



ANNUAL REPORT

FY 2012

(July 1, 2011 - June 30, 2012)

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, State Agency
Directors and Superintendent of Education:

On behalf of the membership of the Community and Residential Services
Authority, I transmit herewith the Twenty Sixth Annual Report. I am pleased to
present this summary of activities for Fiscal Year 2012 in accordance with the
requirements as set forth in Ch. 122, Sec. 14-15.01 of the Illinois School Code.

Respectfully submitted,



Gary Seelbach
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 therefore, 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). In FY 12, the CRSA completed its 26th year of service to Illinois children with behavior disorders or severe emotional disturbances and their families. During FY 12 the CRSA responded to 354 requests for assistance and two service/funding disputes which required full board action.

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 uses this accumulated field experience to draw attention to the service gaps. Consequently, during FY 12, the Authority has discussed adjusting its historic approach to meeting its various statutory powers and duties. This includes anticipating both statewide and national changes in the public and private health care systems and making corresponding adjustments to CRSA's Mission, Vision, Service Principles, Service Plan and direct service strategies. There has been concerted pressure on CRSA to utilize the Authority's interagency platform to assertively address longstanding policy and planning problems related to children and adolescents while simultaneously maintaining its high levels of performance in providing effective technical assistance to referents and efficient administration of the Dispute Resolution process. These pressures to expand the reach of the Authority's work are, however, bracketed by the absence of additional fiscal and staff resources. The Authority also mourns the anticipated demise of the Illinois Local Area Networks (LANs). The LANs represent the only statewide, free standing community-level infrastructure which had potential to accomplish multiple agency service, Wraparound service planning and provision for the CRSA population. At this time CRSA sees no potential infrastructure on the immediate horizon to replace the LANs structure and functions.

During FY 12, the Authority has discussed, in depth, the policy and planning problems related to children and adolescents. This includes the steady erosion of both community-based and residential services across various state service systems. This also includes the increasingly visible lack of state level commitment to effective multiple-agency service planning and service coordination among public agencies on behalf of CRSA populations and their families. The Authority has also discussed Illinois' historic missed opportunities to implement rational service system reforms proposed by many well intended consumer and stakeholder groups over the last 3 decades.

During FY 12, the CRSA board had a steady conversation pertaining to the need for development and implementation of a statewide intergovernmental agreement which can ameliorate some of the increasingly visible and well documented systemic concerns seen on its caseload. This conversation includes discussions about the need for a Children's Human Services Sub-Cabinet, the need for common tools to measure need, provider performance and ultimately to measure consumer outcome, as well as a commitment to adhere to established best practices.

The complexity of the cases referred to the Authority for assistance continues to steadily intensify. 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.

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 outcomes,
- 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 behavior disorders or severe emotional disturbances and their families.

It should be noted that CRSA is a unique state agency that has efficiently and effectively conserved tax dollars over the years and literally saved the lives of the children and families served. Over the past quarter century, the CRSA has excelled in the resolution of interagency conflict and, in the process, helping Illinois children 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 four 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 9,728 children and their families, and successfully addressed several thousand service disputes, including 44 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 recommendations for change, drawing attention to the service gaps and suggesting innovative 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: a vision that is expressed in the CRSA Statewide Service Plans. The CRSA Service Plans have provided an outline for building service partnerships between families, communities and agencies and for advancing a family-focused, child-centered and community-based service planning system with the hope of improving 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 collaboratively bring forward difficult issues that are seen as barriers to interagency agreement 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 including 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.

- The CRSA staff and board have concluded that the human service system in Illinois is being rapidly reshaped by a receding economy both at the state and national levels and by changes in national healthcare policy, all of which challenges the Authority to adapt its approach to technical assistance offered to clients, as well as, system reform recommendations.
- CRSA board members and staff recognize that cultivating and effectively utilizing relationships with member agencies, with 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 maintains productive and cordial relationships with member agencies and working relationships with other governmental entities. Similarly, more groups and individuals both inside the Authority and outside of the Authority are challenging the Authority to work toward accomplishing more of its "systems change" duties through collaborative work with private and governmental providers.
- The CRSA has also been challenged to address the steady erosion of both community-based and residential services across various state service systems. This challenge also includes the increasingly visible lack of state level commitment to effective multiple-agency service planning and service coordination among public agencies on behalf of CRSA populations and their families.

