

2010

# Rosie D. Community Services Review- Northeastern Massachusetts Regional Report

Report of Findings of the Community Services Review  
of Northeastern Massachusetts conducted the week of November 15th, 2010

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### *Executive Summary*

As agreed to in the *Rosie D.* Remedial Plan finalized in July 2007, the Commonwealth of Massachusetts has committed to providing new behavioral health services and an integrated system of coordinated care for youth with Serious Emotional Disturbances (SED) and their families. At the time of the Northeastern Massachusetts Community Services Review (CSR) the *Rosie D.* Remedy Services, with the exception of Crisis Stabilization services, had been in place for just over a year. During this time period, agencies have been providing the new services through a prescribed and decidedly different practice model, one that requires team-based work and fully integrates family voice and choice. Much work and training has been implemented aimed at delivering services through a coordinated approach consistent with System of Care and Wrap-Around principles.

The role of the *Rosie D.* Court Monitor is to receive and review information from a variety of sources in order to monitor compliance and progress with the requirements of the *Rosie D.* Remedial Plan. A monitoring methodology, the Community Services Review was selected in consultation with the Parties to assist the Court Monitor as one of the ways to receive and review information. The CSR is a case-based methodology that reviews how *Rosie D.* class members are doing across key indicators of status and progress as a way to determine how services and practices are being performed. The CSR has been used in jurisdictions across the country to monitor services and stimulate change and improvements in practice.

The purpose of this report is to present findings of the Community Services Review conducted in Northeastern Massachusetts in November, 2010. Expert reviewers used the CSR methodology to conduct intensive reviews of twenty-four randomly selected youth receiving Intensive Care Coordination and/or In-home Therapy (IHT) services through Community Service Agencies (CSAs) and provider agencies throughout Northeastern Massachusetts.

***Characteristics of Youth Reviewed.*** Data that describe the population of youth that were reviewed in Northeastern Massachusetts are presented in this report. The largest number of youth (nine or 37%) were in the 14-17 year old age group; notable is that all but one of these were girls. At the time of the review the vast majority of youth reviewed (88%) were living with their biological parents or in an adoptive home. Forty-six percent (46%) had a change in living or school placement within the past year. The largest ethnicity represented among the youth in the sample was European-American (54%) followed by Latino (25%), and African-American (8%), and youth with Biracial ethnicity (8%). English was the primary language spoken at home for the majority of the youth (83%). The largest percentage of youth (42%) were in a part-time or full-time special education settings. Fifty-four percent (54%) had special education services (some youth were in a full inclusion regular education setting). Several were not in school because they were graduated or dropped out (12%).

Youth in the sample were involved with a variety of other agencies with the highest frequency being the Department of Children and Families (DCF) (63%), and Special Education (54%). The youth were referred to ICC or IHT services in the largest numbers by DCF (21%), and then by their families (17%) and hospitals (17%). Thirteen percent (13%) were referred by outpatient therapists.

The review also collected information related to behavioral health and physical conditions, including co-occurring conditions, with the highest condition prevalence being ADD/ADHD (54%) followed by mood disorders (50%) and PTSD/adjustment to trauma (50%). Twenty-nine (29%) of the youth had a co-occurring medical problem. Current mental health assessments were found for 71% of the youth reviewed. Sixty-seven percent (67%) of the youth were on one or more psychotropic medications, and 41% were on three or more medications. Most of the youth in the sample (88%) had not used any crisis services in the past 30 days.

Caregivers of the youth were facing challenges including their own serious mental illness (25%), extraordinary care burdens (29%), and adverse effects of poverty (25%). Domestic violence was impacting 17% of the caregivers.

***Community Services Review Findings.*** For the CSR indicators presented in this report, most but not all status and performance indicators are applicable to all youth in the sample. For example, work status and substance abuse-related indicators were applicable to only a small subset of the youth reviewed.

*Status and Progress Indicators.* In the CSR, Youth Status, Youth Progress, and Family Status are reviewed as a way to understand the performance of behavioral health services and practices.

*Youth Status.* Most of the youth in the sample were living in stable situation at home (83%) with fewer experiencing favorable school stability (77%). Consistency and permanency was favorable for 75%; a quarter of the youth were not in a permanent situation at the time of the review. Overall, most of the youth were safe in their homes (88%), at school (95%), and in their communities (92%). Most were physically healthy and had their health needs addressed (92%). Most had favorable educational status with 90% doing well in their academic programs, school attendance (95% favorable), and having behavioral supports in school (93% favorable).

Youth status result to note are behavioral risk to self (79% favorable) and others (70% favorable), and youths' emotional status (54% favorable). Living arrangements were favorable for 75% of the sample.

Overall, across the indicators of youth status, 80% of the youth reviewed had a favorable status with 42% with "good" status and 38% with "fair" status. The remaining 20% of youth had unfavorable status with 13% with "marginal" status, and 8% with "poor" status. See Appendix 2 on Page 59 for descriptions of a youth in each status category).

*Family/Caregiver status.* Status of families and caregivers are comprised of a constellation of indicators that reflect measurement of well-being and satisfaction. The data for the Northeastern Massachusetts CSR reflect families experiencing considerable challenges, among the most prevalent being extraordinary care burdens, parental mental illness, adverse effects of poverty, and domestic violence. The data show that voice and choice of mothers and substitute caregivers are being heard in service delivery processes but practices in including fathers could be improved. Family/caregiver and youth satisfaction with services and participation was overall favorable; satisfaction of fathers with service and participation was less favorable.

*Youth progress.* These indicators measure the progress patterns of youth over the six months preceding the review. Youth progress showed variable results with 67% showing favorable progress in reducing symptoms, 100% in reducing substance use (N=1) , 71% in improving coping/self-management, 82% in school progress, and 100% (N=3) in work progress. Overall, 75% were making favorable progress in a range of fair to optimal.

*System/Practice Functions.* Determinations of how key indicators of practice are being performed allows for an evaluation of how well services and service processes provide the conditions that lead to desired changes for youth and families.

The CSR rates twelve core system/practice functions. System practices, as reflected in the knowledge and skills of staff working in concert with youth and their families, support the achievement of sustainable results. The patterns of interactions and interconnections help explain what is working and not working at the practice points in the service system.

The Northeastern Massachusetts CSR found strong practices in Engagement with Families and Cultural Responsiveness with acceptable ratings all above 90% in these indicators. These data show that generally, families reviewed were adequately engaged and participating, and the cultural contexts of families were being addressed. Youth Engagement (79%) was found to need a degree of strengthening.

Teamwork, which focuses on the structure and performance of the youth and family care planning teams, is comprised of two sub-indicators: Team Formation and Team Functioning. Team Formation was acceptable for 75% of the youth, which indicates a level of improvement is needed in order for families to be able to depend on teams with the right composition and continued development of the team. Team Functioning was acceptable for 67% indicating a need for improved teamwork. The overall finding for these indicators is that strengthened practices are warranted in assuring teams fully understand and implement their roles, and know how to work together to implement collective goals reflective of the strengths, needs and choices of youth and families.

The Assessment and Understanding indicator reviewed how well teams and interveners gather all relevant information forming the basis for determining which interventions, supports and/or services will most likely result meeting youth's and families' objectives. Seventy-one percent (71%) had acceptable ratings in this indicator. This foundational practice needs improvement in order to assure teams consistently understand youth's and families' core issues and situations at a level necessary to inform planning.

The Planning Intervention indicators include six sub-indicators. Results for acceptability of care/treatment plans and planning processes show there is room for improvement across most of the core areas including planning for behavior changes (79% acceptable), social connections (71% acceptable), risk and safety planning (43% acceptable), and transitions (60% acceptable). The results indicate that helping teams to improve their plans and planning processes is merited for the population. Planning interventions for symptom/substance abuse reduction was fair for the youth this indicator applied to (80% acceptable). Recovery/relapse planning applied to one youth and was acceptable.

The indicators for identifying and articulating clear Outcomes and Goals for the youth and family also indicate need for practice improvement with only 67% of youth reviewed having acceptable performance. Similarly the indicator for measuring Matching Interventions to Needs, which is assuring services and supports form a cohesive sensible pattern and address the identified needs of the youth and family, needs more attention with 71% of practices reviewed having acceptable performance in this domain.

Care coordination for the youth reviewed was acceptable for 75% of the youth reviewed, indicating some strengthening in practices is needed in order to assure consistently acceptable care coordination is provided. Service implementation was acceptable for 75% of youth, again indicating a degree of improvement is needed to assure timely and consistent implementation of services. Availability of Resources to implement identified services and supports had much better results (88% acceptable). The practice of Adapting and Adjusting plans and services was acceptable for 71% of youth, indicating a need for support for teams in these practices.

Planning, staging and implementing practices for successful Transitions and Life Adjustments was an area that could use some improvement with only 73% of situations having acceptable performance. A concern was the results for Responding to Crises and Risk/Safety Plans with only 53% of youth experiencing acceptable performance.

Overall, 67% of youth were found to have acceptable system/practice performance.

In summary, the data indicate that the strongest areas of practice for the sample as a whole (there was variability in performance results for individual youth) were the indicators: Engagement with Family; Cultural Responsiveness; Planning Interventions for Recovery or Relapse; and Availability and Access to Resources.

Indicators that showed an overall fair performance but at a less consistent or robust level of implementation were: Engagement with Youth; Planning Interventions for Symptom or Substance Reduction; and Planning Interventions for Behavior Changes.

Indicators of system/practice performance that need some level of improvement in order to assure consistency, diligence and/or quality of efforts were: Teamwork (Formation and Functioning); Assessment & Understanding of Youth and Family; Planning Interventions for Social Connections; Outcomes and Goals; Matching Interventions to Needs; Coordinating Care; Service Implementation; Adapting and Adjustment; and Transitions & Life Adjustments.

Review results indicate weak performance was found in the following system/practice indicators: Planning Interventions for Risk and Safety Planning; Planning Interventions for Transitions; and Responding to Crises and Risk & Safety Planning.

Overall, the findings of the CSR showed that key foundational system of care practice such as engagement of families, and cultural responsiveness were strong, although looking at ways to improve engaging youth may be beneficial. There was a strong finding of services and supports needed to implement care plans being available (Availability and Access to Resources). Other core system practices need a degree of improvement to assure performance is consistent and at the skill level needed so that families can reliably depend on services to achieve results.



**Findings: Strengths.** The CSR found many strengths in teams and in the services provided for youth and families in Northeastern Massachusetts. These included examples of excellent work with families by care coordinators and teams. A number of teams were integrating their efforts resulting in effective practices. Most agencies and teams are clearly embracing the wrap-around model and are working to provide family-centered care. The CSR team encountered many talented and diligent staff including Family Partners, Mentors, Skills Trainers, Therapists and Care Coordinators. Also observed were strong working alliances among stakeholders in a number of the System of Care Committees, including identification of service barriers and joint problem-solving.

**Findings: Challenges.** Challenges that were identified through the CSR include staff and teams needing more consistency and skills in using assessments and relevant information to help teams to broadly and collectively understand the needs of the youth and family, the development of plans of care, and assuring plans and services are at the level of intensity to address youth and family needs. Staff did not appear to consistently access supervision and consultation when youths' situations or treatment issues challenged the team in developing the right set of strategies. These issues were often related to the situational and/or clinical complexities and challenges of the youth and family, but teams were also sometimes stymied by systemic or organizational barriers.

Another key set of challenges revolved around the access and quality of mobile crisis interventions services, and the functionality of risk management/safety plans. These findings identify important challenges for the system in preventing and adequately managing crises.

Agencies continue to identify workforce and reimbursement issues impacting their ability to provide service with the continuity and quality necessary. These concerns also appear to be impacting youth's timely access to receiving certain Remedy services.

Families expressed being challenged by issues related to MassHealth eligibility processes, and cite the system as being difficult to navigate, often impacting youth's well-being due to service disruptions.

**Recommendations.** The Recommendations starting on Page 56 reflect the findings of the CSR and are provided as suggestions for further assuring the consistency and quality of behavioral health practices and service delivery for *Rosie D.* class members. Most of the recommendations are for strengthening practices and support of Care Coordinators. Because of the pivotal function that care coordination plays in the system of care and achieving results for youth and families, there is an understandable focus on these practices. There are also recommendation for consideration of services and supports that could enhance the service array and improving crisis planning and crisis services. Another key set of recommendations focuses on the quality management capacities of the system of care including the ability to track and respond to access, continuity of care and quality of practice areas.

**The Rosie D. Community Services Review**  
**Regional Report for Northeastern Massachusetts**  
*For the Review Conducted in November 2010*

**Introduction**

***Overview of Rosie D. Requirements and Services***

The Rosie D Remedial Plan finalized in July, 2007 sets forth requirements that, through their implementation, provides for new behavioral health services, an integrated system of coordinated care, the use of System of Care and Wrap-Around Principles and Practices, thus creating coordinated, child-centered, family driven care planning and services for Medicaid eligible children and their families.

Initially all services were to become available on June 30, 2009. New timelines were established by the Court, whereupon Intensive Care Coordination (ICC), Family Training and Support Services (commonly called Family Partners), and Mobile Crisis Intervention began on July 1, 2009. In-home Behavioral Services and Therapeutic Mentoring began on October 1, 2009 and In-home Therapy Services (IHT) started on November 1, 2009. Crisis stabilization services were to begin on December 1, 2009, but have not yet been approved by the Centers for Medicare and Medicaid Services (CMS) as part of the Massachusetts Medicaid state plan.

More specifically, the Remedial Plan requires behavioral health screenings for all Medicaid eligible children in primary care settings during periodic and inter-periodic screenings. Standardized screening tools are to be made available. Children identified will be referred for a follow-up behavioral health assessment when indicated. A primary care visit or a screening is not a prerequisite for an eligible child to receive behavioral health services. MassHealth eligible children (and eligible family members) can be referred or self-refer for Medicaid services at any time.

Early Periodic Screening Diagnostic and Treatment (EPSDT) services include a clinical assessment process, a diagnostic evaluation, treatment planning and a treatment plan. The Child and Adolescent Needs and Strengths Assessment (CANS) will be completed. These activities will be completed by licensed clinicians and other appropriately trained and credentialed professionals.

ICC includes a comprehensive home based, psychosocial assessment, a Strengths, Needs and Culture Discovery process, a single care coordinator who facilitates an individualized, child-centered, family focused care planning team who will organize and guide the development of a plan of care that reflects the identification and use of strengths, identification of needs, is culturally competent and responsive, multi-system and results in a unique set of services, therapeutic interventions and natural supports that are individualized for each child and family to achieve a positive set of outcomes. ICC services are intended for Medicaid eligible children with Social Emotional Disturbance (SED), who have or need the involvement of other state agency services and/or receiving multiple services, and need a care planning team. It is expected that the staff of the involved agencies and providers are included on the care team.

Family Support and Training provides a family partner who works one-on-one and maintains frequent contact with the parent(s)/caregiver(s) and provides education and support throughout the care planning process, attends CPT meetings, and may assist the parent(s)/caregiver(s) in articulating the youth's strengths, needs and goals. The family partner educates parent(s)/caregiver(s) how to effectively navigate the child-serving systems for themselves and about the existence of informal/community resources available to them, and facilitates the parent/caregiver access to these resources. ICC and FPs work together with youth with SED and their families.

In Home Therapy provides for intensive child and family based therapeutic services that are provided in the home and/or other community setting. In Home Behavioral Services are also provided in the home or community setting and is a specialized service that uses a behavioral treatment plan that is focused on specific behavioral objectives using behavioral interventions. Therapeutic Mentoring services are community based services designed to enhance a child's behavioral management skills, daily living skills, communication and social skills and competencies related to defined objectives.

Mobile Crisis Intervention (MCI) services are provided 24 hours a day and 7 days a week. MCI provides a short term therapeutic response to a youth who is experiencing a behavioral health crisis with the purpose of stabilizing the situation and reducing the immediate risk of danger to the youth or others. There is the expectation that the service be community based to the home or other community location where the child is. There may be times when the family would prefer to bring the youth to the MCI site location or when it is advisable for specific medical or safety reasons to have the child transported to a hospital and for the MCI team to meet the child and family at the hospital. Continued crisis support is available for up to 72 hours as determined by the individual needs of the child and family. The MCI is expected to collaborate and coordinate with the child's current community behavioral health providers during the MCI as appropriate and possible, and after the MCI.

***Purpose of monitoring***

In order to monitor compliance and progress with the requirements of the Judgment, the Court Monitor is to receive and independently review information about how youth with SED and their families are accessing, using and benefiting from changes in the service delivery system, and how well core service system functions (examples: identification and screening; assessment of need; care/treatment planning; coordination of care; management of transitions) are working for them. In order to make such determinations, the Community Services Review (CSR) methodology was selected in consultation with the Parties. The CSR uses a framework that yields descriptions and judgments about child status and system performance in a systematic manner across service settings. In combination with performance data provided by the Commonwealth and other facts gathered by the Court Monitor, information from the CSRs will be used to assess the overall status of implementation.

In June, 2007 Karen L Snyder was appointed as the Rosie D Federal Court Monitor.

### ***Overview of the CSR methodology***

The CSR constitutes a case-review monitoring methodology that provides focused assessments of recent practice using the context of how *Rosie D.* class members are doing across key measures of status and progress, and provides point-in-time appraisals of how well specific behavioral health service system functions and practices are working for youth and their families. In a CSR, each youth/family reviewed serves as a unique “test” of the service system. Each CSR involves a small randomly drawn sample of youth in a particular area.

