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: January 11, 2010

Subject: JFO #2419, #2420, #2421, #2422

No Joint Fiscal Committee member has requested that the following items be held for review:

JFO #2419 — $1,198,956 grant from the U.S. Department Health and Human Services to the Vermont Department of Mental Health. These funds will be used to implement the Attachment, Self-Regulation and Competency (ARC) framework for complex trauma treatment aimed at improving outcomes for children ages 3 – 18 years old that have experienced complex trauma. **One (1) limited service position is associated with this request.**
[*JFO received 12/8/09*]

JFO #2420 — $237,500 grant from the U.S. Department of Housing and Urban Development (HUD) to the Vermont Department of Children and Families, Office of Economic Opportunity. These grant funds will be used to cover building rehabilitation and/or new construction costs for seven homeless shelters across Vermont.
[*JFO received 12/8/09*]

JFO #2421 — $250,000 grant from the U.S. Department Justice to the Vermont Judiciary. These grant funds will be used to support modeling (in Chittenden County) a statewide approach for creating integrated "criminal justice-capable" systems of care that divert persons with mental illness from the criminal justice system. **This request includes establishment of one (1) limited service position.**
[*JFO received 12/8/09*]

JFO #2422 — $830,600 grant from the U.S. Centers for Disease Control and Prevention to the Vermont Department of Health, awarded under the American Recovery and Reinvestment Act. These grant funds will be used to establish an internal surveillance and prevention strategy designed to reduce the incidence of health care-associated infections. **This request includes establishment of one (1) limited service position.**
[*JFO received 12/10/09*]

The Governor's approval may now be considered final. We ask that you inform the Secretary of Administration and your staff of this action.

cc: Michael Hartman, Commissioner
Wendy Davis, Commissioner
Stephen Dale, Commissioner
Robert Greemore, Court Administrator

1 BALDWIN STREET,
MONTPELIER, VT 05633-5701

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

STATE OF VERMONT
JOINT FISCAL OFFICE

MEMORANDUM

To: Joint Fiscal Committee Members

From: Nathan Lavery, Fiscal Analyst

Date: December 9, 2009

Subject: Grant Requests

Enclosed please find five (5) requests that the Joint Fiscal Office has received from the administration. If approved, these requests would result in the establishment of 4 new limited service positions.

JFO #2418 — Request to **establish one (1) limited service position** in the Department of Public Safety. Funding for this position is provided by the $3,061,782 Byrne Justice Assistance Grant awarded under the American Recovery and Reinvestment Act, and **expedited review of this item has been requested.** Joint Fiscal Committee members will be contacted within two weeks with a request to waive the statutory review period and accept this item. Note: The underlying grant was approved as part of the FY2010 budget (Sec. B.209).
[*JFO received 12/3/09*]

JFO #2419 — $1,198,956 grant from the U.S. Department Health and Human Services to the Vermont Department of Mental Health. These funds will be used to implement the Attachment, Self-Regulation and Competency (ARC) framework for complex trauma treatment aimed at improving outcomes for children ages 3 – 18 years old that have experienced complex trauma. **One (1) limited service position is associated with this request.** Note: Request is comprised of selected pages from complete submission; additional information available upon request.
[*JFO received 12/8/09*]

JFO #2420 — $237,500 grant from the U.S. Department of Housing and Urban Development (HUD) to the Vermont Department of Children and Families, Office of Economic Opportunity. These grant funds will be used to cover building rehabilitation and/or new construction costs for seven homeless shelters across Vermont in order to increase capacity or improve safety.
[*JFO received 12/8/09*]

JFO #2421 — $250,000 grant from the U.S. Department Justice to the Vermont Judiciary. These grant funds will be used to support modeling (in Chittenden County) a statewide approach for creating integrated "criminal justice-capable" systems of care that divert persons with mental illness from the criminal justice system. **This request includes establishment of one (1) limited service position.**
[*JFO received 12/8/09*]

JFO #2422 — $830,600 grant from the U.S. Centers for Disease Control and Prevention to the Vermont Department of Health, awarded under the American Recovery and Reinvestment Act. These grant funds will be used to establish an internal surveillance and prevention strategy designed to reduce the incidence of health care-associated infections. **This request includes establishment of one (1) limited service position.**
[*JFO received 12/10/09*]

In accordance with the procedures for processing such requests, we ask you to review the enclosed and notify the Joint Fiscal Office (Nathan Lavery at (802) 828-1488; nlavery@leg.state.vt.us) if you have questions or would like an item held for Joint Fiscal Committee review. Unless we hear from you to the contrary by December 23 we will assume that you agree to consider as final the Governor's acceptance of these requests.

cc: James Reardon, Commissioner
Thomas Tremblay, Commissioner
Wendy Davis, Commissioner
Stephen Dale, Commissioner
Robert Greemore, Court Administrator

JFO 2419

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:	Under this grant the Department of Mental Health will work with the Vermont Child Treatment Collaborative (made up of the 12 community mental health treatment centers) to fully implement the Attachment, Self-Regulation and Competency (ARC) Framework for complex trauma treatment. The new system is aimed at improved outcomes for children 3-18 who have experienced complex trauma.
Date:	11/20/2009
Department:	Vermont Department of Mental Health
Legal Title of Grant:	National Child Traumatic Stress Initiative Community Treatment and Services Centers Grant.
Federal Catalog #:	93.243
Grant/Donor Name and Address:	Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Rockville , MD
Grant Period: From:	9/30/2009 **To:** 9/29/2012
Grant/Donation	$1,198,956

	SFY 1	SFY 2	SFY 3	Total	Comments
Grant Amount:	$204,879	$399,054	$595,023	$1,198,956	SFY3 includes remainder to be spent in SFY13 as well as amount spent in SFY12

	# Positions	Explanation/Comments
Position Information:	1	Mental Health Systems Improvement Chief (funded partially through this grant, 34%, and partially through the Co-occurring State Incentive Grant, 56%, that was approved several years ago by JFO)

Additional Comments:

RECEIVED
DEC 03 2009
JOINT FISCAL OFFICE

STATE OF VERMONT FINANCE & MANAGEMENT GRANT REVIEW FORM		
Department of Finance & Management		(Initial)
Secretary of Administration		(Initial)
Sent To Joint Fiscal Office		**Date**

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

BASIC GRANT INFORMATION

1. Agency:	Human Services
2. Department:	Mental Health
3. Program:	Childrens Mental Health
4. Legal Title of Grant:	National Child Traumatic Stress Initiative Community Treatment and Services Centers Grants
5. Federal Catalog #:	93.243

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

7. Grant Period:	**From:**	9/30/2009	**To:**	9/29/2012

8. Purpose of Grant:
To implement and evaluate effective trauma-focused and trauma-informed treatment and services for youth in community settings and youth-serving service systems

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

10. BUDGET INFORMATION

	SFY 1	SFY 2	SFY 3	Comments
Expenditures:	**FY** 10	**FY** 11	**FY** 12 and beyond	
Personal Services	$94,874	$180,779	$265,948	
Operating Expenses	$15,005	$18,275	$29,075	
Grants	$95,000	$200,000	$300,000	
Total	$204,879	$399,054	$595,023	
Revenues:				
State Funds:	$	$	$	
Cash	$	$	$	
In-Kind	$	$	$	
Federal Funds:	$204,879	$399,054	$595,023	
(Direct Costs)	$199,450	$388,448	$579,241	
(Statewide Indirect)	$54	$106	$158	
(Departmental Indirect)	$5,375	$10,500	$15,624	
Other Funds:	$	$	$	
Grant (source)	$	$	$	
Total	$204,879	$399,054	$595,023	

Appropriation No:	3150070000	**Amount:**	$204,879
			$
			$
			$
			$
			$
			$

RECD NOV 13 2009

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

		Total	$204,879

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 process/policy.

Appointing Authority Name: Michael Hartman Agreed by: BHT (initial) Beth Tanzman Deputy

12. Limited Service Position Information:	**# Positions**	**Title**
	1	Mental Health Systems Improvement Chief
Total Positions	1	

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

13. AUTHORIZATION AGENCY/DEPARTMENT

I/we certify that no funds beyond basic application preparation and filing costs have been expended or committed in anticipation of Joint Fiscal Committee approval of this grant, unless previous notification was made on Form AA-1PN (if applicable):	Signature: Beth M. Tanzman	Date: 10/16/09
	Title: BETH TANZMAN - DEPUTY COMMISSIONER	11/6/09
	Signature:	Date:
	Title:	

14. ACTION BY GOVERNOR

☑	Check One Box: Accepted		12/5/09
☐	Rejected	(Governor's signature)	Date:

15. SECRETARY OF ADMINISTRATION

☐	Check One Box: Request to JFO		12/4/09
☐	Information to JFO	(Secretary's signature or designee)	Date:

16. DOCUMENTATION REQUIRED

Required GRANT Documentation	
☒ Request Memo	☐ Notice of Donation (if any)
☐ Dept. project approval (if applicable)	☒ Grant (Project) Timeline (if applicable)
☒ Notice of Award	☐ Request for Extension (if applicable)
☐ Grant Agreement	☒ Form AA-1PN attached (if applicable)
☒ Grant Budget	

End Form AA-1

State of Vermont
Department of Mental Health
108 Cherry Street, PO Box 70
Burlington, VT 05402-0070
healthvermont.gov/mh

Agency of Human Services

[phone] 802-652-2000
[Legal] 802-657-4310
[fax] 802-652-2005
[tty] 800-253-0191

To: Shirley Dow, AHS

From: Bill Snyder, DMH Financial Manager

Re: AA-1 for National Child Traumatic Stress Initiative Community Treatment and Services Center Grant

Date: November 10, 2009

I am enclosing the documents requesting approval for a new National Child Traumatic Stress Initiative Community Treatment and Services Center Grant for the Department of Mental Health, including a copy of the original application for funding, the grant award letter from the Substance Abuse and Mental Health Services Administration, the AA-1 form with an attached Supporting Schedule for the first year's funding, and the AA-1PN form. Please let me know when the AA-1 has been signed by the Secretary and the packet is on its way to Budget and Management in Montpelier.

Please note that DMH plans to create a Limited Service Position (Mental Health Systems Improvement Chief) that will be partially funded by this grant. This position will replace the Administrative Assistant B position listed in the original grant application to SAMHSA (see attached). We have received written approval from SAMHSA to fund the position of Mental Health Systems Improvement Chief using the federal grant listed in this AA-1 application and a *Co-Occurring State Incentive (COSIG) Grant* also funded through SAMHSA. This position will oversee and coordinate both the National Child Traumatic Stress Initiative Community Treatment and Services Center Grant and the COSIG grant.

If you have any questions, please contact me at 657-4257 or Nick Nichols at 652-2000.

STATE OF VERMONT
Joint Fiscal Committee Review
Limited Service - Grant Funded
Position Request Form

This form is to be used by agencies and departments when additional grant funded positions are being requested. Review and approval by the Department of Human Resources must be obtained prior to review by the Department of Finance and Management. The Department of Finance will forward requests to the Joint Fiscal Office for JFC review. A Request for Classification Review Form (RFR) and an updated organizational chart showing to whom the new position(s) would report **must** be attached to this form. Please attach additional pages as necessary to provide enough detail.

Agency/Department: AHS/Mental Health Date: October 12, 2009

Name and Phone (of the person completing this request): Nick Nichols, 652-2029

Request is for:
☒Positions funded and attached to a new grant.
☐Positions funded and attached to an existing grant approved by JFO #_____

1. Name of Granting Agency, Title of Grant, Grant Funding Detail (attach grant documents):

Department of Health and Human Services-Substance Abuse and Mental Health Services Administration

National Child Traumatic Stress Initiative Community Treatment and Services Centers Grants

2. List below titles, number of positions in each title, program area, and limited service end date (information should be based on grant award and should match information provided on the RFR) position(s) will be established only after JFC final approval:

Title* of Position(s) Requested	# of Positions	Division/Program	Grant Funding Period/Anticipated End Date
Mental Health Systems Improvement Chief	**1**	**N/A**	**9/30/09 – 9/29/2012 / January 2nd, 2013**

*Final determination of title and pay grade to be made by the Department of Human Resources Classification Division upon submission and review of Request for Classification Review.

3. Justification for this request as an essential grant program need:

This position will oversee 5 different multi-year federal grant projects focused on the improvement of services and expansion of treatment and support capacity to address gaps in the mental health system. Given the amount of funding available through these federal grants (approximately $9 million), the multiple and complex federal expectations and reporting requirements, and the potential for overlap of systems improvement activities across these projects, DMH requires a state position to ensure proper oversight and coordination among all of the grants.

I certify that this information is correct and that necessary funding, space and equipment for the above position(s) are available (required by 32 VSA Sec. 5(b).

Beth M. Tanzman — 10/16/09
Signature of Agency or Department Head — Date

Approved/Denied by Department of Human Resources — Molly Paul — 11/18/09
Date

Approved/Denied by Finance and Management — 11/23/09
Date

DHR – 11/7/05

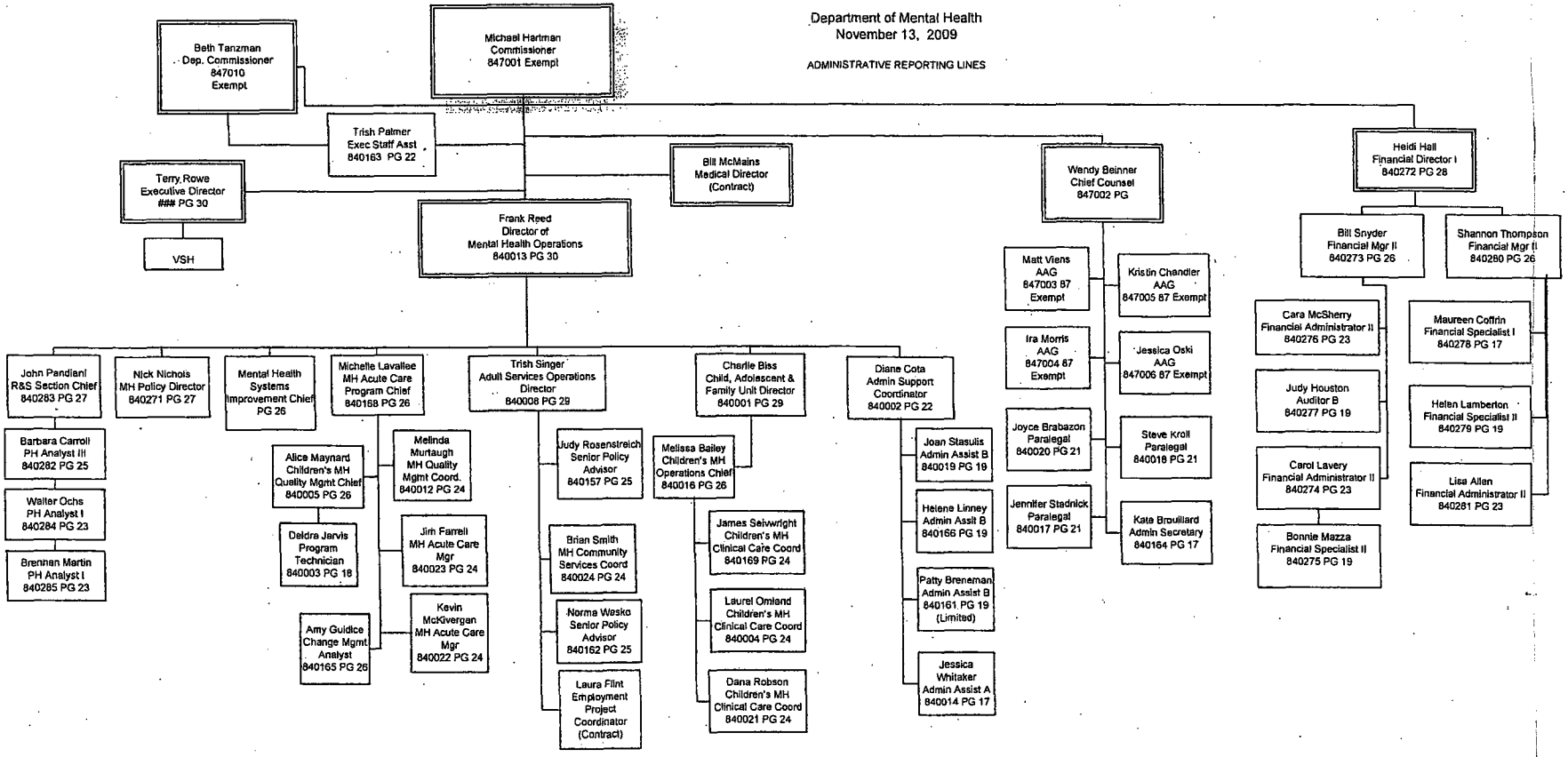
STATE OF VERMONT
Joint Fiscal Committee Review
Limited Service - Grant Funded
Position Request Form

Approved/Denied by Secretary of Administration — Date 1/30/06

Comments:

Department of Mental Health
November 13, 2009

ADMINISTRATIVE REPORTING LINES



STATE OF VERMONT GRANT SPENDING PRE-NOTICE (Form AA-1PN)

PURPOSE & INSTRUCTIONS:

*This form is intended solely as notification to the Joint Fiscal Committee of the unavoidable need to spend State funds in advance of Joint Fiscal Committee approval of grant requests and with the intent of securing a federally or privately funded grant award. Pre-notification is required for expenditures of state funds beyond basic grant application preparation and filing costs. Expenditure of these state funds does not guarantee that a grant will be awarded to the State of Vermont, or that a future grant award will be accepted by the Joint Fiscal Committee. If a grant award is subsequently received, a completed **Form AA-1 Request for Grant Acceptance** must be submitted to the Joint Fiscal Committee for review and approval before spending or obligating additional funds.*

BASIC GRANT INFORMATION

1. Agency:	Human Services
2. Department:	Mental Health
3. Program:	Childrens Mental Health
4. Legal Title of Grant:	National Child Traumatic Stress Initiative Community Treatment and Services Centers Grants
5. Federal Catalog #:	93.243

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

7. Grant Period:	**From:**	9/30/2009	**To:**	9/29/2012

8. Purpose of Grant:
To implement and evaluate effective trauma-focused and trauma-informed treatment and services for youth in community settings and youth-serving service systems

9. STATE FUNDS TO BE SPENT IN ADVANCE OF GRANT ACCEPTANCE BY JOINT FISCAL:

Expenditures:	**FY** 10	**Required Explanation/Comments**
Personal Services	$	(Include type of expenditures to be incurred, i.e. training, planning, proposal development, etc.) Travel expenses to SAMHSA Grantee Orientation meeting
Operating Expenses	$4,275.00	
Grants	$	
Total	$4,275.00	

10. AUTHORIZATION AGENCY/DEPARTMENT

I/We certify that spending these State funds in advance of Joint Fiscal Approval of a Grant is unavoidable, and that a completed ***Form AA-1 Request for Grant Acceptance*** will be submitted for Joint Fiscal Committee approval if a grant award is received for this program:	Signature: [signature]	Date: 10/1/09
	Title: Commissioner	
	Signature:	Date:
	Title:	

11. ATTACHMENTS: Attach relevant documentation that demonstrates the necessity of this expenditure. (example: funding opportunity guidelines require training, etc.)

Distribution:
Original - Joint Fiscal Office;
Copy 1 – Department Grant File;
Copy 2 – Attach to Form AA-1 (if grant is subsequently received).

(End Form AA-1PN – Grant Spending Pre-Notice – Form AA-1PN)

Job Description: Mental Health Systems Improvement Chief

Job Title: Mental Health Systems Improvement Chief

Agency: Department of Mental Health

Location: Waterbury

Job Type: Limited Service

Full/Part Time: Full Time

Shift: N/A

Hourly Rate: $24.15

Pay Grade: 26

Class Definition:

Developmental, administrative, coordinating and monitoring work for the Department of Mental Health (DMH) involving the development of state and local capacity to provide evidence-based treatment and support through the administration of multiple federal grant programs. This position will oversee and coordinate the resources of multiple federal grant projects to improve the mental health treatment system, including 1) development of statewide evidence-based trauma treatment and support for youth, 2) development of jail diversion and trauma treatment capacity for veterans and other adults with trauma-related disorders, and the 5) development of comprehensive, integrated treatment for individuals with mental health and substance abuse disorders across multiple mental health and substance abuse treatment systems. Duties are performed under the general direction of the DMH Operations Director. All employees of the Agency of Human Services perform their respective functions adhering to four key practices: customer service, holistic service, strengths-based relationships and results orientation.

Examples of Work:

Responsible for day-to-day management and oversight of multiple federal grant projects. Duties may include: Overseeing and coordinating development and and monitoring of mulitple state grants and contracts to support federal grant project activities and deliverables. Evaluating current policies and procedures to determine needed changes to comply with federal requirements. Formulating strategies for the effective integration and deployment of grant resources to maximize the collective impact of grant funding. Implementing systems, including writing policies and procedures, to ensure proper accounting of federal funds and the collection of appropriate data. Preparing statistical and narrative reports on program activities. Ensuring all federal reporting requirements are met in a timely fashion. Serving as liaison with federal administrators. Representing DMH in state and federal audits. Analyzing changes in federal regulations in light of their impact on DMH. Developing new grant applications in response to funding opportunities. Coordinating departmental collaboration with other organizations implementing federal grant projects. Developing and staffnig work teams to manage grant activities. Coordinating planning, training, consultation, and evaluation activities in support of

multiple grant projects. Coordinating multiple statewide initiatives led by distinct stakeholders groups. Interfacing and coordinating with key DMH operations, information technology and business staff to assure completion of grant deliverables.

Performs other duties as required.

Environmental Factors: Duties are performed in a variety of settings, including offices and facilities of direct care providers. Travel will be necessary, for which private means of transportation must be available. Some evening or weekend work may be required. Strong differences of opinion may be encountered for which positive resolutions must be sought.

Minimum Qualifications

Knowledge, Skills and Abilities:

Knowledge of federal, state, and local mental health services and programs.

Knowledge of best and evidence-based practices regarding the treatment of individuals with mental health disorders.

Knowledge of the principles and practices of public administration.

Knowledge of supervisory principles and practices.

Knowledge and skills in strategic planning and systems change.

Knowledge and skills in project management.

Skills in leadership and multi-stakeholder consensus-building.

Ability to develop and negotiate contracts.

Ability to evaluate program effectiveness

Ability to communicate effectively orally and in writing.

Ability to establish and maintain effective working relationships.

Ability to perform job duties within the framework of the four key practices of the Agency of Human Services: customer service, holistic service, strengths-based relationships and results orientation.

Education and Experience:

Education: Master's Degree in public administration or in a human services field

Experience: Four years at a professional level in substance abuse or mental health field, with at least 2 years in a management, supervisory or administrative level position

VERMONT CHILD TRAUMA COLLABORATIVE

ABSTRACT

The Vermont Department of Mental Health, through the creation of the **Vermont Child Trauma Collaborative** (VCTC) comprised of 12 community mental health treatment centers serving Vermont's 14 counties, will fully implement and sustain the Attachment, Self-Regulation and Competency (ARC) Framework for complex trauma treatment. The VCTC will change the standard of practice so that: 1) children in Vermont have access to trauma-informed services in the system of care; 2) children who screen positively for trauma receive a standardized trauma assessment; and 3) children with complex trauma and their families are referred for and receive empirically-based trauma treatment services. Outcomes will include reduced trauma symptoms, increased child competency, reduced parenting stress, and reduced need for intensive services.

We will target children ages 3-18 who have experienced complex trauma, multiple and/or chronic exposure to developmentally adverse interpersonal victimization, and their families. We will principally target new referrals from: 1) the Vermont child welfare system's newly implemented centralized intake and differential response to child abuse and neglect reports, 2) schools, and, in year three, 3) children from refugee communities in two counties. By the end of the project, clinicians from the 11 community mental health centers and one private group practice, totaling 12 identified sites serving every county in the state, will use trauma-informed empirically based methods to identify, assess, and treat a total of 350 (5-6 per site in YR 1, 12 in YRS 2-3) children who have experienced complex trauma and their families.

The VCTC will consult with The Trauma Center at Justice Resource Institute for the statewide dissemination of ARC. ARC is an empirically based framework recognized by the NCTSN as a promising practice for addressing the developmental and relational vulnerabilities of children and families who have experienced complex trauma. Consultation with the University of Vermont Connecting Cultures Program will allow VCTC to adapt the ARC framework to better serve our refugee communities. The VCTC has the support of key stakeholders including the state child welfare system, education system, domestic and sexual violence programs, and public/private mental health providers.

VCTC's objectives are to: 1) Establish a Vermont Child Trauma Collaborative Infrastructure at the state and local level; 2) Create a Trauma-Informed Interagency Referral Network among child and family-serving programs; 3) Use existing ARC Community Treatment and Services Teams (ARC Teams) to implement the use of standardized trauma assessment and empirically-based trauma treatment using the ARC Framework in 12 identified sites serving all 14 Vermont counties; 4) Develop In-state Trauma Consultation and Training Capacity for implementation and sustainability of ARC; 5) Participate in NCTSN to incorporate lessons learned in trauma service implementation; and 6) Establish systematic Data Collection and Evaluation to monitor the quality and quantity of services and treatment.

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. Child Traumatic Stress Initiative CTS Centers	93.243	$	$	$ 399,999.89	$	$ 0.00
2.		$	$	$	$	$ 0.00
3.		$	$	$	$	$ 0.00
4.		$	$	$	$	$ 0.00
5. TOTALS		$ 0.00	$ 0.00	$ 399,999.89	$ 0.00	$ 0.00

SECTION B - BUDGET CATEGORIES

6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY				Total
	(1)	(2)	(3)	(4)	(5)
a. Personnel	$ 18,562.00	$	$	$	$ 0.00
b. Fringe Benefits	$ 5,568.60	$	$	$	$ 0.00
c. Travel	$ 4,275.00	$	$	$	$ 0.00
d. Equipment	$ 2,230.00	$	$	$	$ 0.00
e. Supplies	$ 3,000.00	$	$	$	$ 0.00
f. Contractual	$ 154,758.13	$	$	$	$ 0.00
g. Construction	$ 0.00	$	$	$	$ 0.00
h. Other	$ 201,000.00	$	$	$	$ 0.00
i. Total Direct Charges *(sum of 6a -6h)*	$ 389,393.73	$ 0.00	$ 0.00	$ 0.00	$ 0.00
j. Indirect Charges	$ 10,606.16	$	$	$	$ 0.00
k. TOTALS *(sum of 6i and 6j)*	$ 399,999.89	$ 0.00	$ 0.00	$ 0.00	$ 0.00
7. Program Income	$	$	$	$	$ 0.00

SECTION C - NON- FEDERAL RESOURCES

(a) Grant Program	(b) Applicant	(c) State	(d) Other Sources	(e) TOTALS
8. Child Traumatic Stress Initiative CTS Centers	$	$	$	$ 0.00
9.	$	$	$	$ 0.00
10.	$	$	$	$ 0.00
11.	$	$	$	$ 0.00
12. TOTALS *(sum of lines 8 and 11)*	$ 0.00	$ 0.00	$ 0.00	$ 0.00

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. Child Traumatic Stress Initiative CTS Centers	$ 399,999.89	$ 399,054.57	$ 399,903.36	$
17.	$	$	$	$
18.	$	$	$	$
19.	$	$	$	$
20. TOTALS *(sum of lines 16 -19)*	$ 399,999.89	$ 399,054.57	$ 399,903.36	$ 0.00

SECTION F - OTHER BUDGET INFORMATION

21. Direct Charges:	22. Indirect Charges:
23. Remarks	

SECTION A: STATEMENT OF NEED AND READINESS

A.1: Description of Community

The Vermont Department of Mental Health, through the creation of a *Vermont Child Trauma Collaborative* (VCTC) comprised of 12 community-based mental health treatment providers, will implement empirically-based child trauma treatment in each of the state's 14 counties. Vermont's population is 621,254 and is one of the most rural states in the country. Vermont's largest city, Burlington, has a population of only 38,889, and the majority of Vermonters live in or near communities with populations of 2,000 to 20,000. The state has a mountainous topography, with roads covered by snow and ice many months of the year, and public transportation is limited or non-existent in most rural areas. While Vermont's size and rural nature help to maintain its beauty, independence, and strong family ties, these factors contribute to isolation and fewer jobs, limit access to affordable and quality child care, social services and medical care,[1] and mask the mental health and social service needs of its communities. Vermont rates of serious psychological distress and depression in young adults, as well as rates of illicit drug use and alcohol binging for Vermonters aged 12 or older, are among the highest in the country.[2] Of the 140,732 children and youth aged 0-18 (inclusive) in Vermont,[3] approximately 12% may be "experiencing serious or severe emotional disturbance each year."[4] Thus, between 16,887 – 28,146 children and youth in Vermont experience varying intensities of need for mental health services per year.

Child abuse and neglect is also quietly present in communities throughout Vermont. The Agency of Human Services' Department for Children and Families (DCF) and the courts treat this as a confidential matter to help ensure child victims are not further stigmatized and families are open to receiving help. The unintended consequence of this privacy approach is that many Vermonters are unaware of the seriousness of this problem.[5]

In Vermont, 95.3% of the population are Caucasian persons who are non-Hispanic; 1.3% of the population is of Hispanic or Latino origin. 1.2% are Asian people, 1.1% are of two or more races, 0.8% are Black, and 0.4% are American Indian or Alaskan Native.[6] Most Native Americans live in Northwestern Vermont, including Vermont's largest tribe, the Abenaki Nation, with about 1500 members. Through the Vermont Refugee Resettlement Program, Chittenden and Washington Counties are also home to hundreds of Vietnamese, Bosnians, and Somalis as well as dozens of Meskhetian Turks, Sudanese, Congolese, and others from more than 20 additional countries.[7] Now about 3.8% of Vermont's population is foreign-born, and 5.9% speak a language other than English at home[8] though may be proficient in English.

A.2: Target Population and Geographic Area

The Vermont Child Trauma Collaborative (VCTC) will target male and female children and adolescents ages 3-18 who have experienced complex trauma and their caregivers. Complex trauma is defined as chronic or multiple exposure to developmentally adverse interpersonal victimization, including physical, sexual and emotional abuse, neglect, witnessing of domestic and community violence, and impaired care-giving due to substance abuse or mental illness. With the presence of refugee communities in Chittenden and Washington County (see A.1: p.5), in Year 3 VCTC will also target refugee children of war-torn countries who have witnessed trauma.

Children and their families will be primarily identified through the State's child welfare/ protection agency, the Department for Children and Families (DCF), due to a report of suspected child abuse, neglect or other risk of harm. Children and families may also be identified through the local school system or other child-serving agencies (e.g. domestic violence shelters) when there is concern about the presence of trauma. VCTC will screen and provide empirically-based trauma treatment services for an estimated 350 children through the project period.

This target population was selected for several reasons:

- A state-wide needs assessment of community providers and child-serving organizations (completed by the *Child Trauma Workgroup* – see A.3: p.8) identified complex multi-generational trauma among children aged 3-18 as the most challenging clinical issue facing Vermont's System of Care (SOC) for children.
- Despite recent efforts to improve access to mental health services for children involved in child welfare, only 24% of young people identified by the state child welfare agency (DCF) as having been abused and/or neglected are served by the public mental health system.[9] This data indicates that this population has limited access to comprehensive empirically-based treatment for trauma resulting from abuse and/or neglect.
- Vermont's small population, rural nature and limited resources require community treatment teams to work across a broad spectrum of ages and disorders.

VCTC's implementation will occur statewide through the 10 designated community mental health centers (CMHC's), each of which are responsible for providing core mental health services in a specified geographic "catchment area" to the most needy Vermonters. Given Vermont's small population and size it is ideal for statewide programming (see p.5 for a full description of Vermont). This approach will ensure that children and families in each of the state's 14 counties have access to appropriate trauma treatment. In Chittenden County, the state's most populated region and home to its largest city, implementation will also occur in an additional public specialized service agency (Northeastern Family Institute) and a private treatment center (New England Counseling and Trauma Center) to improve access in that region and help to improve partnerships between public and private mental health programs.

A.3: Major Needs and Opportunities for Trauma-Informed Treatment and Services

Major Needs of the Community

Complex trauma, defined as the experience of chronic or multiple traumatic events that occur within the caregiving system, carries an enormous cost to Vermont communities both in lives impacted and dollars spent: [10]

- In 2007, mandated reporters (including mental health professionals) and others made 12,829 contacts with the DCF regarding potential instances of child abuse and neglect. Of this number, 2,633 were accepted for investigation and 687 were substantiated for abuse or neglect.[11]
- In 2008 DCF received 1,892 intake calls that identified co-occurring domestic violence and child maltreatment. 527 of these intakes were opened for investigation, of which 106 were substantiated and 52 remained open cases.[12]
- 2008 data published by the Vermont Network Against Domestic and Sexual Violence reported that approximately 7,853 children/youth were exposed to domestic violence. In that

same year, 193 children were sheltered in Network shelters or safe homes; 1,175 children received services in addition to shelter, and 180 children and youth under the age of 18 were victims of sexual violence.[13]

Early chronic or repeated childhood exposure to these types of traumatic experiences can impact a child's capacity to develop skills to regulate affect and increase the incidence of depression, suicidal ideation, self-injury, substance abuse, difficulty modulating sexual impulses, and sexually transmitted diseases.[14] Other manifestations of exposure to early trauma include falling behind in school readiness and school performance, diminished cognitive abilities, and significantly higher levels of behavioral and emotional problems.[15] Trauma-related emotional problems also increase risk of unhealthy behaviors such as smoking, excessive alcohol or other drug use, poor diet, lack of sleep, and insufficient physical exercise, possibly contributing to future health complications including chronic mental health problems.[16]

Children and families who have experienced trauma must have access to appropriate care. Early recognition and treatment of trauma yields better outcomes; reduces the severity and chronicity of mental and physical health problems as well as the economic impact on health care systems and the criminal justice system; and for long-term trends, increases the skills and resilience of those who become parents so they can better provide for their developing child.

Vermont's system of human service providers have increasingly become more aware of the need to address complex trauma; however, the system is taxed by the demand for services for children/families with complex trauma in need of skilled practitioners, coordinated treatment and support. This increase in recognition and demand is illustrated by the following Vermont data:

- In 1994 only 30 or .1% of the CMHC's caseload in Vermont was identified as having Post-traumatic Stress Disorder, but by 2007 that number had grown to 2,455 clients or 9.6% of the caseload.[17]
- In 2008, the CMHC's reported that 10.3% - or 939 – of the children and youth aged 0-18 who were served had a diagnosis of PTSD; they also reported serving 1,736 children and youth known to be victims of abuse, assault, or rape.[18]

It should be noted that many children who suffer from complex trauma may not meet the full diagnosis for PTSD, and therefore the numbers are likely an underestimate of the actual presence of complex trauma in children served by the public community mental health system. "Children exposed to maltreatment, family violence, or loss of their caregivers often meet diagnostic criteria from the [DSM-IV] for depression, attention-deficit/hyperactivity disorder, oppositional defiant disorder, conduct disorder, anxiety disorders...and reactive attachment disorder."[19]

Opportunities to Promote and Implement Trauma-Informed Interventions

Vermont's growing recognition of the need to address complex trauma has created multiple opportunities to implement trauma-informed interventions. DCF recently implemented a statewide Centralized Intake Unit (CIU) to screen all reports of suspected child abuse/ neglect for acceptance before referral to DCF District Offices for investigation, with the goal of statewide consistency in responses. Since implementation of the CIU in September 2008, DCF has seen a substantial rise in the number of accepted reports of child abuse/neglect. In July 2009, DCF will begin a Differential Response system which will provide two options for response to reported child abuse/neglect: 1) a "forensic" investigation involving the courts to achieve a determination

of substantiation or 2) an "assessment" response for lower risk situations to focus on improving factors that interfere with effective parenting. DCF's anticipation of the impact of differential response is that 47% of current investigations can be diverted to the assessment track. Through Differential Response, DCF will improve its ability to identify children who are experiencing complex trauma and refer these cases to those CMHC treatment teams that are implementing trauma treatment for this population[20] (see DCF Letter of Commitment – Appendix 1).

Through the work of the *Child Trauma Workgroup*, a statewide planning group comprised of child and family-serving community and state organizations, DMH has also initiated a training and consultation relationship with the Trauma Center at Justice Resource Institute (TC-JRI) to support CMHC implementation of the Attachment, Self-Regulation and Competence (ARC) Framework[21] for the treatment of complex trauma in children (see p.8 for a full description of the *Vermont ARC Project*). The consensus-building, planning and training accomplished through the Vermont ARC Project will support further implementation of empirically-based trauma treatment throughout the state.

A.4: Availability of Trauma-informed Treatment and Services

There are significant areas for development in the provision of trauma-informed and trauma-specific services within Vermont's community mental health system. Until recently, there has not been consensus across providers about the use of empirically-based assessment, treatment, or service models for trauma treatment. As such, many programs lacked staff with the specialized skills to assess, treat and coordinate care for children who had experienced complex trauma.

In recognition of these challenges, DMH has been working with the CMHC's and other child-serving agencies over the last 36 months to improve their ability to deliver effective trauma-informed care and trauma treatment for children, youth, and their families. Through the DMH-funded *Vermont ARC Project*, the CMHC's have begun to develop capacity for complex trauma treatment using the Attachment, Self-Regulation and Competence (ARC) Framework. The following activities have been completed:

- Creation of a DMH Trauma Policy (based on an AHS Trauma Policy) to highlight the significance of trauma in the lives of the people we serve and our commitment to providing quality trauma-specific services within a trauma-informed mental health system
- Consensus-building to identify target population, the proposed model of trauma services, and the activities of training and implementation at the community level
- Training on *Trauma-Informed Care* and the ARC Framework for CMHC, child welfare, post-adoption, private practice, and school-based providers state-wide
- The creation of clinical teams (i.e. **ARC Community Treatment and Services Teams** - ARC Teams) at each CMHC focused on practice implementation within their service area
- Training and monthly consultation by TC-JRI for all ARC Teams focused on integrating the ARC concepts into daily practice
- Initial self-assessments at each CMHC to determine key areas of challenge, priorities for change, and consideration of factors relevant to implementing ARC
- Commitment from each CMHC to become familiar with trauma screening and assessment tools (Trauma Symptom Checklist for Children, Trauma Symptom Checklist for Young Children, Parenting Stress Index, and Child Behavior Checklist).

While initial efforts have created a solid foundation, the majority of CMHC's are still in the initial stages of implementing ARC. This proposal would support full implementation of ARC throughout children's mental health outpatient services across Vermont. This proposal will also support other community child-serving agencies to 1) receive additional training on trauma-informed service delivery and 2) improve the identification and referral of children for trauma assessment and treatment (see Appendix 1 - Letters of Support).

A.5: Existing Collaborations

The Vermont Child Trauma Collaborative (VCTC) will be supported by several different collaborations. For the past 20 years, DMH and DCF, along with representatives from the Department of Education (DOE), families, and other partners, have met monthly through the Vermont Act 264 *State Interagency Team (SIT)* to resolve problems in the coordinated service planning for children and youth with serious emotional disturbance or other disabilities. SIT and the *Local Interagency Teams (LIT)*, which exist in each of the state's twelve Agency of Human Services' districts to serve as a resource for interagency planning teams and a forum to address regional service needs, will support the VCTC. Members of these teams will be targeted to participate on the State and Local VCTC Advisory Committees (as described in C.1: p.14) to support adoption of trauma-informed practices.

VCTC will also be supported by the Agency of Human Services (AHS) *Child Trauma Workgroup,* which formed in 2004 to identify unmet needs in Vermont's System of Care (SOC) for traumatized children and families and support the development of enhanced trauma treatment in the state. The workgroup is comprised of representatives from child welfare, mental health, domestic and sexual violence programs, adoption programs, Prevent Child Abuse Vermont, consumers/parents, the AHS Refugee Coordinator, and the AHS Trauma Coordinator. Members of the Child Trauma Workgroup will participate on the State Advisory Committee of this project.

Finally, VCTC will benefit from an existing collaboration between DOE and DMH in which 90% of supervisory unions contract with CMHCs for school-based mental health services. To enhance these services and support DOE's implementation of Positive Behavioral Supports (PBS) in 16 of the 54 supervisory unions, DOE and DMH have focused on the need for schools to be trauma informed and effectively access trauma treatment services when warranted. VCTC will capitalize on this existing collaboration to increase trauma informed school services and clearly establish referral protocols for trauma specific treatment.

SECTION B: PROPOSED TRAUMA-INFORMED PRACTICES OR INTERVENTIONS

B.1: Purpose, Goals, Objectives, and Results

This grant initiative will establish a *Vermont Child Trauma Collaborative (VCTC)* comprised of 12 community-based mental health treatment centers to ensure trauma-informed care and empirically-based trauma treatment are available to children with complex trauma and their families throughout Vermont. The goals of this service and treatment collaborative are:

1. children in Vermont will have access to trauma-informed services throughout the SOC;
2. children who screen positively for trauma will receive a standardized trauma assessment;
3. children with complex trauma and their families will be referred for and receive trauma-specific treatment services that are empirically based;

In order to achieve these goals, the VCTC will complete the following objectives:

a) Establish *Vermont Child Trauma Collaborative Infrastructure* at the state and local level to oversee and coordinate implementation of ARC;
b) Create a *Trauma-Informed Interagency Referral Network* among child and family-serving state and community programs (child welfare, education, domestic violence) to ensure consistent screening and referral to treatment for children exposed to trauma;
c) Use existing *ARC Community Treatment and Services Teams (ARC Teams)* to implement the use of standardized trauma assessment and empirically-based trauma treatment in 12 community treatment programs serving all 14 Vermont counties;
d) Develop *In-state Trauma Consultation and Training Capacity* to support implementation of trauma-informed care and the ARC framework and ensure sustainability of the practice;
e) *Participate in NCTSN* to incorporate lessons learned in trauma service implementation; and
f) Establish systematic *Data Collection and Evaluation* to improve the quality and quantity of services and treatment being provided through the VCTC.

With implementation of the VCTC objectives, we will achieve the following results:

- The number and consistency of referrals for ARC trauma treatment services from child-serving programs will increase.
- The number of children and families receiving ARC trauma treatment will increase.
- Children and families receiving ARC will experience improved clinical outcomes, including:
  - Reduction of trauma-related symptoms
  - Increased child competency
  - Reduction of caregiver parenting stress
  - Reduced need for intensive services (psychiatric hospital and long-term residential).

B.2. <u>The ARC Framework and Its Evidence-Base</u>

Vermont will expand its implementation of the Attachment, Self-Regulation, and Competence (ARC) Framework. This model was developed by Margaret Blaustein, Ph.D. and Kristine Kinniburgh, LICSW of the Trauma Center at Justice Resource Institute (TC-JRI) to intervene with youth and families who have experienced complex trauma such as chronic or multiple sexual abuse, physical abuse, neglect, domestic violence, and community violence. The ARC model is based on an empirical framework that includes components of cognitive-behavioral therapy, attachment theory, and trauma theory to address the central goals of safety, self-regulation, self-reflective information processing, traumatic experience integration, and relational engagement or attachment. ARC provides a framework for clinicians to work collaboratively with children and their families to build/strengthen secure attachments, develop/enhance self-regulatory capabilities, and increase child and parent competencies across multiple domains. The approach was developed to be respectful of the strengths, resources, and individual characteristics of the child and care-giving system and can be adapted to the unique cultural needs of various ethnic populations.

ARC involves conducting a sound clinical assessment to identify strengths and needs of the youth and uses phase-oriented interventions that appropriately match the individual level of need. The ARC framework is a component-based framework built around three core domains

the supervisors to offer ARC training to VCTC site staff who are hired after the initial rollout of training.

Objective (e): *Participate in NCTSN* to incorporate lessons learned in trauma service implementation

Collaboration with NCTSN will consist of: 1) partnership with the TC-JRI Level III and Level II Center for training/consultation on the ARC Framework and collaboration for cultural adaptations to the model; 2) collaboration with other NCTSN sites who are implementing ARC to share lessons learned; 3) use of existing NCTSN resources (e.g. publications, web training programs, Listserves); 4) contribution of developed materials from our project (see C.10, p.24) and 5) participation in NCTSN meetings.

Objective (f): Establish systematic *Data Collection and Evaluation* to monitor the quality and quantity of services and treatment being provided through the VCTC

Evaluation data will be continually fed back to VCTC participants to inform and improve grant activities. See Section E (p.30) for a full description of the evaluation process.

Project Timeline

Key: ARC Lead Supervisor (ALS); Project Co-Directors (PD); Project Evaluator (PE); Principle Investigator (PI); Trauma Center at JRI (TC-JRI); VCTC Consultation Team (VCTC-CT); VCTC Advisory Committee (VCTC-AC)

Period	Key Activity & Milestone	Responsible Staff
YR1, Q1 (1-3 Mo.)	Convene **State Advisory Committee**: delineate roles and responsibilities; establish quarterly meeting schedule; recruit youth/ family representatives.	PI *(see key above)
	Hire Project Co-Director and create sub-grant for PE.	PI
	Establish contract with NCTSN Center (TC-JRI) for consultation on ARC Framework.	PI
	Evaluator works with NCTSN to establish reporting and data exchange protocol.	PE*
	Create memoranda of understanding with identified sites to establish the VCTC.	PI
	Convene **VCTC Consultation Team**.	PD*
	VCTC "Kick-off" meeting (3-days): 1-day orientation to program goals, activities, and evaluation. 2-day training on ARC Framework, assessment, clinical concepts.	PD, PE, TC-JRI*
	Develop trauma-informed interagency referral network structure.	VCTC-AC*
	Develop VCTC outreach and education materials.	PD
	Establish monthly local ARC Team meetings; identify ARC Lead Supervisor.	PD, ALS *
	Convene the **Local Advisory Committees**: build local consensus for project.	ALS, PD
	Establish communication systems for distance learning and project information.	PD, PE
	In month 3, begin monthly clinical consultation for ARC Teams.	TC-JRI
	Submit quarterly progress report to SAMHSA.	PD
YR1, Q2 (4-6 mos)	Continue **monthly ARC training/consultation** for ARC Teams.	TC-JRI
	Implement ARC in **direct clinical services** at CMHC's by month 4: conduct clinical assessments; initiate provision of clinical services with the target goal of serving **5-6** clients at each site during Year One (YR 1 total **60** clients).	PD, ARC Teams
	Continue monthly local internal agency ARC Team meetings for implementation.	ALS
	Initiate **data collection** for client assessment and evaluation of implementation efforts.	PE
	Submit quarterly progress report to SAMHSA.	PD
YR1, Q3 (7-9	Continue provision of clinical services using ARC framework.	ARC Teams
	Continue monthly ARC training/consultation for ARC Teams.	TC-JRI
	Continue monthly local ARC Team meetings focused on implementation .	ALS
	1-day in-person training, followed by monthly consultations for **ARC Lead**	TC-JRI

mos)	**Supervisor/Trainer Series**	
	Continue evaluation activities: conduct client satisfaction surveys, site visits; Provide feedback from data collection for clinical utility and project activities.	PE
	Develop Train-the-Trainer curriculum for TIC training of community partners.	VCTC-CT
	Identify local providers from each region to participate in TIC Train-the-Trainer Series	ALS
	Submit quarterly progress report to SAMHSA.	PD
YR 1, Q4 (10-12 mos)	Conduct **"TIC for Community Partners" Train-the-Trainer Series**	VCTC-CT
	Continue provision of clinical services, consultations and ARC Team meetings.	ARC Teams TC-JRI
	Submit annual report to SAMHSA, including sustainability efforts and plan.	PD, PE
YR 2, Q1 (13-15 mos)	Continue to implement ARC: provision of clinical services with the target goal of serving **12** new clients at each of the 12 sites (YR 2 total **145** clients).	PD, ALS, TC-JRI
	Continue monthly consultations for ARC Teams and ARC Lead Supervisors.	TC-JRI
	Continue evaluation activities: Provide feedback from Core Data Set for clinical utility and project activities; NCTSI Cross-Site Evaluation.	PE
	Continue internal agency monthly ARC Team implementation/supervision meetings.	ALS
	Continue TIC Train-the-Trainer series.	VCTC-CT
YR2, Q2 (16-18 mos)	Ongoing provision of clinical services & evaluation activities.	ARC Teams PE
	Phase out monthly ARC Team consultation by TC-JRI; ARC Lead Supervisors oversee ARC Teams with monthly mentorship/consultation from TC-JRI.	TC-JRI
	Provide **Local TIC trainings** to child-serving partners; consultation for TIC trainers.	TIC trainers VCTC-CT
YR 2, Q3 – Q4 (19-24 mos)	Ongoing provision of clinical services & evaluation activities.	ARC Teams PE
	Month 20: 1-day in-person training/consultation for ARC Lead Supervisors to continue to solidify skills and sustain VCTC trainings on ARC framework.	TC-JRI
	Continue internal agency monthly ARC Team implementation/supervision meetings.	ALS
	Continue monthly ARC Lead Supervisor/Trainer consultations.	TC-JRI
	Continue to offer Local TIC trainings to child-serving partners; on-going consultation for TIC trainer collaborative.	VCTC-CT, TIC trainers
	Submit quarterly and annual reports to SAMHSA including sustainability efforts/ plan.	PD, PE
YR 3	Ongoing provision of clinical services & evaluation activities: target goal of serving **12** new clients at each of the 12 sites (YR 3 total **145** clients); Provide ARC trauma-treatment to total of **350** clients by the end of Y3.	ARC Teams PE
	Continue internal agency monthly ARC Team implementation/supervision meetings.	ALS
	UVM Connecting Cultures Program Director joins VCTC-CT. **Adapt ARC model for refugee populations** in Chittenden and Washington Counties.	VCTC-CT, TC-JRI
	Quarterly phone consultations and 1 in-person meeting to develop cultural adaptations. Document adaptations.	TC-JRI, VCTC-CT
	Quarterly phone consultations for ARC Lead Supervisor/Trainers to develop & finalize curriculum for internal VCTC ARC trainings.	TC-JRI
	Continue client data collection; continue TA system.	PE
	Continue to offer Local TIC trainings to child-serving partners; on-going consultation for TIC trainer collaborative.	VCTC-CT, TIC trainers
	Submit quarterly and final reports to SAMHSA including sustainability efforts & plan.	PD, PE

C.2: Characteristics of the Target population:

The target population is male and female children and adolescents ages 3-18 who have experienced complex trauma (as described in A.2, p.5). Treatment services will also target the child's caregiver (parent, adoptive parent, foster parent, kinship care, etc) according to clinical need, developmental age of the child, and treatment goals. A significant benefit of the ARC

JFO 2419

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:	Under this grant the Department of Mental Health will work with the Vermont Child Treatment Collaborative (made up of the 12 community mental health treatment centers) to fully implement the Attachment, Self-Regulation and Competency (ARC) Framework for complex trauma treatment. The new system is aimed at improved outcomes for children 3-18 who have experienced complex trauma.
Date:	11/20/2009
Department:	Vermont Department of Mental Health
Legal Title of Grant:	National Child Traumatic Stress Initiative Community Treatment and Services Centers Grant.
Federal Catalog #:	93.243
Grant/Donor Name and Address:	Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Rockville , MD
Grant Period: From:	9/30/2009 **To:** 9/29/2012
Grant/Donation	$1,198,956

	SFY 1	SFY 2	SFY 3	Total	Comments
Grant Amount:	$204,879	$399,054	$595,023	$1,198,956	SFY3 includes remainder to be spent in SFY13 as well as amount spent in SFY12

	# Positions	Explanation/Comments
Position Information:	1	Mental Health Systems Improvement Chief (funded partially through this grant, 34%, and partially through the Co-occurring State Incentive Grant, 56%, that was approved several years ago by JFO)

Additional Comments:

RECEIVED
DEC 03 2009
JOINT FISCAL OFFICE

STATE OF VERMONT FINANCE & MANAGEMENT GRANT REVIEW FORM		
Department of Finance & Management	11/25/08	(Initial)
Secretary of Administration	11/26/08	(Initial)
Sent To Joint Fiscal Office		**Date**

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

BASIC GRANT INFORMATION	
1. Agency:	Human Services
2. Department:	Mental Health
3. Program:	Childrens Mental Health
4. Legal Title of Grant:	National Child Traumatic Stress Initiative Community Treatment and Services Centers Grants
5. Federal Catalog #:	93.243

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

7. Grant Period:	**From:**	9/30/2009	**To:**	9/29/2012

8. Purpose of Grant:
To implement and evaluate effective trauma-focused and trauma-informed treatment and services for youth in community settings and youth-serving service systems

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

10. BUDGET INFORMATION

	SFY 1	SFY 2	SFY 3	Comments
Expenditures:	FY 10	FY 11	FY 12 and beyond	
Personal Services	$94,874	$180,779	$265,948	
Operating Expenses	$15,005	$18,275	$29,075	
Grants	$95,000	$200,000	$300,000	
Total	$204,879	$399,054	$595,023	
Revenues:				
State Funds:	$	$	$	
Cash	$	$	$	
In-Kind	$	$	$	
Federal Funds:	$204,879	$399,054	$595,023	
(Direct Costs)	$199,450	$388,448	$579,241	
(Statewide Indirect)	$54	$106	$158	
(Departmental Indirect)	$5,375	$10,500	$15,624	
Other Funds:	$	$	$	
Grant (source)	$	$	$	
Total	$204,879	$399,054	$595,023	

Appropriation No:	3150070000	**Amount:**	$204,879
			$
			$
			$
			$
			$
			$

RECD NOV 13 2009

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

		Total	$204,879

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 process/policy.

