Identifying Opportunities for Integrated Service Delivery to Children, Youth, and Young Adults with Disabilities

Report to the Vermont

Agency of Human Services

and

Department of Education

Submitted by:

The University *of* Vermont

James M. Jeffords Center

February 23, 2012

(802) 656-3161

Table of Contents

..... 1

Acknowledgements 2

Executive Summary 3

Purpose of the Study 5

Introduction 6

Background – Prior Research, Legislation and Interagency Agreements 6

Summary Table of Legislation Related to Service Integration 10

Recent Initiatives and Programs to Integrate Services 11

Current Study – Gaining Local Perspective about Service Integration 12

Sources of Data Used to Frame Study 13

Waiver Requests and Remediation Plans for High Spending Schools 13

Special Education Expenditures 14

Human Service Expenditures 14

Conduct Focus Groups in Three Supervisory Unions 14

Analysis of Special Education and Human Service Expenditure Data to Determine Focus Group Locations 15

Waiver Requests for High Spending Schools 15

Spatial Distribution of Special Education and Human Service Expenditures 18

Description of Selected Areas for Focus Group Interviews 21

Focus Group Research in Three Supervisory Unions 21

Focus Group Methods 21

Focus Group Discussion 23

1) Description of the Most Frequently Used Services 23

2) Current Processes Used to Coordinate Services 26

3) Benefits Related to Design of the Current Service Delivery System 28

4) Needs Related to the Current Service Delivery System 29

5) Suggestions for Improved Service Coordination 38

Conclusions 46

Appendices: 50

Literature Review 50

ECS Legislative Review 50

Focus Group Questions 50

Acknowledgements

The James M. Jeffords Center at the University of Vermont is very grateful for the important contributions made by:

Dr. Susan Brody Hasazi whose vision and commitment to Vermont's children and families sustained this work.

James M. Jeffords Center Writing Team

Monika Baege, Dean Corrigan, Laurie Eddy, H. Bud Meyers, Cheryl Mitchell, John Rogers, Meaghan Roy, Jesse Suter, Beth Cheng Tolmie, and Zelda Zeleski

Vermont Agency of Human Services Staff

Doug Racine, Patrick Flood, Rob Hofmann, Melissa Bailey, Robert Bower, Barbara Cimaglio, Laurie Hurlburt, Diane Nealey, Christine Oliver, and Suzanne Santarcangelo

Vermont Department of Education Staff

Armando Vilaseca, Rae Ann Knopf, Douglas Dows, Karin Edwards, Alice Farrell, Maureen Gaidys, Carol King, Deborah Quackenbush, and Margaret Schelley

Identifying Opportunities for Integrated Service Delivery to Children, Youth and Young Adults with Disabilities

Executive Summary

In January of 2010, the James M. Jeffords Center began a collaborative study of the delivery of services to children, youth and young adults with disabilities in Vermont. To inform this study, we conducted a review of previous legislative and organizational attempts to improve services, as well as a review of the literature related to the delivery of services to children and families and current efforts to bring about collaboration among agencies. Data describing current levels of funding and spending were reviewed and mapped across the state in an effort to identify locations that experienced high demand. Three focus groups were held in locations that experienced high demand on education and human services resources in order to probe questions concerning effectiveness and efficiency.

The findings detailed in the following report suggest that Vermont has made considerable progress in the coordination of services and the collaboration between and among the various departments within the Agency of Human Services (AHS) and the Department of Education (DOE) over the past twenty years. Now, however, at the dawn of a new day in the design and delivery of health care there comes the opportunity to re-examine the structures and the assumptions that support the current system of service delivery to children and families with disabilities and all families. The data that include spending as well as the reported experience of those who serve children and families suggest that the current model, largely based on fee for services and administered by disparate and disconnected, however dedicated and well intentioned professionals is less effective in serving families than it should be.

Highlights of the study findings from interviews and focus groups include the following:

- Families continue to experience multiple partners in their midst who work hard at coordination but have difficulty communicating and providing services in concert rather than piecemeal. An integrated family oriented model should be structured to be integrated at the state, community and family levels.
- A particular source of tension in the current service delivery model often places those who are legally responsible for removing threatened children from families in the role of attempting to avert or manage family crises. There appears to be no sanctioned role for effective coordination at the interface of the social services, judicial and educational systems.
- Service providers experience frustration with the “silo” problem. That is, when attempting to serve children or families they encounter needs that they cannot

serve because their funding source is not categorized in such a way as to support a solution to a particular need.

- Criteria for effective services are not systematically employed for evaluating the outcomes of service delivery in family wellness terms. Criteria for evaluation should include health promotion, prevention, intervention and long term needs expressed in family oriented terms.
- The spending data from both agencies show that there are children and families who are clients of both AHS and DOE. Both agencies recognize the need to collaborate in the attempts to deliver services through human service agency teams as well as schools.
- The experiences reported among both school and agency professionals have a common theme that identifies gaps in service eligibility and thus in services provided.
- The progress now being made in the design of the medical home and its implementation in a comprehensive system that emphasizes prevention appears to be relatively unknown to most service providers. Questions about roles, responsibilities, resources, data integration, and the authority to complete referral with appropriate resources are yet to be answered. (see report of the Vermont Leadership Workshop on Children's Integrated Services, September 15, 2009; Vermont Blueprint for Health Implementation Manual, http://hcr.vermont.gov/sites/hcr/files/printforhealthimplementationmanual2010-11-17.pdf)

Previous attempts to provide for coordination and collaboration among departments and between the agencies of Human Services and Education have lacked sufficient structure and mandate to put families at the center of the community's concern for health and well-being. This study suggests that a stronger mechanism for integrating services rather than coordinating them is needed.

In light of what we have learned from this study, we should ask the question: If AHS and DOE were together under one organization (or, reporting to one Governor) what might (and should) change in order to provide more integrated, responsive and appropriate services to families?

What actions and/or system changes are needed to place the families at the center of Vermont's service delivery system(s)?

This is the question that is now suggested, not merely for yet another study, but for reasoned debate and action.

Identifying Opportunities for Integrated Service Delivery to Children, Youth and Young Adults with Disabilities

Purpose of the Study

In 2009 the James M. Jeffords Center for Policy Research at the University of Vermont was asked by the Secretary of Vermont's Agency of Human Services (AHS) and Commissioner of Department of Education (DOE) to conduct a study exploring factors that impact the efficient and effective integration of services to children with disabilities and their families. Integrated service delivery has been an elusive goal of state leadership, complicated by "siloed" funding streams, an uneven distribution of resources and personnel, perceptions that coordination is limited and services are sometimes duplicated; often in an environment where unfunded mandates create competition for a scarcity of resources.[1]

The study was designed to identify opportunities for integrated service delivery between AHS and DOE for children, youth and young adults (age 0 – 22) with disabilities. The goals of the exploratory research were to: (a) Identify school supervisory unions (SUs) associated with a high concentration of services, and to conduct an inventory of the current service delivery practices within AHS' 12 districts where services and supports are provided in schools or support positive educational or health outcomes for students; (b) Map the overlap in services delivered between SUs and the AHS districts and explore baseline measures for future tracking of client outcomes; (c) Analyze current service delivery practices to inform opportunities for outcome based improvements and enhanced interagency collaboration and integrated service delivery; and (d) collect focus group data related to an integrated service delivery system that supports improved outcomes for children and families.

The research was intended to answer study questions that:

- ✓ Identify best practices
- ✓ Better integrate services for children across DOE and AHS
- ✓ Describe the drivers for cost increases, if relevant
- ✓ Improve services for children
- ✓ Target future service efforts to promote early intervention

[1] Vermont Research Partnership memorandum dated November 9, 2009

Introduction

The cost of providing education and human services to children, youth and young adults with disabilities has been scrutinized in Vermont for many years. Special education costs continue to increase with projections for state fiscal year (FY) 2012 spending 2.51% higher, an increase of 6.5 million dollars over actual spending in FY 2010. During recent declines in state revenue, research related to opportunities for integrated service delivery aimed at reducing costs are not only timely, but necessary. The report initially reviews prior studies, legislative initiatives and interagency efforts to address education and human service expenditures and the delivery of services. Current initiatives aimed at integrating the service delivery system are discussed next. A report of the research follows, concluding with recommendations for future policy consideration. Appendices include a Literature Review conducted during 2010, a review of legislation related to the integration of service delivery and, the questions utilized to gather the focus group data.

Background – Prior Research, Legislation and Interagency Agreements

The state of Vermont has taken a number of steps to coordinate the combined efforts of education and human services. With each effort, new research endeavors have been initiated to evaluate the effectiveness of these steps and identify areas for further improvement. Recent economic realities have focused new attention on the need to examine current practices, to look not simply at ways to gain financial efficiencies but also at the effectiveness of our programs for the children and families they are meant to serve. These activities have generated a substantial body of research, only a sampling of which is considered in the current report.

Act 264. The passage of Act 264 in 1988 instituted a requirement for AHS and DOE to work collaboratively on behalf of children and adolescents experiencing severe emotional disturbance. A coordinated system of care was specified and developed in order to ensure that children and their families receive the full range of appropriate services. Children and adolescents experiencing a severe emotional disturbance who need services from multiple agencies are entitled to a *coordinated services plan* (CSP), which is a written addendum to each individual agency plan. The CSP consists of a goal, outcomes that measure progress toward the goal, and the services and supports to achieve it. Each CSP is developed and supervised by a Local Interagency Team (LIT). The State Interagency Team (SIT) is available as a resource to a

LIT when problems cannot be resolved at the local level. The Case Review Committee (CRC), a committee of the SIT, becomes involved whenever a LIT makes a recommendation for residential treatment or a high-end wraparound plan.

An Interagency Agreement between AHS and DOE governs services provided under Act 264. The Agreement covers the coordination of services, financial responsibilities, and resolution of interagency disputes. The Interagency Agreement was expanded in 2005, and now serves a larger target population. Currently entitled to a coordination of services are all students who meet eligibility requirements under special education, and who are eligible to receive disability-related services by at least one AHS Department.

A preliminary evaluation of the coordinated services planning process, completed in 2009, produced several important recommendations for improvement, including the need for a systematic procedure for collecting information on youth with CSPs, standardized tracking of relevant outcomes, measures of the CSP process, and increased partnership with families.[2]

Individuals with Disabilities Education Act. The federal Individuals with Disabilities Education Act (IDEA), enacted in 1990, replaced the Education of Handicapped Act and was designed to ensure students with disabilities receive a free, appropriate public education. IDEA requires states to identify students who have disabilities and offer them Individualized Education Programs (IEPs) including a provision of special education and related services, to the maximum extent appropriate, with students who are not disabled. In Vermont, these services are delivered by a complex system of educational and human services agencies, financed by an equally complex combination of federal, state, and local resources.

Act 60 and Act 68. Vermont's Act 60 (1997), the Equal Educational Opportunity Act (EEOA), equalized education tax rates across the entire state and moved the accounting of local K-12 education spending to the Education Fund. When education spending per equalized pupil exceeds the prescribed limit, additional tax rates are imposed. Act 60 increased the state's share of special education costs and introduced greater uniformity of financial reporting. In 2003, a variety of amendments to Act 60 were enacted with the passage of Act 68. A key element of this act required the Commissioner of Education and the Secretary of AHS to prepare a plan to establish a cost effective system for delivery of special education services to

[2] http://www.uvm.edu/~jsuter/files/vtcsp/CSP-ExecutiveSummary.pdf

children served by both agencies in order to contain growth in special education costs. The School Quality Standards (SQS) survey implemented in 2006 revealed progress towards implementing EEOA requirements. A comprehensive outcomes report was released in 2008.[3] The report showed increased equity as measured by the variation in spending among districts, but revealed complexities in the measurement of equitable spending due to cost fluctuations over time. In 2009, about 60% of special education spending - $142,500,000 - was paid through the State.[4]

The Child Development Division of AHS' Department for Children and Families (DCF) houses Children's Integrated Services (CIS). CIS emerged in the past several years through IDEA part C, which addresses early intervention services for infants, toddlers, and their families through age three. Children who have identified developmental delays are eligible for services under this section of IDEA. Funding for these services are varied and include Medicaid, participating agencies, local schools, family cost share, insurance, etc. CIS works to coordinate services for these families. The program aims to combine three prevention, early intervention and treatment programs into one child development and family support services system. CIS addresses prevention and early intervention for children and their families from birth to age six.

Reimbursement for medically related services is managed through the Medicaid School Based Health Services Program. For students to be eligible, they must be enrolled in Medicaid, receiving special education services according to an IEP, and receiving Medicaid billable services. A wide variety of services are reimbursable, including case management, developmental and assistive therapy, mental health counseling, rehabilitative nursing services, occupational and physical therapy, and speech, language and hearing services. Supervisory unions/school districts receive 50% of Medicaid reimbursements, and the remainder is retained by the State. Funds must be used for prevention and intervention programs in grades K-12.

Act 117. Act 117 of 2000 directed the Joint Fiscal Office (JFO) to produce a study on the provision of special education services; to assess the degree to which service costs may have been shifted to local school districts from other providers, and to make recommendations on possible adjustments to the DOE/AHS Interagency Agreement that was active at that time. The 2001 study, sometimes referred to as "The Pink Report", defined a variety of factors associated with changes in the distribution of special education costs, ranging from real increases in the

[3] http://education.vermont.gov/new/pdfdoc/laws/act_60/act_60_eeo_report_08.pdf
[4] http://education.vermont.gov/new/pdfdoc/laws/act68/educ_edfund_overview_0409.pdf

numbers of children with high-cost diagnoses to cultural expectations of integration. Even a decade ago, the complexity of institutional relationships and funding practices was evident.

Act 34. Most of the recommendations in the "Pink Report" are for additional research to better understand the relationship between funding streams and best practices in special education, transition planning for disabled students, assessing the applicability of the Act 264 model beyond emotional impairments to other types of disabilities, establishing best practices for case management, and identifying federal barriers to renewal of the active Interagency Agreement. Perhaps most importantly, the "Pink Report" concluded "Special education does bear the burden of cost for human services that are related to education, but not directly a result of educational need." These recommendations resulted in the passage of Act 34 in 2001, which called for the general assembly to "develop a system in which the costs of special education services delivered by human service providers shall be paid for primarily by federal and state dollars."

An additional report was produced in 2002 providing a number of options for shifting the costs of special education, including (a) AHS pays for human services provided by schools; (b) AHS provides and pays for all human services; (c) Education pays for 100% of the cost of human services on IEPs; (d) Return the 50% of Medicaid receipts to local school districts for reduction in special education services costs and reinvestment in prevention and intervention programs; (e) Cost sharing through an AHS funding pool for residential and intensive community based services, increased federal financing through expansion of Success Beyond Six and EPSDT; (f) DOE operates all Special Education in the state; and (g) Create a single human service agency to provide and pay for human services. The report offered a number of conclusions and challenges to implementation, most notably that the proposed changes should not create incentives for the segregation of students with disabilities from their peers, and that "implementation of any of the options has the potential to increase the overall costs of special education.".[5]

Act 82. Responding to continued perceptions of increases in educational costs, a study of special education services was prepared by JFO as directed by Act 82 (2007).[6] A key finding of this report was that there was still no way to clearly identify the distribution of human services provided by schools versus those provided by other agencies. The authors estimated the cost of human services provided in FY 2006 within the special education framework at $33 million, and expenses of approximately $5 million associated with regular education. The local share of

[5] http://www.leg.state.vt.us/jfo/reports/Provisions%20of%20Special%20Education%20Services%202008.pdf.
[6] IBID.

human service spending was estimated to be 37% of this total, or $17.4M. The report noted that some progress had been achieved, namely that "many of the recommendations from the Pink Report have been incorporated, particularly the recommendation to expand the Act 264 process for interagency coordination to all children eligible for both special education and disability-related services. The authors recommended, however, that SIT develop methods to differentiate between human service and educational components of CSPs and their associated costs, in order to aid coordination, identify future funding needs, and to understand how funding decisions are affected by the structure of the Interagency Agreement.

Summary Table of Legislation Related to Service Integration

Act (year)	Title	Summary
264 (1988)	Relating to a Coordinated System of Care	The act requires collaboration of AHS and DOE and seeks to address seven components: create an interagency definition of extreme emotional disturbance, create a coordinated service plan, create one local interagency team in each agency human services district (12), create a state interagency team, create a governor appointed advisory board, increase parent involvement, and complete a submission to state legislature of an annual system of care plan.
IDEA (1990)	Relating to Free Appropriate Public Education to Students w/ Disabilities	This act reauthorized federal law 94-142, originally established in 1975, which requires states to identify students who have disabilities and to offer Individualized Education Programs (IEPs) including appropriate special education and related services. These services are to be provided to the maximum extent appropriate with students who are not disabled. The act carried forward the principle of inclusion in a least restrictive alternative / environment.
Act 60 (1997)	Relating to Equal Educational Opportunity	The act creates new grants to support small schools and transportation. Equal access to revenues per pupil is now provided to all towns through state block grants. The act also eliminates the wide variations of tax rates that were based on local grand lists. When districts spend the same amount per pupil, residents will have identical tax rates regardless of the town's property wealth.

Act (year)	Title	Summary
Act 117 (2000)	Relating to cost shifting	This act directed the Joint Fiscal Office to produce a study on the provision of special education services, to assess the degree to which service costs may have been shifted to local school districts from other providers, and to make recommendations on possible adjustments to the interagency agreement.
Act 34 (2001)	Relating to sharing of Special Education Service Costs	The act develops a system in which the cost of special education services delivered by human service providers shall be paid for primarily by federal and state dollars. The act aims to build an agreement that delineates which services are paid for by school districts and which are paid for by human service providers.
Act 68 (2003)	Relating to Amendments to Act 60	This act required the Commissioner of Education and the Secretary of the Agency of Human Services to prepare a plan to establish a cost effective system for delivery of special education services to children served by both agencies in order to contain growth in special education costs.
Act 82 (2007)	Relating to Education Quality and Cost Control	The act is comprised of multiple sections including: Cap of Property Tax Adjustments, Education Property Tax Rates, Education Spending/ Divided Question for Voters, Weighted Membership, Fiscal Review of Special Education Spending, Analysis of High Spending, Notice to Taxpayers, Cost Drivers, Collaboration; Efficiencies, School construction and State Aid, Special Education; Miscellaneous Provisions, Three- to Five-Year Rolling Reappraisals Reappraisal; Study, Small School Consolidation, Collective Bargaining at the Supervisory Union Level

Recent Initiatives and Programs to Integrate Services

Several AHS and DOE related initiatives have recently emerged, which aim to address service integration for children, youth and young adults with disabilities. These include AHS' efforts to provide Integrated Family Services (IFS), an umbrella for: Children's Integrated Services (CIS); Enhanced Family Services (EFS); and Children's Health and Support Services (CHaSS). IFS' goal is to integrate human service efforts to create a continuum of services for families based on assessments including diagnostic and functional needs of the child, youth and family. CIS

provides early intervention, prenatal to age 6. EFS targets higher end services including those needed for children with mental health and developmental disabilities. CHaSS supports children with health related and/or developmental needs, such as personal care and high-tech nursing services. Funds from across AHS will be used to support IFS. Core elements include one coordinated family plan, lead service coordinator, unified and simplified reimbursement and oversight, outcome based contracts and modern information technology (IT) structures.[7]

Current Study – Gaining Local Perspective about Service Integration

Since implementation of the most recent interagency agreements, which aim to coordinate services for children and families, a number of important events have occurred. First, the Blueprint for Health has made considerable progress towards an integrated system of health care with community-based health teams as mechanisms for deepening coordination and addressing costs.[8] Second, the development of three Blueprint pilot communities with 11 patient centered medical home (PCMH) models has been reported in January, 2011, which indicates progress towards developing a 'one-stop' care coordinating mechanism that would center all available resources on the family (note that care coordination is a component of the PCMH model).[9] Third, the American Academy of Pediatrics has developed several initiatives that may link the medical home model for health care to schools.[10]

These events, together with rising health and education costs indicate that the time may be right for an examination of the structures and policies that govern health care and education with a focus towards the integration rather than the coordination of services.

Again, the research was intended to answer study questions that:

- ✓ Identify best practices
- ✓ Better integrate services for children across DOE and AHS
- ✓ Describe the drivers for cost increases, if relevant
- ✓ Improve services for children
- ✓ Target future service efforts to promote early intervention

[7] Personal communication, M. Bailey, AHS IFS Director, October 31, 2011
[8] http://hcr.vermont.gov/blueprint_for_health
[9] http://pcmh.ahrq.gov/portal/server.pt/community/pcmh__home/1483/ahrq_commissioned_research
[10] http://www.medicalhomeportal.org/clinical-practice/education-and-schools

The current study provides an opportunity to analyze local perspectives based on the following assumptions:

- Mapping of expenditure data between AHS and DOE has not previously been completed,
- Inclusion of three local AHS districts/SU regions with high concentration of services would inform possible improvements for integration beyond that which previous studies have suggested,
- Focus group interview questions would explore how the delivery system might respond with preventive, early intervention strategies rather than during crisis situations in which the level of need outstrips AHS and DOE capacity, and
- Current research works to provide possibilities for consideration, including possible options for restructuring the delivery system of services for children, youth and young adults with disabilities.

Sources of Data Used to Frame Study

The following four data sources were identified and used in the current study:

- Waiver requests and remediation plans for high spending schools,
- Special education expenditures,
- Human service expenditures, and
- Based on analysis of the three data sources listed above, conduct focus groups in three supervisory unions.

Waiver Requests and Remediation Plans for High Spending Schools

In Act 82 of 2007, 16 V.S.A. § 2974 requires "high spending" districts as those that exceeded spending on special education by 20 percent more relative to the state average, based on average daily membership (ADM). The law requires that districts identified as "high spending" must annually submit a spending reduction plan or request and justify a waiver of this requirement. DOE provided the research team with waiver requests from the 2009 academic year, and spending reduction plans from the 2008 academic year. All documents were redacted before release in order to protect individual identities. Documents were reviewed and a list was constructed with a running tally of the reasons cited for high costs.

