Coordinated Services Teams Initiatives
2014 Annual Report

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dhs.wisconsin.gov/cst/index.htm

EXECUTIVE SUMMARY

State law requires an annual report on Coordinated Services Teams (CSTs) Initiatives be forwarded to the Children Come First Advisory Committee, the group that is statutorily responsible for monitoring the development of CSTs in Wisconsin. This report is written for the Children Come First Advisory Committee and highlights the work of Wisconsin CSTs for calendar year 2014.

State investment fuels expansion, with 27 new sites added in 2014

The 2013-2015 state budget included $3.75 million in funding to support expansion of CSTs to additional countries and tribes. As a result, at the end of 2014, there were 64 counties and 11 tribes funded to provide an initiative, including 43 established CSTs with three or more years of funding, five developing CSTs with two years of funding, and 27 CSTs with new funding in 2014. Each new or expansion county and tribe in 2014 received approximately $60,000 in state money to fund their initiative.

New sites received funding to initiate services in April 2014. New CSTs typically require six to 12 months to develop their initiative before enrolling youth and families. Between April and December 2014, the new sites were focused on initiative development, including recruiting, hiring, and training staff and partners as well as broad community outreach. In addition, in May 2014, the Department of Health Services (DHS) introduced new requirements for all CSTs regarding data collection and a new system for the submission of this information. Because of this transition, this report has limits to the data available for analysis.

CSTs serve a record-high number of youth in 2014

Wisconsin CSTs served a record 1,097 youth in 2014, with 97 percent of youth served by established CSTs. The average number of youth served per CST in 2014 was 25. There were 1,973 additional family members served in developed CSTs in 2014, averaging 46 per CST.

CSTs serve many youth with serious, multi-system needs

Most CSTs have developed an extensive system of care in their community. Of the 41 developed CSTs that reported in 2014, 85 percent receive referrals from three or more different child-serving agencies. According to provider assessments using the Child and Adolescent Needs and Strengths (CANS) assessment tool, 85 percent of youth (N=391) had multi-dimensional, or multi-system, needs at the time of enrollment into their CST. More than half of these youth had needs that warranted intervention from the mental health, school, child welfare, and/or juvenile justice systems.

The Family Team approach works for parents and providers

CST parents and providers reported high levels of agreement about the CST Family Team process being inclusive of youth and families, strengths based, and accessible. Slightly more than 80 percent of CST providers reported parents were always full partners on their individual teams regarding activities such as setting convenient meeting times, selecting their team members, and having their child present at team meetings. More than 90 percent of providers reported their individualized plans of care were always culturally sensitive and strengths based. Ninety-five percent of parents agree they are treated as an important member of their team. Another 90 percent of parents agree the team used their child's strengths in setting goals and 90 percent would refer another family/child to a CST.

Preliminary cost savings estimates look promising

CSTs are community-based initiatives that serve as alternatives to more restrictive out-of-home placements for some youth. Of the 458 youth participants in 2014 with available data, 46 percent were projected at a group home level of need and 16 percent were projected at a residential treatment level of need. Because these youth were served through CSTs instead, an estimated savings of $2,838,220 in group home costs and $3,664,308 in residential treatment center costs were incurred, or $14,198 per enrolled youth. If complete data were available for all of the 1,092 youth who participated in CSTs in 2014, the projected savings could potentially be twice as high. Cost savings are preliminary estimates until data on other factors are available for consideration.

Most youth benefit from CST participation, but a minority may still need more

Parent satisfaction data indicated 60 to 70 percent of parents were satisfied with their youth's progress in handling daily life with their family, friends, and schooling. Parents were surveyed during their child's participation, so the satisfaction levels could change before actual disenrollment.

Of the 182 discharged youth with placement data participating in a CST in 2014, 83 percent were living with their parents, relatives, or friends at the time of their enrollment. At discharge, slightly fewer youth (78%) were at home with family and slightly more youth were in out-of-home settings. Among the youth discharged in 2014, 8 percent were in foster care, 6 percent in residential/group home facilities, 3 percent in institutional inpatient settings, 3 percent in correctional facilities, and 2 percent in other settings. Of the 175 youth discharged with offense data and more than six months of participation in 2014, 83 percent had no offenses after the first six months of involvement with their CST. The other 17 percent of youth committed offenses after six months of participation in a CST. Youth with no history of offenses in the six months prior to their enrollment were slightly less likely to commit offenses after CST involvement than those with a prior history.

CST providers' overall rating of a youth's final status at discharge revealed that 29 percent had completed participation successfully, 45 percent had a continuing need for services to which they were transferred or an unknown reason for their disenrollment, and 26 percent experienced an early disenrollment caused by voluntary family withdrawal, a provider-initiated withdrawal, or loss of eligibility. Other data indicate the group of youth with ongoing needs or unknown reasons for disenrollment had a median length of stay in their CST of 13 months, one month longer than youth who completed successfully. Also, half of youth reported with unknown reasons were in out-of-home placements at disenrollment.

For youth and families with an early disenrollment from their CST, the average length of stay was eight months, 25 percent shorter than other youth. Youth in this group were the most likely (29%) to have committed offenses after the first six months of CST participation. Only 17 percent of youth with an early disenrollment ended in an out-of-home placement, so the decision to disenroll was more likely to be a family- or agency-initiated early withdrawal for other reasons.

Across different indicators, a fairly consistent 75 to 80 percent of youth and families have a successful CST experience. More complete, consistent data will help in further exploring reasons why the remaining 20 to 25 percent have ongoing needs or unsuccessful experiences. A full year of data from the new data system for CSTs in 2015 may provide more consistent data.

Organizational, resources, and youth engagement cited as areas for improvement

Both CST parents and providers were asked for their recommendations on what, if anything, needs to be done to improve their CST initiative. The most common response by parents and providers was that their local CST was mostly successful and no changes were needed. Of the parents who responded to the survey, 58 percent specifically wrote a response that indicated nothing needed to be changed and everything was working well.

When providers described areas of need, their top-rated items focused on organizational needs:

- Increase community outreach and integration with other agencies
- Increase parent participation on coordinating committee
- Increase use of parent and peer supports

When parents described areas of need, their top-rated items focused on the need for additional service resources and youth engagement techniques:

- Increase CST facilitators and teams
- Increase service resources for CST
- Improve methods to motivate youth to participate

THE COORDINATED SERVICES TEAMS INITIATIVES APPROACH

Wisconsin has been developing collaborative systems of care since 1989. The original initiatives, called Integrated Services Projects (ISPs), focused on supporting families with children diagnosed with Severe Emotional Disorders (SED) in their homes and communities. In 2002, the collaborative process used by ISPs was expanded with the development of Coordinated Services Teams (CSTs) Initiatives. While CSTs use the same wraparound process as ISPs, the target group for CSTs 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. Since 2009, state law has identified all collaborative systems of care programs as CSTs. This update to the law also included language and information related to tribal CSTs; expansion of the target group to no longer require an SED diagnosis, although children with SED are the priority target group; expansion of coordinating committee membership and responsibilities, including a focus on sustainability of CSTs; creation of the role of Initiative Coordinator; and expansion of requirements for referral, assessment, planning, and closure processes, including a stronger role for parents, advocates, and service coordinators and an emphasis on meaningful outcomes.

CST is an intervention and support model that offers participants a team-centered, strengths-based assessment and planning process. In Wisconsin, CST is based on the traditional wraparound philosophy, with an emphasis on a collaborative system change approach. The vision of CST is to implement a practice change and system transformation in Wisconsin by having a strengths-based system of care, driven by a shared set of core values, that is reflected and measured in the way CST providers interact with and deliver supports and services for families involved in multiple systems of care, such as: child welfare, juvenile justice, mental health, special education, and substance use. To follow through with this vision, the CSTs are guided by the following core values:

- **Family-Centered:** A family-centered approach means that the families are a family of choice defined by the consumers themselves.
- **Consumer Involvement:** The family's involvement in the process is empowering and increases the likelihood of cooperation, ownership, and success.
- **Natural and Community Supports:** Recognizes and utilizes all resources in our communities creatively and flexibly, including formal and informal supports and service systems.
- **Strengths-Based:** Strengths-based planning builds on the family's unique qualities and identified strengths that can be used to support strategies to meet the family's needs.
- **Unconditional Care:** This 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.
- **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.
- **Youth Safety:** When child protective services are involved, the team will maintain a focus on youth safety. When safety concerns are present, a primary goal of the family team is the protection of the citizens from crime and fear of crime.
- **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 embrace an 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. These 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.
- **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.

When implemented effectively, wraparound facilitates changes in a community's child welfare, juvenile justice, mental health, and substance use systems that reduce barriers to engagement, increase youth and family participation, and achieve positive child and family outcomes. During the past 20 years, the wraparound process has been implemented widely across the world for several reasons, including its documented success in promoting shifts from residential treatment and inpatient options to community-based care and associated cost savings, its alignment with the value base for systems of care, and its resonance with families and family advocates.

EXPANSION EFFORT

In 2014, funding for Coordinated Services Teams (CST) Initiatives came from several different sources. The 2013-2015 state budget included $3.75 million of state funding for the expansion of CST. Additionally, DHS allocated portions of Wisconsin's share of the federal mental health block grant and federal substance abuse block grant as well as hospital diversion funds to the expansion plan. In 2014, there were 64 counties and 11 tribes with funded CSTs. Each new initiative received $62,123. To achieve financial sustainability and further expand services, many initiatives have tapped other funding streams, including funds from the Comprehensive Community Services Program, the Targeted Case Management benefit, and other Medicaid billing sources.

For purposes of this report, Wisconsin's CSTs are divided into groups to explain the status of their development. The different phases of development are described below.

The Development Phase (Year 1) is characterized by activities such as the development of the Interagency Coordinating Committee, policy and procedure development, training of service facilitators, and community education. Frequent technical assistance and training is provided on-site as well as at regional and statewide meetings to give counties and tribes the information and skills needed to establish a CST.

