

# Children Come First Advisory Committee 2007 Annual Report On Collaborative Systems of Care



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For additional copies of this report or for more information on  
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The 2007 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: "Children Come First" (CCF), ISP, CST, and Wraparound Milwaukee are all projects using 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 of Care, 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.

*"With the help of wraparound, I was able to focus on short and long term goals. The team was able to point me toward resources I never knew about."*  
 - A Parent Involved in Wraparound

**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 used 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 sites ranges from \$33,000 to \$63,000 annually.

In 2007, 43 counties and 2 tribes received funding through contracts with the Bureau of Mental Health and Substance Abuse Services (as of July 1, 2007 the Bureau of Prevention Treatment and Recovery (BPTR)). The funding came from MHBG funds, Substance Abuse Block Grant funds, and Hospital

Diversion funding. In addition, the Division of Children and Family Services collaborated with BPTR to contribute funding for CST sites.

*Working with the family as a team gave us [in-home therapists] a perspective that no professional working alone could have figured out."*  
 - Intensive In-home Therapist

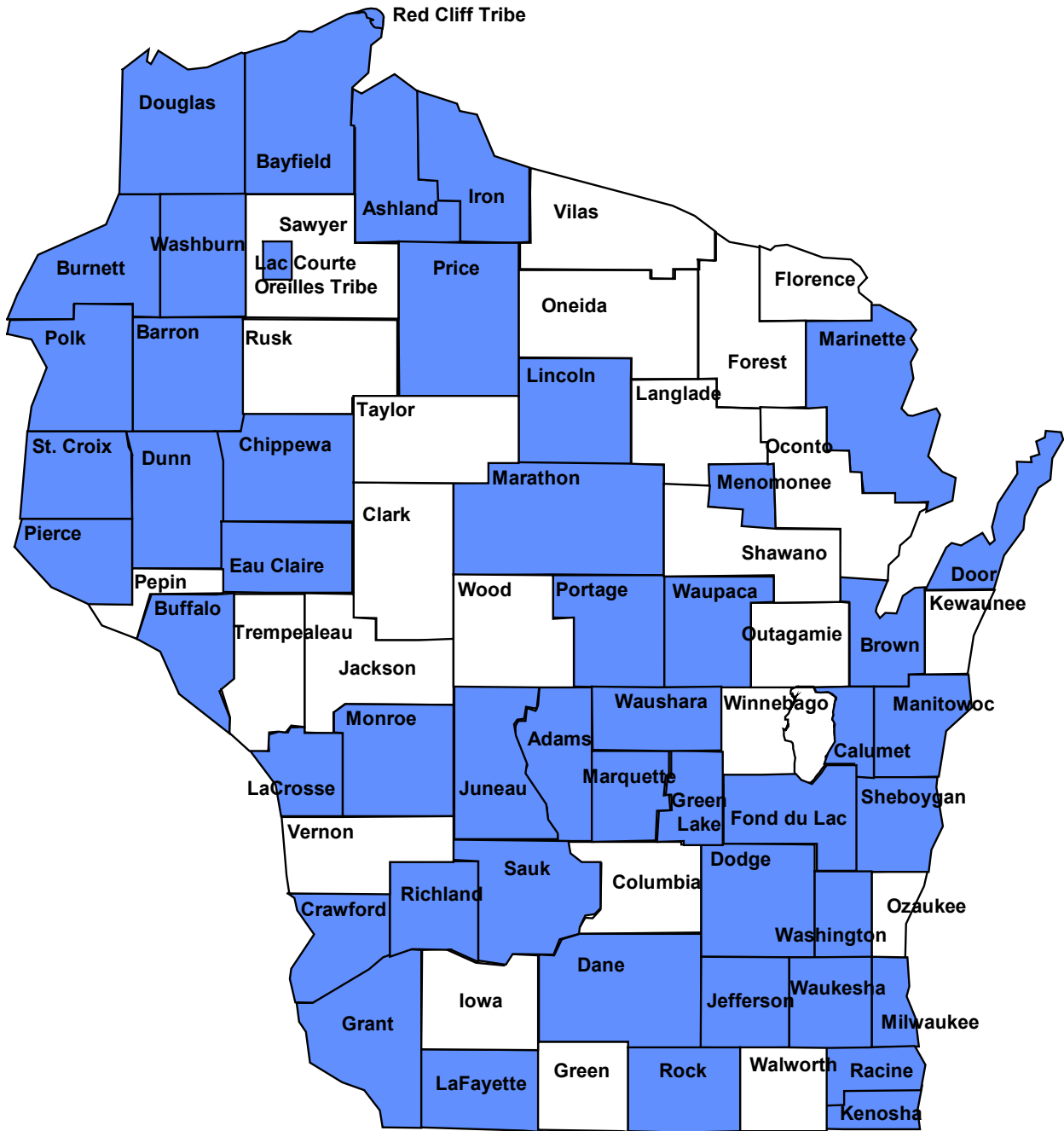
Wisconsin began funding ISP in the late 1980's. As of 2007, eighteen counties have ISP. From 2002-2006 twenty-six counties received funds to develop CST projects. In 2007, grant funding for eight of the original CST sites ended, freeing up funds for six additional counties and two tribes to develop CST.

<b>Integrated Services Projects</b>		
• Ashland	• Kenosha	• Rock
• Chippewa	• La Crosse	• Sheboygan
• Door	• Marinette	• Washburn
• Dunn	• Marquette	• Washington
• Eau Claire	• Portage	• Waukesha
• Fond du Lac	• Racine	• Waushara
<b>CST Sites added 2002 – 2003</b>		
• Bayfield	• Jefferson*	• Sauk
• Calumet*	• Manitowoc*	• Waupaca*
• Green Lake*	• Marquette*	
• Iron*	• Portage*	
<b>CST Sites added 2004</b>		
• Adams	• Grant**	• Polk
• Crawford	• Lafayette	• Richland
• Douglas	• Pierce	• St. Croix
<b>CST Sites added 2005</b>		
• Eau Claire	• Sheboygan	
• La Crosse	• Washburn	
<b>CST Sites added 2006</b>		
• Brown	• Dodge	• Buffalo**
<b>CST Sites added 2007</b>		
• Ashland	• Juneau	• Monroe
• Burnett	• Menominee	• Price
• Lac Courte Oreilles Band of Lake Superior Chippewa Indians		
• Red Cliff Band of Lake Superior Chippewa Indians		
<small>* Grant funding ended in 2007; limited funds for training and technical assistance (TTA) are available</small>		
<small>** Grant &amp; Buffalo Counties are developing their initiatives with limited funds for TTA</small>		

## 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*)
- Without early and effective identification and interventions, childhood disorders can persist and lead to a downward spiral of school failure, poor employment opportunities, and poverty in adulthood. (*President's New Freedom Commission on Mental Health, 2003*)
- The "systems of care" approach is an effective way of serving children with mental health needs...The system of care approach can reduce the need for out-of-home placements that can strain a family. (*U.S. Department of Health and Human Services, 1999; Mental Health: A Report of the Surgeon General*)
- 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.
- At admission to Wisconsin Juvenile Justice institutions, over half of the males are about four grade levels behind their peers in both reading and math. (*Silvia Jackson, Wisconsin Division of Juvenile Corrections, July 2007*)

