Don Taylor

Children Come First
Advisory Committee

September 20, 2006

The Children Come First Advisory Committee is pleased to issue the 2005 Annual Report on Wisconsin's Collaborative Systems of Care. The report, prepared by the Wisconsin Bureau of Mental Health and Substance Abuse Services, summarizes the outcomes of collaborative systems of care – also known as "wraparound" systems -- serving children with multiple needs and their families.

Wisconsin has been developing collaborative systems of care since 1989. In 2005, 40 counties operated wraparound systems serving 1,103 children and youth. These initiatives also provided support and services to 2,739 _additional_ family members of the enrolled child – services which may not have been received if not for the family's involvement in a collaborative system of care.

Most importantly, children and youth enrolled in Wisconsin's collaborative systems of care showed improved functioning at home, in school and in the community. Data collected show a reduction in school problems and delinquent acts. Also, 69% percent of families reported they were better able to cope with life and its daily challenges.

The Children Come First Advisory Committee is established by Wisconsin Act 31, Statute 46.56. Its mission is to champion collaborative systems of care for children and their families. For more information on the CCF Advisory Committee and Wisconsin's collaborative systems of care, please visit www.wicollaborative.org.

We hope you find the 2005 Annual Report provides compelling evidence of the value of collaborative systems of care.

Sincerely,

Hugh Davis
Co-chair

Jim Moeser
Co-chair

www.wicollaborative.org/ccf

Children Come First Advisory Committee
2005 Annual Report
On Integrated Services Projects and Coordinated Services Teams

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For additional copies of this report or for more information on
Wisconsin's Collaborative Systems of Care, please visit:
www.wicollaborative.org

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This report is written for the Children Come First Advisory Committee, the group statutorily responsible for monitoring the development of Integrated Services Projects in Wisconsin. This report highlights the accomplishments and challenges faced by collaborative systems of care in Wisconsin, specifically the Integrated Services Projects (ISP) and Coordinated Services Teams (CST).

Wisconsin's collaborative systems of care go by different names: ISP, CST, and "Children Come First" (CCF). All are names of projects which use the wraparound process to respond to children and families with multiple and often serious needs in the least restrictive setting possible. This wraparound process is based on family and community values, is unconditional in its commitment to creatively address needs, and supports community-based options. Each child and family centered team develops an individualized plan, incorporating the strengths of the child, family, and team members to work toward identified goals. Parents/caregivers are equal partners and have ultimate ownership of their Plan of Care.

"People are now looking at what my son can do instead of what he can't do."
Parent comment, 2005 Family Satisfaction Survey

———————— **BACKGROUND** ————————

Wisconsin has been developing collaborative systems of care since 1989. The original initiatives, ISPs, focused on supporting families with children with Severe Emotional Disabilities (SED) in their homes and communities. ISPs receive $80,000 annually in Mental Health Block Grant (MHBG) funds.

In 2002, the collaborative process employed by ISP was expanded with the development of CST. While CST uses the same process as ISP, the target group is broader and includes children and families who do not necessarily have an SED diagnosis but who do have complex needs and are involved in at least two systems of care (e.g., substance abuse, child welfare, juvenile justice, special education, and/or mental health). Funding for CST ranges from about $33,000 to $63,000 annually.

In 2005, 40 ISP/CST projects received funding through contracts with the Bureau of Mental Health and Substance Abuse Services (BMHSAS). The funding came from MHBG funds, Substance Abuse Grant funds, and Hospital Diversion funding. In addition, the Division of Children and Family Services collaborated with BMHSAS to contribute funding for CST sites.

"My input is respected and I feel I am an important part of the team."
Parent comment, 2005 Family Satisfaction Survey

At the end of December 2005, the BMHSAS released a new Request for Proposals (RFP) soliciting additional sites interested in starting CST. This followed funding of all of the 2002 RFP respondents who were interested in beginning CST with the level of funding available at that time. The most recent RFP is offering funding to begin two new CST sites in 2006. In 2007, funding may become available for additional sites.

INTEGRATED SERVICES PROJECTS

Ashland	Kenosha	Rock
Chippewa	La Crosse	Sheboygan
Door	Marinette	Washburn
Dunn	Marquette	Washington
Eau Claire	Portage	Waukesha
Fond du Lac	Racine	Waushara

COORDINATED SERVICES TEAMS
(SITES ADDED 2002 – 2003)

Bayfield	Jefferson	Sauk
Calumet	Manitowoc	Waupaca
Green Lake	Marquette	
Iron	Portage	

COORDINATED SERVICES TEAMS
(SITES ADDED IN 2004)

Adams	Grant*	Polk
Crawford	Lafayette	Richland
Douglas	Pierce	St. Croix

COORDINATED SERVICES TEAMS
(SITES ADDED IN 2005)

Eau Claire	Sheboygan
La Crosse	Washburn

* Grant County is developing its project with limited funds for training and technical assistance

A Snapshot of Children's Mental Health

- One in five young people have at least one diagnosable mental or addictive disorder, according to the U.S. Surgeon General *(U.S. Dept. of Health & Human Services, 2001)*.

- In the U.S. today, 1 in 10 children suffer from a mental disorder serious enough to cause some level of impairment. *(National Institute of Mental Health, 2005)*.

- The high school non-completion rate for children with emotional and behavioral disorders is reported as high as 68%. Even when using lower statistics from other studies, these children have the highest non-completion rate of any disability group and twice the rate of the general population *(Council for Exceptional Children, 2002)*.

- As reported by the President's New Freedom Commission on Mental Health in 2003, 80% of young people in the juvenile justice system have a mental or substance abuse disorder.

- According to the Department of Public Instruction's 2005 Youth Risk Behavior Survey, among high school students:

	Males	Females
Considered suicide	14%	22%
Made a suicide plan	12%	18%
Attempted suicide	7%	11%

- The suicide rate of youth under the age of 25 in Wisconsin is 36% higher than the national average; this is 28% higher than fatalities due to cancer and infectious disease combined in the same age group *(WisKids Count 2005)*.

- Persons with mental health and alcohol and other drug abuse disorders receive more limited health insurance coverage than persons with other illnesses. The Federally mandated *minimum* level of coverage for these disorders has become the *maximum* provided by most insurance plans *(WisKids Count 2005)*.

Integrated Services Projects

Coordinated Services Team Initiatives

Sites with both ISP and CST Initiatives

Wraparound Milwaukee, Children Come First Dane County, and the Northwoods Alliance
(Collaborative Systems that do not have contracts with the Bureau of Mental Health and Substance Abuse Services)
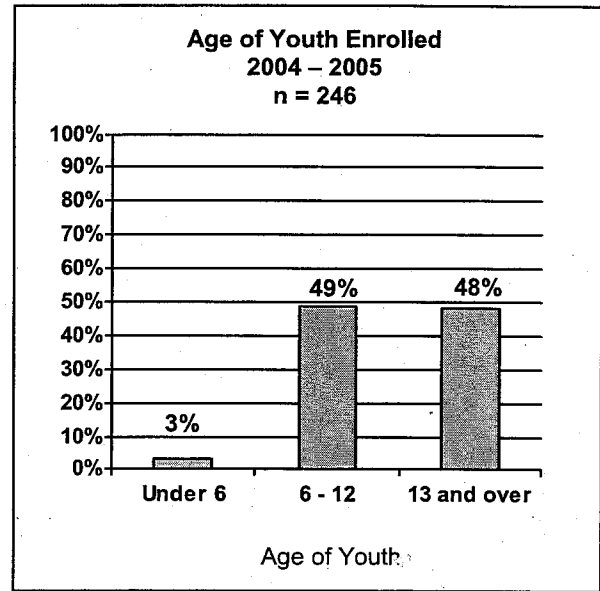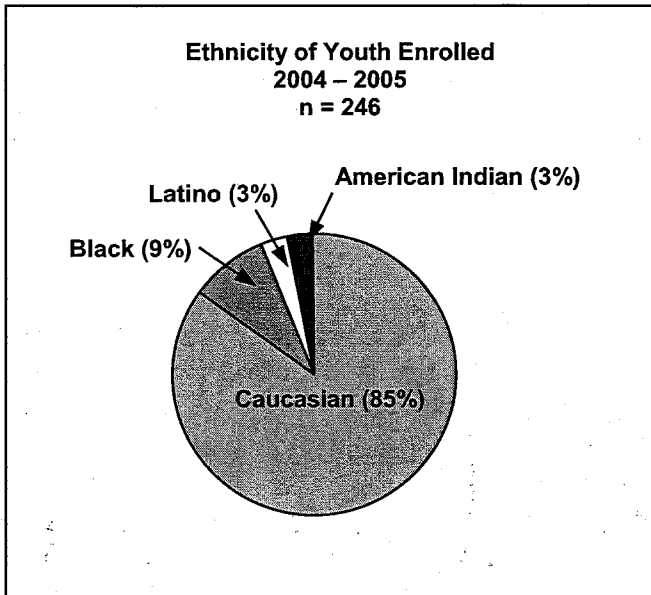
The following information is based on data from sites who submitted data quarterly to the BMHSAS 2004 – 2005.

