



ANNUAL REPORT

FY 2009

(July 1, 2008 - June 30, 2009)

Building Partnerships for Children and Families

The mission of the Community and Residential Services Authority is to actively advocate, plan and promote the development and coordination of a full array of prevention and intervention services to meet the unique needs of individuals with a behavior disorder or a severe emotional disturbance and their family.

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LETTER OF TRANSMITTAL

Governor Pat Quinn
Members of the General Assembly
State Agency Directors and
State Superintendent of Education
Springfield, Illinois

Dear Governor Quinn, Members of the General Assembly, Agency Directors and
Superintendent of Education:

On behalf of the membership of the Community and Residential Services Authority, I transmit herewith the Twenty Third Annual Report. I am pleased to present this summary of activities for Fiscal Year 2009 in accordance with the requirements as set forth in Ch. 122, Sec. 14-15.01 of the Illinois School Code.

Respectfully submitted,



Alan Dietrich
Chairperson

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EXECUTIVE SUMMARY

Children who exhibit multiple impairments/disabilities, including behavior disorders or severe emotional disturbances historically present challenges to Illinois' state service system as agencies and schools try to address the diverse service needs of this population. Many of these children do not clearly fit the service eligibility criteria or funding streams of state and local public agencies and unacceptable numbers of children and families go un-served or are underserved by the very systems established to help them. It is this disconnect between service needs and service provision that provided the impetus for the creation of the Community and Residential Services Authority (CRSA). The CRSA completed its 23rd year of service to Illinois children with behavior disorders or severe emotional disturbances and their families during FY 09. The CRSA staff and board has assisted in the service planning for 8,594 children and their families and successfully addressed several thousand service disputes, including 37 disputes that required formal CRSA board action to resolve. During FY 09 the CRSA responded to 357 requests for assistance and no service or funding disputes reached the level where board action was necessary to resolve a dispute.

Through its service planning assistance and dispute resolution activities, the CRSA has been able to identify how, when and why the Illinois service system breaks down around many Illinois children and their families. The CRSA then translates this accumulated field experience into system's change activities, drawing attention to the service gaps. . The Authority has also made formal system reform recommendations in the form of three successive CRSA Service Plans, the first in 1991, the second in 1994 and the most recently updated Statewide Service Plan adopted in FY 00. The CRSA Service Plans have served as a framework for building service partnerships between families, communities and agencies and for advancing a family-focused, child-centered and community-based service planning system with improved coordination and communication at all levels

The Authority has renewed support for the child and adolescent Local Area Networks (LANs) movement in Illinois. While the LANs continue to be instrumental in advancing the Mission, Vision and Service Plans of the Authority, CRSA member agencies, for the most part still make service and funding decisions within their own closed and centralized networks and a general resistance to multi-disciplinary Child and Family Teaming in communities continues to be an issue.

The challenges that we see coming for children and adolescents with mental illness are that as more ICG eligible children are transitioned back to their home communities from residential placements, local mental health resources at the community level will need to be increased in both overall availability and in intensity if the clinical gains made in residential treatment are to be maintained in the community. Another concern that CRSA has expressed for this population is that children and families who are not Medicaid eligible (privately insured and under-insured) have increasing difficulty getting their mental health service needs met at the community level.

During FY 09 the CRSA board had ongoing conversations about the state's fiscal crisis and its impact on the child and adolescent service system. Conversational threads included administrative changes to the Individual Care Grant program, sufficiency of community-based mental health services relative to client need, administrative barriers to mental health service expansion through EPSDT, Medicaid Caps on public mental health centers, and the lack of coordinated, statewide multiple-agency service planning and intervention as suggested by the CRSA Statewide Service Plan. There has been discussion at the board level that multiple-agency service planning and delivery, as outlined in the

CRSA Statewide Service Plans may ultimately require legislation to become a reality in Illinois. The Authority has continued to become aware of other states which have used the legislative approach to promote multiple agency collaboration for similar populations of children and adolescents served by CRSA. During FY 09 the CRSA Board suggested that a CRSA “Gaps Conference” be convened to reassess the service system, identify current challenges and to help further advance CRSA’s mission and vision.

The CRSA revised the dispute resolution process during FY 09. The revised process draws relevant member agencies into the technical assistance phase of CRSA services, earlier, to maximize multiple agency problem solving deliberations and to resolve emerging dispute without the need for formal board action.

The complexity of the cases referred to the Authority for assistance has steadily intensified since 2005. Among the children and adolescents referred for treatment in a residential setting are an increasing number of children whose disabilities, diagnostic profiles and life circumstances are so complex that they could qualify for residential funding from three or more agencies. As such, CRSA staff are challenged by the time consuming process of pulling member agencies together to actively collaborate with one another at the front end of the decision making process to determine which system is best suited to meeting the child and family’s needs and to avoid the cases progressing into bone fide Dispute Resolution cases.

HISTORY & BACKGROUND

The Community and Residential Services Authority (CRSA) was established by the Illinois General Assembly in 1985, initially as the Residential Services Authority, and was given three broad responsibilities:

- Assist parents and providers to access the state's human service system in a way that minimizes barriers and maximizes outcome,
- Act as a "safety net" for the system by resolving multiple-agency service disputes that arise when essential services cannot be provided among existing service providers/programs, and
- Plan for a more responsive, efficient and coordinated system of services to address the needs of children with severe emotional disturbances/behavior disorders and their families.

The CRSA has nineteen members: nine representatives of child-serving state agencies, six public and private sector gubernatorial appointees and four members of the General Assembly or their designees. The CRSA employs an Executive Director who operates with the assistance of five professional Regional Coordinators, an Administrative Assistant and an Office Specialist to fulfill the CRSA's statutory mandates.

To date, the CRSA has assisted in the service planning for 8,594 children and their families, and successfully addressed several thousand service disputes, including 37 of which required formal CRSA board action to resolve. The Authority has also made formal system reform recommendations in the form of three successive CRSA Service Plans, the first in 1991, the second in 1994 and the most recently updated Statewide Service Plan adopted in FY 2000.

Through its service planning assistance and dispute resolution activities, the CRSA has been able to identify how, when and why the Illinois service system breaks down around many Illinois children and their families. The CRSA then translates this accumulated field experience into system's change activities, drawing attention to the service gaps and suggesting innovative and successful practices and approaches from around the nation to help solve the unique challenges in Illinois' child and adolescent service system. A collective vision for Illinois has evolved from these activities, a vision that is expressed in the CRSA Statewide Service Plans. The CRSA Service Plans have served as a framework for building service partnerships between families, communities and agencies and for advancing a family-focused, child-centered and community-based service planning system with improved coordination and communication at all levels.

FUTURE DIRECTIONS & PLANNING

The CRSA has a responsibility to actively support all initiatives that are consistent with its Mission, Vision and Statewide Service Plan. CRSA pledges to continue to bring forward difficult issues that are seen as barriers to collaboration and foster an interactive, inclusive and meaningful process for resolving these barriers.