# A Statewide look at Collaborative Systems of Care Serving Children and Families in 2007



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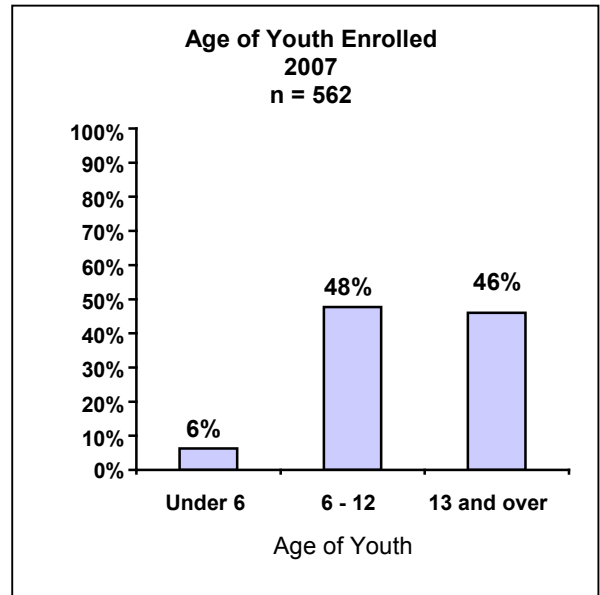
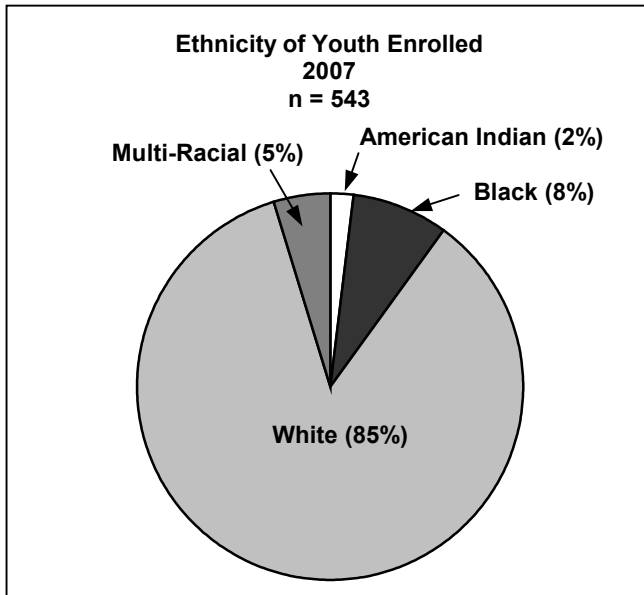
## QUARTERLY REPORT DATA

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The following information is based on data from ISP and CST sites that submitted data quarterly to the BPTR in 2007.

### Demographic Information

Information from 562 youth was collected in 2007. Of these youth, 64% were male and 36% female, with an average age of 11.7 years.



### Children's Outcome Indicators

ISP/CST staff members collect outcome data from children and families on a regular basis for as long as the child is enrolled in their initiative. While data is not collected prior to enrollment or after discharge, the data collected at enrollment and throughout a child's service experience is useful for measuring changes in children's lives during treatment and assessing their final status as they are disenrolled. There are three primary areas of children's lives that are monitored to determine the outcomes of their participation in the ISP/CST initiatives: living situation, school performance, and involvement with the juvenile justice system.

#### Living Situation

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 in a more restrictive setting at time of referral. ISP and CST strive to support youth and their families in the least restrictive setting possible. Practice within ISP and CSTs is to divert children from costly, inappropriate out-of-home placements into their community-based ISP/CST initiative. Thus, some children would be expected to be in community placements, such as with their own families, when they are enrolled into an ISP or CST. In fact, 91 percent of children were in a community placement (i.e. with parents, relatives, or friends) at the time of their enrollment into an ISP/CST in 2007.

Other children may be living in a restrictive placement at the time of enrollment which the ISP/CST staff then addresses by making community placement a primary goal of the child's plan of care. In 2007, two percent of all newly-enrolled children were living in mental health institutions, inpatient hospitals, and residential facilities at the time of their enrollment. Seven percent of children were living in group homes or foster care placements at the time of their enrollment.

The expectation for children in community placements when enrolled into the initiative is that their community placement is maintained throughout their initiative enrollment. The expectation for children in restrictive out-of-home placements when enrolled into the initiative is that they are placed in more appropriate and less costly community placements by the time of their disenrollment. In 2007, 151 children were disenrolled from ISP/CSTs. Of all the children disenrolled, ISP/CSTs were 93 percent successful in achieving the combination of these two children's placement goals. The highlights from monitoring children's placement status while enrolled in ISP/CST's include:

- Of the 10 children in state mental health facilities, inpatient hospitals, and residential treatment centers at the time of enrollment, 90 percent were in community placements by the time of their disenrollment from the initiative.
- Of the 132 children living with a parent, friend, or relative at the time of their enrollment, 92 percent were still living with a parent, friend, or relative at the time of their disenrollment. Four percent were living in foster care or group home placements and the other four percent were in inpatient and residential treatment placements.

### **School Attendance, Behavior, and Performance**

ISP and CST initiatives make it a priority within children's plans of care to address any existing educational issues. Academic performance in school suffers for some children dealing with mental health issues. For other children, their mental health disorder may lead to aggressive anti-social behavior that leads to school sanctions or emotional problems that lead to depression and a lack of self-confidence that compounds academic performance struggles. All of the above issues may decrease school attendance which can only compound performance issues further.

In the most recently completed semester/trimester in 2007, most of the 410 children with school setting data were receiving some form of special educational assistance:

- 65% were receiving special educational services within a regular public school,
- 15% were placed in special educational schools or other alternative educational settings,
- 15% needed no special educational services or alternative educational settings, and
- 5% were in "other" educational settings.

Despite the issues children were dealing with while enrolled in the ISP/CST initiatives, they attended school very regularly. The 405 children who were enrolled in school and for whom data was available during 2007 attended school or had excused absences for 97% of all school days. Some of the absences were due to expulsions and suspensions, but most children had none. Of all children served in 2007, 78% had no school suspensions or expulsions.

In the most recently completed semester/trimester for the 367 children with school performance data in 2007, 79% had an average overall grade of "C" or better, or had "satisfactory" performance. For those children disenrolled in 2007, 81 percent had an average overall grade of "C" or better or had "satisfactory" performance upon their disenrollment from the initiative.

### Involvement with the Juvenile Justice System

Involvement with the juvenile justice system is also a common indicator for measuring the success of children’s mental health services. Each ISP/CST reports the number and type of offenses committed by each child while enrolled in the initiative, with the goal being to reduce and prevent offenses while the child is receiving services.

Of the 562 children served in 2007, 79% committed no offenses at any time in 2007. However, certain ISP and CST initiatives work closely with their local juvenile justice systems to establish the agency as a primary referral source. Such initiatives have a larger percentage of children who commit offenses than others which inflates the overall rate of offenses for all ISP/CST initiatives. Of the 116 children who committed offenses in 2007, 53% were from 4 of the 28 county ISP/CST initiatives reporting data. When the children from these four initiatives are excluded, the percentage of children who committed no offenses in 2007 in the remaining 24 initiatives is 90%.

