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February 15, 2008

The Children Come First Advisory Committee is pleased to issue the 2006 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 2006, 42 counties received grant funding to operate wraparound systems serving 1,102 children and youth, and two additional sites received limited funding to support technical assistance. These initiatives also provided support and services to 2,558 *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, 71% 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 2006 Annual Report provides compelling evidence of the value of collaborative systems of care.

Sincerely,

A handwritten signature in black ink, appearing to read "Hugh Davis".

Hugh Davis
Co-chair

A handwritten signature in black ink, appearing to read "Jim Moeser".

Jim Moeser
Co-chair

2006 Annual Report on Integrated Services Projects and Coordinated Services Team Initiatives Executive Summary

Each year, the Bureau of Mental Health and Substance Abuse Services (BMHSAS) prepares an annual report for the Children Come First Advisory Committee, the group statutorily responsible for monitoring the development of Wisconsin's Integrated Services Projects. This summary report highlights some of the accomplishments and challenges faced by collaborative systems of care, specifically the Integrated Services Projects (ISP) and Coordinated Services Team Initiatives (CST). The full report can be viewed and downloaded from:
http://dhfs.wisconsin.gov/mh_bcmh/CST_ISP/reports.htm.

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.

Beginning in 2002, the collaborative process employed by ISP was expanded with the development of CST. While CST uses the same wraparound process as ISP, the target group is broader and includes families and children who do not necessarily have an SED diagnosis but who do have complex needs. Funding for CST sites range from about \$33,000 to \$63,000 annually.

In 2006, 42 ISP/CST projects received funding through contracts with the BMHSAS, and two additional sites received limited funding to support technical assistance. MHBG, Substance Abuse Grants and Hospital Diversion were the sources of funding. In addition, the Division of Children and Family Services collaborated with BMHSAS by contributing funding for CST sites.

Funding will be available in 2007 to develop eight additional ISP/CST projects; two additional sites will receive limited funding to support technical assistance.

Profile of Children and Families Served

In 2006, ISP/CST projects served:

- 1,102 children and youth.
- 2,558 family members of enrolled children – services which may not have been received if not for the family's involvement in a collaborative system of care.

Referral sources to the programs included: Mental Health – 20.2%, Child Welfare – 19.8%, Juvenile Justice – 13.8%, Schools – 20.9%, Family – 15.4%, AODA – 2.4% and Other – 7.5%.

Demographic data collected indicated that the children in programs were 63% male and 37% female, with the average age of 15.9 years.

Outcomes

One tool used to collect data in these projects is the Child and Adolescent Functional Assessment Scale (CAFAS) 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. Data are reported at enrollment, 6 months post enrollment, and 12 months post enrollment. The data collected show:

- 28% problem severity reduction and corresponding improvements in functioning during that time period;
- 25% school problem severity reduction and corresponding improvements in school functioning; and
- 29% reduction in delinquency severity and corresponding improvements in community functioning.

Consumer Satisfaction

Each year, enrolled ISP/CST families are asked to complete a Family Satisfaction Survey. The survey gathers information from a family perspective about areas of strength and need. Results of the 2006 survey show:

- 93% agree they are treated as an important member of their child and family team;
- 71% agree their family is getting better at coping with life and its daily challenges;
- 85% agree their team is sensitive to their cultural, ethnic, and religious preferences and values; and
- 87% agree that overall they are satisfied with the efforts of the team on their families’ behalf.

Financial Savings

Counties with ISP/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. Twenty-four of 25 sites who responded to the survey identified financial savings (one site answered “not-applicable” due to the newness of their project). Below are selected comments:

Involvement in the team process reduces the length of out-of-home placements, and also prevents placement. Cost savings were presented to the County Board early this year, and the estimated cost savings for the first six months of 2006 was \$242,939.

The county has been able to save in the neighborhood of \$300,000 per year in out-of-home placement costs. Much of this cost savings can be attributed to Integrated Services Projects keeping children in the community rather than an out-of-placement.

Keeping the 6 children we serve through our team process safely at home versus foster care (all of them probably would have required treatment foster care) saved us in the neighborhood of \$15,000-\$18,000 a month.

For additional information, please contact:

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Children Come First Advisory Committee

2006 Annual Report

On Integrated Services Projects and Coordinated Services Team Initiatives



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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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"The roles of the parent, family, and consumer in CST are to be active members on state and local committees, and to be active members on individual family teams."

Federal Mental Health Block Grant Plan, 2006

The 2006 Annual 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 Team Initiatives (CST).

Wisconsin's collaborative systems of care go by different names: ISP, CST, "Children Come First" (CCF), and Wraparound Milwaukee. All are names of projects which use the wraparound process to respond to children and families with multiple and 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.

"My child is starting to care about other people and their feelings."

Parent comment, 2006 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 wraparound 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 \$33,000 to \$63,000 annually.

In 2006, 42 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.

"Our family finally has the support and guidance we need to deal with daily problems".

Parent comment, 2006 Family Satisfaction Survey

Wisconsin started out in the late '80s funding Integrated Services Projects (ISPs). As of 2006, eighteen counties have ISPs. From 2002-2003, ten counties developed CST projects and an additional eight counties received funding for CST in 2004. In 2005, four more CST counties were added and finally, in 2006 two additional counties received funds to develop CST projects. Six counties have both ISP and CST projects.

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 TEAM INITIATIVES (SITES ADDED 2002 – 2003)

Bayfield	Jefferson	Sauk
Calumet	Manitowoc	Waupaca
Green Lake	Marquette	
Iron	Portage	

COORDINATED SERVICES TEAM INITIATIVES (SITES ADDED IN 2004)

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

COORDINATED SERVICES TEAM INITIATIVES (SITES ADDED IN 2005)

Eau Claire	Sheboygan
La Crosse	Washburn

COORDINATED SERVICES TEAM INITIATIVES (SITES ADDED IN 2006)

Brown	Buffalo*
Dodge	

* Grant & Buffalo Counties are developing their initiatives 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*).
- Researchers supported by the National Institute of Mental Health (NIMH) have found that half of all lifetime cases of mental illness begin by age 14, and that despite effective treatments, there are long delays — sometimes decades — between the first onset of symptoms and when people seek and receive treatment. The study also reveals that an untreated mental disorder can lead to a more severe, more difficult to treat illness, and to the development of co-occurring mental illnesses (*National Institute of Mental Health, 2006*).
- 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.
- 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*).
- An estimated 98,000 Wisconsin children were uninsured for all or part of 2006 (*WisKids Count 2006*).
- The incidence of suicide attempts reaches a peak during the midadolescent years, and mortality from suicide, which increases steadily through the teens, is the third leading cause of death at that age (*CDC, 1999; Hoyert et al., 1999*).

