

Coordinated Services Team Initiative Handbook for Working with Children & Families

Module 1

1.1 Overview of Coordinated Services Teams (CST)

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Articles

“Access, Voice and Ownership: Examining Service Effectiveness from the Family’s Perspective”, by Patricia Miles and John Franz

1.1 Overview of Coordinated Services Teams (CST)

Introduction

Collaborative systems of care go by many names: Coordinated Services Teams (CST), Wraparound, Integrated Service Projects (ISP), and “Children Come First” are all collaborative approaches to respond to individuals with multiple, often serious needs in the least restrictive setting. They are not specific programs or services; rather a family and community based **process** that is unconditional in its commitment to develop supports and services to address the needs of each child and family. Creative services developed by a child and family team support normalized, community-based options for children and families.

Each team develops an individualized Plan of Care. Supports and services used by the team are determined by identified strengths and needs of the family and team members. Parents are partners on the team and have ultimate ownership of the plan. The strength-based approach builds on responses and activities that have worked. Each individualized child & family Plan of Care focuses on what is normal for the child’s age, gender, and culture.

Plans change as circumstances in the life of the child and family change. Services are supported through collaborative efforts of agencies, government and volunteer efforts. Flexible funds are available to support the Plan of Care. Outcomes and progress are measured and evaluated often.

History of Coordinated Services Teams in Wisconsin

1960’s – 1980’s	Growing recognition that children with mental health needs were not being adequately served by “the system”
1984	The National Institute for Mental Health (NIMH) created a mental health model for serving children with Severe Emotional Disabilities (SED). Core values included: child-centered and family focused; community-based; and culturally competent
1984	Wisconsin received an NIMH grant to assess service needs of children with SED and promote a model/approach among counties in WI
1987/88	Wisconsin Department of Health & Human Services awarded grant to Dane & Kenosha Counties to implement intensive case management projects
1989	Wisconsin began developing collaborative systems of care. 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.
2002 - 2006	The collaborative process employed by ISP was expanded with the development of CST. While CST uses the same wraparound process as ISP, the target group is broader and includes children and families who do not necessarily have an SED diagnosis but who do have complex needs and are involved in at least two systems of care (e.g., substance abuse, child welfare, juvenile justice, special education, and/or mental health). Funding for CST ranges from \$33,000 to \$63,000 annually. From 2002-2006 twenty-six counties received funds to develop CST projects.
2007	43 counties and 2 tribes received funding in 2007 through contracts with the Bureau of Mental Health and Substance Abuse Services (BMHSAS). The funding came from MHBG funds, Substance Abuse Grant funds, and Hospital Diversion funding. In addition, the Division of Children and Family Services collaborated with BMHSAS to contribute funding for CST sites.

Core Values of CST

Family-Centered: A family-centered approach means that families are a family of choice defined by the consumers themselves. Families are responsible for their children and are respected and listened to as we support them in meeting their needs, reducing system barriers, and promoting changes that can be sustained over time. The goal of a family-centered team and system is to move away from the focus of a single client represented in systems, to a focus on the functioning, safety, and well being of the family as a whole.

Consumer Involvement: The family's involvement in the process is empowering and increases the likelihood of cooperation, ownership, and success. Families are viewed as full and meaningful partners in all aspects of the decision making process affecting their lives including decisions made about their service plans.

Builds on Natural and Community Supports: Recognizes and utilizes all resources in our communities creatively and flexibly, including formal and informal supports and service systems. Every attempt should be made to include the families' relatives, neighbors, friends, faith community, co-workers or anyone the family would like to include in the team process. Ultimately families will be empowered and have developed a network of informal, natural, and community supports so that formal system involvement is reduced or not needed at all.

Strength-Based: Strength-based planning builds on the family's unique qualities and identified strengths that can then be used to support strategies to meet the families needs. Strengths should also be found in the family's environment through their informal support networks as well as in attitudes, values, skills, abilities, preferences and aspirations. Strengths are expected to emerge, be clarified and change over time as the family's initial needs are met and new needs emerge with strategies discussed and implemented.

Unconditional Care: Means that involvement with the family is not dependent on something the child or family does or doesn't do. Rather, it's a commitment on the part of system partners to be there when the family needs them. It is a pledge on the part of the family and providers to work collaboratively to determine appropriate services, support or interventions. It is a vow by the team to not unilaterally assign or terminate services.

Collaboration Across Systems: An interactive process in which people with diverse expertise, along with families, generate solutions to mutually defined needs and goals building on identified strengths. All systems working with the family have an understanding of each other's programs and a commitment and willingness to work together to assist the family in obtaining their goals. The substance abuse, mental health, child welfare, and other identified systems collaborate and coordinate a single system of care for families involved within their services.

Team Approach Across Agencies: Planning, decision-making, and strategies rely on the strengths, skills, mutual respect, creative, and flexible resources of a diversified, committed team. Team member strengths, skills, experience, and resources are utilized to select strategies that will support the family in meeting their needs. All family, formal, and informal team members share responsibility, accountability, authority, and understand and respect each other's strengths, roles, and limitations.

Ensuring Safety: When child protective services are involved, the team will maintain a focus on child safety. Consideration will be given to whether the identified threats to safety are still in effect, whether the child is being kept safe by the least intrusive means possible, and whether the safety services in place are effectively controlling those threats. When safety concerns are present, a primary goal of the family team is the protection of citizens from crime and the fear of crime. The presence of individuals who are potentially dangerous requires that protection and supervision be sufficiently effective to dispel the fears of the public.