Appointing Authority Name: Michael Hartman Agreed by: BHT (initial) Beth Tanzman Deputy

12. Limited Service Position Information:	**# Positions**	**Title**
	1	Mental Health Systems Improvement Chief
Total Positions	1	

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

13. AUTHORIZATION AGENCY/DEPARTMENT

I/we certify that no funds beyond basic application preparation and filing costs have been expended or committed in anticipation of Joint Fiscal Committee approval of this grant, unless previous notification was made on Form AA-1PN (if applicable):	Signature: Beth M. Tanzman	Date: 10/16/09
	Title: Beth Tanzman - Deputy Commissioner 10/16/09	
	Signature:	Date:
	Title:	

14. ACTION BY GOVERNOR

☑	Check One Box: Accepted		12/5/09
☐	Rejected	(Governor's signature)	Date:

15. SECRETARY OF ADMINISTRATION

☐	Check One Box: Request to JFO		12/4/09
☐	Information to JFO	(Secretary's signature or designee)	Date:

16. DOCUMENTATION REQUIRED

Required GRANT Documentation

☒ Request Memo	☐ Notice of Donation (if any)
☐ Dept. project approval (if applicable)	☒ Grant (Project) Timeline (if applicable)
☒ Notice of Award	☐ Request for Extension (if applicable)
☐ Grant Agreement	☒ Form AA-1PN attached (if applicable)
☒ Grant Budget	

End Form AA-1

State of Vermont
Department of Mental Health
108 Cherry Street, PO Box 70
Burlington, VT 05402-0070
healthvermont.gov/mh

Agency of Human Services

[phone] 802-652-2000
[Legal] 802-657-4310
[fax] 802-652-2005
[tty] 800-253-0191

To: Shirley Dow, AHS

From: Bill Snyder, DMH Financial Manager

Re: AA-1 for National Child Traumatic Stress Initiative Community Treatment and Services Center Grant

Date: November 10, 2009

I am enclosing the documents requesting approval for a new National Child Traumatic Stress Initiative Community Treatment and Services Center Grant for the Department of Mental Health, including a copy of the original application for funding, the grant award letter from the Substance Abuse and Mental Health Services Administration, the AA-1 form with an attached Supporting Schedule for the first year's funding, and the AA-1PN form. Please let me know when the AA-1 has been signed by the Secretary and the packet is on its way to Budget and Management in Montpelier.

Please note that DMH plans to create a Limited Service Position (Mental Health Systems Improvement Chief) that will be partially funded by this grant. This position will replace the Administrative Assistant B position listed in the original grant application to SAMHSA (see attached). We have received written approval from SAMHSA to fund the position of Mental Health Systems Improvement Chief using the federal grant listed in this AA-1 application and a *Co-Occurring State Incentive (COSIG) Grant* also funded through SAMHSA. This position will oversee and coordinate both the National Child Traumatic Stress Initiative Community Treatment and Services Center Grant and the COSIG grant.

If you have any questions, please contact me at 657-4257 or Nick Nichols at 652-2000.

STATE OF VERMONT
Joint Fiscal Committee Review
Limited Service - Grant Funded
Position Request Form

This form is to be used by agencies and departments when additional grant funded positions are being requested. Review and approval by the Department of Human Resources must be obtained prior to review by the Department of Finance and Management. The Department of Finance will forward requests to the Joint Fiscal Office for JFC review. A Request for Classification Review Form (RFR) and an updated organizational chart showing to whom the new position(s) would report **must** be attached to this form. Please attach additional pages as necessary to provide enough detail.

Agency/Department: AHS/Mental Health Date: October 12, 2009

Name and Phone (of the person completing this request): Nick Nichols, 652-2029

Request is for:
- ☒ Positions funded and attached to a new grant.
- ☐ Positions funded and attached to an existing grant approved by JFO #_____

1. Name of Granting Agency, Title of Grant, Grant Funding Detail (attach grant documents):

Department of Health and Human Services-Substance Abuse and Mental Health Services Administration

National Child Traumatic Stress Initiative Community Treatment and Services Centers Grants

2. List below titles, number of positions in each title, program area, and limited service end date (information should be based on grant award and should match information provided on the RFR) position(s) will be established only after JFC final approval:

Title* of Position(s) Requested	# of Positions	Division/Program	Grant Funding Period/Anticipated End Date
Mental Health Systems Improvement Chief	**1**	**N/A**	**9/30/09 – 9/29/2012 / January 2nd, 2013**

*Final determination of title and pay grade to be made by the Department of Human Resources Classification Division upon submission and review of Request for Classification Review.

3. Justification for this request as an essential grant program need:

This position will oversee 5 different multi-year federal grant projects focused on the improvement of services and expansion of treatment and support capacity to address gaps in the mental health system. Given the amount of funding available through these federal grants (approximately $9 million), the multiple and complex federal expectations and reporting requirements, and the potential for overlap of systems improvement activities across these projects, DMH requires a state position to ensure proper oversight and coordination among all of the grants.

I certify that this information is correct and that necessary funding, space and equipment for the above position(s) are available (required by 32 VSA Sec. 5(b).

Signature of Agency or Department Head — Date: 10/16/09

Approved/Denied by Department of Human Resources — Date: 11/18/09

Approved/Denied by Finance and Management — Date: 11/23/09

RECEIVED 2009

DHR – 11/7/05

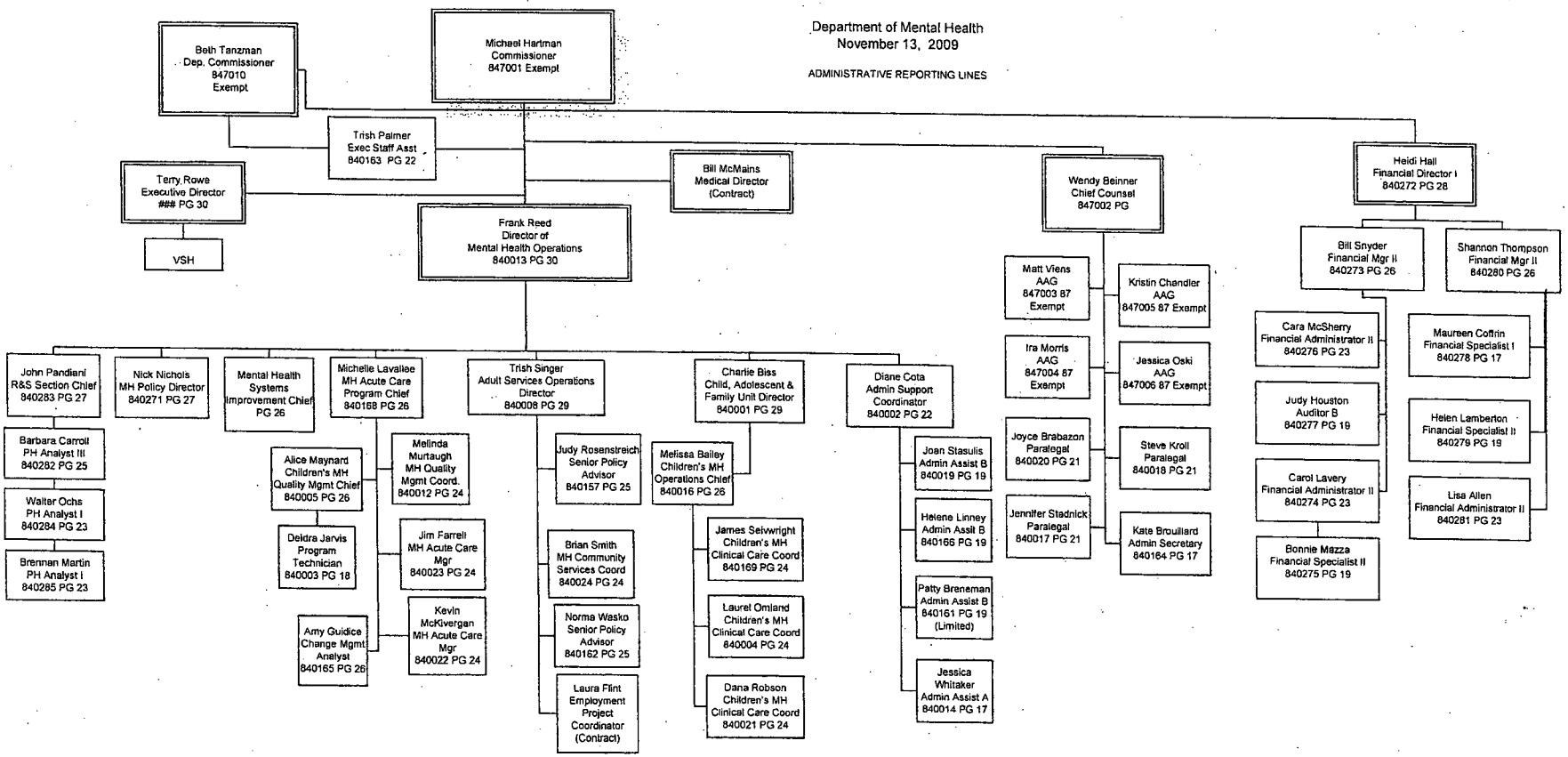
STATE OF VERMONT
Joint Fiscal Committee Review
Limited Service - Grant Funded
Position Request Form

Approved/Denied by Secretary of Administration — Date 1/3/06

Comments:

Department of Mental Health
November 13, 2009

ADMINISTRATIVE REPORTING LINES



STATE OF VERMONT GRANT SPENDING PRE-NOTICE (Form AA-1PN)

PURPOSE & INSTRUCTIONS:

This form is intended solely as notification to the Joint Fiscal Committee of the unavoidable need to spend State funds in advance of Joint Fiscal Committee approval of grant requests and with the intent of securing a federally or privately funded grant award. Pre-notification is required for expenditures of state funds beyond basic grant application preparation and filing costs. Expenditure of these state funds does not guarantee that a grant will be awarded to the State of Vermont, or that a future grant award will be accepted by the Joint Fiscal Committee. If a grant award is subsequently received, a completed ***Form AA-1 Request for Grant Acceptance*** *must be submitted to the Joint Fiscal Committee for review and approval before spending or obligating additional funds.*

BASIC GRANT INFORMATION

1. Agency:	Human Services
2. Department:	Mental Health
3. Program:	Childrens Mental Health
4. Legal Title of Grant:	National Child Traumatic Stress Initiative Community Treatment and Services Centers Grants
5. Federal Catalog #:	93.243

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

7. Grant Period:	**From:**	9/30/2009	**To:**	9/29/2012

8. Purpose of Grant:
To implement and evaluate effective trauma-focused and trauma-informed treatment and services for youth in community settings and youth-serving service systems

9. STATE FUNDS TO BE SPENT IN ADVANCE OF GRANT ACCEPTANCE BY JOINT FISCAL:

Expenditures:	**FY** 10	**Required Explanation/Comments**
Personal Services	$	(Include type of expenditures to be incurred, i.e. training, planning, proposal development, etc.) Travel expenses to SAMHSA Grantee Orientation meeting
Operating Expenses	$4,275.00	
Grants	$	
Total	$4,275.00	

10. AUTHORIZATION AGENCY/DEPARTMENT

I/We certify that spending these State funds in advance of Joint Fiscal Approval of a Grant is unavoidable, and that a completed ***Form AA-1 Request for Grant Acceptance*** will be submitted for Joint Fiscal Committee approval if a grant award is received for this program:

Signature: [signature]	Date: 10/1/09
Title: Commissioner	
Signature:	Date:
Title:	

11. ATTACHMENTS: Attach relevant documentation that demonstrates the necessity of this expenditure. (example: funding opportunity guidelines require training, etc.)

Distribution:
Original - Joint Fiscal Office;
Copy 1 – Department Grant File;
Copy 2 – Attach to Form AA-1 (if grant is subsequently received).

(End Form AA-1PN – Grant Spending Pre-Notice – Form AA-1PN)

Job Description: Mental Health Systems Improvement Chief

Job Title: Mental Health Systems Improvement Chief

Agency: Department of Mental Health

Location: Waterbury

Job Type: Limited Service

Full/Part Time: Full Time

Shift: N/A

Hourly Rate: $24.15

Pay Grade: 26

Class Definition:

Developmental, administrative, coordinating and monitoring work for the Department of Mental Health (DMH) involving the development of state and local capacity to provide evidence-based treatment and support through the administration of multiple federal grant programs. This position will oversee and coordinate the resources of multiple federal grant projects to improve the mental health treatment system, including 1) development of statewide evidence-based trauma treatment and support for youth, 2) development of jail diversion and trauma treatment capacity for veterans and other adults with trauma-related disorders, and the 5) development of comprehensive, integrated treatment for individuals with mental health and substance abuse disorders across multiple mental health and substance abuse treatment systems. Duties are performed under the general direction of the DMH Operations Director. All employees of the Agency of Human Services perform their respective functions adhering to four key practices: customer service, holistic service, strengths-based relationships and results orientation.

Examples of Work:

Responsible for day-to-day management and oversight of multiple federal grant projects. Duties may include: Overseeing and coordinating development and and monitoring of mulitple state grants and contracts to support federal grant project activities and deliverables. Evaluating current policies and procedures to determine needed changes to comply with federal requirements. Formulating strategies for the effective integration and deployment of grant resources to maximize the collective impact of grant funding. Implementing systems, including writing policies and procedures, to ensure proper accounting of federal funds and the collection of appropriate data. Preparing statistical and narrative reports on program activities. Ensuring all federal reporting requirements are met in a timely fashion. Serving as liaison with federal administrators. Representing DMH in state and federal audits. Analyzing changes in federal regulations in light of their impact on DMH. Developing new grant applications in response to funding opportunities. Coordinating departmental collaboration with other organizations implementing federal grant projects. Developing and staffnig work teams to manage grant activities. Coordinating planning, training, consultation, and evaluation activities in support of

multiple grant projects. Coordinating multiple statewide initiatives led by distinct stakeholders groups. Interfacing and coordinating with key DMH operations, information technology and business staff to assure completion of grant deliverables.

Performs other duties as required.

Environmental Factors: Duties are performed in a variety of settings, including offices and facilities of direct care providers. Travel will be necessary, for which private means of transportation must be available. Some evening or weekend work may be required. Strong differences of opinion may be encountered for which positive resolutions must be sought.

Minimum Qualifications

Knowledge, Skills and Abilities:

Knowledge of federal, state, and local mental health services and programs.

Knowledge of best and evidence-based practices regarding the treatment of individuals with mental health disorders.

Knowledge of the principles and practices of public administration.

Knowledge of supervisory principles and practices.

Knowledge and skills in strategic planning and systems change.

Knowledge and skills in project management.

Skills in leadership and multi-stakeholder consensus-building.

Ability to develop and negotiate contracts.

Ability to evaluate program effectiveness

Ability to communicate effectively orally and in writing.

Ability to establish and maintain effective working relationships.

Ability to perform job duties within the framework of the four key practices of the Agency of Human Services: customer service, holistic service, strengths-based relationships and results orientation.

Education and Experience:

Education: Master's Degree in public administration or in a human services field

Experience: Four years at a professional level in substance abuse or mental health field, with at least 2 years in a management, supervisory or administrative level position

VERMONT CHILD TRAUMA COLLABORATIVE

ABSTRACT

The Vermont Department of Mental Health, through the creation of the **Vermont Child Trauma Collaborative** (VCTC) comprised of 12 community mental health treatment centers serving Vermont's 14 counties, will fully implement and sustain the Attachment, Self-Regulation and Competency (ARC) Framework for complex trauma treatment. The VCTC will change the standard of practice so that: 1) children in Vermont have access to trauma-informed services in the system of care; 2) children who screen positively for trauma receive a standardized trauma assessment; and 3) children with complex trauma and their families are referred for and receive empirically-based trauma treatment services. Outcomes will include reduced trauma symptoms, increased child competency, reduced parenting stress, and reduced need for intensive services.

We will target children ages 3-18 who have experienced complex trauma, multiple and/or chronic exposure to developmentally adverse interpersonal victimization, and their families. We will principally target new referrals from: 1) the Vermont child welfare system's newly implemented centralized intake and differential response to child abuse and neglect reports, 2) schools, and, in year three, 3) children from refugee communities in two counties. By the end of the project, clinicians from the 11 community mental health centers and one private group practice, totaling 12 identified sites serving every county in the state, will use trauma-informed empirically based methods to identify, assess, and treat a total of 350 (5-6 per site in YR 1, 12 in YRS 2-3) children who have experienced complex trauma and their families.

The VCTC will consult with The Trauma Center at Justice Resource Institute for the statewide dissemination of ARC. ARC is an empirically based framework recognized by the NCTSN as a promising practice for addressing the developmental and relational vulnerabilities of children and families who have experienced complex trauma. Consultation with the University of Vermont Connecting Cultures Program will allow VCTC to adapt the ARC framework to better serve our refugee communities. The VCTC has the support of key stakeholders including the state child welfare system, education system, domestic and sexual violence programs, and public/private mental health providers.

VCTC's objectives are to: 1) Establish a Vermont Child Trauma Collaborative Infrastructure at the state and local level; 2) Create a Trauma-Informed Interagency Referral Network among child and family-serving programs; 3) Use existing ARC Community Treatment and Services Teams (ARC Teams) to implement the use of standardized trauma assessment and empirically-based trauma treatment using the ARC Framework in 12 identified sites serving all 14 Vermont counties; 4) Develop In-state Trauma Consultation and Training Capacity for implementation and sustainability of ARC; 5) Participate in NCTSN to incorporate lessons learned in trauma service implementation; and 6) Establish systematic Data Collection and Evaluation to monitor the quality and quantity of services and treatment.

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. Child Traumatic Stress Initiative CTS Centers	93.243	$	$	$ 399,999.89	$	$ 0.00
2.		$	$	$	$	$ 0.00
3.		$	$	$	$	$ 0.00
4.		$	$	$	$	$ 0.00
5. TOTALS		$ 0.00	$ 0.00	$ 399,999.89	$ 0.00	$ 0.00

SECTION B - BUDGET CATEGORIES

6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY (1)	(2)	(3)	(4)	Total (5)
a. Personnel	$ 18,562.00	$	$	$	$ 0.00
b. Fringe Benefits	$ 5,568.60	$	$	$	$ 0.00
c. Travel	$ 4,275.00	$	$	$	$ 0.00
d. Equipment	$ 2,230.00	$	$	$	$ 0.00
e. Supplies	$ 3,000.00	$	$	$	$ 0.00
f. Contractual	$ 154,758.13	$	$	$	$ 0.00
g. Construction	$ 0.00	$	$	$	$ 0.00
h. Other	$ 201,000.00	$	$	$	$ 0.00
i. Total Direct Charges *(sum of 6a -6h)*	$ 389,393.73	$ 0.00	$ 0.00	$ 0.00	$ 0.00
j. Indirect Charges	$ 10,606.16	$	$	$	$ 0.00
k. TOTALS *(sum of 6i and 6j)*	$ 399,999.89	$ 0.00	$ 0.00	$ 0.00	$ 0.00
7. Program Income	$	$	$	$	$ 0.00

SECTION C - NON- FEDERAL RESOURCES

(a) Grant Program	(b) Applicant	(c) State	(d) Other Sources	(e) TOTALS
8. Child Traumatic Stress Initiative CTS Centers	$	$	$	$ 0.00
9.	$	$	$	$ 0.00
10.	$	$	$	$ 0.00
11.	$	$	$	$ 0.00
12. TOTALS *(sum of lines 8 and 11)*	$ 0.00	$ 0.00	$ 0.00	$ 0.00

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. Child Traumatic Stress Initiative CTS Centers	$ 399,999.89	$ 399,054.57	$ 399,903.36	$
17.	$	$	$	$
18.	$	$	$	$
19.	$	$	$	$
20. TOTALS *(sum of lines 16 -19)*	$ 399,999.89	$ 399,054.57	$ 399,903.36	$ 0.00

SECTION F - OTHER BUDGET INFORMATION

21. Direct Charges:	22. Indirect Charges:
23. Remarks	

SECTION A: STATEMENT OF NEED AND READINESS

A.1: Description of Community

The Vermont Department of Mental Health, through the creation of a *Vermont Child Trauma Collaborative* (VCTC) comprised of 12 community-based mental health treatment providers, will implement empirically-based child trauma treatment in each of the state's 14 counties. Vermont's population is 621,254 and is one of the most rural states in the country. Vermont's largest city, Burlington, has a population of only 38,889, and the majority of Vermonters live in or near communities with populations of 2,000 to 20,000. The state has a mountainous topography, with roads covered by snow and ice many months of the year, and public transportation is limited or non-existent in most rural areas. While Vermont's size and rural nature help to maintain its beauty, independence, and strong family ties, these factors contribute to isolation and fewer jobs, limit access to affordable and quality child care, social services and medical care,[1] and mask the mental health and social service needs of its communities. Vermont rates of serious psychological distress and depression in young adults, as well as rates of illicit drug use and alcohol binging for Vermonters aged 12 or older, are among the highest in the country.[2] Of the 140,732 children and youth aged 0-18 (inclusive) in Vermont,[3] approximately 12% may be "experiencing serious or severe emotional disturbance each year."[4] Thus, between 16,887 – 28,146 children and youth in Vermont experience varying intensities of need for mental health services per year.

Child abuse and neglect is also quietly present in communities throughout Vermont. The Agency of Human Services' Department for Children and Families (DCF) and the courts treat this as a confidential matter to help ensure child victims are not further stigmatized and families are open to receiving help. The unintended consequence of this privacy approach is that many Vermonters are unaware of the seriousness of this problem.[5]

In Vermont, 95.3% of the population are Caucasian persons who are non-Hispanic; 1.3% of the population is of Hispanic or Latino origin. 1.2% are Asian people, 1.1% are of two or more races, 0.8% are Black, and 0.4% are American Indian or Alaskan Native.[6] Most Native Americans live in Northwestern Vermont, including Vermont's largest tribe, the Abenaki Nation, with about 1500 members. Through the Vermont Refugee Resettlement Program, Chittenden and Washington Counties are also home to hundreds of Vietnamese, Bosnians, and Somalis as well as dozens of Meskhetian Turks, Sudanese, Congolese, and others from more than 20 additional countries.[7] Now about 3.8% of Vermont's population is foreign-born, and 5.9% speak a language other than English at home[8] though may be proficient in English.

A.2: Target Population and Geographic Area

The Vermont Child Trauma Collaborative (VCTC) will target male and female children and adolescents ages 3-18 who have experienced complex trauma and their caregivers. Complex trauma is defined as chronic or multiple exposure to developmentally adverse interpersonal victimization, including physical, sexual and emotional abuse, neglect, witnessing of domestic and community violence, and impaired care-giving due to substance abuse or mental illness. With the presence of refugee communities in Chittenden and Washington County (see A.1: p.5), in Year 3 VCTC will also target refugee children of war-torn countries who have witnessed trauma.

Children and their families will be primarily identified through the State's child welfare/ protection agency, the Department for Children and Families (DCF), due to a report of suspected child abuse, neglect or other risk of harm. Children and families may also be identified through the local school system or other child-serving agencies (e.g. domestic violence shelters) when there is concern about the presence of trauma. VCTC will screen and provide empirically-based trauma treatment services for an estimated 350 children through the project period.

This target population was selected for several reasons:

- A state-wide needs assessment of community providers and child-serving organizations (completed by the *Child Trauma Workgroup* – see A.3: p.8) identified complex multi-generational trauma among children aged 3-18 as the most challenging clinical issue facing Vermont's System of Care (SOC) for children.
- Despite recent efforts to improve access to mental health services for children involved in child welfare, only 24% of young people identified by the state child welfare agency (DCF) as having been abused and/or neglected are served by the public mental health system.[9] This data indicates that this population has limited access to comprehensive empirically-based treatment for trauma resulting from abuse and/or neglect.
- Vermont's small population, rural nature and limited resources require community treatment teams to work across a broad spectrum of ages and disorders.

VCTC's implementation will occur statewide through the 10 designated community mental health centers (CMHC's), each of which are responsible for providing core mental health services in a specified geographic "catchment area" to the most needy Vermonters. Given Vermont's small population and size it is ideal for statewide programming (see p.5 for a full description of Vermont). This approach will ensure that children and families in each of the state's 14 counties have access to appropriate trauma treatment. In Chittenden County, the state's most populated region and home to its largest city, implementation will also occur in an additional public specialized service agency (Northeastern Family Institute) and a private treatment center (New England Counseling and Trauma Center) to improve access in that region and help to improve partnerships between public and private mental health programs.

A.3: Major Needs and Opportunities for Trauma-Informed Treatment and Services

Major Needs of the Community

Complex trauma, defined as the experience of chronic or multiple traumatic events that occur within the caregiving system, carries an enormous cost to Vermont communities both in lives impacted and dollars spent: [10]

- In 2007, mandated reporters (including mental health professionals) and others made 12,829 contacts with the DCF regarding potential instances of child abuse and neglect. Of this number, 2,633 were accepted for investigation and 687 were substantiated for abuse or neglect.[11]
- In 2008 DCF received 1,892 intake calls that identified co-occurring domestic violence and child maltreatment. 527 of these intakes were opened for investigation, of which 106 were substantiated and 52 remained open cases.[12]
- 2008 data published by the Vermont Network Against Domestic and Sexual Violence reported that approximately 7,853 children/youth were exposed to domestic violence. In that

same year, 193 children were sheltered in Network shelters or safe homes; 1,175 children received services in addition to shelter, and 180 children and youth under the age of 18 were victims of sexual violence.[13]

Early chronic or repeated childhood exposure to these types of traumatic experiences can impact a child's capacity to develop skills to regulate affect and increase the incidence of depression, suicidal ideation, self-injury, substance abuse, difficulty modulating sexual impulses, and sexually transmitted diseases.[14] Other manifestations of exposure to early trauma include falling behind in school readiness and school performance, diminished cognitive abilities, and significantly higher levels of behavioral and emotional problems.[15] Trauma-related emotional problems also increase risk of unhealthy behaviors such as smoking, excessive alcohol or other drug use, poor diet, lack of sleep, and insufficient physical exercise, possibly contributing to future health complications including chronic mental health problems.[16]

Children and families who have experienced trauma must have access to appropriate care. Early recognition and treatment of trauma yields better outcomes; reduces the severity and chronicity of mental and physical health problems as well as the economic impact on health care systems and the criminal justice system; and for long-term trends, increases the skills and resilience of those who become parents so they can better provide for their developing child.

Vermont's system of human service providers have increasingly become more aware of the need to address complex trauma; however, the system is taxed by the demand for services for children/families with complex trauma in need of skilled practitioners, coordinated treatment and support. This increase in recognition and demand is illustrated by the following Vermont data:

- In 1994 only 30 or .1% of the CMHC's caseload in Vermont was identified as having Post-traumatic Stress Disorder, but by 2007 that number had grown to 2,455 clients or 9.6% of the caseload.[17]
- In 2008, the CMHC's reported that 10.3% - or 939 – of the children and youth aged 0-18 who were served had a diagnosis of PTSD; they also reported serving 1,736 children and youth known to be victims of abuse, assault, or rape.[18]

It should be noted that many children who suffer from complex trauma may not meet the full diagnosis for PTSD, and therefore the numbers are likely an underestimate of the actual presence of complex trauma in children served by the public community mental health system. "Children exposed to maltreatment, family violence, or loss of their caregivers often meet diagnostic criteria from the [DSM-IV] for depression, attention-deficit/hyperactivity disorder, oppositional defiant disorder, conduct disorder, anxiety disorders...and reactive attachment disorder."[19]

Opportunities to Promote and Implement Trauma-Informed Interventions

Vermont's growing recognition of the need to address complex trauma has created multiple opportunities to implement trauma-informed interventions. DCF recently implemented a statewide Centralized Intake Unit (CIU) to screen all reports of suspected child abuse/ neglect for acceptance before referral to DCF District Offices for investigation, with the goal of statewide consistency in responses. Since implementation of the CIU in September 2008, DCF has seen a substantial rise in the number of accepted reports of child abuse/neglect. In July 2009, DCF will begin a Differential Response system which will provide two options for response to reported child abuse/neglect: 1) a "forensic" investigation involving the courts to achieve a determination

of substantiation or 2) an "assessment" response for lower risk situations to focus on improving factors that interfere with effective parenting. DCF's anticipation of the impact of differential response is that 47% of current investigations can be diverted to the assessment track. Through Differential Response, DCF will improve its ability to identify children who are experiencing complex trauma and refer these cases to those CMHC treatment teams that are implementing trauma treatment for this population[20] (see DCF Letter of Commitment – Appendix 1).

Through the work of the *Child Trauma Workgroup*, a statewide planning group comprised of child and family-serving community and state organizations, DMH has also initiated a training and consultation relationship with the Trauma Center at Justice Resource Institute (TC-JRI) to support CMHC implementation of the Attachment, Self-Regulation and Competence (ARC) Framework[21] for the treatment of complex trauma in children (see p.8 for a full description of the *Vermont ARC Project*). The consensus-building, planning and training accomplished through the Vermont ARC Project will support further implementation of empirically-based trauma treatment throughout the state.

A.4: Availability of Trauma-informed Treatment and Services

There are significant areas for development in the provision of trauma-informed and trauma-specific services within Vermont's community mental health system. Until recently, there has not been consensus across providers about the use of empirically-based assessment, treatment, or service models for trauma treatment. As such, many programs lacked staff with the specialized skills to assess, treat and coordinate care for children who had experienced complex trauma.

In recognition of these challenges, DMH has been working with the CMHC's and other child-serving agencies over the last 36 months to improve their ability to deliver effective trauma-informed care and trauma treatment for children, youth, and their families. Through the DMH-funded *Vermont ARC Project*, the CMHC's have begun to develop capacity for complex trauma treatment using the Attachment, Self-Regulation and Competence (ARC) Framework. The following activities have been completed:

- Creation of a DMH Trauma Policy (based on an AHS Trauma Policy) to highlight the significance of trauma in the lives of the people we serve and our commitment to providing quality trauma-specific services within a trauma-informed mental health system
- Consensus-building to identify target population, the proposed model of trauma services, and the activities of training and implementation at the community level
- Training on *Trauma-Informed Care* and the ARC Framework for CMHC, child welfare, post-adoption, private practice, and school-based providers state-wide
- The creation of clinical teams (i.e. **ARC Community Treatment and Services Teams** - ARC Teams) at each CMHC focused on practice implementation within their service area
- Training and monthly consultation by TC-JRI for all ARC Teams focused on integrating the ARC concepts into daily practice
- Initial self-assessments at each CMHC to determine key areas of challenge, priorities for change, and consideration of factors relevant to implementing ARC
- Commitment from each CMHC to become familiar with trauma screening and assessment tools (Trauma Symptom Checklist for Children, Trauma Symptom Checklist for Young Children, Parenting Stress Index, and Child Behavior Checklist).

While initial efforts have created a solid foundation, the majority of CMHC's are still in the initial stages of implementing ARC. This proposal would support full implementation of ARC throughout children's mental health outpatient services across Vermont. This proposal will also support other community child-serving agencies to 1) receive additional training on trauma-informed service delivery and 2) improve the identification and referral of children for trauma assessment and treatment (see Appendix 1 - Letters of Support).

A.5: Existing Collaborations

The Vermont Child Trauma Collaborative (VCTC) will be supported by several different collaborations. For the past 20 years, DMH and DCF, along with representatives from the Department of Education (DOE), families, and other partners, have met monthly through the Vermont Act 264 *State Interagency Team (SIT)* to resolve problems in the coordinated service planning for children and youth with serious emotional disturbance or other disabilities. SIT and the *Local Interagency Teams (LIT)*, which exist in each of the state's twelve Agency of Human Services' districts to serve as a resource for interagency planning teams and a forum to address regional service needs, will support the VCTC. Members of these teams will be targeted to participate on the State and Local VCTC Advisory Committees (as described in C.1: p.14) to support adoption of trauma-informed practices.

VCTC will also be supported by the Agency of Human Services (AHS) *Child Trauma Workgroup,* which formed in 2004 to identify unmet needs in Vermont's System of Care (SOC) for traumatized children and families and support the development of enhanced trauma treatment in the state. The workgroup is comprised of representatives from child welfare, mental health, domestic and sexual violence programs, adoption programs, Prevent Child Abuse Vermont, consumers/parents, the AHS Refugee Coordinator, and the AHS Trauma Coordinator. Members of the Child Trauma Workgroup will participate on the State Advisory Committee of this project.

Finally, VCTC will benefit from an existing collaboration between DOE and DMH in which 90% of supervisory unions contract with CMHCs for school-based mental health services. To enhance these services and support DOE's implementation of Positive Behavioral Supports (PBS) in 16 of the 54 supervisory unions, DOE and DMH have focused on the need for schools to be trauma informed and effectively access trauma treatment services when warranted. VCTC will capitalize on this existing collaboration to increase trauma informed school services and clearly establish referral protocols for trauma specific treatment.

SECTION B: PROPOSED TRAUMA-INFORMED PRACTICES OR INTERVENTIONS

B.1: Purpose, Goals, Objectives, and Results

This grant initiative will establish a *Vermont Child Trauma Collaborative (VCTC)* comprised of 12 community-based mental health treatment centers to ensure trauma-informed care and empirically-based trauma treatment are available to children with complex trauma and their families throughout Vermont. The goals of this service and treatment collaborative are:

1. children in Vermont will have access to trauma-informed services throughout the SOC;
2. children who screen positively for trauma will receive a standardized trauma assessment;
3. children with complex trauma and their families will be referred for and receive trauma-specific treatment services that are empirically based;

In order to achieve these goals, the VCTC will complete the following objectives:

a) Establish *Vermont Child Trauma Collaborative Infrastructure* at the state and local level to oversee and coordinate implementation of ARC;
b) Create a *Trauma-Informed Interagency Referral Network* among child and family-serving state and community programs (child welfare, education, domestic violence) to ensure consistent screening and referral to treatment for children exposed to trauma;
c) Use existing *ARC Community Treatment and Services Teams (ARC Teams)* to implement the use of standardized trauma assessment and empirically-based trauma treatment in 12 community treatment programs serving all 14 Vermont counties;
d) Develop *In-state Trauma Consultation and Training Capacity* to support implementation of trauma-informed care and the ARC framework and ensure sustainability of the practice;
e) *Participate in NCTSN* to incorporate lessons learned in trauma service implementation; and
f) Establish systematic *Data Collection and Evaluation* to improve the quality and quantity of services and treatment being provided through the VCTC.

With implementation of the VCTC objectives, we will achieve the following results:

- The number and consistency of referrals for ARC trauma treatment services from child-serving programs will increase.
- The number of children and families receiving ARC trauma treatment will increase.
- Children and families receiving ARC will experience improved clinical outcomes, including:
  - Reduction of trauma-related symptoms
  - Increased child competency
  - Reduction of caregiver parenting stress
  - Reduced need for intensive services (psychiatric hospital and long-term residential).

B.2. The ARC Framework and Its Evidence-Base

Vermont will expand its implementation of the Attachment, Self-Regulation, and Competence (ARC) Framework. This model was developed by Margaret Blaustein, Ph.D. and Kristine Kinniburgh, LICSW of the Trauma Center at Justice Resource Institute (TC-JRI) to intervene with youth and families who have experienced complex trauma such as chronic or multiple sexual abuse, physical abuse, neglect, domestic violence, and community violence. The ARC model is based on an empirical framework that includes components of cognitive-behavioral therapy, attachment theory, and trauma theory to address the central goals of safety, self-regulation, self-reflective information processing, traumatic experience integration, and relational engagement or attachment. ARC provides a framework for clinicians to work collaboratively with children and their families to build/strengthen secure attachments, develop/enhance self-regulatory capabilities, and increase child and parent competencies across multiple domains. The approach was developed to be respectful of the strengths, resources, and individual characteristics of the child and care-giving system and can be adapted to the unique cultural needs of various ethnic populations.

ARC involves conducting a sound clinical assessment to identify strengths and needs of the youth and uses phase-oriented interventions that appropriately match the individual level of need. The ARC framework is a component-based framework built around three core domains

the supervisors to offer ARC training to VCTC site staff who are hired after the initial rollout of training.

Objective (e): *Participate in NCTSN* to incorporate lessons learned in trauma service implementation

Collaboration with NCTSN will consist of: 1) partnership with the TC-JRI Level III and Level II Center for training/consultation on the ARC Framework and collaboration for cultural adaptations to the model; 2) collaboration with other NCTSN sites who are implementing ARC to share lessons learned; 3) use of existing NCTSN resources (e.g. publications, web training programs, Listserves); 4) contribution of developed materials from our project (see C.10, p.24) and 5) participation in NCTSN meetings.

Objective (f): Establish systematic *Data Collection and Evaluation* to monitor the quality and quantity of services and treatment being provided through the VCTC

Evaluation data will be continually fed back to VCTC participants to inform and improve grant activities. See Section E (p.30) for a full description of the evaluation process.

Project Timeline

Key: ARC Lead Supervisor (ALS); Project Co-Directors (PD); Project Evaluator (PE); Principle Investigator (PI); Trauma Center at JRI (TC-JRI); VCTC Consultation Team (VCTC-CT); VCTC Advisory Committee (VCTC-AC)

Period	Key Activity & Milestone	Responsible Staff
YR1, Q1 (1-3 Mo.)	Convene **State Advisory Committee**: delineate roles and responsibilities; establish quarterly meeting schedule; recruit youth/ family representatives.	PI *(see key above)
	Hire Project Co-Director and create sub-grant for PE.	PI
	Establish contract with NCTSN Center (TC-JRI) for consultation on ARC Framework.	PI
	Evaluator works with NCTSN to establish reporting and data exchange protocol.	PE*
	Create memoranda of understanding with identified sites to establish the VCTC.	PI
	Convene **VCTC Consultation Team**.	PD*
	VCTC "Kick-off" meeting (3-days): 1-day orientation to program goals, activities, and evaluation. 2-day training on ARC Framework, assessment, clinical concepts.	PD, PE, TC-JRI*
	Develop trauma-informed interagency referral network structure.	VCTC-AC*
	Develop VCTC outreach and education materials.	PD
	Establish monthly local ARC Team meetings; identify ARC Lead Supervisor.	PD, ALS *
	Convene the **Local Advisory Committees**: build local consensus for project.	ALS, PD
	Establish communication systems for distance learning and project information.	PD, PE
	In month 3, begin monthly clinical consultation for ARC Teams.	TC-JRI
	Submit quarterly progress report to SAMHSA.	PD
YR1, Q2 (4-6 mos)	Continue **monthly ARC training/consultation** for ARC Teams.	TC-JRI
	Implement ARC in **direct clinical services** at CMHC's by month 4: conduct clinical assessments; initiate provision of clinical services with the target goal of serving **5-6** clients at each site during Year One (YR 1 total **60** clients).	PD, ARC Teams
	Continue monthly local internal agency ARC Team meetings for implementation.	ALS
	Initiate **data collection** for client assessment and evaluation of implementation efforts.	PE
	Submit quarterly progress report to SAMHSA.	PD
YR1, Q3 (7-9	Continue provision of clinical services using ARC framework.	ARC Teams
	Continue monthly ARC training/consultation for ARC Teams.	TC-JRI
	Continue monthly local ARC Team meetings focused on implementation .	ALS
	1-day in-person training, followed by monthly consultations for **ARC Lead**	TC-JRI

mos)	**Supervisor/Trainer Series**	
	Continue evaluation activities: conduct client satisfaction surveys, site visits; Provide feedback from data collection for clinical utility and project activities.	PE
	Develop Train-the-Trainer curriculum for TIC training of community partners.	VCTC-CT
	Identify local providers from each region to participate in TIC Train-the-Trainer Series	ALS
	Submit quarterly progress report to SAMHSA.	PD
YR 1, Q4 (10-12 mos)	Conduct **"TIC for Community Partners" Train-the-Trainer Series**	VCTC-CT
	Continue provision of clinical services, consultations and ARC Team meetings.	ARC Teams TC-JRI
	Submit annual report to SAMHSA, including sustainability efforts and plan.	PD, PE
YR 2, Q1 (13-15 mos)	Continue to implement ARC: provision of clinical services with the target goal of serving **12** new clients at each of the 12 sites (YR 2 total **145** clients).	PD, ALS, TC-JRI
	Continue monthly consultations for ARC Teams and ARC Lead Supervisors.	TC-JRI
	Continue evaluation activities: Provide feedback from Core Data Set for clinical utility and project activities; NCTSI Cross-Site Evaluation.	PE
	Continue internal agency monthly ARC Team implementation/supervision meetings.	ALS
	Continue TIC Train-the-Trainer series.	VCTC-CT
YR2, Q2 (16-18 mos)	Ongoing provision of clinical services & evaluation activities.	ARC Teams PE
	Phase out monthly ARC Team consultation by TC-JRI; ARC Lead Supervisors oversee ARC Teams with monthly mentorship/consultation from TC-JRI.	TC-JRI
	Provide **Local TIC trainings** to child-serving partners; consultation for TIC trainers.	TIC trainers VCTC-CT
YR 2, Q3 – Q4 (19-24 mos)	Ongoing provision of clinical services & evaluation activities.	ARC Teams PE
	Month 20: 1-day in-person training/consultation for ARC Lead Supervisors to continue to solidify skills and sustain VCTC trainings on ARC framework.	TC-JRI
	Continue internal agency monthly ARC Team implementation/supervision meetings.	ALS
	Continue monthly ARC Lead Supervisor/Trainer consultations.	TC-JRI
	Continue to offer Local TIC trainings to child-serving partners; on-going consultation for TIC trainer collaborative.	VCTC-CT, TIC trainers
	Submit quarterly and annual reports to SAMHSA including sustainability efforts/ plan.	PD, PE
YR 3	Ongoing provision of clinical services & evaluation activities: target goal of serving **12** new clients at each of the 12 sites (YR 3 total **145** clients); Provide ARC trauma-treatment to total of **350** clients by the end of Y3.	ARC Teams PE
	Continue internal agency monthly ARC Team implementation/supervision meetings.	ALS
	UVM Connecting Cultures Program Director joins VCTC-CT. **Adapt ARC model for refugee populations** in Chittenden and Washington Counties.	VCTC-CT, TC-JRI
	Quarterly phone consultations and 1 in-person meeting to develop cultural adaptations. Document adaptations.	TC-JRI, VCTC-CT
	Quarterly phone consultations for ARC Lead Supervisor/Trainers to develop & finalize curriculum for internal VCTC ARC trainings.	TC-JRI
	Continue client data collection; continue TA system.	PE
	Continue to offer Local TIC trainings to child-serving partners; on-going consultation for TIC trainer collaborative.	VCTC-CT, TIC trainers
	Submit quarterly and final reports to SAMHSA including sustainability efforts & plan.	PD, PE

C.2: Characteristics of the Target population:

The target population is male and female children and adolescents ages 3-18 who have experienced complex trauma (as described in A.2, p.5). Treatment services will also target the child's caregiver (parent, adoptive parent, foster parent, kinship care, etc) according to clinical need, developmental age of the child, and treatment goals. A significant benefit of the ARC

1 BALDWIN STREET
MONTPELIER, VT 05633-5701

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

STATE OF VERMONT
JOINT FISCAL OFFICE

MEMORANDUM

To: Representative Ann Pugh
Senator Douglas Racine

From: Nathan Lavery, Fiscal Analyst

Date: December 9, 2009

Subject: JFO #2419 & #2420

Representative Michael Obuchowski asked that I forward to you a copy of the enclosed grant materials and cover memo. He requests your observations regarding the enclosed items.

cc: Rep. Michael Obuchowski
Stephen Klein

JFO 2419

VERMONT

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

Agency of Administration

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

STATE OF VERMONT
FINANCE & MANAGEMENT GRANT REVIEW FORM

Grant Summary:	Under this grant the Department of Mental Health will work with the Vermont Child Treatment Collaborative (made up of the 12 community mental health treatment centers) to fully implement the Attachment, Self-Regulation and Competency (ARC) Framework for complex trauma treatment. The new system is aimed at improved outcomes for children 3-18 who have experienced complex trauma.				
Date:	11/20/2009				
Department:	Vermont Department of Mental Health				
Legal Title of Grant:	National Child Traumatic Stress Initiative Community Treatment and Services Centers Grant.				
Federal Catalog #:	93.243				
Grant/Donor Name and Address:	Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Rockville , MD				
Grant Period: From:	9/30/2009	**To:**	9/29/2012		
Grant/Donation	$1,198,956				

	SFY 1	SFY 2	SFY 3	Total	Comments
Grant Amount:	$204,879	$399,054	$595,023	$1,198,956	SFY3 includes remainder to be spent in SFY13 as well as amount spent in SFY12

	# Positions	Explanation/Comments
Position Information:	1	Mental Health Systems Improvement Chief (funded partially through this grant, 34%, and partially through the Co-occurring State Incentive Grant, 56%, that was approved several years ago by JFO)

Additional Comments:	

STATE OF VERMONT FINANCE & MANAGEMENT GRANT REVIEW FORM		
Department of Finance & Management		(Initial)
Secretary of Administration		(Initial)
Sent To Joint Fiscal Office		**Date**

State of Vermont
Department of Mental Health
108 Cherry Street, PO Box 70
Burlington, VT 05402-0070
healthvermont.gov/mh

[phone] 802-652-2000
[Legal] 802-657-4310
[fax] 802-652-2005
[tty] 800-253-0191

Agency of Human Services

To: Shirley Dow, AHS

From: Bill Snyder, DMH Financial Manager

Re: AA-1 for National Child Traumatic Stress Initiative Community Treatment and Services Center Grant

Date: November 10, 2009

I am enclosing the documents requesting approval for a new National Child Traumatic Stress Initiative Community Treatment and Services Center Grant for the Department of Mental Health, including a copy of the original application for funding, the grant award letter from the Substance Abuse and Mental Health Services Administration, the AA-1 form with an attached Supporting Schedule for the first year's funding, and the AA-1PN form. Please let me know when the AA-1 has been signed by the Secretary and the packet is on its way to Budget and Management in Montpelier.

Please note that DMH plans to create a Limited Service Position (Mental Health Systems Improvement Chief) that will be partially funded by this grant. This position will replace the Administrative Assistant B position listed in the original grant application to SAMHSA (see attached). We have received written approval from SAMHSA to fund the position of Mental Health Systems Improvement Chief using the federal grant listed in this AA-1 application and a *Co-Occurring State Incentive (COSIG) Grant* also funded through SAMHSA. This position will oversee and coordinate both the National Child Traumatic Stress Initiative Community Treatment and Services Center Grant and the COSIG grant.

If you have any questions, please contact me at 657-4257 or Nick Nichols at 652-2000.

STATE OF VERMONT
Joint Fiscal Committee Review
Limited Service - Grant Funded
Position Request Form

This form is to be used by agencies and departments when additional grant funded positions are being requested. Review and approval by the Department of Human Resources must be obtained prior to review by the Department of Finance and Management. The Department of Finance will forward requests to the Joint Fiscal Office for JFC review. A Request for Classification Review Form (RFR) and an updated organizational chart showing to whom the new position(s) would report **must** be attached to this form. Please attach additional pages as necessary to provide enough detail.

Agency/Department: AHS/Mental Health Date: October 12, 2009

Name and Phone (of the person completing this request): Nick Nichols, 652-2029

Request is for:
- ☒ Positions funded and attached to a new grant.
- ☐ Positions funded and attached to an existing grant approved by JFO #_____

1. Name of Granting Agency, Title of Grant, Grant Funding Detail (attach grant documents):

Department of Health and Human Services-Substance Abuse and Mental Health Services Administration

National Child Traumatic Stress Initiative Community Treatment and Services Centers Grants

2. List below titles, number of positions in each title, program area, and limited service end date (information should be based on grant award and should match information provided on the RFR) position(s) will be established only after JFC final approval:

Title* of Position(s) Requested	# of Positions	Division/Program	Grant Funding Period/Anticipated End Date
Mental Health Systems Improvement Chief	**1**	**N/A**	**9/30/09 – 9/29/2012 / January 2nd, 2013**

*Final determination of title and pay grade to be made by the Department of Human Resources Classification Division upon submission and review of Request for Classification Review.