A Statewide look at Collaborative Systems of Care Serving Children and Families in 2006

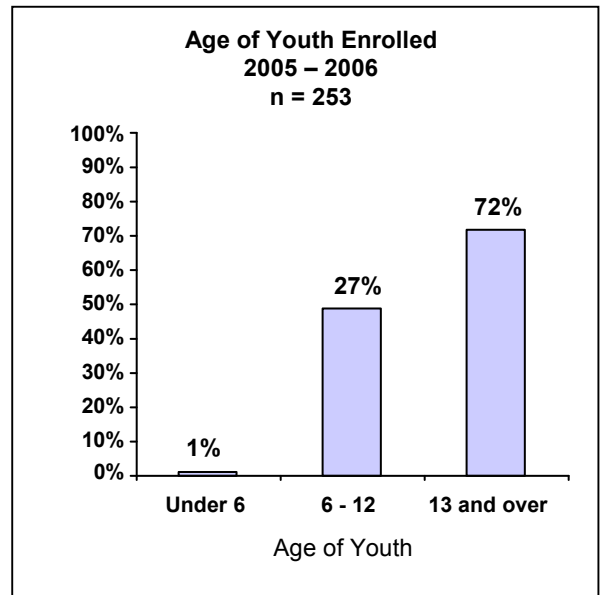
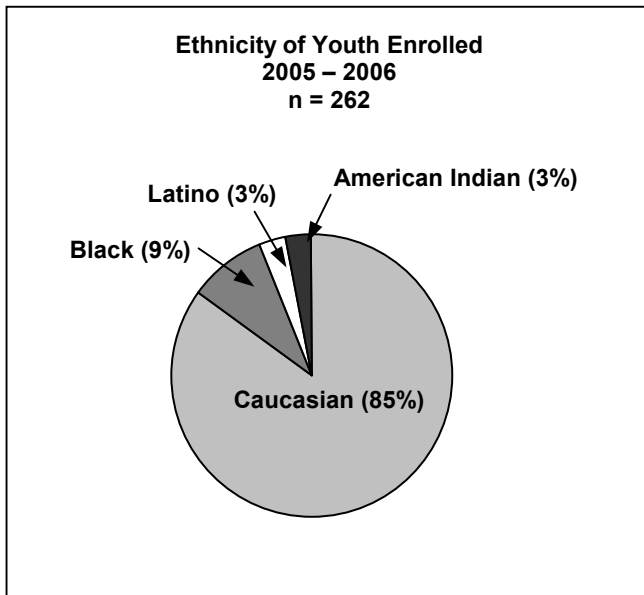


QUARTERLY REPORT DATA

The following information is based on data from ISP and CST sites who submitted data quarterly to the BMHSAS 2005 – 2006.

Demographic Information

Information from over 250 youth with SED has been collected from 2005 to 2006. Of these youth, 63% were male and 37% female, with an average age of 15.9 years.



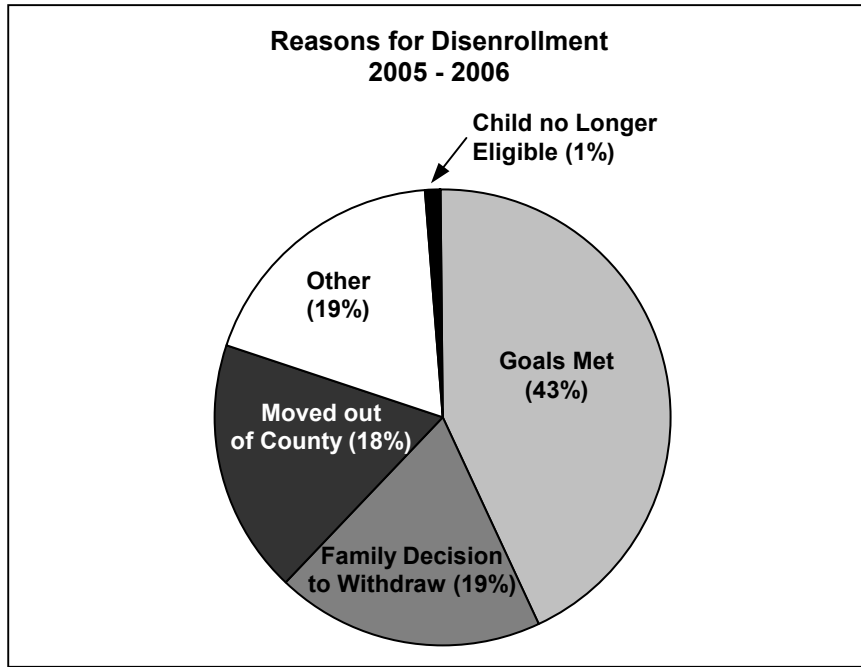
Disenrollment/Transition

ISP/CST projects submitting quarterly data during 2005 – 2006 reported an average length of enrollment of 11.8 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 enrollment if he/she no longer meets criteria for Severe Emotional Disturbance (SED), and/or the child no longer meets age requirements.
- **Other:** This category serves as a “catch all” for reasons that do not clearly fit into other categories.

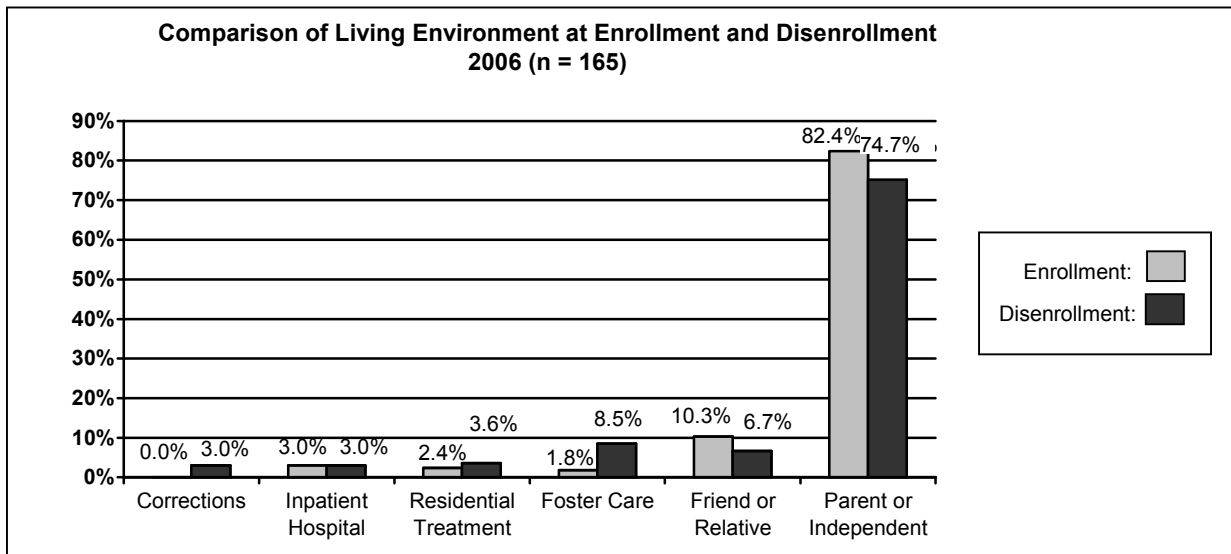
The chart below summarizes reasons for disenrollment in 2005-2006:



Changes in Restrictiveness of Living Environment: 2006

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 for all families disenrolled in 2006. Please note the data reflects the living environments of all children at time of disenrollment regardless of reason for disenrollment identified above.



