

Children Come First Advisory Committee

2009 Annual Report

On Integrated Services Projects and Coordinated Services Team Initiatives



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The 2009 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 the wraparound team I was able to get the help my family needed... I am filled with hope."
- 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 2009, 38 counties and 4 tribes received funding through contracts with the Bureau of Prevention Treatment and Recovery (BPTR). The funding came

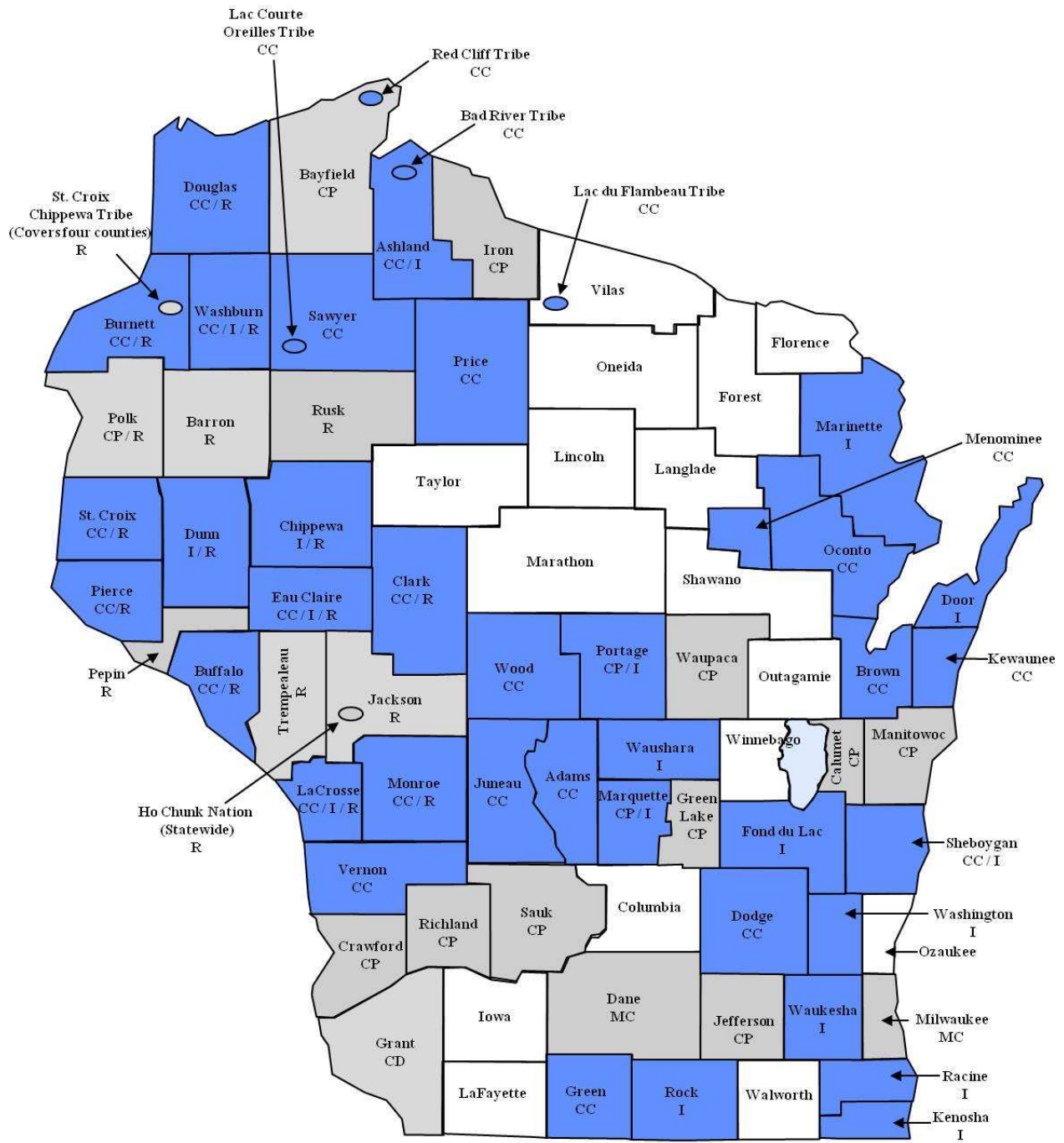
from MHBG funds, Substance Abuse Grant funds, and Hospital Diversion funding. In addition, the Division of Children and Family Services collaborated with BPTR to contribute funding for CST sites. Below is a summary of counties and tribes with Integrated Services Projects and Coordinated Services Team Initiatives.

Integrated Services Projects		
<ul style="list-style-type: none"> • Ashland • Chippewa • Door • Dunn • Eau Claire • Fond du Lac 	<ul style="list-style-type: none"> • Kenosha • La Crosse • Marinette • Marquette • Portage • Racine 	<ul style="list-style-type: none"> • Rock • Sheboygan • Washburn • Washington • Waukesha • Waushara
Counties and Tribes Receiving 5-Year CST Implementation Grants in 2009		
Counties:		
<ul style="list-style-type: none"> • Adams • Ashland • Brown • Buffalo • Burnett • Clark • Crawford • Dodge • Douglas 	<ul style="list-style-type: none"> • Eau Claire • Green • Juneau • Kewaunee • La Crosse • Menominee • Monroe • Oconto • Pierce 	<ul style="list-style-type: none"> • Polk • Price • Richland • Sawyer • Sheboygan • St Croix • Vernon • Washburn • Wood
Tribes:		
<ul style="list-style-type: none"> • Bad River Band of Lake Superior Chippewa Indians • Lac Courte Oreilles Band of Lake Superior Chippewa Indians • Lac du Flambeau Band of Lake Superior Chippewa Indians • Red Cliff Band of Lake Superior Chippewa Indians 		
Counties whose 5-Year CST Implementation Grants Have Ended		
<ul style="list-style-type: none"> • Bayfield • Calumet • Green Lake 	<ul style="list-style-type: none"> • Iron • Jefferson • Manitowoc 	<ul style="list-style-type: none"> • Marquette • Portage • Sauk • Waupaca

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.