FISCAL YEAR 2012 CASELOAD TRENDS

The CRSA receives requests for assistance from parents or professionals who are experiencing difficulty garnering appropriate services for a child with a behavior disorder or severe emotional disturbance often accompanied by other disabling conditions. 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 12, CRSA staff responded to 354 calls for assistance; 343 of which pertained to children and adolescents requiring assistance with service planning and service provision and 11 of which were *information* requests. During FY 12, 144 of the requests for CRSA assistance were individuals seeking help with community-based plans of service and 177 of the requests for CRSA assistance were calling to explore pathways to publicly funded residential placement for very severely impaired children. While CRSA staff note a gradual shift in emphasis from residential treatment to community-based approaches in recent years, 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, CRSA member agencies, for the most part, continue to make service and funding decisions within closed and centralized networks and resistance to multiple-agency Child and Family Team planning in communities continues to be an issue triggering referrals to CRSA.

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.

Special Education: Special education continues to be a common denominator for the majority of children served by CRSA. During FY 12, 253 of the children and adolescents referred to CRSA (73.7%) were involved in special education or were actively seeking special education services at the time of referral. There were 96 requests for CRSA assistance in FY 12 specifically requesting CRSA assistance to address issues and concerns related to special education (27.9% of the FY 12 caseload). 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 with children in special education who were seeking residential placements through their Local Educational Agencies (LEAs) was 49.4% of this special education cohort. CRSA has taken 5 referrals from parents in FY 12 who were seeking ways to address bullying at school (1.4%).

CRSA has observed that as residential placements within DHS/DMH and DHS/DDD are more difficult to obtain, parents are increasingly looking to their public school districts for residential treatment and to DCFS for residential treatment of publicly adopted children. There is a consensus on CRSA that the time is right for Illinois to revisit the interagency agreement mandated by the Individuals with Disabilities Education Act (IDEA), involving ISBE, DHS/DMH and DHS/DDD and

which has not been updated since 2002. CRSA concludes that Interagency Agreement deliberations should ideally include ISBE, DHS, DCFS, IDJJ and HFS.

Children with Major Mental Illness: There were 230 requests for assistance in FY 12 (67%) pertaining to children with one or more documented major mental illnesses. Among the children within this cohort, the most commonly documented major mental illnesses were Bi-polar disorder (49.8%), Depression (39.1%), Schizophrenia/Psychosis (23.4%), Post Traumatic Stress Disorder (11.7%) and Obsessive Compulsive Disorder (11.7%). 104 children were diagnosed with more than one mental illness during FY 12 comprising 30.3% of all of the children referred to CRSA during FY 12.

The challenge that we see coming for children and adolescents with mental illness is that while state fiscal resources continue to shrink, both residential and community-based supports for children with mental illness are becoming more limited. 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, eventually resulting in more costs expended in other parts of the system, such as psychiatric hospitals, child welfare and corrections.

Children Diagnosed with Attention Deficit Disorder with or without Hyperactivity: 164 children referred to CRSA in FY 12 (47.8%) were documented with either Attention Deficit Hyperactivity Disorder or Attention Deficit Disorder. This continues to be the most common co-existing clinical condition/diagnosis seen on our caseload.

Medicaid Eligible Children and Families: 201 children referred to CRSA for assistance in FY 12 (58.6%) were Medicaid eligible. This includes children who live in families at or under the poverty level, publicly adopted children, children whose families are eligible for Medicaid and children in ICG residential placements for more than 90 days under 94(r), a Medicaid eligibility category and designation for children who have not lived with a caretaker relative for more than 90 days.

Children with Behavior Disorders: There were 133 requests for assistance in FY 12 (38.7%) pertaining to children with one or more documented behavior disorders. Within this cohort, the most commonly documented behavior disorders were Oppositional Defiant Disorder (57.9%), Attachment Disorders (32.3%), Intermittent Explosive Disorder (22.5%), Conduct Disorder (9.7%) and Other (11.3%).

