

**Report On The Provision Of Special Education Services
In regard to cost allocation, upper limit on age eligibility, and
interagency coordination**

Prepared in accordance with:
Act 117 Section 12 of 2000
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I. Executive Summary

The reauthorization of the IDEA in 1997 (Individuals with Disabilities Education Act) has clarified that children should be supported in reaching the same goals as their non-disabled peers. Specifically, the Congress wanted to make clear that children with disabilities are entitled to the special education and related services they need to prepare them for employment and independent living which includes post-secondary education and transition to community based services for adults with disabilities. The standard is not to be set lower or higher for children with disabilities than it is for children without disabilities. Under the IDEA they are to be provided an equal opportunity reach the same goals. The definition of “related services” is purposefully broad to be as inclusive as possible, making the boundaries of special education elastic.

There are many factors which have contributed to special education bearing a large burden of responsibility across many areas of student and family need.

- ◆ Real increases in several disability categories that require intensive and high-cost treatments.
- ◆ Regulatory and education demands that result in more paperwork and administrative responsibilities for special educators.
- ◆ Medical and technological advances resulting in increased survival rates of children born with conditions or who have sustained injuries that result in lifelong disabilities.
- ◆ Social factors of poverty and single parenthood which has a direct correlation to incidence of disabilities.
- ◆ Cultural expectations that children and adults with disabilities be fully integrated into the community.

A. Cost Sharing/Cost Shifting

Special education does bear the burden of cost for human services that are related to education, but not directly a result of educational need. An example is the decision-making and funding process involved in residential placements. This can also be seen in growth of several service categories within special education, as well the limited funding that is available for these services from other agencies.

In Vermont, the current system of payment for special education services has *not* been the result of an explicit public policy decision. Rather, this system has evolved in the absence of a clear public policy directive. The evolution of these trends has resulted in the cost allocation system currently in place. The General Assembly can opt to make no change to the current system of cost allocation which places most of the cost burden for these services on the local school district and the state’s Education Fund or can engage in a policy discussion that considers shifting responsibility for certain services to other agencies and providing other funding sources. This report makes two recommendations regarding the issues of cost-sharing and cost-shifting.

Recommendation 1 – Acknowledge How Service Provision Has Evolved

The State should acknowledge the extent to which local special education service provision for children with disabilities, is the product of several factors. These are: collaboration at the community level; the legal obligation of the school to assure special education and related services; the fact that services historically paid by a variety of human services agencies, or not provided at all, have become services paid by school districts; and actual increases in the incidence and kinds of service needs.

The costs for such services paid by school districts, therefore, reflect a shift in payment from the state General Fund to both the Education Fund and the local school taxpayers. As a result, any consideration of special education costs should acknowledge that they are, in part, a function of this historic development.

Recommendation 2 – Funding Relationship To Best Practice

Continued study that looks at the existing funding streams and their relationship to best practice protocols in special education. Specifically, such study should identify whether the current funding system impacts special education outcomes positively, negatively or neutrally, and should identify whether alternative funding and cost-sharing systems would result in better outcomes.

B. Upper Limit of Age Eligibility

Because clarification over the upper limit of age eligibility is likely to be provided through a Vermont case currently pending in the US Court of Appeals for the Second Circuit, no recommendation is made on this issue at this time.

C. Interagency Coordination

In order to ensure that children with disabilities receive all the services they need to achieve the goals of their individual plans in a cost-efficient and effective manner, the special education system must have strong, enduring partnerships with social service agencies and community service providers. Successful interagency collaboration and coordination require that all partners participate programmatically and fiscally in the provision of services. While there are many models for successful interagency collaboration, barriers that prevent or break down coordination exist and will continue to arise. This report offers the following recommendations to help ensure interagency coordination in the provision of special education and related services.

Recommendation 1 - Renewal of Interagency Agreement

The current Interagency Agreement (IA) expires on June 30, 2001. The Interagency Agreement should provide the framework for identifying the roles and responsibilities of the various state agencies in regard to special education services, including the funding of these services. It should encompass all aspects of special education, including transition services, and should provide mechanisms for resolving funding disputes. Partnership should be a priority of both leadership and field staff at all levels of each agency, department and division. Implementation

of a new IA should include a plan for continuous education/updating on the roles and responsibilities of the various partners.

Recommendation 2 - Comprehensive Study For Transition Planning

Transition planning should be a priority of leadership in the Agency of Human Services and the Department of Education and the Department of Employment and Training. A comprehensive study should be commissioned and funded that projects the needs of disabled students who are entering adulthood. A study would provide the basis for continued strategic planning so that consideration of the long-term (3-5 years) funding needs for transition services becomes an institutionalized practice for AHS.

Recommendation 3 - Act 264 Model for Other Disability Categories

Act 264 is the statutory requirement for interagency coordination for services to children with severe emotional disturbances. No similar structure currently exists for other disabilities. There should be a public policy discussion to determine if a similar statutory model is needed for other severe and high intensity disabilities.

Recommendation 4 - Establish Best Practice Agreement on Case Management

Case management is the service area where the most funding is expended by DDMHS and others. Case management services are a significant element of special education. Questions remain as to whether case management services are duplicative at the expense of direct services or at the other extreme may be non-existent. The establishment of best practice for case management services in AHS and DOE should be a goal of both the General Assembly and the Administration

Recommendation 5 - Replication of Successful Local Models

There are regional differences in how comprehensively and successfully special education services are provided. These differences are a result of different programs and practices developed and supported at the local community level. There should be a mechanism that encourages the replication of successful local and regional models for service provision. This mechanism should recognize that successful replication incorporates flexibility to accommodate the differing cultures and histories of each unique region.

Recommendation 6 - Identify Federal Barriers

Vermont should support and participate in a multi-state effort to identify federal barriers that prevent strong interagency collaboration and coordination in the provision of services to children with disabilities. Vermont should vigorously press for changes at the federal level that would eliminate barriers, encourage collaboration, and increase federal funding for special education and services for individuals with disabilities.

II. Introduction

A. Statutory Charge

In Section 12 of Act 117, the Secretary of Administration and the Joint Fiscal Office were requested to study several specific aspects of special education service provision.

Sec. 12. SPECIAL EDUCATION SERVICES PROVISIONS; STUDY

The secretary of administration and the Joint Fiscal Office in consultation with the secretary of the agency of human services, the commissioners of the department of education and the department of employment and training, the Vermont Superintendents' Association, the Vermont School Board Association and other members of the education community shall study how the agency of human services, the department of education and the department of employment and training should provide for special education services for eligible persons under 22 years of age in school or out of school. They shall also:

(1) assess the extent to which school districts have absorbed service costs for special needs children that were historically paid by other service providers including the extent to which:

(A) children formerly admitted to institutional care are now being provided services through special education;

(B) costs now found in school budgets historically were part of the budgets of non-school agencies; and

(C) costs now found in school budgets would be attributable to nonschool agencies;

(2) examine whether the upper limit of age eligibility should be 21 or 22 years of age;

(3) examine the interagency agreement regarding coordination of special education services entered into pursuant to 20 U.S.C. § 1412(a)(12) to determine if services are currently provided and paid for in the most appropriate and cost-effective way; and

(4) report their findings and recommendations to the general assembly by January 15, 2001.

B. Methodology

Four meetings of an ad-hoc working group were held from November 2000 through January 2001. The list of participants at these meeting is included in the appendix of this report. In addition to the meetings of the work group, one public hearing was held. Also, school administrators, parents, and interested parties were asked to submit written testimony regarding the issues of special education service provision, particularly regarding payment for services and interagency coordination and collaboration.

Examples of the questions that guided these group discussions include:

- ◆ Are local special education budgets and the Education Fund bearing a burden for service cost beyond the scope of what might be reasonable to expect from education funding sources?
- ◆ What are appropriate roles and expectations of each of the key partners who impact the services provided to children with disabilities?
- ◆ What are the conditions/factors that would promote better coordination among agencies and result in more timely, efficient and effective services to children, youth and families?

III. Why Special Education Services And Cost Are An Issue

A. Background Discussion

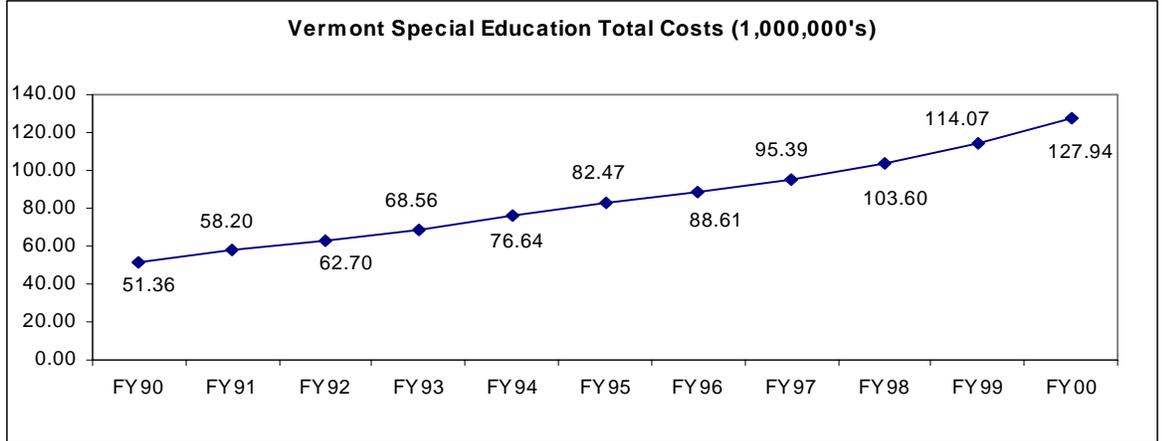
The reauthorization of the IDEA in 1997 (Individuals with Disabilities Education Act) has clarified that children should be supported in reaching the same goals as their non-disabled peers. Specifically, the Congress wanted to make clear that children with disabilities are entitled to the special education and related services they need to prepare them for employment and independent living which includes post-secondary education and transition to community based services for adults with disabilities. The standard is not to be set lower or higher for children with disabilities than it is for children without disabilities. Under the IDEA they are to be provided an equal opportunity reach the same goals. The definition of “related services” is purposefully broad to be as inclusive as possible. A copy of the definition is contained in the appendix of this report. It is the broadness of this federal definition which makes the boundaries of special education very elastic.