Special Education Expenditures

The research team acquired special education financial reports from the publicly available web site of the Vermont DOE.[11] From this source the team identified special education expenditure listings by SU for FY 2009, by total expense and on the basis of average daily membership (ADM). This source was used because it is the basis for the determination of high and low spending districts in accordance with 16 VSA §2974, which specifies high spending districts as those that spend at least 20 percent more than the state wide average of special education formula-eligible costs per average daily membership. High spending districts must submit a remediation plan or a request for waiver of the provisions of the high spending statute.

Human Service Expenditures

There is no publicly available data concerning human service expenditures that is equivalent to the special education financial reports. In order to provide a basis for comparison, AHS staff prepared a database extract from the Central Source for Measurement and Evaluation (CSME) database identifying all claims from the Medicaid School Based Health Services Program flagged with a fund code indicating a DOE source. [12] These expenditures are used to generate Medicaid reimbursements for medically related services provided in accordance with an IEP. Expenses paid through the Vermont Department of Health (VDH), such as Early Periodic Screening, Diagnosis, and Treatment (EPSDT) or Student Assistance Programs (ADAP) are tracked in a different database system under contract with VDH and were unavailable for the current study.

Conduct Focus Groups in Three Supervisory Unions

The research team identified three SUs with expenditure profiles indicating a high concentration of delivered services: Chittenden South (CS), North Country (NC), and Windham Southeast (WSE). In each SU a broad range of stakeholders were invited to participate in a focus group session to acquire a more nuanced understanding of potential opportunities for enhanced interagency collaboration, integrated service delivery, and improved outcomes.

[11] http://education.vermont.gov/new/html/pgm_finance_sped.html
[12] http://education.vermont.gov/new/html/pgm_finance_sped/medicaid.html

Analysis of Special Education and Human Service Expenditure Data to Determine Focus Group Locations

Current expenditure data was analyzed to target areas to select as focus group locations. Data sources also informed understanding of service system activities and most frequently utilized and concentrated services delivered to children, youth and young adults with disabilities.

Waiver Requests for High Spending Schools

In Act 82 of 2007, 16 V.S.A. § 2974 requires "high spending" districts as those that exceeded spending on special education by 20 percent more relative to the state average, based on average daily membership (ADM). The law requires that districts identified as "high spending" must annually submit a spending reduction plan or request and justify a waiver of this requirement. DOE provided us with waiver requests from the 2009 academic year, and spending reduction plans from the 2008 academic year. All documents were redacted before release in order to protect individual identities. The research team reviewed the documents and constructed a list with a running tally of the reasons cited for high costs. In considering the contents of the waiver requests and spending plans, it is important to remember that contents varied considerably across schools and districts, and information that could identify individuals was redacted. Researchers cannot conclude that a factor cited by one school was not present at another one just because it was not mentioned. For this reason the research team did not compare or name individual schools or districts. Additionally, the frequency with which a reason is cited does not demonstrate how much of the total spending can be attributed to that factor. Nonetheless, the research team believes several clear conclusions can be drawn from these documents.

DOE provided waiver requests representing 32 schools / districts, of which 19 were approved (59%) and 13 were denied (41%). Considering all of the requests together, the most frequently stated factors of high spending status were transportation (41%), alternative (out of district) placements (24%), staffing costs for para-educators and special educators (24% and 21% respectively), and disproportionately declining enrollments in the general population.

TABLE 1. MOST FREQUENTLY MENTIONED REASONS FOR HIGH COSTS CITED ACROSS ALL WAIVER REQUESTS

Reasons for High Spending	***N***	***Percent***
Transportation	14	41
Cost of alternative (out of district) placements	8	24
Cost of staff: Para-educators	8	24
Cost of staff: Special educators	7	21
Declining general enrollment	7	21

Note: Table does not reflect information redacted to protect named individuals.

Several of the waiver requests included enumeration of steps that were being taken to reduce costs. Each of these steps is listed below:

Actions to address high costs, specified in approved waiver requests
Sharing resources with another district.
New options for local alternative programs (reducing alternate placements).
Task force for researching implications of new programs.
Find new efficiencies.
Build capacity so that fewer alternate placements are needed.

Actions to address high costs, specified in denied waiver requests
Examine school-wide support systems.
Proactive systems for intervening early.
Develop capacity to support students with intensive needs, and students returning from alternate placements.
Reconfigure classroom supports to reduce need for para-educators.
Professional development.

The research team also reviewed the 2008 spending reduction plans and listed the key elements of each plan in similar fashion. Eight plans were submitted, representing 18 different districts and schools. The following counts are based on the lowest level of organization within each spending plan, which include individual schools, districts, and entire supervisory unions.

The most common themes (aside from nonspecific statements about improved performance) concerned the replacement of contracted services and out of district placements with services to be developed and implemented locally. These included the retraining of teachers and staff, the addition of new courses and services, and the review of existing out of district placements to see if any students could be re-integrated into local schools. Reduction of para-education staff was proposed in six plans.

TABLE 2. KEY ELEMENTS OF PROPOSED HIGH SPENDING REMEDIATION PLANS, BASED ON 8 REMEDIATION PLANS FILED IN 2008 (REPRESENTING 18 DISTRICTS).

Proposed Remediation	***N***
Improved performance of existing procedures (e.g. Complete billing documents, following regulations, improved efficiency, more careful evaluations)	10
Review of disability evaluations and/or IEPs / look for opportunities to reintegrate students placed out of district	6
Discuss / study staffing levels and effectiveness of existing programs	6
Retrain teachers and staff members to provide services that would otherwise be contracted	6
Reduce number of para-educators (5) and case managers (1)	6
Add new courses / programs to reduce out of district placements	4
Add new services / staff to reduce out of district placement and reliance on contractors	3
Review evaluation skills of teachers to see if more testing can be done in-house	3
Contractual agreements for each consultant outlining responsibilities, rate, and hours per year	1
Redesign programs from focus on specific disability categories to a focus on independent living	1
Add a Special education consultant for each school, responsible for oversight of referral and evaluation processes, program development, compliance, professional education	1

Proposed Remediation	***N***
Contracting mental health and alternative programming services	1
Agreement to not charge individual tuitions to special education when student educated in neighboring town	1
Trade special education bus to a neighboring district for a smaller / older one	1
Students moving out of area (reason for actual reduction)	1
Find lower cost alternative to costly private transportation provider	1
Redefinition of EST as Base of ESS	1
Schools become Title I "school wide plan" schools	1
Make a half time Title 1 teacher into full time position in order to pursue early intervention	1

The waiver requests and spending plans suggest several implications for interagency collaboration. As described by the districts submitting plans, the development of local capacity to reduce alternative placements was the most commonly cited need. Interestingly, although transportation costs were featured in a large number of waiver requests, only two of the spending reduction plans addressed transportation issues. Three key questions, then, are (1) How AHS can support the reintegration of students currently placed out of their districts?, (2) What are the cost implications of reintegration?, and (3) Why are transportation costs noted in so many waiver requests, but under-represented in cost reduction plans, and does the discrepancy mean that there may be opportunities for transportation cost savings that have not yet been identified?

Spatial Distribution of Special Education and Human Service Expenditures

In order to better understand the variability in service provision across supervisory unions (SUs), we examined maps of special education expenditures and school-based health services (Medicaid) claims. We expected areas with high levels of expenditures in both areas to represent the areas with the highest levels of service provision and thus the most significant challenges for integrated service delivery. The SUs with the highest levels of *total* spending in 2009 were Chittenden South, Windham Southeast, and Southwest Vermont, respectively. As shown in Figure 1 below, there is substantial variation across SUs, from $9.6M at the high end

(Chittenden South), to $562,533 at the low end of the spectrum (Essex North). Not surprisingly, the most populous areas are generally associated with higher total spending. Because our goal was to identify areas most likely to experience high service demands, we did not consider per capita spending in this report.

To assess the distribution of human services expenditures, we obtained a listing of all school-based health services (Medicaid) claims reported in 2009. These expenditures represent all services provided to children with an IEP that were billed to Medicaid during 2009. As shown below in Figure 2, the highest supervisory union (SU) expenditures were reported in Burlington, Chittenden South, and Orleans Essex-North (North Country).

FIGURE 1. VERMONT SPECIAL EDUCATION SPENDING, 2009

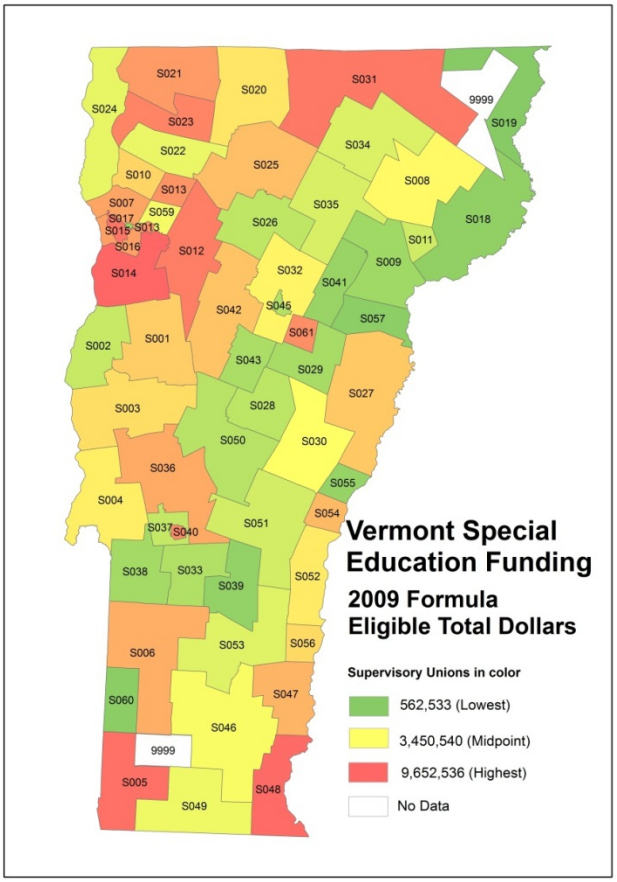
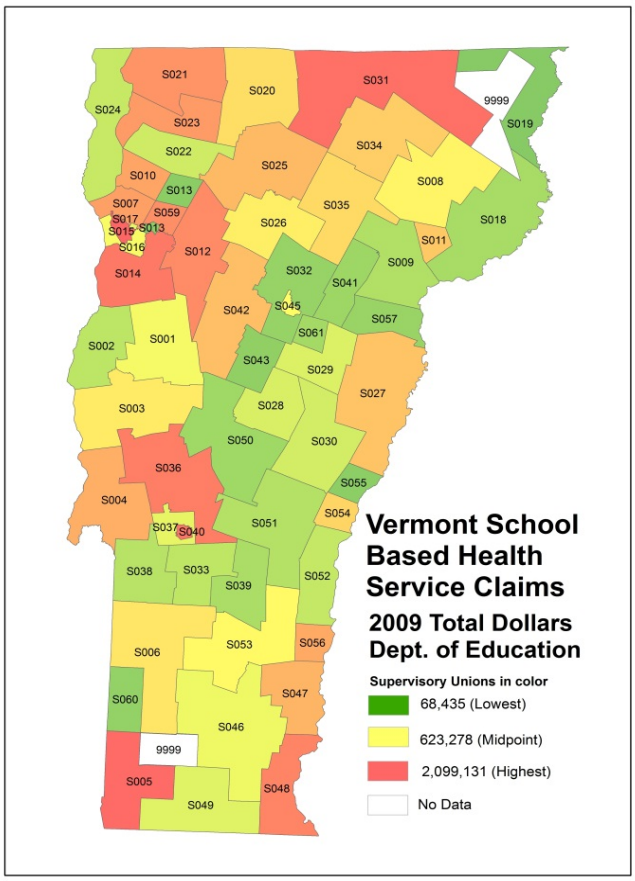


FIGURE 2. VERMONT SCHOOL BASED HEALTH SERVICES CLAIMS, 2009



Focus group SU selection was based on determination of high spending on both AHS and DOE expenditures. Sites selected were also intended to characterize a broad geographical representation of the State. To meet these criteria three SU were selected for further study: Chittenden South (CS), North Country (NC), and Windham Southeast (WSE).

An overview of special education spending across these three areas is presented in Table 3 below. Overall, direct instruction consists of about two-thirds (64%) of the statewide total, followed by Tuition (17%) and Speech / Language services (8%). Notably, the percentage of funds attributable to direct instruction is unusually low in WSE (43%), which allocates proportionally more of its spending to Tuition (44%). Administrative costs were highest in CS (9%). Transportation costs were comparatively low at 3% in each selected area, consistent with the statewide total (also 3%). Health related expenditures were also low, ranging from 1% in WSE to 2% in CS and NC. However, these costs considered with Psychological Services (an additional 1% to 4% of spending) may potentially represent areas of overlap with AHS-based (Medicaid) spending.

TABLE 3. FY-2011 K-12 SPECIAL EDUCATION ESTIMATED COST BY BUDGET ENTITY, BASED ON OCTOBER 15, 2009 SERVICE PLANS: SELECTED SUS[13]

	Chittenden South		North Country		Windham Southeast		State Total	
	Total	*Pct.*	*Total*	*Pct.*	*Total*	*Pct.*	*Total*	*Pct.*
Direct Instruction	8,358,767	68%	5,531,939	62%	4,875,548	43%	170,309,214	64%
Tuition/Excess	1,397,626	11%	1,343,638	15%	4,938,899	44%	45,869,005	17%
Speech/Language	1,047,353	9%	769,819	9%	562,751	5%	21,491,965	8%
Psychological	382,985	3%	327,280	4%	132,740	1%	9,610,829	4%
Transportation	360,642	3%	283,255	3%	332,000	3%	8,455,745	3%
Health and Other Support	257,065	2%	176,328	2%	109,108	1%	7,883,847	3%
Admin/Training	1,076,177	9%	614,071	7%	297,342	3%	15,342,524	6%
Tot. Eligible Cost	**12,279,945**		**8,937,752**		**11,248,388**		**267,701,671**	

[13] http://www.education.vermont.gov/new/pdfdoc/data/spedfund/educ_spedfund_11_estimated.pdf

Description of Selected Areas for Focus Group Interviews

The NC SU (formerly Orleans-Essex North), based on geographical area, is the largest in the state. It includes the following schools: Brighton Elementary, Charleston Elementary, Coventry Village, Derby Elementary, E. Taylor Hatton, Holland Elementary, Jay/Westfield Elementary, Lowell Graded, Newport City Elementary, Newport Town Elementary, Troy School, North Country Union Junior High School, and North Country Union High School. NC 2009-2010 enrollment was 2,857 students.

The WSE SU includes the following schools: Brattleboro, Dummerston, Guilford, Putney, Vernon, Brattleboro Union High School, Brattleboro Area Middle School and the Windham Regional Career Center. As of August 2010, the total enrollment was 2,921 students.

The CS SU includes Hinesburg Community School, Shelburne Community School, Allenbrook and Williston Central, and Champlain Valley Union High School. 2009-2010 enrollment was at 4,282 students.

Focus Group Research in Three Supervisory Unions

Focus Group Methods

During early spring of 2011, AHS and DOE leadership requested that LIT Coordinators and Special Education Administrators in each of the selected SU regions submit a roster of potential focus group participants. Using these lists, electronic mail invitations were sent to each region inviting individual's participation. Interview scheduling was arranged so that each region's LIT Coordinator and Special Education Administration could be present. Confidentiality in reporting was assured, such that participant names or specific roles (beyond LIT Coordinators and Special Education Administrators) are not identified. Focus groups were held on April 21, April 26 and May 17, 2011. Interviews were approximately two hours in length and held either at a local school or designated agency providers' place of business.

Efforts to include participants with different levels of experience and engagement with the service system were successful. Limited participant availability meant that components of the service delivery network were not equally represented among the three sites. In all, 35 individuals from 19 different organizations participated in the interviews. As seen in Table 4 below, the number, organizational affiliation and participant roles varied among the three SUs.

TABLE 4: FOCUS GROUP INTERVIEW PARTICIPANT'S AFFILIATION

Participant's Organizational Affiliation	Chittenden South	North Country	Windham SE	Total
LIT Coordinator	1	1	1	3
Special Education Admin.	1	2	1	4
Designated Agency	4	3	3	10
School Administrator or Principal		3	3	6
Agency of Human Service Staff	2	2	2	6
Community or Family Based Org.	1	3	1	5
Home Health Agency	1			1
Total Number of Participants	10	14	11	35

All discussions were conducted by the same experienced research team. The team used a semi-structured interview format; asking questions based on the interview question guide and probing for details and elaboration when appropriate. Focus group participation was voluntary and no compensation was provided.

All three focus group interviews were recorded with participant consent and then transcribed for analysis. Participants were assured that identifiable information shared during the course of the interviews would remain confidential. References to organizational names and individuals have thus been removed from the findings section of the report. Transcribed interviews ranged from 30 to 36 pages in length. In all, 98 pages of text were reviewed, coded, and analyzed

thematically using techniques commonly associated with qualitative research methods.[14,15] The focus group findings reflect the opinions and experiences of participants included in the interviews. These views may not be representative of their organization, the SUs being studied, or other SUs across the state.

Procedures and Context. Focus group interviews were conducted, as previously mentioned, in three local SUs/AHS districts: Chittenden South (CS), North Country (NC), and Windham Southeast (WSE). With questions that addressed coordination across AHS and DOE the discussions yielded rich data (See Appendix for focus group questionnaire). The strengths of these focus groups included the diverse representation of staff members from the two institutions and beyond. Speaking from years of experience within their various specialties, respondents reflected on problems and opportunities in the current state of service delivery and integration.

The limitations of these focus groups included uneven representation: sometimes an area of service was only represented at one site, or some people were less vocal than others. In addition, certain topics were given more weight at one site than another. Each used the language and terms common to their organization or specialty. Acronyms were many and the research team has done their best to translate them here. Throughout the focus group discussion section of this report, the term "youth with disabilities" includes young people from birth to age 22, who have some kind of disability that includes, but is not limited to, an emotional, developmental, learning or physical disability.

Focus Group Discussion

1) Description of the Most Frequently Used Services

According to focus group participants, each of the three SUs/AHS districts offers a continuum of services, where collaborative processes across organizations, programs, and funding streams help address the needs of youth with disabilities. This system relies on good working relationships and the experience and knowledge of staff that have become familiar with

[14] Patton, Michael Q.(2002). *Qualitative Research and Evaluation*. Thousand Oaks, CA: Sage.
[15] Miles, M. & Huberman, M. (1994). Qualitative Data Analysis: An Expanded Sourcebook (2nd ed.). Thousand Oaks, CA: Sage.

programs and resources in order to best utilize them. Overall, each SU contracts with its local designated agency/children's mental health agency to bring services into the schools. A variety of services are also offered in the home, through fee-for-service contracts and waivers. Some focus on early childhood and others address complex medical issues. A small percentage of services involve short term or long term residential placements out of the home. Services reported are not necessarily exhaustive or representative of the actual array of programs offered in a particular SU/AHS district. Rather, the following is a synopsis of services as described by focus group participants at the three sites.

School-Based Services. Common among all sites is a variety of services that include school-based clinicians (e.g., social workers, home school coordinators), counselors, special education teachers or behavioral specialists made available through contracts with local service providers such as Northeast Kingdom Human Services (NKHS), the Howard Center, and Health Care and Rehabilitation Services (HCRS). Other options mentioned by NC include elementary and secondary school day programs; alternative schools; and treatment programs.

CS spoke of building a continuum of services within the schools by adding school counselors (social workers), mentors, and part time school psychologists in every school. They place a special education administrator in each school to support staff and coordinate services, plus professional special educators to enhance preventive case management. Principals and teachers employ an inclusive model, so that children with special education needs are placed in regular classrooms as often as possible.

Specialized expertise may be brought into the schools to round out its own continuum of services. For instance, the CS autism program provides many specialists for children on the spectrum, funded completely by DOE. In some cases, a particular child is served by mental health dollars (Medicaid) in addition to DOE funding. As part of their continuum of care, a school district decides to bring in other resources to meet the child's needs. Due to variation of staff expertise among the five schools in the CS SU, they rely on Howard Center staff for resources so they can provide the continuum of services consistently, which allows more children to remain in school. WSE spoke of locating speech and language pathologists in all schools, with two school psychologists dispersed throughout the SU.

In addition, intensive case managers and planning room staff are part of a wide spectrum of support to students with an IEP. WSE noted frequent use of IEPs, which provide evaluation and determine disability and services needed. They also offer additional supports through specialized programs for children with emotional or behavioral needs, and children on the more intense end of the autism spectrum. In addition, privately contracted individuals work with the middle and high school and some specialized programs.

In-Home and Community-Based Services. NC respondents highlighted in-home services offered by NKHS and AHS's DCF Family Services. These address various issues such as behavior problems, respite care, housing, and employment. Staff also work on getting children back into school, and providing referrals to other services. One of the most sought after services in Chittenden County, is the Developmental Services (DS) Medicaid Waiver (for children with cognitive impairments and autism). It provides case management, respite, clinical support, and crisis intervention. In addition, youth and families frequently access Howard Center's 24/7 mental health crisis services (First Call). The Visiting Nurses Association (VNA) provides hourly nursing at home and in school to children with high needs. While this only involves three children in Chittenden South, the cost for these services is high. DCF oversees a small Intensive Family Based Services (IFBS) contract, for which demand is high. Easter Seals has case workers and social workers through their umbrella that provide support to families, again funneled through DCF. Some families benefit from multiple contracts, such as Easter Seals or IFBS.

In WSE, developmental services are community based, focusing more on home living situations and supporting families with shared living providers. Creative use of funding helps with managing youth with disabilities, and with community, job, and home living supports. Staff also collaborate with an alternative school for boys in Newfane, called Kindle Farm, where behavioral interventionists work with emotional behavioral issues. HCRS's developmental and mental health outpatient services balance each other in provision of clinical services, counseling, case management, and respite (including some overnight respite and home providers, licensed through DCF's Family Services Division). There is a continuum of care and collaboration with Developmental Services (DS) to provide clinical support psychiatry, to write waivers, and to do "wrap-arounds." The waiver may be funded from multiple collaborative sources. For those young people who are not DS eligible but almost meet the criteria, staff offer a mental health or DCF collaboration. High-risk pool dollars are available through certain vehicles, such as the LIT process. WSE frequently uses personal care services, from the Department of Aging and Independent Living (DAIL).