3. Justification for this request as an essential grant program need:

This position will oversee 5 different multi-year federal grant projects focused on the improvement of services and expansion of treatment and support capacity to address gaps in the mental health system. Given the amount of funding available through these federal grants (approximately $9 million), the multiple and complex federal expectations and reporting requirements, and the potential for overlap of systems improvement activities across these projects, DMH requires a state position to ensure proper oversight and coordination among all of the grants.

I certify that this information is correct and that necessary funding, space and equipment for the above position(s) are available (required by 32 VSA Sec. 5(b).

Beth M. Tanzman — 10/16/09
Signature of Agency or Department Head — Date

Molly Paul — 11/18/09
Approved/Denied by Department of Human Resources — Date

11/23/09
Approved/Denied by Finance and Management — Date

DHR – 11/7/05

RECEIVED 2009

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

BASIC GRANT INFORMATION	
1. Agency:	Human Services
2. Department:	Mental Health
3. Program:	Childrens Mental Health
4. Legal Title of Grant:	National Child Traumatic Stress Initiative Community Treatment and Services Centers Grants
5. Federal Catalog #:	93.243

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

7. Grant Period:	**From:**	9/30/2009	**To:**	9/29/2012

8. Purpose of Grant:
To implement and evaluate effective trauma-focused and trauma-informed treatment and services for youth in community settings and youth-serving service systems

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

10. BUDGET INFORMATION

	SFY 1	SFY 2	SFY 3	Comments
Expenditures:	**FY** 10	**FY** 11	**FY** 12 and beyond	
Personal Services	$94,874	$180,779	$265,948	
Operating Expenses	$15,005	$18,275	$29,075	
Grants	$95,000	$200,000	$300,000	
Total	$204,879	$399,054	$595,023	
Revenues:				
State Funds:	$	$	$	
Cash	$	$	$	
In-Kind	$	$	$	
Federal Funds:	$204,879	$399,054	$595,023	
(Direct Costs)	$199,450	$388,448	$579,241	
(Statewide Indirect)	$54	$106	$158	
(Departmental Indirect)	$5,375	$10,500	$15,624	
Other Funds:	$	$	$	
Grant (source)	$	$	$	
Total	$204,879	$399,054	$595,023	

Appropriation No:	3150070000	**Amount:**	$204,879
			$
			$
			$
			$
			$
			$

REC'D NOV 13 2009

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

		Total	$204,879

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 process/policy.

Appointing Authority Name: Michael Hartman Agreed by: BHT (initial) Beth Tanzman Deputy

12. Limited Service Position Information:	**# Positions**	**Title**
	1	Mental Health Systems Improvement Chief
Total Positions	1	

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

13. AUTHORIZATION AGENCY/DEPARTMENT

I/we certify that no funds beyond basic application preparation and filing costs have been expended or committed in anticipation of Joint Fiscal Committee approval of this grant, unless previous notification was made on Form AA-1PN (if applicable):	Signature: Beth M. Tanzman	Date: 10/16/09
	Title: BETH TANZMAN - DEPUTY COMMISSIONER 11/6/09	
	Signature: OK per JC	Date:
	Title:	

14. ACTION BY GOVERNOR

☑	Check One Box: Accepted		12/5/09
☐	Rejected	(Governor's signature)	Date:

15. SECRETARY OF ADMINISTRATION

☐	Check One Box: Request to JFO		12/4/09
☐	Information to JFO	(Secretary's signature or designee)	Date:

16. DOCUMENTATION REQUIRED

Required GRANT Documentation

☒ Request Memo	☐ Notice of Donation (if any)
☐ Dept. project approval (if applicable)	☒ Grant (Project) Timeline (if applicable)
☒ Notice of Award	☐ Request for Extension (if applicable)
☐ Grant Agreement	☒ Form AA-1PN attached (if applicable)
☒ Grant Budget	

End Form AA-1

State of Vermont
Department of Mental Health
108 Cherry Street, PO Box 70
Burlington, VT 05402-0070
healthvermont.gov/mh

Agency of Human Services

[phone] 802-652-2000
[Legal] 802-657-4310
[fax] 802-652-2005
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Please note that DMH plans to create a Limited Service Position (Mental Health Systems Improvement Chief) that will be partially funded by this grant. This position will replace the Administrative Assistant B position listed in the original grant application to SAMHSA (see attached). We have received written approval from SAMHSA to fund the position of Mental Health Systems Improvement Chief using the federal grant listed in this AA-1 application and a *Co-Occurring State Incentive (COSIG) Grant* also funded through SAMHSA. This position will oversee and coordinate both the National Child Traumatic Stress Initiative Community Treatment and Services Center Grant and the COSIG grant.

If you have any questions, please contact me at 657-4257 or Nick Nichols at 652-2000.

STATE OF VERMONT
Joint Fiscal Committee Review
Limited Service - Grant Funded
Position Request Form

This form is to be used by agencies and departments when additional grant funded positions are being requested. Review and approval by the Department of Human Resources must be obtained prior to review by the Department of Finance and Management. The Department of Finance will forward requests to the Joint Fiscal Office for JFC review. A Request for Classification Review Form (RFR) and an updated organizational chart showing to whom the new position(s) would report **must** be attached to this form. Please attach additional pages as necessary to provide enough detail.

Agency/Department: AHS/Mental Health Date: October 12, 2009

Name and Phone (of the person completing this request): Nick Nichols, 652-2029

Request is for:
☒Positions funded and attached to a new grant.
☐Positions funded and attached to an existing grant approved by JFO #_____

1. Name of Granting Agency, Title of Grant, Grant Funding Detail (attach grant documents):

Department of Health and Human Services-Substance Abuse and Mental Health Services Administration

National Child Traumatic Stress Initiative Community Treatment and Services Centers Grants

2. List below titles, number of positions in each title, program area, and limited service end date (information should be based on grant award and should match information provided on the RFR) position(s) will be established only after JFC final approval:

Title* of Position(s) Requested	# of Positions	Division/Program	Grant Funding Period/Anticipated End Date
Mental Health Systems Improvement Chief	**1**	**N/A**	**9/30/09 – 9/29/2012 / January 2nd, 2013**

*Final determination of title and pay grade to be made by the Department of Human Resources Classification Division upon submission and review of Request for Classification Review.

3. Justification for this request as an essential grant program need:

This position will oversee 5 different multi-year federal grant projects focused on the improvement of services and expansion of treatment and support capacity to address gaps in the mental health system. Given the amount of funding available through these federal grants (approximately $9 million), the multiple and complex federal expectations and reporting requirements, and the potential for overlap of systems improvement activities across these projects, DMH requires a state position to ensure proper oversight and coordination among all of the grants.

I certify that this information is correct and that necessary funding, space and equipment for the above position(s) are available (required by 32 VSA Sec. 5(b).

Beth M. Tanzman — 10/16/09
Signature of Agency or Department Head — Date

Molly Paul — 11/18/09
Approved/Denied by Department of Human Resources — Date

[signature] — 11/23/09
Approved/Denied by Finance and Management — Date

DHR – 11/7/05

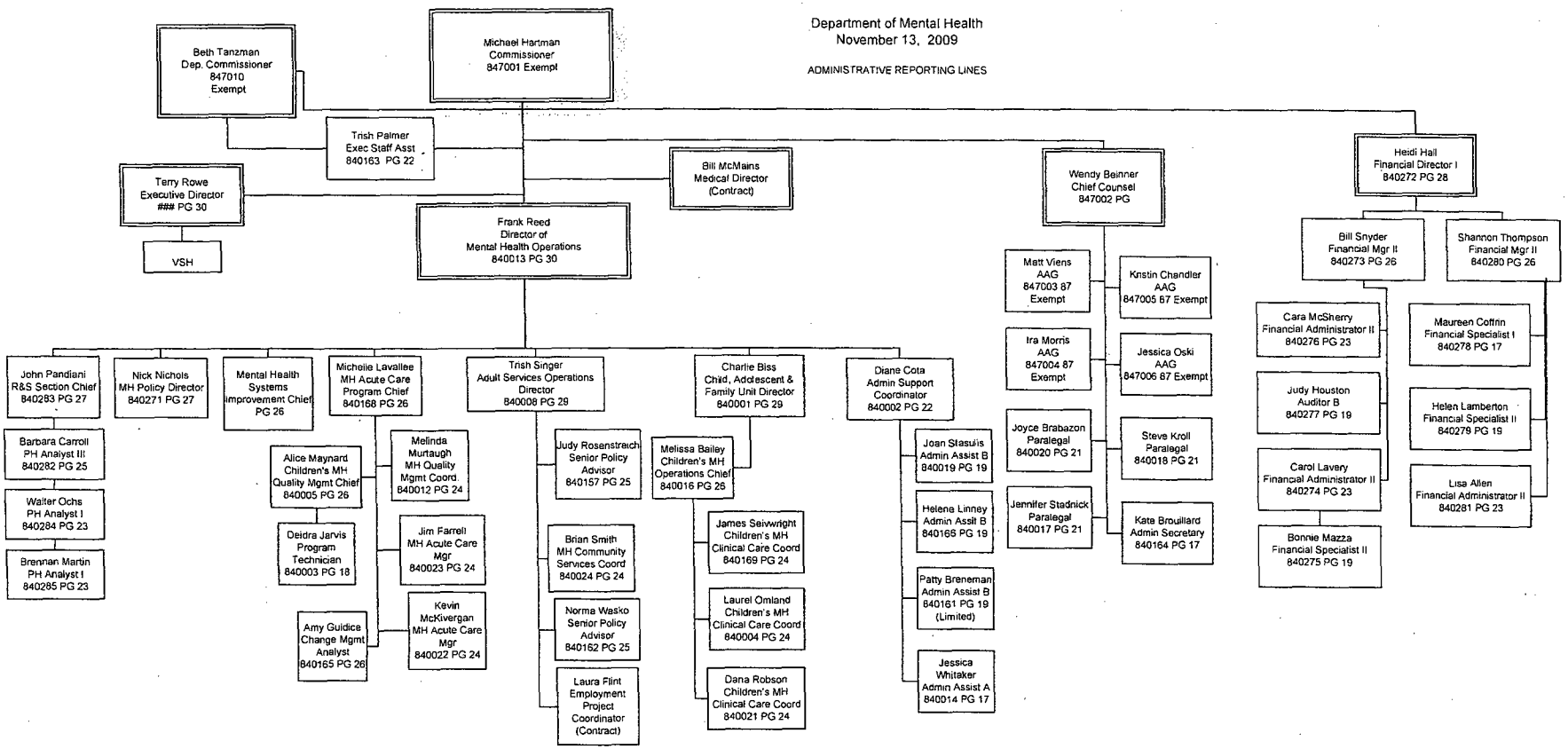
STATE OF VERMONT
Joint Fiscal Committee Review
Limited Service - Grant Funded
Position Request Form

Approved/Denied by Secretary of Administration — Date 12/30/11

Comments:

Department of Mental Health
November 13, 2009

ADMINISTRATIVE REPORTING LINES



Request for Classification Review
Position Description Form A

For Department of Personnel Use Only

Date Received (Stamp)

Notice of Action #_____

Action Taken: _____

New Job Title _____

Current Class Code _____ New Class Code _____

Current Pay Grade _____ New Pay Grade _____

Current Mgt Level____ B/U ____ OT Cat. ____EEO Cat. ____FLSA _____

New Mgt Level _____ B/U ____OT Cat. ____EEO Cat. ____FLSA _____

Classification Analyst_____Date _____ Effective Date: _____

Comments:

Date Processed: _____

Willis Rating/Components: Knowledge & Skills: _____ Mental Demands: _____ Accountability: _____
Working Conditions: _____ Total: _____

Incumbent Information:

Employee Name: [ ] Employee Number: [ ]

Position Number: [ ] Current Job/Class Title: [ ]

Agency/Department/Unit: [ ] Work Station: [ ] Zip Code: [ ]

Supervisor's Name, Title, and Phone Number: [ ]

How should the notification to the employee be sent: ☐ employee's work location [ ] or ☐ other address, please provide mailing address: [ ]

New Position/Vacant Position Information:

New Position Authorization: [ ] Request Job/Class Title: [Mental Health Systems Improvement Chief]

Position Type: ☐ Permanent or ☒ Limited / Funding Source: ☐ Core, ☐ Partnership, or ☒ Sponsored

Vacant Position Number: [ ] Current Job/Class Title: [ ]

Agency/Department/Unit: [Agency of Human Services/Department of Mental Health] Work Station: [Burlington] Zip Code: [05401]

Supervisor's Name, Title and Phone Number: [Frank Reed, Director of Operations, 652-2021]

Type of Request:

☒ **Management:** A management request to review the classification of an existing position, class, or create a new job class.

☐ **Employee:** An employee's request to review the classification of his/her current position.

1. Job Duties

This is the ***most critical*** part of the form. Describe the activities and duties required in your job, **noting changes (new duties, duties no longer required, etc.) since the last review**. Place them in order of importance, beginning with the single most important activity or responsibility required in your job. The importance of the duties and expected end results should be clear, including the tolerance that may be permitted for error. Describe each job duty or activity as follows:

- **What** it is: The nature of the activity.
- **How** you do it: The steps you go through to perform the activity. Be specific so the reader can understand the steps.
- **Why** it is done: What you are attempting to accomplish and the end result of the activity.

For example a Tax Examiner might respond as follows: **(What)** *Audits tax returns and/or taxpayer records.* (**How**) *By developing investigation strategy; reviewing materials submitted; when appropriate interviewing people, other than the taxpayer, who have information about the taxpayer's business or residency.* (**Why**) *To determine actual tax liabilities.*

Developmental, administrative, coordinating and monitoring work for the Department of Mental Health involving the development of state and local capacity to provide evidence-based treatment and support through the adminstration of mulitiple federal grant programs. Oversees and administratively coordinates the resources of multiple federal grant projects to improve the mental health treatment system, including 1) development of statewide evidence-based trauma treatment and support for youth, 2) development of jail diversion and trauma treatment capacity for veterans and other adults with trauma-related disorders, 3) development of a system of care for youth in transition, 4) implementation of alternatives to seclusion and restraint at psychiatric inpatient programs, 5) development of comprehensive, integrated treatment for individuals with mental health and substance abuse disorders across multiple mental health and substance abuse treatment systems.

Responsible for day-to-day management and oversight of mulitple federal grant projects. Analyzes complex reporting and policy requirements of a variety of federal funding sources. Evaluates current policies and procedures to determine needed changes to comply with federal requirements. Formulates strategies for the effective integration and deployment of grant resources to maximize the collective impact of grant funding. Implements systems, including writing policies and procedures, to ensure proper accounting of federal funds and the collection of appropriate data. Interprets data and prepares statistical and narrative reports on program activities. Ensures all federal reporting requirements are met in a timely fashion. Serves as liaison with federal administrators. Represents the Department in state and federal audits. Analyzes changes in federal regulations in light of their impact on the Department. May draft and develop new grant applications in response to funding opportunities. May oversee a department's accounts receivable functions. Coordinates departmental collaboration with other organizations implementing federal grant projects. Develop and staff work teams to manage grant activities. Coordination of all planning, training, consultation, and evaluation activities in support of multiple grant projects. Responsible for coordination of multiple statewide initiatives led by distinct stakeholders groups. Oversee and coordinate development and and monitoring of mulitple state grants and contracts to support federal grant project activities and deliverables. Interfaces and coordinates with key Department of Mental Health (DMH) operations, information technology and business staff to assure completion of grant deliverables.

Performs other duties as required.

2. Key Contacts

This question deals with the personal contacts and interactions that occur in this job. Provide brief typical examples indicating your primary contacts (**not** an exhaustive or all-inclusive list of contacts) other than those persons to whom you report or who report to you. If you work as part of a team, or if your primary contacts are with other agencies or groups outside State government describe those interactions, and what your role is. For example: you may *collaborate, monitor, guide, or facilitate change.*

Works closely with key operations, information technology, business, and program directors and chiefs within the Department of Mental Health to ensure alignment of DMH policy and operations practices with federal grant projects. Regular contact with state-level representatives of multiple stakeholder groups (e.g. Friends of Recovery-Vermont, Vermont Council of Substance Abuse and Mental Health Providers, Vermont Psychiatric Survivors) and Executive Directors and Program Directors of Mental Health Agencies to faciliate consensus-building, treatment capacity development, and systems imporvement among treatment providers.

3. Are there licensing, registration, or certification requirements; or special or unusual skills necessary to perform this job?

Include any special licenses, registrations, certifications, skills; (such as counseling, engineering, computer programming, graphic design, strategic planning, keyboarding) including skills with specific equipment, tools, technology, etc. (such as mainframe computers, power tools, trucks, road equipment, specific software packages). Be specific, if you must be able to drive a commercial vehicle, or must know Visual Basic, indicate so.

Education: Master's Degree in public administration or in a human services field

Experience: Four years at a professional level in substance abuse or mental health field, with at least 2 years in a management, supervisory or administrative level position

Skills and Knowledge:

Knowledge of federal, state, and local mental health services and programs.

Knowledge of best and evidence-based practices regarding the treatment of individuals with mental health disorders

Knowledge of the principles and practices of public administration.

Knowledge of supervisory principles and practices.

Knowledge and skills in strategic planning and systems change

Knowledge and skills in project management

Skills in leadership and multi-stakeholder consensus-building

Ability to develop and negotiate contracts.

Ability to evaluate program effectiveness

Ability to communicate effectively orally and in writing.

Ability to establish and maintain effective working relationships.

4. Do you supervise?

In this question "supervise" means if you direct the work of others where you are held **directly** responsible for assigning work; performance ratings; training; reward and discipline or effectively recommend such action; and other personnel matters. List the names, titles, and position numbers of the classified employees reporting to you:

The position coordinates multiple departmental grant leads and promotes team collaboration.

5. In what way does your supervisor provide you with work assignments and review your work?

This question deals with how you are supervised. Explain how you receive work assignments, how priorities are determined, and how your work is reviewed. There are a wide variety of ways a job can be supervised, so there may not be just one answer to this question. For example, some aspects of your work may be reviewed on a regular basis and in others you may operate within general guidelines with much independence in determining how you accomplish tasks.

Works with supervisors to effectively set goals and establish priorities;understand, prepare and adhere to project goals, objectives, tasks, deadlines and time lines

Effectively solicits, integrates and responds to regular input, consultation and directives from multiple sources, including state work team, state leadership, project staff, national expert consultants, federal administrators, treatment providers, consumers, families, and community representatives

Works with supervisor to montior and adhere to expectations and requirements of federal adminstration funding the project

Clearly communicates grant project and departmental expectations, desired outcomes, and effectively delegates responsibilities to project staff, providing necessary oversight and management of resources to accomplish expectations

Performs work activities with modest superivion; expected to complete many work projects independently without direct superivion

6. Mental Effort

This section addresses the mental demands associated with this job. Describe the most mentally challenging part of your job or the most difficult typical problems you are expected to solve. Be sure to give a specific response and describe the situation(s) by example.

- For example, a purchasing clerk might respond: *In pricing purchase orders, I frequently must find the cost of materials not listed in the pricing guides. This involves locating vendors or other sources of pricing information for a great variety of materials.*
- Or, a systems developer might say: *Understanding the ways in which a database or program will be used, and what the users must accomplish and then developing a system to meet their needs, often with limited time and resources.*

Expected to effectively understand, evaluate, and develop strategies to overcome multiple, complex barriers at local, state and federal level to implementing evidence-based treatment and support. Examples include:

-evaluating how federal, state and private funds are and can be used to pay for evidence-based practices and how those funds can be used to efficiently support improved outcomes

-evaluating how multiple DMH initiatives overlap and contribute to the overall improvement of the mental health system

-evaluating how existing DMH policy and operation practices need to be modified/improved to support mulitple initiatives to improve system capacity

Expected to oversee implementation of mulitple multi-year, state-wide systems change initiatives involving multiple treatment systems.

7. Accountability

This section evaluates the job's expected results. In weighing the importance of results, consideration should be given to responsibility for the safety and well-being of people, protection of confidential information and protection of resources.

What is needed here is information not already presented about the job's scope of responsibility. What is the job's most significant influence upon the organization, or in what way does the job contribute to the organization's mission?

Provide annualized dollar figures if it makes sense to do so, explaining what the amount(s) represent.

For example:

- A social worker might respond: *To promote permanence for children through coordination and delivery of services*;
- A financial officer might state: *Overseeing preparation and ongoing management of division budget: $2M Operating/Personal Services, $1.5M Federal Grants.*

Overseeing implemenation and management of mulitple, multi-year, federal grants totaling over $9 million.

Changing the Vermont mental health system to make evidence-based treatment and supports more accessible and effective for people.

Helping treatment providers to help people recover from mental health disorders, reducing their need for inpatient and community-based professional services.

8. Working Conditions

The intent of this question is to describe any adverse conditions that are routine and expected in your job. It is not to identify special situations such as overcrowded conditions or understaffing.

a) What significant mental stress are you exposed to? All jobs contain some amount of stress. If your job stands out as having a significant degree of mental or emotional pressure or tension associated with it, this should be described.

Type	How Much of the Time?

b) What hazards, special conditions or discomfort are you exposed to? (Clarification of terms: **hazards** include such things as potential accidents, illness, chronic health conditions or other harm. Typical examples might involve exposure to dangerous persons, including potentially

violent customers and clients, fumes, toxic waste, contaminated materials, vehicle accident, disease, cuts, falls, etc.; and **discomfort** includes exposure to such things as cold, dirt, dust, rain or snow, heat, etc.)

Type	How Much of the Time?

c) What weights do you lift; how much do they weigh and how much time per day/week do you spend lifting?

Type	How Heavy?	How Much of the Time?

d) What working positions (sitting, standing, bending, reaching) or types of effort (hiking, walking, driving) are required?

Type	How Much of the Time?

Additional Information:

Carefully review your job description responses so far. If there is anything that you feel is important in understanding your job that you haven't clearly described, use this space for that purpose. Perhaps your job has some unique aspects or characteristics that weren't brought out by your answers to the previous questions. In this space, add any additional comments that you feel will add to a clear understanding of the requirements of your job.

This position will oversee 5 different multi-year federal grant projects focused on the improvement of services and expansion of treatment and support capacity to address gaps in the mental health system. Given the amount of funding available through these federal grants (approximately $9 million), the multiple and complex federal expecations and reporting requirements, the need for organizational effectiveness in bringing all resources to the service system efficiently, and the potential for overlap of systems improvement activities across these projects, DMH requires a limited service state position to ensure proper oversight and coordination among all of the existing grants.

Employee's Signature **(required)**:_____Date:_____

Supervisor's Section:

Carefully review this completed job description, but **do not** alter or eliminate any portion of the original response. Please answer the questions listed below.

1. What do you consider the most important duties of this job and why?

Develop and staff a state commissioner and director-level work team to initiate state-level policy, infrastructure, and funding changes. Interface and coordinate with key DMH operations, information technology, and business staff to support achievement of deliverables for multiple federal grant projects.

Strategically coordinate multiple systems improvement projects occuring at the state and local level involving a complex mix of stakeholders, outside consultants, and state representatives

2. What do you consider the most important knowledge, skills, and abilities of an employee in this job (not necessarily the qualifications of the present employee) and why?

A keen understanding of the federal, state and local mental health treatment systems, including the historical, polical, economic and cultural factors which must be taken into consideration when attempting to make changes to the system

Ability to provide leadership among high-level staff at DMH and in the community regarding changing the status quo of how DMH manages treatment services and how treatment providers provide services

Ability to strategically plan for and manage a multi-year, multi-stakeholder and multi-pronged initiatives focused on achieving substantial change at the state and local level in all counties within Vermont

Ability to develop a working knowledge of the key business, information technology, adminstrative, program and clincial functions at the state and local level that will need to changed to support evidence-based treatment and support, and the ability to work collaboratively with staff from each of these areas to initiate change

3. Comment on the accuracy and completeness of the responses by the employee. List below any missing items and/or differences where appropriate.

N/A

4. Suggested Title and/or Pay Grade:

Mental Health Systems Improvement Chief PG 26

Supervisor's Signature **(required):** _____ Date: 10/16/09

Personnel Administrator's Section:

Please complete any missing information on the front page of this form before submitting it for review.

Are there other changes to this position, for example: Change of supervisor, GUC, work station?

☐ Yes ☐ No If yes, please provide detailed information.

N/A

Attachments:

☐ Organizational charts are **required** and must indicate where the position reports.

☐ Draft job specification is **required** for proposed new job classes.

Will this change affect other positions within the organization? If so, describe how, (for example, have duties been shifted within the unit requiring review of other positions; or are there other issues relevant to the classification review process).

Suggested Title and/or Pay Grade:

as requested

Personnel Administrator's Signature **(required):** Gail Rushford Date: 11/16/09

Appointing Authority's Section:

Please review this completed job description but **do not alter** or eliminate any of the entries. Add any clarifying information and/or additional comments (if necessary) in the space below.

Suggested Title and/or Pay Grade:

Bet M. Tanzman 10/16/09

Appointing Authority or Authorized Representative Signature **(required)** Date

Vermont Department of Mental Health
National Child Trauma Stress Initiative CTS Centers - RFA #SM-09017
Supporting Schedule for SAMHSA Grant AA-1
September 29, 2009

Expenditures	Amount in Application Budget for Year One	Amount in AA-1 Budget for SFY 2010
Administrative Assistant - Salary (.5 FTE)	Full Year Salary - $18,562.00	Assume Start Date of Jan 1, 2010 - $9,281.00
Administrative Assistant - Fringe (.5 FTE)	Full Year Fringe - $5,568.60	Assume Start Date of Jan 1, 2010 - $2,784.30
Travel	Full Year Travel - $4,275.00	Assume All Travel Costs - $4,275.00
Equipment	New Computer - $2,230.00	Assume Computer Cost - $2,230.00
Supplies	Full Year Supplies - $3,000.00	Assume All Supplies - $3,000.00
Contractual	Full Year Contractual - $154,758.13	Assume Half Year of Contractual - $77,379.06
Service Grants to DA's	Full Year of Service Grants - $180,000.00	Assume Half Year of Service Grants - $90,000.00
Other Subgrants	Full Year of Other Subgrants - $10,000.00	Assume Half Year of Other Subgrants - $5,000.00
Instate Meeting Costs	Full Year of Instate Meeting Costs - $7,800.00	Assume Half Year Instate Meeting Costs - $3,900.00
Stipends/Mileage for Consumer Meetings	Full Year of Stipends/Mileage for Consumer Meetings - $3,200.00	Assume Half Year of Stipends/Mileage - $1,600.00
Indirect Cost	$10,606.16	$5,429.28
Total Cost	**$399,999.89**	**$204,878.64**

Application for Federal Assistance SF-424

Version 02

*1. Type of Submission:
- ☐ Preapplication
- ☒ Application
- ☐ Changed/Corrected Application

*2. Type of Application:
- ☒ 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 Department of Mental Health

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

*c. Organization DUNS:
809376155

d. Address

*Street1: P.O. Box 70
Street2: 108 Cherry Street
*City: Burlington
County:
*State: Vermont
Province:
*Country: USA: United States
*Zip/Postal Code: 05402-0070

e. Organizational Unit

Department Name:
Mental Health

Division Name:

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

Prefix:

*First Name: Laurel

Middle Name:

*Last Name: Omland

Suffix:

Title: Clinical Care Coordinator

Organizational Affiliation:
Department of Mental Health

*Telephone Number: (802) 652-2037 Fax Number: (802) 652-2005

*Email: laurel.omland@ahs.state.vt.ys

Application for Federal Assistance SF-424 Version 02

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

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

* Other (specify)

10. Name of Federal Agency:
Substance Abuse & Mental Health Services Adminis.

11. Catalog of Federal Domestic Assistance Number
93.243

CFDA Title:
Substance Abuse and Mental Health Services_Projects of Regional and National Significance

*12. Funding Opportunity Number:
SM-09-017

*Title:
National Child Traumatic Stress Initiative Community Treatment and Services Centers Grants

13. Competition Identification Number:

Title:

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

15. Descriptive Title of Applicant's Project:
Vermont Child Trauma Collaborative

Attach supporting documents as specified in agency instructions.

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

Application for Federal Assistance SF-424

Version 02

16. Congressional Districts Of:

*a. Applicant VT-All

b. Program/Project VT-All

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

17. Proposed Project:

*a. Start Date: October 1, 2009

b. End Date: September 30, 2012

18. Estimated Funding($):

*a. Federal	$ 1,199,999.67
*b. Applicant	$0
*c. State	$0
*d. Local	$0
*e. Other	$0
*f. Program Income	$0
*g. TOTAL	$ 1,199,999.67

*** 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

☐ 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 ☒ 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)**

☒ ** 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: Department of Mental Health Commissioner

*Telephone Number: (802) 652-2002 Fax Number: (802) 652-2036

*Email: Michael.hartman@ahs.state.vt.us

*Signature of Authorized Representative: Michael Hartman Date Signed: 5/12/09

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.

Job Description: Mental Health Systems Improvement Chief

Job Title: Mental Health Systems Improvement Chief

Agency: Department of Mental Health

Location: Waterbury

Job Type: Limited Service

Full/Part Time: Full Time

Shift: N/A

Hourly Rate: $24.15

Pay Grade: 26

Class Definition:

Developmental, administrative, coordinating and monitoring work for the Department of Mental Health (DMH) involving the development of state and local capacity to provide evidence-based treatment and support through the administration of multiple federal grant programs. This position will oversee and coordinate the resources of multiple federal grant projects to improve the mental health treatment system, including 1) development of statewide evidence-based trauma treatment and support for youth, 2) development of jail diversion and trauma treatment capacity for veterans and other adults with trauma-related disorders, and the 5) development of comprehensive, integrated treatment for individuals with mental health and substance abuse disorders across multiple mental health and substance abuse treatment systems. Duties are performed under the general direction of the DMH Operations Director. All employees of the Agency of Human Services perform their respective functions adhering to four key practices: customer service, holistic service, strengths-based relationships and results orientation.

Examples of Work:

Responsible for day-to-day management and oversight of multiple federal grant projects. Duties may include: Overseeing and coordinating development and and monitoring of mulitple state grants and contracts to support federal grant project activities and deliverables. Evaluating current policies and procedures to determine needed changes to comply with federal requirements. Formulating strategies for the effective integration and deployment of grant resources to maximize the collective impact of grant funding. Implementing systems, including writing policies and procedures, to ensure proper accounting of federal funds and the collection of appropriate data. Preparing statistical and narrative reports on program activities. Ensuring all federal reporting requirements are met in a timely fashion. Serving as liaison with federal administrators. Representing DMH in state and federal audits. Analyzing changes in federal regulations in light of their impact on DMH. Developing new grant applications in response to funding opportunities. Coordinating departmental collaboration with other organizations implementing federal grant projects. Developing and staffnig work teams to manage grant activities. Coordinating planning, training, consultation, and evaluation activities in support of

multiple grant projects. Coordinating multiple statewide initiatives led by distinct stakeholders groups. Interfacing and coordinating with key DMH operations, information technology and business staff to assure completion of grant deliverables.

Performs other duties as required.

Environmental Factors: Duties are performed in a variety of settings, including offices and facilities of direct care providers. Travel will be necessary, for which private means of transportation must be available. Some evening or weekend work may be required. Strong differences of opinion may be encountered for which positive resolutions must be sought.

Minimum Qualifications

Knowledge, Skills and Abilities:

Knowledge of federal, state, and local mental health services and programs.

Knowledge of best and evidence-based practices regarding the treatment of individuals with mental health disorders.

Knowledge of the principles and practices of public administration.

Knowledge of supervisory principles and practices.

Knowledge and skills in strategic planning and systems change.

Knowledge and skills in project management.

Skills in leadership and multi-stakeholder consensus-building.

Ability to develop and negotiate contracts.

Ability to evaluate program effectiveness

Ability to communicate effectively orally and in writing.

Ability to establish and maintain effective working relationships.

Ability to perform job duties within the framework of the four key practices of the Agency of Human Services: customer service, holistic service, strengths-based relationships and results orientation.

Education and Experience:

Education: Master's Degree in public administration or in a human services field

Experience: Four years at a professional level in substance abuse or mental health field, with at least 2 years in a management, supervisory or administrative level position

STATE OF VERMONT GRANT SPENDING PRE-NOTICE (Form AA-1PN)

PURPOSE & INSTRUCTIONS:

This form is intended solely as notification to the Joint Fiscal Committee of the unavoidable need to spend State funds in advance of Joint Fiscal Committee approval of grant requests and with the intent of securing a federally or privately funded grant award. Pre-notification is required for expenditures of state funds beyond basic grant application preparation and filing costs. Expenditure of these state funds does not guarantee that a grant will be awarded to the State of Vermont, or that a future grant award will be accepted by the Joint Fiscal Committee. If a grant award is subsequently received, a completed ***Form AA-1 Request for Grant Acceptance*** *must be submitted to the Joint Fiscal Committee for review and approval before spending or obligating additional funds.*

BASIC GRANT INFORMATION

1. Agency:	Human Services
2. Department:	Mental Health
3. Program:	Childrens Mental Health
4. Legal Title of Grant:	National Child Traumatic Stress Initiative Community Treatment and Services Centers Grants
5. Federal Catalog #:	93.243

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

7. Grant Period: **From:** 9/30/2009 **To:** 9/29/2012

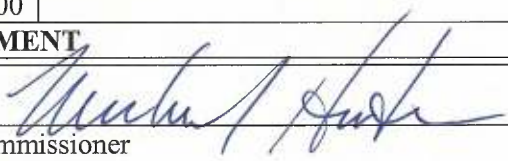
8. Purpose of Grant:
To implement and evaluate effective trauma-focused and trauma-informed treatment and services for youth in community settings and youth-serving service systems

9. STATE FUNDS TO BE SPENT IN ADVANCE OF GRANT ACCEPTANCE BY JOINT FISCAL:

Expenditures:	**FY** 10	**Required Explanation/Comments**
Personal Services	$	(Include type of expenditures to be incurred, i.e. training, planning, proposal development, etc.) Travel expenses to SAMHSA Grantee Orientation meeting
Operating Expenses	$4,275.00	
Grants	$	
Total	$4,275.00	

10. AUTHORIZATION AGENCY/DEPARTMENT

I/We certify that spending these State funds in advance of Joint Fiscal Approval of a Grant is unavoidable, and that a completed ***Form AA-1 Request for Grant Acceptance*** will be submitted for Joint Fiscal Committee approval if a grant award is received for this program:

Signature: 	Date: 10/1/09
Title: Commissioner	
Signature:	Date:
Title:	

11. ATTACHMENTS: Attach relevant documentation that demonstrates the necessity of this expenditure. (example: funding opportunity guidelines require training, etc.)

Distribution:
Original - Joint Fiscal Office;
Copy 1 – Department Grant File;
Copy 2 – Attach to Form AA-1 (if grant is subsequently received).

(End Form AA-1PN – Grant Spending Pre-Notice – Form AA-1PN)

Vermont Department of Mental Health
National Child Trauma Stress Initiative CTS Centers - RFA #SM-09017
Supporting Schedule for SAMHSA Grant AA-1
September 29, 2009

Expenditures	Amount in Application Budget for Year One	Amount in AA-1 Budget for SFY 2010
Administrative Assistant - Salary (.5 FTE)	Full Year Salary - $18,562.00	Assume Start Date of Jan 1, 2010 - $9,281.00
Administrative Assistant - Fringe (.5 FTE)	Full Year Fringe - $5,568.60	Assume Start Date of Jan 1, 2010 - $2,784.30
Travel	Full Year Travel - $4,275.00	Assume All Travel Costs - $4,275.00
Equipment	New Computer - $2,230.00	Assume Computer Cost - $2,230.00
Supplies	Full Year Supplies - $3,000.00	Assume All Supplies - $3,000.00
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Stipends/Mileage for Consumer Meetings	Full Year of Stipends/Mileage for Consumer Meetings - $3,200.00	Assume Half Year of Stipends/Mileage - $1,600.00
Indirect Cost	$10,606.16	$5,429.28
Total Cost	**$399,999.89**	**$204,878.64**

Notice of Award

National Child Traumatic Stress Initiative Cat 3 **Issue Date:** 09/21/2009
Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services

Grant Number: 1U79SM059492-01 REVISED

Program Director:
Charlie Biss

Project Title: Vermont Child Trauma Collaborative

Grantee Address	Business Address
VERMONT STATE DEPT OF HEALTH Heidi Hall Mental Health P.O. Box 70 108 Cherry Street Burlington, VT 054020070	Heidi Hall Executive Director Department of Mental Health P.O. Box 70 Burlington, VT 05402

Budget Period: 09/30/2009 – 09/29/2010
Project Period: 09/30/2009 – 09/29/2012

Dear Grantee:

The Substance Abuse and Mental Health Services Administration hereby revises this award to reflect an increase in the amount of $3,000 (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 290hh-1 (42 U.S.C.) 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 – 1U79SM059492-01 REVISED

Award Calculation (U.S. Dollars)

Salaries and Wages	$18,562
Fringe Benefits	$5,568
Personnel Costs (Subtotal)	$24,130
Equipment	$2,230
Supplies	$3,000
Consortium/Contractual Cost	$154,758
Travel Costs	$4,275
Other	$201,000
Direct Cost	$389,393
Indirect Cost	$10,606
Approved Budget	$399,999
Federal Share	$399,999
Cumulative Prior Awards for this Budget Period	$396,999
AMOUNT OF THIS ACTION (FEDERAL SHARE)	$3,000

SUMMARY TOTALS FOR ALL YEARS	
YR	AMOUNT
1	$399,999
2	$399,054
3	$399,903

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

Fiscal Information:

CFDA Number:	93.243
EIN:	1036000274E7
Document Number:	U9SM59492A
Fiscal Year:	2009

IC	CAN	Amount
SM	C96C505	$399,999

SM Administrative Data:
PCC: NCTSI-TX / **OC:** 4145

SECTION II – PAYMENT/HOTLINE INFORMATION – 1U79SM059492-01 REVISED

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 – 1U79SM059492-01 REVISED

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 – 1U79SM059492-01 REVISED

Due to an administrative error, this award refects an additional $3,000, to meet the reccommended level of funding. This award is an addition to Notice of Award dated 09/15/2009.

All previous terms and conditions remain in effect.

CONTACTS:
Jean Plaschke, Program Official
Phone: (240) 276-1847 **Email**: jean.plaschke@samhsa.hhs.gov

Sherie Fairfax, Grants Specialist
Phone: 240-276-1415 **Email**: sherie.fairfax@samhsa.hhs.gov **Fax**: 240-276-1430

VERMONT CHILD TRAUMA COLLABORATIVE

ABSTRACT

The Vermont Department of Mental Health, through the creation of the **Vermont Child Trauma Collaborative** (VCTC) comprised of 12 community mental health treatment centers serving Vermont's 14 counties, will fully implement and sustain the Attachment, Self-Regulation and Competency (ARC) Framework for complex trauma treatment. The VCTC will change the standard of practice so that: 1) children in Vermont have access to trauma-informed services in the system of care; 2) children who screen positively for trauma receive a standardized trauma assessment; and 3) children with complex trauma and their families are referred for and receive empirically-based trauma treatment services. Outcomes will include reduced trauma symptoms, increased child competency, reduced parenting stress, and reduced need for intensive services.

We will target children ages 3-18 who have experienced complex trauma, multiple and/or chronic exposure to developmentally adverse interpersonal victimization, and their families. We will principally target new referrals from: 1) the Vermont child welfare system's newly implemented centralized intake and differential response to child abuse and neglect reports, 2) schools, and, in year three, 3) children from refugee communities in two counties. By the end of the project, clinicians from the 11 community mental health centers and one private group practice, totaling 12 identified sites serving every county in the state, will use trauma-informed empirically based methods to identify, assess, and treat a total of 350 (5-6 per site in YR 1, 12 in YRS 2-3) children who have experienced complex trauma and their families.

The VCTC will consult with The Trauma Center at Justice Resource Institute for the statewide dissemination of ARC. ARC is an empirically based framework recognized by the NCTSN as a promising practice for addressing the developmental and relational vulnerabilities of children and families who have experienced complex trauma. Consultation with the University of Vermont Connecting Cultures Program will allow VCTC to adapt the ARC framework to better serve our refugee communities. The VCTC has the support of key stakeholders including the state child welfare system, education system, domestic and sexual violence programs, and public/private mental health providers.

VCTC's objectives are to: 1) Establish a Vermont Child Trauma Collaborative Infrastructure at the state and local level; 2) Create a Trauma-Informed Interagency Referral Network among child and family-serving programs; 3) Use existing ARC Community Treatment and Services Teams (ARC Teams) to implement the use of standardized trauma assessment and empirically-based trauma treatment using the ARC Framework in 12 identified sites serving all 14 Vermont counties; 4) Develop In-state Trauma Consultation and Training Capacity for implementation and sustainability of ARC; 5) Participate in NCTSN to incorporate lessons learned in trauma service implementation; and 6) Establish systematic Data Collection and Evaluation to monitor the quality and quantity of services and treatment.

Table of Contents

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. Child Traumatic Stress Initiative CTS Centers	93.243	$	$	$ 399,999.89	$	$ 0.00
2.		$	$	$	$	$ 0.00
3.		$	$	$	$	$ 0.00
4.		$	$	$	$	$ 0.00
5. TOTALS		$ 0.00	$ 0.00	$ 399,999.89	$ 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	$ 18,562.00	$	$	$	$ 0.00
b. Fringe Benefits	$ 5,568.60	$	$	$	$ 0.00
c. Travel	$ 4,275.00	$	$	$	$ 0.00
d. Equipment	$ 2,230.00	$	$	$	$ 0.00
e. Supplies	$ 3,000.00	$	$	$	$ 0.00
f. Contractual	$ 154,758.13	$	$	$	$ 0.00
g. Construction	$ 0.00	$	$	$	$ 0.00
h. Other	$ 201,000.00	$	$	$	$ 0.00
i. Total Direct Charges *(sum of 6a -6h)*	$ 389,393.73	$ 0.00	$ 0.00	$ 0.00	$ 0.00
j. Indirect Charges	$ 10,606.16	$	$	$	$ 0.00
k. TOTALS *(sum of 6i and 6j)*	$ 399,999.89	$ 0.00	$ 0.00	$ 0.00	$ 0.00
7. Program Income	$	$	$	$	$ 0.00

SECTION C - NON- FEDERAL RESOURCES

(a) Grant Program	(b) Applicant	(c) State	(d) Other Sources	(e) TOTALS
8. Child Traumatic Stress Initiative CTS Centers	$	$	$	$ 0.00
9.	$	$	$	$ 0.00
10.	$	$	$	$ 0.00
11.	$	$	$	$ 0.00
12. TOTALS *(sum of lines 8 and 11)*	$ 0.00	$ 0.00	$ 0.00	$ 0.00

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. Child Traumatic Stress Initiative CTS Centers	$ 399,999.89	$ 399,054.57	$ 399,903.36	$
17.	$	$	$	$
18.	$	$	$	$
19.	$	$	$	$
20. TOTALS *(sum of lines 16 -19)*	$ 399,999.89	$ 399,054.57	$ 399,903.36	$ 0.00

SECTION F - OTHER BUDGET INFORMATION

21. Direct Charges:	22. Indirect Charges:
23. Remarks	

SECTION A: STATEMENT OF NEED AND READINESS

A.1: Description of Community

The Vermont Department of Mental Health, through the creation of a *Vermont Child Trauma Collaborative* (VCTC) comprised of 12 community-based mental health treatment providers, will implement empirically-based child trauma treatment in each of the state's 14 counties. Vermont's population is 621,254 and is one of the most rural states in the country. Vermont's largest city, Burlington, has a population of only 38,889, and the majority of Vermonters live in or near communities with populations of 2,000 to 20,000. The state has a mountainous topography, with roads covered by snow and ice many months of the year, and public transportation is limited or non-existent in most rural areas. While Vermont's size and rural nature help to maintain its beauty, independence, and strong family ties, these factors contribute to isolation and fewer jobs, limit access to affordable and quality child care, social services and medical care,[1] and mask the mental health and social service needs of its communities. Vermont rates of serious psychological distress and depression in young adults, as well as rates of illicit drug use and alcohol binging for Vermonters aged 12 or older, are among the highest in the country.[2] Of the 140,732 children and youth aged 0-18 (inclusive) in Vermont,[3] approximately 12% may be "experiencing serious or severe emotional disturbance each year."[4] Thus, between 16,887 – 28,146 children and youth in Vermont experience varying intensities of need for mental health services per year.

Child abuse and neglect is also quietly present in communities throughout Vermont. The Agency of Human Services' Department for Children and Families (DCF) and the courts treat this as a confidential matter to help ensure child victims are not further stigmatized and families are open to receiving help. The unintended consequence of this privacy approach is that many Vermonters are unaware of the seriousness of this problem.[5]

In Vermont, 95.3% of the population are Caucasian persons who are non-Hispanic; 1.3% of the population is of Hispanic or Latino origin. 1.2% are Asian people, 1.1% are of two or more races, 0.8% are Black, and 0.4% are American Indian or Alaskan Native.[6] Most Native Americans live in Northwestern Vermont, including Vermont's largest tribe, the Abenaki Nation, with about 1500 members. Through the Vermont Refugee Resettlement Program, Chittenden and Washington Counties are also home to hundreds of Vietnamese, Bosnians, and Somalis as well as dozens of Meskhetian Turks, Sudanese, Congolese, and others from more than 20 additional countries.[7] Now about 3.8% of Vermont's population is foreign-born, and 5.9% speak a language other than English at home[8] though may be proficient in English.

A.2: Target Population and Geographic Area

The Vermont Child Trauma Collaborative (VCTC) will target male and female children and adolescents ages 3-18 who have experienced complex trauma and their caregivers. Complex trauma is defined as chronic or multiple exposure to developmentally adverse interpersonal victimization, including physical, sexual and emotional abuse, neglect, witnessing of domestic and community violence, and impaired care-giving due to substance abuse or mental illness. With the presence of refugee communities in Chittenden and Washington County (see A.1: p.5), in Year 3 VCTC will also target refugee children of war-torn countries who have witnessed trauma.

Children and their families will be primarily identified through the State's child welfare/ protection agency, the Department for Children and Families (DCF), due to a report of suspected child abuse, neglect or other risk of harm. Children and families may also be identified through the local school system or other child-serving agencies (e.g. domestic violence shelters) when there is concern about the presence of trauma. VCTC will screen and provide empirically-based trauma treatment services for an estimated 350 children through the project period.

This target population was selected for several reasons:

- A state-wide needs assessment of community providers and child-serving organizations (completed by the *Child Trauma Workgroup* – see A.3: p.8) identified complex multi-generational trauma among children aged 3-18 as the most challenging clinical issue facing Vermont's System of Care (SOC) for children.
- Despite recent efforts to improve access to mental health services for children involved in child welfare, only 24% of young people identified by the state child welfare agency (DCF) as having been abused and/or neglected are served by the public mental health system.[9] This data indicates that this population has limited access to comprehensive empirically-based treatment for trauma resulting from abuse and/or neglect.
- Vermont's small population, rural nature and limited resources require community treatment teams to work across a broad spectrum of ages and disorders.

VCTC's implementation will occur statewide through the 10 designated community mental health centers (CMHC's), each of which are responsible for providing core mental health services in a specified geographic "catchment area" to the most needy Vermonters. Given Vermont's small population and size it is ideal for statewide programming (see p.5 for a full description of Vermont). This approach will ensure that children and families in each of the state's 14 counties have access to appropriate trauma treatment. In Chittenden County, the state's most populated region and home to its largest city, implementation will also occur in an additional public specialized service agency (Northeastern Family Institute) and a private treatment center (New England Counseling and Trauma Center) to improve access in that region and help to improve partnerships between public and private mental health programs.

A.3: Major Needs and Opportunities for Trauma-Informed Treatment and Services

Major Needs of the Community

Complex trauma, defined as the experience of chronic or multiple traumatic events that occur within the caregiving system, carries an enormous cost to Vermont communities both in lives impacted and dollars spent: [10]

- In 2007, mandated reporters (including mental health professionals) and others made 12,829 contacts with the DCF regarding potential instances of child abuse and neglect. Of this number, 2,633 were accepted for investigation and 687 were substantiated for abuse or neglect.[11]
- In 2008 DCF received 1,892 intake calls that identified co-occurring domestic violence and child maltreatment. 527 of these intakes were opened for investigation, of which 106 were substantiated and 52 remained open cases.[12]
- 2008 data published by the Vermont Network Against Domestic and Sexual Violence reported that approximately 7,853 children/youth were exposed to domestic violence. In that

same year, 193 children were sheltered in Network shelters or safe homes; 1,175 children received services in addition to shelter, and 180 children and youth under the age of 18 were victims of sexual violence.[13]

Early chronic or repeated childhood exposure to these types of traumatic experiences can impact a child's capacity to develop skills to regulate affect and increase the incidence of depression, suicidal ideation, self-injury, substance abuse, difficulty modulating sexual impulses, and sexually transmitted diseases.[14] Other manifestations of exposure to early trauma include falling behind in school readiness and school performance, diminished cognitive abilities, and significantly higher levels of behavioral and emotional problems.[15] Trauma-related emotional problems also increase risk of unhealthy behaviors such as smoking, excessive alcohol or other drug use, poor diet, lack of sleep, and insufficient physical exercise, possibly contributing to future health complications including chronic mental health problems.[16]

Children and families who have experienced trauma must have access to appropriate care. Early recognition and treatment of trauma yields better outcomes; reduces the severity and chronicity of mental and physical health problems as well as the economic impact on health care systems and the criminal justice system; and for long-term trends, increases the skills and resilience of those who become parents so they can better provide for their developing child.