Illinois is a diverse state. Service delivery capability, service infrastructure and funding are influenced by variables like geographic location, demographics, local taxing realities, local/regional service traditions and political considerations. As such, CRSA recognizes the need to account for these variables in both its service delivery and service planning functions.

- CRSA recognizes the strategic importance of improving its capability to monitor and anticipate short term and long term changes in funding trends, in legislative issues and in service trends that impact the CRSA population. During this decade, changes in the public workforce and CRSA's legislative base of support coupled with leadership changes and fiscal realities continue to challenge CRSA to rethink its approach to service delivery and planning.
- CRSA board members and staff recognize that cultivating and effectively utilizing relationships within member agencies, within the legislature and with the Governor's office is a strategic goal for the CRSA. Goal attainment in these areas will be needed so that the CRSA may more effectively work toward accomplishing all of its powers and duties and will be required to advance and promote legislative solutions to systemic services delivery and funding problems.
- The Authority has renewed support for the Child and Adolescent Local Area Networks (LANs) movement in Illinois. While the LANs continue to be instrumental in advancing the Mission, Vision and Service Plans of the Authority, CRSA member agencies, for the most part still make service and funding decisions within their own closed and centralized networks and a general resistance to multiple-agency child and family teaming in communities continues to be an issue. The Authority may soon conclude that legislation may be required if crucial elements of the CRSA Service Plan are to become a reality.

FISCAL YEAR 2009 CASELOAD TRENDS

The CRSA receives requests for assistance from parents or professionals who are experiencing difficulty garnering appropriate services for a child with a severe emotional disturbance and/or behavior disorders. A referral to CRSA often implies a breakdown or a gap somewhere in the state service system. The CRSA caseload gives us the ability to sample the overall functioning and effectiveness of the child and adolescent service system and document trends.

During FY 09, CRSA staff responded to 357 calls for assistance, 355 of which pertained to children and adolescents requiring assistance with service planning and service provision and 2 of which were systemic *Information Only* requests. During FY 09 46% of the requests for CRSA assistance (165 referrals) were individuals seeking help with community-based plans of service and 46% of the requests for CRSA assistance (165 referrals) were calling to explore pathways to public funded residential placement. While CRSA staff note a gradual shift in emphasis from residential treatment to community-based approaches, the staff support activities required to establish and or assist multidisciplinary, multiple-agency child and family teams at the community level to support community-based plans of services is both time and travel intensive. In spite of the increasing numbers of multiple-agency initiatives and the existence of the child and adolescent local area networks (LANs) through out Illinois, CRSA member agencies, for the most part, continue to make service and funding decisions within their own closed and centralized networks and general resistance to multiple-agency Child and Family Team planning in communities continues to be an issue that trigger referrals to CRSA..

During FY 09 the Illinois Mental Health Collaborative for Options and Choice “The Collaborative” implemented substantial changes in the way that the DHS/DMH Individual Care Grant (ICG) program is administered. The changes increase the responsibilities and accountability for both ICG consumers and providers, utilize medical necessity as the basis of service decisions and draws the collaborative into every facet of decision making around ICG consumers. The ICG program is a staple for the population of individuals served by CRSA and its staff experienced a sharp increases in ICG related technical assistance activities as consumers, SASS agencies and ICG provider agencies adapted to the changes during the spring and summer of 2009. Two of the six cases that have potential to enter formal dispute resolution in FY 09 involved children who’s ICGs were terminated and those cases remain unresolved as we move into FY 10.

The CRSA has a case monitoring system in place that tracks key client demographics, reasons for referral, diagnostic information, as well as agency involvements and service history information. This helps the CRSA identify referral trends and diagnostic sub-populations needing service assistance.

Children with Major Mental Illness: There were 189 requests for assistance in FY 09 (53%) pertaining to children with one or more documented major mental illnesses. The most commonly documented major mental illnesses were Bi-polar disorder (54%), Depression (32%) Schizophrenia/Psychosis (18%) Post Traumatic Stress Disorder (17%) and Obsessive Compulsive Disorder (13%). This data is very similar to FY 08 data.

The challenges that we see coming for children and adolescents with mental illness are that as more ICG eligible children are transitioned back to their home communities from residential placements, local mental health resources at the community level will need to be increased in both overall availability and in intensity of interventions and treatment if the clinical gains made in residential treatment are to be maintained in the community. Another concern that CRSA has expressed for this population is that children and families who are not Medicaid eligible (privately insured and under-insured) have increasing difficulty getting their mental health service needs met at the community level. The CRSA caseload in recent years identifies an increasing sub-population of “Transition Planning” cases as adolescents with mental illness, often in combination with other disabilities, need to transition into the adult service sphere.

Medicaid Eligible Children and Families: 185 children referred to CRSA for assistance in FY 09 (52%) were Medicaid eligible. This includes publically adopted children, children whose families are eligible for Medicaid and children in ICG residential placements for more than 90 days under the 94(r), a Medicaid eligibility category and designation for children who do not live with a caretaker relative.

Privately Insured and Under-Insured Children and Families: 170 children referred to CRSA for assistance in FY-09 (48%) are covered by private health insurance, which either does not cover community-based or residential services needed by the children and families served by CRSA or which have annual or lifelong benefit caps to recipients. These exclusions comprise a population of children and families that are under-insured: unable to purchase the services they need through either the private or the public sectors.

Children Diagnosed with Attention Deficit Disorder with or without Hyperactivity: 153 children referred to CRSA in FY 09 (43%) were documented with either Attention Deficit Hyperactivity Disorder or Attention Deficit Disorder. This continues to be the most common co-existing condition/diagnosis seen on our caseload.

Children with Behavior Disorders: There were 142 requests for assistance in FY 09 (40%) pertaining to children with one or more documented behavior disorders. The most commonly documented behavior disorders were Oppositional Defiant Disorder (52%), Reactive Attachment Disorder (30.9%), Conduct Disorder (16%), Intermittent Explosive Disorder (14%) and Tourettes Syndrome (2.8%)

Children with Developmental Disabilities: There were 107 requests for CRSA assistance in FY 09 (30.1%) pertained to children with a documented developmental disability in combination with either a mental, emotional and/or behavioral problems. This has been the fastest growing CRSA sub-population in recent years, comprising 8% of CRSA's caseload in FY 06, 14% of CRSA's caseload in FY 07, 30% of CRSA's caseload in FY 08 and again 30% of CRSA's caseload in FY 09.

Children diagnosed on the autism spectrum comprise 75% this sub-population. Children with IQs less than 70 comprise 27% of this sub-population. During FY 09, 42% of the referents for this sub-population were seeking residential treatment. In FY 08 only one third of this sub population were seeking residential treatment. This increase in demand for residential treatment is discouraging because CRSA staff observe that very few children and adolescents with developmental disabilities return to community-based settings once they enter residential settings, regardless of the age of residential entry. Given this reality, the long range goal of successfully assisting individuals with developmental disabilities to live in community-based settings as adults is hindered as more and more of these individuals enter residential treatment facilities as children and adolescents.

