Rosie D.
Community Services Review
Annual Report

Report of Statewide Findings
Fiscal Year 2010-2011

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Executive Summary

Between September 2010 and May 2011, five regional Community Services Reviews (CSR) were conducted across the Commonwealth of Massachusetts. The five regional CSRs were conducted in the Western, Northeastern, Boston/Metro-Boston, Southeastern and Central areas. This report presents the statewide findings of the CSRs. In total, 139 youth and families receiving Intensive Care Coordination (ICC) and/or In-home Therapy (IHT) services through Community Service Agencies (CSAs) and provider agencies were reviewed to determine how *Rosie D.* class members are doing across key indicators of status and progress as a way to determine how services and practices are working.

At the point of each of the regional CSRs the *Rosie D.* Remedy Plan and Remedy Services, with the exception of Crisis Stabilization services that have not yet been implemented, had been in place between one and two years. The Remedy Plan commits the Commonwealth to providing the new services through a practice model that requires team-based work and fully integrates family voice and choice. Services are required to be delivered through a coordinated approach consistent with System of Care and Wrap-Around principles.

This Annual Report of Statewide Findings of the Community Services Review provides information about how well behavioral health services and the integrated system of coordinated care for youth with Serious Emotional Disturbances (SED) and their families committed through the *Rosie D.* Remedy Plan are performing for class members. It reflects trends and pattern, strengths and challenges of the system of services as determined through intensive case-reviews of the 139 youth and families, as well as interviews with approximately 1080 stakeholders statewide. Data are presented at the statewide aggregate level for most of the indicators in this report. As well, comparative data of the five regional CSRs are displayed for the System/Practice Performance indicators. Reports were published throughout the year for each of the five regional CSRs.

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. The CSR was selected in consultation with the Parties to assist the Court Monitor as one way to receive and review information about the status and progress of services and requirements of *Rosie D.*

The work of providing services and supports to assure youth are served adequately within the framework of care required through *Rosie D.* is a complex one. It requires consistency of practice and results across many provider agencies, communities and child and family teams. Infrastructure, service array, standards, quality management processes and communications are among the many service functions that must work in concert to support effective practices at the level of the youth and family. Issues such as administrative requirements, the business environment, workforce capacity and caseload size have a continual and dynamic impact on programs' ability to adequately serve each youth. These are among the many contextual, and often developmental factors that provide the frame for how well services work. The CSR is designed to examine how current practices are working including the fundamental task of how well teams can understand the youth and families receiving services, and craft supports and interventions that are responsive to their individual needs.

Characteristics of Youth Reviewed.
Of the 139 youth randomly sampled and reviewed across the state, the largest percentage (35%) was in the 10-13 year old age group, closely followed by 33% on the 14-17 year old range. Twenty-one percent (21%) were in the 5-9 year old range, 6% were 18-21, and only 2% were in the 0-4 age range. Only the Western Massachusetts CSR had youth in the 0-4 age range in their random sample. The proportion of boys to girls reviewed was 62% boys to 38% girls. More boys than girls were reviewed in every age range, except in the 14-17 year old group where girls outnumbered boys 59% to 41%.

At the time of they were reviewed, 87% at the statewide level were living with their biological parents or in an adoptive home; the remaining youth were living in a range of settings which included community-based acute treatment (CBAT), group homes, residential/hospital-based treatment settings, and others. Thirty-five percent (35%) of the youth had experienced a change in living and/or school placement within the year previous to their review.

The largest ethnicity represented among the youth in the statewide sample was European-American (47%) followed by Latino (30%), African-American (14%) and Multi-racial (5%). Youth reviewed of other ethnicities (1% each) were Asian-American, Pacific-Islander, Bengali, Haitian, and West-Indian. English was the primary language spoken at home for the vast majority of the youth (79%), followed by Spanish (9%), and English and Spanish (7%).

The most frequent educational setting was in a regular educational classroom (29%), followed by a fully self-contained special educational classroom (25%), and then by part-time special education (14%). Seven percent (7%) of the youth had an IEP and were fully included. Ten percent (10%) were in an alternative education setting. Four percent (4%) had completed or graduated from school, and 2% had dropped out of school.

Youth in the sample were involved with a variety of other agencies with the highest frequency being Special Education (58%) followed by the Department of Children and Families (DCF) (47%). The youth were referred to ICC or IHT services in the largest numbers by DCF (28%), followed by their families (19%), outpatient providers (9%), hospitals (8%), and crisis providers (6%).

The behavioral health and physical conditions, including co-occurring conditions, of the highest prevalence was mood disorders (56%) and ADD/ADHD (50%). This was followed by 30% with anxiety disorders, 29% with PTSD/adjustment to trauma, and 27% with anger control issues. Twenty-four percent (24%) of the youth had a co-occurring medical problem. Current mental health assessments were evident for 78% of the youth reviewed, and only 33% of parents had received a copy of their child's current mental health assessment.

Seventy percent (70%) of youth in the sample were on one or more psychotropic medication; 73% of those prescribed a psychotropic medication were prescribed two or more medications, and 43% three or more medications. Most of the youth in the sample (88%) had not used a crisis services in the 30 days prior to the review. Thirty-five percent (35%) had experienced a special procedure for managing behaviors during the 30 days preceding the review with a voluntary time out (17%), and a disciplinary consequence for rule violation (10%) being the most frequent.

Caregivers of the youth were facing challenges with the most frequent being extraordinary care burdens (37%), adverse effects of poverty (35%), and/or serious mental illness (26%). These were followed by serious physical illness or disabling condition (14%), and cultural/language barriers (10%.)

Statewide 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 the indicators of Youth Status, Youth Progress, and Family Status are reviewed as a context for understanding the performance of behavioral health services and practices.

Youth Status. In terms of being in a stable situation free of unplanned disruptions, 78% of youth statewide were found to have favorable stability status at home and 76% at school indicating teams should consider ways to strengthen supports to increase youth's stability. Consistency and permanency for youth was favorable for 83% of the youth. Overall, youth were safe at school (94%), home (91%), and in their communities (83%). As well, youth for the most part had favorable physical health status and had their health needs were being addressed (84%). Living arrangements were favorable for 81% of the sample, indicating a need for support for those families experiencing challenges in providing for basic needs. The sub-indicators for educational status showed 83% of the youth having favorable status in their attendance, and 85% with a favorable level behavior supports in the school setting. Fewer (78%) were doing well in their academic or vocational program.

The following indicators of youth status were concerning for the youth reviewed across all of the CSRs. Behavioral risk to self was favorable for only 71% of the youth and toward others for only 74%. A primary status concern was youth's emotional/behavioral status with only 42% having favorable emotional/emotional well-being. This interprets to 58% of the youth reviewed statewide demonstrating limited to poor or worsening levels of emotional development, adjustment problems and/or poor behavioral functioning, and were not responding well to attempts to address these issues.

Across the indicators of youth status, 76% of the youth reviewed had an overall favorable status with no youth with 1% found to have "optimal" status, 29% with "good" status and 45% with "fair" status. The remaining 24% of youth had unfavorable status with 18% with "marginal" status, 6% with "poor" status, and 1% with "adverse" status. Please see Appendix 2 on Page 70 for descriptions of each status category.

Family/Caregiver status. Status of families and caregivers are comprised of a constellation of indicators that measure well-being and satisfaction. The statewide data supports that families are experiencing significant levels of challenges. Only 56% of mothers and 53% of fathers had a favorable level of challenge. The exception to this was substitute caregivers, who all (100%) had a favorable situation in terms of the level of challenge they were experiencing. The data show that voice and choice of mothers (91% favorable), substitute caregivers (100% favorable) and youth aged 18-21 (100% favorable) are clearly part of the

planning and service delivery process, but far less integrated for fathers (73% favorable) and youth aged 12-17 (76%). Mother/caregiver and youth satisfaction with their needs being understood, services, and their participation in the service delivery process was overall favorable. Fathers were less satisfied across all of the domains measured.

Youth progress. The patterns of progress along key indicators over the six months preceding the review were evaluated for each youth. Overall, only 71% of the youth reviewed were making favorable progress. Seventy percent (70%) were making favorable progress in reducing symptoms, 58% in reducing substance use (N=12), 68% in improving coping/self-management, 72% in school progress and 85% (N=13) in work progress. Progress in building relationships was 79% favorable for relationships with their families or caregivers, 63% for relationships with peers, and 83% for relationships with other adults. Progressing in well-being/quality of life for youth was 66% favorable, and for families 73%. These data indicate youth are progressing most in work progress and improved relations with other adults, but are making progress that is weak to needing improvement in most of the progress indicators.

System/Practice Functions.
Determinations of performance in key indicators of system and practice functions are made to evaluate how well services and service processes provide the conditions that lead to desired changes for youth and families. The CSR rates thirteen core system/practice functions. System practices, as reflected in the knowledge, skills and actions of staff and teams 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 overall goal is system and practices to be performing at consistently acceptable level for a threshold of youth.

The CSRs found strong practices at the statewide level in Engagement with youth and families and with respective ratings of 89% and 92% acceptable performance on these indicators. Cultural Responsiveness also reflected strong performance for both youth and families with respective 92% and 94% acceptable performance ratings for those the indicator applied to.

The two indicators for Teamwork focus on the structure and performance of youth and family care planning teams. Team Formation was acceptable for only 72% of the youth, indicating improvements are needed in order for families to be able to reliably depend on teams with the right composition and practices to communicate and plan. Team Functioning was performing even less well with only 64% of teams functioning acceptably well. The statewide data indicate focused work is needed to help teams across the state to consistently form and work together to unify efforts and achieve common goals for youth and families.

The Assessment and Understanding indicators for youth and families 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 in meeting youth's and families' objectives. There was acceptable understanding for only 68% of youth, and 72% of families at the statewide level. These data indicate improvements are needed in practices that

assure better understanding of the key determinants of the youth's emotional and behavioral issues, and the foundations for building effective plans.

The Planning Intervention measure encompasses six sub-indicators. Results for acceptability of care/treatment plans and planning processes showed improvements are needed across of the indicators of planning in order to achieve consistently effective plans for a threshold of youth. Planning for symptom/substance abuse reduction was acceptable for only 72% of youth, for behavior changes for 71%, and for social connections 70%. Planning for effective recovery and/or relapse prevention applied to 17youth and was acceptable for only 65% of them. Planning for supporting transitions was acceptable for 56% of the 81 youth the indictor was applicable for. Risk and safety planning was acceptable for 72% of the youth. This indicator was noted to improve in performance in each successive CSR over the course of the year, which may have been due to system interventions occurring mid-way through the year.

The indicator for identifying and articulating clear Outcomes and Goals for the youth and family was rated as acceptable for 68% of the youth reviewed statewide, indicating room for improvement in this system practice. The indicator for Matching Interventions to Needs, which measures practices in assuring services and supports form a cohesive sensible pattern and address the identified needs of the youth and family, also requires attention with 68% of those reviewed found to have acceptable performance.

Care coordination for the youth reviewed was acceptable for 71% of the youth reviewed, also indicating a need for strengthened practices. Service implementation was acceptable for 75% of youth, indicating f more diligence is required to assure services and supports that are needed by youth are implemented. There was Availability and Access of Resources for 79% of the youth statewide reflecting some improvements are needed to assure access necessary supports and services in a timely manner. Availability and access was particularly problematic for youth in the Central region, with only 58% of youth found to have acceptable performance in this indicator.

The practice of Adapting and Adjusting plans and services was acceptable for 72% of youth, indicating improvements are needed in making changes to plans and interventions as needed. Planning, staging and implementing practices for successful Transitions and Life Adjustments was an area where practices need considerable work, with only 57% of the youth for which the indicator applied experiencing adequate transitions. Seventy-three (73%) of youth who experienced a crisis over the ninety days previous to their review were found to acceptable crisis management as reflected in the indicator for Responding to Crises and Risk/Safety Plans. Improvements are also indicated in this crucial system practice.

Overall across the CSRs, 66% of youth were found to have acceptable system/practice performance. A need for focused improvements in a number of system/practice areas is indicated by the data.

The data indicate that the <u>strongest</u> areas of practice for youth across the Commonwealth were:
- Engagement with the Youth and Family; and
- Cultural Responsiveness to Youth and Family.

The system/practice indicator that showed an overall <u>fair</u> performance but at a less consistent or robust level of implementation was:

- Availability and Access to Resources.

Areas of system/practice performance that <u>need improvement</u> in order to assure consistency, diligence and/or quality of efforts are:
- Team Formation;
- Assessment & Understanding of the Youth and Family;
- Planning Interventions for Symptom or Substance Reduction;
- Planning Interventions for Behavioral Changes;
- Planning Interventions for Social Connections;
- Outcomes and Goals;
- Matching Interventions to Needs;
- Coordinating Care;
- Service Implementation;
- Adapting and Adjusting; and
- Responding to Crisis & Risk and Safety Planning.

Review results indicate <u>weak</u> performance for the following system/practice domains:
- Team Functioning;
- Planning Intervention for Recovery/Relapse;
- Planning Interventions for Transitions, and
- Transitions & Life Adjustments.

Summary of Findings

Overall, statewide results indicate that certain foundational system of care practices such as engagement and cultural responsiveness to youth and families were strong. Generally, a threshold of youth and families across the state had access to necessary resources, although in some of the regional CSRs, waitlists to access services such as comprehensive assessments, psychiatric services, and in home behavioral services, as well as therapeutic mentoring and intensive in-home therapy in some areas were reported. Access to reliable mobile crisis services was also noted as an issue in a number of areas.

The majority of system/practice results were found to need improvement. Focused efforts could improve these service processes so a greater threshold of youth and families can rely on the practice functions to perform in a dependable and effective manner. Teams for over a third of the youth were not functioning at an adequate level, were splintered or inconsistent in planning and evaluating results, and were not engaged in collaborative and problem-solving. A challenge for nearly a third (32%) of teams was using information, including in existing assessments and information that is held by other providers, schools, etc., to increase team-based understanding of youths' strengths and needs at a scope and depth necessary to develop the right set of interventions and supports.

Planning interventions across all indicators needed strengthening particularly in the areas of recovery/relapse and assuring successful transitions. With 36% of teams found to have weak functioning, concerted development is clearly indicated to strengthen the ability of teams to plan together, collaboratively problem-solve and unify their implementation efforts. The system practice where attention is highly indicated is assuring adequate supports for managing youths' transitions. Sixty-three percent (63%) of youth were found to have an unacceptable level management of their transitions.

Overall, one out of three youth reviewed did not have an acceptable level of system/practice performance. These results indicate focused improvements are needed before consistently strong results are achieved for more youth. While certain foundational practices were found to be working well, teams will continue to need to strengthen in areas that can assure a threshold of youth can reliably depend on service functions that will help them progress, achieve desired outcomes and/or maintain the gains they have made through services.

Findings: Strengths. The CSRs found availability of an expanded array of services in most areas of the State, although there were exceptions for certain services and areas. Youth reviewed in the Northeastern Massachusetts and Boston/Metro-Boston areas in particular had access to most of the services they needed. As previously described, family engagement and cultural responsiveness were strong system of care practices across all of the regions. There were many examples of service teams and service providers providing effective services. In particular, Family Partners are seen as an important addition to the system of care. System of Care Committees are increasingly becoming venues for intersystem and community partnerships, and active problem-solving.

Findings: Challenges. The CSRs identified concerns with the capacity of teams to uniformly use assessments, clinical/behavioral data and other relevant information to inform care plans. This included systematic use of information to make adjustments to plans and strategies as needed. Intervention planning and teamwork was found to need strengthening in all areas of the state. A crux issue appears to be the skills and abilities of many staff and teams to provide adequate coordination, plan development and treatment. Outpatient providers were noted to be less integrated into the work of teams. A theme found in many of the reviews was unclear role definition for IHT providers in coordinating care, and knowing when it may be indicated to consider a referral for a youth for ICC services.

As noted previously, risk and safety plans were increasingly evident in youth's files, but the overall dependability and quality of crisis services was identified as an issue in communities across the state. Access and availability to other services and in certain communities was found to be a challenge to providing effective care.

There were recurring reports by agencies regarding challenges related to the "business model" that should be evaluated for their impact on the provision of services. Families statewide reported that changes in the youth's MassHealth eligibility status, navigating the eligibility system, and access to timely, consistent and responsive eligibility and coverage questions are impacting the continuity of care for children and have created additional administrative demands and loss of revenues for providers.

Recommendations. The Recommendations starting on Page 66 reflect the themes and patterns of the CSRs statewide and are provided as suggestions for further assuring the consistency and quality of behavioral health practices and service delivery for *Rosie D.* class members. Recommendations relate to core system functions that include the use of assessments, the development of effective plans, and strengthening of the formation and functioning of teams. Recommendations also suggest improving access to consultation, support, supervision and training for teams, and as well as providing guidance and training for IHT providers to strengthen their care coordination functions. Clear and accessible information for staff and families regarding accessing care and eligibility information is recommended. As well, recommendations are provided to improve the performance of crisis services, assuring access to all necessary services, and assuring decisions for services are based on what each child needs to make progress.

The Rosie D. Community Services Review
Annual Report
For the Reviews Conducted during Fiscal Year 2010-2011

Introduction

This report presents findings for the five Community Service Reviews (CSR) conducted throughout Massachusetts between September 2010 and May 2011. Reports for each of the regional reviews (Western Massachusetts, Northeastern Massachusetts, Boston and Metro-Boston, Southeastern Massachusetts, and Central Massachusetts) were published throughout the year. Aggregate demographic data for the 139 youth reviewed are presented, as well as overall CSR findings and selected comparative data of system performance. The purpose of this report is to present findings regarding youth status and system/practice performance of the system of care for youth and families during the first full fiscal year of implementation of the full complement of Rosie D. Remedial Services (less crisis stabilization services).

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, and a family-focused care planning team who will organize and guide the development of a plan of care. Features of the plan of care is to be reflective of the identification and use of strengths, identification of needs, 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

The Court Monitor monitors compliance and progress with the requirements of the Judgment. The Court Monitor receives and independently reviews 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.

Overview of the CSR methodology

The CSR is 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 uses 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 70 for a full description of how each of the terms is 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 16, 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

Rosie D. CSRs Conducted During Fiscal Year 2010-2011

Review Participants

Approximately 2050 people throughout Massachusetts participated in the five regional CSRS in either the youth-specific reviews or in the stakeholder focus groups. Table 1 displays data related to the youth-specific reviews where a total of 971 interviews were conducted for the 139 youth reviewed. As can be seen, the average number of interviews was 7.0 with a maximum of 18 and a minimum of 2 interviews conducted. A total of 53 agencies were visited over the course of the five reviews.

Child Status and Performance Profile - Number of Interviews

Number of cases: 139

Number of Interviews

Total number of interviews	971
Average number of interviews	7.0
Minimum number of interviews	2
Maximum number of interviews	18

Table 1

CSR Sampling

The samples for each of the CSRs were drawn from the population of children who were enrolled at the time of sampling in Intensive Care Coordination (ICC) or In-Home Therapy (IHT) without currently receiving ICC services, inclusive of children from birth to twenty-one years old who are covered by Medicaid. 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 lists were sorted to create a list of youth who were currently enrolled within open cases.