Children with Developmental Disabilities: There were 114 requests for assistance in FY 12 (33.2%) pertaining to children with one or more documented developmental disability diagnoses. Within this cohort 56 children had Autism diagnoses (49.1%), 56 children had Asperger's Syndrome diagnoses (49.1%), 18 children had Pervasive Developmental Disorder diagnoses (15.7%), 22 children had IQs rated as Below 70 (19.2%), 17 children had diagnoses of Mild Mental Retardation (14.9%) and 4 children with documented Down Syndrome (3.5%). It was common for children diagnosed with developmental disabilities to have more than one developmental disability diagnoses simultaneously, in various combinations.

Children with developmental disabilities have become a large CRSA sub-population in recent years, increasing from 8% of CRSA's caseload in FY 06, peaking to 36% of CRSA's caseload in FY 10 and has now at 33.7% of CRSA's caseload in FY 12. Among the 114 children referred to CRSA in FY 12

with one or more Developmental Disability, 59 children (51.75%) were being referred for services in community-based living arrangements, and 55 children (48.25%) were referred for services in out-of-home/residential service arrangements.

In FY 08 only one third of the children in the developmental disability cohort were seeking out-of-home/residential service arrangements. By FY 11 this number had steadily increased to a peak of 52.8%. During FY 12, the number of children in the developmental disability cohort who were referred to CRSA seeking out-of-home/residential service arrangements appears to have dropped to 48.25%. This slight reverse in demand for out-of-home/residential service arrangements residential treatment is a hopefully sign.

Adoption Services: 20.9% of the initial service requests for CRSA assistance in FY 12 (72 referrals) pertained to children who have been adopted. 54.2% of those requests pertained to public adoptions. 25% pertained to children who were privately adopted including 8 requests for assistance for children who were adopted from foreign countries. The remaining 15 adopted children (20.8%) were family adoptions in which relatives took over guardianship of children from the extended family. The majority (50 children or 69.4%) of requests for assistance with children who are adopted come from adoptive parents seeking funding for residential placements. This represents a 16 percentage point decrease from FY 11, and is nearly the same percentage as documented in FY 10. DCFS continues to maintain an internal process for evaluating and making decisions about children who are publicly adopted and whose adoption is at risk of disruption or failure. 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 for international adoptions and adopted children and their families who are not Medicaid eligible. Parents often "lock out" their publicly adopted child when the child presents a danger to others, thereby involving DCFS.

Children who are as classified Sexually Aggressive or Sexually Abused: During FY 12, 49 children (14.2%) referred to CRSA were classified as exhibiting sexual aggression as an at-risk behavior; 20 (40.8%) for whom referents were seeking residential placement, 40 children (11.6%) were classified as have been sexually abused.

Children with Dual Diagnoses: During FY 12, 36 children (10.4%) referred to CRSA, carried dual diagnoses. This cohort broke down into two sub groups: 34 children (94.4%) diagnosed with mental illness(es) and developmental disability(ies) (MI/DD) and 2 (5.6%) children diagnosed with mental illness(es) and substance abuse problems (MI/SA). During FY 12, both of the MI/SA referents were requesting residential treatment.

CRSA has noted a deliberate systemic trend toward assisting individuals with either developmental disabilities, mental illness or both, to ultimately be served in community-based settings rather than in residential treatment settings or long term institutional settings. In FY 12 we witnessed the closure of adult state operated living facilities for individuals with either developmental disabilities or mental illness. Simultaneously we have also witnessed an alarming decrease in the children and adolescents with mental illness found eligible for Individual Care Grants (ICGs), a third of whose licensed residential facilities serve children diagnosed with some combination of both mental illness and developmental disabilities. Additionally, CRSA continues to express concern about the system-wide

absence of, and resistance to, coordinated, multiple-agency service planning and funding for dually diagnosed children and adolescents, many of whom will not transition smoothly from the child and adolescent service system to the adult service system. CRSA observes that often, the coordinated decision making surrounding which agency(ies) should accept service planning and implementation responsibility for individuals with mental illness, developmental disability and educational disability is frequently put off so long that smooth transitions for the child and adolescent to the adult service sphere are unlikely. During this transitional period and public schools are challenged to shoulder more and more responsibility for social and emotional skills development, functional daily living skills development and vocational readiness training.