A Statewide look at Collaborative Systems of Care Serving Children and Families in 2009



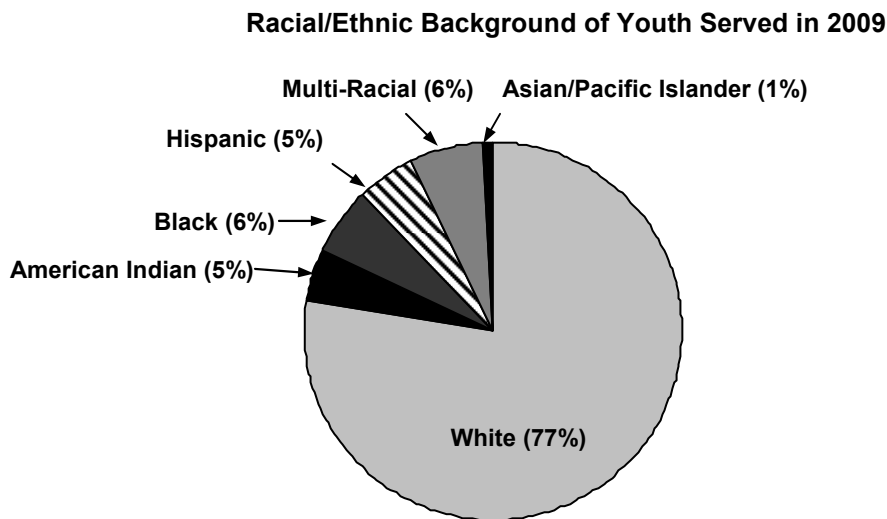
C	Receiving Coordinated Services Team (CST) Implementation Grants in 2009	CD	Developing CST with limited training & technical assistance (without implementation grant)
I	Receiving Integrated Services Project (ISP) grant funding in 2009	R	Receiving Regional Partnership (RPG) initiative funding in 2009
C P	No longer receiving CST Implementation Grants; sustaining CST without grant	MC	Managed Care Sites

CHILDREN'S OUTCOME DATA

The following information is based on data from Integrated Services Projects (ISP) and Coordinated Services Team (CST) sites that submitted quarterly data to the Bureau of Prevention Treatment and Recovery (BPTR) in 2009.

Demographic Information

Information from 766 youth who were served for at least part of 2009 was submitted by the ISP/CST initiatives. Of these youth, 63% were male and 37% female, with an average age of 11.6 years. Forty percent of children are 14 years old and over and 31% are between the ages of 10 and 13. Twenty-three percent of children were 6-9 years old and a small number of children (6%) served were under 5 years old. The ISP/CST initiatives serve a relatively racially-diverse population of children. Twenty-three percent of children served in 2009 had a non-Caucasian racial/ethnic background compared to 20% of youth in the general population (2008 Youth Risk Behavior Survey, Wisconsin DPI). See the chart below for more information.



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. 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, parents and service providers having considered placement in a more restrictive setting at time of referral, or behavior not improving despite multiple supports and services. ISP and CST initiatives strive to support youth and their families in the least restrictive setting possible, diverting children when appropriate, from costly out-of-home placements by developing supports and services that meet their needs in the community. In fact, at the time of enrollment in an ISP or CST, 87% of children were in a community placement (i.e. with parents, relatives, or friends).

Other children are living in a more restrictive placement at the time of enrollment, which the ISP/CST interagency team then addresses by making community placement a primary goal of the child's plan of care. In 2009, 4% of all newly-enrolled children were living either in mental health institutions, inpatient hospitals, or residential facilities at the time of their enrollment. Eight percent of children were living in group homes or foster care placements.

A primary goal for children living in community placements at time of enrollment in the initiative is that their community placement be maintained. A primary goal for children living in restrictive out-of-home placements at enrollment is that the team plan for placement in less restrictive and less costly community placements by the time of their disenrollment. Of all the children disenrolled in 2009 for whom complete data was available (n=260), 93% experienced reduced levels of restrictiveness with regards to placement, or maintained low levels of restrictiveness while being served in the ISP/CST initiatives. 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, or residential treatment centers at the time of enrollment, six children were living with their biological parents and three children were living in less restrictive out-of-home placements at time of disenrollment.
- Of the 230 children living with a parent, friend, or relative at the time of their enrollment, 95% were still living in the same environment at disenrollment.

School Attendance, Behavior, and Performance

ISP and CST initiatives make it a priority within children's plans of care to address educational needs that are identified as part of the team process. Academic performance in school may suffer for some children dealing with mental health issues, for some their issues may lead to aggressive or anti-social behavior that can lead to school sanctions. Their emotional problems may also lead to or increase 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 school period in 2009, a majority of the 594 children with school setting data were receiving some form of special educational assistance:

- 61% were receiving special educational services within a regular public school,
- 21% were placed in special educational schools or other alternative educational settings, and
- 18% needed no special educational services or alternative educational settings.

School performance and behavior are monitored by ISP/CST's every school semester for enrolled children. Data from 155 children disenrolled from ISP/CST in 2009 was used to determine changes in school performance and behavior. Despite the issues enrolled children faced, they attended school very regularly. Of the 155 children, 72% had no unexcused absences in the semester preceding their enrollment and repeated that attendance record in the last semester before their disenrollment. Twelve percent were able to reduce their unexcused absences.

For children who exhibit behavioral problems in school, ISP/CST's often work to reduce those behaviors that may lead to suspensions and expulsions. Of the 155 children, 75% had no school suspensions or expulsions in the semester before their program enrollment; 67% had no suspensions or expulsions at the time of their disenrollment.

School performance is also monitored by ISP/CST's. At the time of enrollment, 75% of the 130 children who were eventually disenrolled in 2009 had an average overall grade of "C" or better, or had "satisfactory" performance. By their 2009 disenrollment there was a slight improvement to 77% having an average overall grade of "C" or better, or having "satisfactory" performance. Nine percent of children were failing at the time of enrollment, but were able to improve their grade average to a "C" or better by the time they were disenrolled. Another 5% of children were able to lift their grade average from below to above a "C" by the time they were disenrolled.

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 777 children served in 2009, 263 (34%) were disenrolled during some time during 2009. Of the 263 children disenrolled in 2009, 70% (n=184) committed no offenses at any time during their enrollment or shortly before their enrollment. Another 5% of children committed an offense shortly before their enrollment into ISP/CST services, but committed no offenses during their enrollment. Thus, a combined 75% (n=197) of children committed no offenses during their enrollment in ISP/CST services. Although the rest of the children committed at least one offense during their enrollment, a portion of children were able to reduce their juvenile offenses while participating in the ISP/CST programs. Of the 67 discharged children who committed offenses during enrollment, 46% (n=31) committed no offenses after the first six months of their ISP/CST services. Of all children disenrolled in 2009, 14% (n=36) continued to commit offenses after six months of ISP/CST services.

