State and Local Interagency Teams and to build upon the existing JOBS program makes good use of our proven infrastructure. It also serves as a platform to more systematically extend our system of care to youth who are in contact with the adult criminal or juvenile justice systems, either pre-adjudication or post-adjudication. This proposal also offers opportunities for enhancing the JOBS program with additional evidence-based practices such as treatment for co-occurring substance abuse and mental health problems and treatment for trauma.

The Vermont Federation of Families is interested in this effort because we have been supporting families and youth in the transition to adult life for many years. We continue to see "the cliff" that happens when young people age out of the children's system, as the current adult system has eligibility criteria that our youth cannot reach and services that do not meet the needs of this population. They often end up homeless or incarcerated. We are also actively partnering with the system of care as parent members of Vermont's State and Local Interagency Team.

The Vermont Federation of Families will actively participate in the strategic planning for this project during Year 1 through both the State and Local Interagency Teams and will continue to advise it in subsequent years.

Sincerely,



Kathleen Holsopple
Executive Director

P.O. Box 507 Waterbury, Vermont 05676-0507

(802) 434- 6757 * (800) 639-6071 Family Members only * Fax (802) 329 2135 * Email vffcmh@vffcmh.org

115 STATE STREET
MONTPELIER, VT 05633-5201

PHONE: (802) 828-2228
FAX: (802) 828 2424

STATE OF VERMONT
GENERAL ASSEMBLY
STATE HOUSE

January 18, 2008

Crystal Saunders, Director of Grant Review
Substance Abuse and Mental Health Services Administration
Room 3-1044
1 Choke Cherry Road
Rockville, MD 20850

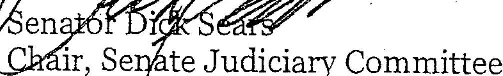
Dear Ms. Saunders:

As chair persons of the Senate Judiciary and House Judiciary Committees in the Vermont Legislature, we are writing in support of Vermont's grant application to expand capacity in our communities to serve transition-aged youth who have serious emotional disturbance. Addressing the mental health needs of these young people sets the table to assure that they are productively engaged in work or education activities and remain outside the corrections system.

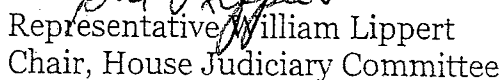
The proposal from the Department of Mental Health to use the existing State and Local Interagency Teams and to build upon Vermont's JOBS program - which has been successfully serving this age group for a decade - makes good use of our proven infrastructure. This also provides a platform for a systematic extension of that system of care to youth who are in contact with the criminal or juvenile justice systems. Their proposal details opportunities for enhancing evidence-based practices like treatment for co-occurring substance abuse and mental health disorders, and treatment for trauma.

We also would like to commit to involvement in the strategic planning and implementation of this project. This is an exciting opportunity to provide our best support to the young people who need it most.

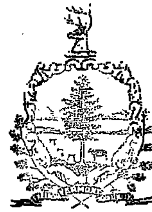
Sincerely,



Senator Dick Sears
Chair, Senate Judiciary Committee



Representative William Lippert
Chair, House Judiciary Committee



January 25, 2008

Crystal Saunders, Director of Grant Review
Substance Abuse and Mental Health Services Administration
Room 3-1044
1 Choke Cherry Road
Rockville, MD 20850

Dear Ms. Saunders:

We are writing to voice our whole-hearted support for this grant project to expand community capacity in Vermont to serve transition age youth with serious emotional disturbance.

As chair persons of the House Human Services Committee and the Senate Health & Welfare Committee, this population is of special interest to us. Over the past few years we have initiated legislative efforts that have had bi-partisan support and will over time produce tangible results for youth. This SAMHSA grant will be an important investment to augment our work and strengthen the mental health supports for these young people.

We have a unique opportunity with this group as they transition to adulthood and early in their adult lives to prevent long term, more intensive and expensive interventions including incarceration. Building on the existing State and Local Interagency Teams and JOBS program makes use of two platforms that have been successful for a number of years in Vermont.

We both look forward to supporting this grant effort and both of us will happily serve in an advisory capacity throughout the grant term.

Sincerely,

Senator Doug Racine
Chair, Senate Health and Welfare Committee

Representative Ann Pugh
Chair, House Human Services Committee

University of Massachusetts
UMASS Medical School

Center for Mental Health Services Research
University of Massachusetts Medical School
Psychiatry Department, WSH 8C
55 Lake Avenue North
Worcester, MA 01655-0002 USA
508.856.5498 (office) 508.856.8700 (fax)

www.umassmed.edu/cmhsr/ (website)

Crystal Saunders, Director of Grant Review
Substance Abuse and Mental Health Services Administration
Room 3-1044
1 Coke Cherry Road
Rockville, MD 20850

January 18, 2008

Re: Vermont's application for RFA# CMHI-SM-08-004
Appendix 1: Letters of Commitment and Support

Dear Ms Saunders:

I am writing to whole-heartily support this grant application to expand the community capacity in Vermont to serve transition-aged youth (aged16-21) with serious emotional disturbance so that they have adequate preparation and the necessary supports to be productively engaged and free from incarceration. In my previous research we found that youth in this age group, receiving standard public mental health services, are at very high risk of arrest. Those with a recent arrest are at particularly high risk, with about 50% of males and 30% of females getting rearrested within a year of an arrest. In addition, mine and other's research have shown that transition age youth with serious mental health conditions struggle with school completion, obtaining work, moving into their own or supporting a household, and developing an adult social network. This is a critical stage of life for all young people, and a particularly vulnerable period for those with serious mental health conditions. They need a well coordinated and comprehensive system of services that is developmentally appropriate for this stage of life and appealing to them. Unfortunately, my research has also shown such systems to be extraordinarily rare. Thus, Vermont's proposal is an important opportunity to develop knowledge about how to achieve this, which will be an important contribution for the rest of the country as well.

I have had a long involvement with Vermont's development of the JOBS program as an important part of system of care for transition aged youth. I'm very excited and interested in Vermont's development of a statewide system of care for this population. I feel that Vermont's pioneering efforts with JOBS provides them with a solid foundation to build a much needed systems' expansion of services and supports for this population.

I applaud the dedication and commitment of the leadership in Vermont which often leads the field in developing promising practices. I will be actively involved with this project if and when Vermont's grant gets funded.

Sincerely,

Maryann Davis, Ph.D.
Associate Research Professor

Appendix 3: Data Collection Procedures and Instruments

The Vermont-specific component of the VCHIP CMHI evaluation will use 3 data collection instruments to compliment the assessment tools being using for the national evaluation. These tools will be: 1) the Youth Self Report (YSR, or for youth over 18 years of age, the Adult Self Report (ASR)) tools from the Achenbach System for Empirically Based Assessment, a self report assessment of a wide range of behaviors that has been extensively tested and validated, 2) the Young Adult Health Care Survey (YAHCS) version 2.0, developed by the Foundation for Accountability and that is used to assess adolescents' and young adults' perceptions and experiences of health care and that also assesses specific health-related behaviors, and 3) the Stress Index for Parents of Adolescents (SIPA) developed by P. Sheras and colleagues, a parent self report instrument filled out by parents of youth aged 11-19 years and that assesses adolescent and parent stress-related characteristics.

All youth and caregivers receiving services through the CMHI project will be invited to participate in the Vermont CMHI evaluation, across all years of the project. After giving informed consent, youth with SED and their caregivers will be contacted by the VCHIP CMHI evaluation team and asked to schedule an appointment at which a baseline interview will be conducted. This interview will be scheduled at the same time for both the youth and the caregiver, but these individuals will be interviewed and fill out questionnaires in separate rooms. In cases where youth and caregivers cannot be present at the same time, VCHIP will make arrangements for separate interviews. Interviews are anticipated to last between 1.5 and 2 hours, and $20 stipend will be paid to each individual participant.

All 3 data collection instruments, the YSR (or ASR), YAHCS and SIPA will be collected at baseline and follow-up interviews. Interviews will be conducted by the 2 VCHIP CMHI PhD-level evaluators and by graduate student supervisees from the University of Vermont Department of Psychology PhD program. Interviewers will have conducted practice interviews and will be trained on use of the interview and questionnaire tool prior to the baseline interviews being conducted. All data will be collected on hard copy and subsequently entered and scored using the appropriate software by the VCHIP CMHI evaluation team.

While all 3 instruments are typically administered as self report questionnaires, the VCHIP CMHI evaluation team anticipates that in many cases they will be administered by one of the evaluators as an interview, or at least with the evaluator providing assistance (in the form of helping with reading, answering process questions, etc.) as the tools are being filled out. VCHIP will develop and adhere to a protocol for the evaluators that will specify the order for the instruments to be administered as well as the specific wording to be used during the interviews.

Follow up interviews will be conducted with the youth and caregivers approximately 12 months after entry into the CMHI project, or sooner for individuals who exit the program prior to 12 months. Procedures for scheduling the interviews and collecting the data will be essentially identical to those used at the baseline assessment.

See attached copies of the YSR, ASR, YAHCS and SIPA.

OMB No. 0930-0285
Expiration Date 04/30/2010

CMHS NOMs
Child Consumer Outcome Measures for Discretionary Programs
Child or Adolescent Respondent Version

Public reporting burden for this collection of information is estimated to average 20 minutes per response if all items are asked of a consumer/participant; to the extent that providers already obtain much of this information as part of their ongoing consumer/participant intake or followup, less time will be required. Send comments regarding this burden estimate or any other aspect of this collection of information to SAMHSA Reports Clearance Officer, Room 7-1045, 1 Choke Cherry Road, Rockville, MD 20857. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. The control number for this project is 0930-0285.

1st Revision 8/13/2007

A. RECORD MANAGEMENT

Consumer ID |___|___|___|___|___|___|___|___|___|___|___|

Grant ID (Grant/Contract/Collaborative Agreement) |___|___|___|___|___|___|___|___|___|___|

Site ID |___|___|___|___|___|___|___|___|___|___|

Interview Type *[SELECT ONLY ONE]*

O **Baseline**
Did you conduct a baseline interview? O Yes O No

Consumer Type *[SELECT ONLY ONE]*

O New [A **first-time** consumer to your grant]
[INTERVIEW REQUIRED; FILL IN INTERVIEW DATE, THEN RECORD MANAGEMENT-DEMOGRAPHICS]

O Continuing [An active consumer who is in treatment with the grant]
[FOR ADMINISTRATIVE BASELINES, FILL IN THE DATE THE CONSUMER WAS FIRST INTERVIEWED BY YOUR GRANT, THEN RECORD MANAGEMENT – DEMOGRAPHICS FOR BASELINE INTERVIEWS, FILL IN INTERVIEW DATE, THEN RECORD MANAGEMENT – DEMOGRAPHICS]

O **3 month reassessment** [NCTSI only]
Did you conduct a reassessment interview?

O Yes *[INDICATE REASSESSMENT TO BE CONDUCTED, FILL IN INTERVIEW DATE, THEN SKIP TO SECTION B]*
O No *[INDICATE REASSESSMENT TO BE CONDUCTED, THEN SKIP TO SECTION I]*

O 1st 3 Month Reassessment O 9th 3 Month Reassessment O 17th 3 Month Reassessment
O 2nd 3 Month Reassessment O 10th 3 Month Reassessment O 18th 3 Month Reassessment
O 3rd 3 Month Reassessment O 11th 3 Month Reassessment O 19th 3 Month Reassessment
O 4th 3 Month Reassessment O 12th 3 Month Reassessment O 20th 3 Month Reassessment
O 5th 3 Month Reassessment O 13th 3 Month Reassessment O 21st 3 Month Reassessment
O 6th 3 Month Reassessment O 14th 3 Month Reassessment O 22nd 3 Month Reassessment
O 7th 3 Month Reassessment O 15th 3 Month Reassessment O 23rd 3 Month Reassessment
O 8th 3 Month Reassessment O 16th 3 Month Reassessment

O **6 month reassessment** [CMHI only]
Did you conduct a reassessment interview?

O Yes *[INDICATE REASSESSMENT TO BE CONDUCTED, FILL IN INTERVIEW DATE, THEN SKIP TO SECTION B]*
O No *[INDICATE REASSESSMENT TO BE CONDUCTED, THEN SKIP TO SECTION I]*

O 1st 6 Month Reassessment O 5th 6 Month Reassessment O 9th 6 Month Reassessment
O 2nd 6 Month Reassessment O 6th 6 Month Reassessment O 10th 6 Month Reassessment
O 3rd 6 Month Reassessment O 7th 6 Month Reassessment O 11th 6 Month Reassessment
O 4th 6 Month Reassessment O 8th 6 Month Reassessment

A. RECORD MANAGEMENT (Continued)

○ **Clinical Discharge**
Did you conduct a discharge interview?

○ Yes *[FILL IN INTERVIEW DATE, THEN SKIP TO SECTION B]*

○ No *[SKIP TO SECTION J]*

Interview Date |___|___| / |___|___| / |___|___|___|___|
MONTH DAY YEAR

A. RECORD MANAGEMENT (Continued) - DEMOGRAPHICS

[DEMOGRAPHIC DATA ARE ONLY COLLECTED AT THE BASELINE INTERVIEW OR THE ADMINISTRATIVE BASELINE]

1. **What is your gender?**

O MALE
O FEMALE
O TRANSGENDER
O OTHER (SPECIFY) ______________________________
O REFUSED

2. **Are you Hispanic or Latino?**

O YES
O NO
O REFUSED

[IF YES] **What ethnic group do you consider yourself? Please answer yes or no for each of the following. You may say yes to more than one.**

	YES	NO	REFUSED
Central American	O	O	O
Cuban	O	O	O
Dominican	O	O	O
Mexican	O	O	O
Puerto Rican	O	O	O
South American	O	O	O
OTHER	O	O	O *[IF YES, SPECIFY BELOW]*

(SPECIFY) ________________________

3. **What race do you consider yourself? Please answer yes or no for each of the following. You may say yes to more than one.**

	YES	NO	REFUSED
Black or African American	O	O	O
Asian	O	O	O
Native Hawaiian or other Pacific Islander	O	O	O
Alaska Native	O	O	O
White	O	O	O
American Indian	O	O	O

4. **What is your month and year of birth?**

|___|___|/ |___|___|___|___|
MONTH YEAR O REFUSED

[IF THIS IS AN ADMINISTRATIVE BASELINE (NO INTERVIEW CONDUCTED) STOP HERE. NO ADDITIONAL INFORMATION IS REQUIRED.]

B. FUNCTIONING

In order to provide the best possible mental health services, we need to know what you think about how well you were able to deal with your everyday life during the last 30 days. Please indicate your disagreement/agreement with each of the following statements.

[READ EACH STATEMENT FOLLOWED BY THE RESPONSE OPTIONS TO THE CHILD/ADOLESCENT]

STATEMENT	RESPONSE OPTIONS					
	Strongly Disagree	**Disagree**	**Undecided**	**Agree**	**Strongly Agree**	**REFUSED**
1. I am handling daily life.	○	○	○	○	○	○
2. I get along with family members.	○	○	○	○	○	○
3. I get along with friends and other people.	○	○	○	○	○	○
4. I am doing well in school and/or work.	○	○	○	○	○	○
5. I am able to cope when things go wrong.	○	○	○	○	○	○
6. I am satisfied with our family life right now.	○	○	○	○	○	○

[OPTIONAL: GAF SCORE REPORTED BY GRANTEE STAFF AT PROJECT'S DISCRETION]

DATE GAF WAS ADMINISTERED: |___|___| / |___|___| /|___|___|___|___|
MONTH DAY YEAR

WHAT WAS THE CONSUMER'S SCORE? GAF = |___|___|___|

C. STABILITY IN HOUSING

1. In the past 30 days, where have you been living most of the time?

[DO NOT READ RESPONSE OPTIONS TO THE CHILD/ADOLESCENT. SELECT ONLY ONE.]

- O CAREGIVER'S OWNED OR RENTED HOUSE, APARTMENT, TRAILER, OR ROOM
- O SOMEONE ELSE'S HOUSE, APARTMENT, TRAILER, OR ROOM
- O HOMELESS (SHELTER, STREET/OUTDOORS, PARK)
- O GROUP HOME
- O FOSTER CARE (SPECIALIZED THERAPEUTIC TREATMENT)
- O TRANSITIONAL LIVING FACILITY
- O HOSPITAL (MEDICAL)
- O HOSPITAL (PSYCHIATRIC)
- O CORRECTIONAL FACILITY (JUVENILE DETENTION CENTER/JAIL/PRISON)
- O OTHER HOUSED (SPECIFY) ______________________________
- O REFUSED
- O DON'T KNOW

2. Who have you lived with during the past 30 days? *[THE INTERVIEWER MAY CHOOSE MORE THAN ONE ANSWER.]*

- O BIOLOGICAL PARENT(S)
- O ADOPTIVE PARENT(S)
- O RELATIVE OTHER THAN PARENT(S)
- O NON-RELATIVE
- O INDEPENDENT LIVING
- O REFUSED
- O DON'T KNOW

D. EDUCATION

1. During the last 30 days of school, how many days were you absent for any reason?

- O 0 DAYS
- O 1 DAY
- O 2 DAYS
- O 3 TO 5 DAYS
- O 6 TO 10 DAYS
- O MORE THAN 10 DAYS
- O REFUSED
- O DON'T KNOW
- O NOT APPLICABLE

a. [If absent], how many days were unexcused absences?