In the CSR, youth and family experiences with services form the basis and context for understanding how practices are working and how the system is performing. When a youth's status is unfavorable in an area such as their emotional well-being for example, the family often seeks help. In behavioral health systems, ideally, effective and diligent practice is used to change the youth's status from unfavorable to favorable through the delivery of effective interventions. The CSR is designed around this construct of examining the current situations and well-being of youth and families to understand how recent services and practices are working.

The CSR process involves a cadre of trained reviewers who interview those involved with providing services and supports for the youth, along with parents and/or caregivers, and the youth if appropriate. Also interviewed are members of the care team which may include teachers, child welfare workers, probation officers, psychiatrists and others. Reviewers also read ICC and/or IHT case records.

Through using a structured protocol, reviewers make determinations about youth status/progress (favorable or unfavorable) and system/practice performance (acceptable or unacceptable) through a six-point scale. Refer to Appendix 2 on Page 56 for a full description of how each of the terms are defined. The six-point ratings are overlaid with “zones” of improvement, refinement, or maintenance. This overlay is provided to help care planning teams focus on youth concerns and/or system practices that may need attention. When reviewing the status and performance indicators that start on Page 24, it will be helpful to refer to Appendix 2 in understanding the ratings and findings.

Another component of the CSR is interviews/focus groups conducted with stakeholders in the behavioral health system of care. Interviewed are parents, system of care committees, supervisors, care coordinators, Family Partners and community partners of behavioral health agencies.

The CSR provides focused feedback for use by system managers, practitioners and system stakeholders about the performance of behavioral health services, practices and key service system functions. Included in this feedback are areas for improvements at the service delivery and system level, in practice level patterns, and at the individual youth/family level. It also identifies which practices/service delivery are consistently and reliably being performed as the well-being of youth depends on services being delivered in a consistent and reliable manner. The CSR provides quantitative and qualitative data that allows for the tracking of performance of behavioral health service delivery for youth across the Commonwealth over time.

Key inquiries related to monitoring for compliance with the *Rosie D.* Remedy addressed in the CSR include:

- Once a youth is enrolled in ICC and or IHT, are services being implemented in a timely manner?
- Are services engaging families and youth and are families participating actively in care teams and services? How are Parent Partners being utilized in engaging and supporting families?
- For youth in ICC, how well are teams forming; do teams include essential members actively engaging in teamwork and problem solving?
- Are services effective in helping youth to make progress emotionally, behaviorally and in key areas of youth well-being?
- Do teams and practitioners understand the needs and strengths of the child and family across settings (school, home, community) through comprehensive/functional assessments and other sources of information? Does the team use multiple inputs, including from the family and youth when age-appropriate, to guide the development of individualized plans that meet the child's changing needs?
- Are families and other child serving systems satisfied with services?
- Are Individualized Care Plans addressing core issues and using the strengths of youth and their families; do teams have a long term view versus addressing only immediate crisis, do they address transitions, and needed supports for parents/caregivers? Is the family and youth voice supported and reflected in assessing and planning for youth?
- Do services and the service mix reflect family choice, selected after the development of service and support options consistent with comprehensive clinical, psychosocial in home assessments and are efforts are unified, dependable, coherent, and able to produce long term results?
- Is the service resource array available? Is care strength-based, child-centered, family-focused, and culturally competent? Are youth served and supported in their family and community in the least restrictive, most appropriate settings?
- Are services well-coordinated and implemented in a timely, competent, culturally responsive and consistent way? Are services monitored and adjusted as needed?
- Is there an adequate and effective crisis plans and responses?
- Are services (in-home, in-home behavioral, mentoring, etc.) having a positive impact on youth progress and producing results

## **The Northeastern Massachusetts CSR (November 2010)**

### ***Description of the Region***

The Northeast region of Massachusetts encompasses the area north/northeast of Boston along the “northshore” coast to New Hampshire. The region then follows the New Hampshire border west and south along RT 495, a major highway that provides a South/North route along the western edge of Greater Boston. The central area of this region that border greater Boston is quite congested. The small cities of Medford, Malden, Lynn, Peabody, Salem and Danvers (10- 20 miles from Boston) comprise the more southerly area of this region along with many other smaller communities. It is a mix of lovely coastal areas and small inland cities and communities. Cape Ann is a small land extension along the Atlantic Ocean. Beverly, Gloucester, Rockland, Essex, Ipswich and other small, coastal and

fishing communities line the coast north to Newburyport and the New Hampshire border. This area of the region is less populated and has some quite rural areas.

Following RT 495 South from the New Hampshire border, are the old industrial, cities of Haverhill, Lawrence and Lowell. The Merrimack River flows through these cities. Lawrence has a strong Hispanic influence. Lowell (25 miles from Boston) sits at the intersection of three key highways, RT 495, RT 93 and RT 3. From Lowell the region is southeast towards Boston and includes the border cities of Billerica, Woburn, Lexington and several other communities. This area is congested and populated.

***Community Service Agencies (CSAs) and In Home Services***

There are six Community Service Agencies (CSAs) provided by four human service agencies in the Northeast Region of Massachusetts. CSAs are the designated agencies across the Commonwealth for the provision of Intensive Care Coordination. At this time, the CSAs also provide Family Support and Training (more commonly called Family Partners) Services. In the central northeast region, the CSA is Eliot Community Human Services. The CSA is located in Malden, administrative offices are located in Lexington and the CSA provides services to the surrounding communities. Children’s Friend and Family has a CSA located in Lynn, 7 miles north of Boston, and a second CSA in Lawrence, with each CSA serving the surrounding communities. The MSPCC (Massachusetts Society for the Prevention of Cruelty to Children) CSA is located in Lowell, 25 miles from Boston, and provides services for Lowell and surrounding communities. HES/NHS has two CSAs, one located in Beverly and provides CSA services to the Greater Cape Ann area. The second CSA is located in Haverhill, which is about 15 miles south of the New Hampshire border, and provides services to Haverhill and surrounding communities.

There are In -Home Therapy Services (IHT) throughout the Northeast region, with IHT services being provided by CSA agencies as well as other private agencies. The Community Service Review (CSR) included IHT services provided by Family Continuity Program, HES/NHS/Beverly, Lowell Treatment Center, MSPCC, South Bay Mental Health Center, and Wayside Youth and Family Support Network.

***Review Participants***

Altogether, over 400 people from Northeastern Massachusetts participated either in the youth-specific reviews or were interviewed in stakeholder focus groups. Table 1 displays data related to the youth-specific reviews where a total of 172 interviews were conducted. As can be seen, the average number of interviews was 7.2 with a maximum of 11 and a minimum of 3 interviews conducted.

**Child Status and Performance Profile - Number of Interviews**

Number of cases: 24 Northeast MA 11/2010

**Number of Interviews**

Total number of interviews	172
Average number of interviews	7.2
Minimum number of interviews	3
Maximum number of interviews	11

Table 1

***How the sample was selected***

The sample for the Northeastern Massachusetts CSR was drawn from the population of all children who received Intensive Care Coordination (ICC) or In-Home Therapy (IHT) without currently receiving ICC service, inclusive of children from birth to twenty-one years old, who are covered by Medicaid. The CSR sample included 16 ICC youth and 8 IHT youth who were not also currently receiving ICC.

Prior to the review, each agency was asked to submit lists of the children who were enrolled since the initiation of the service. The caseload enrollment list was sorted to create a list of youth who were currently enrolled within open cases.

*ICC Selections.* For ICC, a random sample of youth was drawn from the open caseload list. The number of youth selected from each agency was determined based on the number of youth meeting the sampling parameter against the population of enrolled youth at the time of selection.

*IHT Selection.* For IHT, the open caseload list was further sorted to create a list of youth who were receiving IHT but not currently also receiving ICC. There were twelve agencies, which were actively providing IHT in Northeastern Massachusetts at the time the lists were submitted. Of the twelve agencies, six was serving very few youth, and was dropped from the selection process. Eight youth were randomly selected from the remaining six agencies for inclusion in the CSR. One youth were randomly selected from four of the agencies, and two youth were randomly selected from the two of the agencies. The number of youth who had been served since the start of the program and the number of youth currently receiving services were taken into consideration, leading to the decision to include two youth from these agencies.

*Tables.* The data in Tables 2 and 3 are based on the information that were submitted by the ICC and IHT provider agencies.

The second column of Table 2 displays the number of unduplicated youth enrolled in ICC since the start of the ICC service on June 30, 2009. The third column displays the total number of youth by agency, who were served within open cases at the time the agencies submitted lists. The number of youth to be included from each agency was then determined by

Northeastern Agency	Total Enrolled Since Start of ICC Opening (7/1/09)	Number Open at List Submittal	Number ICC Cases Selected
Children's Friend	347	145	3
Eliot	305	180	4
NHS/HES	534	320	7
MSPCC	161	80	2
<b>Total</b>	<b>1347</b>	<b>725</b>	<b>16</b>

Table 2

comparing the number of youth being served by that agency to the total number of youth being served in the Northeast Region. Northeast Health System (NHS), actively serving the largest number of youth, had 7 youth in the sample.

Eliot Community Human Services had 4 youth in the sample; Children's Friend and Family Services had 3 youth in the sample. The Massachusetts Society for the Prevention of Cruelty to Children had 2 youth in the sample. These ICC youth may have been receiving services in addition to ICC, including IHT.

In Table 3, the second column, displays the total unduplicated enrollment for youth receiving IHT by agency since November 1, 2009. The third column displays the number of youth who were included in open cases at the time the list was submitted. The fourth column displays the total number of youth who were receiving IHT without current ICC services. The last column lists by agency, the number of IHT youth who were designated for selection in the CSR.

As can be seen, each of the following agencies had one youth included in the

CSR: NHS/HES, Lowell Treatment Center, Massachusetts Society for the Prevention of Cruelty to Children, and Wayside Youth and Family Support Network. Two agencies had two youth included from each of their programs: Family Continuity Program and South Bay Mental Health. In total, the CSR sample included 14 youth where ICC coordinate their care and 8 youth where IHT coordinated their care.

Agency	Total Enrolled Since Start of IHT Opening (11-1-2009)	Total Open at List Submittal (6-28-2010)	Total Open and Receiving IHT/No ICC	Number IHT Only Selected
Children's Friend and Family Services	*			
Eliot Community Human Services	*			
Family Continuity	250	98	74	2
NHS/ HES	237	90	59	1
Key Program	*			
Lowell Treatment Center	142	46	40	1
MSPCC	112	62	49	1
North American Family Institute	*			
Pyramid Builders	*			
St. Ann's Home	*			
South Bay Mental Health	142	89	65	2
Wayside Youth & Family Support Network	54	23	18	1
<b>TOTAL</b>	<b>937</b>	<b>408</b>	<b>305</b>	<b>8</b>

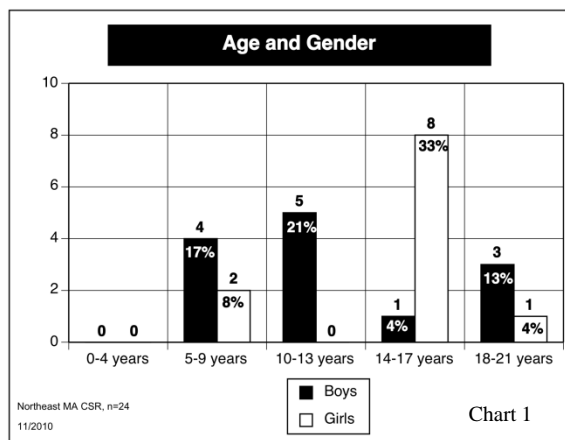
\* Six agencies were not included in the sampling based on small numbers of youth on their lists.

Table 3



### Characteristics of Youth Reviewed

*Age and Gender.* There were 24 youth reviewed in the Northeastern Massachusetts CSR. *Chart 1* at right shows the distribution of genders across age groups in the sample. There were 13 boys and 11 girls in the sample. This proportion of boys to girls was 54% boys to 46% girls. Four youth, three males and one female, or 17% of the sample were in the 18-21 age range. The largest number of youth (nine or 37%) was in the 14-17 year old age range. Of note is that there were eight females and only one male in the 14-17 age range in the sample. The second largest group (6 or 25%) were youth in the 5-9 year old range. Five youth or 21% were in the 10-13 year old range; all five in this group were male. There were no children in the sample in the 0-4 age group.



#### Child Status and Performance Profile - Current Placement Frequency

Number of cases: 24 Northeast MA 11/2010

Type of Current Placement	Number	Percent
Family bio./adopt. home	21	88%
Kinship/relative home	2	8%
Group home	1	4%
	24	100%

Table 4

#### Child Status and Performance Profile - Legal Permanency Frequency

Number of cases: 24 Northeast MA 11/2010

Legal Permanency Status	Number	Percent
Birth family	17	71%
Adopted family	3	13%
Permanent guardianship	1	4%
Adult	2	8%
DCF custody	1	4%
	24	100%

Table 5

The review tracked placement changes over the last twelve months for the 24 children reviewed (*Table 6*). Placement change refers to both changes in living situation, as well as changes in the type of program in which the child receives educational services. Achieving stability and minimizing disruptions are important factors in the lives of youth with SED. Among the sample, the majority of youth (13 or 54%) had no placement changes in the last year, reflecting stability in their home setting over the last year for these

*Current placement, placement changes and permanency status.* The overwhelming majority of youth (96%) in the Northeastern Massachusetts CSR sample lived with their families, either their biological/adoptive families, or in a kinship/relative home. One youth in the sample was living in a group home at the time of the review (*Table 4*).

The legal status (*Table 5*) of most of the children in the sample (71%) was with their birth families. Three (13%) youth's permanency was with their adopted families, and one or 4% of the sample was in permanent legal guardianship. Two (8%) in the sample were adults, and one youth (4%) was in the custody of the Department of Children and Families (DCF).

#### Child Status and Performance Profile - Placement Changes Frequency

Number of cases: 24 Northeast MA 11/2010

Placement Changes (past 12 months)	Number	Percent
None	13	54%
1-2 placements	9	38%
3-5 placements	2	8%
	24	100%

Table 6

youth. Nine of the youth or 38% had 1-2 placement changes, and two or 8% had 3-5 changes.

Of the two youth who were in out of home placements at the time of the review, one had been in placement for 1-3 months, and one had been in placement for 4-6 months. (Table 7).

**Child Status and Performance Profile - Length of Stay in Current OOH Placement**  
 Number of cases: 24 Northeast MA 11/2010

Length of Stay in Current OOH Placement	Number	Percent
1 - 3 mos.	1	4%
4 - 6 mos.	1	4%
Not applicable	22	92%
	24	100%

Table 7

**Child Status and Performance Profile - Ethnicity Frequency**

Ethnicity	Number	Percent
Euro-American	13	54%
African-American	2	8%
Latino-American	6	25%
Asian-American	1	4%
Biracial	2	8%
	24	100%

*Ethnicity and primary languages (Table 8 and 9).* Of the 24 youth in the sample, thirteen or 54% were Euro-American, six or 25% were Latino-American, and two or 8% were African-American. There was one (4%) Asian-American youth, and two (8%) youth who were Biracial.

English was the primary language spoken at home for twenty or 83% of the youth, Spanish for two or 8%, both English and Spanish for one or 4%, and Portuguese for one or 4%.

**Child Status and Performance Profile - Language Spoken Frequency**  
 Number of cases: 24 Northeast MA 11/2010

Primary Language Spoken at Home	Number	Percent
English	20	83%
Spanish	2	8%
English & Spanish	1	4%
Portuguese	1	4%
	24	100%

Table 9

**Child Status and Performance Profile - Educational Placement Frequency**

Educational Placement or Life Situation	Number	Percent
Regular K-12 Ed.	6	25%
Full inclusion	2	8%
Part-time Sp. Ed.	4	17%
Self-cont. Sp. Ed.	6	25%
Parenting teen	0	0%
Adult basic/GED	0	0%
Alternative Ed.	4	17%
Vocational Ed.	2	8%
Expelled/Suspended	0	0%
Home hospital	0	0%
Day treatment program	1	4%
Work	1	4%
Completed/graduated	2	8%
Dropped-out	1	4%
Other	5	21%

Table 10

*Educational placement (Table 10).* Youth reviewed were receiving educational services in a variety of settings. Half of the youth in the sample (twelve or 50%) were receiving special education services either in a full-inclusion, part-time or full-time setting. Six or 25% of the youth were attending school in a regular education setting. Four youth (17%) were enrolled in an alternative education program and two (8%) were in a vocational education program and may have also had special education services in that setting. Four of the youth (16%) were not

enrolled in school as they had graduated, dropped out of school or were working. Youth in the “Other” category were in a tutoring program, enrolled in college, or working on a General Education Diploma (GED). Please note that the total numbers and percentages in Table 10 add up to more than the total number of youth in the sample as youth may be involved in more than one educational placement or life situation.

*Other state agency involvement (Table 11).* Youth in the sample were involved with a range of other agencies. Note that youth may be involved with more than one agency, so the overall number in Table 11 is more than the number of youth reviewed. The Department of Children and Families (DCF) was the agency most frequently involved and had involvement with nearly two-thirds of the families (15 or 63%). Over half of the youth in the sample was involved

**Child Status and Performance Profile - Agencies Involved Frequency**

Number of cases: 24 Northeast MA 11/2010		
Agencies Involved	Number	Percent
DCF	15	63%
DMH	1	4%
Special Ed	13	54%
Early intervention	0	0%
Developmental disabilities	1	4%
DYS	1	4%
Probation	3	13%
Vocational Rehabilitation	2	8%
Substance abuse	0	0%
Other	3	0%

Table 11

with Special Education (13 or 54%). The Department of Mental Health (DMH) and Developmental Disabilities were each involved with one youth or 4% of the youth for each agency. One youth (4%) was involved with the Department of Youth Services, and three or 13% were on probation. Two youth or 8% had involvement with Vocational Rehabilitation.