For ICC, a random sample of youth was drawn from each CSA or agency's open caseload list. The number of youth selected from each CSA was determined based on the number of youth meeting the sampling parameter against the population of enrolled youth at the time of selection. For IHT, the lists were sorted to determine which of the youth were receiving IHT, but not concurrently also receiving ICC. Although it is possible that some of the youth who were selected from the ICC lists were also receiving other types of services including IHT, the IHT lists were used to identify youth who were receiving IHT but not currently also receiving ICC. The number of youth to be included from each agency was then determined by comparing the number of youth being served by that agency to the total number of youth being served in the region.

A total sample of 139 youth, which included 90 ICC youth and 49 IHT youth drawn from the 53 agencies were reviewed in the five regional CSRs conducted over the fiscal year.

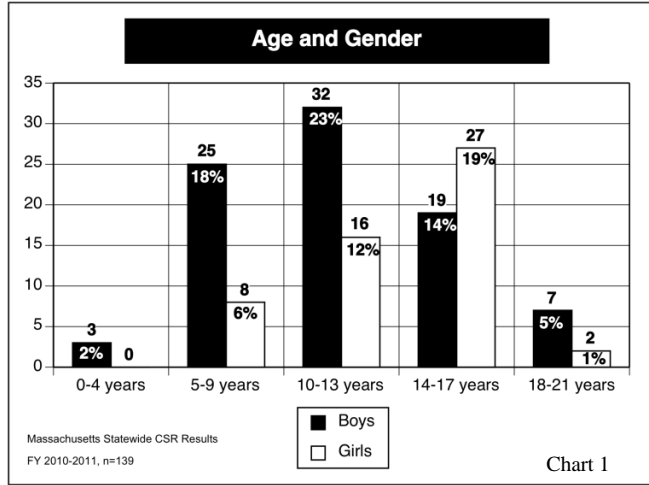### Child Status and Performance Profile - Case Type Frequency

Number of cases: 139

Case Type	Number	Percent
ICC	90	65%
IHT	49	35%
	139	100%

Table 2

Characteristics of Youth Reviewed

Age and Gender. There were 139 youth reviewed across the five regions. *Chart 1* displays the distribution of genders across age groups in the combined samples with a total of 86 boys and 53 girls distributed among the regional samples. The proportion of boys to girls was 62% boys to 38% girls. The only age range that had more girls than boys was the 14-17 year old range, where the proportion was 41% boys to 59% girls.

Age and Gender

	Boys	Girls
0-4 years	3 (2%)	0
5-9 years	25 (18%)	8 (6%)
10-13 years	32 (23%)	16 (12%)
14-17 years	19 (14%)	27 (19%)
18-21 years	7 (5%)	2 (1%)

Massachusetts Statewide CSR Results
FY 2010-2011, n=139

Chart 1

Two percent (2%) of the statewide sample was in the 0-4 age range, 21% were in the 5-9 age range, 35% were in the 10-13 age range, 33% in the 14-17 range, and 6% in the 18-21 age range. Only the Western Massachusetts CSR had children in the 0-4 age range. Youth in the 18-21 range were in the samples for all CSRs except for Central Massachusetts

Current placement, placement changes and permanency status. The preponderance of youth in the CSRs lived with their families (87%), either their biological/adoptive families or in a kinship/relative home. Three percent of youth (3%) were in a Community-Based Acute Treatment (CBAT) program at the time of the review, 2% resided in a group home, and 2% in residential treatment center. The remaining youth were in a variety of placements as displayed in *Table 3*.

Child Status and Performance Profile - Current Placement Frequency

Number of cases: 139

Type of Current Placement	Number	Percent
Family bio./adopt. home	111	80%
Kinship/relative home	10	7%
Foster home	2	1%
Therapeutic foster home	2	1%
Group home	3	2%
CBAT	4	3%
Independent living	1	1%
Detention	1	1%
Residential treatment facility	3	2%
Family shelter homeless	1	1%
Psychiatric Hospital	1	1%
	139	100%

Table 3

Child Status and Performance Profile - Legal Permanency Frequency

Number of cases: 139

Legal Permanency Status	Number	Percent
Birth family	107	77%
Adopted family	14	10%
Foster care	7	5%
Permanent guardianship	7	5%
Adult	2	1%
DCF custody	1	1%
Step-father	1	1%
	139	100%

Table 4

The legal status (*Table 4*) of most of the youth in the sample was with their birth families (77%). Ten percent (10%) of the youth's permanency status was with their adopted families, 5% was with the foster parents, and 5% were in permanent guardianship. The remaining youth were adults, were in DCF guardianship, or temporary guardianship.

The review tracked placement changes experienced by the youth in the twelve months preceding their review. (*Table 5*). Placement change refers to changes in living situation, as well as changes in the type of program where

the child received educational services. These data yields information about the youth's relative stability the living and/or school setting. Among the youth in the statewide sample, 65% had no placement changes in year preceding the time they were reviewed. Of the 35% who experienced a change in placement, 23% had 1-2 placement changes, and 10% had 3-5 changes in placement. One percent (1%) of the sample had experienced 6-9 placement changes.

Seventeen percent (17%) of the youth were in an out of home placements at the time they were reviewed. Six percent (6%) of the sample had been in the current out of home placement for 30 days or less, 4% for 1-3 months, 3% for 4-6 months, 1% for 7-9 months, and 1% for 19-36 months. Two percent of the statwide sample had been out of home for 37 months or more (*Table 6*).

Child Status and Performance Profile - Placement Changes Frequency

Number of cases: 139

Placement Changes (past 12 months)	Number	Percent
None	91	65%
1-2 placements	32	23%
3-5 placements	14	10%
6-9 placements	2	1%
	139	100%

Table 5

Child Status and Performance Profile - Length of Stay in Current OOH Placement

Number of cases: 139

Length of Stay in Current OOH Placement	Number	Percent
0-30 days	8	6%
1 - 3 mos.	5	4%
4 - 6 mos.	4	3%
7 - 9 mos.	1	1%
19 - 36 mos.	2	1%
37 + mos.	3	2%
Not applicable	116	83%
	139	100%

Table 6

Child Status and Performance Profile - Ethnicity Frequency

Number of cases: 139

Ethnicity	Number	Percent
Euro-American	66	47%
African-American	19	14%
Latino-American	42	30%
Asian-American	1	1%
Pacific Is. American	1	1%
Bengali	1	1%
Biracial	7	5%
Haitian	1	1%
West Indian	1	1%
	139	100%

Table 7

English was the primary language spoken at home for 79% of the youth. Spanish was the primary language for 9% of families and both English and Spanish for 7% those reviewed. Other languages spoken at home (1% each) were Bengali, Creole-French, American Sign Language, English/Portuguese, and Portuguese.

Ethnicity and primary languages (Table 7 and 8). Of the 139 youth reviewed, 47% were Euro-American, 14% were African-American and 30% were Latino-American. Five percent (5%) of those reviewed were Biracial. Youth reviewed of other ethnicities (1% each) were Asian-American, Pacific-Islander, Bengali, Haitian, and West-Indian.

Child Status and Performance Profile - Language Spoken Frequency

Number of cases: 139

Primary Language Spoken at Home	Number	Percent
English	110	79%
Spanish	13	9%
Bengali	1	1%
Creole/French	1	1%
English & ASL	1	1%
English & ASL (some)	1	1%
English & Portuguese	1	1%
English & Spanish	10	7%
Portuguese	1	1%
	139	100%

Table 8

Child Status and Performance Profile - Educational Placement Frequency

Number of cases: 139

Educational Placement or Life Situation	Number	Percent
Regular K-12 Ed.	41	29%
Full inclusion	10	7%
Part-time Sp. Ed.	19	14%
Self-cont. Sp. Ed.	35	25%
Adult basic/GED	1	1%
Alternative Ed.	14	10%
Vocational Ed.	2	1%
Day treatment program	2	1%
Work	2	1%
Completed/graduated	5	4%
Dropped-out	3	2%
Other	23	17%

Table 9

Educational placement (Table 9). Youth reviewed were receiving their educational in a variety of settings. Of the youth reviewed statewide, 46% were receiving special education services in a full inclusion, part-time or fully self-contained special education setting. Twenty-nine percent (29%) were attending school in regular education classrooms. Ten percent (10%) were in alternative education settings. Others were attending school in an adult educational program (1%), vocational education (1%) and a day treatment program (1%). These youth may have also have been receiving special education services in these settings. One percent (1%) of the youth was working, 4% had completed school, and 2% had dropped out. Youth in the "Other" category included youth in a variety of settings for education including youth receiving education through home tutoring, preschool, private special education school, hospital setting, college, and other settings. Note that the total numbers and percentages in *Table 9* 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 10). The majority of the youth in the sample were involved with other State and community 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. Youth across the Commonwealth were most frequently involved with Special Education (58%). The Department of Children and Families (DCF) had involvement with 47% of the families reviewed. The Department of Mental Health (DMH) was involved with 16%, Probation with 9%, Developmental Disabilities with 6%, Department of Youth Services with 4%. Vocational Rehabilitation was involved with 3% of the youth, and a Substance Abuse agency with 1%. Youth in the "Other" category were involved with a variety of agencies including housing, healthcare, educational advocacy, and legal entities.

Child Status and Performance Profile - Other Agencies Involved Frequency

Number of cases: 139

Agencies Involved	Number	Percent
DCF	66	47%
DMH	22	16%
Special Ed	81	58%
Early intervention	0	0%
Developmental disabilities	9	6%
DYS	5	4%
Probation	12	9%
Vocational Rehabilitation	4	3%
Substance abuse	1	1%
Other	14	0%

Table 10

Referring agency (Table 11). Youth reviewed came into ICC and/or IHT services from a variety of referral sources. The largest single referral source at the statewide level was DCF, which referred 28% of the youth reviewed. This was followed by families, who referred 19% of the youth. Outpatient providers, primarily youth's therapists, referred 9% of those reviewed. Eight percent (8%) of the youth were referred by hospitals and 6% through crisis services. Schools and DMH each referred 4% of the sample, followed by primary care physicians (3%), DYS (2%) and Courts (1%).

Referral sources in the "Other" category included residential treatment programs, family stabilization services, an after-school program, and a partial-hospitalization program.

Child Status and Performance Profile - Referral Source

Number of cases: 139

Referral Source	Number	Percent
Court	1	1%
DCF	39	28%
DMH	6	4%
DYS	3	2%
School	5	4%
Family	27	19%
Primary care physician	4	3%
Hospital	11	8%
Outpatient	12	9%
Crisis	9	6%
Other	22	16%
	139	100%

Table 11

Child Status and Performance Profile - Co-Occurring Condition Frequency

Number of cases: 139

Co-Occurring Condition	Number	Percent
Mood Disorder	78	56%
Anxiety Disorder	42	30%
PTSD/Adjustment to Trauma	40	29%
Thought Disorder/Psychosis	6	4%
ADD/ADHD	70	50%
Anger Control	38	27%
Substance Abuse/Dependence	6	4%
Learning Disorder	25	18%
Communication Disorder	6	4%
Autism	22	16%
Disruptive Behavior Disorder (CD, ODD)	23	17%
Mental Retardation	7	5%
Medical Problem	34	24%
Other Disability/Disorder	16	12%

Table 12

Behavioral health and co-occurring conditions (Table 12). Table 12 displays the conditions and/or co-occurring conditions present among the youth reviewed. Youth may have one or more than one condition. The most prevalent diagnoses among the youth were mood disorders (56%) and attention deficit or attention deficit hyperactivity disorder (50%). This was followed with 30% of youth with an anxiety disorder, 29% with PTSD, and 27% with anger control. Eighteen percent (18%) of the youth reviewed had a learning disorder, and 17% a disruptive behavior disorder. Sixteen percent of the youth were diagnosed with autism, and 5% with mental retardation. Other less prevalent diagnoses were thought disorder/psychosis (4%), and communication disorder (4%).

Co-occurring medical problems were prevalent among nearly a quarter of the youth (24%). Of these, over half (53%) had asthma. Other medical disorders youth were afflicted with included obesity, enuresis, encopresis, hearing and vision problems, fetal alcohol syndrome, cardiac problems, gastro-intestinal issues, epilepsy, and other medical conditions.

Youth in the "Other Disability" category included youth with pervasive developmental disorder, adjustment disorder, reactive attachment disorder, and other disabilities.
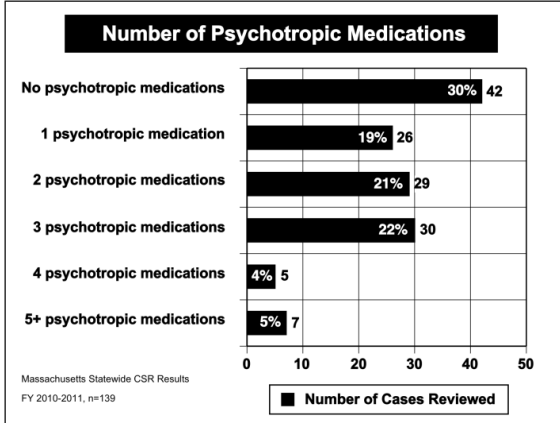
Number of Psychotropic Medications

Chart 2

Medications (Chart 2). Seventy percent (70%) of the youth were prescribed one or more psychotropic medications at the time of the review. As seen in *Chart 2*, 19% of the sample was prescribed one medication, 21% two medications, and 22% three medications. Four percent (4%) of the youth were prescribed 4 medications, and 5% were on five or more medications. Seventy-three percent (73%) of youth prescribed psychotropic medications were prescribed two or more medications, and 43% were prescribed three or more medications.

Youths' levels of functioning (Chart 3). The functioning of each youth in the CSR is rated using the General Level of Functioning scale, a 10-point scale that can be viewed in Appendix 1 of this report. Most of the youth in the CSR samples were functioning at a moderately to severely impaired level. Forty-nine percent (49%) 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"). Forty-seven percent (47%) were rated in the Level 6-7 range ("variable functioning with sporadic difficulties or

Child Level of Functioning (CGAF)
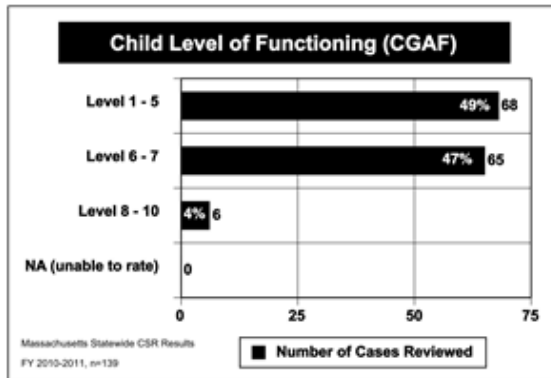
Chart 3

symptoms in several but not all social areas" to "some difficulty in a single area, but generally functioning pretty well"). Four percent (4%) of the sample 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"). Note that although there were youth in the 0-4 age range in the sample, these data reflect that the reviewers were able to rate their level of functioning despite their young age.

Use of Crisis Services (Table 13). The use of crisis services or crisis responses over the 30 days prior to the review was tracked for each youth. There was low incidence of the use of crisis services among the youth reviewed. Eighty-eight percent (88%) of the youth did not access crisis service during the time period. For the 12% of youth that used crisis services 7% used mobile crisis services. Five percent (5%) accessed crisis help through a 911 call from emergency medical services or the police. Two percent (2%) went to an emergency department of a hospital when experiencing a crisis. Youth in the "Other" category used a crisis hot-line, support through a pediatrician, and a CBAT placement.

Child Status and Performance Profile - Crisis Services Used Frequency

Number of cases: 139

Crisis Services Used Past 30 Days	Number	Percent
Mobile crisis	10	7%
911 Emergency call: EMS	3	2%
911 Emergency call: Police	4	3%
Emergency department	2	1%
Other	3	2%
None	123	88%

Table 13

Mental health assessments (Tables 14 and 15). CSR reviewers tracked whether or not youth had a current mental health assessment. Having a current mental health assessment is a foundational component of behavioral health practice. Assessments are part of the complement of information that helps clinicians and teams to understand the strengths, needs and context of the youth and family, and to formulate an overall picture of how the youth is doing emotionally, cognitively, behaviorally and socially. Seventy-eight percent (78%) of the youth statewide had a current mental health assessment that was in their files. Twenty-two percent (22%) of the youth did not have a current mental health assessment available.

Child Status and Performance Profile - Mental Health Assessment

Number of cases: 139

MH assessment performed	Number	Percent
Yes	108	78%
No	31	22%
	139	100%

Table 14

The CSRs also determined for those youth that had a current mental health assessment, who had received the assessment. Planning ideally includes team members developing a shared understanding about the needs, strengths, choices and preferences of the youth and family. Only a third (33%) of parents had received their child's assessment. Schools received a copy of the mental health assessment for 11% of the youth reviewed, Courts for 4%, and Child Welfare for 11%. Child welfare was involved with 47% of the youth in the sample so the percentage of families reviewed that were DCF-involved and had their assessments shared with DCF was 23%. In the "other" category were assessments distributed primarily to therapists and other team members. The assessment had not been distributed for 37% of youth who had a mental health assessment.

Child Status and Performance Profile - Received Mental Health Assessments

Number of cases: 139

Received MH Assessments	Number	Percent
Parent	46	33%
Education	15	11%
Court	6	4%
Welfare	15	11%
DOC	0	0%
Not applicable	30	22%
Not Distributed	51	37%
Other	20	14%

Table 15

Child Status and Performance Profile - Special Procedures Frequency

Number of cases: 139

Special Procedures Used Past 30 Days	Number	Percent
Voluntary time-out	24	17%
Loss of privileges via point & level system	10	7%
Disciplinary consequences for rule violation	14	10%
Room restriction	2	1%
Exclusionary time out	5	4%
Seclusion/Locked room	1	1%
Take-down procedure	2	1%
Physical restraint (hold, 4-point, cuffs)	9	6%
Emergency medications	0	0%
Medical restraints	0	0%
None:	91	65%
Other:	2	1%

Table 16

Special Procedures

Special Procedures data were collected in the CSRs to better understand behavioral interventions occurring (*Table 16*). Sixty-five percent (65%) of the youth did not experience a special procedure in the 30 days preceding the review. For the 35% of youth that did, 17% had experienced a voluntary time-out; 7% loss of privileges in a points and level system, and 10% a disciplinary consequence. Seven percent (7%) of the youth reviewed had experienced a recent physical restraint that could have been a hold, a "take-down", or a mechanical restraint. Four percent (4%) had experienced an exclusionary time out, and 1% a seclusion in a locked room. Procedures in the "Other" category were school suspensions as a behavioral consequence.

Note youth may have experienced more than one special procedure, thus the total percentage of discreet procedures is more than the overall 35% of youth who experienced a procedure.

Caregiving challenges

Reviewers gathered information about the challenges experienced by the parents and caregivers of the youth reviewed *(Table 17)*. The most frequently noted challenge was extraordinary care burdens experienced by 37% of caregivers, closely followed by adverse effects of poverty (35%). Twenty-six (26%) of the caregivers were challenged by their own serious mental illness and 14% by disabling physical conditions. Other challenges were cultural language barriers experienced by 10%, domestic violence by 10%, substance abuse or serious addiction by 9%, limited cognitive abilities by 3%,

Child Status and Performance Profile - Caregiver Challenges Frequency

Number of cases: 139

Challenges in the Child's Birth Family or Adoptive Family	Number	Percent
Limited cognitive abilities	4	3%
Serious mental illness	36	26%
Substance abuse impairment or serious addiction w/ frequent relapses	12	9%
Domestic violence	14	10%
Serious physical illness or disabling physical condition	19	14%
Unlawful behavior or is incarcerated	1	1%
Adverse effects of poverty	49	35%
Extraordinary care burdens	52	37%
Cultural/language barriers	14	10%
Undocumented	1	1%
Teen parent	3	2%
Other	20	14%

Table 17

challenges associated with being a teen parent by 2%, and incarceration or undocumented status by 1% each. Challenges in the "Other" category included parental isolation, history of

abuse impacting the caregiver's current functioning, challenges associated with securing transition-aged services, legal challenges, and parenting skills deficits.