- O 0 DAYS
- O 1 DAY
- O 2 DAYS
- O 3 TO 5 DAYS
- O 6 TO 10 DAYS
- O MORE THAN 10 DAYS
- O REFUSED
- O DON'T KNOW
- O NOT APPLICABLE

2. What is the highest level of education you have finished, whether or not you received a degree?

- O NEVER ATTENDED
- O PRESCHOOL
- O KINDERGARTEN
- O 1ST GRADE
- O 2ND GRADE
- O 3RD GRADE
- O 4TH GRADE
- O 5TH GRADE
- O 6TH GRADE
- O 7TH GRADE
- O 8TH GRADE
- O 9TH GRADE
- O 10TH GRADE
- O 11TH GRADE
- O 12TH GRADE/HIGH SCHOOL DIPLOMA/EQUIVALENT (GED)
- O VOC/TECH DIPLOMA
- O SOME COLLEGE OR UNIVERSITY
- O REFUSED
- O DON'T KNOW

E. CRIME AND CRIMINAL JUSTICE STATUS

1. In the past 30 days, how many times have you been arrested?

|____|____| TIMES   O REFUSED   O DON'T KNOW

[FOR BASELINE INTERVIEWS, SKIP TO SECTION G]

F. PERCEPTION OF CARE

[SECTION F IS COLLECTED ONLY AT THE REASSESSMENT OR THE DISCHARGE INTERVIEW]

[FOR BASELINE INTERVIEWS, SKIP TO SECTION G]

In order to provide the best possible mental health services, we need to know what you think about the services you received during the last 30 days, the people who provided it, and the results. Please indicate your disagreement/agreement with each of the following statements.

[READ EACH STATEMENT FOLLOWED BY THE RESPONSE OPTIONS TO THE CHILD/ADOLESCENT]

STATEMENT	RESPONSE OPTIONS					
	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree	REFUSED
1. Staff here treated me with respect.	○	○	○	○	○	○
2. Staff respected my family's religious/spiritual beliefs.	○	○	○	○	○	○
3. Staff spoke with me in a way that I understood.	○	○	○	○	○	○
4. Staff was sensitive to my cultural/ethnic background.	○	○	○	○	○	○
5. I helped to choose my services.	○	○	○	○	○	○
6. I helped to choose my treatment goals.	○	○	○	○	○	○
7. I participated in my treatment.	○	○	○	○	○	○
8. Overall, I am satisfied with the services I received.	○	○	○	○	○	○
9. The people helping me stuck with me no matter what.	○	○	○	○	○	○
10. I felt I had someone to talk to when I was troubled.	○	○	○	○	○	○
11. The services I received were right for me.	○	○	○	○	○	○
12. I got the help I wanted.	○	○	○	○	○	○
13. I got as much help as I needed.	○	○	○	○	○	○

G. SOCIAL CONNECTEDNESS

Please indicate your disagreement/agreement with each of the following statements. Please answer for relationships with persons other than your mental health provider(s) over the past 30 days.

[READ EACH STATEMENT FOLLOWED BY THE RESPONSE OPTIONS TO THE CHILD/ADOLESCENT]

STATEMENT	RESPONSE OPTIONS					
	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree	REFUSED
1. I know people who will listen and understand me when I need to talk.	○	○	○	○	○	○
2. I have people that I am comfortable talking with about my problems.	○	○	○	○	○	○
3. In a crisis, I would have the support I need from family or friends.	○	○	○	○	○	○
4. I have people with whom I can do enjoyable things.	○	○	○	○	○	○

[IF THIS IS A BASELINE INTERVIEW STOP NOW, THE INTERVIEW IS COMPLETE.]

[IF THIS IS A REASSESSMENT INTERVIEW (3 OR 6 MONTH) GO TO THE NEXT PAGE, SECTION I.]

[IF THIS IS A CLINICAL DISCHARGE INTERVIEW, SKIP TO SECTION J.]

I. REASSESSMENT STATUS

[SECTION I IS REPORTED BY GRANTEE STAFF ONLY AT REASSESSMENT]

1. **What is the reassessment status of the consumer?**

   - O Completed interview within specified window
   - O Completed interview outside specified window
   - O Refused interview
   - O No contact within 90 days of last encounter
   - O Other (Specify) ________________________

2. **Is the consumer still receiving services from your project?**

   - O Yes
   - O No

[SKIP TO SECTION K]

J. CLINICAL DISCHARGE STATUS

[SECTION J IS REPORTED BY GRANTEE STAFF ONLY IF A CONSUMER IS DISCHARGED BY THE GRANTEE]

1. On what date was the consumer discharged?

|___|___| / |___|___|___|___|
MONTH YEAR

2. What is the consumer's discharge status?

- ○ Mutually agreed cessation of treatment
- ○ Death
- ○ No contact
- ○ Clinically referred out
- ○ Other (Specify) ______________________

[GO TO NEXT PAGE, SECTION K]

K. SERVICES RECEIVED

[SECTION K IS REPORTED BY GRANTEE STAFF ONLY AT REASSESSMENT OR DISCHARGE]

1. On what date did the consumer last receive services?

|___|___| / |___|___|___|___|
MONTH YEAR

[IDENTIFY ALL OF THE SERVICES YOUR PROJECT PROVIDED TO THE CONSUMER SINCE HIS/HER LAST NOMs INTERVIEW; THIS INCLUDES CMHS-FUNDED AND NON-FUNDED SERVICES.]

Core Services	Provided Yes	Provided No
1. Screening	O	O
2. Assessment	O	O
3. Treatment Planning or Review	O	O
4. Psychopharmacological Services	O	O
5. Mental Health Services	O	O

[IF YES, PLEASE SELECT THE FREQUENCY MENTAL HEALTH SERVICES WERE DELIVERED]:

Daily O Weekly O Less than Monthly O Monthly O

Core Services	Provided Yes	Provided No
6. Co-Occurring Services	O	O
7. Case Management	O	O
8. Trauma-specific Services	O	O

9. Was the consumer referred to another provider for any of the above core services?

Yes O No O

Support Services	Provided Yes	Provided No
1. Medical Care	O	O
2. Employment Services	O	O
3. Family Services	O	O
4. Child Care	O	O
5. Transportation	O	O
6. Education Services	O	O
7. Housing Support	O	O
8. Social Recreational Activities	O	O
9. Consumer Operated Services	O	O
10. HIV Testing	O	O

11. Was the consumer referred to another provider for any of the above support services?

Yes O No O

OMB No. 0930-0285
Expiration Date 04/30/2010

CMHS NOMs
Child Consumer Outcome Measures for Discretionary Programs
Caregiver Respondent Version

Public reporting burden for this collection of information is estimated to average 20 minutes per response if all items are asked of a consumer/participant; to the extent that providers already obtain much of this information as part of their ongoing consumer/participant intake or followup, less time will be required. Send comments regarding this burden estimate or any other aspect of this collection of information to SAMHSA Reports Clearance Officer, Room 7-1045, 1 Choke Cherry Road, Rockville, MD 20857. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. The control number for this project is 0930-0285.

1st Revision 8/13/2007

A. RECORD MANAGEMENT

Consumer ID |___|___|___|___|___|___|___|___|___|___|___|

Grant ID (Grant/Contract/Collaborative Agreement) |___|___|___|___|___|___|___|___|___|___|

Site ID |___|___|___|___|___|___|___|___|___|___|

Interview Type [*SELECT ONLY ONE]*

O **Baseline**

Did you conduct a baseline interview? O Yes O No

Consumer Type *[SELECT ONLY ONE]*

O New [A **first-time** consumer to your grant]
[INTERVIEW REQUIRED; FILL IN INTERVIEW DATE, THEN RECORD MANAGEMENT-DEMOGRAPHICS]

O Continuing [An active consumer who is in treatment with the grant]
[FOR ADMINISTRATIVE BASELINES, FILL IN THE DATE THE CONSUMER WAS FIRST INTERVIEWED BY YOUR GRANT, THEN RECORD MANAGEMENT – DEMOGRAPHICS FOR BASELINE INTERVIEWS, FILL IN INTERVIEW DATE, THEN RECORD MANAGEMENT – DEMOGRAPHICS]

O **3 month reassessment** [NCTSI only]

Did you conduct a reassessment interview?

O Yes *[INDICATE REASSESSMENT TO BE CONDUCTED, FILL IN INTERVIEW DATE, THEN SKIP TO SECTION B]*
O No *[INDICATE REASSESSMENT TO BE CONDUCTED, THEN SKIP TO SECTION I]*

O 1st 3 Month Reassessment
O 2nd 3 Month Reassessment
O 3rd 3 Month Reassessment
O 4th 3 Month Reassessment
O 5th 3 Month Reassessment
O 6th 3 Month Reassessment
O 7th 3 Month Reassessment
O 8th 3 Month Reassessment
O 9th 3 Month Reassessment
O 10th 3 Month Reassessment
O 11th 3 Month Reassessment
O 12th 3 Month Reassessment
O 13th 3 Month Reassessment
O 14th 3 Month Reassessment
O 15th 3 Month Reassessment
O 16th 3 Month Reassessment
O 17th 3 Month Reassessment
O 18th 3 Month Reassessment
O 19th 3 Month Reassessment
O 20th 3 Month Reassessment
O 21st 3 Month Reassessment
O 22nd 3 Month Reassessment
O 23rd 3 Month Reassessment

O **6 month reassessment** [CMHI only]

Did you conduct a reassessment interview?

O Yes *[INDICATE REASSESSMENT TO BE CONDUCTED, FILL IN INTERVIEW DATE, THEN SKIP TO SECTION B]*
O No *[INDICATE REASSESSMENT TO BE CONDUCTED, THEN SKIP TO SECTION I]*

O 1st 6 Month Reassessment
O 2nd 6 Month Reassessment
O 3rd 6 Month Reassessment
O 4th 6 Month Reassessment
O 5th 6 Month Reassessment
O 6th 6 Month Reassessment
O 7th 6 Month Reassessment
O 8th 6 Month Reassessment
O 9th 6 Month Reassessment
O 10th 6 Month Reassessment
O 11th 6 Month Reassessment

A. RECORD MANAGEMENT (Continued)

○ **Clinical Discharge**
Did you conduct a discharge interview?

- ○ Yes *[FILL IN INTERVIEW DATE, THEN SKIP TO SECTION B]*
- ○ No *[SKIP TO SECTION J]*

Interview Date |___|___| / |___|___| / |___|___|___|___|
MONTH DAY YEAR

A. RECORD MANAGEMENT (Continued) - DEMOGRAPHICS

[DEMOGRAPHIC DATA ARE ONLY COLLECTED AT THE BASELINE INTERVIEW OR THE ADMINISTRATIVE BASELINE]

1. What is your child's gender?

- O MALE
- O FEMALE
- O TRANSGENDER
- O OTHER (SPECIFY) ______________________________
- O REFUSED

2. Is your child Hispanic or Latino?

- O YES
- O NO
- O REFUSED

[IF YES] **What ethnic group do you consider your child? Please answer yes or no for each of the following. You may say yes to more than one.**

	YES	NO	REFUSED
Central American	O	O	O
Cuban	O	O	O
Dominican	O	O	O
Mexican	O	O	O
Puerto Rican	O	O	O
South American	O	O	O
OTHER	O	O	O *[IF YES, SPECIFY BELOW]*

(SPECIFY) ________________________

3. What race do you consider your child? Please answer yes or no for each of the following. You may say yes to more than one.

	YES	NO	REFUSED
Black or African American	O	O	O
Asian	O	O	O
Native Hawaiian or other Pacific Islander	O	O	O
Alaska Native	O	O	O
White	O	O	O
American Indian	O	O	O

4. What is your child's month and year of birth?

|___|___| / |___|___|___|___|
MONTH YEAR O REFUSED

[IF THIS IS AN ADMINISTRATIVE BASELINE (NO INTERVIEW CONDUCTED) STOP HERE. NO ADDITIONAL INFORMATION IS REQUIRED.]

B. FUNCTIONING

In order to provide the best possible mental health services, we need to know what you think about how well your child was able to deal with his/her everyday life <u>during the last 30 days</u>. Please indicate your disagreement/agreement with each of the following statements.

[READ EACH STATEMENT FOLLOWED BY THE RESPONSE OPTIONS TO THE CAREGIVER]

STATEMENT	RESPONSE OPTIONS					
	Strongly Disagree	**Disagree**	**Undecided**	**Agree**	**Strongly Agree**	**REFUSED**
1. My child is handling daily life.	○	○	○	○	○	○
2. My child gets along with family members.	○	○	○	○	○	○
3. My child gets along with friends and other people.	○	○	○	○	○	○
4. My child is doing well in school and/or work.	○	○	○	○	○	○
5. My child is able to cope when things go wrong.	○	○	○	○	○	○
6. I am satisfied with our family life right now.	○	○	○	○	○	○

[OPTIONAL: GAF SCORE REPORTED BY GRANTEE STAFF AT PROJECT'S DISCRETION]

DATE GAF WAS ADMINISTERED: |___|___| / |___|___| / |___|___|___|___|
MONTH DAY YEAR

WHAT WAS THE CONSUMER'S SCORE? GAF = |___|___|___|

C. STABILITY IN HOUSING

1. In the past 30 days, where has your child been living most of the time?

[DO NOT READ RESPONSE OPTIONS TO THE CAREGIVER. SELECT ONLY ONE.]

- O CAREGIVER'S OWNED OR RENTED HOUSE, APARTMENT, TRAILER, OR ROOM
- O SOMEONE ELSE'S HOUSE, APARTMENT, TRAILER, OR ROOM
- O HOMELESS (SHELTER, STREET/OUTDOORS, PARK)
- O GROUP HOME
- O FOSTER CARE (SPECIALIZED THERAPEUTIC TREATMENT)
- O TRANSITIONAL LIVING FACILITY
- O HOSPITAL (MEDICAL)
- O HOSPITAL (PSYCHIATRIC)
- O CORRECTIONAL FACILITY (JUVENILE DETENTION CENTER/JAIL/PRISON)
- O OTHER HOUSED (SPECIFY) ________________________________
- O REFUSED
- O DON'T KNOW

2. **Who has your child lived with during the past 30 days?** ***[THE INTERVIEWER MAY CHOOSE MORE THAN ONE ANSWER.]***

- O BIOLOGICAL PARENT(S)
- O ADOPTIVE PARENT(S)
- O RELATIVE OTHER THAN PARENT(S)
- O NON-RELATIVE
- O INDEPENDENT LIVING
- O REFUSED
- O DON'T KNOW

D. EDUCATION

1. During the last 30 days of school, how many days was your child absent for any reason?

- O 0 DAYS
- O 1 DAY
- O 2 DAYS
- O 3 TO 5 DAYS
- O 6 TO 10 DAYS
- O MORE THAN 10 DAYS
- O REFUSED
- O DON'T KNOW
- O NOT APPLICABLE

a. [If absent], how many days were unexcused absences?

- O 0 DAYS
- O 1 DAY
- O 2 DAYS
- O 3 TO 5 DAYS
- O 6 TO 10 DAYS
- O MORE THAN 10 DAYS
- O REFUSED
- O DON'T KNOW
- O NOT APPLICABLE

2. What is the highest level of education your child has finished, whether or not he or she received a degree?

- O NEVER ATTENDED
- O PRESCHOOL
- O KINDERGARTEN
- O 1ST GRADE
- O 2ND GRADE
- O 3RD GRADE
- O 4TH GRADE
- O 5TH GRADE
- O 6TH GRADE
- O 7TH GRADE
- O 8TH GRADE
- O 9TH GRADE
- O 10TH GRADE
- O 11TH GRADE
- O 12TH GRADE/HIGH SCHOOL DIPLOMA/EQUIVALENT (GED)
- O VOC/TECH DIPLOMA
- O SOME COLLEGE OR UNIVERSITY
- O REFUSED
- O DON'T KNOW

E. CRIME AND CRIMINAL JUSTICE STATUS

1. In the past 30 days, how many times has your child been arrested?

|___|___| TIMES O REFUSED O DON'T KNOW

[FOR BASELINE INTERVIEWS, SKIP TO SECTION G]

F. PERCEPTION OF CARE

[SECTION F IS COLLECTED ONLY AT THE REASSESSMENT OR THE DISCHARGE INTERVIEW]

[FOR BASELINE INTERVIEWS, SKIP TO SECTION G]

In order to provide the best possible mental health services, we need to know what you think about the services your child received during the last 30 days, the people who provided it, and the results. Please indicate your disagreement/agreement with each of the following statements.

[READ EACH STATEMENT FOLLOWED BY THE RESPONSE OPTIONS TO THE CAREGIVER]

STATEMENT	RESPONSE OPTIONS					
	Strongly Disagree	**Disagree**	**Undecided**	**Agree**	**Strongly Agree**	**REFUSED**
1. Staff here treated me with respect.	○	○	○	○	○	○
2. Staff respected my family's religious/spiritual beliefs.	○	○	○	○	○	○
3. Staff spoke with me in a way that I understood.	○	○	○	○	○	○
4. Staff was sensitive to my cultural/ethnic background.	○	○	○	○	○	○
5. I helped to choose my child's services.	○	○	○	○	○	○
6. I helped to choose my child's treatment goals.	○	○	○	○	○	○
7. I participated in my child's treatment.	○	○	○	○	○	○
8. Overall, I am satisfied with the services my child received.	○	○	○	○	○	○
9. The people helping my child stuck with us no matter what.	○	○	○	○	○	○
10. I felt my child had someone to talk to when he/she was troubled.	○	○	○	○	○	○
11. The services my child and/or family received were right for us.	○	○	○	○	○	○
12. My family got the help we wanted for my child.	○	○	○	○	○	○
13. My family got as much help as we needed for my child.	○	○	○	○	○	○

G. SOCIAL CONNECTEDNESS

Please indicate your disagreement/agreement with each of the following statements. Please answer for relationships with persons other than your child's mental health provider(s) over the past 30 days.