**Child Status and Performance Profile - Referral Source**

Number of cases: 24 Northeast MA 11/2010		
Referral Source	Number	Percent
DCF	5	21%
DYS	1	4%
Family	4	17%
Hospital	4	17%
IHT	2	8%
Mobile Crisis	2	8%
Outpatient therapist	3	13%
Partial Program	1	4%
Probation	1	4%
School	1	4%
	24	100%

Table 12

The “Other” category represents youth involved with healthcare and educational advocacy.

*Referring agency (Table 12).* Youth in the sample were referred to ICC and/or IHT services from a variety of sources as seen in Table 12. The largest referral source was DCF (5 or 21%), closely followed by self-referrals from Families (4 or 17%) and Hospitals (4 or 17%). Outpatient therapists referred three of the youth or 12% of the sample. Two youth (8%) were referred by an IHT program, and likewise two youth (8%) were referred following a Mobile Crisis Intervention. Other agencies and programs each referred one of the children in the sample.

*Behavioral health and co-occurring conditions (Table 13).* Table 13 displays the conditions and/or co-occurring conditions present among the youth reviewed. Youth may have one or more than one condition. The three primary diagnostic conditions were attention deficit disorder/attention deficit hyperactivity disorder seen in 13 or 54% of the youth, mood disorders prevalent in 12 or 50% of the youth, and youth diagnosed with post-traumatic stress disorder/adjustment to trauma issues also prevalent in 12 or 50% of the youth. The other prevalent diagnoses were anxiety disorders (8 or 33%), anger control (7 or 29%), learning disorder (6 or 25%) and medical problems (7 or 29%). Three of the youth (13%) had an autism spectrum disorder, and two (8%) had mental retardation. Of note is that only

one youth (4%) had a diagnosed disruptive behavior disorder as national studies generally describe significantly higher prevalence rates of youth with conduct and/or oppositional defiant disorders among youth with SED.<sup>1</sup> Only one youth (4%) was diagnosed with a substance abuse disorder.

**Child Status and Performance Profile - Co-Occurring Condition Frequency**

Number of cases: 24 Northeast MA 11/2010

Co-Occurring Condition	Number	Percent
Mood Disorder	12	50%
Anxiety Disorder	8	33%
PTSD/Adjustment to Trauma	12	50%
Thought Disorder/Psychosis	0	0%
ADD/ADHD	13	54%
Anger Control	7	29%
Substance Abuse/Dependence	1	4%
Learning Disorder	6	25%
Communication Disorder	1	4%
Autism	3	13%
Disruptive Behavior Disorder (CD, ODD)	1	4%
Mental Retardation	2	8%
Medical Problem	7	29%
Other Disability/Disorder	2	8%
Other	0	0%

Table 13

*Medications (Table 14).* The majority of the youth in the sample (67%) were currently prescribed at least one psychotropic medication. As seen in Table 14, one of the youth (4%) was prescribed one medication, five (21%) were on two medications, and seven (29%) were on three medications. There was one youth on four (4%) and two (8%) on five or more medications. Forty-one percent (41%) of the youth who were prescribed psychotropic medications were prescribed three or more medications.

Two youth in the sample had other disabilities which included one with William’s Syndrome, a genetic disorder that typically causes mild to moderate intellectual or learning disabilities, and one with Fetal Alcohol Syndrome. Among the medical problems experienced by youth in the sample were asthma, cardiac problems, obesity, vision problems, gastro-intestinal issues, enuresis and cancer. There was one youth with a hearing impairment in the sample.

**Child Status and Performance Profile - Psy Meds Frequency**

Number of cases: 24 Northeast MA 11/2010

Number of Psy Meds	Number	Percent
No psy meds	8	33%
1 psy med	1	4%
2 psy meds	5	21%
3 psy meds	7	29%
4 psy meds	1	4%
5+ psy meds	2	8%
	24	100%

Table 14

*Youths’ levels of functioning (Table 15).* The general level of functioning for the youth was rated by each reviewer. The General Level of Functioning is a 10-point scale that can be viewed in Appendix 1 of this report. Thirteen youth or 54% were rated to be functioning in the Level 1-5 range (“needs constant supervision” to “moderate degree of interference in functioning in most social areas or severe impairment of functioning in one area”). This means that over half of the sample were youth with considerable functional impairment. Nine youth or 38% were rated in the Level 6-7 range (“variable functioning with sporadic difficulties or symptoms in several but not all social areas” to “some difficulty in a single area, but generally

**Child Status and Performance Profile - Level of Functioning Frequency**

Number of cases: 24 Northeast MA 11/2010

Level of Functioning	Number	Percent
In level 1-5	13	54%
In level 6-7	9	38%
In level 8-10	2	8%
	24	100%

Table 15

<sup>1</sup> Garland, A. A., Hough, R. L., McCabe, K. M., Yeh, M., Wood, P. A., & Aarons, G. A. (2001). Prevalence of Psychiatric Disorders in Youths Across Five Sectors of Care. *Journal of the American Academy of Child and Adolescent Psychiatry*, 40:4, 409-418.

functioning pretty well”). The remaining two youth (8%) were rated in the Level 8-10 range (“no more than slight impairment in functioning at home, at school, with peers” to “superior functioning in all areas”).

*Use of Crisis Services (Table 16).* The review tracked whether or not, and the form of, crisis services or crisis responses that were used by youth over the last 30 days. Crisis service/responses were used five times including mobile crisis, 911 EMS or police, a hospital emergency department, and another type of crisis response all accessed one time each. Eighty-eight percent (88%) did not use a crisis service or response over the last 30 days.

**Child Status and Performance Profile - Crisis Services Used Frequency**  
Number of cases: 24 Northeast MA 11/2010

Crisis Services Used Past 30 Days	Number	Percent
Mobile crisis	1	4%
911 Emergency call: EMS	1	4%
911 Emergency call: Police	1	4%
Emergency department	1	4%
Other	1	4%
None	21	88%

Table 16

**Child Status and Performance Profile - Mental Health Assessment**

Number of cases: 24 Northeast MA 11/2010

MH assessment performed	Number	Percent
Yes	17	71%
No	7	29%
	24	100%

Table 17

*Mental health assessments (Tables 17 and 18).* Mental health assessments are a core component of understanding youth and their families. A mental health assessment gives practitioners and teams an overall picture of how the youth is doing emotionally and cognitively, as well as the social/familial context of a youth’s behaviors and well-being. Seventy-one percent (71%) of the youth had a current mental health assessment that was in their files. Seven youth or 29% of the youth did not have a current mental health assessment available.

Seventy-one percent (71%) of the youth had a current mental health assessment that was in their files. Seven youth or 29% of the youth did not have a current mental health assessment available.

**Child Status and Performance Profile - Received Mental Health Assessments**

Number of cases: 24 Northeast MA 11/2010

Received MH Assessments	Number	Percent
Parent	4	17%
Education	2	8%
Court	2	8%
Welfare	2	8%
DOC	0	0%
Not applicable	7	29%
Not Distributed	9	38%
Other	6	25%

Table 18

The reviewers also examined for those that had a current mental health assessment, whether or not the assessment had been distributed to team members. Team members should have a common understanding of the youth and family. Sharing assessments in the wraparound model follows the family’s choices and

so these data need to be understood within this context. Among families in the sample, 17% of parents had received their child’s assessment, which appears to be a relatively low number. Eight percent (8%) of each of the following agencies received the mental health assessment: schools, the courts, and child welfare. The assessment had not been distributed for 38% of youth when it was applicable. There were several other people who received the Mental Health Assessment for youth which included a primary care physician, a mentor, and the intensive home-based therapist.

**Caregiving challenges**

Reviewers recorded the challenges experienced by the parents and caregivers of the youth in the sample (Table 19). Serious mental illness was present in 25% of the families reviewed. Twenty-nine (29%) of the caregivers had extraordinary care burdens, and 25% were experiencing adverse effects of poverty. Domestic violence was impacting 17% of the families. Cultural/language barriers were a challenge for 8% of caregivers. Other challenges noted were supervision needs for the child, family conflict and violence in the family, having multiple children with special needs, and challenges associated with having a transition-aged young adult in the family.

**Child Status and Performance Profile - Caregiver Challenges Frequency**

Number of cases: 24		
Northeast MA 11/2010		
Challenges in the Child's Birth Family or Adoptive Family	Number	Percent
Limited cognitive abilities	1	4%
Serious mental illness	6	25%
Substance abuse impairment or serious addiction w/ frequent relapses	1	4%
Domestic violence	4	17%
Serious physical illness or disabling physical condition	2	8%
Unlawful behavior or is incarcerated	1	4%
Adverse effects of poverty	6	25%
Extraordinary care burdens	7	29%
Cultural/language barriers	2	8%
Undocumented	0	0%
Teen parent	0	0%
Recent life disruption/homelessness due to a natural disaster	0	0%
Other	8	33%

Table 19

**Care Coordination**

During the CSR, data are collected about care coordination through the person providing the care coordination function, whether this was through the ICC Care Coordinator or through the IHT therapist. Among the data collected was information about the length of time the care coordinator was in the position (therapists may have been in the position before the start of IHT services), the current caseload size of the individual, and barriers they perceive to be impacting their work. These data were collected to better understand factors that may be impacting the provision of care coordination services.

As can be seen in Table 20, the bulk of Care Coordinators (43%) had been in their positions for 7-12 months, followed by 33% in their positions for 13-24 months. Fourteen percent (14%) had been in the Care Coordinator position for 4-6 months. One Care Coordinator each had been in the position for 1-3 months and 25-36 months.

**Child Status and Performance Profile - Length of Time CM in Position Frequency**

Number of cases: 21		
Northeast MA 11/2010		
Length of Time CM in Position	Number	Percent
1-3 months	1	5%
4-6 months	3	14%
7-12 months	9	43%
13-24 months	7	33%
25-36 months	1	5%
	21	100%

Table 20

Also tracked was the length of time the Care Coordinator had been assigned to the youth being reviewed. As can be seen in *Table 21*, 42% of the Care Coordinators had been providing coordination for the youth for 4-6 months, and 33% for 7-12 months. Seventeen percent (17%) of Care Coordinators had been assigned to the youth for 1-3 months, 4% for less than a month, and 4% for 13-24 months.

Caseload frequency, as reported by the Care Coordinator, was measured along the scale seen in *Table 22*. Twenty-four percent (24%) of Coordinators had less than 8 cases, 14% had 9-10 cases, 10% had 11-12 cases, 24% had 13-14 cases, 14% had 15-16 cases, and 14% had more than 18 cases on their caseload.

**Child Status and Performance Profile - Length of Time CM Assigned**  
Number of cases: 24 Northeast MA 11/2010

Length of Time CM Assigned to Child/Youth	Number	Percent
<1 month	1	4%
1-3 months	4	17%
4-6 months	10	42%
7-12 months	8	33%
13-24 months	1	4%
	24	100%

Table 21

**Child Status and Performance Profile - CM Current Caseload Frequency**  
Number of cases: 21 Northeast MA 11/2010

CM Current Caseload Size	Number	Percent
<8 cases	5	24%
9-10 cases	3	14%
11-12 cases	2	10%
13-14 cases	5	24%
15-16 cases	3	14%
>18 cases	3	14%
	21	100%

Table 22

**Child Status and Performance Profile - Barriers Affecting Case or Services**  
Number of cases: 24 Northeast MA 11/2010

Barriers Affecting Case Management or Services	Number	Percent
Caseload size	1	4%
Eligibility/access denied	3	13%
Inadequate parent support	1	4%
Inadequate team member participation	1	4%
Family disruptions	1	4%
Billing requirements/limits	5	21%
Case complexity	4	17%
Treatment compliance	4	17%
Team member follow-thru	1	4%
Acute care needs	1	4%
Driving time to services	1	4%
Culture/language barriers	2	8%
Refusal of treatment	2	8%
Family instability/moves	0	0%
Arrest/detention of child/youth	0	0%
Other	10	42%

Table 23

providers, barriers to building sustainable natural supports, parental availability to participate in services, lack of particular services (vocational, housing, therapeutic mentoring, outpatient therapy), need for more training of community partners, inconsistent supervision, need for flex funds, and barriers in transporting children.

*Table 23.* Barriers that affect the provision of care coordination or other services was another data set collected in the CSR. The challenges cited most often were billing requirements and limits to billing (21%). Case complexity and treatment compliance were each cited as barriers in 17% of the reviews. Eligibility and access issues were mentioned as barriers in 13% of cases. In 8% of situations each, cultural/language barriers and treatment refusal were cited.

Barriers cited less frequently were caseload size, inadequate parent support, inadequate team member participation, family disruptions, team member follow-through, acute care needs, and driving time to services. Barriers that were cited in the “Other” category included connecting with

## Community Services Review Findings

### *Ratings*

For each question deemed applicable in a child's situation, findings are rated on a 6-point scale. Ratings of 1-3 are considered "unfavorable" for status and progress indicators and "unacceptable" for system/practice indicators. Ratings of 4-6 are considered "favorable" for status and progress ratings, and "acceptable" for system/practice indicators. The 6-point descriptors fall along a continuum of optimal, good, fair, marginally inadequate, poor, adverse/worsening). A detailed description of each level in the 6-point rating scale can be found in Appendix 2.

A second interpretive framework is applied to this 6-point rating scale with a rating of 5 or 6 in the "maintenance" zone, meaning the current status or performance is at a high level and should be maintained; a rating of 3 or 4 in the "refinement" zone, meaning the status is at a more cautionary level; and a rating of 1 or 2 in the "improvement" zone, meaning the status or performance needs immediate improvement. Oftentimes, this three-tiered rating system is described as having review findings in the "green, yellow, or red zone."

The actual review protocol provides item-appropriate guidelines for rating each of the individual status, progress, and performance indicators. Both the three-tiered action zone and the favorable vs. unfavorable or acceptable vs. unacceptable interpretive frameworks are used for the following presentations of aggregate data.

In this section, ratings are provided in the charts and narrative for favorable status/progress and acceptable system/practice performance. In the narrative results are described for these ratings, as well as a combined percentage for results that fell in the refinement/improvement zone. It is important to remember that a portion of results in the refinement zone can in fact be a favorable or acceptable finding.



## STATUS AND PROGRESS INDICATORS

Review questions in the CSR are organized into four major domains. The first domain pertains to inquiries concerning the current status of the child. The second domain explores parent or caregiver status, and includes several inquiries pertaining to youth voice and choice, and satisfaction. The third domain pertains to recently experienced progress or changes made as they may relate to achieving care and treatment goals. The fourth domain contains questions that focus on the performance of system and practice functions in alignment with the requirements described in the *Rosie D. Remedy*.

### Youth Status Indicators

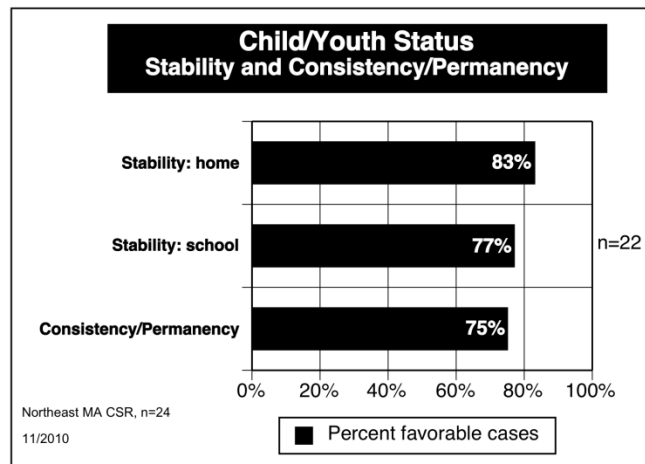
(Measures Youth Status over the last 30 days unless otherwise indicated)

Determinations about youth well-being and functioning help with understanding how well the youth is doing currently across key areas of their life.

The following indicators are rated in the Youth Status domain. Determinations are made about how the youth is doing currently and over the last 30 days, except for where otherwise indicated.

1. Community, School/Work & Living Stability
2. Safety of the Youth
3. Behavioral Risk
4. Consistency and Permanency in Primary Caregivers and Community Living
5. Emotional and Behavioral Well-being
6. Educational Status
7. Living Arrangement
8. Health/Physical Well-Being

*Overall Youth Status*



### *Community, School/Work and Living Stability*

In the sub-indicators of Stability, reviewers are asked to determine the degree of stability the youth is experiencing in their daily living and learning arrangements in terms of those settings being free from risk of unplanned disruption. Reviewers look at whether or not the

youth's emotional and behavioral conditions are addressed that may be putting the youth at risk of disruption in home or school. When reviewing for stability, reviewers track disruptions over the past twelve months and based on the current pattern of overall status and practice, predict disruptions over the next six months.

