WHO PARTICIPATES IN ONE COMMUNITY ONE FAMILY: DEMOGRAPHICS AND DIAGNOSES AT ENROLLMENT

Lauren A Wright, B.S., Tianqian Wang, M.A., & Jeffrey A. Anderson, PhD.

Executive Summary: These data are taken from the *Enrollment and Demographic Information Form* (EDIF) at the time in which young people and their families entered the One Community One Family (OCOF) system of care. Using this form, One Community One Family collects data related to gender, ethnicity, diagnosis, age, and other relevant information that describes the families enrolled in OCOF.

- As of November 2013, of the 600 families who have entered OCOF since October 2008, approximately 163 have been enrolled into national evaluation.
- At the time of enrollment, the average age of young people who participated in OCOF was 12 years old.
- Similar to previous findings, males comprised almost two thirds of the young people served in OCOF. Females comprised just under 40% of those served in OCOF.
- As in previous years, almost all of young people who come into OCOF are Caucasian.
- At the time of enrollment into OCOF, 23.8% of the youth had experienced maltreatment (i.e. child abuse or neglect).
- At the time of enrollment into OCOF, approximately a fifth (20.3%) of the youth had mothers who were dependent on substances, abusing substances, or had a history of substance dependence or abuse, and 15.2% had fathers who were dependent on substances, abusing substances, or had a history of substance dependence or abuse.
- At the time of enrollment into OCOF, 16.3% of the youth had mothers who were depressed or had a history of depression.
- At the time of enrollment into OCOF, almost a fourth (23.8%) of the youths had mothers who had other mental health issues, and 14.7% had fathers who had experienced other mental health issues.

Table 1. Characteristics of Young People Participating in One Community One Family

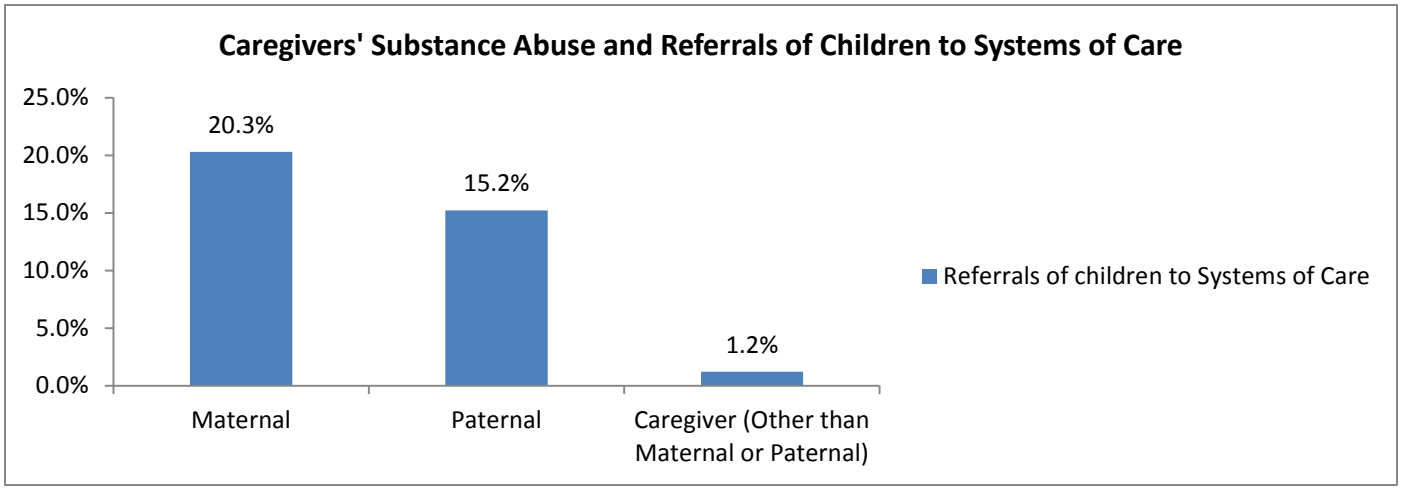
	Number of Youth	Percentage of Respondents
Gender		
Male	364	60.7%
Female	236	39.3%
Race		
White	589	98.2%
Age		
0 to 5	95	15.8%
6 to 10	156	26.0%
11 to 17	261	43.5%
18 and up	88	14.7%
Mean Age	12.08	
Major Overarching Categories for Primary Diagnosis		
Conduct Disorders	165	27.5%
Mood Disorders	123	20.5%
ADHD	110	18.3%
Anxiety Disorders	86	14.3%
Reactive Attachment Disorders	45	7.5%
Psychotic Disorders	15	2.5%
Other	43	7.2%
Not Applicable	13	2.2%
Risk Factors		
Maltreatment (child abuse and neglect)	143	23.8%
Maternal Depression	98	16.3%
Maternal Mental Health	143	23.8%
Paternal Mental Health	88	14.7%
Caregiver Mental Health	31	5.2%
Maternal Substance Use/Abuse	122	20.3%
Paternal Substance Use/Abuse	91	15.2%
Family Health Problems	69	11.5%
Other Parent/Caregiver/Family Problems	109	18.2%
Problems Related to Housing (including homelessness)	50	8.3%

CAREGIVER PROFILE IN ONE COMMUNITY ONE FAMILY

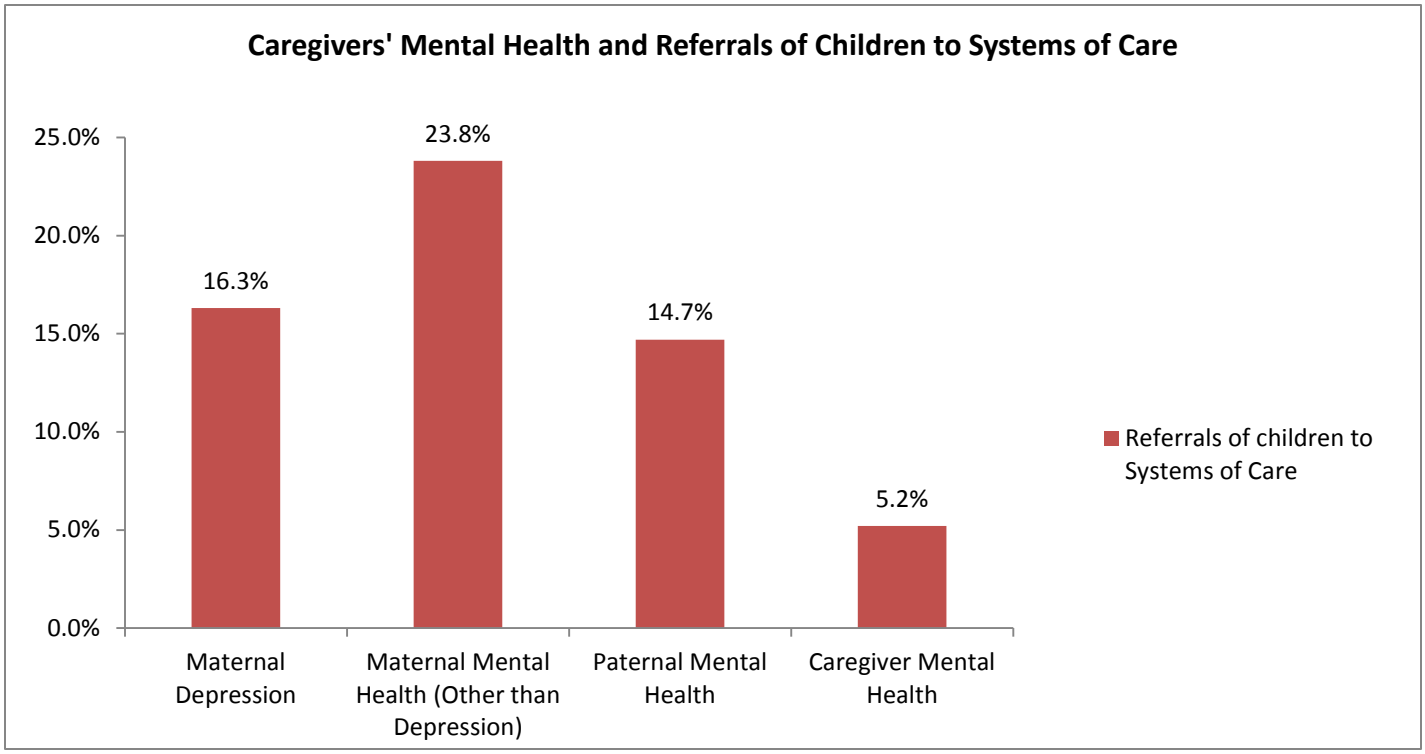
Allison A. Howland, PhD., Jeffrey A. Anderson, PhD.,
& Mina Min, M.S.

Overview: This report summarizes some of the unique challenges faced by OCOF caregivers, including biological parents (45.2%), grandparents (13.5%), foster parents (5.8%), aunts and uncles (4.5%), adoptive/step-parents (3.3%), and others (27.7%).

Substance abuse. At their child's enrollment into OCOF (600 total caregivers), 122 mothers, 91 fathers, and fewer than 10 caregivers other than mothers and fathers reported substance abuse problems.