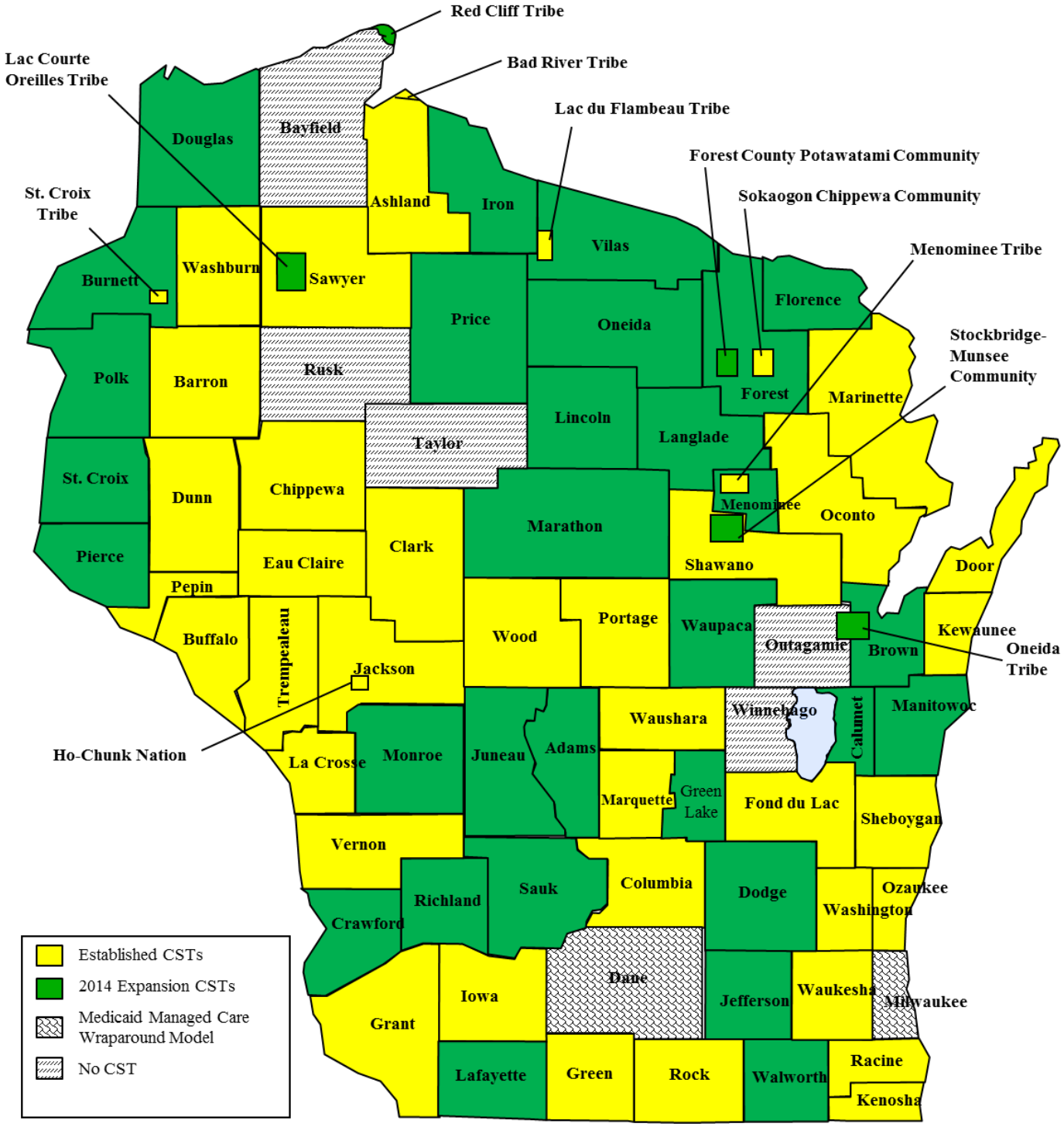
The Early Implementation Phase (Year 2) is characterized by an increase in the enrollment of families. CSTs in this phase typically do not reach capacity. Training and technical assistance activities include service facilitator training, ongoing support for the CST coordinator, administrative coaching, and support for coordinating committee expansion.

The Implementation Phase (Years 3-4) is characterized by the number of families served. CSTs in this phase typically are close to full capacity. At this time, the Interagency Coordinating Committee meets regularly to support the initiative, address system issues, and plan for sustainability. Technical assistance and training is more specialized, including workshops on 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.

In addition to the expansion in 2014, CSTs were given a new set of data requirements to track and a new data system to use to submit their data to DHS/Division of Mental Health and Substance Abuse Services. As of May 1, 2014, all CSTs started collecting the same assessment data as counties collect for all other youth served in Wisconsin's public mental health system. The consistency of data requirements will allow for future comparisons of CST performance and other programs and services used in the public mental health system to address youth needs. CSTs were briefed about the changes in data collection at the beginning of 2014. Webinar trainings on how to collect and report the data were held for all CSTs. State staff also provided targeted assistance when requested.

Because the data requirements changed in mid-2014, this report represents results that have been merged from two data systems. When the two sets of data were incompatible, results were not able to be analyzed. Future reports will include more comprehensive analyses when one consistent set of data requirements are available.

2014 Coordinated Services Teams Map



Status of Implementation Efforts

Only five sites that received funding under the 2014 expansion project were classified as new sites that had never operated a CST in the past. These included: Florence County, Walworth County, Forest County Potawatomi Community, Oneida Tribe, and Stockbridge-Munsee Community. The majority of the expansion initiatives previously operated a CST and sought funding to restore services or to meet new legislative requirements.

Twenty-seven expansion initiatives received funding, effective April 1, 2014. The majority of these sites required six months to set up their initiatives to serve children and families. Between April and December 2014, these new initiatives were focused on several priorities:

- Hiring a Project Director to oversee all aspects of the initiative
- Hiring CST Coordinators and Service Facilitators to work with families
- Training staff
- Developing an Interagency Coordinating Committee and agreements
- Approving policies and procedures through the Coordinating Committee
- Recruiting and educating community-based referral sources

Some of the expansion initiatives began serving a limited number of children and families by the end of 2014. Most expansion initiatives did not begin serving large numbers of participants until 2015. Therefore, 2014 data describing these expansion initiatives in this report are limited.

Training and Technical Assistance for Expansion CSTs

Most CSTs, at least in their early stages of development, rely to some extent on outside people for training and consultation on procedures for staff development, coordinating committees, and quality assurance. For the expansion CSTs, this training and consultation was provided by DHS staff and staff from White Pine Consulting, which has a team of consultants with experience in collaborative systems of care at the county, state, and national levels. In years past, a one-on-one approach was utilized to get new CSTs up and running. Due to the high number of new CSTs in 2014, DHS and White Pine Consulting developed a regional training and consultation model in which meetings attended by local CST staff were held around the state in the spring and fall. Due to the increase in CSTs in 2014, wait lists for the two-day care coordination training hosted by DHS and White Pine Consulting were initially established, but were eventually alleviated with additional trainings.

In 2014, all expansion CSTs requested and received training on the following topics:

- Coordinating Committee Operations
- Planning for Crisis
- Leading Effective Systems Change
- Developing Collaborative Plans of Care

Barriers to Implementation

In 2014, three major challenges to implementation of CSTs emerged for the expansion sites, including skills of the workforce, competing priorities for the workforce, and capacity of the service system. Establishing a CST is a complex process involving many different skill sets. People with key roles for carrying out the process require substantial training, as well as ongoing coaching and supervision to ensure they have the necessary knowledge and skills. Unfortunately, several CSTs experienced staff turnover in 2014. These sites started over with hiring and training new staff, delaying their ability to serve youth and families. Additionally, staff at these expansion initiatives had many responsibilities, which limited the amount of time they spent on CST work. Finally, a majority of expansion funding was awarded to initiatives located in rural areas, which tend to have fewer options for community supports.

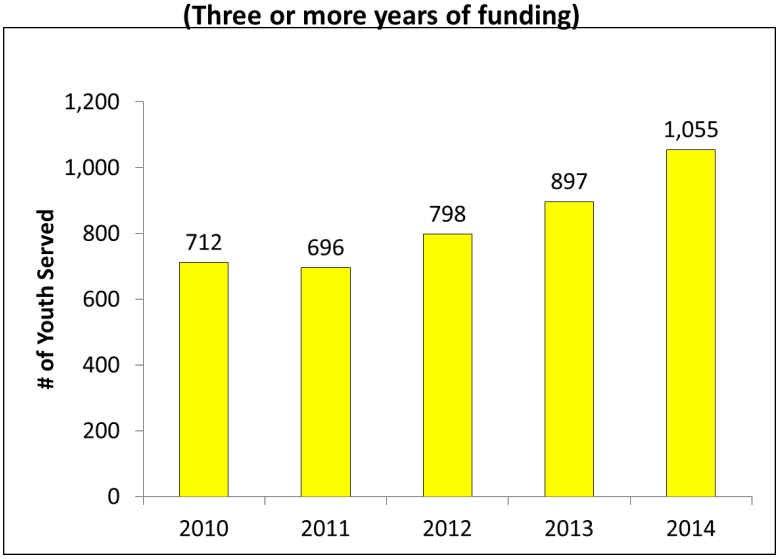
PROFILE OF YOUTH AND FAMILIES SERVED

With the expansion of Coordinated Services Teams (CST) Initiatives in 2014, the number of youth and families served was expected to increase significantly. However, the expansion funds were distributed to new counties and tribes in April or later and the work required of a CST prior to enrolling youth and families typically takes a year or longer. Thus, a significant increase in youth served is not reflected in this 2014 report.

Total Youth and Families Served

Wisconsin's CSTs served a record 1,097 youth in 2014, with nearly all of these youth (N=1,055) enrolled in CSTs operating for three or more years. The remaining youth (N=37) were enrolled in CSTs operating for two years or less, including CSTs established in 2014. (Figure 2 on following page).

Figure 1:
Youth Served in Developed CSTs Statewide
(Three or more years of funding)



The average number of youth served per CST in 2014 was 25, with most CSTs serving between 5 and 50 youth. Some of the variation in numbers of youth served is due to the size of the area's population. For example, most tribal CSTs serve ten or fewer youth per year, but have a smaller pool of eligible youth than most counties. Variations in the local approach to implementing a CST may also have an impact. CSTs in Eau Claire and Kenosha counties notably served about twice as many youth as other CSTs because they have implemented the CST approach beyond the staffing levels funded with the DHS grant. Staff turnover and hiring delays can decrease enrollment numbers for a period of time. La Crosse County only served one youth in 2014 due to staff turnover, but will likely see a large increase in youth served in 2015, following the hiring of a new CST Coordinator. Moving forward, DHS plans to work with initiatives on cross-training workers so families won't be left without a coordinator when turnover occurs. An additional DHS training focus is on supervisor practices to assist with workforce development and lessen turnover.

Since 2011, the number of youth served each year in developed CSTs has steadily increased (Figure 1). The primary reason for the jump in the number of youth served in 2014 was improved reporting by the developed CSTs. All of the developed CSTs in 2014 reported this data for 2014. In contrast, only about three-quarters of these sites consistently submitted reports of youth served from 2010-2013.

Developed CSTs also reported the number of family members other than the youth who received support and services. In 2014, developed CSTs provided support and services to 1,973 family members, an average of 46 per CST and two per youth enrolled in CSTs.