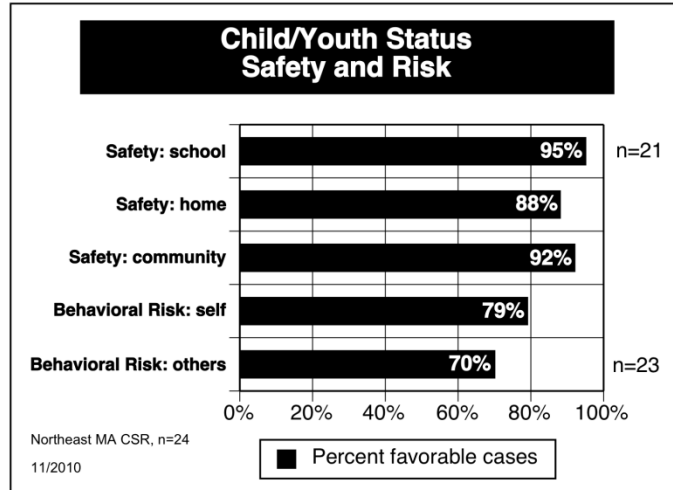
Practice is defined as actions taken by practitioners that help an individual and/or family move through a change process that improves functioning, well-being, and supports. Practice is best supported by using a practice model that works (example: engage, fully assess and understand youth and family, teamwork/shared decisions, choose effective change strategies, coordinate services, track/measure, learn and adjust) and having adequate local conditions that support practitioners (examples: worker craft knowledge, continuity of relationships, clear worker expectations practice supports/supervision, timely access to services/supports, dependable system of care practices and provider network).

Among the 24 youth in the CSR sample in Northeastern Massachusetts, 83% of them had favorable stability at home. Eleven of the youth (45%) had good stability with established positive relationships and well-controlled risks that otherwise could jeopardize stability. Another 11, or 45% of the youth, were rated to be in the "refinement" area, which means that conditions to support stability are fair.

Of the 22 youth for which school stability was applicable (two of the youth in the sample were not in school), 77% had a stable school situation. Thirty-six percent (36%) or 8 youth had issues with their school stability that needed "refinement" or "improvement." For one youth (5% of total) who had unfavorable stability in school, there was some indication there would be an imminent placement disruption in school suggesting the need for focused attention by the youth's team.

### ***Consistency/Permanency in Primary Caregivers & Community Living Arrangements***

The Consistency/Permanency Indicator measures the degree to which the youth reviewed are living in a permanent situation, or if not that there is a clear strategy in place by teams to address permanency issues including identifying the conditions and supports that may be needed to assure the youth is able to have enduring relationships and consistency in their lives. Absent these conditions, there is often a direct impact on a youth's emotional well-being and behaviors. Among the youth reviewed in Northeastern Massachusetts, 75% had favorable consistency and permanency in their lives. Six youth (25%) had marginal or uncertain permanence that needed a level refinement in in order to improve their emotional and behavioral well-being.



### ***Safety of the Youth***

Safety is examined to measure the degree to which each youth is free from exploitation, harassment, bullying, abuse or neglect in his or her home, community, and school. Safety includes being free from psychological harm. Reviewers also examine the extent to which caregivers, parents and others charged with the care of children provide the supports and actions necessary to assure the youth is free from known risks of harm. Freedom from harm is a basic condition for youth well-being and healthy development.

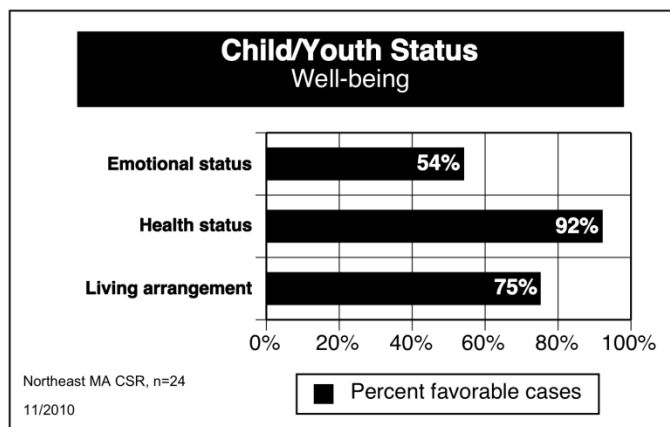
In the sample of youth reviewed for Northeastern Massachusetts, for those who were attending school (N=21), 95% of youth were found to have favorable safety status at school, 88% were safe at home and 92% were safe in the community. Six of the youth (30%) reviewed needed their school safety to be “refined” or “improved”. One youth (5%) was found to have poor safety in the school setting, due to bullying and intimidation leading to the youth’s elevated suicidal ideation and other issues of concern. This youth also was found to have poor status in community safety. Eleven youth (46%), including three (12%) with unfavorable status in safety in their homes, may benefit from their care planning teams reviewing any potential safety issues in their homes (needed Refinement or Improvement). Likewise eleven youth, including two youth (8%) with unfavorable status, might benefit from their teams reviewing their safety status in their communities

### ***Behavioral Risk to Self and Others***

Reviewers determine the degree to which the youth is avoiding self-endangerment situations and refraining from using behaviors that may be placing him/herself or others at risk of harm. Behavioral risk is defined as a constellation of behaviors including self-endangerment/self-harm, suicidality, aggression, severe eating disorders, emotional dysregulation resulting in harm, severe property destruction, medical non-compliance resulting in harm and unlawful behaviors.

The results of the review show that 79% of youth had a favorable level of behavioral risk to themselves. Half of the sample (50% or 12 youth) were found to need “refinement” or “improvement” in their current status of behavioral risk to themselves indicating teams may want to evaluate strategies in youths’ plans in this area including level of risk. Among these were three youth (12%) with poor status, but none with serious or worsening status.

The subindicator of behavioral risk toward others was applicable to 23 of the 24 youth in the sample. Seventy percent (70%) or 16 youth had a favorable level of behavioral risk toward others. Eight of the youth (35%) needed “refinement” or “improvement” in their risk to others, including three (13%) who had poor risk status, with a presence of potential of harm. Again, there were no youth with serious or worsening status on this subindicator.



### ***Emotional and Behavioral Well-being***

Youth are reviewed to determine to what degree they are presenting age and developmentally-appropriate emotional, cognitive, and behavioral development and well-being. Factors examined include youth’s levels of adjustment, attachment, coping, self-regulation and self-control as well as whether or not symptoms and manifestations of disorders are being managed and addressed. Reviewers look at emotional and behavioral issues that may be interfering with the youth’s ability to make friends, learn, participate in activities with peers in increasingly normalized settings, learn appropriate boundaries and self-management skills, regulate impulses and emotions, and other important domains of well-being. Addressing emotional and behavioral issues of youth is a core charge of mental health systems.

Emotional and behavioral well-being was favorable for 54% youth reviewed in the Northeastern Massachusetts CSR. The other 46% were found to have unfavorable status in this indicator, indicating fairly high levels of inconsistent or poor emotional development, adjustment problems, emotional/adaptive distress, or serious behavioral problems present among the youth reviewed. Among the youth, 75% were determined to need “refinement” or “improvement” in their emotional/behavioral status. Four of these youth (16%) were found to have poor status and were not currently progressing in this area. Focus and support for teams in developing strategies for refining and/or improving youth’s levels of emotional and behavioral well-being was warranted for a large percentage of youth reviewed.

### ***Health Status***

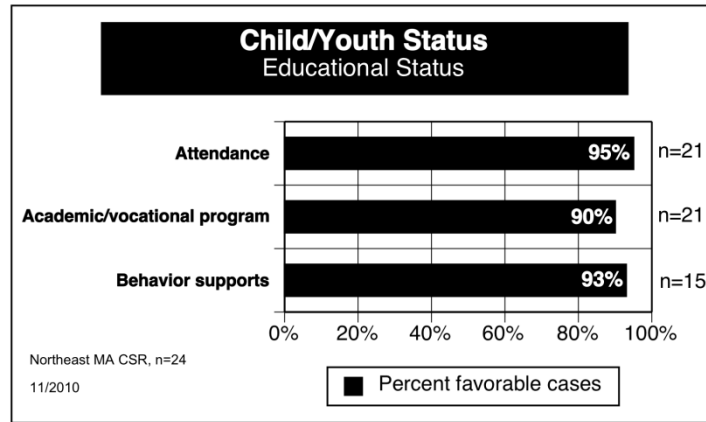
The health of the youth was reviewed to determine whether or not they were achieving and maintaining optimal health status including basic and routine healthcare maintenance. Youth’s basic needs for nutrition, hygiene, immunizations, and screening for any possible development or physical problems should be met. Health is an important component of overall well-being. For the youth in the sample, 92% had favorable status. Of these, 46%

were noted to need some refinement in their health status. One of the youth had poor health status that also impacted their emotional well-being.

***Living Arrangements***

Living in the most appropriate and least restrictive living arrangement that allows for family relationships, social connections, emotional support and developmental needs to be met is necessary for any youth. Basic needs for supervision, care, and management of special circumstances are part of what constitutes a favorable status in a living arrangement. These factors are important whether the youth is living with their family, or in a temporary out of home setting. Often families, especially those with considerable challenges in their lives, need support in providing a favorable living arrangement for their children.

For the youth reviewed in the Northeastern Massachusetts CSR, 75% were found to have a favorable living arrangement. Thirty-eight percent (38%) could benefit for “refinement” or “improvement” in their living arrangement. One youth (4%) had an adverse living arrangement with a poor and worsening situation. Follow-up on this youth’s situation is warranted.



***Educational Status***

This indicator looks at how youth are doing educationally. Three specific areas are examined as seen in the chart above. The sub-indicators may not be applicable to all youth in the sample, as youth may not be enrolled in school, or do not need specific behavioral supports during the school day in order to succeed in school.

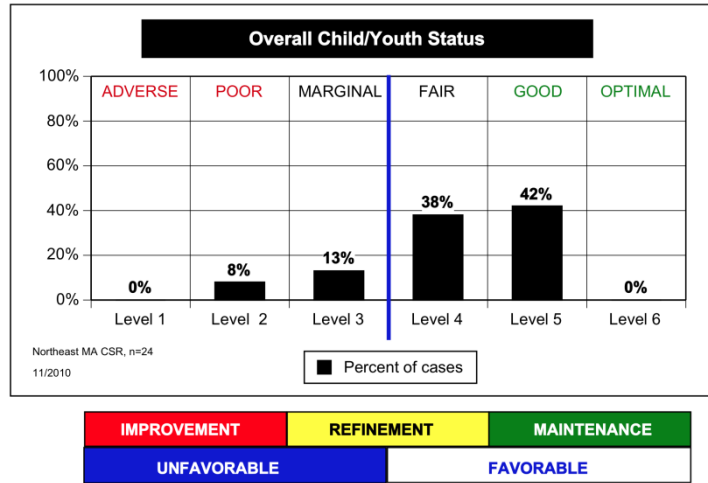
Whether or not a youth receives special accommodations or special education services in school, the youth is expected to attend regularly, and be able to benefit from instruction and make educational progress. If the youth does need behavioral supports in school, he or she should be receiving those supports at a level needed to reach their goals. The role of behavioral healthcare is to coordinate with schools as educational success is a core component of a child’s well-being. If a youth needs support in this area, care plans optimally include strategies to help the youth attend and succeed in school. The family with the support of the family partner, care coordinator or IHT (or others) meets and collaborates with school personal in support of youth progress and success.

In the Northeastern Massachusetts review, for the 21 youth this indicator was applicable to, a full 95% had favorable patterns of attendance. Fourteen percent (14% or 3 youth) of the sample would benefit from some refinement in their school attendance pattern. For the 21

youth who were enrolled in an academic or vocational program, 90% of them were doing favorably well in their educational program. Six youth or 29% the youth needed their teams to look at any needed refinements in their school program in order to do well emotionally and behaviorally, including one that was doing poorly and was not progressing. Fourteen youth required behavioral supports in their school setting, and this was working favorably well for 93% of them. Only two or 13% of them needed their teams to consider planning for refinements in the adequacy or consistency of implementation of behavioral supports. Overall findings of status in the Educational indicators were strong for the youth reviewed.

**Overall Youth Status**

The overall results for Youth Status for the 24 youth reviewed in Northeastern Massachusetts are displayed below. Overall, 80% or 19 youth were found to be doing favorably well. These youth fell in Levels 4-5, and had Fair (38% or 9 youth), or Good (42% or 10 youth) status. There were no youth in the Optimal category. The remaining five youth had unfavorable status. They had either Marginal (13% or 3 youth) or Poor (8% or 2 youth) status. There were no youth found to have overall Adverse status.



The Youth Status Overall results are also categorized as needing Improvement, Refinement, or Maintenance. This allows for identification of youth that may need focused attention. Two youth (8%) fell into the Improvement area, meaning their status is currently problematic or risky, and action should likely be taken to improve the situation for the youth. Just over half the youth fell in the Refinement area (51% or 12 youth), which is interpreted to mean their status is minimal or marginal, and are potentially unstable with further efforts likely necessary to improve their well-being. For the ten youth (42%) whose status should be maintained, efforts should likely be sustained and leveraged to build upon a fairly positive situation.

Several observations can be drawn about the status of youth reviewed in Northeastern Massachusetts. Most of the youth were in stable living situations. Fewer were in stable school situations, but educational status was overall favorable for most of the youth. Permanency was a concern for 22% of the youth. The majority of youth were safe in their homes, schools and communities. Additional supports to shore up families' capacity to

provide a favorable living situation were warranted for a quarter of the sample. A primary concern for almost half of the youth reviewed was their unfavorable emotional status. Behavioral risk to self and others was also a concern for a number of youth.

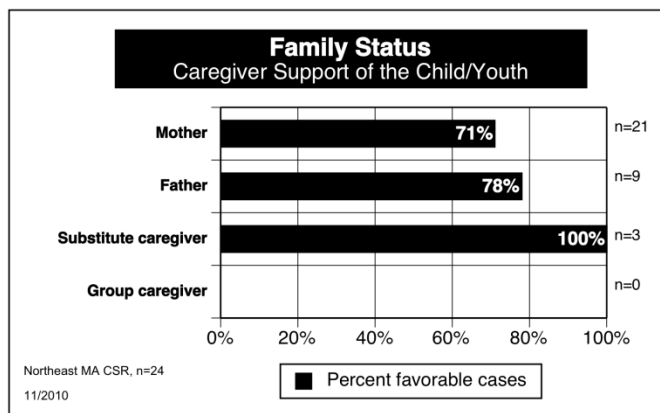
### Caregiver/Family Status

(Measures the status of caregivers over the last 30 days)

Determinations in these status indicators help us to understand if parents and caregivers are able and willing to provide basic supports for the youth on a day-to-day basis. It also examines the level of family voice and choice present in service processes, as well as family satisfaction.

1. Parent/Caregiver Support of the Youth
2. Parent/Caregiver Challenges
3. Family Voice and Choice
4. Satisfaction with Services/Results

*Overall Caregiver/Family Status*



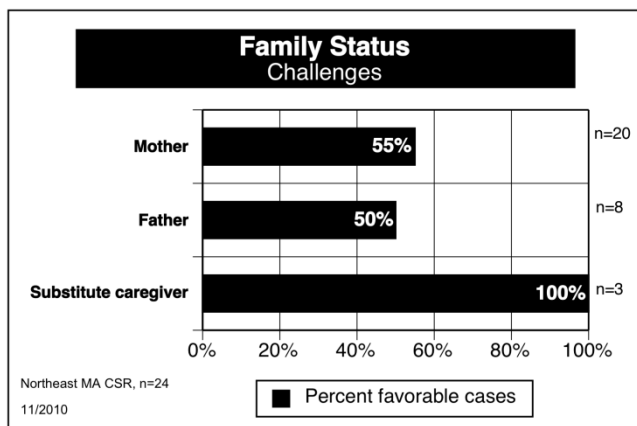
#### *Parent/Caregiver Support of the Youth*

This indicator measures the degree of support the person that the youth resides with is able and willing to provide for the youth in terms of giving assistance, supervision and support necessary for daily living and development. Also considered is if supports are provided to the parent/caregiver if they need help in meeting the needs of the youth. Parent/caregiver support includes understanding any special needs and challenges the youth has, creating a secure and caring home environment, performing parenting functions adequately and consistently, and assuring the youth is attending school and doing schoolwork. It also means connecting to community resources as needed, and participating in care planning whenever possible. This domain is measured as applicable for the youth’s mother, father, substitute caregiver, and if in congregate care, for the group caregiver.

For the youth reviewed in the Northeastern Massachusetts CSR, the measure was applicable to mothers for 21 youth, and favorable support was found 71% of the time (15 youth). Maternal support needed “refinement” or “improvement” for 52% or 11 youth. The measure for support from fathers was applicable for only nine of the 24 youth in the sample, and favorable support was found from 78% or 7 of them. Support from fathers needed

“refinement” or “improvement” for 89% or 8 youth in the sample. For the three youth with substitute caregiving (adoptive or kinship care), support was favorable for all of them, with two of the three needing some refinement in their support of youth

There was one youth in group care in the sample at the time of the review, but the reviewer was unable to rate support of the youth in this situation.



### *Parent/Caregiver Challenges*

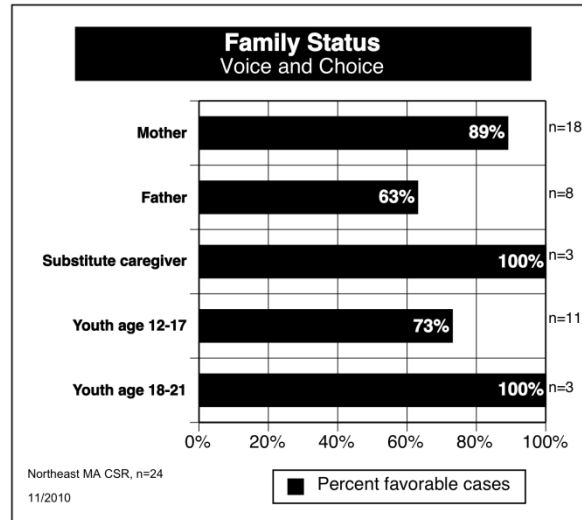
Parents’ and caregivers’ situations are reviewed to determine the degree of challenges they have that may limit or adversely impact their capacity to provide caregiving. Also considered is the degree to which challenges have been identified and reduced via recent interventions. Challenges are rated as applicable for the youth’s mother, father and substitute caregiver.