Ratings with the Child and Adolescent Needs and Strengths (CANS) Assessment Tool

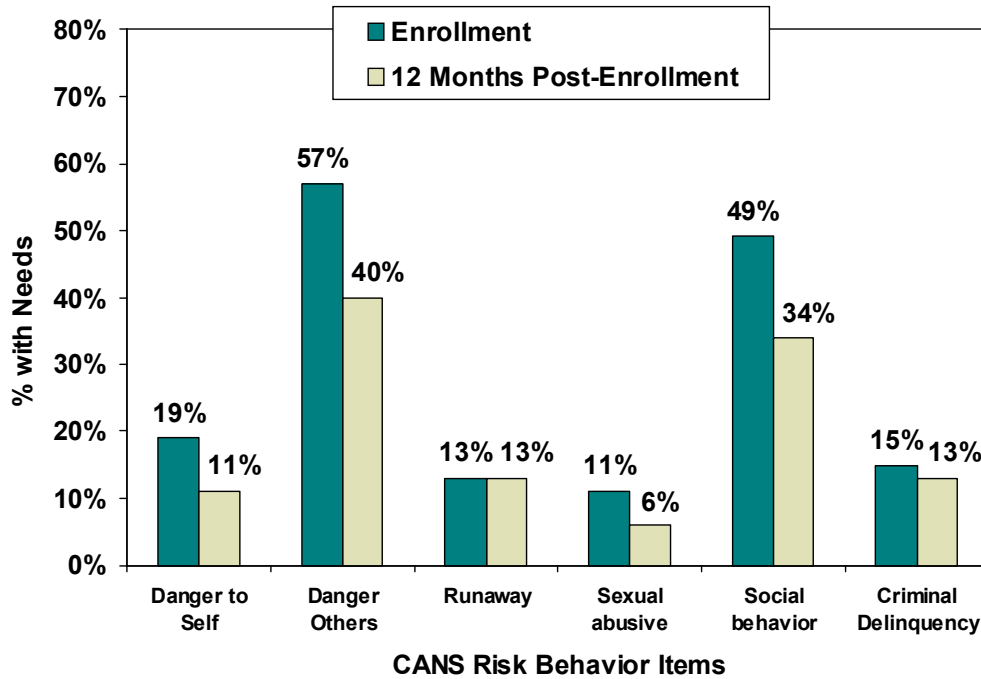
The Child and Adolescent Needs and Strengths (CANS) tool was developed to assist in the management and planning of services to children and adolescents and their families with the primary objectives of permanency, safety, and improved quality of life. The dimensions and objective anchors used in the CANS were developed by focus groups with a variety of participants including families, family advocates, representatives of the provider community, mental health case workers and staff. The CANS is designed for use at two levels—for the individual child and family and for the system of care. The CANS provides a structured assessment of children along a set of dimensions relevant to service planning and decision-making. Also, the CANS provides information regarding the child and family's service needs for use during system planning and/or quality assurance monitoring. The CANS instrument for children with mental health needs includes domains that cover Clinical Problem Presentation, Risk Behaviors, Functioning, Child Safety, Caregiver Needs, and Child Strengths. ISP/CST Coordinators work with families and team members to determine an appropriate rating for the child based on a 4-point scale. The ratings are based on the intensity of the child's need or strength and are used to determine what areas need to be addressed in the child and families' plan of care. The ratings used are:

- '0' indicates *no need for action*
- '1' indicates *a need for watchful waiting* to see whether action is needed
- '2' indicates *a need for action*
- '3' indicates the need for either immediate or intensive action

A rating of 2-3 indicates areas that should be addressed in the plan of care. The CANS tool is used to assess the child's status at enrollment and every 6 months thereafter as long as the child is enrolled in the ISP/CST. In addition to its use as an assessment tool, the CANS can also be used to monitor outcomes for children and families.

The chart below describes the change in the percentage of children exhibiting risky behaviors at enrollment and 12 months after enrollment (data was available for 47 children). For 4 of the 6 risk behaviors listed, the percentage of children with needs had dropped significantly. The percentage of children that were a danger to themselves or sexually abusive was reduced by about half. At enrollment, 57 percent of children were a danger to others and another 49% of children exhibited "social behavior" that was defiant and sanction-seeking. However, at the time of their discharge, the percentage of children who displayed these risky behaviors had been reduced to 40 and 34 percent respectively.

Change in Children's Risk Behaviors (N=47)

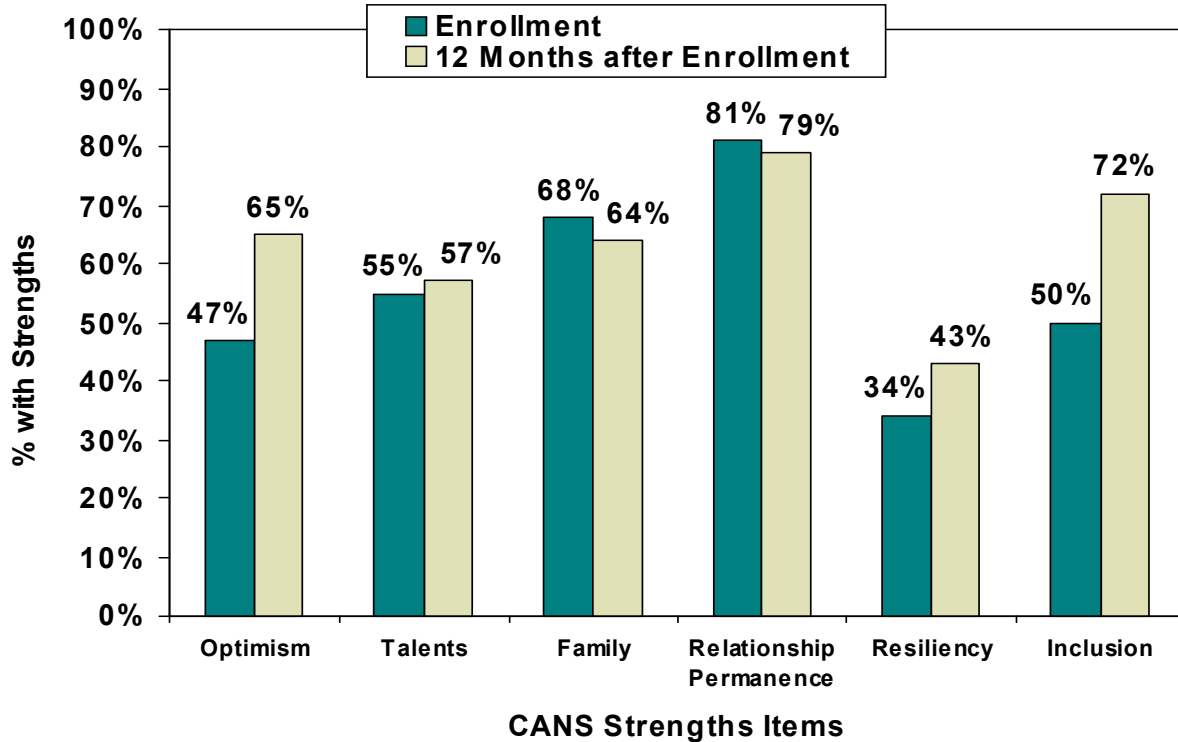


In addition to needs and deficits, the CANS is also used to measure the strengths of the child. Twelve areas of potential strengths are assessed with the CANS using the rating scale below. When a centerpiece strength is identified (rating=0), it becomes a potential area to “build around” in the plan of care; when an area is identified without a strength for the child (rating=3), it becomes a potential area to “build up” in the plan of care.