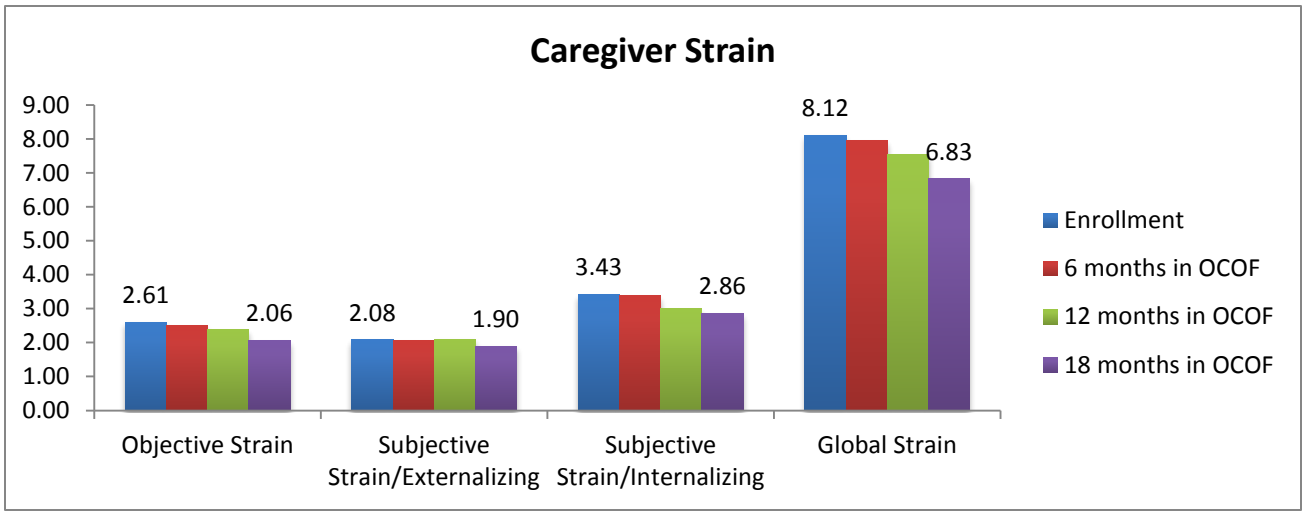


Mental health issues: At their child's enrollment into OCOF (600 total caregivers), 98 mothers reported depression, 133 mothers reported mental issues other than depression, 88 fathers reported mental health issues, and 31 caregivers (other than the mother or father) reported mental health issues.



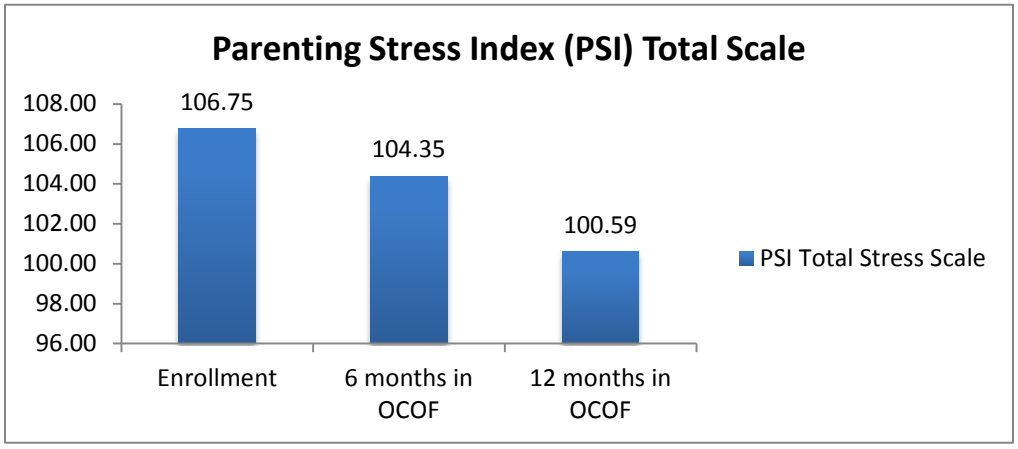
Caregiver Strain (CGSQ). Caregiver Strain refers to the special demands involved with caring for a child/youth with emotional and behavioral problems. The average scores reported at enrollment into OCOF, 6 months, 12 months and 18 months show that caregiver strain (objective strain, subjective strain/externalizing, subjective strain/internalizing and global strain) has decreased from enrollment in OCOF to 18 months after enrollment.

- Objective Strain: Observable disruptions in family and community life (e.g. interruption of personal time, lost work time, financial strain)
- Subjective Externalizing Strain: The negative and "externalized" feelings about the child such as anger, resentment, or embarrassment
- Subjective Internalizing Strain: The negative "internalized" feelings such as worry, guilt, and fatigue
- Global Strain: Sum of the mean scores of the above three subscales (total impact on the family)



Note that the sample sizes became much smaller as time went on. At enrollment, 119 caregivers responded. At 6 months post enrollment, 59 caregivers responded. At 12 months post enrollment, 36 youths responded. At 18 months post enrollment, 31 youths responded. At 24 months post enrollment, 16 youths responded.

Parenting Stress Index (PSI). The PSI is a tool designed to provide a measure of overall stress in the parent-child system. The average scores of caregivers at enrollment, 6 months, and 12 months post-enrollment indicate a decrease in parenting stress over time for caregivers participating in OCOF.



Note that the sample sizes were much smaller as time went on. At enrollment, 69 caregivers responded. At 6 months post enrollment, 31 caregivers responded. At 12 months post enrollment, 17 youths responded. At 18 and 24 months post enrollment, the number of respondents was fewer than 10.

DOES YOUTH FUNCTIONING IMPROVE OVER TIME IN ONE COMMUNITY ONE FAMILY: BEHAVIOR AND STRENGTH SCORES OVER TIME

Lauren A Wright, B.S. & Jeffrey Anderson, PhD

Indiana University

Overview: One Community One Family collects data directly from youths and caregivers about the youths' behavior, strengths, and functioning. This brief details how youths and their caregivers rate improvement in their behavior, strengths, and functioning over time. They were questioned at enrollment, 6 months after enrollment, 12 months after enrollment, 18 months after enrollment, and 24 months after enrollment.

- There were no relationships between youths' ratings of their own strengths and caregivers' ratings of their youths' strengths.
- However, young people rated their own strengths higher than their caregivers rated them.
- At enrollment, boys, who had an average score of 100.09, rated their strengths higher than girls, who had an average score of 87.20.
- As expected, high problem scores were associated with low strength scores, and low problem scores were associated with high strength scores.

Limitations: As with all of the briefs, we encourage readers to be cautious about how they interpret and use the findings of this work. Sample sizes were small to begin with and decreased over time, sometimes dramatically (sample sizes containing fewer than 10 are not reported).

Conclusions: Reviewing these data across several years now, we see similar findings. First, youth saw themselves as having more strengths than their caregivers. Second, boys rate themselves as having more strengths than girls. Finally, the trends of improvements in both internalizing and externalizing behaviors, while not statistically significant, appear to be in the right direction. Internalized symptoms are turned inward; they include feeling sad, feeling anxious, and withdrawing socially. Externalized symptoms are turned outward; they include dysfunctional behavior at school and at home. In other words, young people are not getting worse and may be improving during their time in the One Community One Family system of care.

Parent Ratings of Youth Strengths

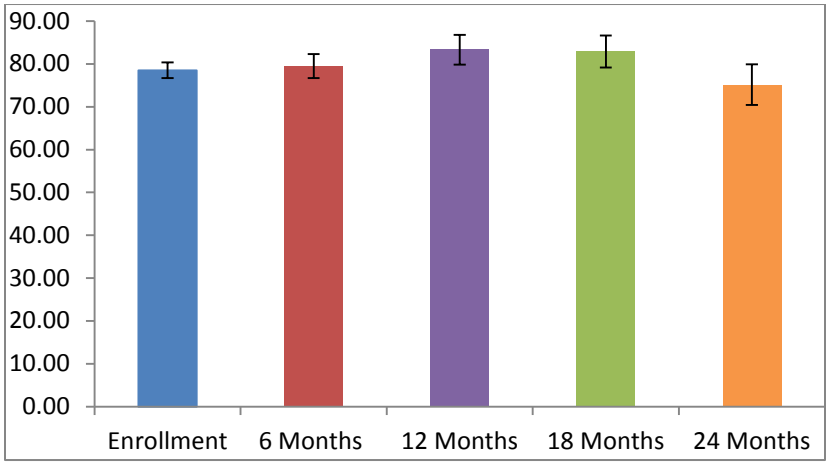


Figure 1. Parents rated their youths' strengths similarly at all five time points.

- At enrollment, 91 caregivers responded, and the average score was 78.53.
- At 6 months post enrollment, 47 caregivers responded, and the average score was 79.51.
- At 12 months post enrollment, 38 caregivers responded, and the average score was 83.33.
- At 18 months post enrollment, 28 caregivers responded, and the average score was 82.89.
- At 24 months post enrollment, 13 caregivers responded, and the average score was 75.15.