Demographic Information

Information from 246 youth with SED has been collected from 2004 to 2005. Of these youth, 67% were male and 33% female, with an average age of 11.3 years.
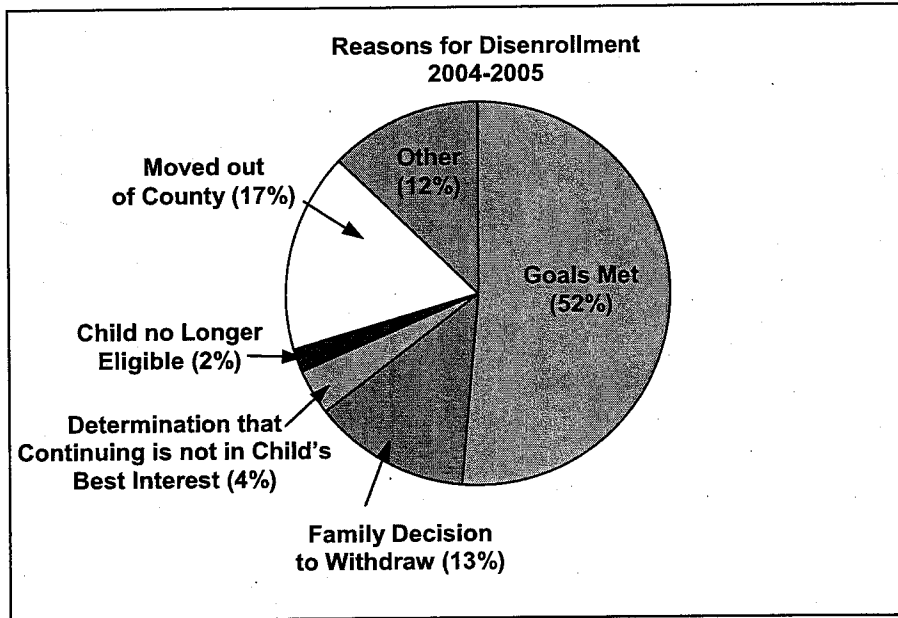
Ethnicity of Youth Enrolled
2004 – 2005
n = 246

Latino (3%)
American Indian (3%)
Black (9%)
Caucasian (85%)

Age of Youth Enrolled
2004 – 2005
n = 246

Under 6	6 - 12	13 and over
3%	49%	48%

Age of Youth

Disenrollment/Transition

The average length of enrollment in ISP/CST in 2004 – 2005 was 19.4 months.

Reasons a child and family may disenroll include:

- **Goals Met:** All team members agree that the goals outlined in the Plan of Care have been met. The family feels they have a voice in decisions made concerning their child & family, access to services they need, and ownership of their Plan of Care.
- **Family Decision to Withdraw:** Families may choose to withdraw for various reasons. Examples include: team support is no longer desired by the family due to a family situation change; family believes there is a less intensive way to get their needs met, etc.
- **Moved out of County:** If the child is no longer a resident of the county, he/she may no longer be eligible to receive services from that county.
- **Child no Longer Eligible:** A child is no longer eligible for ISP/CST if he/she no longer meets criteria for Severe Emotional Disturbance (SED), and/or the child no longer meets age requirements.
- **Determination that Continuing is not in the Child's Best Interest:** A team makes a decision to end ISP/CST for reasons which may include: goals aren't being met, team process isn't moving forward, or team lacks trust or cooperation among members.
- **Other:** This category serves as a "catch all" for reasons that do not clearly fit into other categories.
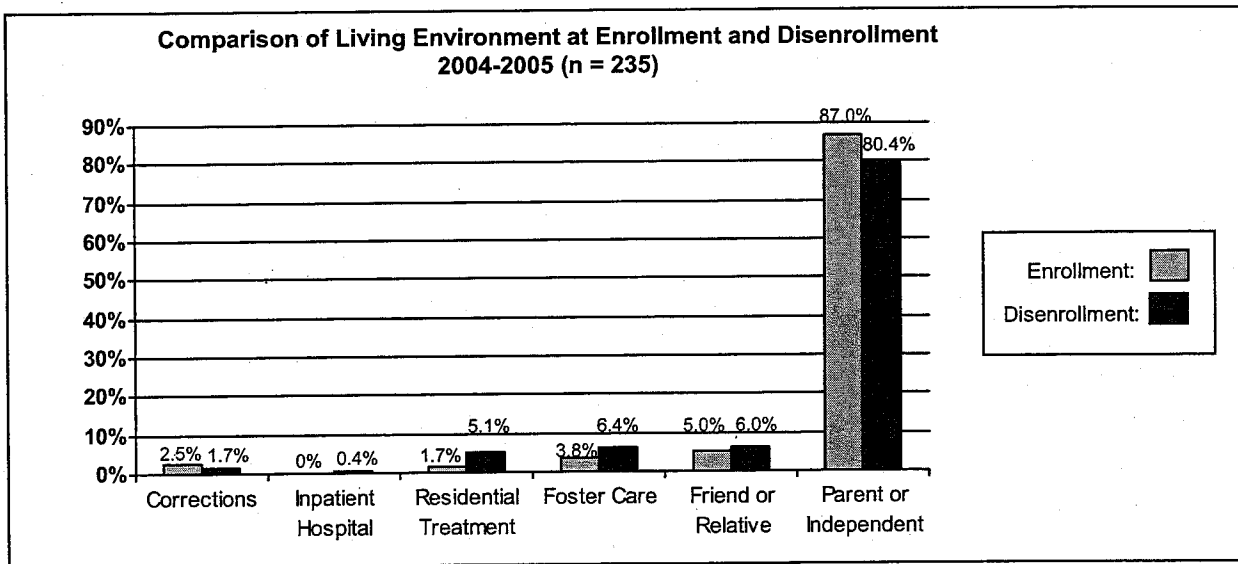
The chart on the next page summarizes reasons for disenrollment in 2004-2005:

**Reasons for Disenrollment
2004-2005**

- Moved out of County (17%)
- Other (12%)
- Goals Met (52%)
- Child no Longer Eligible (2%)
- Determination that Continuing is not in Child's Best Interest (4%)
- Family Decision to Withdraw (13%)

Changes in Restrictiveness of Living Environment: 2004-2005

One characteristic of youth enrolled in ISP/CST is that they are at risk of out-of-home placement. This risk is determined by many factors including: past out-of-home placements, behavior not improving despite multiple supports and services, or parents and service providers are considering placement at time of referral. ISP and CST strive to support youth and their families in the least restrictive setting possible.

The chart below shows a comparison of living environments at time of enrollment and disenrollment. Please note the data reflects the living environments of all children at time of disenrollment regardless of reason for disenrollment (Goals Met = 52%; Other, Moved out of County, Child no Longer Eligible, etc. = 48%).

**Comparison of Living Environment at Enrollment and Disenrollment
2004-2005 (n = 235)**

	Corrections	Inpatient Hospital	Residential Treatment	Foster Care	Friend or Relative	Parent or Independent
Enrollment	2.5%	0%	1.7%	3.8%	5.0%	87.0%
Disenrollment	1.7%	0.4%	5.1%	6.4%	6.0%	80.4%

Functioning at Home, School, and in the Community

One of the tools used to collect data is the Child and Adolescent Functional Assessment Scale (CAFAS). The CAFAS is a nationally recognized instrument developed by Kay Hodges, Ph.D., which provides a "behavioral snapshot" of a child's functioning across eight subscales: role performance at school, role performance at home, role performance in the community, behavior toward others, moods and emotions, self-harmful behaviors, substance use, and thinking. Changes over time in individual subscale scores, as well as changes in total scores, serve as indicators to teams of where a child has improved and where additional planning is needed.

