

2010

Rosie D. Community Services Review- Western Massachusetts Regional Report

Report of Findings of the Community Services Review
of Western Massachusetts conducted the week of September 20th, 2010

Prepared for Karen L. Snyder, *Rosie D.* Court Monitor
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Executive Summary

As agreed to in the *Rosie D.* Remedial Plan finalized in June 2007, the Commonwealth of Massachusetts has committed to providing new behavioral health services and an integrated system of coordinated care for youth with Serious Emotional Disturbances (SED) and their families. The Remedy services, with the exception of Crisis Stabilization services, have been in place for approximately one year. In that year, in addition to hiring and training staff, agencies have been charged with providing new services through a prescribed and decidedly different practice model, one that requires team-based work and fully integrates family voice and choice. Much work and training has occurred aimed at delivering services through a coordinated approach consistent with System of Care and Wrap-Around principles.

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

The purpose of this report is to present findings of the Community Services Review conducted in Western Massachusetts in September, 2010. Expert reviewers used the CSR methodology to conduct intensive reviews of twenty-two randomly selected youth receiving Intensive Care Coordination and/or In-home Therapy (IHT) services through Community Service Agencies (CSAs) and provider agencies throughout Western Massachusetts. The CSR included a number of youth served through Gandara, a specialty CSA providing behavioral health services for Latino youth and their families.

Characteristics of Youth Reviewed. Data that describe the population of youth that were reviewed are presented in this report. At the time of the review most of the youth (82%) were living with their biological parents or in an adoptive home. More than half of them had a change in living or school placement within the past year. The largest ethnicity represented among the youth in the sample was Latino (45%), followed by European-American (32%), and African-American (14%). Spanish was the primary language spoken at home for 23% of youth. The largest percentage of youth (36%) was going to school in a regular education setting, and 32% were in a part-time or full-time special education setting. Fifty percent (50%) had special education services (some youth were in a full inclusion regular education setting). Several were not in school because they were young children not yet enrolled (14%), or had graduated/were working (10%).

Youth in the sample were involved with a variety of other agencies with the highest frequency being Special Education (50%), the Department of Children and Families (DCF) (41%), and the Department of Mental Health (DMH) (27%). The youth were referred to ICC or IHT services in the largest numbers by DCF (32%), and then by their families (18%), followed by DMH (14%). The review also collected information related to behavioral health and physical conditions, including co-occurring conditions, and found an unusually high

prevalence of youth diagnosed with mood disorders (59%). Sixty-eight percent (68%) of the youth were on one or more psychotropic medications, with a 40% on three or more medications. Most of the youth in the sample (86%) had not used any crisis services in the past 30 days. Caregivers of the youth had considerable challenges with a large number having extraordinary care burdens (41%), serious mental illness of their own (32%), and adverse effects of poverty (27%).

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. These data are presented for use in informing improvements and refinements to services and practices.

Status and Progress Indicators. In the CSR, Youth Status, Youth Progress, and Family Status are reviewed as a way to understand the performance of behavioral health services and practices. Most of the youth in the sample were living in a permanent living situation with favorable home stability (82%) and permanency status (91%). School stability (75%) was slightly less favorable for a portion of the youth. Overall, most of the youth were safe in their homes (100%) at school (95%), and in their communities (95%). Most were physically healthy and had their health needs addressed (91%). Most were doing well in their academic programs (85%), with a few having concerns with their attendance (79% favorable) and behavioral supports in school (79% favorable). Additional supports to help families' capacities to provide favorable living arrangements were indicated for about a third of the sample (68% favorable).

Of concern were the youth status results for behavioral risk to self (59% favorable) and others (67% favorable), and emotional status (32% favorable). Despite living and going to school in safe and for the most part stable situations, behavioral risk and emotional status were unfavorable for a large number of the youth reviewed.

Overall, across the indicators of youth status, 82% of the youth had a favorable status with 23% with "good" status and 59% with "fair" status. The remaining youth had unfavorable status with 14% with "marginal" status, and 5% with "poor" status. See Appendix 2 on Page 50 for descriptions of a youth in each status category).

Family/Caregiver status is comprised of a constellation of indicators that reflect measurement of family/caregiver well-being and satisfaction. The data for the Western Massachusetts CSR reflect challenges, but strong evidence that family/caregiver voice and choice is being considered in service delivery processes, as well as overall family/caregiver satisfaction with services.

Youth progress measures the progress patterns of youth over the six months preceding the review. Youth progress showed variable results with 59% showing favorable progress in reducing symptoms, 100% in reducing substance use (N=1) , 68% in improving coping/self-management, 80% in school progress, and 100% (N=1) in work progress. Overall, 68% were making favorable progress.

System/Practice Functions. Determinations of acceptability of how key indicators of practice are being performed allows for an evaluation of how well services and service processes provide the conditions that lead to desired changes for youth and families. These results are presented in the context of a system of care that has approximately one year of implementation.

The CSR rates twelve core system/practice functions. Together, these discreet system practices work together to create change for the youth and family.

The Western Massachusetts CSR found strong practices in Engagement and Cultural Responsiveness with ratings of 86% and 90% acceptability respectively in these indicators. These data show that youth and families reviewed were adequately engaged and participating, and the cultural contexts of families were being addressed.

Teamwork, which focuses on the structure and performance of the youth and family care planning teams, is comprised of two sub-indicators: Team Formation and Team Functioning. Team Formation was acceptable for 73% of the youth, which indicates improvement is needed in order for families to be able to depend on teams with the right composition and continued development of the team. Team Functioning was more concerning, with only 55% of teams functioning acceptably well. The overall finding for these indicators is that improvement is needed in assuring teams fully understand their roles, and know how to work together to implement collective goals reflective of the strengths, needs and choices of youth and families.

The Assessment and Understanding indicator reviewed how well teams and interveners gather all relevant information forming the basis for determining which interventions, supports and/or services will most likely result in desired changes for the youth and family. Just over half (55%) had acceptable ratings in this indicator, again indicating room for improvement in understanding youth's and families' core issues and situations at a level necessary to inform planning.

The planning indicators include six sub-indicators. Results for acceptability of care/treatment plans and planning processes show there is room for improvement across each of the core areas including intervention planning for symptom/substance abuse reduction (62% acceptable), behavior changes (68% acceptable), social connections (65% acceptable), risk and safety planning (57% acceptable), recovery/relapse (0% acceptable), and transitions (38% acceptable). Supporting teams in improving their plans and planning processes is warranted for the population.

Indicators for identifying and articulating clear Outcomes and Goals for the youth and family also indicate need for practice improvement with only 45% of situations having acceptable performance. Similarly the indicator for measuring Matching Interventions to Needs, which is assuring services and supports form a cohesive sensible pattern and address the identified needs of the youth and family, needs more attention with 59% of situations having acceptable performance.

Care coordination for the youth reviewed was acceptable for 68% of the youth reviewed, indicating strengthening in practices is needed in order to assure consistently acceptable care coordination is provided. Service implementation was acceptable for 64% of youth, again indicating a need to assure timely and consistent implementation of services. Availability of Resources to implement identified services and supports had better results (77% acceptable), although some improvement is needed for a portion of youth. The practice of Adapting and Adjusting plans and services was acceptable for 64% of youth.

Planning, staging and implementing practices for successful Transitions and Life Adjustments was an area that could use considerable improvement with only 43% of situations having acceptable performance. A concern was the results for Responding to Crises and Risk/Safety Plans with 55% of youth experiencing acceptable performance.

Overall, 60% of youth were found to have acceptable system/practice performance.

Findings: Strengths. The CSR found a number of strengths in teams and in the services provided for youth and families in Western Massachusetts. These included the previously noted finding of teams and behavioral health agency staff engaging families and providing culturally relevant supports for them. As well families, staff, and community partners see clear value in the role of Family Partners and the team-based family-centered model.

Findings: Challenges. Challenges identified include a number of teams lacking a depth of understanding of the youth, as well the necessary skills and knowledge to plan and implement interventions at a level needed to impact emotional and behavioral well-being. Another set of challenges heard from provider agencies were their struggles with retaining qualified staff and balancing the requirements in their contracts with quality service provision. The review team also heard from families experiencing service disruptions due to health plan changes and/or service authorization issues. Reviews and stakeholder interviews identified challenges with full engagement of outpatient providers at the referral and team participation levels. The last major challenge identified was the dependability of crisis services in terms of reliability and quality.

Recommendations.

The Recommendations provided reflect aspects of behavioral health service provision that are foundational and should likely be addressed early in the development of the system of care. Recommendations are framed for the Commonwealth of Massachusetts for use in continuous quality improvement efforts in assuring consistency and quality of practices for *Rosie D.* class members.

The Rosie D. Community Services Review

Regional Report for Western Massachusetts

September 2010

Introduction

Overview of Rosie D. Requirements and Services

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

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

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

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

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

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

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

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

Purpose of monitoring

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

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

Overview of the CSR methodology

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

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

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

Through using a structured protocol, reviewers make determinations about youth status/progress (favorable or unfavorable) and system/practice performance (acceptable or unacceptable) through a six-point scale. Refer to Appendix 2 on Page 56 for a full description of how each of the terms are defined. The six-point ratings are overlaid with “zones” of improvement, refinement, or maintenance. This overlay is provided to help care planning teams focus on youth concerns and/or system practices that may need attention. When reviewing the status and performance indicators that start on Page 22, it will be helpful to refer to Appendix 2 in understanding the ratings and findings.

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

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

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

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

The Western Massachusetts CSR (September 2010)

Description of the Region

The Western region of Massachusetts is a large area defined by a mix of the small urban area of Greater Springfield, smaller more rural towns, such as Pittsfield, Greenfield, Northampton, and Amherst with a large expanse of rural countryside. The most western towns of Lenox, Stockbridge, Great Barrington Pittsfield, and North Adams generally follow south to north to the Vermont border with many smaller communities bordering these small towns. This area is generally known as the "Berkshires" after a low mountain range that separates MA from NY. As you travel eastward from North Adams along Rt. 2, there are the towns of Greenfield and Athol, with many small villages slightly north along the MA/NH border and others to the south in the greater Quabbin Reservoir valley. This area is less

developed and has economic challenges. Going south along the Ct River, the rural nature of the area continues but with an increase in populations as you near Northampton, Amherst, Hadley, all three towns are home to several very good colleges. The communities reflect having students and academic institutions. As one continues south towards the Ct border, it becomes more urban, diverse, and has the more populated areas of Holyoke, Springfield and Westfield. It is often said that the West is so far away from the “power center” of Boston, that it is like a step child or another state.

CSAs and agencies reviewed

There are five Community Service Agencies (CSA) in the Western Region of Massachusetts. CSAs are the designated agencies across the state for the provision of Intensive Care Coordination. At this time, the CSA also provides Family Support and Training (more commonly called Family Partners) services. There are four CSAs with designated service areas. In the “Berkshires”, the most western part of the Western Region and the state, the CSA is the Brien Center. Pittsfield is home to the Brien administrative offices, and services span north to North Adams and surrounding towns and south to Great Barrington and the surrounding towns. In the north, central part of the Western Region, Clinical Support Options (CSO) is the CSA. The service area encompasses the greater Greenfield, Athol and Northampton areas. The Carson Center is the CSA for the Greater Westfield area, which is east of the Berkshires and west of Greater Springfield. Behavioral Health Network (BHN) is the CSA for the Greater Springfield area and extends up to Holyoke and to the surrounding towns to the west of Springfield, with a contracted site in Ware. Gandara is a “specialty” CSA and provides linguistically and culturally responsive services to Latino families in the Greater Holyoke and Springfield areas.