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*.

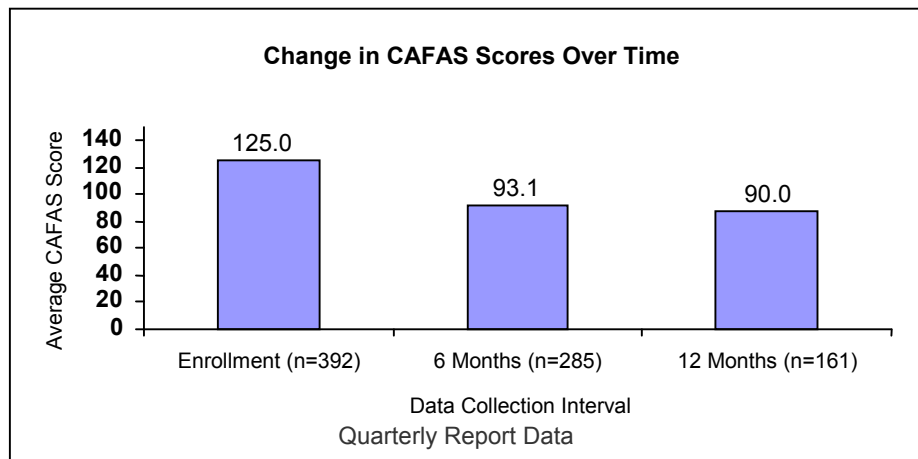
Results of averaging all CAFAS scores collected for each subscale during the years 2005 to 2006, regardless of when a child’s treatment began or ended or when the CAFAS was administered, show that children served through an ISP/CST system of care have the most impairment at home and school (subscale scores were 16.5 and 16.9, respectively). Children have the least impairment in the areas of self-harm behavior and substance use (subscale scores were 8.2 and 1.5, 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:

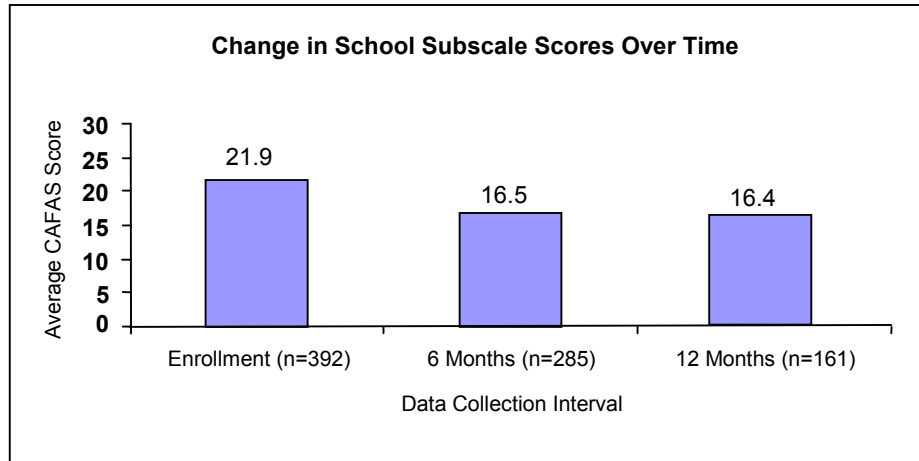
CAFAS Scoring: Total Score*	
8-Scale Sum	Description
0 – 10	No noteworthy impairment
20 - 40	Youth can likely be treated on an outpatient basis
50 - 90	Youth may need additional services beyond outpatient care
100 - 130	Youth likely needs care which is more intensive than outpatient and/or which includes 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.

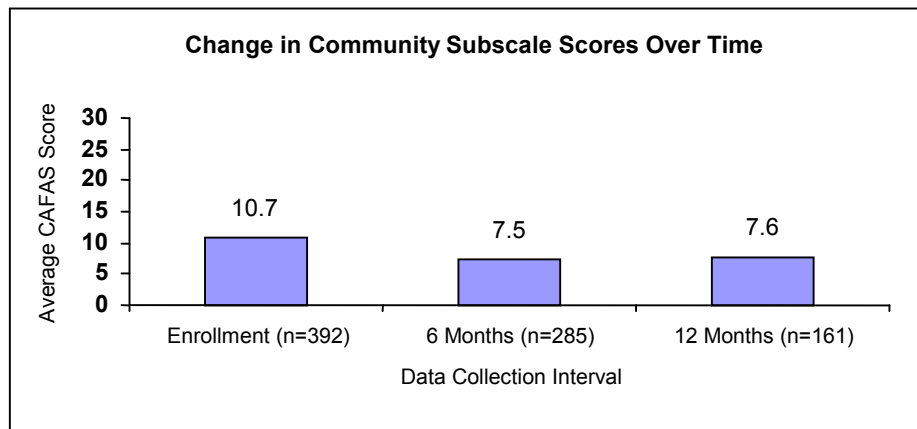
Changes in Overall CAFAS Scores at Points in Time: The following graph reflects youth served 2003 – 2006 (n=392). Note that the data is not a matched sample. The data are reported CAFAS scores at enrollment, 6 months after enrollment, and 12 months after enrollment. The data show a meaningful (28 percent) reduction in problem severity and corresponding improvements in functioning during that time period.



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 (25 percent) reduction in school problem severity and corresponding improvements in school functioning from enrollment through 12 months after enrollment.



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 (29 percent) reduction in delinquency severity and corresponding improvements in community functioning from enrollment through 12 months after enrollment.



SYSTEM UPDATE

Counties with ISP and CST 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 in Part B).

The following incorporates data submitted by 26 sites that completed the survey (7 ISP, 13 CST, and 6 that have both ISP and CST).

For information on Wraparound Milwaukee, and Children Come First Dane County (Collaborative Systems of Care in Wisconsin that do not have contracts with the BMHSAS), 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”

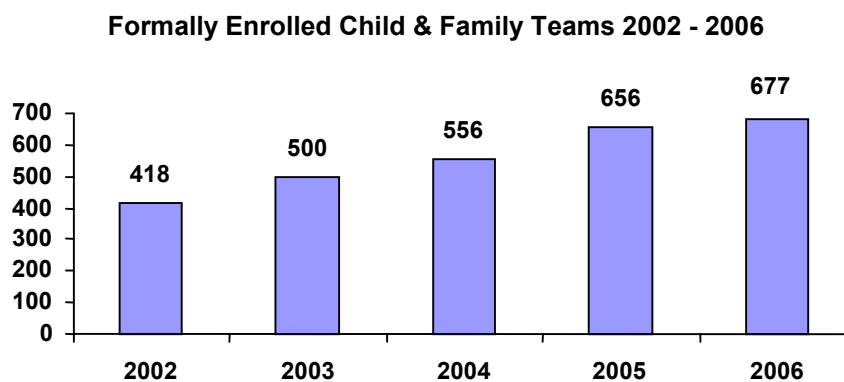
Children Come First Dane County: www.community-partnerships.org

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; these teams 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.