Figure 2: Number of Youth Served in 2014
For CSTs in Different Phases of Development

Developed CST With 3 or More Years of Funding	Number of Youth	Developing CST (2nd Year of Funding)	Number of Youth
Eau Claire	118	Pepin	3
Kenosha	99	Sokaogon Chippewa Community	2
Waupaca	53	Jackson	0
Rock	52	Menominee Tribe	0
Chippewa	45	Ho-Chunk Nation	NR
Marinette	39	**New CST (1st Year of Funding)**	
Fond du Lac	38		
Portage	36	Lincoln, Langlade, and Marathon	9
Sheboygan	36	Green Lake	5
Clark	35	Iron	5
Jefferson	35	Adams	4
Ozaukee	35	Lac Courte Oreilles Tribe	4
Sauk	33	Richland	4
Marquette	25	Pierce	2
Washburn	24	Crawford	1
Wood	23	Florence	1
Grant	21	Forest and Vilas	1
Kewaunee	20	Oneida	1
Shawano	18	Brown	0
Vernon	18	Burnett	0
Ashland	16	Calumet	0
Door	16	Douglas	0
St. Croix	16	Forest County Potawatomi Community	0
Waukesha	16		
Oconto	15	Lafayette	0
Waushara	15	Manitowoc	0
Barron	14	Menominee	0
Trempealeau	14	Monroe	0
Washington	14	Oneida Tribe	0
Columbia	13	Polk	0
Juneau	13	Stockbridge-Munsee Community	0
Bad River Tribe	12	Walworth	0
Sawyer	12	Red Cliff Tribe	NR
Iowa	10	**TOTAL**	**42**
Green	9	**2014 STATEWIDE TOTAL = 1,097 YOUTH SERVED** *NR=No data reported.*	
Price	9		
Dodge	8		
Dunn	8		
Racine	8		
Lac du Flambeau Tribe	6		
St. Croix Tribe	5		
Buffalo	2		
La Crosse	1		
TOTAL	**1,055**		

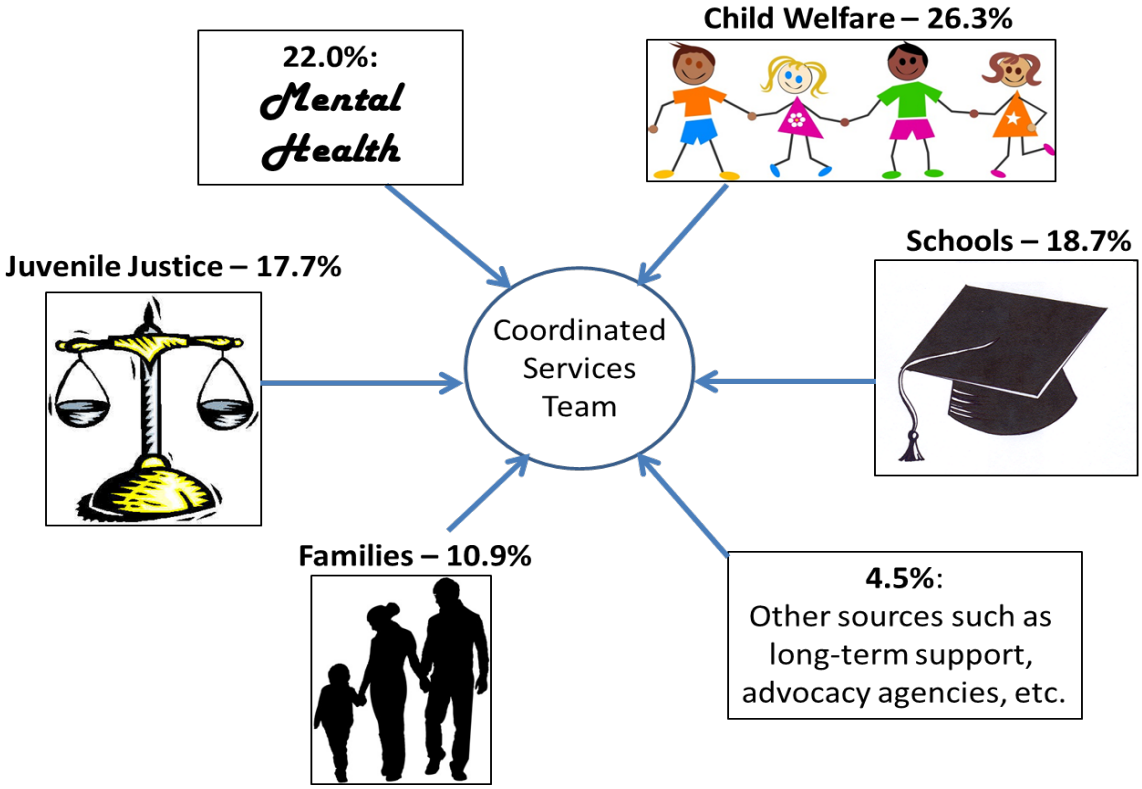
Information from 906 youth who were served for at least part of 2014 was included in demographic analyses. Of these youth, 66 percent were male, 34 percent were female. The average age of youth served in 2014 was 12.2 years. The majority of youth (61%) were between the ages of 12-17, but there was also a small number of youth served at each end of the spectrum. Four percent of youth were five and under and two percent were young adults, 18 or 19 years old. The population of children served in CST in 2014 is slightly more racially diverse than the general population of Wisconsin. Twenty-two percent of those served identified as Native American, African-American, Asian American, multiracial, or Hispanic compared to 20 percent of all youth in Wisconsin (2010 U.S. Census Bureau).

Community Referral Connections

One of the primary eligibility criteria in state law for CST is that youth must be involved with two or more child-serving agencies. In other words, youth must have multi-dimensional needs. To enroll youth with such needs, CSTs must establish relationships with many different child-serving agencies. Figure 3 below shows the number of referrals made to CSTs by referral source in 2014.

Most CSTs have developed an extensive system of care in their community. Of the 41 developed CSTs who reported in 2014, 85 percent receive referrals from three or more different child-serving agencies. While some CSTs may work with youth primarily from their county child welfare or mental health agency, many other CSTs serve youth with a variety of needs indicated by a balanced set of referral sources. In fact, 27 percent of developed CSTs have at least three child-serving agencies from which they receive 20 percent or more of their referrals each or over 60 percent combined. When considering mental health, child welfare, juvenile justice, and the other referral sources from child-serving providers together, a minimum of 70 percent of youth have already been engaged with formal services of some kind. Thus, CSTs appear to be intervening to help youth with a recent history of services that have been at least partially unsuccessful as opposed to youth whose CST participation may be their first experience with formal services.

Figure 3: 2014 CST Referral Sources (N=1,084)



The Comprehensive Needs of Youth

The two primary eligibility criteria defined in state law for CST are:

- All children must be involved with two or more child-serving agencies (systems of care), and
- Any CST using DHS funding must enroll children with a serious emotional disorder (SED) as a priority target group.

Although the first eligibility criterion is phrased as "involved with two or more child-serving agencies," the intent is to serve youth with multiple health and functional needs that require a more comprehensive approach to service planning and delivery.

In 2014, results from the Child and Adolescent Needs and Strengths (CANS) assessments at the time of enrollment revealed:

- Eighty-five percent of youth (N=391) had multi-dimensional, or multi-system, needs.
- Ten percent of youth (N=47) had one serious need, the majority (79%) of which were child welfare or mental health needs.
- Five percent of youth (N=20) had more mild needs.

MORE INFORMATION

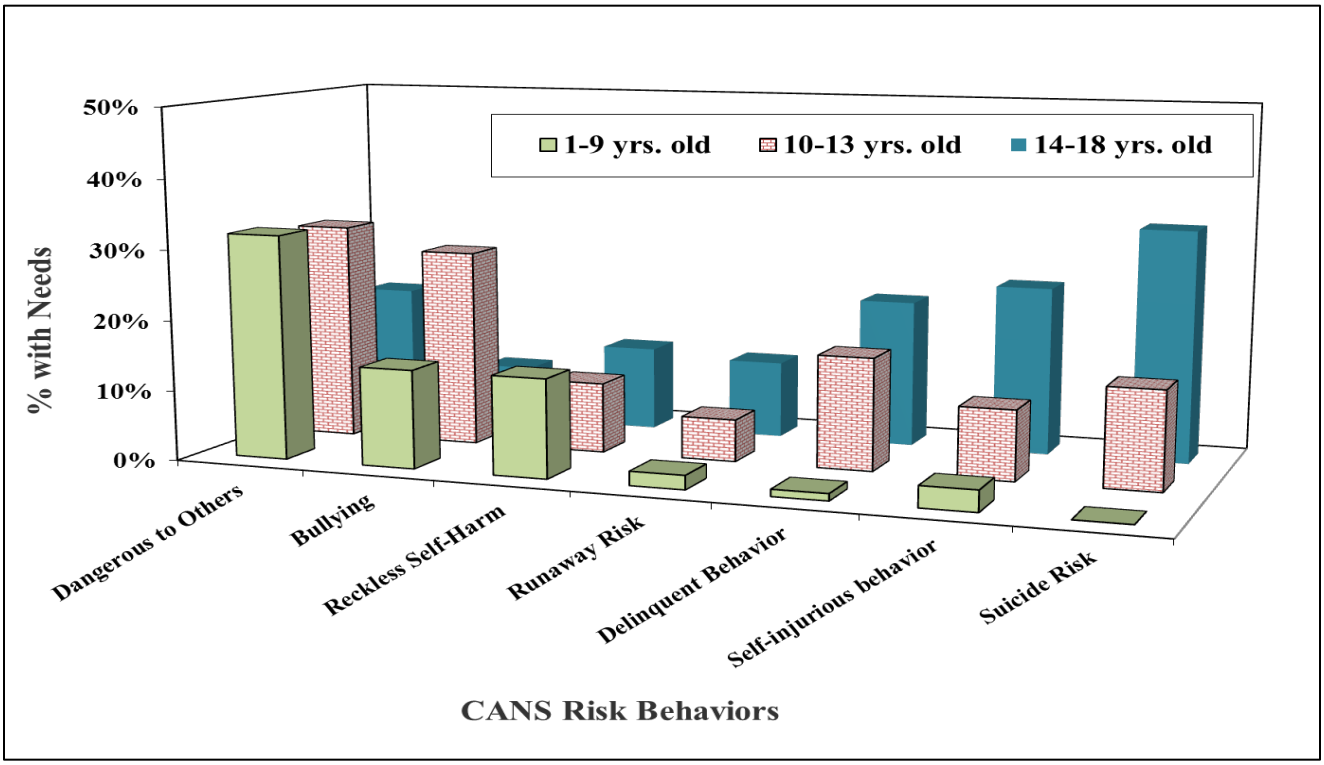
See Appendix A for a description of the 116 items included in the CANS assessment tool

Not only did most youth have multidimensional needs, but many needs are serious enough to impact the youth's functioning and warrant a service intervention. Figure 4 below describes the types of health or social service needs for the 391 youth with multidimensional needs. Of the 391 youth with multi-dimensional needs, more than half had needs that warrant intervention from the mental health, school, child welfare, and/or juvenile justice systems.