- '0' indicates a *centerpiece strength*. The focus of a strength-based plan.
- '1' indicates a *useful strength*. It can be included in a strength-based plan.
- '2' indicates an *identified strength*. It could be developed to become useful.
- '3' indicates *no strength has been identified*.

The chart below displays the progress children and families made in building additional strengths (rating of 0 or 1) from the time of enrollment to 12 months after enrollment for the 47 children for whom complete data was available. For the six strength areas displayed, a significant increase in identified strengths occurred between enrollment and 12 months after enrollment in three areas. The percentage of children who felt optimistic about their current and future lives increased 18 percent. Similarly, the percentage of children who became involved in their community through activities like Girl/Boy Scouts, athletics, etc., increased by 22 percent up to 72 percent after 12 months. “Resiliency” describes a child’s ability to utilize his/her internal, individual strengths such as music and art to cope with difficult times in their life. Fewer children exhibited this strength relative to others, but the percentage of resilient children increased by approximately 10 percent. The percentage of children who have had permanent and stable relationships with parents or other adults did not change; approximately 80 percent of children entered services with strong, permanent adult relationships.

Change in Children's Strengths (N=47)

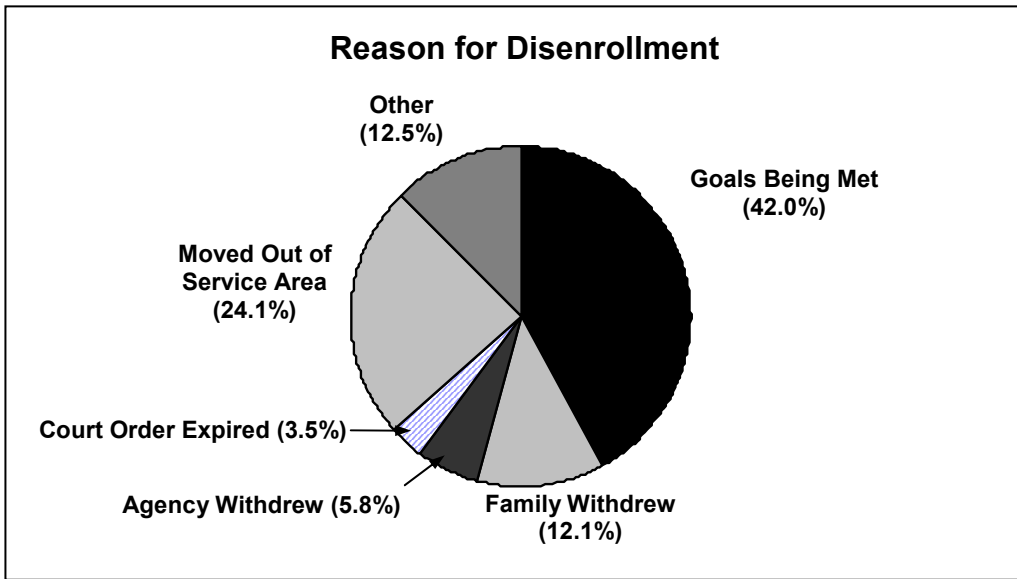


Disenrollment/Transition

ISP/CST projects submitting quarterly data during 2009 reported that of 261 children disenrolled, the average length of enrollment was 15 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.
- **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.
- **Court Order Expired:** If services for the child are court-ordered and the order expires.
- **Other:** This category serves as a "catch all" for reasons that do not clearly fit into other categories.

The following chart summarizes the reasons for disenrollment in 2009:



SYSTEMS CHANGE UPDATE SURVEY RESULTS

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).

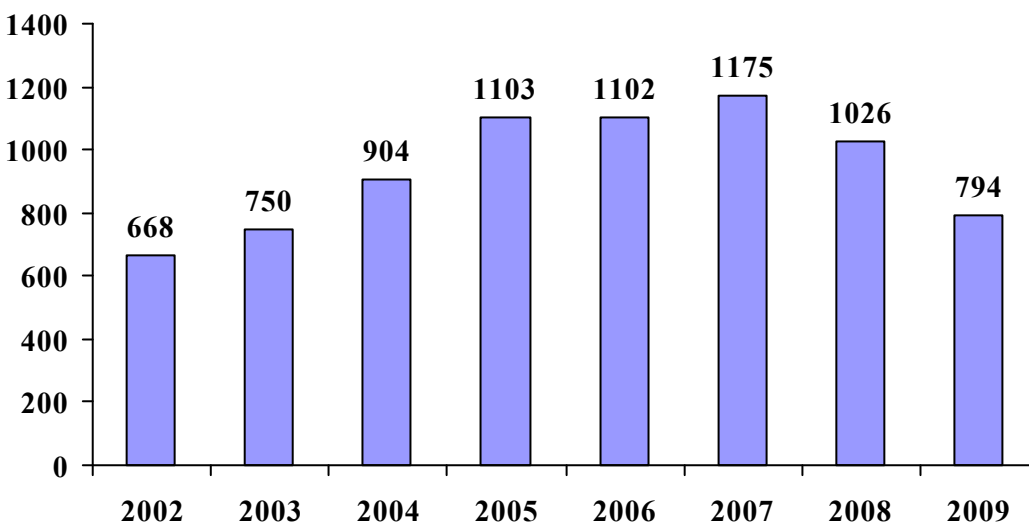
Part A: Enrollment Information

Due to resource constraints, ISP/CST initiatives are asked to report children's outcome data for just a portion of all children served. Thus, the children's outcome data reported in the previous section does not provide an accurate count of all children served. The Systems Change Update Survey was implemented to allow the initiatives to report the total number of children and families served which is displayed below.

Child and Family Teams

In 2009, there were 794 child and family teams being served by CST and ISP across Wisconsin. The average length of enrollment per child and family team was 13.4 months. The median number of family teams served per county in 2009 was 16. The graph below summarizes the number of enrolled teams over the past eight years:

Child and Family Teams 2002 - 2009



Although the number of child and family teams decreased significantly from 2008 to 2009, the number of programs submitting data remained the same at 38. However, five new CST's replaced five non-reporting existing ISP/CST's in 2009. The five start-up CST's that submitted enrollment data for the first time in 2009 (Buffalo, Red Cliff tribe, Sawyer, Vernon, and Wood) reported a total of 27 child and family teams served. The five existing ISP/CST's that did not submit data in 2009 (Door, Eau Claire, Jefferson, Menominee, and Sauk) reported a total of 184 child and family teams served in 2008. This shift to more start-up CST's who typically serve fewer children in their first year accounts for a large percentage of the decline in child and family teams in 2009. When existing CST's complete their 5-year state-funded phase of development, their data reporting becomes optional. Three of the five programs that did not report data in 2009 fit this category. If this trend continues, the number of enrolled child and family teams reported can only level off or decrease.