Children with Special Health Needs. Another frequently used service noted by WSE respondents is Children with Special Health Needs (CSHN). This serves youth with complex medical or developmental issues. Typically, VDH staff members identify those with high medical needs and refer them to 'high tech' nursing or other available services. This might involve assessments through HCRS, VNA, and Families First, with the assistance of case managers. CSHN is one of the first points of contact for families, simplifying the process for them by providing clinics that bring various professionals together, on topics such as speech

pathology or cleft palates. CSHN provides a system of care that provides consistent medical follow up from birth to adulthood, such as nursing care, social work assistance, personal care attendants, and respite.

Early Childhood and Children's Integrated Services. All three sites spoke of CIS as including prevention and early intervention for birth to age 3, essential early education for 3 to 5 year-olds, nursing and family support for early childhood, family mental health, and specialized child care. CIS involves testing to determine disabilities at a very young age as well as referral intake evaluation, developmental therapies, and service coordination.

2) Current Processes Used to Coordinate Services

Services are coordinated through a mix of partnerships and teams, often dependent on long term working relationships. Focus group participants reported service coordination in each SU/AHS district works well. Examples provided include CIS, Family Safety Planning (FSP), Integrated Family Services (IFS), LIT, and Act 264 Coordinated Services Plans (CSPs). NCSU respondents, who had a VR representative present, highlighted partnerships between Vocational Rehabilitation (VR), Developmental Services (DS), and NKHS. Teams function through various configurations of meetings and planning processes within and across organizations. Some processes prevent duplication, such as NC's resource team referral process, CIS's intake process, and LIT's process for solving difficult cases. Coordination also happens through case management and through schools linking families to services. These are described further below.

Teams that Help Coordinate Services. At WSE, coordination happens through treatment team meetings, LIT meetings, finance family services meetings, Act 264 CSPs; and CIS clinical meetings. At NC, the Home School Coordinator Program assists many students by working with the school and the home. Some of NKHS school staff bridge between home and school, doing home visits and helping the parents work with their children to help them be successful at school. Teams help coordinate services so that families are receiving what they need as often as possible. For example, a student with a disability but not on an IEP does not have access to the in-school therapist because that service is funded with special education dollars. Instead, an intensive family-based person works with this child and his family at home and at school. Longstanding relationships between the schools and NKHS foster collaboration when a situation needs to be brought to the LIT Coordinator. One respondent at CS highlighted a positive family centered partnership between principal, teacher, special educator, and

parents, with the special education administrator nearby to ask how the meeting went. This was one example of partners coming out of their silos to work together with monthly meetings held after hours.

Centralized Referral and Intake Process that Prevents Duplication. Many years ago, NC developed a resource team referral process so that requests for in-home services are reviewed by one central resource team that meets weekly. It helps avoid duplication of services and promotes better coordination. Two CIS staff assigned to CS coordinate a centralized intake process for children from birth to 3. At age 3, children are referred to Essential Early Education (EEE) once an EEE teacher is identified who then can help link them to services. At WSE, a case that needs a high level of coordination goes to LIT. For example, a school might refer a family's request for residential placement to LIT. Sometimes the LIT meeting is used to determine what services are needed to help mediate challenging family situations.

Overall, respondents said they do their best to avoid unnecessary duplication by communicating with families and team members regularly. NC respondents acknowledge that families have many people coming into their homes (such as school clinicians; home visitors; and school, agency and DCF case managers). They try to mitigate that with team meetings and other ways of keeping in touch with the family about who else is involved.

Schools that Link Families to Services. When a child experiences a crisis, the WSE school contacts the parents and links them to other services (such as DCF, or HCRS) and has follow-up meetings. Sometimes the schools are involved in the FSP meetings. They coordinate Act 264 meetings and subsequent plans. Schools also provide the resource for the behavioral interventionists. When an Act 264 meeting is not needed, schools will involve these other service groups in IEP meetings or they will attend treatment planning meetings at HCRS as appropriate.

Case Managers that Coordinate Services. At CS, case managers coordinate and connect service providers with families and other key players that are involved on a case by case basis. In elementary schools, special education administrators fill this role. In high schools, case managers also coordinate out of district placements. In developmental services, a case manager is identified for each child who is on a waiver. That person coordinates all of their services and works with the school case manager or a mental health professional, if involved. Those in the Bridge Program and not on DS waivers have a care coordinator. At WSE,

each staff coordinates their own caseload. They consider themselves very responsive to requests to collaborate with each initiating agency to address client needs.

Case management in schools is different than the case management services offered by designated agency providers, such as HCRS, Howard, or NKHS. Families know who their school case manager is by the lead case manager listed on the IEP. Beyond that, a family might have multiple case managers. Generally, the community of service providers uses a teaming model. Here there is often a lead agency (school, HCRS, DCF) and a designated person from that agency will invite others to their meeting.

Usage of Act 264 Coordinated Services Plans. The three sites vary in the frequency and formality with which Act 264 plans, also known as Coordinated Services Plans (CSPs) are implemented. For example, CS uses CSPs frequently. NC respondents use Act 264 CSPs as an informal tool for conversations as well as to encourage clarity and avoid redundancy among teams that have a number of providers serving students. When the need arises to meet about a child, they brainstorm with the family, sometimes using the format of the plan and sometimes not. The NC LIT team also does not review a significant amount of CSPs.

3) Benefits Related to Design of the Current Service Delivery System

Respondents discussed positive effects of coordinated services, such as better student outcomes in school, the ability of parents to build positive connections with school staff, family stability, and reduced incidence of expensive hospitalization or residential placements.

Students Succeed in School. Among the comments about the positive effects of services embedded in schools are earlier access and fewer stigmas. Service integration also increases the capacity of school staff to serve more youth and to handle issues on site rather than send children away as an automatic solution. Children develop a more positive outlook about coming into school and getting homework done. Overall, it helps young people stay in school and be successful there.

Students Transition to Work. Partnerships and collaboration between Vocational Rehabilitation (VR), Developmental Services (DS), and NKHS have led to more positive employment outcomes for youth who are transitioning. VR at NC described a well-coordinated service as a youth (with a qualifying disability) that has found a paid position with help from the high school and VR. At NC, VR contracts with the human service organization's Jump on Board

for Success (JOBS) program. They found that by having a JOBS coordinator in that contract, more youth are either getting their high school diploma, going through the Northeast Kingdom Learning Services, or getting their GED.

Parents Build Connections with School Staff. To support the educational success of children, parents get help, too. Those with difficult educational histories who are uncomfortable in a school develop a better relationship with school staff. They learn how to actively participate in their children's school success, how to be advocates, and how to promote their child's learning. For example, North Country services include helping parents learn how to participate in school meetings and build a constructive relationship with the school staff.

Families Stabilize. Respondents also noted other positive outcomes for families. Services stabilize families, reduce homelessness, and help families learn to manage their own stressors. Children and their families have access to more services. Families get needed supports and children and adults learn to better communicate with each other. This allows children to stay living with their families in their communities, and provides the least restrictive home, school, and community environment. Families receive guidance and support in addressing their own priorities.

Reduced Need for Higher Level of Services (Prevention). Services also prevent the need for higher and more costly levels of services, such as hospitalizations and residential placements. For example, NC noted fewer students in residential placements than anticipated; placements were under the cut-off point for meeting the indicator goal in its annual performance reports to DOE. WSE has reduced residential placements over the years and developed ways to keep children in the community and in their homes. The number of students at the Austine School for the deaf has dropped significantly due to cochlear implants, allowing most youth to attend regular high school. Early intervention and prevention through CIS prevents unnecessary need for higher levels of service. Plus, WSE helps families identify and involve natural supports to decrease their dependence on services.

4) Needs Related to the Current Service Delivery System

Respondents discussed a variety of needs that arise in the pursuit of accessing services for youth with disabilities. The needs identified are categorized according to various components of the service delivery system.

Resources Needed to Provide Early Intervention Services.

Limited resources for in-home services results in lack of a timely or effective response. Demand is greater than current resources for in-home services. Respondents in CS identified a greater need and demand than they can provide for family outreach and in-home family work, often referred to as intensive family based services (IFBS). Due to limited resources, response can be slow, resulting in more use of costly crisis services, or less interest from families after waiting several weeks for help. At NC (Charleston School), families occasionally wait for someone to visit their home. Respondents attribute this to budget and staffing shortfalls. One situation recently elevated to a crisis in the absence of a prompt response. In this case, the student was not on an IEP, which also contributed to the gap in service.

More resources needed for helping youth transition to supported employment. A VR respondent spoke highly of partnerships, but acknowledged the need for more resources with which to work. For example, staff capacity is problematic, since the caseload reaches 200 students, and high school seniors are considered priority. VR is looking forward to an upcoming pilot project where a youth employment specialist will help find jobs for youth with disabilities by the time they graduate, which is currently a gap in service.

Funding for Alcohol, Tobacco and Other Drug (ATOD) programming misses opportunities for early intervention with adolescents and their families. Respondents added that Alcohol and Drug Abuse Program (ADAP) funding for Student Assistance Programming in the school (alcohol and tobacco education and counseling) can only fund an identified abuser with a diagnosis. This leaves out other adolescents who use substances and misses influencing the whole family on substance abuse related issues.

Need for In-Home and Community-Based Services.

Shortage of temporary placements for youth when families need time out. NC indicated a need for more temporary homes in which to place students when there is a negative impact of the home environment on the child's ability to function in school. These voluntary out of home placements generally last 30, 60 or 90 days, in order to give families a break. Parents receive support and the child is then transitioned back to the home. There is a shortage of people who are well-trained and capable of bringing youth with disabilities into

their homes. There is also a great shortage of foster family homes in WSE, as well as staffed homes for transition-aged youth where several youth could be accommodated by rotating staff.

Less costly and more appropriate alternatives to residential and hospital level care are lacking. Hospital diversion programs are needed. WSE respondents expressed awareness that their hospitalization rates are high compared to other areas of the state. They explained that young people frequently come into the emergency room, clearly not able to go home, and yet not necessarily in need of hospital level of care. What they often need instead is a family intervention. One respondent estimated that 60% of crisis cases for children under age 12 with disabilities relate to a family conflict and manageability issue. Having places for these children to go for a night or two while staff provide family interventions could drastically reduce hospitalization rates.

Respondents said this holds true for the DS population as well, where nine times out of ten the screener classifies the crisis as a behavioral issue rather than a mental health issue. Without a place for time out, these children are sent to the hospital. This is similar in the adolescent population as well. Often, there is a family conflict, and the teen may be actively expressing suicidality. When offered a safe place away from the home for a few nights, the suicidality subsides and it is possible to begin addressing underlying family dynamics that fueled the crisis.

In contrast, when schools experience a crisis, they call the family to take the child home. Some families will ask for residential placement because they say school is not working for their child. However, when investigating the situation, it is often a way to relieve chronic stress and crisis at home. Respondents believe more options are needed besides residential placement. For those respondents who are using family safety planning, a practice change within the DCF model, find it a valuable tool. This mediated format addresses safety with a plan that families can take home and implement. Some respondents commented on the increased investment and involvement from families in this planning tool, in contrast to CSPs, where the majority of those involved in the process are professionals. Only those who meet certain criteria go to the hospital. However, more homes and resources are needed to provide emergency care. When families feel they can no longer tolerate their situation and lobby individual staff for a solution that staff cannot realistically offer, this can lead to less well coordinated services.

In WSE, DS has one residential bed through the Vermont Crisis Intervention Network in Putney and one in Moretown, but they only take one youth at a time and there is often a long waiting list. These networks offer a few levels of care, including support in the home. Currently the primary option for families in Windham Southeast is Northeastern Family Institute (NFI) in Winooski, which is often not a realistic option because of the travel distance. Consequently, unnecessary hospitalizations take place when going home is not suitable and there is no in-between step. Other needs include “step downs,” respite and shared living providers.

Three adolescents at NC are in short-term out-of-home placements. They cannot go back home due to chronic crisis, yet they do not need to go into custody either. They are not eligible for DS, but are also not ready to be on their own. The short-term placements are not sustainable. Respondents are hopeful that two of them will qualify for SSI and find a place to live that will take their SSI. Two are still involved with JOBS and one is still in HS. They say forcing these youth to go back home would be detrimental. NKHS are sharing the cost of one of placements. If they do not, it is likely the youth will show up at the hospital in crisis. After screening, they might be placed at Brattleboro Retreat for 5 days. Upon return, the child and family are traumatized and trying to return to a more stable situation is much more difficult than it could have been with more preventive measures.

Families need additional home and community supports. CS respondents noted that additional home and community supports are needed for many families, especially in early childhood. Services include a need for respite for children with developmental disabilities (e.g. autism) and transportation. Access to private insurance coverage to support case management and respite is also needed.

More staff are desired to handle expanding caseloads. According to CS respondents, DCF's differential response to youth in custody has strengthened families and benefited children. At the same time, it has increased demands on the social worker, because each case includes work with extended family of youth in custody. It requires more communication with partners to foster understanding and more social worker support. NC would like to increase their capacity to help students who participated in their day treatment program, Turning Points, successfully transition back to their sending school. A dedicated staff person would help because current staff case loads are full.

Development of Alternatives to Stringent Eligibility Criteria.

Limited access to DS waivers often results in crisis-driven access to care, which costs more and sets children and families back. CS and NC interview participants said suspension of the System of Care funding priorities for children in 2001 limited access to the DS waiver, resulting in crisis-driven access. Often, because children cannot enter the system until they are in crisis, their needs, along with the costs to support them, have increased. Families often seek a shared parenting situation or behavioral consultation because they run into trouble supporting their child at home full-time. The Bridge program, added two years ago, helps some families access a few services by providing care coordination. The Bridge program, however, has limited availability and does not provide the level of service that a lot of the children and families need. Some children can receive services when they happen to have

two diagnoses (mental health and developmental disability) or if the child is adopted, but the capacity is not there to serve DS kids in the same way as other children.

Some young people do not meet the criteria for any service. A gap mentioned by NC respondents includes very challenged young adults that do not meet criteria for any service. Estimated at 5% of the population, this includes people with organic brain syndrome and different disabilities after the age of 18. They do not qualify for developmental or other services. These individuals may visit the emergency room in the absence of other services being available, which is costly.

Service gaps are created due to strict eligibility criteria. Pre-school age children with challenging behaviors, but those who do not necessarily have a developmental delay (according to either an AHS or DOE definition), are often ineligible for services leaving them and their families in a bind. School age children can usually qualify for some services on the continuum. However, some behaviors may have existed for quite some time at home before a child reaches school age, and therefore is more challenging to resolve. Transition aged youth face a similar dilemma of an identified need that does not necessarily meet an eligibility criterion.

Need for Simplified Funding and Billing Mechanisms.

Few people understand complex financial incentives tied to certain funding. A CS respondent explained that although it costs more upfront, districts can benefit two years down the road with a tax reduction that will allow them to have more money. CS worked with their business manager, since it is tied to tax rates and other variables. Vermont Community Preschool Collaborative (VCPC) has supported those looking at expanding. However, few people understand how it works and some communities cannot take advantage of it.

DS funding to support employment for youth age 18 and over is contingent on finding paid employment by a deadline, which can create a "Catch 22" for disabled youth. Policies and funding restrictions can create roadblocks for students with disabilities preparing for the workforce. NC respondents described a recent case. It involves finding a job for a youth who is graduating this year. The job takes place during after-school hours, so the school is expected to contract with someone to accompany that student after school. However, if the youth does not have employment six weeks before graduation, he cannot qualify for the waiver to continue the job. Funding is contingent on employment before graduation, but jobs are scarce even for those without a disability.

Fee-for-service model has drawbacks. NC respondents pointed out that a fee-for-service model requires that a child must be diagnosed for the case to be opened. The model also requires staff time on billing and paperwork, which could be spent assisting children. Plus, the institution of care is mobilized around the identified child. Some WSE respondents discussed their view that problems include the family system around the child, but schools lack the resources to effect change at this level. Respondents believe part of the solution may be support from the community, because it is bigger than a school issue.

Need for Changes in Policy and Practice.

A shift in DCF's practice to avoid negative consequences of taking a child into custody (e.g. differential response) has decreased money available to families for important services. CS respondents described a practice change over the last two years, resulting in a dramatic decrease in children under custody of the state and a dramatic increase in "open" cases, where parents retain custody and DCF's Family Services works with them. When a child is in custody, or legal guardianship of the State, then the State funds everything except their education. If a child is not in legal custody, then DCF Family Services does not fund certain services. Consequently, there has been a cost shift, so that state and federal (Medicaid) dollars are coming through different funding streams, some with caps on them and others without. Therefore, DCF does not fund services for an open case that needs more intensive help, like a residential placement or wrap around services in the home (mental health or DS).

Transition from Early Intervention to Early Essential Education Services.

Early childhood service coordination changes at age 3, which can be confusing for families. There is a transition at age 3 from CIS's centralized coordination of services to EEE services at individual schools. Respondents say this is more confusing for families. There is a change from children having professionals that work across the SU to having them work in each school district. (This varies with each school district. The minority have dedicated people such as certified special education teachers). Two specialized teachers or staff manage the most complex and challenging cases.

Respondents find it much easier for children to transition when they know the schools and have a relationship with someone there. Because of this, CS has its own Occupational Therapist (O.T.) in the district. The O.T. meets with the provider of services from birth to 3 to plan the transition. CS is in the minority of school districts that has dedicated staff for this

transition. More often, there is sharing between the EEE teachers and those coordinating birth to 3. The host agency is the Vermont Family Network. They provide family resource coordinators and developmental educators as well, plus services to children with special health needs. VNA provides the therapies.

Family Engagement.

In practice, families rarely initiate an Act 264 CSP meeting. WSE respondents discussed how practice has veered away from the original intent of Act 264. They explained that the Act gave families the right to require agencies to meet and work together to provide them with services. However, in practice the school or agency initiates the process and requires families to attend. At times this can be useful to families new to the system but more frequently the families who attend already have multiple services. Respondents say it is not the most supportive process for families and is very overwhelming.

Respondents explained that some parents have their own limitations, which require help from staff so they can negotiate the system of care or even engage in the system at all. Many children who are referred to school-based clinicians would never get services in any other way, which means they are from families who are disengaged from the system of care. Respondents say the logistics of getting a piece of paper signed by the parent is a major challenge. These families often have substance abuse and other issues going on at home that they are not ready to look at; and the kind of parenting that brings children to school who are under-socialized and traumatized. These are the cases where service coordination does not go well. Staff, who are at their wit's end, call an Act 264 CSP meeting. Yet the family has no interest in being there.

Families vary in their receptivity to help. Respondents noted that families vary on receptivity to in home services. Some welcome it while others refuse it. Parents can be defensive about having a child identified as needing help in school, especially if they themselves had a challenging school history. Some respondents gave examples of situations where they feel helpless about abusive home atmospheres that they see impact on the child's ability to focus and learn in school. Yet, mandated reporting that does not result in DCF intervention can lead to other complications that impede helping a child, such as holding back information and other defensive action by families. In small communities, families have withdrawn from voluntary DCF services because they worry their neighbors will think their children are going to be taken away.

Respondents explained that major agency transformation has resulted in a focus on how to respectfully engage with very challenged families in order to build positive relationships and

address important issues constructively. They said this takes time. In the meantime, schools see children with immediate needs that are not yet being addressed that interfere with learning. Still, respondents said that mandatory reporting makes a difference, because families are offered services and with enough reports, families can be more receptive and change can happen.

Locally Initiated Services to Meet Needs of Children and Families.

Some areas creatively develop needed services in the absence of a state-directed effort. Respondents noted that one community, Hinesburg, has developed an organization, Friends of Families, which works closely with the elementary school, the play group, and the CIS providers to provide a wraparound effort. This early learning partnership has grown from 30 to 200 people in three years. CS has invested in creative curriculum screening for children who are in play groups and child care centers. They have also supported state-wide training for care providers on setting up nurturing environments for children. CS has written grants to help support families with this work and to increase collaboration with home providers. This year, evaluations from the creative curriculum will be shared with EEE and Kindergarten teachers. This will give them important information about the entering kindergartners' social, emotional, and language status. Overall, they see this as strengthening connections between child care providers, school staff, and families.

As a voluntary effort, CS's approach is seen by some as unique, compared to other districts with fewer resources. Each district had a choice about transitioning to the requirements for Act 63, or for pre-K, Act 62. CS asked for a financial commitment from their school boards, which had to be approved by each district after an agreement to monitor spending. They are currently over their cap in Hinesburg and demand is much higher than what they can meet (up to 20 more families). Districts and SUs vary in their participation in this. Vermont preschool community collaborative funding grants help areas do studies and get it started.

Need for Designated Primary Service Coordination.

Communication gaps in the absence of designated primary service coordinator. In a county rich in resources and multidisciplinary work, one challenge that can arise is communication about who is the point person for the family. Conversation between CS focus group participants indicated that there can be a lack of clarity about who is responsible

for initiating communication with nursing staff. This tends to happen when there is no case management or designated planning process to coordinate it. In one case, a hospice nurse was accidentally not invited to a team meeting to plan how to work with a family whose child had died. One respondent at NC indicated that when partners collaborate to find jobs for youth with disabilities, sometimes the same employers are approached by more than one partner.

Respondents emphasized that duplication is rare and occurs primarily in the arena of case management. However, sites varied in their views. Some said it did not result in duplication, and others thought it can, due to funding and eligibility mandates that divide staff into multiple silos.

Complexity of service coordinator and requisite case management skills sometimes results in duplication of effort. Within AHS services in CS, respondents say there is some duplication in case management. The current system results in case managers working within their own silo, leaving some families with multiple case managers and others with none. Respondents did not see this as efficient or family-centered. They look forward to the IFS/EFS movement toward more family-oriented services that transcend silos.

Funding, eligibility gates, and different mandates cause artificial restrictions in what each service provider can do and who they can serve, resulting in multiple providers. Respondents gave the example of a family with five children, each with special needs. Each child might have a separate case manager, outpatient therapist, early childhood organizer, school social worker, and liaisons with the school and with the VNA. The family does not have a single point person. Respondents question whether this is cost effective or results in the best outcomes. Some of it was set up inadvertently by having the State designate some funding for case management. Those needing to fund a service might call it case management in order to qualify.

At NC, case management is a term that can mean different things to different organizations (e.g., special education, human services). NKHS does not have more than one case manager involved. Case coordinators for the Bridge Program (in Developmental Services) make sure that individuals are not receiving case management from any of the other services. In the schools, the special education teacher takes the leading role in the program and all related services for the special education student.