Sites are asked to rate youth using the CAFAS at enrollment and every six months thereafter. The rater, using information gathered from the family, natural supports, and service providers, considers a variety of possible indicators to assign a score of 0, 10, 20, or 30 on each of the eight subscales listed above, with 0 indicating *no impairment* and 30 indicating *significant impairment*.

Results of averaging all CAFAS scores collected for each subscale during the years 2004 to 2005, regardless of when a child's treatment began or ended or when the CAFAS was administered, show that children enrolled in ISP/CST have the most impairment at home and school (subscale scores were 19.0 and 18.7, respectively). Children have the least impairment in the areas of self-harm behavior and substance use (subscale scores were 7.8 and 2.5, respectively).

The total score on the CAFAS (sum of all subscale scores) can range from 0 to 240.The chart that follows illustrates Dr. Hodges' interpretation of a youth's total score:

	*CAFAS Scoring: Total Score**
8-Scale Sum	*Description*
0 – 10	*No noteworthy impairment*
20 - 40	*Youth can likely be treated on an outpatient basis*
50 - 90	*Youth may need additional services beyond outpatient care*
100 - 130	*Youth likely needs care which is more intensive than outpatient and/or which includes multiple sources of supportive care*
140+	*Youth likely needs intensive treatment, the form of which would be shaped by the presence of risk factors and the resources available within the family and the community*
Taken from "CAFAS Self-Training Manual", Kay Hodges, PhD.	

Changes in Overall CAFAS Scores at Points in Time: The following graph reflects youth served 2003 – 2005 (n=285). Note that the data is not a matched sample. The data are reported CAFAS scores at enrollment, 6 months after enrollment, and 12 months after enrollment. The data show a meaningful (26 percent) reduction in problem severity and corresponding improvements in functioning during that time period.

Change in CAFAS Scores Over Time
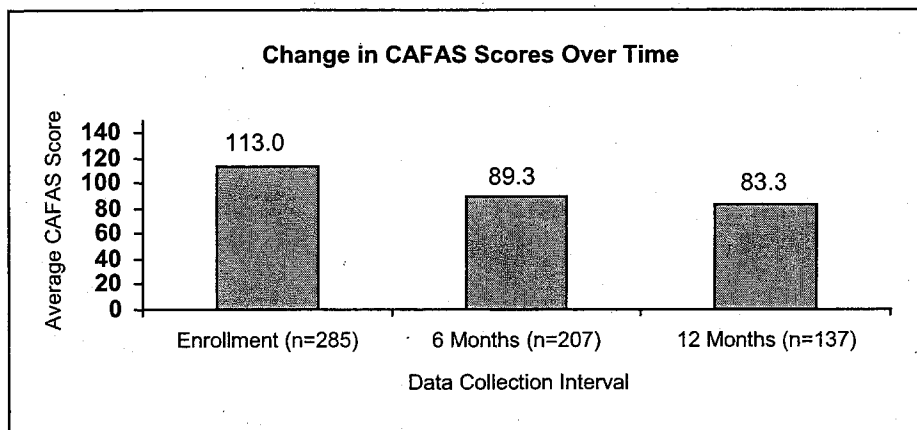
Changes in Educational Scores at Points in Time: The **School subscale** of the CAFAS measures school functioning based upon grades, attendance, special education needs, behavior toward other children, and behavior toward teachers and other school authority figures. Subscale scores range from 0 (no impairment) to 30 (severe impairment). The following graph presents changes in school subscale scores over time. The data show a meaningful (21 percent) reduction in school problem severity and corresponding improvements in school functioning from enrollment through 12 months after enrollment.

Change in School Subscale Scores Over Time

Data Collection Interval	Average CAFAS Score
Enrollment (n=285)	22.2
6 Months (n=207)	16.7
12 Months (n=137)	17.6
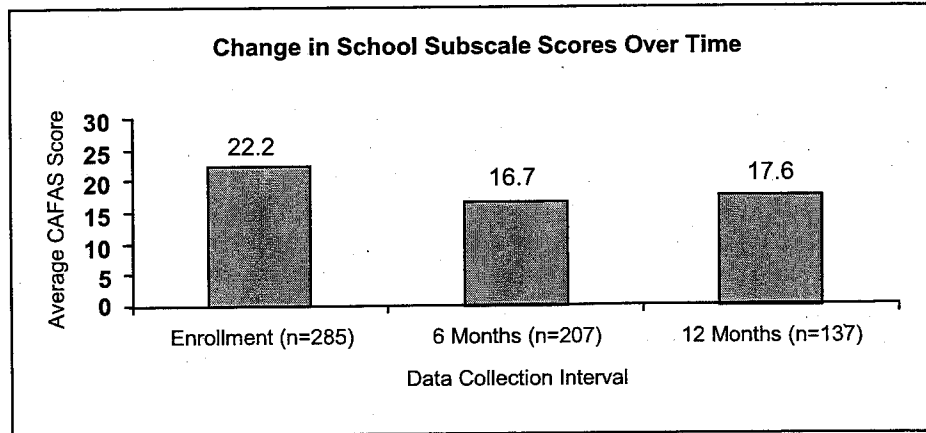
Changes in Delinquency Scores at Points in Time: The **Community subscale** of the CAFAS measures levels of delinquency based upon the frequency, type, and severity of delinquent acts. Subscale scores range from 0 (no impairment) to 30 (severe impairment). The following graph presents changes in community subscale scores over time. The data show a meaningful (28 percent) reduction in delinquency severity and corresponding improvements in community functioning from enrollment through 12 months after enrollment.

Change in Community Subscale Scores Over Time

Data Collection Interval	Average CAFAS Score
Enrollment (n=285)	11.4
6 Months (n=207)	9
12 Months (n=137)	8.2
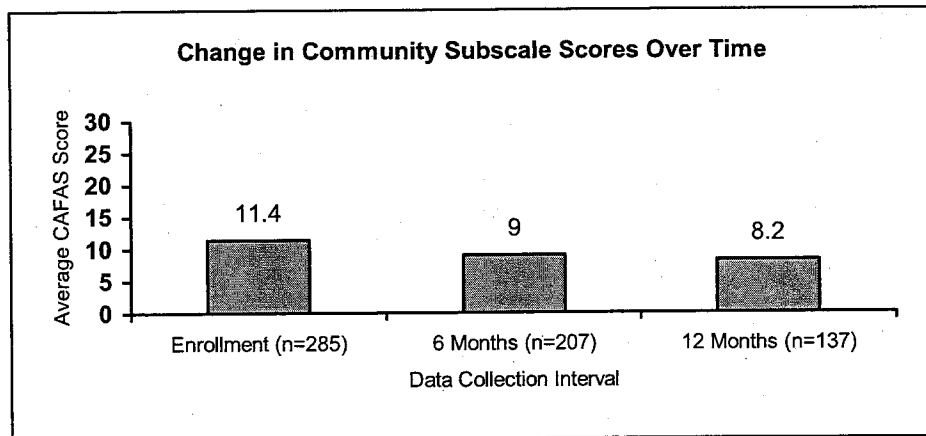
Counties with ISPs and CSTs are asked to complete an annual survey to capture information on enrollment (summarized in Part A of this section) and the impact of their collaborative initiative on the larger service system (summarized Part B of this section).

The following incorporates data submitted by 34 sites that completed the survey (16 ISP, 16 CST, and 2 that have both ISP and CST).

For information on Wraparound Milwaukee, Children Come First Dane County, and the Northwoods Alliance (Collaborative Systems of Care in Wisconsin that do not have contracts with the Bureau of Mental Health and Substance Abuse Services), please see the following websites:

Wraparound Milwaukee: http://www.co.milwaukee.wi.us/ click on "Info on Health & Human Services", Behavioral Health Division", then "Wraparound Milwaukee"

Children Come First Dane County: www.community-partnerships.org

PART A: Enrollment Information

The number of child and family teams for which evaluation data is collected and reported to the State is only a partial indicator of the actual number of individuals served by collaborative systems of care in Wisconsin. Each site collects evaluation data on only a portion of the children served due to resource constraints. The child and family teams for which sites collect and report evaluation data to the State are referred to as "formal enrollments"; the additional child and family teams served by each site are referred to as "informal enrollments". "Informal" teams are expected to adhere to the same key principles and values as "formally" enrolled teams, but are not required to send evaluation data to the BMHSAS.