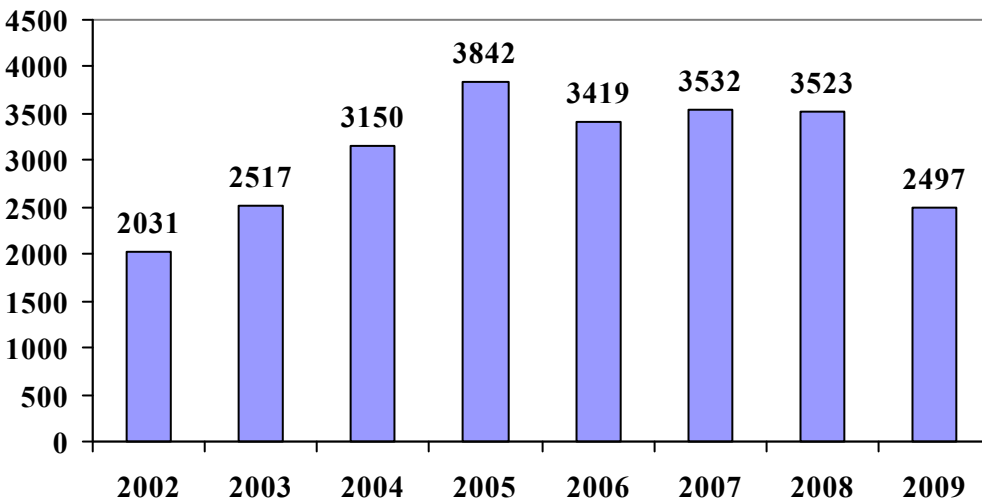
For a small number of programs that responded in 2008 and 2009, there was a drop in the number of children and families served. For example, in Waupaca, 79 teams existed in 2008 and that dropped to 16 teams in 2009. The median number of enrolled teams in 2008 was 17 compared to 16 teams in 2009. The similarity in the median number of teams reinforces the fact that the few large programs that did not report in 2009 account for much of the reported decline in 2009.

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 2009, there were 1,703 additional family members served and a median of 30 served per site. The median number of family members other than the child receiving services in 2008 was 38.

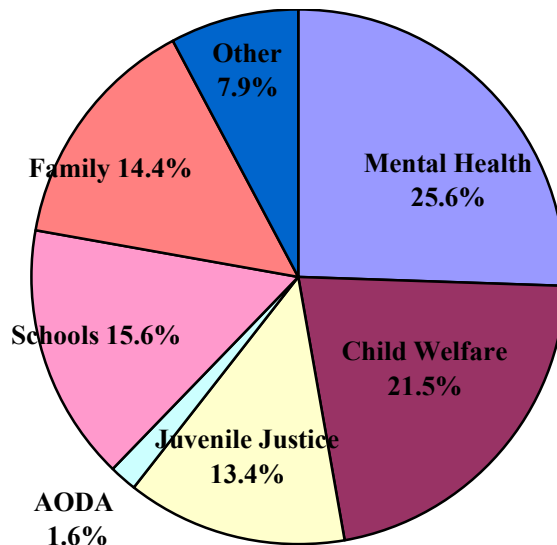
The total number of children and family members served in 2009 was 2,497 (794 children and 1,703 additional family members). The graph below summarizes the total number of children and family members served over the past eight years.

Total Number of Children & Family Members Served by Teams 2002 - 2009



Referral Source

The chart below summarizes sources of referrals made to Collaborative Systems of Care in 2009.



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

Counties and tribes with an ISP and/or a 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
- Cost effectiveness
- 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?

- Twenty-two sites (69%) identified an increase in inter-system and cross-system collaboration, coordination and teaming.
 - One CST program stated, “Before our ISP started there was not much going on in terms of teaming in the community. Now that we started doing this and others are starting to become part of our teams; they took this concept back to their agencies, school buildings and within their families and now more are doing this on their own and with other families as well.”
- Fourteen sites (44%) identified a high level of parent and participant satisfaction.
 - One CST initiative shared quotes from team participants responding to the question: “In what ways has the team experience benefitted you?” Responses included:
 - “I would not be where I am without them; my son is doing great! “
 - “I am not alone in this process and it is great to have the support and ideas of team members.”
 - “I have enjoyed the team process. I couldn’t have imagined having to do this on my own.”
- Five sites (16%) identified a decrease in juvenile justice involvement and/or out of home placement.
- Five sites (16%) identified an increase in the service population and having the ability to provide more resources to more families in the community.

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

- Twenty-seven sites (84%) identified the ISP/CST process as “cost effective.”
- Four sites (13%) replied that they were uncertain.
- One site (3%) did not find the ISP/CST process to be “cost effective.”

2B. Please explain why you believe your program is or is not cost effective. If you don’t know, please explain what information you are missing or why the information you have is unclear.

- Twenty-four sites (75%) identified a decrease in out-of-home placements for the children and shorter placements when placements are necessary.
 - One site stated, “Although there are no current figures to provide, supporting families through ISP saves the county money by preventing out of home placements; shorter hospital stays and shorter out of home placements.”
- Ten sites (31%) identified bringing resources together and locating natural supports for the families are helpful.

- One site used the following description: “ISP also promotes cost effective services by helping to identify and utilize informal and natural supports in the community.”

3A. Are there cost savings?

- Twenty-two sites (69%) identified the ISP/CST process as having “cost savings.”
- Ten sites (31%) reported that they were uncertain.

3B. Please explain why you believe your program does or does not have cost savings. If you don’t know, please explain what information you are missing or why the information you have is unclear.

- Fourteen sites (44%) identified that the ISP/CST process eliminates and shortens out-of-home placements.
 - Per one site: “The ISP program decreases placement costs as it decreases out of home placements and shortens the length of time children are in placement.”
- Six sites (19%) identified that creating community collaboration and informal supports for the family has cost savings.
 - One used this illustration: “The program emphasizes community collaboration, resulting in less duplication of services and higher efficiency. The team process allows for constant quality improvement.”
- Six sites (19%) said the cost savings are hard to measure.
 - One site explained this by stating: “At this time; our agency does not have a system in place to capture data regarding cost savings.”