Care Coordination

During the CSR, data are collected to better understand various factors that may be impacting the provision of care coordination services. Information is collected through the person providing the care coordination function, which could have been the ICC or the IHT therapist. Among the data collected are 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. In the CSR conducted over the year, there were 129 individuals providing care coordination for the 139 youth reviewed.

The review tracked the length of time the Care Coordinator had been assigned to the youth being reviewed. As can be seen in *Table 18,* 3% of care coordinators had been assigned to the youth being reviewed for less than a month, and 14% for three months or less. The majority of care coordinators had provided care coordination for the youth reviewed in the 4-12 month range, with 32% assigned between 4-6 months, and 35% between 7-12 months. Sixteen percent (16%) had been assigned to the youth 13-24 months, and 1% between 25-36 months.

Child Status and Performance Profile - Length of Time CM Assigned

Number of cases: 139

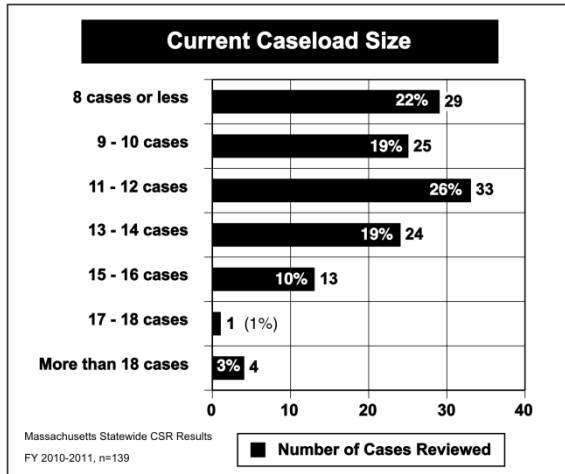| Length of Time CM Assigned to Child/Youth	Number	Percent
<1 month	4	3%
1-3 months	19	14%
4-6 months	44	32%
7-12 months	48	35%
13-24 months	22	16%
25-36 months	2	1%
	139	100%

Table 18

Chart 4

Caseload frequency as reported by the 129 care coordinators who participated in the CSR was measured along the scale seen in *Chart 4.* Twenty-two percent (22%) of coordinators had 8 or fewer cases, and 19% had 9-10 cases. Just over a quarter (26%) of coordinators had cases in the 11-12 case range. Nineteen percent (19%) were coordinating care for 13-14 cases, and 10% for 15-16 cases. One percent (1%) had a caseload of 17-18, and 3% had more than 18 cases. A third of care coordinatiors (33%) had more than 12 cases on their caseload.

Table 19 presents the length of time care coordinators statewide had been in their positions. As can be seen, the majority (74%) had been in their positions between 7 months and two years with 31% in the position between 7-12 months, and 43% between 13-24 months. Three percent (3%) had been in their positions for 1-3 months, and 14% between 4-6 months. The remainder

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

Number of cases: 129

Length of Time CM in Position	Number	Percent
1-3 months	4	3%
4-6 months	18	14%
7-12 months	40	31%
13-24 months	55	43%
25-36 months	6	5%
37-60 months	3	2%
>60 months	3	2%
	129	100%

Table 19

were in their positions 25-36 months (5%), 37-60 months (2%) and over 60 months (2%). Those in positions at the longer ranges were primarily therapists who started providing care coordination when this function was assigned at the advent of Rosie D. IHT services.

Table 20. Information on barriers that affect the provision of care coordination or other services is collected through each CSR. The challenges cited by care coordinators statewide most often were case complexity cited by 22%, billing requirements and limits by 18%, and treatment compliance by 17%. This was followed by driving time to services cited by 12%, caseload size by 11%, inadequate parent support by 10%, and inadequate team member participation by 9%.

Barriers cited less frequently were team member follow-through (8%), eligibility and access denial (7%), cultural/language barriers (6%), treatment refusal (6%), acute care needs of youth (4%), family disruptions (3%), family instability (2%), and arrest/detention of youth (1%). Themes cited in the "Other" barriers category included waitlists for services and resource unavailability, turnover of team members, scheduling of meetings, paperwork demands, productivity demands, and inability to bill for time

Child Status and Performance Profile - Barriers Affecting Case or Services

Number of cases: 139

Barriers Affecting Case Management or Services	Number	Percent
Caseload size	15	11%
Eligibility/access denied	10	7%
Inadequate parent support	14	10%
Inadequate team member participation	12	9%
Family disruptions	4	3%
Billing requirements/limits	25	18%
Case complexity	31	22%
Treatment compliance	23	17%
Team member follow-thru	11	8%
Acute care needs	6	4%
Driving time to services	16	12%
Culture/language barriers	8	6%
Refusal of treatment	8	6%
Family instability/moves	3	2%
Arrest/detention of child/youth	1	1%
Other	52	37%

Table 20

with family partners inhibiting collaboration. Other issues cited that were impacting care was the need for more education of other agencies about the wraparound model, the need for more training and supervision of care coordinators, lack of flexible funding, and the need for legal consultation on cases. Also cited were timelines required for family engagement being unrealistic, and practice being driven by insurance requirements versus an individualized process.

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 <u>current status of the child</u>. The second domain explores <u>parent or caregiver status</u>, and includes several inquiries pertaining to youth voice and choice, and satisfaction. The third domain pertains to <u>recently experienced progress</u> or changes made as they may relate to achieving care and treatment goals. The fourth domain contains questions that focus on the <u>performance of system and practice functions</u> 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
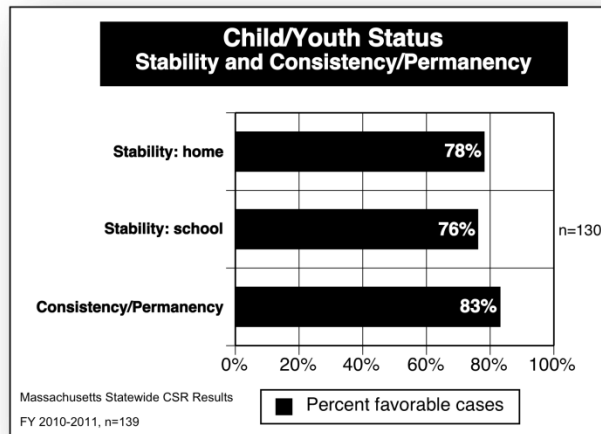
Community, School/Work and Living Stability
For the two sub-indicators of Stability (*Home and School*), reviewers determine the degree of stability the youth is experiencing in their daily living and learning arrangements in terms of those settings being free from risk of unplanned disruption. Reviewers note if there are any

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

Among the 139 youth in the CSR sample statewide, 78% overall had favorable home stability. Just over half of the youth (51%) had good or optimal stability with established positive relationships and well-controlled to no risks that otherwise could jeopardize stability. Forty percent (40%) of the youth were rated to be in the "refinement" area, meaning conditions to support their stability at home are fair to marginal. Eight percent (8%) of the youth were rated to need improvement with poor or adverse stability marked by substantial to serious and worsening problems with home stability.

School stability was applicable for 130 youth in the CSR sample. Of these, 76% were in a stable school situation. Just over half of the sample (51%) had good or optimal stability with only age appropriate or planned changes occurring in their school program. Thirty-five percent (35%) had stability issues at school that needed "refinement," with fair to marginal stability issues that were minimally to inadequately addressed. Eleven percent (11%) needed their stability in school "improved." This included 8% with poor stability in the school setting with uncertainty about next steps and 3% with adverse school stability (serious and worsening problems and no foreseeable next-step placements with the necessary level of supports).
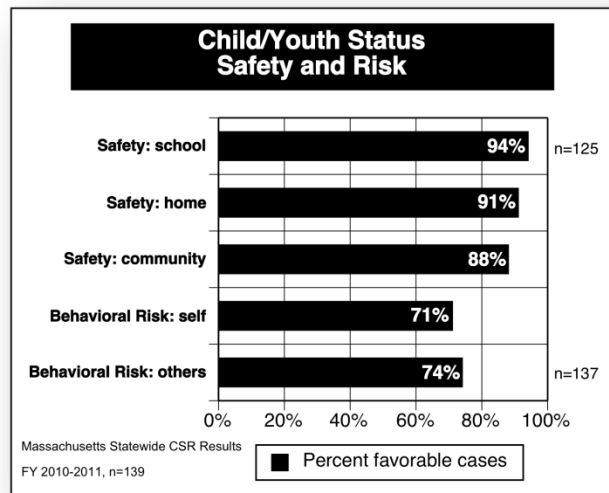
These results showed that 22% of youth reviewed were experiencing instability in their home situations, and 24% in their school settings indicating teams should consider strategies for strengthening supports to increase stability for youth.

Consistency/Permanency in Primary Caregivers & Community Living Arrangements
The Consistency/Permanency Indicator measures the degree to which the youth reviewed were living in a permanent situation, or if not that there was 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.

Of the youth reviewed throughout Massachusetts, 83% had a favorable level of consistency and permanency in their lives. Among these, 68% of youth had "good" or "optimal" status, meaning they were in an enduring permanent living situation with their family of other legally permanent caregivers. Twenty-eight percent (28%) were at a level of consistency and permanency situation that needed "refinement" in in order to assure enduring relationships and consistent caregiving/living supports, meaning they were either in a minimal to fair status, or in a marginal status with somewhat inadequate or uncertain permanence. Four percent (4%) of youth reviewed had poor or adverse status with substantial to serious problems of unresolved permanence.

These data indicate that many of the youth reviewed had favorable levels of consistency and permanency.

**Child/Youth Status
Safety and Risk**

Safety: school	94% n=125
Safety: home	91%
Safety: community	88%
Behavioral Risk: self	71%
Behavioral Risk: others	74% n=137

0% 20% 40% 60% 80% 100%

Massachusetts Statewide CSR Results
FY 2010-2011, n=139

■ Percent favorable cases

Safety of the Youth

In the CSR, 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. Whenever there is an identified safety risk, there should be immediate response by the youth's team.

In the CSR samples statewide, for those who were getting their education in a school setting (N=125), 94% of youth were found to have favorable safety status at school, 91% were safe at home and 88% were safe in the community. These data indicate high levels of favorable safety status for the population of youth reviewed.

For the youth attending school, 71% were safe at school at a "good" or "optimal" level with no risk to generally risk-free school programs. Twenty-six percent (26%) had a school safety status that needed "refinement" in terms of the school setting assuring the youth to be free from abuse or neglect. For these youth, the school setting was minimally risk-free, or had a somewhat inadequate to inconsistent level of protection. Two percent (2%) of the youth reviewed were found to have a "poor safety" or "high safety risk" status indicating substantial to serious and worsening risk of harm in the school setting.

Among the youth reviewed, (56%) had "good" or "optimal" safety status in their homes. Forty percent (40%) were found to need "refinement" with a fair to minimally adequate situation free from abuse or neglect, or marginal safety with somewhat inadequate protection posing an elevated risk of harm. Four percent (4%) were found to have "poor safety" or a "high safety risk" at home with substantial and continuing risk of harm.

Fifty-five percent (55%) of the youth reviewed were experiencing "good" to "optimal" safety in their communities. "Refinement" in community safety was needed for 41% of the youth

who had fair to marginal safety status indicating minimally adequate to somewhat inadequate levels of protection. Four percent (4%) of the youth overall had poor to high community safety risk status.

Generally the youth reviewed had favorable safety status across settings. Because of the importance of safety in the lives of youth, teams should constantly monitor safety status including any risks for intimidation or fear of harm.

Behavioral Risk to Self and Others
The CSR reviews the degree to which each youth is avoiding self-endangerment and refraining from behaviors that may be placing him/herself or others at risk of harm. When determining behavioral risk, a constellation of behaviors are considered including self-endangerment/self-harm, suicidality, aggression, severe eating disorders, emotional disregulation resulting in harm, severe property destruction, medical non-compliance resulting in harm and unlawful behaviors.

The statewide results showed that only 71% of youth had a favorable level of behavioral self-risk. Among these, 37% had "good" or "optimal" status. The preponderance of youth (73%) were found to need "refinement" in their level of behavioral risk, including youth with fair status that may occasionally present behavior that has low or mild risk of harm, and those that have a marginal risk staus that is inconsistent and concerning. Ten percent (10%) of youth needed "improvement" and had poor or serious and continuing behavioral self-risk status.

The subindictor of behavioral risk toward others was favorable for 74% of the youth in the sample. Forty-four percent (44%) of youth a "good" or "optimal" level of behavioral risk toward others. Forty-six percent (46%) needed "refinement" and presented a fair to marginal level of risk toward others. Nine percent (9%) needed "improvement" in their level of risk toward others, with poor status and a potential for harm to others present.

Overall, 29% of youth had an unfavorable self-risk status, and 26% an unfavorable level of risk toward others. Stronger planning, and/or evaluation of existing strategies and supports by teams are indicated to more consistently ameliorate youths' levels of behavioral risk.
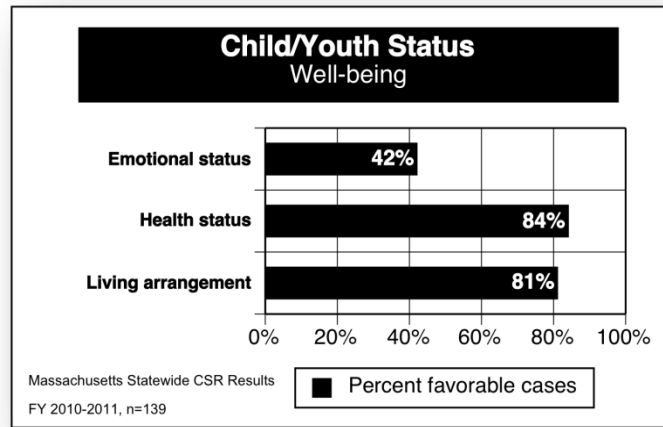
Emotional and Behavioral Well-being

Youth are reviewed to determine the degree to which 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 consider 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 only 42% youth reviewed statewide indicating a high number of youth with emotional/behavioral issues that included inconsistent or poor emotional development, adjustment problems, emotional/adaptive distress, and/or serious behavioral problems.

Of the youth reviewed statewide, 16% had a "good" or "optimal" level of emotional/behavioral status that should be maintained. The preponderance of youth (70%) were found to need "refinement" in their emotional/behavioral well-being, and were functioning at a "fair" to "marginal" level. The remaining 14% of youth had "poor" or "worsening" levels of functioning and were not making progress.

Overall, 58% of the youth reviewed statewide were demonstrating limited to poor or worsening levels of emotional development, adjustment problems, and/or poor behavioral functioning in daily settings, and were not responding well to attempts to address these issues. Focused support for teams in developing individualized and effective strategies for refining or improving youth's emotional and behavioral well-being is recommended.

Health Status

Health of each 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.

Statewide, 84% had favorable health/physical well-being status. Fifty-two percent (52%) of the youth had "good" or "optimal" health status. Forty-four percent (44%) would benefit from "refinement" in their health status. Only 4% were considered to need "improvement" with poor or worsening health status.

As seen in the demographics of youth in *Table 12* on page 9, 24% of the youth reviewed had a co-occurring medical problem. The Health Status data indicate most of the youth were achieving their best attainable health status, for many despite a co-occurring medical condition. A number of youth could have benefitted from refinements of work by teams to address health issues.

L*iving 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 youth reviewed across the Commonwealth, 81% were found to have a favorable living arrangement. The majority of youth (57%) had living arrangements that were "good" or "optimal." Thirty-seven percent (37%) needed "refinement" in their living arrangements with fair to marginal situations. Six percent (6%) of the youth had poor or adverse living arrangements that were inappropriate for the youth, and needed " improvement."
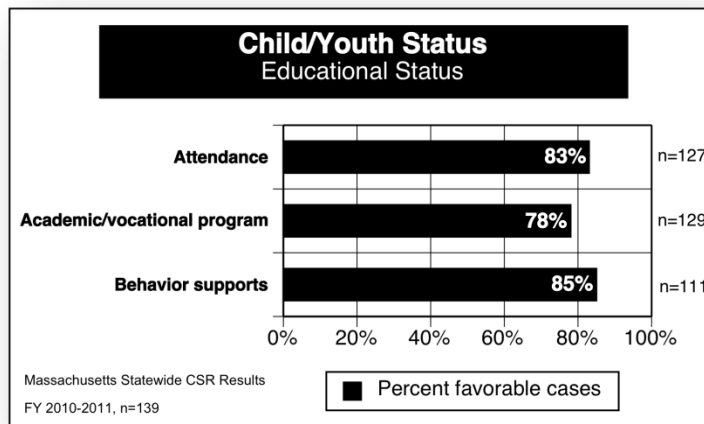
Educational Status

Three specific areas of educational status are examined to determine how well youth are doing in their educational programs across these domains. 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 in a situation where he/she can 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.

For the 127 youth the school attendance sub-indicator was applicable to statewide, 83% had favorable patterns of attendance. Sixty-three (63%) were found to have "good" or "optimal" school attendance. A quarter of the youth reviewed (25%) would benefit from "refinement" in their attendance patterns and had minimally adequate to marginally inadequate attendance. Five percent (5%) of the youth needed "improvement" and had poor to adverse rates of attendance, including those that were chronically truant, suspended or expelled from school.

For the 129 youth who were enrolled in an academic or vocational program, 78% were doing favorably well in their program. Nearly half of the statewide sample (49%) had "good" or "optimal" status in their academic or vocational program. Forty-seven percent (47%) needed "refinement" in their status in their academic or vocational program. Only 4% of the youth reviewed needed "improvement" in their educational programs, and were not meeting educational expectations, or were losing existing skills and regressing.
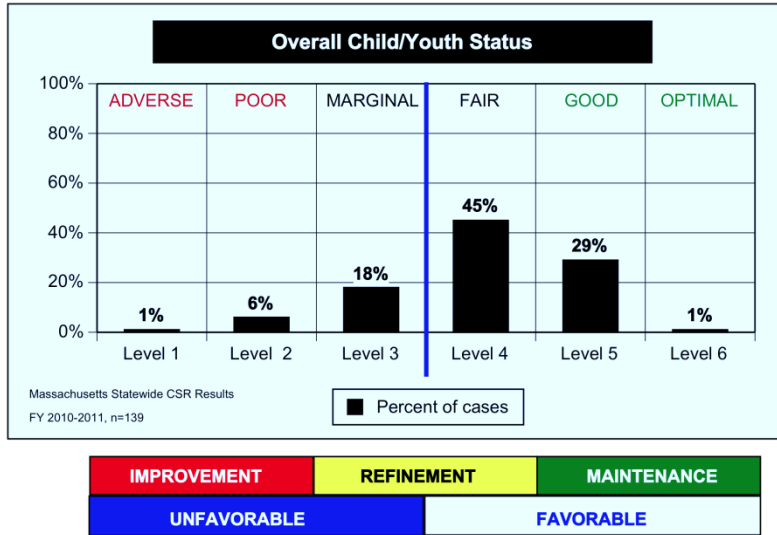
Statewide 111 of the youth in the sample required behavioral supports in their school setting. Behavioral supports were working favorably well for 85% of them. Forty-seven percent (47%) had a "good" or "optimal" level of supports. Forty-one percent (41%) could benefit from "refinement" in their level of supports. Five percent (5%) had a poor level of behavioral support that needed improvement; supports were not adequate in helping the youth do well in school.