There are In Home Therapy Services (IHT) throughout the Western District, with IHT services being provided by CSA agencies and many other private providers. The Community Services Review included IHT services provided by Valley Human Services, Brightside, Key Services, Massachusetts Society for the Prevention of Cruelty to Children (MSPCC), Behavioral Health Network, Brien Center, Clinical Support Options, and Gandara.

Review Participants

Altogether, over 350 people from Western Massachusetts participated either in the youth-specific reviews or were interviewed in stakeholder focus groups. Table 1 displays data related to the youth-specific reviews where a total of 171 interviews were conducted. As can be seen, the average number of interviews was 7.8 with a maximum of 12 and a minimum of 2 interviews conducted.

Child Status and Performance Profile - Number of Interviews

Number of cases: 22 Western MA 9/2010

Number of Interviews

Total number of interviews	171
Average number of interviews	7.8
Minimum number of interviews	2
Maximum number of interviews	12

Table 1

How the sample was selected

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

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

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

IHT Selection. For IHT, the open caseload list was further sorted to create a list of youth who were receiving IHT but not currently also receiving ICC. There were twelve agencies, which were actively providing IHT in Western Massachusetts at the time the lists were submitted. Of the twelve agencies, one was serving very few youth (only 1), and was dropped from the selection process. Eight agencies were randomly selected from the remaining eleven agencies for inclusion in the CSR. One youth was randomly selected from each of these eight agencies.

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

The second column of Table 2 displays the number of the unduplicated youth enrolled in ICC since the start of the ICC service on June 30, 2009. The third column displays the total number of youth by agency, who were being served within open cases at the time the agencies submitted lists on June 28, 2010. 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 Western Massachusetts region. Behavioral

Agency	Total Enrolled Since Start of ICC Opening (7/1/09)	Number Open at List Submittal	Number ICC Cases Selected
CSO	135	126	3
Brien	201	102	2
Gandara	448	129	3
BHN	419	222	5
BHN (VHS)	70	50	1
Carson	203	101	2
Total	1476	730	16

Table 2

Health Network (BHN), actively serving the largest number of youth, had 5 youth in the sample. Clinical Services Options (CSO) and Gandara, a specialty CSA serving Latino families, had 3 youth in the sample; Brien and The Carson Center for Human Services had two ICC youth in the sample, and BHN—Valley Human Services Inc. (BHN—VHS) had one youth in the sample. These ICC youth may have been receiving services in addition to ICC, including IHT.

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

Agency	Total Enrolled Since Start of IHT Opening (11-1-2009)	Total Open at List Submittal (6-28-2010)	Total Open and Receiving IHT / No ICC	Number IHT Only Selected
NCYF	79	52	46	0
Brightside	121	66	61	1
Servicenet	144	75	75	0
Cutchins	2	1	1	0
CSO	407	317	168	1
Brien	98	62	49	1
BHN	303	197	152	1
Gandara	24	14	12	1
Key	41	39	32	1
MSPCC	333	193	183	1
Carson/ VHS	21	20	18	1
Carson	56	41	22	0
TOTAL	1629	1077	405	8

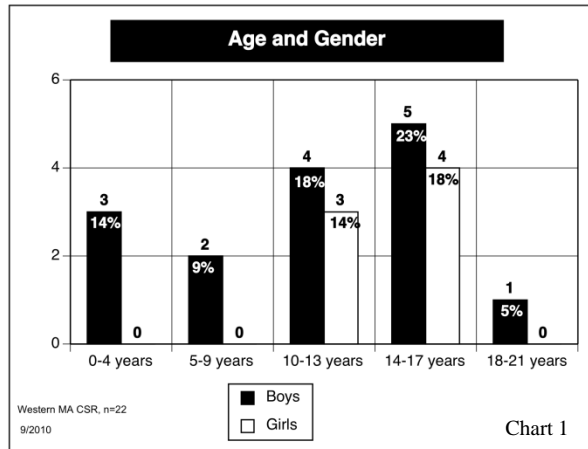
Table 3

As can be seen, each of the following agencies had one youth included in the CSR: Brightside, CSO, Brien Center, BHN, Gandara, Key Program Inc., Massachusetts Society for the Prevention of Cruelty to Children (MSPCC), and Carson-VHS.

Sample Attrition. In total, the CSR reviewed twenty-two youth rather than twenty-four. For unexpected reasons, two ICC youth could not be included in the CSR, one from Gandara and one from Carson. As a result 14 ICC youth and 8 IHT youth were included in the CSR.

Characteristics of Youth Reviewed

Age and Gender. There were 22 youth reviewed in the Western Massachusetts CSR. *Chart 1* at right shows the distribution of genders across age groups in the sample. There were 15 boys and 7 girls in the final sample. This proportion of boys to girls was 70% boys to 30% girls. Only one youth, or 5% of the sample was in the 18-21 age range. The largest number of youth (nine or 41%) were in the 14-17 year old age range, and the second largest (7 or 32%) were in the 10-13 year old range. Two youth or 9% were in the 5-9 year old range. Of note is that 14% of the sample was in the 0-4 age group.



Child Status and Performance Profile - Current Placement Frequency

Number of cases: 22 Western MA 9/2010

Type of Current Placement	Number	Percent
Family bio./adopt. home	18	82%
Kinship/relative home	2	9%
Foster home	1	5%
Residential treatment facility	1	5%
	22	100%

Table 4

Current placement, placement changes and permanency status. The vast majority of youth in the Western Massachusetts CSR sample lived with their families, either their biological families, an adoptive home, or in a kinship/relative home. One youth in the sample was living in a foster home at the time of the review, and one was receiving treatment in a residential setting (*Table 4*).

Child Status and Performance Profile - Legal Permanency Frequency

Number of cases: 22 Western MA 9/2010

Legal Permanency Status	Number	Percent
Birth family	17	77%
Adopted family	2	9%
Foster care	1	5%
Permanent guardianship	2	9%
	22	100%

Table 5

Likewise, the legal status (*Table 5*) of most of the children in the sample (77%) was with their birth families. Two (9%) youth's permanency was with their adopted families, and two were in permanent legal guardianship (9%), one was in foster care status (5%).

Placement change refers to both changes in living situation, as well as changes in the type of program the child receives educational services in. Achieving stability and minimizing disruptions are important factors in the lives of youth with SED. Among the sample, the majority of youth (12 or 55%) had no placement changes in the last year. Eight of the youth, or 36% had one to two

The review also tracked placement changes over the last twelve months for the 22 children reviewed (*Table 6*).

Child Status and Performance Profile - Placement Changes Frequency

Number of cases: 22 Western MA 9/2010

Placement Changes (past 12 months)	Number	Percent
None	12	55%
1-2 placements	8	36%
3-5 placements	2	9%
	22	100%

Table 6

placement changes, and two or 9% had 3-5 changes.

Of the five youth who were in out of home placements at the time of the review, one had been in that placement for less than 30 days, one had been in placement for 1-3 months, two had been in placement for 4-6 months, and one had been in an out of home setting more than 19 months (*Table 7*).

Child Status and Performance Profile - Length of Stay in Current OOH Placement
Number of cases: 22 Western MA 9/2010

Length of Stay in Current OOH Placement	Number	Percent
0-30 days	1	5%
1 - 3 mos.	1	5%
4 - 6 mos.	1	5%
19 - 36 mos.	1	5%
Not applicable	18	82%
Table 7	22	100%

Child Status and Performance Profile - Ethnicity Frequency

Number of cases: 22 Western MA 9/2010

Ethnicity	Number	Percent
Euro-American	7	32%
African-American	3	14%
Latino-American	10	45%
Biracial	1	5%
West Indian	1	5%
Table 8	22	100%

Ethnicity and primary languages (Table 8 and 9). As seen in this chart 32% of the sample was youth of a Euro-American ethnicity, and 14% were African-American. The majority of the youth in the sample (51%) were of Hispanic ethnicity.

Among the youth, English was the primary language spoken at home for 68% of the youth, Spanish for 23%, and both English and Spanish for 9% or 2 youth. Gandara, a specialty CSA for Latino youth and families was providing care coordination for four youth in the sample.

There were two youth from Spanish-speaking only homes served by agencies other than Gandara in the sample. There were no youth in the sample where languages other than English or Spanish were the primary language spoken at home.

Child Status and Performance Profile - Language Spoken Frequency

Number of cases: 22 Western MA 9/2010

Primary Language Spoken at Home	Number	Percent
English	15	68%
Spanish	5	23%
English & Spanish	2	9%
Table 9	22	100%

Child Status and Performance Profile - Educational Placement Frequency

Number of cases: 22 Western MA 9/2010

Educational Placement or Life Situation	Number	Percent
Regular K-12 Ed.	8	36%
Full inclusion	0	0%
Part-time Sp. Ed.	3	14%
Self-cont. Sp. Ed.	4	18%
Parenting teen	0	0%
Adult basic/GED	0	0%
Alternative Ed.	4	18%
Vocational Ed.	0	0%
Expelled/Suspended	0	0%
Home hospital	0	0%
Day treatment program	0	0%
Work	1	5%
Completed/graduated	1	5%
Dropped-out	0	0%
Other	3	14%
Table 10		

Educational placement (Table 10). Youth reviewed were receiving educational services in a variety of settings. The largest percentage of youth (36%) was attending school in a regular education setting. Seven, or 32% of the youth were receiving special education services, either in a part-time or full-time arrangement. Four youth were enrolled in an alternative education program, and may have also had special education services in that setting. Two of the youth were not enrolled in school as they had graduated, or were working. Youth in the Other category were all young children, one in a Special Education preschool, one in a Pre-K inclusion

classroom, and one not yet enrolled in school.

Other state agency involvement (Table 11). Youth in the sample were involved with a range of other agencies. Note that youth may be involved with more than one agency, so the overall number in Table 11 is more than the number of youth reviewed. The Department of Children and Families (DCF) had involvement with nine families and 41% of the families. The Department of Mental Health (DMH) was involved with six youth, or 27% of the youth. The largest agency involvement was Special Education where half of the sample had involvement. One youth was involved with the Department of Youth Services, and three or 14% were on probation.

Child Status and Performance Profile - Other Agencies Involved Frequency

Number of cases: 22 Western MA 9/2010		
Agencies Involved	Number	Percent
DCF	9	41%
DMH	6	27%
Special Ed	11	50%
Early intervention	0	0%
Developmental disabilities	0	0%
DYS	1	5%
Probation	3	14%
Vocational Rehabilitation	0	0%
Substance abuse	0	0%
Other	0	0%

Table 11

Child Status and Performance Profile - Referral Source

Number of cases: 22 Western MA 9/2010		
Referral Source	Number	Percent
Court	1	5%
DCF	7	32%
DMH	3	14%
DYS	1	5%
Family	4	18%
Family Stabilization	1	5%
IHT	1	5%
Inpatient hospital	1	5%
Mobile crisis	1	5%
Residential program	1	5%
Therapist	1	5%
	22	100%

Table 12

Referring agency (Table 12). Youth were referred to ICC and/or IHT services from a variety of sources as seen in Table 12. Most of the youth (32%) were referred through DCF. The youth's family self-referred in 18% or four of the cases. Other agencies and programs each referred one of the children in the sample.