In the sample, for the 20 youth who had their mother as a caregiver, 55% or 11 mothers had favorable status in terms of their challenges. Thirteen or 65% of the mothers had a level of challenge that needs to be “refined” or “improved,” which indicates a significant level of challenge and hardships impacting parenting among families in the sample.

For the eight youth where the fathers were present, 50% or 4 of them had a favorable level of challenge. The other half had a range of challenges from minor limitations with adequate supports to major life challenges with inadequate or missing supports.

The three substitute caregivers of youth in the sample were all found to have favorable status in terms of life challenges, with few to minor limiting conditions. Status was favorable for 100% of them.





### *Family Voice and Choice*

Family Voice and Choice is rated across a range of people as seen in the Caregiver Status: Family Voice and Choice chart above. For this indicator, in addition to parents/caregivers, the voice and choice of the youth is rated for youth who are over age 12. The variables that are considered when rating for this indicator include the degree to which the parents/caregivers and youth (as age appropriate) have influence in the team's understanding of the youth and family, and decisions that are made in care planning and service delivery. Examined are the input the family has had in a strengths and needs discovery, the role they play in the care planning team and care planning process, how included they feel in the various processes, and if they receive adequate support to participate fully.

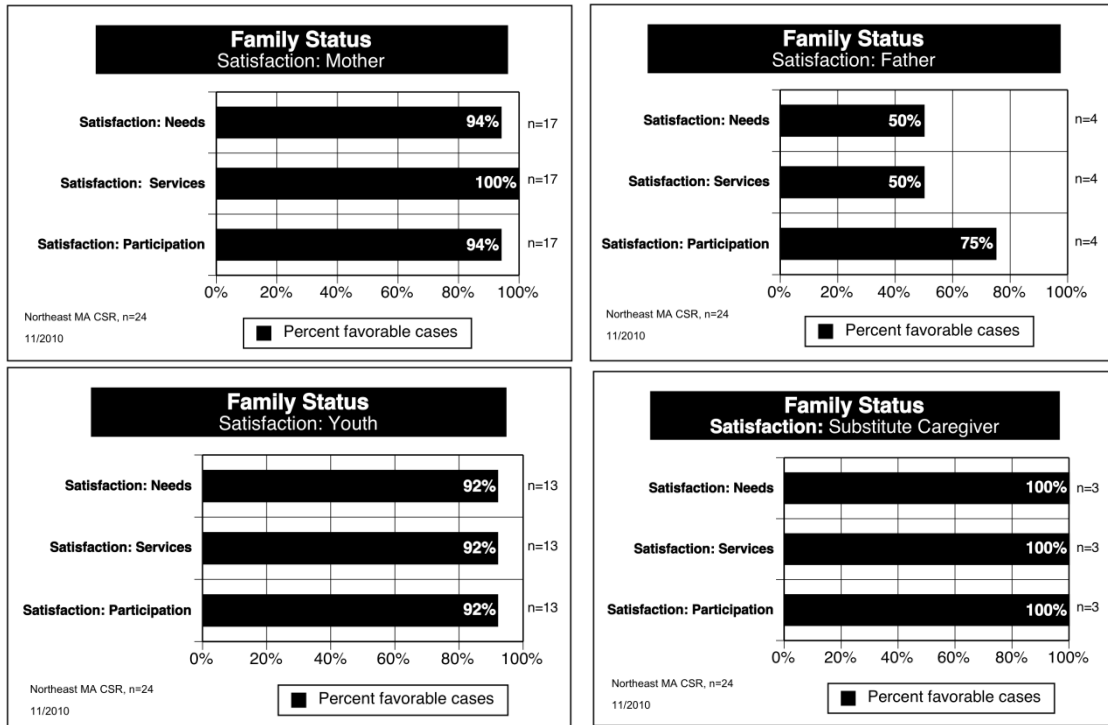
For the youth reviewed where their mother was their caregiver (N=18), 89% or 16 mothers had favorable voice and choice in their child's assessments, planning and service delivery processes. There were three youth or 16% of the sample where there could be some refinement in strengthening the voice and choice of mothers. One mother, or 5% of those reviewed did not feel her voice and choice was adequately considered. Overall, the data indicate that a significant percentage of mothers felt included in team processes, an important foundation for engagement of families, and reflective of use of system of care principles.

For youth whose fathers were involved and information could be gathered (N=8), 63% or 5 fathers had favorable voice and choice in involvement with their child's service processes. Six of the fathers or 75% could benefit from "refinement" or "improvement" in the influence of their voice and choice, indicating an area where service planning could improve.

For the three youth with a substitute caregiver, all had a favorable situation in terms of their voice and choice in service processes. All three were in the "maintenance" area indicating an ongoing positive pattern of inclusion of their voice and choice in service delivery processes.

There were eleven youth in the 12-17 age range in the sample. Of these 73% or eight youth had a favorable experience in having a voice and choice in their own services, with "refinement" or "improvement" indicated for 4 youth or 36% of youth who fell in this age

range. There were three youth age 18 and older, with very strong inclusion of their voice and choice for all three, or 100% favorable.



**Satisfaction with Services and Results**

Satisfaction is measured for the Mother, Father, Youth and Substitute Caregiver. The inquiry looks at the degree to which caregivers and youth are satisfied with current supports, services and service results. It looks at a number of aspects of satisfaction including satisfaction with the youth’s strengths and needs being understood, satisfaction with the present mix and match of services offered and provided, satisfaction with the effectiveness in getting the results they were seeking and satisfaction with how they are able to participate in the care planning process.

The charts above display the results for how satisfied each of the role groups were with having their needs understood, services and results, and participation. Mothers’ satisfaction was applicable for 17 families, with fairly high satisfaction across the domains measured. For the 4 fathers that satisfaction was measured for, half were satisfaction in having their child’s needs addressed and their ability to participate in services, and 75% were satisfied with services. The thirteen youth for which satisfaction was measured were generally satisfied with the aspects of services examined. Satisfaction was measured for the three substitute caregiver, who were satisfied across all sub-indicators.

**Summary: Caregiver/Family Status**

Overall, many parents were found to be experiencing considerable challenges in their lives, often impacting their ability to provide support for their children. Caregiver voice and choice was strong for mothers, substitute caregivers and older youth, but could be improved for fathers and youth in the 12-17 age range. Mothers, youth, and substitute caregivers

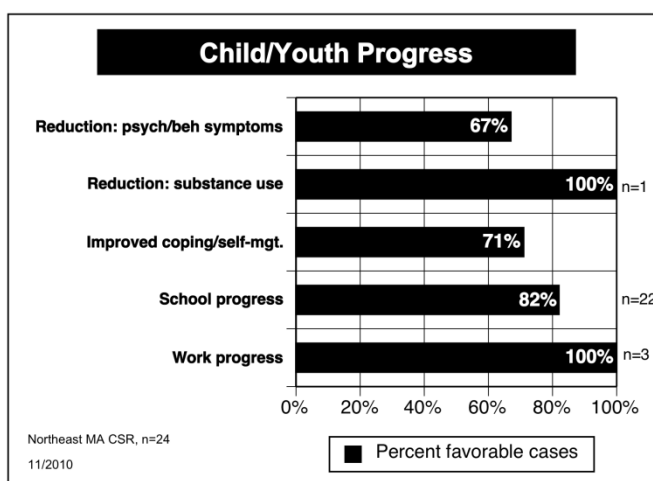
expressed satisfaction with the services; fathers were less satisfied with identifying their children's needs, services, and their level of participation.

### Youth Progress

*(Measures the progress pattern of youth over the last 180 days)*

Determinations about a youth's progress serve as a context for understanding how much of an impact services and supports are having on a youth's forward movement in key areas of her/his life.

1. Reduction of Psychiatric Symptoms/Substance Use
  2. Improved Coping/Self-management
  3. School/Work Progress
  4. Progress Toward Meaningful Relationships
  5. Overall Well-being and Quality of Life
- Overall Youth Progress Patterns



### ***Reduction of Psychiatric Symptoms and/or Substance Use***

This set of indicators measure the degrees to which target symptoms, problem behaviors and/or substance use patterns causing impairment have been reduced. Change in this area is reviewed over the past six months or since the beginning of treatment if it has been less than six months. For the 24 youth reviewed, 67% of them had made favorable progress in reducing symptomatology and/or problem behaviors over the last six months. Sixteen or 67% percent of the youth could benefit from “refinement” or “improvement” in reduction in the psychiatric symptoms. Eight youth (33%) had made optimal or good progress with ongoing positive patterns. Four of the youth (16%) had made little or inconsistent progress or were not improving with mild to serious levels of risk present.

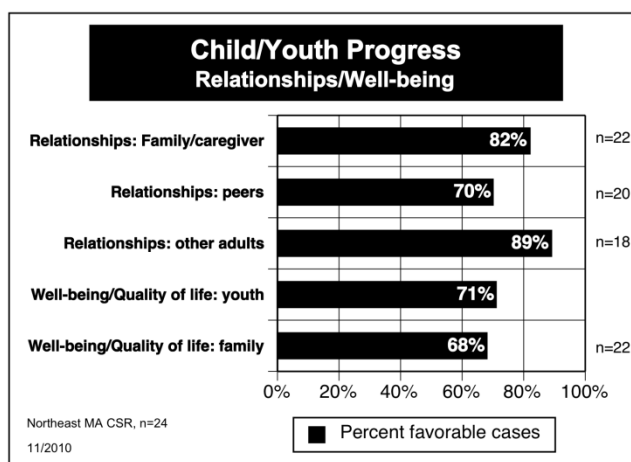
The one youth with substance abuse issues had made progress; the data indicates progress could benefit from refinement.

### ***Improved Coping and Self-Management***

This indicator looks at the degree to which the youth has made progress in building appropriate coping skills that help her/him to manage symptoms/behaviors including preventing substance abuse relapse, gaining functional behaviors and improving self-management. Among the youth reviewed, 71% had made favorable progress in improving their coping skills and ability to self-manage their emotions and behaviors. Eight of the youth (33%) had made good or optimal progress in improving their ability to cope and manage their own behaviors. Thirteen or 54% of the youth reviewed could benefit from “refinement” or “improvement” in their progress in this area. Four youth (16%) were making poor progress at levels well-below expectations.

### ***School or Work Progress***

Being able to succeed in the school or work setting for youth with SED is often dependent on their ability to make progress academically and behaviorally during the school/work day. This indicator looks at the degree of progress the youth is making consistent with age and ability in her/his assigned academic or vocational curriculum or work situation. Of the 22 youth for which school progress was applicable, 82% were making favorable progress, with 54% making good or optimal progress. Ten youth or forty-five (45%) of the sample could benefit from a level of “refinement” or “improvement” in their school progress. Three youth were making limited to no progress, and one youth was regressing. Progress in a work setting applied to three youth, all who were making good to optimal progress in satisfying expectations necessary for maintaining employment.



### ***Progress Toward Meaningful Relationships***

The focus of this indicator is to measure progress for the youth relative to where they started six months ago in developing and maintaining meaningful and positive relationships with their families/caregivers, same-age peers, and other adult supporters. Many youth with SED face difficulties in this area, resulting in isolation or poor decisions. If making and maintaining relationships is a need for a youth, care plans should identify strategies for engaging youth in goal-directed relationship-building.

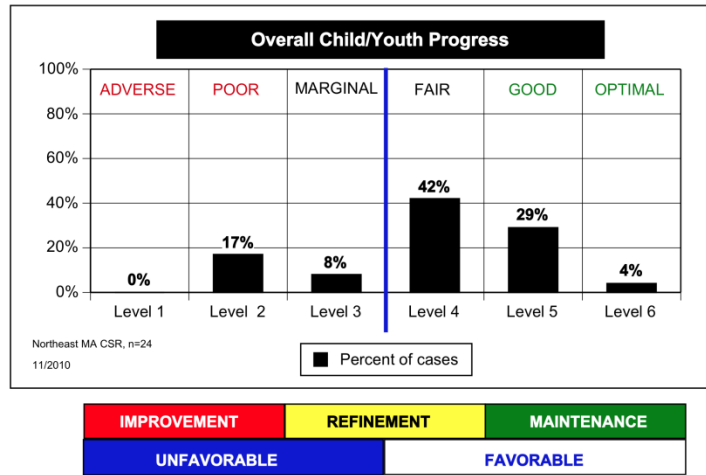
For the 22 youth reviewed for which this indicator was applicable, 18 or 82% of them were making progress in their relationships with their families or caregivers. For youth where

building peer relationships was a goal and was not restricted (N=14) due to current hospitalization, residential treatment, or in detention, 70% were making favorable progress. Progress in developing relationships with positive supportive adults (teachers, coaches, etc.) was favorable for 89% of the youth for which the sub-indicator applied (N=18), which was a positive finding.

**Overall Well-being and Quality of Life**

Measured for the youth and the family, this indicator reviews to what degree is progress being made in key areas of life such as having basic needs met, having increased opportunities to develop and learn, increasing control over one’s environment, developing social relationships/reducing social isolation, having good physical and emotional health, and increasing sustainable supports from one’s family and community. For the youth in the CSR, 71% or 17 youth were making favorable progress in improved overall well-being and quality of life. Sixty-two percent (62%) or 15 of the youth reviewed could benefit from “refinement” or “improvement” in this area, indicating that teams and services may be underpowered in their ability to help many youth in making progress in improving their overall well-being. Of these, four youth had substantial and growing concerns in making progress in their overall quality of life.

For the families and caregivers, 68% were making favorable progress in improving the overall quality of life.



**Overall Youth Progress**

A goal of care planning is to coordinate strategies across settings, and identify any needed treatments or supports youth need to make progress in key areas of their lives. Overall, 75% of the youth were making favorable progress (Fair, Good or Optimal Progress), which is an overall fair finding for progress. Of these 17% were determined to need improvement, and 50% needed refinement in moving forward in the areas measured. For these youth, the right strategies at the right intensity may have been missing or underdeveloped. The remaining 33% were experiencing progress that should be maintained and sustained.

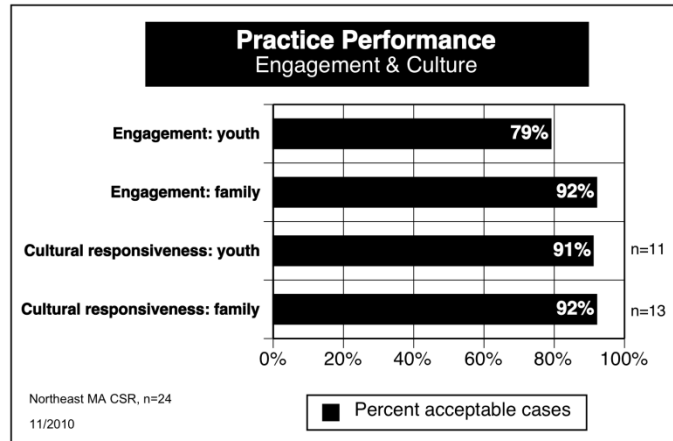
### **System/Practice Functions**

(System/Practice functions are measured as pattern of performance over the past 90 days)

Determining how well the key elements of practice are being performed allow for discernment of which practice functions need to be maintained, refined or improved/developed.

1. Engagement
2. Cultural Responsiveness
3. Teamwork
  - a. Formation
  - b. Functioning
4. Assessment and Understanding
5. Planning Interventions
6. Outcomes and Goals
7. Matching Interventions to Needs
8. Coordinating Care
9. Service Implementation
10. Availability and Access to Resources
11. Adapting and Adjusting
12. Transition and Life Adjustments
13. Responding to Crisis/Risk and Safety Planning

The Commonwealth of Massachusetts is charged with creating the conditions that should lead to improvements for youth and families, and the CSR examines the diligence of services and service practices in providing those conditions. In other words, the review of youth status and progress provides the context for understanding their services; in the CSR, system/practice indicators are rated independently of how youth are doing and progressing. The system/practice functions are rated as how they are being performed. Having services is necessary but not necessarily sufficient; having services and practices that function consistently well is a key to having a dependable system that can reliably create the conditions where youth will make progress.



### ***Engagement***

The central focus of reviewing engagement is to determine how diligent care coordinators and care planning teams are taking actions to engage and build meaningful rapport with a youth and family, including working to overcome any barriers to participation. Emphasis is on eliciting and understanding the youth's and family's perspectives, choices and preference in assessment, planning and service implementation processes. Youth and families should be helped to understand the role of all services providers, as well as the teaming and wrap around processes. Relationships between the care coordinator and the youth/family should be respectful and trust-based. Engagement for this indicator is reviewed for the youth as age appropriate, and for the family.