Vermont's system of human service providers have increasingly become more aware of the need to address complex trauma; however, the system is taxed by the demand for services for children/families with complex trauma in need of skilled practitioners, coordinated treatment and support. This increase in recognition and demand is illustrated by the following Vermont data:

- In 1994 only 30 or .1% of the CMHC's caseload in Vermont was identified as having Post-traumatic Stress Disorder, but by 2007 that number had grown to 2,455 clients or 9.6% of the caseload.[17]
- In 2008, the CMHC's reported that 10.3% - or 939 – of the children and youth aged 0-18 who were served had a diagnosis of PTSD; they also reported serving 1,736 children and youth known to be victims of abuse, assault, or rape.[18]

It should be noted that many children who suffer from complex trauma may not meet the full diagnosis for PTSD, and therefore the numbers are likely an underestimate of the actual presence of complex trauma in children served by the public community mental health system. "Children exposed to maltreatment, family violence, or loss of their caregivers often meet diagnostic criteria from the [DSM-IV] for depression, attention-deficit/hyperactivity disorder, oppositional defiant disorder, conduct disorder, anxiety disorders...and reactive attachment disorder."[19]

Opportunities to Promote and Implement Trauma-Informed Interventions

Vermont's growing recognition of the need to address complex trauma has created multiple opportunities to implement trauma-informed interventions. DCF recently implemented a statewide Centralized Intake Unit (CIU) to screen all reports of suspected child abuse/ neglect for acceptance before referral to DCF District Offices for investigation, with the goal of statewide consistency in responses. Since implementation of the CIU in September 2008, DCF has seen a substantial rise in the number of accepted reports of child abuse/neglect. In July 2009, DCF will begin a Differential Response system which will provide two options for response to reported child abuse/neglect: 1) a "forensic" investigation involving the courts to achieve a determination

of substantiation or 2) an "assessment" response for lower risk situations to focus on improving factors that interfere with effective parenting. DCF's anticipation of the impact of differential response is that 47% of current investigations can be diverted to the assessment track. Through Differential Response, DCF will improve its ability to identify children who are experiencing complex trauma and refer these cases to those CMHC treatment teams that are implementing trauma treatment for this population[20] (see DCF Letter of Commitment – Appendix 1).

Through the work of the *Child Trauma Workgroup*, a statewide planning group comprised of child and family-serving community and state organizations, DMH has also initiated a training and consultation relationship with the Trauma Center at Justice Resource Institute (TC-JRI) to support CMHC implementation of the Attachment, Self-Regulation and Competence (ARC) Framework[21] for the treatment of complex trauma in children (see p.8 for a full description of the *Vermont ARC Project*). The consensus-building, planning and training accomplished through the Vermont ARC Project will support further implementation of empirically-based trauma treatment throughout the state.

A.4: Availability of Trauma-informed Treatment and Services

There are significant areas for development in the provision of trauma-informed and trauma-specific services within Vermont's community mental health system. Until recently, there has not been consensus across providers about the use of empirically-based assessment, treatment, or service models for trauma treatment. As such, many programs lacked staff with the specialized skills to assess, treat and coordinate care for children who had experienced complex trauma.

In recognition of these challenges, DMH has been working with the CMHC's and other child-serving agencies over the last 36 months to improve their ability to deliver effective trauma-informed care and trauma treatment for children, youth, and their families. Through the DMH-funded *Vermont ARC Project*, the CMHC's have begun to develop capacity for complex trauma treatment using the Attachment, Self-Regulation and Competence (ARC) Framework. The following activities have been completed:

- Creation of a DMH Trauma Policy (based on an AHS Trauma Policy) to highlight the significance of trauma in the lives of the people we serve and our commitment to providing quality trauma-specific services within a trauma-informed mental health system
- Consensus-building to identify target population, the proposed model of trauma services, and the activities of training and implementation at the community level
- Training on *Trauma-Informed Care* and the ARC Framework for CMHC, child welfare, post-adoption, private practice, and school-based providers state-wide
- The creation of clinical teams (i.e. **ARC Community Treatment and Services Teams** - ARC Teams) at each CMHC focused on practice implementation within their service area
- Training and monthly consultation by TC-JRI for all ARC Teams focused on integrating the ARC concepts into daily practice
- Initial self-assessments at each CMHC to determine key areas of challenge, priorities for change, and consideration of factors relevant to implementing ARC
- Commitment from each CMHC to become familiar with trauma screening and assessment tools (Trauma Symptom Checklist for Children, Trauma Symptom Checklist for Young Children, Parenting Stress Index, and Child Behavior Checklist).

While initial efforts have created a solid foundation, the majority of CMHC's are still in the initial stages of implementing ARC. This proposal would support full implementation of ARC throughout children's mental health outpatient services across Vermont. This proposal will also support other community child-serving agencies to 1) receive additional training on trauma-informed service delivery and 2) improve the identification and referral of children for trauma assessment and treatment (see Appendix 1 - Letters of Support).

A.5: Existing Collaborations

The Vermont Child Trauma Collaborative (VCTC) will be supported by several different collaborations. For the past 20 years, DMH and DCF, along with representatives from the Department of Education (DOE), families, and other partners, have met monthly through the Vermont Act 264 *State Interagency Team (SIT)* to resolve problems in the coordinated service planning for children and youth with serious emotional disturbance or other disabilities. SIT and the *Local Interagency Teams (LIT)*, which exist in each of the state's twelve Agency of Human Services' districts to serve as a resource for interagency planning teams and a forum to address regional service needs, will support the VCTC. Members of these teams will be targeted to participate on the State and Local VCTC Advisory Committees (as described in C.1: p.14) to support adoption of trauma-informed practices.

VCTC will also be supported by the Agency of Human Services (AHS) *Child Trauma Workgroup,* which formed in 2004 to identify unmet needs in Vermont's System of Care (SOC) for traumatized children and families and support the development of enhanced trauma treatment in the state. The workgroup is comprised of representatives from child welfare, mental health, domestic and sexual violence programs, adoption programs, Prevent Child Abuse Vermont, consumers/parents, the AHS Refugee Coordinator, and the AHS Trauma Coordinator. Members of the Child Trauma Workgroup will participate on the State Advisory Committee of this project.

Finally, VCTC will benefit from an existing collaboration between DOE and DMH in which 90% of supervisory unions contract with CMHCs for school-based mental health services. To enhance these services and support DOE's implementation of Positive Behavioral Supports (PBS) in 16 of the 54 supervisory unions, DOE and DMH have focused on the need for schools to be trauma informed and effectively access trauma treatment services when warranted. VCTC will capitalize on this existing collaboration to increase trauma informed school services and clearly establish referral protocols for trauma specific treatment.

SECTION B: PROPOSED TRAUMA-INFORMED PRACTICES OR INTERVENTIONS

B.1: Purpose, Goals, Objectives, and Results

This grant initiative will establish a *Vermont Child Trauma Collaborative (VCTC)* comprised of 12 community-based mental health treatment centers to ensure trauma-informed care and empirically-based trauma treatment are available to children with complex trauma and their families throughout Vermont. The goals of this service and treatment collaborative are:

1. children in Vermont will have access to trauma-informed services throughout the SOC;
2. children who screen positively for trauma will receive a standardized trauma assessment;
3. children with complex trauma and their families will be referred for and receive trauma-specific treatment services that are empirically based;

In order to achieve these goals, the VCTC will complete the following objectives:

a) Establish *Vermont Child Trauma Collaborative Infrastructure* at the state and local level to oversee and coordinate implementation of ARC;
b) Create a *Trauma-Informed Interagency Referral Network* among child and family-serving state and community programs (child welfare, education, domestic violence) to ensure consistent screening and referral to treatment for children exposed to trauma;
c) Use existing *ARC Community Treatment and Services Teams (ARC Teams)* to implement the use of standardized trauma assessment and empirically-based trauma treatment in 12 community treatment programs serving all 14 Vermont counties;
d) Develop *In-state Trauma Consultation and Training Capacity* to support implementation of trauma-informed care and the ARC framework and ensure sustainability of the practice;
e) *Participate in NCTSN* to incorporate lessons learned in trauma service implementation; and
f) Establish systematic *Data Collection and Evaluation* to improve the quality and quantity of services and treatment being provided through the VCTC.

With implementation of the VCTC objectives, we will achieve the following results:

- The number and consistency of referrals for ARC trauma treatment services from child-serving programs will increase.
- The number of children and families receiving ARC trauma treatment will increase.
- Children and families receiving ARC will experience improved clinical outcomes, including:
  - Reduction of trauma-related symptoms
  - Increased child competency
  - Reduction of caregiver parenting stress
  - Reduced need for intensive services (psychiatric hospital and long-term residential).

B.2. The ARC Framework and Its Evidence-Base

Vermont will expand its implementation of the Attachment, Self-Regulation, and Competence (ARC) Framework. This model was developed by Margaret Blaustein, Ph.D. and Kristine Kinniburgh, LICSW of the Trauma Center at Justice Resource Institute (TC-JRI) to intervene with youth and families who have experienced complex trauma such as chronic or multiple sexual abuse, physical abuse, neglect, domestic violence, and community violence. The ARC model is based on an empirical framework that includes components of cognitive-behavioral therapy, attachment theory, and trauma theory to address the central goals of safety, self-regulation, self-reflective information processing, traumatic experience integration, and relational engagement or attachment. ARC provides a framework for clinicians to work collaboratively with children and their families to build/strengthen secure attachments, develop/enhance self-regulatory capabilities, and increase child and parent competencies across multiple domains. The approach was developed to be respectful of the strengths, resources, and individual characteristics of the child and care-giving system and can be adapted to the unique cultural needs of various ethnic populations.

ARC involves conducting a sound clinical assessment to identify strengths and needs of the youth and uses phase-oriented interventions that appropriately match the individual level of need. The ARC framework is a component-based framework built around three core domains

(in bold) and ten foundational building blocks (organized as they relate to the 3 domains): **Attachment**: 1) Caregiver Affect Management, 2) Attunement, 3) Consistent Response, 4) Routines and Rituals; **Self-Regulation**: 5) Affect Identification, 6) Affect Modulation, 7) Affect Expression; and **Competency**: 8) Developmental Tasks, 9) Executive Functions, 10) Self Development. The core domains, which form the acronym of the framework, drive the assessment and treatment intervention process through use of the ARC-Focused Trauma Assessment (see Appendix 2 for sample) and an ARC manual [21] with a menu of activities to target each foundational skill for intervention.

ARC is recognized by the National Child Traumatic Stress Network Empirically Supported Treatments and Promising Practices www.NCTSNet.org, and TC-JRI has worked with multiple programs implementing ARC to evaluate program outcomes. Preliminary findings from pilot studies indicate that ARC leads to a reduction in child posttraumatic stress symptoms, anxiety, and depression, as well as increased adaptive and social skills, and that caregivers report reduced distress and view their child's behavior as less dysfunctional.[22] Specific findings include:

- In a pilot of ARC in a large special needs adoption agency (Bethany Christian Services, Holland, MI), initial findings indicated: 1) reductions in targeted PTSD symptoms (based on clinician interview and child-self report), 2) reduction of child-reported dissociation, depression, anger and anxiety, 3) reduction of care-giver reported child externalizing problems, depression and anxiety, 4) increases in care-giver reported child adaptive behaviors, and 5) reduction of caregiver self-report of parenting stress.[23]
- In a pilot of ARC in 3 residential JRI programs, initial findings indicate significant decreases in the use of restraints compared to similar residential programs not implementing ARC.[24]
- In an ARC pilot in rural Alaskan community mental health outpatient program, initial findings indicate that 90% of children who complete treatment achieve placement permanency (adoptive, pre-adoptive or biological family reunification) compared with the state-wide permanency rate of 40%. This pilot also found a clinically significant drop in caregiver-reported pathology for children completing treatment.[25]

The ARC model is currently being used in community settings through the National Child Traumatic Stress Network, including The Trauma Center at JRI in Massachusetts; Bethany Christian Services in Grand Rapids, Michigan; Los Angeles Child Guidance Clinic; Anchorage Community Mental Health Center in Anchorage, Alaska; La Rabida Children's Hospital in Chicago, Illinois; and most recently at Aliviane Community Treatment and Services Center in El Paso, Texas. Pilot trials of the implementation of ARC at these NCTSN Centers target children from Alaskan Native, foster/adoptee, and urban African-American, Latino, and Asian cultures.

Given the initial successes in implementing ARC across multiple populations and programs, this model fits well with Vermont's broadly defined target population (see Section A). ARC is designed to be used in clinic, school, or community settings; it is appropriate for urban and rural settings; ARC targets both male and female participants ranging from early childhood through school age and late adolescence. The ARC Framework is specifically designed as a flexible model of intervention; at each site components can be identified and implemented after a thorough needs assessment with key stakeholders and adaptation to meet community and population needs.[26] ARC recognizes the multiple needs of children and families who have experienced complex trauma and therefore values multi-systemic collaboration and intervention in the treatment approach. This dovetails well with Vermont's SOC values in which all

providers strive to offer community-based services that are child-centered and family-focused, individualized to the child's and family's needs, build on strengths inherent in the child, family and community, inclusive of family at all levels of participation, and culturally competent.

B.3: Evidence that ARC is appropriate for Grant Outcomes

The evidence regarding the effectiveness of ARC indicates that the implementation of this model will help Vermont achieve the outcomes/results of this proposal (see above – Section B.1.). As described above in Section B.2., ARC has been shown to decrease child posttraumatic symptoms,[23,27] which corresponds with the target outcome of reducing children's trauma-related symptoms. ARC has been shown to increase children's adaptive behaviors,[23,27] supporting the proposal's goal of increasing child competency. ARC has also been shown to decrease caregiver stress [23, 27] and caregiver-reported pathology,[25] both of which support Vermont's expected outcome of "reduction of caregiver parenting stress." These demonstrated outcomes, along with ARC's effectiveness in helping to reduce the use of seclusion and restraint,[24] indicate that children and families will require less professional services because children will have reduced symptoms and increased competency, and parents and caregivers who experience less stress and report less pathology in their children will be less likely to request/require services. ARC's demonstrated effectiveness in achieving placement permanency[25] also indicates that fewer and less intensive services will be required upon the successful completion of ARC treatment.

B.4: Modifications/Adaptations to ARC

ARC is designed as an adaptable treatment framework; it identifies 10 core targets of intervention within 3 broad domains, and provides guidelines and examples of interventions. The design of this adaptable framework allows for differences in implementation and application across settings and populations while maintaining model fidelity. ARC has been used successfully with a range of populations (e.g. pre/post adoptive, internationally adopted, urban high risk, juvenile-justice, child welfare, war refugee) in a range of settings (outpatient, residential, secure facility, domestic violence shelter) and age groups (ages 5 – late adolescence). This adaptability makes the model ideal for implementation in Vermont across multiple programs, ages and settings. Regional differences and differences in the type of program where ARC is being implemented will require local adaptations to meet local needs, achieve the goals of the project, and improve outcomes in each community program. Each ARC Team will be responsible for working with Local Advisory Committees comprised of local stakeholders involved in the care of the target population. These teams will serve as a vehicle for involving the community in the program, identifying local cultural influences, developing trauma informed community services, and raising awareness of the impact of complex trauma. Consultation from TC-JRI will also be available to support local adaptations to meet grant goals and improve outcomes. For a discussion of how ARC will be adapted for the refugee populations in Chittenden and Washington Counties, see below - Section B.6.

B.5: Rationale for Choosing ARC

As described above, Vermont has already begun to implement ARC. The Child Trauma Workgroup (CTWG) identified the ARC framework after consultation with several national trauma experts and a careful review of different evidence-based practices and resources through the NCTSN and SAMHSA's National Registry of Evidence Based Programs and Practices. Through its review, CTWG members sought to determine which approach best matched the well-established System of Care (SOC) for children in Vermont and would best meet the varied and unique needs of Vermont families. The final determination for choosing ARC included:

- ARC is designed as a flexible model of intervention with a manual to guide implementation;
- ARC targets both male and female youth ranging from early childhood to late adolescence;
- ARC is adaptable across settings (clinic, school, community-based in urban and rural locations); populations (adoptive, refugee, cultural groups) and age;
- ARC recognizes the multiple needs of children and families who have experienced complex trauma and values multi-systemic collaboration and intervention in the treatment approach;
- ARC is individualized to the child's and family's needs, involving family at all levels of participation;
- ARC builds on strengths inherent in the child, family and community, and facilitates the development of competencies so that the child and family will no longer need to be involved in intensive services.
- ARC is designed to treat complex, multi-generational trauma, which is the type of trauma community mental health providers consistently cite as the most difficult to address in treatment of children and families.

B.6: <u>Addressing Cultural Issues</u>

Responsibility for making local adaptations based on local population differences will rest with community mental health ARC Teams (see above) who are implementing ARC within their treatment program. During the first and second year of the grant, each ARC Team, in conjunction with the Local Advisory Committee, will identify local population needs and work with TC-JRI to make necessary adaptations specific to issues of age, race, ethnicity, culture, language, sexual orientation, disability, literacy, and gender. As the developers of ARC, TC-JRI has a history of working with local implementer in other sites (e.g. rural Alaska) to adapt the framework in a manner that is applicable to the local population. TC-JRI is also in the process of working with experts in cultural competence to incorporate cultural-specific adaptations in the ARC treatment manual. This adaptable framework allows for implementation modifications across settings and populations while maintaining model fidelity

Local ARC Teams will work with the Department of Mental Health to access existing state resources that are available to ensure ARC is fully accessible for diverse populations. For example, in-person interpretive services, written translation services, and telephonic interpretative and translation services are all available through the Vermont Agency of Human Services to assist in providing services to persons whose native language is not English, and whose proficiency in English is limited.

During Year Three of the grant, the VCTC will focus specifically on adapting the model for the sizable refugee communities (see Section A.1: p.5) that live primarily in Chittenden and Washington Counties. At the start of Year Three, Karen Fondacaro, PhD, of the University of Vermont *Connecting Cultures Program,* a program which specializes in adapting mental health

treatment for Vermont refugees (see sections D and H), will join the VCTC Consultation Team to provide consultation to the ARC Teams in Chittenden and Washington Counties, in conjunction with TC-JRI, to further adapt the provision of ARC. The Cultural and Linguistic Competence Coordinator from Vermont's SAMHSA grant for Youth in Transition will also consult about how to best serve minority populations.

B.7: Logic Model

Needs of Vermont	*Characteristics of ARC that Meet Vermont's Need*	*Outcomes*
1) Treatment providers struggle with addressing complex trauma 2) Children with complex trauma have limited access to empirically-based trauma treatment 3) Due rural nature of Vermont, treatment providers must work across broad spectrum of ages and disorders 4) Treatment practices must fit with Vermont's System of Care values: resiliency, strengths, permanency and collaboration	- designed to treat complex trauma - flexible framework includes manual for interventions - targets male and female youth ranging from early childhood through school age and late adolescence - adaptable across settings, populations and age - recognizes the multiple needs of children and families and supports multi-systemic collaboration and intervention - builds on strengths and facilitates the development of competencies	Children and families receiving ARC from Vermont treatment providers will experience improved clinical outcomes: -Reduction of trauma-related symptoms -Increased child competency -Reduction of caregiver parenting stress -Reduced need for intensive services (psychiatric hospital and long-term residential)

SECTION C: PROPOSED IMPLEMENTATION APPROACH

C.1: How Project will be Implemented:

Vermont will implement empirically-based trauma treatment statewide by creating a Vermont Child Trauma Collaborative (VCTC) comprised of 12 community-based mental health treatment centers. DMH staff and Project Co-Directors will oversee and manage the continuity and sustainability of the collaborative functions to solidify and build on the current Vermont ARC Project and accomplish the six objectives described below.

Objective (a): Establish *VCTC Infrastructure* at the state and local level to oversee and coordinate implementation of ARC and the activities of the VCTC

State and local advisory committees will oversee the VCTC activities. These entities will ensure that the local implementation of trauma-informed care and trauma treatment are matched with the local SOC, client, community, and provider characteristics.

State VCTC Advisory Committee: The State VCTC Advisory Committee (State AC), under the leadership of the Project Co-Directors, will be a subgroup of the existing Child Trauma Workgroup (see A.5, p. 9), with membership from mental health, child welfare, education, domestic violence, family advocates, and youth/family representation recruited through outreach efforts (see C.4, p. 21). The State AC will: 1) Oversee the infrastructure and activities of the grant, 2) Develop the structure for the trauma-informed interagency referral network, and 3) Advise & support the Local Advisory Committees with local implementation.

Local VCTC Advisory Committees: The Local VCTC Advisory Committees (Local AC) will be a subgroup of the existing Local Interagency Teams (described in A.5, p. 9) with membership

from the local ARC Team, DCF District office, local schools, youth/family representative and additional entities as deemed appropriate to meet local needs. The Local AC will: 1) Achieve consensus about the local SOC need for trauma-informed services, 2) Oversee local implementation of the trauma-informed interagency referral process in coordination with the State AC and Project Co-Directors, 3) Educate its members about changes within their own agencies/programs to jointly support, brainstorm and address issues that impact children and families, 4) In Chittenden and Washington Counties, provide input on the modifications to the ARC model for local refugee populations.

Objective (b): Create a *Trauma-Informed Interagency Referral Network* among child and family-serving state and community programs (child welfare, education, and domestic violence) to ensure consistent screening and referral to treatment for children exposed to trauma

The State AC will work with the DCF Centralized Intake Unit (CIU) and Department of Education (DOE) to develop the structure for the interagency referral network, including the processes within the child welfare and educational systems for identification of the target population, referral for trauma assessment and treatment services, and coordination of trauma-informed services. Referral procedures will be developed or strengthened between local VCTC site and the corresponding DCF District office and schools.

The trauma-informed screening and referral procedures developed for this proposal will be incorporated within existing functions in child welfare and school systems to insure that the referral network will be successful and enduring beyond the project period. Work will first begin at the state DCF and DOE level to develop the overarching process and then will be spread to the Local AC, District Offices, and school system. This will assure both State level and local structures for trauma-informed interagency networks.

Objective (c): Use existing *ARC Community Treatment and Services Teams* (ARC Teams) to implement standardized trauma assessment and empirically-based trauma treatment in 12 community treatment programs serving all 14 Vermont counties

The ARC Teams will recruit and provide trauma treatment services using the ARC Framework to children with complex trauma and their families. The VCTC will be a collaborative of 12 sites: 11 community mental health centers and 1 private practice, all of which already have a foundation in the ARC framework (see A.4: p.8). Three to five clinicians at each Site form local ARC community treatment and services teams (ARC Teams). The ARC Teams will participate in the intensive training and consultation with TC-JRI on the ARC Framework. A monthly consultation with TC-JRI will focus on integrating ARC concepts into daily clinical practice, assessment and treatment planning, and clinician self-care practices to address vicarious trauma. Each of the 12 ARC Teams will have one member who is in a supervisory role to facilitate changes within his/her agency as necessary. This supervisor will be the *ARC Lead Supervisor/Trainer* for that site and will receive additional consultation from TC-JRI to incorporate ARC into clinical supervision practices and train new clinical staff in the framework. The VCTC will use distance learning approaches, including web- and tele- conferencing, Listserves, and user-friendly websites to support the 12 ARC Teams around the state in sharing challenges and ideas for implementation, ARC activities, and other resources. Recognizing that some project activities may demand staff time away from providing billable services, *Incentive*

Service Grants will be offered to support the sites' service provision, training/consultation, and data and evaluation activities. Grant payment to sites will be connected to achievement of identified benchmarks of fidelity to ARC implementation, as follows:

- Participation in monthly ARC consultations with TC-JRI
- Participation in monthly internal agency ARC Team meetings focused on implementation and clinical application of model
- Administration of ARC Assessment with clients
- Administration of identified trauma instruments with clients
- Development of treatment plan using ARC's 3 Domains and 10 Building Blocks
- Provision of clinical treatment services
- Use of data and clinical profiles to inform treatment planning and service provision
- Quarterly re-assessment of clients

In Year 3, VCTC will collaborate with the Connecting Cultures Program in the University of Vermont Department of Psychology, as well as with the Cultural and Linguistic Competency Coordinator through the Vermont's Youth-In-Transition grant, for consultation on application of the ARC model to better reach out to and serve children and families of refugee communities in Chittenden and Washington Counties (See B.4, p.12). Cultural modifications will be made in collaboration with TC-JRI and documented for benefit of other NCTSN members.

Objective (d): Develop *Instate Trauma Consultation and Training Capacity* to support implementation of trauma-informed care and the ARC framework and ensure long-term sustainability of the practice

In order to sustain the efforts of the VCTC, it will be important to mobilize and expand the in-state expertise and capacity for training, supervision, and consultation about the ARC framework and trauma-informed care (TIC). This will be accomplished through the following methods:

VCTC Consultation Team: The VCTC Consultation Team will be a sub-group of the State AC comprised of in-state clinical providers who have expertise in trauma (e.g. foundation in trauma treatment theory, the ARC framework, trauma-informed system development, and training skills). The Consultation Team will develop the Trauma-Informed Care (TIC) Training-of-Trainers curriculum, conduct the TIC Trainer Series, and offer on-going support/consultation to the trainers. In Year 3, the Connecting Cultures Program Director will join the consultation team and facilitate modifications of the ARC Framework for refugee populations (as described in B.6, p. 13). For a full listing of membership on the team, see D.2: p.28).

Trauma-Informed Care (TIC) Trainers: One clinician from the ARC Team and one individual from another child-serving entity will be identified in each region to participate in the TIC Training-of-Trainer Series with the VCTC Consultation Team, for a total of 20-25 trainers (see Timeline). Starting in Year 2 these local trainers will begin to provide trainings to child and family service providers in their region about trauma-informed service delivery.

ARC Lead Supervisors/Trainers: One supervisor from each of the ARC Teams will participate in the ARC Lead Supervisor/ Trainer Series with TC-JRI (see Timeline). The consultation with TC-JRI will progressively shift from a training focus to a mentoring focus. By developing a cohort of supervisors capable of providing training and clinical supervision to ARC Teams on the framework, we will be able to sustain the implementation and training of future clinicians after the funding period. The ARC Lead Supervisor/ Trainer Certification will allow

the supervisors to offer ARC training to VCTC site staff who are hired after the initial rollout of training.

Objective (e): *Participate in NCTSN* to incorporate lessons learned in trauma service implementation

Collaboration with NCTSN will consist of: 1) partnership with the TC-JRI Level III and Level II Center for training/consultation on the ARC Framework and collaboration for cultural adaptations to the model; 2) collaboration with other NCTSN sites who are implementing ARC to share lessons learned; 3) use of existing NCTSN resources (e.g. publications, web training programs, Listserves); 4) contribution of developed materials from our project (see C.10, p.24) and 5) participation in NCTSN meetings.

Objective (f): Establish systematic *Data Collection and Evaluation* to monitor the quality and quantity of services and treatment being provided through the VCTC

Evaluation data will be continually fed back to VCTC participants to inform and improve grant activities. See Section E (p.30) for a full description of the evaluation process.

Project Timeline

Key: ARC Lead Supervisor (ALS); Project Co-Directors (PD); Project Evaluator (PE); Principle Investigator (PI); Trauma Center at JRI (TC-JRI); VCTC Consultation Team (VCTC-CT); VCTC Advisory Committee (VCTC-AC)

Period	Key Activity & Milestone	Responsible Staff
YR1, Q1 (1-3 Mo.)	Convene **State Advisory Committee**: delineate roles and responsibilities; establish quarterly meeting schedule; recruit youth/ family representatives.	PI *(see key above)
	Hire Project Co-Director and create sub-grant for PE.	PI
	Establish contract with NCTSN Center (TC-JRI) for consultation on ARC Framework.	PI
	Evaluator works with NCTSN to establish reporting and data exchange protocol.	PE*
	Create memoranda of understanding with identified sites to establish the VCTC.	PI
	Convene **VCTC Consultation Team.**	PD*
	VCTC "Kick-off" meeting (3-days): 1-day orientation to program goals, activities, and evaluation. 2-day training on ARC Framework, assessment, clinical concepts.	PD, PE, TC-JRI*
	Develop trauma-informed interagency referral network structure.	VCTC-AC*
	Develop VCTC outreach and education materials.	PD
	Establish monthly local ARC Team meetings; identify ARC Lead Supervisor.	PD, ALS *
	Convene the **Local Advisory Committees**: build local consensus for project.	ALS, PD
	Establish communication systems for distance learning and project information.	PD, PE
	In month 3, begin monthly clinical consultation for ARC Teams.	TC-JRI
	Submit quarterly progress report to SAMHSA.	PD
YR1, Q2 (4-6 mos)	Continue **monthly ARC training/consultation** for ARC Teams.	TC-JRI
	Implement ARC in **direct clinical services** at CMHC's by month 4: conduct clinical assessments; initiate provision of clinical services with the target goal of serving **5-6** clients at each site during Year One (YR 1 total **60** clients).	PD, ARC Teams
	Continue monthly local internal agency ARC Team meetings for implementation.	ALS
	Initiate **data collection** for client assessment and evaluation of implementation efforts.	PE
	Submit quarterly progress report to SAMHSA.	PD
YR1, Q3 (7-9	Continue provision of clinical services using ARC framework.	ARC Teams
	Continue monthly ARC training/consultation for ARC Teams.	TC-JRI
	Continue monthly local ARC Team meetings focused on implementation .	ALS
	1-day in-person training, followed by monthly consultations for **ARC Lead**	TC-JRI

mos)	**Supervisor/Trainer Series**	
	Continue evaluation activities: conduct client satisfaction surveys, site visits; Provide feedback from data collection for clinical utility and project activities.	PE
	Develop Train-the-Trainer curriculum for TIC training of community partners.	VCTC-CT
	Identify local providers from each region to participate in TIC Train-the-Trainer Series	ALS
	Submit quarterly progress report to SAMHSA.	PD
YR 1, Q4 (10-12 mos)	Conduct **"TIC for Community Partners" Train-the-Trainer Series**	VCTC-CT
	Continue provision of clinical services, consultations and ARC Team meetings.	ARC Teams TC-JRI
	Submit annual report to SAMHSA, including sustainability efforts and plan.	PD, PE
YR 2, Q1 (13-15 mos)	Continue to implement ARC: provision of clinical services with the target goal of serving **12** new clients at each of the 12 sites (YR 2 total **145** clients).	PD, ALS, TC-JRI
	Continue monthly consultations for ARC Teams and ARC Lead Supervisors.	TC-JRI
	Continue evaluation activities: Provide feedback from Core Data Set for clinical utility and project activities; NCTSI Cross-Site Evaluation.	PE
	Continue internal agency monthly ARC Team implementation/supervision meetings.	ALS
	Continue TIC Train-the-Trainer series.	VCTC-CT
YR2, Q2 (16-18 mos)	Ongoing provision of clinical services & evaluation activities.	ARC Teams PE
	Phase out monthly ARC Team consultation by TC-JRI; ARC Lead Supervisors oversee ARC Teams with monthly mentorship/consultation from TC-JRI.	TC-JRI
	Provide **Local TIC trainings** to child-serving partners; consultation for TIC trainers.	TIC trainers VCTC-CT
YR 2, Q3 – Q4 (19-24 mos)	Ongoing provision of clinical services & evaluation activities.	ARC Teams PE
	Month 20: 1-day in-person training/consultation for ARC Lead Supervisors to continue to solidify skills and sustain VCTC trainings on ARC framework.	TC-JRI
	Continue internal agency monthly ARC Team implementation/supervision meetings.	ALS
	Continue monthly ARC Lead Supervisor/Trainer consultations.	TC-JRI
	Continue to offer Local TIC trainings to child-serving partners; on-going consultation for TIC trainer collaborative.	VCTC-CT, TIC trainers
	Submit quarterly and annual reports to SAMHSA including sustainability efforts/ plan.	PD, PE
YR 3	Ongoing provision of clinical services & evaluation activities: target goal of serving **12** new clients at each of the 12 sites (YR 3 total **145** clients); Provide ARC trauma-treatment to total of **350** clients by the end of Y3.	ARC Teams PE
	Continue internal agency monthly ARC Team implementation/supervision meetings.	ALS
	UVM Connecting Cultures Program Director joins VCTC-CT. **Adapt ARC model for refugee populations** in Chittenden and Washington Counties.	VCTC-CT, TC-JRI
	Quarterly phone consultations and 1 in-person meeting to develop cultural adaptations. Document adaptations.	TC-JRI, VCTC-CT
	Quarterly phone consultations for ARC Lead Supervisor/Trainers to develop & finalize curriculum for internal VCTC ARC trainings.	TC-JRI
	Continue client data collection; continue TA system.	PE
	Continue to offer Local TIC trainings to child-serving partners; on-going consultation for TIC trainer collaborative.	VCTC-CT, TIC trainers
	Submit quarterly and final reports to SAMHSA including sustainability efforts & plan.	PD, PE

C.2: Characteristics of the Target population:

The target population is male and female children and adolescents ages 3-18 who have experienced complex trauma (as described in A.2, p.5). Treatment services will also target the child's caregiver (parent, adoptive parent, foster parent, kinship care, etc) according to clinical need, developmental age of the child, and treatment goals. A significant benefit of the ARC

Framework is the focus on the attachment/caregiver system and a nonjudgmental approach that engages the caregiver in the treatment to their highest capability and works to overcome barriers that may have previously prevented effective caregiver involvement.

Implementation of the ARC framework will take into consideration the unique characteristics of the individuals to be served, as described in Section A.1 and A.2. Vermonters have a proud history of independence and self-sufficiency; privacy is highly valued and stoicism is a common trait. These characteristics, combined with the impact of geography and climate, often reinforce the value that Vermonters should be able to take care of themselves and their families without the "interference" from outsiders. Implementation of ARC will involve conducting a thorough psychosocial and trauma assessment including identification of the child and family's strengths and needs. ARC honors families' value for independence by shoring up the caregiver's own skills and natural supports to create a safe care-giving system and by facilitating the development of child and parent competencies to reduce the need for intensive services.

As members of the community, the local ARC Teams and Local Advisory Committees will be attuned to the unique community characteristics of their regions and can make adjustments to implementation, with consultation, to better meet these needs. The ARC providers will use a flexible approach in offering clinical services to children and families in their own communities including some capacity to bring services into the home. Many communities have available Medicaid funded transportation to medical and therapeutic appointments.

The involvement of the Vermont Federation of Families for Children's Mental Health, including the Youth Coordinators, on the VCTC Advisory Committee, and parent/youth involvement on the Local Advisory Committees are important for ensuring that implementation of the ARC model successfully addresses the values, beliefs and needs of the families served.

In many of the home countries represented in Vermont's refugee resettlement communities, the only mental health services provided are psychiatric inpatient services; thus they may experience stigma regarding seeking and using comprehensive mental health services. For ongoing consultation with this issue, VCTC will maintain an active relationship with the AHS Refugee Coordinator (see Appendix 1: Letters of Support), who is an adjunct member of the AHS Child Trauma Workgroup. Dr. Karen Fondacaro, Director of the Connecting Cultures Program, will provide consultation in year three for the adaptation of the model for refugee populations (see Appendix 1: Letters of Support). VCTC will also coordinate with the Cultural and Linguistic Competency Coordinator through the Youth-In-Transition grant, another DMH SAMHSA-funded project, for modifications to the model. These consultants will offer assistance with how to best outreach to the refugee community, build a culturally sensitive network of clinicians, and increase awareness of and collaboration with available resources, including accessing Limited English Proficiency services, as described in B.6 (p. 13), to meet the unique needs of refugee trauma survivors and their families.

Those children who are referred for services but are not eligible for participation in the VCTC project will receive treatment as usual including clinically appropriate trauma assessment and trauma treatment, but they will not be included in the evaluation process for this project. However, the skills gained by clinicians to become trauma-informed, including a welcoming approach, creating safety, and building strengths and resiliency factors, can be globally applicable for any mental health or social service. Therefore, the efforts of this project may impact the service provision beyond that of treatment for complex trauma.

C.3: Numbers of Individuals Served, Clinical Services, and Recruitment/Retention:

Though not yet proficient in the use of the model, clinicians at each of the sites have a received foundational training in ARC and will begin providing direct trauma-treatment services using the ARC model by the 4th month of this VCTC project. In Year One, each of the 12 sites will provide ARC services to an average of 5-6 new clients (families), with the larger sites potentially serving more clients than the smaller sites. A total of 60 children and their families will receive trauma-specific clinical services in Year One. In Years Two and Three, each site will serve an average of 12 new clients (families), for a total of 145 each year. Over the course of the funding period, VCTC will serve 350 new clients (families) throughout Vermont using the ARC framework. Clinical services will include at minimum clinical assessment, treatment planning, individual or group therapy, psycho-education, and skills integration. When clinically indicated, services may also include family therapy, caregiver groups, adult mental health treatment (for the caregiver), psychiatry, crisis intervention, and/or case coordination. Typical length of service for this model is 6 months, with the potential for extension if clinically indicated. The nature of the target population is such that there is ongoing exposure to traumatic stress, therefore the approach is a "during-trauma' rather than a "post-trauma" intervention. As such it can be difficult to predict treatment length. The ARC Framework includes 10-session curricula for child, adolescent and caregiver groups. Each site will offer at minimum two group interventions: a child or adolescent ARC group and an ARC caregiver group.

Clients will be identified through a trauma-informed referral protocol with child-serving partners. The VCTC will develop materials describing ARC trauma treatment services for distribution to DCF, schools, Domestic Violence (DV) programs and other child-serving sites. The locally offered trauma-informed trainings will support the referral protocol. DCF Family Services will be a primary referral source. We will work with DCF Centralized Intake Unit to develop a clear protocol within their Structured Decision Making process for assessing safety and risk of harm to identify children who have experienced chronic or multiple traumas who may be appropriate for receiving ARC treatment services and thus should be referred to the VCTC for assessment.

VCTC will work with the Department of Education to identify the protocol in the school system for screening of trauma and referral to VCTC sites for further assessment. For schools where the PBS model is being implemented, VCTC will help DOE to incorporate trauma-informed concepts into its PBS trainings for schools to understand trauma at the universal level. We will develop the protocol for screening for trauma at the small group (Secondary) and individual (Tertiary) levels of the PBS system (see A.5, p.9). For schools not yet involved with PBS, we will target the existing cadre of school-based mental health providers and other school personnel to become more trauma-informed and use the protocol for screening and referral.

The ARC Team will recruit families referred from DCF and schools according to the following criteria: 1) presence of complex trauma (identified through the assessment process, including scores in the clinical range on trauma instruments); 2) willingness to participate in the assessment and data collection activities; and 3) willingness to participate in treatment with the ARC Framework for at least 3 months. A core ARC component focuses treatment for the attachment system, therefore it is essential that an identified caregiver (e.g. parent, legal guardian (kin or adoptive parent), or foster parent) participate in the clinical services. Children and families will be educated about the ARC trauma services offered. By ensuring a welcoming,

trauma-informed approach at the site, children and families will be more likely to continue services until treatment goals are met. VCTC sites may use their incentive service grants to offer non-monetary help to families to access clinical services, such as gas cards to offset transportation costs or childcare while caregivers participates in clinical groups.

C.4: Input from Consumer constituency groups:

Consumers and families have been and will continue to be involved at all levels of the project. During the planning process for the VT ARC Project and pre-planning for this proposal, consumer input was sought through DMH State Standing Committee with over 50% consumer/family representation, the Child Trauma Workgroup with parent representation from Vermont Federation of Families for Children's Mental Health (VFFCMH), and public notice of the application through the DMH website which posts Bi-weekly Mental Health Updates.

The VCTC State Advisory Committee and Local Advisory Committees will each include one or more youth/ parent representatives. The State AC will include one or two VFFCMH Youth Coordinators from the SAMHSA-funded Youth-In-Transition project. Other consumer and family representatives will be recruited from Vermont Psychiatric Survivors, AHS Peer Navigators, Vermont Kin As Parents, and the Vermont Foster/Adoptive Family Association (See Letters of Support - Appendix 1). Finally, client satisfaction surveys will be an additional and valuable means of eliciting consumer feedback directly from those who are experiencing the program (see E, p.30).

C.5: Involvement of Key Stakeholders:

The Vermont Child Trauma Collaborative has already begun the work to ensure that community and state partners are actively engaged in the project and efforts to solicit input and participation will continue throughout the project. By contributing to the development of implementation plans, referrals systems, policies and procedures, and further program refinement stakeholders "buy into" the overall process.

The AHS Child Trauma Work Group (CTWG), as described in Section A.5, has been highly active in the preparation for this project, including the first phase that is now the Vermont ARC Project, and will contribute members to the VCTC State Advisory Council. Through the existing Vermont ARC Project, many community and state partners were invited to participate in the Trauma Informed Care conference in 2008. This highlighted the need for continued efforts to create a trauma-informed child-serving system. Information about the activities of the current ARC Project have been published through the DMH bi-weekly "Mental Health Update" to keep stakeholders and youth/families informed of the efforts to develop trauma-informed and trauma-specific services. Finally, the CTWG hosted a public input meeting in April 2009 to solicit input for the planning of this VCTC project.

Consensus building at the State level for the VCTC has continued through information exchange and dialogue with DCF, DOE, Alcohol and Drug Abuse Programs, and the Agency of Human Services Trauma Coordinator, all of whom have all expressed support for and commitment to this project. These partners are excited for the opportunities to become more trauma informed in their practices and contribute to a trauma-informed system for children (see Letters of Support - Appendix 1). Similarly, at the local level the public CMHC Child and

Family Services' Directors have been engaged in the Vermont ARC Project and in the planning for the VCTC and are committed to dedicating staff to clinical service delivery, data and evaluation activities, and training/ consultation activities (see Appendix 1 for letters of support).

The private group practice of clinicians at the New England Counseling and Trauma Center (see D.1, p.27) has representation on the CTWG and has engaged in private consultation with TC-JRI on the ARC Framework. This group practice is involved in the planning of the VCTC and will be one of the community treatment and services sites for the project (see Letters of Support – p.1).

C.6: Strategies to Build Consensus:

The Department of Mental Health, as applicant, and the Child Trauma Workgroup (CTWG) have already engaged in activities to build consensus for the chosen treatment model and proposed project. As noted in Section B.5 (p.13), the CTWG went through an extensive process to identify the targeted population, review evidence-based practices to address the needs of complex trauma in children, and determined that the ARC Framework was the best practice to incorporate into Vermont's SOC. The CTWG also reviewed standardized instruments for trauma screening and assessment, including use of resources available through the NCTSN, and endorsed several for use in Vermont's service system.

The history of these efforts will be shared with the Local Advisory Committees (Local AC; see C.1, p.14). The Local ACs will have opportunities from the beginning to build awareness of and consensus about the local needs for trauma-informed services, also about the process to implement the model within the local SOC. Many of the Local Interagency Teams (see A.5: p.9), the existing groups that will form the Local AC for this project, have already identified a need to be more trauma-informed and to have access to more effective trauma treatment services.

A barrier to developing and maintaining consensus is the challenge of communicating to make sure all parties feel – and are – heard. Having informed partners in any initiative is critical to the growth and sustainability of the work. However, having informed partners is not simply providing access to information and data, but *communicating* the information to stakeholders and communities in a meaningful way and *soliciting and listening to* input from a variety of perspectives. The VCTC will actively facilitate communication with stakeholders about the project goals, activities, and outcomes. Communications will occur through multiple channels, including a) a "kick-off" meeting/training for stakeholders and project participants; b) a project list serve; c) a project web-site with publication retrieval capability; d) teleconferencing capability for Advisory Committee and ARC Teams; e) face to face meetings; and, f) regular communication at the staff level in each site. The VCTC is also committed to effective communication with NCTSN members.

C.7: Consumer Input: Strategic Planning and Advisory Process:

State and local advisory teams will be created for this project. Youth/families will be essential members of the State and Local Advisory committees. These committees will oversee the development and implementation of the trauma-informed interagency network, adaptations to the ARC framework for refugee populations, and development of family-friendly communications and publications about the VCTC services. As previously noted, youth/families

will be recruited through numerous existing advocacy and support entities. Consumer participation in committee meetings will be supported through small stipends.

C.8: Embedding ARC within Existing Service Delivery System:

The VCTC will be embedded within the existing community mental health provider system to deliver the trauma-focused treatment, including the standard intake and assessment protocol for diagnosis and evaluation of new clients. This protocol will be enhanced with the trauma-focused assessment instruments and ARC-focused assessment. The project will continue the training of existing clinical staff at the CMHC's and private group practice. The CMHC's have been providing public mental health services to Vermonters for well over 30 years and have fully established infrastructure for clinic, home-, and community-based outpatient services. The private group practice, NECTC, has been providing outpatient clinical services since 2005 in Chittenden County and has infrastructure for clinic-based outpatient services. Each VCTC site has clinical and supervisory staff dedicated to the current Vermont ARC Project. With these SAMHSA funds, the staff will be supported to continue their efforts to more fully implement the ARC model. All of the VCTC clinical providers have a solid understanding of clinical treatment modalities, many with over 12 years experience. Through the VCTC, they will become more knowledgeable and expert at the application of ARC in their clinical work and increase their capacity as local trauma experts to provide training and consultation to other child-serving partners (especially DCF and DOE).

As previously noted, the creation of a *trauma-informed interagency referral network* will be embedded within DCF's Differential Response System, establishing a more structured process for identifying and referring children for trauma-specific assessment and treatment.

Components of VCTC will also interface with other SAMHSA-funded mental health projects in Vermont. Lessons learned will be exchanged with the SAMHSA-funded grant to Build Capacity for Alternatives to Restraint and Seclusion in the only inpatient psychiatric facility for children and adolescents in Vermont, the Brattleboro Retreat. The Youth Coordinators associated with Vermont's Youth-In-Transition project (SAMHSA-funded) have identified trauma-treatment services as a priority need and a service that transition-age youth are more likely to voluntarily access. We will also seek to connect with the VT Youth Suicide Prevention Coalition (also SAMHSA funded) to incorporate TIC principles in their gatekeeper training and public awareness campaign. Finally, VCTC will coordinate with Vermont's new **Jail Diversion and Trauma Recovery Program – Priority to Veterans** Pilot (funded through SAMHSA) in which providers will be trained on trauma-informed care. VCTC will work with the pilot to increase providers' awareness of complex trauma with the goal of improving identification and referral of children and families of veterans involved in jail diversion who may benefit from ARC treatment.

C.9: Mobilizing/Developing Existing Expertise & Resources:

VCTC will use the existing in-state experts in trauma, trauma-informed care, and trauma treatment to serve as trauma-champions in their local regions and form the VCTC Consultation Team (see D.2: p.28 & Section H for bios of these individuals). The Department of Mental Health will bring to the VCTC extensive experience with the statewide implementation of new

practices in the service provider system. The DMH will bridge the efforts of VCTC with several existing projects of the family court system's collaboration with mental health and substance abuse treatment, transition-age youth services, and alternatives to seclusion and restraint.

Every VCTC site has an existing infrastructure of clinical, supervisory and support staff, building facilities, administration, insurance billing, and IT hardware and support. Other existing resources that will be mobilized for this project include the availability of the State web- and phone- conferencing systems. These technologies will be used for the distance learning activities to provide trainings, consultations and meetings with all regions of the state without unduly impacting the VCTC sites limited resources (reducing staff travel time and costs). The DMH website will host a page on Child Trauma and the efforts of the VCTC. Additionally, Listserves will be established to connect all participating individuals and agencies for discussions on implementation efforts, upcoming events and trainings, and other important information.

C.10: Collaborating with National Child Traumatic Stress Network:

Collaboration with NCTSN will consist of 1) partnership with TC-JRI Level III and Level II Center for training/consultation on the ARC Framework and collaboration for cultural adaptations to the model; 2) collaboration with other NCTSN sites who are implementing ARC to share lessons learned; 3) use of existing NCTSN resources (e.g. publications, web training programs, Listserves); 4) contribution of developed materials from our project (see C.10, p.24) and 5) participation in NCTSN meetings.

VCTC will continue the current working relationship with Dr. Margaret Blaustein and her colleagues at The Trauma Center at JRI in Massachusetts, a Community and Treatment Services Center (Category III) within the NCTSN. As one of the founding Centers of the NCTSN, Trauma Center has extensive knowledge and expertise in complex trauma, child development and treatment; contributed important research to the field of complex trauma; and, as a Category II Center, conducts extensive trainings within and external to the NCTSN on complex trauma and empirical treatment approaches. As exemplified in the existing Vermont ARC Project, Dr. Blaustein and the DMH are committed to training clinicians and supporting full implementation of the ARC Framework in all regions of Vermont, including the development of Lead ARC Supervisor/ Trainers for sustainability of the ARC framework.

VCTC will access NCTSN resources such as the Child Trauma Toolkit for Educators, the white paper on Mental Health Interventions for Refugee Children in Resettlement, and the Child Welfare Training Toolkit, to name a few. VCTC will increase awareness of the wealth of NCTSN resources by publicizing information through our materials, website, and communications. If VCTC sites identify the need for other treatment modalities, they can access the NCTSN trainings and other learning opportunities. For example, if a need is identified for targeted acute trauma treatment, VCTC clinicians can complete the NCTSN web-based training for the evidence-based Trauma-Focused Cognitive-Behavioral Treatment (TF-CBT) model. Finally, the DMH, Project Co-Directors, and Project Evaluators will actively participate in Network meetings, conferences and other activities as required. VCTC will share with the NCTSN lessons learned and any relevant materials that are developed.

C.11: Potential Barriers:

Our greatest challenge is also our greatest asset: we are conducting statewide implementation. With the VCTC encompassing 12 sites, we will need to be attentive to fidelity issues. Opportunities for face- to-face meetings, development of strong ARC Teams, and distance learning technologies for easy and frequent communication provide strategies for addressing this barrier. Moreover, having DMH as lead, supporting and encouraging connections among the sites and community partners will be a vital strategy for a successful collaborative. Continuous evaluation activities, consistent quality improvement feedback cycles, and on-going training/consultation are key to ensuring fidelity to the model across sites.

The rigorous evaluation activities may place an increased burden on VCTC sites, particularly staff resources, to conduct standardized assessments and submit data. We will overcome this potential barrier by awarding sub-grants as incentive funds to the sites for completing and submitting data (perhaps through the use of additional administrative staff) from the requisite trauma assessment protocol. Also, in the earlier phase of the project, the Evaluators will take on the primary responsibility for collating and scoring clinical data and providing results back to ARC Teams. In later phases, the Evaluators will create a process for easy generation of clients' complete profiles so providers can become more independent in obtaining clinical feedback.

The sites may see significant increases in referrals following successful efforts to increase the System of Care's awareness of and screening for trauma, which may place additional demand on treatment sites that already over- taxed. We expect that by using an empirically based model, providers will be more effective and efficient in the clinical service delivery, thereby maximizing the existing resources and reducing the length and intensity of services. With effective reduction of symptoms and increased competencies in children and families, it is likely that the long-term impact on the human service system may be a reduction in services and related costs. Finally, full implementation of the model may also reduce clinician vicarious trauma and thus increase in staff retention, which would further increase the effectiveness of service delivery.