Children who engage in Fire Setting: During FY 12, 30 children (8.7%) referred to CRSA exhibited fire setting as an at-risk behavior.

Children exhibiting Eating Disorders: During FY 12, 27 children referred to CRSA exhibited eating disorders (7.8%) which required active treatment at the time of referral.

Transition Planning to Adult Services: The CRSA caseload in recent years also identifies an increasing sub-population of “Transition Planning” cases as adolescents with varying disability profiles need to transition into the adult service sphere. In FY 12 CRSA was contacted to help facilitate the development of transition plans from the child and adolescent system to the adult service system planning for 20 individuals, comprising 5.8% of CRSA caseload in FY 12. 80% of this cohort were either considering or actively seeking to arrange for adult residential service options for their would-be adult children. This represents a 5 percent increase since FY 11. The slowly increasing number of these cases over time is worrisome for CRSA staff who observe many of the children on our caseload are not capable of living independently as adults and many are not capable of either competitive or supported employment as adults. Several of the most challenging dispute resolution cases in Authority history presented as young adults who required organized transitions into adult residential service environments. Staff observe that children on the autism spectrum, children with serious head injuries and children with deteriorating neurological profiles present challenges to the fragmented service system as agencies struggle to arrange for seamless transitions from child and adolescent services to the adult service realm.

Children with Neurological Impairments: In FY 12, CRSA received 15 calls for assistance for children with neurological impairments, (4.4% of the FY 12 caseload). In this cohort we assisted 9 children with Traumatic Brain Injury (TBI) or Acquired Brain Injury (ABI), 2 children diagnosed with Tourette’s syndrome, 2 children diagnosed with Epilepsy and 2 children diagnoses with Cerebral Palsy.

Other Sub-Populations: Other sub-populations of children with specialized service needs that have been referred to CRSA for assistance during FY 12 include: 16 children with documented prenatal substance exposure (4.8%); 10 parents who contacted CRSA who were considering “psychiatric lock-outs” (2.9%); 1 of which was a voluntary relinquishment and 9 of whom were actively considering relinquishing custody to DCFS, but who would not have considered it had there been another systemic pathway to viable treatment; 4 children who were homeless (1.1%) at the point of referral, and 2 children with hearing impairments in combination with behavior disorders (less than 1%).

FISCAL YEAR 2012 ACTIVITIES

During FY 12, the CRSA Authority held six full board meetings that focused on promoting and implementing the concepts advanced in the CRSA Statewide Service Plan in addition providing technical assistance and carrying out dispute resolution responsibilities.

During FY 12, the Authority has discussed adjusting its historic approach to meeting its various statutory powers and duties. This includes anticipating both statewide and national changes in the public and private health care systems and making corresponding adjustments to CRSA's Mission, Vision, Service Principles, Service Plan and direct service strategies. There has been concerted pressure from both within CRSA's board and outside of CRSA's board to utilize the Authority's interagency platform to assertively address longstanding policy and planning problems related to children and adolescents while simultaneously maintaining its high levels of performance in providing effective technical assistance to referents and efficient administration of the Dispute Resolution process. These pressures to expand the reach of the Authority's work are however bracketed by the absence of additional fiscal and staff resources.

In FY 12 CRSA continues to maintain its reputation for assisting families through the maze of the Illinois service system on a case-by-case basis and for working to secure agreement between state agencies that are often in conflict. In FY 12 the CRSA (and all other Boards and Commissions) were audited by the Office of Auditor General. In its final report The Auditor General gave the Authority a clean bill of health.