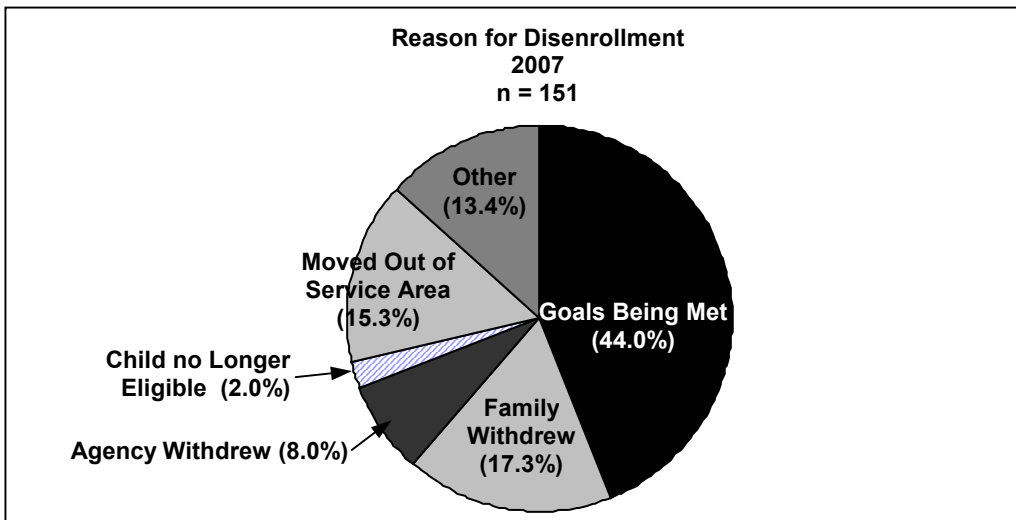
### Disenrollment/Transition

ISP/CST projects submitting quarterly data during 2007 reported that of 151 children disenrolled during 2007, the average length of enrollment was 16 months.

Reasons a child and family may disenroll include:

- **Goals Being Met:** All team members agree that the goals outlined in the Plan of Care are being 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.
- **Agency Decision to Withdraw:** The lead agency may choose to end the team process if it is determined that continuing would not be in the best interest of the child.
- **Moved out of the Service Area:** If the child is no longer a resident of the county or tribal service area, he/she may no longer be eligible to receive services from that county/tribe.
- **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 exceeds 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 2007:



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## SYSTEM UPDATE

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Counties and tribes with ISP and/or 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 38 sites that completed the survey (11 ISP, 20 CST, and 7 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”

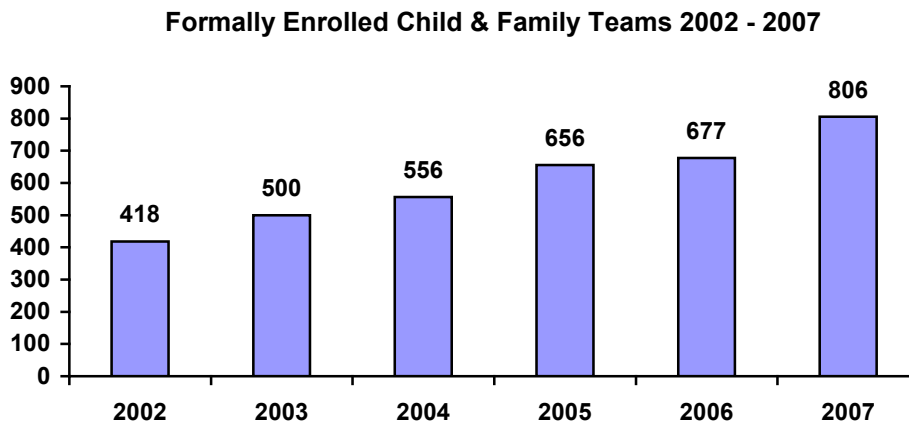
**Children Come First Dane County:** [www.community-partnerships.org](http://www.community-partnerships.org)

### 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 reflection 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 BPTR.

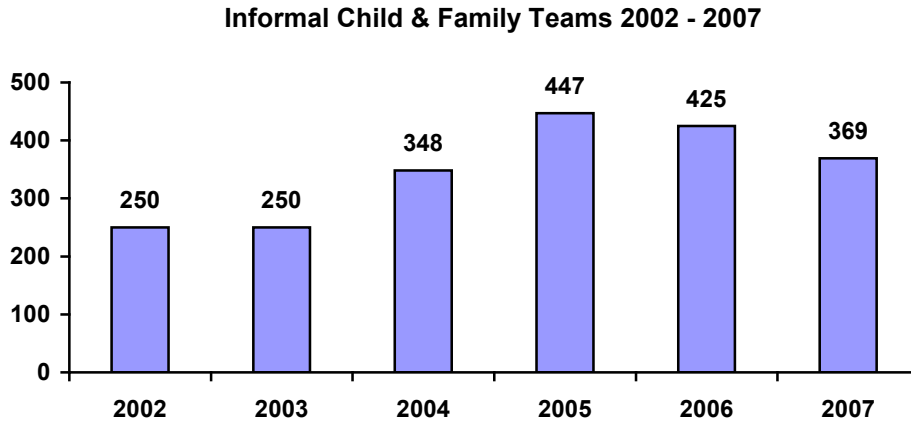
#### Formal Enrollment

In 2007 there were 806 formally enrolled teams being served by CST and ISP across Wisconsin. The average length of enrollment per child and family team was 15.4 months. The average number of formally enrolled teams per county was 21. The graph below summarizes the number of formally enrolled teams over the past six years:



### Informal Enrollment

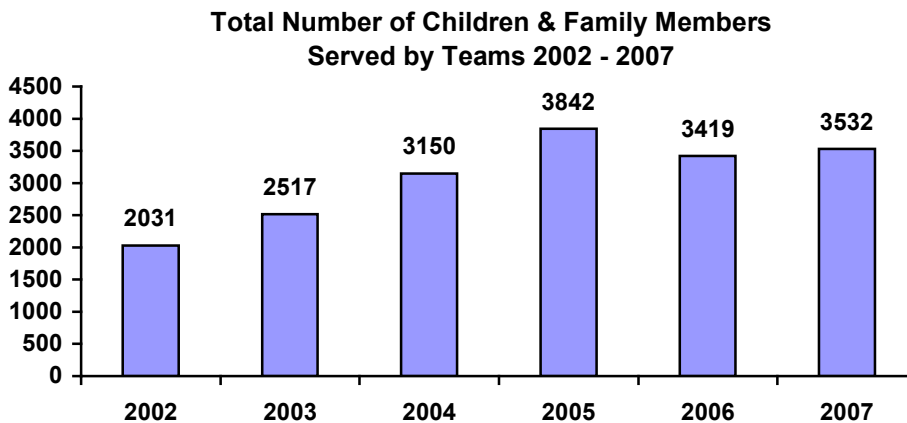
In 2007, CST and ISP sites reported serving 369 “informal” teams. The graph below summarizes teams served “informally” over the past six years:



### Total Children and Family Members Served

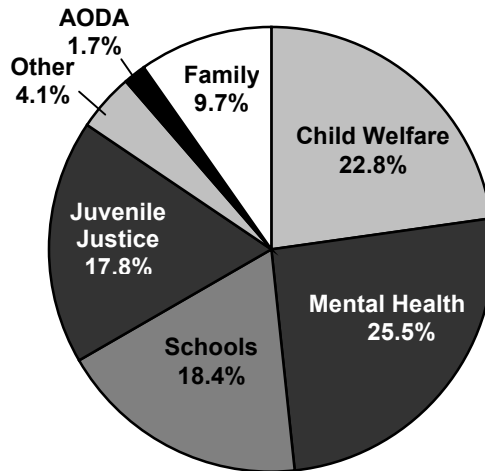
In addition to identifying the number of teams/identified children served, sites were asked to report the number of family members other than the identified child who received support and services that they may not have received had the family not been involved in the team process. In 2007 there were 2,357 additional family members served, an average of 62 people per site.

The total number of children and family members served in 2007 was 3,532 (1,175 children and 2,375 additional family members). The graph below summarizes the total number of children and family members served over the past six years.



## Referral Source

The chart below summarizes sources of referrals made to Collaborative Systems of Care in 2007.



## PART B: Impact of Collaborative Systems of Care on the Larger Service System

Counties and tribes 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 five 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
- Cost savings
- Concerns, issues, and challenges
- Recommendations for improvement

Below is a summary of the most common responses to each question from the 38 sites that completed the survey.

### 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?

Fourteen sites identified a high level of family satisfaction.

Eleven sites identified the ability to serve and provide additional resources to more families.

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

Seven sites identified an increase in cross-system collaboration/coordination.

Five sites identified a strengthening of relationships between agencies and service providers.

Six sites noted that ISP/CST has opened lines of communication among service providers; the process helps get everyone “on the same page”.

Four sites identified a high level of provider satisfaction.

Three sites identified a decrease in intensive care/out-of-home placements.

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

Thirty sites identified the ISP/CST process as “cost effective”.

Six sites replied that they were uncertain.

One site reported that their collaborative team process lost its cost-effectiveness due to the separate administrative demands of the various collaborative initiatives/grant funding sources.

**3. Are there cost savings?**

Twenty-nine sites identified financial savings.

Eight sites replied that they were uncertain.

**4. What concerns, issues, and challenges do you identify?**

Twelve sites identified financial concerns, including financial sustainability of their ISP/CST.

Twelve sites identified the lack of community services and resources.

Seven sites identified a need for additional staff resources, including service coordination.

Four sites identified Coordinating Committee issues.

Four sites identified educating community partners on the ISP/CST process.

Four sites identified the need to strengthen cross-agency collaboration.

Three sites identified paperwork requirements.

Three sites identified the increasingly complex needs of children and families.

Two sites identified the challenge of managing multiple collaborative initiatives.

Two sites identified the lack of referrals to their project.

Two sites identified internal agency/staff resistance.

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

Seven sites identified the need for continued funding, including financial support from the State as well as identifying additional funding sources.

Four sites identified expansion and strengthening of their Coordinating Committees and community partnerships.

Five sites identified continued and expanded training efforts and outreach.

Three sites identified continued system redesign/systems change efforts.

Three sites identified a focus on fidelity of the CST team process.

Three sites identified expansion of the number of children & families served.

## FAMILY SATISFACTION SURVEY

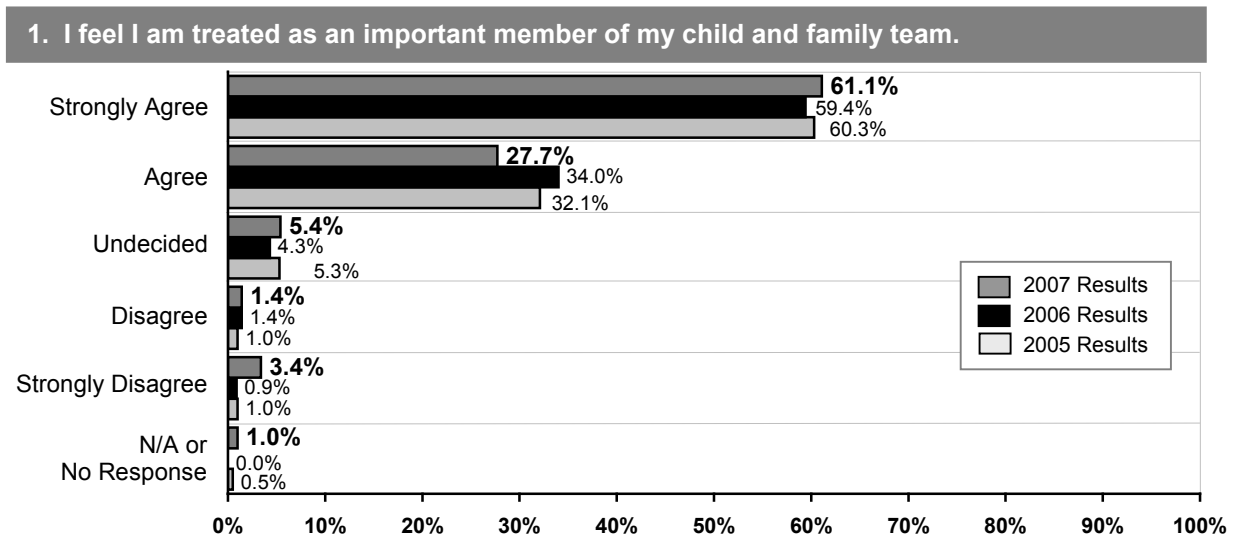
Each year, families enrolled in ISP and CST across the state are asked to complete a Family Satisfaction Survey. The survey gathers information from families, asking their opinion about areas of strength and need in collaborative systems of care serving children and families in Wisconsin. To encourage candid responses and to help ensure confidentiality, the surveys are distributed with stamped, addressed envelopes to Wisconsin Family Ties, a not-for-profit advocacy organization that tabulates the results. An anonymous on-line survey tool is also available.