[READ EACH STATEMENT FOLLOWED BY THE RESPONSE OPTIONS TO THE CAREGIVER]

STATEMENT	RESPONSE OPTIONS					
	Strongly Disagree	**Disagree**	**Undecided**	**Agree**	**Strongly Agree**	**REFUSED**
1. I know people who will listen and understand me when I need to talk.	○	○	○	○	○	○
2. I have people that I am comfortable talking with about my child's problems.	○	○	○	○	○	○
3. In a crisis, I would have the support I need from family or friends.	○	○	○	○	○	○
4. I have people with whom I can do enjoyable things.	○	○	○	○	○	○

[IF THIS IS A BASELINE INTERVIEW STOP NOW, THE INTERVIEW IS COMPLETE.]

[IF THIS IS A REASSESSMENT INTERVIEW (3 OR 6 MONTH) GO TO THE NEXT PAGE, SECTION I.]

[IF THIS IS A CLINICAL DISCHARGE INTERVIEW, SKIP TO SECTION J.]

I. REASSESSMENT STATUS

[SECTION I IS REPORTED BY GRANTEE STAFF ONLY AT REASSESSMENT]

1. What is the reassessment status of the consumer?

- O Completed interview within specified window
- O Completed interview outside specified window
- O Refused interview
- O No contact within 90 days of last encounter
- O Other (Specify) ______________________

2. Is the consumer still receiving services from your project?

- O Yes
- O No

[SKIP TO SECTION K]

J. CLINICAL DISCHARGE STATUS

[SECTION J IS REPORTED BY GRANTEE STAFF ONLY IF A CONSUMER IS DISCHARGED BY THE GRANTEE]

1. On what date was the consumer discharged?

|___|___| / |___|___|___|___|
MONTH YEAR

2. What is the consumer's discharge status?

- O Mutually agreed cessation of treatment
- O Death
- O No contact
- O Clinically referred out
- O Other (Specify) ____________________

[GO TO NEXT PAGE, SECTION K]

K. SERVICES RECEIVED

[SECTION K IS REPORTED BY GRANTEE STAFF ONLY AT REASSESSMENT OR DISCHARGE]

1. On what date did the consumer last receive services?

|___|___| / |___|___|___|___|
MONTH YEAR

[IDENTIFY ALL OF THE SERVICES YOUR PROJECT PROVIDED TO THE CONSUMER SINCE HIS/HER LAST NOMs INTERVIEW; THIS INCLUDES CMHS-FUNDED AND NON-FUNDED SERVICES.]

Core Services	**Provided**	
	Yes	**No**
1. Screening	○	○
2. Assessment	○	○
3. Treatment Planning or Review	○	○
4. Psychopharmacological Services	○	○
5. Mental Health Services	○	○

[IF YES, PLEASE SELECT THE FREQUENCY MENTAL HEALTH SERVICES WERE DELIVERED]:

Daily ○ Weekly ○ Less than Monthly ○ Monthly ○

6. Co-Occurring Services	○	○
7. Case Management	○	○
8. Trauma-specific Services	○	○

9. Was the consumer referred to another provider for any of the above core services?

Yes ○ No ○

Support Services	**Provided**	
	Yes	**No**
1. Medical Care	○	○
2. Employment Services	○	○
3. Family Services	○	○
4. Child Care	○	○
5. Transportation	○	○
6. Education Services	○	○
7. Housing Support	○	○
8. Social Recreational Activities	○	○
9. Consumer Operated Services	○	○
10. HIV Testing	○	○

11. Was the consumer referred to another provider for any of the above support services?

Yes ○ No ○

///

Please print

YOUTH SELF-REPORT FOR AGES 11-18

For office use only
ID # 0015551212

YOUR FULL NAME: Youth Child

YOUR GENDER ☐ Boy ☐ Girl

YOUR AGE

YOUR ETHNIC GROUP OR RACE

TODAY'S DATE Mo. ____ Day ____ Year ______

YOUR BIRTHDATE Mo. ____ Day ____ Year ____

GRADE IN SCHOOL ________

NOT ATTENDING SCHOOL ☐

IF YOU ARE WORKING, PLEASE STATE YOUR TYPE OF WORK:

____

____

PARENTS' USUAL TYPE OF WORK, even if not working now. *(Please be specific — for example, auto mechanic, high school teacher, homemaker, laborer, lathe operator, shoe salesman, army sergeant.)*

FATHER'S TYPE OF WORK ______________________

MOTHER'S TYPE OF WORK ______________________

Please fill out this form to reflect *your* views, even if other people might not agree. Feel free to print additional comments beside each item and in the spaces provided on pages 2 and 4. ***Be sure to answer all items.***

I. Please list the sports you most like to take part in. For example: swimming, baseball, skating, skate boarding, bike riding, fishing, etc.

None ☐

	Compared to others of your age, about how much time do you spend in each?			Compared to others your age, how well do you do each one?		
	Less Than Average	Average	More Than Average	Below Average	Average	Above Average
a. ________	☐	☐	☐	☐	☐	☐
b. ________	☐	☐	☐	☐	☐	☐
c. ________	☐	☐	☐	☐	☐	☐

II. Please list your favorite hobbies, activities, and games, other than sports. For example: cards, books, piano, crafts, cars, computers, etc. (Do ***not*** include listening to radio or TV.)

None ☐

	Compared to others of your age, about how much time do you spend in each?			Compared to others of your age, how well do you do each one?		
	Less Than Average	Average	More Than Average	Below Average	Average	Above Average
a. ________	☐	☐	☐	☐	☐	☐
b. ________	☐	☐	☐	☐	☐	☐
c. ________	☐	☐	☐	☐	☐	☐

III. Please list any organizations, clubs, teams, or groups you belong to.

None ☐

	Compared to others of your age, how active are you in each?		
	Less Active	Average	More Active
a. ________	☐	☐	☐
b. ________	☐	☐	☐
c. ________	☐	☐	☐

IV. Please list any jobs or chores you have. For example: paper route, babysitting, making bed, working in store, etc. (Include ***both*** paid and unpaid jobs and chores.)

None ☐

	Compared to others of your age, how well do you carry them out?		
	Below Average	Average	Above Average
a. ________	☐	☐	☐
b. ________	☐	☐	☐
c. ________	☐	☐	☐

Be sure you answered all ***items. Then see other side.***

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V. 1. About how many close friends do you have? (Do *not* include brothers & sisters)

☐ None ☐ 1 ☐ 2 or 3 ☐ 4 or more

2. About how many times a week do you do things with your friends outside of regular school hours? (Do *not* include brothers & sisters)

☐ Less than 1 ☐ 1 or 2 ☐ 3 or more

VI. Compared to others of your age, how well do you:

	Worse	Average	Better	
a. Get along with your brothers & sisters?	☐	☐	☐	☐ I have no brothers or sisters
b. Get along with other kids?	☐	☐	☐	
c. Behave with your parents?	☐	☐	☐	
d. Do things by yourself?	☐	☐	☐	

VII.1. Performance in academic subjects. ☐ I do not attend school because ____________________

Check a box for each subject that you take

		Failing	Below Average	Average	Above Average
	a. Reading, English, or Language Arts	☐	☐	☐	☐
Other academic subjects–for example: computer courses, foreign language, business. Do *not* include gym, shop, driver's ed., or other nonacademic subjects.	b. History or Social Studies	☐	☐	☐	☐
	c. Arithmetic or Math	☐	☐	☐	☐
	d. Science	☐	☐	☐	☐
	e. ____________	☐	☐	☐	☐
	f. ____________	☐	☐	☐	☐
	g. ____________	☐	☐	☐	☐

Do you have any illness, disability, or handicap? ☐ No ☐ Yes—please describe:

Please describe any concerns or problems you have about school:

Please describe any other concerns you have:

Please describe the best things about yourself:

Below is a list of items that describe kids. For each item that describes you ***now or within the past 6 months***, please circle the ***2*** if the item is ***very true or often true*** of you. Circle the ***1*** if the item is ***somewhat or sometimes true*** of you. If the item is ***not true*** of you, circle the ***0***.

0 = Not True **1 = Somewhat or Sometimes True** **2 = Very True or Often True**

0 1 2 1. I act too young for my age
0 1 2 2. I drink alcohol without my parents' approval (describe): ______________________

0 1 2 3. I argue a lot
0 1 2 4. I fail to finish things I start
0 1 2 5. There is very little that I enjoy
0 1 2 6. I like animals
0 1 2 7. I brag
0 1 2 8. I have trouble concentrating or paying attention
0 1 2 9. I can't get my mind off certain thoughts; (describe): ______________________

0 1 2 10. I have trouble sitting still
0 1 2 11. I'm too dependent on adults
0 1 2 12. I feel lonely
0 1 2 13. I feel confused or in a fog
0 1 2 14. I cry a lot
0 1 2 15. I am pretty honest
0 1 2 16. I am mean to others
0 1 2 17. I daydream a lot
0 1 2 18. I deliberately try to hurt or kill myself
0 1 2 19. I try to get a lot of attention
0 1 2 20. I destroy my own things
0 1 2 21. I destroy things belonging to others
0 1 2 22. I disobey my parents
0 1 2 23. I disobey at school
0 1 2 24. I don't eat as well as I should
0 1 2 25. I don't get along with other kids
0 1 2 26. I don't feel guilty after doing something I shouldn't
0 1 2 27. I am jealous of others
0 1 2 28. I break rules at home, school, or elsewhere
0 1 2 29. I am afraid of certain animals, situations, or places, other than school (describe): ______________________

0 1 2 30. I am afraid of going to school
0 1 2 31. I am afraid I might think or do something bad
0 1 2 32. I feel that I have to be perfect
0 1 2 33. I feel that no one loves me
0 1 2 34. I feel that others are out to get me
0 1 2 35. I feel worthless or inferior
0 1 2 36. I accidentally get hurt a lot
0 1 2 37. I get in many fights
0 1 2 38. I get teased a lot
0 1 2 39. I hang around with kids who get in trouble
0 1 2 40. I hear sounds or voices that other people think aren't there (describe): ______________________

0 1 2 41. I act without stopping to think
0 1 2 42. I would rather be alone than with others
0 1 2 43. I lie or cheat
0 1 2 44. I bite my fingernails
0 1 2 45. I am nervous or tense
0 1 2 46. Parts of my body twitch or make nervous movements (describe): ______________________

0 1 2 47. I have nightmares
0 1 2 48. I am not liked by other kids
0 1 2 49. I can do certain things better than most kids
0 1 2 50. I am too fearful or anxious
0 1 2 51. I feel dizzy or lightheaded
0 1 2 52. I feel too guilty
0 1 2 53. I eat too much
0 1 2 54. I feel overtired without good reason
0 1 2 55. I am overweight

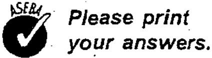
56. Physical problems ***without known medical cause:*** ______________________

0 1 2 a. Aches or pains (***not*** stomach or headaches)
0 1 2 b. Headaches
0 1 2 c. Nausea, feel sick
0 1 2 d. Problems with eyes (***not*** if corrected by glasses) (describe): ______________________
0 1 2 e. Rashes or other skin problems
0 1 2 f. Stomachaches
0 1 2 g. Vomiting, throwing up
0 1 2 h. Other (describe): ______________________

0 = Not True **1 = Somewhat or Sometimes True** **2 = Very True or Often True**

0 1 2 57. I physically attack people
0 1 2 58. I pick my skin or other parts of my body (describe): ____________________
0 1 2 59. I can be pretty friendly
0 1 2 60. I like to try new things
0 1 2 61. My school work is poor
0 1 2 62. I am poorly coordinated or clumsy
0 1 2 63. I would rather be with older kids than kids my own age
0 1 2 64. I would rather be with younger kids than kids my own age
0 1 2 65. I refuse to talk
0 1 2 66. I repeat certain acts over and over (describe): ____________________
0 1 2 67. I run away from home
0 1 2 68. I scream a lot
0 1 2 69. I am secretive or keep things to myself
0 1 2 70. I see things that other people think aren't there (describe): ____________________
0 1 2 71. I am self-conscious or easily embarrassed
0 1 2 72. I set fires
0 1 2 73. I can work well with my hands
0 1 2 74. I show off or clown
0 1 2 75. I am too shy or timid
0 1 2 76. I sleep less than most kids
0 1 2 77. I sleep more than most kids during day and/ or night (describe): ____________________
0 1 2 78. I am inattentive or easily distracted
0 1 2 79. I have a speech problem (describe): ____________________
0 1 2 80. I stand up for my rights
0 1 2 81. I steal at home
0 1 2 82. I steal from places other than home
0 1 2 83. I store up too many things I don't need (describe): ____________________
0 1 2 84. I do things other people think are strange (describe): ____________________
0 1 2 85. I have thoughts that other people would think are strange (describe): ____________________
0 1 2 86. I am stubborn
0 1 2 87. My moods or feelings change suddenly
0 1 2 88. I enjoy being with people
0 1 2 89. I am suspicious
0 1 2 90. I swear or use dirty language
0 1 2 91. I think about killing myself
0 1 2 92. I like to make others laugh
0 1 2 93. I talk too much
0 1 2 94. I tease others a lot
0 1 2 95. I have a hot temper
0 1 2 96. I think about sex too much
0 1 2 97. I threaten to hurt people
0 1 2 98. I like to help others
0 1 2 99. I smoke, chew, or sniff tobacco
0 1 2 100. I have trouble sleeping (describe): ____________________
0 1 2 101. I cut classes or skip school
0 1 2 102. I don't have much energy
0 1 2 103. I am unhappy, sad, or depressed
0 1 2 104. I am louder than other kids
0 1 2 105. I use drugs for nonmedical purposes (***don't*** include alcohol or tobacco) (describe): ____________________
0 1 2 106. I like to be fair to others
0 1 2 107. I enjoy a good joke
0 1 2 108. I like to take life easy
0 1 2 109. I try to help other people when I can
0 1 2 110. I wish I were of the opposite sex
0 1 2 111. I keep from getting involved with others
0 1 2 112. I worry a lot

Please write down anything else that describes your feelings, behavior, or interests:



Please print your answers.

Adult Self-Report for Ages 18-59

For office use only
ID# 0015551313

YOUR FULL NAME: Adult Person

YOUR GENDER ☐ Male ☐ Female

YOUR AGE

ETHNIC GROUP OR RACE

TODAY'S DATE Mo._____ Date _____ Yr. _____

YOUR BIRTHDATE Mo._____ Date _____ Yr. _____

Please fill out this form to reflect ***your*** views, even if other people might not agree. You need not spend a lot of time on any item. Feel free to print additional comments. ***Be sure to answer all items.***

YOUR USUAL TYPE OF WORK, even if not working now. Please be specific—for example, auto mechanic; high school teacher; homemaker; laborer; lathe operator; shoe salesman; army sergeant; student (indicate what you are studying & what degree you expect).

Your work __________ Spouse or partner's work __________

PLEASE CHECK YOUR HIGHEST EDUCATION

- ☐ 1. No high school diploma and no GED
- ☐ 2. General Equivalency Diploma (GED)
- ☐ 3. High school graduate
- ☐ 4. Some college but no college degree
- ☐ 5. Associate's Degree
- ☐ 6. Bachelor's or RN Degree
- ☐ 7. Some graduate school but no graduate degree
- ☐ 8. Master's Degree
- ☐ 9. Doctoral or Law Degree
- ☐ Other education (specify): __________

I. FRIENDS:

A. About how many close friends do you have? (Do not include family members.)

☐ **None** ☐ **1** ☐ **2 or 3** ☐ **4 or more**

B. About how many times a month do you have contact with any of your close friends? (Include in-person contacts, phone, letters, e-mail.)

☐ **Less than 1** ☐ **1 or 2** ☐ **3 or 4** ☐ **5 or more**

C. How well do you get along with your close friends?

☐ **Not as well as I'd like** ☐ **Average** ☐ **Above average** ☐ **Far above average**

D. About how many times a month do any friends or family visit you?

☐ **Less than 1** ☐ **1 or 2** ☐ **3 or 4** ☐ **5 or more**

II. SPOUSE OR PARTNER:

What is your marital status?

☐ **Never been married**
☐ **Married, living with spouse**
☐ **Widowed**
☐ **Married but separated from spouse**
☐ **Divorced**
☐ **Other—please describe:** __________

At any time in the past 6 months, did you live with your spouse or with a partner?

☐ **No—please skip to page 2.**

☐ **Yes**—Circle ***0, 1,*** or **2** beside items A-H to describe your relationship ***during the past 6 months:***

0 = Not True **1 = Somewhat or Sometimes True** **2 = Very True or Often True**

0 1 2 A. I get along well with my spouse or partner

0 1 2 B. My spouse or partner and I have trouble sharing responsibilities

0 1 2 C. I feel satisfied with my spouse or partner

0 1 2 D. My spouse or partner and I enjoy similar activities

0 1 2 E. My spouse or partner and I *disagree* about living arrangements, such as where we live

0 1 2 F. I have trouble with my spouse or partner's family

0 1 2 G. I like my spouse or partner's friends

0 1 2 H. My spouse or partner's behavior annoys me

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Please be sure you have answered all items. Then see other side.