Behavioral health and co-occurring conditions (Table 13). Table 13 displays the conditions and/or co-occurring conditions present among the youth reviewed. Youth may have one or more than one condition. The two primary diagnostic conditions were mood disorders, prevalent with 13 or 59% of the youth, and attention deficit disorder/attention deficit hyperactivity disorder seen in 12 or 55% of the youth. The five youth diagnosed with post-traumatic stress disorder were 23% of the sample. The other prevalent

Child Status and Performance Profile - Co-Occurring Condition Frequency

Number of cases: 22 Western MA 9/2010		
Co-Occurring Condition	Number	Percent
Mood Disorder	13	59%
Anxiety Disorder	7	32%
PTSD/Adjustment to Trauma	5	23%
Thought Disorder/Psychosis	0	0%
ADD/ADHD	12	55%
Anger Control	4	18%
Substance Abuse/Dependence	1	5%
Learning Disorder	2	9%
Communication Disorder	1	5%
Autism	1	5%
Disruptive Behavior Disorder (CD, ODD)	5	23%
Mental Retardation	0	0%
Medical Problem	4	18%
Other Disability/Disorder	5	23%
Other	0	0%

Table 13

diagnoses were disruptive disorders (23%), medical problems (18%) and other disabilities (23%). The Other Disabilities/Disorder category included three youth diagnosed with reactive attachment disorder (one with co-occurring intermittent explosive disorder), one with a pervasive developmental delay, and one diagnosed with an adjustment disorder. Medical problems present for four youth in the sample included asthma, chronic hives, insomnia and asthma. There were no youth with Hearing Impairments in the sample.

Of note is that based on prevalence studies, prevalence of mood disorders among youth with SED nationally have been estimated at between 6.2% at 9.4%.¹ The high prevalence of youth diagnosed with mood disorders among the Western Massachusetts CSR sample may mean several things including an over diagnosis of mood disorders in this population, or more referrals being made to Remedy services of youth with mood disorders. These data should not be over-interpreted due to the small sample and the lack of more information about the population.

Medications (Table 14). The majority of the youth in the sample (68%) were currently prescribed at least one psychotropic medication. As seen in one of the youth was prescribed one medication, four were on two medications, and seven were on three medications. There was one youth on four and one on five or more medications. Sixty percent of the youth prescribed psychotropic medications were prescribed three or more medications.

Child Status and Performance Profile - Psy Meds Frequency

Number of cases: 22 Western MA 9/2010		
Number of Psy Meds	Number	Percent
No psy meds	7	32%
1 psy med	2	9%
2 psy meds	4	18%
3 psy meds	7	32%
4 psy meds	1	5%
5+ psy meds	1	5%
Table 14	22	100%

Youths' levels of functioning (Table 15). The general level of functioning for the youth was rated by each reviewer. The General Level of Functioning is a 10-point scale that can be viewed in Appendix 1 of this report. Half of the sample was rated to be function 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”). The other half were rated in the Level 6-7 range (“variable functioning with sporadic difficulties or symptoms in several but not all social areas” to “some difficulty in a single area, but generally functioning pretty well”). What these results interpret to is that half of the youth reviewed were experiencing serious impairment such as unmanaged mood disorders or serious PTSD symptoms. The other half had difficulties of a moderate degree.

Child Status and Performance Profile - Level of Functioning Frequency

Number of cases: 22 Western MA 9/2010		
Level of Functioning	Number	Percent
In level 1-5	11	50%
In level 6-7	11	50%
Table 15	22	100%

Child Status and Performance Profile - Crisis Services Used Frequency

Number of cases: 22 Western MA 9/2010		
Crisis Services Used Past 30 Days	Number	Percent
Mobile crisis	2	9%
911 Emergency call: EMS	1	5%
911 Emergency call: Police	0	0%
Emergency department	0	0%
Other	0	0%
None	19	86%

Table 16

Use of Crisis Services (Table 16). The review tracked whether or not any form of crisis services or formal crisis response were used by any of the youth over the last 30 days. Three of the youth had used a mobile crisis

¹ Garland, AS., Hough, R.L., McCabe, K.M., Yeh, M., Wood, P.A., & Sarons, G.A. (2001). Prevalence of Psychiatric Disorders in Youths Across Five Sectors of Care. *Journal of the American Academy of Child and Adolescent Psychiatry*

service, and one had an emergency medical service response via a 911 call.

Mental health assessments (Tables 17 and 18). Mental health assessments are an important component of understanding youth and their families. A mental health assessment

gives practitioners and teams an overall picture of how the youth is doing emotionally and cognitively, as well as the social/familial context of a youth's behaviors and well-being. The majority of youth in the sample (82%) had a current mental health assessment that was in their files. The reviewers also examined for those that had a current mental health

Child Status and Performance Profile - Mental Health Assessment

Number of cases: 22		Western MA 9/2010	
MH assessment performed	Number	Percent	
Yes	18	82%	
No	4	18%	
	22	100%	

Table 17

Child Status and Performance Profile - Received Mental Health Assessments

Number of cases: 22		Western MA 9/2010	
Received MH Assessments	Number	Percent	
Parent	8	36%	
Education	2	9%	
Court	0	0%	
Welfare	3	14%	
DOC	0	0%	
Not applicable	4	18%	
Not Distributed	9	41%	
Other	1	5%	

Table 18

educators, and 14% of child welfare workers. The assessment had not been distributed for 41% of youth where it was applicable.

Caregiving challenges

Reviewers recorded the challenges experienced by the parents and caregivers of the youth in the sample (Table 19). There were fairly serious and significant challenges found among many of the caregivers. Serious mental illness was present in 32% of the cases reviewed. Three of the caregivers were challenged with substance abuse issues, three with domestic violence, and three with a disabling physical condition. Among the families, six or 27% were impacted by adverse effects of poverty. Nearly half of the families (41%) were faced with extraordinary care burdens. Cultural or language barriers were observed to be a challenge in two family situations.

Child Status and Performance Profile - Caregiver Challenges Frequency

Number of cases: 22		Western MA 9/2010	
Challenges in the Child's Birth Family or Adoptive Family	Number	Percent	
Limited cognitive abilities	0	0%	
Serious mental illness	7	32%	
Substance abuse impairment or serious addiction w/ frequent relapses	3	14%	
Domestic violence	3	14%	
Serious physical illness or disabling physical condition	3	14%	
Unlawful behavior or is incarcerated	0	0%	
Adverse effects of poverty	6	27%	
Extraordinary care burdens	9	41%	
Cultural/language barriers	2	9%	
Undocumented	0	0%	
Teen parent	0	0%	
Recent life disruption/homelessness due to a natural disaster	0	0%	
Other	1	5%	

Table 19

Care Coordination

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

As can be seen in *Table 20*, about a quarter of the care coordinators had been in the position for 4-6 months, and just over half had been in the position for 7-12 months. Eighteen percent had been in their positions for 13-24 months, and only one had been working in the position over 60 months.

Caseload frequency was measured along the scale seen in *Table 21*. Three of the care coordinators or 14% had less than eight cases. The largest number (8 or 36%) had 9-10 cases. Ten care coordinators had cases in the 11-16 range. Only one had a caseload larger than 18.

Child Status and Performance Profile - Length of Time CM in Position Frequency		
Number of cases: 22		
Western MA 9/2010		
Length of Time CM in Position	Number	Percent
4-6 months	5	23%
7-12 months	12	55%
13-24 months	4	18%
>60 months	1	5%
	22	100%

Table 20

Child Status and Performance Profile - CM Current Caseload Frequency		
Number of cases: 22		
Western MA 9/2010		
CM Current Caseload Size	Number	Percent
<8 cases	3	14%
9-10 casee	8	36%
11-12 cases	4	18%
13-14 cases	3	14%
15-16 cases	3	14%
>18 cases	1	5%
	22	100%

Table 21

Child Status and Performance Profile - Barriers Affecting Case or Services
Number of cases: 22 Western MA 9/2010

Barriers Affecting Case Management or Services	Number	Percent
Caseload size	5	23%
Eligibility/access denied	2	9%
Inadequate parent support	1	5%
Inadequate team member participation	2	9%
Family disruptions	0	0%
Billing requirements/limits	4	18%
Case complexity	8	36%
Treatment compliance	5	23%
Team member follow-thru	3	14%
Acute care needs	2	9%
Driving time to services	2	9%
Culture/language barriers	1	5%
Refusal of treatment	1	5%
Family instability/moves	1	5%
Arrest/detention of child/youth	0	0%
Other	3	14%

Table 22

Table 22. In terms of barriers that affect the provision of care coordination or other services, the challenge cited the most often and at nearly double any other barrier was the complexity of the case (36%). This was followed by caseload size (23%) and treatment compliance (23%). Billing requirements/limits (18%) was the next most frequently expressed barrier followed by team member follow-through (14%).

Other barriers mentioned at by one person each that are not listed here include unreliable transportation and family finances, paperwork, and difficulty contacting the parent. Transportation, especially in the rural areas, was frequently noted as a major barrier to accessing services in stakeholder interviews.

Community Services Review Findings

Ratings

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

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

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

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

STATUS AND PROGRESS INDICATORS

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

Youth Status Indicators

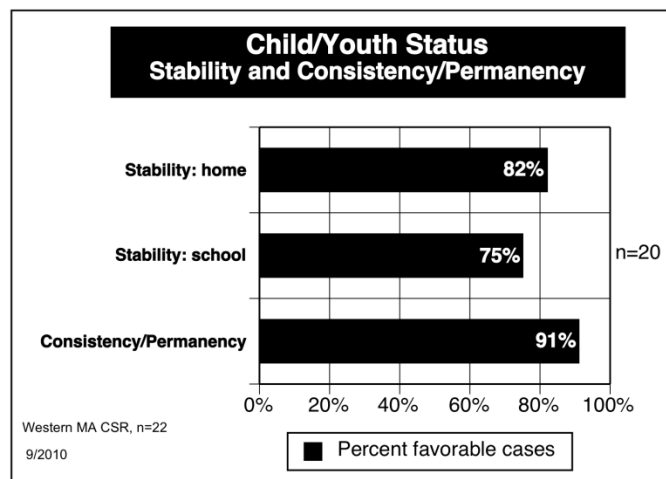
(Measures Youth Status over the last 30 days unless otherwise indicated)

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

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. Education Status
7. Living Arrangement
8. Health/Physical Well-Being

Overall Youth Status



Community, School/Work and Living Stability

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

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

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

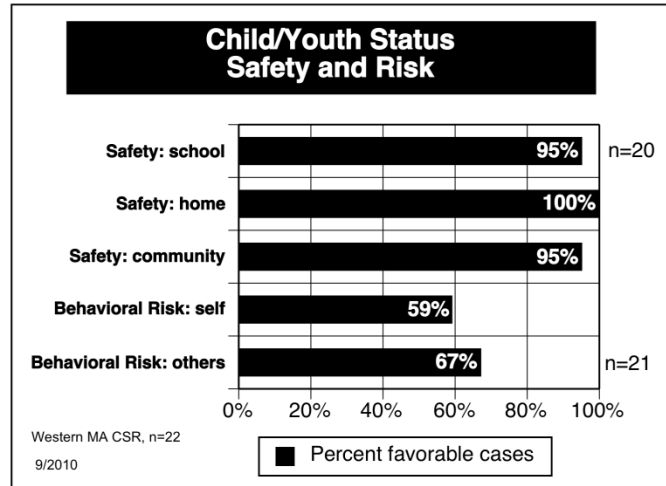
Among the 22 youth in the CSR sample, 82% of them had favorable stability at home. Ten of the youth (45%) had good stability with established positive relationships and well-controlled risks that otherwise could jeopardize stability. Eleven or 50% of the youth were rated to be in the “refinement” area, which means that conditions to support stability are fair. An example of a condition to support stability is teaching the youth replacement behaviors that will minimize the chances of an out of home placement.