Parent Ratings of Youth Internalizing and Externalizing Problems

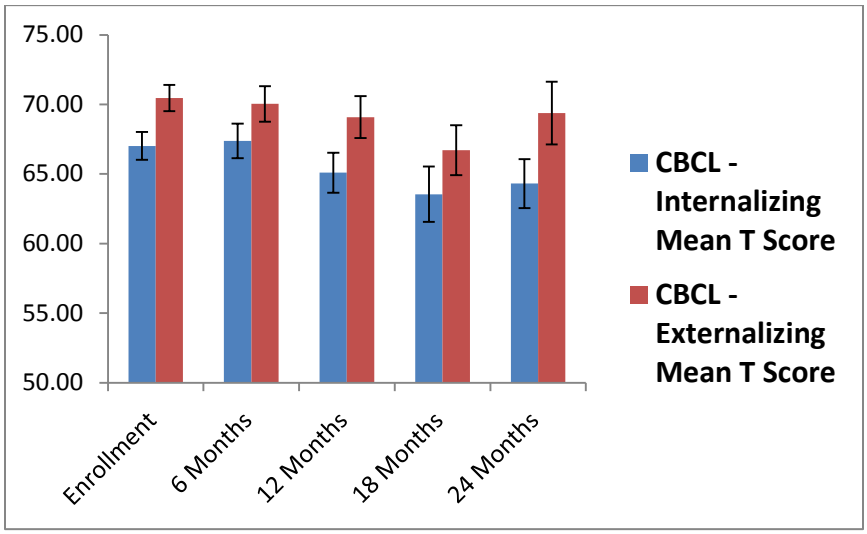


Figure 2. Parents rated their youths' internalizing symptoms and externalizing symptoms similarly across all five time points. Externalized behavior scores were rated higher and thus more problematic than internalized symptoms.

- At enrollment, 90 caregivers responded, and the average score was 67.02 for internalized symptoms and 70.46 for externalized symptoms.
- At 6 months post enrollment, 46 caregivers responded, and the average score was 67.37 for internalized symptoms and 70.04 for externalized symptoms.
- At 12 months post enrollment, 34 caregivers responded, and the average score was 65.09 for internalized symptoms and 69.09 for externalized symptoms.
- At 18 months post enrollment, 28 caregivers responded, and the average score was 63.54 for internalized symptoms and 66.71 for externalized symptoms.
- At 24 months post enrollment, 16 caregivers responded, and the average score was 64.31 for internalized symptoms and 69.38 for externalized symptoms.

SYMPTOMOLOGY BY GENDER

Tianqian Wang, MA. & Jeffrey Anderson, PhD

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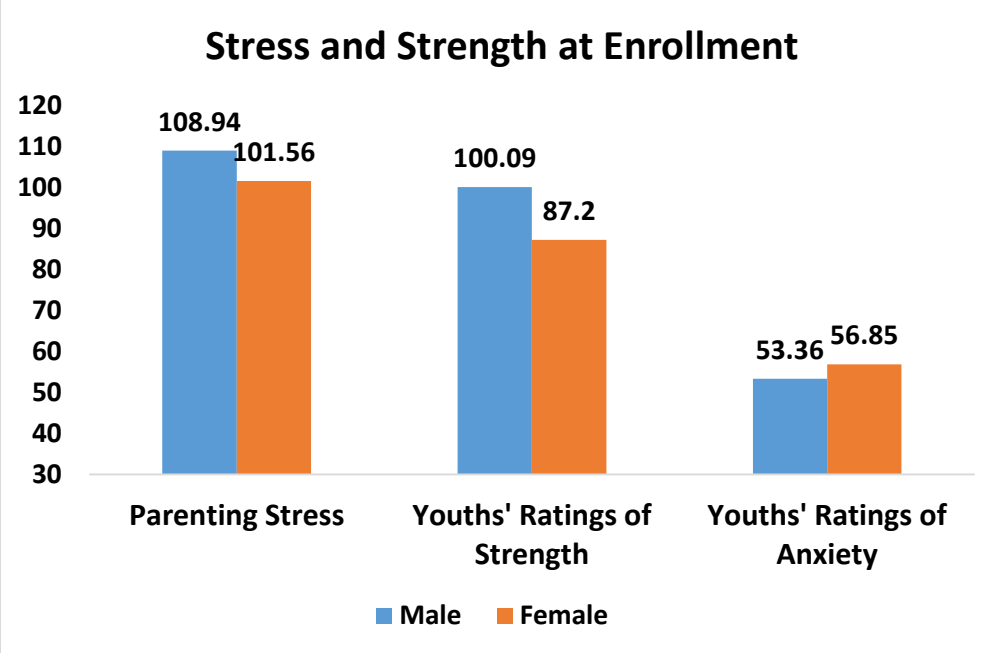
Overview

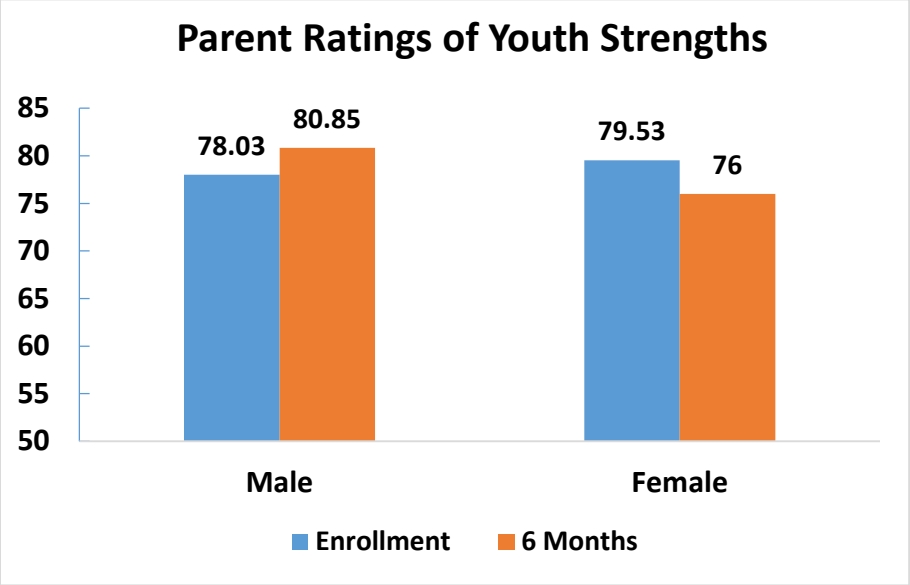
One Community One Family (OCOF) provides intervention services to children, youth, and their families once they enter OCOF. This brief describes how gender may influence youths' behavior, strengths, and functioning both when they enroll in OCOF and after receiving services for six months. The results need to be interpreted with caution because of the small sample sizes.

Executive Summary

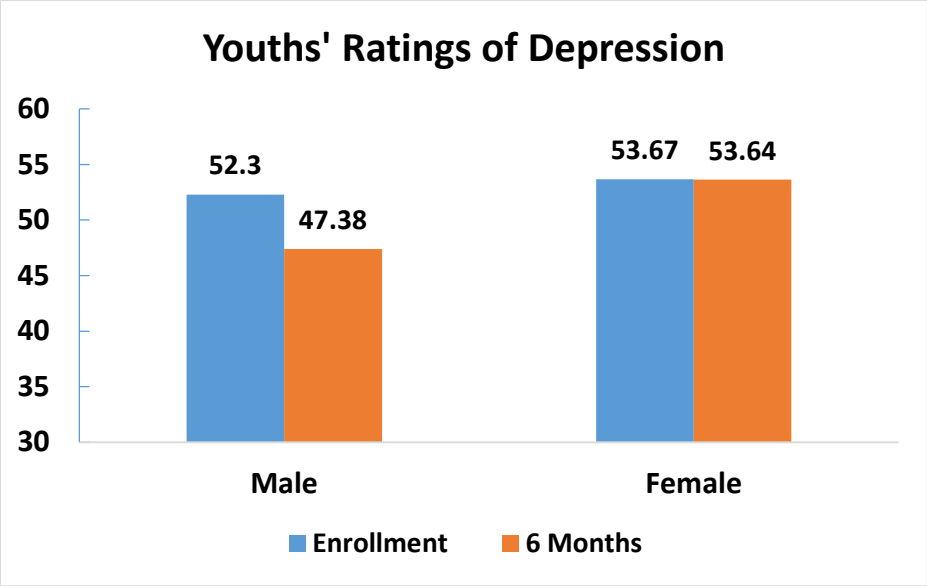
At enrollment, the stress experienced by parents of female children appeared to be lower than for parents with male children. On the other hand, female youth rated themselves with lower emotional and behavioral strengths as compared to their male counterparts. Female youth also reported higher levels of anxiety than male youth at enrollment.



Between enrollment and six months in OCOF, caregivers appeared to rate male children and youth as showing more improvement in strengths as compared to their female counterparts.



Male children and youth also demonstrated more reductions in depression after receiving services for six months. On the other hand, female children and youth did not show improvement over time in depressive symptoms. It is not clear why these distinctions between males and females exist and further examinations are being conducted.



Early Intervention Services in One Community One Family

Sarah Hurwitz, PhD, Tianqian Wang, M.A., & Jeff Anderson, PhD

Indiana University

Introduction

One Community One Family (OCOF) provides intervention services to children and adolescents across a wide age range. This brief describes outcomes for the youngest children who participate in OCOF and their caregivers. The families included in this brief were enrolled in OCOF when their children were babies through the age of eight.