While the federal government has recently increased the level of funding it provides for special education, the federal funding level is substantially below the amount anticipated by the maximum funding language contained in the federal legislation. In Vermont, this federal under-funding leads to the state and local districts funding approximately \$20 million more from local sources than if the federal funding were provided at the maximum level. The issue of special education cost growth and increases in complex disability categories is not unique to Vermont, but is shared by school districts and states across the country.

The work group felt it was important to include a discussion that summarizes the various contexts in which special education is provided. There are two underlying and opposing perspectives that tend to inform general opinions and public sentiment regarding the special education system.

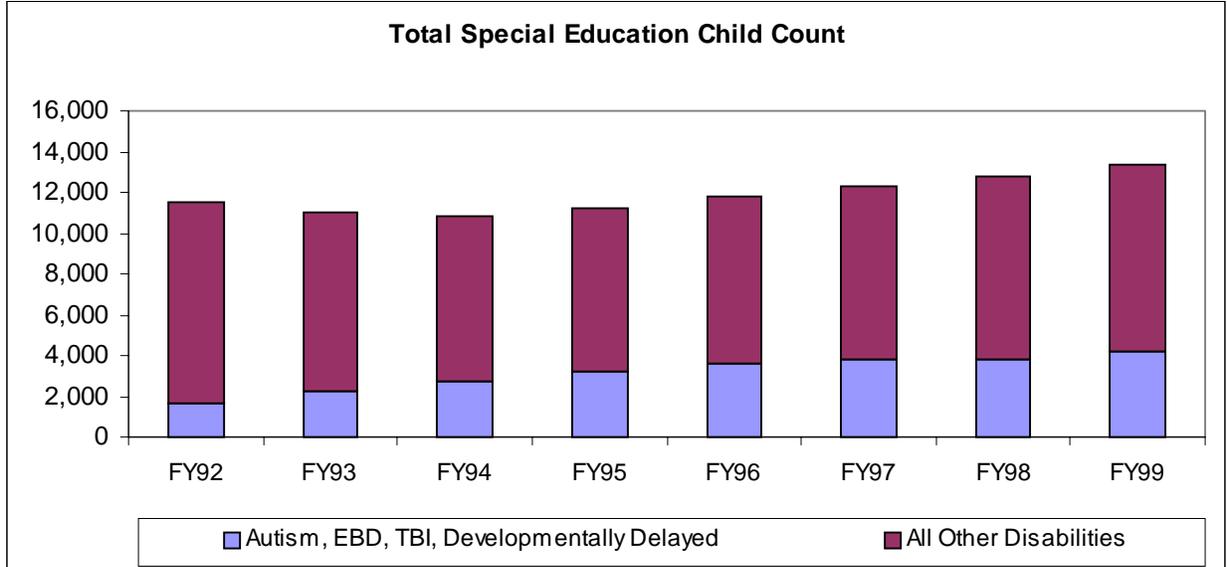
Outsiders see...

Many non-system participants’ perception of special education is a system that is out of control in spending. Over the past 10 years in Vermont, the special education costs have increased by 150% (see chart below), with the most current annual increases running 10%-12%. Some feel the expectations of parents and advocates for services are unreasonable. In some cases, there is suspicion of the diagnoses and labeling of children leading to the perception that needs are not real or are overstated. This results in a focus on the legal obligation to serve as opposed to a collaborative focus on the child. It also results in legislative efforts to reduce ever-expanding special education costs through the institution of funding caps or restricted access to special education services through tightening eligibility requirements.



Insiders see...

From the perspective of system participants this is a system that is driven by a need for services, needs which are real. For service providers and school administrators, cases and treatment approaches have become more complex and the demands on special educators continue to grow. Many feel that both caseloads and paperwork are excessive. For parents and children there are mixed results. For some, special education works very well, providing the services that lead to success for their children. For others, their experience requires constant vigilance and persistence to obtain needed services. For others, the system appears chronically under-resourced with needed services simply unavailable.



There have been real increases in several disability categories that require intensive and high cost intervention. The chart above shows that as a percentage of total special education child count, the high-intensity, high-cost disability categories of Autism, Emotional Behavior Disorders (EBD), Traumatic Brain Injury (TBI), and Developmental Delays collectively have grown from 14% to 31% of total special education child count from FY92 to FY99.

B. Factors of Growth in Special Education

In addition to the growth in specific high-cost disability categories, there are a wide range of factors which have contributed to special education bearing a large burden of responsibility across many areas of student and family need.

i. Regulatory/Education Context

Special education has the responsibility to respond in several regulatory areas that have increased paperwork and administrative costs¹. These include paperwork related to Special Education Process, Interagency Coordinated Service Plans (Act 264), Medicaid, and State Assessment System Implementations. These are in addition to basic responsibilities of special educators for Section 504 (a civil rights law which bans discrimination against people with disabilities and which requires support and services to children with disabilities who are not eligible for services under IDEA). As well as involvement in the educational support team under Acts 230/157 and now Act 117, including delivering services to non-special education eligible children under these state laws. In the appendix is a summary list of services that special education addresses.

ii. Medical/Technological

Medical and technological advances have also led to increased pressure on special education. Examples include: the survival of children born prematurely, later-in-life child-bearing which increases risk for disability, and survival of traumatic brain injuries.² These children often have significant developmental disabilities or medical conditions requiring a range of services. Some children only need the supports that can be provided within the framework of services generally provided in schools such as specialized instruction in academic skill areas, and related services such as occupational, physical, or speech-language therapies. Others require intensive supports such as residential placement, wrap-around services to provide supports at home to prevent institutionalization or residential treatment, in-school nursing care (e.g., ventilators, feeding tubes, suctioning), intensive physical and occupational therapies, or specialists not generally or readily available to the education system.

Both children's mental health and developmental services are developing fields. In the past, some service needs were not recognized and options for treatment were limited. The expansion in practice and research in this area has led to growth in recognizing disabilities, diagnosing multiple disabilities, and the development of more and more intensive and costly treatment options. As the efficacy of new treatments is proven, expectations increase and demand for services rise. Similar to health care utilization, the immediate availability and wide dissemination of information through the internet can also accelerate the demand for services.

iii. Social Context

There is a well-established correlation between socioeconomic status and prevalence of disabilities. The risk for disability "is mediated through family and parenting practices, positive affective relationships, discipline and control, degree of involvement, structural stability and

¹*The Council for Exceptional Children survey found 68% of special education teachers spend less than two hours per week on one-to-one instruction because of caseload size and regulatory paperwork.*

²*In the recent past the survival rate of TBI was 1-in-8; it is now 7-in-8 and can result in lifelong disability.*

income stability”.³ There has been a significant increase in the rate of childhood disability over the past 14 years, with the locus of increased risk among constituencies defined by poverty and single-parent-headed households.⁴ The linkages in the triangle formed by poverty, single parenthood and disability go in each direction. At the same time that poverty and single parenthood are predictors of disability, disability is a predictor of economic and family status.

There are other social aspects which create pressure on schools to provide more services. For single-parent families, or where both parents need to work, juggling work and family responsibilities, difficulty accessing safe affordable childcare, the inability of families to earn a livable wage, and accessing health care can impact negatively on parental ability to monitor or respond to a child’s needs. Society, in general, has expectations that the education system will solve issues of poverty and meet increasing needs. This expands the concerns of special education beyond a narrow educational disciplinary niche.⁵

iv. Cultural Expectation of Integration

Children with substantial needs are remaining in their homes, schools and community rather than being placed in institutions. In 1993, the Brandon Training School was closed.⁶ Other institutions now closed include the Weeks School which served children with emotional disabilities and the Vermont Achievement Center where many children with multiple medical or physical disabilities were placed for many years prior and subsequent to the IDEA. There is no question that individuals, especially children, who would have been candidates for placement at Brandon 20 years ago are better served by remaining in the local community. However, those services that were provided in an institutional setting were paid entirely by the state. Those services, plus additional services as a result of improving treatment practices, are now primarily provided to school-age children in the context of their special education plan. The cost for those services falls onto the local school district in their special education budgets, and to the Education Fund when costs are reimbursed through the state placed students budget and special education formula. In order for alternatives to institutional settings to be successful, the appropriate level of skilled care is required. When insufficient funding is available to support children in their community, this support fails, and the child ends up in a more restrictive placement and requires more intensive services.

The cultural expectation that people with disabilities will be integrated into the community has been solidified by the passage of both reauthorization of the IDEA (Individuals with Disabilities Education Act in 1997) and the ADA (Americans with Disabilities Act in 1990). The current demands on the special education system are a result of this three-decade-long evolution of increased expectations for the outcomes of children with disabilities. There is broad awareness of the entitlement to special education services; at the same time, there is increasing sophistication on the part of teachers, parents and advocates in accessing services.

³Fujiura and Yamaki, “*Trends in Demography of Childhood Poverty and Disability*”, *Exceptional Children*, Vol. 6, No.2, pp187-199.

⁴ Ibid

⁵ Ibid

⁶ In the last four years of operation at Brandon, there were four residents who ranged in age from 19 to 21. There were no residents less than 19. In last ten years of operation, there were two admissions of individuals aged 19.

IV. Concurrent Issues/Activities Affecting Special Education

The legal and regulatory context within which special education operates continues to evolve. Change coming from both within and outside Vermont will affect the future provision of services and how they are funded.