One youth in the sample had poor stability at home that was substantial, with limited interventions to stabilize the situation. Strengthening supports by teams for these youth is warranted.

Of the 20 youth for which school stability was applicable (two of the youth in the sample were not in school), 75% had a stable school situation. Forty-five percent (45%) or 9 youth had school stability that needed “refinement” or “improvement.” An example of refining or improving school stability would be to provide an individualized program for systematically reinforcing positive behaviors in the classroom. For the 25% (5 youth) who had unfavorable stability in school, there was some indication that they may experience a placement disruption in school in the near term suggesting the need for focused attention by teams.

Consistency/Permanency in Primary Caregivers & Community Living Arrangements

The Consistency/Permanency Indicator measures the degree to which the youth reviewed are living in a permanent situation, or if not that there is a clear strategy in place by teams to address permanency issues including by identifying the conditions and supports that may be needed to assure the youth is able to have enduring relationships and consistency in their lives. Absent these conditions, there is often a direct impact on a youth’s emotional well-being and behaviors. Among the youth reviewed in Western Massachusetts, 91% had favorable consistency and permanency in their lives. Only two youth (9%) had marginal or uncertain permanence that needed refinement in in order to improve their emotional and behavioral well-being.



Safety of the Youth

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

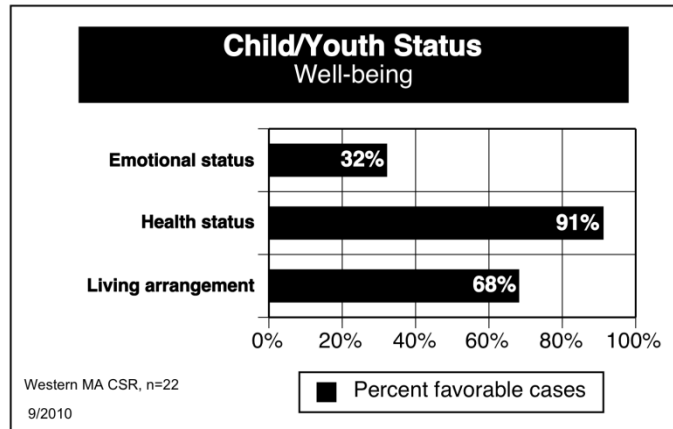
In the sample of youth reviewed for Western Massachusetts, for those who were attending school (N=20), a full 95% of youth were found to have favorable safety status at school and in the community, and all of the youth were safe at home. Six of the youth (30%) reviewed needed their school safety to be refined, for example a youth who is getting into altercations at school because of sexual orientation issues. One youth was found to have poor safety in the school setting. This youth expressed feeling unsafe in a new middle school, would not attend as a result, and was recently hospitalized. Ten youth (45%) may benefit from their care planning teams reviewing any potential safety issues at home or the community.

Behavioral Risk to Self and Others

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

The results of the review show that 59% of youth had a favorable level of behavioral risk to themselves and 67% had favorable level of behavioral risk toward others. These are both indications of serious concern about the risky behaviors of youth in this sample. Seventy-two percent (72% or 16 youth) of the sample were found to need “refinement” or “improvement” in their current status of behavioral risk to themselves. Among these were two youth with poor status, and one with serious and worsening status in this area. Fifteen youth (68%) need refinement or improvement in their risk to others, including 3 who had poor risk status, with a presence of potential of harm.

The overall results for this indicator likely means that care planning teams may need to look more closely at how they can positively impact behaviors of risk for a significant number of youth in their care. This is a key concern and focused attention and training/support for teams should be considered.



Emotional and Behavioral Well-being

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

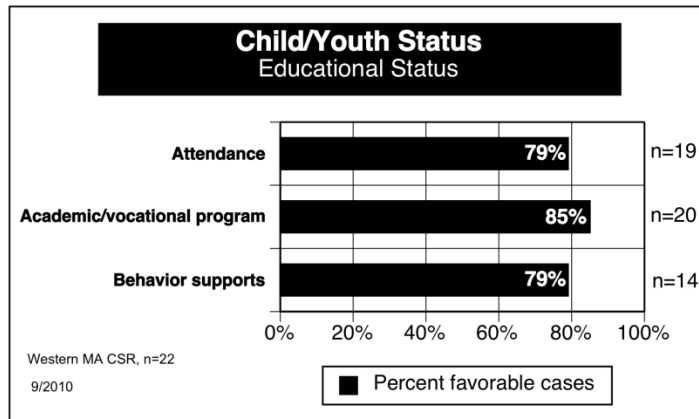
Emotional and behavioral well-being was a concern for over two thirds of the youth reviewed in the Western Massachusetts CSR. Only 32% were found to have favorable status in this indicator, indicating a fairly high level of inconsistent or poor emotional development, adjustment problems, emotional/adaptive distress, or serious behavioral problems that were present addressed among the youth reviewed. Further review of the data indicates that reviewers found nearly all of the youth in the sample needed refinement or improvement in their emotional/behavioral well-being. This clearly indicates that teams should be supported in planning, including using the expertise of families and what they bring to the table to inform planning, and implementing more effectively in this domain. The finding of reviewers was that many teams lack the "clinical presence" and oversight in order to successfully understand, plan, implement and track strategies and supports that would result in more favorable emotional status for youth. A number of teams had a weak understanding of core clinical/mental health issues or had not fully understood youth's trauma or mental health histories resulting in missing identifying strategies all together. There were a number of instances of inconsistent diagnosis or no clinical assessments in charts for youth who had complex or serious clinical issues. Because addressing emotional and behavioral issues of youth is a core charge of mental health systems, focused discussion about these findings are warranted.

Health Status

The health of the youth was reviewed to determine whether or not they were achieving and maintaining optimal health status through basic and routine healthcare maintenance. Youth’s basic needs for nutrition, hygiene, immunizations, and screening for any possible development or physical problems should be met. Health is an important component of overall well-being. For the youth in the sample, 91% had favorable status. However, 91% were noted to need some refinement in their health status, which is important information for teams to be aware of.

Living Arrangements

Living in the most appropriate and least restrictive living arrangement that allows for family relationships, social connections, emotional support and developmental needs to be met is necessary for any youth. Basic needs for supervision, care, and management of special circumstances are part of what constitutes a favorable status in a living arrangement. These factors are important whether the youth is living with their family, or in a temporary out of home setting. Often families, especially those with considerable challenges in their lives, need support in providing a favorable living arrangement for their children. For the youth reviewed in the Western Massachusetts CSR, 68% were found to have a favorable living arrangement. About half of the youth could benefit for some refinement in this area. As seen in the caregiver challenges data presented on Page 10, many parents and caregivers in this particular cohort are extremely challenged. There was a good amount of family support being offered to many of the parents of youth in the sample. However, several of the parents commented that they were unclear about what the purpose of this services was, indicating a need in these situations to clarify roles. More integration with adult mental health services would likely be helpful for a number of families.



Educational Status

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

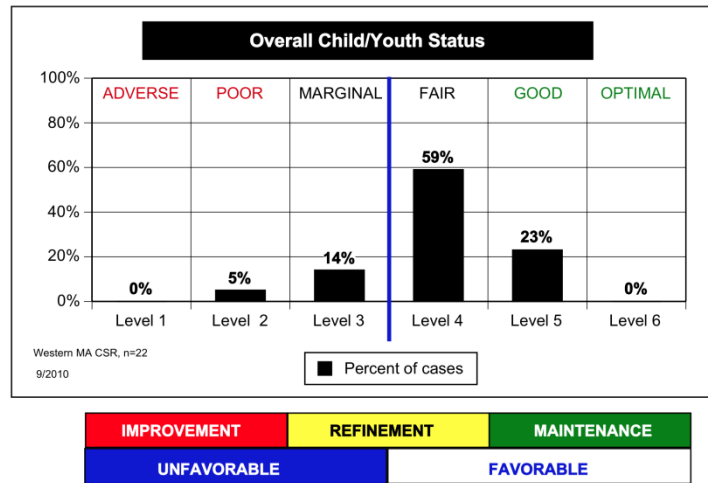
Whether or not a youth receives special accommodations or special education services in school, the youth is expected to attend regularly, and be able to benefit from instruction and

make educational progress. If the youth does need behavioral supports in school, he or she should be receiving those supports at a level needed to reach their goals. The role of behavioral healthcare is to coordinate with schools as educational success is a core component of a child's well-being. If a youth needs support in this area, care plans optimally include strategies to help the youth attend and succeed in school. The family with the support of the family partner, care coordinator or IHT (or others) meets and collaborates with school personal in support of youth progress and success.

In the Western Massachusetts review, for the 19 youth this indicator was applicable to, 79% had favorable patterns of attendance. Thirty-one percent (31% or 6 youth) of the sample would benefit from improvements in their school attendance pattern. For the 20 youth who were enrolled in an academic or vocational program, 85% of them were doing favorably well in their educational program. Ten youth or half the youth needed their teams to look what refinements they might need in their school program in order to do well emotionally and behaviorally. Fourteen youth required behavioral supports in their school setting, and this was working favorably well for 79% of them. Nine or 64% of them needed their teams to consider planning for refinements in the adequacy or consistency of implementation of behavioral supports. In some of these situations, the families had concerns in this area, and may have benefited from some support in bringing these issues to their teams.

Overall Youth Status

The overall results for Youth Status for the 22 youth reviewed are displayed below. Overall, 82% or 18 youth were found to be doing favorably well. These youth fell in Levels 4-6, and had Fair (59% or 13 youth), or Good (23% or 5 youth) status. There were no youth in the Optimal category. The remaining four youth had unfavorable status. They had either Marginal (14% or 3 youth) or Poor (5% or 1 youth) status.



The Youth Status Overall results are also categorized as needing Improvement, Refinement, or Maintenance. This allows for identification of youth that may need focused attention. One youth (5%) fell into the Improvement area, meaning their status is currently problematic or risky, and action should likely be taken to improve the situation for the youth. The majority of youth in this particular sample fell in the Refinement area (73% or 16 youth), which is interpreted to mean that status is minimal or marginal, and may be unstable

with further efforts likely necessary to improve their well-being. For the five youth (23%) whose status should be maintained, efforts should likely be sustained and leveraged to build upon a fairly positive situation.

Several observations can be drawn about the status of youth reviewed in Western Massachusetts. Most of the youth were in their birth homes or a permanent living situation which lent to their living stability, and most were safe in their homes, schools and communities. Additional supports to shore up the family’s capacity to provide a favorable living situation were warranted for about a third of the sample. Although school stability and educational status was favorable for the majority of the youth, several were less stable in their school settings, with some at risk of school placement disruption. A primary concern for a sizeable proportion of the youth reviewed was the level of behavioral risk to self and others, and the problematic emotional status for most of the youth in the sample. Despite living and going to school in primarily safe and stable settings, behavioral risk and emotional status was substantially unfavorable and unresolved for most of the youth reviewed.