Approximately 193 children between 0 and 8 years old enrolled in the OCOF program from 2008 to 2013. Of these, 46 families participated in the Federal Longitudinal Outcomes Study and were interviewed when their children entered OCOF and then again after they had received services for six months. Data for this brief were gathered from the Caregiver Strain Questionnaire, the Parenting Stress Index and the Child Behavior Checklist.

Table 1. Children ages 0-8 years who participated in OCOF.

	Enrolled in OCOF Services	Participated in Longitudinal Study
Boys	125	35
Girls	68	11
Total	193	46

Findings

From enrollment to six months, participating families reported improvements in parental stress and strain levels on two separate measures. In addition, they reported a reduction in the number of problem behaviors that their children exhibited between enrollment and six months in OCOF (see figure on back page).

These young children appeared to do well; in fact, their outcomes were better than for older children in the OCOF. Specifically, caregivers of children who were older than 8 years when they entered the study did not report improvements in stress or strain, nor did they see any change in the number of problem behaviors exhibited by their children.

This graph shows how parents' strain and stress were reduced from when they entered OCOF to having received services for six months.

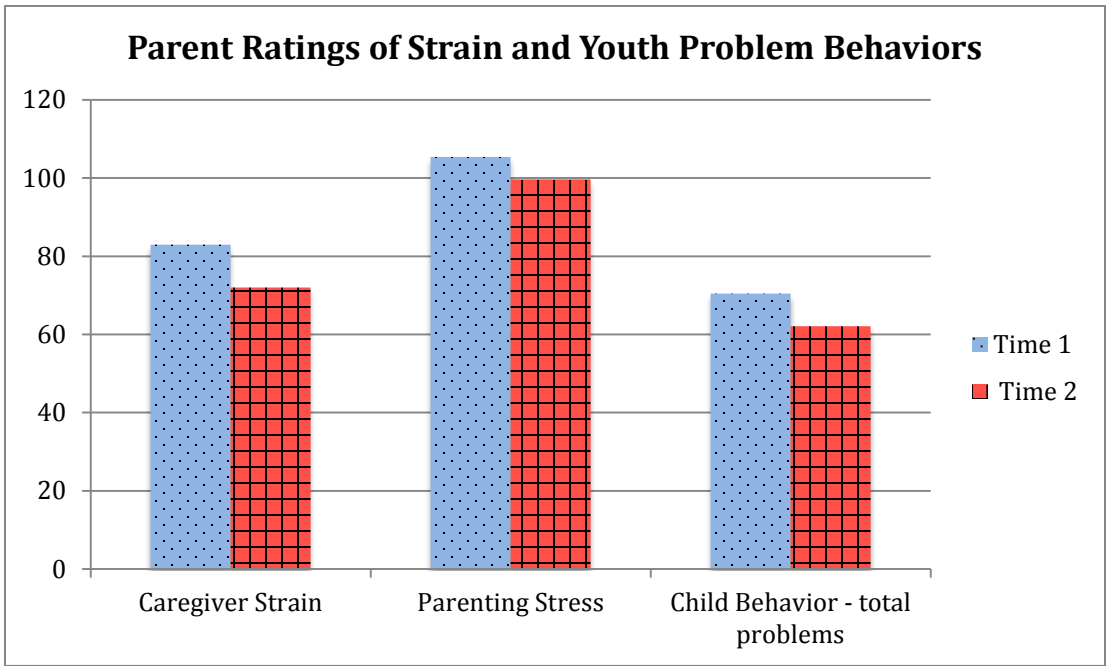


Figure 1: Reduction in parental stress, strain, and number of problem behaviors exhibited by children from enrollment (Time 1) to six months of receiving OCOF services (Time 2).

*Note: CBCL data for children ages 1-5 only

- Families of young children (age 0-8) reported improvements in the stress levels that caregivers experienced over time.
- Families also saw a reduction in the number of problem behaviors that their children exhibited after just six months of receiving OCOF services.
- Early system of care intervention appears to have a stronger impact on young children than comparable services provided to older children.

Conclusion

Researchers have suggested that, as compared to younger children, older youth have received more services prior to enrolling in OCOF and may have had more negative experiences with child serving systems. On the other hand, one of the core features of OCOF is to engage families using strengths-based approaches. Early intervention in OCOF appears to help reduce problematic behaviors in children as well as support caregivers, which in turn reduces their levels of stress.

SYMPTOMOLOGY AND PARENT STRAIN BY DIAGNOSTIC CATEGORIES

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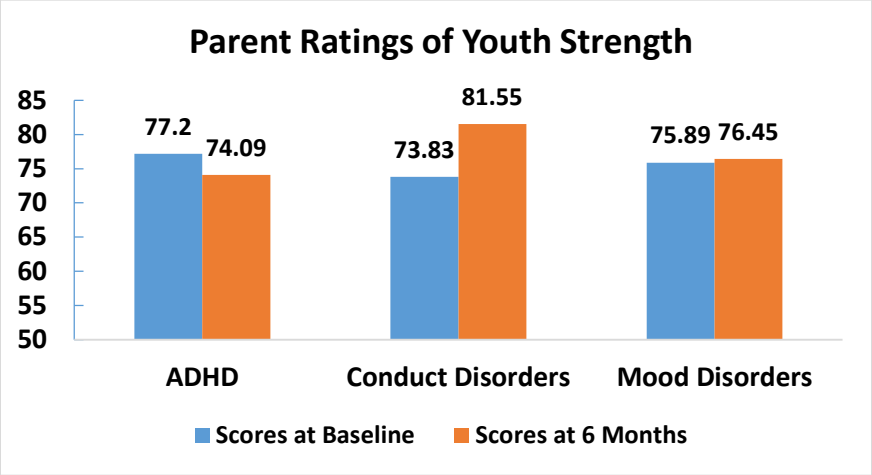
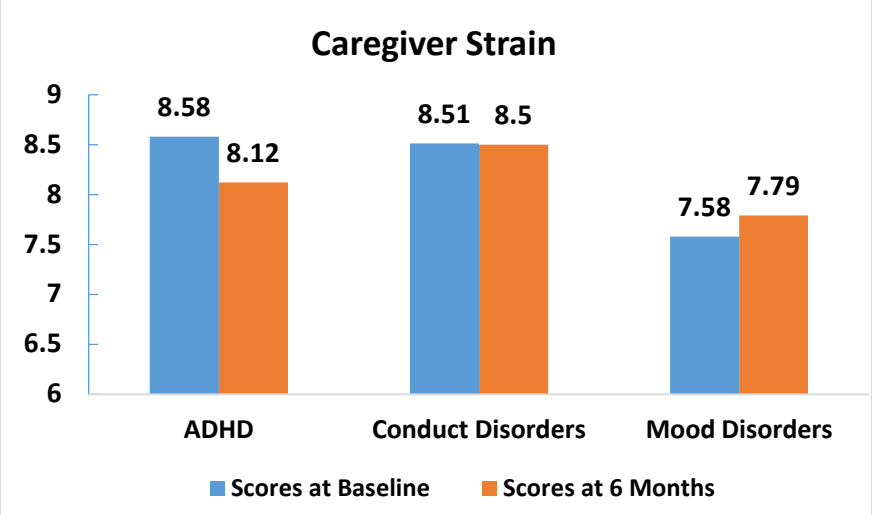
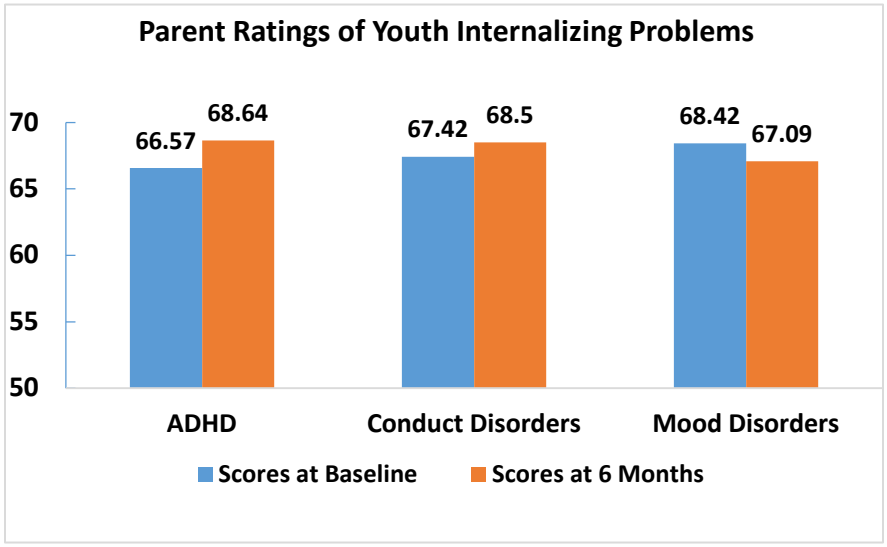
Overview: When children and youth enroll in One Community One Family, their primary mental health diagnosis is recorded. This brief assesses how different general diagnostic categories might differentially impact changes in stress and symptoms between enrollment and six months. Only three diagnostic categories with sample sizes more than 10 at both time points were analyzed: ADHD, conduct disorders, and mood disorders. Still, results need to be interpreted with caution because of small sample sizes.