Overall educational status was moderately strong for youth reviewed, particularly in the area of school-based behavioral supports. Youth's academic/vocational status may benefit from strategies focused in this domain.

Overall Youth Status

The overall results for Youth Status for the 139 youth reviewed statewide in Fiscal Year 2010-2011 are displayed below. Overall, 76% of the youth were found to be doing favorably well. These youth fell in Levels 4-6; youth had Fair status (45% or 63 youth), Good status (29% or 40 youth) or Optimal status (1% or 2 youth)

The remaining youth (24%) had unfavorable status. They had either Marginal status (18% or 25 youth), Poor status (6% or 8 youth), or Adverse status (1% or 1 youth).

Overall Child/Youth Status

	ADVERSE	POOR	MARGINAL	FAIR	GOOD	OPTIMAL
	1%	6%	18%	45%	29%	1%
	Level 1	Level 2	Level 3	Level 4	Level 5	Level 6

Massachusetts Statewide CSR Results
FY 2010-2011, n=139

■ Percent of cases

IMPROVEMENT	REFINEMENT	MAINTENANCE
UNFAVORABLE	FAVORABLE	

Overall Youth Status results are also categorized as needing Improvement, Refinement, or Maintenance. This allows for identification of youth that may need focused attention. Seven percent (7%) of youth fell into the Improvement area, meaning their status was problematic or risky. For these youth, action should likely be taken to improve their situation. The majority of the youth (63%) fell in the Refinement area. The status of these youth was minimal or marginally good, and potentially unstable with further efforts likely necessary to improve their well-being. Thirty percent (30%) of the youth statewide had status that should be maintained, and efforts for them should likely be sustained and leveraged to build upon a fairly positive situation.

Several observations can be drawn about the status of youth reviewed statewide. Overall, youth were in permanent situations and safe across home, school and community settings. Youth were generally attending school regularly, and had adequate behavioral supports in their school settings, although academic status was a concern for a number of youth. A significant number of youth had favorable physical health status. Refinements in youths' living arrangements, as well as home and school stability were indicated for a number of youth in the statewide sample.

A primary issue was the level of behavioral risk to self and others, which impacted risk status for over a quarter of the youth. Most concerning was the emotional status of youth; 58% of those reviewed were found to have unfavorable emotional well-being.

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
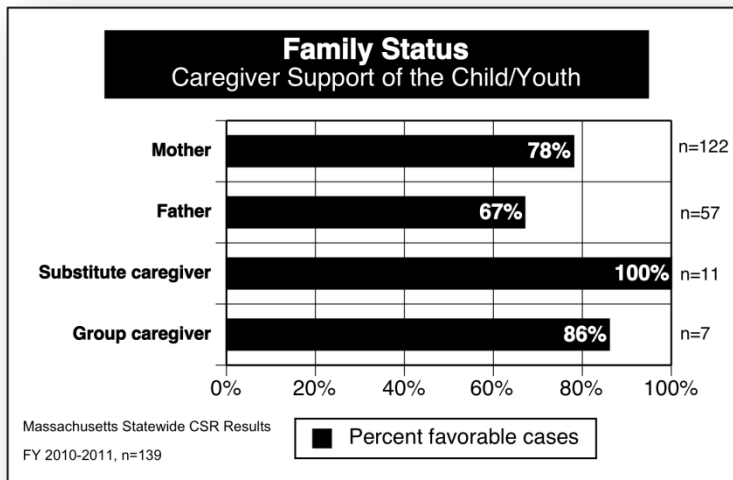
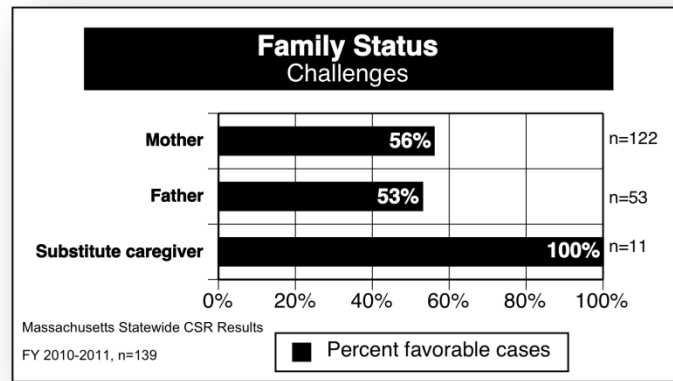*Parent/Caregiver Support of the Youth*
The Parent/Caregiver Support indicator measures the degree of support the person(s) that the youth resides with is able and willing to provide for the youth in terms of giving assistance, supervision and care necessary for daily living and development. Also considered 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 across the Commonwealth, favorable support by mothers was found 78% of the time. There was "good" or "optimal" support for 45% of youth. Maternal support was fair or marginally inadequate and needed "refinement" for half of the youth reviewed (50%). "Improvement" was needed for 5% of the youth.

The measure for support from fathers was applicable for 57 of the youth in the statewide sample. Favorable support was found from 67% of the fathers. Support from fathers was "good" or "optimal" for 21% of the youth, needed "refinement" for 58%, and "improvement" for 21%.

Support was favorable for 100% of the 11 youth with a substitute caregiver. Sixty-four percent (64%) of the youth were determined to have a "good" or "optimal" level of support, and the remaining 36% had fair support that could benefit from "refinement."

For the 7 youth reviewed who were in group care, support of the youth was favorable for 86% of them. Fifty-seven percent (57%) of them had "good" or "optimal" support that should be maintained. Twenty-eight percent (28%) were experiencing a fair level of support in need of "refinement." One youth or 14% of those in group care had a moderate level of supports with continuing problems of caregiving adequacy.

Family Status
Challenges

Mother	56%	n=122
Father	53%	n=53
Substitute caregiver	100%	n=11

0% 20% 40% 60% 80% 100%

Massachusetts Statewide CSR Results
FY 2010-2011, n=139

■ Percent favorable cases

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.

For the 122 youth the indicator was applicable for, 56% of mothers had favorable status in terms of the level challenge they were experiencing. Twenty percent (20%)/of mothers had a "good" or "optimal" level of challenge with few limitations and good supports, or no limitations. Most of the mothers (55%) needed "refinement" in their level of challenge, with minor limitations and adequate supports, or limits with inadequate or inconsistent supports. Fourteen percent (14%) of the mothers had a level of challenge that needed to be "improved," and were experiencing major life challenges with inadequate or missing supports.

Fifty-three percent (53%) of fathers had a favorable level of challenge. Of these, 17% had a "good" or "optimal" challenge level (few to no challenges). The majority (58%) needed "refinement" in their level of challenge. A quarter of the fathers (25%) were experiencing major to overwhelming/worsening levels of challenge with inadequate to no supports.

These data need to be understood within the context of the specific caregiving challenges identified in the population as reflected in Table 17 on page 12 of this report where 37% of caregivers were experiencing extraordinary care burdens, 35% adverse effects of poverty, and 26% challenged by their own mental illnesses.

For 11 youth with substitute caregivers, 100% were experiencing a favorable level of challenge with 54% have few to no limitations, and 46% needing "refinement" with some minor limitations, but with adequate supports.
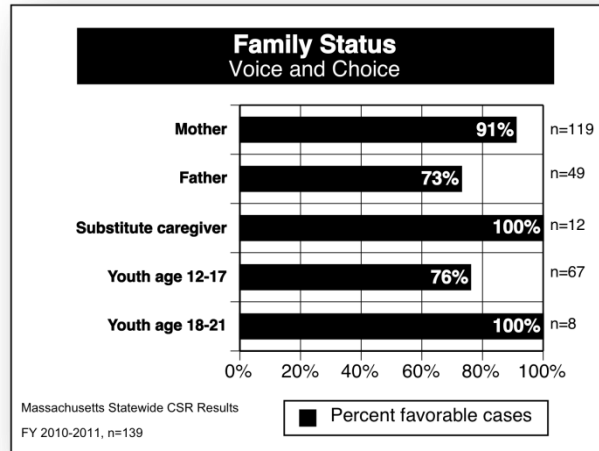
Family Voice and Choice
Family Voice and Choice is rated across the range of individuals as seen in the Caregiver Status: Family Voice and Choice chart above. For this indicator, in addition to parents/caregivers, the voice and choice of the youth is rated for youth who are over age 12. The variables 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.

Ninety-one percent (91%) of mothers were experiencing favorable voice and choice in their child's assessments, planning and service delivery processes. Of these, 76% were experiencing a "good" to "optimal" level of voice and choice. Twenty-two percent (22%) would benefit from "refinement" and strengthening of their voice and choice. Only 3% were found to have a substantially inadequate or no voice and choice in the service process.
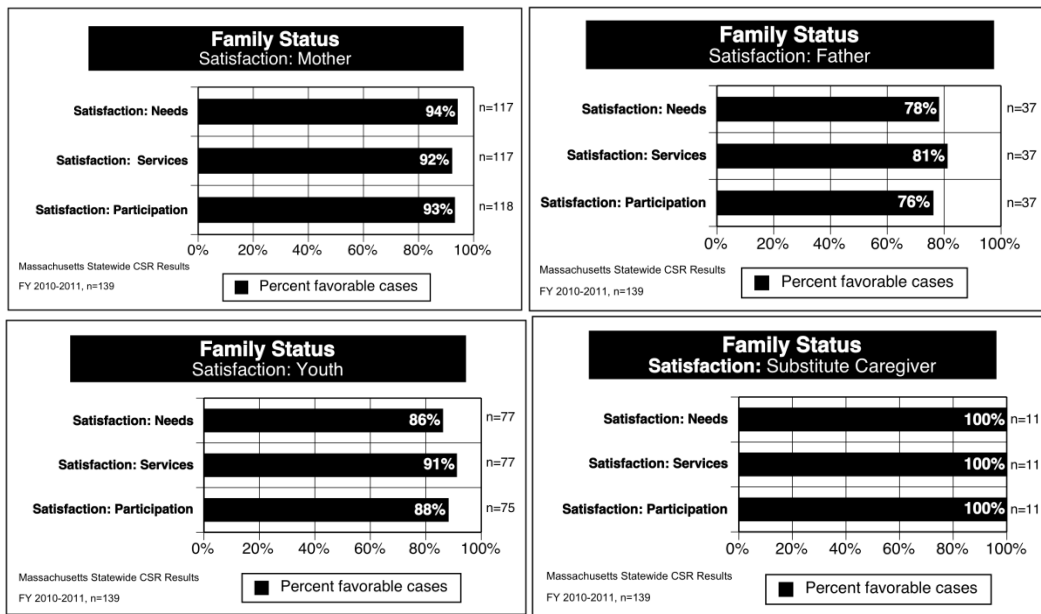
For youth whose fathers were involved and information could be gathered (N=49), 73% had a favorable level of voice and choice with their child's service processes. Thirty-seven percent (37%) had "good" or "optimal" voice and choice, and 49% needed refinement. Fourteen percent (14%) of the fathers fell in the range of having substantially inadequate to no voice and choice in planning and services.

Of the substitute caregivers of youth reviewed, 100% had a favorable level of voice and choice in service delivery processes. This included 97% with "good" or "optimal" voice and choice, and 3% with minimally adequate voice and choice that would benefit from "refinement."

Of the youth reviewed in the 12-17 age range, 76% had a favorable level of voice and choice in their own services, with 47% in the "good" or "optimal" category. "Refinement" was indicated for 43% of youth who fell in this age range. Nine percent (9%) of youth aged 12-17 had substantially inadequate to no voice in their planning and service delivery and would benefit from "improvement" in their voice and choice.

Youth in the 18-21 age range were all (100%) experiencing a favorable level of voice and choice in their planning and services. All of the youth's experiences were in the "good" or "optimal" level.

These data indicate voice and choice is strong for mothers, substitute caregivers and youth in the 18-21 age range, and can be strengthened for fathers and youth aged 12-17.

Family Status
Satisfaction: Mother

Satisfaction: Needs	94%	n=117
Satisfaction: Services	92%	n=117
Satisfaction: Participation	93%	n=118

Massachusetts Statewide CSR Results
FY 2010-2011, n=139

■ Percent favorable cases

Family Status
Satisfaction: Father

Satisfaction: Needs	78%	n=37
Satisfaction: Services	81%	n=37
Satisfaction: Participation	76%	n=37

Massachusetts Statewide CSR Results
FY 2010-2011, n=139

■ Percent favorable cases

Family Status
Satisfaction: Youth

Satisfaction: Needs	86%	n=77
Satisfaction: Services	91%	n=77
Satisfaction: Participation	88%	n=75

Massachusetts Statewide CSR Results
FY 2010-2011, n=139

■ Percent favorable cases

Family Status
Satisfaction: Substitute Caregiver

Satisfaction: Needs	100%	n=11
Satisfaction: Services	100%	n=11
Satisfaction: Participation	100%	n=11

Massachusetts Statewide CSR Results
FY 2010-2011, n=139

■ Percent favorable cases

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 displays above show the results for how satisfied each of the role groups were with needs understood, services and results, and participation. Mothers' satisfaction overall was

strong and ranged with 94% satisfied with their needs being understood, 92% with services, and 93% with their participation.

Fathers' were less satisfied with 78% satisfied with their child and family's needs understood, 81% satisfied with services, and 76% satisfied with their participation in planning and services.

Youth satisfaction was sought in the CSRs for youth age 12 and older. Eighty-six percent (86%) were satisfied with their needs being understood, 91% with services, and 88% with their participation.

Of the 11 substitute caregivers of youth reviewed, 100% were satisfied in all categories measured.

Summary: Caregiver/Family Status

A significant percentage of the parents of youth reviewed statewide were found to be experiencing substantial life challenges. Support for youth was negatively impacted more for fathers than mothers. These results indicate that teams need to be vigilant in developing strategies to link parents to specialized supports and services when needed. Many of the reviews of youth found that when parents' challenges were not consistently acknowledged and adequate support and services were not provided, youth were less likely to achieve favorable levels of status and progress. Teams may need to find ways to help parents to link to services, especially services to address their own mental health issues.

Support for youth in group caregiving situations was favorable for 86%. Family voice and choice was strong for mothers, substitute caregivers, and youth age 18-21. Fathers and youth in the 12-17 age range had far less adequate voice and choice in service processes, indicating improvements are needed in assuring their voice and choice. Mothers, youth and substitute caregivers at the statewide level expressed high satisfaction across service processes; fathers were found to be less satisfied across the aspects of service delivery measured.

Youth Progress
(M*easures 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. Progress is measured at a level commensurate with the youth's age and abilities and is measured as positive changes over the past six months or since the beginning of treatment if it has been less than six months.

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
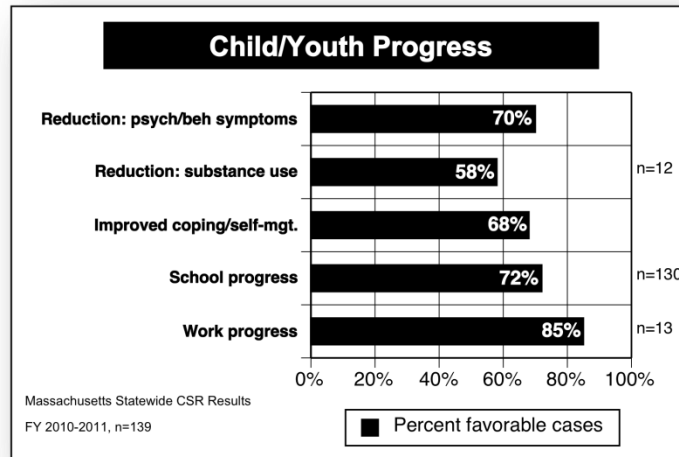
Reduction of Psychiatric Symptoms and/or Substance Use
These two indicators measure the degrees to which target symptoms, problem behaviors and/or substance use patterns causing impairment have been reduced.

For the youth reviewed statewide, 70% had made favorable progress in reducing symptomatology and/or problem behaviors over the previous six months or since beginning services. Twenty-seven percent (27%) of the sample had made "good" or "optimal" progress at levels above expectation. Over half of the youth (58%) could benefit from "refinement" in their level and rate of progress in reducing their symptoms and were making fair progress near expectations or marginal progress somewhat below expectations. The remaining 15% had made no progress in reducing targeted symptoms and/or behavioral issues, including one percent (1%) that was declining with symptoms and behaviors increasing.

Of youth in the sample with substance abuse issues, only 58% had made favorable progress. Of these, one or 8% of the youth with substance abuse issues was making "good" progress. Two thirds of the youth (66%) needed their level of progress to be "refined" and had made

fair to marginal progress. Twenty-five percent (25%) of the youth with substance abuse issues had made no progress.

Improved Coping and Self-Management

This indicator measures 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.
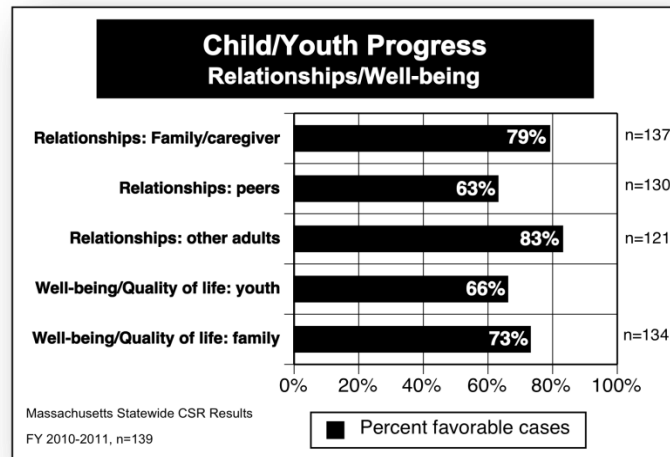
Among the youth reviewed statewide, 68% had made favorable progress in improving their coping skills and ability to self-manage their emotions and behaviors. Thirteen percent (13%) had made "good" or "optimal" progress in improving their ability to cope and manage their own behaviors. Sixty-one percent (61%) of the sample fell in the "refinement" area and had made fair to marginally inadequate progress in coping and self-management. A quarter of the youth (25%) were making poor progress in advancing coping and self-management at levels well-below expectations and needed improvement.

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, vocational curriculum or work situation.

Of the youth for which school progress was applicable, 72% had made favorable progress in school. Forty-two percent (42%) of the youth were making "good" or "optimal" progress in school. Forty-seven percent (47%) were determined to need "refinement" and had made fair to marginally inadequate progress. Eleven percent (11%) had made making no progress or and were regressing in school.

Progress in a work setting applied to 13 youth and 85% had made favorable progress in satisfying expectations necessary for maintaining employment. Six of the 13 or 46% had made "good" to "optimal" progress in the work setting. Another 46% needed their level of progress with work to be "refined." One youth (8%) was making no progress in satisfying work expectations necessary to maintain employment.