C.12: <u>Sustainability after the grant</u>:

Vermont has a long history of success in sustaining grant initiatives beyond the funding period (for examples, see D.1, p.26. It is critical that the VCTC sustain trauma informed and trauma-specific treatment services. With the DMH as lead for this project, there will be a central entity focused on trauma policy and sustainability issues and needs. DMH finalized a Trauma Policy in 2009 based on the Agency of Human Services 2006 Trauma Policy, which establishes the value of increasing trauma-informed and trauma-specific services, reducing the likelihood of re-traumatization, and reducing and/or eliminating the use of seclusion and restraint. The DMH Trauma Policy applies to all contracted entities and outlines the process to ensure adherence to the policy through the existing Quality Review and Designation process.

During the course of the grant, DMH will explore with the State Medicaid program and insurance companies how all of the ARC trauma services can be reimbursed on a fee for service basis. The infrastructure for the interagency referral network will be sustained by the Child Trauma Workgroup and Local Interagency Teams. A central component of the project is the creation of local expertise to continue ARC and TIC trainings beyond the funding period and to embed the models in supervisory practices. The value of regional collaborative groups is their ability to advocate for services, funding, and discuss on-going local needs.

C.13: Seclusion and Restraint Reduction/Elimination:

In addition to complying with DMH Trauma Policy (see C.12. above) and the DMH Quality Review and Designation Standards, several of the ARC sites are also CARF (Commission on Accreditation of Rehabilitation Facilities) accredited and therefore meet the minimum standard of having an established policy to address the reduction/elimination of seclusion/restraint, identify rare instances when it may be warranted, and establish procedures for safe and appropriate use. DMH is completing the first year of its Alternatives to Seclusion and Restraint (S/R) SAMHSA-funded State Incentive Grant which is targeting two inpatient sites, including the Brattleboro Retreat's child and adolescent inpatient units. Lessons learned from this S/R grant will be shared and incorporated into the VCTC as warranted.

SECTION D: STAFF AND ORGANIZATIONAL EXPERIENCE

D.1: Capability/Experience of Applicant & Other Participating Organizations

The ***Department of Mental Health (DMH)***, as grant applicant, will oversee and coordinate grant activities to ensure the creation and sustainability of the Vermont Child Trauma Collaborative. DMH is responsible for administering a very broad range of federal and state programs, block grants, and entitlements. 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. DMH has a long history of implementing and sustaining state-wide initiatives funded through SAMHSA, including three different SAMHSA Center for Mental Health Services (CMHS) Children's Mental Health Initiative (CMHI) 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, and 3) in 2008, Youth in Transition (YIT), for youth and young adults aged 16-21 (inclusive) with SED. DMH also has extensive experience with conducting broad community education activities, training and consultation activities for the implementation of new clinical practices and models. Examples of this include statewide implementation of Wraparound, Respite, Therapeutic foster care, DBT, Integrated Mental Health and Substance Disorder Treatment, and Early Childhood Mental Health Consultation. As described in Section A.4 (p. 8), DMH also has experience in developing trauma-informed care through the initial ARC Project.

The ***10 Vermont Community Mental Health Centers and one Specialized Service Agency (CMHC's)*** are 11 of the 12 VCTC sites for the project covering the 14 Vermont counties. The CMHC's have extensive experience and infrastructure for providing mental health treatment and support services to children, adolescents, adults and families throughout Vermont's regions (most centers have been in existence since the 1960's), and each center is imbedded within the local systems of care. For children with serious emotional disturbance, each CMHC maintains core service capacities in prevention, early intervention and community consultation; supports; treatment; and immediate response and acute care.[28] As described in Section A.4 (p. 8), the CMHC's already have experience with the initial implementation of ARC, and several have already begun to provide trauma treatment based on the ARC Model.

The New England Counseling and Trauma Center (NECTC) is a private group practice formed in 2005 and located in Chittenden County, the most populated region NECTC will be the 12th VCTC site, forming the public/private partnership of the Collaborative. The independent practitioners at NECTC specialize in the comprehensive assessment and treatment of children, adolescents and families impacted by trauma. NECTC provides individual, group, and family therapy, and caregiver psycho-educational groups. NECTC clinicians participated in a year-long consultation relationship with TC-JRI focused on the implementation of the ARC model.

The Trauma Center at Justice Resource Institute (TC-JRI) will provide training and consultation to VCTC. JRI was established in 1973, to work as a partner of government to respond to the most resistant problems of child human services and juvenile justice. JRI provides mental health services to over 4,000 adolescents each year throughout Metro Boston (MA). It has an active training program for post-doctoral psychologists, psychiatrists and social workers in the treatment of Child Traumatic Stress. Since 2001 TC-JRI has been active in the National Child Trauma Stress Network (NCTSN). TC-JRI founded and leads the Complex Trauma Work Group (WG). It produced a White Paper on Complex Trauma, leads the NCTSN DSM-V WG on Developmental Trauma, and has developed and implemented ARC, a systemic treatment model for complex trauma. TC-JRI is involved in numerous research studies on the subject of child trauma. For over 27-years, TC-JRI has provided national and international training in understanding and treating traumatic stress. TC-JRI trains over 5,000 providers per year through workshops, seminars, and an academic-year certificate program in Traumatic Stress Studies.

The Vermont Child Health Improvement Program (VCHIP) will conduct the evaluation of the VCTC project. Founded in 1999, VCHIP is a research and quality improvement organization based in the Department of Pediatrics of the University of Vermont (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. VCHIP has considerable resources relating to the collection, analysis and reporting of quantitative and qualitative data. VCHIP will obtain UVM Institutional Review Board (IRB) approval for all VCTC evaluation activities.

D.2: <u>Project/Key staff: Level of Effort, Qualifications, and Experience</u>

Charlie A. Biss, MSW, Principal Investigator, is the Child, Adolescent, and Family Unit Director in the Vermont Department of Mental Health and will be the PI (.05 FTE – In-kind) for this project. He has 36 years of Human Services experience as a clinician, local program developer, and a state level implementer of systems of care. As Project Director and/or Principal Investigator, he has secured and overseen many public and private grants to develop and sustain statewide systems of care (SOC) for very young children, school age children, and transition-aged young adults (see description of DMH - Section D.1.). Mr. Biss has extensive experience working with the State and Local Interagency Teams (SIT and LITs), CMHC Children's Mental Health Directors, other state agencies (e.g. DOE and DCF) and community/ family advocates.

Laurel Omland, MS, NCC, Project Co-Director, is Clinical Care/ Trauma Coordinator in the Child, Adolescent and Family Unit in the Department of Mental Health. Ms. Omland will be the Project Co-Director (.5 FTE – In-kind). She is a member of the Child Trauma Workgroup and oversees the current DMH "Vermont ARC Project" of training/ consultation with the Trauma Center at JRI. She developed the DMH Trauma Policy and DMH plan[29] for building trauma-informed mental health services in the public system. As a Nationally Certified

Counselor, Ms. Omland has provided clinical services, trainings, and consultation in children's mental health for over 8 years and is skilled at working with State and local SOC partners.

A Project Co-Director will be hired upon award of this grant. The Project Co-Director (.5 FTE) will share management and oversight of the VCTC (see job description in Section H). DMH has several highly qualified individuals from the provider system as candidates for this position, with extensive clinical, supervisory, and training/consultation experience in trauma treatment, the ARC Model, and trauma-informed service delivery.

Margaret Blaustein, PhD, ARC Trainer/ Consultant, is the Director of Training and Education at The Trauma Center at Justice Resource Institute (TC-JRI). Dr. Blaustein will be the primary NCTSN Category III Center consultant (.15 FTE) for this project. Dr. Blaustein is co-developer, with Kristine Kinniburgh, of the ARC Framework and has published and provided consultation and training on the assessment and treatment of complex trauma in children and adolescents. Together, they are currently responsible for overseeing comprehensive ARC training and adaptation initiatives at over 20 agencies throughout the country.

Thomas V, Delaney, PhD, Evaluation Principal Investigator, will oversee all evaluation activities for the project (.05 FTE). Thomas Delaney is a Research Analyst in the Vermont Child Health Improvement Program (VCHIP) in the Department of Pediatrics, University of Vermont College of Medicine. Dr. Delaney specializes in the evaluation of quality improvement and applied research projects in healthcare and mental health systems. He has been the lead evaluator on several statewide evaluations in Vermont, including the Vermont Blueprint for Health, The Children's Mental Health Initiative and the Vermont Suicide Prevention Project.

Alison K. Howe, M.S., Evaluator, will conduct the evaluation activities (.60 FTE). Alison Howe is a Program Evaluator at VCHIP and is responsible for overseeing research and data collection activities, developing and implementing summative and process evaluation procedures, analyzing data and presenting results for several health care quality improvement projects aimed at improving the quality of health care for Vermont children and their families.

An Administrative Assistant will be hired upon award of this grant (.5 FTE) to support the project activities (see job description in Section H). Duties will include: work in preparing documents and mailings, assisting in the planning for meetings and training events and designing informational documents.

VCTC Consultation Team members: As described in Section C.1. (p. 16), this project will create a VCTC Consultation Team to provide instate leadership, training and consultation to programs implementing TIC and ARC. In addition to Laurel Omland and her Project Co-Director, the following personnel will serve on the team:

Margaret Joyal, MA is the Director for Washington County Mental Health Services Counseling and Psychological Services, and co-founder of Linking Community Supports (LINCS) adult trauma treatment program. Ms. Joyal has provided trainings and workshops state-wide on recent advances in trauma treatment, effects of psychological trauma, treatment of PTSD, and treating survivors of childhood abuse. She is a current Consultant Trainer for the Center for Crime Victim Services and the Agency of Human Services. Ms. Joyal serves on the AHS Trauma Workgroup charged with transforming state-based services to be trauma informed.

Allyson DeMaggio, MSW, LiCSW is the Trauma Coordinator for Child, Youth and Family Services at the HowardCenter, Vermont's largest CMHC. Ms. DeMaggio is a skilled trauma-informed clinician, clinical supervisor, program developer, and psychosexual and trauma evaluator serving youth, adults, and families experiencing broad based symptoms often related to

childhood trauma, particularly sexual traumas. Ms. DeMaggio is an experienced trainer and consultant in the areas of child trauma and sexual abuse.

Tammy Leombruno, MA, LCMHC, is co-founder of the New England Counseling and Trauma Center, the one private practice VCTC site. Ms. Leombruno specializes in the assessment and treatment of sexual abuse and trauma and has worked in the field for 17 years. Ms. Leombruno provides individual, group, and family therapy, trauma evaluation/ consultations and psychosexual consultations. She is a member of the Chittenden Unit for Special Investigations (of child sexual abuse) and has extensive training experience.

Karen Fondacaro, PhD, is Director of the Behavior Therapy and Psychotherapy Center and Connecting Cultures Program, a not-for-profit outpatient clinic and training facility in the Department of Psychology at the University of Vermont. She specializes in community outreach, assessment, and direct mental health services for resettled refugees. She will consult on cultural modifications to the ARC Framework for refugee children and families in Year 3.

D.6: Advisory Body

The Vermont Child Trauma Collaborative will convene on a *quarterly* basis a multi-disciplinary State Advisory Committee (State AC). The State AC will be comprised of members of the AHS Child Trauma Workgroup and stakeholders with representation from the Vermont Federation of Families for Children's Mental Health, Vermont Network Against Domestic and Sexual Violence, AHS Refugee Coordinator, Department for Children and Families, Department of Mental Health, Department of Education, Vermont Psychiatric Survivors, Prevent Child Abuse Vermont, public/private community mental health, and youth/family representatives. As noted in Section C.1 (p. 14), the State AC will 1) oversee the infrastructure and activities of the grant, 2) develop the structure for the interagency referral network, 3) advise & support the Local Advisory Committees with local implementation, 4) review and use evaluation data (see Section E) to improve project activities and outcomes, and 5) disseminate resources and "lessons learned" available from other members of the NCTSN. The Project Co-Directors will facilitate State AC meetings; minutes will be recorded and posted on the VCTC website.

D.7: Budget, Resources Available, and ADA Compliance

The Project Co-Directors will be located in the DMH and have use of all DMH facilities: space, desk, phone, computer, copying machines, parking, etc. DMH is located in downtown Burlington in a relatively new State office building that is on a main bus route. It is easily accessible and compliant with the American with Disabilities Act.

All the CMHC's also have easily accessible, ADA-compliant offices, though much of their work is done on an outreach basis in homes, schools, and communities for the convenience and comfort of children and their families. Each CMHC has full phone, voice and E-mail capacities with remote access, high-quality fax machines, and comprehensive and secure computer networks and IT support. All CMHCs abide by the requirements of the Americans with Disabilities Act and state laws governing employment of individuals with disabilities.

The private group practice, NECTC, has an easily accessible ADA compliant facility. As a stipulation of participation in the collaborative, NECTC will be required to adhere to all ADA

hiring and accessibility practices, to be demonstrated in the Memorandum of Understanding between NECTC and DMH at the start of the funding period.

D.8: Budget Resources for NCTSN Activities

Resources were included in our project budget for participation of at least 3 staff in NCTSN "All Network" annual grantee meetings, consultation with NCTSN Center TC-JRI, collection and reporting of client and performance data, and participation in cross-site evaluation activities.

SECTION E: PERFORMANCE ASSESSMENT AND DATA

E.1: Overview of the Vermont Child Trauma Collaborative Evaluation

The Vermont Child Health Improvement Program (VCHIP) will conduct the evaluation of the Vermont Child Trauma Collaborative (VCTC) project. VCHIP is a research and quality improvement program based in the Department of Pediatrics in the University of Vermont's (UVM) College of Medicine. VCHIP has extensive experience with developing and obtaining approval for research and/or evaluation protocols through UVM's Institutional Review Board.

The goal of the VCTC evaluation will be to assess the impact of implementation of trauma-focused and trauma-informed treatment and services in Vermont community mental health settings and in youth-serving service systems. More specifically, the objectives of VCHIP's proposed evaluation of the VCTC funded activities in Vermont will:

1) assess the effectiveness of the grant funded activities, as reflected in key process and outcome measures[1];
2) develop and conduct an effective and timely local (Vermont-specific) evaluation that characterizes the successes and challenges of the implementation of the VCTC;
3) provide all required study components for the cross-site evaluation; and
4) communicate the evaluation findings to the VCTC team to guide project implementation and inform plans for sustainability.

E.2: Development & Implementation of the VCTC Evaluation

VCHIP's evaluation of the VCTC project will be designed to meet all the criteria set forth in the SAMHSA Request for Applications (SM-09-017). In addition to designing and implementing the national evaluation components (see below), VCHIP will work with partners, including DMH, to develop and conduct an effective and timely local (Vermont-specific) evaluation that characterizes the successes and challenges of the implementation of the VCTC. Consistent with the guidelines contained in the SAMHSA solicitation, the VCHIP evaluation will be based on a range of factors including:

- use of a broad array of indicators/measures

[1] Required measures include the following National Outcome Measures (NOMs): mental illness symptomology; school attendance; criminal justice involvement; stability in housing; social support/social connectedness; and number of children/adolescents receiving trauma-informed services (i.e. number of children/adolescents served by age, gender, race, and ethnicity).

- use of multiple data sources
- a focus on key process and outcome measures, including a formative evaluation related to local consensus building
- use of qualitative and quantitative evaluation approaches
- assessing the impact of DMH's evidence-based interventions

In addition to the instruments used for the national evaluation, the VCTC local evaluation will incorporate the following tools (see Appendix 2 for instrument samples):

- *Parenting Stress Index (PSI)* for ages 0 to 12 or the *Stress Index for Parents of Adolescents (SIPA)* for ages 11 to 19. These instruments are designed for the early identification of parenting and family characteristics that fail to promote normative development and functioning in children or adolescents, children or adolescents with behavioral and emotional problems, and parents who are at risk for dysfunctional parenting.
- *Trauma Symptom Checklist for Children (TSCC)* for ages 8 to 16 or the *Trauma Symptom Checklist for Young Children (TSCYC)*, which is standardized for ages 3 to 12. These surveys assess post traumatic stress in children who have experienced traumatic events such as physical or sexual abuse, major loss, natural disaster, or violence. The survey administered will be chosen by the clinician based on the developmental age of the child.
- The *UCLA PTSD Reaction Index (UCLA PTSDRI)* will be used by the clinician to assess post-traumatic stress reactions among children and adolescents aged 7 to 12 years old.
- The *Achenbach System of Empirically Based Assessment Child Behavior Checklist (ASEBA CBCL)* has two versions: one for ages 1 ½ to 5 and one for ages 6 to 18. The tool offers a comprehensive approach to assessing adaptive and maladaptive functioning for children. The parent/caregiver who spends the most time with the child will complete the survey.
- The *ARC Agency Inventory* will be completed as a group project by the individual local agencies. The survey will be administered at the start of the VCTC in order to collect baseline data and again at the end of the 3-year project.
- *Trauma Center at Justice Resource Institute Pre-Training Questionnaire* was administered to clinicians at the beginning of the current Vermont ARC project and will be completed by clinicians annually, including at the outset of the VCTC.

Data will be used to generate reports and feedback to the DMH team to improve dissemination, training, implementation, and provision of trauma-informed interventions for children and adolescents in Vermont who have experienced traumatic events (see below). An additional component of the VCHIP evaluation will be to evaluate and support the processes by which communities develop consensus around implementing trauma-informed systems of care. VCHIP will also produce quarterly and annual evaluation reports that document local program outcomes as well as the progress towards meeting proposed goals and objectives, as well as preparing a comprehensive evaluation report at the end of the project period.

E.3: Participation in the National and State level Evaluations

VCHIP will participate in all aspects in the NCTSI Cross-site Evaluation. The Vermont components of the evaluation will be communicated to the national evaluation team per the requirements set forth in the call for proposals. VCHIP will also ensure that the Core Data Set

(CDS) prescribed demographic and basic background information on all children receiving services are submitted in a timely and complete manner to the national evaluation contractor. CDS information will initially be submitted at or near the time the child begins receiving services and subsequently at three month intervals or at the conclusion of treatment, should the treatment be less than three months.

As a result of existing evaluation contracts for SAMHSA funded projects, VCHIP staff have received training on the Transformation Accountability System (TRAC) data system and will be well positioned to collect, enter and submit data into the system in an accurate and timely manner. VCHIP will ensure that data, including demographic and basic background information on all children receiving services, are entered into the Core Data Set (CDS) by direct clinical service providers and submitted in a timely fashion. In cases where the clinicians don't have access to necessary data, VCHIP will support collection and transmission of the information by using a combination of DMH and/or DCF data sources. VCHIP will also assist partners in planning for education of clinicians on the clinical utility of the CDS in clinical decision making and treatment planning.

VCHIP is committed to providing SAMHSA, the National Center for Child Traumatic Stress (NCCTS), and the Cross-Site Evaluation contractor with data that will allow for assessing progress towards the following NCTSI goals:

1. Increase the number of children and adolescents receiving trauma-informed services
2. Improve children's outcomes
3. Increase the percentage of child-serving professionals who report implementing trauma-informed practices and services after receiving training

VCHIP will also report the following data in quarterly and final report(s) using NCTSI data collection instruments:

4. Number of children/adolescents reached by effective, trauma-informed treatment and services
5. Children's outcomes, such as increased number of children/adolescents receiving services that show improved scores in various domains that measure psychosocial well-being and quality of life (e.g. interpersonal relationships, school performance) as assessed by standardized assessment tools
6. Systems transformation outcomes, such as implementation and adaptation, and/or increased utilization, of effective trauma-informed treatment and services by local and/or State service system(s) and/or by specific service settings (e.g., schools, child welfare).

Additionally, VCHIP evaluation staff will attend the annual NCTSN "All Network" grantee meeting, and will collaborate on cross-Network working groups, present the results of their projects and discuss project requirements with federal and national evaluation staff.

VCHIP will develop - and gain - UVM Institutional Review Board (IRB) approval for the VCTC project evaluation prior to any participants being enrolled. At the start of the project, the VCHIP team will begin to develop an IRB protocol that accurately and completely reflects the project evaluation activities. VCHIP will make any and all changes to the protocol required by the UVM IRB. 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.

E.4: Data Collection Procedures and Quality Improvement Activities

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, monitoring the implementation of the project interventions and supporting submission of data from clinicians or designated personnel to VCHIP. CDS submission monitoring will be performed by VCHIP to ensure timely and accurate submission. Tracking of data submission, both by the local agencies and by VCHIP will be fostered by establishing an MS Access database that includes prompts (reminders) that are generated monthly and allow for running reports on all data collection and submission activities. This database will provide the summary reports that will also form the basis of the Quarterly and Annual Evaluation reports. Also, each month, VCHIP will send an MS Excel reporting template to the local agencies asking them to provide basic information about newly enrolled service recipients, and will include fields for submission of the CDS, NOMs and other national and local evaluation data.

Data from the MS Access database will be examined on a monthly basis regarding key process (e.g. number of new cases enrolled in trauma-informed services, number of cases for which CDS data were transmitted, timeliness of collection of CBCLs, etc) and clinical (e.g., individual and aggregated scores for children's TSCCs or TSCYCs, CBCL data and CDS information). These data will be the key indicators for the project's quality improvement activities, and serve as the basis for monthly communications between the evaluators and the local agencies (by phone, email or in person) in which the data are reviewed and barriers to timely and thorough data collection are reviewed and solutions can be explored. These monthly data reports will also be shared with the state level VCTC team and training staff in order to support their continued efforts to track and provide feedback on the specific clinical interventions that are being provided.

VCHIP will support local agencies in the collection, scoring and submission of data for all assessment tools. Especially in the first year of the project, data collection by VCHIP will adopt a flexible approach that allows local mental health agencies to collect and transmit their case-level data using the approach that works best for the agency. For example, it will be possible for local agencies to obtain CBCL data either using paper forms or electronically, and if the agency does not have the capacity for scoring CBCLs, VCHIP will score the forms and generate cross informant reports (if applicable), and then return the scored data to the agency. Over the course of the first year of the VCTC project, the VCHIP evaluator will conduct site visits with each agency to assist them in developing their local data collection and submission procedures, towards the goal of the local agencies becoming as self-sufficient as possible in their local data systems. Data submission of the CDS and other elements of the national evaluation, however, will continue to be submitted to the national evaluation contractor by VCHIP.

Logic Model for Vermont Child Trauma Collaborative

Inputs/Resources	Activities	Short Term Outcomes		Medium and Long Term Outcomes
		State Level	*Local Level*	
Funding from SAMHSA NCTSI CMHC and Private Practice infrastructure for clinical treatment services Consensus-building and planning by Child Trauma Workgroup re: Trauma-Informed Care and ARC Existing CMHC ARC Teams Trainers from TC-JRI Trauma assessment tools, CBCLs and scoring software Completed trainings for providers re: trauma-informed care and ARC Framework DMH Management Information System Vermont Connecting Cultures Program NCTSN Resources	Establish the Vermont Child Trauma Collaborative (VCTC) infrastructure Form a trauma-informed interagency referral network Existing ARC Teams receive consultation/training on standardized trauma assessment and empirically-based ARC treatment Develop the state's trauma consultation and training capacity Participate in NCTSN Implement systematic data collection, evaluation and Quality Improvement (QI) processes Cultural modifications to ARC model for serving refugee communities in two Vermont counties (Year 3)	A trauma informed inter-agency referral network structure is established State ARC Consultation Team is formed A Trauma-Informed Care Train the Trainer curriculum is developed and implemented	Local Advisory Committees implement trauma-informed referral network Community treatment provider ARC Teams fully trained and implementing all components of ARC in service delivery ARC model is adapted to fit the local community's characteristics Chittenden and Washington County ARC Teams competent to provide culturally adapted ARC services to refugee communities (year 3) Each ARC Team has an ARC Lead Supervisor/Trainer Each community has Trauma-Informed Care Trainers Local child-serving agencies/programs receive Trauma-Informed Care training/consultation	Increased number of children with complex trauma identified Increased number of children who have experienced trauma receiving trauma informed care Increased referrals of children/families for trauma-informed trauma treatment Increase the positive outcomes for trauma exposed children/families to include: • reduction of child trauma - related symptoms; • increased child competency; • reduction of caregiver parenting stress; and • reduction in psychiatric hospitalization and long term residential services. Refugee communities in 2 counties will have access to culturally competent trauma informed assessment and treatment.

SECTION F: LITERATURE CITATIONS

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Section G: Budget/Budget Justification/Calculation of Future Budgets

Year One Budget

Personnel					
Job Title	Name	Annual Salary	Level of Effort (FTE)	Salary Requested	
Principle Investigator	Charlie Biss	$ 89,336	0.05 (inkind)	$ -	
Project Co-Director	Laurel Omland	$ 50,752	0.5 (inkind)	$ -	
Administrative Assistant	to be hired	$ 37,124	0.5	$ 18,562.00	
Total Personnel					**$ 18,562.00**
Fringe Benefits (30%)				$ 5,568.60	
Total Fringe					**$ 5,568.60**
Travel					
1 Trip for SAMHSA Meetings for 3 attendees:					
Airfare ($600/person x 3 people x 1 trips/year)				$ 1,800.00	
Lodging ($200/person x 3 people x 3 nights				$ 1,800.00	
Per Diem - Meals ($75/day X 3 attendees X 3 days)				$ 675.00	
Total Travel					**$ 4,275.00**
Equipment					
Computer for contractual Project Co-Director				$ 2,230.00	
Total Equipment					**$ 2,230.00**
Supplies					
Production of Training/Educational Materials; Purchase Assessment Instruments				$ 3,000.00	
Total Supplies					**$ 3,000.00**
Contractual					
Project Co-Director					
Job Title	Name	Annual Salary	Level of Effort (FTE)	Salary Requested	
Project Co-Director	To be hired	$ 60,000	0.5	$ 30,000.00	
Expenses (Phone and Travel @ 6000 miles X .55/mile)				$ 3,800.00	
Project Director Subtotal				$ 33,800.00	

Evaluation - Vermont Children's Health Improvement Program (VCHIP)					
Job Title	Name	Annual Salary	Level of Effort (FTE)	Salary Requested	
Principle Evaluator	Tom Delaney	$ 64,539	0.05	$ 3,226.95	
Evaluator	Alison Howe	$ 54,609	0.6	$ 32,765.40	
Admin. Assistant	to be hired	$ 40,766	0.05	$ 2,038.30	
Fringe (41.0%)				$ 15,592.57	
Operating (telephone, printing, postage, supplies, travel)				$ 7,962.00	
VCHIP Direct				$ 61,585.22	
VCHIP Indirect (29.9%)				$ 18,413.98	
VCHIP Subtotal				$ 79,999.20	
Training - Trauma Center at JRI (TC-JRI)					
Job Title	Name	Annual Salary	Level of Effort (FTE)	Salary Requested	
Lead ARC Trainer	Margaret Blaustein	$ 100,000	0.15	$ 15,000.00	
Fringe (32.0%)				$ 4,800.00	
Travel/Lodging/Per Diem				$ 2,277.00	
Additional Training/Consultation ($2000/day X 7.75 Days)				$ 15,500.00	
TC-JRI Direct - Subtotal				$ 37,577.00	
TC-JRI Indirect (9 %)				$ 3,381.93	
TC-JRI Subtotal				$ 40,958.93	
Contractual Subtotal					**$ 154,758.13**
Other					
Incentive Service Grants to VCTC Treatment Agencies				$ 180,000.00	
($15,000/Agency X 12 Agencies)					
Subgrants to WCMH, HC and NECTC for Participation on				$ 10,000.00	
VCTC State Consultation Team					
Instate Meeting/Training Expenses (room rental, AV)				$ 7,800.00	
(6 meetings X $1300/meeting)					
Stipends/Mileage for Consumer/Family Participation at meetings				$ 3,200.00	
($100/meeting X 8 meetings X 4 consumer/family members)					
Other Subtotal					**$ 201,000.00**
TOTALS - Direct					**$ 389,393.73**
Indirect					**$ 10,606.16**
TOTAL					**$ 399,999.89**

BUDGET JUSTIFICATION

PERSONNEL

Charlie A. Biss, MSW, Principal Investigator (.05 FTE - inkind): Mr. Biss is the Child, Adolescent, and Family Unit Director in the Vermont Department of Mental Health and will be the PI for this project. He has 36 years of Human Services experience as a clinician, local program developer, and a state level implementer of systems of care. As Project Director and/or Principal Investigator, he has secured and overseen many public and private grants to develop and sustain statewide systems of care for very young children, school age children, and transition-aged young adults. Mr. Biss has extensive experience working with the State and Local Interagency Teams (SIT and LITs), CMHC Children's Mental Health Directors, other state agencies (e.g. DCF, DOE) and community advocates (e.g. Federation of Families for Children's Mental Health).

Laurel Omland, MS, NCC, Project Co-Director (.5 FTE - inkind): Ms. Omland is the Clinical Care/ Trauma Coordinator in the Child, Adolescent and Family Unit in the Vermont Department of Mental Health. She will act as the Project Co-Director and be responsible for coordinating grant activities. Laurel is a member of the Child Trauma Workgroup and oversees the current DMH "Vermont ARC Project" of training/ consultation with the Trauma Center at JRI. She developed the DMH Trauma Policy and DMH plan for building trauma-informed mental health services in the public system. As a Nationally Certified Counselor, Laurel has provided clinical services, trainings, and consultation in children's mental health for over 8 years in a variety of settings and is skilled at working with State and local partners in the children's System of Care.

Administrative Assistant (.5 FTE – to be hired)*:* The Administrative Assistant will support the project activities. Their duties will include: work in preparing documents and mailings, assisting in the planning for meetings and training events and designing informational documents. Approximately 15% of the Administrative Assistant's time will be devoted to supporting infrastructure development (e.g. support to develop partnerships with other services providers).

FRINGE BENEFITS

The actual cost of fringe benefits (not a fringe benefit rate) will be reported as a direct cost of the program. The actual cost of fringe benefits varies from employee to employee based on salary, employee choice of health care plan, and employee election of certain other benefits. The usual, major components of this cost are FICA at 7.65% of salary, retirement at 9% of salary, and a portion – 80% for medical, 75% for life and 100% for dental - of the actual costs of the medical, dental and life insurance coverage selected by the employee. The cost of each employee's fringe benefits will be allocated to the program based on hours worked in the program relative to all hours worked by the employee. Based on the current cost of fringe benefits for employees in similar programs, we are estimating the cost of these fringe benefits at 30% of salary.

TRAVEL

SAMHSA Funds will be used to cover the costs of three grant participants (Project Director, Grant Evaluator, and a youth/family representative) to attend yearly SAMHSA grantee meetings. It is estimated that approximately 20% of the grant meeting will be devoted to infrastructural development.

EQUIPMENT

Funds will be used to lease a laptop computer for the Project Co-director who will be hired contractually through the grant (see below). This laptop will be used in the management and tracking of grant activities. This line item cost will be considered 100% infrastructural development.

SUPPLIES

Funds will be used to create, purchase and duplicate training and educational materials (e.g. treatment manuals, DVD's) re: evidence-based trauma treatment. Funds will also be used to purchase trauma assessment tools to be used by treatment providers participating in the grant initiative. This line item will focus 100% on the support of service delivery.

CONTRACTUAL COSTS

Project Co-Director (.5 FTE – to be hired): A Project Co-Director will be hired upon award of this grant. The Project Co-Director will share management and oversight of grant activities with Ms. Omland (see above). DMH has several highly qualified individuals from the provider system as candidates for this position, with extensive clinical, supervisory, and training/consultation experience with trauma treatment, the ARC Model, and trauma-informed service delivery. It is estimated that 30% of the project co-directors time will be devoted to infrastructure development.

The Vermont Child Health Improvement Program (VCHIP): VCHIP will conduct the evaluation of the VCTC project. Founded in 1999, VCHIP is a research and quality improvement organization based in the Department of Pediatrics of the University of Vermont (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. VCHIP has considerable resources relating to the collection, analysis and reporting of quantitative and qualitative data. VCHIP will obtain UVM Institutional Review Board (IRB) approval for all VCTC evaluation activities. *Thomas V, Delaney, PhD,* will act as the Evaluation Principle Investigator (.05 FTE) and will oversee all evaluation activities for the project. Dr. Delaney is a Research Analyst at VCHIP. Dr. Delaney specializes in the evaluation of quality improvement and applied research projects in healthcare and mental health systems. He has been the lead evaluator on several statewide evaluations in Vermont, including the Vermont Blueprint for Health, The Children's Mental Health Initiative and the Vermont Suicide Prevention Project. *Alison K. Howe, M.S.,* will act at the grant Evaluator (.60) and will oversee the

data collection and management activities. Alison Howe is a Program Evaluator at VCHIP and is responsible for overseeing research and data collection activities, developing and implementing summative and process evaluation procedures, analyzing data and presenting results for several health care quality improvement projects aimed at improving the quality of health care for Vermont children. 100% of this line item will be devoted to evaluation activities.

The Trauma Center at JRI (TC-JRI*):* The TC-JRI will provide training and consultation to support grant objectives. TC-FRI has a 27-year history of national and international training in understanding and treating traumatic stress. The TC trains over 5,000 service providers per year through workshops, seminars, and an academic-year certificate program in Traumatic Stress Studies. *Margaret Blaustein, PhD*, will be the primary NCTSN Category III Center consultant/trainer (.15 FTE) for this project. Ms. Blaustien is the Director of Training and Education at The Trauma Center at Justice Resource Institute (TC-JRI). Dr. Blaustein is co-developer, with Kristine Kinniburgh, of the ARC Framework and has published and provided consultation and training on the assessment and treatment of complex trauma in children and adolescents. Together, they are currently responsible for overseeing comprehensive ARC training and adaptation initiatives at over 20 agencies the country. 100% of activities under this line item will be devoted to supporting service delivery.

As Vermont develops instate capacity to provide training and consultation, this amount will decrease in Year two and three.

OTHER

Incentive Service Grants: Incentive Service Grants will be offered to support service provision, training/consultation, and data and evaluation activities at each community-based treatment center that will be participating in the Vermont Child Trauma Collaborative. Incentive dollars will be connected to achievement of identified benchmarks of fidelity to ARC implementation, as follows:

- Participation in monthly ARC consultations with TC-JRI
- Participation in monthly internal agency ARC Team meetings focused on implementation and clinical application of model
- Administration of ARC Assessment with clients
- Administration of identified trauma instruments with clients
- Development of treatment plan using ARC's 3 Domains and 10 Building Blocks
- Provision of clinical treatment services
- Use of data and clinical profiles to inform treatment planning and service provision
- Quarterly re-assessment of clients

VCTC will require that each treatment center receiving an Incentive Service Grant use no more than 15% of funds towards infrastructure development.

Subgrants to WCMH, HC, and NECTC for Participation on VCTC State Consultation Team: Grants funds will be used to reimburse Washington County Mental

Health (WCMH, the HowardCenter (HC), and the New England Counseling and Trauma Center (NECTC) for staff participation on the VCTC State Consultation Team. The Consultation Team will develop the Trauma-Informed Care (TIC) Training-of-Trainers curriculum, conduct the TIC Trainer Series, and offer on-going support/consultation to the trainers. As Vermont develops instate capacity to provide training and consultation, this amount will increase in Year two and three. 10% of activities under this line item will be devoted to infrastructural development.

Instate Meeting/Training Expense: Funds will be used to cover the cost of planning meetings to support oversight and management of the grant initiative and training events focused on trauma-informed care. Funds will cover the cost of the meeting space and audio/visual equipment. This amount will increase in Year Three to fund: 1) additional expenses regarding the adaptation of ARC for refugee populations and 2) additional expenses to support VCTC involvement in NCTSN training and networking activities. Approximately 30% of instate meeting/training expenses will be devoted to infrastructure development.

Stipends/Mileage: Stipends ($50 per meeting) and reimbursement for mileage ($50 per meeting) will be provided to designated consumer/youth and family members who participate in the grant planning and oversight meetings. Approximately 60% of activities funded through this line item (e.g. youth/family participating in planning meetings) will focus on infrastructure development.

INDIRECT COST RATE

The Vermont Department of Mental Health uses a Cost Allocation Plan, not an Indirect Rate. This Cost Allocation Plan was approved by the U.S. Department of Health and Human Services effective October 1, 1987 and is available at http://humanservices.vermont.gov/departments/office-of-the-secretary/cost-allocation-plan. The Cost Allocation Plan summarizes and allocates actual, allowable costs incurred in the operation of the program. These costs include items often shown as direct costs, such as telephone and general office supply expenses, as well as items usually included in an indirect rate, such as the cost of office space and administrative salaries. These costs are allocated to the program based on the subgrants paid in the program relative to the total subgrants paid in the department overall. Because these are actual costs, unlike an Indirect Cost Rate, these costs will vary from quarter to quarter and cannot be fixed as a percentage of program costs.

EXISTING SUPPORT

Every VCTC site has an existing infrastructure of clinical, supervisory and support staff, building facilities, administration, Medicaid billing, IT hardware and support, etc. Other existing resources that will be mobilized for this project include the availability of the State web- and phone- conferencing systems. These technologies will be used for the distance learning activities to provide trainings, consultations and meetings with all regions of the state without unduly impacting the VCTC sites limited resources (reducing

staff travel time and costs). The DMH website will host a page on Child Trauma and the efforts of the VCTC. Additionally, Listservs supported by DMH will be established to connect all participating individuals and agencies for discussions on implementation efforts, upcoming events and trainings, and other important information.

FUNDING LIMITATIONS

Evaluation: No more than 20% of the total grant award will be used for data collection and performance assessment, including incentives for participating in required data collection. In each year of the grant, $ 79,999.20 will be used to contract with VCHIP to complete evaluation activities.

Infrastructure Development: No more than 15% of the grant will be used for infrastructure development. The majority of services and activities completed by project staff will be devoted to the support of service delivery. A description of how budget line items will be devoted partially or fully toward infrastructure development is included in the budget narrative (see above). The total amount of funds devoted to infrastructure development in Year One is as follows:

Line Item	Total Line Item Expense	Percentage of Line Item Devoted to Infrastructure Development	Total $ devoted to Infrastructure Development
Adminstrative Assistant (salary + Fringe)	$ 24,130.60	15%	$ 3,619.59
Travel	$ 4,275.00	20%	$ 855.00
Equipment	$ 2,230.00	100%	$ 2,230.00
Supplies	$ 3,000.00	0%	$ -
Project Co-Director	$ 33,800.00	30%	$ 10,140.00
VCHIP	$ 79,999.20	0%	$ -
Trauma Center at JRI	$ 40,958.93	0%	$ -
Incentive Service Grants	$ 180,000.00	15%	$ 27,000.00
Subgrants to WCMH, HC, NECTC	$ 10,000.00	10%	$ 1,000.00
Meeting/Training Expenses	$ 7,800.00	30%	$ 2,340.00
Stipends/Mileage	$ 3,200.00	60%	$ 1,920.00
Indirect	$ 10,606.16	100%	$ 10,606.16
Total			**$ 59,710.75**

$59,710.75 (14.9%) of the total grant funds will be used for infrastructure development.

Calculation of Future Budget Periods			
National Child Traumatic Stress Initiative CTS Centers - RFA #: SM-09017			
Personnel	First 12-month Period	Second 12- month Period	Third 12-month Period
Charlie Biss (inkind)	$ -	0	0
Laurel Omland (inkind)	$ -	$ -	$ -
Administrative Assistant (assumes 2% raise in Year II and III)	$ 18,562.00	$ 18,933.24	$ 19,311.90
Fringe Benefits (30%)	$ 5,568.60	$ 5,679.97	$ 5,793.57
Travel			
(1 Trip for SAMHSA meetings for 3 attendees)	$ 4,275.00	$ 4,275.00	$ 4,275.00
Equipment			
Computer for Project Co-Director	$ 2,230.00	$ -	$ -
Supplies			
Production of Training/Educational Materials	$ 3,000.00	$ 3,000.00	$ 3,000.00
Contractual			
Project Director (assumes 2% raise in Year II and III)	$ 33,800.00	$ 34,476.00	$ 35,165.52
Evaluation - VCHIP	$ 79,999.20	$ 79,999.20	$ 79,999.20
Training - Trauma Center at JRI (TC-JRI)	$ 40,958.93	$ 31,085.00	$ 20,452.00
Other			
Incentive Service Grants to Treatment Agencies ($15,000/Agency X 12 Agencies)	$ 180,000.00	$ 180,000.00	$ 180,000.00
Subgrants to WCMH, HC and NECTC for Participation on VCTC State Consultation Team	$ 10,000.00	$ 20,000.00	$ 25,000.00
Instate Meeting/Training Expenses	$ 7,800.00	$ 7,800.00	$ 13,100.00
Stipends/Mileage for Consumer/Family Participation at meetings	$ 3,200.00	$ 3,200.00	$ 3,200.00
TOTALS - Direct	**$ 389,393.73**	**$ 388,448.41**	**$ 389,297.20**
Indirect	**$ 10,606.16**	**$ 10,606.16**	**$ 10,606.16**
TOTAL	**$ 399,999.89**	**$ 399,054.57**	**$ 399,903.36**

CHARLES A. BISS

EMPLOYMENT HISTORY

1987 – Present 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 that:

- Serves 11,000 children a year
- Manages a budget of $80 million per year
- Directs a workforce of 800 FTE's employed by 11 designated non-profit providers agencies
- Develops, implements and sustains several grants, both federal and private
  - Robert Wood Johnson
  - 3 Federal Community Mental Health Services Comprehensive Grants-Children's Upstream Services, Access, Youth Transitioning to Adulthood
  - 3 Respite Grants
  - Suicide prevention grant
- 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 Psychotropic Consult Service
- Works collaboratively with all child servicing and youth adult servicing 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. 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.

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.

1982-1987 Developed and implement 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 who were at imminent risk of being removed from home/community.

Other Employment/Consultation

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***

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*

1999 – 2004 Peer Mentor Technical Assistance Partnership, Washington DC

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

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.
- Applications of the public Health model within Mental Health

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

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

HONORS AND AWARDS

1992 The First Vermont Family Service Award, Alliance for the Mentally Ill of Vermont: For pioneering efforts in family education and steadfast support of the family movement.

1983 Special Merit Award, Vermont Association of Mental Health: Recognition of contribution to the growth of the support-group concept in Vermont.

LAUREL E. STONE OMLAND

EDUCATION

Master of Science degree, Clinical Mental Health Counseling, 60 credit hours. 02/2001.
College of Education, University of Vermont, Burlington, Vermont. CACREP accredited.
Bachelor of Arts degree, Psychology, *cum laude*. 05/1993.
Bates College, Lewiston, Maine. Member *Sigma Xi*, 1993.

CREDENTIALS

License-eligible as Licensed Clinical Mental Health Counselor (LCMHC).
National Certified Counselor (NCC), National Board for Certified Counselors, since 2001.
Senior Instructor in Life Space Crisis Intervention (LSCI). 2004.
Certified Basic Instructor for Nonviolent Crisis Intervention, Crisis Prevention Institute 2004

PROFESSIONAL EXPERIENCE

Clinical Care/ Trauma Coordinator, Vermont Department of Mental Health, Child, Adolescent and Family Unit, Burlington, Vermont 05/13/2005 – present.

- Assure access to and utilization of intensive behavioral health care components and funding resources for children and families
- Technical assistance with community mental health system to increase effective community-based services, reduce use of residential and psychiatric hospitalization as clinically appropriate
- Planning and support to increase use of empirically-based treatment services in public mental health system for children
- Develop DMH Trauma Policy and plan for building a trauma-informed mental health service system
- Interagency collaboration at State and community levels to address needs of children and families

Clinical Coordinator, Children and Family Services, Lamoille County Mental Health Services, Inc. Morrisville, Vermont. 07/21/2003 – 05/12/2005.

- Clinical oversight of community-based mental health services for children & adolescents with mental, emotional and behavioral disturbances and their families.
- Coordination and collaboration with education, Department of Children & Families – Family Services, and other human service agencies through interagency meetings including Act 264, Local Interagency Team (LIT), and Coordinated Service Plan meetings
- Liaison with Department of Mental Health regarding community-based services, Medicaid Waivers and Individualized Service Budgets, LIT/SIT referrals, residential and inpatient placements.
- Program evaluation involving outcome & data reporting; program development.
- Conduct assessment, treatment planning, individual, group and family counseling, and crisis intervention as needed.

Program Director, Mid-Atlantic Key Program, Inc, Rockville, Maryland. 2/1/2001-6/30/2003.

- Community-based intensive intervention program for youth referred by Department of Juvenile Justice and their families, funded by federal Juvenile Accountability Incentive Block Grant.

- Conducted hiring, training, and performance evaluation of Bachelor-level caseworkers.
- Performed individual and family counseling, youth and parent groups, crisis intervention, court advocacy, educational support, referrals to community resources, recreational activities.
- Wrote program policies and procedures; monitored Quality Assurance, budget expenditures.
- Submitted monthly, quarterly, and annual data and qualitative reports to grant Program Monitor.

Instructor, Diagnosis in Counseling, Johns Hopkins University, School of Professional Studies in Business and Education, Graduate Division of Education, Counseling and Human Services. Fall 2002.

- Developed curriculum of instruction for graduate course utilizing variety of media
- Assessed students in conducting client interview, assessment, clinical diagnosis utilizing DSM-IV-TR, clinical reports, diagnosis-congruent culturally competent treatment plans.

Intern Clinician, Counseling Service of Addison County, Middlebury, VT. 2/2000-11/2000.

- Provided clinical outpatient individual, family, group counseling for adults and adolescents.

Intern Clinician, Continuum Program of Brattleboro Retreat, Essex Jct., VT. 09/1999-02/2000.

- Provided partial hospitalization and intensive outpatient treatment for adult women and adolescents utilizing Dialectical Behavioral Therapy; co-led skill-building, expressive, supportive-eating groups

Team Leader/ Assistant Group Leader, Idaho Youth Ranch, Rupert, Idaho. 12/1997-08/1998.

- Trained, supervised, evaluated Youth Counselors in treatment of adjudicated female adolescents utilizing Positive Peer Culture orientation in residential milieu setting.
- Facilitated group, individual and family counseling, skills training, educational support, experiential adventure-based learning, recreational and community service activities.
- Provided CPI© crisis intervention including nonviolent physical control techniques.

AFFILIATIONS

American Counseling Association (ACA), member since 1999.

PRESENTATIONS AND PUBLICATIONS

- "***Trauma-Informed Care***" conference for Vermont's System of Care for Children, Burnette, S., Joyal, M., and Omland, L. 2008
- "***Trauma Matters: Trauma-informed services, impact of trauma on adults and children, and vicarious trauma***" training for Vermont Department of Health, Children With Special Needs Program staff (2008), Burnette, S. and Omland, L.
- ***Blueprint for Action: Building Trauma-Informed Mental Health Service Systems: State Accomplishments, Activities & Resources.*** (2007). Burnette, S., Omland, L., & Philibert, D. http://healthvermont.gov/mh/documents/SAMHSAVTREPORT07.pdf
- ***Women participants in research: Assessing progress.*** (1994). K.G. Low, Ph.D., M.R. Joliceour, R.A. Colman, L.E. Stone, C.L. Fleisher. Women's Health V.22 No. 1.
- ***Smokeless tobacco cessation in college students: A pilot study.*** (1994). L.E. Stone, K.G. Low, Ph.D. Annals of Behavioral Medicine: Supplement. Presented in poster session at the Society of Behavioral Medicine Meeting, Boston, MA. 1994.

Vermont Child Trauma Collaborative

Project Co-Director

Description of Duties and Responsibilities

- Convene VCTC State Advisory Committee: delineate roles and responsibilities; establish quarterly schedule of meetings; recruit youth/ family representatives.
- Collaborate with NCTSN Center, The Trauma Center at JRI, for consultation and training on ARC Framework.
- Oversee development of local ARC community treatment and services Teams
- Oversee development of VCTC Local Advisory Committees
- Convene VCTC Consultation Team and oversee activities
- Oversee and support implementation, service delivery, evaluation, and adaptation of ARC throughout 12 VCTC sites.
- Communicate with VCTC State Advisory Committee regarding progress of grant implementation
- Organize training in use of referral protocols, screening assessments, interview protocols, data collection
- Oversee allocation of grant budget
- Complete timely grant reporting in consultation with the grant evaluator
- Communicate with NCTSN regarding lessons learned, project outcomes and strategies for further development of the NCTSN.
- Submit quarterly and annual progress reports to SAMHSA
- Communicate with Department of Mental Health.
- In Year three, oversee VCTC Consultation Team adaptations to the ARC model to meet the needs of minority and refugee populations.

Qualifications

Education: Master's degree in Mental Health field

Experience: Experience in program development and administration of trauma treatment services
At least 5 years experience providing clinical services to individuals and families who have experienced trauma.
Experience providing supervision to clinicians providing trauma treatment
Training and consultation expertise
Knowledge of ARC Framework (preferred)

Personal Qualities

- Ability to develop positive interpersonal relationships with peers, supervisees, supervisors, and clients.
- Excellent communication skills both verbally and in writing
- Strong initiative to promote an effective and efficient work site
- Strong judgment both clinically and administratively to ensure effective decision-making.

Amount of Travel

- Travel required for all trainings, meetings, and consultation and training for future sites.

Salary Requested and Time

$30,000 (0.5 FTE)

MARGARET E. BLAUSTEIN, Ph.D.

EDUCATION

1999 Ph.D. University of Miami (Clinical Psychology), *Award of Academic Merit*
Doctoral Dissertation: Individual Differences in Posttraumatic Symptoms Following Childhood Maltreatment. *Dr. Carol Alson-Fineman Dissertation Award, Research Dealing with Child Abuse/Neglec*

1997 M.S. University of Miami (Clinical Psychology), *Award of Academic Merit University Fellowship Recipient; Seven Departmental Commendations*

1994 B.A. Bryn Mawr College (Psychology), *Magna Cum Laude, Psychology Department Honors Graduate*

REPRESENTATIVE PROFESSIONAL POSITIONS

1998-1999 Predoctoral Intern, Children's Hospital/Harvard Medical School, Boston, MA

1999-2000 Postdoctoral Fellow, Judge Baker Children's Center, Harvard Medical School, Boston, MA

1999-2001 Postdoctoral Fellow, The Trauma Center, Boston, MA

2001-2002 Interim Director of Children's Services, The Trauma Center, Boston, MA

2002-2004 Clinical Training Coordinator, The Trauma Center, Boston, MA

2003-2004 Associate Director of Children's Services., The Trauma Center, Boston, MA

2004- Director of Training and Education, The Trauma Center, Boston, MA

ACADEMIC APPOINTMENTS

1998-2000 Clinical Fellow, Department of Psychiatry, Harvard Medical School

1999- Research Associate, Boston University School of Medicine, Boston, MA

AFFILIATIONS AND PROFESSIONAL MEMBERSHIPS

1993- Member, American Psychological Association

1998- Member, International Society for Traumatic Stress Studies

2001-2006 Chair, Child Trauma Special Interest Group, International Society for Traumatic Stress Studies

2002- Member, Complex Trauma Taskforce, National Child Traumatic Stress Network

2004-2005 Member, Training Committee, National Child Traumatic Stress Network

PUBLICATIONS

Cook, A., Blaustein, M., Spinazzola, J., & van der Kolk, B. (Eds.) (2003). *Complex Trauma in Children and Adolescents.* National Child Traumatic Stress Network www.nctsnet.org

Spinazzola, J., Ford, J., Zucker, M., van der Kolk, B., Silva, S., Smith, S., & Blaustein, M. (2005). National Survey of complex trauma exposure, outcome, and intervention for children and adolescents. Psychiatric Annals, 35(5), 433 - 439.