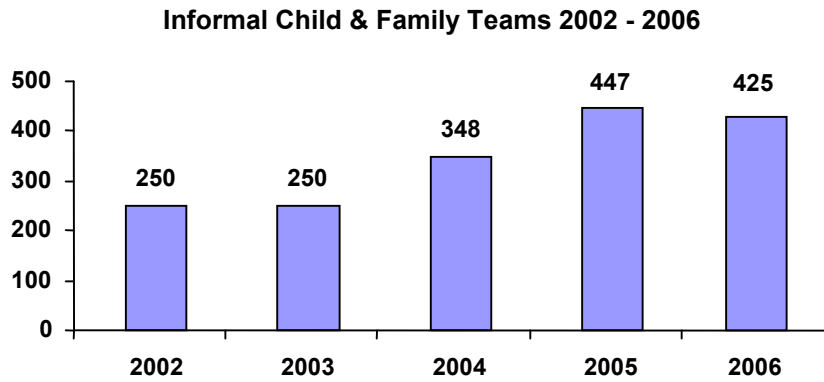
Formal Enrollment

In 2006 there were 677 formally enrolled teams reportedly being served by CST and ISP across Wisconsin. The average length of enrollment per child and family team was 14.6 months. (Note that this figure is longer than the 11.8 average based on evaluation data cited on page 5 of this report. The lower average is based on a sub-sample of the total children served for which evaluation data was collected.) The average number of formally enrolled teams per county was 20, ranging from zero in a site just starting out to 93 teams in a well-established site. The graph below summarizes the number of formally enrolled teams over the past 5 years:



Informal Enrollment

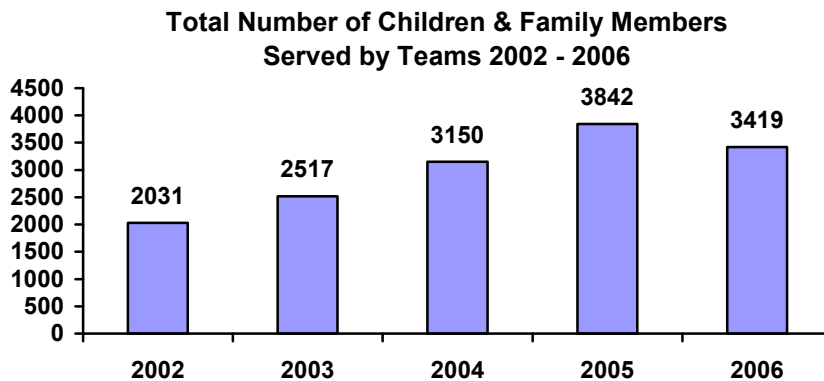
In 2006, CST and ISP sites reported serving 425 “informal” teams. The graph below summarizes teams served “informally” over the past 5 years:



Total Children and Family Members Served

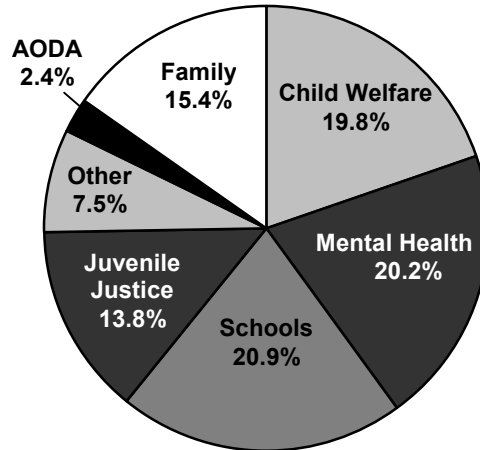
In addition to identifying the number of teams/identified children served, sites were asked to report the number of family members other than the identified child who received support and services that they may not have received had the family not been involved in the team process. In 2006 there were 2,558 additional family members served, an average of 74 people per site and 2.3 family members per team.

The total number of children and family members served in 2006 was 3,660 (1,102 children and 2,558 additional family members). The graph below summarizes the total number of children and family members served over the past five years.



Referral Source

The chart below summarizes sources of referrals made to Collaborative Systems of Care in 2006.



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 26 sites that completed the survey. For a more complete summary including site comments, please visit www.wicollaborative.org (click on "Resources", "Annual Reports", then "System Update 2006").

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:

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

Twelve sites identified the collaborative system of care approach as more effectively using time and resources.

Nine sites identified improved communication.

Six sites stated that the process better identifies and meets individual family needs.

Negative Impacts

One site expressed a “negative impact”: “One of the emerging trends we have noticed is due to our success; it appears we have some families moving here due to what we have to offer and we also seem to be receiving a high number of adoptive placements through the state.”

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

Twenty-four sites identified financial savings.

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

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

Nine sites identified community education on CST and buy-in/commitment from partners.

Five sites identified Coordinating Committee issues.

Five sites identified lack of development or use of informal supports.

Five sites 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?

Six sites identified a need for ongoing training and education.

Eight sites identified a need for strengthening relationships and communication with partners and the community.

Seven sites identified a need for improvements to Coordinating Committees.

FAMILY SATISFACTION SURVEY

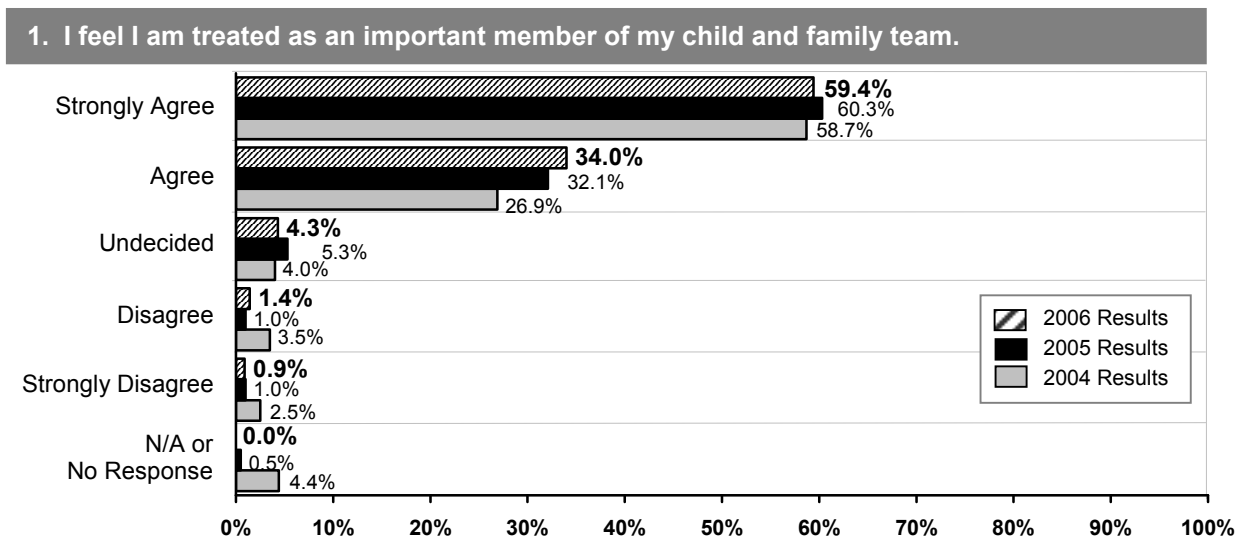
Each year, families enrolled in ISP and CST across the state are asked to complete a Family Satisfaction Survey. The survey gathers information from a family perspective about areas of strength and need in collaborative systems of care serving children and families in Wisconsin. To encourage honest responses 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:

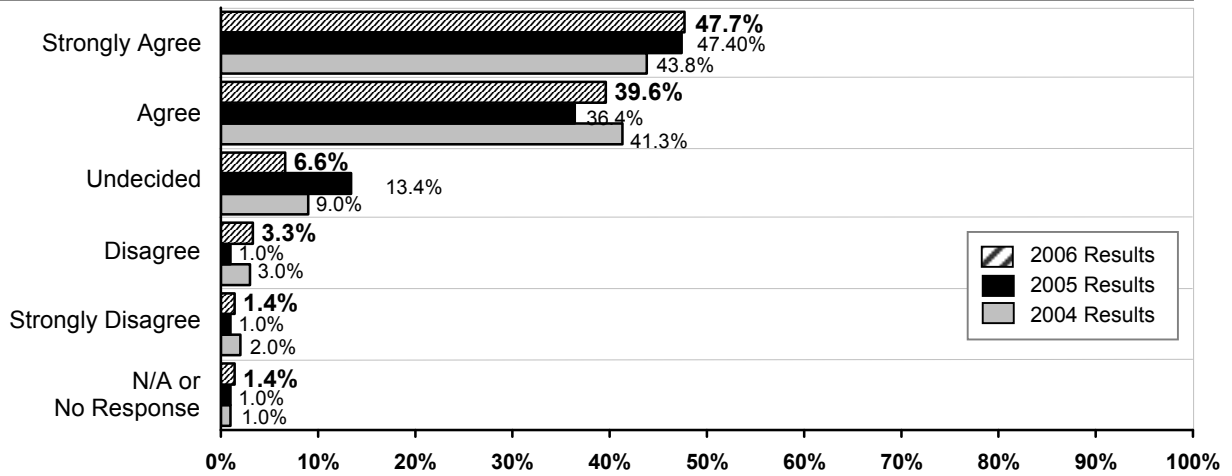
- 1 – Strongly Disagree
- 2 – Disagree
- 3 – Undecided
- 4 – Agree
- 5 – Strongly Agree
- Not Applicable

212 surveys were returned and tabulated in 2006, a 36.2% return rate. This compares with 209 surveys returned in 2005 (a 39.6% return rate), and 205 surveys returned in 2004 (a 48.8% return rate).

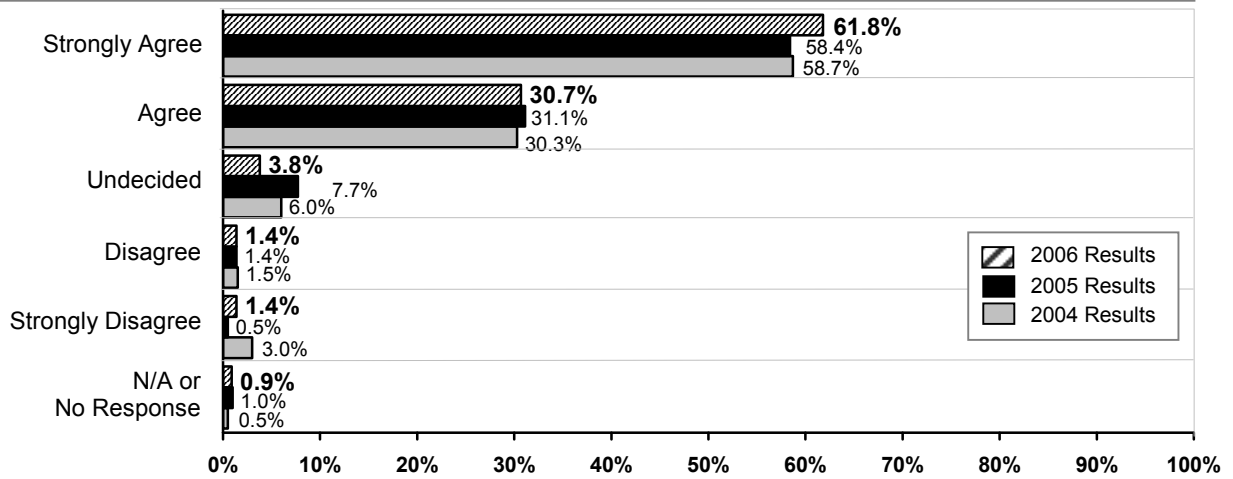
Following is a summary comparing 2004, 2005, and 2006 results:



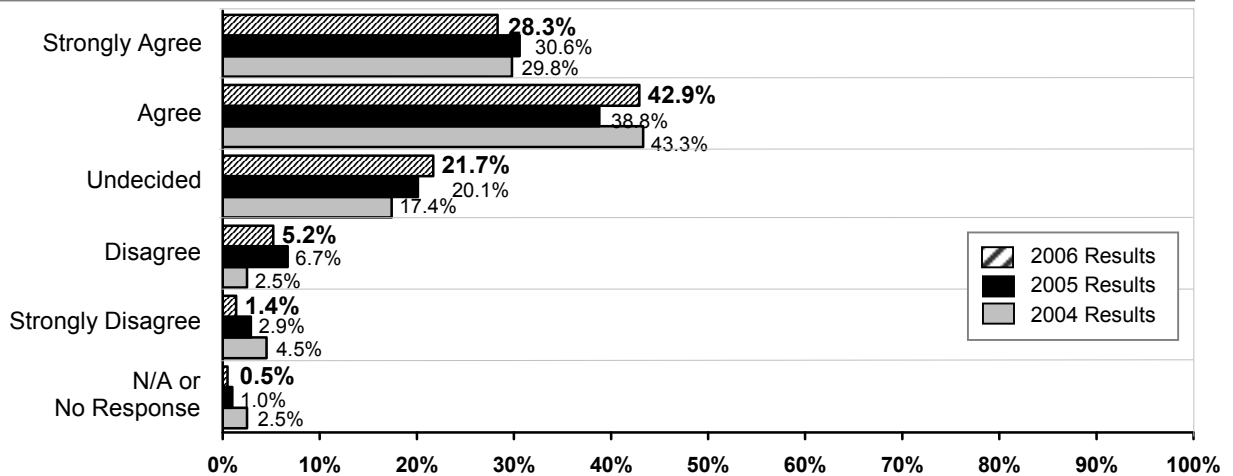
2. I am satisfied with the goals the team and I have set.