Child/Youth Progress
Relationships/Well-being

Relationships: Family/caregiver	79% n=137
Relationships: peers	63% n=130
Relationships: other adults	83% n=121
Well-being/Quality of life: youth	66%
Well-being/Quality of life: family	73% n=134

0% 20% 40% 60% 80% 100%

Massachusetts Statewide CSR Results
FY 2010-2011, n=139

■ Percent favorable cases

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 youth reviewed statewide, 79% of them had made progress in their relationships with their families or caregivers. Progress in building peer relationships was less favorable, with only 63% making progress in building meaningful relationships with peers. Progress in developing relationships with positive supportive adults (teachers, coaches, etc.) was more favorable, 83% making progress in this domain.

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 reviewed in the CSR across the Commonwealth, only 66% had made favorable progress in an improved overall well-being and quality of life. Twenty-four percent (24%) had made "good" or "optimal" progress in developing and using personal strengths, long-term relationships, life skills, and future plans. Fifty-eight percent (58%) were determined to need "refinement," and had made fair or marginally inadequate progress in improved quality of life. Eighteen percent (18%) had made poor or no progress in their overall quality of life and had developed few to no long-term supportive relationships, life skills for problem solving, educational/work opportunities, or meaningful and achievable future plans.

For the families and caregivers, 73% had made favorable progress in improving the overall quality of life. Among these were 35% families who had made "good" to "optimal" progress,

54% needing "refinement," and 10% who had made poor or no progress and needed "improvement."
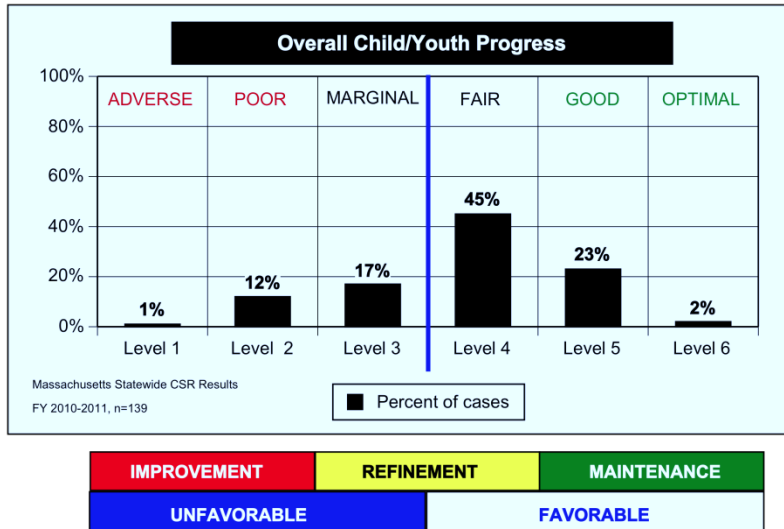
Overall Youth Progress

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, 71% of the youth reviewed statewide were making favorable progress (Fair, Good or Optimal Progress). Of these, 2% had made an "optimal" level of progress, 23% "good" progress, and 45% "fair" progress.

Of the youth who had made unfavorable progress (29% of youth), 17% had made "marginal" progress, 12% "poor" progress, and 1% an "adverse" level of progress.

Twenty-four percent (24%) had a level of progress that should be maintained, 62% a level of progress that needed refinement, and 13% that needed their progress to be "improved."

The data for Youth Progress indicates that youth are progressing most in Work Progress and Improved Relationships with Other Adults. These data indicate teams and services should focus more on other key areas of supporting youth to progress, with particular focus on reducing psychiatric and behavioral symptoms and substance use; improving coping/self-management, school progress, and peer relations; and enhancing the overall well-being and quality of life for youth. Given that only 42% of youth statewide were found to have favorable emotional status, a fundamental task of team members is to improve their ability to understand youths' issues and craft interventions that help youth progress in these key areas.

The data on length of time care coordinators have been assigned to youth show that 84% of care coordinators have been working with the youth and family for greater than four months, with 52% for seven months or longer. This indicates that most youth reviewed were not newly admitted.

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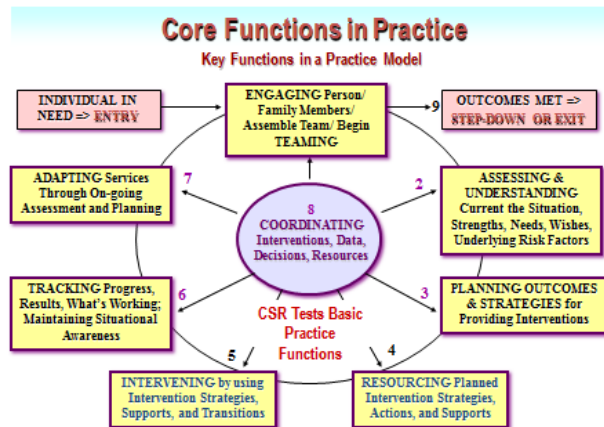
1. Engagement
2. Cultural Responsiveness
3. Teamwork
    a. Formation
    b. Functioning
4. Assessment and Understanding
5. Planning Interventions
6. Outcomes and Goals
7. Matching Interventions to Needs
8. Coordinating Care
9. Service Implementation
10. Availability and Access to Resources
11. Adapting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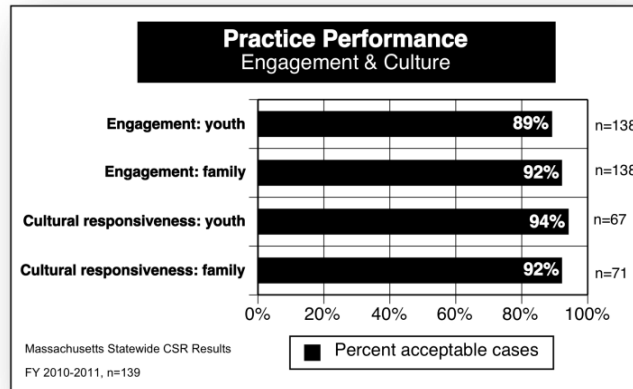
Overall System/Practice Performance

Reviewing System and Practice Performance in the CSR

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.

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). 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.

Each practice function is rated separately to be able to provide foci for understanding system/practice performance for the sample of youth reviewed and where improvements should be made. The practice elements together work in concert to impact positive change for the child and family as displayed below:

Practice Performance
Engagement & Culture

Engagement: youth	89%	n=138
Engagement: family	92%	n=138
Cultural responsiveness: youth	94%	n=67
Cultural responsiveness: family	92%	n=71

Massachusetts Statewide CSR Results
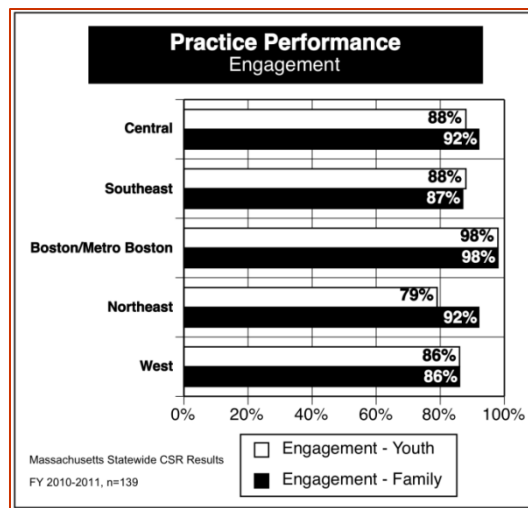FY 2010-2011, n=139
■ Percent acceptable cases

Engagement

Reviewing engagement helps 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, 89% experienced an acceptable level of engagement. Families were engaged at an acceptable level 92% of the time. Two thirds of the youth (66%) and 71% of the families were engaged at a "good" or "optimal" level. Twenty-nine percent (29%) of youth and 26% of families experienced engagement that would benefit from "refinement." Four percent (4%) of youth and 3% of families experienced poor engagement that needed "improvement."

Practice Performance
Engagement

	Youth	Family
Central	88%	92%
Southeast	88%	87%
Boston/Metro Boston	98%	98%
Northeast	79%	92%
West	86%	86%

Massachusetts Statewide CSR Results
FY 2010-2011, n=139
□ Engagement - Youth
■ Engagement - Family

Comparative results data across the five regional CSRs are presented above for Youth and Family Engagement. As can be seen, there was consistently strong performance in engaging

youth and families across the reviews with the exception of the Northeastern review, where youth engagement was weaker.
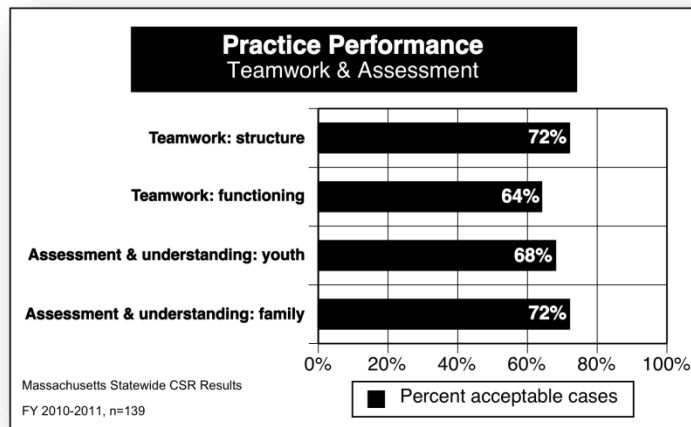
Cultural Responsiveness

Cultural responsiveness is a system practice to be integrated across service functions. Cultural responsiveness 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 youth and families for which the indicator applied Cultural Responsiveness was acceptable for 94% of youth and 92% of families statewide. Cultural Responsiveness was at a "good" or "optimal" level for 78% of youth and 75% of families. For 21% of youth and 23% of families, practices in this area needed "refinement" and was fair to marginal. Cultural Responsiveness was found to be poor and not recognized in service processes for only 1% of youth, and 3% of families.
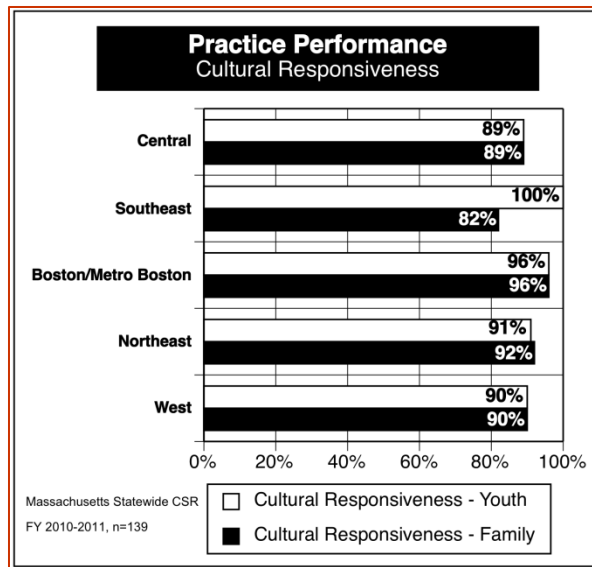
In the chart above, the regional CSR Cultural Responsiveness practice results are presented. Cultural Responsiveness was consistently strong across the regions. For families in Southeastern Massachusetts, some strengthening of Cultural Responsiveness is indicated.

Practice Performance
Teamwork & Assessment

Teamwork: structure	72%
Teamwork: functioning	64%
Assessment & understanding: youth	68%
Assessment & understanding: family	72%

0% 20% 40% 60% 80% 100%

Massachusetts Statewide CSR Results
FY 2010-2011, n=139

■ Percent acceptable cases

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. Statewide, team formation was acceptable for 72% of youth. Teams were formed at a "good" or "optimal" level for 45% of the youth reviewed. Forty-eight percent (48%) needed "refinement." In these cases, team formation was minimally adequate to fair, or marginally inadequate, meaning the care planning team met only occasionally and had few to limited skills, family knowledge, and abilities necessary to organize effective services. Seven percent (7%) were experiencing poor team or absent/adverse team formation indicating a need for improvement.

Team Functioning. Teams were functioning acceptably well for only 64% of youth statewide. Thirty-seven (37%) percent of teams functioned at a "good" or "optimal" level with the skills, family knowledge and abilities necessary to work in a unified manner and organize effective services and supports for the youth and families. For 53% of youth, teams needed "refinement" and were functioning in a somewhat unified and consistent manner, or

were splintered and engaged in a pattern of actions that was usually incoherent with limited problem-solving. Ten percent (10%) of teams were functioning poorly, independently of the family and in isolation of other team members resulting in limited benefits for the youth and family, or there was absent or adverse teamwork.

Practice Performance
Teamwork

Region	Teamwork - Structure	Teamwork - Functioning
Central	63%	58%
Southeast	71%	50%
Boston/Metro Boston	76%	78%
Northeast	75%	67%
West	73%	55%

Massachusetts Statewide CSR Results
FY 2010-2011, n=139

☐ Teamwork - Structure
■ Teamwork - Functioning
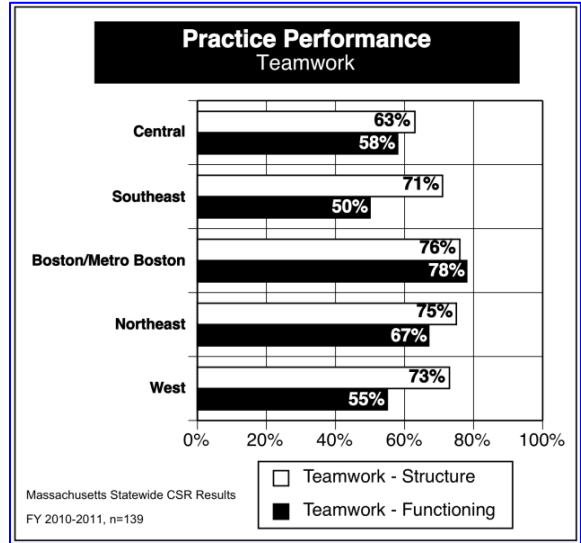
The chart above displays the results for Team Formation and Team Functioning for the five regional CSRs conducted during Fiscal Year 2010-2010. Although Team Formation had stronger performance than Team Functioning, both system processes were weak across all regions, indicating a need for focused improvements. Team Functioning was particularly problematic for many of the youth reviewed in the Central, Southeastern, and Western regions of Massachusetts.

Overall, the data indicate focused work is needed to help teams across the state more consistently form and work together to plan to achieve common goals, unify efforts, communicate regularly, evaluate results, and work in alignment with system of care principles to benefit youth and families.

Assessment and Understanding
The Assessment and Understanding indicator reviews system processes that serve as 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 necessary foundational condition for practitioners to build cohesive care plans that can be implemented by teams toward achieving positive outcomes.
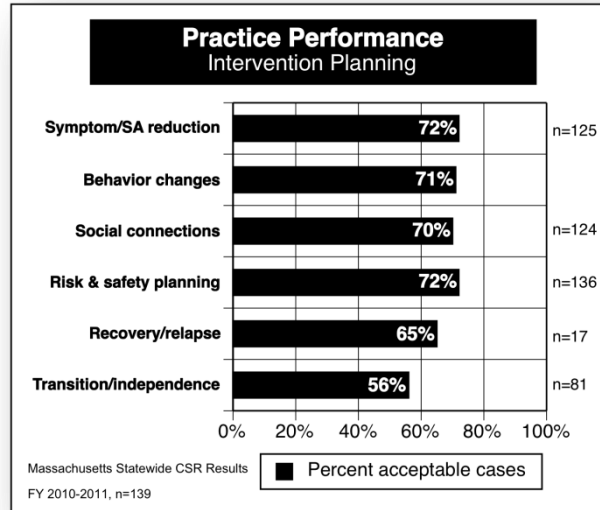
Statewide, only 68% of youth were found to have an acceptable level of assessment and understanding of their core issues and situations. Thirty-five percent (35%) of teams had assessment and understanding of the youth's strengths, underlying issues, needs, risks and preferences at a "good" or "optimal" level. Over half of the youth (53%) would benefit from "refinement" in their teams' level of understanding of them. For these youth, assessment and understanding was at a fair level with efforts made but nominal understanding of the youth's strengths and needs, or marginally inadequate with limited information that was only occasionally updated. Twelve percent (12%) of youth had teams that had poor, incomplete or inconsistent assessment and understanding of the youth. In these cases, information necessary to understand the youth's strengths, needs and underlying issues were absent or outdated.

Assessment and understanding of families was acceptable for 72% of the statewide sample, and was found to be "good" for 8%. "Refinement" was needed for over half of the families (52%) where there was fair/minimal understanding, or marginally inadequate assessment and understanding. In these cases the team needed to better understanding the strengths, context, needs and vision of the family. Eight percent (8%) of family had teams that had a poor level of understanding of their context and dynamics with information that was sometimes confused or contradictory.
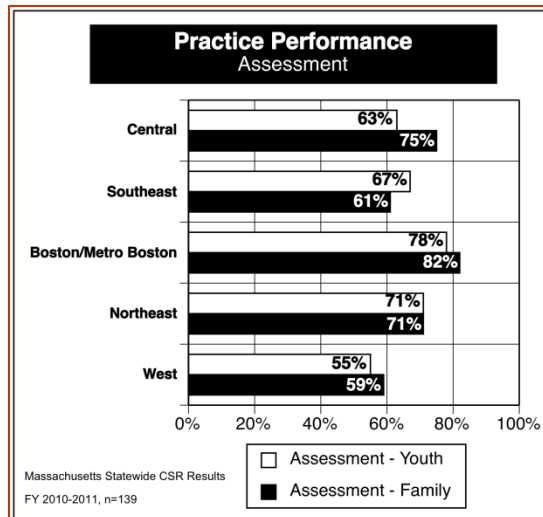
Results of the five CSRs by region for the youth and families reviewed are presented above. There was variable performance across the regions, with the Assessment and Understanding of youth ranging from 55% to 78% acceptable performance. Assessment and Understanding of families ranged from 59% to 82% acceptable performance.