During FY 12, the Authority has discussed, at depth, the following policy and planning problems related to children and adolescents. Steady erosion of both community-based and residential services across various state service systems. This includes increasing reliance upon in-patient psychiatric hospitals and a corresponding cost shift away from critical community level prevention and intervention service infrastructure needed to develop and implement a fuller continuum of badly needed community-based and out-of-home resources. This also includes the increasingly evident lack of state level commitment to effective multiple-agency service planning and service coordination among public agencies on behalf of CRSA populations and their families. Among the populations openly discussed by CRSA in FY 12 are children with obvious needs for out-of home services as adults, young adults with TBI and ABI, children and their families who are forced into Custody Relinquishment as the only clear remedy for getting appropriate mental health services met, would be adult-children with autism and other complex developmental disabilities, children who are dually-diagnosed, as well as, subsets of such individuals who default to the criminal justice systems. The Authority also discussed Illinois' inability to implement rational service system reforms proposed by many well intended consumer and stakeholder groups over the last 30 decades. Instead, critically needed planning data is increasing obtained by FOIA requests and system reforms continue to be driven by litigation rather than through deliberate planning and implementation.

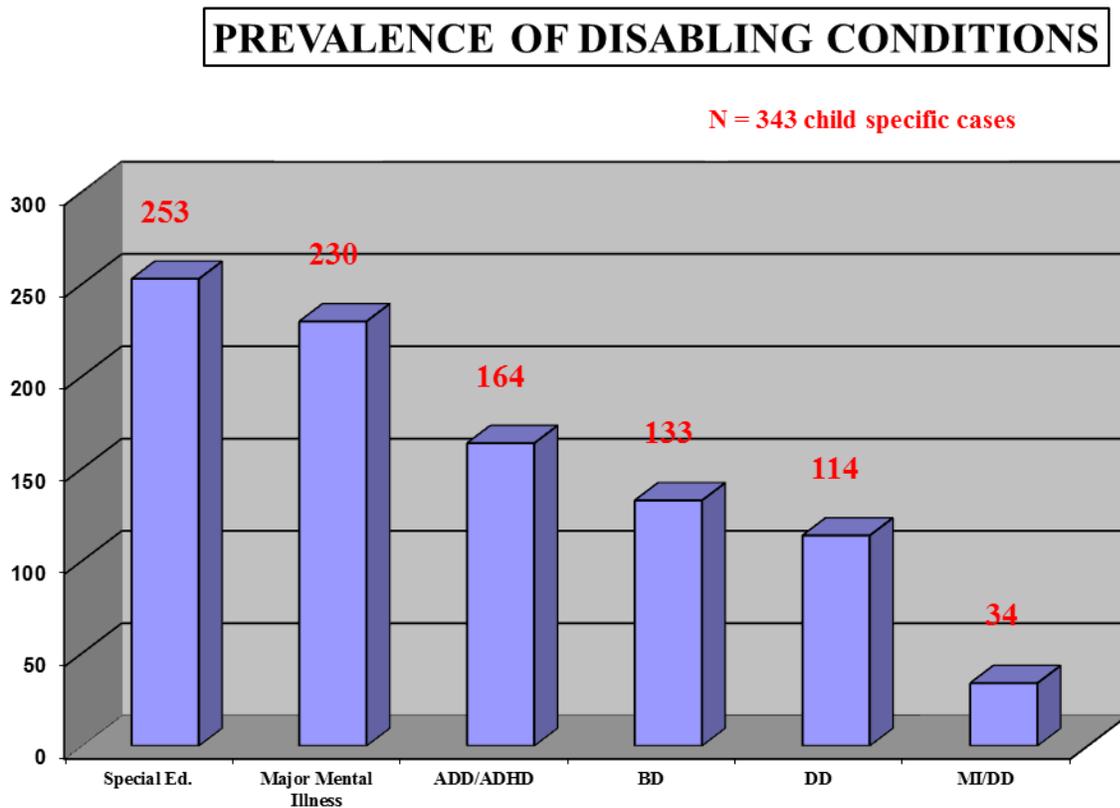
There has been a steady conversation on the CRSA over the last 3 years pertaining to the need for development and implementation of a statewide intergovernmental agreement which can ameliorate some of the above stated concerns. This conversation include discussions about the need for a Children's Human Services Sub-Cabinet, the need for common tools to measure need, provider performance and ultimately measure consumer outcome, as well as a commitment to adhere to established best practices.