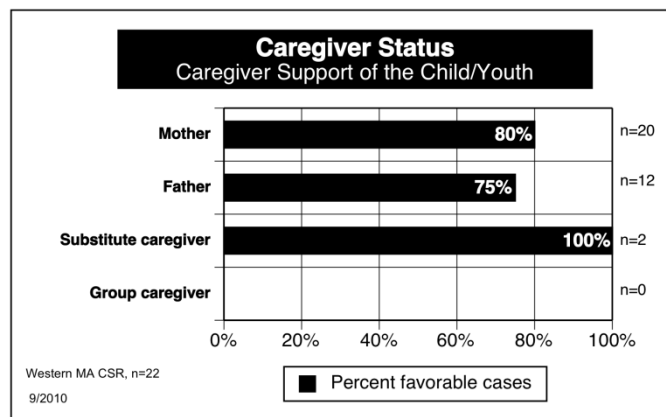
Caregiver/Family Status

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

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

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

Overall Caregiver/Family Status



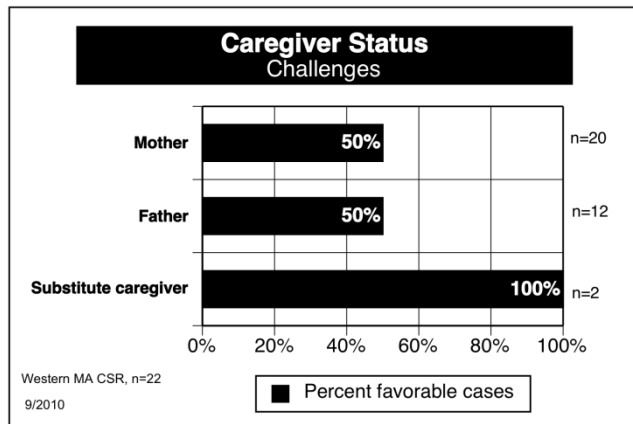
Parent/Caregiver Support of the Youth

This indicator measures the degree of support the person that the youth resides with is able and willing to provide for the youth in terms of giving assistance, supervision and support necessary for daily living and development. Also considered is if supports are provided to the parent/caregiver if they need help in meeting the needs of the youth. Parent/caregiver

support includes understanding any special needs and challenges the youth has, creating a secure and caring home environment, performing parenting functions adequately and consistently, and assuring the youth is attending school and doing schoolwork. It also means connecting to community resources as needed, and participating in care planning whenever possible. This domain is measured as applicable for the youth’s mother, father, substitute caregiver, and if in congregate care, for the group caregiver.

For the youth reviewed in the Western Massachusetts CSR, the measure was applicable to mothers for 20 youth, and favorable support was found 80% of the time (16 youth). Maternal support needed refinement or improvement for 65% or 13 youth. For fathers, the measure was applicable to 12, and favorable support was found for 75% or 9 of them, which indicated slightly less favorable support than with mothers. Support from fathers needed refinement or improvement for 83% or 10 youth in the sample. For the two youth with substitute caregiving (adoptive or kinship care), support was favorable for both of them, and only one could benefit from some refinement in their support.

There were no youth in congregate or group care in the sample.



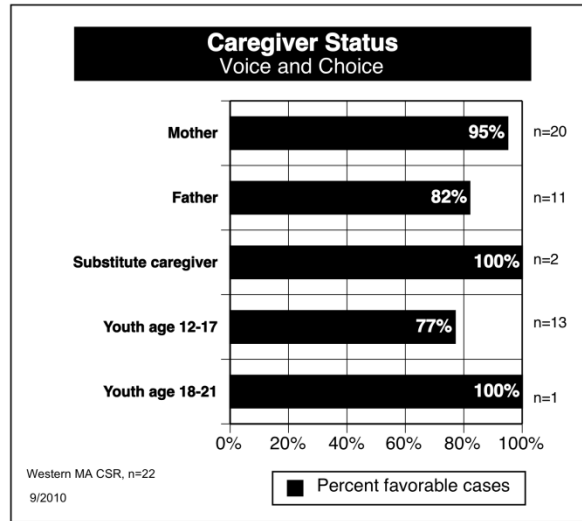
Parent/Caregiver Challenges

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

In the sample, for the 20 youth who have their mother as a caregiver, only 50% or 10 mothers had favorable status in terms of their challenges. Fourteen or 70% of the mothers had a level of challenge that needs to be refined or improved. This is a significant level of challenge, with many mothers impacted by conditions that may create hardships in parenting. As seen previously, despite considerable challenges experienced by many of the mothers, the youth are fairly stable, safe, and living in permanent situations, although living situations was a concern for a number of youth. These challenges mothers are experiencing likely speak to the fragility of the life factors for the families and potential for instability.

For the 12 youth where the fathers were present, 50% or 6 of them had a favorable level of challenge. The other 50% had a range of challenges from minor limitations with adequate supports to major life challenges with inadequate or missing supports.

The 2 substitute caregivers of youth in the sample were found to have favorable status in terms of life challenges, with few or minor limiting conditions. Status was favorable for 100% or both of them.



Family Voice and Choice

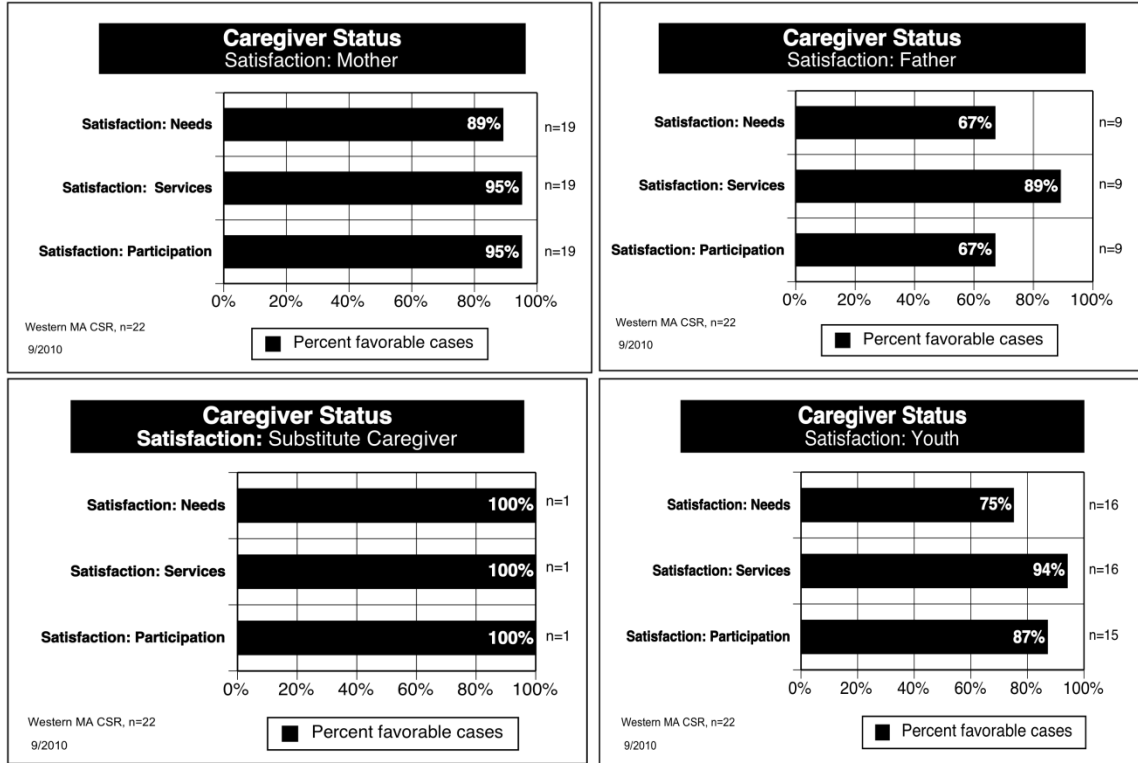
Family Voice and Choice is rated across a range of people as seen in the Caregiver Status: Family Voice and Choice chart above. For this indicator, in addition to parents/caregivers, the voice and choice of the youth is rated for youth who are over age 12. The variables that are considered when rating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

For the youth reviewed where their mother was their caregiver (N=20), 95% or 19 youth had favorable voice and choice in their child’s assessments, planning and service delivery processes. There were four youth or only 20% of the sample where there could be some refinement in strengthening the voice and choice of mothers. This a fairly strong finding, indicating that mothers feel and are included in team processes, which is an important foundation for engagement of families, and reflects use of system of care principles.

For youth whose fathers were involved and information could be gathered (N=11), 82% or 9 fathers had favorable voice and choice in involvement with their child’s service processes. Six of the fathers or 54% could benefit from refinement or improvement in the influence of their voice and choice.

For the two youth with a substitute caregiver, both had a favorable situation in terms of their voice and choice in service processes. Refinement was indicated for one of them.

There were thirteen youth in the 12-17 age range in the sample. Of these 77% or 10 youth had a favorable experience in having a voice and choice in their own services, with refinement indicated for 7 youth or 70% of youth who fell in this age range, indicating room for strengthening support of youth in this domain. There was one youth age 18 and older, and that youth experienced favorable voice and choice.



Satisfaction with Services and Results

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

The charts above display the results for how satisfied each of the role groups were with having their needs understood, services and results, and participation. Mothers’ satisfaction was applicable for 19 youth and there was fairly high satisfaction across the domains measured. For the 9 fathers that satisfaction was measured for, there was less satisfaction in having their child’s needs addressed and their ability to participate in services, but they were fairly satisfied with services. Satisfaction was measured for one substitute caregiver, who was

satisfied across all sub-indicators. Youth were more satisfied with services and their participation, and less satisfied with their needs being understood.

Summary: Caregiver/Family Status

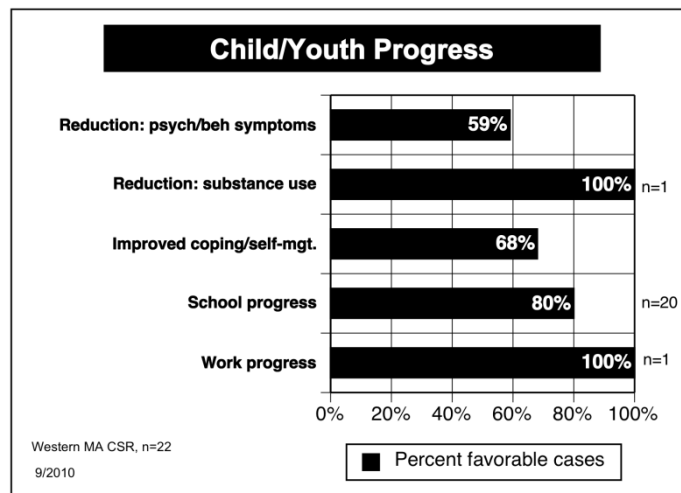
Overall, despite considerable challenges in their lives, parents are providing support for their children, although mothers showed more favorable results in their support than fathers, and there is an indication for refinement. Caregiver voice and choice is a notable strength of the service system. Families and youth expressed satisfaction with the services; fathers and youth are slightly less satisfied with having the needs of youth identified.

Youth Progress

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

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

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



Reduction of Psychiatric Symptoms and/or Substance Use

Measured in these indicators are the degrees to which target symptoms, problem behaviors and/or substance use patterns causing impairment have been reduced. Change in this area is reviewed over the past six months or since the beginning of treatment if it has been less than six months. For the 22 youth reviewed, 59% of them had made favorable progress in reducing symptomatology and/or problem behaviors. Seventy-seven percent of the youth could benefit from refinement or improvement in reduction in the psychiatric symptoms.

Five of the youth (22%) had made little or inconsistent progress with some of them at a moderate to severe level with marked symptoms/functional impairments in school and/or social situations.