Formal Enrollment

In 2005 there were **656** formally enrolled teams reportedly being served by CST and ISP across Wisconsin. The average length of enrollment per child and family team was 17 months. The average number of formally enrolled teams per county was 19, ranging from two in a site just starting out to 87 teams in a well-established site. The graph below summarizes the number of formally enrolled teams over the past 5 years:

Formally Enrolled Child & Family Teams 2001 - 2005

Year	Teams
2001	402
2002	418
2003	500
2004	556
2005	656
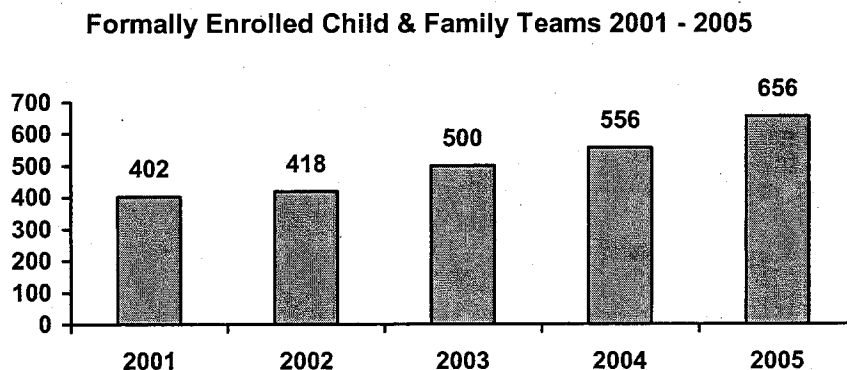
Informal Enrollment

In 2005, CST and ISP sites reported serving **447** "informal" teams. The graph below summarizes teams served "informally" over the past 5 years:

Informal Child & Family Teams 2001 - 2005
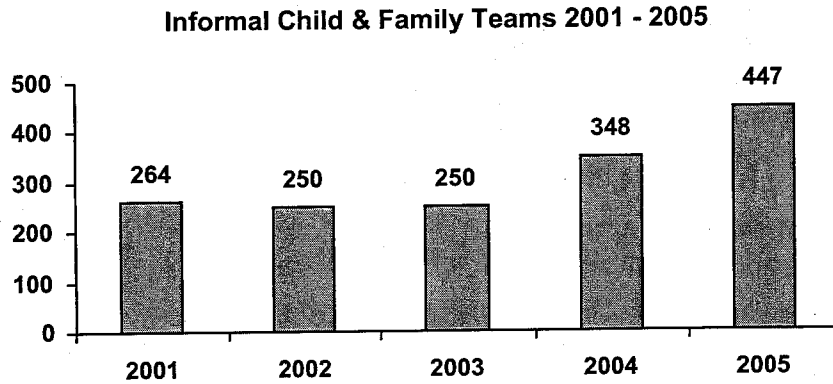
Total Children and Family Members Served

In addition to identifying the number of teams/identified children served, sites were asked to report the number of family members other than the identified child who received support and services that they may not have received had the family not been involved in the team process. In 2005 there were **2,739** additional family members served, an average of 80 people per site and 2.5 family members per team.

The total number of children and family members served in 2005 was **3,842** (1,103 children and 2,739 additional family members). The graph below summarizes the total number of children and family members served over the past five years.

Total Number of Children & Family Members Served by Teams 2001 - 2005
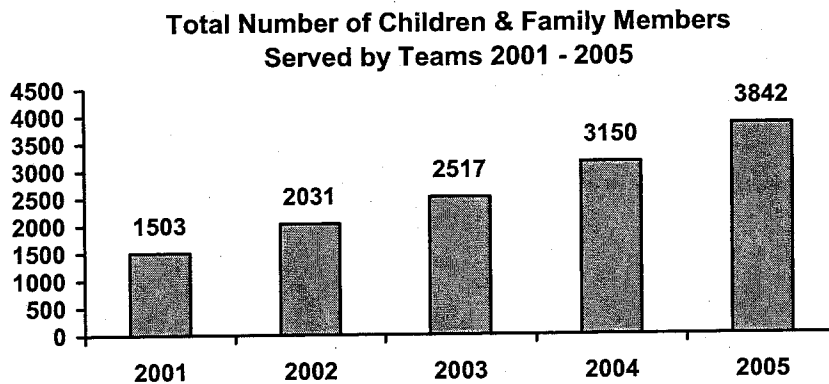
Referral Source

The chart below summarizes sources of referrals made to Collaborative Systems of Care in 2005.
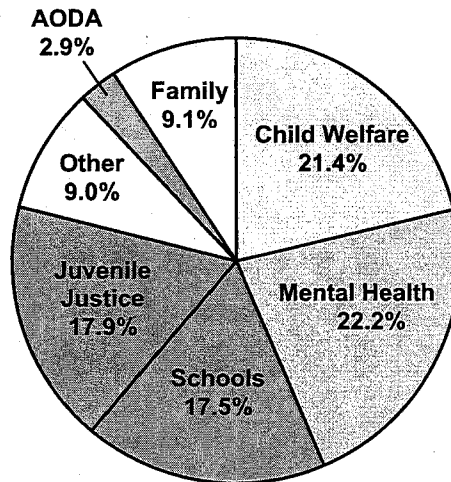
PART B: Impact of Collaborative Systems of Care on the Larger Service System

Counties with ISP and/or CST are asked to fill out an annual "Collaborative Systems of Care Update" survey that captures information on the impact of the collaborative initiative on the larger service system.

Sites were asked to share their comments and recommendations in the following four areas:
- The positive and/or negative impacts of ISP/CST on other parts of the child and family service delivery system
- The cost effectiveness of ISP/CST
- Concerns, issues, and challenges
- Recommendations for improvement

Below is a summary of the most common responses to each question from the **32** sites that completed the survey. For a more complete summary including site comments, please visit www.wicollaborative.org (click on "Resources", "Data & Statistics", then "System Update 2005").

1. **How has the formal collaborative system of care (ISP/CST) positively or negatively impacted other parts of the child and family service delivery system in your county?**

   Positive Impacts:

   Ten sites identified the expansion of the coordinated team process as a "way of doing business" throughout the service system.

   Ten sites identified increased collaboration between agencies & with families.

   Nine sites identified provider and family satisfaction with services.

   Nine sites identified specific positive impacts on children & families, such as less police involvement and improved transitions to adult services.

Negative Impacts

Only one site expressed a "negative impact": "the child is not as involved/vested as others on the team".

2. Is supporting the children and families in your ISP/CST cost effective?

Twenty-eight sites identified financial savings.

Four sites commented they were too new to the process to realize monetary savings.

3. What concerns, issues, and challenges do you identify?

Six counties identified community education on CST and buy-in/commitment from partners.

Five counties identified sustainability and expansion issues.

Five counties identified team process issues such as attendance, commitment, and keeping the process strength-based.

Five counties identified lack of specific services in the community such as mental health, respite, and transportation.

4. What recommendations do you make to improve your ISP process?

Nine counties identified a need for ongoing training and education.

Five counties identified the need for expansion of their coordinating committees.

Each year, families enrolled in ISP and CST across the state are asked to complete a Family Satisfaction Survey. The survey gathers information from a family perspective about areas of strength and need in collaborative systems of care serving children and families in Wisconsin. To encourage honest responses and to help ensure confidentiality, the surveys are distributed with stamped, addressed envelopes that can be returned directly to Wisconsin Family Ties, a not-for-profit advocacy organization that tabulates the results.

The survey consisted of 12 statements regarding satisfaction with different areas of the collaborative family team process. Families were asked to rate each statement using one of the following options:

1 – Strongly Disagree
2 – Disagree
3 – Undecided
4 – Agree
5 – Strongly Agree
Not Applicable

209 surveys were returned and tabulated in 2005, a 39.6% return rate. This compares with 205 surveys returned in 2004 (a 48.8% return rate), and 151 surveys returned in 2003 (a 47.6% return rate).