Special Education: Special education continues to be a common denominator for the majority of children served by CRSA. During FY 09, 230 of the children and adolescents referred to CRSA (65%) were actively involved in special education at the time of referral. This is down from 91% in FY 08. There were 107 requests for CRSA assistance in FY 09 (30.1%) involving initial service requests for issues and concerns related to special education. The majority of these requests are from parents calling CRSA to explore ways to improve their child's academic performance or behavioral adjustment at school or who have general questions about special education procedures. The number of parents seeking residential placements through their Local Educational Agencies (LEAs) continues to increase.

CRSA staff observe that while some public school districts willingly participate in multiple-agency deliberations like Child and Family Teams and are open to inviting relevant community agencies to participate in IEP meetings, schools tend to remain isolated from multiple agency deliberations and decision-making processes. This persistent difficulty connecting schools and other agencies makes it difficult to achieve the multiple-agency coordination that is required by special education students, whose school districts have steadily increasing responsibilities to CRSA's population, including lead agency responsibilities in transition planning.

Adoption Services: 24.5% of the initial service requests for CRSA assistance in FY 09 (87 referrals) pertained to children who have been adopted. 83% of those requests pertained to public adoptions and the remaining 17% pertained to children who were privately adopted, including nine requests for assistance for children who were adopted from foreign countries. The majority (70%) of requests for assistance with children who are adopted come from parents seeking funding for residential placements. This data is nearly identical to FY 08 caseload data.

DCFS continues to maintain an internal process for evaluating and making decisions about children who are publically adopted and whose adoption is at risk of failure or disruption. Although these are time consuming cases CRSA staff observe that many adoptions that seem destined to disrupt at the time of case opening are successfully stabilized over time utilizing DCFS' adoption disruption protocol and by coordinating services in the community. Some adoptions however do fail and the children again become wards of DCFS. We note that there are few resources and service options for disrupting *private* adoptions especially international adoptions and for adopted children and their families who are not Medicaid eligible.

Children with Mental Illness(es) and Developmental Disability(ies): During FY 09, 13% of our caseload (46 referrals) pertained to children who have overlapping diagnoses of mental illness and developmental disabilities, and who most often have educational disabilities and behavior problems as well. This population has more than quadrupled on our caseload since FY 08 when we had 11 such referrals comprises only 2.7% of our caseload.

Over the last decade, the previously sharp distinction between whether a child fit the service criteria for DHS/DDD or DHS/DMH has been blurred to the point that internal deliberations between the DDD and DMH Divisions of DHS are now routinely needed to make effective service planning, transition planning and funding decisions. As problematic behaviors for this population appear more frequently in schools and as public schools shoulder more and more responsibility for social and emotional skills development, functional daily living skills development and vocational readiness training, the decision making surrounding which agency should accept primary service planning and implementation responsibility for an individual with mental illness, developmental disability and educational disability has become very complex. These cases are very labor intensive for local provider agencies, CRSA staff and relevant member agency staff. These cases also carry a high likelihood of advancing to the CRSA dispute resolution process if service planning and or funding decision making breaks down at any level.

Other Sub-Populations: Other sub-populations of children with specialized service needs that have been referred to CRSA for assistance during FY 09 include 52 children who exhibit sexual aggression (14.6%), 21 parents seeking help in achieving coordinated transitions from child and adolescent services to adult services "Transition Planning" (5.9%) and 10 children who have program needs related to epilepsy, seizure disorder, and traumatic brain injury (2.8%). Requests for services for children with hearing impairments and behavior disorders accounted for nearly 1.6% of the FY 09 caseload (6 referrals), half of whom were seeking residential treatment. Documented prenatal substance exposure was also identified in 5.6% of the children referred to CRSA in FY 09 (20 referrals).

ADMINISTRATION OF DISPUTE RESOLUTION

The CRSA was given a statutory mandate to "develop a process for making determinations in situations where there is a dispute relative to placements of individuals or funding of services for individual placements." A process was initiated in 1987 and remains in place. While each state agency has its own internal review process, there was no statewide process to resolve multiple-agency disputes. During the CRSA's twenty three years of service CRSA has had 8,594 requests for help referrals where children were in danger of falling through the cracks of the categorical service systems. Thirty seven of those cases refigured CRSA board actions to resolve.

The following conditions must be met to implement formal dispute resolution:

A. Criteria

1. A parent/guardian or individual claims that one or more agencies represented on the Authority have failed to implement a plan of service on a timely basis, or
2. A member agency alleges that another member agency has failed to respond to an individual's needs as required by its defined missions, rules and/or procedures.

B. Eligibility

1. An individual who may have multiple-agency service needs.
2. An individual who is severely emotionally or behaviorally disordered and his/her family.

CRSA received 357 requests for assistance cases in FY 09. Of these requests for assistance, 355 requests (99.5%) pertained to identified children needing services and the remaining 2 requests (.05%) for assistance pertained to system information requests. During FY 09 six cases were rated by staff as having potential to require board action to resolve developing services or funding disputes. Three of the six cases were resolved successfully at the general services and technical assistance levels of the dispute resolution process. The remaining three cases were carried over into FY 10 as unresolved.

The CRSA revised the Dispute Resolution Process during FY 09. The revised process draws relevant member agencies into the technical assistance phase of CRSA services earlier to maximize multiple agency problem solving deliberations and to resolve emerging dispute without the need for formal board action.

On the systemic level, the CRSA Dispute Resolution Process focuses a spotlight on populations of children who are at risk of going un-served or being underserved in Illinois and provides a directional beacon for system planners interested in service system restructuring to achieve improved outcomes. The following are sub-populations of children exhibiting severe emotional disturbance and behavior disorders who are at significant risk of "falling between the cracks" of the child and adolescent service system and whose parents have turned to the CRSA dispute resolution process to be have their service needs appropriately addressed.

Common CRSA Service Disputes

- ***Children who need intensive clinical/behavioral interventions but who do not meet the state mental health criteria to qualify for funding of needed residential treatment***

The Individual Care Grant (ICG) program operated by the Department of Human Services, Division of Mental Health (DHS/DMH) provides funding for treatment of children with the most intensive and persistent mental health problems. In accordance with DHS/DMH rules children exhibiting severe emotional disturbances and/or mental illness(s) but who do not exhibit impaired reality testing and do not qualify for the ICG program. This is the most common dispute encountered by the CRSA.

- ***Children with cognitive impairments in combination with other disabilities***

Children exhibiting varying levels of cognitive impairment present unique challenges to the existing service system, especially when combined with other disabilities such as special education needs, emotional disturbances, behavioral problems, mental illness, autism, brain injury and physical disabilities. The fastest growing sub-population of this service group on CRSA's caseload during the last four years has been children diagnosed with autistic spectrum disorders. While the Illinois Department of Human Services, Division of Developmental Disabilities (DHS/DDD) offers community-based and residential resources for children with cognitive impairments, the threshold for service eligibility is high and the resources do not always match the need. Parents who are unable to acquire intensive services from the publicly funded developmental disability system often turn to the other state systems for assistance and increasingly look to CRSA to arbitrate service and funding disputes.