At WSE, children can have multiple case managers. If a child is on an IEP, the school has identified a case manager. If the child qualified for disability services, then HCRS has an identified case manager. If that child or youth happens to also then come into DCF custody, an identified social worker is assigned. Yet, most respondents at WSE agreed that there is little duplication in case management. Although the title is the same across the different agencies, case managers play very different roles. A special educator manages the IEP. Nobody else can do that except for a special educator. And the case manager at DCF – nobody else can do that

except for the case manager at DCF. Another respondent added that there are times that it could be handled by one person as opposed to three.

5) Suggestions for Improved Service Coordination

Provide for Integration of Services.

Potential ideas for further coordination and integration of services was difficult for respondents to conceive in that participants had a narrow perspective from which to view the system as a whole. The research team suggested the medical home model of care as a potential source. Recent integration efforts in other states also provided thoughts for consideration. Ideas that surfaced are explored below.

Make service integration a priority and apply strengths in collaboration when addressing gaps. Some respondents believe heavy workloads in education and the need for leaders to focus on immediate funding needs preclude time for long term planning of better service integration. They explained that the financial crunch is pitting resource against resource, with cuts looming on the horizon that may affect the continuum of services offered to children and families. More effort is going into defining job responsibilities so that decision-makers know the impact of potential position cuts on services. One respondent told the story of a school administrator in another district who later regretted cutting a social worker position. To address the problem, one suggestion involves prioritizing service integration so it is embedded in the work differently without adding to the workload. Local districts might be willing to accept facilitation from the state to accomplish this if they saw the common benefits and if it were more cost effective over the long run.

CS respondents said they feel good about how they collaborate, citing for example, a federal grant called Students First, an integration of mental health and education. One of its goals is integration of professional development for leaders in both sectors. However, respondents commented that when it comes to challenges, such as gaps in services, DOE and AHS address them separately. Better integration would begin with a shared understanding that both organizations are "in this together" and provide a way of planning for the future and addressing problems together.

Consider integrating relevant functions of AHS and DOE. As resources become scarcer and frustration mounts with different silos, approaches, funding and accountability streams (as well as all the paperwork involved), respondents are looking for a better way to put

families at the center. What would that look like? Some believe Vermont is small enough to try something new. One idea is to bring services under one umbrella. An open question is the extent to which budget issues would be mitigated in some way by consolidating these services into one. Focus group conversations stimulated thinking about how to shift the paradigm toward prevention, which is more cost effective.

A CS respondent explained that families experience the system of services as if they should be integrated. Without coordination of services, families have to function as their own case managers. Even when families want that role and the power to make decisions, they often lack information. For example, most families do not know they have access to services that might be available through Act 264. Coordination between AHS and DOE would make a lot of sense to families but only if the coordination is intentional, systematic, and grounded in an integrated system of eligibility and service delivery. The coordination would need to be facilitated by a role at the interface between all the sources of assistance.

Several respondents identified instances where families were served by several representatives of various state agencies from both AHS and DOE. One example of a circumstance that seems all too common in special education is a request by one or more social service agencies to maintain the eligibility of an 18 to 22 year old person because no other funding source is available for services. However, the school based programs may no longer be functional or appropriate for that person.

Other states, such as Pennsylvania and Michigan, have joined their equivalents of AHS and DOE to integrate services for the young child while maintaining the integrity of state laws pertaining to education. Pennsylvania created an Office of Child Development and Early Learning (OCDEL). Michigan recently combined the Office of Child Development and Care at the Department of Human Services with the Office of Early Childhood Education and Family Services at the Michigan Department of Education. The new *Michigan Office of Great Start – Early Childhood* will be located at the Department of Education and will coordinate all 84 separate early childhood funding streams currently managed by various state government agencies. This new office will refocus the state's early childhood investment, policy and administrative structures by adopting a single set of early childhood outcomes for prenatal to third grade.

While respondents thought that CS staff and families may find the idea of merging attractive on a state level, one question is how to manage change in the context of complex federal rules and regulations for various funding streams and programs. The state is not operating in isolation. It is dependent on funding from federal programs. At WSE, some respondents were fascinated, even astounded, by the idea of merging and very intrigued at the possibilities it could offer - such as one case manager instead of three or four. Others had a hard time imagining what it would look like. One concern is dilution of services (point of

diminishing return) due to consolidation. Another concern is how to agree on a common language and organizational culture. One person acknowledged that departments inside AHS have not yet solved this issue, so taking on a larger merger could be premature. Yet another concern is the impact of special education spending and the funding streams that are local and not state dollars.

Another issue would be how to share data while preserving confidentiality. This is a particular concern where data systems between health systems (HIPPA) and educational systems (FERPA) mandates for confidentiality have created barriers to the merging of individual records where permission to share may have been obtained in one system but not in the other. Recent changes in policy guidelines for FERPA may enable such sharing, but the procedures for doing so remain unclear.

WSE respondents discussed their vision of a service model where they had the flexibility to address the needs of an entire family system in order to do whatever is needed to help the child and family thrive for the long term. This includes job flexibility ("I'll make sure this happens," rather than "This is not my job") and the ability to meet basic needs (food, clothing, shelter). Respondents also acknowledged the new challenge that children on the autism spectrum and their families present, which has motivated staff to work together better. This includes addressing the impact of the diagnosis on the family.

Some respondents discussed an ideal of developing a state level entity that was familiar with all the different programs and could parcel funds out to the various departments. This could improve on the current fragmentation of many small schools and sporadic availability of services in different rural areas divided by mountains. However, some pointed out the conflict between the need to cut or maintain school budget levels, and the legal obligation to provide services to a child on an IEP. The financial burden falls on the school and community, which needs to raise the funds to support it. Respondents also emphasized the importance of being able to customize programs to meet the needs of their own regions.

The medical home model was briefly mentioned during the focus group conversations. Part of the Blueprint for Health Initiative, physicians' offices go through an accreditation process to become a patient centered medical home. The medical home provides families with a stable point of contact to coordinate chronic care. Sites had some awareness of the model. CS respondents said the medical home model has not yet been applied to children's mental health services in Chittenden County, although effort has been made to begin tracking who is a child's primary care provider.

Combine funding streams and create more flexibility in billing systems.

Another suggestion is to combine funding streams to better use resources and provide better

service and flexibility. However, several respondents indicated there may be barriers to combining federal resources. NC respondents suggested adjusting how funding for Success Beyond Six can be managed or allocated so that non-Medicaid students, including those without IEPs, can benefit. They would like to see funding for ATOD become more flexible so they can provide in-school substance abuse services, including early intervention. They believe this would be more effective outreach than the current requirement that parents and youth contact them.

Another recommendation from NC is to create more flexibility to serve children and families that are not tied to the fee-for-service model - especially for substance abuse services, consultation and brief interventions. Fee-for-service has provided a wonderful opportunity to have contracts with the schools, but the restraints of the documentation limit staff ability to meet more needs. Although it allows staff to work with youth to keep them in school and help their families improve, it has limitations when a brief intervention is needed for a child who is not on the open caseload. On a related note, WSE respondents would like to see more investment in prevention and early intervention. They discussed the desire to create a plan before a situation rises to crisis level in order to prevent it. However, in the absence of releases, it is difficult for staff to discuss a case before it becomes a crisis.

Provide Family-Centered Services and Restructure How Services are Provided.

Focus group participants shared beliefs in the importance of keeping families at the center of the service model. They discussed ways to make services user-friendly for the family, such as a centralized intake process and a responsible lead coordinator or strong teaming process. They also described improvements to the Act 264 planning process, including EFS and family safety planning. Respondents emphasized supporting families so they can better support their children.

Centralized intake process: According to CS respondents, one aspect of well-coordinated services is a centralized intake process with one number for families to call. While not perfect, it is easier to navigate and gives an overview of services available. This would start with a well-coordinated or marketed intake process with defined timelines and response times. Respondents would inform families about their service options and what they can expect next in the process. They would then connect families with local service providers, giving the families a clear idea of what the provider will offer and how those services are going to meet their needs.

When intake is not centralized, it is harder for families and those referring families to navigate and know everything that is available to them. They themselves need to compile a list of all the different points of contact. Intake is more of an issue for families new to an area and for those referring families. If a pediatrician or a primary care provider wants to refer a child

for a developmental assessment, there is not one person to call who will then orchestrate that among the EEE staff or among the different school districts. However, some respondents also emphasized that parents value a local connection to local services; they feel comfortable in a familiar school system with staff they have come to know.

Responsible lead coordinator or strong teaming: When someone takes ownership and responsibility, like a lead service coordinator, that lends itself to well-coordinated services for families. Even if one person has not been identified as the lead, strong teaming amongst the people involved can provide the next best level of coordination. Much more communication between home, schools, and nursing staff is also recommended.

Improve the Act 264 CSP process: Some WSE respondents think it is overwhelming for a child and parent to sit in an Act 264 CSP meeting with up to 10 professionals discussing their case. They do value the group brainstorming brought about through an Act 264 plan. However, they think this part of the process can be confusing for families, especially when there are differences of opinion among staff or discussions of funding sources. One suggestion is to designate a point person to communicate with the family and represent the team. In this case, one or two professionals would meet with the family to assess their needs before the brainstorming and then present options afterwards. Another general suggestion is that the 264 process be revised in some way to give families more ownership over the plan. One respondent suggested intensive case management, a versatile person who can be a generalist with families, to help them access many services.

WSE respondents explained that Act 264 was passed at a time when there was need for "teaming" (people working together and talking) to make things happen. Now there are more appropriate teaming processes in place and being developed that improve on the Act 264 process. Act 264 meetings are still used because they are required legally to obtain state funding, but staff are experimenting with better ways to structure the meetings.

Enhanced Family Services (EFS): Dealing with multiple agencies can be confusing for families, even more so if they have multiple children receiving multiple services. Respondents indicated that staff do their best to work around this encumbrance to provide wrap-around services, as a result of their experience and longevity working together. EFS exists to begin to address this complexity for a child with many needs. EFS not only looks at the child's plan, but also takes into account how it interacts with the plans of siblings and parents. Parents establish goals on these plans. The EFS model is also a way staff are trying to make the Act 264 process more user-friendly and engaging for families.

Family safety planning: NC respondents discussed the challenges of intervening at the family level in order to prevent extreme problems, such as child abuse and children going into state custody. Often, DCF - Family Services cannot intervene because a case does not meet their criteria for involvement. However, respondents cited enough cases where they anticipate

that without some intervention, DCF will eventually be called to intervene. Family safety planning is one effort to address this gap, which requires training of staff to have difficult conversations with families who may not be receptive to getting involved in voluntary preventive services. Family safety planning is a resource that provides a structure and facilitation by a neutral person who brings appropriate parties together, including families and their natural supports. The group meets over time to create a constructive approach to address underlying issues and work toward long term stability within the family unit. Family services staff do this work already, but capacity is scarce. They would like to see capacity expand.

WSE respondents explained that when a coordinated services plan is driven by professionals, it often does not happen because the family is not invested in it. For example, the family does not follow through with getting their child to appointments, or going to their own treatment. However, if in addition to a CSP, there is a family safety plan or just a friendly team meeting that is driven by the family and involves more of the family's natural supports, then WSE respondents believe they can help more effectively because the family is behind it. One caveat is that NC respondents find parents reluctant to invite family (as natural supports) out of embarrassment at being in the situation.

Support families so they can better support their children: WSE respondents expressed interest in improving processes that engage families early on, including teaching parenting skills. Those who recruit mentors or substitute parents for youth emphasized the importance of placing more resources, attention and services into helping to support parents, starting at pregnancy. This could include more paid adults to strengthen parents' ability to handle their children constructively.

When parents lack skills, supports and engagement, the schools do not have a way to engage with them. Those who work with children in the schools often need to debrief the traumatic issues they see elementary age youth dealing with every day. The lack of access to family members is challenging, when the family environment is detrimental and the child is suffering because of it. Without control over their home environment, these children push the limits at school. Engaging and gaining trust of the family is important, but can take time and flexibility to be able to offer perks such as pool passes or a summer program. Even with school-based clinicians and case managers, it sometimes takes a long time to develop positive relationships. Respondents find that a family with a pre-existing relationship will be more apt to reach out during a crisis.

Track Outcomes and Utilize IT Systems to Enhance Coordination.

Focus group respondents raised various questions and issues related to tracking outcomes for children and families. Suggestions included broadening indicators to track family

progress and focusing on the family's goals. Respondents did not see Act 264 CSP as an adequate marker of coordination. They discussed tracking opportunities, such as technological advances that offer opportunities to join databases while preserving confidentiality; and utilization of existing tracking processes.

Questions and issues related to tracking outcomes:

When thinking about tracking outcomes, respondents offered the following considerations:

- What are the criteria for tracking a child?
- Would a child be tracked if they have one service outside of education, if they had a whole continuum of services, or if they were funded by another group?
- Who would be in the best position to be aware of the information that needs to be tracked across organizations?
- How are outcome indicators integrated between agencies and schools?
- What outcomes are already tracked on existing databases?
- How can the information on various databases be combined?

Another problem mentioned is how to find valid and reliable measures:

- What would be trackable measures of success?
- How could outcomes of prevention be measured?

Broaden the indicators to track family progress. Respondents said indicators for tracking should be appropriate to the progress of the family. Long-term developmental issues that have evolved over generations will require support over a lifetime. In this case, an outcome might be that the family is engaged in helping themselves or at least maintaining some stability. Also, tracking should look beyond the child to the multigenerational family – since the child will grow up and have children that often also need services.

Ask families for perceptions of their progress. Respondents thought families could be involved in tracking processes, by asking them about their perceptions of progress. Some measures might include numbers of people with basic needs met such as adequate housing and food security. Another measure is numbers of people who are successful at things they find important. For instance, families could be asked the following questions:

- Do you feel safe?
- Do you have a place to live?
- Are you getting enough food to eat?
- Do you feel like you are getting your needs met?
- Do you think you are doing better?
- Do you think you have gained some parenting skills?

- Do you think your child is learning in school?
- Are your kids growing?
- Are they happy?
- Do you have a doctor you trust?

Act 264 CSPs are not an adequate marker for tracking outcomes. Respondents did not see Act 264 CSPs as an adequate tracking mechanism, because they do not include all the people getting services. For example, students in school who use social workers are not tracked and do not have a CSP. Many children who receive services from more than one agency do not necessarily have a CSP. In CS, an Act 264 meeting is a mechanism for trying to fix a problem; they are not used for situations where the team is working well and the services are being well coordinated and delivered. There are difficulties coding social worker time spent in an Act 264 meeting through normal billing mechanisms. Local DCF departments track requests for DCF staff to attend an Act 264 meeting as well as actual attendance. However, DCF does not attend every Act 264 meeting, so that does not provide an accurate count, either.

Some CS respondents also think many people who might need a CSP are unaware of its expanded definition of disabilities. They believe the provision is being underutilized, especially when it comes to medical disabilities. Others found tracking the frequency of CSPs use to be a challenge. Some attribute this to time restraints, others to the logistics of varying team leadership among departments.

Technological advances may offer opportunities to join databases while preserving confidentiality. One respondent explained that with advances in technology and a governing structure to guide it, a comprehensive data reporting infrastructure may be possible. This would join databases instead of building a new one. Rather than use a unique identifier, probabilistic matching determines that if enough things match, it is the same person. The ideal should be to track all children and families, not a subset. With this comprehensive reporting infrastructure, it would draw from school and agency databases, find the matches, and then show what services families are accessing. There are virtual spaces where data can come together and be held for a period of time. However, it is complicated to develop the MOUs and to respect family confidentiality to get there.

Integrate outcome indicators between agencies and schools. Currently, the agencies are supporting children and families so they can function in school, yet respondents indicated there is no conversation about how agency performance standards align with educational performance standards. Internally, there is some monitoring of how children perform in school by programs that formally partner with schools, but not on a broad scale. Agencies tend to focus on developing their own data systems, sometimes looking to similar organizations for models, but not necessarily across disciplines. For example, NC Family Services has a

committee working on creating an agency database system. They have discovered a fair amount of research on doing this and found that Casey Family Services has done a lot of work in that area.

Utilize existing tracking processes. One WSE program reevaluates students every three years to see if they still qualify for services. This existing data might provide measures of services and skills, as well as self-sufficiency and self-determination indicators. Whether to bring back the former AHS community profiles was discussed briefly. NC respondents commented that adding them to the current outcome and performance measures would be overload. One respondent said that while the community profiles are helpful for writing grants, the surveys were too subjective. Different interpretations made the data challenging. However, the profiles that were tracked for several years are an existing data source that could be summarized and published for the legislature and for the regions to promote family-centered indicators. This process makes the data available for public discussion and begins to shape policy towards the outcome measures to which the state is dedicated, a process that has been missing for the last few years. Surveys related to Building Bright Futures and Kindergarten Readiness may also provide existing data.

Conclusions

A summary of findings that may point to next steps for systems change departs from the common response to previous attempts to bring about better coordination of services and improved collaboration among the professionals who serve children and families.

We began this study with a series of questions that were designed to enable us to understand the current state of the opportunities for integrated service:

(a) Identify school supervisory unions (SUs) associated with a high concentration of services, and to conduct an inventory of the current service delivery practices within AHS' 12 districts where services and supports are provided in schools or support positive educational or health outcomes for students;

(b) Map the overlap in services delivered between SUs and the AHS districts and explore baseline measures for future tracking of client outcomes;

(c) Analyze current service delivery practices to inform opportunities for outcome based improvements and enhanced interagency collaboration and integrated service delivery; and

(d) Collect focus group data related to an integrated service delivery system that supports improved outcomes for children and families.

The research team soon discovered how complex the picture of service delivery was and how long ago those charged with providing services had begun to recognize the barriers to effective service delivery. We immediately noticed the tension in the systems we read and heard about that could best be described as family or person centered or system driven. This, like most dichotomies, is a false distinction, but seems to frame much of the discourse. The implication that this observation offers is that any complete understanding of problems and solutions offered must be viewed through the lens of balance.

Evidence from previous state level reports and the literature we reviewed (spanning twenty years), recent reports on initiatives for IFS and CIS, spending and focus group data collected for the present study, and interviews with AHS and DOE staff members suggest that previous attempts to integrate services for children, youth and young adults with disabilities have made some progress. At the same time, the gains in quality of services, effectiveness and efficiency are modest as reported by the service providers in the three locations studied. Vermont may be a relatively small state with a small population, but the systems of care for children and families that include both human service agencies and schools appear complex. This appears especially to be so in the view of those who work in these systems. Points of relevance arising from the study include:

- Families continue to experience multiple partners in their midst who work hard at coordination but have difficulty communicating and providing services in concert rather than piecemeal. An integrated family oriented model should be structured to be integrated at the state, community and family levels.
- A particular source of tension in the current service delivery model often places those who are legally responsible for removing threatened children from families in the role of attempting to avert or manage family crises. There appears to be no sanctioned role for effective coordination at the interface of the social services, judicial and educational systems.
- Service providers experience frustration with the “silo” problem. That is, when attempting to serve children or families they encounter needs that they cannot serve because their funding source is not categorized in such a way as to support a solution to a particular need.
- Criteria for effective services are not systematically employed for evaluating the outcomes of service delivery in family wellness terms. Criteria for evaluation should

include health promotion, prevention, intervention and long term needs expressed in family oriented terms.

- The spending data from both agencies show that there are children and families who are clients of both AHS and DOE. Both agencies recognize the need to collaborate in the attempts to deliver services through human service agency teams as well as schools.
- The experiences reported among both school and agency professionals have a common theme that identifies gaps in service eligibility and thus in services provided.
- The progress now being made in the design of the medical home and its implementation in a comprehensive system that emphasizes prevention appears to be relatively unknown to most service providers. Questions about roles, responsibilities, resources, data integration, and the authority to complete referral with appropriate resources are yet to be answered. (see report of the Vermont Leadership Workshop on Children's Integrated Services, September 15, 2009; Vermont Blueprint for Health Implementation Manual, http://hcr.vermont.gov/sites/hcr/files/printforhealthimplementationmanual2010-11-17.pdf)

Initiatives that have begun during the time that this study was completed are reported on the AHS Enhanced Family Services website. Descriptions of the problems associated with achieving service integration are consistent with the information gathered during the present study. Suggested solutions to the current problems presented in the April 15, 2010, paper, ***Integrated Family Services prenatal to 22 years old: Redesign Description DRAFT combined with Challenge Summary Document,*** are illustrative of the system wide acknowledgment that the system needs to be redesigned in order to become family centered.[16] However, while the Vermont DOE is identified as a partner and described as a key element and source of funding for services, their role is not described in detail. In the paper ***Vermont's Path Toward Integrated Services for Children, 1985 to 2009,*** published in September 2009, the legislative and executive initiatives aimed at the coordination of services between AHS and DOE are enumerated. Many of these initiatives carried the expectation of collaboration across AHS and DOE. Laws were passed and reports were written (http://humanservices.vermont.gov/integrated-family-services).

The most recent report to the Vermont Legislature, ***Residential and Non-residential Services for Pre-natal to 22 Years Old***, January 15, 2012, calculates the total expenditures for services to be approximately $547,017,006 (http://humanservices.vermont.gov/integrated-family-

[16] http://humanservices.vermont.gov/integrated-family-services/ifs-enhanced-family-treatment-eft/final-ifs-concept-paper-4-15-10/view

services/final-ifs-inventory-report-1-16-12/view). Recommendations for evaluation and development of systems in the AHS report to the Legislature are consistent with observations and many of the recommendations made in the present report.

But the goal of a design for service articulated by Child Development Division that was to be characterized by:

- One team
- One plan
- One financial system
- One local agency

has remained elusive.

While some legislation has mandated cooperation between and among agencies, the bifurcation of health and human services and education stems from a history of separation that emerged shortly after the founding of the state and republic. Education as a public service has a long history of mission development and legislation that is separated from other human services by a wide gulf of money and power. There is, in fact, a part of the culture and tradition of agencies whose primary interest is in health, welfare and public safety that tends to exclude the kinds of services to disabled persons that enable them to have access to learning. The history of special education in this country mirrors the struggle for civil rights that has characterized the attempts by a few to deny access to public education for the many (http://www.wrightslaw.com/law/caselaw/ussupct.rowley).