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III. FAMILY:

Compared with others, how well do you:		Worse than Average	Variable or Average	Better than Average	No Contact
A. Get along with your brothers?	☐ I have no brothers	☐	☐	☐	☐
B. Get along with your sisters?	☐ I have no sisters	☐	☐	☐	☐
C. Get along with your mother?	☐ Mother is deceased	☐	☐	☐	☐
D. Get along with your father?	☐ Father is deceased	☐	☐	☐	☐
E. Get along with your biological or adopted children?	☐ I have no children				
1. Oldest child	☐ Not applicable	☐	☐	☐	☐
2. 2nd oldest child	☐ Not applicable	☐	☐	☐	☐
3. 3rd oldest child	☐ Not applicable	☐	☐	☐	☐
4. Other children	☐ Not applicable	☐	☐	☐	☐
F. Get along with your stepchildren?	☐ I have no stepchildren	☐	☐	☐	☐

IV. JOB: ***At any time in the past 6 months,*** did you have any paid jobs (including self-employment and military service)?

☐ **No—please skip to Section V.**

☐ **Yes—please describe your job(s):** ______

Circle ***0, 1,*** or ***2*** beside items A-I to describe your work experience ***during the past 6 months:***

0 = Not True **1 = Somewhat or Sometimes True** **2 = Very True or Often True**

0 1 2 A. I work well with others	**0 1 2** F. I do things that may cause me to lose my job
0 1 2 B. I have trouble getting along with bosses	**0 1 2** G. I stay away from my job even when I'm not sick or not on vacation
0 1 2 C. I do my work well	**0 1 2** H. My job is too stressful for me
0 1 2 D. I have trouble finishing my work	**0 1 2** I. I worry too much about work
0 1 2 E. I am satisfied with my work situation	

V. EDUCATION: ***At any time in the past 6 months,*** did you attend school, college, or any other educational or training program?

☐ **No—please skip to Section VI.**

☐ **Yes**—what kind of school or program? ______

What degree or diploma are you seeking? ______ Major? ______

When do you expect to receive your degree or diploma? ______

Circle ***0, 1,*** or ***2*** beside items A-E to describe your educational experience ***during the past 6 months:***

0 = Not True **1 = Somewhat or Sometimes True** **2 = Very True or Often True**

0 1 2 A. I get along well with other students	**0 1 2** D. I am satisfied with my educational situation
0 1 2 B. I achieve what I am capable of	**0 1 2** E. I do things that may cause me to fail
0 1 2 C. I have trouble finishing assignments	

VI. Do you have any illness, disability, or handicap? ☐ **No** ☐ **Yes—please describe:**

VII. Please describe your concerns or worries about family, work, education, or other things: ☐ **No concerns**

VIII. Please describe the best things about yourself:

IX. Below is a list of items that describe people. For each item, please circle *0, 1,* or *2* to describe yourself *over the past 6 months.* Please answer all items as well as you can, even if some do not seem to apply to you.

0 = Not True **1 = Somewhat or Sometimes True** **2 = Very True or Often True**

0 1 2 1. I am too forgetful
0 1 2 2. I make good use of my opportunities
0 1 2 3. I argue a lot
0 1 2 4. I work up to my ability
0 1 2 5. I blame others for my problems
0 1 2 6. I use drugs (other than alcohol and nicotine) for nonmedical purposes (describe): _______
0 1 2 7. I brag
0 1 2 8. I have trouble concentrating or paying attention for long
0 1 2 9. I can't get my mind off certain thoughts (describe): _______
0 1 2 10. I have trouble sitting still
0 1 2 11. I am too dependent on others
0 1 2 12. I feel lonely
0 1 2 13. I feel confused or in a fog
0 1 2 14. I cry a lot
0 1 2 15. I am pretty honest
0 1 2 16. I am mean to others
0 1 2 17. I daydream a lot
0 1 2 18. I deliberately try to hurt or kill myself
0 1 2 19. I try to get a lot of attention
0 1 2 20. I damage or destroy my things
0 1 2 21. I damage or destroy things belonging to others
0 1 2 22. I worry about my future
0 1 2 23. I break rules at work or elsewhere
0 1 2 24. I don't eat as well as I should
0 1 2 25. I don't get along with other people
0 1 2 26. I don't feel guilty after doing something I shouldn't
0 1 2 27. I am jealous of others
0 1 2 28. I get along badly with my family
0 1 2 29. I am afraid of certain animals, situations, or places (describe): _______
0 1 2 30. My relations with the opposite sex are poor
0 1 2 31. I am afraid I might think or do something bad
0 1 2 32. I feel that I have to be perfect
0 1 2 33. I feel that no one loves me
0 1 2 34. I feel that others are out to get me
0 1 2 35. I feel worthless or inferior
0 1 2 36. I accidentally get hurt a lot, accident-prone
0 1 2 37. I get in many fights
0 1 2 38. My relations with neighbors are poor
0 1 2 39. I hang around people who get in trouble
0 1 2 40. I hear sounds or voices that other people think aren't there (describe): _______
0 1 2 41. I am impulsive or act without thinking
0 1 2 42. I would rather be alone than with others
0 1 2 43. I lie or cheat
0 1 2 44. I feel overwhelmed by my responsibilities
0 1 2 45. I am nervous or tense
0 1 2 46. Parts of my body twitch or make nervous movements (describe): _______
0 1 2 47. I lack self-confidence
0 1 2 48. I am not liked by others
0 1 2 49. I can do certain things better than other people
0 1 2 50. I am too fearful or anxious
0 1 2 51. I feel dizzy or lightheaded
0 1 2 52. I feel too guilty
0 1 2 53. I have trouble planning for the future
0 1 2 54. I feel tired without good reason
0 1 2 55. My moods swing between elation and depression
56. Physical problems ***without known medical cause:***
0 1 2 a. Aches or pains (***not*** stomach or headaches)
0 1 2 b. Headaches
0 1 2 c. Nausea, feel sick
0 1 2 d. Problems with eyes (***not*** if corrected by glasses) (describe): _______
0 1 2 e. Rashes or other skin problems
0 1 2 f. Stomachaches
0 1 2 g. Vomiting, throwing up
0 1 2 h. Heart pounding or racing
0 1 2 i. Numbness or tingling in body parts
0 1 2 57. I physically attack people
0 1 2 58. I pick my skin or other parts of my body (describe): _______
0 1 2 59. I fail to finish things I should do
0 1 2 60. There is very little that I enjoy
0 1 2 61. My work performance is poor
0 1 2 62. I am poorly coordinated or clumsy

Please be sure you have answered all items. Then see other side.

0 = Not True **1 = Somewhat or Sometimes True** **2 = Very True or Often True**

0 1 2 63. I would rather be with older people than with people of my own age
0 1 2 64. I have trouble setting priorities
0 1 2 65. I refuse to talk
0 1 2 66. I repeat certain acts over and over (describe): ____________________
____
0 1 2 67. I have trouble making or keeping friends
0 1 2 68. I scream or yell a lot
0 1 2 69. I am secretive or keep things to myself
0 1 2 70. I see things that other people think aren't there (describe): ____________
____
0 1 2 71. I am self-conscious or easily embarrassed
0 1 2 72. I worry about my family
0 1 2 73. I meet my responsibilities to my family
0 1 2 74. I show off or clown
0 1 2 75. I am too shy or timid
0 1 2 76. My behavior is irresponsible
0 1 2 77. I sleep more than most other people during day and/or night (describe):
____
0 1 2 78. I have trouble making decisions
0 1 2 79. I have a speech problem (describe):
____
0 1 2 80. I stand up for my rights
0 1 2 81. My behavior is very changeable
0 1 2 82. I steal
0 1 2 83. I am easily bored
0 1 2 84. I do things that other people think are strange (describe): ____________
____
0 1 2 85. I have thoughts that other people would think are strange (describe): ________
____
0 1 2 86. I am stubborn, sullen, or irritable
0 1 2 87. My moods or feelings change suddenly
0 1 2 88. I enjoy being with people
0 1 2 89. I rush into things without considering the risks
0 1 2 90. I drink too much alcohol or get drunk
0 1 2 91. I think about killing myself
0 1 2 92. I do things that may cause me trouble with the law (describe): ____________
____

0 1 2 93. I talk too much
0 1 2 94. I tease others a lot
0 1 2 95. I have a hot temper
0 1 2 96. I think about sex too much
0 1 2 97. I threaten to hurt people
0 1 2 98. I like to help others
0 1 2 99. I dislike staying in one place for very long
0 1 2 100. I have trouble sleeping (describe): ______
____
0 1 2 101. I stay away from my job even when I'm not sick or not on vacation
0 1 2 102. I don't have much energy
0 1 2 103. I am unhappy, sad, or depressed
0 1 2 104. I am louder than others
0 1 2 105. People think I am disorganized
0 1 2 106. I try to be fair to others
0 1 2 107. I feel that I can't succeed
0 1 2 108. I tend to lose things
0 1 2 109. I like to try new things
0 1 2 110. I wish I were of the opposite sex
0 1 2 111. I keep from getting involved with others
0 1 2 112. I worry a lot
0 1 2 113. I worry about my relations with the opposite sex
0 1 2 114. I fail to pay my debts or meet other financial responsibilities
0 1 2 115. I feel restless or fidgety
0 1 2 116. I get upset too easily
0 1 2 117. I have trouble managing money or credit cards
0 1 2 118. I am too impatient
0 1 2 119. I am not good at details
0 1 2 120. I drive too fast
0 1 2 121. I tend to be late for appointments
0 1 2 122. I have trouble keeping a job
0 1 2 123. I am a happy person

124. ***In the past 6 months,*** about how many times per day did you use tobacco (including smokeless tobacco)? __________ times per day.

125. ***In the past 6 months,*** on how many days were you drunk? __________ days.

126. ***In the past 6 months,*** on how many days did you use drugs for nonmedical purposes (including marijuana, cocaine, and other drugs, except alcohol and nicotine)? __________ days.

FACCT
FOUNDATION FOR ACCOUNTABILITY

CAHMI
The Child and Adolescent Health Measurement Initiative

Young Adult Health Care Survey (YACHS)

Author: FACCT

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Young Adult Health Care Survey Version 2.0

Instructions

1. In this survey, the term doctor or other health provider is used. A doctor or other health provider could be a general doctor, a specialist doctor, a nurse practitioner, a physician assistant, a nurse, or anyone else you see for health care.

2. Answer all the questions by checking the box like this:

   ☐ Yes ☑ No

3. You are sometimes told to skip over some questions in this survey. When this happens you will see an arrow and then a note that tells you what question to answer next, like this:

   ☐ Yes ☐ No → **(Go to page 4 and continue with question 10)**

   So, if you choose to answer "No" to this question, then you will go to page 4 of this survey and continue the survey with question 10.

Thank you for your help with this survey !

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YOUNG ADULT HEALTH CARE SURVEY

CONFIDENTIAL CODE

SECTION I – HEALTH CARE UTILIZATION

Please answer all the questions in this survey by checking the box on top of your answer.

1. Have you been to see a doctor or other health provider in the **last 12 months**?

1☐ Yes 2☐ No

2. When was the **last time** you went to a doctor or other health provider for **regular** or **routine** care?

1☐ I did not go to a doctor or clinic for a regular check-up
2☐ 0-6 months ago
3☐ 7-12 months ago
4☐ 13-24 months ago
5☐ more than 2 years ago

3. The **last time** you had a visit with a doctor or other health provider, did you fill out a checklist or survey about your health?

1☐ Yes 2☐ No

4. Where do you **usually** go for medical care?

1☐ Doctor's office or clinic
2☐ School Nurse
3☐ Community clinic/health center
4☐ Hospital clinic
5☐ Hospital emergency room
6☐ Family Planning Center (For example: Planned Parenthood)
7☐ Urgent Care Clinic
8☐ No One Usual Place

5. In **last 12 months** is there any **other** place that you have gone to for medical care?
Check all that apply

1☐ No other place

2☐ Doctor's office or clinic
3☐ School Nurse
4☐ Community clinic/health center
5☐ Hospital clinic
6☐ Hospital emergency room
7☐ Family Planning Center (For example: Planned Parenthood)
8☐ Urgent Care Clinic

SECTION II PRIVACY

6. In the **last 12 months,** did you get a chance to speak with a doctor or other health provider privately? (Meaning one on one - without your parents or other people in the room).

1☐ Yes 2☐ No

7. In the **last 12 months,** did a doctor or other health provider tell you that what you talked about with them was confidential? (Meaning it would not be shared with anyone else.)

1☐ Yes 2☐ No

8. Do you know of a place (other than the school nurse) where teenagers can go to see a doctor or other health provider without their parents knowing about it?

1☐ Yes 2☐ No

CONFIDENTIAL CODE

SECTION III HEALTH AND SAFETY

9. In the **last 12 months,** did a doctor or other health provider talk with you about any of the following?

	Please answer each of the questions below by placing an X in the Yes or No box.	Yes	No
a.	Weight	1☐	2☐
b.	Healthy eating or diet	1☐	2☐
c.	Physical activity or exercise	1☐	2☐

10. In the **last 12 months,** did a doctor or other health provider talk with you about any of the following?

	Please answer each of the questions below by placing an X in the Yes or No box.	Yes	No
a.	Your friends	1☐	2☐
b.	Your school performance or grades	1☐	2☐
c.	Your emotions or moods	1☐	2☐
d.	Suicide	1☐	2☐

11. In the **last 12 months,** did a doctor or other health provider talk with you about any of the following?

	Please answer each of the questions below by placing an X in the Yes or No box.	Yes	No
a.	Using a helmet when riding a bicycle, roller-blading, or skateboarding	1☐	2☐
b.	Riding in a motor vehicle with a driver who has been drinking or using drugs	1☐	2☐
c.	Violence prevention	1☐	2☐
d.	Guns and other weapons	1☐	2☐

12. In the **last 12 months,** did a doctor or other health provider talk with you about any of the following?

	Please answer each of the questions below by placing an X in the Yes or No box.	Yes	No
a.	Chewing tobacco or snuff	1☐	2☐
b.	Drug Use (including marijuana, cocaine, crack, heroin, acid, speed, ecstasy, roofies, or other)	1☐	2☐
c.	Use of steroid pills or shots without a doctor's prescription	1☐	2☐

13. In the **last 12 months,** did a doctor or other health provider talk with you about any of the following?

	Please answer each of the questions below by placing an X in the Yes or No box.	Yes	No
a.	Sexual orientation (that is, being gay or straight)	1☐	2☐
b.	Sexually transmitted diseases, or STD's (such as gonorrhea or chlamydia)	1☐	2☐
c.	Sexual or physical abuse	1☐	2☐

The next questions ask about how you feel.

14. During the **past 12 months,** did you ever feel so sad or hopeless almost every day for **two weeks** or more in a row that you stopped doing some usual activities?

1☐ Yes
2☐ No

15. In the **last 12 months,** did you and a doctor or other health provider talk about whether you ever felt sad or hopeless almost every day?

1☐ Yes
2☐ No

The next questions ask about tobacco and smoking.

16. During the **past 30 days,** on how many days did you smoke cigarettes?

1☐ 0 days (Didn't smoke any cigarettes)
2☐ 1 or 2 days
3☐ 3 to 5 days
4☐ 6 to 9 days
5☐ 10 to 19 days
6☐ 20 to 29 days
7☐ All 30 days

17. In the **last 12 months,** did you and a doctor or other health provider talk about cigarettes or smoking?

1☐ Yes ↓
2☐ No → **Go to question 19**

18. How helpful was this discussion in understanding the risks of cigarettes or smoking to your health?

1☐ Not at all helpful
2☐ Somewhat helpful
3☐ Helpful
4☐ Very helpful
5☐ Not sure

19. In the **last 12 months,** have you **ever** smoked cigarettes?

1☐ Yes ↓
2☐ No → **Go to question 22**

20. In the **last 12 months,** did you and a doctor or other health provider talk about how and why to quit smoking (such as setting a date to quit)?

1☐ Yes ↓
2☐ No → **Go to question 22**
3☐ No, because I did not tell my doctor or other health provider that I have smoked cigarettes → **Go to question 22**

21. How helpful were your discussions in quitting smoking?

1☐ Not at all helpful
2☐ Somewhat helpful
3☐ Helpful
4☐ Very helpful
5☐ Not sure

The next questions ask about drinking alcohol.

Examples of drinking alcohol include drinking beer, wine, wine coolers, and liquor such as tequila, rum, gin, vodka, or whiskey. For these questions, drinking alcohol does not include drinking a few sips of wine for religious purposes.

22. During the **past 30 days,** on how many days did you have at least one drink of alcohol?

☐ 0 days (Didn't drink alcohol) ↓ **Go to question 24**
2☐ 1 or 2 days
3☐ 3 to 5 days
4☐ 6 to 9 days
5☐ 10 to 19 days
6☐ 20 to 29 days
7☐ All 30 days

23. During the **past 30 days,** on how many days did you have 5 or more drinks of alcohol in a row, that is, within a couple of hours?

1☐ 0 days (Didn't drink 5 or more drinks of alcohol in a row)
2☐ 1 or 2 days
3☐ 3 to 5 days
4☐ 6 to 9 days
5☐ 10 to 19 days
6☐ 20 to 29 days
7☐ All 30 days

24. In the **last 12 months,** did you and a doctor or other health provider talk about alcohol use?

1☐ Yes ↓
2☐ No → **Go to question 26**

25. How helpful was this discussion in understanding alcohol use and its risk to your health?

1☐ Not at all helpful
2☐ Somewhat helpful
3☐ Helpful
4☐ Very helpful
5☐ Not sure

The next questions ask about sexual behavior and related topics.