Cook, A., Spinazzola, J., Ford, J., Lanktree, C., Blaustein, M., Cloitre, M., deRosa, R., Hubbard, R., Kagan, R., Liautaud, J., Mallah, K., Olafson, E., & van der Kolk, B. (2005). Complex trauma in children and adolescents. Psychiatric Annals, 35(5), 390 - 398.

Kinniburgh, K., Blaustein, M., Spinazzola, J., & van der Kolk, B. (2005). Attachment, Self-Regulation, and Competency: A comprehensive intervention framework for children with complex trauma. Psychiatric Annals, 35(5), 424 - 430.

Spinazzola, J., Blaustein, M., & van der Kolk, B. (2005). Posttraumatic stress disorder treatment outcome research: The study of unrepresentative samples? Journal of Traumatic Stress, 18(5), 425 - 436.

Kisiel, C., Blaustein, M., Spinazzola, J., Schmidt, C., Zucker, M., & van der Kolk, B. (2006). Evaluation of a Theater-based Youth Violence Prevention Program for Elementary School Children. Journal of School Violence, 5(2), 19-36.

Cook, A., Spinazzola, J., Ford, J., Lanktree, C., Blaustein, M., Sprague, C., Cloitre, M., deRosa, R., Hubbard, R., Kagan, R., Liautaud, J., Mallah, K., Olafson, E., & van der Kolk, B. (2007). Complex trauma in children and adolescents. Focal Point: Research, Policy, and Practice in Children's Mental Health, 21(1), 4-8.

Walsh, K., Blaustein, M., Grant Knight, W., Spinazzola, J., & van der Kolk, B. (2007). Resiliency factors in the relation between childhood sexual abuse and adulthood sexual assault in college-age women. Journal of Child Sexual Abuse, 16, 1-17.

van der Kolk, B., Spinazzola, J., Blaustein, M., Hopper, J., Hopper, E., & Simpson, W. (2007). A randomized clinical trial of EMDR, fluoxetine, and pill placebo in the treatment of PTSD. Journal of Clinical Psychiatry, 68, 37-46.

Blaustein, M. & Kinniburgh, K. (2007). Intervening beyond the child: The intertwining nature of attachment and trauma. Briefing Paper: Attachment Theory Into Practice. British Psychological Society, Briefing Paper 26, 48-53.

Kisiel, C., Blaustein, M., Fogler, J., Ellis, H., & Saxe, G. (in press). Treating children with traumatic experiences: Understanding and assessing needs and strengths. In J.S. Lyons, D.A. Weiner (Eds.), Strategies in Behavioral Health Care: Total Clinical Outcomes Management and Communimetrics. New York: Civics Research Institute.

Blaustein, M. & Kinniburgh, K. (in press). Treating developmental trauma: Fostering resilience through attachment, self-regulation, and competency. New York: Guilford Press.

REPRESENTATIVE CONFERENCE PRESENTATIONS

Spinazzola, J., Ford, J., van der Kolk, B., Blaustein, M., Brymmer, M., Cook, A., & Silva, S. (2003, October/November). Complex trauma in the National Child Traumatic Stress Network. Paper presented at the 19th Annual Meeting of the International Society for Traumatic Stress Studies, Chicago, IL.

Spinazzola, J., Blaustein, M., Kagan, R., Taylor, N., & Lanktree, C. (2005, March). Complex trauma interventions with elementary and middle-school students: The neglected years. Symposium presented at the Annual Meeting of the National Child Traumatic Stress Network, Washington, D.C., March.

Tishelman, A., Greenwald O'Brien, J., Haney, P., Blaustein, M., & Cole, S. (2006, December). Building trauma sensitive, multi-disciplinary evaluations for schools: A psychological perspective. Workshop presented at the 22nd Annual Meeting of the International Society for Traumatic Stress Studies, Los Angeles, CA.

Lanktree, C., Habib, M., Blaustein, M., & Briere, J. (2009, March). Treatment of complex trauma: Multiple approaches, practical applications, and cultural adaptations. Pre-meeting intensive workshop presented at the 8th All-Network Meeting of the National Child Traumatic Stress Network, Orlando, FL.

Blaustein, M., Brylske, P., Arvidson, J., & Spinazzola, J. (2009, March). Core components of change: Adaptations of a components-based intervention model (ARC) across context and populations. Symposium chaired at the 8th All-Network Meeting of the National Child Traumatic Stress Network, Orlando, FL.

Thomas V. Delaney 40 Village Green, Burlington, VT 05408

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:

1994-1995 President, Rutgers Chapter of Psi Chi (Psychology Honor Society)
1996-2000 Colorado Graduate Fellowship ($20,000)
1999 Graduate Students of the Three Faculties Research Award ($400)
2000 Lawrence Miller Graduate Research Fellowship ($1200)
2001 Elected to Sigma Xi, the National Science Honor Society

Memberships in Professional Societies:

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

Grant/Contract Support:

2005 "Improving Mental Health in Primary Care Project." – The American Academy of Child and Adolescent Psychiatry, **Grant Co-writer** ($25,000)
2007 "Educational Interventions for Preventing Head Injuries in Winter Sports," – The Vermont Health Foundation, **Lead Grant Writer** ($19,000)
2008 "The Vermont Children's Mental Health Initiative," – SAMHSA CMHS SM-08-004, **Grant Co-writer** ($9,000,000)
2008 "Vermont Application for SAMHSA CMHS State/Tribal Youth Suicide Prevention Grant Program" – SAMHSA CMHS SM-08-001, **Grant Co-writer** ($500,000)

Recent Publications in Peer Reviewed Journals

1. 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.
2. 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.
3. 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.
4. 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.
5. Duncan P, Frankowski B, Kallock E, *Delaney T*, Dixon R, Garcia A. Shaw J. Improving Adolescent Preventive Services in Primary Care. Submitted.
6. *Delaney T*, Kallock E, Duncan P, Frankowski B, Shaw J. Beyond Time and Money: Assessing Barriers to Improving the Quality of Adolescent Preventive Service Screening in Primary Care. Submitted.

Recent Presentations at National and International Meetings

1. Mercier C, Berry P, Davis W, *Delaney T*, Horbar J, Paul K, Shaw J, Wasserman R. Quality improvement outreach improves newborn services during the birth hospitalization. (Presented at the Pediatric Academic Societies meeting, Washington, D.C., May 2005)
2. Greenblatt J, Brakeley J, *Delaney T*, Davis W, Shaw J, Wasserman R, Kallock E, Keating K,

Berry P, Albinson E. Primary care providers' adherence to guidelines for care of children with ADHD. (Presented at Pediatric Academic Societies meeting, Washington, D.C., May 2005)

3. *Delaney T*, Nelson E, Keating K, Philibert D, Shaw J. (2005). Pediatric injury prevention counseling: providers' thoughts on how to improve. (Presented at the National Injury Prevention and Control Conference, Denver, May 2005)
4. Greenblatt J, Brakeley J, Boltax R, Davis W, Keating K, *Delaney T*, Shea M, Kallock E. Improving care for school-age children with symptoms of ADHD. (Presented at the National Initiative for Children's Healthcare Quality Annual Forum, San Diego, April 2006)
5. Duncan P, Frankowski B, Carey P, *Delaney T*, Kallock E, Barry S, Wasserman R, Philibert D, Shaw J. Exploring barriers to implementing adolescent preventive service screening in primary care. (Presented at Pediatric Academic Societies meeting, San Francisco, May 2006)
6. 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)
7. 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)
8. Brakeley J, Greenblatt J, *Delaney T*, Kallock E, Davis W, & Shaw J. Improving pediatric primary care for children with symptoms of ADHD. (Presented at American Academy of Pediatrics Division 21 Conference: Connecting for Children's Sake, Washington, D.C., October 2006)
9. *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)
10. 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)
11. 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)
12. 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)
13. Carney J, *Delaney T*, Richardson-Nassif K, Youngberg S. What do they think? Faculty and student knowledge and attitudes regarding public health in the medical curriculum. (Presented at American Association of Medical Colleges meeting, Washington D.C., November 2007)
14. Brakeley J, Greenblatt J, *Delaney T*, Kallock E, Shaw J. Vermont ADHD Initiative: A coordinated, statewide approach to diagnosing and treating children with Attention Deficit/Hyperactivity Disorder. (Presented at American Public Health Association meeting, San Diego, November 2008)
15. Carney J, *Delaney T*, Jemison J. Strengthening the Public Health Workforce: Teaching Population Health in Clinical Settings with Public Health Patient Conversations. (Presented at the American Public Health Association meeting, San Diego, November 2008)

ALISON K. HOWE
417 Locust Hill Dr, Shelburne VT 05482 • alisonkhowe@gmail.com • 802.598.7157

EDUCATION:

The University of Buffalo, School of Medicine, Buffalo, NY
Master of Science in Epidemiology
Thesis: Asthma and Autoimmune Disease Rates in Two Communities in Cheektowaga, NY
Graduation: 2004

The University of Buffalo, College of Arts and Sciences, Buffalo, NY
Bachelor of Science in Anthropology, Medical Anthropology focus
Graduation: 2000

EXPERIENCE:

University of Vermont – Vermont Child Health Improvement Program (VCHIP)
Program Evaluator
1/2009-Present

- Perform community research and data collection activities for multiple quality improvement projects
- Develop research plans and protocols and design quantitative and qualitative data collection instruments
- Implement summative and process evaluation procedures
- Conduct complex data analyses, interpret and present results and co-author reports, grants and manuscripts

Vermont Department of Health – Research, Epidemiology & Evaluation
Senior Epidemiologist
2/2005-1/2009

- Analyzed and monitored health status statistics and evaluate the effectiveness of health policies and programs
- Partnered with asthma, immunization and obesity programs to create state plans, grant applications and progress reports by linking health surveillance data with disease prevention and control programs
- Developed research strategies, survey instruments, analysis plans, and quantitative and qualitative evaluation projects to meet federal grant requirements
- Performed surveillance and epidemiologic study design, implementation and evaluation
- Served as primary data liaison for correspondence with federal agencies funding disease prevention and control grants

The University at Buffalo – Department of Social and Preventive Medicine
Research Assistant
9/2001-1/2005

- Collaborated with researchers in various disciplines, physicians, state Department of Health and Department of Environmental Conservation personnel and community members to analyze point sources of pollution and conduct disease surveillance to study rates of disease and associations between health outcomes and environmental hazards
- Performed independent community participatory research including data analysis and preparation of proposals and summaries for governmental agencies, university committees and community organizations

Computer Skills: SPSS, SAS, SUDAAN, ArcGIS, Microsoft Office

Reports and Evaluations:

Howe, Alison. Vermont Asthma Advisory Panel Partnership Self-Assessment Survey Results.

Howe, Alison. Vermont Asthma Surveillance Plan 2008.

Howe, Alison. Vermont Asthma Data 2007.

Howe, Alison. Chronic Disease in Vermont: Adherence to Adult Immunization Recommendations and Implications for Cardiovascular Disease.

Greene, Carolyn; Howe, Alison. Vermont Obesity & Health Status Report 2006.

Margaret Joval

Work Experience

January, 2003-Current — **Agency of Human Services,** Consultant/Trainer on the effects of Psychological Trauma and Creating Trauma Informed Systems of Care

May, 2001-Current — **Center for Crime Victim Services,** Consultant/Trainer on the effects of Psychological Trauma

August, 2000-Current — **Washington County Mental Health Services,** Director, Center for Counseling and Psychological Services.

November, 1994-August, 2000 — **Washington County Mental Health Services,** Co-director, Outpatient Department.

September, 1998-September, 2000 — **Visiting Nurse Association,** Clinical supervisor for St. Michael's psychology practicum and intern students. Clinical consultant for Visiting Nurse Association staff.

September, 1996-May, 1998 — **St. Michael's College**, Adjunct Faculty. Clinical supervisor for psychology practicum and intern students placed the Visiting Nurse Association in the Infant/Maternal Program.

March, 1989-November, 1994 — **Washington County Mental Health**, Outpatient Psychotherapist.

September, 1988-May, 1989 — **Washington County Mental Health,** Psychology Intern.

Education

Fall, 1986-Spring, 1990 — **St. Michael's College.** Degree: Master of Arts. Area of study: Clinical Psychology.

Fall, 1981-Spring, 1984 — **St. Edward's University.** Bachelor of Liberal Studies, Summa Cum Laude. Major: Psychology.

Fall, 1970-Spring, 1972 — **Webster University**. Status: degree student. Area of Study: Creative Writing, Literature.

Professional Membership

Vermont Psychological Association, Chair, Diversity Committee January, 2009-present
Co-Chair Medicare Committee January, 2008-present
North American Masters Psychologists, member 1993-present
Board Member July,1997-September, 2001
President : 2002-2004
Past President 2004-Current
National Association for Rural Mental Health 1997-present
Vermont Association for Mental Health 1996-present

Allyson G. DeMaggio, MSW, LiCSW
132 Lori Lane
Burlington, Vermont 05408
(802) 399-5374

EDUCATION:

1994, received *LiCSW* in MA
1992, received *LCSW* in MA

1989-1992, **Masters in Social Work**
Boston College Graduate School of Social Work
Chestnut Hill, MA 02167

1984-1988, **Bachelor of Arts in Psychology**
Boston College
Chestnut Hill, MA 02167

EXPERIENCE:

2005-Present
Trauma Coordinator
Howard Center, Burlington, Vermont 05401
*Plan and Implement Trainings in trauma throughout the agency, school systems and the community
*Create, implement and continue to coordinate the STAR Program (Sexual Trauma and Recovery)
*Individual, group and family therapist in the Outpatient Clinic
*Psychosexual Evaluations and Trauma Assessments
*Supervise individual clinicians from a multi-disciplinary team
*Attend and collaborate with treatment teams
*Consultations within the agency and the community regarding sexual trauma and reactive/offending behaviors
*Administrative duties
*Member of various community groups regarding trauma, offending behaviors, attachment disorders and anti-violence

1997-2005
Individual and Family Therapist/Clinical Social Worker/Supervisor
Department of Children and Family Services, St. Albans and Newport, Vermont
Woodside Juvenile Rehabilitation Center, Vermont Intensive Treatment Program for Aggressive Adolescents, Colchester, Vermont 05446
The Baird Center for Children and Families (currently Howard Center) Burlington, Vermont 05401
Otter Creek Counseling Associates, Burlington and Essex, Vermont
*Contracted for victims of sexual abuse: therapy weekly with children, adolescents and families, as well as leading therapy groups for latency and adolescent aged females

*Contracted for family support work for adolescent males living on the residential wing, as well as recording clinical treatments meetings and writing reports
*Contracted for treatment of juvenile sexual offenders: therapy weekly with adolescents who have engaged in sexual offending behaviors and their families/foster families
*Outpatient work in a clinical, community setting (mental health agency) and private practice: play therapy, individual, couples and family therapy
*Supervised social work candidates for their Licenses in Clinical Social Work

1996-1997
Therapeutic Case Manager
Northeastern Family Institute, Williston, Vermont 05495
*Clinical case manager for adolescents and their families: engaged in case planning/management, educational meetings, team meetings, coordination with schools, providers, families etc.

1995-1996
Program Manager
Greentree Boys Home, Lutheran Social Services, Brockton, Massachusetts 02301
*9 bed adolescent male group home for the Department of Social Services: responsible for the administrative, personnel and clinical issues of the program
*Substituted as a Professor on a couple of occasions at Bridgewater State College

1990-1995
Outpatient Therapist/Intensive Therapeutic Family Worker/Protective Case Worker/GoodStart Worker
MA Society for the Prevention of Cruelty to Children, Brockton, Massachusetts 02301
*I was trained in various positions during my employment at MSPCC:
* individual and family outreach therapist with children, adolescents and adults
* worked intensively with families involved with DSS in a 3 month treatment program
*protective case worker when MSPCC was a pass agency for Dept. of Social Services
*GoodStart Program which was a prevention program for children ages 3 and under and their parents who were at risk for being in state's custody

1987-1990
Supervisor/Counselor
NOVA Program, Northeastern Family Institute, Brockton, Massachusetts 02302
*6 bed co-ed adolescent group home for the Department of Mental Health: in supervisory position for my last year with the program – overseeing interns and staff schedule etc., as well as being a counselor in the DMH program

Special Trainings:

In 2001, I participated in a one year training with Dan Hughes, Ph.D, for attachment disorders.
In 2006, I was in a 6-month training for conducting psychosexual evaluations.

Tammy L. Leombruno, M.A., LCMHC

EDUCATION

Master of Arts, Clinical Psychology, December, 1993
Saint Michaels College, Colchester Park, Vermont
Bachelor of Arts, Psychology, May, 1990
Alfred University, Alfred, New York

LICENSURE

Licensed Clinical Mental Health Counselor, State of Vermont, September 1998 – present

WORK EXPERIENCE

The New England Counseling & Trauma Center Williston, VT
November 2005 - present

- Provide individual, family and group therapy, specializing in the assessment and treatment of children with sexual behavior problems and child victims of sexual abuse.
- Provide Psychosexual Evaluation and Trauma Consultations.
- Provide consultation and training to mental health agencies, schools, attorneys, physicians.
- Mental Health representative for the Chittenden Unit for Special Investigations' Multi-disciplinary Team.

The Baird Center for Children & Families Burlington, VT
September 2002 – October 2005
Coordinator of Services for Youth with Sexual Behavior Problems

- Oversight of the STEP Treatment Program for children with sexual behavior problems and the Chittenden County Adolescent Sexual Offender community program.
- Provided psychosexual consultation and evaluation for children aged 5-18 years of age.
- Provided consultation/training regarding children/adolescents with sexual behavior problems.

Stone House Counseling Winooski, VT
August 1996 – October 2005

- Provided individual and family therapy for children and adolescents, specializing in the treatment of sexual abuse.
- Conducted psychosexual consultation and evaluation.
- Provided case consultation to various mental health and state agencies.

The Howard Center for Human Services Burlington, VT
July 2000 – August 2002
STEP Program Co-coordinator

- Coordinated the STEP Treatment Program for children with sexual behavior problems and their caregivers.
- Responsible for client intake and assessment.
- Provided clinical supervision to STEP program staff.
- Provided psychosexual consultation and training to various community agencies.

Adolescent Offender Services Program Co-coordinator

- Coordinated the A.S.O. community treatment program for adolescent sexual offenders.
- Co-facilitated treatment groups for adolescents adjudicated for sexual offenses.
- Acted as liaison to Department of Social Services.

Department of Corrections Waterbury, VT
April 1996 – June 1996; January 1998 – May 2000
Contract Evaluator

- Performed risk assessments for the Department of Corrections utilizing the Hare Psychopathy Checklist – Revised and the Violence Risk Appraisal Guide.

The STEP Program Williston, VT
January 1994 – June 2000
Therapist

- Provided therapeutic groups for children with sexual behavior problems aged six to 12 years, and their caregivers initially as part of an NCCAN research project.
- Responsible for administration of psychological measures and the diagnosis of referred clients.
- Worked closely with various community agencies.

The Vt. Treatment Program for Sexual Aggressors Swanton, VT
June 1993 – December 1994; September 1996 – April 1998
Contract Therapist

- Provided individual and group psychotherapy to incarcerated adult male sexual offenders, following the Relapse Prevention Model.
- Performed psychosexual evaluation and case reviews.
- Prepared treatment summaries for the Parole Board.

Professional Organizations/Memberships

- Member of the Safer Society Foundation Board of Directors. December 2005 – Present.
- Mental Health Representative for the Chittenden Unit for Special Investigations Multi-Disciplinary Team. 1/2005 – 1/2009.
- Member of the local resource site team for the Center for Sex Offender Management (C-SOM). 1/2000 – 4/2004.
- Advanced Sexual Abuse Consultation Group (University of Vermont). 8/1998 – Present.
- Member of the Vermont Network for Providers of Adolescents with Sexual Behavior Problems. 3/1996 – Present.
- Member of the Chittenden County Sexual Abuse Response Team (C-SART). 1/1996 – 2001.
- Clinical Member of the Association for the Treatment of Sexual Abusers. 4/1994 – Present.

Trainings and Presentations – Lead Presenter

- **Children and Adolescents with Sexual Behavior Problems: Identification, Assessment and Intervention.** Northeastern Family Institute (1/2008).
- **Working with Children and Families Impacted by Trauma: The Importance of Working Collaboratively**. The 8th Annual Collaboration Conference, Killington, VT (10/2007).
- **Children and Families Impacted by Trauma: Assessment and Treatment**. The 3rd Annual Kinship Care Conference, Burlington, V (April, 2007).
- **Children with Sexual Behavior Problems: A Practical Approach to Assessment and Treatment**. The 8th Annual New England Conference on Child Sexual Abuse (6/2006).
- **Child Traumatic Stress: The impact of trauma on children across settings**. Project SOAR, St. Albans, V (8/2006).
- **The Assessment and Treatment of Juvenile Sexual Offenders**. Annual Public Defender Training Seminar, The Inn at Essex, V (8/2006).
- **Child Sexual Abuse: How to Work with Children and Families Impacted by Sexual Abuse**. Annual Victim's Advocate Training Seminar, Lake Morey, V (10/2004).
- **Assessment and Treatment of Children with Sexual Behavior Problems**: Implementation of the STEP Program Curriculum, Burlington & Rutland, V (7/2004).

BIOGRAPHICAL SKETCH

NAME: **Karen M. Fondacaro, Ph.D.**	POSITION TITLE: Director BTPC, Professor

EDUCATION/TRAINING

INSTITUTION AND LOCATION	DEGREE *(if applicable)*	YEAR(s)	FIELD OF STUDY
State University @ Stony Brook, Long Island, New York	B.A.	1982	Psychology
University of Vermont, Burlington, Vermont	Ph.D.	1988	Clinical Psychology

A. Employment

07/2006 – present	Director, Behavior Therapy and Psychotherapy Center, Burlington, VT
08/2008 - present	Adjunct Clinical Faculty, Antioch University New England
05/2005 – present	Staff Psychologist/Clinical Professor, BTPC, Burlington, VT
08/1995 - 05/2005	Staff Psychologist/Associate Professor, BTPC, Burlington, VT
08/1988 - 07/1995	Staff Psychologist/Assistant Professor, BTPC, Burlington, VT

Selected Academic Honors

- Departmental Honors in Psychology, S.U.N.Y. at Stony Brook
- Magna Cum Laude, S.U.N.Y. at Stony Brook
- Phi Beta Kappa & Sigma Beta Honors, S.U.N.Y. at Stony Brook

B. Selected presentations, program development, evaluations and facilitated groups

Selected presentations

Fondacaro, K.M., Kuny, A., Marshall, E., & Ryan, K. (2008, September).*Connecting Cultures: A Commitment to the Health of Vermont's Resettled Refugees.* 2008 National Refugee and Immigrant Conference, Chicago, IL.

Fondacaro, K.M. (2009, April).*Connecting Cultures: Outreach and Clinical Treatment with Vermont Refugees.* Invited Presentation to the Howard Community Center, Burlington, VT.

Fondacaro, K.M., Decker, W., DeLeonardis, K., Gagne, B., Doyle, C., & Nadeau,L. (2009, February). *Building Capacity to Transform and Sustain Community Response to Crime and Violence & Connecting Cultures Program.* Panel Discussion at the Anti-Violence Partnership: Community Collaboration at the University of Vermont, Burlington, VT.

Selected community program development

- Connecting Cultures: Committed to the Mental Health of Vermont's Refugees (2007-present)
- Helping Offenders thru Prevention & Education (H.O.P.E.; 2001)
- For Parents' S.A.K.E.S (Sexually abused kids; education & support, 1988)
- Children & Parents United Beyond Bars (C.U.B.B.; 2000)

Selected psychological evaluations and groups facilitated

- African Refugee parenting groups; Asylum seeker psychological evaluations
- Child and Adolescent victims of sexual abuse; Non-offending parents of sexually abused children
- Women inmates, continuum of care; Women inmates, PTSD & substance abuse
- Risk Assessment for violence/sexual offenses; Sex offender evaluations
- Family custody, parental competence and trauma evaluations
- Child maltreatment evaluations (e.g., sexual abuse, physical abuse, witnessing domestic violence)

C. Selected Research and Clinical Grants and Contracts

Role	Title of Project	Funding Source	Year
Project Director/ Grantee	Training grant for doctoral student in Connecting Cultures: Committed to the Mental Health of VT's Refugees	Child and Adolescent Training and Research Foundation	2008
Project Director/ Grantee	Cultural Awareness & Sensitivity/ Parenting Skills: VT Refugees	Children's Justice Act, State of Vermont	2007
Clinical Supervisor	Consultation to community professional/sexual abuse treatment	Dept. of Children and Families State of Vermont	1999-present

Job Description: Administrative Assistant

Description of Duties and Responsibilities:
Administrative work as an assistant to a manager, unit or program chief, or with direct responsibility for a specific assigned program or function. While actual duties may vary, positions in this class are characterized by work in a technical or specialized field, decision making with little concurrent supervisory review, and accountability for results. For this project, work will include preparing documents and mailings, assisting in the planning for meetings and training events and designing informational documents. The role differs from higher level administrative assistants by a more limited program or functional area, and less impact upon total department activities. Assignments may generally be characterized as a first level administrative role with clearly indicated functional and authority dimensions. Assigned duties may include employee supervision. Work is performed under the direction of an administrative superior.

Skills and knowledge required/ Supervisory relationships:
As delegated, may perform assigned tasks of a technical nature requiring independent action and full accountability for program results. Examples include but are not limited to managing support services such as budget, personnel, purchasing or space and communications needs for a board, director or program administrator; administering a licensing or service application procedure requiring analysis of data and an approval or disapproval decision; receiving requests and complaints from consumers and taking substantive action(s) to resolve or alleviate the problem; and serving as coordinator of various support services at a department or institutional level. Duties frequently may include staff supervision with delegated authority for hiring, training, assigning and evaluating work, and disciplining lower level employees. May prepare a variety of fiscal, statistical, or narrative reports. May serve as acting head or represent unit in supervisor's absence. May personally perform complex and confidential secretarial related duties. May develop and implement program procedures. Performs related work as required.

Minimum Qualifications:
Associate's degree in business technology, secretarial science or office management; OR High school graduation or equivalent and three years of office clerical experience. Completion of a one-year vocational/technical training program in business and office occupations or related area may be substituted for one year of the work experience. College coursework may be substituted for the work experience on a semester for six months basis.

Personal Qualities:
- Ability to develop positive interpersonal relationships with peers, supervisees, supervisors, and clients.
- Excellent communication skills both verbally and in writing.

Amount of Travel:
Travel required for conferences and meetings.

Salary Requested and Time:
$18,562 (0.5 FTE)

SECTION I: CONFIDENTIALITY AND SAMHSA PARTICIPANT PROTECTION

1. Protection from Potential Risks: Because this grant is focused on improving treatment and implementing an empirically-based practice that has shown effectiveness in other treatment settings, there are little foreseeable physical, medical, psychological, social, or legal risks or potential adverse effects as a result of the project itself or any data collection activity. Individuals may participate in the grant initiative in several different ways. Professionals, consumers, family members and advocates will participate in planning, implementation and training activities. These individuals will participate on a voluntary basis. In situations where participants may be asked to identify areas for improvement or faults in the current system, individuals receiving services may fear that access to services might be limited if they criticize the treatment providers they currently work with. Professional staff involved in the project may be concerned that criticisms of the system might jeopardize their employment. To mitigate this real or perceived barrier, facilitators of the planning process will work to create a safe environment for both positive and negative critiques of the system. The purpose of stakeholder involvement and inclusion of professional staff, consumers and families is to honestly assess and improve the current treatment and support system for children with complex trauma and their caregivers. Children with complex trauma and their caregivers will also be recipients of enhanced screening, assessment and treatment using nationally recognized empirically-based models/treatment, and there are no known risks associated with receiving these types of treatment. As such, individuals receiving enhanced services funded through this grant will likely benefit from improved treatment.

Implementation of enhanced treatment will be overseen by clinical experts, which will help to ensure treatments are developed and provided correctly without posing any risk to participants resulting from incorrect application of a treatment intervention.

2. Fair Selection of Participants: Grant activities are designed to include participation from a wide range of stakeholder groups, including representatives across ages, genders, and racial/ethnic backgrounds. Participants will include consumer leaders, family members, advocates, and administrative and treatment professionals, as evidenced by the *Letters of Support* included in Appendix 1. Children with complex trauma and their family members will be included in the stakeholder groups because of their ability to speak about the mental health system based on personal experience. No one will be excluded from participation in grant activities.

Enhanced trauma-informed trauma treatment services will be provided to children with complex trauma who are in need of trauma-focused treatment and services. Children will be identified through a trauma-informed screening and referral process with child-serving partners (e.g. DCF and schools). No one who meets these criteria will be excluded from having access to these treatments. If the existing service providers are unable to serve all individuals who request supports, every effort will be made to expand the number of service providers. In fact, the grant will specifically focus on expanding the number of services providers who can provide trauma treatment and recovery services to children who experienced complex trauma and their families.

3. Absence of Coercion: Participation in the planning and implementation activities will be entirely voluntary for members of each stakeholder group. In addition, participation in any surveys or interviews used to gather information for the project will be voluntary, without any direct or implied coercion.

Participation in mental health treatment, including trauma-focused treatment, may be recommended as part of a family's case plan with the Department for Children and Families Family Services Division (child welfare). However, it is important to note that individuals who are eligible for the VCTC services will not be required to participate; the child/family may chose to access other treatment services instead of participating in this program to satisfy their case plan. As such, participation in this project does not involve coercion; children and families will have choice to participate in VCTC services or seek alternative treatments.

4. Data Collection: Performance measurement and assessment efforts will rely on data from existing sources as well as information gathered through grant evaluation activities described in Section E. Data collection instruments and interview protocols will be conducted by the treating clinician at the clinic or community-based setting (i.e. home or school); samples of these are provided in Appendix 2. No specimens such as urine or blood will be collected for this project. Data collected on individuals involved in the Vermont Child Trauma Collaborative will be a "limited data set" as defined at 45 CFR 164.514(e). This data may be extracted from protected health information, but will exclude the following direct identifiers of individuals:

- *Names;*
- *Postal address information, other than town or city, State, and zip code;*
- *Telephone numbers;*
- *Fax numbers;*
- *Electronic mail addresses;*
- *Social security numbers;*
- *Medical record numbers;*
- *Health plan beneficiary numbers;*
- *Account numbers;*
- *Certificate/license numbers;*
- *Vehicle identifiers and serial numbers, including license plate numbers;*
- *Device identifiers and serial numbers;*
- *Web Universal Resource Locators (URLs);*
- *Internet Protocol (IP) address numbers;*
- *Biometric identifiers, including finger and voice prints; and*
- *Full face photographic images and any comparable images.*

The evaluation component of this project will only use any protected health information provided by clients for the purpose of evaluating trauma-focused treatment performance. Data analyses or reports produced by this project will not include individually identifiable information. This project will not disclose any information in a manner that would violate the requirements of the HIPAA Privacy Rule. This project will not identify the individuals who are the subject of this evaluation. All identifying personal information will be removed prior to compiling data for review by grant planning participants.

Children and family members/caregivers who participate in the evaluation of the VCTC will receive $20.00 in compensation for each round (i.e., at intake, 3, 6, 9 and 12 months) of data collection session they participate in. This includes separate $20.00 payments for the child and the family member/caregiver.

5. Privacy and Confidentiality: Acknowledgement of involvement in grant activities in any public or written documentation will be voluntary. Data analyses and reports produced by this grant will not include individually identifiable information. The project will not disclose any information in a manner that would violate the requirements of the HIPPA Privacy Rule.

The data collected on individuals involved in the Vermont Child Trauma Collaborative will be a "limited data set" as defined at 45 CFR 164.514(e). This data may be extracted from protected health information, but will exclude direct identifiers of individuals (see #4). The evaluation component of this project will only use any protected health information provided by participants for the purpose of evaluating trauma treatment performance. Data analyses or reports produced by this project will not include individually identifiable information. This project will not disclose any information in a manner that would violate the requirements of the HIPAA Privacy Rule. This project will not identify the individuals who are the subject of this evaluation. All data will be entered into, and maintained within, password protected MS Access database on a University of Vermont secure server, and only the evaluation staff directly involved with the VCTC project will have access to the data.

6. Adequate Consent Procedures: Stakeholders participating in the grant planning activities, and child and caregiver clients will be free to participate or not, as they desire. Participation of minors in treatment services and evaluation activities will require the consent of their parent/legal guardian and assent of the minor. Requests for individuals to complete any evaluation documents will include written explanations, including: (1) completing surveys is voluntary, (2) purpose of surveys, (3) benefits for completing surveys, (4) description of the grant initiative and role of the surveys, (5) no anticipated risks for completing surveys, (6) protections for confidentiality (data collection will use a non-PHI unique identifier), (7) whom to call with questions about the surveys and grant activities, and (8) costs for completing the survey and an explanation of how participants will be paid.

7. Risk-Benefit Discussion: Because this grant is focused on improving and expanding trauma-informed trauma treatment for children with complex trauma and their families using evidence-based practices that have shown effectiveness in other treatment settings, we feel the there is great benefit to be had from participating in and/or evaluating the activities of this grant and no increased risk. Professionals, consumers, family members and advocates participating in the planning and implementation activities will do soon a voluntary basis. Individuals receiving services may fear that access to services might be limited if they criticize the treatment providers they currently work with. Professional staff involved in the project may be concerned that criticisms of the system might jeopardize their employment. As such, facilitators of the planning process must work to create a safe environment for both positive and negative critiques of the system. However, because the purpose of stakeholder involvement is to improve the current system, we feel the benefits greatly outweigh the potential risks. The benefits of participation provide a great deal of promise. We expect broad based stakeholder and professional staff

participation to result in successful efforts to expand trauma treatment for children and their caregivers.

Children with complex trauma will also be recipients of enhanced screening, assessment and treatment using nationally recognized empirically-based models/treatment, and there are no known risks associated with receiving these types of treatment. As such, individuals receiving enhanced services funded through this grant will likely benefit from improved treatment.

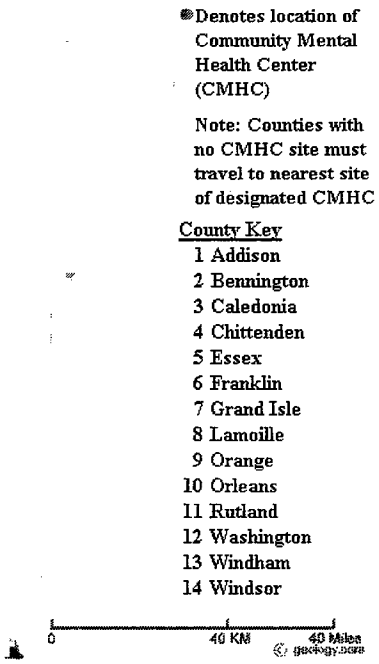
Protection of Human Subjects Regulations

We do not anticipate that any of our evaluation efforts will require compliance with the Protection of Human Subjects Regulations (45 CFR 46). It is important to note that we consider this project an implementation and evaluation of effective trauma-informed trauma treatment and services initiative and not a research study in which an unproven treatment intervention is being tested/piloted with a vulnerable population. However, we will submit an application to the University of Vermont Institutional Review Board to ensure that our activities comply with the requirements. The University's IRB has a well developed process, including the requirement that all applicants complete a web-based tutorial program reviewing the Protection of Human Subjects Regulations (http://www.uvm.edu/irb).

APPENDIX 1: IDENTIFICATION OF SERVICE PROVIDERS, STATEMENT OF ASSURANCE, LETTERS OF COMMITMENT/SUPPORT
1. Licensed Service Provider Organization;
2. List of all Direct Service Provider Organizations
3. Statement of Assurance
4. Letters of commitment/support.

1. Identification of at least one experienced, licensed service provider organization:

- Clara Martin Center (CMC)
- Counseling Services of Addison County (CSAC)
- Health Care and Rehabilitation Services of Southeastern Vermont (HCRS)
- HowardCenter (HC)
- Lamoille County Mental Health Services (LCMH)
- New England Counseling and Trauma Center (NECTC)
- Northeastern Family Institute (NFI)
- Northeast Kingdom Human Services. (NKHS)
- Northwestern Counseling and Support Services (NCSS)
- Rutland Mental Health Services (RMH)
- United Counseling Service (UCS)
- Washington County Mental Health Services (WCMH)



2. Direct service provider organizations:

Mental Health Direct Service Provider Organizations:
- Clara Martin Center (CMC)
- Counseling Services of Addison County (CSAC)
- Health Care and Rehabilitation Services of Southeastern Vermont (HCRS)
- HowardCenter (HC)
- Lamoille County Mental Health Services (LCMH)
- New England Counseling and Trauma Center (NECTC)
- Northeastern Family Institute (NFI)
- Northeast Kingdom Human Services. (NKHS)
- Northwestern Counseling and Support Services (NCSS)
- Rutland Mental Health Services (RMH)
- United Counseling Service (UCS)
- Washington County Mental Health Services (WCMH)

Other Child-Serving Organizations:
- Department of Education
- Department of Children and Families
- Vermont Federation of Families for Children's Mental Health
- Vermont Network Against Domestic and Sexual Violence

3. Statement of Assurance:

4. Letters of Commitment/Support
- Charles Myers, Northeastern Family Institute
- James MacDonald, Lamoille County Mental Health Services
- Todd Bauman, Northwestern Counseling and Support Services
- Catherine Simonson, HowardCenter
- Catherine Burns, Washington County Mental Health Services, Inc.
- Cheryl Huntley, Counseling Service of Addison County, Inc.
- Judith Hayward, Health Care and Rehabilitation Services of Southeastern Vermont
- Dawn Littlepage, Clara Martin Center
- Carol Boucher, Northeast Kingdom Human Services, Inc.
- Doug Norford, Rutland Mental Health Services
- Tammy Leombruno, New England Counseling and Trauma Center
- Robert Hofmann, State of Vermont, Agency of Human Services
- Armando Vilaseca, Vermont Department of Education
- Stephen Dale, Vermont Department of Children and Families
- Joseph Spinazzola, The Trauma Center at Justice Resource Institute
- Judith Shaw, University of Vermont, Vermont Child Health Improvement Program
- Denise Lamoureux, State of Vermont Refugee Resettlement Office
- Karen Fondacaro, Connecting Cultures & Behavior Therapy and Psychotherapy Center
- Kathleen Holsopple, The Vermont Federation of Families for Children's Mental Health
- Karen Tronsgard-Scott, Vermont Network Against Domestic and Sexual Violence

State of Vermont
Department of Mental Health
Office of the Commissioner
108 Cherry Street, PO Box 70
Burlington, VT 05402-0070
healthvermont.gov/mh

Agency of Human Services

[phone] 802-652-2002
[fax] 802-652-2036
[tty] 800-253-0191

As the authorized representative of the Vermont Department 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

5/12/09
Date

VERMONT

Northeastern Family Institute

Bringing Vermont Children, Families & Communities Together

Michael Hartman, Commissioner
Department of Mental Health
State of Vermont
108 Cherry Street
P.O. Box 70
Burlington, VT 05402-0070

May 8, 2009

Dear Commissioner Hartman:

I am exceedingly enthusiastic to write this letter of support for the Vermont Department of Mental Health's application for the federal National Child Traumatic Stress Initiative Community Treatment and Services Centers Grant (CTS Centers) being offered by the Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. I understand the Grant will provide up to $400,000 per year for three years to improve treatment and services for children and adolescents who have experienced traumatic events.

NFI is excited about the opportunity to participate in planning and implementation of trauma informed practices in Vermont. We have in fact lead the state in identifying and implementing trauma informed practices. In addition, we enthusiastically look forward to continuing the implementation of ARC at NFI. It is a great complement to the other trainings we are also pursuing. As you know we will begin providing direct trauma-treatment services using the ARC model by January, 2010 and, we will implement the related evaluation activities concurrently.

Thank you for the leadership provided by the Department and especially the Department Staff who are directly responsible for pursuing this important initiative and this grant opportunity. It is very timely and will support our practice as we continue to move into the trauma world.

Sincerely,

Charles R. Myers, Ph.D.

Charles R. Myers, Ph.D.
Executive Director

30 Airport Road • South Burlington, Vermont 05403 • (802) 658-0040 • Fax: (802) 658-0216

LAMOILLE COUNTY Mental Health SERVICE

520 Washington Highway
Morrisville, VT 05661
802-888-5026 ▪ 802-888-5513
FAX 802-888-6393
OUTPATIENT CLINIC
802-888-4635 ▪ 802-888-4914
FAX 802-888-5916

May 8, 2009

State of Vermont
Department of Mental Health
Office of the Commissioner
108 Cherry St.
PO Box70
Burlington, Vermont 05402-0070

Dear Commissioner Hartman,

I am writing to express Lamoille County Mental Health's commitment to continue the implementation of the ARC model in our agency's Children, Youth and Family Services Programs. We are currently working with the consultation group to implement trauma-treatment services within our outpatient programs. We have also committed to engaging in evaluation activities to measure the effectiveness of interventions and to ensure trauma treatment tools and resources are effectively utilized and outcomes of treatment are successful.

Feedback has been positive from staff participants in the consultation and training processes and we express our appreciation to the Department of Mental Health for making this opportunity available to our agency and community. We look forward to continued collaboration with your department in this area.

Sincerely,

James MacDonald, MBA
Director of Children, Youth and Family Services

107 Fisher Pond Road
St. Albans, VT
05478

Telephone:
(802) 524-6554
Toll Free in VT:
(800) 834-7793
Fax:
(802) 527-7801

NORTHWESTERN COUNSELING & SUPPORT SERVICES

May 11th, 2009

To Whom It May Concern,

Please accept this letter of support for The Vermont Department of Mental Health's application for the National Child Traumatic Stress Initiative Community Treatment and Services Centers Grant.

For the last several years, the Vermont Children's Mental Health System has focused on the impact of trauma on children. As part of a statewide initiative, Vermont created a Child Trauma Workgroup to identify strategies to assure that children, with a history of trauma, have access to effective services. The Vermont Department of Mental Health has taken the lead in this initiative and brought the Attachment, Self Regulation, & Competency (ARC Method) of training and service delivery to Vermont. This comprehensive framework for intervention has enhanced our ability to provide quality supports to traumatized youth.

Through strong community partnerships, Northwestern Counseling & Support Services (NCSS) has been an innovative leader in providing comprehensive quality services to children directly within our local schools, clinic, homes, and the community. We have been an active participant in promoting trauma informed work through our participation in training and consultation on Attachment, Self-Regulation and Competency (ARC) Framework. NCSS is excited for the opportunity to be one of the 12 community treatment and services centers that will form the Vermont Child Trauma Collaborative (VCTC). We are committed to continue the implementation of ARC, to provide direct trauma treatment services using the ARC model, and to engage in planning and evaluation activities.

Vermont's application for the National Child Traumatic Stress Initiative Grant builds on our strong momentum to improve treatment and services for children and adolescents who have experienced traumatic events. A successful application will allow us to strengthen our community partnerships as we work collaboratively to create more effective community based interventions.

Sincerely,

Todd P. Bauman
Director of Children, Youth & Family Services
Northwestern Counseling & Support Services
Chair of Vermont's Children's Directors Workgroup

HowardCenter

1138 PINE STREET / BURLINGTON, VT 05401
T: 802.488.6600 / F: 802.488.6601
WWW.HOWARDCENTER.ORG

May 8, 2009

Commissioner Michael Hartman
Office of the Commissioner
108 Cherry Street, PO Box 70
Burlington, VT 05402-0070

Dear Michael,

On behalf of HowardCenter, I am pleased to offer support for the Vermont Department of Mental Health's application for a SAMHSA National Child Traumatic Stress Initiative Community Treatment and Service Center grant.

HowardCenter has been very excited to participate in the first year of a statewide pilot project focused on the implementation of the ARC (Attachment, Self-Regulation and Competency) Framework across the community mental health centers. There has been tremendous enthusiasm on the part of our participating clinicians in the training and on-going consultation provided by the Trauma Center at Justice Resource Center.

HowardCenter served 4,780 children and families across our comprehensive network of programs. Through our intake process and assessments, we know we are serving many children and families impacted by complex trauma. We are actively involved in current initiatives in our child welfare system through both formal contracts and informal teaming. At the same time, we have an extensive array of programs that partner with local schools so we are closely involved with our region's implementation of the state-wide roll out of Positive Behavioral Supports. This grant proposal will support the implementation of the ARC framework and a standard of practice that will impact our entire system of care including child welfare and education.

We understand and agree to the commitment to begin the provision of direct trauma treatment services using the ARC model by January 2010. The evaluation activities outlined in the proposal are aligned with our own organization's commitment to quality assurance so we look forward to active participation in the outcome process.

We wish you the best in your application. A successful grant award to the state of Vermont will strengthen partnerships and improve outcomes for children and families impacted by trauma.

Sincerely,

Catherine Simonson, LICSW
Child. Youth and Family Services Director
HowardCenter

Children, Youth and Family Services

260 BECKLEY HILL ROAD, BARRE, VT 05641-9080 PHONE: 802-476-1480 FAX: 802-479-4095

WASHINGTON COUNTY MENTAL HEALTH SERVICES, INC.

April 30, 2009

Michael Hartman, Commissioner of Mental Health
State of Vermont, Department of Mental Health
Office of the Commissioner
108 Cherry Street, P. O. Box 70
Burlington, Vermont 05402-0070

Dear Commissioner Hartman,

I am writing in support of Vermont Department of Mental Health's application for the National Child Traumatic Stress Initiative Community Treatment and Services Centers Grant sponsored by the Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. Our agency has been an active participant in promoting this work through the application of the ARC Framework training for the past year and we are eager to continue and expand upon this work.

As you are well aware, providing high quality mental health services to families living with complex trauma is challenging. Ongoing training and support for this effort is critical, in particular when such training can be applied to a rural population living with persistent complex trauma. The ARC model has been a very helpful and effective framework but more intensive and sustained training and support, as is identified in this proposal, is clearly needed in order more effectively address the children and families identified as the target of this grant.

WCMHS has been actively involved at the local and State level supporting the development of effective trauma services. And, again, we are more than willing to participate in the activities described within the grant. As the Clinical Director of Children Youth and Family Services I can offer the full support of our agency and staff to support this effort. We look forward to our ongoing work together on this important task.

Best regards,

Catherine E. Burns, Ph.D.
Clinical Director

Counseling Service
of Addison County, Inc.

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES
89 Main Street, Middlebury, VT 05753
Tel: (802) 388-6751 Fax: (802) 388-3108

25 Mountain View Street, Bristol, VT 05443
(802) 453-3009

DEVELOPMENTAL SERVICES
109 Catamount Park, Middlebury, VT 05753
Tel: (802) 388-4021 Fax: (802) 388-1868

EMERGENCY SERVICES
24 hour coverage: (802) 388-7641

WEBSITE: http://www.csac-vt.org

May 6, 2009

Michael Hartman, Commissioner
Department of Mental Health
108 Cherry St., PO Box 70
Burlington, VT 05402-0070

Dear Commissioner Hartman,

This letter is written in support of the ARC Project---an initiative with the National Child Trauma Stress Center. The Counseling Service has had four clinicians participating in the project over the last year and have found it very helpful and applicable to the population we serve. A large percentage of the children and families we see have trauma backgrounds that seriously interfere with daily functioning. It is critically important for our services to be trauma informed and for staff to have the competencies to intervene effectively and assess the impact of service delivery.

The Counseling Service is willing to continue with the implementation of ARC, continue to provide direct trauma treatment services using the ARC model and to engage in evaluation activities.

We strongly support this effort and recognize the value for the children and families we serve. Thank you.

Sincerely,

Cheryl Huntley

Cheryl Huntley, LICSW
Youth and Family Services Director

HCRS
HEALTH CARE & REHABILITATION SERVICES
OF SOUTHEASTERN VERMONT

May 8, 2009

Springfield
390 River Street
Springfield, VT 05156
886-4500

Hartford
49 School Street
Hartford, VT 05047
295-3031

Windsor
14 River Street
Windsor, VT 05089
674-2539

Bellows Falls
One Hospital Court
Bellows Falls, VT 05101
463-3947

Brattleboro
51 Fairview Street
Brattleboro, VT 05301
254-6028

Brattleboro CRT
29 Elm Street
Brattleboro, VT 05301
254-7511

HCRS Connection
1-888-888-5144

Emergency
1-800-622-4235

www.hcrs.org

A member of the Vermont Council of Developmental and Mental Health Services

Michael Hartman, Commissioner
Vermont Department of Health
P.O. Box 70
Burlington, VT 05402

Re: Vermont Department of Mental Health; Application for National Child Traumatic Stress Initiative CTS Centers Grant

Dear Michael,

I am writing to whole-heartedly support this grant proposal for the National Child Traumatic Stress Initiative Community Treatment and Services Centers Grant Program being submitted by the Vermont Department of Mental Health.

I represent a local community mental health provider, Health Care and Rehabilitation Services (HCRS), in southeastern Vermont. HCRS is a non-profit state designated agency serving almost 5,000 individuals in Windsor and Windham counties each year. HCRS offers five major programs for mental health and substance abuse needs as well as developmental disabilities.

Funding for this proposal from SAMHSA will allow us to improve treatment and services for children and adolescents who have experienced traumatic events.