Following is a summary comparing 2003, 2004, and 2005 results:

1. I feel I am treated as an important member of my child and family team.
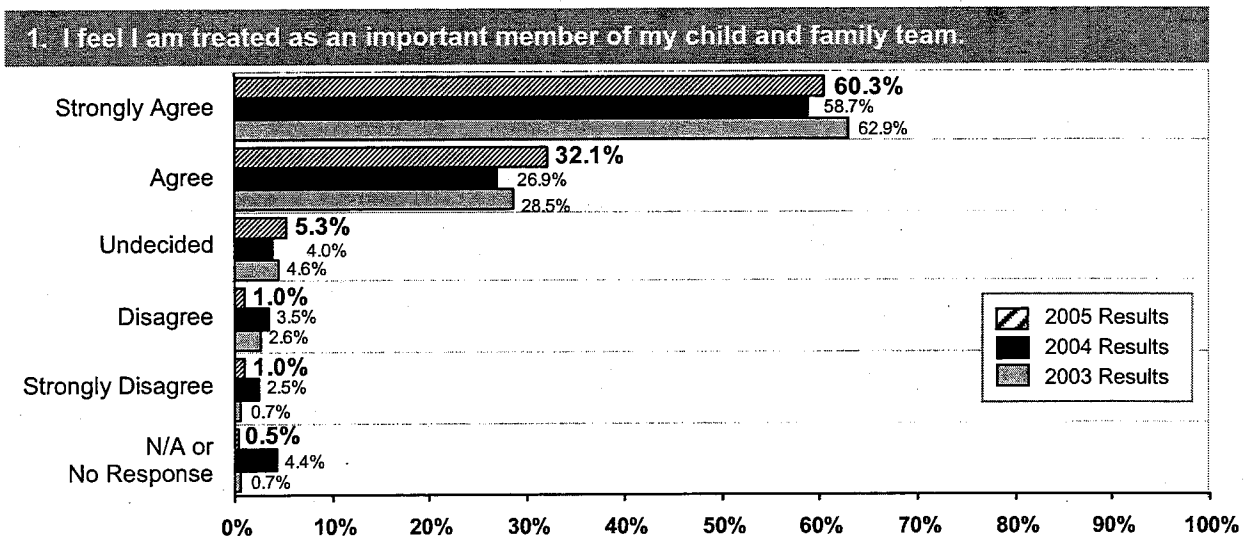
2. I am satisfied with the goals the team and I have set.

	2005 Results	2004 Results	2003 Results
Strongly Agree	47.4%	43.8%	45.7%
Agree	36.4%	41.3%	37.7%
Undecided	13.4%	9.0%	11.3%
Disagree	1.0%	3.0%	3.3%
Strongly Disagree	1.0%	2.0%	1.3%
N/A or No Response	1.0%	1.0%	0.7%

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
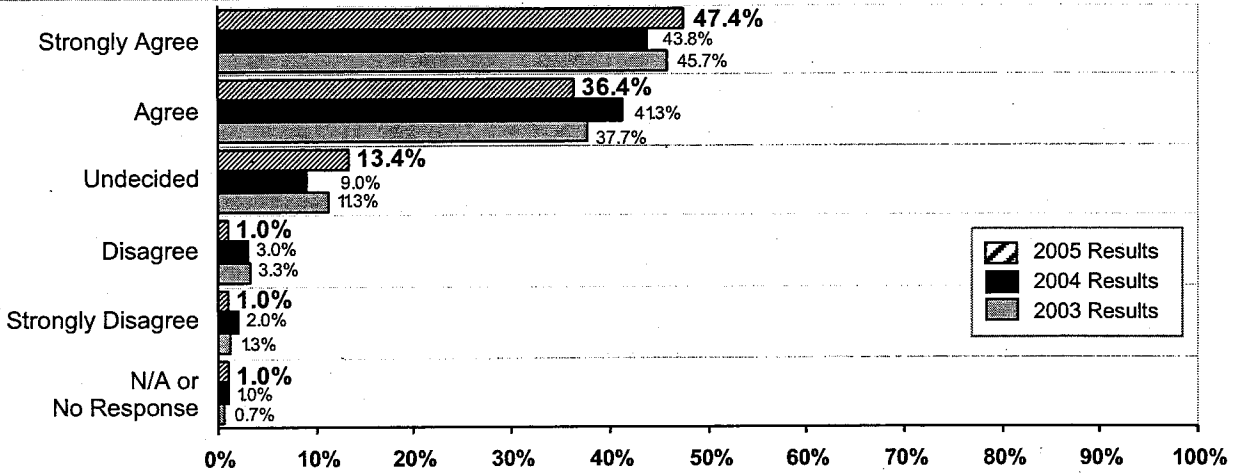
3. The team takes time to listen to my concerns.

	2005 Results	2004 Results	2003 Results
Strongly Agree	58.4%	58.7%	57.6%
Agree	31.1%	30.3%	33.8%
Undecided	7.7%	6.0%	6.0%
Disagree	1.4%	1.5%	1.3%
Strongly Disagree	0.5%	3.0%	0.7%
N/A or No Response	1.0%	0.5%	0.6%

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
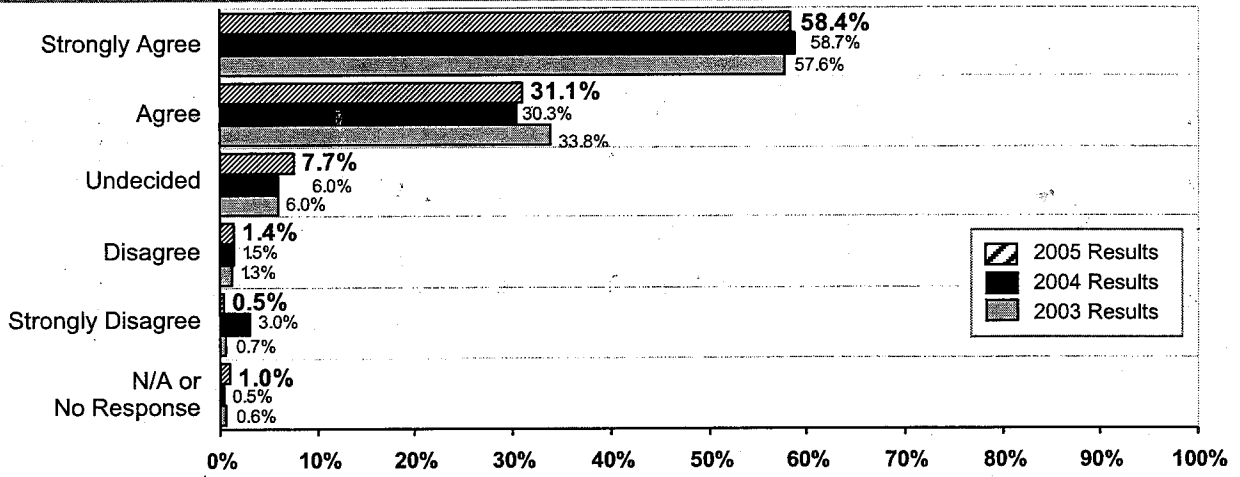
4. My family is getting better at coping with life and its daily challenges.

	2005 Results	2004 Results	2003 Results
Strongly Agree	30.6%	29.8%	21.2%
Agree	38.8%	43.3%	45.7%
Undecided	20.1%	17.4%	24.5%
Disagree	6.7%	2.5%	2.6%
Strongly Disagree	2.9%	4.5%	4.0%
N/A or No Response	1.0%	2.5%	2.0%

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
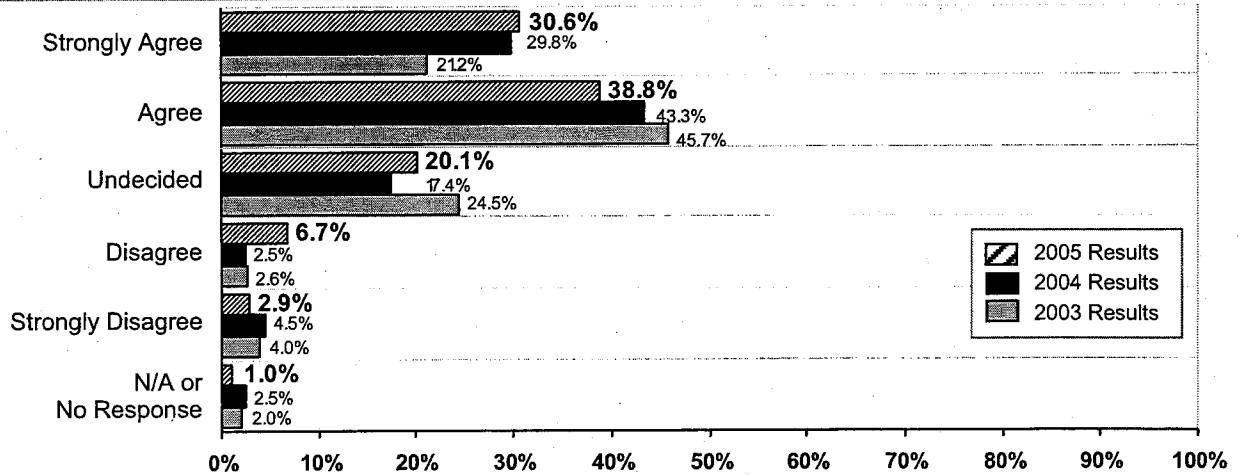
5. I would refer another family/child to the Integrated Services Project