Gender/Age/Culturally Responsive Treatment: Services reflect an understanding of the issues specific to gender, age, disability, race, ethnicity, and sexual orientation and reflect support, acceptance, and understanding of cultural and lifestyle diversity.

Self-sufficiency: Families will be supported, resources shared, and team members held responsible in achieving self-sufficiency in essential life domains. (Domains include but are not limited to, safety, housing, employment, financial, educational, psychological, emotional, and spiritual.)

Education and Work Focus: Dedication to positive, immediate, and consistent education, employment, and/or employment-related activities which results in resiliency and self-sufficiency, improved quality of life for self, family, and the community.

Belief in Growth, Learning and Recovery: Family improvement begins by integrating formal and informal supports that instill hope and are dedicated to interacting with individuals with compassion, dignity, and respect. Team members operate from a belief that every family desires change and can take steps toward attaining a productive and self-sufficient life.

Outcome-oriented: From the onset of the family team meetings, levels of personal responsibility and accountability for all team members, both formal and informal supports are discussed, agreed-upon, and maintained. Identified outcomes are understood and shared by all team members. Legal, education, employment, child-safety, and other applicable mandates are considered in developing outcomes, progress is monitored and each team member participates in defining success. Selected outcomes are standardized, measurable, based on the life of the family and its individual members.

Collaboration with Families

A “family” consists of the child’s primary caregiver(s) and other individuals who live with the child and play an important role in their life. This may include, for example, siblings, grandparents, or an aunt or uncle. The term “parent(s)” refers to individuals who are the primary caregivers of the child. A primary caregiver may be the child’s biological parent, adoptive grandparent, foster parent, or any adult with whom the child lives who is primarily responsible for their care. In order for there to be a collaborative team, at least one primary caregiver must be willing to be involved in the team process and participate in every team meeting.

CST places parents and service providers in heightened roles as collaborators. It is assumed that parents know their children best; and that their perspectives as full-time caregivers are valid; and that they know what it takes for them to provide their child with a successful home placement. These assumptions require a service system shift from asking parents to choose from a menu of existing

services to honestly asking parents what supports and interventions they want and need to provide their child with a normalized growing-up experience.

A collaborative partnership empowers families to act of their own behalf to achieve greater control over their lives, and to influence the people and organizations that affect them. The families' right to make decisions about services and take part in developing further services must be respected and cultivated, empowering the family within the local service system. Ultimately, families are empowered as a group through the influence they can exercise over public policy regarding children with special care needs.

The Research and Training Center at Portland State University conducted research to identify the major factors of successful collaboration from the perspective of family members. One study revealed four major elements:

1. Support and understanding shown by professionals through including families in all decisions and recognizing that families have other responsibilities than the child with a disability;
2. Assistance given in the practical aspects of securing services, such as finding, coordinating and paying for them;
3. A clear and open exchange of information between families and professionals; and,
4. The flexibility and willingness to modify care plans as indicated by parents' feedback.

By keeping these elements in mind and advocating for them, a service coordinator will actively build a partnership with a family.

Voice, Access and Ownership

An underlying goal for every family involved in CST is that they have “*voice, access and ownership*”. The achievement of voice, access and ownership is one indicator that a team is ready to transition out of the formal CST child and family team process.

Voice: Parents should feel they have a voice in decisions that are made about their child and family. This includes being listened to and respected.

Access: The child and parent should have access to the services needed to meet their needs.

Ownership: The parent agrees with and is committed to plans concerning their child and family.

Rights & Responsibilities for Family – Provider Partnerships

Rights and Responsibilities for Parents:

- I am an equal partner with providers on the team, working jointly to address needs and plan on behalf of my child.
- I see the provider as a person who is working with me for the well being of my child & family.
- I see my goal as reaching a mutual understanding of my child and family's needs so that as a team we can take action to meet those needs. I clearly express my own strengths and needs as well as the strengths and needs of my child & family.
- I am an active participant in the decision-making process concerning services for my child & family, and I seek ways to insure my active involvement.
- I know that wraparound does not mean that I will receive large amounts of money or new possessions, but that the focus is on needs.
- I understand that a provider often has responsibility for service coordination and communication with many children & families, including my own.
- I don't let past negative experiences or negative attitudes get in the way of establishing a good working relationship with the providers I am working with now.

- I encourage the providers involved with my child to communicate with each other and to keep me informed as well.
- When I make a commitment to a plan of action, I follow through on my responsibilities.
- I talk with other parents involved in the child serving system, sharing my experiences and knowledge.
- I commit to regarding providers with the same respect that I expect them to give to me. I help promote a culture that is supportive and friendly to providers.

Rights & Responsibilities for Youth:

- The people on my team are a part of the team because they care about my family and me. They are working with me for our well-being.
- I believe that I am a partner with all team members, working together to address needs and make important decisions on behalf of me or other family members.
- I am a person just like my partners and the service providers. I have ideas, feelings, and beliefs that may or may not be different from those on the team. I deserve to have them voiced.
- I know that I am not the only voice to be heard, and that all plans/decisions are the result of the entire team. I also know that I am a child (minor) and sometimes adults in my life make decisions for me.
- I attend and participate in team meetings because the meetings are about me or other family members, and therefore, I should have my feelings, strengths, and needs voiced.
- I come to team meetings prepared. I come to meetings with ideas I want added to the agenda for discussion and questions I want answered.
- I am able to clearly express my own needs and the needs of my family to all team members. I will voice my feelings, needs, and opinions in appropriate and respectful ways.
- Adults, just like children and teenagers, make mistakes and learn things one step at a time. I treat others on the team like I would like them to treat me.
- When I make a commitment to a plan we decided on, I follow through with what I said I would do