A. Revised Vermont Special Education Regulations

The Vermont Department of Education is currently engaged in a lengthy process to revise the state's special education regulations consistent with the recently amended, federal Individuals with Disabilities Education Act and pertinent federal regulations. This revision will have a significant impact on special education in the state, as only just touched upon by the following overview:

- ◆ There have been significant changes in the determination of eligibility section of the regulations for children age 6-21. The proposed regulations include a substantial change in the second gate of the eligibility determination process, which is the determination of “adverse effect” on a student’s educational performance. Earlier drafts excluded children from eligibility if they did not demonstrate a 15% deficit on a nationally norm referenced standardized test. The proposed rule submitted for public comment includes a professional judgement provision that allows the 15% criteria to be overridden.
- ◆ There were changes proposed in classifying a student as one with an emotional disability that would have tightened eligibility. These include clarification of conditions that constitute “social maladjustment” and the exclusion of social skills as a basic skill area. Newer drafts have included revisions to these changes but at this time it is unclear if these revisions will ultimately be adopted in the revised regulations and rule making.
- ◆ For infants and toddlers, a requirement that school representatives must participate in transition meetings for children thought to need services past their third birthday.
- ◆ Specified training and supervision for para-educators who deliver special education services.
- ◆ The ability use existing data when conducting a reevaluation of a student’s eligibility for special education.

B. The Blue Ribbon Commission on Special Education Costs and Act 117

In 1998 the legislature ordered a blue ribbon commission to study special education costs and, as a consequence of the commission's recommendations, the legislature in 2000 passed Act 117.

This act made several sweeping policy statements and set in motion a strategy to attempt to reduce the rate of increase in special education costs:

- ◆ A school district's education support system shall be the responsibility of general education, not special education
- ◆ Special education in Vermont shall mean "to the extent required by federal law"
- ◆ When the special education team has more than one equally viable option for consideration, then cost may be a consideration in the choice of the option to be pursued.
- ◆ Lays out a detailed cost containment plan and series of reports
- ◆ Limits the growth of state aid for special education to the growth in the Vermont State Domestic Product plus four percentage points in fiscal year 2002, three in 2003, and two in 2004
- ◆ On or Before January 15, 2004, the Commissioner of Education shall recommend "a fiscally sustainable formula" for funding special education.

Finally, Act 117 ordered this study.

V. Cost-Sharing/Cost-Shifting Issues

The language in Sec. 12 of Act 117 asks specifically that issues of cost-sharing and cost-shifting be examined:

(1) assess the extent to which school districts have absorbed service costs for special needs children that were historically paid by other service providers including the extent to which:

(A) children formerly admitted to institutional care are now being provided services through special education;

(B) costs now found in school budgets historically were part of the budgets of non-school agencies; and

(C) costs now found in school budgets would be attributable to nonschool agencies;

There are not consistent expense reporting methodologies across school districts. The distinctions are fuzzy regarding exactly when, where, and how a specific expense should be defined as a special *education* item versus a *social/human* service item. Because of this, a straightforward classification and financial accounting of these costs is not possible.

To address the questions above, interested parties, particularly school and supervisory union officials, as well as state agency personnel, were asked to provide examples of how and when special education budgets have absorbed costs that have been traditionally considered human service costs. The examples given by participants show that special education budgets incur costs of a human service nature on a case-by-case basis. This is especially true of high-cost/high-intensity cases, but some areas are experiencing a gradual creep of less intensive services into special education budgets as well.

A. Factors That Lead To Special Education Absorbing Costs

There are several specific factors that are evident as primary reasons for the burden of payment for additional services falling onto special education.

- ◆ Immediacy – The school is the entity with the daily connection to the child, and must respond immediately to the needs of the child. The school cannot postpone providing services because of a lack of capacity or funding at another agency. The schools are required to take everyone.
- ◆ Special education is the payer of last resort because of the federal mandate. Special education becomes a magnet for services; if the service is included in the Individual Education Plan (IEP), then the school is ultimately responsible for ensuring the provision of the IEP prescribed service. Limited funding/limited access to services in the budgets of social services agencies provides an incentive for case managers and social workers to encourage the inclusion of such services in the IEP. These would not typically be considered an educational item, but are included to ensure that these needed, but not directly educational

services are provided. These services can have a benefit on the education component of the student's plan, but the underlying problem that the services address is not educational need.

- ◆ Restrictions on access to services through non-education resources due to limitations in funding available to provide support and services to children with disabilities and their families. For example, the service priorities of DDMHS are directed and focused on crisis intervention and the most severely in need. There is no entitlement to services through other agencies, as is the case under special education law. For other agencies, there are limited funds available in many cases for intervention at an earlier point.
- ◆ There is no continuum of programs and placements for children with disabilities who need blended, highly coordinated or specialized services from education and other agencies, particularly those students with emotional disabilities, pervasive developmental delays, or autism spectrum disorders. Such children often require skills not normally expected of most special education and regular education personnel. As a result, children do not progress, and often their ability to function within their school, home and community deteriorates, which can lead to more costly and restrictive placements.

B. Residential Placement – One Example

The following provides an illustration of how mental health treatment costs can end up in special education budgets where they are paid for by property taxes directly and indirectly through reimbursement from the Education Fund. Residential placements are typically the high-cost, final option after other alternatives have been exhausted. Residential placements are a specific area where many local school officials feel costs are disproportionately borne by the local school district, or in the case of state-placed students, on the Education Fund.

The following are illustrative of the funding issues faced in this arena:

Scenario #1 – The case of a student is brought to the Local Interagency Team (LIT) for consultation. The student is struggling at home, possibly depressed, is oppositional with parents/adults, and experiences incidents of explosive anger. These issues are starting to spill over to school, but so far, school can manage him with extra supports. The case is brought to LIT because several community-based services have been tried but are not successful, including: Intensive Family Based Services (IFBS), anger management group, parenting support, etc. The LIT meets, agrees that a three to six month residential assessment is warranted. The DDMHS agrees that it will cover the treatment and room and board costs for the placement, and the LEA (Local Education Agency) agrees that it will cover the cost of education expenses. This works well when the child is Medicaid-eligible, DDMHS has general fund available as match for Medicaid in residential placements through the Private Non Medical Institution (PNMI) program, the proposed placement is in Vermont, it is approved by the Division of Mental Health (DMH), and there are beds available without too long a wait.

At Community House, for example, the financial split for a six-month placement would be:

	<u>per day</u>	<u>% of total</u>	<u>per six-month placement</u>
Medicaid	\$103.13	42%	\$18,769.66
Medicaid Match	68.76	28%	12,514.32
Room and Board	32.84	13%	5,976.88
<u>Education</u>	<u>40.45</u>	<u>17%</u>	<u>7,361.90</u>
Total	\$245.18	100%	\$44,622.76

In this scenario, the division of funding for 6 months is:

General Fund (DMHS)	\$18,491.20
Federal Medicaid	18,769.66
<u>Local School District</u>	<u>7,361.90</u>
Total	\$44,622.76

Scenario #2 – Same student as above, same situation. However, in this case, the DDMHS has run out of general fund match money for the time being, or the only facility that DMH will approve for the assessment has a six to eight month waiting list. The LIT reconvenes and decides that the student cannot wait that long, so the LEA makes a placement at a similar facility. In this case the LEA is now responsible for the entire expense, including the treatment portion of the costs. The local school district pays the entire cost; in Brookhaven, for example, six months would be:

	<u>per day</u>	<u>% of total</u>	<u>per six-month placement</u>
Medicaid	\$ 86.08	38%	\$15,666.56
Medicaid Match	57.38	26%	10,443.16
Room and Board	50.65	22%	9,218.30
<u>Education</u>	<u>32.34</u>	<u>14%</u>	<u>5,885.88</u>
Total	\$226.45	100%	\$41,213.90

If the child is Medicaid eligible, then the Medicaid portion will be reimbursed to the school, but only for *reinvestment* as part of the School Based Medicaid program. It cannot be used to reduce the cost of the placement. The cost to the district is \$41,213.90 of which a portion is shared by the Education Fund. If the placement is out of state, then the school district pays the entire amount, again with a portion reimbursed by the state from the Education Fund through the special education funding formula, but with no current mechanism for any Medicaid reimbursement.

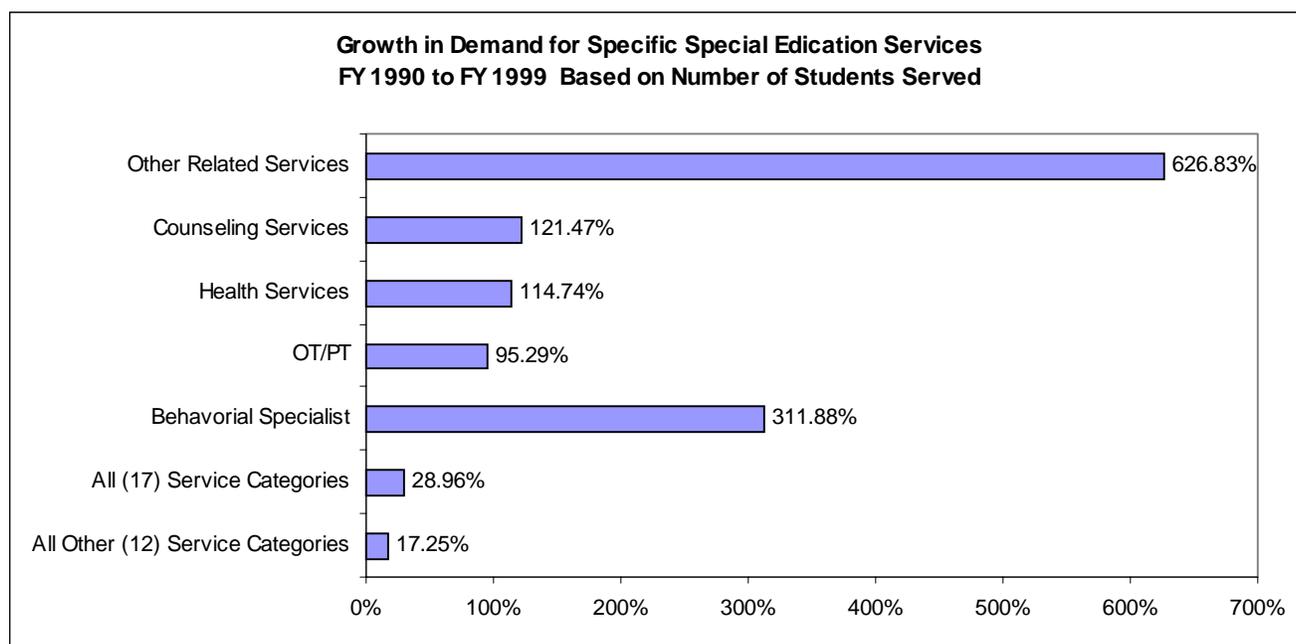
Scenario #3 – Picture the same student, only all the community-based supports have not yet been tried. The team decides on a plan of community-based supports, an integral part of which would be respite services. The problem in this scenario is that DDMHS has no Home and Community Based Waiver funds available, and can't access respite services or some other part of the recommended plan. So, while the team agrees the student could probably be served in the community with intensive supports, there is currently no way to get the child all the mental health services that would allow him to remain in the community. Because the child and the