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:

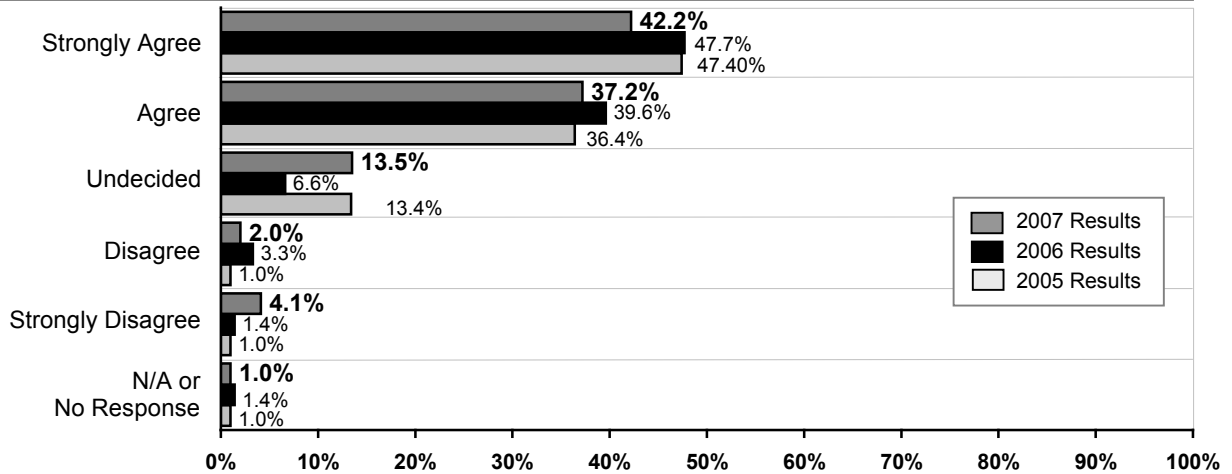
- 1 – Strongly Disagree
- 2 – Disagree
- 3 – Undecided
- 4 – Agree
- 5 – Strongly Agree
- Not Applicable

In 2007, 296 families representing 32 ISP and CST sites across the state completed the survey.

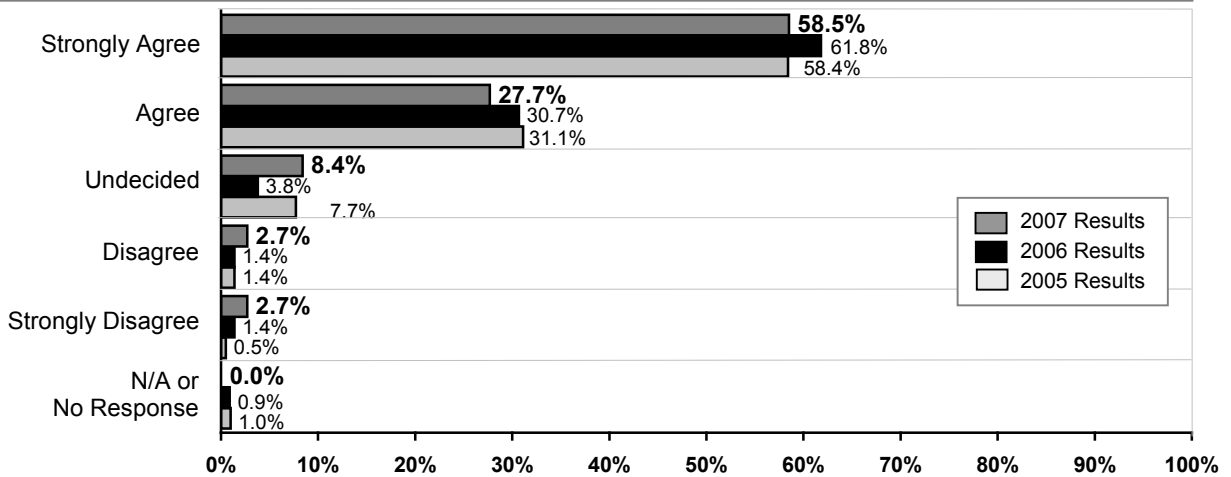
***Following is a summary comparing 2005, 2006 and 2007 results:***



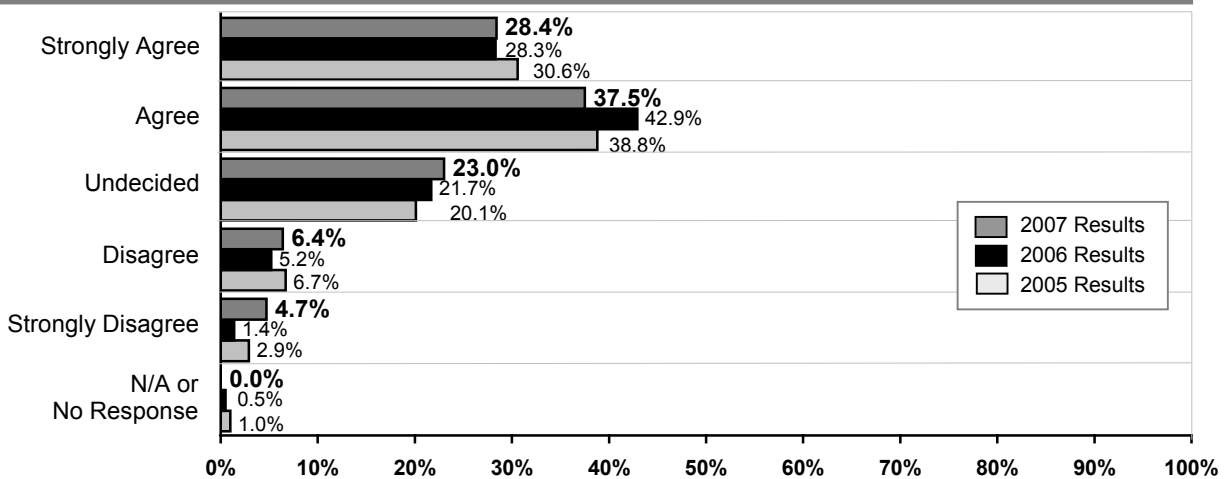
**2. I am satisfied with the goals the team and I have set.**