Rights & Responsibilities for Providers:

- I am an equal partner with parents and other team members, working jointly to address needs and plan on behalf of the child.
- I evaluate the child in terms of progress made, and communicate hope to the parent by doing so.
- I consistently value the comments and insights of the family and make use of their knowledge about the child's needs and activities. I will not impose my own values and how others live.
- I speak plainly, avoiding the jargon of medicine, sociology, education, psychology, or social work.
- I actively involve the parents in the establishment of a plan of action and continually review, evaluate, and revise the plan with them.
- I make appointments and provide services at times and places that are convenient for parents and other team members.
- When I make a commitment of action, I follow through on my responsibilities.
- With appropriate authorization, I obtain and share information with other providers, ensuring services are not duplicated.
- With appropriate authorization, I connect the family with other families in similar situations.
- At the request of parents, I am an active part of their information and referral network, providing them with contacts to services and to parent support networks.
- I will use the family team meeting to honestly and assertively share my concerns and fears.
- I commit to regarding parents with the same respect that I prefer they give me. I help promote an agency culture that is supportive and friendly toward parents

The Changing Role of Parents

As families move through the collaborative process, parents' roles in the system of care begin to change and expand.

Parents as Coordinators

Parents are recognized for the services and supports they provide, including their role as coordinators for their own and their family's lives



Parents as Partners

Parents are partners with service providers on their team. As partners, parents are given the same respect and input into the identification of strengths, needs, and interventions to meet needs.



Parents as Team Coordinators/Facilitators

Parents develop the skills needed to begin coordinating services and getting needs met without the formal assistance of a service coordinator. When the formal team process has ended, parents become their own family's "service coordinator".



Parents as Advocates and Supports

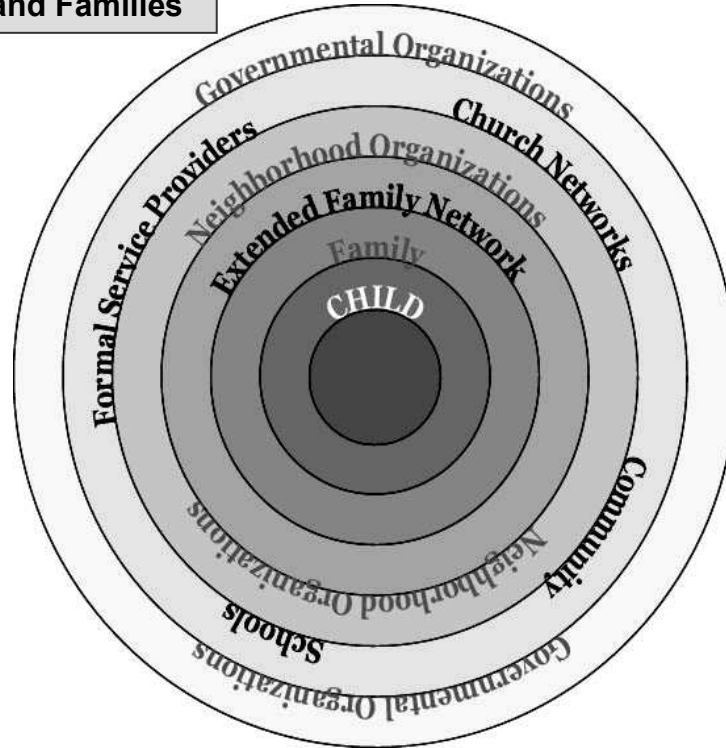
Through their experience with the team process, parents often offer support and resources to other families.



Parents as Leaders and Consultants

Once the formal team process has ended, parent "alumni" offer a valuable perspective on Coordinating Committees, as trainers, and consultants.

Support Map for Children and Families



The Child and Family Team (CFT) Process

The Community Support Team process does not happen simply by chance or from good intentions. Re-designing our approach to children and families with complex needs requires a highly organized series of steps. The key steps are outlined in order below.

Step 1: Identification and Referral

An organized process identifies children and families most in need, for whom other approaches have not worked.



Step 2: Service Coordinator Identification

On a timely basis, a service coordinator is identified to meet with the family.



Step 3: Family Engagement and Strength and Needs Exploration

The service coordinator meets with the child and family to identify their needs as well as their personal and network strengths. Additional information from systems working with the family is also gathered, and a draft of the Summary of Strengths and Needs Assessment is completed. The strengths and needs of the child, family, and support system are explored in the following areas or "life domains":

- | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> • Living Situation • Basic needs and financial status • Child & Family/consumer situation • Mental health • Social interaction • Access to community resources • Cultural involvement | <ul style="list-style-type: none"> • Spiritual status • Education/vocational status • Legal involvement • Medical status • AODA status • Crisis Response |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|



Step 4: Preparing for a Child and Family Team Meeting

The service coordinator and family identify members of the child and family team. All team members should be contacted to review the agenda and how the meeting will work. If there are members new to the team process, orientation should be provided including review of the core values.



Step 5: First Team Meetings & Review of Strengths and Needs

The team establishes a road map for its time together. Activities during the first team meetings should include: clarification of roles and goals, team rules/participant rights, and general overview of the team process. The team should also review and complete the initial Strengths and Needs Assessment Summary (*should be completed within 30 days of enrollment*)



Step 6: Plan of Care

The team prioritizes the top needs as identified in the Strengths and Needs Assessment Summary and, using identified strengths, develops an individualized Plan of Care to address needs. A Plan of Care:

- Defines present level of functioning
- Promotes normalization
- Is culturally competent
- Uses strengths to meet needs
- Uses family and community supports
- Uses services when needed
- Clearly defines outcomes
- Plans for ongoing review and plan refinement



Step 7: Ongoing Meetings and Planning

The CFT meets as necessary, generally every 3 – 6 weeks, to monitor and adjust the Plan of Care. The CFT develops and maintains regular communication and monitoring.