family are in dire need of intensive services, the team is forced into making a residential placement with the LEA and the Education Fund bearing all the costs as in Scenario #2.

C. Growth Of Other Services Within Special Education

Residential placements are not the only area where human service-related costs are borne by special education budgets. The special education annual report lists 17 service categories other than residential placement, the number of students receiving these services, as well as staff providing these services. The list of services includes: Special Class Instruction, Resource Room/Learning Specialist, Behavior Specialist, Integration Facilitator, Employment Specialists, Other Direct Instruction, Vision Services, Adaptive Phys-Ed, Individual Tutor/Aide, Health Services, Occupational and Physical Therapy, Counseling Services, Assessment, Speech/Language, Audio/Deaf, Transportation and Other Related Services.

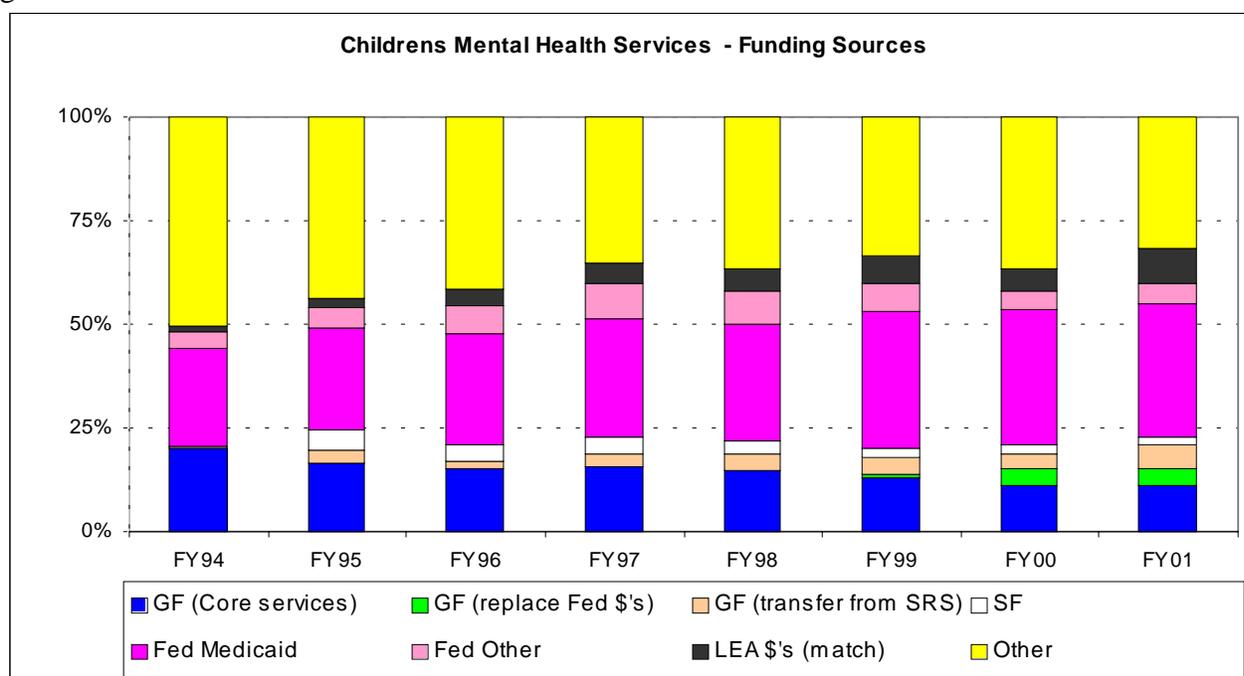
The chart below compares the total growth of five services categories (Behavior Specialist, Health Services, Occupational and Physical Therapy, Counseling Services, and Other Related Services) to the total growth of all the other 12 services combined as well as all 17 services combined from FY1990 to FY1999 based on the number of students served. What this demonstrates, from a demand for services perspective (many students receive more than one service), is that the five areas that are probably considered most social service related each grew at a much faster rate than other more specific education services. It should be noted that of the twelve more specifically education related services Individual Tutor/Aide also grew at a very fast pace (over 1000%). While tutors are generally directly educational, aides are provided to help with health and behavior issues as well as educational issues so the demand for services in this category is another area where special education pays for services that would traditionally be considered a social service.



D. Funding Levels For Children's Services In Other Agencies

The fact that special education is paying for related services that extend beyond traditional academic needs is not because other state social service agencies do not care about or are not interested in helping these children. While field level staff on interagency treatment teams recommend and support specific services for individual cases, their recommendations cannot be supported by higher-level administrators within the agency unless there are sufficient funds. The system of care plans at the Division of Mental Health and the Division of Developmental Services define how their funds are used. The services that these agencies provide are not entitlements as are the services in special education.

While the total children's services provided by the Division of Mental Health has increased, the percentage share of various funding sources had shifted. The total amount of services has increased significantly, but other funding sources, in addition to federal dollars, are paying for these services. This can be seen by the increase in match funds from LEAs as well in the category labeled Other which is the difference between what the community agencies report on their financial reports and what the department tracks. The funds for Other services may come from a combination of out-of-pocket, private insurance, school-purchased services or other grant-funded services.

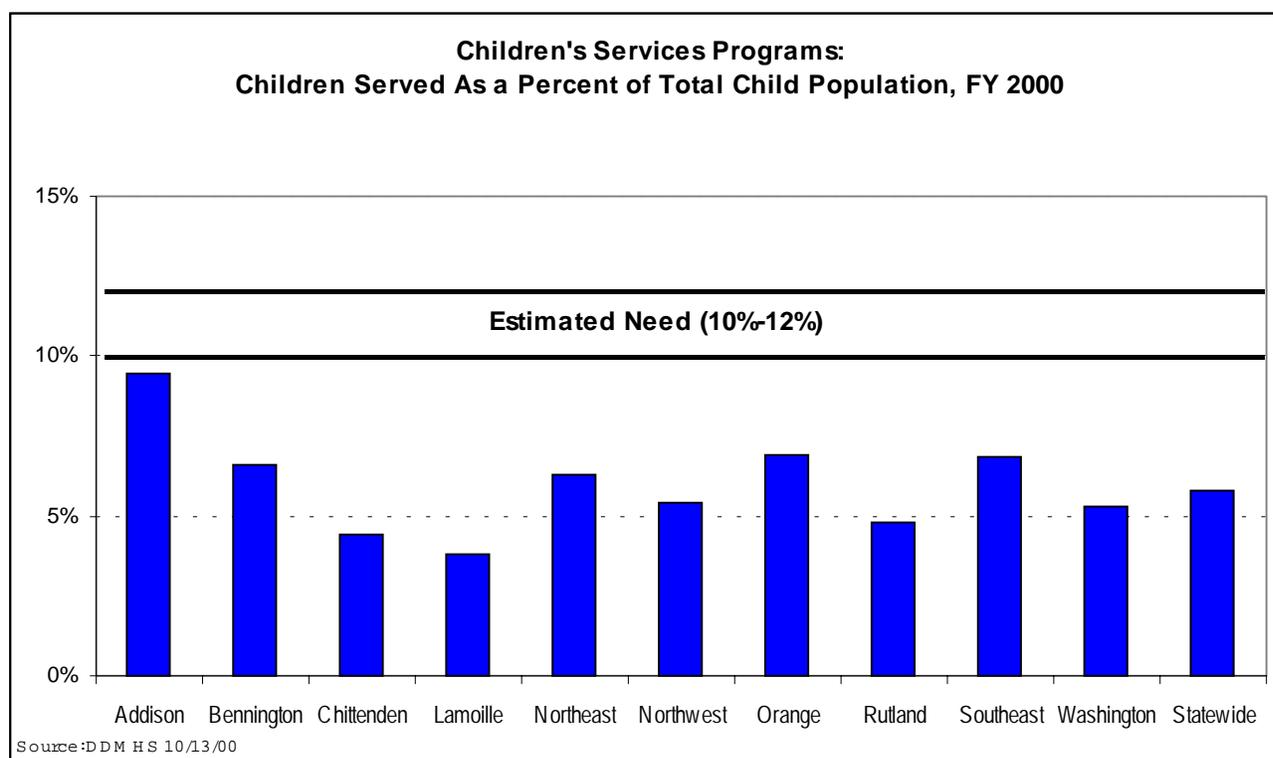


The data table below shows that total General Fund available for children's services has increased in the last three years but much of the increase was replacement of federal dollars in the Access/Families First, a crisis intervention program for children at risk of going into SRS custody. The amount of general fund available for basic core, mental health services has remained relatively flat, only increasing at inflationary rates. Since the need for children's services has increased above inflation the funding source for this need has come from other sources.