HCRS has been actively involved and committed to the state-wide Agency of Human Services and Department of Mental Health's Trauma Initiative. We have five clinical supervisors who are getting the year-long intensive training in the Attachment, Self-Regulation and Competency (ARC) model that is being provided through the state trauma-informed care initiative. Because we are so committed to this model, HCRS will be offering a two-day conference on the ARC model with Margaret Blaustein in August which all of our clinical and case management staff will attend, and which we are offering to the general public and other professionals in Vermont. We believe that this comprehensive framework for intervening with traumatized youth is absolutely critical and fundamental to the success of engaging and working with the youth of Vermont.

As the community mental health agency serving southeastern Vermont, HCRS will participate in the planning and implementation activities of this grant project.

Additionally, HCRS commits to continue implementation of ARC at our agency, will have been providing direct trauma-treatment services using the ARC model, and will be taking part in the evaluation activities.

Please consider funding this critical and necessary effort.

Sincerely,

Judith Hayward

CLARA
MARTIN
CENTER
COMMUNITY MENTAL
HEALTH SERVICES

May 7, 2009

Michael Hartman, Commissioner
State of Vermont
Department of Mental Health
108 Cherry Street
P.O.Box 70
Burlington, VT 05402-0070

Dear Michael,

I am writing in support of the Vermont Department of Mental Health's application for the National Child Traumatic Stress Initiative Community Treatment and Services Centers Grant sponsored by the Substance Abuse and Mental Health Services Administration. Center for Mental Health Services. Our agency has been an active participant in promoting this work through the application of the ARC Framework training for the past year and we are eager to continue and expand upon this work.

The Clara Martin Center is willing to continue with the implementation of ARC, continue to provide direct trauma treatment services using the ARC model and to engage in evaluation activities.

We strongly support this effort and recognize the value for the children and families we serve.

Sincerely,

Dawn Littlepage, MA, LCMHC

Dawn Littlepage, MA, LCMHC
Clinical Director

Green Mountain
United Way

P.O. Box G
Randolph
Vermont
05060-0167
802/728-4466
802/728-4197 fax

P.O. Box 278
Bradford
Vermont
05033-0278
802/222-4477
802/222-3242 fax

P.O. Box 816
Wilder
Vermont
05088-0816
802/295-1311
802/295-1312 fax

5/11/09

Northeast Kingdom Human Services, Inc.

Eric T. Grims
Executive Director

Providing Community-Based Behavioral Health, Substance Abuse and Developmental Services

154 Duchess Ave.
P.O. Box 724
Newport, VT
05855-0724
Phone
802-334-6744
Fax
802-334-7455

2225 Portland St.
P.O. Box 368
St. Johnsbury, VT
05819-0368
Phone
802-748-3161
Fax
802-748-0704

55 Seymour Lane
Newport, VT 05855
Phone 802-334-5246
Fax 802-334-1093

www.nkhs.net

To: Michael Hartman
Commission, DMH
103 South Main Street
Waterbury, Vt. 05671

From: Carol Boucher
Chief Operations Officer, NKHS
PO Box 724
Newport, Vt. 05855

Re: National Child Traumatic Stress Initiative Community Treatment and Services Centers Grants

Dear Mr. Hartman,

I am writing on behalf of NKHS to support the Vt. Department of Mental Health's application of the federal grant referenced above. NKHS is very willing to participate in planning and implementation activities that would be necessary in the process of securing the grant as well as activities related to future provision of trauma-treatment services.

We have been active participants in the ARC model training and practice implementation and are looking forward to continuing that participation and evaluation. We plan to extend the training and involvement to more staff within our agency programs. Our staff is becoming more familiar with the approach and is eager to bring more staff on board. The potential for standardize assessments, delivery of trauma-focused and trauma-informed treatment are welcome as we work to improve outcomes for children, youth and families who have experienced traumatic events.

NKHS is very pleased that DMH is applying for this grant and is available to support and assist in any way possible.

Sincerely,

Carol Boucher

Carol Boucher

Rutland Mental Health Services

Information & Referral: (802) 747-7698 or toll-free 877-430-2279 TT/TDD: 800-253-0191

May 8, 2009

Dear Commissioner Hartman:

I am writing this as a letter of support for the Vermont Department of Mental Health's application for a federal National Child Traumatic Stress Initiative Community Treatment and Services Centers Grant. We have been very pleased with the support that your department has provided over the past year around the training and implementation of the Attachment, Self-Regulation and Competency (ARC) framework. Our agency has been very involved with the training and we are starting to see positive signs in areas where we have begun implementation.

We are very excited about the possibility of DMH continuing this support through a CTS Centers grant. Through the ARC training that is currently being provided, we are beginning to understand the implications that this type of framework has for improving the system wide treatment and services for children and adolescents who have experienced traumatic events. Your plans of using future grant funds to expand the implementation of the ARC framework in the community mental health system are very much appreciated and we look forward to continuing the implementation of the ARC model at our agency.

Specifically, we are committed to participating in further training, using the assessment and evaluation tools and activities and providing direct trauma-treatment services using the ARC model by the 4th month of the project (January 2010). We fully support the goal of all children in Vermont having access to trauma-informed services. As a community mental health center, we strive to provide the best possible services that are available and we view the implementation of the ARC framework as a major step in the pursuit that goal.

If you have any questions, please feel free to contact me at 775-2381.

Thank you.

Sincerely,

Doug Nofford, LICSW
Director of Child and Family Services

UCS

Celebrating Our 50th Year

100 Ledge Hill Drive, P.O. Box 588
Bennington, Vermont 05201-0588
802.442.5491 802.442.3363 Fax
www.ucsvt.org

Ralph J. Provenza
Executive Director

May 11, 2009

Mr. Michael Harman, Commissioner
State of Vermont
Department of Mental Health
108 Cherry St., P.O. Box 70
Burlington, VT 05402-0070

Re: Letter of Support

Dear Commissioner Hartman,

I am writing on behalf of United Counseling Service to offer my heartfelt support for the Vermont Department of Mental Health's application for a National Child Traumatic Stress Initiative Community and Treatment and Services Centers Grant. Not only are we excited about the possibility of creating a Vermont Child Trauma Collaborative to implement the ARC model, we are excited about creating a state-wide system of care for Vermont's children and families affected by trauma. We are aware that the Department recognizes the prevalence of and significant impact of trauma. The Vermont Department of Mental Health has a long and successful history of implementing statewide initiatives that improve the quality of care.

United Counseling Service has had the pleasure of being an active participant in learning about the Attachment, Self-Regulation and Competency (ARC) Framework for the past year. Several clinicians in our agency have begun to incorporate this best practice model into their daily work. We are eager, however, to expand the implementation of this model throughout the agency. We know that children and families affected by trauma can and do recover when provided with effective tools that are sensitive to their needs. The ARC model provides clinicians and the system with those tools. United counseling Service is committed to fully implementing the Vermont Child Trauma Collaborative along with DMH and the 11 other community treatment and service centers in Vermont.

We strongly support this effort and know that the opportunity offered through this grant will enhance our capacity to offer a holistic, strength-based, and results-oriented approach to children and families who have experienced trauma.

Sincerely,

Lorna Mattern, Med
Children's Director

The New England Counseling and Trauma Center
25 Wentworth Drive, Williston, VT 05495 P. 802.878.4990 F. 802.878.1477

Michael Hartman, Commissioner
State of Vermont
Department of Health
Office of the Commissioner
108 Cherry St., P.O. Box 70
Burlington, VT 05402-0070

Re: Letter of Support

Dear Commissioner Hartman:
I am writing on behalf of the New England Counseling and Trauma Center (NECTC), located in Williston, Vermont to offer my strong support for the Vermont Department of Mental Health's application for a National Child traumatic Stress Initiative Community Treatment and Services Centers Grant. We are excited that the Department will create an improved system of care for children and families impacted by trauma by increasing the capacity of the 12 identified sites to effectively assess and treat this population using empirically based methods. We are aware that the Department has been very successful with the statewide implementation of new clinical practices and we are excited that the Department places a high value on public and private partnerships.

I am a partner, and co-founder of the New England Counseling and Trauma Center. NECTC is a collaborative of professionals who specialize in the comprehensive assessment and treatment of trauma. We serve children, adolescents, adults, and families impacted by trauma, utilizing a variety of treatment modalities. Presently we have 16 clinicians who collectively meet with an average of 130 to 150 clients per week. Clinicians at NECTC participate in specialized training and consultation related to trauma-informed and trauma-specific therapeutic interventions. NECTC clinicians have received specialized training through the Trauma Center at the Justice Resource Institute, focusing specifically on the implementation of the Attachment, Self-Regulation, and Competency (ARC) Model.

NECTC is committed to providing evidence-based, efficacious treatment services to our clientele. NECTC recognizes the dual importance of specialized training, consultation and supervision for those who provide trauma-specific services to children, adolescents and families, and the need for systems collaboration amongst the various providers.

NECTC is excited by the opportunity to participate in the grant implementation project as one of the 12 community treatment and services centers that will form the Vermont Child Trauma Collaborative (VCTC). NECTC will fully participate in the planning, training/consultation and implementation of ARC treatment services. This includes compliance with the grant objectives related to implementation of clinical services, data collection and reporting, participation in the requisite trainings and consultation groups, and working collaboratively with other child-serving partners to be trauma-informed.

Thank you for your time and consideration.

Sincerely,

Tammy L. Leombruno, M.A., LCMHC

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

Robert D. Hofmann, Secretary

May 12, 2009

Michael Hartman
Commissioner
Department of Mental Health
108 Cherry Street
Burlington, VT 05402

Dear Mr. Hartman,

I am writing to support your application to the Substance Abuse and Mental Health Services Administration's (SAMHSA) *National Child Traumatic Stress Initiative Community Treatment and Services Centers Grants* to enhance evidence-based practices for treating Vermont's children and families affected by trauma. I fully endorse your application.

As the Secretary of the Agency of Human Services (AHS) for the State of Vermont, I have direct responsibility for the programs most utilized by individuals and families who have significant trauma histories including the Departments of Corrections, Children and Families, Health, Mental Health, and the Office of Vermont Health Access (the State's Medicaid Program). Our Agency has the widest reach in State government and, I believe, the most important mission: to improve the conditions and well-being of Vermonters and protect those who cannot protect themselves. Enhancing trauma services for Vermont's children and families is a critical part of that mission. Governor Douglas has made the improvement of services to Vermonters a top priority in this Administration. Our Agency is charged with the coordination of trauma services in the State and supports the development, implementation, and replication of evidence-based trauma treatment in our provider system.

Vermont's application for this grant opportunity is especially timely, given the recent establishment of the AHS Trauma-Informed System of Care Policy in October 2008. Through this policy, the Agency recognizes the prevalence of trauma victims that access services through its' departments and offices. The Agency supports the principle that persons who have survived a traumatic event need services that are sensitive to their special needs, and that those services are provided through a trauma-informed system of care.

We recognize the responsibility of the Agency to assure that key decision-makers, planning staff, program administrators and service providers are cognizant of the origins of trauma, the effects of trauma on survivors, and the possibility that re-traumatization may occur during the provision of services, or while trying to access services or benefits. Based on this policy, the Agency will:

- seek to reduce and eliminate those practices identified as having a negative or re-traumatizing effect on trauma survivors
- work to assure the provision of trauma-informed services by identifying and eliminating insensitive practices, combating systemic challenges, conducting on-going evaluation of their practices, and providing training to staff and/or providers in contact with trauma victims
- promote the delivery of trauma services through a trauma informed system of care
- designate a lead to work with each of its' departments and offices, in partnership with survivors, family members, advocates, trauma services providers, federal, state, and local agencies, behavioral health and substance abuse professionals, private citizens, and others in support of these principles.

Whether helping a family access health care and child care, protecting a young child from abuse, supporting youth and adults through addiction and recovery, providing essential health promotion and disease prevention services, or supporting victims and offenders, we serve Vermonters with compassion, dedication, and professionalism. We will continue this standard of excellence in services as we support this initiative. I look forward to a favorable review of the proposal.

Sincerely,

Robert Hofmann
Secretary

RDH/dtn

State of Vermont
Vermont Department of Education
120 State Street
Montpelier, VT 05620-2501

May 1, 2009

Mr. Michael Hartman
Commissioner of Mental Health
Vermont Agency of Human Services
103 S. Main St.
Waterbury, Vermont 05671-0203

Dear Commissioner Hartman:

The purpose of this letter is to affirm the Vermont Department of Education's support for the Vermont Department of Mental Health's Project under the National Child Traumatic Stress Initiative Community Treatment and Services Centers Grants (CTS Centers). This grant program is being supported by the Substance Abuse and Mental Health Services Administration (SAMSA), Center for Mental Health Services, and will provide funding over three years to improve treatment and services for youth who have experienced traumatic events. This program will enhance the implementation and evaluate effective trauma-focused treatment services in youth-service delivery systems. The opportunity to collaborate on a statewide basis to support this at risk population is a direct complement to the work of the Department of Education Student Support Team.

The Vermont Department of Education is currently collaborating with the Department of Mental Health on the implementation of Positive Behavioral Supports (PBS) in Vermont schools. As part of this collaboration, we believe the training and consultation on trauma informed care will be particularly beneficial to educators as they work with Vermont children in need of varying levels of support in the school setting. It is our intent to recommend this training to school teams working on implementing secondary and tertiary levels of support within the PBS model. We believe this grant provides an opportunity for us to increase the knowledge base for trauma informed care for all school personnel and clearly describe referral protocols for trauma specific treatment. The interagency work that we do on behalf of this population will be strengthened by this grant proposal and these services can deepen our resources and create new opportunities to increase positive educational and clinical outcomes for our youth.

The Vermont AHS-Department of Mental Health-Division of Children's Services and the Department of Education have a long history of collaboration in supporting youth, families and communities to achieve successful educational outcomes for all students. We look forward to continuing this critical work on behalf of these youth experiencing complex trauma in Vermont.

Sincerely,

Armando Vilaseca
Commissioner
Vermont Department of Education

VERMONT

VERMONT

State of Vermont
Department for Children and Families
Family Services Division
103 South Main Street, Osgood 3
Waterbury, VT 05671-2401
www.dcf.state.vt.us/fsd/

Department for Children and Families
Agency of Human Services
Family Services Division
[phone] 802-241-2131
[fax] 802-241-2407

Telephone: 802-241-2126
FAX: 802-241-2980

http://dcf.vermont.gov

E-mail: cindy.walcott@ahs.state.vt.us

April 27, 2009

Michael Hartman, Commissioner
Department of Mental Health
108 Cherry Street, PO Box 70
Burlington, VT 05402-0070

Dear Commissioner Hartman:

We are writing to express our enthusiastic support of your application for a federal *National Child Traumatic Stress Initiative Community Treatment and Services Centers* grant. It is our understanding that if funded, the Department of Mental Health will implement and evaluate effective trauma-focused and trauma-informed treatment and services in community settings and in youth-serving service systems.

Our department serves as the state's child welfare and juvenile justice agency. Almost without exception, the children and youth we serve have histories of trauma, often severe. In the last several years, we have learned more about the lasting impact of trauma impact of trauma on young people. In order to mitigate this impact, we are motivated to deliver the most relevant, well-informed services.

We highly value our collaboration with your department, and appreciate all that you have done to identify and implement evidence based practices. In particular, we are pleased and excited to see the growth in the implementation of the Attachment, Self-Regulation and Competency (ARC) Framework.

On July 1 of this year, we will implement differential response to child abuse and neglect. Through differential response, we hope to identify at-risk children sooner, and more comprehensively meet their needs through the prompt delivery of targeted services. Increasing the availability of mental health practitioners who can screen for, and then deliver services within the ARC framework will be a critical component of our success.

We are fully supportive of your application for funding. We are committed to participating from the beginning in planning and implementation activities. We are eager for our Centralized Intake Unit, our Child Safety Unit and our district offices to

improve our practice. Our goal is for our entire system to become more trauma-informed. The children and families we serve deserve no less.

Sincerely,

Cynthia K. Walcott
Deputy Commissioner

Stephen R. Dale
Commissioner

JUSTICE FOR CHILDREN TASK FORCE
Vermont Supreme Court
109 State Street
Montpelier, Vermont 05609
(802) 828-5625

May 1, 2009

Michael Hartman, Commissioner
Department of Mental Health
108 Cherry Street
Burlington, VT 05401

Dear Mr. Hartman,

On behalf of the Justice for Children Task Force, I am writing in strong support of your application for the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Child Traumatic Stress Initiative Community Treatment and Services Center grant in order to expand evidence-based practices for treating Vermont's children and families affected by complex trauma.

The Justice for Children Task Force has been working for the past 3½ years to improve the family court system for court-involved youth, and its interactions and referral system to community mental health and substance abuse providers. This Task Force includes me as Chair, an Associate Justice, the Administrative Judge for Trial Courts, Commissioner and Deputy Commissioner level positions within the Agency of Human Services, as well as the Defender General, State's Attorneys Department, legislators, and advocates. Because of the critical impact that mental health and substance abuse treatment has on cases of abused and neglected children, the Task Force formed a subcommittee in 2008 specifically focused on mental health and substance abuse treatment. That subcommittee is co-chaired by the Vermont Commissioner of the Department for Children and Families and the Deputy Commissioners of the Department of Mental Health and Alcohol and Drug Abuse Programs.

It is clear from the Task Force's work that there is a dire need for effective treatment for children and families affected by complex trauma. Strengthening the treatment expertise and increasing the availability of an effective trauma treatment modality is a valuable step towards supporting the goals and efforts of the Task Force. We are also excited about the opportunity for the Vermont Child Trauma Collaborative to impact policy change and strengthen the system of care for Vermont children. We offer our full support for this grant application. The members of the Task Force will be available as a resource to assist in the coordination of the grant work and Task Force work. We look forward to the implementation of your proposal. Thank you for your dedication to the children, youth, and families of Vermont.

Sincerely,

Paul L. Reiber, Chief Justice
on behalf of the Justice for Children Task Force

NCTSI SM-09-017

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

VCHIP
VERMONT CHILD HEALTH IMPROVEMENT PROGRAM

May 7, 2009

Dear Ms. Power,

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 National Child Traumatic Stress Initiative (NCTSI) Community Treatment and Services Centers Grant. Receiving this award will allow the Vermont DMH and the Vermont Agency of Human Services (AHS) to strengthen and expand their statewide efforts to identify and then provide evidence based treatments for children who have experienced traumatic stress. 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 NCTSI National Evaluator to develop, implement and document a comprehensive evaluation of the Vermont Child Traumatic Stress Collaborative (CTSC).

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. 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). VCHIP is also currently conducting statewide evaluations for two SAMHSA funded mental health initiatives: the Vermont Suicide Prevention project (CMHS SM-08-001) and the Vermont Children's Mental Health Initiative (CMHS SM-08-004).

The VCHIP evaluation of the Vermont CTSC project activities will conform to all of the evaluation requirements set forth in the SAMHSA NCTSI grant 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 NCTSI National Outcome Measures) and will conduct an evaluation that is specific to the Vermont CTSC 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 CTSC activities and provide regular feedback to the state DMH and local mental health agency 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 CTSC project.

Sincerely,

Judy Shaw

Judith S. Shaw, EdD, MPH, RN
Executive Director

STATE OF VERMONT

REFUGEE RESETTLEMENT OFFICE
Agency of Human Services
103 South Main Street
Waterbury, Vermont 05671-0203

Telephone (802) 241-2229
Fax: (802) 241-4461
E-mail: Denise.Lamoureux@ahs.state.vt.us

May 5, 2009

Michael Hartman
Commissioner
Department of Mental Health
108 Cherry Street
Burlington, VT 05402-0070

Re: National Child Traumatic Stress Initiative Community Treatment and Service Center grant application

Dear Michael,

I strongly support the Department of Mental Health's application for a grant under the above-mentioned Substance Abuse and Mental Health Services Administration funding opportunity.

Refugee children and adolescents are disproportionally affected by their past traumatic experiences. Providing trauma-informed and culturally-adapted mental health services to this population is a critical need; your proposal includes resources and activities to adapt the ARC framework to serve children and families of Vermont's refugee populations by partnering with the University of Vermont (UVM) affiliated Connecting Cultures program. The Connecting Cultures program at the Behavior Therapy and Psychotherapy Center of UVM has had impressive results in their work with severely traumatized refugees, allowing them to move forward and become productive members of our community. This partnership will develop the capacity of the mainstream mental health services to serve the growing population of refugee children and their families in a culturally sensitive manner. This is vital because diversity is a new reality in Vermont.

As the State Refugee Coordinator, I can support the Department of Mental Health's planning and implementation activities of this grant several ways; I will offer advice on how to reach-out to refugee and immigrant populations, connect them with the Refugee & Immigrant Service Providers Network (RISPNet), a group that I coordinate, and foster coordination and collaboration between the refugee program and the mental health service providers targeted by this grant so that new populations are served in a culturally appropriate fashion.

Do not hesitate to contact me if you need additional information.

Sincerely,

Denise Lamoureux
State Refugee Coordinator

The UNIVERSITY of VERMONT

DEPARTMENT OF PSYCHOLOGY

May 8, 2009

Michael Hartman, Commissioner
Department of Mental Health
Office of the Commissioner
108 Cherry Street, P.O. Box 70
Burlington, VT 05402-0070

Dear Commissioner Hartman:

I am writing in strong support of the Vermont Department of Mental Health's application for a federal *National Child Traumatic Stress Initiative Community Treatment and Services Centers Grants (CTS Centers)* offered by the Substance Abuse and Mental Health Services Administration. As the Director of Connecting Cultures and the Behavior Therapy and Psychotherapy Center, a mental health training clinic in the psychology department at the University of Vermont, I am excited to participate with both local and state-level activities.

Connecting Cultures intends to collaborate closely with the Department of Mental Health and we are eager to provide consultation for the adaptation of the ARC model for refugee populations in Chittenden and Washington Counties in year 3 of the project. This collaboration will offer assistance with how to best outreach to the refugee population, build a culturally sensitive network of clinicians for supervision to reduce vicarious trauma, and increase awareness of and collaboration with available resources to meet the unique needs of refugee trauma survivors and their families. With the support of this grant, critical services to refugees in Vermont can be realized.

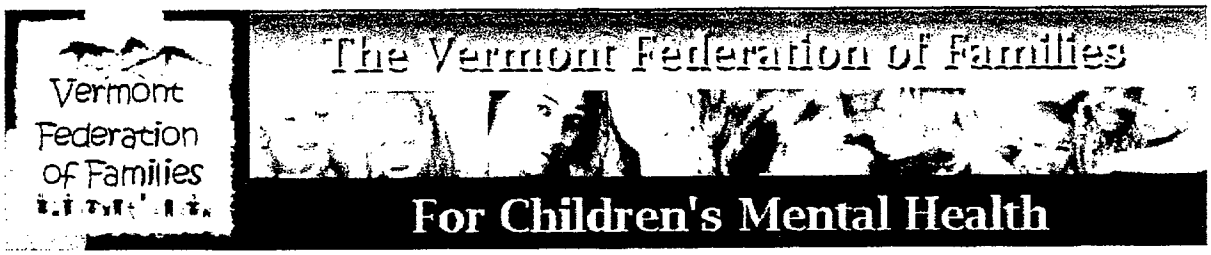
I am also aware of the extremely effective collaborative partnership between DMH and The Trauma Center at Justice Resource Institute (TC-JRI). I fully support this grant so that DMH can build on the current collaboration with TC-JRI to implement the ARC framework in each of the 11 community mental health centers in Vermont. The system-based dissemination of the empirically based ARC model will provide essential services to vulnerable children and families.

In sum, I offer my full and strong support for the application by the Department of Mental Health and applaud the current work being conducted, along with the multiple collaborations sustained by the agency. I believe that with funding from this grant initiative, DMH is poised to enhance critically necessary evidence based treatment services for traumatized children and families in Vermont.

Sincerely,

Karen M. Fondacaro, Ph.D.
Director, BTPC
Clinical Professor

John Dewey Hall, 2 Colchester Avenue, Burlington, VT 05405-0134, Telephone (802) 656-2670, Fax (802) 656-8783



May 7, 2009

To: Michael Hartman
From: Kathleen Holsopple

I am writing to add our voice of support to the Vermont Department of Mental Health's application for SAMHSA grant "National Child Traumatic Stress Initiative Community Treatment and Services Centers (CTS Centers). This grant is designed to improve treatment and services for children and adolescents who have experienced traumatic events through the implementation of effective trauma-focused and informed treatment and services in community settings and youth-serving systems. This grant is also designed to create and nurture collaboration with other grantees on clinical and training issues, service approaches, policy, and financing.

We strongly support a trauma informed and focused approach to creating and improving services for children and adolescents. A large number of the families we, the Vermont Federation of Families for Children's Mental Health, support have had trauma as a part of their experience. We feel that only trauma informed and focused service delivery will be able to truly focus on the "what and how" of treatment. The treatment needs to be effective and not create a negative, re-traumatizing experience for the family.

As a SAMHSA "Statewide Family Network" grantee recipient for many years, we have found the collaboration and sharing of information, practice, sustainability, training , policy and much more, between organizations and grantees to be one of our most valuable resources. This sharing has helped us and other organizations continue to grow and improve in our work with families. This piece of the trauma informed initiative is very exciting as well.

The Vermont Federation of Families will be partnering in several ways in this grant initiative. We will be working with the grant management team/advisory board in recruitment and participation of Family and Youth representatives on the state and local advisory committees and will consult around youth and family perspectives in the development of trauma informed training, materials, communications, and trauma treatment service delivery.

Our Youth Coordinators through the SAMHSA Youth in Transition grant, will be available to assist and consult on the culture of youth as it applies to modifying treatment approaches or any other aspect of this trauma grant.

We look forward to beginning this work together.
Sincerely,

Kathleen Holsopple, Executive Director

P.O. Box 507 Waterbury, Vermont 05676-0507

(802) 244-1955 * (800) 639-6071 Family Members only * Fax (802) 329 2135 * Email vffcmh@vffcmh.org

Vermont Network
Against Domestic and Sexual Violence

April 30, 2009

Michael Hartman, Commissioner
Vermont Department of Mental Health
108 Cherry Street
P.O. Box 70
Burlington VT 05402-0070

Dear Commissioner Hartman:

I am pleased to offer this letter of support for the Vermont Department of Mental Health's application for a federal *National Child Traumatic Stress Initiative Community Treatment and Services Centers Grant.* It is clear that domestic and sexual violence have broad and significant implications for the mental well-being of children and for their non-offending parent.

We will enthusiastically collaborate with the project through the State Advisory Committee, and will encourage our member programs to participate on Local Advisory Committees. We will offer our expertise for the development of trauma-informed training materials, communications, and trauma service delivery. We would also welcome opportunities to be involved in other planning and implementation activities.

The Vermont Network is pleased to collaborate with VDMH to create a response system that recognizes the traumatic impact of domestic and sexual violence on children and families.

Sincerely,

Karen Tronsgard-Scott
Director

PO Box 405 Montpelier, VT 05601 802.223.1302 www.vtnetwork.org

APPENDIX 2: DATA COLLECTION INSTRUMENTS/INTERVIEW PROTOCOLS

Attachment, Self-Regulation, and Competence (ARC) ©
Kinniburgh & Blaustein, 2005

ARC-Focused Trauma Assessment
Guide to supervision and/or case evaluation

AI. ATTACHMENT: Caregiver Management of Affect: ***(Note: This domain should be assessed separately as well as interactively for each primary caregiver)***

Caregiver is/has:

( ) Generally well-managed affect; able to handle child affect across a range of expression; able to express/modulate a range of affect and use good boundaries in doing so; is typically able to identify and use resources when affect intensifies
Priority level - 1 - Low; Support for continued use of skills

( ) Occasional or situational difficulty; caregiver may get triggered by specific child behaviors or emotions; may have periods of dysregulation (i.e., labile or flat affect) triggered by environmental or internal stressors; may only be able to tolerate a certain range of child affect or behavior
Priority level – 2 - Moderate; Support and coaching in use of skill

( ) Consistent difficulty managing emotional reactions; caregiver may be consistently dysregulated (i.e., labile or flat affect); generally unable to acknowledge and/or cope with child affect; unable to acknowledge and/or cope with own affect; unable to identify or use resources *or* over-reliance on resources
Priority level – 3 - High; Vulnerable domain; need for priority focus

Assessment results supportive include:
[Consider: PSI results; extreme patterns on CBCL (i.e., uniformly high scores); level of caregiver confidence in parenting ability; extent of affect present in dyad; ability to recognize own triggers; constriction, over-reaction, or over-control (i.e., observed rigidity with child in room); permissiveness in face of child affect; extent to which caregiver uses clinician or other services]

Concretely, describe caregiver vulnerabilities with affect management:

Concretely, describe caregiver strengths with affect management (consider both internal and external resources):

Concrete treatment goals:

AII. ATTACHMENT: Caregiver – Child Attunement: ***(Note: This domain should be assessed separately as well as interactively for each primary caregiver)***

Caregiver is/has:

( ) Generally highly attuned/sensitive; able to generally/accurately read child non-verbal cues; aware of the impact of trauma and attachment on child behavior(s); typically able to respond to underlying needs rather than react to distressing behaviors; able to provide appropriate comfort or distance in response to child cues; appears to have level of enjoyment of child's company

Priority level - 1 - Low; Support for continued use of skills

( ) Generally invested in/enjoys child's company, though may have periods of disconnection or dissatisfaction; May be generally attuned, but internal or environmental stressors may interfere in a notable way with caregiver ability to respond; Occasional or situational responsivity/reactivity to child behaviors; difficulty reading particular child cues; may at times be overly intrusive or overly withdrawn

Priority level – 2 - Moderate; Support and coaching in use of skill

( ) Consistent difficulty; unaware of underlying affect, unaware of connection between trauma & behaviors, and/or unable to read child intent; may be consistently intrusive or withdrawn, despite child cues; may not appear to take pleasure from interactions with child

Priority level – 3 - High; Vulnerable domain; need for priority focus

Assessment results support include:

[Consider: pattern[illegible]s on TSCL; caregiver love and insight during initial evaluation process; caregiver "[illegible]ing signs" such as child-blaming/negativity; extent of observed reactivity in dyadic interactions; extent to which caregiver personalizes child behaviors; ex[illegible] which child behavior differs with caregiver versus clinician or other adults; extent to which caregiver is able to identify both child strengths and vulnerabilities]

Concretely, describe caregiver vulnerabilities with attunement:

Concretely, describe caregiver strengths with attunement (consider both internal and external resources):

Concrete treatment goals:

AIII. ATTACHMENT: Consistent caregiver response: ***(Note: This domain should be assessed separately as well as interactively for each primary caregiver; consider developmental appropriateness of caregiver response in rating)***

Caregiver is/has: (Note—consider both *actual* caregiver response, as well as caregiver *felt comfort* with managing child behaviors)

( ) Very consistent *and* trauma-sensitive in use of both limits and praise, and feels comfortable managing child behaviors; generally able to be flexible in response; able to incorporate key components of effective limits, including acknowledgment of underlying child emotion, naming of unacceptable behaviors, clarity and follow-through around consequences, and naming and helping child achieve alternative behaviors
Priority level - 1 - Low; Support for continued use of skills

( ) Occasionally inconsistent in use of praise/reinforcement and/or limit-setting, or inconsistent in following through on stated limits; *or* has consistent difficulty with particular behaviors; *or* has situational difficulties; *or* is occasionally overly-punitive or overly-permissive; *or* feels concerned about skill level, despite observed skills
Priority level – 2 - Moderate; Support and coaching in use of skill

( ) Consistent difficulty; may be overtly-focused on limits in absence of praise; may fail to set limits, or set limits inconsistently; may be overly-punitive but may have no organized system for addressing behaviors; and may feel helpless in face of behaviors
Priority level – 3 - High; Vulnerability; need for priority focus

Assessment results supportive include:
[Consider: severity of caregiver report of punitive responses; caregiver description of distressing child behaviors in home setting; extent to which caregiver reports feeling helpless/confident addressing behavior; degree to which caregiver understands need for praise/reinforcement; consistency of reports of behavior to different providers; caregiver ability to consistently follow through with providers; caregiver ability to clearly state rules and consequences; observed caregiver response to child's behavior]

Concretely, describe caregiver vulnerabilities with consistent response:

Concretely, describe caregiver strengths with consistent response (consider both internal and external resources):

Concrete treatment goals:

AIV. ATTACHMENT: Routines and Rituals: ***(Note: Assess/consider implementation of routines at home, in the therapy office, and in collateral settings such as school)***

Need for focus on building routines and rituals is:

( ) Relatively low; child has few identified "trouble spots", and child/caregiver have developed consistent patterns both for problem behaviors/situations as well as key familial daily activities (i.e., bedtime, meals, homework, family together-time, transitions, etc.)
Priority level - 1 - Low; Support for continued use of skills

( ) Moderate; child may have difficulties with 1-2 key areas (i.e., bedtime, transitions); caregiver may have difficulty implementing routines in those areas, and/or be unaware of the role of routines
Priority level – 2 - Moderate; Support and coaching in use of skill

( ) High; caregiver has consistent difficulty following organized patterns, and/or may be disorganized him/herself *or* current routines are not developmentally appropriate *or* there is extensive focus on routines; child has difficulties in one or more key daily activities which interfere significantly with functioning
Priority level – 3 - High; Vulnerable domain; need for priority focus

Assessment results supportive include:

[Consider: consistency of child presentation at home; extent to which caregiver and/or child are able to describe daily patterns; child's ability to negotiate key domains/daily activities; level of developmental appropriateness of current routines; child/family daily structure; consistency/inconsistency of behavior across settings]

Child/family/system vulnerabilities with establishing routine

Concretely, describe child/family/system strengths with establishing routines:

Concrete treatment goals: [Address here routines *across* settings, include Tx routines]

RIa. SELF-REGULATION: Affect Identification - Self:

Child is/has:

( ) Typically see a full range of affect; child can acknowledge a range of feelings; child can acknowledge mixed emotions child can acknowledge, identify, and access feelings in the body; child can link feelings to a cause; child has a basic understanding of the connections among thoughts, feelings, behavior, and body
Priority level - 1 - Low; Support for continued use of skills

( ) Moderate; child may have difficulty accessing at least one feeling state (i.e., denies ever feeling sad or angry); may have difficulty acknowledging mixed emotion; may occasionally misattribute or externalize responsibility for affect; child has some difficulty understanding or explaining the links between experience and emotion; child has some difficulty accessing or understanding at least one of the four channels (thought, feeling, behavior, body)
Priority level – 2 - Moderate; Support and coaching in use of skill

( ) High; child may be very constricted or experience only single emotional states; child may be unable to acknowledge emotions at all; child may be unable to acknowledge mixed emotions; child may consistently externalize responsibility for affect; child may have no access to at least one of the four channels (thought, feeling, behavior, body) *or* has difficulty with multiple channels
Priority level – 3 - High; Vulnerable domain; ne... priority focus

Assessment results supportive inc...:

[Consider: Child ability to self-report feeling sta... observed range of affect; validity of self-report measures (i.e., evidence of over- or un... reporting); ability to identify range of feeling states]

Concre...ely, describe child vulnerabilities with identification:

Concretely, describe child strengths with affect identification (consider both internal and external resources):

Concrete treatment goals:

RIb. SELF-REGULATION: Affect Identification - Other:

Child is/has:

( ) Child is generally able to accurately read others' expressions; child can identify a range of emotions in others
Priority level - 1 - Low; Support for continued use of skills

( ) Moderate; child may be able to accurately identify emotion in some people but not others; child may occasionally misperceive affect, dependent on situation or internal/external stressors (i.e., over-interpretation of anger/danger); child may occasionally overattribute responsibility for others' emotion to self
Priority level – 2 - Moderate; Support and coaching in use of skill

( ) High; child may consistently have difficulty accurately identifying emotion in others, *or* may consistently misread primary caregiver(s), even if accurate in reading others; may consistently overattribute responsibility for others' emotion to self; may often lack awareness of others' affect *or* child may overly tune in to others' emotional states
Priority level – 3 - High; Vulnerable domain; need for priority focus

Assessment results supportive include:

Concretely, describe child vulnerabilities with identification:

Concretely, describe child strengths with affect identification (consider both internal and external resources):

Concrete treatment goals:

RII. SELF-REGULATION: Affect Modulation:

Child is/has:

( ) Child is generally aware of a range of feelings; child is generally aware of variability in the intensity of their own feelings; child is able to tune into changes in intensity; child is able to tolerate a range of intensity; child has an array of tools to manage affect effectively; child is able to generally use tools with minimal or age-appropriate supports to manage affective arousal; child is aware of personal triggers and is generally able to manage his/her response to these

Priority level - 1 - Low; Support for continued use of skills

( ) Occasional difficulties; child may be inconsistently aware of variability in emotional experience; child may be able to tune into some states better than others (i.e., greater awareness of extremes); child may be able to tolerate only a limited range of affect; child may be able to tolerate affect on some occasions, but not others, dependent on situational or internal stressors; child may have some tools for managing affect, but may not be able to consistently use them *or* may not be able to use tools without supports and cuing; child may respond to triggers with dysregulation, but is generally able to return to baseline with cuing and support in use of skills

Priority level – 2 - Moderate; Support and coaching in use of skill

( ) Consistent difficulty; child may be unaware of variability in affective experience; child may only be able to tolerate a very limited range of [illegible] child may be [illegible]tently constricted, consistently hyperaroused, or fluctuate rapidly among extremes, [illegible]d may have a very limited coping repertoire [illegible]ld may be only able to use coping tools with significant supports *or* unable to use [illegible]s, even with supports

Priority level – 3 - High; Vulnerable domain; need [illegible]ority focus

Assessment [illegible] supports include:

[Con[illegible]ration of elevation observed on self- and other-report measures of affect, such as C[illegible]TSC-C, TSC-YC, YSR; reports of behavioral difficulties in school or other domains; observed ability to modulate affect and physiological arousal; observed or reported ability to tolerate frustration or stressors, including limit-setting; observed or reported ability to tolerate positive experiences]

Concretely, describe child vulnerabilities with affect modulation:

Concretely, describe child strengths with affect modulation (consider both internal and external resources):

Concrete treatment goals:

RIII. SELF-REGULATION: Affect Expression

Child is/has:

( ) Generally interested in and willing to share internal experience; child can accurately identify safe communication resources; child has appropriate boundaries and awareness in extent of information to share with different resources; child is able to effectively initiate communication; child has good non-verbal communication skills (i.e., eye contact, awareness of physical boundaries); child has effective verbal skills; child may use self-expression skills to effectively manage a portion of affect.
Priority level - 1 - Low; Support for continued use of skills

( ) Moderate difficulty; may be hesitant/guarded or feel vulnerable sharing internal experience, or there may be a very limited number of people child considers sharing with; child may have occasional difficulty with boundaries in sharing (i.e., overly rigid or overly open); may have occasional or situational difficulty initiating communication with others; may have occasional difficulty with nonverbal skills, or may have trouble with some skills but not others, *or* difficulties interfere with effective communication; child may have occasional difficulty with verbal skills; child may have self-expression skills but is overly reliant on these in the absence of communicating with others
Priority level – 2 - Moderate; Support and coaching in use of skill

( ) Consistent difficulty; child may have significant difficulty trusting others, and may be closed to the idea of communication; child may have significant boundary violations in sharing (overly rigid or open); child may be unable to initiate communication with others; child may lack nonverbal skills or have nonverbal qualities that significantly interfere with effective communication; difficulty with verbal skills may interfere significantly with effective communication
Priority level – 3 - Highly Vulnerable domain; needs priority focus

Assessment responsive include:

Concretely, describe child vulnerabilities with affect expression:

Concretely, describe child strengths with affect expression (consider both internal and external resources):

Concrete treatment goals:

CI. Executive Functions:

***Note: Developmental stage should be considered in rating*

Child is/has:

( ) Generally…able to recognize situations as problematic, both in the moment and in anticipation; able to delay responses when appropriate; able to appropriately ask for help and support when needed; aware of own triggers and ways these may interfere with problem-solving; able to generate realistic choices for a given situation; able to anticipate potential outcomes; able to follow through on choices

Priority level - 1 - Low; Support for continued use of skills

( ) Situational or contextual difficulty (i.e., greater difficulty in unstructured then structured situations); may have impaired problem-solving when triggered; may have certain "blind spots" for recognizing problems; may get stuck or need support in generating choices; inconsistently able to inhibit immediate response; may be able to problem-solve in aftermath but not in-the-moment; may be able to generate choices, but have difficulty following through, *or* picks negative or ineffective choices.

Priority level – 2 - Moderate; Support and coaching in use of skill

( ) Consistent difficulty; lack of awareness of problem situatio[illegible]ck of awareness of choices; impaired sense of agency; may often feel helpless in [illegible]face of challenging situations; difficulty taking responsibility for actions (i.e., often justifies or externalizes responsibility for negative choices); unable to anticipate long-term consequences; frequently repeats past negative behavior despite ass[illegible]ed negative consequences; may be rigidly stuck on single response to a situation, or may have extreme difficulty making a choice, even with supports

Priority level – 3 - High; Vulne[illegible]main; need for priority focus

Assessment results supportive in[illegible]ude:

Con[illegible]y, describe child vulnerabilities with executive functions:

Concretely, describe child strengths with executive functions:

Concrete treatment goals:

CII. Self-Development:

***Note: Developmental stage should be considered in rating*

Child is/has:

( ) Generally has some sense of competence; is able to balance realistic awareness of vulnerabilities with positive attributes; general awareness of preferences, likes/dislikes, values, and individual attributes; sense of self is multi-faceted and includes awareness of multiple qualities, emotions, and experiences; is able to imagine future possibilities in an age-appropriate way

Priority level - 1 - Low; Support for continued use of skills

( ) Moderate impairment in sense of self and identity; may have a range of interests/likes/dislikes, but feel uncomfortable or vulnerable owning these, and/or interests may be limited or rigid; may be willing to explore additional interests, but unable to sustain engagement; may have difficulty establishing sense of self as separate from the peer group; may change projected identity to conform to environmental or peer expectations; some complexity in integration of emotions or experiences, but may have particular feelings or experiences that appear fragmented or disconnected some future orientation, but may be unrealistic or negative

Priority level – 2 - Moderate; Support and coaching in use of skill

( ) Marked impairment; minimal sense of competence; self-perception may be dominated by negative attributes such as shame, damage or vulnerability; *or* may unrealistically overestimate competence, and appear overly defended against any vulnerability evident discomfort with sense of self; may be unwilling or unable to explore aspects of self (i.e., interests, likes/dislikes), or have rigid adherence to single aspect of self; mark fragmentation of emotional states or experiences; may have minimal or no sense of the future, or be overwhelmed or hopeless about the future

Priority level – 3 - High: Notable concern; need for priority focus

Assessment results supportive include:

Concretely, describe child vulnerabilities with self-development:

Concretely, describe child strengths with self-development:

Concrete treatment goals:

PSI Item Booklet

Instructions:

On the PSI Answer Sheet, please write your name, gender, date of birth, ethnic group, marital status, child's name, child's gender, child's 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 120 statements. Read each statement carefully. For each statement, please focus on the child you are most concerned about, and circle the response which best represents your opinion.

Circle the SA if you strongly agree with the statement.
Circle the A if you agree with the statement.
Circle the NS if you are not sure.
Circle the D if you disagree with the statement.
Circle the SD if you strongly disagree with the statement.

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. SA (A) NS D SD

While 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. SA A NS (X) (SD)

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1. When my child wants something, my child usually keeps trying to get it.
2. My child is so active that it exhausts me.
3. My child appears disorganized and is easily distracted.
4. Compared to most, my child has more difficulty concentrating and paying attention.
5. My child will often stay occupied with a toy for more than 10 minutes.
6. My child wanders away much more than I expected.
7. My child is much more active than I expected.
8. My child squirms and kicks a great deal when being dressed or bathed.
9. My child can be easily distracted from wanting something.
10. My child rarely does things for me that make me feel good.
11. Most times I feel that my child likes me and wants to be close to me.
12. Sometimes I feel my child doesn't like me and doesn't want to be close to me.
13. My child smiles at me much less than I expected.
14. When I do things for my child, I get the feeling that my efforts are not appreciated very much.

For statement 15, choose a response from choices 1 to 4 below.

15. Which statement best describes your child?
    1. almost always likes to play with me
    2. sometimes likes to play with me
    3. usually doesn't like to play with me
    4. almost never likes to play with me

For statement 16, choose a response from choices 1 to 5 below.

16. My child cries
    1. much less than I expected
    2. less than I expected
    3. about as much as I expected
    4. much more than I expected
    5. it seems almost constant
17. My child seems to cry or fuss more often than most children.
18. When playing, my child doesn't often giggle or laugh.
19. My child generally wakes up in a bad mood.
20. I feel that my child is very moody and easily upset.
21. My child looks a little different than I expected and it bothers me at times.
22. In some areas, my child seems to have forgotten past learnings and has gone back to doing things characteristic of younger children.
23. My child doesn't seem to learn as quickly as most children.
24. My child doesn't seem to smile as much as most children.

25. My child does a few things which bother me a great deal.

26. My child is not able to do as much as I expected.

27. My child does not like to be cuddled or touched very much.

28. When my child came home from the hospital, I had doubtful feelings about my ability to handle being a parent.

29. Being a parent is harder than I thought it would be.

30. I feel capable and on top of things when I am caring for my child.

31. Compared to the average child, my child has a great deal of difficulty in getting used to changes in schedules or changes around the house.

32. My child reacts very strongly when something happens that my child doesn't like.

33. Leaving my child with a babysitter is usually a problem.

34. My child gets upset easily over the smallest thing.

35. My child easily notices and overreacts to loud sounds and bright lights.

36. My child's sleeping or eating schedule was much harder to establish than I expected.

37. My child usually avoids a new toy for a while before beginning to play with it.

38. It takes a long time and it is very hard for my child to get used to new things.

39. My child doesn't seem comfortable when [illegible]

For statement 40, choose from choices 1 to 4 below.

40. When upset, my child
    1. easy to calm
    2. harder to calm [illegible] expected
    3. [illegible]
    4. [illegible] than my child

For statement 41, choose from choices 1 to 5 below.

41. I have found that getting my child to do something or stop doing something is:
    1. much harder than I expected
    2. somewhat harder than I expected
    3. about as hard as I expected
    4. somewhat easier than I expected
    5. much easier than I expected

For statement 42, choose from choices 1 to 5 below.

42. Think carefully and count the number of things which your child does that bothers you. For example: dawdles, refuses to listen, overactive, cries, interrupts, fights, whines, etc. Please circle the number which includes the number of things you counted.
    1. 1–3
    2. 4–5
    3. 6–7
    4. 8–9
    5. 10+

For statement 43, choose from choices 1 to 5 below.

43. When my child cries, it usually lasts:
    1. less than 2 minutes
    2. 2–5 minutes
    3. 5–10 minutes
    4. 10–15 minutes
    5. more than 15 minutes

44. There are some things my child does that really bother me a lot.

45. My child has had more health problems than I expected.

46. As my child has grown older and become more independent, I find myself more worried that my child will get hurt or into trouble.

47. My child turned out to be more of a problem than I had expected.

48. My child seems to be much harder to care for than most.

49. My child is always hanging on me.

50. My child makes more demands on me than most children.

51. I can't make decisions without help.

52. I have had many more problems raising children than I expected.

53. I enjoy being a parent.

54. I feel that I am successful most of the time when ... get my child to do or not do something.

55. Since I brought my last child home f... ... d that I am not able to take care of this child as well as I thought I could. I ... feel like

56. I often ... ing ... I can't han... thing... very well.

For statemen... ...om choices ... to 5 below.

57. When I ... about ... elf as a parent I believe:
    1. I ... thing that happens
    2. I ... ...ost things pretty well
    3. sometimes I have doubts, but find that I handle most things without any problems
    4. I have some doubts about being able to handle things
    5. I don't think I handle things very well at all

For statement 58, choose from choices 1 to 5 below.

58. I feel that I am:
    1. a very good parent
    2. a better than average parent
    3. an average parent
    4. a person who has some trouble being a parent
    5. not very good at being a parent

For questions 59 and 60, choose from choices 1 to 5 below.

59. What were the highest levels in school or college you and the child's father/mother have completed?
Mother:
    1. 1st to 8th grade
    2. 9th to 12th grade
    3. vocational or some college
    4. college graduate
    5. graduate or professional school

60. Father:
    1. 1st to 8th grade
    2. 9th to 12th grade
    3. vocational or some college
    4. college graduate
    5. graduate or professional school

For question 61, choose from choices 1 to 5 below.

61. How easy is it for you to understand what your child wants or needs?
    1. very easy
    2. easy
    3. somewhat difficult
    4. it is very hard
    5. I usually can't figure out what the problem is

62. It takes a long time for parents to develop close, warm feelings for their children.

63. I expected to have closer and warmer feelings for my child than I do and this bothers me.

64. Sometimes my child does things that bother me just to be mean.

65. When I was young, I never felt comfortable holding or taking care of children.

66. My child knows I am his or her parent and wants me more than other people.

67. The number of children that I have now is too many.

68. Most of my life is spent doing things for my child.

69. I find myself giving up more of my life to meet my children's needs than I ever expected.

70. I feel trapped by my responsibilities as a parent.

71. I often feel that my child's needs control my life.

72. Since having this child, I have been unable to do new and different things.

73. Since having a child, I feel that I am almost never able to do things that I like to do.

74. It is hard to find a place in our home where I can go to be by myself.

75. When I think about the kind of parent I am, I often feel guilty or bad about myself.

76. I am unhappy with the last purchase of clothing I made for myself.

77. When my child misbehaves or fusses too much, I feel responsible, as if I didn't do something right.

78. I feel every time my child does something wrong, it is really my fault.

79. I often feel guilty about the way I feel toward my child.

80. There are quite a few things that bother me about my life.

81. I felt sadder and more depressed than I expected after leaving the hospital with my baby.

82. I wind up feeling guilty when I get angry at my child and this bothers me.

83. After my child had been home from the hospital for about a month, I noticed that I was feeling more sad and depressed than I had expected.

84. Since having my child, my spouse (or male/female friend) has not given me as much help and support as I expected.

85. Having a child has caused more problems than I expected in my relationship with my spouse (or male/female friend).

86. Since having a child, my spouse (or male/female friend) and I don't do as many things together.

87. Since having a child, my spouse (or male/female friend) and I don't spend as much time together as a family as I had expected.

88. Since having my last child, I have had less interest in sex.

89. Having a child seems to have increased the number of problems we have with in-laws and relatives.

90. Having children has been much more expensive than I had expected.

91. I feel alone and without friends.

92. When I go to a party, I usually expect not to enjoy myself.

93. I am not as interested in people as I used to be.

94. I often have the feeling that other people my own age don't particularly like my company.

95. When I run into a problem taking care of my children, I have a lot of people to whom I can talk to get help or advice.