Step 8: Building Family Supports and Competencies

The child, family and their network continue to learn new approaches and find more support in their community with the help of the entire team. The effort moves toward stability and maximum self-reliance.



Step 9: Transition

The activity of a service coordinator is no longer necessary to sustain the plan. Arrangements have been made to continue any needed services. Teams often continue with leadership from the parent and other members.

Team meets once every 1 to 2 weeks for 45 – 60 minutes. This phase typically lasts 2 – 3 months

Team meets once every 3 – 6 weeks or as often as needed for 45 – 60 minutes for an average of 9 – 15 months

Advantages of the Coordinated Services Teams Approach

Too often service providers work long hours with too many families, only to feel unappreciated when families do not appear happy with the services they worked so hard to put in place. When service providers are making the decisions regarding services to be used by children and families, they take on sole responsibility for the quality of service and its effectiveness.

The Primary Reason to Change this Approach to Serving Families

Services and strategies don't work if the child and family are not invested in their success, no matter how elaborate or well intentioned they may be, or how many times it may have worked with other children and families.

When Families are Full Partners

- Families work hard with providers to make their plan a success.
- Service providers are relieved of the burden of responsibility for the performance of every detail of the plan.
- Service providers are assisted by parents who are learning to advocate for themselves, navigating the system of care on their own, and securing services they and their children need.
- Service provider burnout is reduced.
- Opportunities for service provider creativity and flexibility is increased.
- Service providers feel more appreciated and respected.
- Work is more rewarding when goals are shared.

Partnership with Families Makes the Difference Between

- Feeling included and feeling trapped
- Being invested and being resistant
- Social growth and isolation
- Partnership and powerlessness, and
- Success and failure

1.2 The Role and Functions of a Service Coordinator

The terms "service coordinator" and "team facilitator" are often used interchangeably to describe the role of the person who takes the lead on a CFT. Facilitating team meetings is actually one of the functions of a Service Coordinator (title to describe a key person(s) on a CFT).

Key Roles of a Service Coordinator

Key Roles of a Service Coordinator:

- Preserve and promote the Core Values including family-centered, strength-based, unconditional care, and outcome oriented
- Work with the family to construct a CFT
- Ensure planning is based on child, family and community strengths to address needs
- Manage information and resources necessary to support the family, team, and Plan of Care, and make changes to the Plan of Care as needed

The Role of a Service Coordinator is Not:

- Casework, in the traditional social service/human service sense. It does involve some elements of good casework: communication, assessment, and service development. However, as a service

coordinator, these four elements are not the primary focus of *casework*; they are the primary focus of *coordination*.

- Service management. Arranging for and monitoring service provisions are an element of coordination. However, if the above key roles are not the focus, the arranging of services in and of itself is not quality family service coordination.
- Coordinator of “staffings”. A child and family team meeting begins with the child, family and their extended network. Service providers play supportive roles where needs cannot be met without them. Coordination of service delivery comes through the comprehensive plans developed in that team process. Staffings (which some call team meetings) refer to gatherings of professional service providers where, even if the child or family is present, the main functions are to coordinate service delivery and to gain family input about and commitment to the plan that has been developed for them.

Functions of a Service Coordinator

Engaging and Building Trust with the Family

- Meets with the family and develops an understanding of their story
- Assists the family in identifying the initial team members
- Addresses immediate needs identified by the family
- Completes first draft of Strengths and Needs Assessment Summary with the family
- Prepares team members for participation on a CFT

Facilitating Team Meetings

- Maintains a strength-based agenda
- Helps team develop ground rules
- Facilitates the group process and builds agreements on needs, strengths and action plan
- Assures family and other team member participation
- Manages conflict
- Models a strong non-judgmental, family-centered approach

Documenting the Plan of Care and Assuring Team Process to Implement the Plan of Care

- Integrates results of the meeting into the Plan of Care
- Documents needs, strengths, commitments, and outcomes
- Helps family access services and supports where needed
- Arranges for services and supports where none presently exist
- Documents Crisis Response Plan and distributes to necessary people/systems

Managing the Team and Plan of Care over Time

- Works with the family and team in reviewing and modifying the Plan of Care
- Maintains family and team ownership of the Plan of Care over time
- Delivers direct services only when necessary
- Ensures evaluation of Crisis Response Plan

Begins development of phase-out/transition plans to discuss with team

- Utilizes supervisors, administrators, etc., to resolve conflicts, break down service access/development barriers or bend rules
- Maintains team commitment to the family over time
- Models “sharing of responsibility”; ensures all team members have an active role with regards to the activities and responsibilities of the team

Role of the Service Coordinator: Lessons Learned

Role:

- Expert on the Collaborative Team Process
- Assure Team Completes the Assessment and Plan of Care
- Ensure Reassessment and Plan of Care Updates
- Share Outcomes

Not Role:

- Sole Decision Maker
- Person Who Does It All
- The Only Person Team Members Call
- Dictate What Should Be Done, to Infringe on, or be a Substitute for the Policies and Procedures of Other Agencies/Systems

Tools

- Project Coordinator Sample Job Description
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Articles

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Coordinated Services Team Initiative Care Coordinator Job Description

Knowledge and Skills:

With the guidance of the Initiative Coordinator, the Care Coordinator will have a comprehensive knowledge of the human service system; have knowledge of how to access area resources; be skilled in written and oral communication; and be able to successfully facilitate groups and work well with a divergent group of people.