Children's Mental Health Services - Funding Sources								
	FY94	FY95	FY96	FY97	FY98	FY99	FY00	FY01
GF (Core services)	\$3.62	\$3.72	\$3.93	\$3.96	\$4.14	\$4.19	\$4.49	\$4.55
GF (replace Fed \$'s)	-	-	-	-	-	\$0.30	\$1.55	\$1.55
GF (transfer from SRS)	\$0.10	\$0.71	\$0.46	\$0.86	\$1.11	\$1.32	\$1.50	\$2.37
SF	-	\$1.04	\$1.05	\$1.06	\$0.77	\$0.80	\$0.75	\$0.74
Fed Medicaid	\$4.32	\$5.58	\$6.85	\$7.24	\$7.90	\$10.87	\$13.11	\$12.85
Fed Other	\$0.76	\$1.08	\$1.73	\$2.26	\$2.25	\$2.09	\$1.72	\$1.92
LEA \$'s (match)	\$0.24	\$0.55	\$1.07	\$1.25	\$1.49	\$2.19	\$2.23	\$3.39
Other	\$9.17	\$9.80	\$10.63	\$9.00	\$10.12	\$11.02	\$14.59	\$12.70
Provider Financials	\$18.21	\$22.48	\$25.70	\$25.63	\$27.80	\$32.77	\$39.94	\$40.06
DMH Total	\$9.04	\$12.67	\$15.08	\$16.63	\$17.68	\$21.76	\$25.35	\$27.36

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The need for children's mental health service surpasses the system's capacity to provide service and there are marked differences in the amount of services provided in each of the regions of the state. The chart below shows the number of children receiving mental health services range from 3.8% to 9.5% of total child population, while national estimates of need range from 10-12%.



The examples provided above are for mental health services; similar issues of funding constraints exist for developmental services, as well. In the appendix of this report are copies of the written testimony provided by school administrators which describe cost-shifting as a result of funding constraints at other agencies.

E. Recommendations Regarding Sharing Of Service Costs

Special education does bear the burden of cost for social services that are related to education, but not directly a result of educational need. There are more children with more intensive needs. There is increased demand and increased expectation for services. It is not possible to identify a dollar figure for how much traditional social services are included in the statewide special education budget since there are not common definitions and cost allocation methodologies for isolating these services within the system. The degree to which special education picks up these costs is dependent on many factors, and varies from case to case.

The current system of payment for special education services has *not* been the result of an explicit public policy decision. Rather, this payment system has evolved in the absence of a clear public policy directive. Budget constraints in other agencies, institutionalized practices, and the federal mandate with the local education agency being the legally responsible party for all special education services have all combined to create the cost allocation system currently in place. The General Assembly can opt to make no change to the current system of cost allocation, which places most of the cost burden for these services on the local district and the Education Fund or can engage in a policy discussion that considers shifting responsibility for certain services to other agencies and providing other funding sources.

Recommendation 1 – Acknowledge How Service Provision Has Evolved

The State should acknowledge the extent to which local special education service provision for children with disabilities is the product of:

- 1) Actual collaboration at the community level of many service providers;
- 2) The legal obligation of the school to assure special education and related services (those services necessary for the child to benefit from his or her special education program);
- 3) The fact that services historically paid by a variety of social services agencies, or that did not exist previously, over a period of years, have become services paid by school districts; and
- 4) Actual increases in the incidence and kinds of service needs within the overall population of school children (notably, regarding autism spectrum disorders and emotional disturbance).

The costs for such services paid by school districts, therefore, reflect a shift in payment from the state General Fund to both the Education Fund and the local school taxpayers. As a result any consideration of special education costs should acknowledge that they are, in part, a function of this historic development.

Recommendation 2 – Funding Relationship To Best Practice

Continued study that looks at the existing funding streams and their relationship to best practice protocols in special education. Specifically, such study should identify whether the current funding system impacts special education outcomes positively, negatively, or neutrally, and should identify whether alternative funding and costs-sharing systems would result in better outcomes.

VI. Upper Limit of Age Eligibility

The language of Sec. 12 of Act 117 specifically requests:

(2) examine whether the upper limit of age eligibility should be 21 or 22 years of age;

There is confusion over what the intent of the federal language is. The IDEA states that states must have in effect "a policy that ensures that all children with disabilities aged 3-21 residing in the State have the right to FAPE (a free appropriate public education) . . ." There are exceptions to that regulation which states that "the obligation to make FAPE available to all children with disabilities does not apply with respect to children aged 3,4,5,18,19,20, or 21 in a State to the extent that its application to those children would be inconsistent with State law or practice, or the order of any court, respecting the provision of public education to children in one or more of those age groups." Under these regulations, States must provide FAPE (special education) to services to all children age 3-21 unless state law or a court order restricts access to education for all students to age 3-5 and 18-21. The US Dept. of Education, Office of Special Education Programs has interpreted the IDEA to require the provision of special education services to eligible children through to the 22nd birthday. Vermont law makes specific provisions that allows the Commissioner to approve services through 21 so that a student may complete a program.

A. Current Litigation

In a Vermont case pending in *US Court of Appeals for the Second Circuit (St. Johnsbury Academy v. D.H., St. Johnsbury School District, and State of Vermont Department of Education, Docket No. 2:93-CV-398)* the issue of eligibility for special education service based on upper limit of age may be clarified. This is a case involving a student who has multiple disabilities. At the initiation of the case, the student was 15 years old, in State custody and had been mainstreamed in regular education classes while attending the St. Johnsbury Middle School. The IEP for the student determined that the appropriate placement for the student was at the St. Johnsbury Academy with inclusion in some regular education classes. The Academy refused enrollment on the basis that such action was inconsistent with Academy policy that required the student to demonstrate a fifth grade achievement level as a precondition to participation in regular education classes.

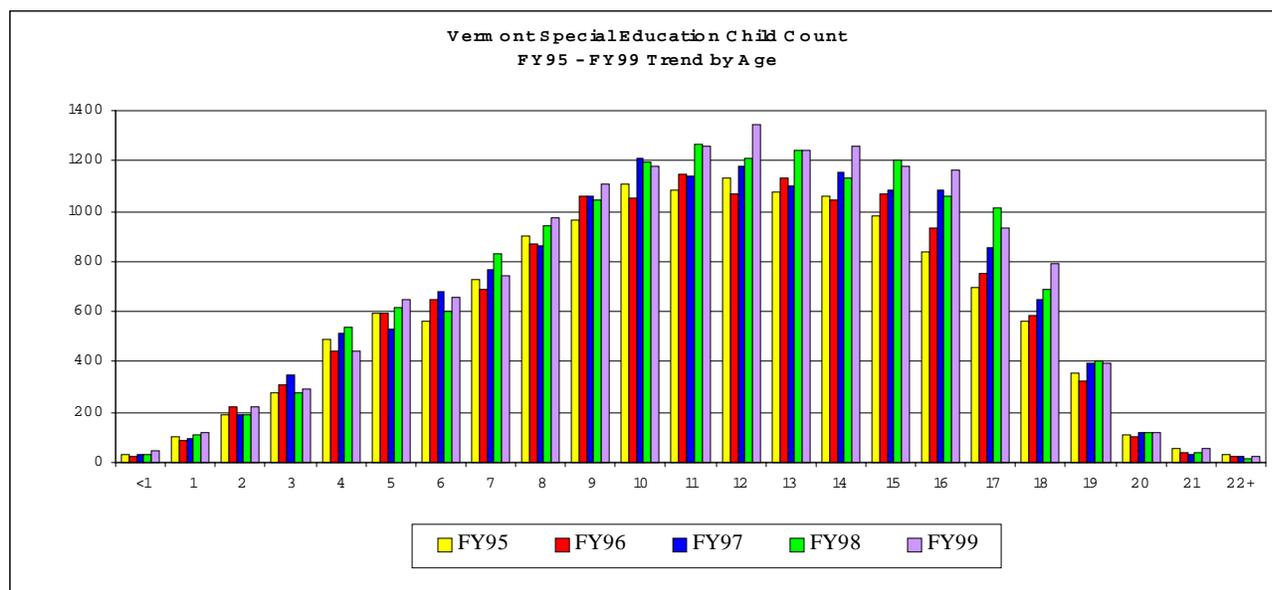
St. Johnsbury Academy appealed the decisions from the due process hearing officer and the US District Court which ordered the school to enroll the student and to integrate him into regular education classes as set forth in the student's IEP. (During the pendency of these appeals the student was enrolled.)

At the oral argument before the Appeals Court, one of the judges raised the question as to whether the case was moot because the student was now over 21 years old. Both the Academy and the student took the position that eligibility based on age under the IDEA as well as Vermont law and regulations encompassed children from age 3 to the 22nd birthday. This interpretation was inconsistent with a prior decision of the Second Circuit Court in *Suffolk Parents of*

Handicapped Adults v. Wingate 101 F3d 818 (1996). Therefore, the Court asked attorneys for the parties to submit written briefs setting forth arguments as to why the Court should disregard their decision in the previous case and accept the interpretation that IDEA eligibility extends *through* the 21st year, not *to* the 21st year. The decision of the Appeals Court is pending.

B. Age Distribution of Special Education Students

The age distribution of students in special education shows that the number of 21 and 22 year old has consistently remained a very small percentage of the total special education student count. In the past five years the number of 21 year old students ranged from 35-55 and the number of 22 year olds ranged from 19 to 30.



It is believed that the outcome of the case currently pending will offer clarification on the age limit and will determine whether service provision extends until the 21st or 22nd birthday. This report makes no recommendation regarding this issue. However, the issues that older special education children face in transition to adult services illustrate an area where there is not currently successful interagency coordination and collaboration. This is discussed in greater detail in the next section of this report.