3. The team takes time to listen to my concerns.

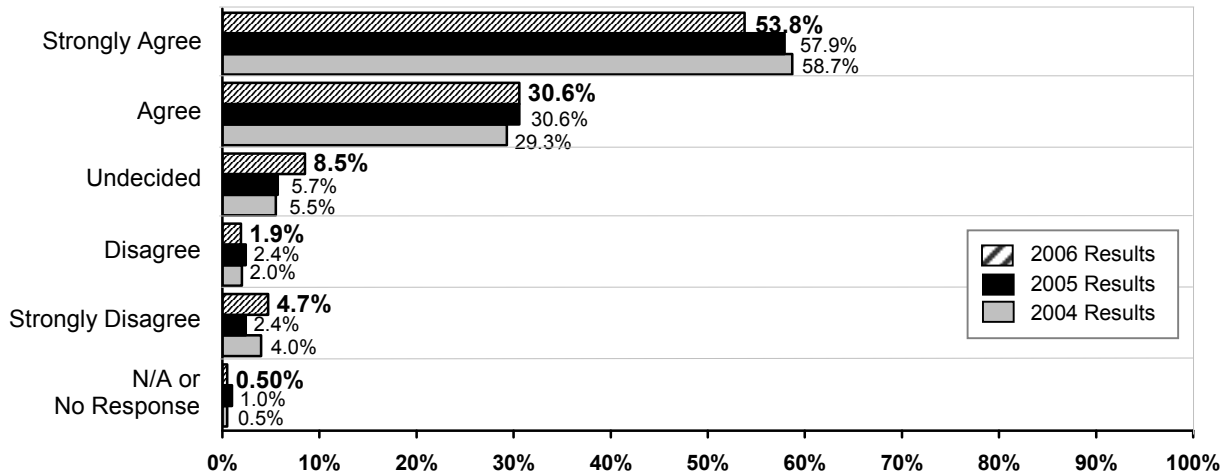


4. My family is getting better at coping with life and its daily challenges.

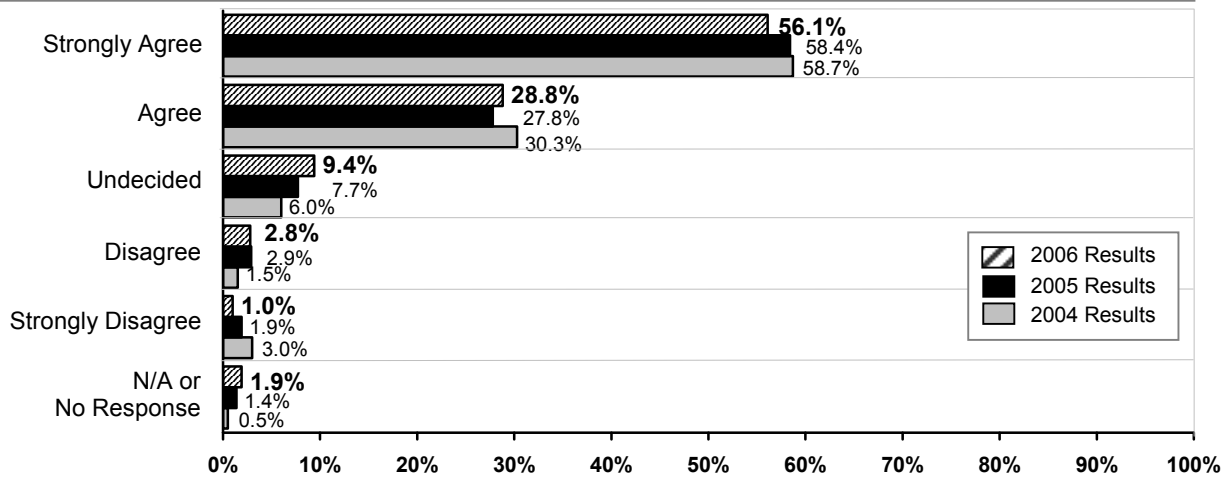


Family Satisfaction Survey

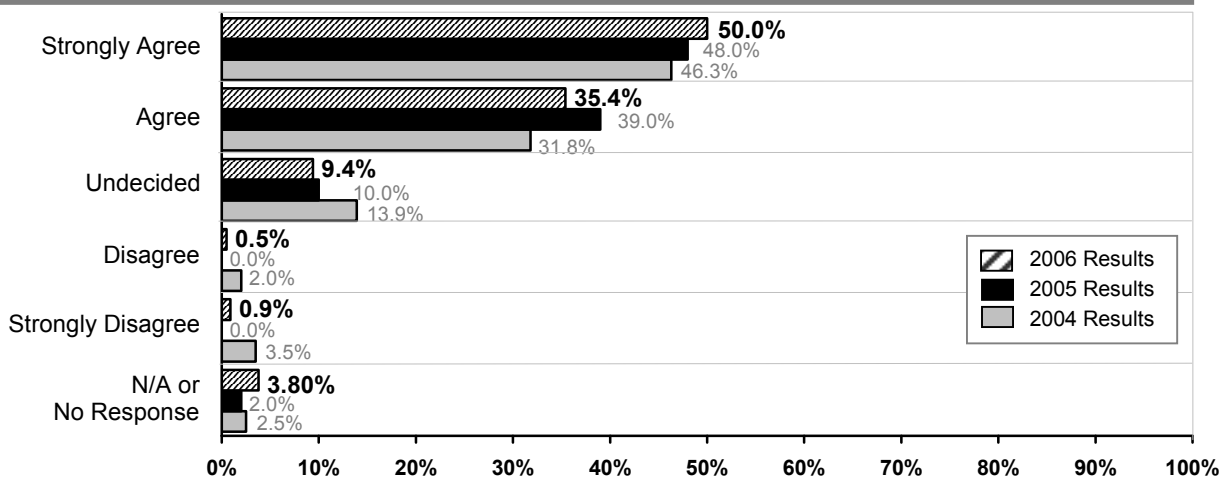
5. I would refer another family/child to the Integrated Services Project