Response	2005	2004	2003
Strongly Agree	57.9%	58.7%	60.9%
Agree	30.6%	29.3%	29.8%
Undecided	5.7%	5.5%	4.0%
Disagree	2.4%	2.0%	0.7%
Strongly Disagree	2.4%	4.0%	4.0%
N/A or No Response	1.0%	0.5%	0.6%

Legend:
- 2005 Results
- 2004 Results
- 2003 Results
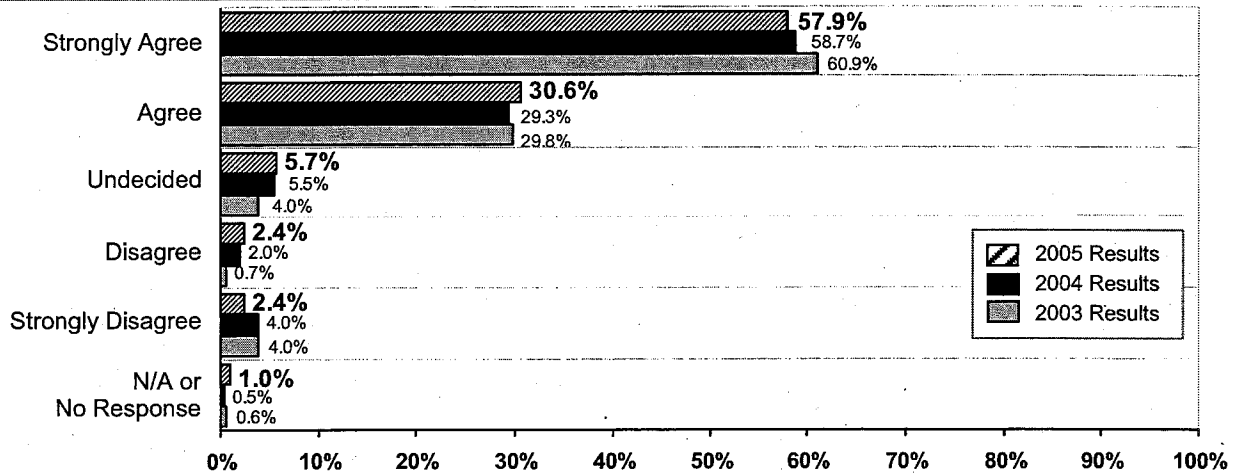
6. My care coordinator speaks up for my child and family.

Response	2005	2004	2003
Strongly Agree	58.4%	58.7%	57.6%
Agree	27.8%	30.3%	33.8%
Undecided	7.7%	6.0%	6.0%
Disagree	2.9%	1.5%	1.3%
Strongly Disagree	1.9%	3.0%	0.7%
N/A or No Response	1.4%	0.5%	0.6%

Legend:
- 2005 Results
- 2004 Results
- 2003 Results
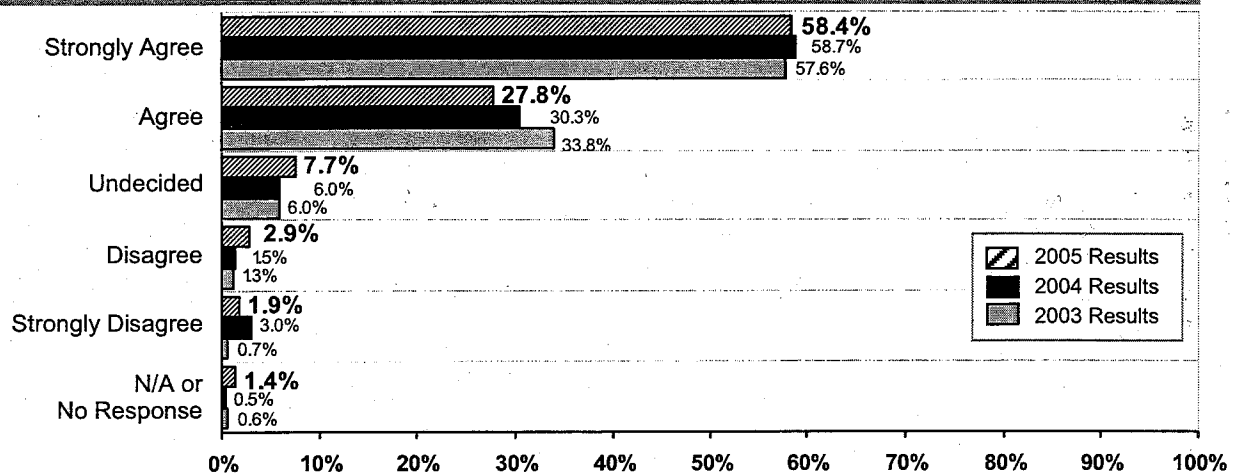
7. The team is sensitive to my cultural, ethnic, and religious preferences and values.

Response	2005	2004	2003
Strongly Agree	48.3%	46.3%	47.7%
Agree	39.2%	31.8%	39.1%
Undecided	9.6%	13.9%	7.3%
Disagree	0.5%	2.0%	1.3%
Strongly Disagree	0.5%	3.5%	1.3%
N/A or No Response	1.9%	2.5%	3.3%

Legend:
- 2005 Results
- 2004 Results
- 2003 Results
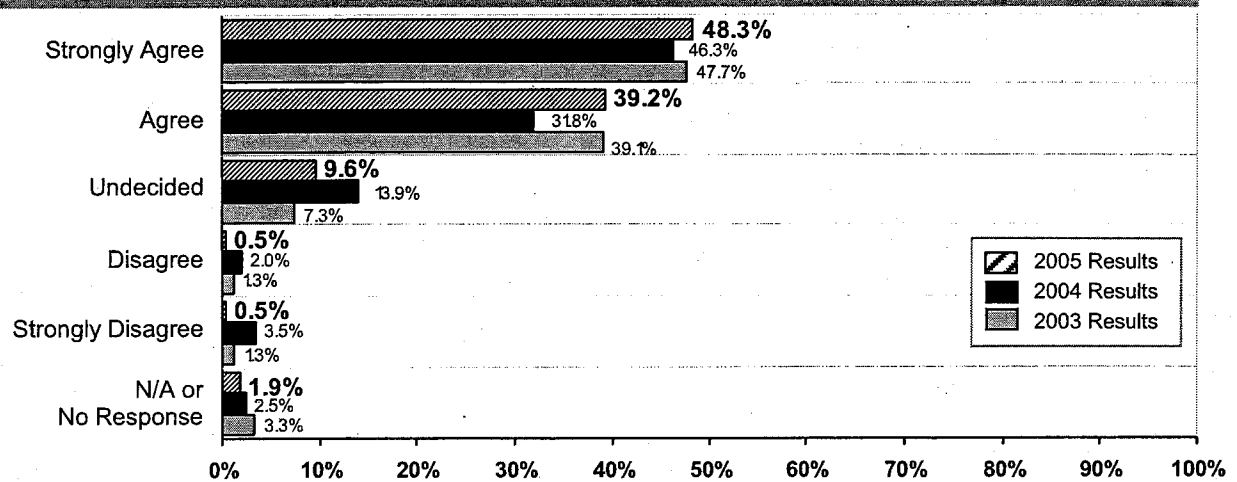
8. The team schedules services and meetings at times that are convenient to my family.