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

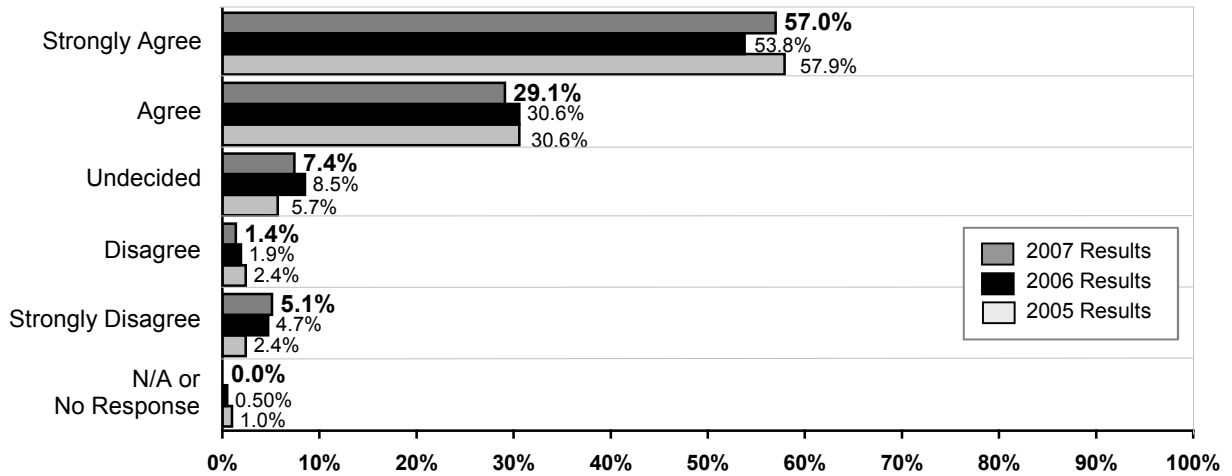


**4. My family is getting better at coping with life and its daily challenges.**

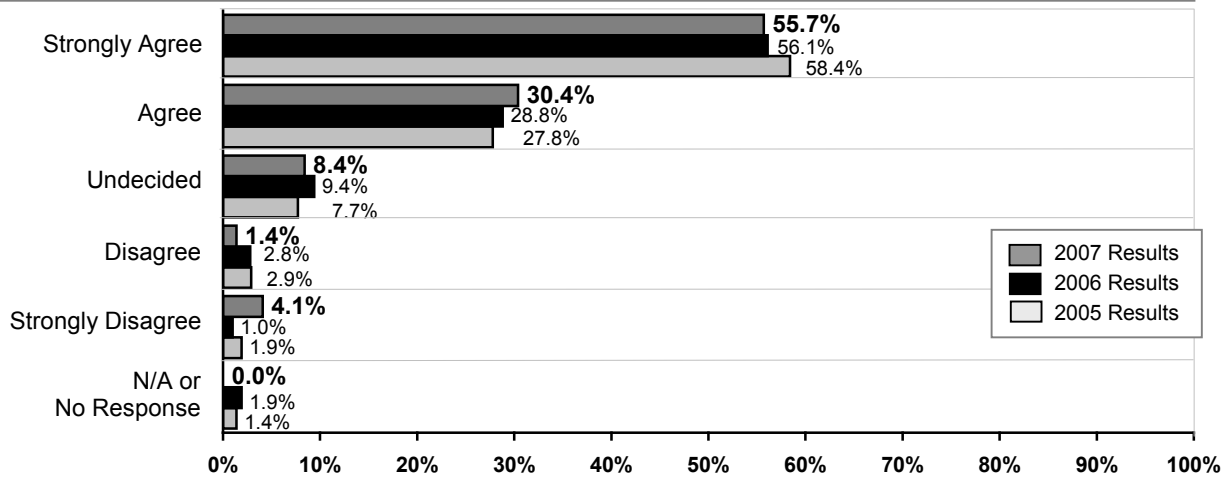


Family Satisfaction Survey

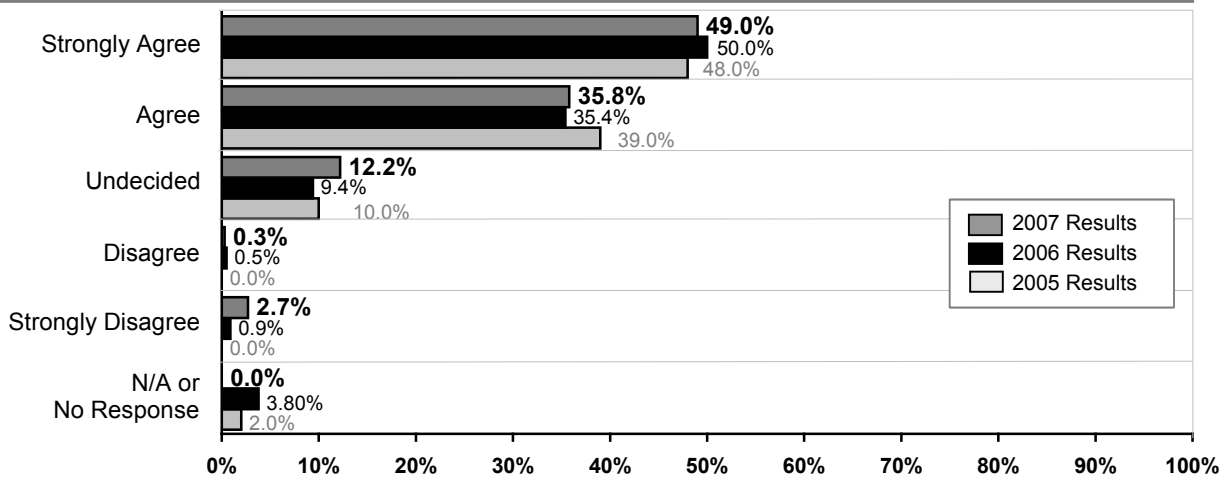
5. I would refer another family/child to the Integrated Services Project



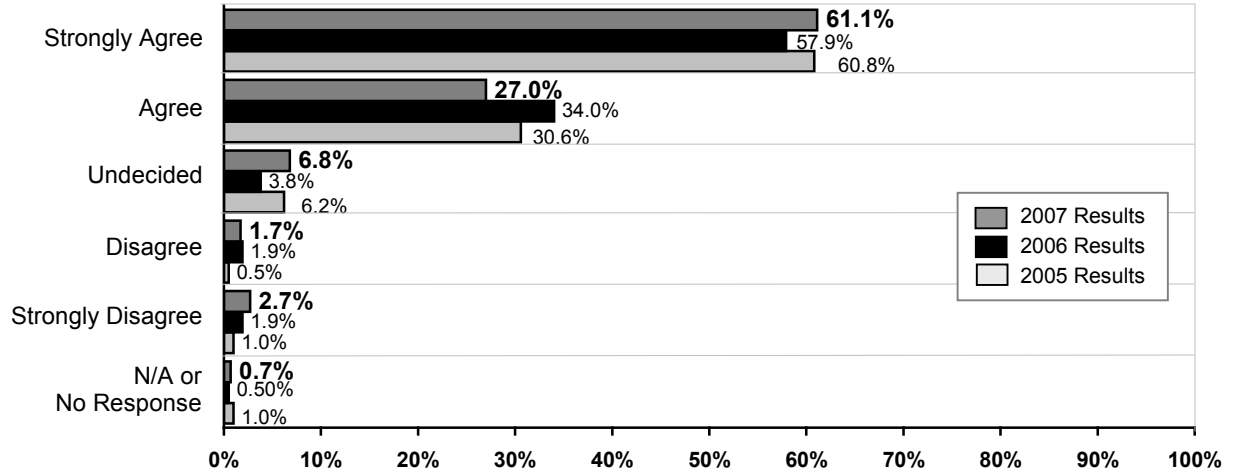
6. My care coordinator speaks up for my child and family.