26. Have you ever had sexual intercourse?

1☐ Yes ↓
2☐ No → **Go to question 28**

27. The **last time** you had sexual intercourse, did you or your partner use a condom?

1☐ Yes
2☐ No

28. In the **last 12 months,** did you and a doctor or other health provider talk about condoms?

1☐ Yes
2☐ No → **Go to question 30**

29. How helpful was this discussion in understanding how to use condoms to prevent HIV and other STD's (Sexually Transmitted Diseases)?

1☐ Not at all helpful
2☐ Somewhat helpful
3☐ Helpful
4☐ Very helpful
5☐ Not sure

30. In the **last 12 months,** did you and a doctor or other health provider talk about birth control?

1☐ Yes ↓
2☐ No → **Go to question 32**

31. How helpful was this discussion in understanding how and why to use birth control?

1☐ Not at all helpful
2☐ Somewhat helpful
3☐ Helpful
4☐ Very helpful
5☐ Not sure

The next questions ask about safety.

32. How often do you wear a seat belt when riding or driving in a car?

1☐ Never
2☐ Rarely
3☐ Sometimes
4☐ Most of the time
5☐ Always

33. In the **last 12 months,** did you and a doctor or other health provider talk about the importance of wearing a seat belt?

1☐ Yes
2☐ No

CONFIDENTIAL CODE

SECTION IV – HEALTH INFORMATION

Health information can be given to you in many different ways from your doctor, other health provider, or health plan. This kind of information can be in written pamphlets, through computers in your doctor's office or posters in the waiting room. Health information can also be given to you through telephone hot lines or an Internet website.

34. In the **last 12 months,** did you see or hear information that provided safety tips for you? (Such as bicycle helmet use, seat belt use, violence prevention)

1☐ Yes 2☐ No

35. In the **last 12 months,** did you see or hear information about the risks of smoking, drinking or other substance abuse?

1☐ Yes 2☐ No

36. In the **last 12 months,** did you see or hear information about the benefits of a healthy diet, physical activity or exercise?

1☐ Yes 2☐ No

37. In the **last 12 months,** did you see or hear information that provided tips about how to prevent Sexually Transmitted Diseases (STD's) ?

1☐ Yes 2☐ No

SECTION V – YOUR HEALTH CARE IN THE LAST 12 MONTHS

The next section asks you to rate your doctor or other health provider and your experience in a health care setting.

38. In the **last 12 months,** how often were office staff at a doctor's office or clinic as helpful as you thought they should be?

1☐ Never 2☐ Sometimes 3☐ Usually 4☐ Always

39. In the **last 12 months,** how often did doctors or other health providers listen carefully to you?

1☐ Never 2☐ Sometimes 3☐ Usually 4☐ Always

40. In the **last 12 months,** how often did you have a hard time speaking with or understanding a doctor or other health provider because you spoke different languages?

1☐ Never 2☐ Sometimes 3☐ Usually 4☐ Always

41. In the **last 12 months,** how often did doctors or other health providers explain things in a way that you could understand?

1☐ Never 2☐ Sometimes 3☐ Usually 4☐ Always

42. In the **last 12 months,** how often did doctors or other health providers show respect for what you had to say?

1☐ Never 2☐ Sometimes 3☐ Usually 4☐ Always

43. In the **last 12 months,** how often did doctors or other health providers spend enough time with you?

1☐ Never 2☐ Sometimes 3☐ Usually 4☐ Always

44. In the **last 12 months,** how much of a problem, if any, was it to get the care you or a doctor or other health provider believed necessary?

1☐ A big problem 2☐ Somewhat of a problem 3☐ A small problem 4☐ Not a problem

45. In the **last 12 months,** have you ever had a serious health problem that went untreated?

1☐ Yes 2☐ No

46. We want to know your rating of all health care in the last 12 months from all doctors or other health providers. Use any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible. How would you rate all of your health care? **Circle one**

0 Worst health care possible
1
2
3
4
5
6
7
8
9
10 Best Health Care Possible

SECTION VI– YOUR HEALTH

The next questions are about your health.

47. How is your health in general?

1☐ Excellent 2☐ Very Good 3☐ Good 4☐ Fair 5☐ Poor

48. For statements **a-c**, check the box below the statement to show if you completely agree, mostly agree, agree a little or do not agree with the statement

a. I am full of energy

1☐ Completely agree 2☐ Mostly agree 3☐ Agree a little 4☐ Do not agree

b. I have a lot of good qualities

1☐ Completely agree 2☐ Mostly agree 3☐ Agree a little 4☐ Do not agree

c. I am satisfied with my life and how I live it

1☐ Completely agree 2☐ Mostly agree 3☐ Agree a little 4☐ Do not agree

49. In the **last 4 weeks,** how often did you have pains that really bothered you?

1☐ No days 2☐ 1 to 3 days 3☐ 4 to 6 days 4☐ 7 to 14 days 5☐ 15 to 28 days

50. In the **last 4 weeks**, on how many days did you exercise or play sports hard enough to make you breathe hard or make you sweat for 20 minutes or more?

1☐ No days 2☐ 1 to 9 days 3☐ 10 to13 days 4☐ 14 to 20 days 5☐ 21 to 28 days

51. In the **last 4 weeks**, on how many days did a **health or emotional** problem keep you from doing what you usually do at school or with friends and family?

1☐ No days 2☐ 1 to 3 days 3☐ 4 to 6 days 4☐ 7 to 14 days 5☐ 15 to 28 days

SECTION VII– Demographics

The next questions are about you. They are being asked for grouping purposes only.

52. How old are you?

1☐ 12 years old or younger 2☐ 13 years old 3☐ 14 years old 4☐ 15 years old 5☐ 16 years old 6☐ 17 years old 7☐ 18 years old 8☐ 19 years old 9☐ 20 years old or older

53. Are you a female or a male?

1☐ Female 2☐ Male

54. How do you describe yourself? **Select all that apply.**

1☐ White 2☐ Black or African American 3☐ Asian 4☐ American Indian or Alaskan Native 5☐ Hispanic or Latino 6☐ Native Hawaiian or Other Pacific Islander 7☐ Other

55. Did someone help you complete this survey?

1☐ Yes ↓ 2☐ No → **You are Done!**

56. How did that person help you? **Please choose all that apply.**

1☐ Read the questions to me 2☐ Wrote down the answers I gave 3☐ Answered the questions for me 4☐ Helped me remember when I last went to a doctor or other health provider 5☐ Translated the questions into my language

Helped in some other way. Please print:____________

____

____

YOU'RE DONE!!
Thank you for completing the survey. Please return the completed survey in the envelope provided.

If you want additional information on any of the topics covered in this survey, please call **1-800-XXX-XXXX**.

(We also have a TDD number: **1-800-XXX-XXXX**.)

SIPA™

Peter L. Sheras, PhD, and Richard R. Abidin, EdD

Item Booklet

Instructions:

On the SIPA Answer Sheet, please write your name, gender, date of birth, ethnic group, marital status, your child's name, gender, and date of birth, and today's date. Please mark all your responses on the answer sheet. **DO NOT WRITE ON THIS BOOKLET.**

This questionnaire contains 112 statements. Read each statement carefully. Please focus on the adolescent you are currently concerned about, and circle the response which best represents your opinion.

For statements 1-90,

Circle SD if you *strongly disagree* with the statement.

Circle D if you *disagree* with the statement.

Circle NS if you are *not sure* how you feel about the statement.

Circle A if you *agree* with the statement.

Circle SA if you *strongly agree* with the statement.

For statements 91-112,

Circle Y for "Yes."

Circle N for "No."

For example, if you sometimes enjoy going to the movies, you would circle A in response to the following statement:

I enjoy going to the movies. SD D NS (A) SA

Although you may not find a response that exactly states your feelings, please circle the response that comes closest to describing how you feel. **YOUR FIRST REACTION TO EACH QUESTION SHOULD BE YOUR ANSWER.**

Circle only one response for each statement, and respond to all statements. **DO NOT ERASE!** If you need to change an answer, make an "X" through the incorrect answer and circle the correct response. For example:

I enjoy going to the movies. ~~SD~~ (D) NS A SA

Questions about your "spouse or partner" refer to your husband or wife, or other parenting partner (i.e., the other person who is most involved in the parenting of your child). If you do not currently have a spouse or partner, leave these items blank.

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9 8 7 6 5 4 3 2

1. My child has sudden changes of feelings or moods.
2. My child has many friends.
3. My child has never been in trouble with the police.
4. My child does his or her best in school.
5. My child shows affection toward me.
6. My child becomes very upset or angry when he or she does not get his or her own way.
7. My child has little or no energy.
8. My child has become physically violent.
9. My child seems motivated to work hard.
10. My child talks to me about problems.
11. My child has a negative attitude.
12. It bothers me that my child is so quiet.
13. I think my child steals things.
14. My child does poorly in school.
15. My child tells me where he or she is going.
16. My child is grouchy and irritable.
17. My child has no close friends.
18. My child is always telling lies.
19. My child must get a great deal of attention in order to work well.
20. My child stays out too late at night.
21. My child has a bad temper.
22. My child is not liked by other children the same age.
23. My child has done serious damage to our home.
24. My child gives up easily.
25. My child has the same moral values that I have.
26. My child seems very moody.
27. My child is frequently bossed around or bullied by others.
28. My child respects the property of others.
29. My child could do better in school by trying harder.
30. I believe that my child drinks more alcohol than I would like.
31. My child gets upset over little things.
32. My child is shy with others of the same age.
33. I believe that my child skips school.
34. My child completes the tasks he or she starts.
35. My child avoids me at home.
36. My child yells at me or my spouse/partner.
37. My child gets teased a lot and it bothers me.
38. My child has threatened to hurt people.
39. My child has a short attention span.
40. My child likes to do things with the whole family.
41. My child thinks I am unfair.
42. My child never seems to do anything.
43. My child is disobedient at school.
44. I worry that my child does not do his or her school work.
45. My child does things for me that make me feel good.
46. My child argues too much.
47. I often wonder if my child is lonely.
48. My child often gets in trouble when he or she is with his or her friends.
49. My child puts forth a lot of effort to reach his or her goals.
50. My child thinks I do not love him or her.

51. Since having a teenager, I have a lot fewer chances to see my friends and to make new friends.
52. Since having a teenager, I don't seem to spend as much time with in-laws and relatives as I would like.
53. I feel alone and without friends.
54. I am usually a positive and cheerful person.
55. Since my child became a teenager, my spouse/partner and I don't spend as much time together as a couple as I had expected.
56. I find myself giving up more of my life to meet my child's needs than I ever expected.
57. I often have the feeling that other people my own age don't particularly like my company.
58. When I go to a party, I don't expect to enjoy myself.
59. Having a teenager does not leave me enough time for my own friends.
60. My spouse/partner often hurts my feelings.
61. I can't make decisions without help.
62. I often feel guilty after I get angry at my child.
63. Since my child became a teenager, my spouse/partner and I have been less physically affectionate than I would like.
64. Having a teenager has caused more problems than I expected in my relationship with my spouse/partner.
65. I often feel "left out" when I am around other people.
66. I feel that I am an excellent parent.
67. Since my child became a teenager, I feel that I am almost never able to do things that I like to do.
68. I often need to work hard to avoid conflict with my spouse/partner.
69. I am as capable as most other parents I know.
70. I often have the feeling that I cannot handle things very well.
71. Since my child became a teenager, my spouse/partner and I don't do as many things together.
72. My spouse/partner distrusts my judgment as a parent.
73. Since my child became a teenager, my spouse/partner has not given me as much help and support as I expected.
74. When I think about myself as a parent of a teenager, I believe I can handle anything that happens.
75. Since my child became a teenager, my sexual relationship(s) has (have) been less satisfying.
76. I frequently argue with my spouse/partner about how to raise my child.
77. I don't have anyone who listens to my frustrations.
78. I feel every time my child does something wrong it is really my fault.
79. I felt sadder and more depressed than I expected when my child became a teenager.
80. My spouse/partner and I disagree on the best way to discipline my child.
81. I can talk to my spouse/partner about anything.
82. When my child does things that bother me on purpose, I don't know what to do.
83. It is easy for me to understand what my child wants or needs.
84. I expected to have closer and warmer feelings for my child at this age than I do.
85. My child comes to me for help more than to other people.
86. When I think about the kind of parent I am, I often feel guilty or bad about myself.
87. I am usually successful at getting my child to do what I ask.
88. I enjoy being the parent of a teenager.
89. I cannot get my child to listen to me.
90. When my child misbehaves or gets in trouble, I feel responsible, as if I didn't do something right.

For statements 91-112, please answer Y for "Yes" or N for "No."

During the last 12 months, have any of the following events occurred in your immediate family?

91. Divorce
92. Marital reconciliation
93. Marriage
94. Separation
95. Pregnancy
96. Other relative moved into household
97. Went deeply into debt
98. Income increased substantially (20% or more)
99. Moved to new location
100. Promotion at work
101. Income decreased substantially
102. Alcohol or drug problem
103. Death of close family friend
104. Began new job
105. Entered new school
106. Trouble with superiors at work
107. Trouble with teachers at school
108. Legal problems
109. Death of immediate family member
110. Demands/illness of aging parent
111. Serious injury or medical problem
112. Continuing or chronic medical condition (diabetes, heart disease, etc.)

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ASSENT DOCUMENT FOR PARTICIPATION IN THE CMHI EVALUATION

Title of Research Project: Evaluation of the Vermont CMHI
Principal Investigator: Judy Shaw, RN., MPH., Ed.D.
Sponsor: Department of Pediatrics, University of Vermont

This assent form may contain words that you do not understand. Please ask the interviewer or your case worker to explain any words or information that you do not clearly understand before signing this document.

1. A team of researchers from University of Vermont (UVM) are inviting you to take part in their evaluation of the CMHI project. Why is this being done?
We want to find out how well the CMHI project is working for all the young people who are receiving services as part of the CMHI project. We are asking all the people receiving CMHI services to be part of this evaluation.

2. What will happen?
First you will be interviewed by a member of the UVM team. The interview will take about one half hour. We will also ask you to fill out two surveys, which should take a total of about 45 minutes. We will also collect some information about you such as your age, year in school, job status among others. All of your answers on the surveys and interviews will be kept confidential. We do not plan to share your survey responses or your interviews with anyone outside of the research team and no one will be able to look at them except the UVM evaluation team unless we have to share them by law. Also, the answers to your survey and interview questions will be marked with an identification number assigned to you. Your name will not be on any of this information. Your name will be kept in a safe place away from any of the information we collect so we can protect your privacy. After about 6 months we will ask you to do another round of interviews and surveys, and again at about 12 months from now. We will also ask your caregiver (this might be a parent or a foster parent) to fill out surveys several times.

3. What does it cost and how much does it pay?
You do not have to pay to take part in this study. At the first interview, you will receive $20 from UVM to reward you for the time you spent completing the survey. You can keep this money even you decide to not participate in any more of the interviews and surveys.

4. There are very few risks in taking part in this research, but the following could happen:
Probably: Nothing bad would happen.
Maybe: Your survey and interview answers would be seen by somebody not involved in this study. We will do our absolute best to keep all of your answers private. Your answers will be kept locked up. Your name will not appear on your survey or interview forms; we will use a code number instead. The people who work on the UVM evaluation team are very well trained and understand the importance of confidentiality. But, if the researchers learn that you or someone else is in serious danger they would have to tell an appropriate person, such as your case worker, or the appropriate officials to protect you and other people.

Very unusual: You could be upset or embarrassed by a few of the questions. If this should occur, remember that you don't have to answer any questions you don't want to and you can stop taking the survey at any time.

5. Are there any benefits that you or others will get out of being in this study?
All research must have some potential benefit either directly to those who take part in it or potentially to others through the knowledge gained. You may benefit from answering questions about your experiences as part of the Vermont CMHI project. The knowledge gained through this study may allow us to help the CMHI project improve how it works for yourself and other young people.

6. It is completely up to you!
Both you and your caregiver have to agree to allow you to take part in this study. If you choose not to take part in this study, we will honor that choice. You may agree to take part in this study now and change your mind later, which is OK too. It's always your choice.

7. CONFIDENTIALITY: We will do everything possible to protect your confidentiality.
If we write professional articles about this research, they will never say your name or anything that could give away who you are. We will do a good job at keeping all our records secret by following the rules that the US government has made for researchers.

8. Do you have any questions? If you have any questions or worries about this study, of if any problems come up, you may ask a member of the UVM evaluation team or you can contact the principal investigator, Dr. Judy Shaw, at (802) 656-8210 or Judith.Shaw@uvm.edu. You can also ask questions or talk about any worries with Nancy Stalnaker, the Institutional Review Board Program Director at the University of Vermont at (802) 656-5040

9. The University of Vermont evaluation team appreciates very much your taking part in this study. What if you think something bad happens just because of this study or that people from the University of Vermont are pushing you too much to make you be in the study? Call Nancy Stalnaker, the Institutional Review Board Program Director at the University of Vermont at (802) 656-5040. We will do our best to help and make things right for you.

I assent (that means I agree) to participate in this study called: Evaluation of the Vermont CMHI.

____

Signature Date

____

Name (Please Print)

____

Signature of Principal Investigator or Designee Date

____

Printed Name of Principal Investigator or Designee

Statement of Informed Consent

Title of Research Project: Evaluation of the Vermont CMHI
Principal Investigator: Judy Shaw, RN., MPH., Ed.D.
Sponsor: Department of Pediatrics, University of Vermont

Throughout this document "you" refers to "you and your child." You are being invited to take part in an evaluation of the Vermont CMHI project because you are the caregiver of a young person who is receiving services through the CMHI project. This evaluation is being conducted by Dr. Judy Shaw (PI), Research Associate Professor of Pediatrics at the University of Vermont. We encourage you to ask questions and take the opportunity to discuss the study with anybody you think can help you make this decision.