Strongly Agree	**60.8%** / 57.2% / 62.9%
Agree	**30.6%** / 33.3% / 31.3%
Undecided	**6.2%** / 5.0% / 2.6%
Disagree	**0.5%** / 1.0% / 1.3%
Strongly Disagree	**1.0%** / 3.0% / 0.6%
N/A or No Response	**1.0%** / 0.5% / 1.3%

Legend:
- 2005 Results
- 2004 Results
- 2003 Results

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
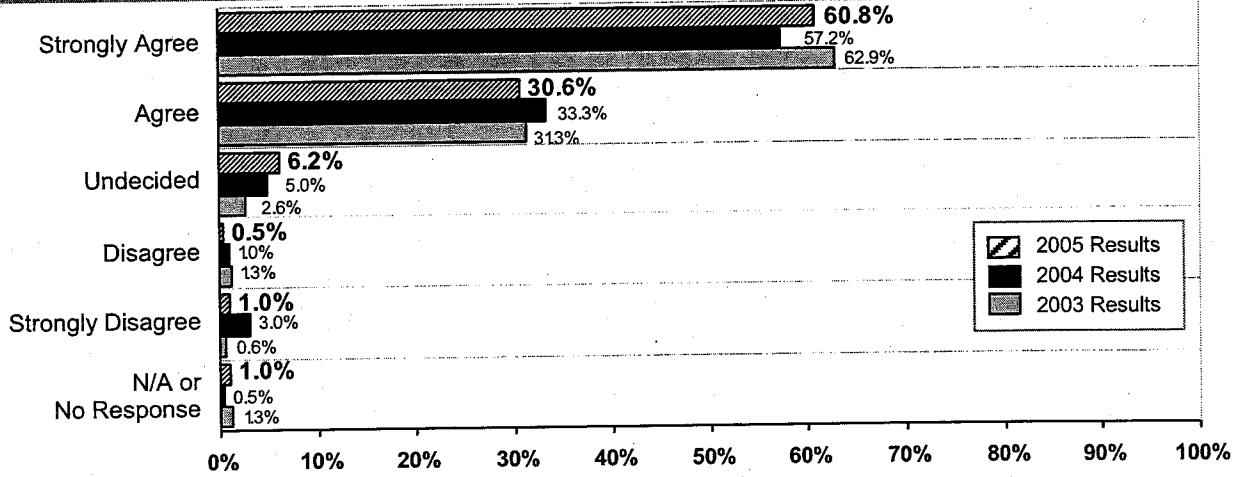
9. If my child is 14 or older there is a plan to insure access to needed services when 18.

Strongly Agree	**11.5%** / 10.5% / 4.6%
Agree	**12.4%** / 11.4% / 11.9%
Undecided	**13.9%** / 10.9% / 12.6%
Disagree	**4.3%** / 4.5% / 6.6%
Strongly Disagree	**3.3%** / 5.5% / 2.6%
N/A or No Response	**54.5%** / 57.2% / 61.7%

Legend:
- 2005 Results
- 2004 Results
- 2003 Results

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
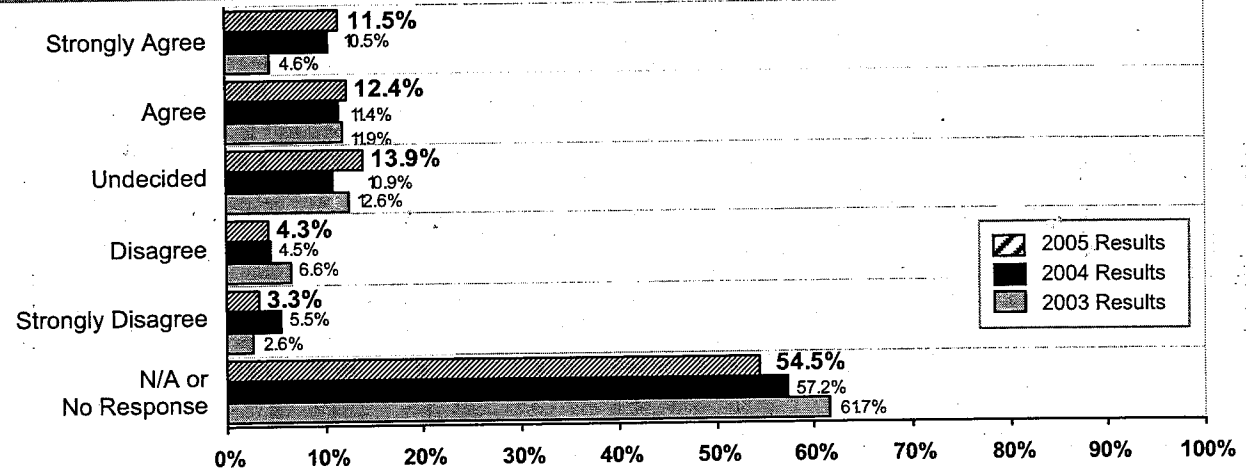
10. I feel the team understands my child's strengths and needs.

Strongly Agree	**45.0%** / 40.8% / 41.1%
Agree	**39.0%** / 39.3% / 45.0%
Undecided	**10.0%** / 7.4% / 7.9%
Disagree	**3.0%** / 4.5% / 4.6%
Strongly Disagree	**1.0%** / 2.5% / 0.7%
N/A or No Response	**2.0%** / 5.5% / 0.7%

Legend:
- 2005 Results
- 2004 Results
- 2003 Results

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
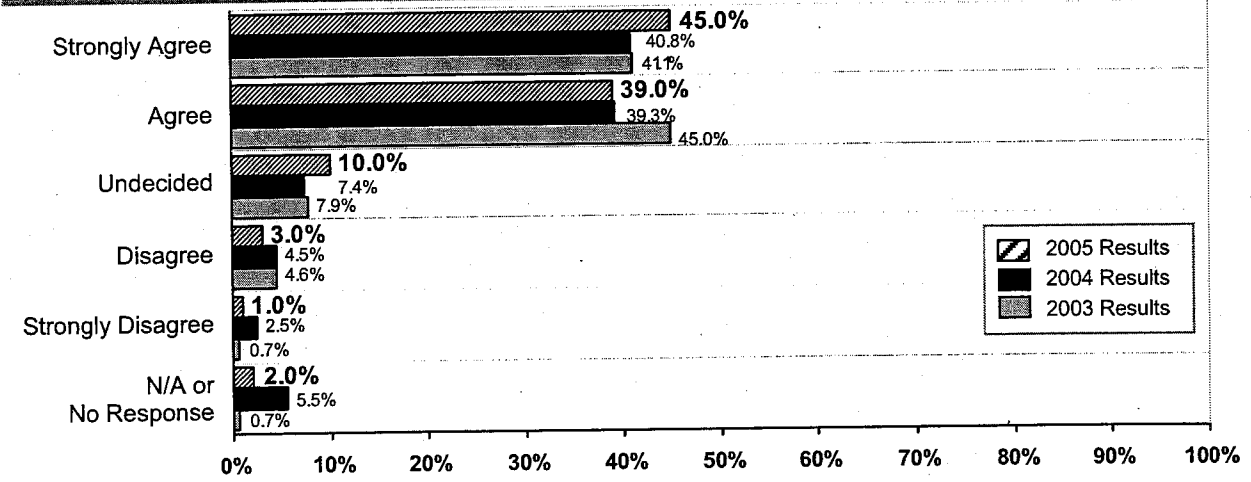
11. I know the team uses my child's strengths in setting goals and making plans.

Strongly Agree	44.5% / 413% / 40.4%
Agree	41.4% / 37.8% / 45.0%
Undecided	10.0% / 9.9% / 9.9%
Disagree	1.4% / 3.5% / 3.3%
Strongly Disagree	1.4% / 15% / 0.7%
N/A or No Response	1.4% / 6.0% / 0.7%

Legend:
- 2005 Results
- 2004 Results
- 2003 Results

X-axis: 0%, 10%, 20%, 30%, 40%, 50%, 60%, 70%, 80%, 90%, 100%
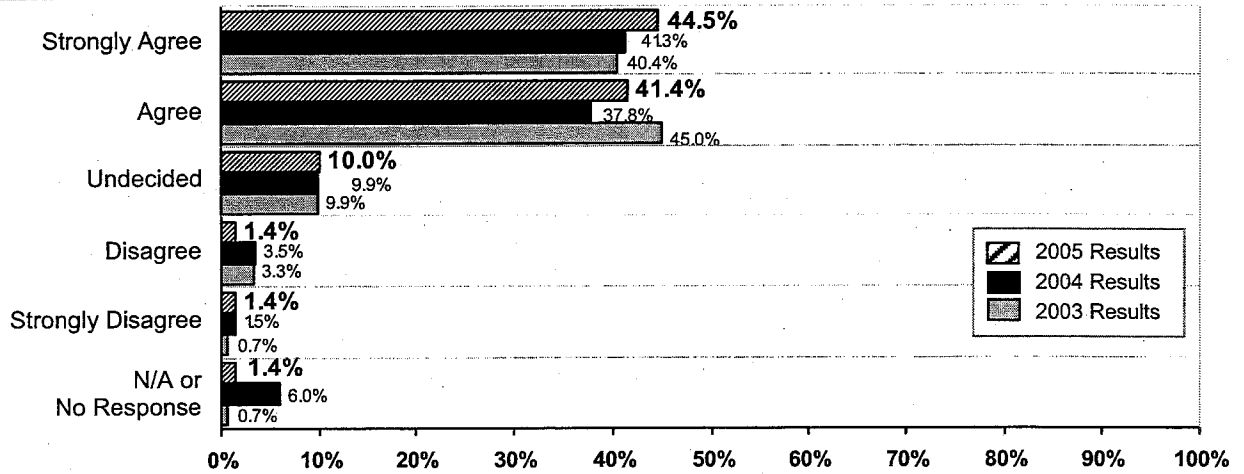
12. Overall, I am satisfied with the efforts of the team on my family's behalf.