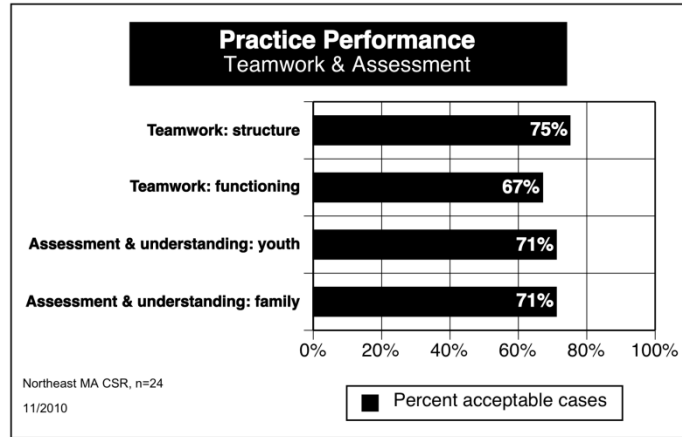
For the youth reviewed, 19 or 79% experienced an acceptable level of engagement, which shows some room for improvement. Families were engaged at an acceptable level 92% of the time, a strong finding. Nine youth (37%) and nine (37%) families in the sample would likely have benefitted from a strengthened level of engagement (Refine or Improve).

An example of Family Engagement that was successful was found for one of the youth reviewed where, "engagement efforts towards the parents were particularly noteworthy. Initial attempts to engage them in the process were met with some resistance. The family was reportedly distrustful of the DCF worker involved at that time, and that worker did not want the parents to attend the CFT meetings. Eventually a strong partnership was formed and the family felt increasingly empowered by the process."

### ***Cultural Responsiveness***

Cultural responsiveness is a practice attribute that should be integrated across all service system functions. It involves attitudes, approaches and strategies used by practitioners to reduce disparities, promote engagement, and individualize the "goodness of fit" between the youth, family and planning/intervention processes. It requires respect and understanding of the youth's and family's preferences, beliefs, culture and identity. Specialized accommodations should be provided as needed.

For the eleven youth reviewed for which the indicator applied Cultural Responsiveness was acceptable for 91% of them, and for the thirteen families where it was applicable, it was acceptable for 92%. These are very positive findings.



***Teamwork: Team Formation and Team Functioning***

Teamwork focuses on the structure and performance of the youth and family’s care planning team. Team Formation considers the degree to which the care planning team is meeting, communicating, and planning together, and has the skills, family knowledge and abilities to organize and engage the family and the youth whenever appropriate. The “right people” should be part of the team including the youth, family, care coordinator, those providing behavioral health interventions, and others identified by the family. Individuals involved with the youth and family from schools and other child-serving systems, as well as those that make up the family’s natural support system should be engaged whenever possible.

Team Functioning further determines if the members of the team collectively function in a unified manner in understanding, planning, implementing, evaluating results, and making appropriate and timely adjustments to services and supports. Reviewers evaluate the degree to which decisions and actions reflect a coherent, sensible and effective set of interventions and strategies for the child and family that will positively impact core issues. Care coordinators should be communicating regularly with the youth, family and team members particularly when there are any changes in situation. The youth and family’s preference should be reflected in any team actions. Optimally, there is a commitment by all team members to help the youth and family achieve their goals and address needs through consistent problem-solving.

*Team Formation.* For the 24 youth reviewed in Northeastern Massachusetts, team formation was acceptable 75% of the time or for 18 youth, indicating improvement is needed in order for families to be able to depend on teams of the right composition being formed on a consistent basis. Reviewers found that 58% of the teams needed “refinement” or “improvement” in formation through identifying the important team members, and engaging them in meeting, communicating and planning together. Of note is that there were ten teams, or 42% of the sample that had good or optimal formation, meaning there were many examples of dependable working teams meeting, talking and planning together. For two youth or 8% of the sample, there were teams that met infrequently to never, and interveners tended to work in isolation from each other.

*Team Functioning.* Teams were functioning acceptably well for 16 or 67% of the youth reviewed, indicating there are opportunities for improvement in team practices. In 63% of the reviews, or for 15 youth, some level of refinement or improvement was determined to be needed in how well teams were functioning. Again, an important finding is that the review



identified nine teams (38% of the sample) functioning at a good to optimal level. This means that the teams had the skills, family knowledge and abilities necessary to work in a unified manner and organized effective services and supports for youth and families who often had considerable complexities. However, there were four teams (17% of the sample) where teams were functioning poorly, and in one case adversely, resulting in limited benefits for the youth and family.

An example of good team formation and functioning for a youth that had been expected to terminate from services is as follows. “(The team) met somewhat regularly and all key stakeholders were invited. The planning process adhered closely to wraparound principles and there is clear evidence that the plan was family-driven. The ICP has focused on increasing the family’s involvement in the community, increasing quality time spent as a family, increasing the youth’s pro-social behavior (i.e. reducing aggression towards his brother), and planning for a smooth transition to school.”

Also important to look at is an example where team functioning needed improvement. In this example, a number of core system/practice functions needed strengthening in order to better serve this youth and family. “The system has been less effective in coordinating and updating members of the team as well as developing a working formulation of the needs, strengths and risks for (the youth and family). The risk and safety evaluation and considerations are under developed and the team appears not to have come to an informed perspective on current risks, triggers, a working hypothesis about the risks and potential supports and interventions to impact risks. The gap between the parent’s perspectives of the needs and supports for (the youth) and those of the team have not been adequately discussed and a direction determined by the overall team. The team members expressed varying degrees of concern, have some common and some different views and there are key decisions to be made involving risk, safety and next steps. The involvement of DCF and the placement of the youth at the (residential program) followed a period of time with seemingly less than needed coordination of information and care considerations across providers and team members. It appeared to be a committed group of providers and agency members without a unified approach and understanding of (the youth) and the family.”

The overall finding for this indicator is that there were many examples of well-formed teams working well together. Improvement is needed in order to assure more teams consistently address their core responsibilities, unite around common goals, and work in alignment with system of care principles.

### ***Assessment and Understanding***

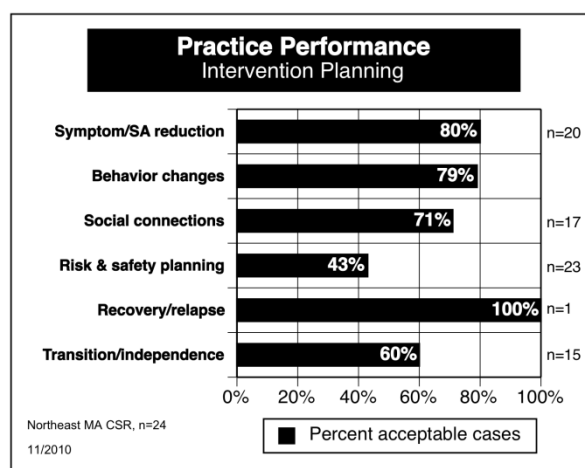
This indicator reviews the basis for determining the set of interventions, supports, and/or services that will be most likely to result in necessary changes for the youth and family. Reviewers assess the degree to which all relevant information has been gathered and synthesized resulting in a complete “big picture” understanding of the strengths, needs, preferences, current situation, risks and core issues of the youth and family. Also important is the ability of teams to assure that assessment and learning is an ongoing process in order to track progress and respond to the changing needs of the youth and family.

Assessment and understanding of youth and families is an important “first step” and foundational condition for practitioners to build cohesive teams and care plans that will result in positive outcomes. Of the 24 youth reviewed, 17 or 71% were found to have an acceptable level of assessment and understanding of their core issues and situations. Fifteen

or 63% of the youth would benefit from “refinement” or “improvement” in the team’s understanding of them. Likewise, assessment and understanding of families was acceptable for 71% of the sample. “Refinement” or “Improvement” was found to be needed for 16 families or 67% of the sample.

An example of assessment and understanding could have been improved was found in a youth’s team where “the initial assessment process identified likely sources of the underlying issues that are sustaining (the youth’s) oppositional behavior and depressive affect, but the mental health professionals have not pursued these issues to expand their understanding and plan and adjust appropriate interventions.”

Another example that also illustrates the connection between assessment/understanding, team functioning and planning is as follows: “The team has not yet widely disseminated or utilized the findings of the recent neuropsychological assessment. It is clear, based both on the report and personal observation that (the youth) is significantly delayed but the team has not incorporated this into their treatment approach in a consistent manner. (The youth) is likely to have the most success when expectations are clearly stated and there is consistency in response to her behavior across settings. This may partially explain the lack of behavioral issues shown at school. As presently constructed, the team appears to lack necessary expertise in programming for developmentally delayed consumers.”



### ***Planning Interventions***

In the CSR, Intervention Planning is evaluated across six sub-indicators. Specific indicators may or may not be applicable to a particular youth depending on what their specific needs and goals might be. Acceptability of intervention planning along these sub-indicators is based on an assessment of the degree to which processes are consistent with system of care and wrap around principles. Reviewers also look at planning from the perspective that plans and processes are cognizant of safety and potential crises, are well-reasoned, well-informed by all available sources of information and are likely to result in positive benefits to the child and family. Plans need to be specific, detailed, accountable and derived from a family-driven team-based planning process. Plans also need to evolve as the youth and family’s situation changes or more or different information is learned.

For the 20 youth the *Symptom or Substance Abuse Reduction* sub-indicator was applicable for, planning for reducing presenting psychiatric symptoms or substance abuse was acceptable

for 80% or 16 of them. Refinement or improvement in planning in this area was needed for 11 or 55% of the youth. There was good or optimal planning in reducing symptoms or substance abuse for 9 or 45% of youth in the sample, hallmarked by well-reasoned strategies. For 3 youth (15%), planning in this area was marginally reasoned, somewhat inadequate, and lacked urgency.

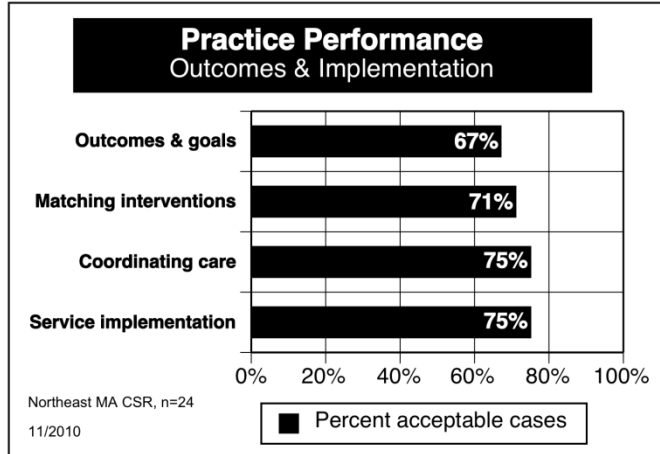
Targeting *Behavior Changes* in planning was applicable to all youth in the sample, and was at an acceptable level for 79% of them. Refinement/improvement was found to be needed 63% of the time. Nine or 37% of youth had good to optimal plans that reflected understanding of the youth and clear interventions for addressing behaviors that created problems for the youth. In two situations (8%) intervention planning to address behaviors was inadequate, and needed improvement.

Planning for increasing *Social Connections* was applicable for 17 youth in the CSR sample and acceptable for 71% of them. Refinement/improvement to assure youth would be supported in developing social connections was needed for 71% of the youth for which the indicator was applicable.

*Risk/Safety* was an identified concern for 23 of the 24 youth in the CSR sample, and was acceptably addressed in planning processes only 43% of the time, indicating a need for improvement in assuring these issues are appropriately addressed. Youth would benefit from refined/improved planning in 61% of the cases for which risk/safety issues were applicable.

Only one youth in the sample needed *Recovery or Relapse* addressed in planning. Planning to address the recovery process and prevention of relapse was acceptable for this youth, but intervention planning could have been refined.

Among youth in the CSR sample, 15 needed to have *Transitions* addressed in their planning processes. Review of transitions in the CSR apply to any transition occurring within the last 90 days or anticipated in the next 90 days including between placements (school and home), programs and to independence/young adulthood. For the 15 youth experiencing transitions in their lives, planning was acceptable for 60%, indicating an area for improvement in order to assure transitions are adequately identified and planned for. Many youth with special needs decompensate or regress if they are not well-supported in a transition. Refinement or improvement in planning was indicated for 67% of the youth experiencing transitions.



***Outcomes and Goals***

The focus of this review is on the degree of specificity, clarity and use of the outcomes and goals that the youth must attain, and when applicable the family must attain, in order to succeed at home, school and the community. Outcomes and goals should be identified and understood by the care planning team so all members can support their achievement. They should reflect a “long-term guiding view” that will help move the youth and family from where they are now, to where they want/need to be in the long-term, as well represent the family’s vision of success for the youth. This indicator is measured as goals and outcomes guiding interventions over the past 90 days.

A clearly stated and understood set of goals and outcomes guiding services and strategies that describe the “ending requirements” for the youth was acceptable for 67% of the youth. A third of the youth, or eight of them had ending goals and outcomes that needed to be “refined” or “improved.” These youth would benefit from stronger practices in specifying outcomes and improvements that reflect the youth and family situation/vision that are known, understood and supported by team members.

***Matching Interventions to Needs***

This indicator measures the extent to which planned elements of therapy and supports for the youth and family “fit together” into a sensible combination and sequence that is individualized to match identified needs and preferences. Interventions can range from professional services to naturally-occurring supports. Reviewers examine the degree of match between interventions and goals of the care plan, and if the level of intensity, duration and scope of services are at a level necessary to meet expressed goals. As well, they look at the unity of effort of interveners, and whether or not there are any contradictory strategies in place. Reviewers commonly refer to this as looking at the “mix, match and fit” of interventions for the youth and family.

For the youth reviewed, there was an acceptable level of matching intervention to need for 71% (17 youth). Overall, 63% of teams could “refine” or “improve” the identification and assembly of services and supports into a more sensible, coherent service process that is coordinated across service providers, and will support youth in meeting their goals.

An example of improvement needed in matching intervention to need was found for a youth with risky behaviors. In this particular situation, despite a shared understanding that team members could articulate, this was not translated into the service plan, goals, nor

interventions that could influence changes for the youth. “Team members seem to share a common and accurate understanding of the barriers and challenges of (the youth and) family, but the treatment plan does not reflect that common understanding. For example, according to the treatment plan, one of the primary goals is to support (the youth) in keeping (the youth’s) room clean. However, interviews with team members suggested much more critical needs, such as facilitating stability in (the youth’s) home and school situations, helping (the youth) to work through issues related to her earlier trauma, assisting (the youth) with developing positive peer relationships and activities outside of the home, and preventing (the youth) from engaging in risky behavior, such as gang involvement or unprotected sexual activity.”

Overall, for this practice domain, more support for teams in better matching interventions to needs is needed to assure all youth and families can consistently depend on a match of their needs to interventions that will work for them. Improvement strategies to consider include team-based understanding of the strengths and needs of a youth and family, clear identification of needs and goals, accountability in the team to assure the right mix and match of service/supports are delivered at the level of intensity and urgency needed and continuous monitoring to assure interventions are working.

### ***Coordinating Care***

Care coordination processes and results were reviewed to determine the extent to which practices aligned with the model of providing a single point of coordination with the leadership necessary to convene and facilitate effective care planning. Reviewers look at care coordination processes including efforts made to ensure that all parties participate and have a common understanding of the care plan, and support the use of family strengths, voices and choices. Other core processes reviewed are the skills of the care coordinator in executing core functions, and assuring the team participates in analyzing and synthesizing assessment information, planning interventions, assembling supports and services, monitoring implementation and results, and adapting and making adjustment as necessary. Care coordinators should be able to manage the complexities presented by the youth and family in their care, and should receive adequate clinical, supervisory and administrative support in fulfilling their role. For youth both in ICC and in-home therapy, the care coordinator should disseminate the youth’s Risk and Safety Plan to all appropriate service providers as well as the family. The care coordinator should facilitate ongoing communications among the entire team

Youth in the sample received care coordination services from both ICC (N=16) and IHT therapists (N=8). Care coordination practices were found to be at an acceptable level for 75% of the youth reviewed. Of note is that care coordination was found to be “good” or “optimal” for half of the youth reviewed. An example of care coordination that was in the acceptable range and working is presented on page 50 of this report.

For the other half of the youth, care coordination needed “refinement” or “improvement” and was found to be at fair or marginal levels. An example was found in one youth’s situation where, “there appears to be a complete absence of any sense of team formation, team functioning or on-going care coordination in this case. Each service provider is working in isolation from one another. The in home therapist has had no contact with either the individual therapist or treating psychiatrist. There have been no (team) meetings surrounding the issues involved in the case. There is some evidence that providers may be working at cross purposes regarding keeping (the youth) in school...the responsibility of

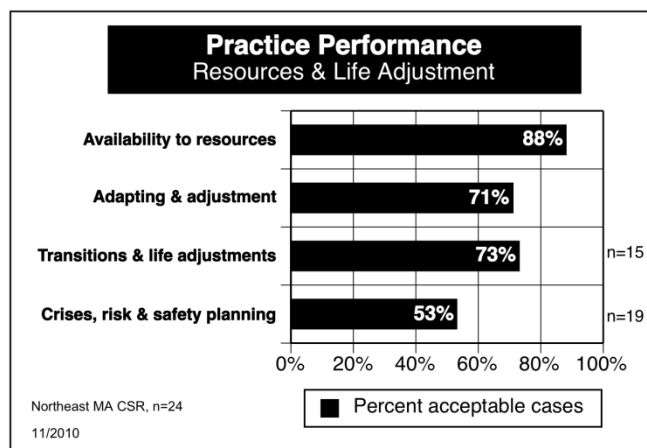
care coordination belongs to the in-home therapy agency but this provider did not appear to be under that impression.” In this case, it is clear to see how care coordination is critical to team formation and functioning.