Specific skills of an effective Care Coordinator/facilitator include the abilities to: focus on strengths, accurately listen, develop trust of team members, understand multiple perspectives, intervene on ineffective behavior, accept feedback without reacting defensively, provide support and encouragement, and maintain/demonstrate patience.

Care Coordinator Activities:

- A. Identify and bring together a team of people that will collaboratively work with the child and family, and provide process orientation to the family and to service providers who are new to the process. These activities take approximately **3 – 5 hours**.
- B. Together with team partners, conduct a comprehensive and multi-dimensional summary of strengths and needs of the child and family. Schedule and facilitate team meetings to complete the summary of strengths and needs and review the results. Ensure completion of corresponding paperwork. This process takes approximately **10 – 15 hours**.
- C. Together with team partners, develop the Plan of Care, specifically outlining each team member's responsibility, time line for accomplishment, and outcome expectations. Schedule and facilitate team meetings. Ensure the development of a safety plan for each child to address potential crisis situations at home, in the community, and at school. Ensure completion of Plan of Care paperwork. This process takes approximately **12 – 16 hours**.
- D. Coordinate the implementation of the Plan of Care and monitor ongoing delivery of services. This responsibility includes regular contact with the child, family, and service providers. Schedule and facilitate regularly scheduled team meetings to monitor the plan as a team. Ensure the Plan of Care is amended as necessary to meet the changing needs of the child, family, service providers, and community. Excluding the provision of direct services (in-home therapy, mentoring, etc.), this process takes approximately **2 – 6 hours per family per month**.
- E. Ensure completion of Quarterly Reports – includes collecting and recording information and data on placement, diagnosis, expenses, outcomes, and activities to determine effectiveness of the Plan. Collection of information and completion of the report takes approximately **2 hours per child**.

Paperwork:

Depending each team's situation and experience of the Care Coordinator, paperwork time will vary. Typical forms to be completed by or arranged to be completed by the Service Coordinator include:

- Release of Information
- Assessment Summary of Strengths & Needs (to be completed within 30 days of enrollment)
- Plan of Care (to be completed within 60 days of enrollment)
- Home/Community Crisis Response Plan
- School Crisis Response Plan (often incorporated into the school Behavior Intervention Plan)
- Ongoing reporting of outcomes to the State
- Meeting minutes
- Team correspondence

Other documents which may be reviewed by the team and incorporated into the plan include:

- Individual Education Plan (IEP)
- Behavior Intervention Plan (BIP)
- Court Order
- Permanency Plan
- Psychotherapy/In-home assessment, goals, evaluations, case notes, etc.

Coordinated Services Team Initiative Initiative Coordinator Job Description

The primary responsibility of the initiative coordinator is to promote collaborative relationships between systems of care.

The initiative coordinator shall do all of the following:

- Bring together parents and relevant staff from various agencies and organizations to comprise the Coordinating Committee. Support their activities, ensuring compliance with established policies and procedures.
- Work with the coordinating committee to maintain and support agency participation as established in the Interagency Agreement.
- Work with the coordinating committee and service coordination agency to receive and review referrals.
- Work with the coordinating committee and service coordination agency to assure provision of service coordination services for all groups of people working with the child and his or her family.
- Guide the development of the coordinated service team working with the child and his or her family in order to ensure compliance with basic principles of the initiative core values.
- Review plans of care, including crisis response plans, for consistency with the coordinated services team approach to providing services to a child and his or her family and core values.
- Assist the Coordinating Committee and coordinated services teams in establishing consistent measures for program development, implementation, evaluation, and monitoring of the initiative and its outcomes.
- Facilitate public education and awareness of issues and programs for children who are involved in 2 or more systems of care and their families.
- Ensure provision of ongoing support and training that is related to the coordinated services team process for families, care/service coordinators, and providers and ensure orientation for coordinated services team members.
- Support service providers in developing strategies to enhance existing programs, to increase resources, and to establish new resources relevant to project goals and objectives.
- Ensure that local and state agencies submit data and reports in an accurate and timely manner.
- If directed to do so by the coordinated committee, perform any of the duties listed below:
 - Maintain data of enrollments in the initiative and results of screening.
 - Establish and report monitoring and evaluation results.
 - Monitor, or ensure proper monitoring of targeted case management and in-home services provided under the Medical Assistance Program, including recordkeeping and billing processes.
 - Assist in developing and maintaining additional funding sources, including collaborative efforts with system partners.
 - Assist in the development and implementation of advocacy for families.

Sources: WI Act 334 and WI State Statute 46.56

Sample Service Coordinator Performance Review

Coordinator Name:					
Supervisor Name:					
Date of Review:					
Quarterly Review: (circle one)	1	2	3	4	5

