Children Come First Advisory Committee
2013 Annual Report
On Coordinated Services Team Initiatives
(Pre-Expansion)

For additional information, please contact:

Wisconsin Division of Mental Health and Substance Abuse Services
1 W. Wilson Street, Room 850
Madison, WI 53707-7851

Joyce Allen
(608) 266-1351
Joyce.Allen@wisconsin.gov

Wisconsin
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EXECUTIVE SUMMARY

While 902 youth participated in 42 Coordinated Service Team (CST) Initiatives in 2013, this Annual Report focuses primarily on the 252 youth who completed their participation in CST in 2013 and were disenrolled. Youth outcomes are most accurately represented when youth have completed their participation in a CST Initiative.

Most youth upon completing their participation in CST Initiatives were functioning well in several life domains according to select indicators measured through the CST evaluation. A significant minority of youth were either still in out-of-home placements, struggling behaviorally or academically at school, or engaging in juvenile delinquent behavior that brought them in contact with the juvenile justice system.

- CST sites reported serving 902 total child and family teams across Wisconsin in 2013 and the average number of teams served per site was 26. The average length of enrollment was 16.1 months.

- The most referrals came from child welfare agencies (28%), but youth were referred to CSTs from a very balanced variety of child-serving agencies which aptly reflects the multi-system needs that youth are expected to have as a criterion for enrollment into a CST. Mental health agencies, juvenile justice agencies, schools, and families each referred 14-22% of youth.

- Youth are expected to be maintained in community in-home placements or diverted from out-of-home placements during CST participation whenever possible. Of all youth disenrolled in 2013, 82% were living with a parent, friend, or relative at enrollment and maintained in a similar in-home placement throughout their CST participation. Nine percent of youth were still in out-of-home placements living in foster care, a group home, a residential treatment center, or a shelter facility when disenrolled from their CST.

- Of those youth with failing grades upon CST enrollment, 50% had raised their grades to a “C” average or better by the time of their disenrollment. Overall, upon disenrollment from a CST in 2013, 73% of youth had a “C” average or better while the remaining 27% continued to struggle academically in school with lower grades.

- Of the youth disenrolled in 2013, 71% had no offenses reported at any time shortly before or during their participation in a CST. Of the youth who had a reported offense before and/or in the first six months of participation, 65% committed no further offenses and 35% continued to commit juvenile offenses.

- CST staff reported upon disenrollment that 43% of youth had met their individual goals as described in each youth’s plan of care.

- A majority of CST initiatives believe that their work creates savings in the substitute care budget for children, but very few can describe their savings with data. Consultation on how best to document cost savings was described as an area of need by CSTs.

- The most common needs described by CSTs include parent and youth participation on the CST Coordinating Committee, CST Coordinator training on team facilitation and individual care planning, community outreach and referral, and expanded CST capacity to serve more families.

CST INTRODUCTION AND BACKGROUND

The 2013 Annual Report is written for the Children Come First Advisory Committee, the group that is statutorily responsible for monitoring the development of Coordinated Services Teams (CSTs) in Wisconsin. This report highlights the work of the CSTs for calendar year 2013.

Wisconsin has been developing collaborative systems of care since 1989. The original initiatives, called Integrated Services Projects (ISP), focused on supporting families with children with Severe Emotional Disabilities (SED) in their homes and communities. In 2002, the collaborative process used by ISP was expanded with the development of CSTs. While CSTs use the same wraparound process as ISPs, the target group is broader and includes children and families who do not necessarily have an SED diagnosis, but do have complex needs and are involved in at least two systems of care such as juvenile justice, special education, child welfare, etc.

Wis. Stat. § 46.56 historically governed the Integrated Services Projects. In 2009, Wisconsin Act 334 updated the language in state law to identify all programs as Coordinated Services Team Initiatives. Other notable changes included: inclusion of language and information related to tribal initiatives; an expansion of target group to no longer require an SED diagnosis (although children with SED are required to be a priority target group); expansion of coordinating committee membership and responsibilities, including a focus on sustainability; creation of the role of "Initiative Coordinator"; and expanded requirements for referral, assessment, planning, and closure processes – strengthening the role of parent, advocacy, and service coordinator, and emphasizing meaningful outcomes.

Training and technical assistance was provided in 2011 to support the transition of the 18 original Integrated Services Projects to Coordinated Services Team Initiatives. Individualized assessments of sites' strengths and needs were conducted, and individualized work plans were developed. As of January 1st, 2012, all 18 former ISP sites were operating as CST sites.

What is CST?

CST is an evidence-based practice model of care for youth with mental health needs. CST is a systems approach designed to assure children and their families have support and access to mental health and other services in their communities. CST is a recovery and resiliency-oriented, intensive case management, community-based rehabilitation and outreach service for children and their families. It is team-based and focused on the child and their family along with the various systems involved in the child's life. The supports and services include the mental health rehabilitation interventions and other supports necessary to assist the recipient in achieving and maintaining rehabilitative, resiliency, and recovery goals. CST is developed and designed to meet the educational, vocational, residential, mental health, co-occurring, financial, social, and other treatment support needs of the youth and their families.

Eligibility

Youth who are involved in two or more systems of care (such as juvenile justice, special education, child welfare, etc.) and their families shall be eligible for CST, except that the coordinating committee may establish specific additional criteria for eligibility for services, and may establish certain target groups of children who are involved in two or more systems of care to receive services. After the criteria of involvement in multiple systems of care is met, youth with severe emotional disorders (SED) are a second priority target group as outlined in state statutes. Any eligibility criteria shall meet all of the following conditions:

- Be based on a community assessment that identifies areas of greatest need for coordinated services

- Give priority to children who are at risk of placement outside the home or who are in an institution and are not receiving coordinated services based in the community and other resources, or who would be able to return to community placement or their homes from an institutional placement if the services and other resources were provided

- Not exclude a child or his or her family from services or other resources because of lack of ability to pay

Enrollment Process

Participation in CST may begin through a referral from any systems of care agency, tribal courts, or any other organization a child is involved with, as well as family or self-referrals. Upon referral, staff from the service coordination agency or individuals designated by the coordinating committee shall screen the referral to determine if the child and his or her family appear to meet the eligibility criteria and any target group requirements established by the coordinating committee. If the child and his or her family appear to be eligible, the staff shall assist the entity that made the referral under CST program guidelines. A "system of care team" will coordinate and provide the needed specialized services and resources to the participant and his or her family.

Services

Upon enrollment, the client should receive "service coordination." A service coordinator will work with the multiple service providers and family resources that are serving a particular child involved in two or more systems of care, and his or her family. Each child's "system of care team" is composed of these multiple providers and family resources. Following completion of a comprehensive assessment of strengths and needs, a team-authored, individualized Plan of Care is created for each family. Advocacy for the family and referrals to individualized services will be provided as identified in in this plan.

Treatment services should be provided for children with a severe disability, and they should include individualized social, emotional, behavioral, and medical services that are designed to bring about rehabilitation and appropriate developmental growth of a child. These treatment services are provided by trained clinicians, and the coordination of these services is provided by CST.

Advocacy services should include actively supporting and helping families, and fostering strong working relationships among families, systems of care, and providers, with the goal of improving the lives of children who are involved in two or more systems of care and their families.