Figure 4: Types of Needs for Youth with Multi-Dimensional, Serious Needs (N=391)

95% = Mental health needs	• Serious symptoms affecting functioning and requiring intervention
72% = School needs	• Serious problems in attendance, behavior, academics, and/or relations with teachers
71% = Child welfare needs	• Trauma, self-injurious behaviors, and/or caregiver problems putting the youth at risk of harm or placement
53% = Juvenile justice needs	• Aggressive, dangerous, and other behaviors that have or could lead to sanctions in the juvenile justice system
23% = Developmental needs	• Developmental delays, possibly severe, requiring intervention
10% = Physical/medical needs	• Physical/medical issues affecting functioning and requiring ongoing intervention
10% = Substance abuse needs	• Substance abuse that clearly impacts functioning

Figure 5: Youth Risk Behaviors at Enrollment by Age Group



	Dangerous to Others	Bullying	Reckless Self-Harm	Runaway Risk	Delinquent Behavior	Self-injurious behavior	Suicide Risk
1-9 yrs. old (N=74-122)	32%	14%	14%	2%	1%	3%	0%
10-13 yrs. old (N=112-164)	31%	28%	10%	6%	16%	10%	14%
14-18 yrs. old (N=103-171)	19%	8%	12%	11%	21%	24%	33%
ALL YOUTH (N=289-457)	27%	17%	12%	6%	14%	13%	17%

When establishing a plan of care, immediate attention usually is given to addressing any current behaviors that put the youth or others at risk of harm. Using the CANS assessment tool, CST providers rate the youth's need on a variety of high-risk behavioral needs. Those youth with high-risk behaviors serious enough to warrant addressing in the initial plan of care are included in Figure 5 above for different age groups. See Appendix B for a more complete definition of these CANS assessment items.

- Youth 1-9 years old infrequently engage in risky behaviors with one notable exception. Thirty-two percent exhibited violent or aggressive behavior that was potentially "Dangerous to Others," which is equal to or more frequent than older youth.
- A similar proportion of youth 10-13 years old (31%) also exhibit behavior potentially dangerous to others. A similar proportion of youth (28%) exhibit bullying behavior in this age group, which distinguishes them from the younger and older age groups. Self-harming behaviors start to increase at this age as well.
- Youth 14 years and older are more likely than younger youth to engage in suicidal and intentional self-injurious behavior. One-third of all CST youth participants in 2014 were a suicide risk when they were initially enrolled. One out of five youth engaged in delinquent, potentially criminal behavior.

Most youth (61%) had at least one risk behavior identified at their initial CANS assessment. A total of 39 percent had at least two risk behaviors and 28 percent had three or more. Youth with multiple risk behaviors likely pose a significant risk to harm themselves or others and their plans of care were likely dedicated to addressing these behaviors as a priority. As far as the number of risk behaviors, no difference existed between males and females. The exact same percentage of males and females had at least one risk behavior (61%) and two or more risk behaviors (39%).

Most youth had or were given a mental health diagnosis at enrollment that further described their symptoms and needs. The most frequent diagnoses given to youth in CSTs in 2014 across the state were Attention-Deficit Hyperactivity Disorder (ADHD)(17%) and mood disorders (16%), which include depression and bipolar disorders (Figure 6). Notably, 26 percent of youth were not given any formal diagnosis. However, almost all of these youth (92%) were rated on the CANS assessment as having moderate to severe behavioral health symptoms in at least one area, so these appear to be youth with behavioral health needs without a formal clinical diagnosis.

Figure 6: Behavioral Health Diagnoses at CST Enrollment

Primary Diagnosis	% of Youth (N=906)
ADHD, ADD	17%
Mood Disorder (Depression, bipolar)	16%
Other disorders diagnosed in childhood (learning disorders, communication disorders, autism)	10%
Developmental Disorder	8%
Conduct Disorder-Oppositional Defiant	7%
Adjustment Disorder	6%
Anxiety Disorder	5%
Other diagnosis	6%
Unspecified or no diagnosis	26%

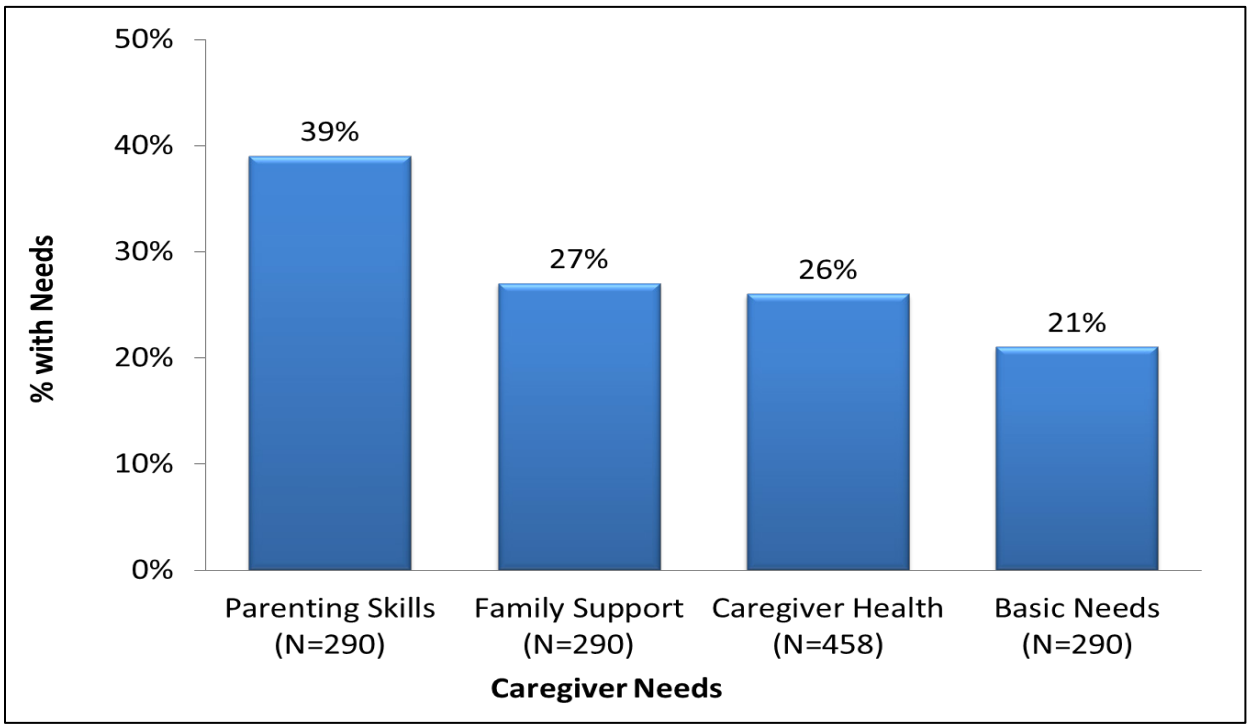
Needs of Parents and Caregivers

CSTs use a holistic approach, including assessment and care planning for the entire family unit. CST providers assess a comprehensive set of 23 potential caregiver and family needs with the CANS assessment tool, including the following general areas:

- **Basic Needs:** Caregivers' financial, employment, legal, housing, and self-care needs
- **Health:** Caregiver mental health, substance use, physical, medical, and developmental disability issues
- **Parenting Skills:** Caregivers' ability to supervise the child, understand the child's development and mental health needs, participate in the child's care plan, problem-solve, stay organized, etc.
- **Family Support:** Support for the youth and family from extended family, friends, and the community in areas like transportation and child care.

Most caregivers (65%) had some level of need, but only 51 percent had needs that were causing moderate to severe functional problems within the family and warranted inclusion in the CST family plan of care. The most common type of need warranting inclusion was parenting skills. Thirty-nine percent of caregivers at the time of enrollment had assessed parenting skill needs in at least one area and 21 to 27 percent had needs in at least one of the other three areas (Figure 7). While 12 percent of caregivers had just one need, a significant number of caregivers (30%) had three or more needs that were causing moderate to severe functional problems with their ability to care for their child.