Why is this Evaluation Being Conducted?

- It is very important that we assess how well the CMHI project is working, in order to understand the impact the project is having on youth peoples' lives and the lives of their caregivers.
- The results of this evaluation should go far in understanding which aspects of the CMHI project are associated with improved outcome for young people receiving CMHI services and their caregivers, and to help us improve the CMHI project.

How Many People Will Take Part in this Evaluation?

- All youth and their caregivers who receive services through the CMHI project are being asked to participate in the evaluation.

What is Involved in this Study?

- The main part of the evaluation will involve paper-and-pencil surveys that youth and their caregivers will fill out during a meeting with the project evaluator. Only youth who assent (agree) to be in the evaluation and whose caregivers also agree to be in the evaluation will fill out the surveys. It is expected to take approximately one and one half hour to complete the surveys, and we will try to schedule a time to do them soon after the youth starts receiving services through the CMHI project.
- Approximately one year later, we will contact you to schedule a time to do another round of the same surveys.

What are the Risks and Discomforts of the Study?

- The only possible risk is a breach of confidentiality. VCHIP will use only trained interviewers to minimize this risk. In addition, VCHIP will store all data in a locked cabinet and on a secure, password-protected network. Furthermore, all identifying information about you (name, age, etc.) will be kept separate from the actual data we collect.

What are the Benefits of Participating in this Evaluation?

- This evaluation will help us understand which aspects of the CMHI project are working well, and which aspects may need to be improved, and we will then work to improve how the project is working with the aim of all people who receive services benefitting.

What is the Compensation?

- You will a $20 payment for each interview; each youth will also receive $20 for participating in each interview.

Can You Withdraw from the Evaluation?

- Yes, you can stop participating or skip any questions that you do not want to answer, without penalty.
- Participating in the first interview does not obligate you to participate in any future interviews.

What about Confidentiality?

- All surveys and questionnaires will be coded with a number that protects youths' and caregivers' identity and keeps their responses confidential.
- The master list of youth and caregiver identities will be kept separately from the data, in a locked laboratory at UVM.
- The surveys will be kept in a locked filing cabinet in a locked suite (PI's laboratory).
- The electronic data will be kept on a secure network, with password access. Only members of the PI's evaluation team will have access to these data.
- The results of this study may eventually be published and information may be exchanged between researchers; however, your confidentiality will be maintained.

Contact Information

You may contact Dr. Judy Shaw, the Investigator in charge of this study, at (802) 656-8210 for more information about this study. If you have any questions about your rights as a participant in a research project or for more information on how to proceed should you believe that you may have been injured as a result of your participation in this study you should contact Nancy Stalnaker, the Institutional Review Board Administrator at the University of Vermont at (802) 656-5040.

Statement of Consent

You have been given and have read or have had read to you a summary of this evaluation. Should you have any further questions about the evaluation, you may contact the person conducting the study at the address and telephone number given below. Your participation is voluntary and you may refuse to participate or withdraw at any time without penalty or prejudice to your present and/or future care.

You agree to participate in this study and you understand that you will receive a signed copy of this form.

____ **Yes, I agree to participate.**

____ **No, I do not agree to participate.**

(go to next page)

____

Signature of Legal Guardian or Legally Authorized Representative **Date**

____

Printed Name of Legal Guardian or Legally Authorized Representative

____

Signature of Minor Providing Assent **Date**

____

Printed Name of Legal Minor Providing Assent

____

Signature of Principal Investigator or Designee **Date**

____

Printed Name of Principal Investigator or Designee

Name of Principal Investigator: Judy Shaw, RN., MPH, Ed.D.
Address: UVM VCHIP, UHC St. Joseph 7, University of Vermont, Burlington, VT 05401
Telephone Number: (802) 656-8210 **Email Address:** **Judith.Shaw@uvm.edu**

Documentation of Informed Consent/Assent Process Form

Protocol: Adolescents' Beliefs about School Study

Participant ID:

Participant Initials:

Date of Participation:

PI/Designee:

Participant, ____________________________, assented to the above named protocol after
(participant's name)
researchers obtained parent/guardian permission form indicating that the participant was able to be invited to participate in the above named research study.

Prior to signing the assent form the participant:

- Read the information sheet and assent form
- Discussed the protocol participation with researcher including:
    - Purpose of the study
    - Risks/benefits
    - Alternatives
    - Who to contact with questions
    - Withdrawal rights
- Asked questions; and
- *Consulted with family or other physicians.*

Informed assent was conducted prior to any research-related procedures.

The subject was provided with a fully executed copy of the information sheet and assent form.

Other Comments:

PI/Designee Signature: ____________________________ Date:__________________

Note: Parental permission form and participant assent form should be attached to this form.

WCMHS,Inc.

Consent and Agreement to the Use and Disclosure of Health Information For Treatment, Payment or Healthcare Operations

I understand that as part of my care, the Corporation originates and maintains records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the professionals who contribute to my care,
- A source of information for applying my diagnosis and information to my bill,
- A means by which a third-party can verify that services billed were actually provided,
- And a tool for routine healthcare operations such as assessing quality, reviewing the competence of health care professionals and the services that are offered and for performing specially approved research studies.

I understand that the Corporation is a Designated Agency by the Commissioner of the Vermont Department of Developmental and Mental Health Services (DDMHS) and that DDMHS may access my health information as necessary to fulfill its legal responsibilities under Vermont Law. I have been provided with a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures (release of, or access to, your information). I understand that I have the right to review the notice prior to signing this consent. I understand that the Corporation reserves the right to change their notice and practices. However, prior to a material change taking effect, the Corporation will publish an announcement of the change at every Corporation facility, on its website and in the Times Argus. I understand that a new Notice will be distributed to me.

I understand that my records are subject to confidentiality imposed by state and federal regulations. I also understand that alcohol and drug abuse client records are protected by 42CFR part 2, and that records may not be released or disclosed without my written consent unless otherwise provided for in the regulations.

I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations. I understand that the organization is not required to agree to the restrictions requested, however if the Corporation agrees to the requested restrictions, they are bound by our agreement.

By signing this form, I consent to the Corporation's use and disclosure of protected health information about me (1) for treatment, payment and health care operations consistent with Corporation's Notice of Privacy Practices and (2) for the purpose of fulfilling DDMHS' responsibilities as granted and permitted under Vermont law. I understand that I may revoke this consent in writing, except to the extent that the Corporation has already taken action based upon my prior consent.

____
Name of Individual Receiving Services (please print)

________________________________	______________________________
Signature of Individual Receiving Services Or Legal Representative	Witness
	JUNE 15, 2004
Date	Notice Effective Date or Version

2. Consent for Eligibility Determination & Coordinated Services Planning

Child/Youth's Name	Lead Agency

A Coordinated Services Plan (CSP) is a process that follows a series of steps to help children and youth realize their hopes and goals. People from the child or youth's life work as a team to develop a plan that brings together the services and supports needed. I understand that as a parent I am a member of the CSP team.

I give my consent to the lead agency to start the process of determining if my child is eligible for a CSP. Often eligibility is part of the initial CSP meeting when information is gathered and reviewed about how particular agencies or departments are involved with the child/youth.

If my child is eligible, I give consent for the CSP team to develop a coordinated services plan.

I understand that:

- I must also sign a *Consent for Release of Information* form (page 3). The *Consent for Release of Information* will let the lead agency share my child's information with the CSP team. The CSP team members are listed on page 4.
- The lead agency will let me know within 30 days of when it gets this signed form and the signed *Consent for Release of Information* whether or not my child is eligible.
- Records that the lead agency has gathered throughout the coordinated services planning process are confidential. The lead agency will not share these records with others without first getting my consent in writing unless the law says they must be shared.
- I can look at or get a copy of these records by writing a letter to the lead agency.
- I will be given a copy of this consent form after I sign it.
- If I do not give my consent the lead agency cannot determine if my child is eligible for a CSP and a CSP cannot be developed.
- My child's current benefits and services will not be affected if I do not give my consent.

If my child is found eligible, I want to speak with my Local Interagency Team's parent representative before the *Coordinated Services Plan* meeting.	☐ Yes ☐ No

	Print Name	Signature	Date
Parent / Guardian			
Witness			
Educational Surrogate Parent (*if applicable*)			

State of Vermont
Department of Mental Health
Office of the Commissioner
108 Cherry Street, PO Box 70
Burlington, VT 05402-0070
healthvermont.gov/mh

[phone] 802-951-1258
[fax] 802-951-1275
[tty] 800-253-0191

Agency of Human Services

January 24, 2008

Ms. Crystal Saunders, Director of Grant Review
Office of Program Services
Substance Abuse and Mental Health Services Administration
Room 3-1044
1 Choke Cherry Road
Rockville, MD 20850

Re: Vermont's application for RFA # CMHI – SM – 08 – 004
Appendix 5: Non-Federal Match Certification

Dear Ms. Saunders:

As Commissioner of the Vermont Department of Mental Health who will receive the funds for this cooperative agreement, if they are awarded, I hereby certify that Vermont does have the non-Federal matching funds for our proposed project.

The attached chart shows the new investments that Vermont expects to make in the system of care over the next 6-7 years for youth aged 16-21 (inclusive) who are experiencing serious emotional disturbance and their families. These investments are above the average expenditures for State FY06 and FY07 for the chosen programs and reflect our estimated expenditures for this target population. We have been conservative in our estimates. There will undoubtedly be even more investments made in the future that we cannot at this time accurately predict. For example, some of the changes in Medicaid that are currently being discussed at the national level may cause significant new investments of State funds to off-set loss of federal Medicaid revenues.

The Department of Mental Health has a strong track record for sustaining its grant-funded initiatives. Our two prior CMHI grants (Access Vermont for children's crisis outreach services and for CUPS for children aged 0-6) were replaced with State funding by the Legislature because of good outcomes and interagency and consumer support. We will provide the leadership for this project, closely supervise the work, and do all we can to ensure its sustainability. Our transition-aged youth sorely need these services.

In this Appendix 5 you will find letters from the other departments of state government that have pledged their expected investments as match for this CMHI project.

Sincerely,

Michael Hartman, MSW
Commissioner

VERMONT

AGENCY OF HUMAN SERVICES

Department for Children and Families
Office of the Commissioner
103 South Main Street
Waterbury, VT 05671-2401
(802) 241-2100 Fax (802) 241-2980
www.dcf.state.vt.us

Crystal Saunders, Director of Grant Review
Office of Program Services
Substance Abuse and Mental Health Services Administration
Room 3-1044
1 Choke Cherry Road
Rockville, MD 20850

January 22 , 2008

Re: Vermont's application for RFA # CMHI – SM – 08 – 004

Appendix 5: Non-Federal Match Certification

Dear Ms. Saunders:

As Commissioner of the State Department for Children and Families (DCF) – and as a former Children's Mental Health Director for the HowardCenter - I am acutely aware of the needs of transition-aged youth for services and supports that offer them safety and guidance in moving toward adult roles and responsibilities.

With the support of the Governor and Legislature and under my leadership, the DCF has recently and significantly expanded the State-funded supports and services it can offer to this population – e.g., housing for youth aging out of foster care, mentoring opportunities, restorative justice and street checkers, and Reach-up outside the TANF work restrictions for people with disabilities or babies under two.

Because DCF is committed to the goal of this CMHI project to support transition-aged youth with SED and help them be free of incarceration, we are pledging this expanded service as match, as indicated on the attached chart. The chart shows new investments above the average expenditures for State FY06 and FY07 for the chosen programs and reflects our estimated expenditures for this target population for the future.

DCF is very active on the Act 264 SIT and LITs and will be deeply involved with the planning for this project, which I surely hope you will fund.

Sincerely,

Steve Dale, Commissioner

Department of Health
Div. of Alcohol and Drug Abuse Programs
108 Cherry Street - PO Box 70
Burlington, VT 05402-0070
www.state.vt.us/adap

[phone] 802-651-1550
[fax] 802-651-1573

Agency of Human Services

January 24, 2008

Ms. Crystal Saunders, Director of Grant Review
Office of Program Services
Substance Abuse and Mental Health Services Administration
Room 3-1044
1 Choke Cherry Road
Rockville, MD 20850

Re: Vermont's application for RFA # CMHI – SM – 08 – 004
Appendix 5: Non-Federal Match Certification

Dear Ms. Saunders:

The Department of Health, Division of Alcohol and Drug Abuse Programs (ADAP), is very interested in the CMHI grant project being proposed by the Department of Mental Health (DMH) because, if funded, it will offer services that can be of great benefit to transition-aged youth who are struggling with co-occurring mental health and substance abuse challenges. We have been working closely with, especially, the adult mental health programs to develop and deliver co-occurring treatment and appreciate any increased capacity for treatment of adolescents, too.

For this reason, we are pledging non-Federal matching funds for the project based upon the recent increases in our budget for centers for adults (aged 18 or older) recovering from substance abuse, as shown on the attached chart. These investments are above our average expenditures for State FY06 and FY07 for Recovery Centers and reflect our estimated expenditures for this target population.

ADAP will actively participate in the strategic planning for this project during Year 1 through both the State and Local Interagency Teams and will continue to advise it in subsequent years.

I hope you will fund this enhancement of Vermont's System of Care for transition-aged youth with severe emotional disturbance.

Sincerely,

Barbara Cimaglio

Barbara Cimaglio
Deputy Commissioner
for Alcohol & Drug Abuse Programs

State of Vermont
Department of Corrections
103 South Main Street
Waterbury, VT 05671-1001
www.doc.state.vt.us

[phone] 802-241-2263
[fax] 802-241-2565

Agency of Human Services

January , 2008

Crystal Saunders, Director of Grant Review
Office of Program Services
Substance Abuse and Mental Health Services Administration
Room 3-1044
1 Choke Cherry Road
Rockville, MD 20850

Re: Vermont's application for RFA # CMHI – SM – 08 – 004
Appendix 5: Non-Federal Match Certification

Dear Ms. Saunders:

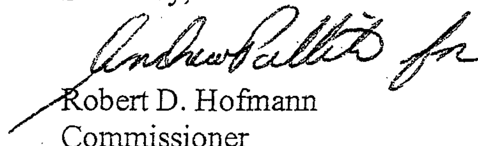
The State Department of Corrections is very interested in the CMHI grant project being proposed by the Department of Mental Health because, if funded, it will offer services that can be of great benefit to the youth under our supervision. For this reason we are pledging non-Federal matching funds for the project based upon the recent increases in our budget for Transitional Housing and Community Justice Centers, as shown on the attached chart.

These investments are above our average expenditures for State FY06 and FY07 for the chosen programs and reflect our estimated expenditures for this target population. As mentioned in this proposal, if the Legislature does decide to reinvest funds saved from future increased costs for incarceration, we may well be able to make even more investments in the future for community justice and treatment alternatives to incarceration for offenders, including young offenders.

The Department of Corrections will actively participate in the strategic planning for this project during Year 1 through both the State and Local Interagency Teams and will continue to advise it in subsequent years.

I hope you will fund this enhancement of Vermont's System of Care for transition-aged youth with severe emotional disturbance.

Sincerely,



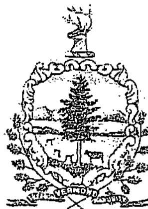
Robert D. Hofmann
Commissioner

VERMONT

WILLIAM H. SORRELL
ATTORNEY GENERAL

JANET C. MURNANE
DEPUTY ATTORNEY GENERAL

WILLIAM E. GRIFFIN
CHIEF ASST. ATTORNEY GENERAL



TEL.: (802) 828-3171
FAX: (802) 828-2154
TTY: (802) 828-3665
CIVIL RIGHTS:(802) 828-3657

http://www.atg.state.vt.us

STATE OF VERMONT
OFFICE OF THE ATTORNEY GENERAL
109 STATE STREET
MONTPELIER, VT
05609-1001

January 24, 2008

Crystal Saunders, Director of Grant Review
Office of Program Services
Substance Abuse and Mental Health Services Administration
Room 3-1044
1 Choke Cherry Road
Rockville, MD 20850

Re: Vermont's application for RFA # CMHI – SM – 08 – 004
Appendix 5: Non-Federal Match Certification

Dear Ms. Saunders:

I am writing to express my support for the CMHI grant proposal from the Department of Mental Health and to pledge non-Federal matching funds for it from the increases to our Court Diversion budget.

Court Diversion serves many youth aged 16-21 with serious emotional disturbance who need the mental health services planned for this project, and our programs recognize the importance of early assessment and access to treatment. When concerned about a young person's mental health or substance use, Court Diversion review boards will ask the youth to obtain a mental health or substance abuse assessment, and follow through on the counselor's recommendations. Court Diversion case management, provided in close collaboration with other service providers, plays an important role in youth benefiting from these interventions.

The investments in Court Diversion documented in the attached chart are above the average expenditures for State FY06 and FY07 and reflect our estimated expenditures for the future for this target population.

The Attorney General's Office will participate in the strategic planning for this grant project during its first and subsequent years of funding and look forward to being a partner in this important system development.