Funded CSTs

In 2013, 41 counties and tribal agencies were funded to provide CST using multiple sources of funding. Funding sources included mental health block grants, substance abuse block grants, hospital diversion funds, and a small amount of funds from the Department of Children and Families. The CST contract amount ranged from $48,000 to $79,000 per county or tribal agency. Additional CSTs are operated by county and tribal agencies that do not receive Department of Health Services (DHS) funding, but DHS does not monitor these CSTs and does not have a reliable count of how many such CSTs exist.

Stages of Development for CST Sites

Throughout the five years of CST grant funding, sites progress through different phases of system development. Training and technical assistance (T&TA) is available to support sites through the process, with the goal of ongoing sustainability of their system of care. In 2013, Waupaca County Department of Health and Human Services (DHHS) held the contract with the Division of Mental Health and Substance Abuse Services to provide statewide T&TA. Waupaca County DHHS contracted with White Pine Consulting Service (WPCS), based in the Waupaca area, to provide these services. WPCS consists of a team of consultants from across the state with experience in collaborative systems of care at the county, state, and national levels.

There are generally three phases of CST system development:

- The "Development Phase," year 1
- The "Implementation Phase," years 2-5
- The "Sustainability Phase," year 6 and beyond

The state map on the following page documents the counties and tribes in these different phases.

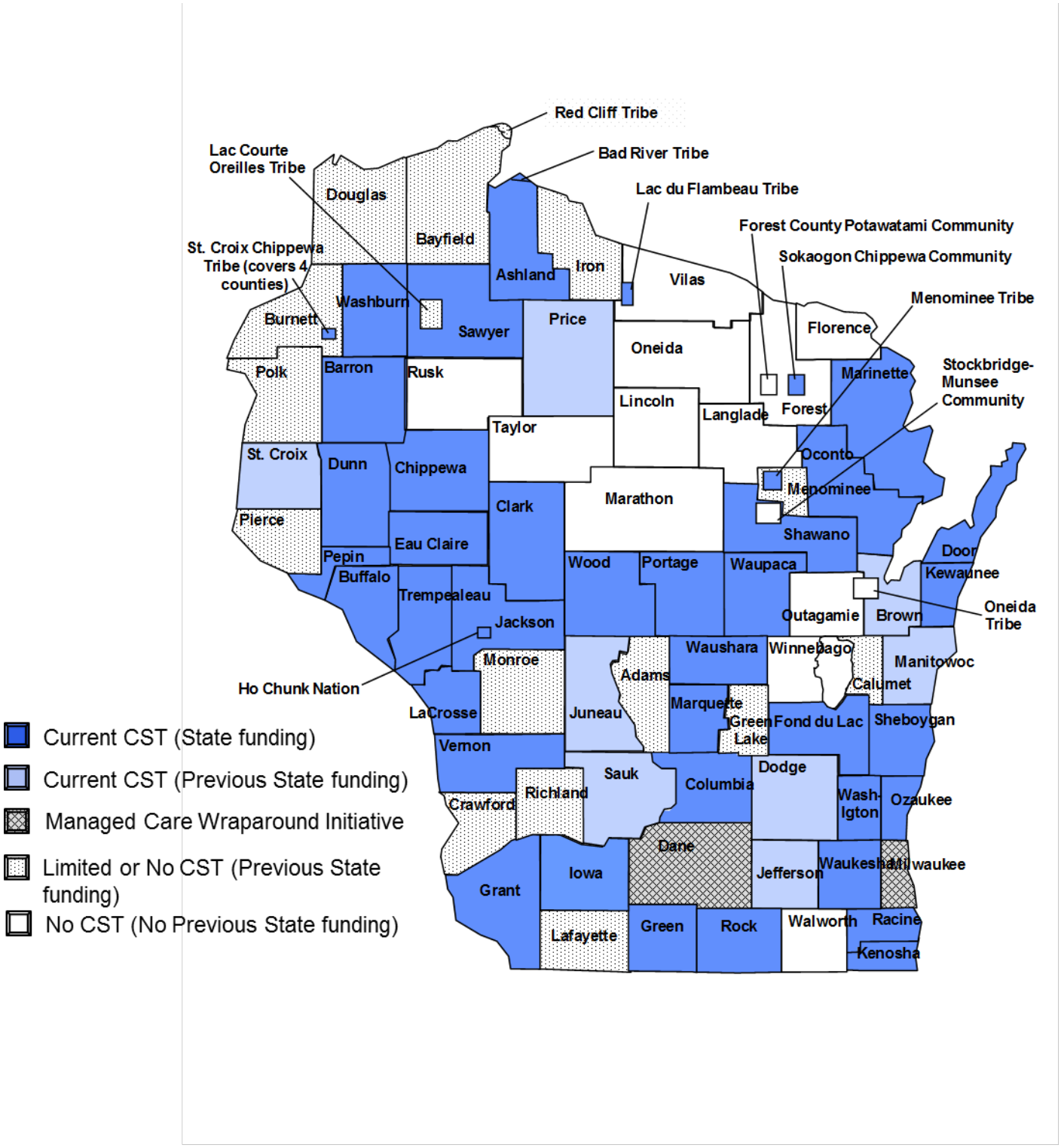
The Development Phase typically takes place during the first year of grant funding and is characterized by activities such as: the development of the Interagency Coordinating Committee, policy and procedure development, training of service facilitators, and community education. Much of the support during this phase is provided on-site, although there are also regional and statewide support opportunities such as two annual statewide CST Project Coordinator meetings as well as two annual Project Coordinator meetings in each of the state's five regions. The CST sites in the developmental phase in 2013 include the Ho Chunk Nation, Jackson County, Pepin County, and the Sokaogon Chippewa tribe.

The Implementation Phase is marked by the enrollment of families in the CST initiative. The Coordinating Committee meets regularly to support the initiative, address system issues, and plan for sustainability of the collaborative system of care. Training and technical assistance activities are based on the unique strengths and needs of each site, and may be provided locally, regionally, or on a statewide basis. Consultants provide activities such as: service facilitator training, ongoing support for the initiative coordinator, administrative coaching, and support for Coordinating Committee expansion. Specialized CST-related training and workshops are provided based on need, in areas such as: community overview of the CST process, coordinating committee development and rejuvenation, advanced team facilitation, development of plans of care and crisis response plans, conflict resolution, strengthening family involvement, leadership for effective change, and sustainability of the CST process.

The Sustainability Phase. Planning of the long-term sustainability of the CST process should start in Year 1, and be an on-going subject of discussion at the Coordinating Committee level. Sites technically reach the sustainability phase in Year 6, when formal grant funding to support system development has ended. Sustaining a collaborative approach has two major elements: ensuring the collaborative approach is firmly established in agency and community values and practices, and the availability of funding for staff and resources necessary to carry out the collaborative service. Consultants who specialize in this area are available to support sites in sustainability planning by focusing on areas such as strengthening roles of partner agencies, expanding the service coordination resource, reviewing options for financial sustainability, and promoting mentoring and networking opportunities.