VII. Interagency Coordination and Collaboration

The language of Sec. 12 of Act 117 requested us to:

(3) examine the interagency agreement regarding coordination of special education services entered into pursuant to 20 U.S.C. § 1412(a)(12) to determine if services are currently provided and paid for in the most appropriate and cost-effective way; and

Interagency collaboration and coordination is essential to ensure that services are provided in an efficient and cost-effective manner. The education system alone cannot provide the services. The ideal is true partnership at all levels: local, regional, and state, and across all divisions and departments.

The federal IDEA, as reauthorized in 1997, requires that an interagency agreement or other mechanism be in effect between the state educational agency and each public agency that provides special education or related services in order that all services that are needed to ensure a free appropriate public education are provided. In addition to specialized instruction in schools these service may include items such as: residential treatment, transition services, related services, counseling, mental health services and vocational services. While the current Interagency Agreement states this as its purpose, the agreement limits the Agency of Human Services responsibilities to administration of the Medicaid Plan. Many special educators feel they are assembling service packages by “buying retail” while the efficiencies and expertise of the social service agencies are not maximized because they are not full partners in many cases.

A. Models of Success for Interagency Collaboration and Coordination

While the current state of interagency coordination and collaboration is mixed, there are several programs that provide models for a working partnership. Examples include:

i. The Family and Infant Toddler Program

The federal Individuals with Disabilities Education Act (IDEA) – Part C provides for early intervention services for infants and toddlers with disabilities and their families. Implementation of these services in Vermont is through a family-centered coordinated system called the Family, Infant and Toddler Project of Vermont. The Agency of Human Services and the Vermont Department of Education share responsibility for implementation as co-lead agencies.

The Family, Infant and Toddler Project of Vermont is a family-centered coordinated system of early intervention services for infants and toddlers who have a delay in their development, or a health condition which may lead to a delay in development, and their families. The Project brings together families and service providers from many aspects of the community, including public and private agencies, parent-child centers, local school districts, health care practitioners, private therapists, and child care providers. Supports and services come together to meet each child's unique needs and the needs of their family in their home and community. By assisting in the coordination of locally-available services, the Family, Infant and Toddler Project works to

ensure that Vermont's young children and their families have access to the widest possible array of early intervention services.

Services are provided through an Individualized Family Service Plan (IFSP). Parents and other members of the team are partners in developing and implementing this plan to achieve the best possible results for the child and family. Along with early intervention resources and services, the family may include in the plan other community supports or resources they would like help in exploring or obtaining. Services and supports will be provided in the most convenient and natural places for the family and their child. This can include the family's home, child care setting, community play group, etc. Early intervention services should be supportive of families in the context of their own unique daily routine, lifestyle, culture, and community.

A core team, including the family, an early interventionist, a local school district representative, a social worker, and a community resource parent, plans evaluation activities, determines eligibility for services, and provides interim service coordination. A service coordinator, chosen by the family in partnership with other core team members, is available for each family. This person's role is to assist in helping families obtain the services and assistance they need and have identified, and to help coordinate services across agencies. Service coordinators will: 1) enable families to play a central role in defining the types of services and supports appropriate for their child and family; 2) respond to family-identified concerns and priorities; and 3) enhance the capacity of families to meet the needs of their children.

ii. Access/Families First Program

The Access/Families First was initiated with federal grant funds to support and serve families of children experiencing severe emotional disturbance. Children and families in crisis, and children at risk of separation from their families, are priority populations. The program funding allowed for statewide implementation of and expansion of needed services include "Statewide Priority" services of crisis outreach, short-term residential crisis stabilization program, intensive home-based services, respite and therapeutic case management.

The program strengthened interagency planning and coordination. The planning involved SRS, Division of Mental Health, both state and local education input, as well as families and crisis services such as substance abuse and domestic violence intervention at both the state and community level.

The success of the program appears to be evident in the satisfaction of clients with the services received, reports of a decline in challenging behavior, and increased academic performance for program participants. The number of children entering state custody is lower than would have been anticipated for the families served by the program. Continued funding for this program was supported by the legislature when general funds were appropriated to replace the federal funds that initiated the program.

iii. The Children's Upstream Services (CUPS) Program

The CUPS program is another recent initiative funded with federal grants funds. The program provides behavioral health treatment and consultation for the early childhood system of care for families with young children age 0-6.

The objectives of CUPS is to enhance Vermont's existing Community Partnerships to link the system of care for emotionally disturbed school-age children with the early childhood system of care, thereby providing more support for the behavioral health of families with young children, including treatment teams.

This effort is supported by several interagency groups including agency department involvement, as well as support from higher education and local community providers. There is interagency collaboration on planning, implementation and funding

There are many other examples that could be looked to as examples of interagency collaboration and coordination across the state in addition to the three large statewide programs summarized above. There are other state-level programs, as well as local alternative education programs, that are the result of local education, mental health and developmental service organizations developing and supporting initiatives that meet specific identified needs of a community.

What these programs indicate is that, in order for successful interagency collaboration and coordination, there is both physical and fiscal partnership from the departments and agencies involved. Programs work well when there is strong leadership, a clear understanding of funding obligations, a proactive approach to problem-solving, and a critical mass of expertise. The goal of true partnership and collaboration is to remain child-focused, and avoid conflicts over jurisdictional responsibility.

B. An Example of Inadequate Coordination - Transition to Adult Services

The public policy question that is raised when older children transition from the mandated and integrated system of special education to the fragmented system of adult service is: how to protect the investment made in special education with successful supported adulthood? The reauthorization of the federal Workforce Investment Act in 1998 specifically requires that an interagency agreement or other mechanism be in effect to ensure interagency coordination of services that are included in an individual's plan for employment. The definition of "transition services" under federal special education law is included in the appendix of this report, and includes services that allow for community employment, independent living, community participation, and continuing education.

The perception of families facing transition is of being on the edge of a cliff with no bridge in sight. Sometimes, a tour guide offers directions but these are confusing or incomplete. The impact this has is that families, advocates and providers try to postpone facing the service gap by extending the child's enrollment in school in order to obtain needed services through special education. An example is an 18-19 year-old special education student who has met the necessary education requirements to graduate. Since services are not available in the adult system to

support him in employment and/or independent living, the family/advocates feel they must insist that the child remain in school to obtain these services through the special education mandate.

The Division of Developmental Services (DDS) is the agency that provides, through a system of private, nonprofit community mental health/developmental services agencies, community living services to people with developmental disabilities. The perception of some local special educators involved in planning the transition of students is that the developmental services system is not an active partner in the transition planning process. The frustration of special educators stems transition team meetings which are not consistently attended by representatives of from DDS and a lack of available funding for services.

There *are* differences in eligibility criteria between the special education system and the adult system of services. Adult developmental services eligibility is limited by statute to individuals with mental retardation and/or pervasive developmental disorders who have concurrent deficits in adaptive functioning. The legally mandated special education population encompasses a much broader array of disabilities and functioning levels. There is, therefore, a significant discrepancy between the numbers of people who special education professionals believe should be eligible for adult services, and those who are actually eligible according to state statute. This difference also adds to the frustration that local educators feel when trying to assist youth in planning for the future.

Another example is personal attendant services for adults. There is an entitlement to personal attendant services as a child through the Medicaid state plan service administered via collaboration of the Vermont Office of Health Access, the Division of Developmental Services, and the Division of Children with Special Health Needs. However, as an adult, a person with those same needs must access services through DAD on a funds available basis either through the waiver or general state support.

Other partners in the transition process are the Division of Vocational Rehabilitation (VR) and the Department of Employment and Training. In Vermont, the majority of transition service activity is limited to what is offered by VR with little support from other agencies. On the other hand, VR has collaborative interagency agreements with the Department of Developmental and Mental Health Services to serve individuals with mental health or developmental services needs. Vermont's collaboration in this particular area has been used as a model in other states and has been cited on numerous occasions as an example of effective outcomes. At the same time, from the perspective of advocates and the education community, long-term strategic planning regarding transition is an area where Vermont still needs to do more. Currently Vermont's transition services are implemented under a set of guidelines that have not been revised since 1996.

C. Other Barriers That Impede Interagency Collaboration

In addition to the issues of transition services, there are other barriers that make interagency coordination and collaboration in the provision of special education services an illusion more than a reality.

i. Examples From Public Hearing

The public hearing provided a few specific case examples that highlight many of the issues that currently exist to hinder effective interagency collaboration. These are stories offered by the families of children in special education on IEP's. They illustrate that, in spite of the entitlement, certain barriers to service do occur.

Case 1 - A four year-old child with multiple severe emotional and behavior disabilities as a result of abuse and neglect was placed with, and eventually adopted by, a central Vermont family. The assessment of his needs at age eight led to enrollment in a local alternative day, and eventual combination day/residential treatment program that resulted in progress for the child. This approach with additional wrap-around services for the family, was supported financially and philosophically by all partners on the treatment team. At age 13, the child "aged-out" of the local day/residential program. The child's success and growth began to decline under the wrap-around approach. The treatment team's assessment was for a residential placement that would meet the varied needs of the child. After contact and review, it was determined that no Vermont program contained all the components to meet the child's needs, but a program in New Hampshire was identified and had space available. This placement was recommended by all parties of the treatment team with the exception of the Division of Mental Health. DMH did not support an out-of-state placement, and recommended several different approaches including therapeutic foster care or several Vermont-based programs. None of these would meet all the needs of the child, some would not accept the child and/or did not have available space. SRS had a contract with the New Hampshire program, so if funding had been available, the child would have been eligible for placement in that program. As of the date of the public hearing, five months after the process began, DMH had just agreed to provide some funding for the New Hampshire program. The child continues to remain at home where his progress has declined but will attend this program as soon as space becomes available. Several openings were missed in the interim.