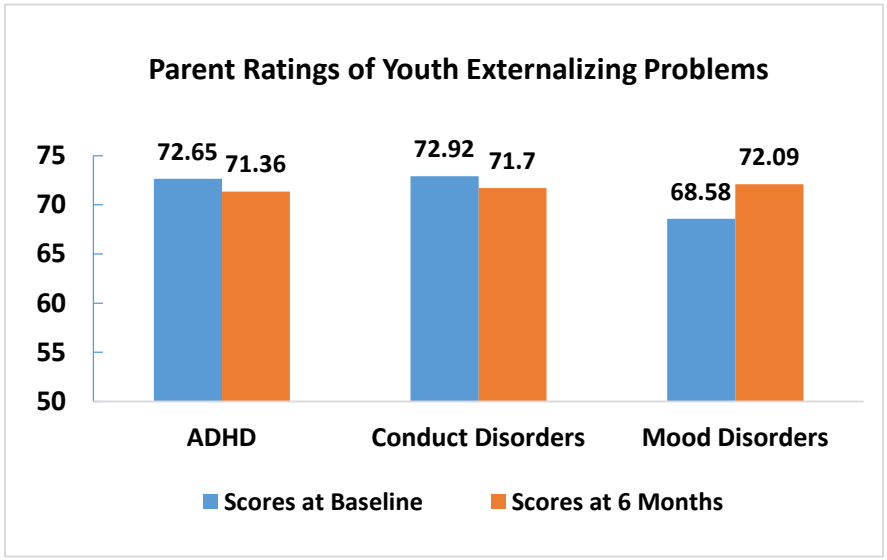


Findings: Caregivers of children with conduct disorders who participated in OCOF for six months were the only group of the three diagnostic groups to report improvements in strengths.



Findings: The level of strain associated with caring for a child/youth with ADHD, as reported by caregivers, decreased after six months in OCOF. Reported levels of strain by caregivers of children/youth with conduct disorder and mood disorders did not decrease.





Findings:

Children in each of the three diagnostic categories did not show much change from enrollment to six months, but slight changes included:

(1) Children with mood disorders showed a slight decrease in the number of internalized symptoms (e.g., anxious, withdrawn, depressed) after six months of receiving services.

(2) Children with ADHD and conduct disorders showed a slight decrease in externalized symptoms (e.g., rule-breaking behavior, aggressive behavior) after receiving services for six months.

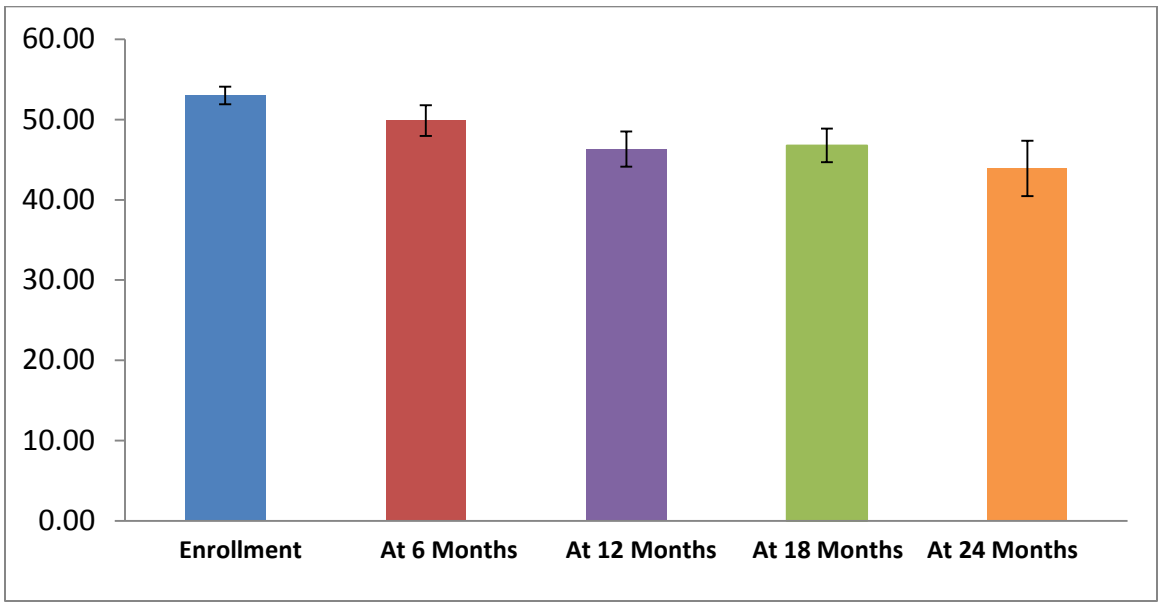
DOES MENTAL HEALTH IMPROVE OVER TIME IN ONE COMMUNITY ONE FAMILY: DEPRESSION AND ANXIETY

Lauren A. Wright, B.S., & Jeffrey A. Anderson, PhD

Indiana University

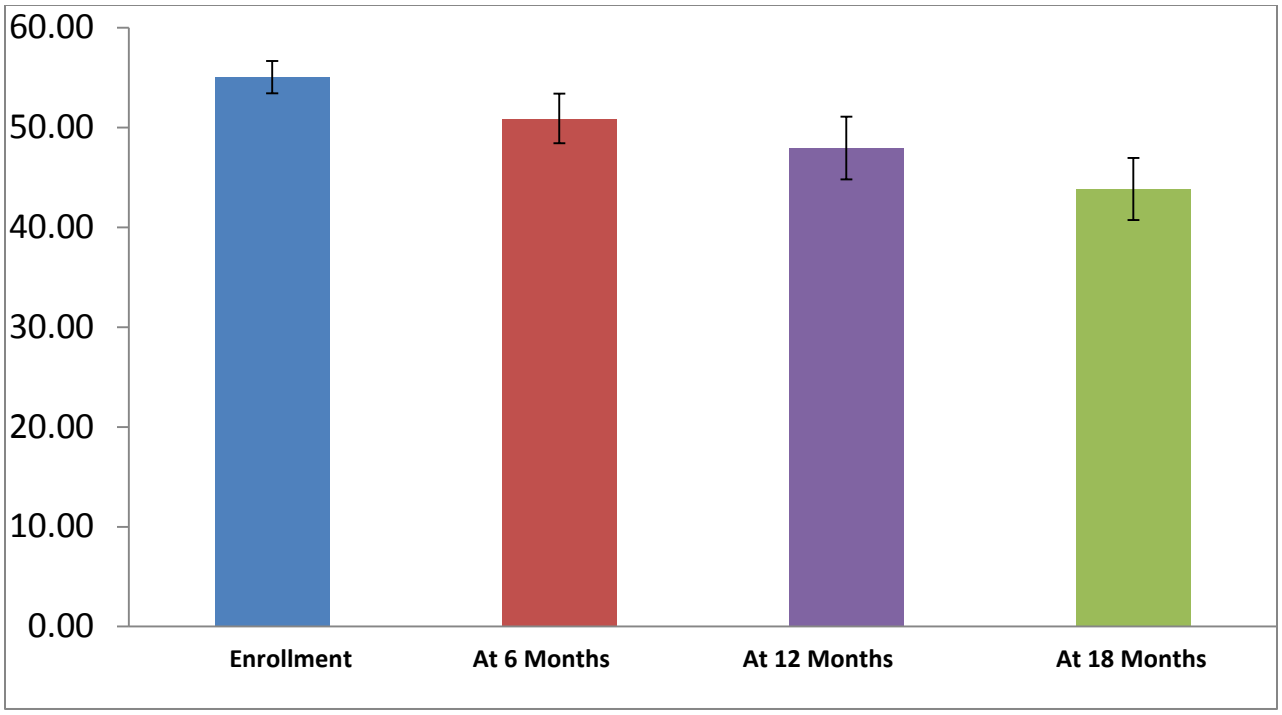
Overview: One Community One Family collects data directly from youth, 11 years of age and older, about the presence and severity of their depressive and anxious symptoms. This brief details how youth rate their symptoms over time. They were questioned at enrollment, 6 months after enrollment, 12 months after enrollment, 18 months after enrollment, and 24 months after enrollment.

Graph 1. Reynolds Adolescent Depression Scale (RADS) from Enrollment to 24 Months



Graph 1. While youth in this sample were not found to be clinically depressed at enrollment and therefore could not improve and drop below the cut-off score for clinical depression, there was a decrease in youths' average scores from enrollment to 6 months. Youths' mean depression scores also decreased from enrollment (average= 53.00) to 24 months post enrollment (average = 43.91). At enrollment, there were 78 respondents. At 6 months, 12 months, 18 months, and 24 months, there were 33, 25, 22, and 11 respondents respectively.

Graph 2. Revised Children's Manifest Anxiety Scale Scores from Enrollment to 18 Months*



*At 24 months, the number of youth is fewer than 10.

Graph 2. While youth in this sample were not found to be clinically anxious and therefore could not improve and drop below the cut-off score for clinical anxiety, there was a decrease in the youths' average anxiety scores from enrollment to 6 months. The youths' mean anxiety scores also decreased from enrollment (average = 55.04) to 18 months post enrollment (average = 43.85). At enrollment, there were 54 respondents. At 6 months, 12 months, 18 months, there were 22, 19, and 13 respondents respectively.