Sincerely,

Michael McShane
Assistant Attorney General

VERMONT

RECEIVED
JAN 18 2008
CHILD DEVELOPMENT DIVISION

State of Vermont
Department of Labor
5 Green Mountain Drive
P.O. Box 488
Montpelier, VT 05601-0488
www.labor.vermont.gov

[phone] 802-828-4000
[fax] 802-828-4022

January 16, 2008

Crystal Saunders, Director of Grant Review
Office of Program Services
Substance Abuse and Mental Health Services Administration
Room 3-1044
1 Choke Cherry Road
Rockville, MD 20850

Re: Vermont's application for RFA # CMHI – SM – 08 – 004
Appendix 5: Non-Federal Match Certification

Dear Ms. Saunders:

The State Department of Labor is very interested in the CMHI grant project being proposed by the Department of Mental Health because, if funded, it will offer services that can be of great benefit to the youth we are preparing to enter Vermont's workforce. Many of our youth need extra support such as that available through the JOBS program in order to successfully transition to independent living and working.

For this reason we are pledging non-Federal matching funds for the project based upon the recent increases in our budget for Career Exploration and Alternative Education and for Secondary School Internship Grant, as shown on the attached chart. These investments are above our average expenditures for State FY06 and FY07 for the chosen programs and reflect our estimated expenditures for this target population.

The Department of Labor and our Workforce Investment Boards will actively participate in the strategic planning for this project during Year 1 through both the State and Local Interagency Teams and will continue to advise it in subsequent years.

I hope you will fund this enhancement of Vermont's System of Care for transition-aged youth with severe emotional disturbance.

Sincerely,

Pat McPowden

Patricia Moulton Powden
Commissioner

New System of Care and Mental Health Treatment Investments for Transition-Aged Youth (in therapeutic community or residential programs with fewer than 10 beds)

Expected [*Replace with Actual*] New State General or Private Funds Counted as Match							
Source of $ - Cash or In-kind	FFY Year #1 – SFY 2009	FFY Year #2 – SFY 2010	FFY Year #3 – SFY 2011	FFY Year #4 – SFY 2012	FFY Year #5 – SFY 2013	FFY Year #6 – SFY 2014	FFY Year #7 – SFY 2015
DCF - Family Services	Youth Aging Out of Foster Care (Housing Supports) $967,575	Youth Aging Out of Foster Care (Housing Supports) $1,448,944	Youth Aging Out of Foster Care (Housing Supports) $1,891,272	Youth Aging Out of Foster Care (Housing Supports) $1,929,097	Youth Aging Out of Foster Care (Housing Supports) $1,967,679	Youth Aging Out of Foster Care (Housing Supports) $2,007,033	Youth Aging Out of Foster Care (Housing Supports) $2,047,174
	Restorative Justice + Street Checkers $33,233	Restorative Justice + Street Checkers $33,233	Restorative Justice + Street Checkers $33,233	Restorative Justice + Street Checkers $33,233	Restorative Justice + Street Checkers $33,233	Restorative Justice + Street Checkers $33,233	Restorative Justice + Street Checkers $33,233
	Mentoring $25,000	Mentoring $25,000	Mentoring $25,000	Mentoring $25,000	Mentoring $25,000	Mentoring $25,000	Mentoring $25,000
DCF Family Services Sub-total	*$1,025,808*	*$1,507,177*	*$1,949,505*	*$1,987,330*	*$2,025,912*	*$2,065,266*	*2,105,407*
DCF - Economic Services	Reach-up – Solely State-funded Share $65,539	Reach-up – Solely State-funded Share $79,253	Reach-up – Solely State-funded Share $92,967	Reach-up – Solely State-funded Share $106,681	Reach-up – Solely State-funded Share $122,709	Reach-up – Solely State-funded Share $136,423	Reach-up – Solely State-funded Share $147,823
DCF Sub-total	***$1,091,3478***	***$1,586,430***	***$2,042,472***	***$2,094,011***	***$2,148,621***	***$2,201,689***	***$2,253,230***
VDH - Alcohol and Drug Abuse	Recovery Centers ***$46,500***	Recovery Centers ***$46,500***	Recovery Centers ***$46,500***	Recovery Centers ***$46,500***	Recovery Centers ***$46,500***	Recovery Centers ***$46,500***	Recovery Centers ***$46,500***
Corrections	Transitional Housing $125,000 Return House	Transitional Housing $125,000 Return House	Transitional Housing $125,000 Return House	Transitional Housing $125,000 Return House	Transitional Housing $125,000 Return House	Transitional Housing $125,000 Return House	Transitional Housing $125,000 Return House
Corrections	Community Justice Centers $60,000	Community Justice Centers $60,000	Community Justice Centers $60,000	Community Justice Centers $60,000	Community Justice Centers $60,000	Community Justice Centers $60,000	Community Justice Centers $60,000
Corrections Sub-total	*$185,000*	*$185,000*	*$185,000*	*$185,000*	*$185,000*	*$185,000*	*$185,000*

Attorney General	***$19,879*** for Diversion	***$19,879*** for Diversion	***$19,879*** for Diversion	***$19,879*** for Diversion	***$19,879*** for Diversion	***$19,879*** for Diversion	***$19,879*** for Diversion
Labor	Career Exploration and Alternative Education $400,00	Career Exploration and Alternative Education $400,00	Career Exploration and Alternative Education $400,00	Career Exploration and Alternative Education $400,00	Career Exploration and Alternative Education $400,00	Career Exploration and Alternative Education $400,00	Career Exploration and Alternative Education $400,00
Labor	Secondary School Internship Grants $200,000	Secondary School Internship Grants $200,000	Secondary School Internship Grants $200,000	Secondary School Internship Grants $200,000	Secondary School Internship Grants $200,000	Secondary School Internship Grants $200,000	Secondary School Internship Grants $200,000
Labor Sub-total	***$600,000***	***$600,000***	***$600,000***	***$600,000***	***$600,000***	***$600,000***	***$600,000***
Mental Health						***$800,000***; replace fed CMHI $	***$1,500,000*** replace fed CMHI $
Total Match for SOC	***$1,942,726***	***$2,437,809***	***$2,893,851***	***$2,945,390***	***$3,000,000***	***$3,853,068***	***$4,604,609***
Match Required	$333,333	$500,000	$666,667	$2,000,000	$3,000,000	$2,000,000	Depends on carry-forward $

AHS Office of the Secretary

- AHS Field Services Division
- AHS Operations and Planning Division

Department for Children and Families
- Child Development
- Child Support
- Family Services
- Disability Determination
- Economic Services
- Economic Opportunity

Department of Health
- Alcohol and Drug Abuse Programs Division
- Community Public Health
- Health Protection
- Health Surveillance
- Health Improvement
- Medical Practice Board

Department of Corrections
- Administration
- Facilities
- Program Services
- Restorative and Community Justice
- Placement Services
- Field Services

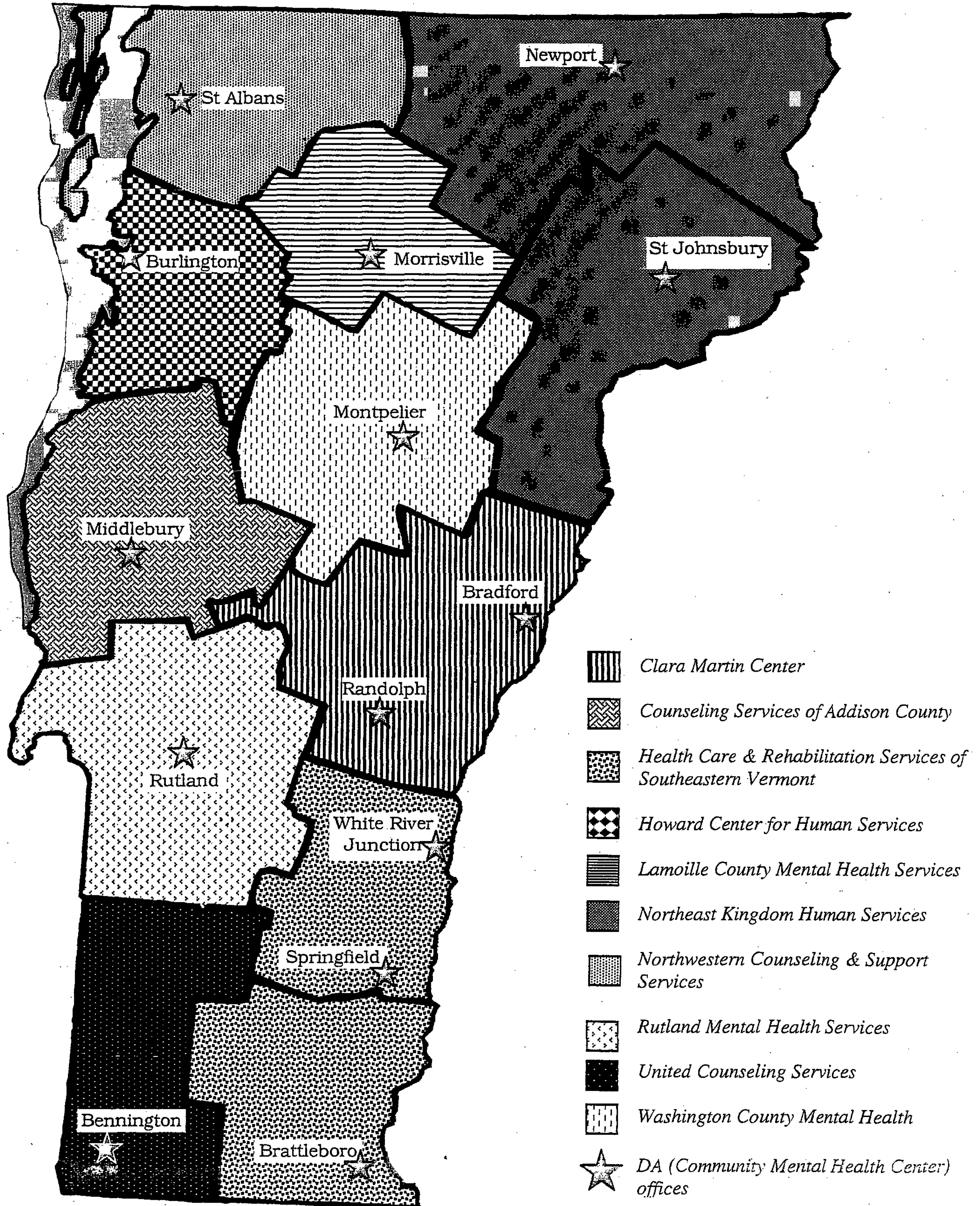
Department of Disabilities, Aging and Independent Living
- Division of Licensing & Protection
- Division of Disability and Aging Services
- Division for the Blind & Visually Impaired
- Vocational Rehabilitation

Department of Mental Health
- Child, Adolescent and Family Unit
- Division of Adult Services
- Vermont State Hospital
- VSH Futures Project

Office of VT Health Access
- Operations
- Clinical Services

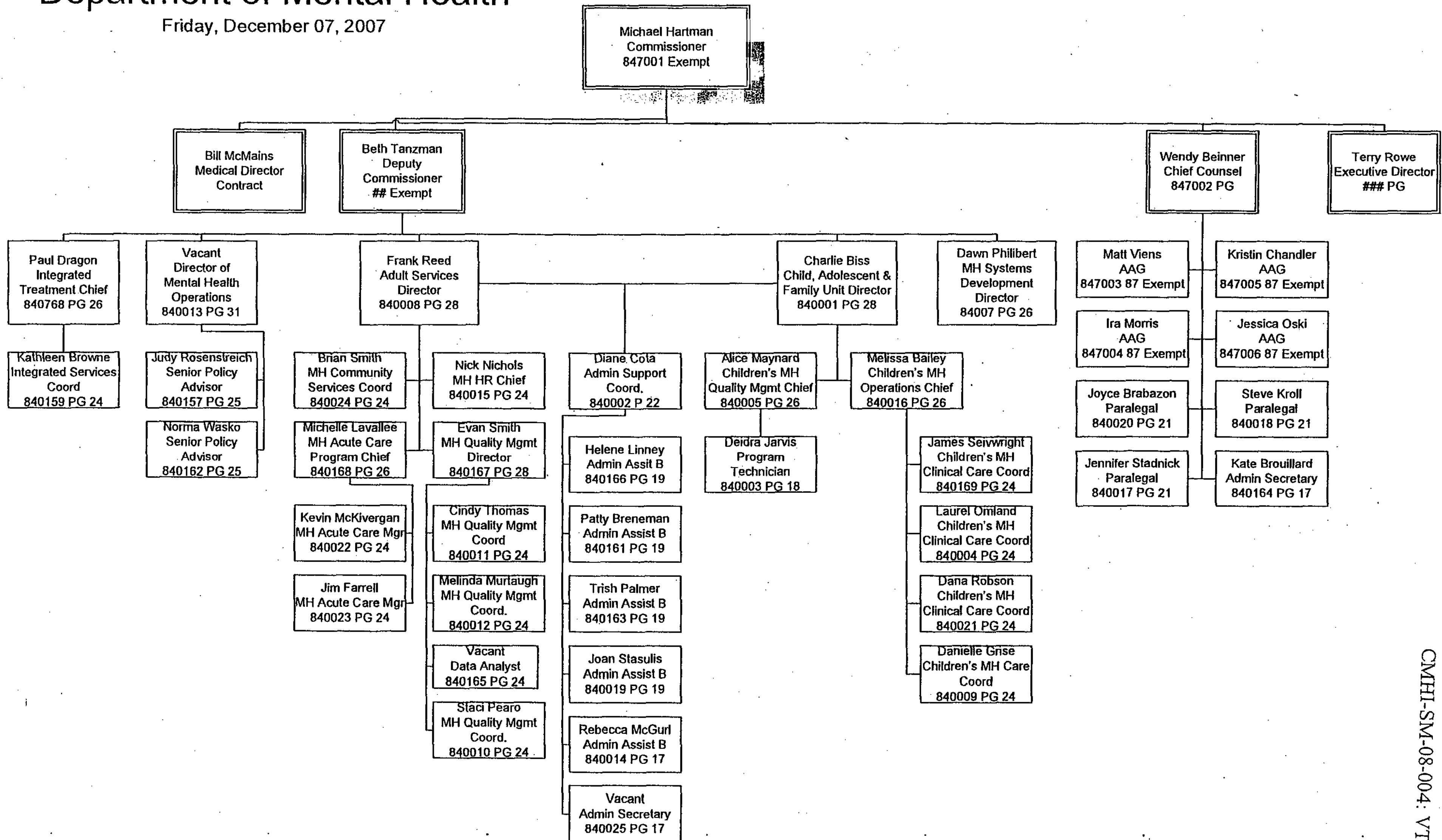
reated by C. Young

DESIGNATED AGENCIES BY REGION



Department of Mental Health

Friday, December 07, 2007



CMHI-SM-08-004: VT Appendix 6

Management, Staffing, and Timeline Chart
Year 1

TASKS	STAFFING	TIMELINE IN MONTHS
STATE-LEVEL		
Apply to Joint Fiscal Committee of Legislature to accept grant	DMH Principal Investigator	Upon notice of grant award; no funds can be spent until Joint Fiscal approval given
Negotiate final terms for Cooperative Agreement with CMHS	DMH Principal Investigator	Upon notice of grant award or as soon afterwards as possible
Convene State Outreach Team* of Act 264 SIT	DMH Principal Investigator	Upon notice of grant award
Begin strategic planning for statewide sustainability, including adopting a logic model	DMH Principal Investigator and State Outreach Team	1st -3rd month
Hire Project Director (contractor)	DMH Principal Investigator with State Outreach Team input	1st -3rd month
Issue Invitation to Act 264 LITs for regional planning, including for management and sustainability of services	Principal Investigator and/or Project Director, and State Outreach Team	3rd month
Award planning grants ($10,000) to each of 12 regions	Project Director	3rd month
Award sub-grants to VCHIP for evaluation, Vermont Federation of Families for Children's Mental Health for family and youth liaisons, and HowardCenter for cultural and linguistic competence	Project Director	3rd month
2nd Evaluator hired/assigned	VCHIP	3rd – 4th month
Family Liaison hired/assigned	Federation	3rd – 4th month
Youth Coordinator hired	Federation	4th month
Cultural and Linguistic Competence Coordinator hired/assigned	HowardCenter	3rd – 4th month
Form Evaluation Committee to get input to evaluation design from families, youth, cultural consultants, and service providers	VCHIP	5th – 6th month

Form Cultural and Linguistic Competence Committee to begin statewide planning for cultural and linguistic competence, with particular focus on Chittenden County	Cultural and Linguistic Competence Coordinator	5th – 6th month
Provide on-site TA to regions as they plan	Principal Investigator, Project Director, and State Outreach Team	4th -6th month
Application for IRB approval for evaluation submitted to University of Vermont	VCHIP	7th month
Issue Requests for Bids for Training and Technical Assistance and for Social Marketing expertise	Principal Investigator, Project Director, and State Outreach Team	7th month
Review and approve or seek revisions to regional plans	Principal Investigator, Project Director, and State Outreach Team	8th month
Award service grants to regions	Project Director	9th month
IRB approval obtained from University of Vermont for evaluation design	VCHIP	9th month
Review and approve or seek revisions to bids for T/TA and Social Marketing	Principal Investigator, Project Director, and State Outreach Team	9th month
Award sub-grants for Training and Technical Assistance and for Social Marketing expertise	Project Director	9th month
Hire/assign T/TA Coordinator	Successful bidder for T/TA	9th – 10th month
Hire/assign Social Marketing-Communications Manager	Successful bidder for Social Marketing	9th – 10th month
Form T/TA Committee to begin statewide planning for technical assistance	T/TA Coordinator	11th – 12th month
Form Social Marketing Committee to begin statewide planning for social marketing-communications	Social Marketing-Communications Manager	11th – 12th month
Provide on-site TA to regions as they start-up services	Principal Investigator, Project Director, and State Outreach Team	10th -12th month
Support to regions as needed	Project Director	Ongoing

Meet National CMHS expectations for quarterly and annual progress reports and annual financial reports	Project Director and VDH/DMH Business Office	Quarterly and annually
Attend required CMHS sub-grantee meetings	Principal Investigator, Project Director, and State Outreach Team	Twice a year
REGIONAL-LEVEL		
Convene local planning group* and decide how to best use planning resources (including for translation and interpreters)	AHS Field Services Directors with LITs	4th month
Conduct local assessment and planning for services	Assigned local planning group, including families, youth, mental health, and key community stakeholders	4th -7th months
Submit to State Outreach Team the regional plan and request for funds for services, with designation of fiscal agent and ongoing management group	LITs	8th month
Hire service staff	CMHC and/or other regionally-chosen providers	10th -12th months
Start providing services	CMHC and/or other regionally-chosen providers	10th -12th months
Participate in evaluation	CMHC and/or other regionally-chosen providers	10th -12th months
Provide quarterly progress report and monthly financial reports to DMH	Regional fiscal agent, with information from providers	12th month, and ongoing
Attend State-level and National meetings as required	CMHC and/or other regionally-chosen providers and members of regional management group	Ongoing

*State Outreach Team includes State-level staff required for project (including evaluators, youth coordinator, family liaison, cultural competence coordinator, T/TA coordinator, and social marketing-communications manager) and representatives from the State departments and organizations which have pledged match for the system of care, as well as interested others. Local planning teams include similar representation from the regions.