In the Northeastern Massachusetts CSR, care coordination was adequate for the majority of youth reviewed, although some strengthening of practice and supervision is needed in order for youth to fully and consistently benefit from this service.

### ***Service Implementation***

The Service Implementation indicator measures the degree to which intervention services, strategies, techniques, and supports as specified in the youth’s Individualized Care Plan (ICP) are implemented at the level of intensity and consistency needed to achieve desired results. To make a determination on the adequacy of service implementation reviewers weigh if implementation is timely and competent, if team members are accountable to each other in assuring implementation and if barriers to implementation are discussed and addressed by the team. They also look to see if any urgent needs are met in ways that they protect the youth from harm or regression.

For the youth reviewed, 75% of them had acceptable service implementation. Forty-six percent (46%) needed implementation to be “refined” or “improved.”



### ***Availability and Access to Resources***

Measured in this indicator is the degree to which behavioral health and natural/informal supports and services necessary to implement the youth’s care plan are available and easily accessed. Reviewers look at the timeliness of access as planned, and any delays or interruptions to services due to lack of availability or access in the last 90 days.

In the CSR, 88% of youth had acceptable access to available resources, a strong finding. There was a good and substantial array of supports and services for 75% of the sample, and room for refinement, meaning fair to marginal resource availability, for the remaining 25%.

### ***Adapting and Adjustment***

This indicator examines the degree to which those charged with providing coordination, treatment and support are checking and monitoring service/support implementation, progress, changing family circumstances, and results for the youth and family.

For youth reviewed, practices related to adapting and adjusting plans and services was acceptable for 71% of the youth, with 50% requiring some level of “refinement” or “improvement.” Twelve youth or 50% had good adapting and adjustment practices.

An example of good adapting and adjusting was found for youth where: “The team is well-formed; in particular, this team has shown flexibility and responsiveness to the family’s needs. For example, following communication between the teacher and mother, the IHT recently requested that the former outpatient therapist become re-involved with (youth). Not having to start over with a new therapist was very important for this family and child. Furthermore, this family is not ‘over-serviced’; that is, the level of services matches the family’s needs.”

### ***Transitions and Life Adjustments***

For youth who have had a recent transition, or one is anticipated, reviewers examined the degree to which the life or situation change was planned, staged and implemented to assure a timely, smooth and successful adjustment. If the youth is over age 14, a view by the team as well step-wise planning to assure success as the youth transitions into young adulthood is most often warranted. Transition management practices include identification and discussion of transitions that are expected for the youth, and planning/addressing necessary supports and services necessary at a level of detail to maximize the probabilities for success.

For the 15 youth this indicator applied to, 73% or 11 youth had acceptable transition management practices in place. Nine youth (38%) could benefit from “refined” or “improved” transition supports. Five youth (33%) had good transition planning and interventions taking place, and for one youth (6%) the practices were optimal. One youth (6%) experienced a poor transition that was basically unaddressed.

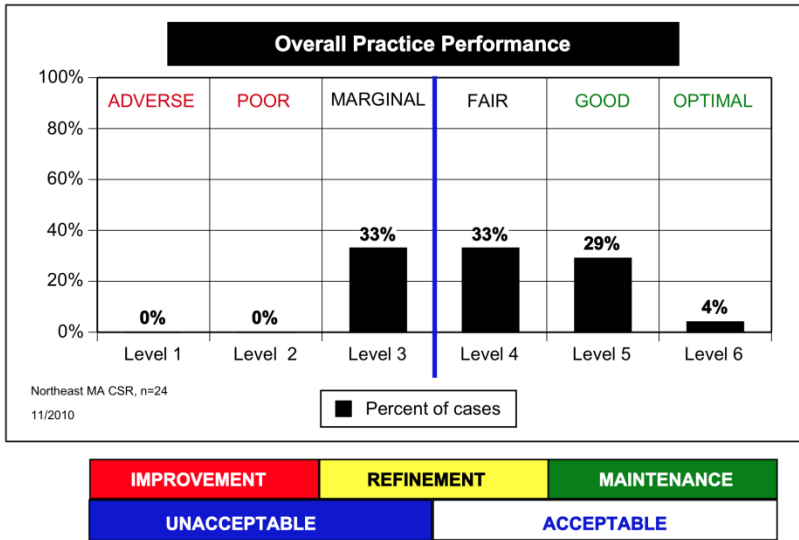
Overall, improving the ability to identify, plan for and implement supporting youth in their life transitions could be improved through strategies such as training, supervision and quality management.

### ***Responding to Crises and Risk/Safety Planning***

The CSR reviewed the timeliness and effectiveness of planning, supports and services for youth who had a history of psychiatric or behavioral crises or safety breakdowns over the past six months, or recurring situations where there was a potential of risk to self or others. Also examined was evaluation of the effectiveness of crisis responses and resulting modifications to Risk and Safety Plans. Plans should include strategies for preventing crises as well as clear responses known to all interveners including the family. Having reliable mobile crisis services is critical for many youth with SED, and is a requirement of the *Rosie D. Remedy*.

For youth where this indicator was applicable (N=19), only 53% or 10 youth had an acceptable crisis response and risk plan that worked acceptably well. Five of the youth were rated to have either an optimal or good response to crisis and/or safety issues. However, 73% needed “refinement” or “improvement” in crisis response and risk/safety planning. One of them experienced crisis responses that were unprepared to recognize and respond, or risk/safety plan provision that incomplete and unable to manage risk for the youth.

An example was reported by one mother where “the mobile crisis team reportedly will not come to the home when any of the children is (experiencing tantrums) or engaging in aggressive behavior.”



**Overall System/Practice Performance**

The chart above shows the distribution of scores for System/Practice Performance across the six point rating scale. For the youth reviewed, when rounded, 66% were found to have acceptable system/practice performance. Performance scores clustered at the good, fair and marginal levels with 95% of youth reviewed falling in this range. In interpreting the results for system/practice performance, it is important to see them in the light of how youth are doing and progressing. In looking at expectations of system performance, youth and families come into services with the expectation that they can depend on services that will help them. In other words, the expectation is that the system and practices should be performing acceptably well for most of the youth and families services.

Thirty-three percent (33%) of those reviewed fell in the “Maintenance” area, meaning the system and practices were effective for a third of the youth, and efforts should be made to sustain and build upon a positive practice situation.

Sixty-six percent of youth reviewed fell in the “Refinement” area which means that performance was limited or marginal, and further efforts are necessary to refine the practice situation. Practice patterns in these situations need a level of refinement in order to impact better youth engagement, teamwork, understanding, planning, matching interventions to needs, coordinating, implementation/adjustment of services and crisis responses as described in this section.

The data indicate that the strongest areas of practice for the sample as a whole (there is variability in performance results for individual youth) were Engagement with Family; Cultural Responsiveness; Planning Interventions for Recovery or Relapse; and Resource Availability.

Indicators that showed an overall fair performance but at a less consistent or robust level of implementation were Engagement with Youth; Planning Interventions for Symptom or Substance Reduction; and Planning Interventions for Behavior Changes.

Areas of system/practice performance that need some level of improvement in order to assure consistency, diligence and/or quality of efforts are Teamwork (Formation and



Functioning); Assessment & Understanding of Youth and Family; Planning Interventions for Social Connections; Outcomes and Goals; Matching Interventions to Needs; Coordinating Care; Service Implementation; Adapting and Adjustment; and Transitions & Life Adjustments.

Review results indicate weak performance was found in the following system/practice domains: Planning Interventions for Risk and Safety Planning; Planning Interventions for Transitions; and Responding to Crises and Risk & Safety Planning.

Overall, the findings of the CSR showed that certain foundational system of care practice such as engagement of families, and cultural responsiveness were strong, although looking at ways to improve engaging youth may be beneficial. Strong practices were found for several youth in intervention planning to enhance substance abuse recovery and relapse prevention. Outside of crisis services, needed resources were available for most youth.

Other core system practices need a degree of improvement to assure performance is consistent and at the skill level needed so that families can reliably depend on services to achieve results. Teams are being assembled with the right people for many youth, but not at the level of consistency needed to deem teamwork as a fully dependable system practice. Likewise, some improvement is needed in how teams are functioning once assembled, including fully using assessment information and broad understanding of the youth and family to create workable plans. Planning functions that were measured need some level of improvement in most areas, particularly in risk/safety and transition planning in order to assure all youth have plans that are targeting the right issues and achieving the desired results though active care coordination and systematic review and adjustment of plans and services.

These findings suggest that the system of care in Northeastern Massachusetts is well on its way to achieving dependable functional teams and well-coordinated care, however stronger training, support and oversight is likely needed to assure all teams are working toward bringing together collective understandings of the youth and family, establishing agreed upon goals, and working in concert to identify and implement strategies. As will be discussed in the next section, 67% of the youth were found to have overall acceptable system practices, which suggests focused strategic, and sustained improvements in practice will likely move system performance to the desired levels.

## CSR Outcome Categories

		Status of Child/Youth/Family			
		Favorable Status	Unfavorable Status		
<div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 0 auto;"> <b>Acceptability of Service System Performance by Individual Youth</b> </div>	Acceptable System Performance	<b>Outcome 1:</b> Good status for child/youth/family, ongoing services acceptable.  <b>67% (16 youth)</b>	<b>Outcome 2:</b> Poor status for child/youth/family, ongoing services minimally acceptable but limited in reach or efficacy.  <b>0% (0 youth)</b>	<b>67%</b>	
	Unacceptable System Performance	<b>Outcome 3:</b> Good status for child/youth/family, ongoing services mixed or unacceptable.  <b>13% (3 youth)</b>	<b>Outcome 4:</b> Poor status for child/youth/family, ongoing services unacceptable.  <b>21% (5 youth)</b>	<b>34%</b>	
		<b>80%</b>	<b>21%</b>		

Northeast MA CSR, n=24  
11/2010

### CSR Outcome Categories Defined

Youth in the CSR sample can be classified and assigned to one of four categories that summarize review outcomes. Children and youth having overall status ratings in the 4, 5, and 6 levels are considered to have “favorable status.” Likewise, those having overall practice performance ratings of 4, 5, and 6 are considered to have “acceptable system performance” at the time of the review. Those having overall status ratings less than 4 had “unfavorable status” and those having overall practice performance ratings less than 4 had “unacceptable system performance.” These categories are used to create the following two-fold table. Please note that numbers have been rounded and overall totals may add up to slightly more than 100%.

### CSR Results

#### *Outcome 1*

As this display indicates, 67% (16 youth) of the 24 youth fell into outcome category 1. Outcome 1 is the desired situation for all children and families receiving services.

An example of a youth’s situation that was rated as an Outcome 1 is as follows.

*“All the right people are represented on the team for members of the family. The service providers that were interviewed expressed consistently that the communication and coordination of the team was very good. Everyone on the team understood their roles and was complimentary of the ICC. The team has met on a consistent basis and the clinical record reflected that the individual care plan was being tracked and adjusted. Overall, the team had a good understanding of the dynamics within the family. The service system has effectively obtained important information from prior placements including the DCF service plan and the Individual Education Plan from school. The ICC and Family Support provider were both involved in the transition/discharge plan in preparation for (the youth’s) return home. (The youth’s) individual care plan was relevant and*

*updated as needed. The CANS reflected and identified the relevant issues and the intensity of services was appropriately matched.”*

### **Outcome 2**

No youth in the fell in Outcome category 2. This category represents children whose needs are so great or complex that despite the best practice efforts and diligent system performance of the service system, the overall status of the child or youth is still unacceptable.

### **Outcome 3**

Thirteen percent (13%) or 3 youth were in outcome category 3. Outcome 3 reflects youth whose status was favorable at the time of the review, but who were receiving less than acceptable service system performance. Some children are resilient and may have excellent naturally occurring supports provided by family, friends, school personnel, or some other key person in their life whose efforts are significantly contributing to the child’s favorable status at the present time. However, current service system/practice performance is limited, inconsistent, or inadequate at this time. For these children, when teams and interveners adequately form, understand the youth and family, and function well, the youth could likely progress into the outcome 1 category.

The following is an example of a youth in Outcome 3. This youth currently in a stable situation in kinship care, but the family continues to face significant challenges. The service system has been sporadic in its ability to provide dependable services and supports. The forecast for this youth’s status over the next six-months based on the current pattern of performance is to decline.

*“The system functions that are not working can be attributed to the new ICC challenges with scheduling a meeting with the family (with no meeting) since August 2010. The team is operating off of an outdated plan that needs to be modified to reflect the family’s current status. The team has not coordinated all the needed services and resources to assist the family. The family has experienced a turnover (of) multiple providers in a small span of time (and) the family now has been slow to engage with some providers. (The youth’s) emergency reunification to home was without a transition plan. However there was no reassessment and plan implemented after (the youth) was in the home to ensure stability.”*

### **Outcome 4**

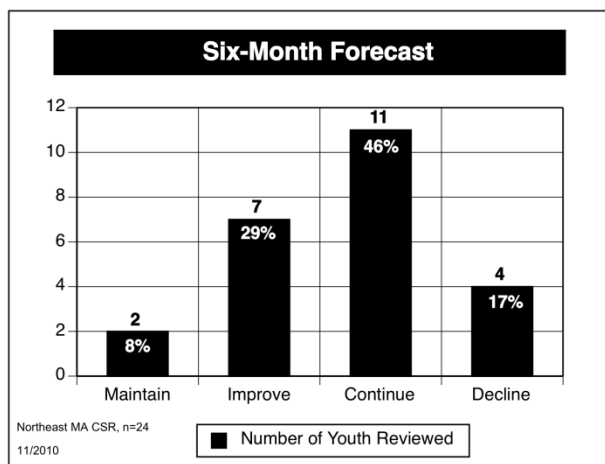
In the Northeastern Massachusetts CSR, 21% of the sample or 5 youth fell into outcome category 4. Outcome 4 is the most unfavorable outcome combination as the child’s status is unfavorable and system performance is inadequate. For many of the youth who are in Outcome 4, a better understanding of the youth and family coupled with stronger teamwork and planning interventions that meet the needs of the youth with strong oversight of implementation would move the youth into a better Outcome classification.

An example of a youth who fell in Outcome 4 is as follows. This youth is currently in an out of home setting, has exhibited behaviors that put others at risk, and there is not a clear unified understanding or discussion about the core issues that may be provoking his behaviors. Lack of informed planning in this situation may result in an unsafe situation for this youth and/or family.

*“The system has been less effective in coordinating and updating members of the team as well as developing a working formulation of the needs, strengths and risks for (the youth and family). The risk and safety evaluation and considerations are under developed and the team appears not to have come to an informed perspective on current risks, triggers, a working hypothesis about the risks and potential supports and interventions to impact risks. The gap between the parent’s perspectives of the needs and supports for (the youth) and those of the team have not been adequately discussed and a direction determined by the overall team. The team members expressed varying degrees of concern, have some common and some different views and there are key decisions to be made involving risk, safety and next steps... It appeared to be a committed group of providers and agency members without a unified approach and understanding of (and with the youth) and the family.”*

### **Overall outcome findings**

The percentages on the outside of the two-fold table on Page 50 represent the total percentages in each category. The percentage at outside, top right (67%) is the total percentage of youth with acceptable system/practice performance (sum of Outcomes 1 and 2). The percentage below this (34%) is the inverse- the percentage of youth with unacceptable system/practice performance. Again, these numbers reflect rounding and the total is slightly more than 100%. Likewise the number on the outside lower left is the percentage of youth that has favorable status (80%) and under the next block the percentage of youth with unfavorable status (20%).



### **Six-month Forecast**

Based on review findings, reviewers are asked if the child’s situation is likely maintain, improve, continue or decline. For 2 youth or 8%, the prediction is that the youth would maintain their current status. For 7 youth or 29% of the sample, the prediction was for improvement in situation. For 11 youth or 46%, the reviewers predicted the youth’s situation to remain the same, which could be favorable or unfavorable. For four youth or 17%, the prediction was that their situation would decline.

## Summary of Findings

Data, Findings and Recommendations in this report are presented through the lens of examining the consistency and quality of service provision and practices in meeting requirements of the *Rosie D. Remedy*. These include requirements for services provided consistent with System of Care Principles, and wraparound principles and phases. Eligible youth are also required to be provided timely access to necessary services through effective screening, assessment, coordination, treatment planning, pathways to care and mobile crisis intervention when needed. In addition, services and practices need to support youth and families to participate in teams, have teams with the involved people that work together to solve problems, and understand the changing needs and strengths of youth and families across settings. As well, it requires well-executed care coordination that results in care consistent with the CASSP principles; and is strength-based, individualized, child-centered, family-focused, community-based, multi-system and culturally competent. The Remedy requires individualized care plan to be updated as needed, addressing transition and discharge planning specific to child needs.

Following is the qualitative summary of CSR findings highlighting the themes and patterns found in the CSR data, stakeholder interviews and youth-specific findings.

### Strengths

#### ***There were examples of strong practices including in care coordination, teamwork and integration of efforts with other agencies.***

The CSR for Northeastern Massachusetts found many Care Coordinators who understood their roles and communicated consistently with team members. This facilitated teamwork hallmarked by regular meetings, good communication, identification of youths' and families' needs and strengths, and care plans that resulted in youth making progress. Notable were observations of teams that built strong positive working relationships with other child-serving agencies including Probation, DYS and DCF. Integration of work with other agencies was seen resulting in better therapeutic impact with youth and their families including several examples of blending of resources.