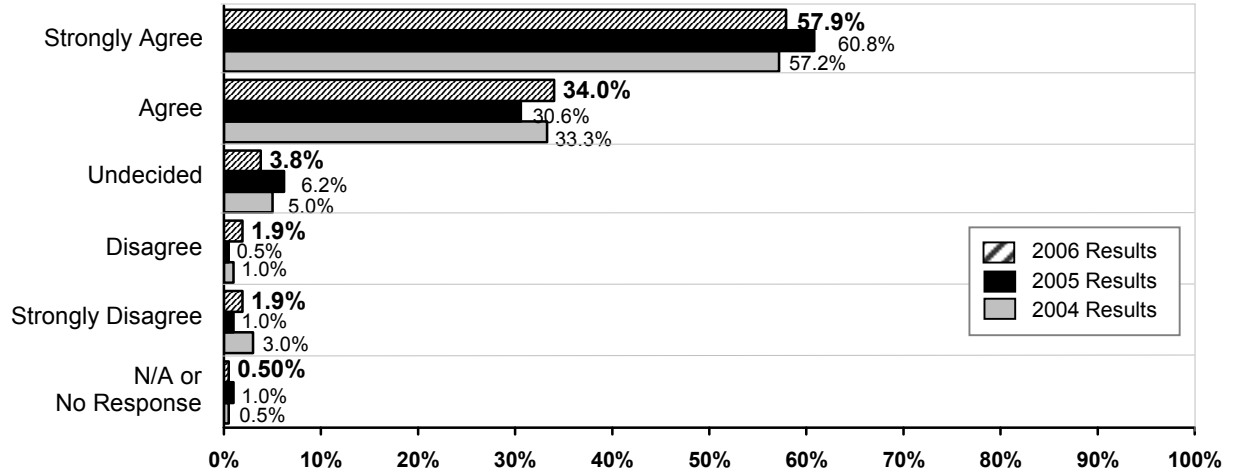
6. My care coordinator speaks up for my child and family.



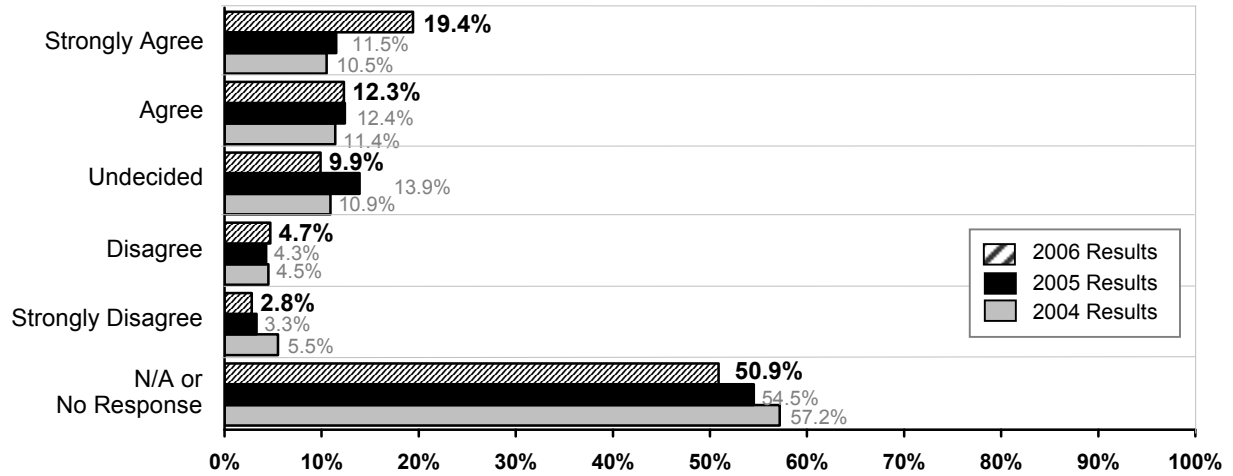
7. The team is sensitive to my cultural, ethnic, and religious preferences and values.



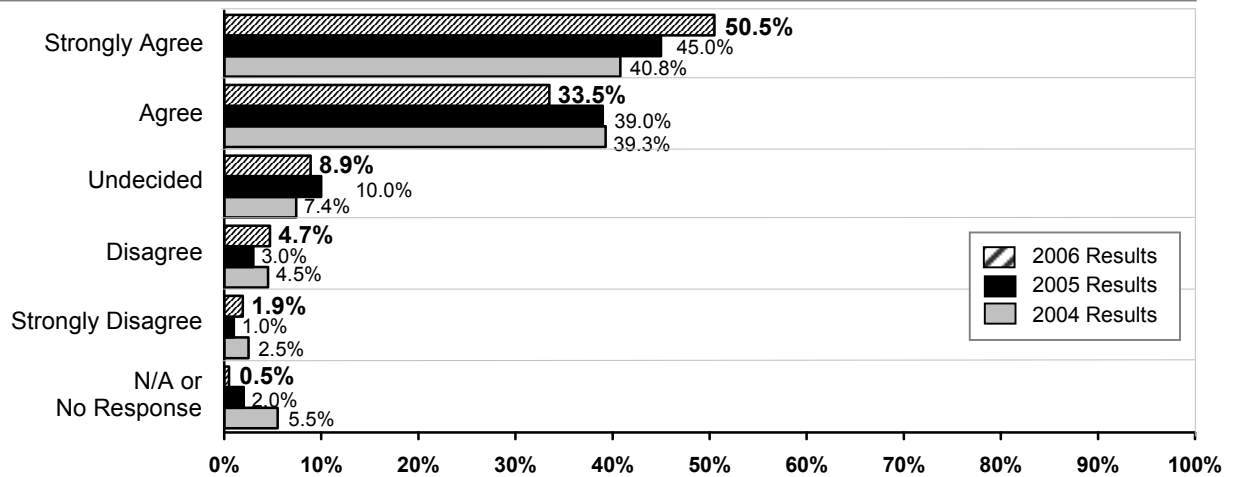
8. The team schedules services and meetings at times that are convenient to my family.