Management, Staffing, and Timeline Chart
Years 2-6

TASKS	STAFFING	TIMELINE PER YEAR
STATE-LEVEL		
State Outreach Team meetings, with continued development of strategic sustainability plan	DMH Principal Investigator and Project Director, with SIT	Quarterly
Inform State Outreach Team of evaluation findings and recommendations	VCHIP	Quarterly
Inform regions of evaluation findings and recommendations	VCHIP	Annually
State Outreach Team site visits to regions	DMH Principal Investigator, Project Director, and State Outreach Team	Annually, in spring before refunding regional service sub-grants
Award regional service sub-grants	Project Director	June (for next State FY, 7/1 – 6/30)
Award sub-grants for evaluation, family liaison and youth coordination, cultural and linguistic competence, T/TA, and social marketing-communications	Project Director	June (for next State FY)
Cultural and Linguistic Competence Committee meetings, with continued development of cultural and linguistic competence plan and activities	Cultural and Linguistic Competence Coordinator	Monthly
T/TA Committee meetings, with continued development of technical assistance plan and activities	T/TA Coordinator	Monthly
Social Marketing Committee meetings, with continued development of social marketing-communications plan	Social Marketing-Communications Manager	Monthly
Support to regions and Committees as needed	Project Director and all other key staff	Ongoing

Submit data for National Evaluation and TRAC as required	VCHIP	Ongoing
Meet National CMHS expectations for quarterly and annual progress and financial reports	Project Director and VDH/DMH Business Office	Quarterly and Annually
Attend required CMHS sub-grantee meetings	Principal Investigator, Project Director, and State Outreach Team	Twice a year
Host National site visits (program, evaluation, etc.) to Vermont	Principal Investigator, Project Director, and all other key staff	At least years 2 and 4 for National CMHS site visits
REGIONAL LEVEL		
Local management group meetings, with continued development of strategic sustainability plans	AHS Field Services Directors, with LITs	Quarterly
Provide regional services	CMHC and/or other regionally-chosen provides	Ongoing
Participate in evaluation	CMHC and/or other regionally-chosen providers	Ongoing
Participate in TA activities and state-level committees as requested	CMHC and/or other regionally-chosen providers	Ongoing
Provide quarterly and annual progress reports and monthly financial reports to DMH	Regional fiscal agent, with information from service providers	Quarterly, Annually, and Ongoing
Attend State-level and National meetings as required, including National site visits to Vermont	CMHC and/or other regionally-chosen providers and members of regional management group	Ongoing, including at least years 2 and 4 for National CMHS site visits

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).

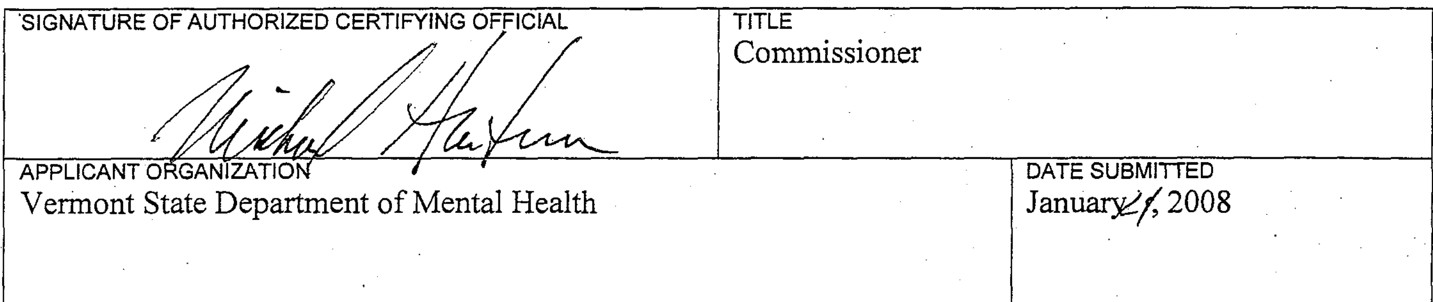
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

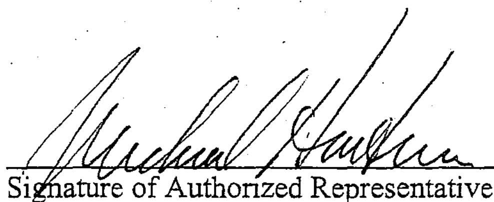


SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE
[signature]	Commissioner
APPLICANT ORGANIZATION	DATE SUBMITTED
Vermont State Department of Mental Health	January 2[illegible], 2008

Appendix C - Statement of Assurance

As the authorized representative of [*insert name of applicant organization*] ____VT Dept. of Mental Health____________, I assure SAMHSA that all participating service provider organizations listed in this application meet the two-year experience requirement and applicable licensing, accreditation, and certification requirements. If this application is within the funding range for a grant award, we will provide the SAMHSA Government Project Officer (GPO) with the following documents. I understand that if this documentation is not received by the GPO within the specified timeframe, the application will be removed from consideration for an award and the funds will be provided to another applicant meeting these requirements.

- a letter of commitment that specifies the nature of the participation and what service(s) will be provided from every service provider organization listed in Appendix 1 of the application, that has agreed to participate in the project;
- official documentation that all service provider organizations participating in the project have been providing relevant services for a minimum of 2 years prior to the date of the application in the area(s) in which services are to be provided. Official documents must definitively establish that the organization has provided relevant services for the last 2 years; and
- official documentation that all participating service provider organizations are in compliance with all local (city, county) and State/tribal requirements for licensing, accreditation, and certification or official documentation from the appropriate agency of the applicable State/tribal, county, or other governmental unit that licensing, accreditation, and certification requirements do not exist. (Official documentation is a copy of each service provider organization's license, accreditation, and certification. Documentation of accreditation will not be accepted in lieu of an organization's license. A statement by, or letter from, the applicant organization or from a provider organization attesting to compliance with licensing, accreditation and certification or that no licensing, accreditation, certification requirements exist does not constitute adequate documentation.)



Signature of Authorized Representative

January 24, 2008
Date

OMB Approval No. 0920-0428

CERTIFICATIONS

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

(a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;

(b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and

(d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, In eligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with sub- grantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 45 CFR Part 76 by:

(a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dis-pensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;

(b) Establishing an ongoing drug-free awareness program to inform employees about--
  (1) The dangers of drug abuse in the workplace;
  (2) The grantee's policy of maintaining a drug-free workplace;
  (3) Any available drug counseling, rehabil-itation, and employee assistance programs; and
  (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

(c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

(d) Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
  (1) Abide by the terms of the statement; and
  (2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

(e) Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central

point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

(f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted--
   (1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   (2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

(g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget
Department of Health and Human Services
200 Independence Avenue, S.W., Room 517-D
Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

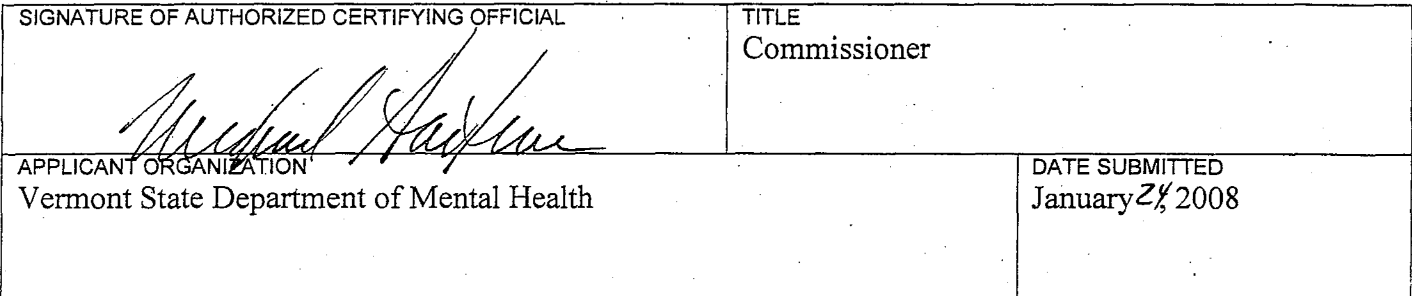
Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical an mental health of the American people.



SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE
[signature]	Commissioner
APPLICANT ORGANIZATION	DATE SUBMITTED
Vermont State Department of Mental Health	January 24, 2008

N/A

DISCLOSURE OF LOBBYING ACTIVITIES

Approved by OMB
0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure.)

1. Type of Federal Action:	2. Status of Federal Action	3. Report Type:
☐ a. contract b. grant c. cooperative agreement d. loan e. loan guarantee f. loan insurance	☐ a. bid/offer/application b. initial award c. post-award	☐ a. initial filing b. material change **For Material Change Only:** Year ______ Quarter ______ date of last report ______

4. Name and Address of Reporting Entity:	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:
☐ Prime ☐ Subawardee Tier ______, if known: ______ Congressional District, *if known:* ______	 Congressional District, *if known:* ______
6. Federal Department/Agency:	7. Federal Program Name/Description: CFDA Number, *if applicable:* ______
8. Federal Action Number, if known:	9. Award Amount, if known: $
10.a. Name and Address of Lobbying Entity *(if individual, last name, first name, MI):*	b. Individuals Performing Services *(including address if different from No. 10a.) (last name, first name, MI):*
11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.	Signature: ______ Print Name: ______ Title: ______ Telephone No.: ______ Date: ______

Federal Use Only:	Authorized for Local Reproduction Standard Form - LLL (Rev. 7-97)

OMB Approval No. 0920-0428

CHECKLIST

Public Burden Statement: Public reporting burden of this collection of information is estimated to average 4 - 50 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC, Clearance Officer, 1600 Clifton Road, MS D-24, Atlanta, GA 30333, ATTN: PRA (0920-0428). Do not send the completed form to this address.

NOTE TO APPLICANT: This form must be completed and submitted with the original of your application. Be sure to complete both sides of this form. Check the appropriate boxes and provide the information requested. This form should be attached as the last page of the signed original of the application. This page is reserved for PHS staff use only.

Type of Application: X NEW ☐ Noncompeting Continuation ☐ Competing Continuation ☐ Supplemental

PART A: The following checklist is provided to assure that proper signatures, assurances, and certifications have been submitted.

		Included	NOT Applicable
1.	Proper Signature and Date for Item 18 on SF 424 (FACE PAGE)	X	
2.	Proper Signature and Date on PHS-5161-1 "Certifications" page.	X	
3.	Proper Signature and Date on appropriate "Assurances" page, i.e., SF-424B (Non-Construction Programs) or SF-424D (Construction Programs)	X	
4.	If your organization currently has on file with DHHS the following assurances, please identify which have been filed by indicating the date of such filing on the line provided. (All four have been consolidated into a single form, HHS Form 690)		
	X Civil Rights Assurance (45 CFR 80)	Signed August 20, 2007 (AHS)	
	X Assurance Concerning the Handicapped (45 CFR 84)	Signed August 20, 2007 (AHS)	
	X Assurance Concerning Sex Discrimination (45 CFR 86)	Signed August 20, 2007 (AHS)	
	X Assurance Concerning Age Discrimination (45 CFR 90 & 45 CFR 91)	Signed August 20, 2007 (AHS)	
5.	Human Subjects Certification, when applicable (45 CFR 46)	X	☐

PART B: This part is provided to assure that pertinent information has been addressed and included in the application.

		YES	NOT Applicable
1.	Has a Public Health System Impact Statement for the proposed program/project been completed and distributed as required?	☐	X
2.	Has the appropriate box been checked for item # 16 on the SF-424 (FACE PAGE) regarding intergovernmental review under E.O. 12372 ? (45 CFR Part 100)	X	
3.	Has the entire proposed project period been identified in item # 13 of the FACE PAGE?	X	
4.	Have biographical sketch(es) with job description(s) been attached, when required	X	☐
5.	Has the "Budget Information" page, SF-424A (Non-Construction Programs) or SF-424C (Construction Programs), been completed and included?	X	
6.	Has the 12 month detailed budget been provided?	X	☐
7.	Has the budget for the entire proposed project period with sufficient detail been provided?	X	☐
8.	For a Supplemental application, does the detailed budget address only the additional funds requested?	☐	X
9.	For Competing Continuation and Supplemental applications, has a progress report been included?	☐	X

PART C: In the spaces provided below, please provide the requested information.

Business Official to be notified if an award is to be made.

Name Heidi Hall
Title Assistant Fiscal Operations Director
Organization Vermont State Dept. of Health
Address 108 Cherry Street, Burlington, VT 05401
E-mail Address hhall@vdh.state.vt.us
Telephone Number 802-652-2047
Fax Number 802-865-7754
APPLICANT ORGANIZATION'S 12-DIGIT DHHS EIN (If already assigned) 1-03-6000274-A8

Program Director/Project Director/Principal Investigator designated to direct the proposed project or program.

Name Charles Biss
Title Director of Child, Adolescent and Family Unit
Organization Vermont State Dept. of Mental Health
Address 108 Cherry Street, PO Box 70, Burlington, VT 05402
E-mail Address cbiss@vdh.state.vt.us
Telephone Number 802-652-2009
Fax Number 802-652-2005
SOCIAL SECURITY NUMBER 113-44-7453
HIGHEST DEGREE EARNED MSW

(OVER)

PART D: A private, nonprofit organization must include evidence of its nonprofit status with the application. Any of the following is acceptable evidence. Check the appropriate box or complete the "Previously Filed" section, whichever is applicable.

- ☐ (a) A reference to the organization's listing in the Internal Revenue Service's (IRS) most recent list of tax-exempt organizations described in section 501(c)(3) of the IRS Code.
- ☐ (b) A copy of a currently valid Internal Revenue Service Tax exemption certificate.
- ☐ (c) A statement from a State taxing body, State Attorney General, or other appropriate State official certifying that the applicant organization has a nonprofit status and that none of the net earnings accrue to any private shareholders or individuals.
- ☐ (d) A certified copy of the organization's certificate of incorporation or similar document if it clearly establishes the nonprofit status of the organization.
- ☐ (e) Any of the above proof for a State or national parent organization, and a statement signed by the parent organization that the applicant organization is a local nonprofit affiliate.

If an applicant has evidence of current nonprofit status on file with an agency of PHS, it will not be necessary to file similar papers again, but the place and date of filing must be indicated.

Previously Filed with: *(Agency)* ______ on *(Date)* ______

INVENTIONS

If this is an application for continued support, include: (1) the report of inventions conceived or reduced to practice required by the terms and conditions of the grant; or (2) a list of inventions already reported, or (3) a negative certification.

EXECUTIVE ORDER 12372

Effective September 30, 1983, Executive Order 12372 (Intergovernmental Review of Federal Programs) directed OMB to abolish OMB Circular A-95 and establish a new process for consulting with State and local elected officials on proposed Federal financial assistance. The Department of Health and Human Services implemented the Executive Order through regulations at 45 CFR Part 100 (Inter-governmental Review of Department of Health and Human Services Programs and Activities). The objectives of the Executive Order are to (1) increase State flexibility to design a consultation process and select the programs it wishes to review, (2) increase the ability of State and local elected officials to influence Federal decisions and (3) compel Federal officials to be responsive to State concerns, or explain the reasons.

The regulations at 45 CFR Part 100 were published in the *Federal Register* on June 24, 1983, along with a notice identifying the Department's programs that are subject to the provisions of Executive Order 12372. Information regarding PHS programs subject to Executive Order 12372 is also available from the appropriate awarding office.

States participating in this program establish State Single Points of Contact (SPOCs) to coordinate and manage the review and comment on proposed Federal financial assistance. Applicants should contact the Governor's office for information regarding the SPOC, programs selected for review, and the consultation (review) process designed by their State.

Applicants are to certify on the face page of the SF-424 (attached) whether the request is for a program covered under Executive Order 12372 and, where appropriate, whether the State has been given an opportunity to comment.