Case 2 - Testimony was provided by a parent of an autistic child with severe needs. The child needs extended services and treatment beyond that provided in school. This case requires the integration of education, family and individual therapies, one reinforcing and building off the success of the other. While this family is able to access a variety of services, the majority of funding goes toward case management services. The parent faces a variety of frequently changing case managers from all organizations involved with her child. Each case manager is focused primarily on his or her particular narrow niche, and none is consistently or effectively communicating and coordinating services among the other case managers. While the mother feels that each of these individuals truly cares about her child, there is a feeling that more funding goes to case management than to direct services provision, not to mention the role the parent plays of ultimately managing all the case managers. In the end, while optimal treatment and best practice for her child is a generalized goal for the various providers, this is not consistently the reality of the services the child receives as a result of a lack of true coordination.

Case 3 – In written testimony, the parent of an eight year-old child with Developmental Apraxia echoes many of the concerns raised by the other cases. She finds the system fragmented with no one to help guide parents in accessing appropriate services. The parent also finds an

unwillingness on the part of various providers to work as a coordinated team to deal with the extreme issues facing her child.

ii. Medicaid Reimbursement for School-Based Services

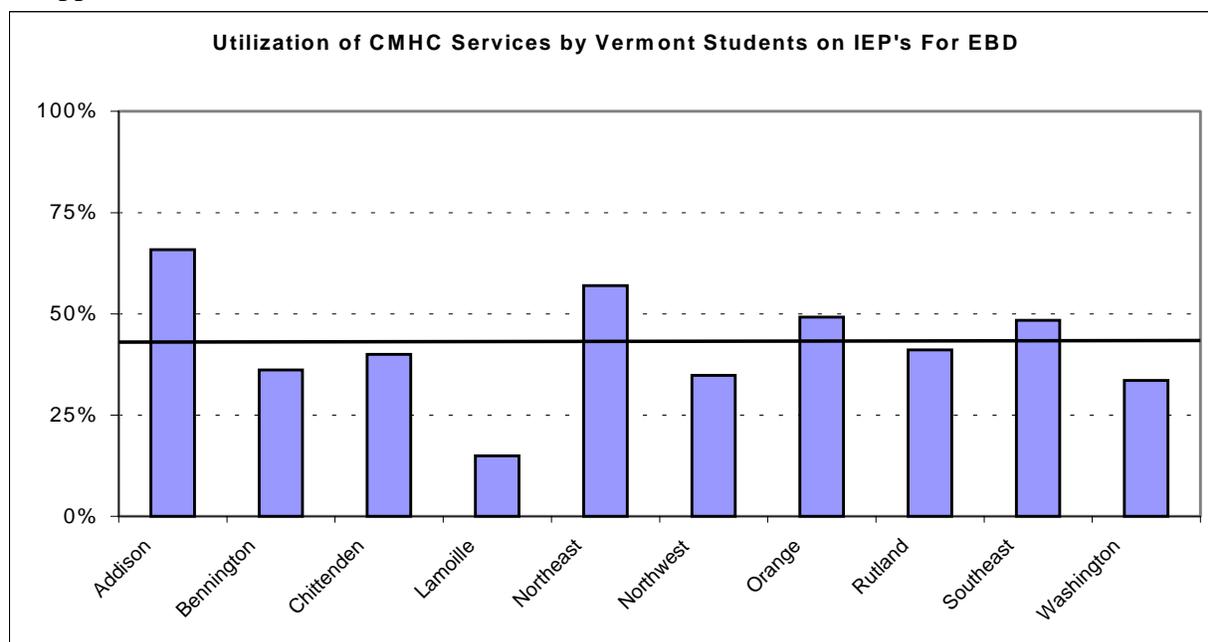
Certain eligible special education expenses are reimbursed by Medicaid at a rate of approximately 60% under a bundled rate system. Schools receive 50% of the funds that are reimbursed under this system. 11% is allocated at the state level to support statewide child care and early math and reading programs, and to support the administration of this school-based program. The remaining 39% is deposited into the Education Fund. For every \$1.00 of eligible expense the local school district receives approximately \$0.30, which can be used for prevention and intervention programs. The Department of Education is currently collecting data on how local schools are utilizing these funds. There is a perception that Medicaid reimbursement provides new funds for special education, and therefore, special education should bear costs of a variety of additional services. This can create confusion on the part of other agencies who perceive these funds as being available for additional special education services and thus eliminating the need to joint-fund services. In fact, these funds are not available to apply to offset special education.

iii. Summary of Existing Barriers

The cases above, as well as the work group discussions, illustrate several barriers that continue to hinder consistent partnership across all divisions and levels of relevant agencies.

a) Regional Differences That Are Relationship Driven

It is evident that there are marked differences across various regions of the state. This is largely a function of the relationships that develop among providers in each region, combined with individual understandings of the roles, responsibilities, and limitations of the each of the partners. Success results from a willingness to work collectively and creatively to move beyond the apparent limitations.



Evidence of the differences across regions is illustrated in the chart above which shows, by region, the utilization of services from Community Mental Health Centers (CMHC) by students who are on IEP's for Emotional/Behavior Disability. The range is from 15% in Lamoille to 66% in Addison, while the statewide average is 43%.

Almost every family of a disabled child finds the process of accessing needed services from the array of various programs and providers arduous. Whether the result is one of continued frustration and settling for a less than optimal array of services, or is one of grudging satisfaction and feeling the most appropriate services are being provided, depends very much on where you live and who the particular individuals addressing your case happen to be. There is not a framework that is reliable system-wide to ensure successful service provision for all children. The Interagency Agreement should provide that framework.

b) Lack of Consistent Service as Children Age

Pre-school programs are generally family-focused and offer an array of wrap-around services that families find easy to access. As the child moves higher into the education system, the focus changes: parents must now more actively seek each service and funding from the array of providers. When true coordination and collaboration, including funding, is present this system works extremely well and the process for participants is successful. Where a partnership is not present, the system is fragmented, and the process is difficult and more likely to result in a less successful outcome for the child. As the child moves into high school, there is limited access to SRS funding and services for troubled adolescents, a significant portion of whom are children with disabilities, particularly emotional behavioral disturbance. There are limited comprehensive services for older juvenile offenders or "unmanageable" adolescents.

c) Fragmented Programs That Don't Facilitate Access

Eligibility depends on the program you are trying to access. Some are income-based, some require specific diagnoses which can be problematic in young children, given the nature of the cases. There are few and time-limited family-based intervention services. There are inconsistencies across the procedures and practices of various agencies that result in the perception that some agencies are not timely in responding to applications and requests.

d) Lack of Support for Traditional Families

There is a perception that children in traditional family settings may have less access to services than children in state custody. In the extreme, there are concerns that this creates a perverse incentive for parents to transfer custody of children to the state as the only means of obtaining services.

e) Inflexibility

There is often a perception that agencies can adhere rigidly to interpretations for philosophical reasons, or as a means of avoiding participation in joint-funding of services. An example offered by the work group includes DMH opposition to out-of-state placement, and reliance on a limited number of in-state programs which can result in significant delays for children receiving services.

f) Duplicative Case Management Services At The Expense Of Direct Services

Case management is the service area where the largest amount of DDMHS funding is expended; case management is also a large component of special education. Case managers do not always coordinate their efforts and, in some cases, can seem to be pitted against each other. An example is when a social services case manager recommends that parents sue local school districts in order to ensure that certain services are paid for by the school because there are no funds available within an agency to directly provide the services. This dynamic clearly erodes collaboration and partnership.

A new model for case coordination is the Green Mountain Family Network Project. The federally funded project will develop a pool of Independent Service Brokers with direct experience with disabilities who can help families who self-manage their care to be informed about all available resources, services, and opportunities. It will also build a cross-disability network of peer support for parents with disabilities to strengthen their ability to keep their children out of state custody, and develop greater regional capacity for peer and other natural support and advocacy networks. The project's plan of action has five components:

- engage the consumer-directed Vermont Family Council as the project steering committee;
- award, monitor, and evaluate grants to three to six regions to strengthen regional family support capacity;
- substantially strengthen regional and statewide peer support for parents with physical and cognitive disabilities;
- develop and deliver training and technical assistance to prepare a core of highly qualified Independent Service Brokers and enhance the ability of family support facilitators, Independent Service Brokers, developmental service workers, Social and Rehabilitation Services (SRS) workers, and others to support parents with disabilities; and
- evaluate all aspects of the grant in light of its systems change objectives, the desired benefits/results, and its impact on improving case management.

g) Turnover and Training Issues

The issue of turnover and training is a concern to both the education community as well as human service providers. Low wages for aides, mental health workers, and developmental services providers result in a significant and frequent turnover of staff that impacts on the stability of treatment teams.

D. Recommendations for Interagency Coordination

In order to ensure that children with disabilities receive, in a cost-efficient and effective manner, all the services and supports they require to reach the same goals as their non-disabled peers, the special education system must have strong, enduring partnerships with human service agencies and community service providers. Successful interagency collaboration and coordination requires that all partners participate programmatically and fiscally in the provision of services.

The barriers that prevent or breakdown coordination will continue to arise. This report offers the following recommendations to help ensure that interagency coordination in the provision of special education services.

Recommendation 1 – Renewal of Interagency Agreement

The current Interagency Agreement (IA) expires on June 30, 2001. The federal law requires that an IA or other mechanism be in place for the provision of special education services. The Interagency Agreement should provide the framework for identifying the roles and responsibilities of the various state agencies in regard to special education services, including the funding of these services. It should encompass all aspects of special education, including transition services, and should provide mechanisms for resolving funding disputes

Partnership should be a priority of both leadership and field staff at all levels of each agency, department and division. Implementation of a new IA should include a plan for continuous education/updating on roles and responsibilities of the various partners.