9. If my child is 14 or older there is a plan to insure access to needed services when 18.

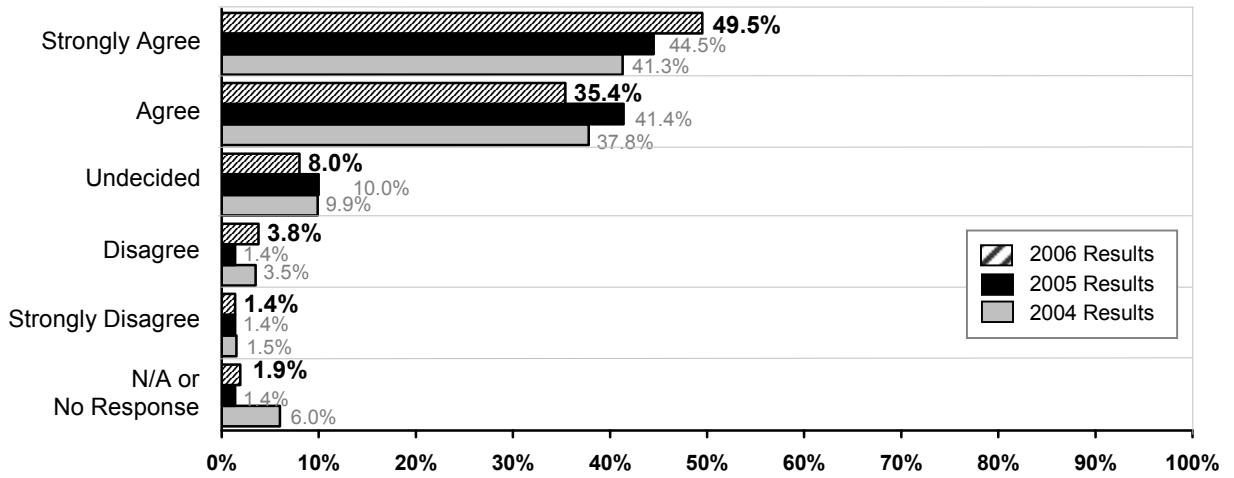


10. I feel the team understands my child's strengths and needs.

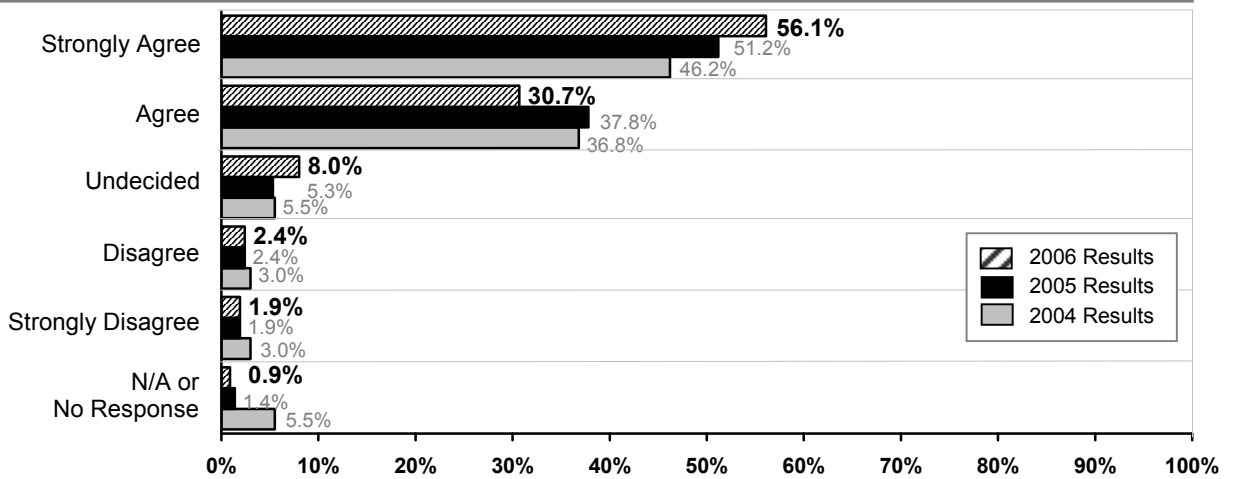


Family Satisfaction Survey

11. I know the team uses my child's strengths in setting goals and making plans.



12. Overall, I am satisfied with the efforts of the team on my family's behalf.



8 KEY COMPONENTS OF COLLABORATIVE SYSTEMS OF CARE

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

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.	91.9%	8.1%	0%	0%
2. Parents are present @ team meetings. Children are present whenever possible and appropriate.	95.2%	4.8%	0%	0%
3. Parents’ needs are considered in scheduling meetings.	98.7%	1.3%	0%	0%
4. Parents are involved in selection of team members.	98.6%	1.4%	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.	34.9%	39.5%	16.3%	9.3%
3. Parents feel they are listened to by other committee members and that they have an important role on the committee.	41.5%	43.9%	7.3%	7.3%

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).	91% - YES		9% - NO	
2. The Coordinating Committee reviews interagency agreements at least every three years.	93% - YES		7% - NO	
3. Coordinating Committee meets at least quarterly.	100% - YES		0% - NO	
4. Conflict resolution policies are clearly written and reviewed at least annually.	86% - YES		14% - NO	
5. Conflict resolution policies are followed when disagreements arise.	95% - YES		5% - 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.	68.3%	29.3%	2.4%	0%
7. Collaborating agencies are satisfied with process.	26.2%	73.8%	0%	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.	95% - YES		5% - NO	
2. Team facilitator and/or service coordinator receive training and support.	74.4%	25.6%	0%	0%
3. Collaborative family team includes membership from home, school and community.	50%	50%	0%	0%
4. Team composition is consistent with family culture and preferences.	76.3%	23.7%	0%	0%
5. Family is satisfied with its team.	8.3%	91.7%	0%	0%
6. Family is satisfied with the team process.	9%	91%	0%	0%
7. Process is a collaborative team effort that begins with an individualized strengths- and needs-based assessment.	78.4%	21.6%	0%	0%
8. Plan of Care flows from assessment.	73%	27%	0%	0%
9. Plan of Care incorporates strengths of child, family and team.	78.4%	21.6%	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.	44.7%	55.3%	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.	95% - YES			5% - NO
12. Transition is addressed for major life changes.	48.6%	51.4%	0%	0%

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.	20%	65%	15%	0%
2. Child and family teams use funding flexibly to support individualized service.	48.7%	43.6%	5.1%	2.6%
3. Child and family team accesses informal community resources.	48.7%	46.2%	5.1%	0%

5. Advocacy is provided for each family				
Indicators	4 – Always	3 – Often	2 – Seldom	1 - Never
1. Family advocacy information and options are provided.	92% - YES			8% - NO
2. Advocates may participate as team members as requested by the family.	100% - YES			0% - NO
3. Service Coordinators advocate for families	76%	24%	0%	0%

6. Ongoing training is provided to all participants				
Indicators				
1. Coordinating Committee and Project Coordinator identify training needs on an ongoing basis.	98% - YES			2% - NO
2. Annual local training opportunities are made available to families, staff, and all others involved with the ISP process.	90% - YES			10% - NO

7. Functional goals are monitored and measured, emphasizing participant satisfaction				
Indicators	4 – Always	3 – Often	2 – Seldom	1 - Never
1. Generally, Outcomes show: <ul style="list-style-type: none"> Decrease in police contact/recidivism rates Maintenance or decrease in level of restiveness of living environment Improvement in grades Improvement in attendance Decrease in problem behaviors 	96% - YES			4% - NO
	100% - YES			0% - NO
	96% - YES			4% - NO
	100% - YES			0% - NO
	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.	22%	78%	0%	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: <ul style="list-style-type: none"> Action steps are clearly defined Needed referrals have been made Future collaborators are invited to team meetings 	36%	52%	12%	0%
	44%	48%	8%	0%
	40%	44%	16%	0%