As with the other briefs: due to drastically different sample sizes at different time points, all changes apparent from the graphs and the data presented should be interpreted with caution.

SUBSTANCE USE BRIEF

Sarah Hurwitz, PhD, Tianqian Wang, M.A., & Jeff Anderson, PhD

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Introduction

One Community One Family (OCOF) collects data directly from young people, 11 years old and older, who are enrolled in service provision. One of the topics of interest to the Southeastern Indiana community is the exposure to tobacco, alcohol, and drugs reported by young people in OCOF. This brief details how youth report their use of these substances and then examines how the data varies by their primary diagnoses.

Findings

In the most recent dataset, approximately 104 youths reported on their substance use. Participants were asked if they had ever tried cigarettes, other forms or tobacco (like chewing tobacco and snuff), alcohol, marijuana, and cocaine as well as a variety of other drugs. The table below presents the most frequently used substances (cigarettes, alcohol, marijuana, other tobacco, and cocaine). Very few respondents reported using any of the other drugs.

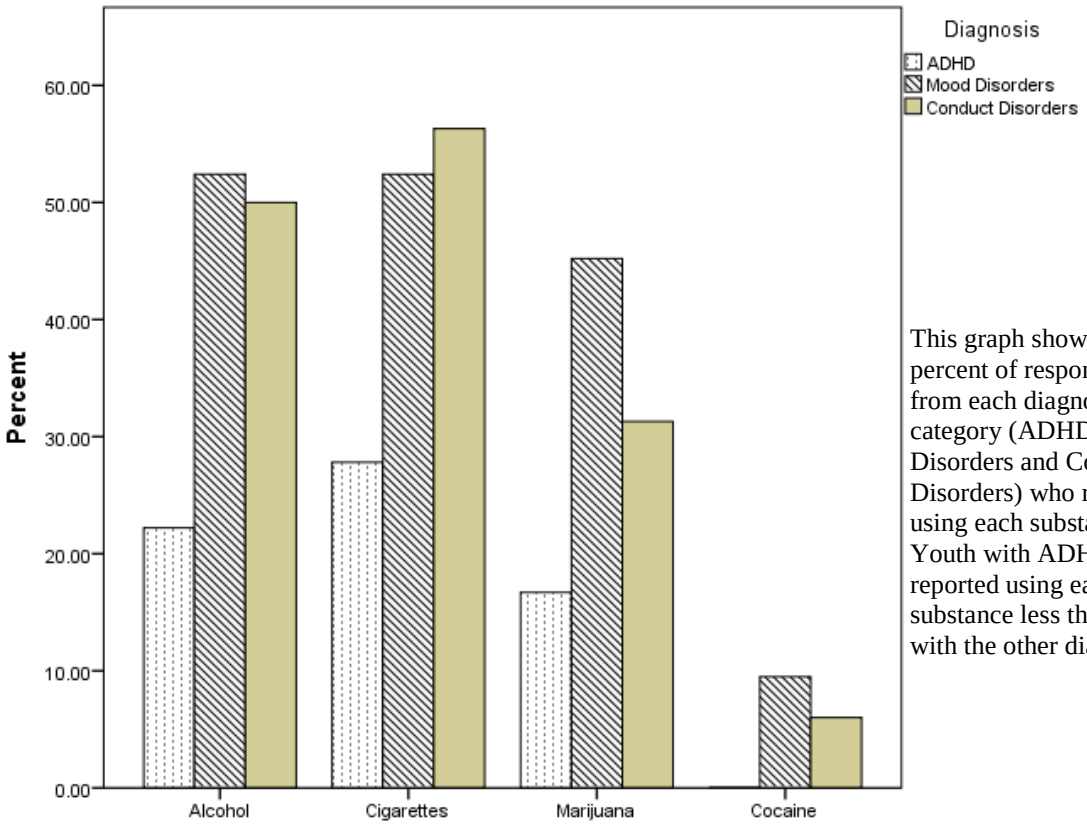
Substance	Number reported using	Average age of first use
Cigarettes	44	12.0 years
Alcohol	42	13.9 years
Marijuana	33	13.8 years
Tobacco	29	13.8 years
Cocaine	Fewer than 10	15.4 years

Substance Use and Diagnostic Categories

When youths enroll in OCOF, a primary diagnosis is recorded. We were interested to see how their diagnosis might impact whether they used substances. The most common diagnostic categories were Mood Disorders, Conduct Disorders, and ADHD.

We found that many youths with diagnoses of Mood or Conduct Disorders reported they had tried alcohol and cigarettes, and some had tried marijuana and other forms of tobacco. The youths with Mood and Conduct Disorders had tried these substances at significantly higher frequencies than youths with ADHD.

Youths from all diagnostic categories reported trying cigarettes at the highest frequency of all substances. Alcohol, marijuana, and tobacco were also commonly reported (see the graph below). Respondents from all diagnostic categories reported very infrequent use of cocaine, hallucinogenic drugs, and other types of drugs.



This graph shows the percent of respondents from each diagnostic category (ADHD, Mood Disorders and Conduct Disorders) who reported using each substance. Youth with ADHD reported using each substance less than youth with the other diagnoses.

Figure 1. Substances that youth reported using by diagnostic category.

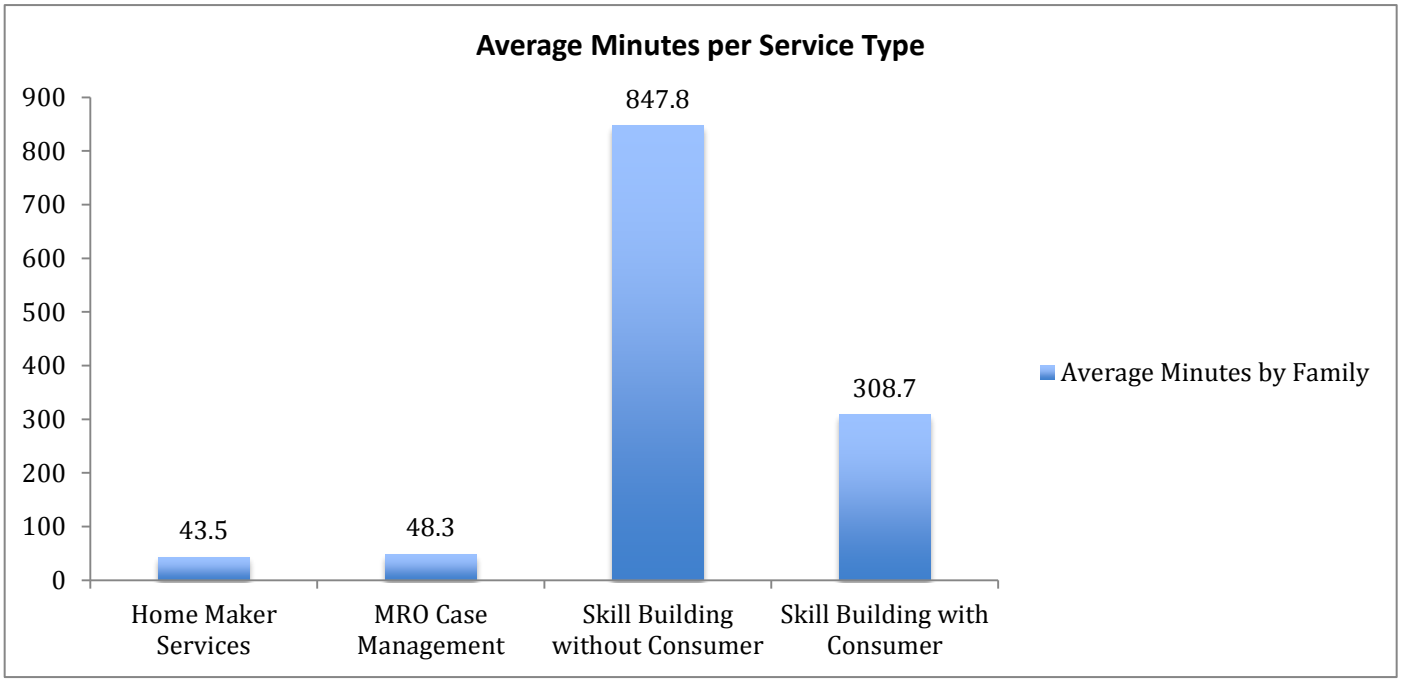
EVALUATION OF UNITED FAMILIES PROGRAM SERVICES

Allison A. Howland, Ph.D., Jeffrey A. Anderson, Ph.D.,
& Mina Min, M.S.

Overview: United Families (UF) is a peer to peer support program for caregivers of youth with mental health challenges and their families sponsored by One Community One Family (OCOF). Since 2006, UF has been dedicated to empowering families to address the challenges of parenting/care giving through education, support, and advocacy. This report summarizes UF program review data, including types and amounts of services provided by UF staff and findings from a caregiver survey conducted in 2010 and again in 2012.