Principles/Indicators	Progress	Comments/Action Plan
1. Demonstrates respect for children, adolescents and their families		
a) Uses language and behavior that consistently respects the dignity of children and families		
b) Solicits family input and collaboration in CST process		
c) Involves child, adolescent and family in all aspects of planning and support activities		
d) Demonstrates knowledge of family support resources that support the value of family involvement		
e) Communicates understanding of unique issues facing family members		
f) Provides direct support as needed		
2. Demonstrates knowledge about children's issues		
a) Demonstrates basic knowledge about children's issues		
b) Demonstrates ability to obtain consultation on information about children's issues for the Community Support Team		
c) Demonstrates understanding of the effects of stressful life events on children and families		
3. Demonstrates understanding of principles of collaborative community-based care		
a) Understands and demonstrates principles of unconditional care		
b) Understands the principles of child and family centered services		
c) Understands the principles of community-based care		
4. Demonstrates knowledge of a variety of approaches to intervention and support for children, adolescents and their families		
a) Understands the importance of informal supports		
b) Understands and demonstrates the concept of flexible services		
c) Understands and utilizes a variety of program models and philosophies		
d) Understands and utilizes a range of crisis prevention and intervention approaches		
5. Demonstrates ability to design, deliver, and ensure highly individualized services and supports		
a) Routinely solicits personal goals and preferences of family as part of the team process		
b) Designs individualized plans with the team that utilizes the strengths and that "fit" the needs and preferences of the child and family		

Principles/Indicators	Progress	Comments/Action Plan
c) Encourages self-sufficiency by transitioning formal services to informal supports		
d) Facilitates and supports natural support networks		
6. Demonstrates ability to facilitate community support team meetings		
a) Works in a cooperative and collaborative manner as a team facilitator		
b) Ensures to the best of his/her ability that all necessary team members are present for child and family team meetings		
c) Is prepared for team meetings including preparing family members and other participants, preparing an agenda and having necessary documents and material ready		
d) Assists in building positive team relationships		
e) Provides communication to those unable to attend team meetings		
f) Coordinates service and support activities with others through the use of a plan of care		
7. Demonstrates knowledge of a variety of resources, both formal and informal, for children and families		
a) Identifies and accesses a wide range of community resources		
b) Develops and maintains a good relationship with community representatives		
c) Demonstrates knowledge of entitlement and benefit programs and/or has referral information		
d) Integrates community resources into service planning		
e) Participates in public education and overall advocacy		
8. Completes required administrative work in a timely manner		
a) Completes strength and cultural discovery, crisis/safety plan and plan of care within agency expectations		
b) Completes other paperwork within agency expectations		
9. Actively participates as part of a team		
a) Participates in team meetings		
b) Participates in group supervision		
c) Participates in individual supervision		
d) Covers for other team members as needed		

Access, Voice and Ownership: Examining Service Effectiveness from the Family's Perspective

By Patricia Miles and John Franz

How can we tell if our systems of care are effective? One strategy looks solely at outcomes: are children remaining at home or at least in the community, are they progressing from grade to grade in school, being kept free from harm caused by abuse and neglect, and not harming or abusing others? This is the idea. If we could monitor outcomes, find out what works and do more of it, we would be constantly improving our services. (As long as we can all agree on a common definition of "good outcomes.") However, there is a practical limitation on this strategy: our current ability to collect, maintain and analyze concrete outcome data across a community-wide collection of systems of care is limited, and even when small amounts of outcome data are available, it is often difficult to link them directly to questions of system redesign. This article explores another option which may be more workable.

Linking Positive Outcomes to System Characteristics

An alternative is to determine whether good service outcomes can be linked with certain system attributes that are easier to monitor. This second tack was taken by Washington State under the leadership of Dr. John Whitbeck, who is the director of research for state's Mental Health Division. He began his study with a large sample of individual cases from a wide variety of human service disciplines which were identified as having good outcomes. He then assembled teams, which did in-depth analyses of these successful interventions to determine whether any common elements could be identified. The initial results were then rechecked through follow up investigations.

What the Washington State team discovered was that positive service situations nearly always had three key clusters of attributes. Participants described them in a variety of ways, but what they boiled down to was that successful outcomes were highly correlated with strategies that provided clients with feelings of access, voice and ownership in the development and implementation of their service plans. These qualities seemed essential to good results, regardless of the type of service being offered, the technique being used or even the individual or family receiving help. Whitbeck's group defined each of these attributes in the following way:

Access occurred when clients (parents, children, individuals receiving services) were offered valid opportunities for inclusion in the process of deciding what sort of services would be provided and how they would be delivered. In other words, family members had a seat at the table when the real work of planning was taking place.

Voice was present in those situations in which clients not only had a seat at the table, but actually had an opportunity to present their perspectives and to be heard during the planning process.

Ownership existed when clients felt a sense of commitment to the course of action which was developed through the planning process, identified with it and believed it to be worth while.

The concept of access, voice and ownership have a ring of common sense about them. Any of us are more likely to agree with, participate in and benefit from a course of intervention that we feel we are a part of than one which we feel is being done to us. We respond better when we are treated like people than we do when we are manipulated like objects.