- ***Families of adopted children in crisis***

A common type of dispute addressed by CRSA in the last decade is for children who are adopted and who exhibit severe emotional disturbances, mental illness(s), developmental disabilities and/or persistent behavioral problems but who are not eligible for needed residential treatment or funding through the Department of Children and Family Services, through the Department of Human Services or through their school districts.

- ***Children who need specialized treatment to address inappropriate sexual behavior***

There are few public funding sources that parents can access to purchase specialized treatment for children who are victims of sexual aggression and/or exhibit sexual aggression or other sexually inappropriate behaviors. Accurate sexual risk assessment and treatment planning, inherent public safety risks and the scarcity of qualified providers are all barriers to effective service provision. Many of these children "default" to the justice system when their behavior warrants court intervention or to the child welfare system when families are unable to effectively implement mandatory safety plans.

- ***Children with Brain Injuries***

Children who have sustained brain injuries are particularly difficult to serve in the Illinois service system. Parents look to the public service sector to provide the needed medical treatments, highly specialized rehabilitation and training as well as educational services needed for the child to restore/achieve maximum functioning. Brain injuries typically require rapid, multi-system treatment planning and service delivery. While many Illinois public agencies acknowledge limited commitment to this population, no single child serving agency has the specific legislative responsibility to fund the array of services needed by this population. Parents seeking specialized services for their child with brain injuries often look to CRSA to acquire needed services.

Common Service Barriers Identified in CRSA Cases

Systemic deflection: Many parents assisted by CRSA experience a “ping-pong effect” as public agencies or their private sector provider agencies actively deflect to each other’s systems. Delays in making eligibility decisions until other funding sources have been explored are the most common example of this practice. Although timely acknowledgments or documented eligibility for children who appear to have overlapping service and funding eligibilities are improving, we still see some resistance to timely acknowledgement of responsibility and/or eligibility.

Schools refusing to support or fund a residential placement: Public school districts have a statutory responsibility to educate certain students in residential schools and are also statutorily obligated to support state funded residential placements by paying for the special education services associated residential placements supported by state agencies or the courts. This places a potentially significant burden on schools and creates confrontations between the school and parents that frequently can be resolved only through expensive and time consuming special education due process legal proceedings. While recent amendments to the Illinois School Code have reduced educational co-funding disagreements the line between where a school district’s responsibility ends and other public agencies responsibilities begin is less clear.

Lock-out: When the service system is unable to address the needs of a child who presents a risk to public safety and requires intensive interventions, parents are sometimes coached or pressured by service providers to refuse to accept the child into their home (termed a “lock-out”) as a means of accessing needed treatment or services for the child. Parents who attempt to access services through lock-out in many instances end up relinquishing guardianship to the state and are often treated systemically as abusive or neglectful parents. CRSA staff do not believe that lock-out is an effective mechanism for service planning and the CRSA board has long believed that parents should not be forced to give up guardianship and parental rights to their children simply to get their service needs met.

Serving pre-adolescents: Historically, children under the age of twelve have been more likely to be served with community-based services rather than in residential treatment settings. During the last decade there has been an increase in the number of children ages 12 and under referred to CRSA to address needs for intensive education and intervention services, including treatment in residential settings. This provides challenges to the Illinois Service System both in terms of securing funding for services and identifying and developing developmentally appropriate and age appropriate treatment settings for this population.

Emerging diagnostic classifications: It can take a decade or more for the state service system to respond administratively and programmatically to emerging diagnostic classifications. Recent examples include: traumatic brain injury, autism, attachment disorder or reactive attachment disorder, all of which require specialized assessments and often specialized and expensive treatment. The scarcity of qualified diagnosticians, licensed providers and specialized treatment programs are common barriers to service. Legislative activity is often required to define state and departmental responsibility and to develop funding paths for specialized programs.

Lack of services available in a geographic area: Throughout CRSA's history we have observed that child and family teams and other service planning networks often decide that a child requires treatment in an out-of-home/out-of-community residential setting primarily because the needed community-based services are either not available in the child's community, are not available at the level of intensity needed by the child and family or because coordination among community-based providers is weak or absent. This is an ongoing barrier/concern for CRSA.

Resistance to decentralized, multiple-agency decision making: In spite of the increasing numbers of multiple-agency initiatives and the existence of the child and adolescent local area networks (LANs) throughout Illinois, the majority of CRSA member agencies make service and funding decisions within their own closed and centralized networks and resistance to multiple-agency child and family teaming continues to be an issue in many Illinois communities.

FISCAL YEAR 2009 ACTIVITIES

The CRSA board held six full board meetings during FY 09 that focused on promoting and implementing the concepts advanced in the CRSA Statewide Service Plan in addition to providing technical assistance and carrying out dispute resolution responsibilities.

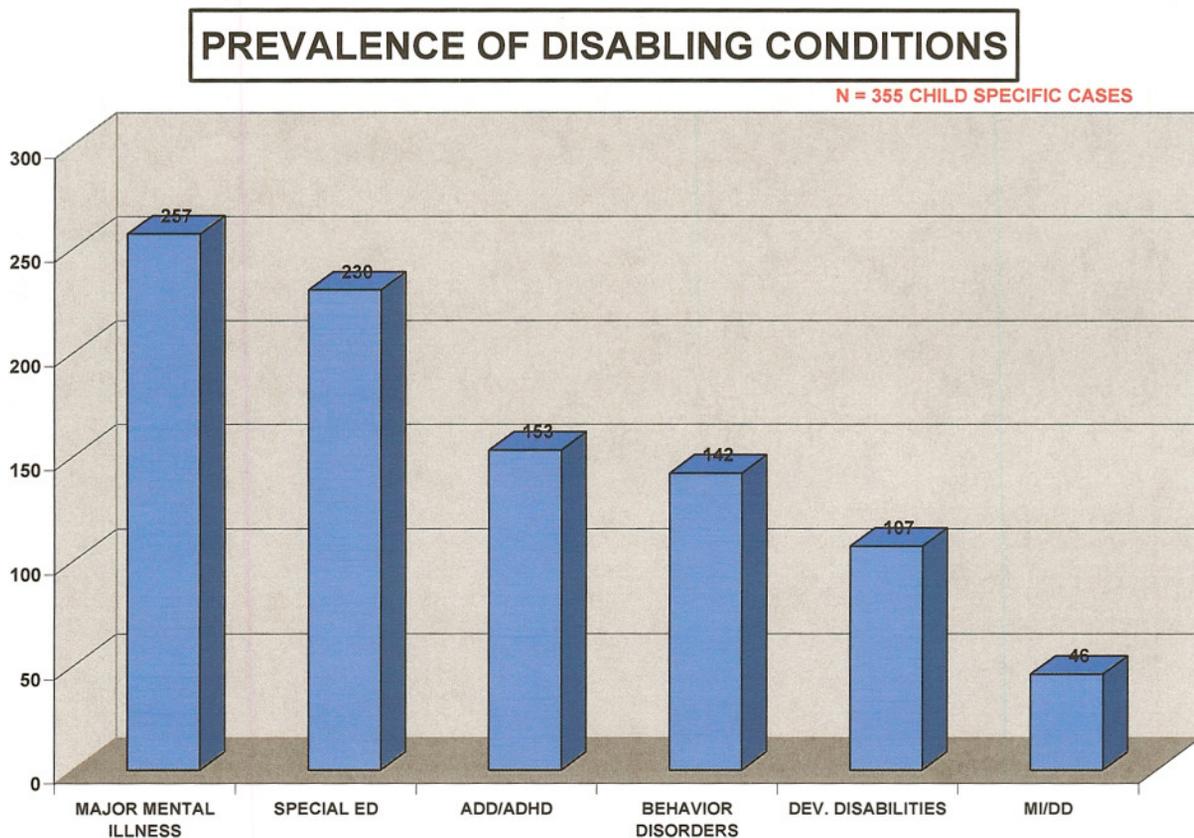
The CRSA continued to advance the goal of interagency collaborative efforts during FY 09 by engaging in the following activities:

- The CRSA board had ongoing conversations about the state's fiscal crisis and its impact on the child and adolescent service system. Conversational threads included administrative changes to the ICG program, sufficiency of community-based mental health services relative to client need, administrative barriers to mental health service expansion through EPSDT, Medicaid caps on public mental health centers, and the lack of coordinated, statewide multiple-agency service planning and intervention as suggested by the CRSA Statewide Service Plan. There has been discussion at the board level that multiple-agency service planning and delivery, as outlined in the CRSA Statewide Service Plans may ultimately require legislation to become a reality in Illinois due to continued resistance to voluntary collaboration. The Authority has continued to become aware of other states which have used the legislative approach to mandate multiple agency collaboration for similar populations of children and adolescents served by CRSA.
- During FY 09 the CRSA board suggested that a CRSA "Gaps Conference" be convened to reassess the service system, identify current challenges and to help further advance CRSA's mission and vision. The CRSA board has also suggested that CRSA needs to hold another Strategic Planning Conference, the last one being held in the spring of 2005 and which was regarded as a five year plan.
- CRSA staff participated in 312 activities with agencies, organizations and groups in FY 09. These numbers are up sharply from FY 08 primarily due to CRSA hiring a Network Development Coordinator. This is a newly created full time, professional systems-integration position within the agency specifically created to respond to the needs of youth serving networks in communities around the state as well as to strengthen the Local Area Networks. In addition, CRSA staff continued to maintain liaison relationships with statewide planning groups including the Illinois State Advisory Council on the Education of Students with Disabilities, Positive Behavior Interventions and Support Network: Statewide Leadership Team, Illinois Federation of Families, Attorney General's Special Education Committee, Children's Mental Health Partnership: Educational and Residential Workgroups, Individual Care Grant Advisory Council, the DHS/DMH Statewide Children and Adolescent Advisory Council and Transition Workgroup, the Children's Behavioral Health Association and the Lockout Sub-Committee.
- CRSA staff collaborated with Central Management Services designing a CRSA logo, designing and testing a Beta CRSA website, and discussing the feasibility of eventually creating a secure, web-based case recording system.
- The Authority updated and revised the CRSA Dispute Resolution Process following a year of deliberations by the Ad Hoc Dispute Resolution Committee.

CASE INFORMATION AND CLIENT STATISTICS

Prevalence of Disabling Conditions

This graph shows the range and the prevalence of disabling conditions exhibited by the 397 children and adolescents for whom CRSA was contacted for assistance during FY 08. It is the norm for children and adolescents served by CRSA to exhibit two to five diagnosed disabilities and behavior problems at the time of referral.



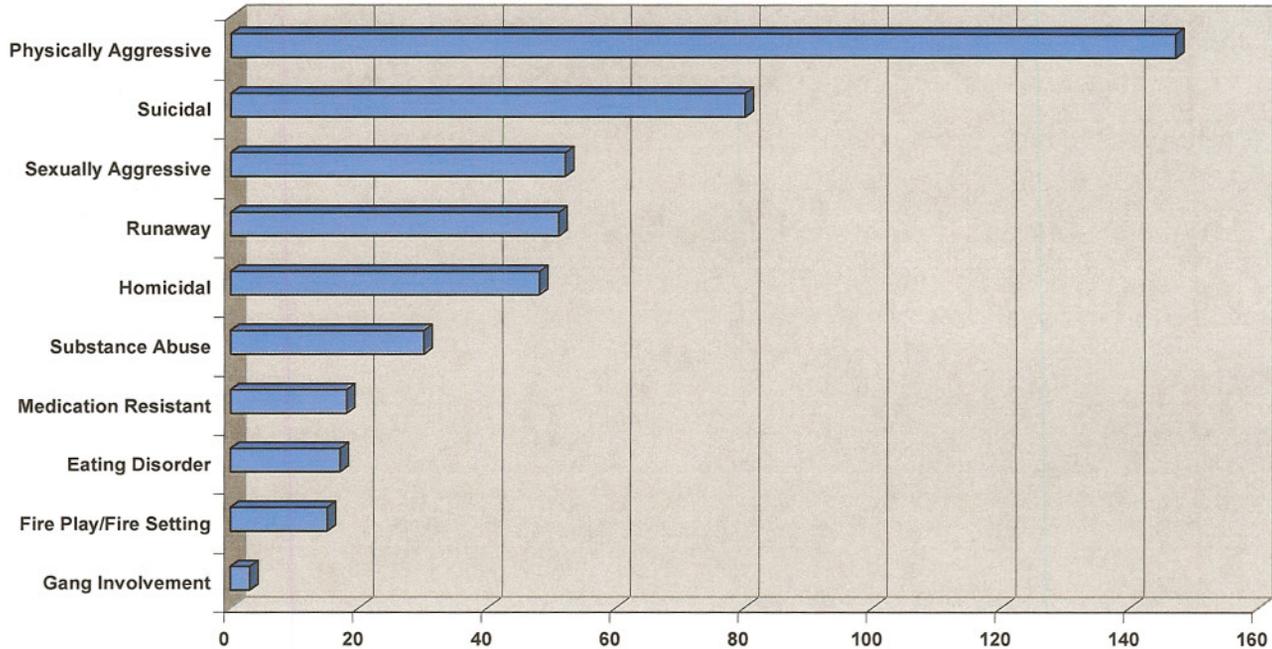
Multi-disciplinary and multiple-agency service planning is a common denominator for the children served by CRSA, given the multiple disabilities profile of the typical CRSA client. Refer to Fiscal Year 09 Caseload Trends (*pages 5 through 7*) in this report for further discussion.