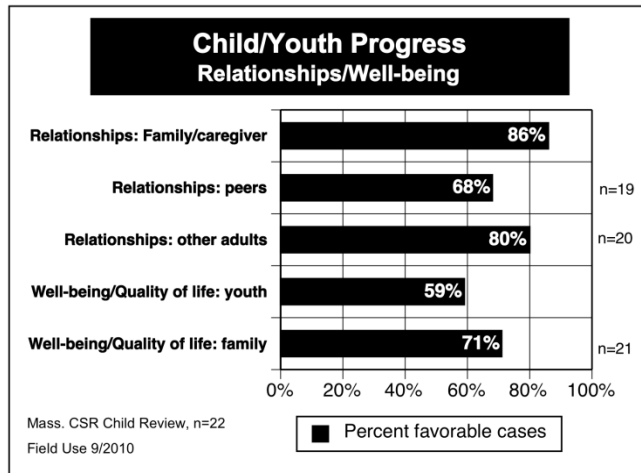
The one youth with substance abuse issues had made progress; the data indicates progress could benefit from refinement.

Improved Coping and Self-Management

This indicator looks at the degree to which the youth has made progress in building appropriate coping skills that help her/him to manage symptoms/behaviors including preventing substance abuse relapse, gaining functional behaviors and improving self-management. Among the youth reviewed, 68% were making favorable progress in improving their coping skills and ability to self-manage their emotions and behaviors. Three of the youth (13%) had made good progress in this area. Seventy-seven percent of the youth could benefit from refinement or improvement in their progress in this area. Four youth (18%) were making poor progress at levels well-below expectations.

School or Work Progress

Being able to succeed in the school or work setting for youth with SED is often dependent on their ability to make progress academically and behaviorally during the school/work day. This indicator looks at the degree of progress the youth is making consistent with age and ability in her/his assigned academic or vocational curriculum or work situation. Of the youth for which school progress was applicable, 80% were making favorable progress, with 50% making good progress. Forty percent (40%) of the sample could benefit from a level of refinement or improvement in their school progress. Only one youth was making little or no progress, but was not regressing. Progress in a work setting applied to one youth who was making good progress in satisfying expectations necessary for maintaining employment.



Progress Toward Meaningful Relationships

The focus of this indicator is to measure progress for the youth relative to where they started six months ago in developing and maintaining meaningful and positive relationships with their families/caregivers, same-age peers, and other adult supporters. Many youth with SED

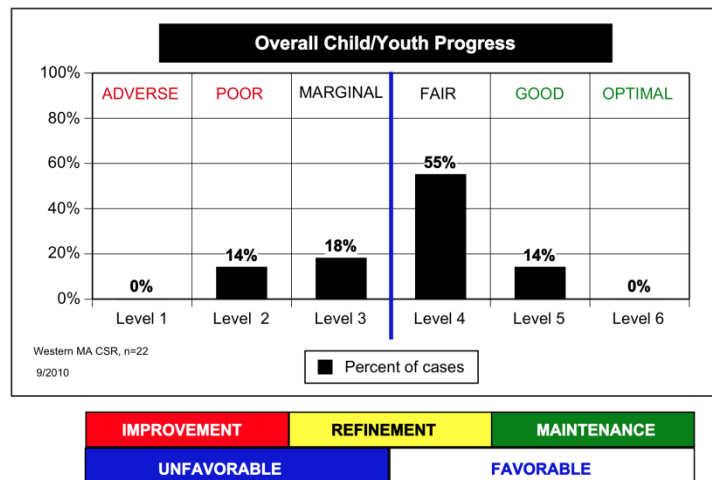
face difficulties in this area, resulting in isolation or poor decisions. If making and maintaining relationships is a need for a youth, care plans should identify strategies for engaging youth in goal-directed relationship-building.

For the youth reviewed, 86% of them were making progress in their relationships with their families or caregivers, which is a positive finding. For youth where building relationships was a goal and was not restricted (N=19) in this area due to current hospitalization, residential treatment, or in detention, 68% were making favorable progress. Of the 19 youth, 68% (13 youth) needed some improvement or refinement in progress in developing peer relationships. Progress in developing relationships with positive supportive adults (teachers, coaches, etc.) was favorable for 80% of the youth for which the sub-indicator applied (N=20), again a positive finding.

Overall Well-being and Quality of Life

Measured for the youth and the family, this indicator reviews to what degree is progress being made in key areas of life such as having basic needs met, having increased opportunities to develop and learn, increasing control over one’s environment, developing social relationships/reducing social isolation, having good physical and emotional health, and increasing sustainable supports from one’s family and community. For the youth in the CSR, 59% or 13 youth were making favorable progress in improved overall well-being and quality of life. Eighty-one percent (81%) of the youth reviewed could benefit from refinement or improvement in this area, indicating that teams and services may be underpowered in their ability to help many youth in making progress in improving their overall well-being.

For the families and caregivers, 71% were making favorable progress in improving the overall quality of life.



Overall Youth Progress

Overall, 68% of the youth were making favorable progress (Fair or Good Progress). Of these 87% were determined to need improvement or refinement in moving forward in the areas measured. 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. For a number of the youth reviewed, the right strategies at the right intensity may have been missing or underdeveloped.

One example was a youth who was having frequent tardiness and absences from school, attributed to different reasons by team members including health issues to social phobias to supervision concerns. While this youth received a number of services, the lack of understanding of underlying issues related to family dynamics, and the pending action by the school to act on the absences in a punitive manner was leading this youth to lose progress in a number of areas. What remained unaddressed for this youth were severe anxiety, and no specific treatment that was addressing relationships in the family. In this situation, although the team was meeting and including the youth's mother, they did not have an understanding of the underlying issues that included, in this case, a father-child concern.

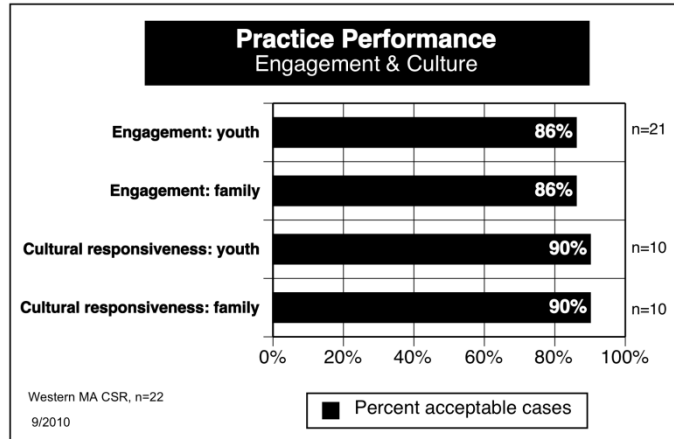
System/Practice Functions

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

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

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

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



Engagement

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

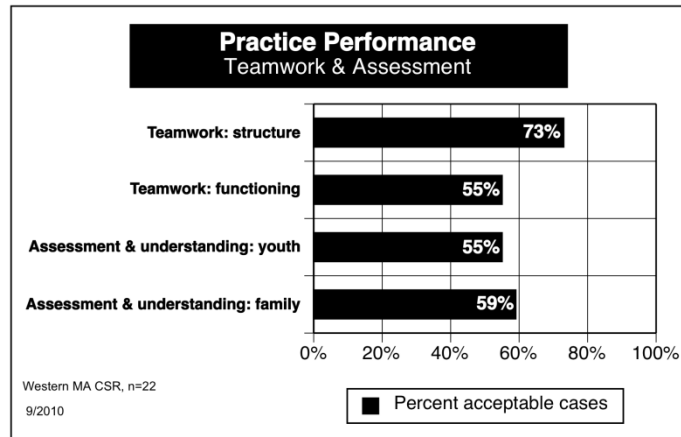
Results for care coordinators and care planning team's engaging youth and families were fairly strong among the CSR sample. For the 21 youth the sub-indicator was applicable to, 86% of them experienced an acceptable level of engagement. Similarly, 86% of families were engaged at an acceptable level. Ten youth and ten families would likely have benefitted from a strengthened level of engagement (Refine or Improve). There were a number of examples of strong engagement with families by care coordinators and teams, including making accommodations for family culture and language. There were also a number of instances where teams met at the family home on a regular basis. A number of parents said they felt respected and listened to by team members and appreciated their care coordinators and Family Partners. One mother shared that she felt she had a significant role in defining the goals of services.

Cultural Responsiveness

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

For the youth and families reviewed and this indicator was applicable for (N=10) Cultural Responsiveness was acceptable for 90% of them, which is considered to be a very positive finding. One reviewer found not only strong understanding by the care planning team of the family's Latino culture and language by seeking providers who spoke Spanish, they also

found the care plan written both in English and Spanish. In other instance, reviewers found that the care coordinator and Family Partner were responsive to ways the culture of the family was influencing parenting styles and familial expectations.



Teamwork: Team Formation and Team Functioning

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

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

Team Formation. For the 22 youth reviewed in Western Massachusetts, team formation was acceptable 73% of the time, indicating a degree of improvement is needed in order for families to be able to depend on teams of the right composition being formed on a consistent basis. Reviewers found that 68% of the teams needed some refinement or improvement in formation through identifying the important team members, and engaging them in meeting, communicating and planning together.

While team formation was occurring for most of the youth and there were examples of good engagement with schools, a noticeable absence for a number of the teams was participation by schools. There were also several instances where psychiatrists and an advance practice

nurse expressed wanting to have more contact and information from care the care teams. In one situation, the psychiatrist working to reduce medications said it would be helpful to know what strategies were being used to help the youth manage emotions and behaviors, and also wanted to know more about the youth's academic progress. At the same time, school personnel who were not engaged in the team felt that there were emerging problematic behaviors corresponding to the change in medications, and would have been better prepared to support the youth during this time if they knew more about what to expect. Assuring all relevant people are participating on the team would help to address situations that require joint planning and regular communication.

Team Functioning. Team functioning was more concerning, with only 55% of teams functioning acceptably well. Many of the youth and families in the Western Massachusetts had difficult situations that can be challenging for teams to address. Similar to team formation, 68% of teams were found to need some level of refinement or improvement in their functioning. Where teams were working well, reviewers saw team members with a common understanding of youth/family challenges, and examples of very creative problem solving to better support youth. For example, one team “did an excellent job of advocating for an appropriate school placement... the family requested that (the youth) be placed in the same school as (a sibling). This request was supported by the team in order to facilitate parent involvement and allow (the youth) to participate in a (school) program.” This level of teamwork resulted in positive status and progress for the youth.

However, a number of teams were splintered or working together inconsistently, with limited collaborative problem-solving. Others had difficulty functioning strategically because of lack of clarity about roles and redundant functions. One example was found in a team where “the roles of each professional are unclear and it is difficult for the IHT and the mother to articulate who is responsible for assembling and driving the team...the members are not functioning as a unified team; the parents are concerned that the treatment providers are not listening to their concerns about (youth's) unstable behaviors.” Another example was “the team does not appear to be meeting regularly, and this is reflected by inconsistent crisis plans (e.g., the school and agency teams have different plans) and an insufficient understanding of the roles of the various team members.”

The overall finding for this indicator is that improvement is needed in how teams address core responsibilities of a team and work together around common goals.