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

- Nine sites (28%) identified a lack of or decrease in community resources and services.
 - One site explained this by stating, “CST has positively impacted the child and family service delivery system. Unfortunately, we are in a time where, because of fiscal pressures, resources are becoming scarce. Usually early intervention and prevention services are the first services to be cut as they are not mandatory. When this occurs, the county system then becomes responsible for serving larger number families with increasing levels of need.”
- Eight sites (25%) identified financial concerns, including financial sustainability of the ISP/CST.
 - Per one site, “Loss of IV-E dollars and levy limits of counties and flat (actually reduced) state funding jeopardize the program and threaten to reduce its utilization dramatically.”
- Seven sites (22%) identified team process issues.
 - One site stated, “Our team facilitators are relatively new to the field of social work and often work with families who have been in the system for a very long time and know more about it than the facilitators. This is intimidating and troublesome. Continued experience and training along with support meetings help with regard to this problem.”
- Four sites (13%) identified a lack of school participation and dedication.
 - One site used this example: “CST is also being viewed as a program within the community and other entities, such as the schools, have not been willing to put energy into taking on the CST model as they don't feel they could do it effectively.”
- Four sites (13%) identified that the ISP/CST initiatives should provide services to a broader range of clients.
- Four sites (13%) identified paperwork and reporting issues.
- Four sites (13%) identified family financial issues including lack of transportation.

5. What recommendations would you make to improve your ISP/CST process?

- Twelve sites (38%) identified the need to continue to engage the community and maintain relationships with community partners.

- One site stated, "Continue to support others in recognizing the benefits of teaming. Continue to meet with the community partners to spread the concept of teaming in other agencies as well as our own."
- Eleven sites (34%) identified the need for continued funding.
 - One site mentioned, "In an economic time in which budgets are getting cut year after year; it does not appear likely that our county is going to be able to sustain this program without new funding being identified. This would have been a great program to utilize IV-E money towards in the past; however; that funding does not exist anymore."
- Five sites (16%) identified continued training efforts on the CST process.
- Four sites (13%) identified the need for more family and parental involvement.
- Four sites (13%) identified the need for more communication and collaboration with schools.

FAMILY SATISFACTION SURVEY RESULTS

Methods

The Division of Mental Health and Substance Abuse Services administered the youth Mental Health Statistics Improvement Program (MHSIP) Satisfaction Survey via mail. The MHSIP survey is the federally-recommended survey to measure client perception of care in mental health programs. Currently, 52 states and territories use the MHSIP Satisfaction Survey to measure consumer satisfaction and guide quality improvement efforts. Wisconsin administers the MHSIP youth survey to a random sample of parents in the statewide public mental health system on an annual basis. In 2009 for the first time, Wisconsin also administered the MHSIP youth survey to parents of children in ISP/CST initiatives. For more information on the MHSIP, please visit: www.mhsip.org.

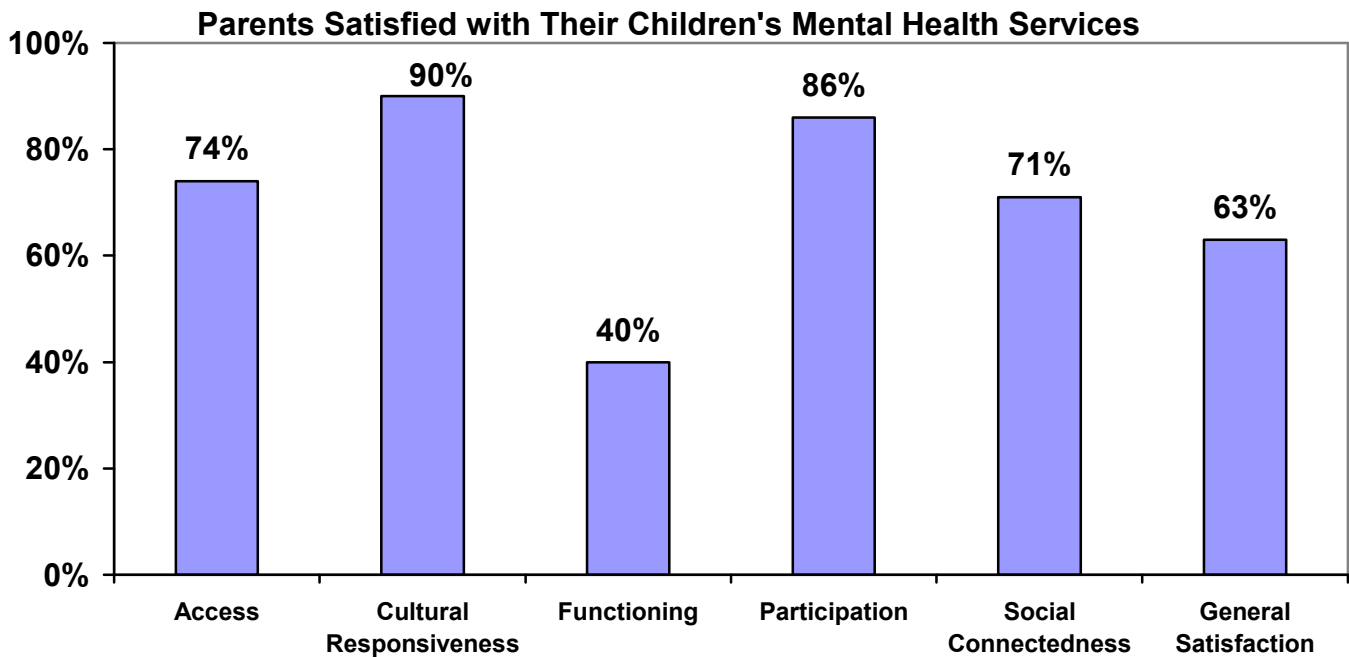
Parents or guardians were asked to complete surveys about their satisfaction with mental health services for their children who are 6-17 years old. All children and families enrolled in an ISP/CST as of October 1, 2009 were eligible to be surveyed. A \$2 bill was sent in the first mailing as an incentive and three follow-up mailings were used to remind parents to complete the survey. The University of Wisconsin Survey Center (UWSC) in Madison conducted the mail survey and the response rate was 52 percent.

Demographics

The parents and legal guardians of 204 youth around the state completed surveys regarding their satisfaction with the mental health services their child received while enrolled in ISP and CST initiatives. Of the 204 respondents, 67% were male and 33% were female, with an average age of 13. About half of children are aged 13 and over, 29% are between the ages of 10 and 12, and 23% are between 6-9 years old. The racial background of most children (79%) surveyed was Caucasian, but 5% were African American, 4% were American Indian, and another 7% had a mixed racial background. Of the parent respondents, 88% were the child's biological parent, step-parent, or adoptive parent.