Figure 7: Type and Frequency of Caregiver Needs at Enrollment



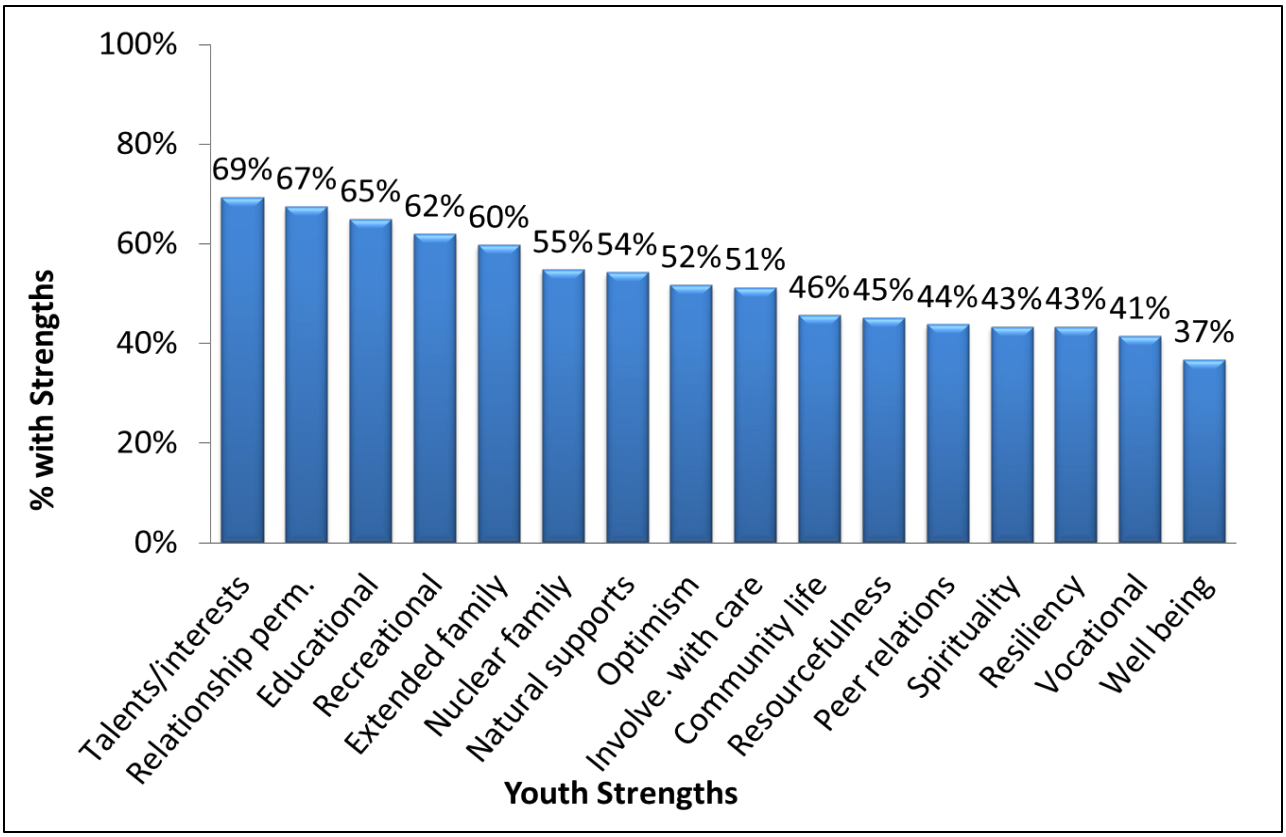
Youth Strengths and Opportunities

In addition to assessing caregiver and youth needs, CST providers also assess youth strengths. CSTs work with families through their plan of care to build and support youth strengths as a method to improve the youth's well-being and ability to deal with adversity. CST providers use the CANS tool to assess 17 possible youth strengths. Existing strengths can be used in the plan of care to support the youth's well-being. Other strengths may be developed as a goal of the plan of care to build the youth's ability to cope with adversity. Examples of some types of strengths assessed by CST providers include (see more detail in Appendix A):

- Strong nuclear and extended family relationships as well as the permanency of these relationships with the youth.
- Involvement in positive recreational, vocational, and community activities, including personal talents and interests that provide happiness and confidence.
- Internal and external self-management skills and perspectives such as an optimistic outlook, sense of well-being, ability to make sensible decisions, and the resiliency to recognize and use these and other strengths when needed.

Figure 8 below describes how frequently youth possess strengths at the time of their enrollment into a CST. In nine of 17 areas, more than half of youth have existing strengths at enrollment that could be used to support their care within a CST. Overall, youth have an average of eight existing strengths at the time of enrollment. Only seven percent of youth have less than two strengths and 33 percent have 10 or more strengths. Upon enrollment, providers have many opportunities to build strengths into plans of care to complement efforts to address the youth's needs.

Figure 8: Youth Strengths at the Time of Enrollment



PARENT AND PROVIDER PERSPECTIVES

A True Story from a CST Provider

Luke's Story of Resiliency

"Luke" (alias), 17, has been working with a CST Family Team along with his mother for two years. Luke had been expelled from school after repeated violations of drug possession and use on school grounds. Luke also had lengthy involvement in the juvenile justice system dating back four years when he was first placed on juvenile supervision. Luke had been in and out of treatment multiple times over the years with little lasting success. Along with being on supervision, Luke was also enrolled in a Juvenile Treatment Court Program to address his substance use needs.

The CST Family Team process helped Luke turn his life around. Regular team meetings, the support and accountability of his diverse team, planning for and managing crisis, and the collaborative planning efforts by everyone involved were essential in helping to support Luke getting to where he is today. Luke had setbacks along the way, but his determination, the strong advocacy from his mother, and the commitment of the team members helped keep him on track to his goals.

Luke currently is finishing up the credits needed to graduate high school and plans to enroll in a local community college. Luke also successfully ended his involvement with the juvenile justice system and graduated from the Juvenile Treatment Court Program. Luke has also agreed to be part of the committee working towards the certification of the Comprehensive Community Services program in his county. Luke has a promising future ahead of him and he continues to facilitate his own CST Family Team.

Upon enrollment in Coordinated Services Teams (CST) Initiatives, the CST coordinator schedules a Family Team meeting with various formal and informal family supports (e.g., family members, members of the family's social support network, service providers, and agency representatives). The service coordinator works with all the service providers and family resources that are serving the child and his or her family. The Family Team is instrumental in assessing strengths and needs through the use of the CANS assessment. The Family Team develops a trauma-informed individualized plan of care and crisis plan. The Family Team meets regularly to monitor progress, pool resources, and provide support to the family. A critical element in the wraparound process is that it is driven by the perspectives of the youth and his or her family. The plan of care is monitored for progress and adherence to the principles and values of CST. Advocacy for the family and referrals to individualized services are provided as identified 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.

Parents and providers are surveyed annually about their experience with the CST process. The provider survey is administered as a web-based survey and focuses on the initiative's adherence to the key principles of collaborative systems of care. Each CST completes only one survey and it is often completed in conjunction with the CST Coordinating Committee reflecting on the work in the calendar year just completed. Of the 73 funded CSTs in 2014, 69 (95%) completed their survey. Providers rate items on a four-point scale from "Never" to "Always." Only results from the 41 developed CSTs who reported are included below because newly funded CSTs began the implementation process in the middle of 2014.

Near the end of every year, currently participating CST parents are surveyed about their experience with their Family Team. The anonymous survey is administered

through the mail. In 2014, 122 parent surveys were completed and the response rate was estimated at 25 percent. An exact response rate could not be calculated because some CSTs did not report how many surveys they distributed. Parents rated items on a five-point scale from “Strongly Agree” to “Strongly Disagree.”

Historically, parents and providers have both reported very high levels of satisfaction and commitment regarding the key CST principles. This trend continued in 2014. Providers report on their own adherence to the key principles, which may inflate some rates compared to results from a neutral program monitor. However, parents frequently agree that the key principles are used within their Family Team, which corroborates provider perceptions. Figure 9 below provides a summary of parent and provider perceptions of their experience with some of the key principles that guide the CST process.

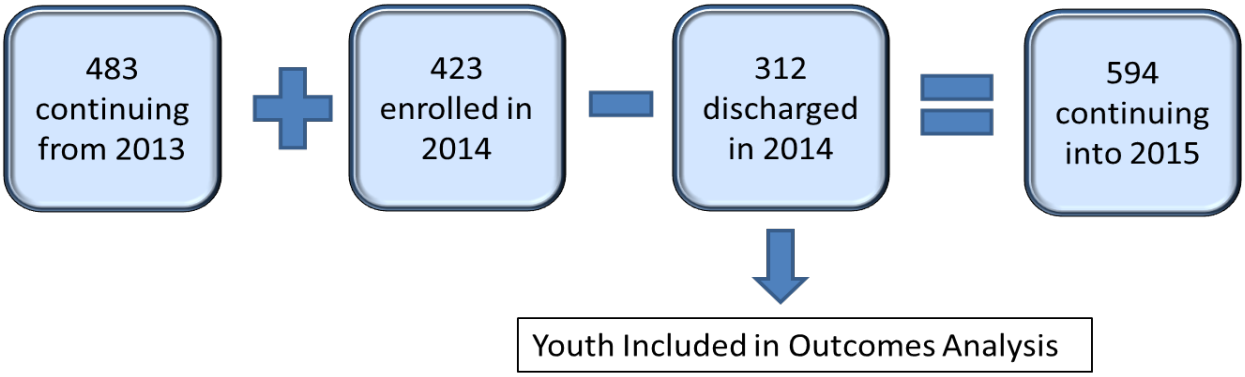
Figure 9: Parent and Provider Perceptions of the CST Experience

CST Principle	Provider Perception	Parent Perception
Parents are involved as full partners at every level of activity.	• 80 percent reported parents were always full partners on their Family Teams regarding activities such as setting convenient meeting times, selecting their team members, and having their child present at team meetings. • 44 percent reported parents always having an important role on the CST Coordinating Committee.	• 95 percent agree they are treated as an important member of their Family Team. • 96 percent agree their Family Team takes time to listen to their concerns. • 99 percent agree their Family Team scheduled meetings at times that were convenient. • 83 percent agree they were involved in the selection of their Family Team members. • 88 percent agree their child participated in Family Team meetings whenever possible and appropriate.
Collaborative Family Teams create and implement individualized plans of care for families.	90 percent reported their individualized plans of care were always culturally sensitive and strengths-based	• 97 percent agree their Family Team was respectful of their cultural background • 90 percent agree the Family Team used their child's strengths in setting goals
Advocacy is provided for each family.	All reported their service coordinators and team members provided advocacy to youth and families when needed	93 percent agree their service coordinator spoke up for their child and family
Adolescents are ensured a planned transition to adult life.	90 percent reported having a process in place to identify youth with long-term treatment needs beyond age 18	73 percent agree their Family Team had a plan to get the needed supports and services when their child turns 18
Parents are satisfied overall with the Family Team process.	• All perceived the majority of their families to be satisfied with the Family Team process • 33 of CSTs believe all of percent their families were satisfied	• 96 percent are satisfied with the efforts of the Family Team on their family's behalf • 90 percent agree they would refer another family/child to the CST

YOUTH OUTCOMES

CST staff collect data on various outcomes at enrollment and throughout enrollment until a youth is disenrolled. This data provides information for measuring changes during participation in CST and assessing status at disenrollment. In 2014, of the 1,092 youth served, data was submitted for 906 youth. Of these 906 youth, 312 were disenrolled in 2014 (Figure 10). Data from these 312 disenrolled youth are the focus of this outcomes section, which examines changes in youth's behavior, functioning, and strengths.

Figure 10: CST Youth Participation Status in 2014 (from available data)



Out-of-Home Placements, Diversions, and Cost Savings

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 severity of youth behavioral needs, past duration of youth needs, success or failure of past interventions, and family or caregiver stability. Practice within CSTs is to prevent these potential out-of-home placements where appropriate by developing supports and services that meet youth needs in the community instead.

How can the impact of preventing out-of-home placements for at-risk youth be measured? The Child and Adolescent Needs and Strengths (CANS) assessment used by CSTs provides some answers.