Ten Values for Responsive System of Care	
Basic Values	Levels of Implementation
<p>1. Access. Families identified as having a significant service needs are provided meaningful access to the decision-making process.</p>	<ul style="list-style-type: none"> a. The community's systems of care give parents at least two weeks lead time prior to routine planning meetings and give parents both written and phone or face-to-face notice of the meetings. b. The systems of care have the capacity to schedule meetings outside the usual 9-5 work day, and are observed to occasionally rearrange meetings around parents' work schedules and choose alternative sites more convenient to parents. c. All meetings which include important decision-making are automatically built around parents' schedules and preferences for location.
<p>2. Voice. Parents have an active voices in the development of service plans.</p>	<ul style="list-style-type: none"> a. Parents are present during planning meetings and are given an opportunity to respond to proposals made by potential service providers and to select from available options. b. A staff person meets with parents before key decision-making meetings to explain the structure and purpose of the meeting and to determine the concerns and needs of the parent. c. Parents are given the opportunity and support to be the agenda-setters for meetings, including making choices about the structure and membership of the meeting and selecting the key issues to be determined.
<p>3. Ownership. Family members feel a thorough sense of ownership with the plans of care which are developed.</p>	<ul style="list-style-type: none"> a. In most systems of care within the community, families are generally perceived as being given the opportunity to receive these needed services. b. Families are viewed as active partners with professionals in selecting plans of care most likely to achieve good outcomes. c. Families take a lead role in guiding the service development and implementation process, including configuring the planning team, helping to select or design service options and identifying key outcome indicators.
<p>4 Effective parent support. The community's systems of care have specific structures in place which support parent participation and empowerment.</p>	<ul style="list-style-type: none"> a. Parents are referred to support groups which provide companionship and emotional support form other parents in similar situations. b. One or more formal, parent-run organizations are available in the community to provide advocacy and system orientation services for parents, generally in the form of other parents who volunteer to provide this support. c. Each parent who comes into a community system of care is put in contact with a parent-run project that includes the availability of paid parent-partners who are able to function as formal advocates or system-conductors for new parents, if the parent chooses to use them.
<p>5. Flexible access. Families are able to tap into a full range of integrated services and supported through any of a variety of access points within the community.</p>	<ul style="list-style-type: none"> a. Each primary service provider within a community (i.e. schools, social services, juvenile justice, mental health,) has formal, or regularly-used informal, channels of communication with other providers which allow for the development of coordinated plans of care. b. For at least one target population, a mechanism exists which allows all of the service providers offering components of the full range of support needed by a family to join together to develop a single plan of care using pooled resources. Leadership for joint planning is usually housed in one or more specialized agencies. c. Each primary service provider in the community has the ability to respond in a flexible, integrated manner to assist families who present complex, multi-categorical needs, including tapping into other system resources when needed. Leadership for supporting the development of an integrated plan of care can be in a variety of sites, based on the needs and concerns of the community as a

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Basic Values	Levels of Implementation
	whole.
<p>6. Outcome-focused planning. Service providers throughout the community consistently use a planning process which focuses on the individual strengths and needs of the family and their natural supports in order to overcome the primary barriers to positive outcomes.</p>	<ul style="list-style-type: none"> a. Staff of most community agencies are trained to provide blame-free service planning, although some families are still primarily assessed in terms of their problems and diagnoses. b. Family members served by any of the primary service providers are viewed as people with strengths as well as deficits. Families throughout the community report that they are in an environment in which they can take responsibility for helping to develop solutions for their problems. c. Staff and all primary providers are trained to view family members as resources with skills, abilities and strengths. Supports and interventions are provided based on needs identified throughout the major life domains of the families. Ongoing adjustments are made to facilitate the transition of families from professionally-provided to naturally-occurring supports.
<p>7. Strength-based, need-driven services. Supports and interventions are developed individually, respond to the specific strengths and needs of the family, and focus on producing successful long-term outcomes.</p>	<ul style="list-style-type: none"> a. Family members receive services from various community agencies in the context of a coordinated plan of care. b. Family members not only receive pre-existing services from community agencies, but also receive unique, individualized services developed by a specialized agency using flexible funds. Cooperation agencies are willing to adjust their categorical programs to some extent in order to meet specific family needs. c. Each service plan is individually developed based on the strengths and needs of the family members and their natural supports. Fiscal flexibility as well as programmatic resource realignment are controlled by the agency with primary responsibility for serving the family. Services are continually evaluated and adjusted based on progress toward identified outcomes.
<p>8. Flexible, integrated service delivery. Traditional primary service providers adapt their family support strategies to permit flexible, multi-categorical responses.</p>	<ul style="list-style-type: none"> a. Families in a specific target population are made the responsibility of a certain staff. Staff of that agency are viewed as primarily assigned to a specific system of care and function as case managers for a designated caseload. Each case manager then attempts to help her or his clients access other system resources, while also often providing direct services for families. b. Community agencies take joint responsibility for families with complex needs. Staff of a specialized agency with leadership responsibility for a particular family may facilitate the development of a plan of care, and provide technical assistance and backup, but primary services are likely to come from a variety of sources throughout the community, based on the family's combination of strengths and needs. c. A family with complex needs is able to access a full array of community services through the primary agency with whom they have the most comfort and contact. Lead facilitation may come from a variety of sources, including generic staff who are provided sufficient backup to adjust their roles to provide special care for a family during a crisis or while a plan of care is being developed. Staff or specialized agencies are community-owned and may be drawn in for technical assistance and support by any primary service agency.
<p>9. Community-based care. Service environments are community-based and maintained through an unconditional commitment to meet the needs of the family in as normalized a process as possible.</p>	<ul style="list-style-type: none"> a. When children are placed out of the community for care, their return is viewed as a reward for improved behavior or progress toward treatment goals in the restrictive-setting. b. Leadership agencies focus on providing unconditional care across domains and strive to provide or develop community-based services regardless of the severity of a child's needs. Use of out-of-community, restrictive treatment options is viewed as a system weakness to be overcome, rather than a failure.