Billable Hours. UF Family Support Specialists have provided about 1,040 billable hours of one-to-one community based peer supports (Graph 1) for over 50 families enrolled in OCOF. These supports include *Home Maker Services*, defined as activities that help to maintain a safe, healthy environment for individuals residing in their homes; *Case Management*, which describes referral and other activities that assist families in accessing outside services and resources; *Skill Building without Consumer*, refers to modeling and other supports to develop advocacy and self-determination skills with caregivers; and *Skill Building with Consumer* includes the youth enrolled in OCOF, along with caregivers in these same activities. Graph 1 below illustrates the average time (in minutes) per family contact devoted to each different service type.

Graph 1. Average Minutes per Service Type by Family



***United Families Caregiver Survey*.** A test of proportions indicated statistically significant differences between the satsifaction of cargivers in 2010 (53 respondents) compared to 2012 (84 respondents) with the UF program and their child's school. These results suggest that the increased focus of UF to provide skill building in order to increase caregiver involvement with schools resulted in greater caregiver satisfaction with the UF program and their child's school in 2012 compared to 2010.

Table 1. Results of Two-sample Test of Proportions for United Families by 2010 and 2012

Survey indicators	Agree & Agree a lot		
	2010	2012	Change in Percentage from 2010-2012
	Respondents	Respondents	
The topics covered at Family Gatherings are important to me and my family	40%	98%	58%
United Families staff do a good job supporting parents and caregivers.	47%	98%	51%
United Families has helped me to better understand and/or cope with my child's challenges.	43%	97%	54%
I believe it is important for me to communicate regularly with this child's teacher(s)	55%	98%	43%
I believe my involvement makes a positive difference in this child's school behavior	40%	96%	56%
I feel successful about my efforts to help this child succeed in school	31%	90%	59%
I have enough information and/or support from the school about what this child is learning to feel confident in helping this child with homework	22%	80%	58%
Teachers of this child are interested and cooperative when they discuss this child	25%	86%	61%
I feel welcome at this child's school	34%	88%	54%
Parent activities/events are scheduled at this child's school so that I can attend	20%	92%	72%
This child's school lets me know about meetings and special school events	17%	94%	77%
This school contacts me promptly about any problems involving this child	20%	91%	71%
This child's teacher(s) regularly informs me about what this child does well or if he/she is improving	17%	80%	63%
This child's teacher(s) asked for my suggestions at a school conference or meeting about this child	22%	71%	49%
My suggestions/input regarding my child's school performance are well-received by this child's teacher(s)	20%	93%	73%
The principal/vice-principal of this child's school is responsive to the needs of students and families.	24%	81%	57%

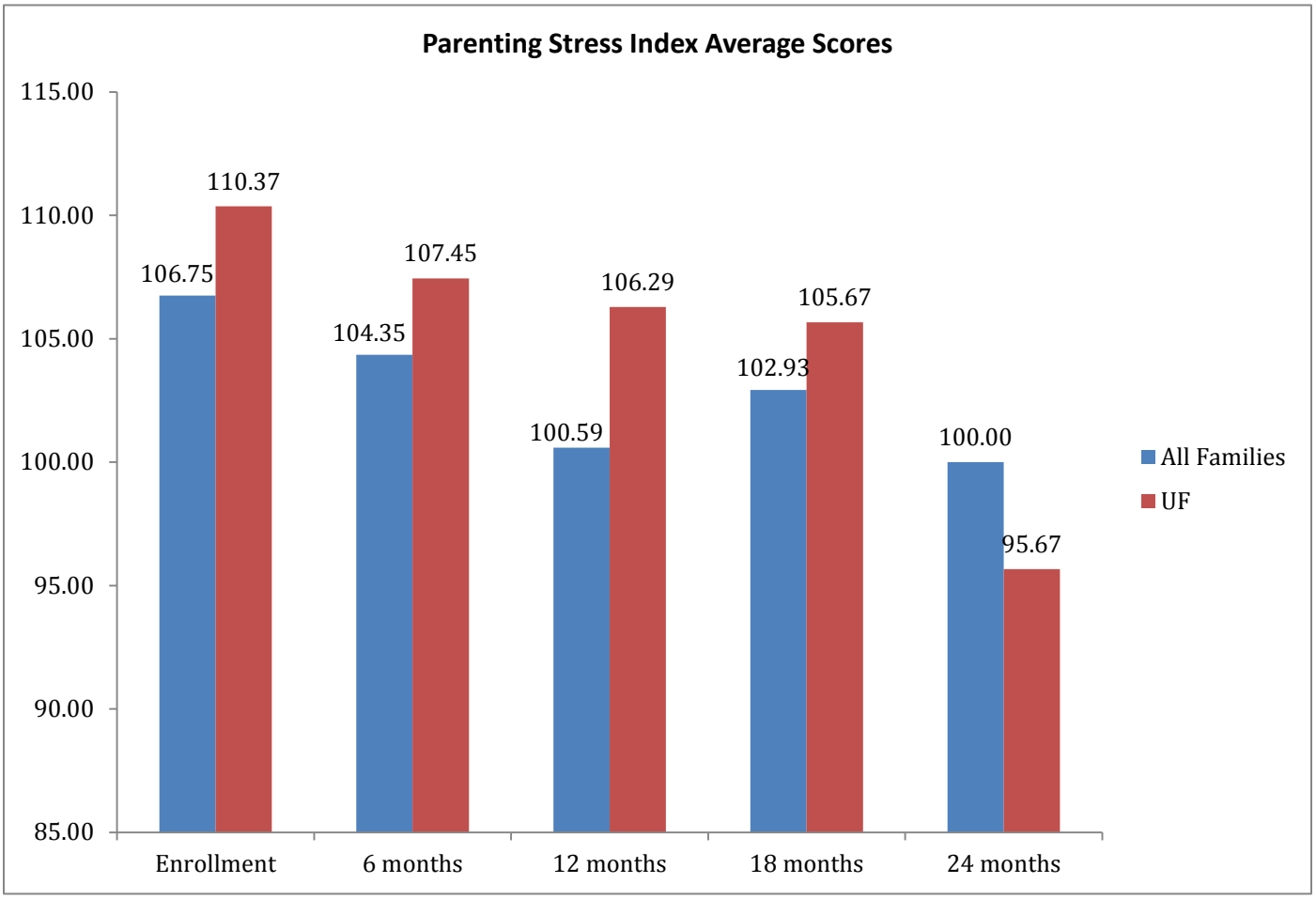
A COMPARISON OF FAMILIES PARTICIPATING IN THE UNITED FAMILES PROGRAM SERVICES

Allison A. Howland, Ph.D., Jeffrey A. Anderson, Ph.D.,
& Mina Min, M.S.

Overview: Since 2006, United Families (UF) has been dedicated to empowering families to address the challenges of parenting/care for youth who have mental health challenges through education, support, and advocacy. This brief provides a comparison of caregivers participating in UF and all other families in OCOF on measures of *Parenting Stress Index (PSI)* and *Caregiver Strain Questionnaire (CGSQ)* over time (2009-2013).

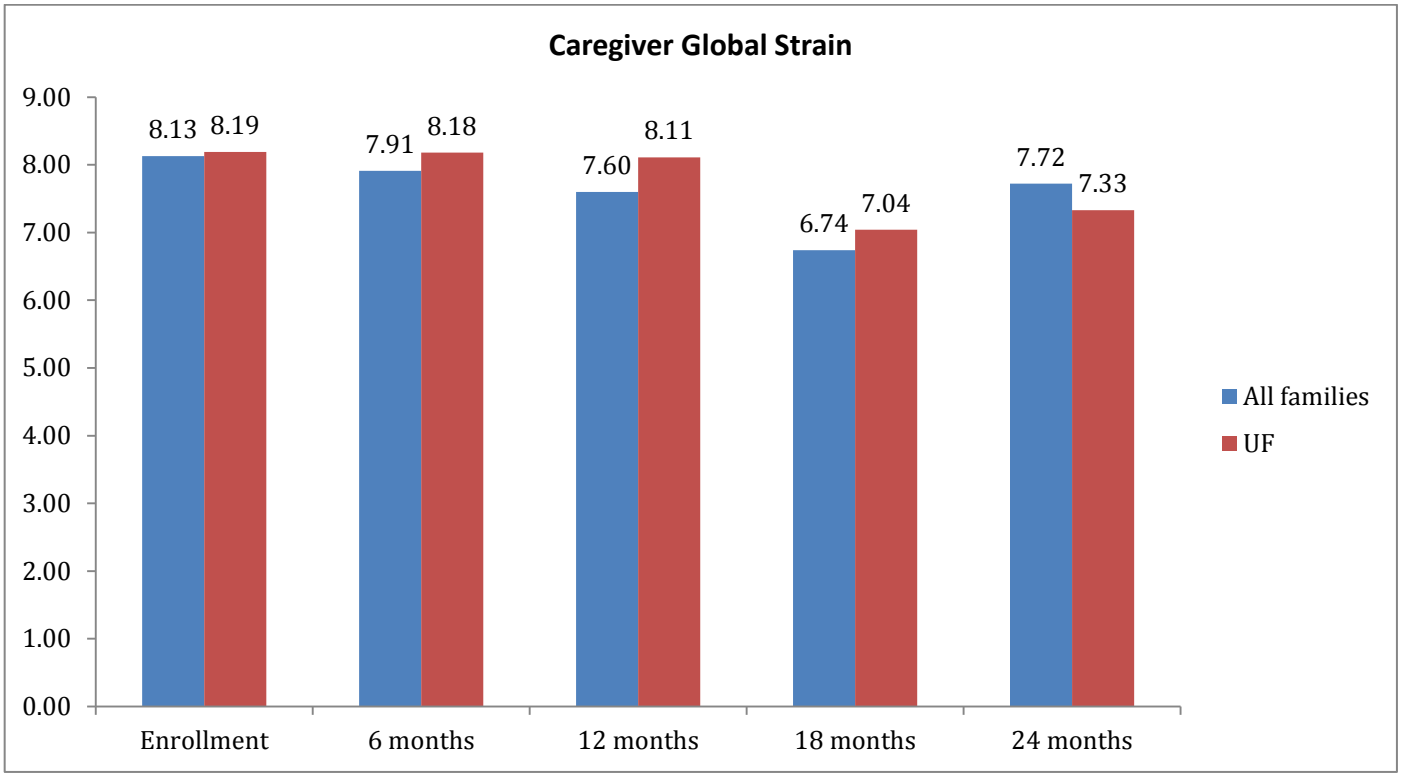
Parenting Stress Index (PSI). The Parenting Stress Index (PSI) is a tool that provide a measure of overall stress in the parent-child system. The average scores of UF Caregivers (and the sample size for each time point) who completed the PSI at enrollment into OCOF (19), 6 months (11), 12 months (7), 18 months (6), and 24 months (3) were compared to PSI average scores of all OCOF caregivers (and the sample size for each time point) at enrollment (69), 6 months (31), 12 months (17), 18 months (15), and 24 months (7). Graph 1 indicates that **caregivers participating in UF had higher stress at most time points, but also experience a greater decrease in stress scores from 110.37 (enrollment) to 95.67 (24 months)** compared to all caregivers who show a decrease from 106.75 (enrollment) to 100.00 (24 months).