CRSA staff participated in 425 activities with agencies, organizations and groups and child staffings: including direct participation in 330 multiple-agency staffings, including Wraparound staffings, school staffings and other Multiple-agency planning staffings. The CRSA staff also participated in 95 activities with agencies, organizations and groups and maintaining liaison relationships with statewide planning groups. Such groups included: Statewide LAN Leadership Team, Attorney General's Special Education Committee, Children's Mental Health Partnership: Residential Workgroup, Individual Care Grant Advisory Council, the DHS/DMH Statewide Children and Adolescent Advisory Council and Transition Workgroup, NAMI, Children's Behavioral Health Association and the Governor's Human Services Planning Commission, Rationalizing Services Workgroup.

CASE INFORMATION AND CLIENT STATISTICS

Prevalence of Disabling Conditions

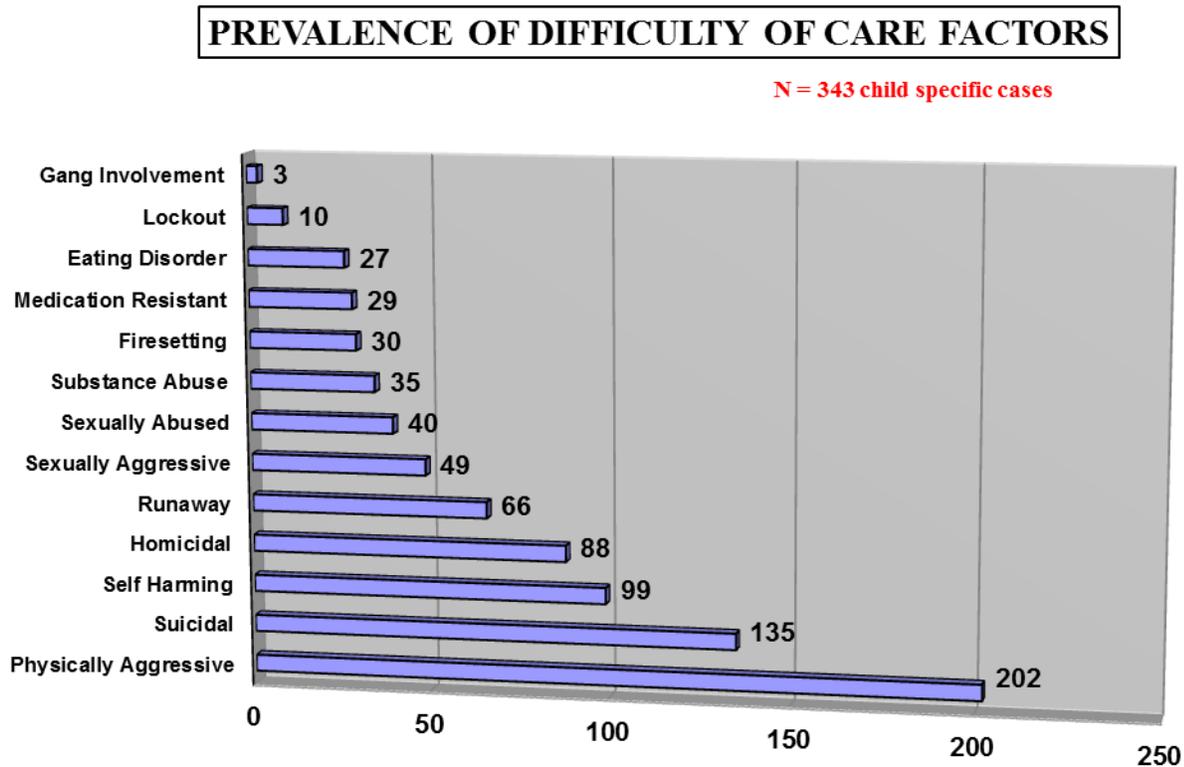
This graph shows the range and the prevalence of disabling conditions exhibited by the 343 children and adolescents for whom CRSA was contacted for assistance during FY 12. It is the norm for children and adolescents served by CRSA to exhibit two to five diagnosed disabilities and behavior problems at 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