The items in the CANS assessment can be scored with an algorithm to determine a categorical level of overall need. The algorithm uses items from the Behavioral Health, Functioning, Risk Behavior, School, and Trauma Sections (see Appendix A) to determine the youth's level of need. CANS author John Lyons, Ph.D., developed this algorithm for the Wisconsin Department of Children and Families (DCF) to determine a child's level of need, which corresponds with a recommended level of placement. Thus, CANS can be used to project a youth's potential level of placement based on assessed needs even if no placement occurs. Data describing the child's strengths and caregiver's status are not used. The algorithm uses the following general principles:

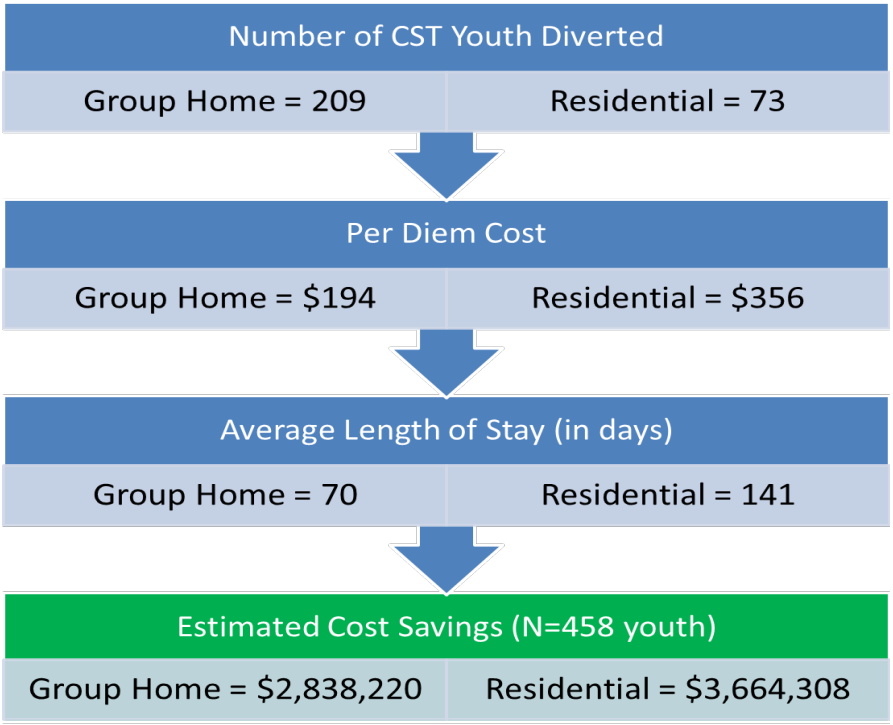
- The greater the severity and quantity of behavioral health needs (depression, anxiety, etc.), the higher the level of need and more restrictive the recommended placement.
- The greater the severity and quantity of high-risk behaviors (suicidal behavior, aggression, etc.), the higher the level of need and more restrictive the recommended placement.
- Serious developmental, physical, and daily functioning needs may further increase the level of need and recommended placement.
- Inability to adjust to recent or past trauma may further increase the level of need and recommended placement.

The results of the calculations generate three basic levels of need that are best described by the associated recommended placement: 1) community services, 2) group home placement, and 3) residential treatment center.

DCF uses CANS results to inform the placement of youth in their child welfare system and associates per diem rates with each level of care. DCF shared its 2014 per diem rates and average lengths of stay for these three types of placements with DHS for this report. With the calculated level of need using CANS, the per diem placement rates, and the average lengths of stay, cost savings can be calculated for youth projected as diversions from these out-of-home placement settings.

Of all participants in 2014, complete and valid CANS data was available for 458 youth. Of these youth, 38 percent had a level of need that did not appear to warrant a potential out-of-home placement. Of the remainder of the CST youth, 46 percent (N=209) scored at a group home level of need and 16 percent (N=73) scored at a residential treatment level of need. Because these youth were diverted to a community-based CST, the total calculated potential savings amounts to $2,838,220 in group home costs and $3,664,308 in residential treatment center costs, which is a combined total of $6,502,528 or $14,198 per enrolled youth (Figure 11). If CANS data were available for all of the 1,092 youth who participated in CSTs in 2014, the projected savings could potentially be twice as high.

Figure 11: Projected CST Placement Diversions and Cost Savings



The cost savings estimated for this report do not include all important factors for the calculation due to some missing data. Other factors to account for in estimating cost savings from diverted placements would be:

- Some crisis inpatient hospitalizations are likely to have been averted due to CST participation. These costs are unaccounted for, but would increase the actual cost savings.
- Some youth experience out-of-home placements despite the involvement of a CST. These costs incurred should be calculated and subtracted from the estimated savings.

- Some literature suggests that the average cost of community mental health services for youth in programs similar to a CST is approximately $5,300 per youth[1,2,3]. This cost would reduce the above estimate of cost savings to $8,898 per youth.

More complete CANS assessment data, CST placement data, and actual CST community services costs may be available in future reports to provide more precise estimates of diversions and cost savings.

What changes in placement settings actually occurred?

CSTs strive to support youth and their families in the least restrictive setting possible. For youth who reside in an out-of-home placement at the time of their enrollment, CSTs work to return the youth to a community placement with family or relatives, as appropriate. When youth already live with family at the time of enrollment, CSTs work to prevent an out-of-home placement from occurring.

Most CST participants were living with their families at the time of their enrollment. Of the 182 discharged youth with placement data participating in a CST, 83 percent were living with their parents, relatives, or friends at the time of their enrollment. Most of the remaining 17 percent were in out-of-home placements including 8 percent in foster care, 3 percent in residential/group home facilities, 2 percent in institutional inpatient settings, 1 percent in correctional facilities, and 1 percent in other settings.

At discharge, slightly fewer youth were at home with family and slightly more youth were in out-of-home settings. Among the youth discharged, 78 percent were living in a community placement with parents, relatives, or friends when initially enrolled into a CST. The remaining 22 percent were in out-of-home placements including 8 percent in foster care, 6 percent in residential/group home facilities, 3 percent in institutional inpatient settings, 3 percent in correctional facilities, and 2 percent in other settings. Overall, if out-of-home placements at enrollment that CSTs inherited are excluded, 32 percent of discharged youth experienced new out-of-home placements while participating in a CST.

A True Story from a CST Provider

Ella's Successful Diversion

"Ella" (alias), 15, was referred to a CST jointly by her school district and a hospital. Ella is a survivor of sexual abuse and was abandoned by her birth parents when she was nine. She was abused for four years by her uncle and struggled with depression, anxiety, and thoughts of suicide. She was hospitalized six times in a seven-month period and missed a semester of school.

The CST intervened and began meeting weekly. Ella's case manager from the hospital was initially recommending an out-of-state residential treatment facility. However, I convinced them to give CST a chance instead. We worked together to build a team that would provide the best support for Ella. Ella and her family were very receptive to help and her grandmother recognized that having Ella stay in her care could provide the best outcomes for the family. Ella's grandmother is very involved in her care.

Ella has shown a great interest in equestrian therapy. The owner of the horse farm attends all CST meetings and also provides respite. Ella continues to make great strides both emotionally and academically. At our last team meeting, the school psychologist reported that Ella currently has all A's and B's and her visits to the guidance department have decreased. Ella's therapist attends meetings as well and has shared some of the gains Ella has made in counseling. Ella is on track to graduate with her class and has told the team she would like to work with animals when she graduates.

[1] DePanfilis D., Dubowitz H., Kunz J. (2008). Assessing the cost-effectiveness of Family Connections. Child Abuse & Neglect. vol:32 iss:3 pg:335-351.
[2] Foster, E.M., Connor, T. (2005). A Road Map for Cost Analyses of Systems of Care. In Epstein, M., Kutash, K., Duchnowski, A., (Eds.) *Outcomes for Children and Youth with Behavioral and Emotional Disorders and Their Families.* (pp. 225-245). Austin: Pro-Ed.
[3] Foster, E.M., Kelsch, C.C., Kamradt, B., Sosna, T., & Yang, Z. (2001). Expenditures and sustainability in systems of care. *Journal of Emotional and Behavioral Disorders*, 9(1), 53-62.

Changes in Juvenile Offenses

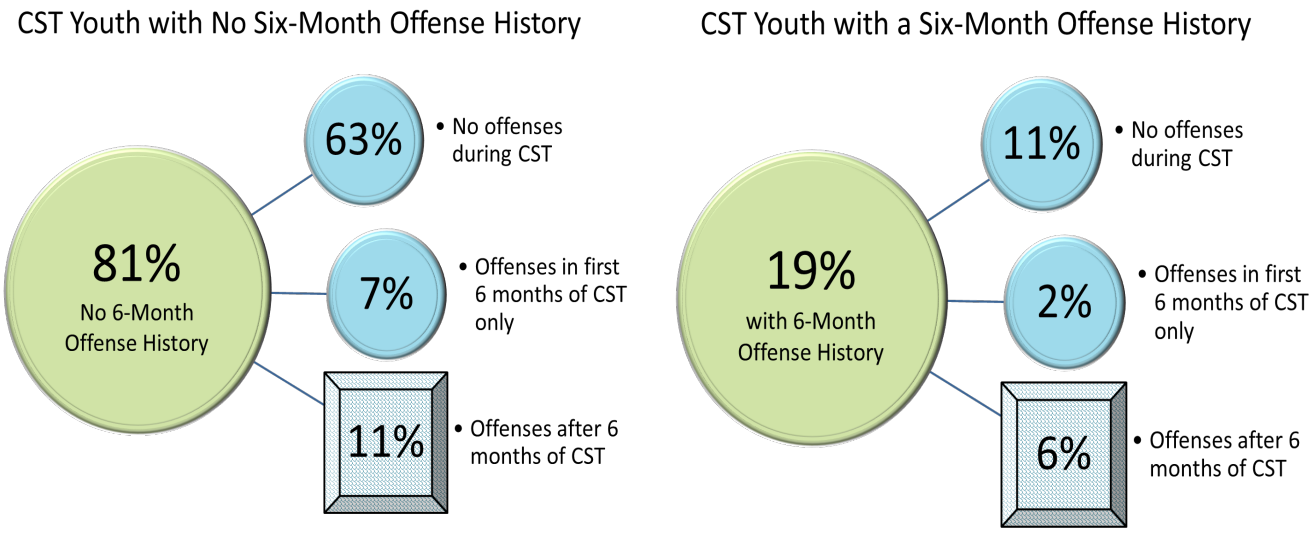
Reducing juvenile offenses is another indicator for measuring the success of CST. As described earlier, 18 percent of youth are referred to CSTs from the local juvenile justice system and 53 percent of youth exhibited some form of dangerous or risky behaviors at the time of their enrollment that could lead to involvement with the juvenile justice system if it hasn't already. CSTs are required to report formal arrests for offenses committed in the six months prior to enrollment and throughout the youth's participation in a CST so reductions in arrests can be measured. All types of offenses were included in the analysis as the type of offense is not distinguished in the new Program Participation System (PPS).