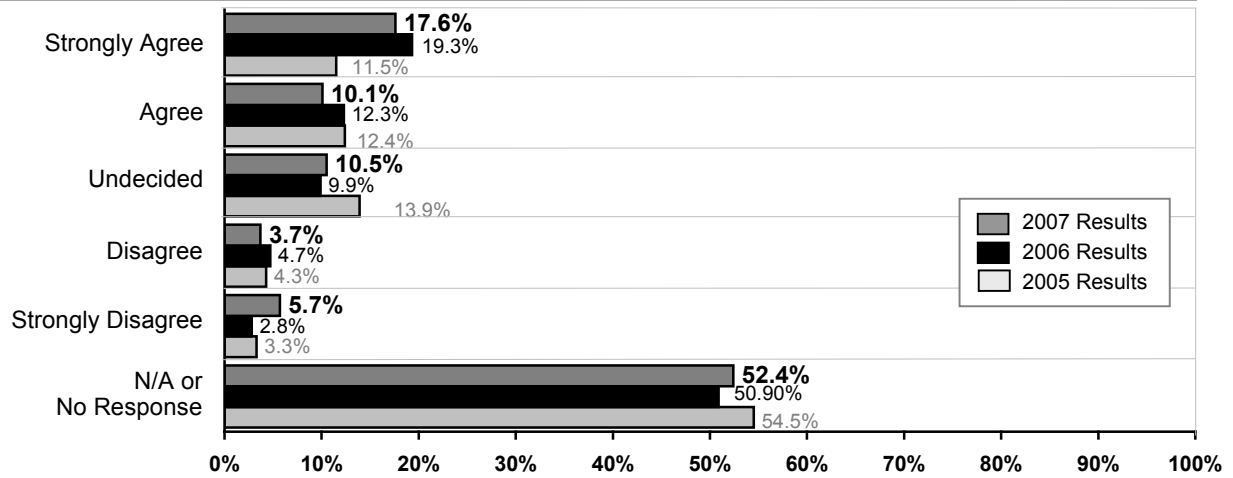
7. The team is sensitive to my cultural, ethnic, and religious preferences and values.



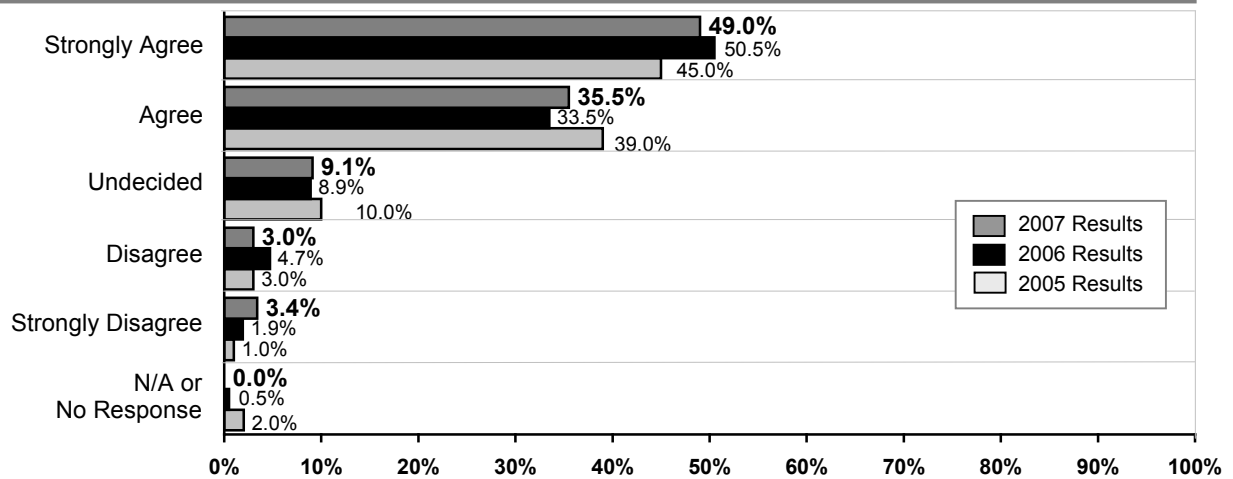
**8. The team schedules services and meetings at times that are convenient to my family.**



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

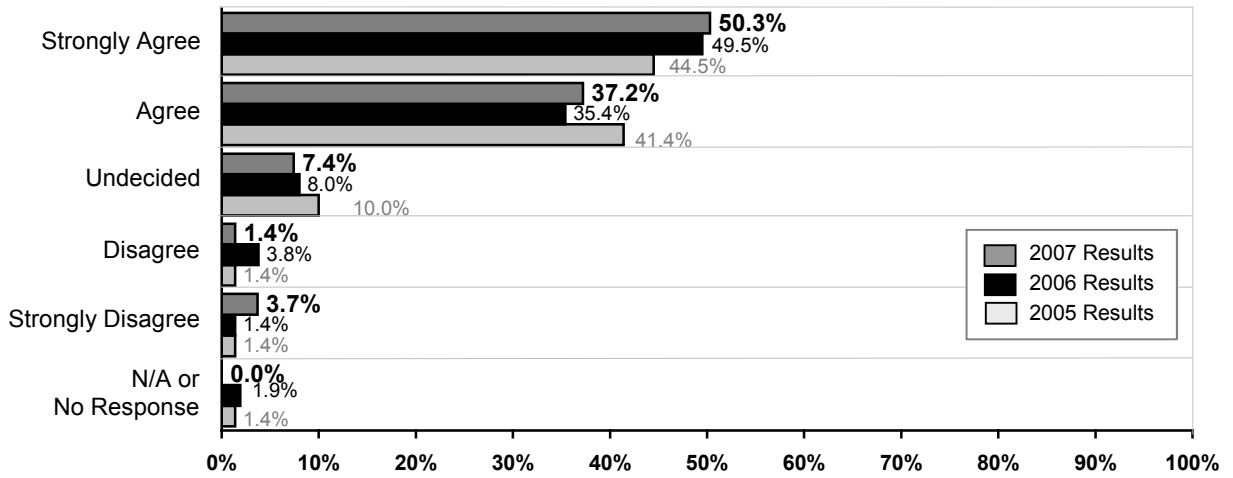


**10. I feel the team understands my child's strengths and needs.**

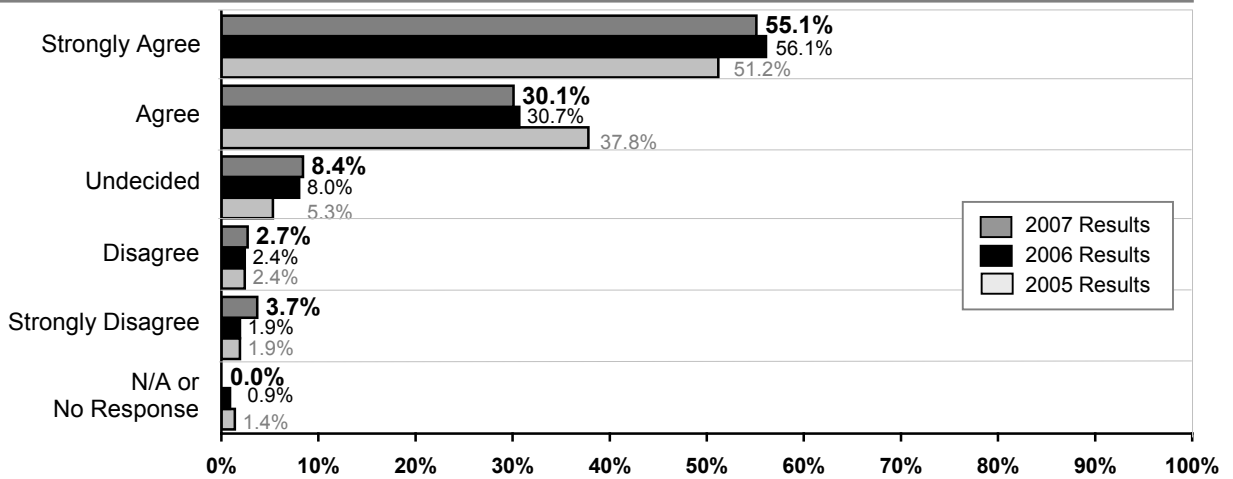


Family Satisfaction Survey

**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 38 sites that completed the report in 2007. For most indicators, sites were asked to choose a response from a Likert scale; responses that differ (e.g. "yes/no" responses) are noted.