Prevalence of Difficulty-of-Care Factors

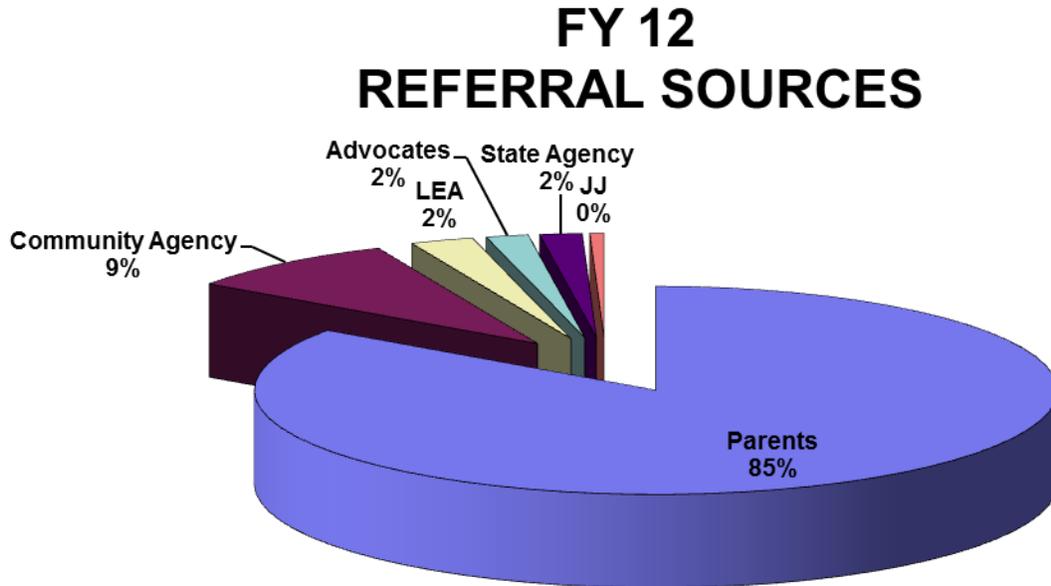
This graph shows the range and the prevalence of serious behavior problems which CRSA tracks as “difficulty-of-care factors” exhibited by the children and adolescents for whom CRSA was contacted for assistance during FY 12. These behaviors present programming challenges for both community-based and residential service providers, thereby limiting service availability and treatment options. 264 or 77% of the children and adolescents for whom CRSA was contacted for assistance in FY 12 exhibited one or more difficulty-of-care factors. All together 813 difficulty-of-care factors were recorded among the 264 referrals who exhibited such behaviors. This suggests that the average number of factors per referent is three.



FY 08 was the first year that CRSA published prevalence of difficulty-of-care data. The FY 12 data is very similar to FY 08, FY 09, FY 10 and FY 11 data in terms of the hierarchy of prevalent behaviors. Physical aggression and suicidal behavior remain the two most prevalent difficulty-of-care factors.

Referral Source

This chart shows the distribution of the 354 FY 12 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 of 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, lawyers

PARENTS:

Parent(s) or legal guardian

COMMUNITY AGENCIES:

Local community direct service provider agency

Number of Referrals

The Authority received and responded to 354 requests for assistance in FY 12. Of those, 343 were *client-specific referrals* and 11 referrals were *Information Only requests*.

The gender data we collected during FY 12 indicates that 236 (68.8%) of individuals referred for services were male and 107 (31.2%) were female. This 2 to 1 male-to-female ratio is very consistent with historical agency norms.

Demand for CRSA services has stabilized in recent fiscal years, hovering in the range of 350 to 400 referrals per year. CRSA staff continue to utilize the capacity within the LANs and other local systems of care to address multiple-agency cases and increase consumer access to general services/program information through the Internet. The Authority continues to note steady changes in CRSA referral trends: a widening population of children which are presenting as under-served or un-served and a significant increase in case complexity and severity.

Dispute Resolution Activity

During FY 12, five individual cases progressed far enough into the CRSA Dispute Resolution process to require Board intervention. During FY 12 five Technical Assistance Conferences pertaining to four CRSA cases were held and among those cases one dispute was successfully resolved at that level of board involvement. Among the remaining three cases heard at the technical assistance level, two cases remained unresolved, to be carried over into FY 13 and the one remaining case which was unresolved at that level, moved to the Authority Hearing level where it was successfully resolved. Also in FY 12, one case was heard at the Director Review and was successfully resolved. In that case, the service plan had moved through lower levels of the Dispute Resolution process during FY 11. CRSA Dispute Resolution cases are generally much more labor intensive and increasingly require a higher degree of multi-systems specialization for both CRSA staff and member agencies to resolve.