The counties and tribes listed in this report in the sustainability phase are known to have varying levels of success in sustaining their CST efforts. Although the DHS does not monitor CST initiatives when they are no longer funded by DHS, a 2013 DHS survey of unfunded CSTs provided some information on the degree to which the CST approach has been sustained in these sites. The map on the following page distinguishes these sites and all others based on their stage of development.

Wisconsin Counties and Tribes Developing or Sustaining Coordinated Services Team and Svstems of Care Initiatives in 2013



DESCRIPTION OF YOUTH SERVED IN CSTs

Counties and tribes with CST Initiatives are asked to complete an annual survey reporting information on enrollment and the impact of their initiative on the larger service system. A total of 37 CSTs were eligible to complete the survey in 2013 excluding four first-year sites who had not yet begun serving children, and surveys were received from 35 sites across the state (95% of eligible sites).

Enrollment Numbers

CSTs are currently asked to report children's outcome data for just a portion of all children served (a minimum of 10 children are required to be entered in the data system). Thus, the children's outcome data described in ensuing sections of this report does not provide a complete count of all children served. The CST Initiative Survey was implemented to allow the initiatives to report the total number of children and families served which is displayed in the table on the next page.

CST sites reported serving 897 total child and family teams across Wisconsin in 2013 and the average number of teams served per site in 2013 was 26. The average length of enrollment was 16.3 months as reported by CSTs through the survey. Results from individual-level data examined later in the report reveals an average length of enrollment of 15.3 months which correlates closely with this figure. Both the range of number of youth served and average length of enrollment among the 35 reporting CSTs varies greatly. The number of youth served ranges from 3 to 101 and the average length of enrollment ranges from 1.7 to 31.2 months. In addition, the volume of youth and families served does not always correlate with the population size of a county or tribe.

In addition to reporting the number of youth served with a team, sites also reported the number of family members other than the identified child who received support and services from their CST. There were 1,868 additional family members served in 2013 averaging 53 per site.

Number of Child and Family Teams Served in 2013
For CSTs in the Implementation Phase (Years 2-5 of Funding)

Site	Number of Youth with Teams	Average Length of Stay (in months)	Number of Additional Youth and Parents Served
Ashland County	17	16	37
Bad River Band of Lake Superior Chippewas	11	18	33
Barron County	27	6	22
Buffalo County	6	11	14
Chippewa County	19	23	63
Clark County	12	14	41
Columbia County	9	14	6
Door County	44	22	92
Dunn County	10	14	21
Eau Claire County	101	14	181
Fond du Lac County	54	27	70
Grant County	11	3	20
Green County	9	18	2
Iowa County	6	DNR	9
Kenosha County	95	31.2	285
Kewaunee County	25	15	6
La Crosse County	DNR	DNR	DNR
Lac du Flambeau Band of Lake Superior Chippewas	8	7	2
Marinette County	31	18	97
Marquette County	31	13.5	44
Menominee Tribe	DNR	DNR	DNR
Oconto County	9	9	4
Ozaukee County	49	10	124
Portage County	26	25	34
Racine County	13	6	27
Rock County	62	9	166
Sawyer County	27	12	40
Shawano County	33	10	12
Sheboygan County	38	26	105
St. Croix Band of Lake Superior Chippewas	3	3	2
Trempealeau County	15	1.7	69
Vernon County	17	6.8	10
Washburn County	21	14	102
Washington County	20	8	21
Waukesha County	9	26	36
Waushara County	15	13	48
Wood County	14	7.5	23
STATEWIDE	**897**	**16.3 months average**	**1,868**

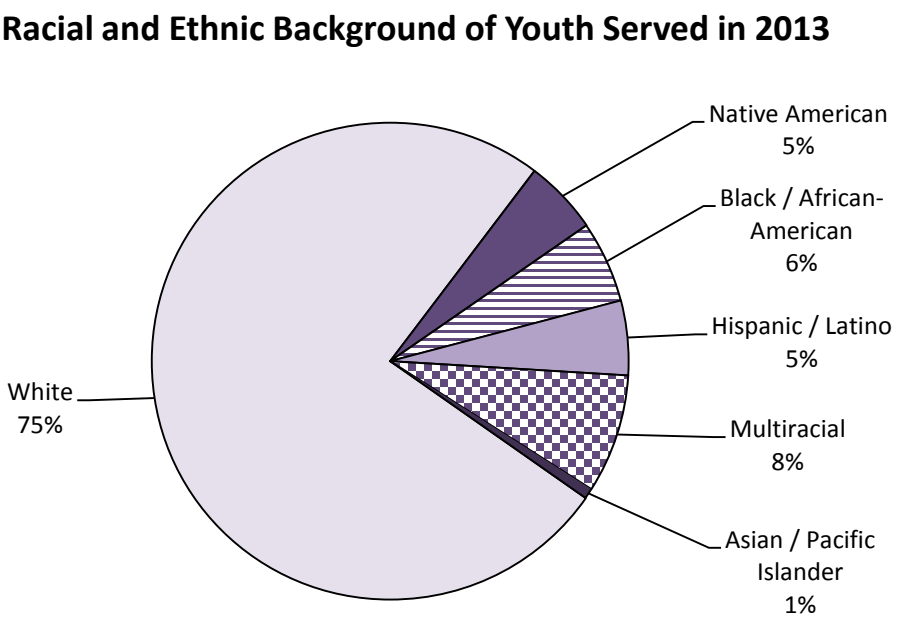
Note: DNR = Did Not Report.

Demographic Description of Youth Served in CSTs

The following information is based on data from CST sites that submitted data to the Bureau of Prevention Treatment and Recovery in 2013.

Information from 838 youth who were served for at least part of 2013 was included in demographic analyses. Of these youth, 64% were male, 36% were female. The average age of youth served in 2013 was 12.5 years (N = 755). Forty-three percent of children were 14 years old and over, 33% were ages 10-13, 20% were ages 6-9, and 4% were ages 2-5.

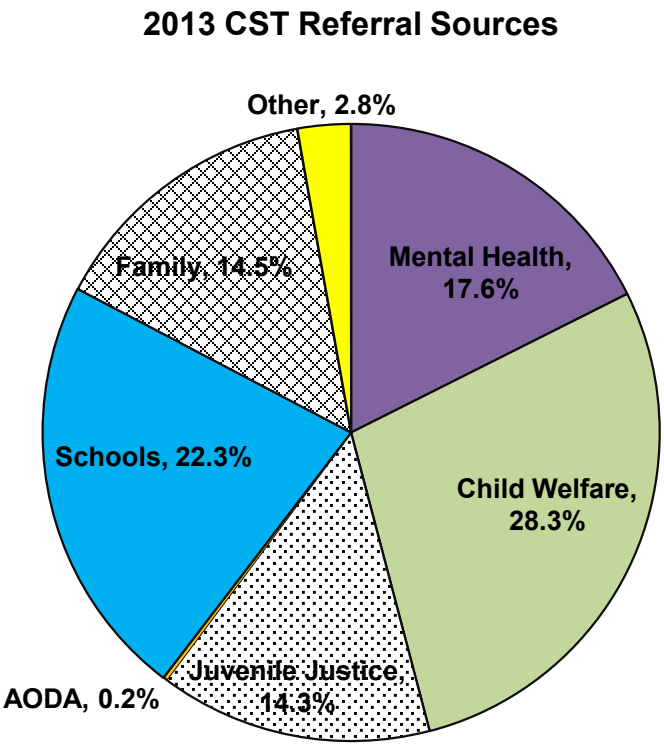
The population of children served in CST Initiatives in 2013 is slightly more racially diverse than the general population of Wisconsin. Twenty-five percent of those served identified as Native American, African-American, Asian American, or multiracial compared to 20% of all youth in Wisconsin (2010 U.S. Census Bureau).