In light of what we have learned from this study, we should ask the question: If AHS and DOE were together under one organization (or, reporting to one Governor) what might (and should) change in order to provide more integrated, responsive and appropriate services to families?

What actions and/or system changes might place the families at the center of Vermont's service delivery system(s)?

This is the question that is now suggested, not merely for yet another study, but for reasoned debate and action.

Appendices:

Literature Review

ECS Legislative Review

Focus Group Questions

Interagency Collaboration for Children with Disabilities:

A Review of the Literature

Meagan E. Roy, Ed.D.

for

The James M. Jeffords Center

University of Vermont

April, 2010

Interagency Collaboration for Children with Disabilities:

A Review of the Literature

The state of Vermont is not unique in its desire to improve the social service delivery system for children with disabilities. The notion that interagency collaboration is essential for the effective service delivery for children and adults accessing social services is not new; however, the recent economic realities have once again brought to the forefront the need to examine current practices. As we examine our funding system for children with disabilities, we look not simply at ways to gain financial efficiencies, but rather at the effectiveness of our programs for the children and families they are meant to serve. Are we indeed providing the best possible services for our most vulnerable children?

Framing the Issue

Historically, the social service needs of children were understood to fall within one of three distinct categories: health, education and social or welfare services (Dyson, Lin & Millworth, 1998). In theory, this made it relatively easy to understand which social service agency (human services, education or the medical field) would be responsible for providing services to children, particularly those with disabilities. The current conditions for children (widespread poverty, family challenges including violence and abuse, complex health conditions), however, have made this type of single-issue program ineffective and inefficient in meeting the needs of our current population (Corrigan & Udas, 1996). A more contemporary (and, indeed, intuitive) view is that very rarely do children exhibit only challenges in a single area. Rather, children demonstrate complex needs that cross disciplines, requiring a service delivery model that understands and treats the entire child.

This notion of integrated services as a "coordinated, systemic approach to addressing the needs of children, youth and their families by providing a comprehensive range of educational, health and human services" (van Veen & Day, 1998, p. 8) is certainly not new. Across the country, efforts have been underway to establish collaborative interagency partnerships for several years, with a number of states passing legislation mandating the coordination of health, social services and education (Corrigan & Udas, 1996). Despite these long-standing efforts, states are still struggling with how best to implement consistent, streamlined services that are effective for children and families.

Beginning with the passage of Act 264 in 1998, the state of Vermont has required that the agency of human services and the department of education work collaboratively to meet the needs of children and adolescents experiencing social service needs. Among other things, the passage of the law mandated that those agencies create a coordinated service plan for children experiencing significant social service needs. The Joint Fiscal Committee became concerned, however, that for children with disabilities, a broad number of human services that had previously been provided by agencies of human services were now being provided and funded by local education agencies, through special education funding. In order to examine this potential cost-shift, the Joint Fiscal Committee produced a report analyzing, among other things, the provision of human services in special education (Joint Fiscal Office, 2008).

The Provision of Special Education Services Report (Joint Fiscal Office, 2008) attempted to quantify the amount of money schools are currently spending to meet the human services needs of children in schools, particularly children with disabilities. Although the authors of the report caution that the cost estimates are based on the assumption that the services analyzed are, indeed, human services and not educational services and for that reason may be high estimates,

the potential rise in costs is staggering. In Fiscal Year 2006, the report estimates that $33.1 million was spent via special education dollars to provide human services to children with disabilities. These costs include significant increases in a number of related services, including a 381% increase in the use of occupational and physical therapy professionals, 254% increase in the provision of counseling services, and a 1354% increase in the use of paraprofessionals to provide health services (Joint Fiscal Office, 2008). The main concern on the part of the Joint Fiscal Committee is that there are costly overlaps occurring between special education related services and various services provided by the agency of human services.

The financial implications of such a lack of coordination are real, and can perpetuate the marginalization of children with disabilities by blaming them for the increased tax burden. More real, however, is the impact this failure to collaborate effectively has on the children and families in need of the services provided. The purpose of the current work, then, is not simply to better understand the financial impact of disconnected service delivery; rather, it is to truly examine how successful interagency collaborations can result in improved services for children with disabilities and their families. This literature review will focus first on examining current practices in interagency service coordination, as well as describe the barriers that exist. It will then discuss emerging themes from successful examples of collaboration in other states, countries and agencies and will begin to outline best practices. Finally, this work will synthesize the research about how best to measure what is arguably the most important aspect of this work: the long-term outcomes for children with disabilities who should be benefiting from the services. This work can inform statewide agencies and stakeholders alike about how best to meet the needs of children with disabilities.

Current Realities

A significant amount of research has been completed to better understand the impact that a lack of service coordination has on the children with disabilities and their families that are in need of services. In her introduction to *Partnerships at Work*, a publication profiling successful parent and interprofessional collaboration efforts, Bishop (1997) notes that the current system of services for education, social services and healthcare for children with disabilities is fragmented and unable to be responsive to the needs of the family. "Families search from one agency to another, explaining and re-explaining what they need, with no hope of coordination, cooperation, or collaboration among the many professionals and paraprofessionals upon whom they depend for services and support" (p. 12). This sentiment is echoed by other families contributing to this work, including Pat Hackett-Walters, a mother of an adult child with special health needs and an advocate for interagency collaboration in health policy. She notes that when coordination of services doesn't exist, families are left to make sense of often conflicting recommendations regarding care. At times, recommendations from different agencies can be contradictory; a failure to coordinate services means that families are responsible for making decisions about which recommendation to follow (Bishop, 1997).

Even in systems where collaboration is demonstrated, the barriers that exist can be significant and deeply held. Dyson et al (1998) conducted a study of ten Local Education Authorities in England that were identified by the districts as demonstrating "good practice" in interagency cooperation. Interviews and document reviews of thirty individual schools indicated that despite the positive practices in place, each school faced challenges in truly coming together and moving toward a common goal. A larger European study published by the Organization for Economic Cooperation and Development (OECD) covered 14 areas in seven countries between

1993-1996 and used a four-tier model to analyze service provision. Although significant advantages of coordinating services were identified (to be discussed in a later section), administrators still worried about increased workload and were concerned that their individual jobs would change drastically (Evans, P, 1998). This concern raises questions about the true collaborative nature of such partnerships, as a common and shared belief is central to the collaborative process.

Barriers to Effective Collaboration

What is clearly evident in the research is that when agencies fail to collaborate effectively, the result is poor service delivery, duplication of services, gaps in services and poor outcomes for children and their families (Bishop, 1997; Dyson et al, 1998; New Partnerships, 1991; Van Veen & Day, 1998). The charge, then, is to better understand the barriers that exist that block successful collaborative efforts. The following is an examination of common barriers cited in the research that can derail even the most promising of collaborative efforts.

Differing Philosophies and Beliefs:

There is overwhelming agreement that when agencies have differing beliefs and philosophies, it can be difficult to reconcile those differences in their work toward a common goal. In 1991, Florida International University hosted the National Public Child Welfare Training Symposium to address the disconnect between university social work programs and state agencies employing child welfare workers. Their publication, New Partnerships (1991), compiled eight examples of collaborative efforts between universities and state human service agencies; in each of these eight examples, the greatest barrier identified was the absence of a common philosophy and a shared agenda between the participating institutions.

In California's model of collaboration, the participating agencies found it difficult to reconcile the development of a new curriculum for social work graduates because they felt the agencies could not agree on a common philosophy around the training needs of child welfare workers (Grossman, Laughlin & Specht, 1991). In their examination of why interagency collaboration so often fails despite widespread agreement that it is necessary, Dyson et al (1998) cite a lack of cohesion among the mission and therefore initiatives of the agencies involved. Given that having a shared mission and belief system is essential for the success of even a single organization, it is not surprising that when two or more different agencies attempt to collaborate, conflict would arise when they are unable to reconcile their philosophical differences (Corrigan & Bishop, 1997; Corrigan & Udas, 1996; VT State Leadership Workshop, 2009).

Organizational Structure and Regulatory Challenges:

A second identified barrier to collaboration is the organizational structure of the agencies involved. Organizational structure can refer to a number of things, from functional structures like length of work day, job responsibilities and governance to more abstract elements of structure such as the expectation to work in teams versus independently and how "formal" or "casual" an agency's employees are expected to be (Morgan, 2006). When the cooperating agencies are not finding alignment with their differing organizational structures, the result can be a failure to effectively reconcile those differences in order to continue functioning collaboratively (Corrigan & Bishop, 1997; Corrigan & Udas, 1996; Dyson et al, 1998; Grossman, Laughlin & Specht, 1991)

Related to organizational structure but often coming from a non-collaborating agency (such as state or federal government or other entities governing funding) are difficulties with the regulatory policies and procedures in place that hinder collaboration. In many cases, state

regulations governing contracts (procurement of services, RFPs) do not give weight to established personal and collaborative relationships between agencies. This can have the effect of sabatoging successful collaborative efforts (Abramczyk, Raymond & Barbell, 1991). In other cases, the regulatory policies regarding intake and assessment for services can unwittingly make it difficult for agencies to collaborate (Dyson et al, 1998). Many families report frustration at the need to complete several different intake forms in order to access services (Bishop, 1997); the need for these separate systems is often governed by regulatory processes and serve as a barrier to effective interagency collaboration.

Interagency Blame-Placing:

Interestingly, a number of works cited the tendency for collaborating agencies to blame each other for current realities as a barrier to effective collaboration. In California's attempt to establish collaboration between their university programs for social work, social welfare services and private organizations, there was a perception that university affiliates placed blame on the social service agencies for the current gaps in services; at the same time, agencies held on to significant distrust based on previous attempts at collaboration (Grossman et al, 1991). Those affiliated with the universities in collaboration noted that "it is a challenge to be a responsible advocate without overtly or covertly "bashing" the agency, and we must be sensitive to the repercussions of taking public positions" (Abramczyk et al, 1991, p. 96). Agencies entering into collaborative efforts understand that they are doing so generally because the existing structures are not demonstrating results; when organizations have this as the context, it is no surprise that tensions arise.

Corrigan & Udas (1996) suggest that successful information sharing and communication between agencies (or lack thereof) can impact the tendency for agencies to blame one another.

When collaborating organizations have clear, established lines of communication, they are able to dispel myths and clarify realities about a given situation, hopefully lessening the tendency for blame to occur.

Funding and Financial Challenges:

It is no surprise that among the barriers to effective collaboration between agencies are the very real funding constraints that all agencies (education, social and health related) are facing (Corrigan & Bishop, 1997; Corrigan & Udas, 1996; New Partnerships, 1991). In many of the university and agency partnerships described in New Partnerships (1991), the university affiliated staff were often funded via grant dollars ("soft money"), making the security and longevity of staff difficult. Further, many of the initiatives have a common commitment to increase training; however, conflict arises between agencies related to funding that training. It is perhaps ironic that reduced costs is one reason why interagency collaboration is suggested, yet funding issues remain a barrier to the development of successful cooperative efforts.

Many more examples of each of the above barriers exists in the literature; what is striking, however, is the commonality of those listed above. Even highly successful collaborations cite those barriers as ongoing issues that must be addressed in order to promote the longevity of the relationships between agencies. Being aware of those barriers may help facilitate agencies' ability to overcome them.

Effective Practices in Interagency Collaboration: What Works?

An examination of successful interagency collaboration efforts can yield important information about those practices that make a collaborative relationship successful. In addition, studies have been conducted that suggest frameworks for establishing collaborations between

agencies and can be helpful in informing the planning process. The following section will describe some of those established best practices.

A number of studies have pointed to the importance of community involvement when it comes to the development of collaborative approaches to social service delivery. Having community-centered organizations in place can foster buy-in from stakeholders, reaches greater numbers of the client population, and empowers community members (Burchard & Burchard, 1993; Evans, J, 1998; Corrigan & Bishop, 1997; Partnerships at Work, 1997). In a subsequent examination of the data from the European OECD study of interagency agreements in multiple countries (Evans, P, 1998), a specific emphasis was placed on the definition of community and how to include and empower local community members in their participation with integrated service planning and policy making (Evans, J, 1998). This article suggests that the move to decentralize education and social welfare systems may be related to criticisms that those institutions are becoming out of touch with the clients they are serving.

Jennifer Evans (1998) suggests that there are four models for community participation, and that a community and the agencies serving it must select from the model that will work best. The first model is described as community participation that is part of an overall strategy mandated and promoted at the government level. In Finland, all responsibilities for social welfare were taken out of central government and given instead to the local level; funding comes from the central government but is used wholly according to local priorities. The goal of this model is to make services more efficient and effective; decision-making, however, still lies with local level politicians and officials rather than community members themselves.

A second example of community involvement is known as localized autonomy, in which funding and decision-making is delegated to the community level. In this model, services are

then developed by local professionals in the field. Germany has used this model since 1945, in which each Land (province) is autonomous and develops welfare and education policies according to its own traditions (Evans, J., 1998).

Community autonomy, where decisions are made by actual local community members and funding is then delegated to support community projects, is used in Saskatchewan, Canada's social services agencies (Evans, J, 1998). This bottom-up type of development is based on groups of residents taking on initiatives of their choosing; support is provided by local professionals and funding is accessed through a Provincial policy that focuses on locally-based integrated services.

A final model of community involvement suggested by Evans (1998) is referred to as a mixed economy and includes elements of both top-down and bottom-up decision-making. Legislation is permissive enough to allow the development of localized services. California's Children and Youth Services Councils are examples of organizations developed to coordinate local services; these councils provide support for school-linked services in the community.

Clearly, the central focus in each of these four models is the importance of community involvement in the development of effective, collaborative social service partnerships. Even the most successful agency partnership will fail if it is not responsive to the true needs of a given community, and if it is not clearly aware of and sensitive to the culture of that community.

Related to the notion of community involvement, a second common element in successful collaborative partnerships is the need to be family centered. Each of the examples cited in Partnerships at Work (1997), a collection of examples of effective partnerships established to meet the needs of children with special health needs, focus on children, families and communities as the center of planning. "Make commitment to children and families the

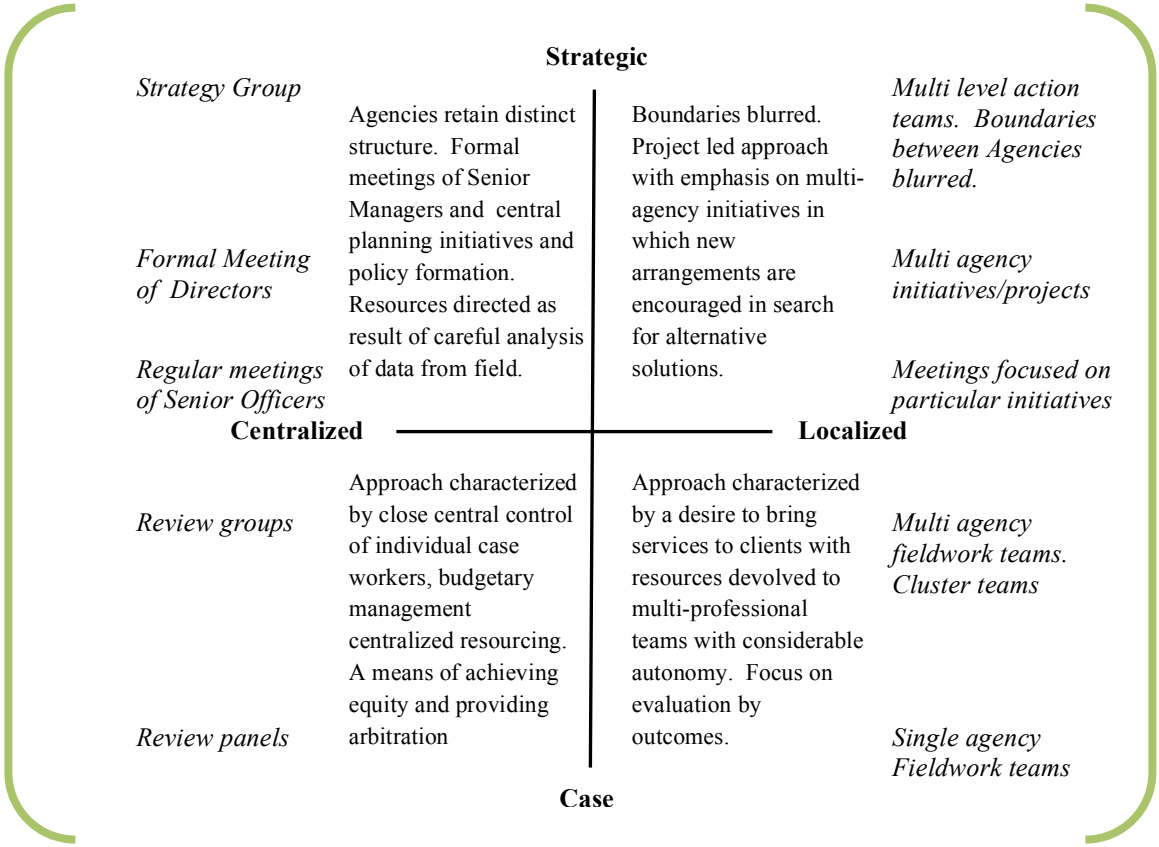
foundation for all programs" (p. 51). In fact, family-centered planning is frequently identified as an important missing component in studies examining family satisfaction with social and educational services (Corrigan & Bishop, 1997; Corrigan & Udas, 1998; Partnerships at Work, 1997). An advantage to interagency collaboration is that with a single entity for families to access, the challenges in navigating multiple systems is decreased, allowing the services to become more family centered and supportive.

Perhaps the most important element of a successful collaborative effort that results in positive outcomes for children with disabilities is the notion that appropriate care must be multidisciplinary and holistic, treating the whole child rather than individual symptoms. These collaborations often include agencies of human services, education and in some cases private nonprofit corporations dedicated to child welfare. There is a clear focus on early intervention and prevention, and a centralized "hub" exists for accessing those services (Corrigan & Bishop, 1997; Corrigan & Udas, 1996).

Corrigan and Udas (1996) also discuss the importance of "simultaneous reform." Their belief is that reforms must occur concurrently at the higher education level and in the field, and that universities must be preparing new professionals to meet the need at the same time issues are being addressed in the field. This requires a collaborative relationship between the agencies and the university.

Dyson et al (1998) suggest a framework that can help collaborative initiatives understand their path to partnership. Specifically, they suggest that two continuums exist: 1). the strategic planning and casework continuum and 2). the centralized and localized continuum. These intersect to form four quadrants of a framework that represent a method for organizations to interpret their current practices and review their current approaches to collaboration.

Figure 1[1]:



Successful Interagency Collaborations

A number of successful community partnerships exist that have both successfully overcome the identified barriers and demonstrate some of the key components described above. The following section describes a selection of these examples and an examination of the common themes that occur regarding successful collaboration.

National Public Child Welfare Training Symposium:

The publication New Partnerships (1991) is focused on examples across the United States of effective collaborative partnerships between university programs for social work and state child welfare agencies. Each of the partnerships was developed in response to the recognition

[1] Dyson et al, 1998, pg. 84

that child welfare workers were overwhelmingly undertrained for the work they were completing, and graduate programs in social work were focused more on preparing graduates for private practice than they were for work in the social service realm. Each partnership was similarly developed with the state's public university system and relevant social service agency; some partnerships also included professional organizations related to child welfare. Successful partnerships in Pennsylvania, California, South Carolina, North Dakota and Washington State were profiled.

In their discussion of South Carolina's partnership between the state university and agencies for child welfare, Abramczyk et al (1991) cited a number of key components of the successful partnership, including a shared mission and purpose and close, trusting personal relationships. They also noted the importance of having each agency be mindful of the political realities that exist in each organization. Stakeholders involved with the South Carolina project note a number of benefits to the collaborative effort. The most immediate benefits were an apparent cost savings in shared overhead, as overlap and duplication of administrative-related services was avoided. They also found that they were able to expand the professional staff beyond what the agencies alone could do with their employees. Stakeholders also noted that the university affiliation tended to heighten the credibility of the work, particularly the training of staff; at the same time, the university felt they were kept informed of current realities in the field that were important for them to understand in order to meet the needs of their student population (Abramczyk et al, 1991).

In North Dakota (a state with a geographically dispersed and rural population), a collaboration between the single state agency for human services and the state university was developed (Schmid & Dawes, 1991). Authors cited that a key aspect to the success of this effort

was a joint recognition that both agencies would mutually benefit; there was a shared commitment to quality, a mutual expectation that the partnership will succeed and a positive attitude.

School and Agency Partnerships:

A number of successful collaborative efforts have been established specifically between human service agencies or non-profits and educational systems to meet the needs of children with disabilities. These partnerships, too, are examples of efforts that have been able to overcome the identified barriers and have led to successful outcomes for children.

Partnerships at Work (1997) describes a statewide partnership in Minnesota between youth with disabilities and schools. This program, known as Parent Advocacy Coalition for Educational Rights (PACER), provides a variety of programs that are collaboratively run. One such program, PACER's Team Training on Transition, works with transition-age youth with disabilities, collaborating with local public schools in the development of transition plans for Individualized Education Plans (IEPs). The focus of the program is on self-advocacy, and teens are trained to take the lead on their transition preparation.

Like the other successful programs, PACER notes that the key to the success of their collaboration is a family-centered, culturally competent focus that seeks non-traditional partners. They have been able to successfully articulate a shared mission of improved transition outcomes for youth with disabilities, but also employ flexibility in defining roles and securing funding. The focus of PACER is on creative problem-solving. PACER officials understand that attitudes shift slowly, and note that they have faced resistance from their educational partners at times. They believe it is their commitment to allowing youth and their families to tell their stories that most often brings about the shift in belief systems. "[F]amily members who, as individuals and

as trainers, talk with honesty and intensity about their experiences do change minds and hearts, a little bit at a time" (Partnerships at Work, 1997, p. 71).