Prevalence of Difficulty of Care Factors

This graph shows the range and the prevalence of serious behavior problems which CRSA tracks as “difficulty of care factors” exhibited by the children and adolescents for whom CRSA was contacted for assistance during FY 09. CRSA tracks difficulty of care factors because these behaviors present programming challenges for both community-based and residential service providers thereby limiting service availability and treatment options. 58.5% or (208) of the children and adolescents for whom CRSA was contacted for assistance in FY 09 exhibited one or more difficulty of care factors in addition to one or more disabilities.

PREVALENCE OF DIFFICULTY OF CARE FACTORS

N = 208 CHILD SPECIFIC CASES



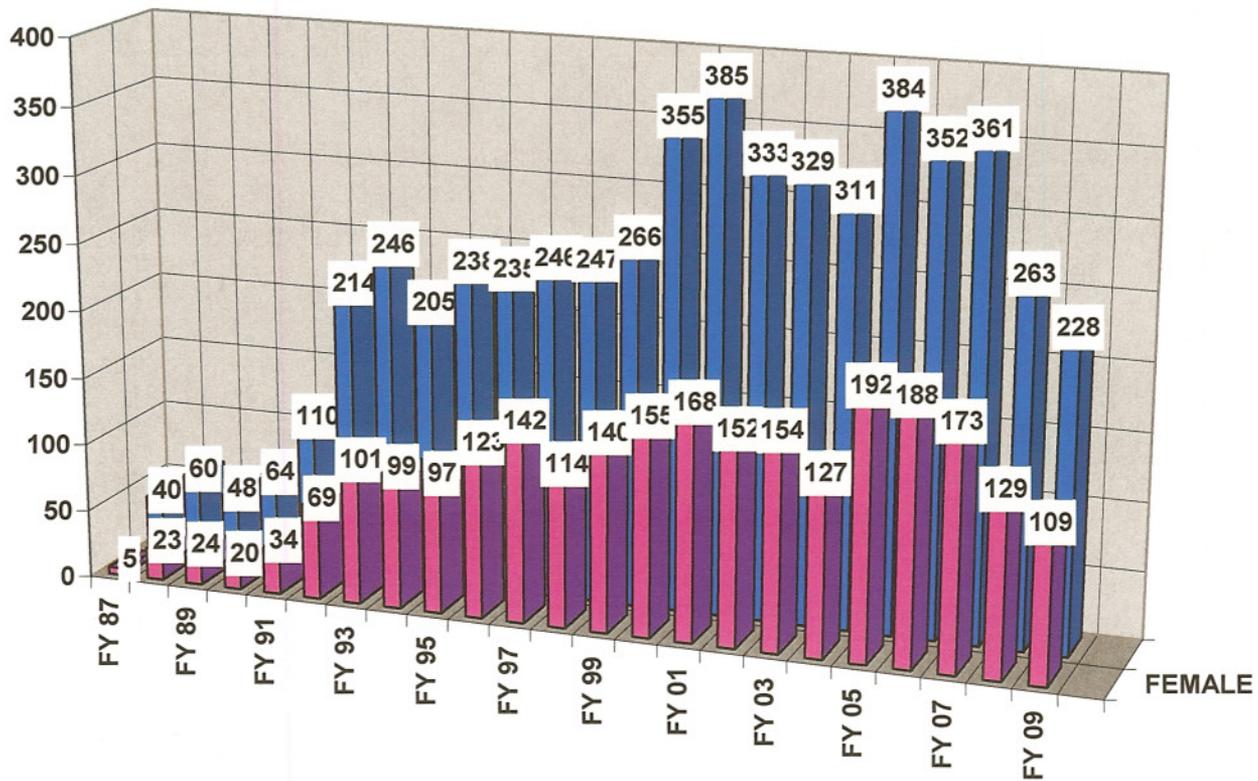
FY 08 was the first year that CRSA published prevalence of difficulty of care data. The FY 09 data, while similar, offers several interesting points CRSA client needs appear to be more severe in FDY 09 where nearly 60% of children referred to CRSA had difficulty of care factors, compared to 50% last year. Physical aggression and suicidal behavior remain the two most prevalent difficulty-of-care factors but in FY 09 the Authority noted a 7% increase in children exhibiting sexual aggression when compared to FY 08 data.

Gender

This graph shows the number of males and females served by the CRSA in all fiscal years from 1987 through 2009. During FY 09 CRSA was able to identify the gender of 337 children and adolescents for whom CRSA was contacted for assistance.

Males historically have been referred about twice as often as females. This trend continues in FY 09 with 67% of all referrals being male.

COMPARISON OF REFERRALS BY GENDER



The ratio of male to female referrals for assistance remains generally stable over time and CRSA regards the FY 09 gender data as unremarkable.

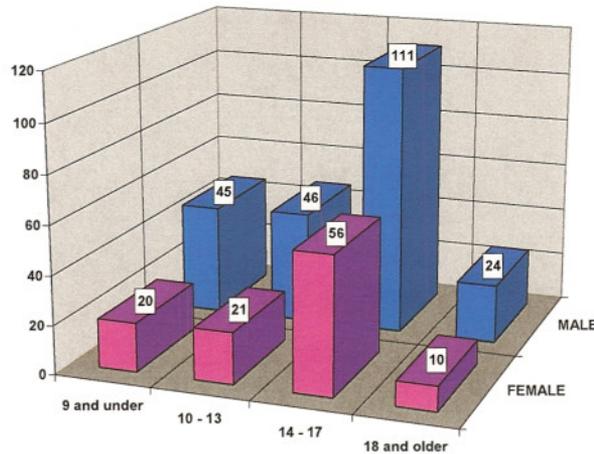
Age and Gender

During FY 09, the average age of children served by CRSA is 13.4 years. In FY 09 the average age of males served is 13.4 years and females served is 13.5 years. The most frequently referred age ranges for CRSA referrals remains the 10-to-13 year olds and 14-to-17 year-olds, collectively accounting for 70% of all referrals in FY 09.

This tablet shows the distribution of referrals by age groupings and gender for selected periods.