Overall Results

The percentage of parents/guardians with positive perceptions of their child's mental health care in each domain of questions is presented in the figure below. The highest rated domain of questions across the 2009 survey was the Cultural Sensitivity domain. Ninety percent of parents felt staff were sensitive and respectful of their cultural background. Overall, however, the parents of youth consumers reported generally lower levels of satisfaction in the functioning domain; only forty percent reported satisfaction with their child's improvement as a result of their mental health services.



Item-Level Results

When individual questions were examined for quality improvement efforts, the most positively rated questions are about how the staff spoke in an understandable way and that the parent participated in the child's treatment. Eighty-eight percent of parents said that staff were sensitive to their cultural/ethnic background. All five of the lowest rated questions were in the functioning scale (see all item-level results on the next page).

The questions in the functioning scale that were rated lowest were questions about the child being better able to cope when something goes wrong and the whether the child is better able to do things he or she wants. Forty percent of parents agreed that the child was better able to cope when something goes wrong, and forty-five percent of parents agreed that the child is better able to do things that he or she wants.

Overall, the questions that make up each scale are representative of the overall scale score that they are associated with. Parents seemed to be most satisfied with their participation in their child's treatment. Parents were least satisfied with the status of the family life at the time that they completed the survey.

Satisfaction for Children Enrolled vs. Disenrolled

When looking at the results overall, it is clear that parents are more satisfied if their child is still receiving mental health services. After children are disenrolled, parents' satisfaction tends to decline. For example, parents whose child was still receiving mental health services at the time of the survey were significantly more satisfied with whether the staff spoke in an understandable way. Eighty-six percent of satisfied parents had children still receiving mental health services. This same trend was also prevalent with many other questions regarding cultural responsiveness and participation in treatment planning.

Parent Responses to Open-Ended Questions

In addition to the other questions, parents were also asked questions about what was most helpful about the mental health services they had received in the last year, and some suggestions for improvement.

1. What has been most helpful about mental health services you and your child received over the last 12 months?

There were 165 respondents to this question. The answers showed some common themes throughout that are summarized below.

- Appreciate the counseling and services our child has received
- Our child and family has been able to open up to staff
- Like having a professional to talk to about our child's needs and learn more from professionals about how to understand and best care
- Like that our child has someone to talk to
- Saw positive changes in our child
- Appreciate convenience of counseling (appointment times, come to home, etc.)
- Appreciate the services with medication that our child has received
- Feel supported by the staff and team
- Some issues with insurance and issues with various sites, but were mostly resolved

2. What suggestions for improving the mental health services you and your child received in the last 12 months?

There were 159 respondents to this question. The summary of the most common responses is below.

- Would like more one-on-one counseling with our child
- Would like more psychiatric youth doctors
- Availability/variety of services in rural areas is lacking
- Treatment is expensive- city or county should help cover costs
- Communication between all stakeholders (doctors, social workers, mental health staff, schools, parents, child, etc.) is key and is lacking in some situations
- Schools should be more involved in the mental health diagnoses/needs of children in their schools
- Some said the treatment their child received was not enough (not long enough, not often enough, etc.)
- Lots of insurance issues need explaining, especially Badger Care issues

**2009 Positive Responses From Parents About Youth Mental Health Services
(Percent Who Agree or Strongly Agree)**

	Percent
GENERAL SATISFACTION WITH MENTAL HEALTH SERVICES	
Overall, I am satisfied with the services my child received.	72%
The people helping my child stuck with us no matter what.	73%
I felt my child had someone to talk to when he/she was troubled.	68%
The services my child and/or family received were right for us.	65%
My family got the help we wanted for my child.	67%
My family got as much help as we needed for my child.	51%
PARTICIPATION IN TREATMENT PLANNING	
I helped to choose my child's services.	80%
I helped to choose my child's treatment goals.	83%
I participated in my child's treatment.	93%
ACCESS TO MENTAL HEALTH SERVICES	
The location of services was convenient for us	79%
Services were available at times that were convenient for us.	77%
CULTURAL RESPONSIVENESS OF MENTAL HEALTH SERVICES	
Staff treated me with respect.	87%
Staff respected my family's religious/spiritual beliefs.	90%
Staff spoke with me in a way that I understood.	92%
Staff were sensitive to my cultural/ethnic background.	89%
FUNCTIONING	
My child is better at handling daily life.	50%
My child gets along better with family members.	49%
My child gets along better with friends and other people.	47%
My child is doing better in school and/or work.	55%
My child is better able to cope when things go wrong.	40%
My child is better able to do things he or she wants to do.	45%
SOCIAL CONNECTEDNESS	
I know people who will listen and understand me when I need to talk.	77%
I have people that I am comfortable talking with about my child's problems.	81%
In a crisis, I would have the support I need from family or friends.	69%
I have people with whom I can do enjoyable things.	77%

ANNUAL SYSTEM OF CARE REVIEW SURVEY RESULTS

In years past, sites with CST and ISP were asked to complete the “Eight Key Components of Collaborative Systems of Care”, 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. In 2009, this tool, renamed the “Annual System of Care Review” was expanded to include three parts: Part A: Eight Key Components of Collaborative Systems of Care; Part B: System of Care and Process Outcomes, and Part C: Coordinating Committee Recommendations.

Nineteen CST sites completed the report in 2009. Six of these sites were new sites (began developing CST in 2009) and utilized the tool to establish a baseline. *Below is a summary of responses from the thirteen established CST sites who completed the survey (“established sites” are defined as sites who have been developing CST for at least a year).*

Please note: 2009 was a transition year for this new evaluation tool, and was only required of some CST sites. Beginning in 2010, all CST and ISP sites will be required to complete the tool.

PART A: Eight Key Components of Collaborative Systems of Care

A Snapshot of 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

For each of the Eight Key Components listed above, sites were asked to respond to several indicators related to the “Key Component”. For most indicators, sites were asked to choose a response from a Likert scale (shown below); responses that differ (e.g. “yes/no” responses) are noted.