Two studies focusing on program evaluation in interagency collaborative looked at similar collaborative efforts that employed a model of services known as "wraparound," in which a variety of agencies and disciplines work collectively. In wraparound programs, which are used frequently in disability, mental health, juvenile justice and education fields, the development of an individual plan is wholly client- and family-focused and works within their support network to provide services. Ten principles guide the wraparound approach: family voice and choice, team-based decision-making, use of natural supports, collaboration, community-based, culturally competent, individualized, strength-based, outcome-based and persistent (Wyles, 2007). Evaluations of two such programs, one in Australia and one in Vermont, had similar results regarding outcomes. An evaluation of the Turnaround Program in Australia's Capital Territory (ACT) was conducted to understand the outcomes and results of wraparound care (Wyles, 2007). In Vermont, the New Directions Initiative and Vermont's statewide system of care for children with significant emotional disturbance was evaluated (Santarcangelo, Bruns & Yoe, 1998).

In both initiatives, a significant decrease in the frequency of behavioral outbursts, leading to the reduction of restrictive out-of-home placements was reported (Santarcangelo et al, 1998; Wyles, 2007). In Vermont, this led to a significant decrease in costly out-of-state residential placements. Santarcangelo et al (1998) noted the most significant decrease in outbursts occurred within the first six months of the program; children then tended to maintain static for the next eighteen months. Wyles (2007) also reported an increase in school engagement, and children in the program were less likely to drop out. There is a clear belief that the interdisciplinary model is successful, and despite the need for further refinement of collaborative partnerships, integrated

service delivery with a streamlined intake process and easy-to-navigate care management is essential for both reduction of costs and improved outcomes (Santarcangelo, 1998; Wyles, 2007).

Vermont's Children's Integrated Services (CIS)

The state of Vermont has continued to pursue interagency collaboration to improve and extend its service delivery system for children and youth with disabilities. Stemming from an organizational restructuring that occurred in 2006, the state created a unique model that integrated early intervention, early childhood health and mental health services for children prenatal to age six. This endeavor integrated three previously separate systems serving the needs of children with developmental disabilities, health risk factors and early childhood mental health risk factors. CIS regional teams share a single intake system for families and coordinate services for families, children and service providers. Teams include representatives from the social work field, early interventionists (including developmental educators and speech-language pathologists), family mental health and other specialties, including the medical field (VT State Leadership Workshop, 2009).

Spurred by the success of the CIS initiative, the state desires to extend the interagency collaboration beyond age six, resulting in an integrated service delivery model for all children prenatal to age 22. In 2009, a workshop was held bringing the relevant agency representatives together to examine how the premises of CIS could be extended and expanded to meet the needs of children ages six to 22 (VT State Leadership Workshop, 2009). Admittedly, this endeavor includes far more interagency collaboration, including the integration of special education services that carry their own statutory and budgetary regulations. Those involved in the Vermont effort cite similar barriers noted elsewhere in this literature review, including the challenges

faced when organizations have differing philosophies and cultures and the limitations that exist due to differing regulations in the various agencies (VT State Leadership Workshop, 2009). Despite this, the state is actively pursuing the work of integration with the goal of improving services for children and their families.

Emerging Themes

Clearly there are more examples of successful collaborative partnerships that exist. What is most striking in those examined, however, were the common themes in what made a program successful.

- *Family-centered collaborative partnerships have the greatest impact*
- *Shared mission and values must be carefully developed between all involved agencies*
- *A recognition that mutual benefit occurs on the part of both agencies; however, realizing that benefit also involves mutual sacrifice*

Measuring Outcomes: How will we know when it works?

Central to any discussion of the development of new initiatives must be a focus on understanding how best to measure the outcomes of those initiatives once they have begun. Clearly, analysis of funding and cost reductions is an essential element of such an evaluation; however, equally important regardless of funding is information about the outcomes for the beneficiaries of a service. This final section reviews examples of how other researchers have measured outcomes for children accessing social services, using a comprehensive framework suggested by Horsch (1998) that distinguishes between a number of essential elements to measuring outcomes comprehensively. This section also includes a review of additional

evaluative studies that specify essential indicators to measure as well as some examples of standardized tools developed to measure those indicators.

In her article about the evaluation of school-linked social services, Horsch (1998) uses the recommendations of evaluators of such efforts to outline three separate and essential components of an effective evaluation: evaluating outcomes, evaluating collaboration and evaluating sustainability. In addition, Horsch makes recommendations for evaluation design and data collection systems within each.

Evaluating Outcomes

Clearly, understanding the outcomes of any organization or initiative must be a key component. Funding agencies (including the federal government) need to ensure their support of a project is yielding results, staff within agencies want to know if they are being successful, and most importantly the recipients (families and children) of the services want to see that they are making structured improvements. Horsch (1998) emphasizes the study of a variety of long-term outcome measures in order to understand impact beyond immediate gains. The outcomes selected must be related to the services provide and must be broad enough in context to represent many elements of outcomes. Educational outcomes, for example, must be supplemented with other measures, as a variety of other factors may affect those. Horsch (1998) suggests both student level outcomes (school completion, GPA, attendance, behavior rates, substance abuse, employment, health status, pregnancy rates) as well as family level outcomes (child abuse rates, parental attitudes toward schools, safety, health status, employment rates).

In their evaluation of Vermont's New Directions Initiative, Santarcangelo et al (1998) examined similar student level indicators such as behavioral adjustment indicators and the restrictiveness of living setting. In addition, the study examined the youth's satisfaction of the

services, something that is quite important given the client- and family-centered approach recommended for such partnerships. Burchard and Burchard (1993) also addressed student and family outcomes in their case study approach to evaluating the Alaska Youth Initiative Demonstration Project, an interagency collaboration with the goal of meeting the needs of the state's students exhibiting severe emotional challenges. This methodology made it possible for them to understand both student outcomes and the families' satisfaction with the implementation of services.

Horsch (1998) notes that using a theory of change approach when selecting which outcomes to evaluate is essential in order to make a clear link between the mission of the partnership and the outcomes it effects. In a theory of change approach, the program being evaluated specifies short and long term goals, then links these goals with activities and processes and helps to clarify those linkages. This allows evaluators to draw a stronger connection to the outcomes they are measuring as they relate to the program.

Evaluating Collaboration

Given that the focus of the evaluation is not on a single entity but rather the collaborative relationship formed when those entities form a partnership, it makes sense for evaluators to focus on how well the groups are working together. Horsch (1998) suggests examining the structure, nature and image of collaboration. Structure is defined as the contractual arrangement of service provision, and includes such things as services and providers, location of services, degree of budget integration and the number of agencies involved, among other things. The nature of the collaboration is described a more qualitative measure that focuses on how smoothly agencies work together. This can be operationalized by examining the extent of cross-participation in committee work, whether there is shared staff development, and by examining the extent of

knowledge of each program held by members of the other agency. Finally, the image of collaboration gives information about how stakeholders perceive the program (e.g., is the program described in literature from both agencies? Are the services incorporated into school curricula?).

In addition to understanding the collaboration between agencies, the importance of measuring the extent of family involvement in the collaboration is well understood by those charged with evaluating a partnership (Barelds et al, 2010; Burchard & Burchard, 1993; Corrigan & Bishop, 1997; Horsch, 1998; Summers et al, 2005; Wyles, 2007). If families are truly to remain at the center of coordinated service planning for children with disabilities, then any program evaluation must include information about how well families are integrated into the collaboration between agencies.

There have been two tools developed recently that attempt to quantify the qualitative aspects of family and consumer satisfaction with services. The first tool, the QUALITRA-ID was developed for use with adults with intellectual disabilities to measure the quality of care and service trajectory (Barelds et al, 2010). It was created first by operationalizing the concepts of quality of care and service trajectory using survey data and interviews of stakeholders. Focus group interviews were then conducted with adults with intellectual disabilities to further validate the content of the tool. The QUALITRA-ID was then validated for internal consistency and found to be a promising measure of service trajectory and quality for adults with disabilities.

A second promising tool is the Family-Professional Partnership Scale developed using qualitative research from families with children with and without disabilities (Summers et al, 2005). The tool was designed to assess parent perceptions of interagency partnerships whose goal is to integrate services, making it particularly relevant to the evaluation of interagency

partnerships. The Family-Professional Partnership Scale was initially designed around six domains: professional skills, commitment, trust, respect, communication and equality. Later, the categories of child-focused relationships and family-focused relationships were added. This tool has potential value for agency-, school- or district-wide program evaluation (Summers et al, 2005).

Evaluating Sustainability

The sustainability of any partnership is particularly important in an evaluation process, and is one that Horsch (1998) identifies as essential in developing an understanding about how well organizations are able to collaborate. Some measures of sustainability include the extent of support offered by leadership in each member agency (educational leaders, university administration, agency coordinators) and the degree of engagement by children, families and communities. A particularly important element of sustainability is regarding the stability and adequacy of funding for the project (Horsch, 1998). Reduction of costs is often what prompts agencies to enter into collaboration; however, any cost savings that occurs will be eliminated if the partnership itself is not financially sustainable. Examining financial measures (e.g., cost savings in service delivery and overhead and decreasing service delivery costs as children improve) is used in a variety of evaluative studies of interagency partnerships (New Partnerships, 1991; Santarcangelo, 1998; Wyles, 2007) and remains essential to a comprehensive evaluation of a collaborative effort.

Additional Recommendations for Evaluation

Horsch (1998) emphasizes the need for a participative design in the evaluation of interagency partnerships, one that uses multiple methods of gathering information and secures input from a variety of stakeholders, most importantly the children and families themselves. It is

also important to begin evaluating outcomes early and maintain an ongoing information exchange, rather than waiting for the end of a specified period of time before discussing the effectiveness of the program. It can be helpful to consider comparison groups or agencies that function similarly.

Conclusions

The ultimate goal of establishing collaborative partnerships between agencies who serve children with disabilities is to provide comprehensive, effective and efficient services that are family-centered, easy to navigate and result in better outcomes for the children they serve. Stakeholders cannot ignore the current economic realities that exist in the funding of social services for children with disabilities. With very real funding cuts looming, we have a unique and urgent opportunity to both examine how we currently fund services as well as ensure that what we are funding works. The development of interagency partnerships is essential in this work to avoid duplication as well as gaps in service; it is also clear from the research that such family-centered partnerships that treat all aspects of a child are more effective. It is clearly not an easy task that states are faced with; however, the result can be a more positive experience for children and their families.

Bibliography

Abramczyk, L., F. R. III, et al. (1991). Collaboration: The best interests. New Partnerships. Florida International University**:** 81-99.

Advancing a Collaborative Action Agenda to Improve Child Health (2009). Vermont State Leadership Workshop, Montpelier, VT.

Barelds, A., I. V. d. Goor, et al. (2010). "The development of the QUALITRA-ID: A user-orientated interview to assess the quality of care and service trajectories for intellectually disabled persons." Journal of Intellectual Disability Research **54**(3): 224-239.

Bishop, K., M. Taylor, et al., Eds. (1997). Partnerships at work: Lessons learned from programs and practices of families, professionals and communities.

Burchard, J. D., S. N. Burchard, et al. (1993). One kid at a time: Evaluative case studies and description of the Alaska Youth Initiative Demonstration Project. Alaska Division of Mental Health and Mental Retardation.

Corrigan, D. and K. Bishop (1997). "Creating family-centered integrated service systems and interprofessional programs to implement them." National Association of Social Workers, Inc: 149-160.

Corrigan, D. and K. Udas (1996). Creating collaborative, child- and family-centered education, health and human service systems. Emerging Directions in Teacher Education. New York, Simon & Schuster Macmillan**:** 893-921.

Dyson, A., M. Lin, et al. (1998). Interagency cooperation for children with special educational needs: An analytic framework. Multi-service schools: Integrated services for children and

youth at risk. D. van Veen, C. Day and G. Walraven, Eds. Leuven, Belgium, Garant Publishers**:** 75-87.

Evans, J. (1998). Community participation in developting integrated services: A community building perspective on service integration. Multi-service schools: Integrated services for children and youth at risk. D. v. Veen, C. Day and G. Walraven. Leuven, Belgium, Garant Publishers: 39-48.

Evans, P. (1998). Coordinating services for children and families at risk: Conclusions and issues arising from international comparisons. Multi-service schools: Integrated services for children and youth at risk. D. v. Veen, C. Day and G. Walraven. Leuven, Belgium, Garant Publishers**:** 17-24.

Grossman, B., S. Laughlin, et al. (1991). Building the commitment of social work education to publicly supported social services: The California Model. New Partnerships, Florida International University**:** 55-72.

Horsch, K. (1998). Evaluating school-linked services: Considerations and best practices. Multi-service schools: Integrated services for children and youth at risk. D. v. Veen, C. Day and G. Walraven. Leuven, Belgium, Garant Publishers**:** 65-73.

Morgan, G. (2006). Images of Organization. Thousand Oaks, CA, Sage Publications.

New partnerships: Proceedings from the National Public Child Welfare Training Symposium. (1991). K. Briar, V. Hansen and N. Harris, Eds. Florida Institute on Children and Families at Risk.

Santarcangelo, S., E. Bruns, et al. (1998). New directions: Evaluating Vermont's statewide model of individualized care. Outcomes for children and youth with behavioral and emotional

disorders and their families: Programs and evaluation best practices. M. Epstein, K. Kutash and A. Duchnowski. Austin, TX, ProEd**:** 117-139.

Schmid, D. and K. Dawes (1991). North Dakota Model of Collaboration. New Partnerships. Florida International University**:** 101-11.

Summers, J. A., L. Hoffman, et al. (2005). "Measuring the quality of family-professional partnerships in special education services." Exceptional Children **72**(1): 65-81.

Van Veen, D. and C. Day (1998). Multi-service schools: Integrated services supporting vulnerable children, youth and families. Multi-service schools: Integrated services supporting vulnerable children, youth and families. Leuven, Belgium, Garant Publishers.

Vermont Joint Fiscal Office (2008). Provision of Special Education Services. Montpelier, VT.

Wyles, P. (2007). "Success with Wraparound: A collaborative, individualized, integrated and strength-based model." Youth Studies Australia **26**(4): 45-53.

Recent State Policies / Activities
Student Supports--Integrated Services--Evaluation

Education Commission of the States • 700 Broadway, Suite 810 • Denver, CO 80203-3442 • 303.299.3600 • fax 303.296.8332 • www.ecs.org

The following summary includes policies enacted since 2000. Summaries are collected from state Web sites, state newsletters, *StateNet*, *LexisNexis* and *Westlaw*. Descriptions often reflect the content of bills as introduced and may not reflect changes made during the legislative process. To assure that this information reaches you in a timely manner, minimal attention has been paid to style (capitalization, punctuation) or format.

State	Status/Date	Level	Summary
ID	Signed into law 03/2007	pre-K-12	Defines "teens at risk" as public school students in grades 7-12 who have been identified as expressing or exhibiting indications of depression, suicidal inclination, emotional trauma, substance abuse or other behaviors or symptoms that indicate the existence of, or that may lead to, the development of mental illness or substance abuse. Authorizes the department of health and welfare, the state department of education, the department of juvenile corrections, counties, courts and local school districts to collaborate in planning and developing mental health counseling, substance abuse treatment and recovery support services and individual service plans for teens at risk. Creates new section creating a 3-year pilot teen early intervention mental health and substance abuse specialist program. Provides that teen early intervention specialists are to work with individual at-risk teens to offer group counseling, recovery support, suicide prevention and other mental health and substance abuse counseling services to teens as needed, regardless of mental health diagnosis. Provides that districts wishing to

			have a teen early intervention mental health and substance abuse specialist placed in the district may apply may apply to the department of health and welfare for such placement. For 3-year period beginning at the start of the 2008 school year, directs the department of health and welfare to work with districts where teen early intervention specialists have been placed to gather data on the effectiveness of this program. Session Law Chapter 309 http://www3.state.id.us/oasis/S1147.html Title: S.B. 1147 Source: www3.state.id.us
CA	Signed into law 09/2004	pre-K-12	Relates to referral of a pupil suspected of needing mental health services to a community health service by a local education agency, providing mental health services to students with exceptional needs, monitoring of compliance to provide mental health services to disabled pupils and funding therefore. Provides that a county mental health agency does not have fiscal or legal responsibility for certain costs incurred prior to approval of an individualized education program. http://www.leginfo.ca.gov/pub/bill/sen/sb_1851-1900/sb_1895_bill_20040913_chaptered.html Title: S.B. 1895 Source: California Legislative Web site

Recent State Policies / Activities
Student Supports--Integrated Services

Education Commission of the States • 700 Broadway, Suite 810 • Denver, CO 80203-3442 • 303.299.3600 • fax 303.296.8332 • www.ecs.org

The following summary includes policies enacted since 2000. Summaries are collected from state Web sites, state newsletters, *StateNet, LexisNexis* and *Westlaw*. Descriptions often reflect the content of bills as introduced and may not reflect changes made during the legislative process. To assure that this information reaches you in a timely manner, minimal attention has been paid to style (capitalization, punctuation) or format.

State	Status/Date	Level	Summary
MN	Signed into law 07/2011	pre-K-12	Allows a school board to establish full-service school zones and provide transportation for students in these zones. Provides that zones may be created for schools in areas with higher than average crime or other social and economic challenges that provide education, health or human services, or other parental support in a collaborative manner. (Article 2, Sec 23) http://wdoc.house.leg.state.mn.us/leg/LS87/1/HF0026.0.pdf Title: H.F. 26 Source: http://www.house.leg.state.mn.us/
KY	Adopted 03/2011	pre-K-12	Encourages the state department of education, the Kentucky Board of Nursing, the Kentucky Education Association, and the Kentucky School Boards Association to work with the American Diabetes Association, the Epilepsy Foundation of Kentucky, and the American Lung Association to develop a plan to raise awareness among Kentucky public school personnel about the chronic health conditions of asthma, diabetes, epilepsy, and severe allergies, how to recognize a chronic health condition episode, and the appropriate school responses to chronic health condition episodes. Encourages the Kentucky Department of Education, the department of public health, and the department of medicaid services to examine administrative regulations and agreements to remove barriers to collaboration and ensure consistency in the availability and provision of health services to students with chronic health conditions attending school in the state. http://www.lrc.ky.gov/record/11RS/HR187/bill.doc Title: H.R. 187 Source: www.lrc.ky.gov
WI	Signed into law 04/2010	pre-K-12	Requires boards annually to prepare budgets for each school in the district. Requires boards to collaborate with nonprofits and government agencies to provide comprehensive social services and educational support. Requires boards to provide alternative methods of attaining a high school diploma for those pupils who are unlikely to graduate, including a prpogram allowing a pupil or former pupil to retake a course in which he/she was not initially successful. Requires boards to conduct an annual survey of parents to develop of modify parent involvement and school improvement plans. http://www.legis.state.wi.us/2009/data/acts/09Act215.pdf

			Title: S.B. 437 Source: http://www.legis.state.wi.us
CO	Issued 03/2010	pre-K-12	The Commission is to ensure and advance a comprehensive service delivery system for children from birth to age eight using data to improve decision-making, alignment, and coordination among federally-funded and state-funded services and programs. The Early Childhood Colorado Framework will be the Commission's guide for developing this service delivery system across child health, child mental health, early learning, and family support and parent education. The initial charge of the Commission will be to focus on the development of an interagency data system, established by H.B. 09-1285, which expanded data tracking and usage across the multiple agencies and programs. This data system will provide the infrastructure to monitor progress towards meeting the outcomes identified in the Framework. http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheader=application%2Fpdf&blobheadername1=Content-Disposition&blobheadername2=MDT-Type&blobheadervalue1=inline%3B+filename%3D636%2F716%2FB+2010-002+%28Early+Childhood+Leadership+Commission%29+Search.pdf&blobheadervalue2=abinary%3B+charset%3DUTF-8&blobkey=id&blobtable=MungoBlobs&blobwhere=1251607769244&ssbinary=true Title: Exec. Order B 2010-002 Source: http://www.colorado.gov
OH	Signed into law 07/2009	pre-K-12	Establishes the "Help Me Grow" advisory council, to serve as the state interagency coordinating council, as described in 20 U.S.C. 1441. Establishes duties of the council. Authorizes the council to advise and assist the departments of health and education on the provision of appropriate services for children age five and younger, and to advise appropriate agencies on the integration of services for infants and toddlers with disabilities, and at-risk infants and toddlers and their families, regardless of whether at-risk infants and toddlers are eligible for early intervention services. Directs the council to promote family-centered programs and services that acknowledge and support the social, emotional, cognitive, intellectual and physical development of children, and the vital role of families in ensuring the well-being and success of children. Section 289.20: Establishes criteria that home-visiting programs must meet to be eligible for Help Me Grow funding. Pages 1526-1528 and 2858-2859 of 3120: http://www.legislature.state.oh.us/BillText128/128_HB_1_EN_N.pdf Title: H.B. 1 - Section 3701.611 and 289.20 Source: www.legislature.state.oh.us
OH	Signed	pre-K-	Establishes the Service Coordination Workgroup, consisting of a representative

	into law 07/2009	12	of 10 state offices/agencies, including the departments of education; health; job and family services; mental health; developmental disabilities; and youth services, and to be chaired by the representative of the governor's office. Directs the workgroup to develop procedures for coodinating services provided to individuals under age 21 and their families. In developing the procedures, requires the workgroup to focus on maximizing resources, reducing unnecessary costs, removing barriers to effective and efficient service coordination, eliminating duplicative services, prioritizing high risk populations, and any other matters the workgroup considers relevant to service coordination. Directs the workgroup to submit a report to the governor by July 31, 2009 with recommendations for implementing the procedures. Provides the workgroup shall cease to exist June 30, 2011. Pages 3090-3091 of 3120: http://www.legislature.state.oh.us/BillText128/128_HB_1_EN_N.pdf Title: H.B. 1 - Section 751.20 Source: www.legislature.state.oh.us
TX	Signed into law 06/2009	pre-K-12	Creates the Council on Children and Families to coordinate the state's health, education and human services systems to ensure that children and families have access to needed services, and improve efficiency in the provision of services. Establishes council membership, including the commissioner of education. Specifies the duties of the council, including, among others: (1) Analyze council members' biennial legislative appropriation requests and identify appropriations that, through coordination, could be modified in the next request to eliminate waste or increase available services (2) Investigate opportunities to increase flexible funding for health, education and human services for children and families (3) Identify methods to remove barriers to local coordination of health, education and human services provided to children and families (4) Identify methods to ensure that children and youth receive appropriate assessment, diagnoses and intervention services. Authorizes council members to enter into memoranda of understanding with other agencies to implement any method, process, policy, or recommendation identified as part of the council's duties. Establishes procedures that must be followed before a method, process, policy or recommendation is implemented. Directs the council to issue to the governor, lieutenant governor and legislative members a biennial report containing specified content, including recommendations of any legislation needed to improve a statewide system of quality health, education and human services for children and families. Establishes September 2019 sunset provision. http://www.legis.state.tx.us/tlodocs/81R/billtext/pdf/SB01646F.pdf Title: S.B. 1646 Source: www.legis.state.tx.us
TX	Signed into law 06/2009	pre-K-12	Defines "children with special needs" as children younger than 22 diagnosed with a chronic illness, intellectual or other developmental disability, or serious mental illness. Creates the Interagency Task Force for Children with Special Needs to improve the coordination, quality and efficiency of services for

			children and youth with special needs. Directs the task force, among other duties, to: (1) Develop a coordinated strategic plan for improving service delivery for such children (2) Coordinate with federal agencies to compile a list of opportunities to increase flexible funding for services for special needs children, including alternative funding sources and service delivery options (3) Perform a needs assessment, including public hearings to identify service delivery gaps, system entry points and service obstacles. Specifies actions the task force must take in the development of the strategic plan. Requires task force's strategic plan to provide recommendations to achieve specified goals, including improving families' ability to navigate the system through improved coordination between service providers and increased outreach. Directs the task force to submit a biennial report to the governor, lieutenant governor and speaker of the house, documenting each participating agency's progress in accomplishing the goals set forth in the legislation. Specifies additional content the report must include. Establishes September 2015 sunset provision. http://www.legis.state.tx.us/tlodocs/81R/billtext/pdf/SB01824F.pdf Title: S.B. 1824 Source: www.legis.state.tx.us
IN	Signed into law 05/2009	pre-K-12	Creates the board for the coordination of programs serving vulnerable individuals to coordinate the delivery of services to vulnerable individuals in need of services; requires the Superintendent of the Department of Education or designee to serve on the board. Board is to meet every two months and provide quarterly reports to the governor and the general assembly. Public Law 173 http://www.in.gov/legislative/bills/2009/PDF/HE/HE1289.1.pdf Title: H.B. 1289 - Section 1 Source: http://www.state.in.us/legislative
GA	Adopted 03/2009	pre-K-12	Establishes guidelines for the Juvenile Delinquency Prevention and Treatment grant program, the Abstinence Until Marriage grant program, the Juvenile Accountability Block Grant program, and the Caring Communities grant program. Juvenile Delinquency Prevention and Treatment grant program (96-1-.01): http://rules.sos.state.ga.us/docs/96/1/01.pdf Abstinence until Marriage grant program (96-1-.04): http://rules.sos.state.ga.us/docs/96/1/04.pdf Juvenile Accountability block grant program (96-1-.05): http://rules.sos.state.ga.us/docs/96/1/05.pdf Caring Communities grant program (96-1-.07): http://rules.sos.state.ga.us/docs/96/1/07.pdf Title: GAC 96-1-.01, .04, .05, .07 Source: Lexis-Nexis/StateNet