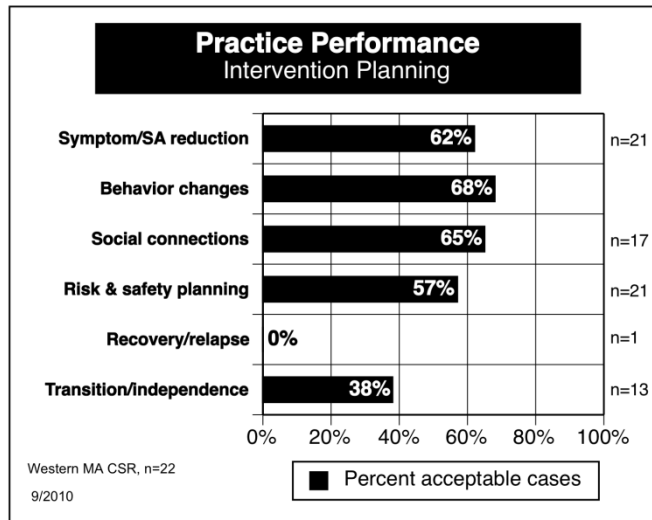
Assessment and Understanding

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

Assessment and understanding of youth and families is an important “first step” and foundational condition for practitioners to build cohesive teams and care plans that will result in positive outcomes. For many of the youth reviewed, this condition of practice was not met. Just over half of the youth (55% or 12 youth) had acceptable Assessment and Understanding of their core issues and situations. Nineteen or 86% of the youth would

benefit from refinement or improvement in the team’s understanding of them. Assessment and understanding of families was acceptable for 59% of the sample. A large disconnect found in a number of the cases came through a weak understanding of clinical issues of the youth. One reviewer’s observation was that “no one really understands who this child is... without this solid foundation, intervention planning has been uneven and with mixed results.” Another found a “general lack of clinical understanding on behalf of most team members regarding (the youth’s) diagnosis. Although (the youth’s) mother expressed a deep appreciation of the kindness and emotional support provided by (the ICC and Family Partner), she does not feel that the team members and those in the community understand what differentiates the behavior of her child from that of his peers, nor does she feel that those involved understand how to intervene with a child with (this diagnosis). This lack of clinical understanding has led to an insufficient crisis plan and an underpowered intervention.”

Many of the youth with complex or serious diagnostic issues did not have a current clinical assessment conducted by a qualified clinician that might have helped their teams and interveners better understand their needs, although most youth did have a current CANS. Some of the teams might have been better guided by some level of consultation or “clinical presence” at team meetings, or strengthened supervision of care coordinators. There was no evidence in the reviews that the MCE consulting psychiatrist had a role in working with teams or care coordinators, which may be an important overlooked resource for teams. Youth and families need to be able to depend on care planning teams fully understanding their situations and issues underlying behaviors, risks and emotional conditions as well as their preferences, information and experiences they bring to the table, at a more consistent level than found in the review.



Planning Interventions

In the CSR, Intervention Planning is evaluated across six sub-indicators. Specific indicators may or may not be applicable to a particular youth depending on what their specific needs and goals might be. Acceptability of intervention planning along these sub-indicators is based on an assessment of the degree to which processes are consistent with system of care

and wrap around principles. Reviewers also look at planning from the perspective that plans and processes are cognizant of safety and potential crises, are well-reasoned, well-informed by all available sources of information and are likely to result in positive benefits to the child and family. Plans need to be specific, detailed, accountable and derived from a family-driven team-based planning process. Plans also need to evolve as the youth and family's situation changes or more or different information is learned.

For the 21 youth the *Symptom or Substance Abuse Reduction* sub-indicator was applicable for, planning for reducing presenting psychiatric symptoms or substance abuse was acceptable for 62% or 13 of them. Refinement or improvement in planning in this area was needed for 81% of the youth.

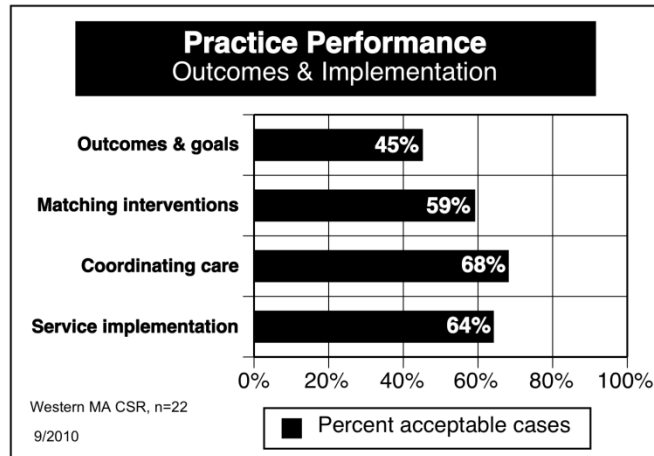
Targeting *Behavior Changes* in planning was applicable to all youth in the sample, and was at an acceptable level for 68% of them. Refinement/improvement was needed 72% of the time.

Planning for increasing *Social Connections* was applicable for 17 youth in the CSR sample and acceptable for 65% of them. Refinement/improvement to assure youth would be supported in developing social connections was needed for 65% of the youth for which the indicator was applicable.

Risk/Safety was a concern for 21 of the 22 youth in the CSR sample, and was acceptably addressed in planning processes only 57% of the time. Youth would benefit from refined/improved planning in 61% of the cases for which risk/safety issues were applicable. This indicates a clear deficit in planning to reduce risk and address safety issues, and will need heightened attention by teams. An example was a youth where after the mobile crisis team did not respond and there was no contingency plan in place, the police responded and the youth was restrained and arrested, causing a decompensation and hospitalization. Effective risk and safety contingency planning may have helped avert such a situation.

Only one youth in the sample needed *Recovery or Relapse* addressed in planning. Planning to address the recovery process and prevention of relapse was not acceptable for this youth.

Among the CSR sample, 13 youth needed to have *Transitions* addressed in their planning process. Review of transitions in the CSR apply to any transition occurring within the last 90 days or anticipated in the next 90 days including between placements (school and home), programs and to independence/young adulthood. For the 13 youth experiencing transitions in their lives, planning was acceptable for only 38%, indicating an important area to target training/supervision efforts. Many youth with special needs decompensate or regress if they are not well-supported in a transition. Refinement or improvement in planning was indicated for 84% of the youth experiencing transitions. Assuring attention is paid to predictable transitions should be integral to planning processes. For example, one of the young children reviewed with serious behavioral issues had been enrolled in ICC for nine months, and did not receive early intervention services in settings with other children prior to entering a kindergarten program. Transition planning in this situation may have made his move into a classroom setting less difficult.



Outcomes and Goals

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

A clearly stated and understood set of goals and outcomes guiding services and strategies that describe the “ending requirements” for the youth was acceptable for only 45% of the youth. This means that most of the youth reviewed had a marginally inadequate to poorly reasoned set of ending goals and outcomes that were known and understood by those involved. An example of unclear outcomes for one youth shared that, “The most recent plan in fact focused exclusively on agency goals and not goals for (the youth). While prior plans did have appropriate behavioral goals, it was never clear exactly what the providers were doing to see that the goals were achieved. Much of the intervention focus appeared to be on the mother, and one provider acknowledged that work with the youth was ‘almost incidental’. As such, there has been minimal progress if any, in important areas such as behavior at school and complying (at home).” While goals for families may be absolutely relevant to impact the youth’s goals, clearly articulated outcomes and goals for youth were needed but absent in this situation.

Overall, 63% of the youth would benefit from stronger practices in specifying outcomes and improvements that reflect the youth and family situation/vision that are known, understood and supported by team members.

Matching Interventions to Needs

This indicator measures the extent to which planned elements of therapy and supports for the youth and family “fit together” into a sensible combination and sequence that is individualized to match identified needs and preferences. Interventions can range from professional services to naturally-occurring supports. Reviewers examine the degree of match between interventions and goals of the care plan, and if the level of intensity, duration and scope of services are at a level necessary to meet expressed goals. As well, they look at

the unity of effort of interveners, and whether or not there are any contradictory strategies in place. Reviewers commonly refer to this as looking at the “mix, match and fit” of interventions for the youth and family.

For the youth reviewed, there was an acceptable level of matching intervention to need for 59% (13 youth). Overall, 77% of teams could refine or improve the identification and assembly of services and supports into a sensible, coherent service process that is coordinated across service providers, and will support youth in meeting their goals.

For some youth, the “mismatch” of intervention to need came as a result of missing the identification of their needs/or an unavailability of the service. For example, one youth had several identified needs; however, “treatment planning that has not focused on addressing (youth’s) diagnosis... (the youth) has been on the waiting list for individual therapy for 6-7 months. Although (the youth) had acquired some coping skills that allow moderation of aggressive and defiant behaviors, the underlying causes of behaviors remain unaddressed. Likewise, the need to plan treatment around building appropriate social connections has not occurred.” In this case, concerns reflected in the youth’s diagnosis had not been addressed, and in this case, the depression that was underlying self-harming behaviors and social isolation remained.

Overall, for this practice domain, supporting teams in better matching interventions to needs is warranted. This work comes through a team-based understanding of the strengths and needs of a youth and family, clear identification of needs and goals, accountability in the team to assure the right mix and match of service/supports are delivered at the level of intensity and urgency needed and continuous monitoring to assure interventions are working.

Coordinating Care

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

Youth in the sample received care coordination services from both ICC (N=14) and IHT therapists (N=8). Care coordination practices were found to be at an acceptable level for 68% of the youth reviewed. It should be noted care coordination was at an optimal level for one of the youth, and at a good level for another 8. An example of care coordination that was in the acceptable range and working was described as, “Coordination by the care coordinator and team communication have been strong. The team has been modified as the

family has moved through treatment, but the current team appears to be the right combination of individuals working with the family” and “Progress has been made by (the youth) and family, and the care coordinator will transition the facilitator role to the mother in the near future.” This is an example of care coordination as a dynamic process, helping to empower a family.

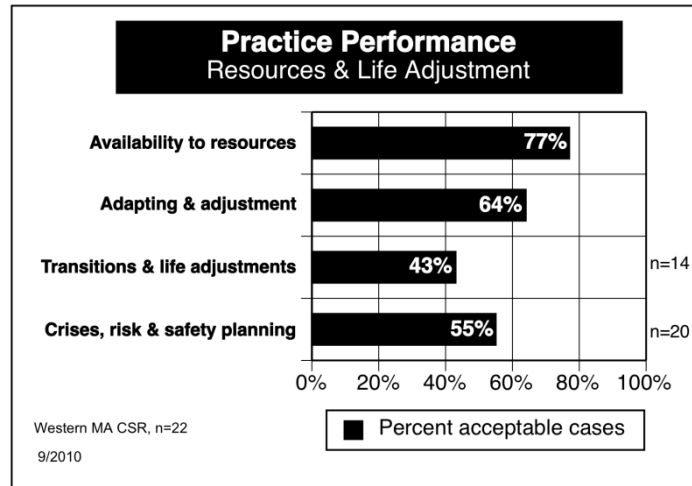
For 59% of the youth, care coordination needed a refinement or improvement; for the majority of youth, coordination was fair or marginal, with strengthening in practice needed in order for youth to fully benefit from this service. For two youth, care coordination was fragmented and inconsistent, and needed focused improvement. An example of how weak care coordination is impacting a youth was described as, “Based upon current service system performance found for this youth and family B.L.’s overall status is likely to decline over the next six months. The team is not well coordinated and communication is poor.”

Because care coordination is a crux system function, an improvement in the consistency of effective practices would be expected.

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, 64% of them had acceptable service implementation. Sixty-three percent (63%) needed implementation to be refined or improved. Some needed refinement in services being implemented in a timely or consistent manner, and others required a higher level of competence and skills by providers of services.