Of the 312 youth discharged in 2014, 175 youth had complete offense data and participated in their CST for more than six months. Of the 175 youth who were discharged in 2014, 63 percent (N=110) had no offenses reported at any time during CST participation or in the six months just prior to enrollment (Figure 12). While offenses may occur in the first six months of participation, CSTs would usually expect to prevent any future offenses after six months of involvement. Since the average length of stay for youth in CST is 12 months, the greatest impact of a CST may occur after the first six months of participation after the Family Team has been established, a full assessment and plan of care have been set, and the family has started working on the plan.

Another 18 percent of youth (N=32) similarly had no six-month offense history, but did commit offenses while enrolled in a CST. Seven percent committed new offenses only in the first six months of their CST participation and another 11 percent committed offenses after the first six months of participation. Thus, when the absence of offenses after six months of CST participation is used as the primary indicator of success, 86 percent of youth with no history of offenses in the six months prior to enrollment were successful.

The remaining youth (19% of all youth; N=33) had a history of at least one offense in the six months prior to their CST enrollment. Eleven percent committed no offenses at all during their participation, 2 percent committed new offenses only in the first six months of their participation, and 6 percent committed offenses after the first six months of participation. Thus, when the absence of offenses after six months of CST participation is used as the primary indicator of success, 67 percent of youth with a history of offenses in the six months prior to enrollment were successful. Among all 175 youth, 83 percent committed no offenses after the first six months of participation and 17 percent committed offenses during that same period despite their CST participation.

Figure 12: CST Youth Juvenile Offenses by Prior History



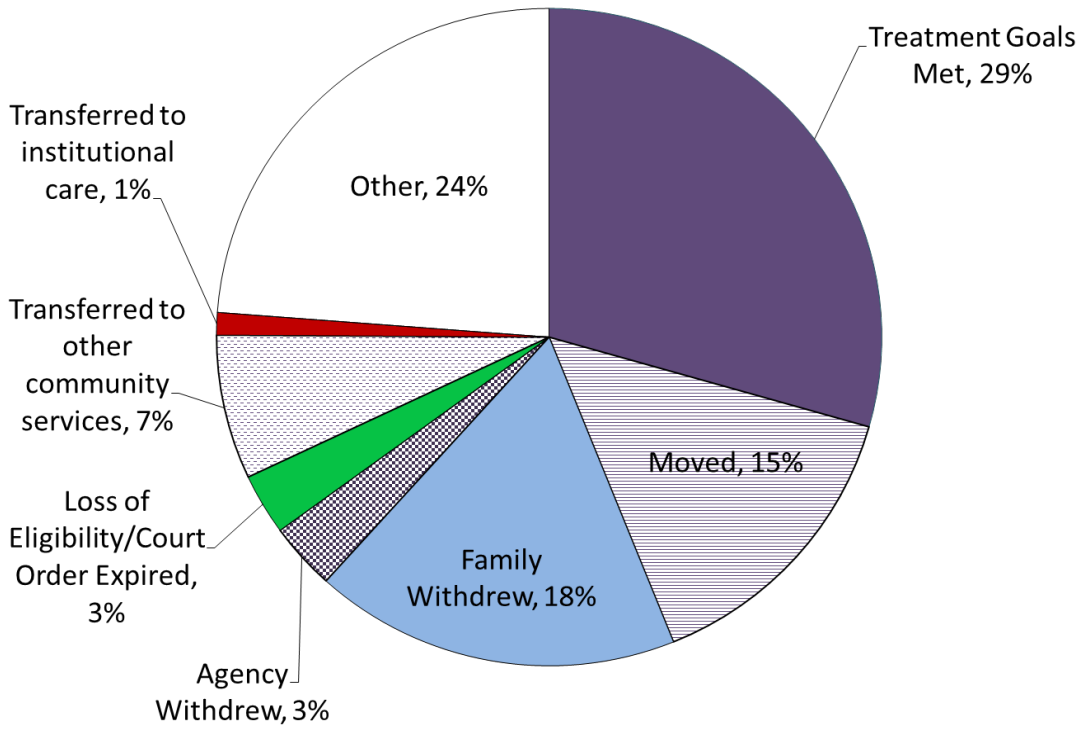
Provider Reasons for Disenrollment

An important goal of CST is to meet the individual goals on each child's plan of care. When youth and families are disenrolled from a CST, the family's CST Coordinator is asked to assess the final status of the youth and the primary reason for the youth's disenrollment.

Of the 312 youth disenrolled in 2014, reasons for disenrollment were available for 269 youth. Coordinators reported that 29 percent of youth and families completed their CST services and met the majority of their service goals (Figure 13). A similar proportion of families (32%) left their CST at their request, 18 percent withdrew on their own and 14 percent moved out of the CST service area. Another 7 percent were transferred to another type of community-based care and 1 percent of youth were transferred to institutional care after an unsuccessful episode of care within a CST. Six percent of youth were disenrolled either due to loss of eligibility, expiration of a court order, or an early agency-initiated withdrawal.

The reason for disenrollment for the remaining 24 percent of youth was reported in an "Other" category and is essentially unknown. The previous CST data system used for the first half of 2014 included fewer choices for a disenrollment reason and thus had 35% of disenrollment reasons reported as "Other." The new PPS data system used in the second half of 2014 has many more options for a disenrollment reason, which resulted in only 3 percent of disenrollment reasons reported as "Other." Data also indicate that two CSTs over-utilized the "Other" disenrollment reason because the two sites reported half of the youth with an unknown "Other" reason. The use of the new PPS data for the future 2015 CST Annual Report will eliminate this data quality issue.

Figure 13: 2014 Disenrollment Reasons



Completed Participation Successfully = 29%
Ongoing or Unknown Disenrollment Reason = 45%
Early Disenrollment = 26%

Another method of examining youth's disenrollment reason includes the following simplified categories also displayed above in Figure 13:

- Completed CST Participation Successfully equals treatment goals met
- Ongoing or Unknown Disenrollment Reason equals moved, transferred to community services, other
- Early Disenrollment equals family or agency withdrawal, loss of eligibility, institutional care

What does other data reveal about these three groups of discharged youth and families? (See Figure 14) The demographic characteristics of youth (gender, age, and race) were also examined, but none were related to the youth's reason for disenrollment. Most youth's diagnoses at enrollment were not related to their status at disenrollment either. However, some characteristics of youth activity during CST participation were related to their final status. For youth and families that completed their CST participation successfully, the average length of stay was 12 months. As would be expected, youth who completed their CST participation successfully were least likely to be in an out-of-home placement or to have committed recent offenses.

Figure 14: Characteristics of CST Youth Participation by Reason for Disenrollment

Completed CST Participation Successfully	• 90 percent were living in their home within the community • Average length of stay was12 months • Just under 10 percent had committed offenses after their first six months of participation
Ongoing or Unknown Disenrollment Reason	• 30 percent in out-of-home placements • Average length of stay is similar to youth who completed successfully • 20 percent of youth committed offenses after their first six months of participation • 67 percent of youth with a developmental disorder
Early Disenrollment	• Out-of-home placement was not typically (17%) related to an early disenrollment • Average length of stay is 25 percent shorter than for youth who completed successfully • The highest percentage of youth (29%) committed offenses after the first six months of participation

For youth and families with an "ongoing or unknown status," 30 percent were actually living in out-of-home placements at disenrollment. When providers reported an unknown "Other" reason for disenrollment, exactly half of youth were in out-of-home placements. Youth with an ongoing or unknown final status did not participate briefly in their CST. Youth's average length of stay within a CST was 13 months—one month longer than youth who completed successfully. Youth's initial diagnoses at enrollment was not usually related to their disenrollment status, but youth with a developmental disorder diagnosis were more likely (67%) to be disenrolled with an ongoing or unknown status than other youth (45%).

For youth and families with an early disenrollment from their CST, the median length of stay was eight months, 25 percent shorter than other youth. Youth were not any more likely than other youth to have committed offenses in the six months before CST enrollment, but were the most likely (29%) to have committed offenses after the first six months of CST participation. Only 17 percent of youth with an early disenrollment ended in an out-of-home placement, so the decision to disenroll was more likely to be a family- or agency-initiated early withdrawal due to lack of fit.

Parent Satisfaction with Youth Outcomes

As described previously in the section on "Parent and Provider Perspectives on the CST Process," each year parents of actively participating youth in a CST are asked to complete a survey on their experience with the CST process, as well as on their satisfaction with their child's progress. Parents are asked to respond to each statement on a five-point scale from "Strongly agree" to "Strongly disagree." The six statements about child outcomes and the results of the survey are displayed in Figure 15 below. Results are from 109 parents who responded to the outcome questions for their child.

"Being informed of opportunities for his personal growth and experiences was a good thing. He has had opportunities that he would otherwise not have had like summer camp. Additional support for adults in the household ... at times just someone to listen." **– CST Parent**

Since the surveys were completed anonymously, results cannot be linked back to provider reports of family progress. However, results are at similar levels to other outcome indicators. Providers reported 75 percent of youth with no offenses during their participation and 78 percent living in the community at disenrollment. Parents' reports of satisfaction with their child's progress in multiple areas generally ranges from 60-70 percent. Parent satisfaction with their child's ability to handle daily life and perform at school is 64 percent and 69 percent respectively. Satisfaction with progress in relationships is closer to 60 percent. The one exception is the 54 percent of parents who agree their youth is "better able to cope when things go wrong."

"Problem solving together is helpful. It hasn't helped our son yet, but has definitely helped our family and other people working with him." **– CST Parent**

Since youth were still actively participating, parents' reports of satisfaction are provisional and feasibly could improve or decline before the child is disenrolled. However, the average length of time that families had participated in a CST when completing the survey was 12 months which is equal to the average length of stay for disenrolled children. Thus, participating families had significant experience with their CST with which to draw upon for their responses.

Figure 15: Parent Satisfaction with Youth Outcomes (N=109)

My child is doing better in school and/or work.	69%
My child is better at handling daily life.	64%
My child gets along better with family members.	62%
My child is better able to do things he or she wants to do.	61%
My child gets along better with friends and other people.	58%
My child is better able to cope when things go wrong.	54%

"They are a great support for me. I don't feel that the team is responsible for my child's decline (my child is making some bad choices)." **– CST Parent**

Also on the parent survey is a question about what could be done to improve the local CST initiative for their child. Another confirmation of the above levels of satisfaction is that 58 percent of parents specifically wrote a response to this question indicating everything was going well for their child and family and that nothing needed to be changed to improve the CST process. Other parent responses to this question are described below in the "Ideas for Quality Improvement" section.

IDEAS FOR QUALITY IMPROVEMENT

Both Coordinated Services Teams (CST) Initiatives providers and parents are asked every year for their recommendations on what, if anything, needs to be done to improve their initiative. Providers respond through the CST Initiative Survey (N=69 CSTs) and parents responded through the CST Family Satisfaction Survey (N=110 parents). The questions asked of the two groups are below as well as a summary of their responses.