Referral Sources

The source of a referral to a program often can indicate the nature of the needs the youth is experiencing at the time. Thus, referral source data can also indicate patterns of youth needs over a period of time and help CSTs target their team efforts to meet those needs. The chart below shows the number of referrals made to CSTs from various referral sources in 2013.

The most referrals came from child welfare agencies (28%), but youth were referred to CSTs from a very balanced variety of child-serving agencies which aptly reflects the multi-system needs that youth are expected to have as a criterion for enrollment into a CST. Of the 897 youth reported on the CST Initiative Survey for 2013, 22% were referred from schools, 18% from mental health agencies, 14% from the juvenile justice system, and less than one percent from alcohol and other drug (AODA) agencies. In addition, 15% of referrals came directly from families. The variety of referral sources used also can be an indicator of CST programs' ability to establish relationships with other child-serving agencies not just for referrals, but also for enlisting the participation of other child-serving agencies on Child and Family Teams.



2013 CST Referral Sources								
	Mental Health	Child Welfare	Juvenile Justice	AODA	Schools	Family	Other	TOTAL
Percentage	17.6%	28.3%	14.3%	0.2%	22.3%	14.5%	2.8%	100.0%
Number	158	254	128	2	200	130	25	897

CHILDREN'S OUTCOME DATA

CST staff collect data on various outcomes at enrollment and throughout enrollment until a youth is disenrolled. This data provides valuable information for measuring changes in children's lives during their time in CST Initiatives, and assessing their final status as they are disenrolled. The analyses described in this section use data reported for each individual youth served through the state data system for CSTs. Although 902 youth were reported as served in 2013 in the annual CST Initiative Survey, slightly fewer (838) were reported by CSTs in the state data system, but the number reported is large enough to fairly describe CST activities in 2013.

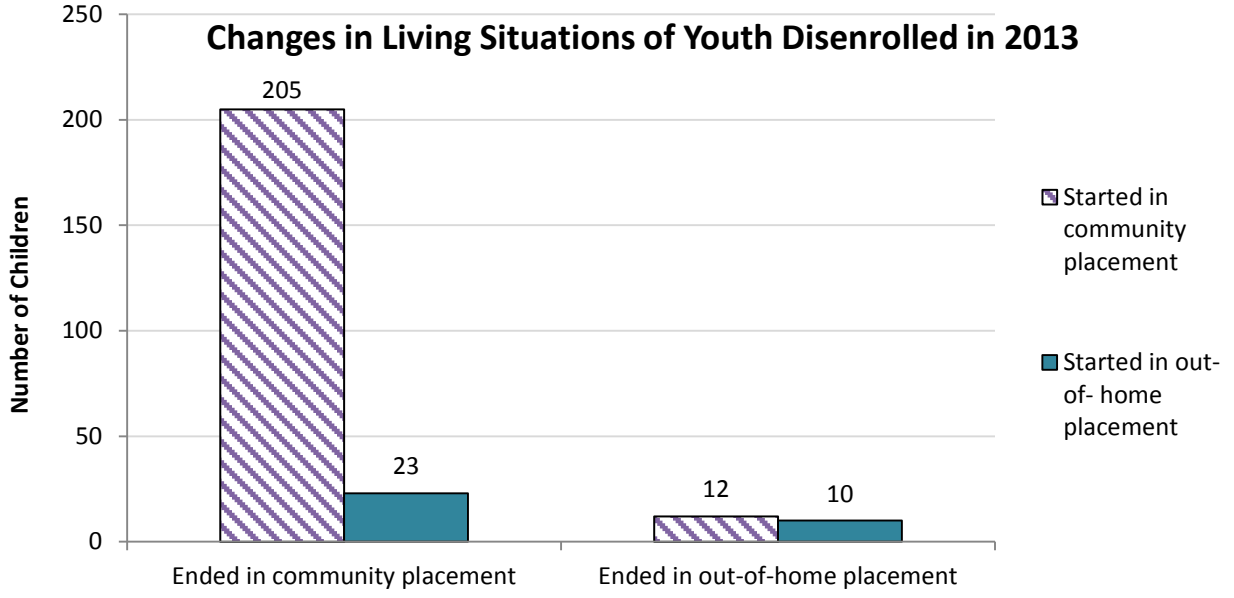
Of the 838 children served in 2013 in CST, 252 were also disenrolled in 2013 (many of these children had been enrolled for several years). Data from children disenrolled in 2013 are the focus of the outcomes section, which compares living situation, school performance, involvement with the juvenile justice system, and other outcomes at the beginning and end of enrollment.

Living Situation

The status of children's living situations at enrollment and disenrollment was evaluated for 252 children disenrolled in 2013 with complete data available. CSTs strive to support youth and their families in the least restrictive living setting possible. One of the qualifications for enrollment in CST is that the child is at risk of out-of-home placement. This risk is determined by many factors, including past out-of-home placements, parents and service providers considering placement in a more restrictive setting at time of referral, or child behavior not improving despite multiple supports and services. Practice within CST is to prevent costly out-of-home placements where appropriate, by developing supports and services that meet the child's needs within the community instead. Thus, despite being at risk of out-of-home placement, many children are still living in community placements at the time they are enrolled into a CST, which will strive to keep them there. Among the children disenrolled in 2013, 87% were living in a community placement with parents, relatives, or friends when initially enrolled into a CST. The remaining 13% were living in a residential or shelter facility, foster care or group home, or inpatient facility.

Maintaining a community placement living situation and preventing out-of-home placement for children living in the community at the time of enrollment is a primary goal for CST. Of the 217 children living with a parent, friend, or relative at enrollment, 94% were also living with a parent, friend, or relative at the time of their disenrollment, successfully meeting this goal. A primary goal for children living in restrictive out-of-home placements at the time of enrollment is for the team to make community placement a primary goal of the child's plan of care. Of the 33 children who began their enrollment while living in a residential or shelter facility, foster care or group home, or inpatient facility, 70% were living with a parent, friend, or relative at the time of their disenrollment, successfully meeting this goal.

Nine percent of youth were still in out-of-home placements living in foster care, a group home, a residential treatment center, or a shelter facility when disenrolled from their CST.