96. Since having children, I have a lot fewer chances to see my friends and to make new friends.

97. During the past six months, I have been sicker than usual or have had more aches and pains than I normally do.

98. Physically, I feel good most of the time.

99. Having a child has caused changes in the way I sleep.

100. I don't enjoy things as I used to.

For statement 101, choose from choices 1 to 4 below.

101. Since I've had my child:
    1. I have been sick a great deal
    2. I haven't felt as good
    3. I haven't noticed any change in my health
    4. I have been healthier

For statements 102 to 120, choose from choices Y for "Yes" and N for "No."
During the last 12 months, have any of the following events occurred in your immediate family?

102. Divorce
103. Marital reconciliation
104. Marriage
105. Separation
106. Pregnancy
107. Other relative moved into household
108. Income increased substantially (20% or more)
109. Went deeply into debt
110. Moved to new location
111. Promotion at work
112. Income decreased substantially
113. Alcohol or drug problem
114. Death of close family friend
115. Began new job
116. Entered new school
117. Trouble with superiors at work
118. Trouble with teachers at school
119. Legal problems
120. Death of immediate family member

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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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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TSCC Booklet

John Briere, PhD

Directions

The items in this booklet **describe things that kids sometimes think, feel**, or do. Read each item, then mark how often it happens to **you by drawing a circle** around the correct number.

Circle **0** if it **never** happens to you.	(0)	1	2	3
Circle **1** if it happens **sometimes**.	0	(1)	2	3
Circle **2** if it happens **lots of times**.	0	1	(2)	3
Circle **3** if it happens **almost all of the time**.	0	1	2	(3)

For example, if you are late for school **sometimes**, you would circle the **1** for this item, like this:

Being late for school.	0	(1)	2	3

If you make a mistake or want to change your answer, do not erase. **Cross** out the wrong answer with an "X" and then circle the correct answer, like this:

Being late for school.	0	(1)	(2)	3

Name _____ Age _____ Sex _____ Identification No. _____ Race _____ Date _____

	Never	Sometimes	Lots of times	Almost all of the time
1. Bad dreams or nightmares	0	1	2	3
2. Feeling afraid something bad might happen	0	1	2	3
3. Scary ideas or pictures just pop into my head	0	1	2	3
4. Wanting to say dirty words	0	1	2	3
5. Pretending I am someone else	0	1	2	3
6. Arguing too much	0	1	2	3
7. Feeling lonely	0	1	2	3
8. Touching my private parts too much	0	1	2	3
9. Feeling sad or unhappy	0	1	2	3
10. Remembering things that happened that I didn't like	0	1	2	3
11. Going away in my mind, trying not to think	0	1	2	3
12. Remembering scary things	0	1	2	3
13. Wanting to yell and break things	0	1	2	3
14. Crying	0	1	2	3
15. Getting scared all of a sudden and don't know why	0	1	2	3
16. Getting mad and can't calm down	0	1	2	3
17. Thinking about having sex	0	1	2	3
18. Feeling dizzy	0	1	2	3
19. Wanting to yell at people	0	1	2	3
20. Wanting to hurt myself	0	1	2	3
21. Wanting to hurt other people	0	1	2	3
22. Thinking about touching other people's private parts	0	1	2	3
23. Thinking about sex when I don't want to	0	1	2	3
24. Feeling scared of men	0	1	2	3
25. Feeling scared of women	0	1	2	3
26. Washing myself because I feel dirty on the inside	0	1	2	3

0 = Never
1 = Sometimes
2 = Lots of times
3 = Almost all of the time

NCTSI SM-09-017

27. Feeling stupid or bad	0	1	2	3
28. Feeling like I did something wrong	0	1	2	3
29. Feeling like things aren't real	0	1	2	3
30. Forgetting things, can't remember things	0	1	2	3
31. Feeling like I'm not in my body	0	1	2	3
32. Feeling nervous or jumpy inside	0	1	2	3
33. Feeling afraid	0	1	2	3
34. Not trusting people because they might want sex	0	1	2	3
35. Can't stop thinking about something bad that happened to me	0	1	2	3
36. Getting into fights	0	1	2	3
37. Feeling mean	0	1	2	3
38. Pretending I'm somewhere else	0	1	2	3
39. Being afraid of the dark	0	1	2	3
40. Getting scared or upset when I think about sex	0	1	2	3
41. Worrying about things	0	1	2	3
42. Feeling like nobody likes me	0	1	2	3
43. Remembering things I don't want to remember	0	1	2	3
44. Having sex feelings in my body	0	1	2	3
45. My mind going empty or blank	0	1	2	3
46. Feeling like I hate people	0	1	2	3
47. Can't stop thinking about sex	0	1	2	3
48. Trying not to have any feelings	0	1	2	3
49. Feeling mad	0	1	2	3
50. Feeling afraid somebody will kill me	0	1	2	3
51. Wishing bad things had never happened	0	1	2	3
52. Wanting to kill myself	0	1	2	3
53. Daydreaming	0	1	2	3
54. Getting upset when people talk about sex	0	1	2	3

0 = Never
1 = Sometimes
2 = Lots of times
3 = Almost all of the time

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Item Booklet

John Briere, PhD

Please read all of these instructions carefully before beginning. Mark all of your answers on the accompanying Answer Sheet and write only where indicated. DO NOT write in this Item Booklet.

On the Answer Sheet, please write the date and the child's name, gender, race, age, and living situation in the spaces provided. Also, please write your name, your gender, and your relationship to the child in the spaces provided.

The following items have to do with things the child does, feels, or experiences. Please indicate how often each of the following things has happened **in the last month**.

Circle 1 if your answer is *Not At All*; it has not happened at all in the last month.	(1) 2 3 4
Circle 2 if your answer is *Sometimes*; it has happened in the last month, but has not happened often.	1 (2) 3 4
Circle 3 if your answer is *Often*; it has happened often in the last month.	1 2 (3) 4
Circle 4 if your answer is *Very Often*; it has happened very often in the last month.	1 2 3 (4)

If you make a mistake or change your mind, **DO NOT ERASE!** Make an "X" through the incorrect response and then draw a circle around the correct response.

Example: 1 (~~2~~) 3 (4)

Please answer each item as honestly as you can. Be sure to answer every item. You can take as much time as you need to finish all of the items.

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NCTSI SM-09-017

1	2	3	4
Not At All	Sometimes	Often	Very Often

The following items have to do with things the child does, feels, or experiences. Please indicate how often he or she has done, felt, or experienced each of the following things **in the last month**.

1. Temper tantrums
2. Looking sad
3. Telling a lie
4. Bad dreams or nightmares
5. Living in a fantasy world
6. Seeming to know more about sex than he or she should
7. Being easily scared
8. Not wanting to go somewhere that reminded him or her of a bad thing from the past
9. Worrying that his or her food was poisoned
10. Flinching or jumping when someone moved quickly or there was a loud noise
11. Being bothered by memories of something that happened to him or her
12. Worrying that someone might be sexual with him or her
13. Not wanting to talk about something that happened to him or her
14. Not doing something he or she was supposed to do
15. Breaking things on purpose
16. Talking about sexual things
17. Having trouble concentrating
18. Blaming himself or herself for things that weren't his or her fault
19. Acting frightened when he or she was reminded of something that happened in the past
20. Pretending to have sex
21. Worrying that bad things would happen in the future
22. Arguing
23. Getting into physical fights
24. Drawing pictures about an upsetting thing that happened to him or her
25. Not noticing what he or she was doing
26. Having trouble sitting still
27. Playing games about something bad that actually happened to him or her in the past
28. Seeming to be in a daze
29. Having trouble remembering an upsetting thing that happened in the past
30. Using drugs
31. Fear of the dark
32. Being afraid to be alone
33. Spacing out
34. Being too aggressive
35. Touching other children's or adults' private parts (under or over clothes)

1	2	3	4
Not At All	Sometimes	Often	Very Often

Please indicate how often the child has done, felt, or experienced each of the following things **in the last month**.

36. Suddenly seeing, feeling, or hearing something bad that happened in the past
37. Hearing voices telling him or her to hurt someone
38. Staring off into space
39. Changing the subject or not answering when he or she was asked about a bad thing that happened to him or her
40. Having a nervous breakdown
41. Not laughing or being happy like other children
42. Crying at night because he or she was frightened
43. Hitting adults (including parents)
44. Being frightened of men
45. Not being able to pay attention
46. Seeming to be a million miles away
47. Being easily startled
48. Watching out everywhere for possible danger
49. No longer doing things that he or she used to enjoy
50. Becoming frightened or disturbed when something sexual was mentioned or seen
51. Not sleeping for two or more days
52. Not paying attention because he or she was in his or her own world
53. Making mistakes
54. Crying for no obvious reason
55. Not wanting to be around someone who did something bad to him or her or reminded him or her of something bad
56. Being tense
57. Worrying about other people's safety
58. Becoming very angry over a little thing
59. Drawing pictures about sexual things
60. Pulling his or her hair out
61. Calling himself or herself bad, stupid, or ugly
62. Throwing things at friends or family members
63. Getting upset about something in the past
64. Temporary blindness or paralysis
65. Getting upset about something sexual
66. Not going to bed at night the first time he or she was asked
67. Fear that he or she would be killed by someone
68. Saying that nobody liked him or her
69. Crying when he or she was reminded of something from the past

1	2	3	4
Not At All	Sometimes	Often	Very Often

Please indicate how often the child has done, felt, or experienced each of the following things **in the last month**.

70. Saying that something bad didn't happen to him or her even though it did happen
71. Saying he or she wanted to die or be killed
72. Acting as if he or she didn't have any feelings about something bad that happened to him or her
73. Whining
74. Not sleeping well
75. Worrying about sexual things
76. Being frightened by things that didn't used to scare him or her
77. Hallucinating
78. Acting like he or she was in a trance
79. Forgetting his or her own name
80. Getting upset when he or she was reminded of something bad that happened
81. Avoiding things that reminded him or her of a bad thing that had happened in the past
82. Acting jumpy
83. Making a mess
84. Acting sad or depressed
85. Being so absent-minded that he or she didn't notice what was going on around him or her
86. Not wanting to eat certain foods
87. Yelling at family, friends, or teachers
88. Not playing because he or she was depressed
89. Being disobedient
90. Intentionally hurting other children or family members

UCLA PTSD INDEX FOR DSM IV ©

Name _____ Age _____ Sex (Circle): Girl Boy

Today's Date (**write month, day and year**) _____ Grade in School _____

School _____ Teacher _____ Town _____

Below is a list of VERY SCARY, DANGEROUS OR VIOLENT things that sometimes happen to people. These are times where someone was HURT VERY BADLY OR KILLED, or could have been. Some people have had these experiences; some people have not had these experiences. Please be honest in answering if the violent thing happened to you, or if it did not happen to you.

FOR EACH QUESTION: **Check "Yes"** if this scary thing **HAPPENED TO YOU**
Check "No" if it **DID *NOT* HAPPEN TO YOU**

1)	Being in a big earthquake that badly damaged the building you were in.	Yes [ ] No [ ]
2)	Being in another kind of **disaster**, like a fire, tornado, flood or hurricane.	Yes [ ] No [ ]
3)	Being in a bad **accident**, like a **very serious** car accident.	Yes [ ] No [ ]
4)	Being in place where a **war** was going on around you.	Yes [ ] No [ ]
5)	Being **hit, punched, or kicked very hard** at home. (**DO NOT INCLUDE** ordinary fights between brothers & sisters).	Yes [ ] No [ ]
6)	Seeing a family member being **hit, punched or kicked very hard** at home. (**DO NOT INCLUDE** ordinary fights between brothers & sisters).	Yes [ ] No [ ]
7)	Being **beaten up, shot at or threatened to be hurt badly** in your town.	Yes [ ] No [ ]
8)	Seeing someone in your town being **beaten up, shot at or killed.**	Yes [ ] No [ ]
9)	Seeing a **dead body** in your town (do not include funerals).	Yes [ ] No [ ]
10)	Having an adult or someone much older touch your **private sexual body parts** when you did not want them to.	Yes [ ] No [ ]
11)	Hearing about the **violent death or serious injury** of a loved one.	Yes [ ] No [ ]
12)	Having **painful and scary medical treatment in a hospital** when you were very sick or badly injured.	Yes [ ] No [ ]

Contact: UCLA Trauma Psychiatry Service
300 UCLA Medical Plaza, Ste 2232
Los Angeles, CA 90095-6968 (310) 206-8973
EMAIL: rpynoos@mednet.ucla.edu

13) **OTHER** than the situations described above, has **ANYTHING ELSE** ever happened to you that was **REALLY SCARY, DANGEROUS OR VIOLENT?** Yes [ ] No [ ]

14) a) If you answered "YES" to only **ONE** thing in the above list of questions #1 to #13, place the number of that thing (#1 to #13) in this blank. # _____

b) If you answered "YES" to **MORE THAN ONE THING,** place the number of the thing that **BOTHERS YOU THE MOST NOW** in this blank. #_____

c) About how long ago did this bad thing (your answer to [a] or [b]) happen to you? _____

d) Please write what happened: _____

FOR THE *NEXT* QUESTIONS, please **CHECK [YES] or [NO]** to answer **HOW YOU FELT during or right after** the bad thing happened that you just wrote about in Question 14.

15) Were you scared that you would die?	Yes [ ]	No [ ]
16) Were you scared that you would be hurt badly?	Yes [ ]	No [ ]
17) Were you hurt badly?	Yes [ ]	No [ ]
18) Were you scared that someone else would die?	Yes [ ]	No [ ]
19) Were you scared that someone else would be hurt badly?	Yes [ ]	No [ ]
20) Was someone else hurt badly?	Yes [ ]	No [ ]
21) Did someone die?	Yes [ ]	No [ ]

22) Did you feel very scared, like this was one of your most scary experiences ever? Yes [ ] No [ ]

23) Did you feel that you could not stop what was happening or that you needed someone to help?	Yes [ ] No [ ]
24) Did you feel that what you saw was disgusting or gross?	Yes [ ] No [ ]
25) Did you run around or act like you were very upset?	Yes [ ] No [ ]
26) Did you feel very confused?	Yes [ ] No [ ]
27) Did you feel like what was happening did not seem real in some way, like it was going on in a movie instead of real life?	Yes [ ] No [ ]

Here is a list of problems people sometimes have after very bad things happen. Please **THINK** about the bad thing that happened to you that you wrote about in Question #14 on the page 2. Then, **READ** each problem on the list carefully. **CIRCLE ONE** of the numbers (0, 1, 2, 3 or 4) that tells how often the problem has happened to you **in the past month**. Use the **Rating Sheet** on Page 5 to help you decide how often the problem has happened in the past month.

PLEASE BE SURE TO ANSWER ALL QUESTIONS

HOW MUCH OF THE TIME DURING THE PAST MONTH	None	Little	Some	Much	Most
1_{D4} I watch out for danger or things that I am afraid of.	0	1	2	3	4
2_{B4} When something reminds me of what happened, I get very upset, afraid or sad.	0	1	2	3	4
3_{B1} I have upsetting thoughts, pictures, or sounds of what happened come into my mind when I do not want them to.	0	1	2	3	4
4_{D2} I feel grouchy, angry or mad.	0	1	2	3	4
5_{B2} I have dreams about what happened or other bad dreams.	0	1	2	3	4
6_{B3} I feel like I am back at the time when the bad thing happened, living through it again.	0	1	2	3	4
7_{C4} I feel like staying by myself and not being with my friends.	0	1	2	3	4

HOW MUCH OF THE TIME DURING THE					

PAST MONTH	None	Little	Some	Much	Most
8_{C5} I feel alone inside and not close to other people.	0	1	2	3	4
9_{C1} I try not to talk about, think about, or have feelings about what happened.	0	1	2	3	4
10_{C6} I have trouble feeling happiness or love.	0	1	2	3	4
11_{C6} I have trouble feeling sadness or anger.	0	1	2	3	4
12_{D5} I feel jumpy or startle easily, like when I hear a loud noise or when something surprises me.	0	1	2	3	4
13_{D1} I have trouble going to sleep or I wake up often during the night.	0	1	2	3	4
14_{AF} I think that some part of what happened is my fault.	0	1	2	3	4
15_{C3} I have trouble remembering important parts of what happened.	0	1	2	3	4
16_{D3} I have trouble concentrating or paying attention.	0	1	2	3	4
17_{C2} I try to stay away from people, places, or things that make me remember what happened.	0	1	2	3	4
18_{B5} When something reminds me of what happened, I have strong feelings in my body, like my heart beats fast, my head aches, or my stomach aches.	0	1	2	3	4
19_{C7} I think that I will not live a long life.	0	1	2	3	4
20_{D2} I have arguments or physical fights.	0	1	2	3	4
21_{C7} I feel pessimistic or negative about my future.	0	1	2	3	4
22_{AF} I am afraid that the bad thing will happen again.	0	1	2	3	4

FREQUENCY RATING SHEET

HOW OFTEN OR HOW MUCH OF THE TIME
DURING THE PAST MONTH, THAT IS SINCE _____,
DOES THE PROBLEM HAPPEN?

0	1	2	3	4
NONE	**LITTLE**	**SOME**	**MUCH**	**MOST**
S M T W H F S	S M T W H F S . X . . . . X .	S M T W H F S . . X . . X . . . X . . . . X . . . . . X . X . .	S M T W H F S . X . X . X . X . X . X . . . X . X . X . X X X	S M T W H F S X X X X X X X . X X X X . . . X X . X X . X X X X X X X
NEVER	**TWO TIMES A MONTH**	**1-2 TIMES A WEEK**	**2-3 TIMES EACH WEEK**	**ALMOST EVERY DAY**

SCORING WORKSHEET FOR UCLA PTSD INDEX FOR DSM-IV, Revision 1: ADOLESCENT VERSION©

Subject ID#_____ **Age**_____ **Sex (circle): M F** **# of days since traumatic event** _____

CRITERION A-TRAUMATIC EVENT

Exposure to Traumatic Event
Questions 1-13: at least 1 "Yes" answer **YES** **NO**

Type of Traumatic Event rated as most distressing (Question 14: write trauma type in the blank) _____

Criterion A1 met
Questions 15-21: at least 1 "Yes" answer **YES** **NO**

Criterion A2 met
Questions 22-26: at least 1 "Yes" answer **YES** **NO**

Criterion A met **YES** **NO**

Peritraumatic Dissociation **YES** **NO**
Question 27: answer "Yes"

PTSD SEVERITY: OVERALL SCORE

Question # /Score	Question # /Score
1. _____	12._____
2. _____	13._____
3. _____	[Omit 14].
+4. *or*	15._____
20. _____	16._____
5. _____	17._____
6. _____	18._____
7. _____	=19. or
8. _____	21._____
9. _____	[Omit 22].
* 10. *or*	**(Sum total** **PTSD SEVERITY**
11._____	**of scores) =** _____ **SCORE**

+Place the highest Score from either Question 4 *or* 20 in the blank above: Score Question 4.____/Score Question 20.____
*Place the highest Score from either Question 10 *or* 11 in the blank above: Score Question 10.____/Score Question 11.____
= Place the highest Score from either Question 19 *or* 21 in the blank above: Score Question 19.____/Score Question 21.____

CRITERION B (REEXPERIENCING) SX.

Question #/DSM-IV Symptom	Score	
3. (B1) Intrusive recollections	_____	
5. (B2) Trauma/bad dreams	_____	
6. (B3) Flashbacks	_____	# of Criterion B
2. (B4) Cues: Psychological reactivity	_____	Questions with Score ≥ Symptom
18. (B5) Cues: Physiological reactivity	_____	Cutoff: _____

CRITERION B SEVERITY SCORE (Sum of above scores): = _____

DSM-IV CRITERION B MET:
(Diagnosis requires at least 1 "B" Symptom): **YES** **NO**

CRITERION C (AVOIDANCE) SX.

Question #/DSM-IV Symptom	Score	
9. (C1) Avoiding thoughts/feelings	_____	
17. (C2) Avoiding activities/people	_____	
15. (C3) Forgetting	_____	# of Criterion C
7. (C4) Diminished interest etc.	_____	Questions with
8. (C5) Detachment/estrangement	_____	Scores ≥ Symptom
*10. *or* 11. (C6) Affect restricted	_____	Cutoff: _____
=19. *or* 21. (C7) Foreshort. future	_____	

[*Place the highest Score from either Question 10 *or* 11 in the blank above; = Place the highest Score from either Question 19 *or* 21 in the blank above.]

CRITERION C SEVERITY SCORE (Sum of above scores): = _____

DSM-IV CRITERION C MET:
(Diagnosis requires at least 3 "C" Symptoms): **YES** **NO**

CRITERION D (INCREASED AROUSAL) SX.

Question #/DSM-IV Symptom	Score	
13. (D1) Sleep problems	_____	
+4. *or* 20. (D2) Irritability/anger	_____	
16. (D3) Concentration problems	_____	# of Criterion D
1. (D4) Hypervigilance	_____	Questions with
12. (D5) Exaggerated startle	_____	Score ≥ Symptom Cutoff: _____

[+Place the highest Score from either Question 4 *or* 20 in the blank above.]

CRITERION D SEVERITY SCORE (Sum of above scores): = _____

DSM-IV CRITERION D MET:
(Diagnosis requires at least 2 "D" Symptoms): **YES** **NO**

DSM-IV PTSD DIAGNOSTIC INFO.

DSM-IV FULL PTSD DIAGNOSIS LIKELY
(Criteria A, B, C, D all met) **YES** **NO**

PARTIAL PTSD LIKELY
(Criterion A met and:
Criteria B + C or B + D or C + D) **YES** **NO**

SCORING WORKSHEET FOR UCLA PTSD INDEX FOR DSM-IV, Revision 1: PARENT VERSION©

Subject ID#_____ Age_____ Sex (circle): M F # of days since traumatic event _____

CRITERION A-TRAUMATIC EVENT

Exposure to Traumatic Event
Questions 1-13: at least 1 "Yes" answer **YES** **NO**

Type of Traumatic Event rated as most distressing (Question 14: write trauma type in the blank) _____

Criterion A1 met
Questions 15-26: at least 1 "Yes" answer **YES** **NO**

Criterion A2 met
Questions 22-26: at least 1 "Yes" answer **YES** **NO**

Criterion A met **YES** **NO**

PTSD SEVERITY: OVERALL SCORE

Question # /Score	Question # /Score
1. _____	=10 or
2. _____	11._____
* 3 or	12._____
21. _____	13._____
4. _____	[Omit 14].
5. _____	15._____
6. _____	16._____
7. _____	17._____
8. _____	18._____
9. _____	19._____ [Omit 20].

(Sum the items from the above 2 columns, write sum below)

(Sum total of scores) = _____ **PTSD SEVERITY SCORE**

*Place the highest Score from either Question 3 *or* 21 in the blank above: Score Question 3. ____/Score Question 21._____
=Place the highest Score from either Question 10 *or* 11 in the blank above: Score Question 10. ____/Score Question 11.

CRITERION B (REEXPERIENCING) SX.

Question #/DSM-IV Symptom	Score	
3. (B1) Intrusive recollections or 21. (B2)Repetitive Traumatic Play	____*	
5. (B2) Trauma/bad dreams	_____	
6. (B3) Flashbacks	_____	# of Criterion B Questions with Score ≥ Symptom Cutoff: _____
2. (B4) Cues: Psychological reactivity	_____	
18. (B5) Cues: Physiological reactivity	_____	

*Place the highest Score from either Question 3 or 21 in the blank above: Score Question 3 (Intrusive recollections) _____
Score Question 21(Repetitive play) _____

CRITERION B SEVERITY SCORE (Sum of above scores): = _____

DSM-IV CRITERION B MET:
(Diagnosis requires at least 1 "B" Symptom): **YES** **NO**

CRITERION C (AVOIDANCE) SX.

Question #/DSM-IV Symptom	Score	
9. (C1) Avoiding thoughts/feelings	_____	
17. (C2) Avoiding activities/people	_____	
15. (C3) Forgetting	_____	# of Criterion C Questions with Scores ≥ Symptom Cutoff: _____
7. (C4) Diminished interest etc.	_____	
8. (C5) Detachment/estrangement	_____	
=10. *or* 11. (C6) Affect restricted	_____	
19. (C7) Foreshortened future	_____	

CRITERION C SEVERITY SCORE (Sum of above scores): = _____

DSM-IV CRITERION C MET:
(Diagnosis requires at least 3 "C" Symptoms): **YES** **NO**

=Place the highest Score from either Question 10 *or* 11 in the blank above: Score Question 10.____/Score Question 11.____

CRITERION D (INCREASED AROUSAL) SX.

Question #/DSM-IV Symptom	Score	
13. (D1) Sleep problems	_____	
4. (D2) Irritability/anger	_____	
16. (D3) Concentration problems	_____	# of Criterion D Questions with Score ≥ Symptom Cutoff: _____
1. (D4) Hypervigilance	_____	
12. (D5) Exaggerated startle	_____	

CRITERION D SEVERITY SCORE (Sum of above scores): = _____

DSM-IV CRITERION D MET:
(Diagnosis requires at least 2 "D" Symptoms): **YES** **NO**

DSM-IV PTSD DIAGNOSTIC INFO.

DSM-IV FULL PTSD DIAGNOSIS LIKELY
(Criteria A, B, C, D all met) **YES** **NO**

PARTIAL PTSD LIKELY
(Criterion A met and:
Criteria B + C or B + D or C + D) **YES** **NO**

SCORING WORKSHEET FOR UCLA PTSD INDEX FOR DSM-IV, Revision 1: CHILD VERSION©

Subject ID#_____ **Age**_____ **Sex (circle): M F** **# of days since traumatic event** _____

CRITERION A-TRAUMATIC EVENT

Exposure to Traumatic Event
Questions 1-13: at least 1 "Yes" answer **YES** **NO**

Type of Traumatic Event rated as most distressing (Question 14: write trauma type in the blank) _____

Criterion A1 met
Questions 15-21: at least 1 "Yes" answer **YES** **NO**

Criterion A2 met
Questions 22-26: at least 1 "Yes" answer **YES** **NO**

Criterion A met **YES** **NO**

Peritraumatic Dissociation **YES** **NO**
Question 27: answer "Yes"

PTSD SEVERITY: OVERALL SCORE

Question # /Score	Question # /Score
1._____	12._____
2._____	13._____
3._____	[Omit 14].
4._____	15._____
5._____	16._____
6._____	17._____
7._____	18._____
8._____	19._____
9._____	[Omit 20].
* 10. *or*	
11._____	

(Sum the items from the above 2 columns, write sum below)

(Sum total of scores) = _____ **PTSD SEVERITY SCORE**

*Place the highest Score from either Question 10 *or* 11 in the blank above: Score Question 10.____/Score Question 11.____

CRITERION B (REEXPERIENCING) SX.

Question #/DSM-IV Symptom	Score	
3. (B1) Intrusive recollections	_____	
5. (B2) Trauma/bad dreams	_____	
6. (B3) Flashbacks	_____	# of Criterion B
2. (B4) Cues: Psychological reactivity	_____	Questions with Score ≥ Symptom
18. (B5) Cues: Physiological reactivity	_____	Cutoff: _____

CRITERION B SEVERITY SCORE (Sum of above scores): = _____

DSM-IV CRITERION B MET:
(Diagnosis requires at least 1 "B" Symptom): **YES** **NO**

CRITERION C (AVOIDANCE) SX.

Question #/DSM-IV Symptom	Score	
9. (C1) Avoiding thoughts/feelings	_____	
17. (C2) Avoiding activities/people	_____	
15. (C3) Forgetting	_____	# of Criterion C
7. (C4) Diminished interest etc.	_____	Questions with
8. (C5) Detachment/estrangement	_____	Scores ≥ Symptom
*10. *or* 11. (C6) Affect restricted	_____	Cutoff: _____
19. (C7) Foreshort. future	_____	

[*Place the highest Score from either Question 10 *or* 11 in the blank above.]

CRITERION C SEVERITY SCORE (Sum of above scores): = _____

DSM-IV CRITERION C MET:
(Diagnosis requires at least 3 "C" Symptoms): **YES** **NO**

CRITERION D (INCREASED AROUSAL) SX.

Question #/DSM-IV Symptom	Score	
13. (D1) Sleep problems	_____	
4. (D2) Irritability/anger	_____	
16. (D3) Concentration problems	_____	# of Criterion D
1. (D4) Hypervigilance	_____	Questions with
12. (D5) Exaggerated startle	_____	Score ≥ Symptom Cutoff: _____

[+Place the highest Score from either Question 4 *or* 20 in the blank above.]

CRITERION D SEVERITY SCORE (Sum of above scores): = _____

DSM-IV CRITERION D MET:
(Diagnosis requires at least 2 "D" Symptoms): **YES** **NO**

DSM-IV PTSD DIAGNOSTIC INFO.

DSM-IV FULL PTSD DIAGNOSIS LIKELY
(Criteria A, B, C, D all met) **YES** **NO**

PARTIAL PTSD LIKELY
[Criterion A met and:
Criteria (B + C) or (B + D) or (C + D)] **YES** **NO**

Please print

CHILD BEHAVIOR CHECKLIST FOR AGES 6-18

For office use only
ID #

CHILD'S FULL NAME First Middle Last

CHILD'S GENDER ☐ Boy ☐ Girl

CHILD'S AGE

CHILD'S ETHNIC GROUP OR RACE

TODAY'S DATE Mo. ____ Day ____ Year ____

CHILD'S BIRTHDATE Mo. ____ Day ____ Year ____

GRADE IN SCHOOL ____

NOT ATTENDING SCHOOL ☐

Please fill out this form to reflect *your* view of the child's behavior even if other people might not agree. Feel free to print additional comments beside each item and in the space provided on page 2. ***Be sure to answer all items.***

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 ____

THIS FORM FILLED OUT BY: (print your full name)

____

Your gender: ☐ Male ☐ Female

Your relation to the child:

☐ Biological Parent ☐ Step Parent ☐ Grandparent
☐ Adoptive Parent ☐ Foster Parent ☐ Other (specify)

I. Please list the sports your child most likes to take part in. For example: swimming, baseball, skating, skate boarding, bike riding, fishing, etc.

None ☐

	Compared to others of the same age, about how much time does he/she spend in each?				Compared to others of the same age, how well does he/she do each one?			
	Less Than Average	Average	More Than Average	Don't Know	Below Average	Average	Above Average	Don't Know
a. ____	☐	☐	☐	☐	☐	☐	☐	☐
b. ____	☐	☐	☐	☐	☐	☐	☐	☐
c. ____	☐	☐	☐	☐	☐	☐	☐	☐

II. Please list your child's favorite hobbies, activities, and games, other than sports. For example: stamps, dolls, books, piano, crafts, cars, computers, singing, etc. (Do *not* include listening to radio or TV.)

None ☐

	Compared to others of the same age, about how much time does he/she spend in each?				Compared to others of the same age, how well does he/she do each one?			
	Less Than Average	Average	More Than Average	Don't Know	Below Average	Average	Above Average	Don't Know
a. ____	☐	☐	☐	☐	☐	☐	☐	☐
b. ____	☐	☐	☐	☐	☐	☐	☐	☐
c. ____	☐	☐	☐	☐	☐	☐	☐	☐

III. Please list any organizations, clubs, teams, or groups your child belongs to.

None ☐

	Compared to others of the same age, how active is he/she in each?			
	Less Active	Average	More Active	Don't Know
a. ____	☐	☐	☐	☐
b. ____	☐	☐	☐	☐
c. ____	☐	☐	☐	☐

IV. Please list any jobs or chores your child has. For example: paper route, babysitting, making bed, working in store, etc. (Include both paid and unpaid jobs and chores.)

None ☐

	Compared to others of the same age, how well does he/she carry them out?			
	Below Average	Average	Above Average	Don't Know
a. ____	☐	☐	☐	☐
b. ____	☐	☐	☐	☐
c. ____	☐	☐	☐	☐

Be sure you answered all items. Then see other side.

Please print. Be sure to answer all items.

V. 1. About how many close friends does your child have? (Do *not* include brothers & sisters)

☐ None ☐ 1 ☐ 2 or 3 ☐ 4 or more

2. About how many times a week does your child do things with any 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 his/her age, how well does your child:

	Worse	Average	Better	
a. Get along with his/her brothers & sisters?	☐	☐	☐	☐ Has no brothers or sisters
b. Get along with other kids?	☐	☐	☐	
c. Behave with his/her parents?	☐	☐	☐	
d. Play and work alone?	☐	☐	☐	

VII. 1. Performance in academic subjects. Does not attend school because _____

Check a box for each subject that child takes	Failing	Below Average	Average	Above Average
a. Reading, English, or Language Arts	☐	☐	☐	☐
b. History or Social Studies	☐	☐	☐	☐
c. Arithmetic or Math	☐	☐	☐	☐
d. Science	☐	☐	☐	☐
e. _____	☐	☐	☐	☐
f. _____	☐	☐	☐	☐
g. _____	☐	☐	☐	☐

Other academic subjects–for example: computer courses, foreign language, business. Do ***not*** include gym, shop, driver's ed., or other nonacademic subjects.

2. Does your child receive special education or remedial services or attend a special class or special school?

☐ No ☐ Yes—kind of services, class, or school:

3. Has your child repeated any grades? ☐ No ☐ Yes—grades and reasons:

4. Has your child had any academic or other problems in school? ☐ No ☐ Yes—please describe:

When did these problems start? _____

Have these problems ended? ☐ No ☐ Yes–when?

Does your child have any illness or disability (either physical or mental)? ☐ No ☐ Yes—please describe:

What concerns you most about your child?

Please describe the best things about your child.

Please print. Be sure to answer all items.

Below is a list of items that describe children and youths. For each item that describes your child ***now or within the past 6 months***, please circle the ***2*** if the item is ***very true or often true*** of your child. Circle the ***1*** if the item is ***somewhat or sometimes true*** of your child. If the item is ***not true*** of your child, circle the ***0***. Please answer all items as well as you can, even if some do not seem to apply to your child.

0 = Not True (as far as you know) **1 = Somewhat or Sometimes True** **2 = Very True or Often True**

0 1 2 1. Acts too young for his/her age
0 1 2 2. Drinks alcohol without parents' approval (describe): _____
_____
0 1 2 3. Argues a lot
0 1 2 4. Fails to finish things he/she starts
0 1 2 5. There is very little he/she enjoys
0 1 2 6. Bowel movements outside toilet
0 1 2 7. Bragging, boasting
0 1 2 8. Can't concentrate, can't pay attention for long
0 1 2 9. Can't get his/her mind off certain thoughts, obsessions (describe): _____
0 1 2 10. Can't sit still, restless, or hyperactive
0 1 2 11. Clings to adults or too dependent
0 1 2 12. Complains of loneliness
0 1 2 13. Confused or seems to be in a fog
0 1 2 14. Cries a lot
0 1 2 15. Cruel to animals
0 1 2 16. Cruelty, bullying, or meanness to others
0 1 2 17. Daydreams or gets lost in his/her thoughts
0 1 2 18. Deliberately harms self or attempts suicide
0 1 2 19. Demands a lot of attention
0 1 2 20. Destroys his/her own things
0 1 2 21. Destroys things belonging to his/her family or others
0 1 2 22. Disobedient at home
0 1 2 23. Disobedient at school
0 1 2 24. Doesn't eat well
0 1 2 25. Doesn't get along with other kids
0 1 2 26. Doesn't seem to feel guilty after misbehaving
0 1 2 27. Easily jealous
0 1 2 28. Breaks rules at home, school, or elsewhere
0 1 2 29. Fears certain animals, situations, or places, other than school (describe): _____
_____
0 1 2 30. Fears going to school
0 1 2 31. Fears he/she might think or do something bad
0 1 2 32. Feels he/she has to be perfect
0 1 2 33. Feels or complains that no one loves him/her
0 1 2 34. Feels others are out to get him/her
0 1 2 35. Feels worthless or inferior
0 1 2 36. Gets hurt a lot, accident-prone
0 1 2 37. Gets in many fights
0 1 2 38. Gets teased a lot
0 1 2 39. Hangs around with others who get in trouble
0 1 2 40. Hears sound or voices that aren't there (describe): _____
_____
0 1 2 41. Impulsive or acts without thinking
0 1 2 42. Would rather be alone than with others
0 1 2 43. Lying or cheating
0 1 2 44. Bites fingernails
0 1 2 45. Nervous, highstrung, or tense
0 1 2 46. Nervous movements or twitching (describe): _____
_____
_____
0 1 2 47. Nightmares
0 1 2 48. Not liked by other kids
0 1 2 49. Constipated, doesn't move bowels
0 1 2 50. Too fearful or anxious
0 1 2 51. Feels dizzy or lightheaded
0 1 2 52. Feels too guilty
0 1 2 53. Overeating
0 1 2 54. Overtired without good reason
0 1 2 55. 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, feels 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): _____
_____

Please print. Be sure to answer all items.

0 = Not True (as far as you know) **1 = Somewhat or Sometimes True** **2 = Very True or Often True**

0 1 2 57. Physically attacks people
0 1 2 58. Picks nose, skin, or other parts of body (describe): _____
_____
0 1 2 59. Plays with own sex parts in public
0 1 2 60. Plays with own sex parts too much
0 1 2 61. Poor school work
0 1 2 62. Poorly coordinated or clumsy
0 1 2 63. Prefers being with older kids
0 1 2 64. Prefers being with younger kids
0 1 2 65. Refuses to talk
0 1 2 66. Repeats certain acts over and over; compulsions (describe): _____
_____
0 1 2 67. Runs away from home
0 1 2 68. Screams a lot
0 1 2 69. Secretive, keeps things to self
0 1 2 70. Sees things that aren't there (describe):
_____
_____
0 1 2 71. Self-conscious or easily embarrassed
0 1 2 72. Sets fires
0 1 2 73. Sexual problems (describe): _____
_____
_____
0 1 2 74. Showing off or clowning
0 1 2 75. Too shy or timid
0 1 2 76. Sleeps less than most kids
0 1 2 77. Sleeps more than most kids during day and/or night (describe): _____
_____
0 1 2 78. Inattentive or easily distracted
0 1 2 79. Speech problem (describe): _____
_____
0 1 2 80. Stares blankly
0 1 2 81. Steals at home
0 1 2 82. Steals outside the home
0 1 2 83. Stores up too many things he/she doesn't need (describe): _____
_____
_____
0 1 2 84. Strange behavior (describe): _____
_____
0 1 2 85. Strange ideas (describe): _____
_____
0 1 2 86. Stubborn, sullen, or irritable
0 1 2 87. Sudden changes in mood or feelings
0 1 2 88. Sulks a lot
0 1 2 89. Suspicious
0 1 2 90. Swearing or obscene language
0 1 2 91. Talks about killing self
0 1 2 92. Talks or walks in sleep (describe): _____
_____
0 1 2 93. Talks too much
0 1 2 94. Teases a lot
0 1 2 95. Temper tantrums or hot temper
0 1 2 96. Thinks about sex too much
0 1 2 97. Threatens people
0 1 2 98. Thumb-sucking
0 1 2 99. Smokes, chews, or sniffs tobacco
0 1 2 100. Trouble sleeping (describe): _____
_____
0 1 2 101. Truancy, skips school
0 1 2 102. Underactive, slow moving, or lacks energy
0 1 2 103. Unhappy, sad, or depressed
0 1 2 104. Unusually loud
0 1 2 105. Uses drugs for nonmedical purposes (***don't*** include alcohol or tobacco) (describe):
_____
_____
0 1 2 106. Vandalism
0 1 2 107. Wets self during the day
0 1 2 108. Wets the bed
0 1 2 109. Whining
0 1 2 110. Wishes to be of opposite sex
0 1 2 111. Withdrawn, doesn't get involved with others
0 1 2 112. Worries
113. Please write in any problems your child has that were not listed above:
0 1 2 _____
0 1 2 _____
0 1 2 _____

Please be sure you answered all items.

Vermont Child Trauma Collaborative

ARC Agency Inventory[1]

Introduction: Vermont is committed to strengthening the trauma-specific services for children and their families throughout the public mental health system. As part of this work, we have chosen to implement the Attachment, Self-Regulation and Competencies (ARC) framework into the Vermont Children's Mental Health system of care. The ARC model, developed by Margaret Blaustein, Ph.D. and Kristine Kinniburgh of the Trauma Center at JRI in Massachusetts, is recognized by the National Child Traumatic Stress Network (NCTSN) as a promising practice for the treatment of complex psychological trauma in children. The ARC framework provides core principles of understanding trauma and core domains to address complex trauma through intervention. Prior to embarking on the multi-year training and consultation project with Dr. Blaustein, we thought it would be useful to have each agency conduct a self-assessment around the key principles of ARC.

Instruction: Please have all participants in the VCTC Project read the journal article "Intervening Beyond the Child: The intertwining nature of trauma and attachment"[2]. You can use this article as a reference for assessing how well your agency is already addressing the components of the ARC framework.

The participating staff at each agency should work together to answer the Agency ARC Inventory questions below. There are no right or wrong answers. This is a chance for agency staff to discuss the domains and building blocks of the ARC model and identify areas of strength and areas for growth or change as an agency.

Each participating staff should also complete the Pre-Training Questionnaire.

Together these will aid planning for the training & consultation. The Agency ARC Inventory & Staff Pre-Training Questionnaire can be completed electronically by clicking on the grey areas.

Please return:

☐ **Agency ARC Inventory**

☐ **4 Staff Pre-Training Questionnaires**

to Laurel Omland at DMH by August 15th.

FAX: 802-652-2005 or EMAIL: lomland@vdh.state.vt.us

[1] ARC Concepts adapted from Kinninburge & Blaustein (2005): Attachment, Self-Regulation & Competency (ARC): A Comprehensive Framework for Intervention with Complexly Traumatized Youth.

[2] Blaustein, M., Kinniburgh, K. (2007). Intervening Beyond the Child: The intertwining nature of trauma and attachment, British Psychological Society, Briefing Paper 26, (48-53).

ARC AGENCY INVENTORY

Completed by:
(Name & Title)
Agency:
Date:

Positive Attachment

1. Circle the number that corresponds to how well your agency already supports positive attachment. For this scale, "1" equals "not at all well" and "5" equals "extremely well".

	☐	☐	☐	☐	☐	
Not at all well	1	2	3	4	5	**Very Well**

2. What aspects of supporting positive attachment is most challenging for your agency?

3. What are the most successful strategies and interventions used by your agency to promote positive attachment?

Self-Regulation

4. Circle the number that corresponds to how well your agency already supports Self-Regulation.

	☐	☐	☐	☐	☐	
Not at all well	1	2	3	4	5	**Very Well**

5. What aspects of supporting Self-Regulation is most challenging for your agency?

6. What are the most successful strategies and interventions used by your agency to promote Self-Regulation?

Developmental Competencies

7. Circle the number that corresponds to how well your agency already supports Developmental Competency.

	☐	☐	☐	☐	☐	
Not at all well	1	2	3	4	5	**Very Well**

8. What aspects of supporting Developmental Competency is most challenging for your agency?

9. What are the most successful strategies and interventions used by your agency to promote Developmental Competency?

General

10. What types of staff training and support are needed in any of the areas mentioned?

11. As a result of this inventory or project, are there any changes that you plan to make? If yes, give examples of the ways that you will change agency policies, procedures, staff training, staff supervision, etc. to adopt the ARC framework.

Your Agency's Priority Areas for Implementation of ARC

Identify the key priorities to target for systems or clinical implementation; at least one target selected in each of Attachment, Self-Regulation, and Competency domains (this will be a work in progress to be further developed through the consultation project):

1.
2.
3.

Please return:

☐ **Agency ARC Inventory**
☐ **Staff Pre-Training Questionnaires**

to Laurel Omland at DMH by _____.

FAX: 802-652-2005 or EMAIL: laurel.omland@ahs.state.vt.us

TRAUMA CENTER

At Justice Resource Institute

Pre-Training Questionnaire

Thank you for participating in the ARC training/consultation. To help us continue to make our training procedures more effective, we appreciate your taking the time to complete the following items.

	Strongly Agree				**Strongly Disagree**
I have a good understanding of normative child development.	1☐	2☐	3☐	4☐	5☐
I have a good understanding of the role of the attachment system in child development.	1☐	2☐	3☐	4☐	5☐
I have a good understanding of the impact of trauma on self-regulation.	1☐	2☐	3☐	4☐	5☐
I have a good understanding of the role of early trauma experiences in my clients' current presentations.	1☐	2☐	3☐	4☐	5☐
I feel confident in my ability to address complex trauma adaptations.	1☐	2☐	3☐	4☐	5☐
I feel frustrated by the behaviors of the children/adolescents I work with.	1☐	2☐	3☐	4☐	5☐
I feel confidence in my skill set for helping caregivers and/or children who have experienced trauma build positive relationships.	1☐	2☐	3☐	4☐	5☐
I feel overwhelmed by the clinical needs of the clients I work with.	1☐	2☐	3☐	4☐	5☐
I feel confidence in my skill set for building self-regulation in traumatized children.	1☐	2☐	3☐	4☐	5☐
I feel empathy toward the children/adolescents I work with.	1☐	2☐	3☐	4☐	5☐
I sometimes feel "burnt out" by the demands of the system I work for.	1☐	2☐	3☐	4☐	5☐
I feel confidence in my skill set for building developmental competencies.	1☐	2☐	3☐	4☐	5☐

CODE: _____

APPENDIX 3: SAMPLE CONSENT FORMS

Title of Research Project: Evaluation of the Vermont VCTC
Principal Investigator: Thomas Delaney, PhD
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 Child Trauma Collaborative (VCTC) project because you are the caregiver of a young person who is receiving services through the VCTC project. This evaluation is being conducted by Ms. Alison Howe and Dr. Thomas Delaney from the Department of Pediatrics at the University of Vermont College of Medicine. 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 VCTC project is working, in order to understand the impact the project is having on children's lives and the lives of their caregivers.
- The results of this evaluation should go far in understanding which aspects of the VCTC project are associated with improved outcomes for children receiving VCTC services and their caregivers, and to help us improve the VCTC project.

How Many People Will Take Part in this Evaluation?

- All children and their caregivers who receive services through the VCTC 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 children and their caregivers will fill out during a meeting with the project evaluator, or in some cases in a meeting with your child's mental health provider. Only children 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 hours to complete the surveys, and we will try to schedule a time to do them soon after the child starts receiving services through the VCTC project.
- Approximately three months, six months, nine months and one year later, we will contact you to schedule a time to do another round of the same or similar 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 VCTC 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 child over the age of 12 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 children's and caregivers' identity and keeps their responses confidential.
- The master list of child 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 VCHIP 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. Thomas Delaney, the Principal 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.

Signature of Legal Guardian or Legally Authorized Representative **Date**

Printed Name of Legal Guardian or Legally Authorized Representative

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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: Thomas Delaney, PhD
Address: UVM VCHIP, UHC St. Joseph 7, University of Vermont, Burlington, VT 05401
Telephone Number: (802) 656-8210 **Email Address:** **Thomas.Delaney@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 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.

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:_____

APPENDIX 4: LETTER TO THE SSA

Not applicable

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.).

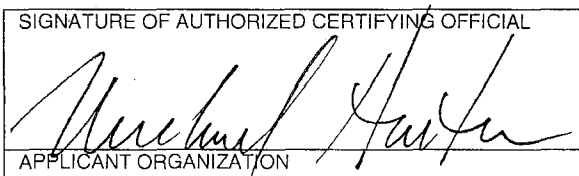
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

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
	Department of Mental Health Commissioner
APPLICANT ORGANIZATION Vermont Department of Mental Health	DATE SUBMITTED 5/12/09

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 Department of Mental Health Commissioner
APPLICANT ORGANIZATION Vermont Department of Mental Health	DATE SUBMITTED 5/12/09

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:
NA a. contract b. grant c. cooperative agreement d. loan e. loan guarantee f. loan insurance	NA a. bid/offer/application b. initial award c. post-award	N/A a. initial filing b. material change **For Material Change Only:** Year N/A Quarter N/A date of last report N/A

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 N/A , if known: N/A **Congressional District**, *if known:* N/A	N/A **Congressional District**, *if known:* N/A
6. Federal Department/Agency: N/A	**7. Federal Program Name/Description:** N/A **CFDA Number**, *if applicable:* N/A
8. Federal Action Number, if known: N/A	**9. Award Amount**, if known: $ N/A
10.a. Name and Address of Lobbying Entity *(if individual, last name, first name, MI):* N/A	**b. Individuals Performing Services** *(including address if different from No. 10a.) (last name, first name, MI):* N/A
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:** N/A **Title:** N/A **Telephone No.:** N/A **Date:** N/A

Federal Use Only:

Authorized for Local Reproduction
Standard Form - LLL (Rev. 7-97)

CHECKLIST

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: ☒ 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)	☒	
2. Proper Signature and Date on PHS-5161-1 "Certifications" page.	☒	
3. Proper Signature and Date on appropriate "Assurances" page, i.e., SF-424B (Non-Construction Programs) or SF-424D (Construction Programs)	☒	
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)		
☐ Civil Rights Assurance (45 CFR 80) _____		
☐ Assurance Concerning the Handicapped (45 CFR 84) _____		
☐ Assurance Concerning Sex Discrimination (45 CFR 86) _____		
☐ Assurance Concerning Age Discrimination (45 CFR 90 & 45 CFR 91) _____		
5. Human Subjects Certification, when applicable (45 CFR 46)	☐	☒

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?	☐	☒
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)	☒	
3. Has the entire proposed project period been identified in item # 13 of the FACE PAGE?	☒	
4. Have biographical sketch(es) with job description(s) been attached, when required	☒	☐
5. Has the "Budget Information" page, SF-424A (Non-Construction Programs) or SF-424C (Construction Programs), been completed and included?	☒	
6. Has the 12 month detailed budget been provided?	☒	☐
7. Has the budget for the entire proposed project period with sufficient detail been provided?	☒	☐
8. For a Supplemental application, does the detailed budget address only the additional funds requested?	☐	☒
9. For Competing Continuation and Supplemental applications, has a progress report been included?	☐	☒

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:
Organization: Department of Mental Health
Address: P.O. Box 70, 108 Cherry Street
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)
03-6000274

Program Director/Project Director/Principal Investigator designated to direct the proposed project or program.

Name: Charlie Biss
Title: Director Child, Adolescent and Family Unit
Organization: Department of Mental Health
Address: P.O. Box 70, 108 Cherry Street
E-mail Address: Charlie.biss@ahs.state.vt.us
Telephone Number: (802) 652-2000
Fax Number: (802) 652-2005

SOCIAL SECURITY NUMBER

HIGHEST DEGREE EARNED

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.