Recommendation 2 – Comprehensive Study For Transition Planning

Transition planning should be a priority of leadership in the Agency of Human Services and the Department of Education and the Department of Employment and Training. A comprehensive study should be commissioned and funded that projects the needs of disabled students entering adulthood, with a focus on what is needed to support their needs as they move from the entitlement of special education into the fragmented categorical nature of the adult services system and independent living and employment. Such a study would provide the basis for continued strategic planning so the consideration of the long-term (3-5 years) funding needs for transition services becomes an institutionalized practice for AHS.

Recommendation 3 – Act 264 Model for Other Disability Categories

Act 264 is the statutory requirement for interagency coordination for services to children with severe emotional disturbances. This legislation helps ensure that, at all levels, there is strong coordination across all public agencies that have an interest in serving an eligible child. A similar structure does not current exist for other disabilities. There should be a public policy discussion to determine if a similar statutory model is needed for other severe and high intensity disabilities.

Recommendation 4 – Establish Best Practice Agreement on Case Management

Case management is the service area where the most funding is expended by DDMHS and others. Case management services are a significant element of special education. Questions remain as to whether case management service are duplicative at the expense of direct services. Do clients have to interact with too many case managers? Are case management services coordinated across agencies? Can case management service be funded by other ways: perhaps through EPSDT instead of waiver slots for example? Or at the other extreme, are there no case management services provided in some cases? Are case mangers trained regarding interagency coordination? Do they have knowledge of other programs? The establishment of best practice for case management services should be a goal of both the General Assembly and the Administration.

Recommendation 5 – Replication of Successful Local Models

There are regional differences in how comprehensively and successfully special education services are provided. These differences are a result of different programs and practices developed and supported at the local community level. There should be a mechanism that encourages the replication of successful regional models for service provision. This mechanism should recognize that successful replication incorporates flexibility to accommodate the differing cultures and histories of each unique region.

Recommendation 6 – Identify Federal Barriers

Vermont should support and participate in a multi-state effort to identify federal barriers that prevent strong interagency collaboration and coordination in the provision of services to children with disabilities. Vermont should vigorously press for changes at the federal level that would eliminate barriers, encourage collaboration, and increase federal funding for special education and services for the disabled.

Appendix

Federal Definition of Related Services

WAIS Document Retrieval[Code of Federal Regulations]
 [Title 34, Volume 2, Parts 300 to 399]
 [Revised as of July 1, 1999]
 From the U.S. Government Printing Office via GPO Access
 [CITE: 34CFR300.24]

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TITLE 34--EDUCATION

PART 300--ASSISTANCE TO STATES FOR THE EDUCATION OF CHILDREN WITH DISABILITIES--Table of Contents

Subpart A--General

Sec. 300.24 Related services.

(a) General. As used in this part, the term related services means transportation and such developmental, corrective, and other supportive services as are required to assist a child with a disability to benefit from special education, and includes speech-language pathology and audiology services, psychological services, physical and occupational therapy, recreation, including therapeutic recreation, early identification and assessment of disabilities in children, counseling services, including rehabilitation counseling, orientation and mobility services, and medical services for diagnostic or evaluation purposes. The term also includes school health services, social work services in schools, and parent counseling and training.

(b) Individual terms defined. The terms used in this definition are defined as follows:

- (1) Audiology includes--
 - (i) Identification of children with hearing loss;
 - (ii) Determination of the range, nature, and degree of hearing loss, including referral for medical or other professional attention for the habilitation of hearing;
 - (iii) Provision of habilitative activities, such as language habilitation, auditory training, speech reading (lip-reading), hearing evaluation, and speech conservation;
 - (iv) Creation and administration of programs for prevention of hearing loss;
 - (v) Counseling and guidance of children, parents, and teachers regarding hearing loss; and
 - (vi) Determination of children's needs for group and individual amplification, selecting and fitting an appropriate aid, and evaluating the effectiveness of amplification.
- (2) Counseling services means services provided by qualified social workers, psychologists, guidance counselors, or other qualified personnel.
- (3) Early identification and assessment of disabilities in children means the implementation of a formal plan for identifying a disability as early as possible in a child's life.

(4) Medical services means services provided by a licensed physician to determine a child's medically related disability that results in the child's need for special education and related services.

(5) Occupational therapy--

(i) Means services provided by a qualified occupational therapist; and

(ii) Includes--

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(A) Improving, developing or restoring functions impaired or lost through illness, injury, or deprivation;

(B) Improving ability to perform tasks for independent functioning if functions are impaired or lost; and

(C) Preventing, through early intervention, initial or further impairment or loss of function.

(6) Orientation and mobility services--

(i) Means services provided to blind or visually impaired students by qualified personnel to enable those students to attain systematic orientation to and safe movement within their environments in school, home, and community; and

(ii) Includes teaching students the following, as appropriate:

(A) Spatial and environmental concepts and use of information received by the senses (such as sound, temperature and vibrations) to establish, maintain, or regain orientation and line of travel (e.g., using sound at a traffic light to cross the street);

(B) To use the long cane to supplement visual travel skills or as a tool for safely negotiating the environment for students with no available travel vision;

(C) To understand and use remaining vision and distance low vision aids; and

(D) Other concepts, techniques, and tools.

(7) Parent counseling and training means--

(i) Assisting parents in understanding the special needs of their child;

(ii) Providing parents with information about child development; and

(iii) Helping parents to acquire the necessary skills that will allow them to support the implementation of their child's IEP or IFSP.

(8) Physical therapy means services provided by a qualified physical therapist.

(9) Psychological services includes--

(i) Administering psychological and educational tests, and other assessment procedures;

(ii) Interpreting assessment results;

(iii) Obtaining, integrating, and interpreting information about child behavior and conditions relating to learning;

(iv) Consulting with other staff members in planning school programs to meet the special needs of children as indicated by psychological tests, interviews, and behavioral evaluations;

(v) Planning and managing a program of psychological services, including psychological counseling for children and parents; and

(vi) Assisting in developing positive behavioral intervention strategies.

(10) Recreation includes--

(i) Assessment of leisure function;

(ii) Therapeutic recreation services;

(iii) Recreation programs in schools and community agencies; and

(iv) Leisure education.

(11) Rehabilitation counseling services means services provided by qualified personnel in individual or group sessions that focus specifically on career development, employment preparation, achieving independence, and integration in the workplace and community of a student with a disability. The term also includes vocational rehabilitation services provided to a student with disabilities by vocational rehabilitation programs funded under the Rehabilitation Act of 1973, as amended.

(12) School health services means services provided by a qualified school nurse or other qualified person.

(13) Social work services in schools includes--

- (i) Preparing a social or developmental history on a child with a disability;
- (ii) Group and individual counseling with the child and family;
- (iii) Working in partnership with parents and others on those problems in a child's living situation (home, school, and community) that affect the child's adjustment in school;
- (iv) Mobilizing school and community resources to enable the child to learn as effectively as possible in his or her educational program; and
- (v) Assisting in developing positive behavioral intervention strategies.

(14) Speech-language pathology services includes--

- (i) Identification of children with speech or language impairments;
- (ii) Diagnosis and appraisal of specific speech or language impairments;
- (iii) Referral for medical or other professional attention necessary for

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the habilitation of speech or language impairments;

- (iv) Provision of speech and language services for the habilitation or prevention of communicative impairments; and
- (v) Counseling and guidance of parents, children, and teachers regarding speech and language impairments.

(15) Transportation includes--

- (i) Travel to and from school and between schools;
- (ii) Travel in and around school buildings; and
- (iii) Specialized equipment (such as special or adapted buses, lifts, and ramps), if required to provide special transportation for a child with a disability.

(Authority: 20 U.S.C. 1401(22))

Federal Definition of Transition Services

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 [Title 34, Volume 2, Parts 300 to 399]
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TITLE 34--EDUCATION

PART 300--ASSISTANCE TO STATES FOR THE EDUCATION OF CHILDREN WITH DISABILITIES--Table of Contents

Subpart A--General

Sec. 300.29 Transition services.

(a) As used in this part, transition services means a coordinated set of activities for a student with a disability that--

(1) Is designed within an outcome-oriented process, that promotes movement from school to post-school activities, including postsecondary education, vocational training, integrated employment (including supported employment), continuing and adult education, adult services, independent living, or community participation;

(2) Is based on the individual student's needs, taking into account the student's preferences and interests; and

(3) Includes--

(i) Instruction;

(ii) Related services;

(iii) Community experiences;

(iv) The development of employment and other post-school adult living objectives; and

(v) If appropriate, acquisition of daily living skills and functional vocational evaluation.

(b) Transition services for students with disabilities may be special education, if provided as specially designed instruction, or related services, if required to assist a student with a disability to benefit from special education.

(Authority: 20 U.S.C. 1401(30))

Summary List: Special Educators' Responsibilities

As a result of the federal regulatory scope in assigning local education agency responsibility, special education addresses needs in the following service areas:

- ◆ Academic Intervention - access regular education curriculum.
- ◆ EBD program planning and intervention - planning and managing a program of psychological services including counseling for children and parents. Assisting in developing positive behavioral intervention strategies.
- ◆ Parent support and communication - parent counseling and training in understanding and working with the child's disability.
- ◆ Interagency collaboration - social work service including group and individual counseling with child and family. Also, working across home, school and community environments with identified problems that affect the child's adjustment in schools, and "mobilizing school and community resources to enable the child to learn as effectively as possible in his or her educational program".
- ◆ Medical and nursing communication and consultation.
- ◆ Classroom support, communication and partnership.
- ◆ Therapeutic communication and consultation - recreation activities including assessment, therapeutic recreation, programming in school and community, and leisure education.
- ◆ Rehabilitation counseling services access.
- ◆ Transition services which promote movement from school to post-school activities including post-secondary education, vocational training, independent living, community participation, integrated employment and adult services.

Written Testimony Provided by Special Educators and Other School Personnel

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