In one of the disputes that went before the Authority during this fiscal year, the young adult and the family were the subject of well publicized newspaper articles, drawing attention to the gaps in the system that the case represented. This case involved a young adult with a Traumatic Brain Injury which prevented the individual from working at any level as an adult and from living in an open community setting without compromising public safety. This case had been open for “Transition Planning” assistance for four years while this individual’s overall needs were met by his public school district.

CRSA CONSUMER SATISFACTION SURVEY

The consumer satisfaction survey is a questionnaire consisting of three simple questions scored on a one to five scale -- 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 your request for assistance?

Question 2.) Were your ideas treated with respect?

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

The “Forms Returned” chart below displays the total number FY 12 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 4.60, shown in the dark-shaded box.

FORMS RETURNED

	Surveys Mailed	Surveys Returned	Percent Returned
Parents Com.	296	59	20%
Agencies	16	4	25%
SA	5	1	20%
Advocates	2	1	50%
JJ	1	0	0%
	320	65	20%

QUESTIONS

Q. #1	Q. #2	Q. #3	Average
4.49	4.61	4.26	4.45
4.50	5.00	4.30	4.60
4.00	4.00	5.00	4.33
5.00	5.00	5.00	5.00
NA	NA	NA	NA
4.50	4.65	4.64	4.60

For FY 12, 20.3%, or 65 of the 320 surveys distributed, were returned.

Additional questions on the survey are optional and answered in narrative style. Of the surveys returned, 93.8% percent or 61 of the returned surveys had a narrative response and their responses were consistent with overall survey ratings. The majority of respondents commented 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 ten years. Scores have been constantly above 4.00 for the last 10 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 SURVEYS

	FY 03	FY 04	FY 05	FY 06	FY 07	FY 08	FY 09	FY 10	FY 11	FY 12	10 YEAR AVERAGE
Q. #1	4.6	4.36	4.66	4.87	4.82	4.93	4.59	4.88	4.61	4.50	4.68
Q. #2	4.71	4.62	4.72	4.85	4.80	4.91	4.75	4.90	4.70	4.65	4.76
Q. #3	4.37	3.75	4.2	4.54	4.49	4.80	4.33	4.60	4.30	4.64	4.40
Yearly Weighted Average	4.54	4.24	4.53	4.53	4.53	4.53	4.56	4.79	4.54	4.60	4.54

COMMUNITY AND RESIDENTIAL SERVICES AUTHORITY

FY 2012

APPROPRIATION/EXPENDITURE SUMMARY

FY 2012 APPROPRIATION	\$592,300.00
FY 2012 EXPENDITURE	\$486,443.69
LAPSED FUNDS	\$105,856.31

TYPE OF EXPENDITURE	ALLOTMENT	EXPENDITURE	BALANCE
PERSONNEL SERVICES			
CRSA Employee Salaries	\$403,000.00	\$399,804.00	\$3,196.00
Contractual Employee	\$20,000.00	\$0.00	\$20,000.00
Retirement Reserve	\$25,000.00	\$0.00	\$25,000.00
Benefits Package	\$34,000.00	\$31,311.95	\$2,688.05
Contractual Services	\$33,800.00	\$0.00	\$33,800.00
Staff Travel	\$25,000.00	\$12,869.29	\$12,130.71
CONTRACTUAL SERVICES			
Members Travel	\$5,000.00	\$5,277.60	(\$277.60)
Space Allocation	\$32,000.00	\$31,000.00	\$1,000.00
Administrative Services	\$6,000.00	\$5,500.00	\$500.00
Website Development	\$2,000.00	\$0.00	\$2,000.00
Meeting Expenses	\$500.00	\$108.14	\$391.86
Staff/Board Training	\$1,000.00	\$0.00	\$1,000.00
COMMODITIES			
Office Expenses	\$5,000.00	\$572.71	\$4,427.29