- **PROVIDER QUESTION:** What recommendations does the Coordinating Committee have to improve the local CST process?
- **PARENT QUESTIONS:** Thinking about your entire CST experience, what is not working well for you and your child? What suggestions do you have for improving the CST Initiative?

Before summarizing the themes from provider and parent responses, it is worth noting that the most common response by both groups was that the local CST was mostly successful and nothing needs to be changed. As mentioned in the previous section, 58 percent of parents specifically wrote a response indicating nothing needed to be changed with their CST because everything was working well. Providers were more likely to provide suggestions as only 12 percent claimed nothing needed to be improved. Another 22 percent of providers gave no response which mostly came from new CSTs that were still developing in 2014.

"Coordinating Committee members have suggested additional collaboration with other community agencies to help them learn about and understand the CST process, specifically our largest school district. This would help with staff being able to identify referrals for the CST as well as what types of supportive services are available." **– CST Provider**

When suggestions were provided, there were common themes, which are described below. CST providers had a fairly succinct list of quality improvement suggestions, which were common themes with the 2013 CST Initiative Survey results. The most common suggestion (17%) identified by providers was the need for outreach and integration with community agencies and resources. Except for some general calls for integration and outreach to law enforcement agencies, the majority of providers identified the need to work more closely with schools.

The second most frequently mentioned area to improve upon was parent and youth participation on the Coordinating Committee, which was the most frequently cited need in 2013. Almost a third of CSTs expressed difficulties in maintaining a representative number of parents and youth on their Coordinating Committee. Of the 69 CSTs responding to the survey, the most commonly mentioned areas for quality improvement are summarized in Figure 16 below.

Figure 16: CST Provider and Parent Recommendations for Quality Improvement Efforts

Recommendations	Provider	Parent
Increase community outreach and integration with other agencies	17%	3%
Increase parent participation on coordinating committee	12%	--
Increase use of parent and peer supports	7%	--
Increase CST facilitators and teams	4%	4%
Provider: Integrate CST and comprehensive community services Parent: More service resources for CST needed	4%	5%
Methods to improve youth motivation to participate	--	9%

"CST works if the child wants it to. My child is very stubborn and chooses to do what she wants to." **– CST Parent**

Figure 16 above also displays the most frequent recommendations from parents about what could be done to improve CSTs. Of the 110 parents who answered the question about possible improvements, 9 percent spoke of the lack of full participation by their child. This was the most frequent problem cited by parents, but specific solutions were not described. Lack of participation or motivation by youth was not mentioned by providers. Providers tended to focus more on system and organizational changes while parents tended to describe the need for more youth commitment and more services.

Five percent of parents described scenarios in which they perceived a lack of mental health and other clinical services to accompany the CST teaming and coordination process. Some specifically mentioned the lack of mental health service options for youth with serious mental health needs, but one parent also described the lack of substance use services for their child. Providers recommended the need to integrate the CST process with the Comprehensive Community Services (CCS) program. The comprehensive array of mental health and substance abuse services available through the CCS program may address the service gaps that parents identified. The current effort to regionally expand the CCS program statewide may reduce this need for families in the future.

On a similar note, 4 percent of parents spoke specifically of the need for more CST coordinators. The lack of coordinators either delayed, shortened, or reduced the quality of families' experiences with CSTs. Some parents described situations in which they felt the need to meet more frequently with their CST coordinator, but they were unavailable due to their workload.

"Have more available coordinators. At first, our coordinator was over-booked. Then we got a new one and our case was closed shortly after." **– CST Parent**

Parents provided a number of issues and recommendations very specific to their personal situation, but the other theme in their feedback was the need to better coordinate the CST process with schools. Three percent of parents mentioned that coordination with teachers and/or other school personnel was needed to provide a consistent approach to their child's behavioral and emotional needs at different settings throughout their day. Providers frequently recommended this improvement, but expanded their recommendation beyond schools to other child-serving agencies including juvenile justice and child welfare.

DHS staff are working in 2015 to address the results from the CST surveys. Staff have planned to increase site visits to counties and tribes to provide technical assistance on the implementation of the essential CST values and principles. Additional technical assistance tailored to CST sites' needs is expected to increase the pace of implementation for new CSTs and improve the effectiveness of the CST intervention where needed.

APPENDIX A: DESCRIPTION OF ASSESSMENT ITEMS CHILD AND ADOLESCENT NEEDS AND STRENGTHS (CANS) ASSESSMENT

Rating Points (Action Levels) for CANS Need Items:

0 - No evidence – This rating indicates that there is no reason to believe that a particular need exists.
1 - Watchful waiting/prevention – This level of rating indicates that you need to keep an eye on this area or think about putting in place some preventive actions to make sure things do not get worse.
2 - Action needed – This level of rating implies that something must be done to address the identified need. The need is sufficiently problematic that it is interfering in the child/family's life in a notable way.
3 - Immediate/intensive action – This level rating indicates a need that requires immediate or intensive effort to address. Dangerous or disabling levels of needs are rated with this level.

Life Functioning

Living Situation - If a child is living with his/her family, this rating is likely similar to the previous one. However, for children in out-of-home placements, this refers to the child's functioning in his/her current living arrangement.

Developmental - This item rates the presence of Developmental Disabilities only and does not refer to broader issues of healthy development.

Communication - This item refers to learning disabilities involving expressive and/or receptive language. This item does not refer to challenges expressing feelings.

Legal - This item indicates the youth's level of involvement with the juvenile justice system.

Sleep - This item is used to describe any problems with sleep, regardless of the cause including difficulties falling asleep or staying asleep.

Life Skills - This rating focuses on the presence or absence of short or long-term risks associated with impairments in independent living abilities.

Other Functioning Items

Family—Nuclear	Dental	Sexual Development
Family—Extended	Social Functioning—Peer	Daily Functioning
Medical	Social Functioning—Adult	Expectant Parent/Parenting
Physical	Eating Disturbance	

Trauma Items

Sexual Abuse	Medical Trauma	Witness/Victim—Criminal Acts
Physical Abuse	Natural Disaster	Adjustment to Trauma
Neglect	Witness to Family Violence	
Emotional Abuse	Witness to Community Violence	

Risk Behaviors

Suicide Risk - This item is intended to describe the presence of suicidal behavior. Only overt and covert thoughts and efforts at attempting to kill oneself are rated on this item. Other self-destructive behavior is rated elsewhere.

Self-Injurious - This item is used to describe repetitive intentional behavior that results in physical injury to the child or adolescent.

Reckless Self Harm - This item is used to describe behavior not covered by either Suicide Risk or Self-Mutilation that places the youth at risk of physical injury. This item refers to the risk of unintentional harm often caused by poor judgment or recklessness.

Danger to Others - This item rates the child/adolescent's violent or aggressive behavior towards others that put them at risk of harm.

Sexual Aggression - This item is intended to describe sexually aggressive (or abusive) behavior committed by the youth.

Runaway - This item describes the risk of or actual runaway behavior.

Delinquency - This relates to delinquent behavior for which the youth may or may not have been caught. The juvenile justice system may be involved, but is not required to be.

Fire-setting - This item describes whether the child intentionally starts fires using matches or other incendiary devices.

Intentional Misbehavior - This item refers to obnoxious behaviors that force adults to sanction the child. The key to rating this behavior is to understand that the child or youth is intentionally trying to force sanctions.

Bullying - This item describes behavior that involves intimidation (either verbal or physical or both) of peers and younger children.

Exploited - This item is used to examine a history and pattern of abuse, and/or includes a level of current risk for re-victimization. This can include parentification of children, being bullied, prostituted, or taken advantage of by others.

Caregiver Needs

Involvement with Care - A ‘0’ on this item is reserved for caregivers who are able to advocate for their child. This requires both knowledge of their child, their rights, options, and opportunities.

Knowledge - The extent to which caregivers effectively use the mental health and care information providers made available to them in working with their child.

Organization - This item is used to rate the caregiver’s ability to organize and manage their household within the context of intensive community services.

Social Resources - In the absence of money, families often rely on social supports to help out in times of need. This item is used to rate the availability of these supports.

Developmental - This item describes the presence of developmental disabilities among caregivers.

Residential Stability - This item refers exclusively to the housing stability of the caregiver and should not reflect whether the child might be placed outside of the home.

Family Stress - This item refers to the impact the child/youth’s challenges place on the family system.

Community Connect - This item is based on the caregiver’s level of involvement in the cultural aspects of life in his/her community.

Cultural Congruence - The degree to which the family has cultural differences related to child rearing practices, child development, and early intervention.

Other Caregiver Needs Items

Residential Stability	Financial Resources	Physical Health
Self Care	Legal	Mental Health
Access to Child Care	Transportation	Substance Use
Employment	Supervision	Problem Solving
Education	Empathy with Child	

Youth Strengths

A different rating scale is used by CST Coordinators to rate youth strengths.

0 = a significant and functional strength that could become the centerpiece in service planning.
1 = the strength clearly exists and could become part of the service plan.
2 = indicates that a potential strength has been identified but requires building and development to become useful to the child.
3 = indicates that no strength has been identified at this time in this area.

Relationship Permanence - This item identifies whether parents or other relatives have been a consistent part of the child's life regardless of the quality of that relationship.

Optimism - This refers to the child's sense of future orientation.

Decision-Making - This rating describes the child/youth's problem solving abilities including his/her ability to assess a situation and anticipate likely consequences of various responses in a developmentally appropriate manner.

Well-Being - This rating should be based on the psychological strengths that the child or adolescent might have developed including both the ability to enjoy positive life experiences and manage negative life experiences.

Educational - This item predominantly refers to the nature of the school's relationship to the child and family and the level of support the child is receiving from the school.

Talents/Interests - This item refers to hobbies, skills, artistic interests, and talents that are positive ways that kids can spend time and also gives them pleasure and a positive sense of themselves.

Spiritual/Religious - This item refers to the child's (and family's) experience of receiving comfort and support from religious or spiritual involvement.

Community Life - This item reflects the youth's connection to their community through their involvement in community groups and institutions.

Youth Involvement - This item identifies whether the youth is an active partner in planning and implementing any treatment plan or service package.

Natural Supports - To be a natural support, one has to be an unpaid non-family individual who has demonstrated the willingness to become involved in the youth's life in a positive and helpful manner.

Resiliency - This rating should be based on the child/youth's ability to identify and use internal strengths in managing his/her healthy development.

Resourcefulness - This rating should be based on the child/youth's ability to identify and use external strengths in managing his/her healthy development.

Other Youth Strengths Items

Family—Nuclear	Positive Peer Relations	Vocational
Family—Extended	Recreational	