Likert Scale: 4 – Always 3 – Often 2 – Seldom 1 - Never

<i>Indicators</i>	<i>Average Rating</i>
1. Parents* are involved as full partners at every level of activity <i>*The term “parent” represents the primary caregiver(s)</i>	
1. Parents may request team meetings.	3.9
2. Parents are present at team meetings.	4.0
3. On child/family teams, the identified child/youth is present whenever possible and appropriate.	3.7
4. Parents’ needs are considered in scheduling meetings.	4.0
5. Parents are involved in selection of team members.	4.0

6. Parents represent at least 25% of the membership on the Coordinating Committee and appropriate subcommittees	50% - Yes 50% - No
7. Parents attend at least 75% of scheduled Coordinating Committee meetings.	3.3
8. Parents feel they are listened to by other committee members and that they have an important role on the committee.	3.5

2. An inclusive interagency group (Coordinating Committee) serving children and families has agreed upon the Core Values and Guiding Principles which are in the Interagency Agreement	
1. The Coordinating Committee reviews interagency agreements annually.	85% - Yes 15% - No
2. Processes for referral, service coordination, intake, assessment, plan of care development, and transition are established.	100% - Yes 0% - No
3. Coordinating Committee meets at least quarterly.	100% - Yes 0% - No
4. Conflict resolution policies are clearly written and reviewed at least annually.	92% - Yes 8% - No
5. The Coordinating Committee assures that the core values and guiding principles are evident in the operation of the integrated services system of care.	3.8
6. The Provider Satisfaction Survey is utilized to monitor the satisfaction of collaborating agencies with the process.	3.0

3. Collaborative family teams create and implement individualized support and service plans of care for families	
1. Orientation to the team process is provided to all team members.	93% - Yes 17% - No
2. The team approach is used to identify and develop needed informal and formal supports and services	3.7
3. There are enough service coordinators to serve the needs of all families screened for enrollment.	2.9
4. Team composition is consistent with family culture and preferences.	3.6
5. Process is a collaborative team effort that begins with an individualized strengths- and needs-based assessment.	3.9
6. A single Plan of Care which guides the team process is developed for each child and family team.	3.8
7. Plans of care incorporate strengths of the child, family and team as identified in the Assessment Summary of Strengths and Needs	3.9
8. Plans of care include specific actions to meet identified needs, including who is responsible for completing the action.	3.7
9. Family and other team members sign the Plans of Care.	93% - Yes 17% - No
10. On child/family teams, transition is addressed for major life changes (e.g. transition to different living environments, educational environments, etc.)	3.3

4. Significant collaborative funding is available to meet the financial needs identified in the Plan of Care	
1. Partner agencies contribute resources such as staff and other in-kind to support the collaborative team process	3.8
2. Partner agencies contribute financial resources to support the collaborative team process	2.5
3. Child and family teams use funding flexibly to support individualized service.	3.2
4. Child and family teams access informal community resources.	3.3

5. Advocacy is provided for each family	
1. Peer support (other parents with children who have multiple needs) and an advocate (someone who has been trained to support families involved in the team process) are offered as an option to enrolled families	2.5
2. Families are provided the option to have peer support specialists participate as team members.	2.7
3. Team members (including the service coordinator) advocate for families	3.9
4. Families are provided the option to attend formal training on how to become better advocates for their children	3.1

6. Ongoing training is provided to all participants	
1. Coordinating Committee and Project Coordinator identify training needs on an ongoing basis.	93% - Yes 17% - No
2. Annual local training opportunities are made available to families, staff, and all others involved with the ISP process.	100% - Yes 0% - No
3. Team facilitator and/or service coordinator receive training and ongoing support	3.8
4. Service coordinators have been trained and are certified to utilize the Child and Adolescent Needs and Strengths (CANS) tool.	3.8
5. A representative of the ISP/CST attends annual statewide and regional project directors meetings.	3.7

7. Functional goals are monitored and measured, emphasizing participant satisfaction	
1. Our CST/ISP participates in the statewide evaluation process, reporting required child and family data, including CANS items, at least every 6 months.	3.1
2. Plans of Care include measureable goals.	3.5
3. Child/family teams review and modify Plans of Care at least every six months, based on progress toward goals	3.5
4. Families are satisfied with the team process.	3.3
5. Families are satisfied with outcomes.	3.2
6. Providers are satisfied with process.	3.1
7. Providers are satisfied with outcomes	3.4
8. Families have a voice in the decisions that are made, access to needed services, and ownership of their plan of care.	3.9
9. Families evidence the ability to provide for the ongoing safety of all family members.	3.3

8. Adolescents are ensured a planned transition to adult life	
1. A process is in place to identify children age 14 and older who have long-term treatment needs and who will require services beyond age 18.	85% - Yes 15% - No
2. For children age 14 and older identified as needing services beyond age 18, do their plans of care (within one year of transition to adult living), contain:	
a. Clearly defined action steps	3.2
b. Documentation that needed referrals have been made	3.3
c. Notation that future collaborators are invited to team meetings	3.0

PART B: System of Care and Process Outcomes

SYSTEM OUTCOMES	
1. CST core values are implemented across substance abuse, mental health, child welfare, and other identified systems as evidenced by consistent use of family-centered, strength-based plans of care and planning process that involves families and natural supports and all key service providers.	67% - Yes 33% - No
2. Any realized savings from substitute care budget are re-invested in the community-based CST process. Savings would be one of the funding sources for future sustainability. Planning for future sustainability begins in year one	75% - Yes 25% - No
3. A formal system change evaluation process is established.	55% - Yes 45% - No

PROCESS OUTCOMES	
1. The administering agency is able to document a reduction in the number of children entering out-of-home care	67% - Yes 33% - No
2. The administering agency is able to document that the length of time children spend in out-of-home care is reduced	75% - Yes 25% - No
3. The administering agency is able to document there is a reduction in the number of children re-entering out-of-home care	80% - Yes 20% - No
4. The administering agency is able to document a reduction in the rate of recurrence of child maltreatment	70% - Yes 30% - No
5. A process evaluation procedure is established	75% - Yes 25% - No

PART C: Coordinating Committee Recommendations

Below is a summary of the most common responses from the 13 sites who completed the survey:

Seven sites are planning to work on a system for documenting outcomes. Selected comments:

Our Department of Human Services will develop tracking mechanisms to identify the effect on our out of home care and cost savings.

We will work toward developing a system evaluation process.

Five sites identified a need to work on sustainability of their project. Selected comments:

We need to strengthen sub-committees, especially "education" & "sustainability".

We will continue sustainability measures for service coordination and family advocacy.

Five sites mentioned a need to strengthen coordinating committee membership. Four sites specifically mentioned the need to increase parent involvement on their committees. Selected comments:

We continue to struggle with parent/family involvement on our Coordinating Committee.

We need to find additional committee members as some have moved or are no longer in the same positions. We need to find more family members to be active on the coordinating committee.

Five sites recommended expansion of their service coordination capacity to meet demand of incoming referrals and/or address the issue of waiting lists. Selected comments:

We have 2 new half-time service coordinators and hope to reduce or eliminate our waiting list.

Our Coordinating Committee feels that as we are now approaching capacity enrollment; we should look at providing training to team facilitators.

Four sites identified a need to strengthen peer supports / mentors for children and adults. Selected comments:

We need to work on finding family advocates, peers, or natural supports to be on family teams.

We should expand the use of volunteer mentors for both parents and children when appropriate.