UT	Signed into law 03/2009	pre-K-12	Modifies provisions regarding local governmental entity and school district cooperation in education matters. Allows a representative of county government to attend and participate in the board discussions at local school board meetings. Requires local boards to give notice of board meetings to a representative of county government. http://le.utah.gov/~2009/bills/sbillenr/sb0092.pdf Title: S.B. 92 Source: le.utah.gov
IL	Signed into law 08/2008	pre-K-12 Postsec. Community College	Creates the Commission on Children and Youth Act. Provides for membership, appointments, goals, recommendations, and reports. Provides that the Early Learning Council must have primary responsibility for development of a five-year strategic plan for children age birth to five, and that the commission on children and youth must develop a comprehensive 5-year strategic plan for providing services to children, youth and young adults ages birth to 24. Requires that the commission's plan include specific recommendations to achieve specified outcomes related to preventive health, education completion, workforce development, social and emotional development, and civic engagement. Requires the commission to provide an interim report to the governor and general assembly by December 31, 2009. Requires that draft strategic plan be submitted to the governor and general assembly by December 31, 2010, and that a final strategic plan be submitted to the same by June 1, 2011. Requires the Department of Human Services to provide administrative support. http://www.ilga.gov/legislation/95/HB/PDF/09500HB4456lv.pdf Title: H.B. 4456 Source: www.ilga.gov
LA	Signed into law 07/2008	pre-K-12	Provides for integrated case management through the use of No Wrong Door; relates to disadvantaged children and their families; relates to student achievement, truancy intervention, drop out prevention, family safety and stability, foster care and adoption, prenatal and early childhood care, preventative health care, behavioral health, adult education and job training, vocational rehabilitation. http://www.legis.state.la.us/billdata/streamdocument.asp?did=504279 Title: S.B. 701 Source: http://www.legis.state.la.us/
KY	Signed into law 04/2008	pre-K-12	Provides that family resource and youth services centers must provide services to enhance a student's ability to succeed in school. Provides that the most economically disadvantaged students and families must receive priority status for receiving services. Provides that family resource centers must be located in or near every elementary school in the state in which at least 20% of the student body are eligible for free/reduced lunch. Provides family resource centers must promote identification and coordination of existing resources, and must include the following core components for each site: (a) Full-time preschool child care for 2- and 3-year-old children

			(b) After-school child care for children ages 4-12, with full-time child care during the summer and on other days when school is not in session (c) Families in training, which shall consist of an integrated approach to home visits, group meetings, and monitoring child development for new and expectant parents (d) Family literacy services or a similar program designed to provide opportunities for parents and children to learn together and promote lifelong learning (e) Health services or referrals to health services, or both. Provides that youth services centers must be located in or near each school in the state, except elementary schools, in which at least 20% of the student body are eligible for free/reduced lunch. Provides youth services centers must promote identification and coordination of existing resources, and must include the following core components for each site: (a) Referrals to health and social services (b) Career exploration and development (c) Summer and part-time job development for high school students (d) Substance abuse education and counseling (e) Family crisis and mental health counseling. Establishes a grant program for the Cabinet for Health and Family Services to award grants to eligible school districts to establish or maintain family resource or youth services centers. Provides that a family resource or youth services center that receives funding for one year or more is not ineligible for funding based solely on the percent of the student body eligible for free/reduced lunch unless the percent of the student body eligible for free/reduced lunch is below 20% for 5 consecutive years. Specifies that a school district may not operate a family resource center or a youth services center that provides abortion counseling or makes referrals to a health care facility for the purpose of seeking an abortion. Directs the division of family resource and youth services centers to promulgate administrative regulations to implement requirements for applications for continuation funding of a family resource or youth services center and establish a continuing education program for coordinators and staff. http://www.lrc.ky.gov/record/08RS/SB192/bill.doc Title: S.B. 192 Source: www.lrc.ky.gov
NY	Vetoed 12/2007	pre-K-12 Postsec.	Directs the department of health to approve the establishment of a college-linked senior living community that has a formal, jointly defined program in collaboration with a local college offering degree programs in gerontology and allied health professions to develop and evaluate a new intergenerational model of delivering long-term care services to the elderly. Provides this college-linked senior living community must consist of senior independent living apartments, an adult care facility and a residential health care facility. Provides that services within the college-linked senior living community must

			be provided based on a partnership that includes a teaching, training, research and clinical affiliation with shared resources including student, staff, faculty, facilities, equipment and scheduled social and recreational activities. Provides that the partnership must be located in a county with a population of more than 96,000 and less than 97,000, according to federal decennial census of 2000 by a college offering degrees in, but not limited to, gerontology and allied health professions to develop and evaluate a new intergenerational model of delivering long-term care services to the elderly. Provides that after the residential health care facility has been operational for two years, the college-linked senior living community project must submit a report to the commissioner of health, the governor, the speaker of the assembly and the temporary president of the senate that includes: an assessment of the cost-effectiveness of the project; the number of individuals served by the project; a description of the demographic and clinical characteristics of the residents served by the project; a survey of the residents and/or family members regarding the quality of life of residents served by the project; a description of the partnership between the senior living community and the college, with an accounting of the exchange of resources, including sharing of space, equipment and personnel, including students and faculty; and recommendations for the replication of the project in other areas of the state. Bill text: http://assembly.state.ny.us/leg/?bn=S02139&sh=t Title: S.B. 2139 Source: assembly.state.ny.us
IL	Adopted 07/2007	pre-K-12	Creates new Part of rules, "Children's Mental Health Initiative Grants." Subpart A, "School Mental Health Support Grants," (pages 136-141 of 201 http://www.cyberdriveillinois.com/departments/index/register/register_volume31_issue30.pdf) includes the following sections: 555.10 Purpose and Applicability 555.20 Eligible Applicants 555.30 Program Specifications 555.40 Application Procedure 555.50 Criteria for the Review of Initial Proposals 555.60 Allocation of Funds Provides that programs will support students' mental health by: (a) enhancing the recipients' capacity to identify and meet students' needs for early, coordinated mental health intervention services in "natural" settings; (b) contributing to the development of a mental health support system for students that is integrated with community mental health agencies and other agencies and systems that serve children; and (c) reducing the stigma associated with mental health and mental illness within the school community.

			Provides that eligible applicants for both "School Mental Health Support Grants" and "Grants for Implementation of Social and Emotional Learning Standards" (below) include school districts, public university laboratory schools, charter schools and area vocational centers. Provides that it is expected that 20% of the available funds will be allocated to the Chicago Public Schools and that approximately 25% of grant recipients will be districts that either operate only one school or enroll no more than 1,000 students. Subpart B, "Grants for Implementation of Social and Emotional Learning Standards," (pages 141-147 of 201 http://www.cyberdriveillinois.com/departments/index/register/register_volume31_issue30.pdf) includes the following sections: 555.110 Purpose and Applicability 555.120 Eligible Applicants 555.130 Program Specifications – Planning and Training Grants 555.135 Program Specifications – Implementation Grants 555.140 Application Procedure 555.150 Criteria for the Review of Planning and Training Grant Proposals 555.155 Criteria for the Review of Implementation Grant Proposals 555.160 Allocation of Funds 555.APPENDIX A Social and Emotional Learning Standards Provides that the goal of each planning and training grant project is the development of a three-year plan for implementation of the state social and emotional learning (SEL) standards. Provides each participating school must establish an implementation team responsible for: (1) Participation in training and technical assistance activities made available by the state-designated regionally based training entity (2) Conducting at least two family education sessions on the social and emotional learning standards (3) Identifying gaps in available resources and services related to social and emotional learning (4) Preparing a plan setting forth a specific, three-year sequence of steps for moving toward the comprehensive integration of the social and emotional learning standards into the participating schools' educational programs, school environment, and other mental health supports. Title: 23 IAC 555.10 thru .160, and Appendix A Source: www.cyberdriveillinois.com
LA	Signed into law 06/2007	pre-K-12	Gives permanent status to truancy and assessment and service centers (which were initially established through a pilot program). Deletes language directing the Families in Need of Services program to serve in a coordinating and facilitating capacity for the centers. http://www.legis.state.la.us/billdata/streamdocument.asp?did=447939 Title: S.B. 187

			Source: www.legis.state.la.us
TX	Signed into law 06/2007	pre-K-12	Codifies provisions concerning program performance goals, objectives, and measures and provides the commissioner of education authority to withhold funding from a Communities In Schools (CIS) program that consistently fails to achieve performance criteria. (CIS has become the largest dropout prevention program in the state.) http://www.legis.state.tx.us/tlodocs/80R/billtext/pdf/HB01609F.pdf Title: H.B. 1609 Source: http://www.legis.state.tx.us
MD	Signed into law 05/2007	pre-K-12	Requires the State Superintendent of Schools, in collaboration with the Department of Health and Mental Hygiene, to establish and promote in schools in the State a public awareness campaign related to self-injury by cutting; provides for the components of the campaign; authorizes the State Superintendent to use specified resources to carry out the provisions of the Act. http://mlis.state.md.us/2007RS/bills/hb/hb1046t.pdf Title: H.B. 1046 Source: Maryland
ID	Signed into law 03/2007	pre-K-12	Defines "teens at risk" as public school students in grades 7-12 who have been identified as expressing or exhibiting indications of depression, suicidal inclination, emotional trauma, substance abuse or other behaviors or symptoms that indicate the existence of, or that may lead to, the development of mental illness or substance abuse. Authorizes the department of health and welfare, the state department of education, the department of juvenile corrections, counties, courts and local school districts to collaborate in planning and developing mental health counseling, substance abuse treatment and recovery support services and individual service plans for teens at risk. Creates new section creating a 3-year pilot teen early intervention mental health and substance abuse specialist program. Provides that teen early intervention specialists are to work with individual at-risk teens to offer group counseling, recovery support, suicide prevention and other mental health and substance abuse counseling services to teens as needed, regardless of mental health diagnosis. Provides that districts wishing to have a teen early intervention mental health and substance abuse specialist placed in the district may apply may apply to the department of health and welfare for such placement. For 3-year period beginning at the start of the 2008 school year, directs the department of health and welfare to work with districts where teen early intervention specialists have been placed to gather data on the effectiveness of this program. Session Law Chapter 309 http://www3.state.id.us/oasis/S1147.html Title: S.B. 1147

Source: www3.state.id.us

ID	Issued 04/2006	pre-K-12	Establishes the Executive Office for Families and Children. Provides that the duties of the council include: A. Coordinating all boards, councils, commissions, and initiatives as recommended by the Governor, within the Executive Office of the Governor with duties and responsibilities affecting families and children, including but not limited to: (i) Governor's Coordinating Council for Families and Children; (ii) Governor's Council on Adolescent Pregnancy Prevention; (iii) Early Childhood Coordinating Council; (iv) Parents as Teachers; (v) Idaho Women's Commission; (vi) Faith Based Liaisons; (vii) Serve Idaho; (viii) Suicide Prevention Advisory Council; (ix) Idaho's Brightest Stars Initiative; (x) Día de los Niños/Day of the Child Initiative. B. Identifying and recommending programs and policies for a comprehensive delivery of effective, efficient and integrated services for families and children, including: (i) Promoting implementation of multi-agency strategic budgeting, common performance measures, and coordination of services; (ii) Promoting an interagency funding system for the delivery of integrated services; (iii) Addressing state strategies, priorities and outcome measures to meet the needs of children. C. Cooperating and consulting with state agencies and departments on programs, policies and issues involving families and children, including but not limited to, the Department of Health and Welfare, Department of Corrections, Department of Juvenile Corrections, the State Department of Education and the Department of Commerce and Labor; D. Participating in national, regional and statewide efforts to cooperatively address issues and policies affecting families and children in Idaho; E. Developing a state plan for promoting the well-being of families and children in Idaho in conjunction with cities and counties, faith based and community organizations, state councils, boards and commissions, state agencies and departments, and federal organizations; F. Serving as a repository of agreements and plans concerning programs for families and children from community organizations and other relevant local, state and federal agencies and facilitating the exchange of this information and data with relevant interstate and intrastate entities; G. Provide input and comment on community, tribal and federal plans, agreements and polices relating to families and children; H. Serving as an advocate for the families and children of Idaho and directing the people of Idaho to the appropriate local, state or federal agency to address issues or concerns related to families or children.

			l. Accepting private contributions, federal funds, funds from other public agencies or any other source. The moneys shall be used solely for the purposes provided under this executive order and shall be expended and accounted for as provided by law. http://gov.idaho.gov/mediacenter/execorders/eo06/eo_2006-09.htm Title: Executive Order 2006-09 Source: gov.idaho.gov
ID	Issued 04/2006	pre-K-12	Continues the "Governor's Coordinating Council for Families and Children" within the governor's office. Provides that the objectives for the Coordinating Council are to: a. Maintain a comprehensive inventory of resources and programs serving families and children in Idaho. b. Facilitate communication among individuals and organizations that provide services to families and children. c. Work with organizations, agencies and individuals to identify gaps in service to families and children. d. Work with organizations, agencies and individuals to develop consistent, accurate and timely collection and reporting of data to provide comprehensive statistical measurements on Idaho's families and children. e. Develop strong state and local partnerships to foster and support results-based community programs. f. Create a statewide awareness of the importance of healthy families and children. http://gov.idaho.gov/mediacenter/execorders/eo06/eo_2006-15.htm Title: Executive Order 2006-15 Source: gov.idaho.gov
MD	Signed into law 04/2006	pre-K-12	Establishes an advisory council to the children's cabinet to make recommendations to the children's cabinet on methods for meeting the policy and program goals of the state for integrated children and family programs, coordinate state programs with local programs, reduce reliance on institutions as the primary mode of intervention for at-risk youth offenders, promote positive outcomes for youths, fund juvenile crime and delinquency prevention practices, and reduce disproportionate minority confinement. http://mlis.state.md.us/2006rs/bills/sb/sb0882e.pdf Title: S.B. 882 Source: Maryland Legislature
KY	Signed into law 04/2006	pre-K-12	Encourages the Cabinet for Health and Family Services to establish the Kentucky Youth Development Coordinating Council; establishes membership and permits the creation of subcommittees of the council; requires the University of Kentucky Cooperative Extension Service to perform the administrative functions of the council; establishes the duties of the council; requires the council to submit a report to the Governor and the General Assembly as specified.

			Includes among the council's duties collaboration with public and private partnerships to support statewide networks connecting quality and sustainable state and local youth development efforts, such as mentoring partnerships and after-school and extended-learning opportunities, and to leverage private, state, and federal resources to support these efforts; and encouraging state agencies and nonprofit organizations to collaborate on model programs and demonstration projects that promote youth and parental involvement, strengthen families, and focus on target populations of youth. http://www.lrc.ky.gov/RECORD/06RS/SJ184/bill.doc Title: S.J.R. 184 Source: Lexis-Nexis/StateNet
TN	Signed into law 06/2005	pre-K-12	Sets the purpose of each family resource center: to maximize the potential learning capacity of the child by ensuring that school environments and neighborhoods are safe and socially enriching, that families are strong and able to protect children and meet their basic needs, and that children are physically healthy, emotionally stable, socially well-adjusted, and able to connect with enriching opportunities and experiences in their schools and communities. Requires the family resource centers to focus on providing information to families about resources, support, and benefits available in the community and on developing a coordinated system of care for children in the community. Requires the Department of Education and the Department of Children's Services to jointly develop guidelines for the operation of family resource centers. Guidelines are to be reviewed every three years. http://tennessee.gov/sos/acts/104/pub/pc0192.pdf Title: S.B. 2115 Source: http://tennessee.gov/sos/acts
MT	Signed into law 04/2005	pre-K-12	AN ACT REVISING THE SCHOOL DISTRICT TUITION LAWS; REQUIRING THE SUPERINTENDENT OF PUBLIC INSTRUCTION TO PAY TUITION FOR CHILDREN WHO ATTEND SCHOOL OUTSIDE OF THE DISTRICT OF RESIDENCE BECAUSE OF PLACEMENT IN FOSTER CARE OR A GROUP HOME; ELIMINATING THE REQUIREMENT THAT A SCHOOL DISTRICT REPORT THE NUMBER OF OUT-OF-DISTRICT STUDENTS ATTENDING SCHOOL IN THE DISTRICT BECAUSE OF GEOGRAPHIC CONDITIONS; ELIMINATING THE REQUIREMENT FOR THE COUNTY SUPERINTENDENT TO PAY TUITION ON BEHALF OF THE STATE UNDER CERTAIN CONDITIONS; ESTABLISHING A TUITION PAYMENT SCHEDULE FOR DISTRICTS THAT PAY TUITION; CLARIFYING WHERE A DISTRICT MUST CREDIT TUITION RECEIPTS; REQUIRING THE SUPERINTENDENT OF PUBLIC INSTRUCTION TO PAY TUITION AND TRANSPORTATION COSTS FOR A CHILD WITH A DISABILITY; PROVIDING AN APPROPRIATION; AMENDING SECTIONS 20-3-205, 20-5-321, 20-5-324, 20-7-420, 20-9-212, 20-9-335, AND 20-10-105, MCA; AND PROVIDING AN EFFECTIVE DATE Title: H.B. 83 Source: StateNet
MD	(H)	pre-K-	Requiring a placement agency responsible for a child in State-supervised care,