Overall statewide, 32% of youth and 28% of families had that teams did not have an acceptable level of assessment and understanding necessary to plan supports and interventions. Statewide data presented on Page 11 showed that 22% of youth statewide did not have a current mental health assessment, and only 33% of parents had received their child's mental health assessment. Overall, this foundational practice needs improvement in order to assure all relevant and current information about youth and families is consistently gathered and synthesized so that teams have the full understanding needed to develop effective plans of care.
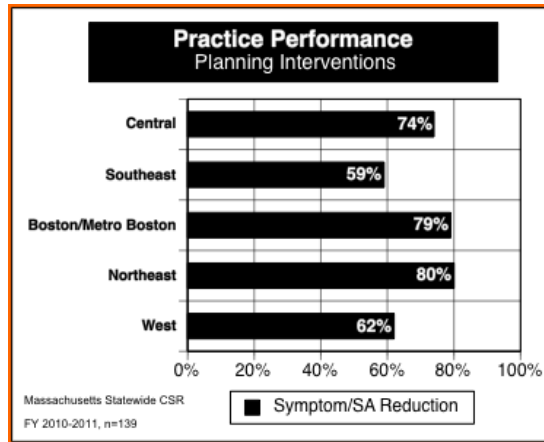
Practice Performance
Intervention Planning

Sub-indicator	Percent acceptable cases	n
Symptom/SA reduction	72%	n=125
Behavior changes	71%	
Social connections	70%	n=124
Risk & safety planning	72%	n=136
Recovery/relapse	65%	n=17
Transition/independence	56%	n=81

Massachusetts Statewide CSR Results
FY 2010-2011, n=139 ■ Percent acceptable cases

Planning Interventions

Intervention Planning was evaluated for each youth and family across six sub-indicators. Specific indicators may or may not be applicable to a particular youth/family depending on their specific needs and goals. Acceptability of intervention planning for each sub-indicator is based on an assessment of the degree to which processes are consistent with system of care and wraparound principles. Reviewers also examine plans and processes to see if they 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.
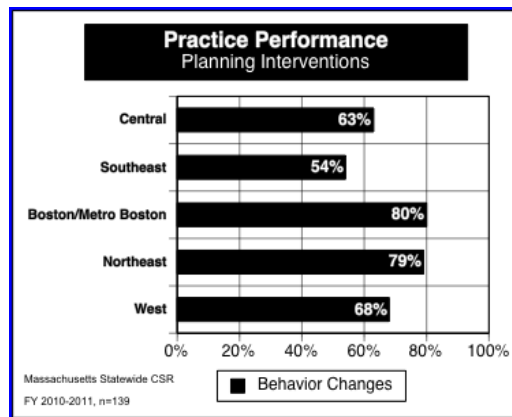
For the 125 youth the *Symptom or Substance Abuse Reduction* sub-indicator was applicable for, planning for reducing presenting psychiatric symptoms or substance abuse was acceptable for 72%. There was "good" or "optimal" planning in reducing symptoms or substance abuse for 34% of youth with well-reasoned strategies informed by an understanding of needs, and the youth and families' preferences and perspectives. "Refinement" in planning to reduce symptoms or substance abuse was identified to be needed for over half of the sample (54%) where planning was fair to marginally inadequate. Planning for symptom/substance abuse reduction was poor or absent/misdirected for 13% of those reviewed.

*Regional CSR Results for Individual Planning Indicators:*

Practice Performance
Planning Interventions

Region	Symptom/SA Reduction
Central	74%
Southeast	59%
Boston/Metro Boston	79%
Northeast	80%
West	62%

Massachusetts Statewide CSR
FY 2010-2011, n=139
■ Symptom/SA Reduction

The chart above displays the comparative results for the five regional CSRs for planning for Symptom or Substance Abuse reduction. Performance in adequately addressing symptom/substance abuse reduction in care plans ranged from 59% to 80% of planning efforts. Strengthening strategies and supports for reducing youth's presenting psychiatric symptoms and/or substance use is indicated across the state, with particular support indicated for teams in Western, Southeastern, and Central Massachusetts.

Addressing *Behavior Changes* in the care plan was applicable to all of the youth reviewed, and was at an acceptable level for only 71%. Thirty-nine percent (39%) had care plans that addressed needed behavior changes in the "good" or "optimal" range. These plans reflected understanding of the youth and family, and had clear interventions for addressing behaviors that created problems for the youth. "Refinement" of behavioral supports and interventions in plans was needed for 54% of the youth. For 8% plan components for supporting behavior changes were poorly reasoned and failed to design interventions that could address core issues, or there was no plan to address presenting behaviors.

Practice Performance
Planning Interventions

Region	Behavior Changes
Central	63%
Southeast	54%
Boston/Metro Boston	80%
Northeast	79%
West	68%

Massachusetts Statewide CSR
FY 2010-2011, n=139
■ Behavior Changes

Performance in addressing youth's problematic behaviors through strategies in care plans for each of the regional CSRs is displayed above. Results ranged from 54% to 80% acceptable performance. Improvements in assuring behaviors are adequately addressed are indicated statewide, with emphasis on strengthening behavioral strategies in care plans in Western, Southeastern and Central Massachusetts.

Planning for increasing *Social Connections* was applicable for 124 of the youth reviewed and acceptable for only 70% of them. Thirty percent (30%) of the youth had "good" or "optimal" strategies in their plans for improving social connections with well-understood and well-reasoned supports. "Refinement" was indicated in plans for 58% of youth who needed stronger social connections in order to do better emotionally or behaviorally. These youth had fair to marginal strategies reflected in their care plans that were somewhat aligned, or limited and inconsistent. Twelve percent (12%) of youth who needed stronger social connections had poor planning reflecting unaligned strategies lacking in clarity and urgency to address their social connection needs, or had absent or misdirected planning.
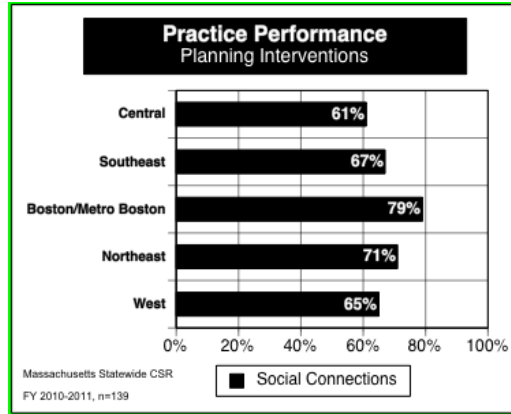
Planning interventions for increased Social Connections was somewhat variable across the five CSRs as seen above, with acceptable performance ranging from for 61% to 79% of the youth in each region. Strengthening of the Social Connection planning domain was indicated for all regions.

Risk/Safety planning was acceptable for 72% of the youth reviewed statewide. The risk/safety component of plans was "good" or "optimal" for 43% of the sample. For 46% of the youth risk and safety planning needed "refinement" with planning found to be fair or marginally inadequate. For 12%, risk/safety planning was poor or absent.
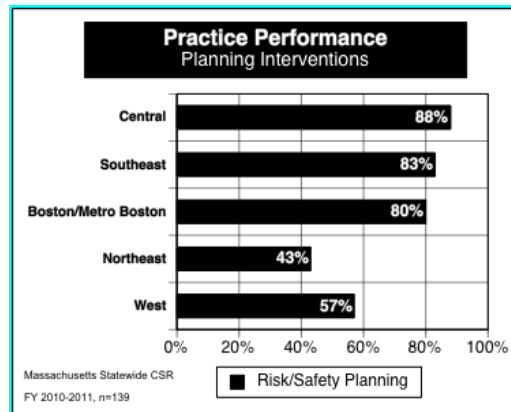

There was wide variation of results for planning to reduce risk and safety issues as seen in the chart above. Of note is that the CSRs that were conducted later in the year had much stronger performance than the two CSRs conducted earlier. Assuring risk and safety issues are anticipated and managed is a planning domain that needs continual monitoring.

Seventeen (17) youth in the sample needed *Recovery or Relapse* issues addressed in planning. Planning to address the recovery process and prevention of relapse was acceptable for only 65% of them. Twenty six percent (26%) were found to have "good" or "optimal" planning in this domain. Planning for all over half (52%) of the youth fell in the "refine" range indicating fair to marginally inadequate planning which could benefit from enhancement of efforts. Six percent (6%)of the youth experienced poor planning to address recovery/relapse issues with a poorly reasoned, inadequate planning process.
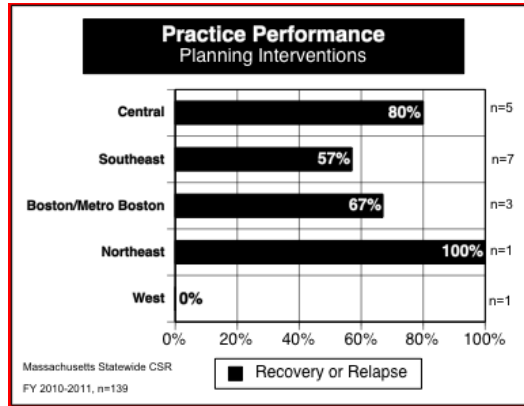
Regional results indicating relative sample size are displayed above. Small sample sizes preclude comparative interpretation of the data. Of note is the relatively large number of youth reviewed who needed recovery/relapse prevention supports in the Southeastern Massachusetts sample.

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. Eighty-one (81) of the 139 youth reviewed had active or imminent transitions that needed to be addressed in their planning processes Transition planning was acceptable for only 56%. Twenty-six percent (26%) experienced transition planning that was "good" or "optimal." Over half (52%) of the youth would have benefitted from "refinement" in planning for transitions. Twenty-two percent (22%) had poor or absent planning for supporting their transitions.
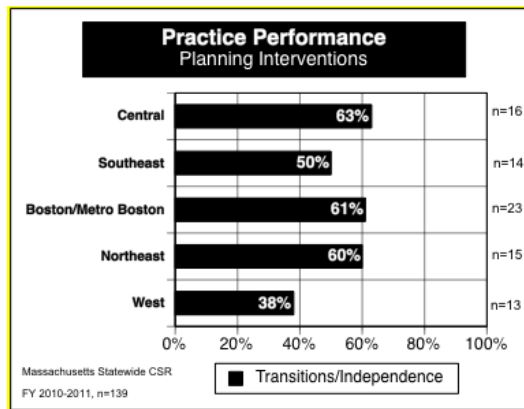
Data from the regional results above clearly indicate improvement is needed in identifying and planning for effective transitions statewide. Performance ranged from 38% to 63% of
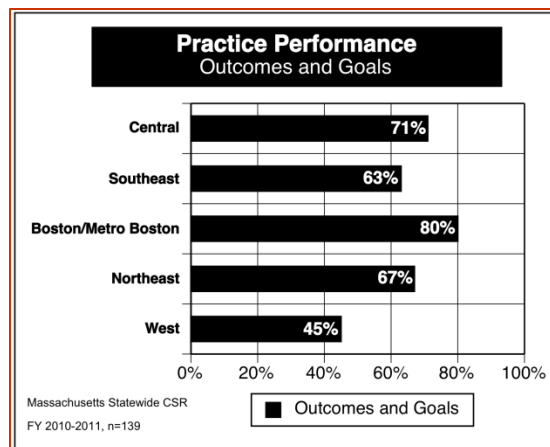
youth experiencing acceptable transition planning. Transitions for youth with SED can be a particularly vulnerable time. For youth transitioning to young adulthood, transition is a physical, emotional, and psychological process rather than an "event." Defining and implementing best practices in supporting youth's transitions at any age are indicated given the results of performance statewide.

Practice Performance
Outcomes & Implementation

	Percent acceptable cases
Outcomes & goals	68%
Matching interventions	68%
Coordinating care	71%
Service implementation	75%

Massachusetts Statewide CSR Results
FY 2010-2011, n=139
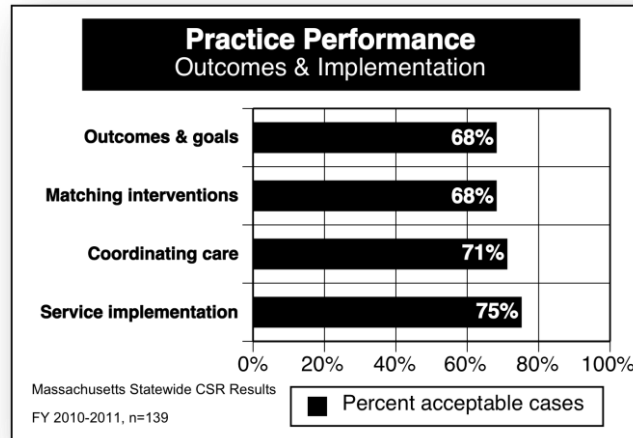
Outcomes and Goals

The focus of the Outcomes and Goals indicator is to measure 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 was acceptable for only 68% of youth statewide. Thirty-eight (39%) of the youth had "good" or "optimal" goals that were well-reasoned and specific. Fifty-two percent (52%) of those reviewed had ending goals and outcomes that were fairly to marginally inadequate and needed "refinement." Nine percent (9%) had poor specification of outcomes and goals insufficient for guiding intervention and change, or absent goals.

Practice Performance
Outcomes and Goals

	Outcomes and Goals
Central	71%
Southeast	63%
Boston/Metro Boston	80%
Northeast	67%
West	45%

Massachusetts Statewide CSR
FY 2010-2011, n=139

Regional results for the Outcomes and Goal indicator displayed above ranged from 45% acceptable to 80% acceptable, indicating a wide range of system/practice performance. Strengthening the specification of outcomes and goals in youth's plans are indicated for most areas of the state.

Matching Interventions to Needs
This Matching Interventions to Needs 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.

There was an acceptable level of matching intervention to need for 68% of the youth reviewed statewide. Forty-one percent (41%) had "good" or "optimal" matching. Over half of the youth (52%) needed their teams to "refine" identification and assembly of services and supports that matched the youth and families' situations and needs. For these youth there was fair matching and integration that could meet short-term objectives or marginal matching that was insufficient. Seven percent (7%) experienced poorly matched interventions resulting in inadequate or conflicting assembly of service and supports, adverse matching of interventions to needs.
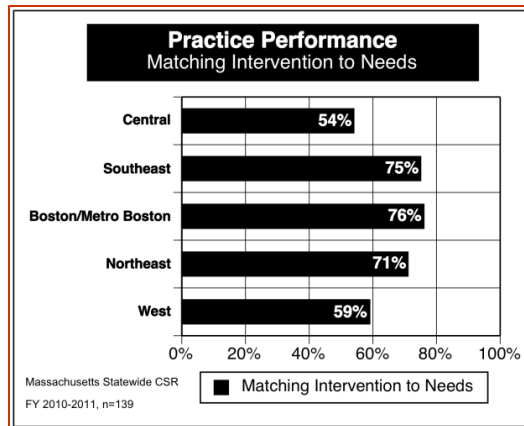

The chart above displays the regional CSR results for Matching Interventions to Needs, which ranged from 54% to 76% acceptable. Strengthening of teams' abilities to assure interventions match what the youth needs to make progress is indicated statewide, with focused support needed in Western and Central Massachusetts.

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 of care 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's role is to facilitate ongoing communications among the entire team

Youth in the sample received care coordination services from both ICC (N=90) and IHT therapists (N=49). Care coordination practices were found to be at an acceptable level statewide for 71% of the youth reviewed. Care coordination was found to be "good" or "optimal" for 44% of the youth hallmarked by effective and dependable coordination. For half the statewide sample (50%), care coordination would benefit from "refinement," and practices were found to be fair and minimally adequate, or marginal and limited with little leadership for service delivery and results. The remaining 6% were found to have poor, fragmented/inconsistent care coordination, or absent/misdirected coordination.
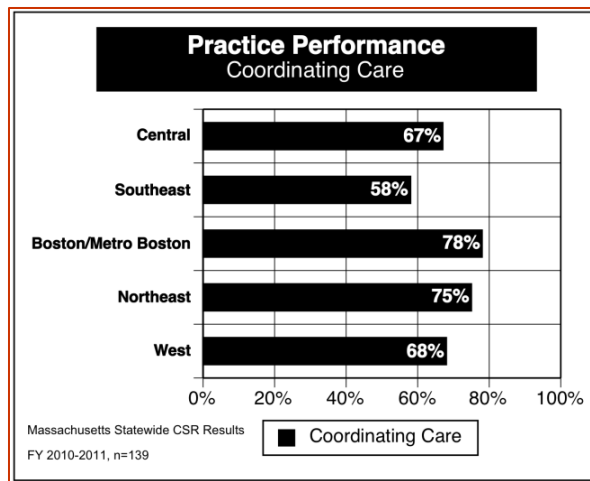

Care coordination performance across the five regional CSRs is displayed above. Results ranged from 58% to 78% of youth in each area receiving acceptable coordination. The data indicate enhancements are needed in the Boston/Metro Boston area to achieve more consistent results, and concerted improvements are indicated in most of the other areas particularly in Western, Southeastern and Central Massachusetts.

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 statewide, 75% were found to have an acceptable level of service implementation. Forty-seven percent (47%) experienced "good" or "optimal" service implementation reflecting a substantial pattern of service implementation that was timely competent and consistent. Another 47% experienced service implementation that needed

"refinement" with an overall pattern of implementing needed services and supports that was fair to marginal/ inconsistent. Six percent (6%) of the youth had poorly implemented services with continuing significant implementation problems, or no needed services implemented.
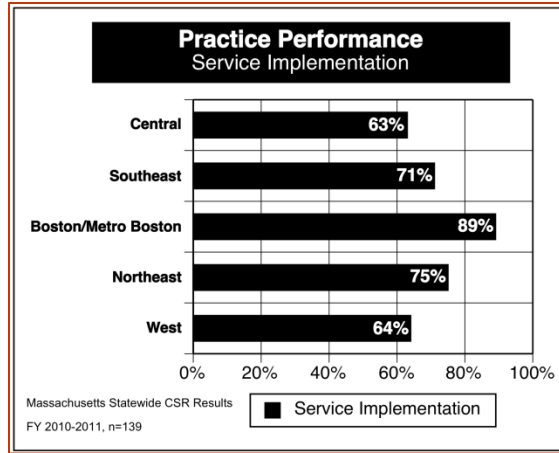

Service Implementation patterns across the five regional CSRs are presented above. Performance for youth reviewed in the Boston/Metro-Boston area demonstrated excellent, consistent and effective overall service implementation. For the remaining regions, results ranged from 63% to 75% acceptable implementation practices, indicating improvements are warranted to assure services and supports youth need to progress are actually implemented.
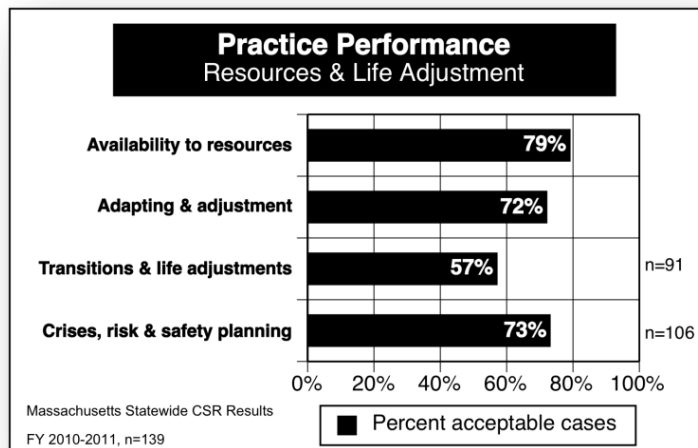
Availability and Access to Resources

The Availability and Access to Resources indicator measures 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. Factors reviewed include the timeliness of access as planned and any delays or interruptions to services due to lack of availability or access over the 90 days preceding the review.

Statewide, 79% of youth were found to have acceptable access to available resources. Forty-nine percent (49%) had a "good" or "optimal" access to needed resources, with a good to excellent array of supports and services available. Forty-seven percent (47%) had fair to marginally inadequate resource availability that reflected a need for "refinement." Four percent (4%) of the sample experienced poor to absent resource access and availability severely limiting their ability to receive needed services.
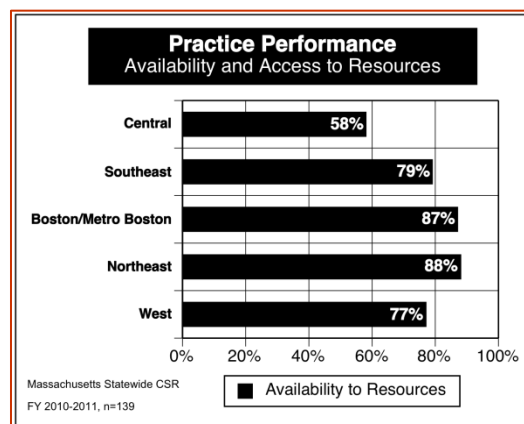

Regional Availability and Access to Resources system/performance results are displayed above. As can be seen, youth reviewed in the Northeast and Boston/Metro Boston reviews were found to have good overall availability and access to necessary services and supports. For youth reviewed in the West and Southeast CSRs, most youth experienced fair availability and access to resources. Availability and access to resources was problematic for many youth in the Central CSR, particularly in the more rural communities.