<b>1. Parents* are involved as full partners at every level of activity</b> (*The term "parent" represents all caregivers)				
Indicators	4 – Always	3 – Often	2 – Seldom	1 - Never
<b>Team Participation</b>				
1. Parents may request meetings.	94.7%	5.3%	0%	0%
2. Parents are present at team meetings. Children are present whenever possible and appropriate.	84.2%	15.8%	0%	0%
3. Parents' needs are considered in scheduling meetings.	97.4%	2.6%	0%	0%
4. Parents are involved in selection of team members.	89.5%	10.5%	0%	0%
<b>Coordinating Committee Participation</b>				
1. Parents on Coordinating Committee and appropriate subcommittees	84.2% - YES			15.8% - NO
2. Parents attend at least 75% of scheduled Coordinating Committee meetings.	34.2%	39.5%	10.5%	15.8%
3. Parents feel they are listened to by other committee members and that they have an important role on the committee.	39.5%	44.7%	2.6%	13.2%

<b>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.</b>				
<b>Indicators</b>	<b>4 – Always</b>	<b>3 – Often</b>	<b>2 – Seldom</b>	<b>1 - Never</b>
1. Agreement incorporates all the members and components listed under State Statute 46.56 (3) (5).	86.8% - YES			13.2% - NO
2. The Coordinating Committee reviews interagency agreements at least every three years.	89.5% - YES			10.5% - NO
3. Coordinating Committee meets at least quarterly.	97.4% - YES			2.6% - NO
4. Conflict resolution policies are clearly written and reviewed at least annually.	92.1% - YES			7.9% - NO
5. Conflict resolution policies are followed when disagreements arise.	94.7% - YES			5.3% - 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.	63.2%	31.6%	2.6%	2.6%
7. Collaborating agencies are satisfied with process.	36.9%	57.9%	2.6%	2.6%

<b>3. Collaborative family teams create and implement individualized support and service Plans of Care for families</b>				
<b>Indicators</b>	<b>4 – Always</b>	<b>3 – Often</b>	<b>2 – Seldom</b>	<b>1 - Never</b>
1. Orientation is provided to all team members.	86.8% - YES			13.2% - NO
2. Team facilitator and/or service coordinator receive training and support.	78.9%	21.1%	0%	0%
3. Collaborative family team includes membership from home, school and community.	68.4%	31.6%	0%	0%
4. Team composition is consistent with family culture and preferences.	78.9%	21.1%	0%	0%
5. Family is satisfied with its team.	15.8%	81.6%	2.6%	0%
6. Family is satisfied with the team process.	15.8%	81.6%	2.6%	0%
7. Process is a collaborative team effort that begins with an individualized strengths and needs based assessment.	76.3%	21.1%	2.6%	0%
8. Plan of Care flows from assessment.	81.6%	15.8%	2.6%	0%
9. Plan of Care incorporates strengths of child, family and team.	76.3%	21.1%	2.6%	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.	65.8%	31.6%	2.6%	0%

<b>3. Collaborative family teams create and implement individualized support and service Plans of Care for families (Continued)</b>				
<b>Indicators</b>	<b>4 – Always</b>	<b>3 – Often</b>	<b>2 – Seldom</b>	<b>1 - Never</b>
11. Family and other team members sign the Plan of Care.	86.8% - YES			13.2% - NO
12. Transition is addressed for major life changes.	34.2%	55.3%	7.9%	2.6%

<b>4. Significant collaborative funding is available to meet the financial needs identified in the Plan of Care</b>				
<b>Indicators</b>	<b>4 – Always</b>	<b>3 – Often</b>	<b>2 – Seldom</b>	<b>1 - Never</b>
1. Agencies contribute resources and funding to meet the needs of families.	21.1%	73.7%	2.6%	2.6%
2. Child and family teams use funding flexibly to support individualized service.	44.8%	36.8%	7.9%	10.5%
3. Child and family teams utilize informal community resources.	47.4%	50.0%	2.6%	0%

<b>5. Advocacy is provided for each family</b>				
<b>Indicators</b>	<b>4 – Always</b>	<b>3 – Often</b>	<b>2 – Seldom</b>	<b>1 - Never</b>
1. Family advocacy information and options are provided.	92.1% - YES			7.9% - NO
2. Advocates participate as team members as requested by the family.	97.4% - YES			2.6% - NO
3. Service Coordinators advocate for families	89.5%	10.5%	0%	0%

<b>6. Ongoing training is provided to all participants</b>				
<b>Indicators</b>				
1. Coordinating Committee and Project Coordinator identify training needs on an ongoing basis.	97.4% - YES			2.6% - NO
2. Annual local training opportunities are made available to families, staff, and all others involved with the ISP and/or CST process.	92.1% - YES			7.9% - NO

<b>7. Functional goals are monitored and measured, emphasizing participant satisfaction</b>				
<b>Indicators</b>	<b>4 – Always</b>	<b>3 – Often</b>	<b>2 – Seldom</b>	<b>1 - Never</b>
1. Generally, Outcomes show: <ul style="list-style-type: none"> <li>Decrease in police contact/recidivism rates</li> <li>Maintenance or decrease in level of restrictiveness of living environment</li> <li>Improvement in grades</li> <li>Improvement in attendance</li> <li>Decrease in problem behaviors</li> </ul>	92.1% - YES			7.9% - NO
	97.4% - YES			2.6% - NO
	83.8% - YES			16.2% - NO
	89.5% - YES			10.5% - NO
	94.7% - YES			5.3% - NO
2. Plan reviews are held at least every six months.	97.4% - YES			2.6% - NO
3. Family is satisfied with process.	15.9%	78.9%	2.6%	2.6%
4. Family is satisfied with outcomes.	18.5%	76.3%	2.6%	2.6%
5. Providers are satisfied with process.	21.1%	73.7%	2.6%	2.6%
6. Providers are satisfied with outcomes.	15.9%	78.9%	2.6%	2.6%

<b>8. Adolescents are ensured a planned transition to adult life</b>				
<b>Indicators</b>	<b>4 – Always</b>	<b>3 – Often</b>	<b>2 – Seldom</b>	<b>1 - Never</b>
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.	86.8% - YES			13.2% - NO
2. Plans of care reflect collaborative transitional planning for children age 14 and older identified as needing services beyond age 18.	84.2% - YES			15.8% - NO
3. For the most seriously ill adolescents, within one year of transition to adult living: <ul style="list-style-type: none"> <li>Action steps are clearly defined</li> <li>Needed referrals have been made</li> <li>Future collaborators are invited to team meetings</li> </ul>	36.8%	42.1%	5.3%	15.8%
	47.4%	34.2%	2.6%	15.8%
	42.2%	36.8%	2.6%	18.4%