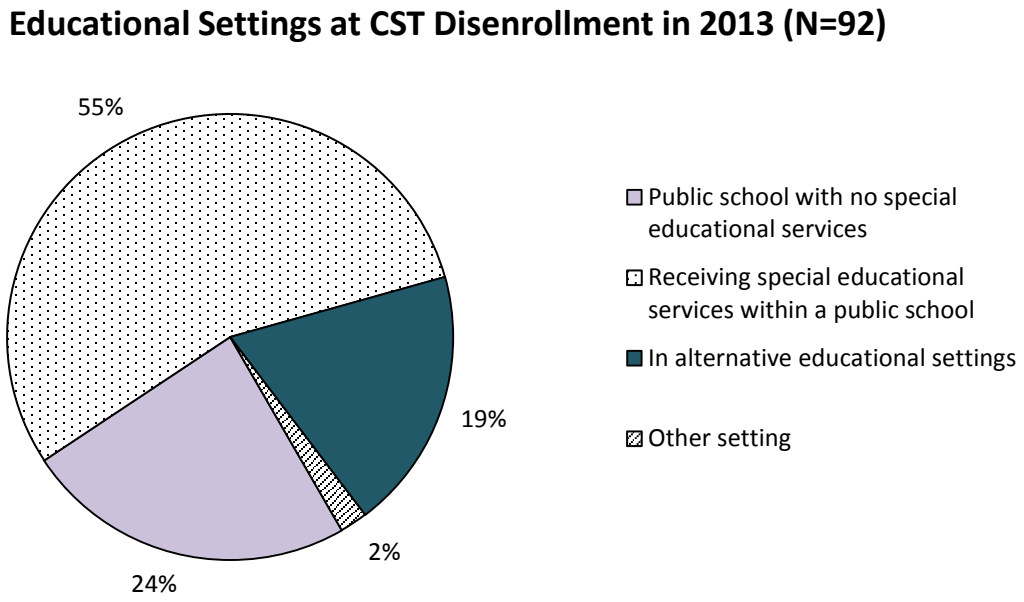


School Performance, Behavior, and Attendance

CSTs make it a priority within children's plans of care to address educational needs that are identified as part of the team process. School performance and behavior are also monitored for progress by CSTs. Data is collected for each school period while a youth is enrolled. To measure youths' progress in school during their CST participation, data from the first and last school period during CST their participation is analyzed. Of the 252 youth disenrolled from CST in 2013, 102 or fewer had information available from their first and last school period to assess their progress at school over time.

Special Education Services. One of the enrollment criteria for CST is that youth must have needs as identified by multiple child-serving systems including the education system. In fact, many of the youth participating in CSTs do have issues they're dealing with in schools and school systems are providing many special services to these youth. CSTs submitted special education data at both the time of enrollment and disenrollment for 92 youth in 2013. For these 92 youth, 67% were receiving special education services in a public school setting at the time of their CST enrollment and another 7% were receiving their education in an alternative setting such as a hospital, residential center, or at home. Twenty-four percent of youth were in a regular public school setting with no special education assistance at enrollment.

At the time of disenrollment from their CST, a slight shift from the use of public schools with special education services to alternative school settings had occurred. At disenrollment, 19% of youth were in alternative school settings and youth receiving special education services through public schools had decreased to 55%.

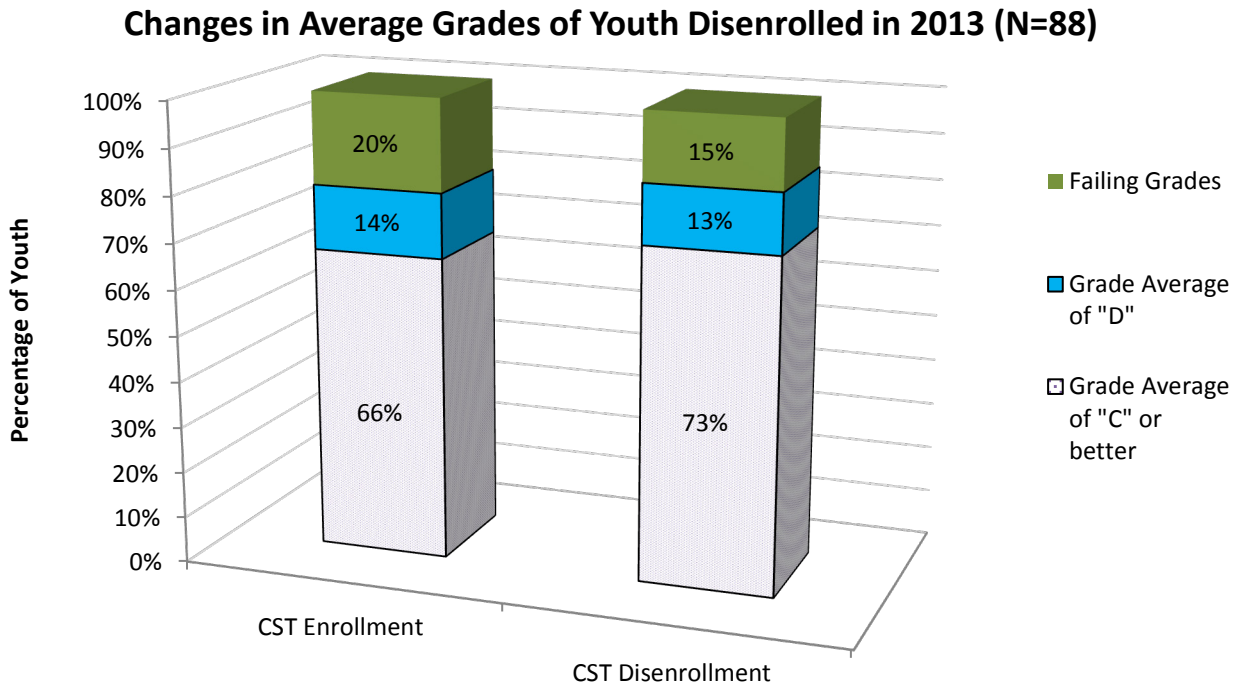


School Performance. Supporting academic performance is a valuable goal of CSTs. The support provided by CSTs is intended to help youth improve their academic performance in school when needed or maintain high academic performance if already achieved. CSTs submitted academic performance data at both the time of enrollment and disenrollment for 88 youth in 2013. At the time of enrollment into their CST, 66% of these 88 youth had grades of "C" or higher, 14% had averages of "D", and 20% were failing at least half of their classes or had "Unsatisfactory" performance (for younger children).

Were youth with average to above average grades able to maintain their level of performance while participating in a CST? Among youth with overall grades of "C" or better for the school period at the time of CST enrollment (n=50), 86% also had grades of "C" or better when disenrolled in 2013 from their CST. Average to above average grades were almost always maintained by youth while participating in a CST.