These data indicate while some improvements are needed to ensure consistent and timely access to necessary resources, with the exception of Central Massachusetts, system/practice performance was fair to strong for this indicator for most of the youth reviewed. In the Central CSR, availability and access to necessary resources for many youth was problematic.

Adapting and Adjustment

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

For youth reviewed statewide, practices related to adapting and adjusting plans and services was acceptable for 72% of the youth. Half of the youth (50%) experienced "good" or "optimal" practices that were responsive to changing conditions, with acceptable levels of monitoring and adjustment. Forty-two percent (42%) of those reviewed were experiencing necessary changes to plans and services at a minimally adequate to marginally inadequate level, with only periodic to occasional monitoring. Nine percent (9%) of the youth had poor and fragmented adapting and adjustment of services and interventions, or an absent or non-operative adapting and adjustment process.
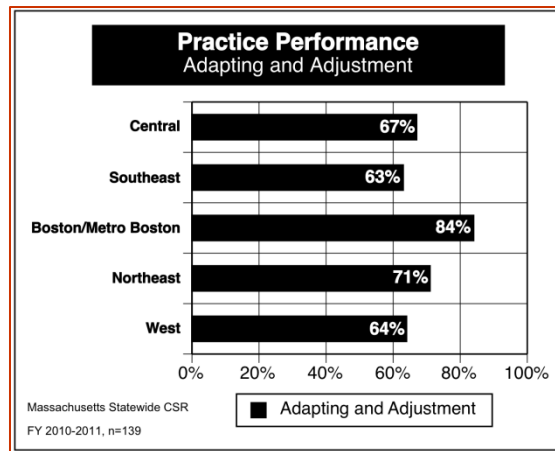

System/practice performance results for each regional CSR are displayed above. Performance ranged from 63% to 84% acceptable. With the exception of the Boston/Metro Boston area, support for teams in assuring consistent adapting and adjusting of strategies and interventions in youth's service plans are indicated.

Transitions and Life Adjustments

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

For the 91 youth this indicator applied to across the state, only 57% were found to have acceptable transition management practices evident. Of these, 29% had "good" or "optimal" transition intervention practices working for them. Fifty-five percent (55%) of youth the indicator was applicable for could benefit from "refined" transition supports. Transition practices for these youth were fair/minimally adequate or marginally inadequate. Sixteen percent (16%) of youth statewide experienced a poor or adverse transition with unaddressed transition issues, or no transition plan for an imminent change.
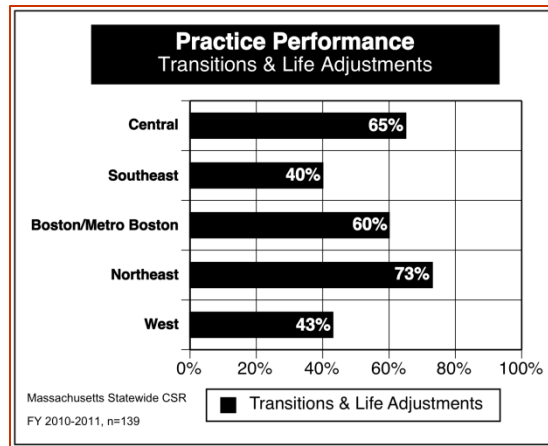

These results indicate practices to improve the ability of teams to identify, plan for and implement supports for youth in their life transitions are warranted statewide.

Responding to Crises and Risk/Safety Planning

The CSRs reviewed the timeliness and effectiveness of planning, supports and services for each 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.

Seventy-three percent (73%) experienced an acceptable crisis response and risk plan that worked for them in a crisis. Forty-six percent (46%) were found to have a "good" or optimal response and risk/safety plan. Another 46% had a fair to marginally inadequate response and plan that was in need of "refinement." The remaining 7% of youth were found to have a poor to adverse response in need of "improvement."
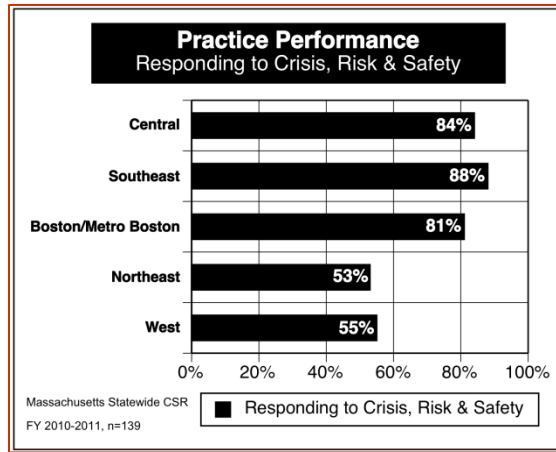
The chart above displays the performance of each of the regional CSRs in Responding to Crisis, Risk and Safety Planning. Similar to the Planning Interventions for Risk/Safety Planning, the CSRs that were conducted earlier showed weaker response than those conducted later. These results likely reflect the system improvements that were implemented mid-cycle.
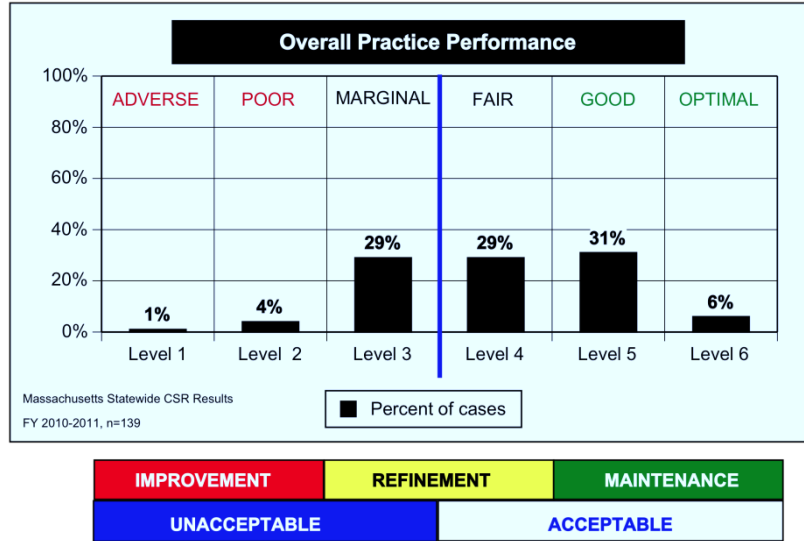
Overall System/Practice Performance

The chart above shows the distribution of scores for System/Practice Performance statewide across the six point rating scale. For the youth reviewed in the five regional CSRs, 66% were found to have acceptable system/practice performance and 34% had unacceptable system/practice performance. Performance scores clustered at the good, fair and marginal levels with 89% of youth reviewed falling in this range. The expectation is that the system and practices should be performing acceptably well for the largest numbers of youth and families receiving services

Thirty-seven percent (37%) of the youth reviewed statewide fell in the "*Maintenance*" area, meaning the system and practices were **effective** for them, and efforts should focus on **sustaining and building** upon positive practice.

Fifty-eight percent (58%) of the youth fell in the "*Refinement*" area which means that performance was **limited or marginal**, and **further efforts are necessary** to refine practices. Practice patterns in these situations **require refinement**.

Five percent (5%) of the youth fell in the "*Improvement*" area meaning performance was **inadequate**. In these cases practices were **fragmented, inconsistent and lacking** in intensity or non-existent. **Immediate action is recommended** to improve practices for youth falling in this category.

The data indicate that the strongest areas of practice for youth across the Commonwealth were:

- Engagement with the Youth and Family; and
- Cultural Responsiveness to Youth and Family.

The system/practice indicator that showed an overall fair performance but at a less consistent or robust level of implementation was:

- Availability and Access to Resources.

Areas of system/practice performance that <u>need improvement</u> in order to assure consistency, diligence and/or quality of efforts are:

- Team Formation;
- Assessment & Understanding of the Youth and Family;
- Planning Interventions for Symptom or Substance Reduction;
- Planning Interventions for Behavioral Changes;
- Planning Interventions for Social Connections;
- Outcomes and Goals;
- Matching Interventions to Needs;
- Coordinating Care;
- Service Implementation;
- Adapting and Adjusting; and
- Responding to Crisis & Risk and Safety Planning.

Review results indicate <u>weak</u> performance for the following system/practice domains:

- Team Functioning;
- Planning Intervention for Recovery/Relapse;
- Planning Interventions for Transitions, and
- Transitions & Life Adjustments.

Overall, statewide results indicate that certain foundational system of care practices such as engagement and cultural responsiveness to youth and families were strong. Generally, a threshold of youth and families across the state had access to necessary resources, although in some of the regional CSRs, waitlist to access services such as comprehensive assessments, psychiatric services, and in home behavioral services were reported. Access to reliable mobile crisis services was also noted in a number of areas.

The majority of system/practice results were found to need improvement. Focused efforts could improve these service processes so a greater threshold of youth and families can rely on the practice functions to perform in a dependable and effective manner. Teams for over a third of the youth were not functioning at an adequate level, were splintered or inconsistent in planning and evaluating results, and were not engaged in collaborative and problem-solving. A challenge for nearly a third (32%) of teams was using information, including in existing assessments and information that is held by other providers, schools, etc., to increase team-based understanding of youths' strengths and needs at a scope and depth necessary to develop the right set of interventions and supports.

Planning interventions across all indicators needed strengthening particularly in the areas of recovery/relapse and assuring successful transitions. With 36% of teams found to have weak functioning, concerted development is clearly indicated to strengthen the ability of teams to plan together, collaboratively problem-solve and unify their implementation efforts. The system practice where attention is highly indicated is assuring adequate supports for managing youths' transitions. Sixty-three percent (63%) of youth were found to have an unacceptable level management of their transitions.

Overall, one out of three youth reviewed did not receive an acceptable level of system/practice performance. These results indicate focused improvements are needed in most areas of practice before consistently strong results are achieved for more youth. While certain foundational practices were found to be working well, teams will continue to need to strengthen in areas that can assure a threshold of youth can reliably depend on service functions that will help them progress, achieve desired outcomes and/or maintain the gains they have made through services.

CSR Outcome Categories

Status of Child/Youth/Family

	Favorable Status	Unfavorable Status	
Acceptable System Performance	**Outcome 1:** Good status for child/youth/family, ongoing services acceptable. **58% (81 youth)**	**Outcome 2:** Poor status for child/youth/family, ongoing services minimally acceptable but limited in reach or efficacy. **8% (11 youth)**	**66%**
Unacceptable System Performance	**Outcome 3:** Good status for child/youth/family, ongoing services mixed or unacceptable. **17% (24 youth)**	**Outcome 4:** Poor status for child/youth/family, ongoing services unacceptable. **17% (23 youth)**	**34%**
Massachusetts Statewide CSR Results FY 2010-2011, n=139	**75%**	**25%**	

Acceptability of Service System Performance by Individual Youth

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%.

Overall outcome findings

The percentages on the outside of the two-fold table above represent the total percentages in each category. The percentage at outside, top right (66%) 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. Likewise the number on the outside lower left is the percentage of youth that has favorable status (75%) and under the next block the percentage of youth with unfavorable status (25%). The percentages of youth that were found to have acceptable system/practice performance in each of the regional CSRs are displayed below.

Region	Acceptable System Performance
Western Massachusetts	60%
Northeastern Massachusetts	67%
Boston/Metro-Boston	76%
Southeastern Massachusetts	55%
Central Massachusetts	66%

Results ranged from 55% of youth in Southeastern Massachusetts to 76% of youth in the Boston/Metro-Boston area experiencing acceptable system/practice performance. These data indicate a range of performance results in the regional CSRs, but none of the regions yet performing at a strong level.

CSR Results by Outcomes

Outcome 1
As the display indicates, 58% of the youth reviewed fell into outcome category 1. Outcome 1 is the desired situation for all children and families receiving services.

Outcome 2
Eight percent (8%) of the statewide sample fell in Outcome 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 remains unacceptable.

Outcome 3
Seventeen percent (17%) 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. Without key practice functions occurring reasonably well, status for youth in this category is often fragile, and at risk of becoming unfavorable.

Outcome 4
Seventeen percent (17%) of the sample 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.

Six-month Forecast

Based on review findings, reviewers are asked if the child's status is likely to maintain at a high status level, improve to higher than the current overall status, continue at the same status level, or decline to a level lower than the current overall status.

For 9%, the prediction was that the youth would maintain at a high status level (youth in the "good" or "optimal" status category).

For 32% of the sample the prediction was for improvement in status.

For 45%, it was predicted the youth's status will continue at the same level ("fair", "marginal", "poor" or "adverse"). *Note:* These are youth <u>not</u> currently at a "good" or "optimal" level, which indicates that a more intensive or sustained level of services may be indicated to help the youth make progress.

For 14%, the prediction was that their status would <u>decline</u>.
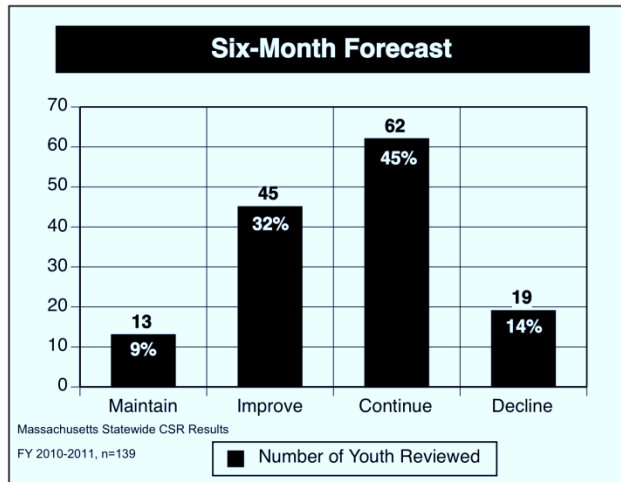
Summary of Findings

Data, Findings and Recommendations in this report are presented in the context of the consistency, quality and capacity of services and practices in meeting requirements of the *Rosie D.* Remedy. This includes requirements for services provided consistent with System of Care Principles, wraparound principles and the four phases of wraparound practice. 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 be active participants and leaders in their teams, have teams that work together to solve problems, and understand the changing needs and strengths of youth and families. 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 the individualized care plan to be updated as needed, addressing transition and discharge planning specific to child needs.

The summary of CSR findings highlighting the themes and patterns found in the statewide CSR data and stakeholder interviews are presented below, followed by recommendations based on findings.

Strengths

There was availability of many of the Rosie D. services in most areas of the Commonwealth, although there were availability issues for certain services and communities.

A greater array of services is clearly available for more youth statewide, and the first year of implementation of Rosie D. services saw initiation of community-based services throughout Massachusetts. The CSR examined access and availability to services for youth who were receiving ICC or IHT service at the time they were reviewed, with a few youth reviewed who had been recently discharged from services. Once found eligible for CBHI services, with some exceptions, youth in the regional CSRs were found to have fair access to and availability of the services and supports they were determined to need most notably ICC, IHT services and Therapeutic Mentoring. As well, youth and families generally had access to Family Partners, a service that families found to extremely valuable. A key variable for access to services for youth in ICC was facilitation by the care coordinator and agency resources with a specific mission to link youth and families to services.

In particular, services for youth in the Boston/Metro Boston and Northeast regional CSRs were dependably implemented and available, although the dependability of mobile crisis services was problematic for a number of youth in Northeastern Massachusetts. There were notable exceptions to service access and availability in certain regions for particular services such as psychiatry, mobile crisis, in-home behavioral therapy, and specialty services such as therapeutic services for developmentally disabled and deaf youth. Resource availability and access was a barrier for a number youth in the Central region, including in the rural areas. Staff turnover in a number of areas also impacted continuity of care for youth.

Family engagement and cultural responsiveness were found to be strong system of care practices across all of the regions.

Most staff providing services were found to be well-acquainted with, and are applying wraparound principles such as facilitating families' voice and choice at team meetings. Family engagement and cultural responsive, important foundational system of care practices was evident in all but a few of the cases reviewed. Many families expressed feeling more empowered and less isolated. ICC staff in particular were immersed in wraparound principles, and working to integrate them into their work. Notable was that for youth aged 18-21, 100% of those in the age range had favorable voice and choice in their care plans and service delivery processes.

While there is a growing knowledge of the system of care approach by other child serving agencies such as schools and DCF, care coordinators statewide identified the need for more training in system of care approaches for partner agencies, schools and outpatient providers.

Key services were seen as being effective for families.
   o Family Partners were seen as an important addition to the system of care. Families were very appreciative of the supportive nature of the service, and felt their perspectives were better heard as a result of their Family Partner.
   o In Home Behavioral Therapy was identified as an effective intervention for those youth and families that had access to this service. These services have been an important component of care plans for many of the youth with co-occurring intellectual and developmental diagnoses served through the CBHI. In the CSR statewide sample, over 20% of the youth had either a co-occurring autism spectrum disorder or an intellectual disability.
   o The review teams observed many Family Partners and Therapeutic Mentors whose interventions and supports were therapeutic and supportive of family and youth progress, as well as IHT clinicians who were skilled and going the "extra mile" in their work.
   o There were staff from diverse ethnicities among provider agencies in a number of the CSRs, although bilingual staff appeared overburdened because of the demand for their services.

System of Care Committees are venues for increasing partnerships and active problem-solving.

System of Care Committees (SOCs) are established statewide, with some committees especially active in developing local partnerships and identifying opportunities for strengthening agency linkages. The reception from schools to the SOCs in some local areas has been positive and teaming with DCF was reported by many as improving. Increased communications were evident and the meetings in many of the communities are gaining focus. There is a growing sense that stakeholders and families are building a common language about services and supports and the system of care philosophy.

Challenges

Staff and teams are not uniformly using assessments, clinical/behavioral data and other relevant information to inform planning, including making adjustments to plans as needed.

The gathering of information and assessment of youth and families that is functional, well-formulated, continuous, identifies unmet needs and reasons for behaviors, and uses all available/relevant information was not consistently evident. This often limited the ability for teams to adequately plan interventions and supports that fully addressed youth and family needs, or identify strategies that could help youth make progress and achieve goals. As a result, many teams had only a surface understanding of needs, and plans often did not identify the right mix or intensity of interventions that were delivered with consistency and beneficial effect. In a number of the CSRs, care coordinators had difficulty in synthesizing information, or were confused about the use of assessment information to inform planning. Clinical assessments or other relevant knowledge were often not current or available, or were lacking information important to building effective plans of care. Many youth did not have comprehensive psychosocial assessments of the quality needed to fully understand the youth and family.

There are requirements for a clinical assessment, an in-home assessment, a strengths needs and culture discovery, and a CANS that is intended to summarize all the gathered information. For youth who had services in place before coming into ICC, there is often an existing assessment, a current CANS, and the ongoing treatment/intervention description and progress documentation. Information should also be gathered from all team members. If assessment and information gathered is accurate, current, reflects the views of the youth and family and is well-understood, it has the potential to provide a great deal of information to use in team brainstorming to craft strategies and interventions/services.