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	<p>by the family or the child.</p> <p>c. All system agencies operate under presumption that a plan of care can be developed to meet any client's needs in a community environment. Mutual support from each agency greatly increases the likelihood that even children with exceptional treatment needs can live successfully in the community. Services change with needs, and crises are managed with most children experiencing minimal or no moves in placement.</p>
<p>10. Consistent interagency coordination. A community-wide group with broad representation and clearly delegated authority provides consistent vision, support and conflict management to insure the delivery of integrated services.</p>	<p>a. A voluntary committee of representatives from primary care agencies, the courts, community leaders and citizen representatives meets regularly to suggest better ways of improving system operation.</p> <p>b. Each primary service agency has made a specific and measurable commitment of resources to an integrated system of care. A formal community organization exists that has the power to direct resources to address unmet or unexpected system needs, to resolve conflicts among service providers and to provide vision and leadership for further improvements in the community's systems of care.</p> <p>c. A formal process for objectively resolving conflicts of values is in place and directly linked to the integrated system of care. Mechanisms and strategies for dealing with issues of coercion and consequences that arise when children and family members refuse or are unable to meet the community's minimum standards of conduct are in place and their operations is understood by staff throughout the systems of care and clearly explained to families.</p>

Process elements that support access, voice and ownership

In looking at their data, the team found a second set of process components that appeared to have a high likelihood of supporting or producing conditions in which the qualities of access, voice and ownership could emerge. These components were:

1. *Holistic reframing* which means that successful outcomes seemed to be linked to planning approaches in which a broad-based course of support and intervention was constructed by operationalizing normal and appropriate outcomes in the context of each of the major domains of the individual to family's life, instead of limiting care and treatment to narrow categories defined more by the provider's structure than the family's needs. (Life domains include areas such as a place to live, a family or surrogate family to live with, a social life including friends and other social contacts, educational or vocational activities, medical concerns, psychological and emotional needs, legal issues, safety issues, and the impact of the person on family's ethnic, cultural, geographical and spiritual needs and values.) In addition, service plans fitting within this cluster were built on the strengths and needs of the participants, rather than limiting the focus to a family's clinically-defined deficits and diagnoses.
2. The second element consisted of various types of *flexible planning issues* that bundled the outcomes from the reframing into the operational, client-based, in-depth strategies which dealt objectively with real-life contingencies and which focused on actions designed to address the primary needs standing as barriers to positive outcomes for families regardless of the domains in which those needs occurred.
3. The final factor was the need for some form of *team-based approach* for developing and implementing the plan of care which actively included the family as well as any natural and system-based support persons who were necessary to design and implement the plan. The team members also had to be hands-on participants who were both willing and able to do the work or commit the resources necessary to carry out the aspect of the plan for which they were responsible.

As is implied by these findings, communities in which the various systems [of care] have a high degree of integration are more likely to generate the process elements that lead to access, voice and ownership. Similarly, the more a community's programs remain highly categorical and avoid pooled planning and service delivery, the more difficult it becomes to introduce positive attributes.

Measuring the elements of access, voice and ownership

For system redesign based on access, voice and ownership to be effective, a feedback mechanism must be established for measuring the presence of those attributes as well as the process components which are their precursors. Dr. Whitbeck and his associates are developing a nationally validated tool which does just that, but in the meantime staff and associates with the Community Partnerships Group have prepared some ad hoc scales based in Dr. Whitbeck's work that are designed to assist system planners for individual communities to at least get a feel for the level of family inclusion in the current operations of their system of care.

These scales are meant to be used in a positive way. They are not constructed to show what's wrong with a community's system of care, but to enable folks to measure how far they have moved toward their goals for system of change. Because these scales have not yet been validated, they cannot be linked definitively to an accurate measure of access, voice and ownership and the supporting process components in a system. On the other hand, within limitations, the scales do provide a framework community groups can use to clarify their values and determine how well their systems of care put those values into action.

For example, charts such as the one on the proceeding pages have been used as the basis for system surveys in several communities. In those situations, the most interesting and helpful results have not been the absolute scores that have been achieved, but the differences in scores reported by participants from various segments of the community. For example, if direct service providers give responses indicating that they feel parents have a high degree of participation in service planning, but parents report otherwise, some important discussions need to take place.

Surveys like this are most useful when they include participants from a wide variety of community roles. It is not unusual for social workers, teachers, youth participating in service programs, parents, youth who are not involved in special programs, law enforcement officers, judges, district attorneys, public defenders, private therapists, foster parents, school principals, agency administrators, sports coaches, siblings of youth in special programs, etc., to all have different opinions, but combining those disparate responses often produces the most accurate topography of a community's system of care.

To help illustrate how these scales operate, we have selected ten examples which focus on the degree to which a community's system of care might come together to support families with children who have severe emotional disabilities. In practice, surveys being developed for specific communities would use items more clearly tied to the nature and needs of the area involved, and break them down into more discrete segments. However, the pattern would be the same: a basic value or goal for the system is stated and a series of examples are given describing levels of development, which might occur as the system matures. We've offered three stages of implementation for each of our ten values; a working survey using 5 levels would provide more room for discrimination by respondents. A point score can be given to each level to provide a way of measuring change over time.

Operationalizing value-driven system redesign

As noted above, these are only sample value statements and descriptions of implementation. The actual values that would be better defined and more complete. However, a group attempting to develop an integrated system of care in a particular community might find this scale useful as part of an exercise during the initial planning process.

First, take time at a meeting to consider each of the values. Do people agree with it, or disagree with it? Can the group reach consensus on a specific value statement that roughly corresponds to each of the categories in the list above? Are there additional value statements your group would add?

Second, look at the implementation examples. Can your group make the examples more applicable to your community's situation? Then, take a few minutes to allow each member of the group to individually score their opinions of the community's current level of practice. Compare your results. Where there is divergence, have each proponent discuss the evidence that she or he feels supports their evaluation.

Using a tool like this one, even while we wait for Dr. Whitbeck and his colleagues to complete their effort at national validation, gives us a far more structured way to put our values into action and form a more objective picture of our communities' strengths and needs.

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