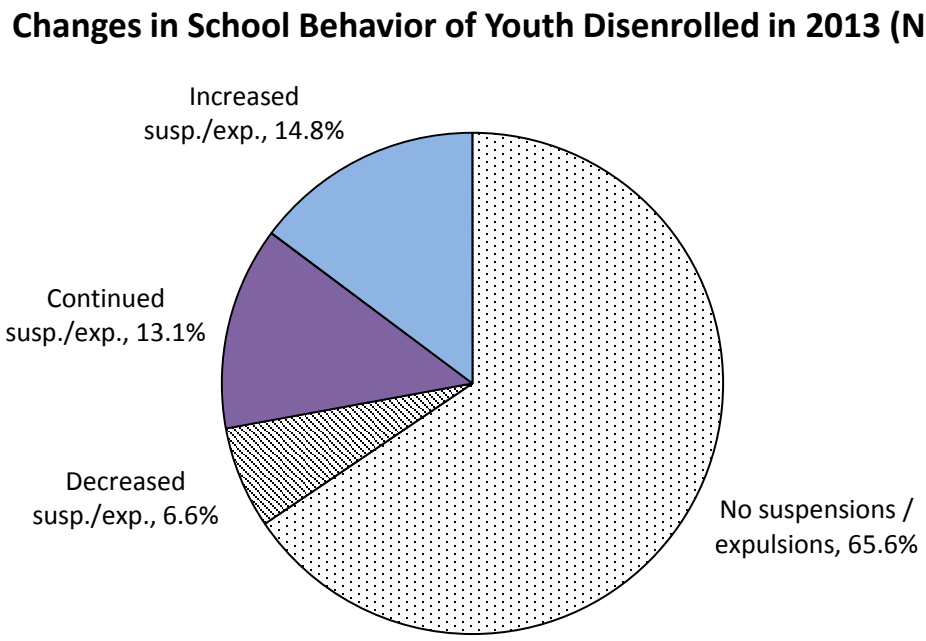
When needed, did youths' academic performance improve while participating in a CST? Of the youth entering CST with academic difficulties, 47% were able to improve their grades to a "C" or better by the time of their disenrollment from CST in 2013. Of those youth with failing grades upon CST enrollment (n=18), 22% had raised their grades to a "D" average and another 50% had raised their grades to "C" or better by the time of their CST disenrollment. Of those youth with "D" averages upon CST enrollment (n=12), 42% had raised their grades to a "C" or better by the time of their disenrollment, but the remaining 58% still had a "D" average or were failing.

Overall, upon disenrollment from a CST in 2013, 73% of youth had a "C" average or better while the remaining 27% continued to struggle academically in school with lower grades.



School Behavior and Attendance. The majority of children participating in CSTs do not appear to have severe behavioral problems in school that result in suspensions and expulsions. In fact, 66% (n=40) of youth had no reported suspensions or expulsions during the school periods coinciding with their CST enrollment or disenrollment dates. However, the other 34% experienced suspensions or expulsions either at CST enrollment, at CST disenrollment, or both. How many of the youth in this group were able to eliminate their suspensions and expulsions during their CST participation?

Overall, between the time of CST enrollment and disenrollment, 6% (n=4) of youth eliminated all of their suspensions or expulsions. Combined with the 66% of youth who never experienced suspensions and expulsions, a total of 72% of youth ended their CST participation successfully based on this one school indicator. The remaining 28% of youth were still exhibiting behaviors in schools that led to suspensions and expulsions at the time of their disenrollment from their CST. Thirteen percent of youth had continued suspensions/expulsions at enrollment and disenrollment and 15% experienced increased suspensions/expulsions at the time of their CST disenrollment.



Given the needs of youth participating in a CST, just attending school on a regular basis to remain engaged with their education can be a challenge and thus an important goal for CST participants. On this indicator, youth and their CSTs are very successful. Sixty-four percent (n=39) of youth had no reported unexcused absences in the school periods coinciding with the time of CST enrollment and disenrollment. In addition, another 8% of youth eliminated all of their unexcused absences by the time of their disenrollment. As with other indicators, a significant minority of youth CST participants experienced no improvement. The number of unexcused absences remained the same or increased from the time of CST enrollment to disenrollment for 26% of youth.

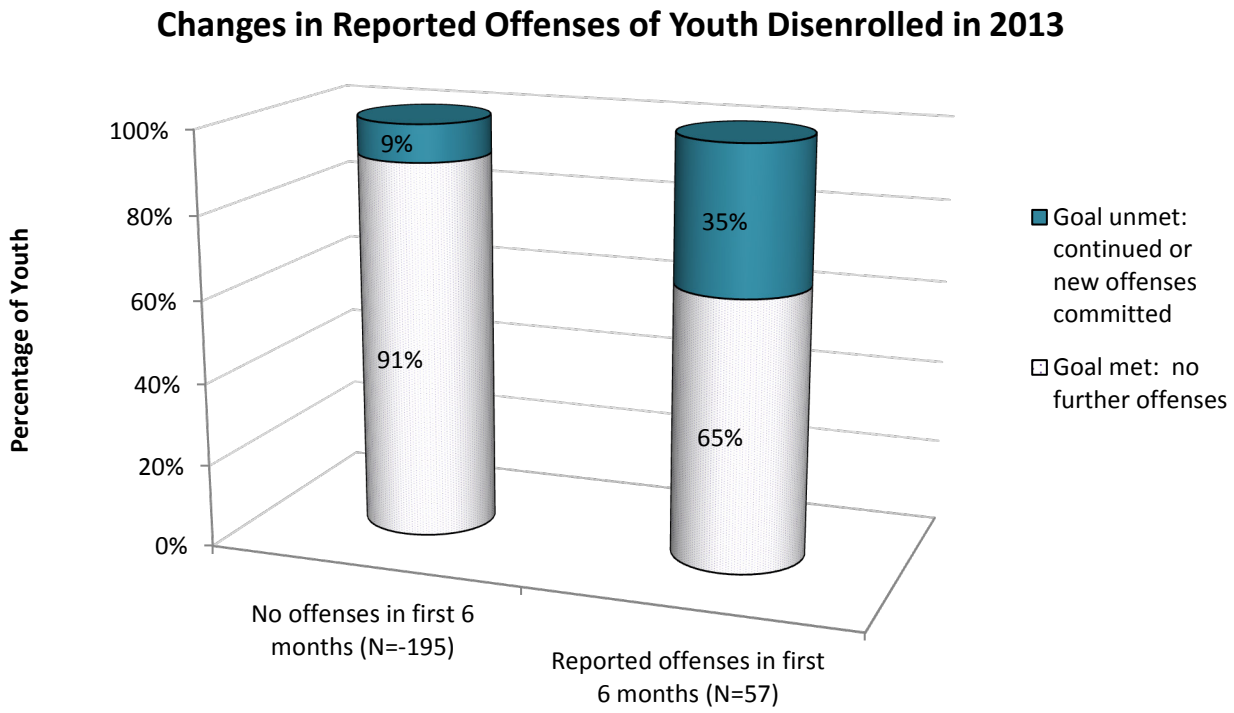
Involvement with the Juvenile Justice System

Involvement with the juvenile justice system is also an important indicator for measuring the success of CST Initiatives. Each CST reports the number and type of offenses committed by each child just before enrollment (within the three months prior to enrollment) and during enrollment in their CST. Since some youth continue their CST participation into 2014, an evaluation of CSTs effectiveness in reducing juvenile offenses will focus on the 252 youth who completed their participation in CST in 2013. Similar to the overall 838 youth served in CST in 2013, 71% of the 252 youth who were disenrolled in 2013 had no offenses reported at any time shortly before or during enrollment.

However, for the 29% (n=74) of youth disenrolled in 2013 who did commit offenses, did their CST participation help prevent further juvenile offenses? Of the 29 children with reported offenses shortly before enrollment, 41% (n=12) had no new offenses reported while they were enrolled in CST and 59% committed at least one more offense. Since the average length of stay for youth in CST is 15 months, it may be that the impact of CST may not always occur until after several months of youth and family participation. In fact, more improvement was reported after the first six months of participation. Of the 57 children who had a reported offense before and/or in the first six months of enrollment, 65% (n=37) committed no further offenses after the first six months in CST until their disenrollment.