There may be barriers impacting the quality of information gathering and how well care coordinators can synthesize and provide information for the team. These issues should be examined as thorough understanding of the youth and families strengths, needs, and core issues is foundational to crafting strategies with the youth and family that will work.

In at least one region, staff interpreted 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, care coordinators were translating the wraparound practice model to be one devoid of using clinical and other existing information about the youth to inform planning.

Intervention planning and teamwork needs strengthening.

Clearly more teams are meeting to create care plans, and families are more engaged in planning and the team-based process. However, and often linked to a lack of depth and scope of understanding of youths' needs, creating plans with interventions that can accomplish family goals and address what the youth and family needs did not occur at the consistency required. For a number of youth, care coordinators could not facilitate the development of a viable care plan. There was often a tendency to provide a lot of services, instead of arriving at a sensible mix that was individualized and could meet the needs of the

youth and family. Plans were often formulaic and itemized a list of services and were not individualized, detailed or accountable at the level needed to impact a youth's progress or status.

Teams are developing their skills in assuring family voice and choice drives planning and are recognizing that the likelihood of successful outcomes and youth and family ownership of the plan are increased when the process reflects family and youth priorities and perspectives. At the same time, care planning is a collaborative activity and team members must reach collective agreement on numerous decisions throughout the process. When team members had a range of concerns and ideas for additional goals or interventions, there often was not sufficient brainstorming to fully explore the considerations of the team. It was reported that at times, the whole team would have benefitted from a fuller discussion and that the subsequent next steps would more fully consider any imminent risks or opportunities for facilitating change and meeting the family's vision. The practice model clearly must address family preferences and reflect family choices in the process of the development of care plans. As well, team discussions must be comprehensive, well-informed, and in-depth so that goals and strategies/interventions, both formal and informal, can viably result in achieving youth and family goals and positive sustainable change and progress.

An example of this from one regional review was where 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. Rather, a goal of doing chores was identified. The youth increasingly disengaged with services, and the team felt helpless in their attempts to provide the "right" service and supports. This situation reflected a well-intended team that did not adequately coalesce to the point where they were advocating for what the youth needed.

For a number of youth, team members that were internal to the agency were meeting, but engagement of external team members and staff from other child-serving agencies especially schools was absent or weak. This often resulted in a narrowing of information needed to better understand the youth and family, and missing foci on the full range of youth needs that was required to develop an effective care plan. Prescribers of psychotropic medications (psychiatrists, primary care, and advanced practice registered nurses) and outpatient therapy providers were less involved in team-based processes, and as a result these domains were often missing or were under-addressed in planning. Often, it was a missed opportunity for the providers who were not engaged or less engaged to provide ideas that the teams could consider, or to play important roles in providing and coordinating interventions and supports to the youth and family.

As reflected in the CSR results, team formation, team functioning and intervention planning need strengthening in order to assure the greatest number of youth and families can consistently depend on their teams and plans to work well for them. Particular attention is indicated in planning for transitions and planning for substance abuse recovery and relapse prevention, as well as assuring youth's favorable emotional status and impacting key areas of youth progress.

Skills of staff were not consistently adequate to address needs.
For a number of youth, the intensity of treatment and/or interventions of the treatment providers were not adequate, or care coordinators could not facilitate the development of a care plan that would likely work to impact change and progress for the youth and family. Often youth needed a specialized mode of treatment that was not provided due to availability, or lack of clear identification and specification in the care or treatment plan.

Supervision and/or consultation did not seem to be consistently addressing the needs of staff to understand and explore more fully options for support, services and treatment approaches that could help the youth and family achieve their goals and vision. This included helping staff to understand complex situations and/or clinical issues of youth and families, achieving diagnostic clarity, and understand more fully what might be the best course of treatments and supports that could help youth to progress. Internal agency processes for early identification when a team may be struggling, or youth and family needed urgent attention to prevent a crisis were not clearly part of the practice model or infrastructure of agencies. Many of the youth and/or families had 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 were family-driven and "simple and focused" while understanding and addressing the complexity of the youth's situation at the right level of urgency and intensity.

Many teams were challenged in their knowledge about the unique needs and strategies that work for youth with autism, sensory challenges, or intellectual disabilities. They had difficulty developing useful plans, and did not consistently consider in-home behavioral services. Specialized therapeutic and community resources were difficult to find or non-existent for a number of the youth reviewed who are hearing-impaired.

Care coordination was not an acceptable level of system/practice performance for nearly 30% of youth statewide, and was unacceptable for over 40% in one of the regional CSRs.

Outpatient providers were less integrated into team-based processes and the system of care.
In a number of the regional CSRs, it was reported that outpatient providers may not referring youth who may need ICC and IHT, and/or are not consistently participating in team meetings when youth are involved with ICC. Many people interviewed identified that there may be barriers and/or disincentives to outpatient provider staff participation. It was often difficult for teams to coordinate and/or integrate the outpatient therapy modalities into the youth's overall treatment, and sometimes teams and outpatient providers were at cross-purposes in their approaches. Engaging psychiatrists and physicians in team-based work was also a challenge for many care coordinators.

Crisis services are not dependable in all communities. However, risk and safety plans were increasingly seen in youth's files
There were examples of mobile crisis teams for youth who experienced a mental health crisis in some areas including responsiveness to the situation, engagement with families, collaboration with teams, and provision of follow-up and linkages. However, crisis mobile services were reported by a number of parents and stakeholders in focus groups to be not

available or did not adequately support the youth during the crisis. Parents in some communities did not feel they could depend on the service to help citing the length of time to respond, no response, and refusal to respond if behaviors are seen as extreme, or youth were aggressive or having a tantrum. The low use of MCI services among the youth reviewed may be a reflection of service access, families being directed to a hospital emergency department, a family choosing to go to the emergency department or to use the police, or a family using the crisis response support from their team members, all points that were supported in the stakeholder interviews. Families perceived the service to be more oriented to 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. Families were most positive when MCI services assisted them both during and after the crisis to ensure youth and family stability, facilitated communication with other team members, used the 72-hour capacity for continued support and/or when there was consultation for continuing care. However, crisis-oriented engagement with a family during or after a crisis appeared to be more of an exception than a standard practice.

Some of the specific issues identified that limited the effectiveness of crisis services were: limited to no face to face contact with psychiatry for MCI teams when needed, lack of continuity of MCI staff and teams when youth needed multiple MCI visits, and a need for Crisis Stabilization Beds, which would help youth remain in their homes and enhance treatment.

Of note is that over the year, risk and safety plans were increasingly found to be a component of youths' overall plan of care. In the initial CSRs, risk and safety plans were not systematically seen in each plan of care. Through the year, risk and safety plans were increasingly evident. The challenge continues to be assuring that the plans are functional and specific, and can help youth, families and others such as teacher to know what to do to address a potential crisis that could prevent a formal crisis intervention.

IHT providers needed clarity in their role in coordinating care and knowing when to refer to ICC.

Although many IHT providers were providing a good level of care coordination, others did not understand their role, or were not providing an adequate level of coordination. There were also instances of youth whose situations may have warranted a referral to ICC, but IHT providers did not consistently know what factors would trigger a referral.

Issues with the business model were seen to be impacting service provision

Business practices that challenged staff in their work were widely identified. Evaluation may be needed to assure greater stabilization of staffing and timely access to all necessary services. In a number of reviews, team and care coordinator turnovers resulted in disruption in relationships and/or service delivery causing youth and families to lose ground.

Issues that were identified include:

- o External utilization management processes and productivity demands of agencies were seen to be hampering team decision making. Productivity requirements to produce "billable" units each week were reported to interfere with the amount of

additional training and coaching staff could be receiving to improve the overall level of practice.

o In at least one regional CSR, agencies reported that MCEs will not approve the team recommendation for service units at the beginning of care; only the "standard" number of units are authorized. The agency must then call back to request and justify the rest of the service units that were initially needed. This process adds burden to administrative time, and has the potential to compromise needed services.

o Solvency for provider agencies often means services being volume sensitive; agencies are cautious about growth and appear to need to build waitlists into their business approaches. Particularly in rural areas, this means youth and families can wait for long periods of time to receive necessary services, which for some of the youth reviewed resulted in further functional regression, or reliance on crisis services.

o Documentation requirements were cited as being onerous, and interfering with direct care.

o Issues were identified regarding the definition of a "billable service" and the crosswalk with mandates for providers which were impacting coordination efforts. For example, there is a need for ICC care coordinators and Family Partners to collaborate, but that collaboration time was not billable. Another example is ICC care coordinators have to meet with inpatient or CBAT staff if a youth is admitted to those service with admissions occurring all over the state, but travel time is not billable, which impacts the ability to coordinate at critical times for the youth. Additional travel time to rural areas not being reimburseable also was reported to impact access and provision of services. There is also the example of supervision being expected and needed, but the rate provides for only a minimal amount of supervision and training.

o Having different MCI processes, procedures and standards adds confusion for staff, additional administrative and staff tracking, and takes time that could be spent in care and activities that are billable.

In some communities and for certain services, access and availability of services was problematic.

Access and availability information collected in the CSR was collected two ways: for youth in the CSR samples who were receiving ICC and/or IHT services, and through stakeholder focus groups. The scope of the case-specific reviews did not focus on access into ICC or IHT services, but did include review of availability of services and supports that were needed for youth to progress, and families' experience with access. The CSRs do not collect population-based data relative to service access for youth and families not in ICC or IHT services.

Access to, and coordination with psychiatric services was also a significant issue identified in a number of the CSRs. Youth were reported to be prescribed psychotropic medications, in some cases many different medications, without integration of treatment to provide a full view of progress, side effects, and impact.

In the Central CSR, specialized assessment resources were difficult to access, often resulting in incomplete understanding of the youth necessary to build successful plans of care that was previously described. Access to services for families after receiving emergency services was also identified as problematic, leaving these families discouraged. As well, waiting lists for

IHT, IHBT, Therapeutic Mentors were reported in a number of the regional CSRs, with less availability in rural areas.

There was a pattern statewide with issues related to changes in families' 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 was reported to cause continuity of care issues and loss of progress. Staff in many agencies spent a good percentage of their time helping families to navigate the eligibility process. The system is described as not user-friendly. For families with children with complex mental health issues that require continuity of care, this appears to be a major issue. The timeliness of service authorizations was also cited in a number of areas as an issue impacting access to services.

Access to psychiatric services was difficult for youth when the pathway to receive psychiatry was through an appointment with an outpatient provider.
In a number of the cases reviewed, and by report of parents, when youth a youth in ICC or IHT needed to see a psychiatrist and did not have access to a private psychiatrist, access to a community psychiatrist was through an outpatient clinic and the youth was also first required to have an outpatient therapist. This was the case even though the youth may not have needed an outpatient therapist, or was already connected to an in-home therapist. Often the waiting lists to see an outpatient therapist was long, thus a youth who had a pressing need for psychiatric services was impacted. In one example, a youth discharging from a residential treatment setting had to go through this process even though family did not need or want outpatient therapy, and access to psychiatry for the youth was delayed.

Recommendations

The following recommendations are offered to help the Commonwealth of Massachusetts set direction in improving services and the practices of staff, and strengthen the framework to achieve more consistent results for more youth.

Develop focused strategies to strengthen the ability of teams to:

➢ ***Use current assessment and all other relevant information to better understand what youth and families need.***
  o Engage families and team members in the process of assessment and gaining understanding of strengths and needs across the range of clinical, educational, safety, and other domains of youth well-being in order to build a collective well-informed and correct understanding, and unity of effort in planning and implementing services and supports.
  o Examine and address barriers or supports care coordinators need to assure teams have a full and accurate understanding of the current strengths and needs of the youth and family.
  o Teams need to improve their practices in continually gathering information, understanding why interventions are or aren't working, and making adjustments as needed.
  o If youth need an updated comprehensive assessment or specialized assessment, assure there is timely access to quality assessments and use of

information by teams to inform their planning. Assure families are offered copies of assessments, assessments are fully explained to them, and questions are answered or misinformation is corrected.
   o Assure teams gather and synthesize all available information about the youth and family in order to inform functional, well-formulated plans.

> **Engage all relevant individuals are in the team process**
   o Assure teams have the right composition of people and agencies, and work together in a unified manner to produce results with the youth and family.

> **Access consultation and specialized information**
   o Provide accessible consultation to teams, including specialized consultation and timely consultation from the CSA psychiatrists or other appropriate staff. Assure help is provided to teams in identifying strengths and needs, and develop the supports and interventions that are most likely to meet youth and family needs
   o If teams do not have the technical skills to understand how to identify, plan and implement care with a family, assure that these issues are identified early in any planning process and remedied. When teams need consultation to better understand clinical recommendations or other information provided in assessments, assure they have access to expert consultation.
   o Develop mechanisms that would trigger a review if a team were struggling, there are interagency barriers, and/or a youth or family are regressing or in crisis.

> **Develop plans, and implement services and supports that will be effective in addressing youth and families' needs.**
   o If youth have specialized needs, assure there is the right match, intensity and duration of services to help the youth and family achieve sustainable results.
   o Establish clear and attainable outcomes and goals that reflect youth and family needs and preferences.
   o Assure service interventions and supports are implemented in an effective and timely manner, and match the level of urgency needed.
   o Adapt and adjust plans and service implementation as needed to address changing circumstances or new information.
   o Assure transitions are identified, plan for and well-managed.

Provide coaching and support for supervisors so they are able to assure practices are implemented at a consistently quality level.

Provide clear and accessible information for families and staff, including:
   o User-friendly information about how to access CBHI services for families and other community members
   o Information about insurance including:
      o How to apply for MassHealth and CommonHealth.
      o How to access printed information and letters in the language of the person served, and ready access to translation services.

- o Identification of who will help when there are barriers or questions about insurance.
- o Assistance in re-instating MassHealth when the redetermination process was not completed and eligibility has been discontinued.
- o A clear and well-communicated process for families to obtain assistance from MassHealth when they need help accessing services, or want to express concerns about quality of care or other issues.
- o Clarification of how services can continue after a youth turns 18.
- o What staff need to communicate during authorization processes so services are based on what the youth needs (medical necessity), do not have specific time-limits, and services will continued to be delivered when there is a continued need.

Ensure teams consider continuity of care for youth when DCF involvement with a family ends.

Ensure "eligibility continuity" is considered as part of the youths' transition planning of a team when DCF involvement had been the "MassHealth" eligibility/access determinant, and DCF closes the case. In these situations eligibility may be discontinued and an application and determination regarding CommonHealth or other MassHealth coverage may be needed to assure continuity of care. Assure applying for insurance coverage occurs as part of teams' plans and action steps in order to provide continued needed BH services for the youth and family, if the family is determined to be eligible.

Provide more training on:

- o The system of care and wrap-around approach for other child-serving agencies, schools and outpatient providers. Teams and families often struggle with schools, DCF, DYS and others they are involved with not knowing about the care planning teams, and the wrap-around model of care.
- o The role of team members on the Care Team
- o The concept, role and operational expectations of HUBs.
- o The IHT's role in coordinating care and when it a referral to ICC may be indicated
- o Support strategies to help parents strengthen their families, including helping them to access mental health, substance abuse, vocational rehabilitation and other services.
- o Education and awareness for non-behavioral health agencies and providers and the general community about CBHI services. Families often to not hear about CBHI services until a professional they are involved with tells them, indicating a need for more widespread outreach and education.

Improve crisis services:

- o Evaluate whether or not MCI agencies in all areas have capacity to provide a broad enough geographical reach so that response is timely and there is capacity for 72-hour continued work with families for linkage to care, continued crisis intervention and/or communication and collaboration with current providers involved with the youth and family.
- o Clarify and monitor the requirements of providing MCI services.

Assure timely access and availability of all necessary services.

Evaluate and address issues related to accessing psychiatric services through outpatient providers and impact on youth who need access to these services.

Assure decisions are based on what the child needs and team decisions.
- o Help providers to build skills that adequately communicate the demonstration of medical necessity of the service so that both MCE's utilization review and providers play a role in ensuring that services are provided based on need and continue when needed.

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 self-destructive 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

Maintenance Zone: 5-6

Status is favorable. Efforts should be made to maintain and build upon a positive situation.

6 = OPTIMAL & ENDURING STATUS The best or most favorable status presently attainable for this person in this area [taking age and ability into account]. The person is continuing to do great in this area. Confidence is high that long-term needs or outcomes will be or are being met in this area.

5 = GOOD & CONTINUING STATUS Substantially and dependably positive status for the person in this area with an ongoing positive pattern. This status level is generally consistent with attainment of long-term needs or outcomes in area. Status is "looking good" and likely to continue.

Favorable - Range: 4-6

Refinement Zone: 3-4

Status is minimum or marginal, may be unstable. Further efforts are necessary to refine the situation.

4 = FAIR STATUS Status is at least minimally or temporarily sufficient for the person to meet short-term needs or objectives in this area. Status has been no less than minimally adequate at any time in the past 30 days, but may be short-term due to changing circumstances, requiring change soon.

3 = MARGINALLY INADEQUATE STATUS Status is mixed, limited, or inconsistent and not quite sufficient to meet the person's short-term needs or objectives 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.

Unfavorable Range: 1-3

Improvement Zone: 1-2

Status is problematic or risky. Quick action should be taken to improve the situation.

2 = POOR STATUS Status is now and may continue to be poor and unacceptable. The person may seem to be "stuck" or "lost" with status not improving. Any risks may be mild to serious.

1 = ADVERSE STATUS. The person's status in this area is poor and worsening. Any risks of harm, restriction, separation, disruption, regression, and/or other poor outcomes may be substantial and increasing.

CSR Interpretative Guide for Practice Performance Indicator Ratings

Maintenance Zone: 5-6

Performance is effective. Efforts should be made to maintain and build upon a positive practice situation.

6 = OPTIMAL & ENDURING PERFORMANCE. Excellent, consistent, effective practice for this person in this function area. This level of performance is indicative of well-sustained exemplary practice and results for the person.

5 = GOOD ONGOING PERFORMANCE. At this level, the system function is working dependably for this person, under changing conditions and over time. Effectiveness level is generally consistent with meeting long-term needs and goals for the person.

Acceptable Range: 4-6

Refinement Zone: 3-4

Performance is minimal or marginal and may be changing. Further efforts are necessary to refine the practice situation.

4 = FAIR PERFORMANCE. Performance is minimally or temporarily sufficient to meet short-term need or objectives. Performance in this area of practice has been no less than minimally adequate at any time in the past 30 days, but may be short-term due to changing circumstances, requiring change soon.

3 = MARGINALLY INADEQUATE PERFORMANCE. Practice at this level may be under-powered, inconsistent or not well-matched to need. Performance is insufficient at times or in some aspects for the person to meet short-term needs or objectives. With refinement, this could become acceptable in the near future.

Unacceptable Range: 1-3

Improvement Zone: 1-2

Performance is inadequate. Quick action should be taken to improve practice now.

2 = POOR PERFORMANCE. Practice at this level is fragmented, inconsistent, lacking necessary intensity, or off-target. Elements of practice may be noted, but it is incomplete/not operative on a consistent or effective basis.

1 = ADVERSE PERFORMANCE. Practice may be absent or not operative. Performance may be missing (not done). - OR - Practice strategies, if occurring in this area, may be contra-indicated or may be performed inappropriately or harmfully.