The review also found strong examples of good use of natural supports in plans, and teams understanding and actively using wrap-around approaches in engaging families and developing plans. Of note was the percentage of families reviewed where particularly mothers and transition-aged youth felt their voice and choice was respected, and they were active in the wrap-around planning process.

#### ***There are many talented and diligent staff including Family Partners, Mentors, Skills Trainers, Therapists and Care Coordinators***

Competent staff at all levels were seen going "above and beyond" in their work with youth and families. Staff appear to be excited about their work, and willing to learn new approaches to achieving results and outcomes. Families in general express satisfaction with many aspects of the new practice model. Teams are generally embracing the wrap-around model, and are working well with most families.

***System of Care Committees are established, working well together, and actively problem solving.***

System of Care Committees (SOC) are active and providing opportunities for joint problem-solving in local-level systems of care. There is a growing sense about the value of doing work in a “different way,” including the team-based wrap-around approach. There is strong leadership from the CSA’s in a number of the SOC Committees, and system partners express that the SOCs are helpful to the work of providing services for children and families.

**Challenges**

***Staff and teams do not consistently know how to use assessments and other relevant information to inform planning.***

The gathering of information and assessment of youth and families that is functional, well-formulated, and uses all available/relevant information is not consistently occurring. Information gathered from multiple sources is critical for informing planning and identifying unmet needs. While most staff believe in the wrap-around approach, many are having difficulty in, or are confused about, using assessment information to inform planning. In a number of situations, the CSR found clinical assessments or other relevant knowledge to be not current or available, or lacking information important to building plans of care.

Staff may have received mixed messages in their training and many are interpreting the need to “start fresh” with families in the wraparound approach to mean they should not read prior assessments or treatment records to aid in their understanding of the youth and family prior to convening initial care planning meetings. As a result, many care coordinators are interpreting the wraparound practice model to be one devoid of using clinical and other existing information about the youth to inform planning. Additionally many youth do not have current comprehensive psychosocial assessments that are of the quality needed to better understand the youth and family. Parents express that they are sometimes assuming that care coordinators know relevant information, but often they do not because of an interpretation of “starting fresh.”

Teams often appear to be challenged in bringing together expectations regarding the use of clinical assessments, diagnoses, comprehensive In Home Assessments, and Strengths, Needs and Challenges Discovery as linked to the Wraparound approach, medical necessity and care planning. Coaching and supervision to help care coordinators and teams “connect the dots” between these system functions could be improved.

The CSR found that 83% of parents had not received their child’s current assessment. This may be an important factor to look at when moving forward the practice model of assuring assessments that help teams to have a broad-based understanding of youth needs.

***Skills of staff are sometimes not at the level needed to address the behavioral health issues of youth and families. Service plans were sometimes overly narrow in their scope.***

In some situations, the intensity of treatment and skills of therapists were not adequate, or care coordinators could not facilitate a viable care plan. Often youth needed a more specialized mode of treatment. There was a tendency in some situations to provide a lot of services, instead of arriving at a sensible mix that is individualized and meets the needs of the youth and family.

Service plans did not always reflect the full range of youth needs, but settled on a narrow focus, even when teams could articulate what the needs were. This pattern was often explained as a concept that plans should only reflect goals selected by the family versus building plans with the team that identify the range of concerns that need to be addressed for a youth to achieve social and psychological well-being. For example, in one situation the family selected the goal of keeping the youth's room clean, which was the primary goal reflected on the plan of care. Team members met regularly and could speak to the broader needs of the youth including achieving stability, addressing trauma, having healthy friendships, choosing healthy behaviors and avoiding gangs; however, none of these needs or strategies to address them appeared in the youth's service plan. The youth increasingly disengaged with services, and the team felt helpless in their attempts to provide the "right" service and supports.

Staff and teams do not appear to be consistently able to access supervision to help with better understanding the complex situations of youth and families, nor consultation on the best course of treatments and supports that will help youth to progress. As well, many of the youth and/or families have a range of behavioral health issues and complex experiences such as sexual abuse, domestic violence, and substance use and teams are struggling with developing plans that are "simple and focused" while understanding and integrating the complexity of the youth's situation at the right level of urgency. Many staff and teams appear to have difficulty with building plans and strategies that help youth and families with attaining near-term results that will help them achieve long-term desired outcomes.

***Mobile Crisis Intervention (MCI) Services have been difficult to access, and teams often do not respond or are not helpful in resolving crises.***

Although there were examples of good performance by mobile crisis teams, dependability of crisis services (length of time to respond, no response, refusal to respond if the behaviors are seen as extreme) was cited as an issue in the reviews and in stakeholder interviews with families and staff. Many families perceive the service to be more oriented to only providing an assessment of need for admission into an inpatient level of care rather providing an intervention with the youth or family to help stabilize a crisis and avert a hospitalization. Crisis-oriented engagement with a family during or after a crisis appears to be more of an exception than a standard practice. Families cited examples of MCI refusing to respond when the child was having a tantrum or being aggressive toward the parent.

***Risk Management/Safety Plans are not consistently useful to families when they experience a crisis.***

Planning to address risk and safety issues was inadequate for the majority of youth reviewed (57%), and plans did not work for well for many youth that experienced crisis (47%). In a number of the reviews, Risk Management/Safety Plans were not found. Stakeholders and staff provided feedback that the Risk Management/Safety Plan form currently in use is not consistently helpful in an actual crisis. Their experience is that the format does not reflect what is really needed to identify risks, to identify when a risk is becoming more acute, nor the actions that the youth and parents can agree would be helpful to reduce the risk. As well, they would like to see a functional plan that identifies what to do when a situation becomes serious to the point where a family needs crisis intervention assistance because the "family plan" has not worked. Ideally the plan would help the family to determine when they would ask for input from their Family Partner or in-home therapist, as opposed to when they

would call mobile crisis intervention. Safety plans need to have the level of specificity to help families describe to MCI what they need and the level of urgency that is present. Ideally, the youth and family, as well as those involved with the youth in their daily activities should understand how to activate the plan.

***Agencies are experiencing workforce issues and stability of staffing.***

Issues that may stem from the business model are impacting the ability of provider agencies to retain competent staff. This in turn is impacting some youth and families in terms of having consistent providers because of high staff turnover in some agencies. The CSR noted service availability issues resulting in delays in accessing the services that have been identified on youths' plans of care.

***For a number of families, there is a growing frustration with issues related to changes in their MassHealth eligibility status***

Families cited that that they were confused about changes in their health plans, their eligibility and the process for regaining eligibility. This is reported to cause continuity of care issues and result in youth and families losing progress. Staff spend an inordinate amount of time helping families to navigate the eligibility process. The system is described as not user-friendly. For youth with complex mental health issues that require continuity of care, this appears to be a major issue for families. Untimely service authorizations were also cited as an issue impacting access to services.

## **Recommendations**

### ***Strengthen Practices and Support of Care Coordinators***

- Help teams and care coordinators to:
  - Review available existing information (assessments, clinical/service files, educational information, medical information, etc.) in order to better understand a youth and family
  - Identify when a current mental health assessment is needed
  - Learn how to connect and use all information, including but not exclusive of the formal mental health assessment, to fully understand the youth and family. Include which approaches have previously worked and which have not, parental reports, observations across settings, and the collective knowledge of team members. Use this comprehensive understanding in a dynamic team-based approach to select goals, outcomes, interventions, supports and services.
  - Assure families are fully engaged and understand the assessment and assessment process. Afford parents the opportunity to ask questions about their child's mental health assessment that may help them better understand the mental health and developmental needs of their child.
- Explore ways to systematically identify situations that need clinical/specialized consultation and more intensive oversight and to access clinical/specialized consultation and supervision for staff and teams. Assure care coordinators and clinicians have access to supervision and consultation.
- Assure plans/interventions are at the intensity needed to address needs and achieve results through processes such as supervision and quality management. Help teams to achieve functional status results and progress for youth in areas such as improved



emotional/behavioral status, coping, social connections and school stability and decreased behavioral risk.

- Help in-home therapists to assess when a youth and family may need ICC. Assure all in-home therapists understand their role in providing care coordination.
- Improve the quality of individualized care plans to assure they have clear outcomes and goals, interventions and supports that address core needs across domains, and address all anticipated transitions that the youth will be experiencing. Assure all goals in plans are addressed and planned strategies are implemented.
- When youth are transitioning from residential programs or inpatient settings, engage staff from these programs in order to better inform transition planning.
- Coach facilitation skills of care coordinators for engaging all relevant people who should be part of a team especially schools.
- Many of the parents of youth reviewed would be better able to provide supports for their children if connected to mental health or other services to address their own needs. Help care coordinators to engage parents in exploring their own needs and making linkages to needed services and supports
- Identify cases where there is high situational and/or clinical complexity, engagement issues, exceptional challenges parents are experiencing, team agreement issues, organizational factors (service delays, staff turnover, etc.) and other “triggers” that may indicate the need for additional supervision, consultation or other supportive review. Provide support for care coordinators and teams where needed. Realizing effective practices to identify and respond to situations that need focused supervision and consultation may involve developing organizational protocols and training for supervisors and care coordinators.

***Consider services and supports that could enhance the service array***

- Examine options for integrating transportation, parent support groups and flexible funds into the service array.

***Improve ability to track and respond to access, continuity of care and quality concerns***

- Strengthen quality management to assure practices and aspects of the service delivery system that need improvement are systematically reviewed and addressed. Track and use data to guide service improvements.
- Assure youth have timely access to all services and continuity of ongoing services.
- Systematically review caseloads that are high. The data in Table 23 indicates that for the youth reviewed, 14% of those coordinating care had caseloads greater than 18.

***Improve Crisis Planning and Crisis Services***

- Assure that Risk Management/Safety Plans are developed, are functional and accurately reflect the level of risk and needs present for the youth. Provide teams with assistance in learning how to develop useful and functional Risk Management and Safety plans including how to help parents and youth participate in the development of plans and learn skills needed to use their plan.
- Take a focused look at youth who are experiencing crises, especially those who are having multiple crises, and evaluate if the responses are adequate.

## Appendix 1

### Child's General Level of Functioning

**Level** (*check the one level that best describes the child's global level of functioning today*)

- 10** Superior functioning in all areas (at home, at school, with peers, in the community); involved in a wide range of activities and has many interests (e.g., has hobbies, participates in extracurricular activities, belongs to an organized group such as the Scouts); likable, confident; "everyday" worries never get out of hand; doing well in school; getting along with others; behaving appropriately; no symptoms.
- 9** Good functioning in all areas: secure in family, in school, and with peers; there may be transient difficulties but "everyday" worries never get out of hand (e.g., mild anxiety about an important exam; occasional "blow-ups" with siblings, parents, or peers).
- 8** No more than slight impairment in functioning at home, at school, with peers, and in the community; some disturbance of behavior or emotional distress may be present in response to life stresses (e.g., parental separation, death, birth of a sibling), but these are brief and interference with functioning is transient; such youth are only minimally disturbing to others and are not considered deviant by those who know them.
- 7** Some difficulty in a single area, but generally functioning pretty well (e.g., sporadic or isolated antisocial acts, such as occasionally playing hooky or committing petty theft; consistent minor difficulties with school work; mood changes of brief duration; fears and anxieties that do not lead to gross avoidance behavior; self-doubts); has some meaningful interpersonal relationships; most people who do not know the youth well would not consider him/her deviant but those who know him/her well might express concern.
- 6** Variable functioning with sporadic difficulties or symptoms in several but not all social areas; disturbance would be apparent to those who encounter the child in a dysfunctional setting or time but not to those who see the youth in other settings.
- 5** Moderate degree of interference in functioning in most social areas or severe impairment of functioning in one area, such as might result from, for example, suicidal preoccupations and ruminations, school refusal and other forms of anxiety, obsessive rituals, major conversion symptoms, frequent anxiety attacks, poor or inappropriate social skills, frequent episodes of aggressive or other antisocial behavior with some preservation of meaningful social relationships.
- 4** Major impairment in functioning in several areas and unable to function in one of these areas; i.e., disturbed at home, at school, with peers, or in society at large; e.g., persistent aggression without clear instigation, markedly withdrawn and isolated behavior due to either thought or mood disturbance, suicidal attempts with clear lethal intent; such youth are likely to require special schooling and/or hospitalization (but this alone is not a sufficient criterion for inclusion in this category).
- 3** Unable to function in almost all areas, e.g., stays at home, in a ward, or in a bed all day without taking part in social activities or severe impairment in reality testing or serious impairment in communication (e.g., sometimes incoherent or inappropriate).
- 2** Needs considerable supervision to prevent hurting self or others (e.g., frequently violent, repeated suicide attempts) or to maintain personal hygiene or gross impairment in all forms of communication (e.g., severe abnormalities in verbal and gestural communication, marked social aloofness, stupor).
- 1** Needs constant supervision (24-hour care) due to severely aggressive or selfdestructive behavior or gross impairment in reality testing, communication, cognition, affect, or personal hygiene.
- 0** Not available or not applicable due to young age of the child.

Appendix 2

**CSR Interpretative Guide for Person Status Indicator Ratings**

<p><b>Maintenance Zone: 5-6</b></p> <p>Status is favorable. Efforts should be made to maintain and build upon a positive situation.</p>	<p>6 = <b>OPTIMAL &amp; ENDURING STATUS</b> The <u>best or most favorable status presently attainable</u> for this person in this area [taking age and ability into account]. The person is <u>continuing to do great</u> in this area. Confidence is high that <u>long-term needs or outcomes will be or are being met</u> in this area.</p> <p>5 = <b>GOOD &amp; CONTINUING STATUS</b> Substantially and dependably positive status for the person in this area with an <u>ongoing positive pattern</u>. This status level is <u>generally consistent with attainment of long-term needs or outcomes</u> in area. Status is "looking good" and likely to continue.</p>	<p><b>Favorable</b> Range: 4-6</p>
<p><b>Refinement Zone: 3-4</b></p> <p>Status is minimum or marginal, may be unstable. Further efforts are necessary to refine the situation.</p>	<p>4 = <b>FAIR STATUS</b> Status is at least <u>minimally or temporarily sufficient</u> for the person to <u>meet short-term needs or objectives</u> in this area. Status has been no less than <u>minimally adequate</u> at any time in the past 30 days, but may be short-term due to changing circumstances, requiring change soon.</p> <p>3 = <b>MARGINALLY INADEQUATE STATUS</b> Status is <u>mixed, limited, or inconsistent</u> and <u>not quite sufficient to meet the person's short-term needs or objectives</u> now in this area. Status in this area has been somewhat inadequate at points in time or in some aspects over the past 30 days. Any risks may be minimal.</p>	
<p><b>Improvement Zone: 1-2</b></p> <p>Status is problematic or risky. Quick action should be taken to improve the situation.</p>	<p>2 = <b>POOR STATUS</b> Status is now and may continue to be <u>poor and unacceptable</u>. The person may seem to be <u>"stuck" or "lost" with status not improving</u>. Any risks may be mild to serious.</p> <p>1 = <b>ADVERSE STATUS</b>. The person's status in this area is <u>poor and worsening</u>. Any risks of harm, restriction, separation, disruption, regression, and/or other poor outcomes <u>may be substantial and increasing</u>.</p>	<p><b>Unfavorable</b> Range: 1-3</p>

**CSR Interpretative Guide for Practice Performance Indicator Ratings**

<p><b>Maintenance Zone: 5-6</b></p> <p>Performance is effective. Efforts should be made to maintain and build upon a positive practice situation.</p>	<p>6 = <b>OPTIMAL &amp; ENDURING PERFORMANCE</b>. <u>Excellent, consistent, effective practice</u> for this person in this function area. This level of performance is indicative of <u>well-sustained exemplary practice and results</u> for the person.</p> <p>5 = <b>GOOD ONGOING PERFORMANCE</b>. At this level, the system function is <u>working dependably</u> for this person, under changing conditions and over time. Effectiveness level is generally <u>consistent with meeting long-term needs and goals</u> for the person.</p>	<p><b>Acceptable</b> Range: 4-6</p>
<p><b>Refinement Zone: 3-4</b></p> <p>Performance is minimal or marginal and may be changing. Further efforts are necessary to refine the practice situation.</p>	<p>4 = <b>FAIR PERFORMANCE</b>. Performance is <u>minimally or temporarily sufficient to meet short-term need or objectives</u>. Performance in this area of practice has been no less than <u>minimally adequate</u> at any time in the past 30 days, but may be short-term due to changing circumstances, requiring change soon.</p> <p>3 = <b>MARGINALLY INADEQUATE PERFORMANCE</b>. Practice at this level may be <u>under-powered, inconsistent or not well-matched to need</u>. Performance is <u>insufficient at times or in some aspects for the person to meet short-term needs or objectives</u>. With refinement, this could become acceptable in the near future.</p>	
<p><b>Improvement Zone: 1-2</b></p> <p>Performance is inadequate. Quick action should be taken to improve practice now.</p>	<p>2 = <b>POOR PERFORMANCE</b>. Practice at this level is <u>fragmented, inconsistent, lacking necessary intensity, or off-target</u>. Elements of practice may be noted, but it is <u>incomplete/not operative on a consistent or effective basis</u>.</p> <p>1 = <b>ADVERSE PERFORMANCE</b>. Practice may be <u>absent or not operative</u>. Performance may be <u>missing (not done)</u>. - OR - Practice strategies, if occurring in this area, may be contra-indicated or <u>may be performed inappropriately or harmfully</u>.</p>	<p><b>Unacceptable</b> Range: 1-3</p>