	THIRD READING PASSED (131-0) 04/2005	12	or the agency's designee, to provide notice to a public school or a specified nonpublic school regarding the enrollment or imminent enrollment of a child in State-supervised care; requiring a sending school to orally inform a receiving school of the grade level of the child; requiring a sending school to convey specified information to a receiving school; etc http://mlis.state.md.us/2005rs/billfile/sb0426.htm Title: S.B. 426 Source: StateNet
MD	Vetoed 04/2005	pre-K-12	Requiring private residential rehabilitative institutions to develop and implement a specified educational program; requiring a specified educational program to be approved by the State Department of Education before the program is implemented; providing for the operating requirements of a private residential rehabilitative institution; etc http://mlis.state.md.us/2005rs/billfile/sb0503.htm Title: S.B. 503 Source: StateNet
MD	(S) THIRD READING PASSED WITH AMENDMENTS (44-2) 04/2005	pre-K-12	Requiring private residential rehabilitative institutions to develop and implement a specified educational program; requiring a specified educational program to be approved by the State Department of Education before the program is implemented; providing for the operating requirements of a private residential rehabilitative institution; etc http://mlis.state.md.us/2005rs/billfile/hb1148.htm Title: H.B. 1148 Source: StateNet
MD	(S) THIRD READING PASSED (46-0) 04/2005	pre-K-12	Requiring a placement agency responsible for a child in State-supervised care, or the agency's designee, to provide notice to a public school or a specified nonpublic school regarding the enrollment or imminent enrollment of a child in State-supervised care; requiring a sending school to orally inform a receiving school of the grade level of the child; requiring a sending school to convey specified information to a receiving school. http://mlis.state.md.us/2005rs/billfile/hb1259.htm Title: H.B. 1259 Source: StateNet
VA	Signed into law 03/2005	pre-K-12	Authorizes the state lead agency for early intervention to contract with local lead agencies for the implementation of local early intervention systems statewide. Under the bill, a local lead agency shall have the duty to (i) establish and administer a local system of early intervention services that are in compliance with all relevant federal and state policies and procedures, (ii) implement consistent and uniform policies and procedures for the

			determination of parental liability and fees for intervention services, and (iii) manage relevant state and federal early intervention funds for the local early intervention system. http://leg1.state.va.us/cgi-bin/legp504.exe?051+ful+CHAP0695 Title: S.B. 1188 Source: http://leg1.state.va.us
CA	Signed into law 09/2004	pre-K-12	Relates to referral of a pupil suspected of needing mental health services to a community health service by a local education agency, providing mental health services to students with exceptional needs, monitoring of compliance to provide mental health services to disabled pupils and funding therefore. Provides that a county mental health agency does not have fiscal or legal responsibility for certain costs incurred prior to approval of an individualized education program. http://www.leginfo.ca.gov/pub/bill/sen/sb_1851-1900/sb_1895_bill_20040913_chaptered.html Title: S.B. 1895 Source: California Legislative Web site
LA	Signed into law 07/2004	pre-K-12	Authorizes the creation of an early intervention pilot program in certain parishes, to address the underlying causes of behavioral problems and school performance problems related to behavior. Authorizes local boards, law enforcement agencies, courts with jurisdiction over juveniles and their caretakers, and designated service providers to establish interagency agreements to exchange student records; provide family services; identify youth for participation and monitor treatment plan progress; provide services related to child abuse and neglect, among other services. Requires the district attorney to annually report on program effectiveness. Requires the pilot to be implemented in three phases: Phase 1: grades pre-K-6; Phase 2: grades 7-8; Phase 3: grades 9-12. Establishes July 1, 2009 as end of pilot program. Creates the Sixteenth Judical District Attorney Early Intervention Fund to support the program. Assesses an additional fee on each criminal bond posted in the three pilot parishes to help support the program. http://www.legis.state.la.us/leg_docs/04RS/CVT2/OUT/0000LU3U.PDF Title: H.B. 956 Source: www.legis.state.la.us
LA	Signed into law 06/2004	pre-K-12	Authorizes any parish in the state, not just pre-existing pilot program parishes, to create truancy and assessment and service centers. Louisiana State University's office of social services research and development to develop and implement a monitoring and evaluation program for all parishes with truancy and assessment and service centers subject to state funding. Extends end of truancy and assessment and service center pilot program from 2005 to 2007. http://www.legis.state.la.us/leg_docs/04RS/CVT5/OUT/0000LV53.PDF Title: H.B. 1527 Source: www.legis.state.la.us
LA	Signed	pre-K-	Specifies that children with exceptionalities enrolled in state-operated

	into law 06/2004	12	facilities and receiving special education services provided by the special school district shall be enrolled as residents of such facilities, and that eligible children enrolled in state-operated mental health facilities and receiving appropriate educational services by the special school district shall be enrolled as residents of such facilities. Authorizes the special school district to enter into interagency agreements with other state agencies to provide appropriate educational services, including special education and related services, to any eligible child who is not a resident of a state-operated facility but who is in the care or custody of a public or private department, agency, or institution, as well as to any eligible individual regardless of age who is enrolled in any state-operated facility as a resident of the facility. http://www.legis.state.la.us/leg_docs/04RS/CVT7/OUT/0000LUT9.PDF Title: H.B. 258 Source: www.legis.state.la.us
LA	Signed into law 06/2004	pre-K-12	Permits city, parish, or other local public or nonpublic school systems to contract with local law enforcement agencies to provide for school resource officers. http://www.legis.state.la.us/leg_docs/04RS/CVT3/OUT/0000LV4G.PDF Title: H.B. 1163 Source: StateNet
AR	Signed into law 02/2004	pre-K-12	Provides for family resource centers to remove nonacademic barriers to academic success; authorizes use of national school lunch funds for this program; provides that the State Child Abuse and Prevention Board shall determine which schools are priority elementary schools and to award grants to qualified school districts. http://www.arkleg.state.ar.us/ftproot/bills/2003s2/public/HB1091.pdf Title: H.B. 1091 Source: StateNet
GA	Signed into law 06/2003	pre-K-12	Relates to child abuse and deprivation records; permits the Department of Human Resources to share access to child abuse records and release information from such records to the Office of School Readiness, includes principals, guidance counselors, school social workers or school psychologist; provides that counseling records are confidential and may not be disclosed to any unauthorized person. http://www.legis.state.ga.us/legis/2003_04/sum/sb201.htm Title: S.B. 201 Source: Georgia Legislative Web site
OR	Signed into law 05/2003	pre-K-12	Includes community learning centers as part of services to children and families system. http://pub.das.state.or.us/LEG_BILLS/PDFs/ESB158.pdf Title: S.B. 158 Source: http://pub.das.state.or.us
	Signed	pre-K-	Improves coordination of services for children's mental health; improves field-

WA	into law 05/2003	12	level cross-program collaboration and efficiency, the early periodic screening diagnosis and treatment plan to reflect the current mental health system structure and identifying and promulgating the approaches used in school districts where mental health and education systems coordinate services and resources to provide public mental health care for children. Title: H.B. 1784 Source: StateNet
TX	Became law without governor's signature 05/2003	pre-K-12	Requires the Texas Education Agency, in conjunction with the Texas Department of Mental Health and Mental Retardation, the Texas Department of Health, and the Texas Commission on Alcohol and Drug Abuse, shall assess existing school-based mental health and substance abuse programs. The assessment must include recommendations regarding further development of such programs, including the incorporation of information regarding substance abuse prevention, mental health education, and access to related services. (b) The Texas Education Agency shall report on the results of the assessment to the 79th Legislature not later than January 11, 2005. http://www.capitol.state.tx.us/cgi-bin/tlo/textframe.cmd?LEG=78&SESS=R&CHAMBER=S&BILLTYPE=B&BILLSUFFIX=00491&VERSION=5&TYPE=B Title: S.B. 491 Source: http://www.capitol.state.tx.us
TN	Signed into law 04/2003	pre-K-12	Includes third party payors or carriers regulated by department of commerce and insurance and self- insured entities as entities authorized to share information regarding child immunization records; relates to schools, child care facilities, and other institutions having care or custody of children. Title: S.B. 1938 Source: StateNet
NM	Signed into law 04/2003	pre-K-12	Creates a youth council within the children, youth and families department; enacts the Youth Council Act; youth membership shall be provided by educational advisors, faith-based organizations and community-based youth-serving organizations; provides that meeting times shall not interfere with council participants' school attendance. Title: S.B. 425 Source: StateNet
NM	Signed into law 03/2003	pre-K-12	Adds Section 66, which allows any school to create a family and youth resources program to provide an intermediary for students and families to access social and health care services. Any school with at least 80% of students eligible for free & reduced lunch is eligible to apply for grants. Creates a "family and youth resource fund" in the state treasury. Title: H.B. 212 (Omnibus Bill) Source: New Mexico Legislature

KY	Signed into law 03/2003	pre-K-12	Includes any county or independent school district in the definition of "public agency" as related to interlocal cooperation agreements. http://www.lrc.state.ky.us/RECORD/03RS/SB133/bill.doc Title: S.B. 133 Source: StateNet
VA	Signed into law 03/2003	pre-K-12	Relates to the State Executive Council for Comprehensive Services for At-Risk Youth and Families; relates to the comprehensive assessment and planning team referral; requires the council to review and approve a request by such team to establish a collaborative, multidisciplinary team process for referral and reviews of at-risk children and families. Title: H.B. 1714 Source: StateNet
AZ	Issued 01/2003	pre-K-12	Establishes a Children's Cabinet to focus attention and resources on problems facing the state's children by collaborating and promoting coordinated policies and service delivery systems that support children, families and communities. Establishes an Advisory Commission on Child Protective Services (CPS) Reform to make recommendations to the governor and the Children's Cabinet on how the state can carry out its mission of serving the best interests of children, particularly those in greatest need of protection. Requires the children's cabinet to (1) Advise and make recommendations to the governor on the most effective policies and programs that promote the best interests of Arizona children. (2) Develop a coordinated inter-agency strategy for serving abused and neglected children with more effective and efficient service delivery, including coordination of behavioral health services, education services, health care services, substance abuse services and child welfare. (3) Develop a plan for maximizing Arizona's share of federal funds for programs that support Arizona children. Establishes membership of the children's cabinet and the Advisory Commission on CPS Reform; states the Advisory Commission on CPS Reform will conclude its work by June 30, 2003. http://www.governor.state.az.us/eo/2003_4.pdf Title: Executive Order 2003-04 Source: www.governor.state.az.us
MI	Rejected by voters 11/2002	pre-K-12	Proposes an amendment to the Constitution to reallocate tobacco settlement revenue on a permanent annual basis funding to certain entities, including nonprofit hospitals, licensed nursing homes, licensed hospices, nurse practitioners, school-linked health centers, Health and Aging Research Development Initiative, the Elder Prescription Drug Program, Nurses Scholarship Program, Tobacco Free Futures Fund, and tobacco use reduction programs. Title: Proposal 02-4 Source: Michigan Secretary of State Web site
NY	Signed	pre-K-	Establishes a coordinated children's services initiative for children with

	into law 07/2002	12	emotional and/or behavioral disorders, within the council on children and families, to provide effective collaboration among State and local health, mental hygiene, education, juvenile justice, probation and other human services agencies for the benefit of such children and their families, and to limit institutional placements of such children. http://assembly.state.ny.us/leg/?bn=S07516&sh=t Title: S.B. 7516 Source: http://assembly.state.ny.us
CT	Signed into law 05/2002	pre-K-12	Mandates that the Commissioner of Education and Public Health create plan for the colocation where possible of family resource centers and school-based health clinics in order to improve access to services and to make the delivery of services more cost-efficient. http://www.cga.state.ct.us/2002/act/Pa/2002PA-00036-R00HB-05179-PA.htm Title: H.B. 5179 Source: www.cga.state.ct.us
AZ	Signed into law 05/2002	pre-K-12	Establishes three-year pilot project for cooperative programs for low incidence pupils. Establishes an advisory committee to assist in establishment of the pilot project for cooperative programs for certain groups of pupils with low incidence disabilities. Defines "low-incidence pupils"; designates committee membership and duties. Includes conditional enactment clause. http://www.azleg.state.az.us/legtext/45leg/2r/laws/0300.htm Title: H.B. 2702 Source: www.azleg.state.az.us
MD	Signed into law 05/2002	pre-K-12	Renames State Coordinating Countil for Residential Placement of Handicapped Children as State Coordinating Council for Children. Adds Maryland School-Based Health Care Center Policy Advisory Council; State Council on Child Abuse and Neglect; and State Commission on Infant Mortality Prevention to units in Office for Children, Youth and Families in Executive Department. Establishes as "Community Partnership Agreements" agreements between the state and local management boards relating to the provision of services for children, youth and families. Adds to purposes of Subcabinet Fund as it relates to services to handicapped children. Requires the Special Secretary to adopt regulations about local management boards. Modifies membership and duties of local coordinating councils. Provides out-of-state placement for children who have behavioral, educational, developmental, or mental needs that can't be met through state agencies; codifies the State School-Based Health Center Policy Advisory Council. Requires Special Secretary for Children, Youth, and Families to appoint a Committee to develop a Subcabinet plan to address provision of services to intensive-needs children. http://mlis.state.md.us/2002rs/bills/hb/hb1386t.rtf Title: H.B. 1386 Source: mlis.state.md.us
IN	Signed	pre-K-	Requires the Director of the Division of Special Education to coordinate an

	into law 03/2002	12	interagency task force to review services and funding sources available for children and young adults with disabilities. Title: S.B. 290 Source: Lexis-Nexis/StateNet
OR	Signed into law 07/2001	pre-K-12	Directs the Departments of Education, Human Services, the State Commission on Children and Families and the Criminal Justice Commission to support development and implementation of community learning centers; requires specified State and local entities to explore the feasibility of conducting statewide evaluation of such centers. Title: H.B. 2082 Source: Lexis-Nexis/StateNet
OR	Signed into law 06/2001	pre-K-12	Modifies the Interagency Shared Information System; defines participating State agency or organization for system; directs the Employment Department to establish system for collecting, analyzing and sharing data for development of education, training and employment programs for development of workforce system performance measures. Title: S.B. 400 Source: Lexis-Nexis/StateNet
AR	Signed into law 04/2001	pre-K-12	Provides licensed social workers to serve the needs of children enrolled in public schools in Arkansas. Title: H.B. 2380 Source: Lexis-Nexis/StateNet
AR	Signed into law 03/2001	pre-K-12	Repeals the Governor's Partnership Council and the Intervention and Prevention Grant Program for Arkansas School Children. Title: H.B. 1633 Source: Lexis-Nexis/StateNet
NY	Signed into law 06/2000	pre-K-12	Authorizes medical assistance payments to certain clinics or diagnostic and treatment centers for services they render to preschool children with disabilities. Title: S.B. 6735 Source: Lexis-Nexis/StateNet
OK	Vetoed 06/2000	pre-K-12	Creates the Partnership for School Readiness Act to facilitate community collaboration of efforts and services that will prepare children to enter school healthy and ready to succeed. Goal also to stress importance of reading to children for 15 minutes per day. Creates an advisory board. Up to six pilot projects (rural and urban) to be selected. Title: S.B. 1597 Source: Lexis-Nexis/StateNet
MS	Signed into law	pre-K-	Establishes an Early Childhood Services Interagency Coordinating Council; provides for the membership and organization of the Council; defines the

	04/2000	12	responsibilities of the Council; establishes an interagency advisory committee to the Council; provides for the membership, organization and responsibilities of the advisory committee. Title: H.B. 418 Source: Lexis-Nexis/StateNet
OK	Signed into law 04/2000	pre-K-12	States legislative intent to address school violence through prevention. Authorizes districts to contract with nonprofit agencies or community-based service providers for the appropriate personnel and services and to seek any available funding, including the use of Medicaid funds through targeted case management, and other funds which may be available for related services. Encourages the state board to allow for the use of licenses professional counselors and licensed social workers in addition to academic counselors. Title: H.B. 2168 Source: 2000 Legislative Summary, Oklahoma
WA	Signed into law 03/2000	pre-K-12	Authorizes blended funding projects for youth; defines youth eligibility for the projects; directs the Superintendent of Public Instruction and the Secretary of the Department of Social and Health Services to transfer appropriated funds to support blended funding projects for youth. Title: H.B. 2807 Source: Lexis-Nexis/StateNet
VA	Signed into law 02/2000	pre-K-12	Creates the Office of Comprehensive Services for At-risk Youth and Families, under the lead of the Secretary of Health and Human Resources; assumes the responsibilities of the State Management Team to develop programs and fiscal policies that promote and support cooperation and collaboration in the provision of services at the State and local levels to troubled and at-risk youth and their families. Title: H.B. 1510 Source: Lexis-Nexis/StateNet

Using State, Intermediary and Local Partners To Improve Academic Achievement

April 2003

Introduction

If you work in a state agency, how do you ensure that goals for children and families developed at the state level are implemented as cohesive initiatives at the local level? Missouri sought to do just this by providing funding to intermediary entities charged with coordinating at the local level the work of communities and state agencies. This case study describes how each level in the system worked together to achieve positive results for children and families.

Background

In Missouri, the heads of several state agencies came together with community representatives to define the outcomes they wanted for children and families. Because of personal relationships and trust among the agency leaders, they were able to work collaboratively and identify six core results that would drive their work:

- ▪ Parents working
- ▪ Children safe in their homes; families safe in their communities
- ▪ Young children ready to enter school
- ▪ Children and families that are healthy
- ▪ Youth ready to enter the workforce and become productive citizens
- ▪ Children succeeding in schools.

Encouragement from the governor to work toward these common goals also provided an incentive for collaboration at the state level. An executive order by the governor created the state-level Family Investment Trust (now known as the Family and Community Trust) with an appointed board of directors consisting of heads of agencies and highly regarded citizens and business leaders from the private sector.

State Partnering with Communities

State agency leaders knew that creating partnerships with communities was the best way to achieve the six core results. They created the Caring Communities Initiative to facilitate partnerships between communities and state agencies. Needs and capacity assessments of local initiatives helped the state identify successful collaboratives that were then invited to join the state in working toward the six core results.

The Local Investment Commission (LINC) in Kansas City was one of five community partnerships chosen by the state of Missouri to receive funds from the Caring Communities Initiative. Started in 1992, LINC is a citizen-driven community collaborative that works to improve the lives of children and families in Kansas City and Jackson County. It functions as an intermediary organization between the state of Missouri and neighborhood leaders, citizens, businesses and civic and labor leaders.

LINC's role varies based on the context of the site they are working with. LINC chose to contract with the Independence School District to administer its own Caring Communities program, while providing the district with technical assistance. This differs, for example, from the Kansas City, Missouri, district, where LINC is the service provider. LINC gave Independence this responsibility because "It was ... a way to build on the strengths that already existed," said Brad Smith, the neighborhood services coordinator and Caring Communities site coordinator at Randall Elementary School, in the Independence School District. Caseworkers and therapists were already in place, for example.

In Independence, Missouri, there were four elementary schools that were in some of the lowest-income communities in the district, and test scores also were among the lowest. LINC's provision of Caring Communities funds to the district provided additional resources that could be used for health care and social services and helped increase parental involvement.

The result? Now those schools outperform all others in the district, and their scores are above state averages. And they have become community hubs, open in the evenings for activities. Throughout the city, pressure has been lessened on teachers and principals to deal with social and behavioral problems, enabling them to concentrate on teaching and learning.

Results at the School Level

Randall Elementary School exemplifies the academic improvements that have taken place in the Independence, Missouri, school district. Randall, a pre-K through grade 5 school with 340 students, was one of the three lowest-performing schools in the district when the Caring Communities program began in 1996. But Randall students have made remarkable gains in reading, math, communication arts and science, topping high-performance numbers as well as district and state averages in all four areas. Randall currently ranks in the top third of schools in the state in all areas on standardized testing.

Some examples of academic performance:

- ▪ Math: Randall's performance score increased from 187.5 in 1998 to 217.5 in 2001, compared to the state average of 210.8 and the district average of 213.
- ▪ Communication Arts: Randall's score leaped from below 190 in 1999 to 212.5 in 2001, beating the district average (211) and state average (202.8).
- ▪ Social Studies: Randall (224.5) outperformed the district (218) and state (208.5) averages in 2001.
- ▪ Science: Randall (225.5) was just ahead of the district (225) and slightly ahead of the state (218.7) in 2001.

Members of the community are actively involved in improvement efforts at Randall. Smith recruited neighborhood residents for an advisory council to help decide how to spend the Caring Communities funds that amounted to $118,000 the first year (and are now up to $145,000). One of the advisory council's first recommendations was to add a preschool for 3- and 4-year-olds. District funds paid for the building while programs were funded with grant dollars from Title I, Caring Communities and a state early education grant. The preschool opened in 1998.

Information from a school needs assessment and a community needs assessment led to some major actions:

- ▪ In partnership with the Medical Center of Independence, a school-based health clinic was opened in late 1997. It operated until 2002, when additional health clinics in the community opened.
- ▪ Winter weather prevented some students from getting to school; 300 of the school's enrollment of 340 walked to school. A parent's suggestion led to the startup of the Winter Bus, which operated November through February, and led to a significant improvement in attendance.
- ▪ Randall advisory council members got involved in convincing the City Council to build a park on vacant land in the neighborhood. It led to the passage of a bond issue to develop the park.

Randall has a social worker, called a family-school liaison, as well as a mental health therapist on site. The school also started in-school tutoring programs, built a computer lab, added a writing teacher, began a phonemic awareness program and created community events to involve neighborhood residents. Those events include Safe Halloween, a safety fair, Christmas program and Camp Wildwood, which takes 5th graders out for two days and one night of camping. Providers of these additional services are held accountable through contracts and performance reviews.

Summary

These accomplishments provide an example of the positive outcomes that can be achieved when the state, intermediary organizations and local partners coordinate efforts to work toward common goals. The ability of the state to identify an intermediary organization with a proven track record of working with communities, along with the provision of additional funding, were key to building upon the efforts to raise student achievement currently under way in the Independence School District.

The Family and Community Trust's Web site contains additional information and can be accessed at http://www.mofact.org/. For more information about LINC and Caring Communities, please visit http://www.kclinc.org/home.html. The Web site of the Independence School District can be accessed at http://www.indep.k12.mo.us/ and that of Randall Elementary School can be found at http://www.indep.k12.mo.us/Schools/SchoolLocation.asp?LocationID=16.

© Copyright 2003 by the Education Commission of the States (ECS). All rights reserved.

The Education Commission of the States is a nonprofit, nationwide organization that helps state leaders shape education policy. It is ECS policy to take affirmative action to prevent discrimination in its policies, programs and employment practices.

Preparation of this case study was supported by funds from The Bill and Melinda Gates Foundation.

To request permission to excerpt part of this publication, either in print or electronically, please fax a request to the attention of the ECS Communications Department, 303-296-8332 or e-mail ecs@ecs.org.

Attachment

Identifying Opportunities for Integrated Service Delivery to Children, Youth & Young Adults with Disabilities

AHS/DOE/UVM Jeffords Center

Spring 2011

Focus Group Interview Questions

Identification of Services, Outcomes & Gaps:

1. What services are most frequently utilized in your district/region? Through AHS? Through DOE?[1]
2. What effects on client/student outcomes do these services have?
3. What services are not available – what is most frequently missing?[2]

Service Coordination, Trends, Gaps, Opportunities & Measurement of Outcomes:

4. How are services coordinated in your district/region?
5. What trends have you observed in the use of Act 264 or Coordinated Services Plans across disability groups? (Ex: frequency of use). Please describe.
6. How would you describe actual differences between well-coordinated and less well-coordinated service delivery (on a continuum)?
    a. What could be learned from areas that appear to be well-coordinated?
    b. In what areas of service delivery, if any, would improvements to coordination be a priority?
    c. Where are AHS/DOE services duplicated in your district/region?
    d. Where are there gaps in the coordination?
7. What are some of the key contextual factors (barriers and opportunities) that affect service delivery coordination?
8. If there was improved coordination between staff and service providers from AHS and DOE:
    a. What might the delivery system look like?
    b. What would need to change at AHS and DOE to support improved coordination/integration?
    c. What collaborative opportunities might result in lower costs and savings to the state?
9. In what practical ways could you envision tracking the coordination of treatment plans and their outcomes for children, youth and young adults with disabilities across service delivery systems?

[1] Capture top five services utilized.

[2] Capture top five services needed, but currently not available.