Graph1. Parenting Stress Index Over Time



Caregiver Strain Questionnaire (CGSQ). The Caregiver Strain Questionnaire measures the strain that results from special demands involved in caring for a child/youth with mental health challenges. The Global Strain Score reported here indicates the impact of such strain on the entire family. The average global strain scores for UF caregivers (and the sample size at each time point) at enrollment (30), 6 months (18), 12 months (14), 18 months (10), and 24 months (8) were compared to the average global strain scores of all OCOF caregivers (and the sample size at each time point) at enrollment (120), 6 months (58), 12 months (37), 18 months (30), and 24 months (12). Similar to the caregiver stress, Graph 2 indicates **higher strain scores, but also a decrease in average strain scores for UF caregivers from 8.19 (enrollment) to 7.33 (24 months)** compared to a decrease for all OCOF caregivers from 8.13 (enrollment) to 7.72 (24 months).

Graph 2. Caregiver Global Strain Over Time



Conclusion: It appears that **caregivers participating in UF experience slightly greater decreases in caregiver strain and stress than all other OCOF caregivers,** however, these results should be interpreted with caution due to small sample sizes. More importantly, caregivers participating in UF have higher average strain and stress scores at most time points which suggests that **UF is serving the caregivers who are experiencing higher strain and stress** as the result of caring for children with mental health challenges.

ONE COMMUNITY ONE FAMILY PROVIDER SURVEY COMPARISON OVER 6 YEARS

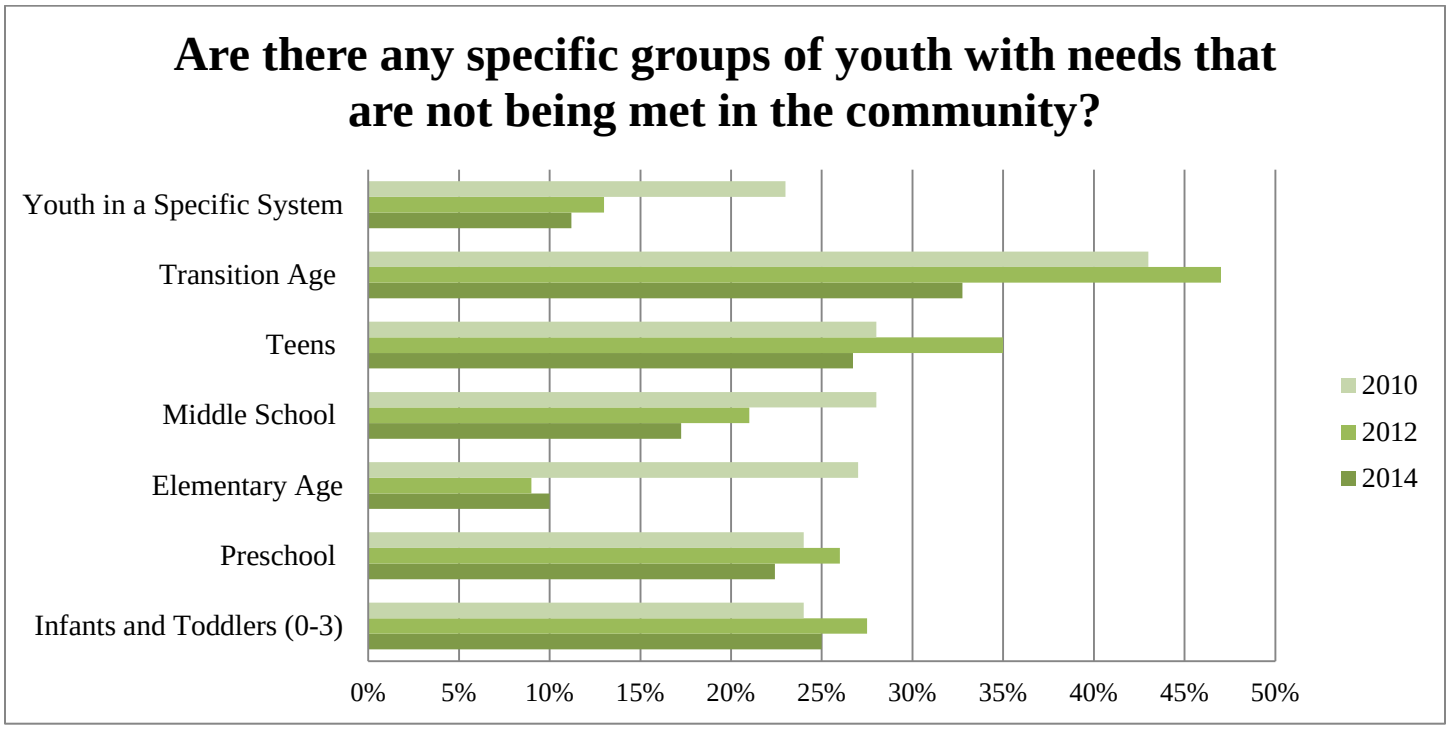
Deborah Cohen, MSW & Jeffrey A. Anderson, Ph.D.

Background

- The survey was developed through input from the OCOF Evaluation Advisory Board (EAB).
- The survey was distributed using Survey Monkey (web-based software) to individuals:
  (1) Having connections to One Community One Family
  (2) Who work in a child serving system throughout OCOF's eight county region

Response Rate

2010 Survey: The survey was distributed to 175 individuals and completed by 88 individuals (50%).
2012 Survey: The survey was distributed to 370 individuals and completed by 116 individuals (31%).
2014 Survey: The survey was distributed to 464 individuals and completed by 124 individuals (27%).



Findings

Results suggest that for the most part, respondents feel the various subgroups of youth are being better served in 2014 than they were in 2010. Groups that did not show significant change from 2010 to 2014 were Teens, Preschool, and Infants and Toddlers. We speculate that there may be better recognition of the needs that exist in the community.

Should providers value youth and family voice?	2010	2012	2014
Youth should have equal say when making care decisions.	9.1%	25.9%	23.4%
Caregivers of youth should have equal say in care decisions.	13.0%	24.7%	26.3%

The most impressive change in terms of community perceptions of the importance of youth and family voice appeared to have occurred between 2010 and 2012.

Alignment with System of Care Values		
2010	**2012**	**2014**
• **Family Guided** • **Individualized** • **Community-based** • **Evidence-based** • **Youth Guided** • **Cultural and Linguistic Competence**	• **Family Guided** • **Individualized** • **Community-based** • **Evidence-based** • **Youth Guided** • **Cultural and Linguistic Competence**	• **Family Guided** • **Individualized** • **Community-based** • **Evidence-based** • **Youth Guided** • **Cultural and Linguistic Competence**
Color Code: **Not Yet**, **Some Evidence**, **Valued in the Community**		

It appears that the community is adopting and valuing system of care principles over time.

OCOF's goal is to be seen as a true collaborative and not a project of only one organization.		
2010	**2012**	**2014**
2.6	3.8	4.3
Scale: 1 = less collaborative; 5 = truly collaborative		

Community perceptions of viewing OCOF as collaborative are increasing over time.

What does this mean?

- Unmet needs for the youngest children still exist; however, services for other age groups are improving.
- Over the past six years, providers believe that the needs of children from all systems are being met more effectively.
- The community is closer to adhering to system of care values.