	9 & Under		10 – 13		14 – 17		18 & Over	
	M	F	M	F	M	F	M	F
FY 91-97	13%	7%	17%	9%	28%	14%	7%	5%
FY 98	14%	9%	24%	8%	25%	12%	5%	3%
FY 99	13%	11%	20%	7%	30%	15%	3%	1%
FY 00	13%	6%	23%	9%	28%	14%	6%	1%
FY 01	14%	6%	19%	6%	31%	15%	6%	3%
FY 02	13%	5%	21%	8%	28%	17%	6%	2%
FY 03	15%	6%	20%	9%	30%	15%	3%	2%
FY 04	17%	4%	20%	10%	29%	12%	5%	2%
FY 05	16%	6%	21%	8%	26%	16%	4%	3%
FY 06	14%	5%	20%	9%	28%	17%	4%	3%
FY 07	16%	4%	20%	9%	26%	17%	6%	2%
FY 08	14%	4%	19%	8%	29%	20%	4%	2%
FY 09	14%	6%	14%	6%	33%	17%	7%	3%

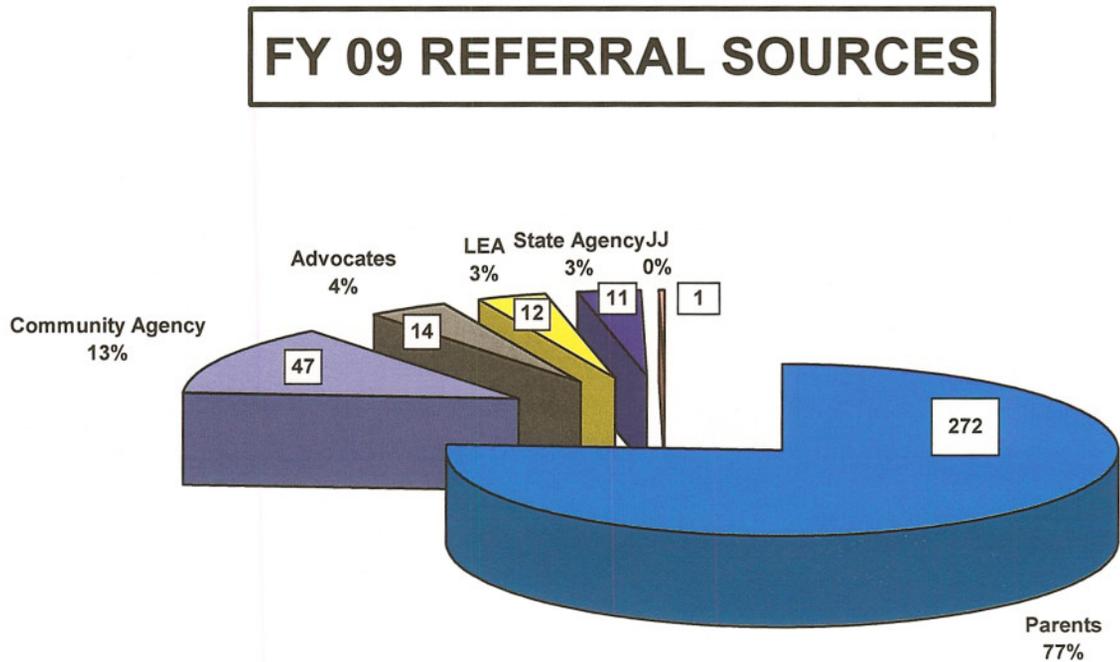
FY 09 REFERRALS BY AGE GROUP & GENDER



The CRSA has age and gender data on 333 children referred for services during FY 09. The referral trends by age and gender are fairly consistent over time and the Authority regards the FY 09 age and gender data as unremarkable.

Referral Source

This chart shows the distribution of the 357 FY 09 requests for assistance by referral sources. Parents remain the largest referral source to CRSA, followed by referrals from Community Agencies and Advocates.



STATE AGENCIES:

Illinois State Board of Education; Department of Children and Family Services; Department Juvenile Justice; Department of Human Services: Divisions of Mental Health, Developmental Disabilities, Rehabilitation Services, and Community Health and Prevention; Department of Healthcare and Family Services

LEAS:

Local Educational Agencies

ADVOCATES:

State, federal and private advocacy agencies/groups/individuals

PARENTS:

Parent(s) or legal guardian

COMMUNITY AGENCIES:

Local community direct service provider agency

LANS:

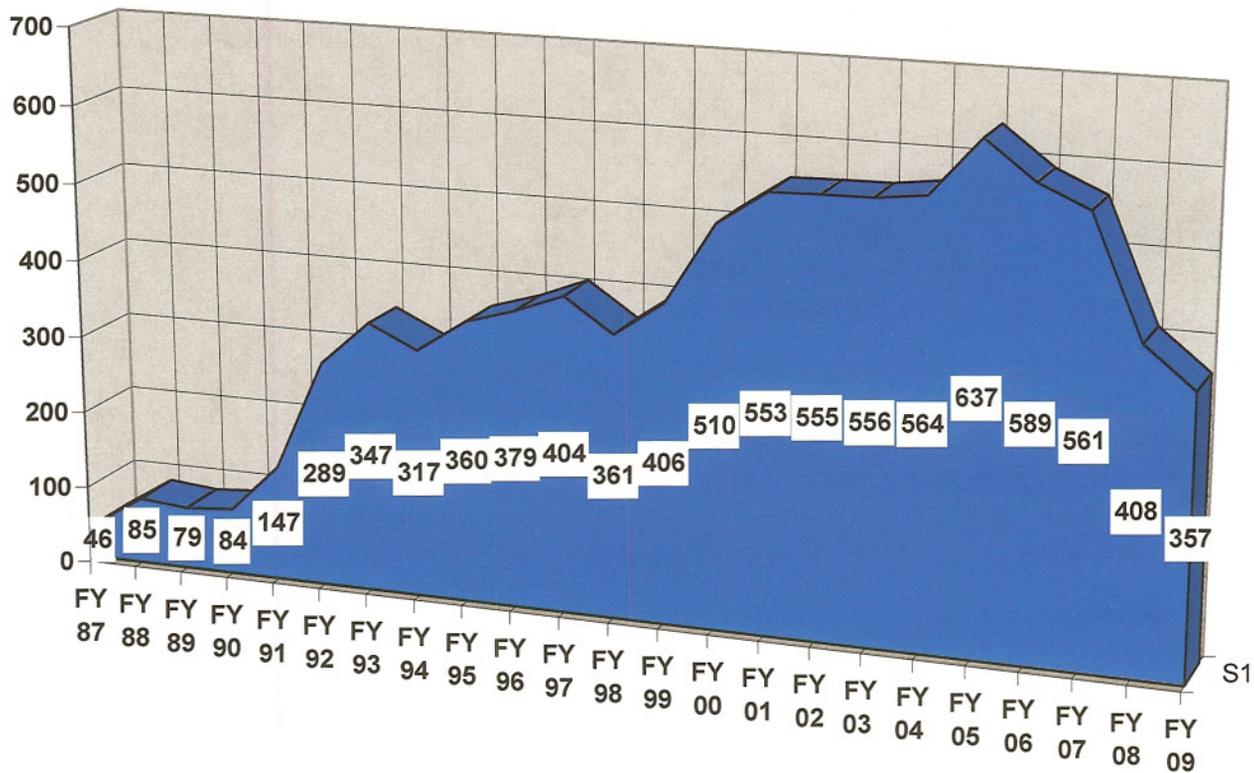
Child & Adolescent Local Area Networks

Number of Referrals

The Authority received and responded to 357 requests for assistance in FY 09.