In addition to CSTs efforts to reduce juvenile offenses, youth with no juvenile offenses in the first six months of participation are expected to avoid committing offenses through the remainder of their CST participation. Of the 252 youth disenrolled in 2013, 195 committed no offenses before or during the first six months of their participation in CST. Most (91%) of these youth avoided committing any offenses through the remainder of their CST participation as well. A small portion (9%) of these youth actually committed juvenile offenses after their first six months of participation even though they had committed none prior.

Of the 10 children with reported offenses both before and during enrollment, 40% (n=4) had the same number of offenses reported during enrollment as shortly before enrollment, and 60% (n=6) increased their number of reported offenses after enrollment into CST.



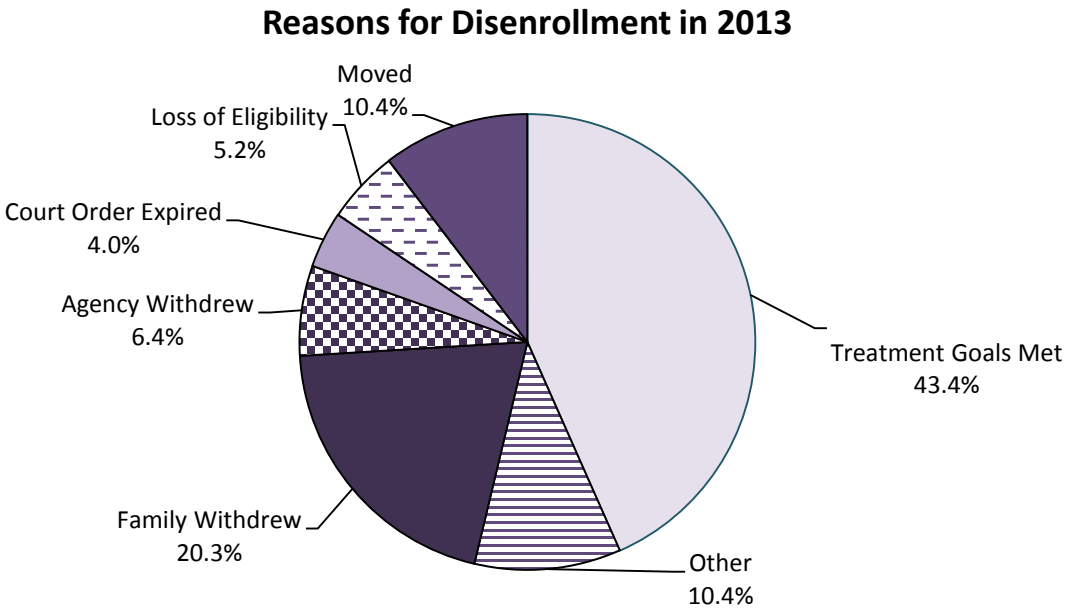
Disenrollment

For the 252 children disenrolled in 2013, the average length of enrollment in CST Initiatives was 15.3 months.

Disenrollment can occur for several reasons, including:

- 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 and family, access to services they need, and ownership of their Plan of Care.
- Family Decision to Withdraw: The family decided that CST could no longer meet their child's needs.
- Agency Decision to Withdraw: The lead agency has chosen to end the CST process because 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, eligibility to receive services from that county or tribe may be lost.
- Court Order Expired: If services for the child are court-ordered and the order expires.
- Loss of Eligibility: If the child no longer meets the eligibility criteria for participation in CST.
- Other: This category serves as a "catch all" for reasons that do not clearly fit into other categories.

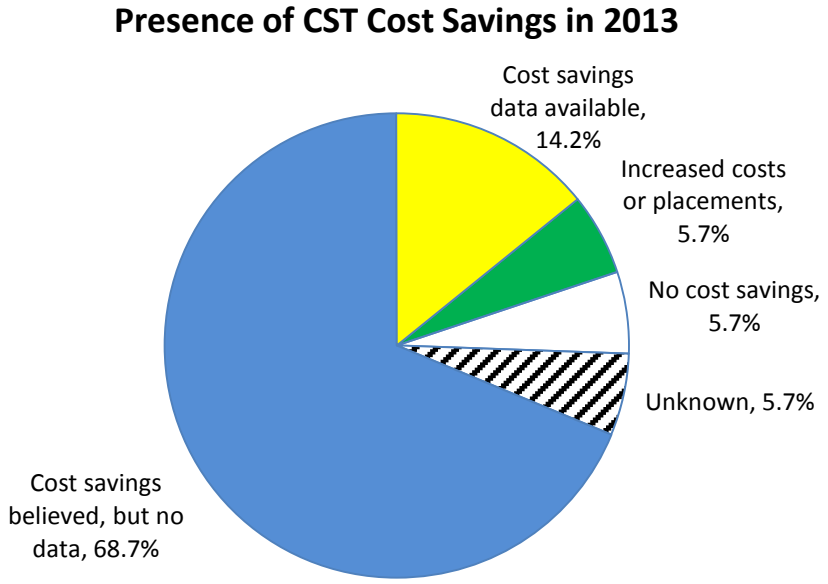
An important goal of CST Initiatives is to meet the individual goals on each child's plan of care, which was accomplished by less than half (43%) of the youth disenrolled in 2013. Of the remaining families, CST participation ended early for 10% of families who moved out of the service area. Another 20% of families decided to withdraw from their CST because they felt it no longer met their child's needs. The remaining 15% of youth were disenrolled either due to loss of eligibility, expiration of a court order, or an early agency-initiated withdrawal.



COST SAVINGS

One of the primary target populations of the Coordinated Service Team initiatives are youth at risk of out-of-home placement. By serving these youth in the community, CSTs are expected to reduce out-of-home placements that result in savings to the human service agency. On the annual CST Initiative Survey, CSTs are asked to describe any realized cost savings related to the CST process and their ability to document their savings.

CSTs are not required to submit financial projections of cost savings, but they are asked to self-report whether or not they believe that cost savings occurred as a result of their CST initiative. Of the 35 CSTs responding to the cost saving question on the survey, 83% believed that their CST Initiative yielded cost savings. Another 11% did not believe or were unsure if any cost savings occurred as a result of their initiative and 6% believe their costs and/or out-of-home placements increased.



Calculated Cost Savings. While most CSTs believed cost savings occurred as a result of their activities, a few of the CSTs (14%) were actually able to use financial data to describe their cost savings. For example:

"The CST program provided cost savings for our county directly by preventing out-of-home placement of kids at great risk or by shortening out-of-home placements through careful team planning and support. CST prevented residential placements last year which would have cost the county $322,000, and saved the county $57,604 by supporting a family so that a child could be released early from a residential treatment center."

"A cost analysis has been completed on one specific CST family in order to show the cost savings. This family has been involved with the County CST initiative since January of 2013. Prior to CST involvement, the identified child was involved in CPS (child protective services intakes) for $5,600.00; out of home at ……. for a 72-hour hold for $4,050.00; mobile crisis calls costing $1,890.00; juvenile intake for $168.00; ……. had Child Psychiatrist intake for 1 hour for $255.00. Since the family became involved in CST, ……. the child has not had any CPS, juvenile justice, mobile crisis, or out of home placements!"