Strongly Agree	51.2% / 46.2% / 52.3%
Agree	37.8% / 36.8% / 35.8%
Undecided	5.3% / 5.5% / 4.0%
Disagree	2.4% / 3.0% / 3.3%
Strongly Disagree	1.9% / 3.0% / 3.3%
N/A or No Response	1.4% / 5.5% / 13%

Legend:
- 2005 Results
- 2004 Results
- 2003 Results

X-axis: 0%, 10%, 20%, 30%, 40%, 50%, 60%, 70%, 80%, 90%, 100%

As a part of their annual reporting requirements, sites with CST and ISP are asked to complete a self-report measuring how well they met the eight key process and outcome areas that are important in maintaining a successful collaborative system of care (outlined below). In completing this report, sites are asked to gather information from Project Coordinators, Service Coordinators, Families, and Coordinating Committee Members. Once completed, each site creates a "Program Development Plan" targeting specific areas to be improved in the coming year.

The Eight Key Components of Collaborative Systems of Care:

1. Parents/caregivers are involved as full partners at every level of activity
2. An inclusive interagency group (Coordinating Committee) serving children and families has agreed upon the Core Values and Guiding Principles of Collaborative Systems of Care which are outlined in an Interagency Agreement
3. Collaborative family teams create and implement individualized support and service Plans of Care for families
4. Significant collaborative funding is available to meet the financial needs identified in the Plan of Care
5. Advocacy is provided for each family
6. Ongoing training is provided to all participants
7. Functional goals are monitored and measured, emphasizing participant satisfaction
8. Adolescents are ensured a planned transition to adult life

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Following is a summary of the responses of 30 sites that completed the report. For most indicators, sites were asked to choose a response from a Likert scale; responses that differ (e.g. "yes/no" responses) are noted.

1. Parents* are involved as full partners at every level of activity
(*The term "parent" represents all caregivers)

Indicators	4 – Always	3 – Often	2 – Seldom	1 - Never
Team Participation				
1. Parents may request meetings.	87%	10%	3%	0%
2. Parents are present @ team meetings. Children are present whenever possible and appropriate.	73%	27%	0%	0%
3. Parents' needs are considered in scheduling meetings.	77%	23%	0%	0%
4. Parents are involved in selection of team members.	87%	13%	0%	0%
Coordinating Committee Participation				
1. Parents on Coordinating Committee and appropriate subcommittees	83% - YES			17% - NO
2. Parents attend at least 75% of scheduled Coordinating Committee meetings.	46%	32%	11%	11%
3. Parents feel they are listened to by other committee members and that they have an important role on the committee.	35%	58%	7%	0%

2. An inclusive interagency group (Coordinating Committee) serving children and families has agreed upon the core values and guiding principles of Collaborative Systems of Care which are outlined in an Interagency Agreement.				
Indicators	**4 – Always**	**3 – Often**	**2 – Seldom**	**1 - Never**
1. Agreement incorporates all the members and components listed under State Statute 46.56 (3) (5).	93% - YES			7% - NO
2. The Coordinating Committee reviews interagency agreements at least every three years.	81% - YES			19% - NO
3. Coordinating Committee meets at least quarterly.	93% - YES			7% - NO
4. Conflict resolution policies are clearly written and reviewed at least annually.	89% - YES			11% - NO
5. Conflict resolution policies are followed when disagreements arise.	92% - YES			8% - NO
6. The Coordinating Committee assures that the core values and guiding principles are evident in the operation of the integrated services system of care.	52%	44%	4%	0%
7. Collaborating agencies are satisfied with process.	36%	57%	7%	0%

3. Collaborative family teams create and implement individualized support and service Plans of Care for families				
Indicators	**4 – Always**	**3 – Often**	**2 – Seldom**	**1 - Never**
1. Orientation is provided to all team members.	100% - YES			0% - NO
2. Team facilitator and/or service coordinator receive training and support.	63%	37%	0%	0%
3. Collaborative family team includes membership from home, school and community.	62%	35%	0%	3%
4. Team composition is consistent with family culture and preferences.	73%	27%	0%	0%
5. Family is satisfied with its team.	30%	70%	0%	0%
6. Family is satisfied with the team process.	27%	70%	3%	0%
7. Process is a collaborative team effort that begins with an individualized strengths- and needs-based assessment.	57%	43%	0%	0%
8. Plan of Care flows from assessment.	63%	34%	3%	0%
9. Plan of Care incorporates strengths of child, family and team.	63%	37%	0%	0%
10. The Plan of Care includes specific actions to meet identified needs, including who is responsible (including parents) for completing the action, and the plan is being followed.	52%	48%	0%	0%

3. Collaborative family teams create and implement individualized support and service Plans of Care for families *(Continued)*

Indicators	4 – Always	3 – Often	2 – Seldom	1 - Never
11. Family and other team members sign the Plan of Care.	100% - YES			0% - NO
12. Transition is addressed for major life changes.	32%	60%	4%	4%

4. Significant collaborative funding is available to meet the financial needs identified in the Plan of Care

Indicators	4 – Always	3 – Often	2 – Seldom	1 - Never
1. Agencies contribute resources and funding to meet the needs of families.	21%	58%	21%	0%
2. Child and family teams use funding flexibly to support individualized service.	32%	57%	7%	4%
3. Child and family team accesses informal community resources.	38%	48%	11%	3%

5. Advocacy is provided for each family

Indicators	4 – Always	3 – Often	2 – Seldom	1 - Never
1. Family advocacy information and options are provided.	93% - YES			7% - NO
2. Advocates may participate as team members as requested by the family.	100% - YES			0% - NO
3. Service Coordinators advocate for families	79%	21%	0%	0%

6. Ongoing training is provided to all participants

Indicators		
1. Coordinating Committee and Project Coordinator identify training needs on an ongoing basis.	100% - YES	0% - NO
2. Annual local training opportunities are made available to families, staff, and all others involved with the ISP process.	93% - YES	7% - NO

7. Functional goals are monitored and measured, emphasizing participant satisfaction

Indicators	4 – Always	3 – Often	2 – Seldom	1 - Never
1. Generally, Outcomes show:				
• Decrease in police contact/recidivism rates	96% - YES			4% - NO
• Maintenance or decrease in level of restiveness of living environment	100% - YES			0% - NO
• Improvement in grades	96% - YES			4% - NO
• Improvement in attendance	100% - YES			0% - NO
• Decrease in problem behaviors	96% - YES			4% - NO
2. Plan reviews are held at least every six months.	96% - YES			4% - NO
3. Family is satisfied with process.	46%	54%	0%	0%
4. Family is satisfied with outcomes.	18%	82%	0%	0%
5. Providers are satisfied with process.	31%	69%	8%	0%
6. Providers are satisfied with outcomes.	24%	72%	4%	0%

8. Adolescents are ensured a planned transition to adult life

Indicators	4 – Always	3 – Often	2 – Seldom	1 - Never
1. A mechanism is in place to identify children age 14 and older who have long-term treatment needs and who will require services beyond age 18.	86% - YES			14% - NO
2. Plans of care reflect collaborative transitional planning for children age 14 and older identified as needing services beyond age 18.	72% - YES			28% - NO
3. For the most seriously ill adolescents, within one year of transition to adult living:				
• Action steps are clearly defined	36%	52%	12%	0%
• Needed referrals have been made	44%	48%	8%	0%
• Future collaborators are invited to team meetings	40%	44%	16%	0%