This graph shows the number of referrals by Fiscal Year since initiating service in April 1987. A total of 8,594 requests for assistance were made since 1987.

REFERRALS BY FISCAL YEAR



Demand for CRSA services has been changing steadily since FY 05 and represents both positive and negative systemic trends. On the positive side the Authority notes steadily increasing capacity within the LANs and other local systems-of-care to address multiple-agency cases and increasing consumer access to general services/program information through the internet. Both tend to decrease the need for direct CRSA staff assistance to address general service access. On the negative side the Authority notes steady changes in CRSA referral trends: a widening population of children which are presenting as under-served or un-served (*See pages 5-7*) and an increase in case complexity (*See pages 13-14*). As such a typical CRSA case situation (service dispute) is more labor intensive and increasingly requires a higher degree of multi-systems specialization for both CRSA staff and member agencies to resolve.

CRSA CONSUMER SATISFACTION SURVEY

The consumer satisfaction survey is a questionnaire consisting of three simple questions scored on a one to five scale; with five being the highest rating and one being the lowest rating. The survey is distributed to each referent approximately 30 days after the date of referral with a self-addressed stamped envelope to maximize returns. Responses indicate the levels of satisfaction with:

Question 1.) Was the Community and Residential Services Authority prompt in acting on you request for assistance?

Question 2.) Were your ideas treated with respect?

Question 3.) Did the CRSA you or the child needed help?

The "Forms Returned" chart below displays the total number FY 09 surveys mailed out, the number returned and the percentage of return by referral source. The "Questions" chart is the average of surveys received for that referral source. The column designated "Average" shows the average score across all three questions by referral source. The lightly shaded items are weighted averages of the total responses for each question. The weighted average* for all questions across all referral sources is 4.24, shown in the dark-shaded box.

	FORMS RETURNED			QUESTIONS			
	Surveys Mailed	Surveys Returned	Percent Returned	Q. #1	Q. #2	Q. #3	Average
Parents Com.	268	79	29%	4.17	4.33	3.92	4.14
Agencies	19	9	47%	5.00	5.00	4.88	4.96
Advocates	7	3	43%	4.67	4.67	4.00	4.45
LEA	4	2	50%	4.50	5.00	4.50	4.67
SA	2	0	0%	n/a	n/a	n/a	n/a
JJ	1	0	0%	n/a	n/a	n/a	n/a
	301	93	31%	4.27	4.42	4.02	4.24

For FY 09, 31%, or 93 of the 301 surveys distributed, were returned.

Additional questions on the survey are optional and answered in narrative style. Of the surveys returned, 94% percent or 88 of the returned surveys had a narrative response, and their responses were consistent with overall survey ratings. The majority of respondents comment that there is nothing they dislike about CRSA services.

* *Weighted averages are used to assure that each survey is equally weighted, offsetting the skew from any single referral source being over-represented.*

Overall Consumer Satisfaction Rates

The chart below displays the weighted average response rating for each question across the last seven years. Scores have been constantly 4.00 or above for the last 7 years.

Overall satisfaction scores indicate that CRSA service recipients appreciate having their calls for assistance answered immediately, or at latest, within 24 hours, appreciate the active listening practiced by CRSA staff and appreciate the individualized, solution-oriented assistance offered by CRSA staff.

CONSUMER SATISFACTION RATES

	FY 03	FY 04	FY 05	FY 06	FY 07	FY 08	FY 09
Q. #1	4.60	4.53	4.66	4.51	4.76	4.77	4.27
Q. #2	4.71	4.58	4.72	4.60	4.70	4.79	4.42
Q. #3	4.37	4.18	4.19	4.20	4.29	4.43	4.02
Yearly Weighted Average	4.55	4.43	4.52	4.44	4.58	4.66	4.24

COMMUNITY AND RESIDENTIAL SERVICES AUTHORITY

FY 2009

APPROPRIATION/EXPENDITURE SUMMARY

FY 2009 APPROPRIATION	\$575,000.00
FY 2009 EXPENDITURE	\$533,125.70
FY 2009 RETIREMENT RESERVE (UNUSED)	\$25,000.00
LAPSED FUNDS	\$16,874.30

OBJECTIVE OF EXPENDITURE	EXPENDITURE	TOTAL
PERSONNEL SERVICES		
CRSA Employee Salaries	\$396,996.25	
Benefits Package	\$63,737.79	
Staff Travel	\$29,447.64	
		\$490,181.68
CONTRACTUAL SERVICES		
Members Travel	\$5,557.18	
Space Allocation	\$28,219.00	
Administrative Services	\$5,230.00	
Website Development	\$1,036.57	
Meeting Expenses	\$519.33	
Staff/Board Training	\$558.50	
		\$41,120.58
COMMODITIES		
Office Expenses	\$1,823.44	
		\$1,823.44
TOTAL FY 09 EXPENDITURE		\$533,125.70

IN-KIND CONTRIBUTIONS TO CRSA

CRSA board members and staff would like to take a moment to thank member agencies, legislative members, gubernatorial appointees and other state agencies that contribute to the operation of the Authority, through their time and through in-kind services and expenditures.

Illinois State Board of Education (ISBE): ISBE is CRSA's fiscal agent and house the Central Office of the Authority in Springfield. ISBE provides a range of gratis administrative services and support services both in Chicago and Springfield that contribute to the smooth and effective operation of the Authority, thereby keeping CRSA's operating costs down.

Department of Children and Family Services (DCFS): DCFS provides in-kind office space and telecommunications services for two CRSA staff through their Regional Offices in Aurora and Marion Illinois that contribute to the smooth and effective operation of the Authority, thereby keeping CRSA's operating costs down.

Member agencies and legislative designees: (*refer to page iii*) provide the time of their primary designees and alternate designees as well as provide for their CRSA related travel and lodging expenditures. Many of these CRSA members also participate on the CRSA Executive Committee and various CRSA Ad Hoc Committees which represents a tangible additional contribution and commitment to the functioning of the Authority

Gubernatorial Appointees: provide their time to participate on the Authority. Many of these CRSA gubernatorial appointees also participate on the CRSA Executive Committee and various CRSA Ad Hoc Committees which represents a tangible additional contribution and commitment to the functioning of the Authority.

Video-conference facilities: The Illinois State Board of Education, the Illinois Department of Corrections, and Illinois Central Management Services allow CRSA to use its video conference equipment in Chicago and Springfield to conduct Board meetings and committee meetings. This helps to reduce member travel thereby keeping CRSA's operating costs down.

Internet Technology infrastructure and technology: The Illinois State Board of Education, Central Management Services and the Department of Children and Family Services donate internet technology infrastructure, human technical assistance and computer hardware/software and assist in the development of a CRSA web-presence that connect CRSA staff with one another. These contributions help CRSA to reach more potential CRSA consumers more quickly and efficiently as well as keeping CRSA staff around the state connected.