Reinvestment of Savings. Although few had data, most CSTs (63%) also reported that savings in the county/tribal substitute care budget resulting from their activities were "always" or "often" reinvested in their CST initiative. Two CSTs were able to provide examples:

"By utilizing the Children's Long Term Support (CLTS) Waiver and Family Support Program funds, CST Service Facilitators have developed Plans of Care that help divert children from additional hospitalizations, maintained youth in their family home, and reduced the cost of out-of-home care for children with disabilities. Evidence of these cost savings and re-investment can be seen in the addition of a 5th service facilitator to increase the number of children served in 2013."

"Cost savings occur when children do not have to be placed in residential care or hospitals. Crisis planning and supportive services, along with teaming, have assisted in preventing more costly and traumatic out of home placements. With these savings, we have been able to contract with (agency) to provide additional in home therapy services to our families. This in turn assists families in meeting goals and maintaining stability for our consumers."

Challenges in Measuring Cost Savings. Measuring cost savings for out-of-home placements that did not occur is difficult. While it is assumed that many children served by CSTs may have been placed in costly out-of-home care settings if not for the intervention of the CST, the type of placement, the length of placement, and the exact cost of the placement are difficult to project. Thus, while many CSTs believe their activities result in cost savings, very few have financial data as evidence. In other cases, some CSTs do not believe cost savings occurred because they are not targeting youth at risk of out-of-home placement with their program eligibility criteria. Some CSTs commented on these difficulties:

"We have not been able to come up with a reliable way to determine and/or document cost savings. While we believe CST prevents placement, it is very difficult to determine this in a way that can show evidence of this which can hold up under scrutiny. Additionally, our CST serves many families/youth that we would typically refer to community resources and not serve. The provision of services to these families, offsets potential savings in placement costs and again, we have not been able to find a way to show that these costs are offset by a reduction in placement costs….. Obviously we track placements, however, what has been challenging is being able to tie any of the (substitute care) reductions specifically to CST when our entire Family Services Unit is a part of these child welfare outcomes."

"Regarding cost savings directly correlated to CST, the initiative is missing specific information. The primary target of our CST Initiative is not focused on children in Out-of-Home, as we have focused on a more pro-active approach before children reach this outcome."

TRAINING NEEDS AND AREAS FOR QUALITY IMPROVEMENT

The CST Initiative Survey is also used as a mechanism for CSTs to communicate what training needs they have and what areas they need to work on in the coming year. Common needs described by CSTs are described below. Two of the most common needs identified as both training and quality improvement needs are 1) CST Coordinating Committee member training and retention, and 2) the increased use of peer/parent supports.

What consultation and training do CSTs need in 2014?

Of the 36 CSTs responding to the survey, the most commonly requested areas of training and consultation are summarized in the table below.

Training and Consultation Needs

CST Administration and Oversight	
Coordinating Committee roles and operation	25%
Tracking efforts with data	19%
Use of CCS and other Medicaid benefits	14%
Individual CST Coordinator Needs	
Service Coordinator individual care planning (developing plans of care, crisis planning, trauma-informed care, motivational interviewing, transitional planning)	39%
CST Coordination training (facilitation, team-building, service coordination)	28%
Use of peer supports	11%

In the area of CST initiative administration and oversight, the most common training need was the need to train and retain Coordinating Committee members. Of the 36 CSTs responding to the survey, 25% described this need. While most CSTs described a need for training their Coordinating Committee members on their roles, a few others mentioned a need for training on the basic concepts of the CST process. Also in the area of administration and oversight, 19% of CSTs described a need for training and consultation on documenting cost savings and tracking client outcomes. Requests for consultation on how to measure cost savings to document CST initiative benefits and how to use the new Mental Health Program Participation System for client data tracking were both made. Training and consultation on the use of the Comprehensive Community Services (CCS) benefit and other Medicaid benefits (Children's Long-Term Support waiver, Targeted Case Management) to sustain their efforts was also mentioned by 14% of CSTs.

The most frequent type of training requested by CSTs was specific individual treatment and care planning for service coordinators. The most frequently mentioned areas of need were crisis planning, developing plans for transitional youth ages 16 and over, and a trauma-informed approach to care and planning. More training on how to better engage families and youth in the CST process was also mentioned frequently and motivational interviewing as a technique to address this need was suggested. Training on CST facilitation and service coordination for Coordinators was also mentioned frequently (28%).

What other recommendations does the Coordinating Committee have to improve the local CST process?

Of the 36 CSTs responding to the survey, the most commonly mentioned areas for quality improvement in the coming year are summarized in the table below.

Recommendations for Quality Improvement Efforts

Increase Parent/Youth Participation On Coordinating Committee	31%
Expand CST Capacity	22%
Increase Community Outreach	22%
Use Surveys of Partners and Families for Quality Improvement	19%
Improve System Collaboration	17%
Increase Use of Parent/Peer Supports	17%

The most frequent mentioned area to improve upon was parent and youth participation on the Coordinating Committee. Almost a third of CSTs expressed difficulties in maintaining a representative number of parents and youth on their Coordinating Committee. In some cases, the structure and operation of the Committee was identified as needing to improve so parents and youth participate. According to one CST, there's a need to "restructure the current Coordinating Committee so members feel they have a purpose and understand their roles."

Most of the 22% of CSTs who wish to expand their capacity reflected on the need for more service facilitators to meet the demand in the community, but a few also mentioned they intend to work on closing service gaps in their CST.

The desire to increase community outreach efforts was also mentioned by 22% of CSTs. While most CSTs describe increasing basic outreach and awareness efforts in the general community, some described intentions to reach out to specific child-serving agencies and target populations as illustrated by this quote:

> *"A major focus was about getting information to school districts within the county. Such ideas involving schools included: having a link about CSTs on school's websites or blogs, including information in a school newsletter, attending an in-service training, and sharing information with parents during an open house/orientation for the beginning of the school year. Another area of focus was on public relations. Such ideas relating to public relations include: printed materials such as newspapers, social media outlets, billboards, and including information on the county website."*

Another 17% of CSTs emphasized the need to focus on system collaboration efforts in the next year. Some areas of focus were developing collaborative funding models and working more closely with specific child-serving sectors like schools and law enforcement. Two CSTs also mentioned expanding the entire CST process to all child-serving sectors as illustrated by this quote:

> *"We are moving toward a combined coordinating committee with other children's program, offering a subcommittee specific to CST to assure authenticity to the program requirements and oversight. However, the blending of program representation and community partners with parents will be progressive and we believe an effective strategy to bring unison to our mission in serving children with all special needs."*

Two final areas for improvement were also related to training needs identified by CSTs. Seventeen percent of CSTs would like to increase their use of parent and/or peer supports in their care plans. A need to create and/or increase the pool of parent and peer specialists was identified, but also a need to "create parent support groups that meets on a regular basis for education, speakers or just support." Reemphasizing the need to know how to use data identified as a training need, 19% of CSTs also want to use more parent and provider surveys to inform their quality improvement efforts.