Availability and Access to Resources

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

In the CSR, 77% of youth had acceptable access to available resources. There was a good and substantial array of supports and services for 45% of the sample, and room for refinement, meaning fair resource availability, for the remaining 55%. One reviewer commented for the youth/family reviewed, "Resources were available to support the family and the services were effective due to appropriate frequency and intensity."

Resource availability and access due to service delay and interruptions services was a concern for youth in the "refinement" zone primarily because of timely access to ICC, IHT and MCI due to lack of available staff or staff turnovers.

Adapting and Adjustment

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

For youth reviewed, practices related to adapting and adjusting plans and services was acceptable for 64% of the youth, with 63% requiring some level of refinement or improvement. Eight youth or 36% had good adapting and adjustment process in place.

Transitions and Life Adjustments

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

For the 14 youth this indicator applied to, it was observed that only 43% or 6 youth had acceptable transition management practices in place. One youth had good transition planning and interventions taking place, and for one youth the practices were optimal. The data indicated that the other 12 youth needed refined or improved transition management.

An example of a transition that could have been better supported was for a young child who had responded favorably to interventions received through an in-home behaviorist. At the end of the three-month intervention the child was supposed to have transitioned to outpatient therapy. The in-home behaviorist closed the case, assuming that the family had transitioned to the new therapist. The outpatient therapist saw the mother one time, and then closed the case after the next two appointments were missed. Since then, the strategies are no longer being used at home, and the child's behaviors have returned to baseline. In this situation, the family was involved with ICC and had a parent partner. It is likely that identification of needed transitional supports and team communications may have yielded a different result in this situation.

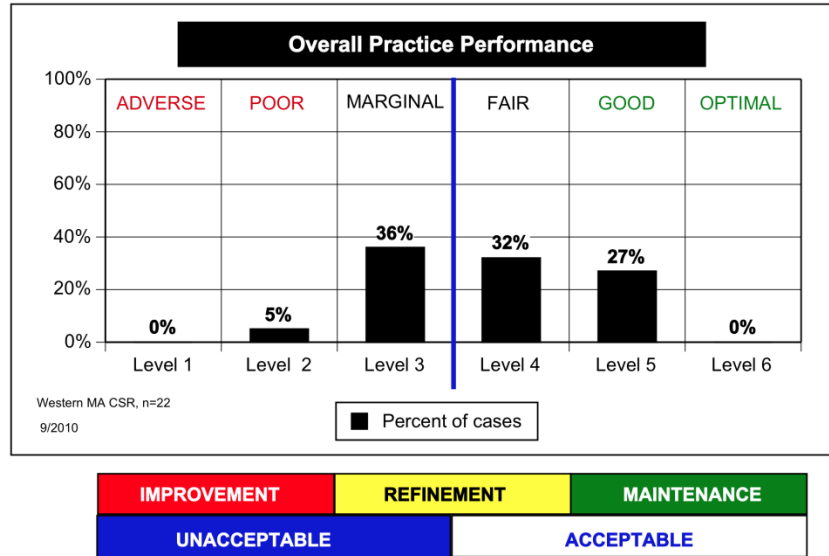
Improving the ability to identify and plan for supporting youth transitions should be a focus area for the Western Massachusetts services system.

Responding to Crises and Risk/Safety Planning

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

For youth where this indicator was applicable (N=20), only 55% or 11 youth had an acceptable crisis response and risk plan that worked acceptably well. Of note is that 8 of the youth were rated to have either an optimal or good response to crisis and safety planning meaning that all appropriate people were prepared to recognize early indicators of the onset of a crisis, and to implement the risk/safety plan. However, almost half of the youth needed considerable refinement and improvement in crisis response and risk/safety planning with 3 of them experiencing crisis responses that were unprepared to recognize and respond, or risk/safety plan provision incomplete and unable to manage risk for the youth.

The reliability of mobile crisis services was noted both in several of the child-specific reviews and by a number of stakeholders to be problematic in some communities. More than one family reported mobile crisis services arriving late or not coming at all when called. The result of undependable mobile crisis services in one instance resulted in an aversive police intervention, and decompensation of the youth resulting in an inpatient admission. Having reliable mobile crisis services is critical for many youth with SED, and is a requirement of the *Rosie D. Remedy*.



Overall System/Practice Performance

The chart above shows the distribution of scores across the six point rating scale. For the youth reviewed, when rounded, 60% were found to have acceptable system/practice performance. Most of the performance clustered at the marginal and fair levels (68%), or cases that require a level of refinement in order to impact better understanding, planning, coordinating and implementation of services and supports as described in this section. In interpreting the results for system/practice performance, it is important to see them in the light of how youth are doing and progressing. In looking at expectations of system performance, youth and families come into services with the expectation that they can depend on services that will help them. In other words, the expectation is that the system and practices should be performing acceptably well for most of the youth and families services.

What the findings have shown is that a threshold of youth in the CSR sample was basically safe and stable, but were doing far less well emotionally and behaviorally, or areas that are traditionally the domain of mental health. Additionally progress for a large percentage of youth in these domains was an area of concern.

Overall, the CSR points out that there are several practice domains that are being implemented at a fairly strong and consistent level for most youth and families reviewed. Engagement of youth and families by care coordinators, Family Partners, and care planning teams is occurring, and as a result families appear to be more engaged in teaming and planning. There also appears to be an awareness of families' cultures, and there are good examples of care planning and service delivery occurring in culturally responsive ways.

Other core system practices are occurring at a less consistent and skilled level. It appears that teams are starting to assemble, although not as consistently as expected for a large percentage of youth. How teams function once when assembled is a broader concern, with just over half of the youth realizing functional teams. This implies a core area for development as teams working together are the lynchpin for bringing together a collective understanding of the youth and family, establishing agreed upon goals, and working in concert to identify and implement strategies. Youth, especially those with SED and complex

life situations are dependent on having well-functioning teams that will help them make progress and ultimately do well across the key areas of their lives.

The results of the CSR showed that the foundational system practice of functioning teams is not yet something a larger percentage of youth and families can expect, and that as a result the assessment and understanding of youth and families is not at a level of performance needed in order to develop well-reasoned plans. Planning functions that were measured need improvement across the board in order to assure all youth have plans that are targeting the right issues and achieving the desired results. Planning for managing risk and safety, and transitions was a particular concern. Although resource availability is at a fair level and accessible for just over three-quarters of youth, there are still a fair number of youth that are waiting for the right resources.

Because many system/practice functions depend on effective care coordination, some bolstering of care coordination will likely begin to impact improvements in a number of areas. The overall impression is that many of the expectations of services are happening, but need to happen more consistently, and at a higher level of skill and/or supervisory oversight.

Managing risks for a population of youth with fairly severe and concerning emotional/behaviorally situations was found to be a key concern in the CSR. Again, families and youth in crisis need to depend on having plans that work and services that will respond effectively. This was not the case for nearly half of the sample for which risks were a concern. A focused look at practices and services in this domain is indicated by the data.

CSR Outcome Categories

		Status of Child/Youth/Family			
		Favorable Status	Unfavorable Status		
Acceptability of Service System Performance by Individual Youth	Acceptable System Performance	Outcome 1: Good status for child/youth/family, ongoing services acceptable. 55% (12 youth)	Outcome 2: Poor status for child/youth/family, ongoing services minimally acceptable but limited in reach or efficacy. 5% (1 youth)	60%	
	Unacceptable System Performance	Outcome 3: Good status for child/youth/family, ongoing services mixed or unacceptable. 27% (6 youth)	Outcome 4: Poor status for child/youth/family, ongoing services unacceptable. 14% (3 youth)	41%	
		82%	19%		

Western MA CSR, n=22
9/2010

CSR Outcome Categories Defined

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

CSR Results

Outcome 1

As this display indicates, 55% (12 youth) of the 22 youth fell into outcome category 1. Outcome 1 is the desired situation for all children and families receiving services.

An example of a youth’s situation that was rated as an Outcome 1 is as follows. Although a number of the ratings were in the “Refine” zone (there were a few cautionary issues that are risky for this youth), overall the youth was rated as having favorable status and progress, and acceptable system/practice performance:

“The team was adequately formed and has worked to provide (youth) and family with a continual array of services. Several natural supports have been identified as team members. Team members seem to have a shared and adequate understanding of (youth’s) emotional and behavioral challenges, and assessments have been appropriately utilized. Team members have a common understanding of the family’s challenges, particularly in regards to (youth’s) mother’s difficulties with rule enforcement.”

The goals are consistent across team members. The ICC and Family Partner are sufficiently coordinating care, and are highly motivated to engage with (the youth) and family on a frequent and consistent basis.”

Outcome 2

One youth or 5% of the sample fell in Outcome category 2. This category represents children whose needs are so great or complex that despite the best practice efforts and diligent system performance of the service system, the overall status of the child or youth is still unacceptable.

An example of status and practices related to a youth who fell into Outcome 2 was found in a youth who had significant current emotional and behavioral issues impacting her health, education and decision-making. The youth was hospitalized at the time of the review. The overall system/practice performance was identified to need some refinement, but was overall fair and acceptable.

“There is a positive and respectful working relationship between (the agency) and the Department of Family and Child Services. The Intensive Care Coordinator ensures that all members of the team are aware of meetings and are kept abreast of what is going on with the family. The case worker has assumed the role of ensuring compliance with the family so the clinical team could work more effectively with the family. The previous therapist recognized that (youth) needed to have the expertise of someone who specialized in trauma and made the referral. The In Home Therapist worked closely with the trauma therapist so when he left the agency she was able to continue to work with (the youth) through the transition with services.”

Outcome 3

Twenty-seven percent (27%) or 6 youth were in outcome category 3. Outcome 3 reflects youth whose status was favorable at the time of the review, but who were receiving less than acceptable service system performance. Some children are resilient and may have excellent naturally occurring supports provided by family, friends, school personnel, or some other key person in their life whose efforts are significantly contributing to the child’s favorable status at the present time. However, current service system/practice performance is limited, inconsistent, or inadequate at this time. For these children, when teams and interveners adequately form, understand the youth and family, and function well, the youth could likely progress into the outcome 1 category.

The following is an example of a youth in Outcome 3. This youth is doing well now in a highly structured setting, but has a number of stability and permanency issues that is making the situation precarious, coupled with an unformed, poorly functioning team.

“Overall child status is good. Of note is the fact that the child has the best possible educational situation to meet his needs and his behavior has improved because of this. There is, however, no single point of coordination for this child and team work is at best fragmented and incomplete across agencies. The planning process does not reflect a shared in-depth understanding across agencies, goals are not measurable, coordinated or widely understood and significant pieces of information that should be used to guide the service delivery process are missing.”

Outcome 4

In the Western Massachusetts CSR, 14% of the sample or 3 youth fell into outcome category 4. Outcome 4 is the most unfavorable outcome combination as the child’s status is

unfavorable and system performance is inadequate. For many of the youth who are in Outcome 4, a better understanding of the youth and family coupled with stronger teamwork and planning interventions that meet the needs of the youth with strong oversight of implementation would move the youth into a better Outcome classification.

An example of a youth who fell in Outcome 4 is as follows. This is a youth experiencing a difficulty with a school transition, has a history of self-harm, is currently exhibiting anxiety and depressive symptoms, is not attending school and is at high-risk for re-hospitalization. For this youth with very complex issues receiving IHT and no ICC, coordination was not occurring.

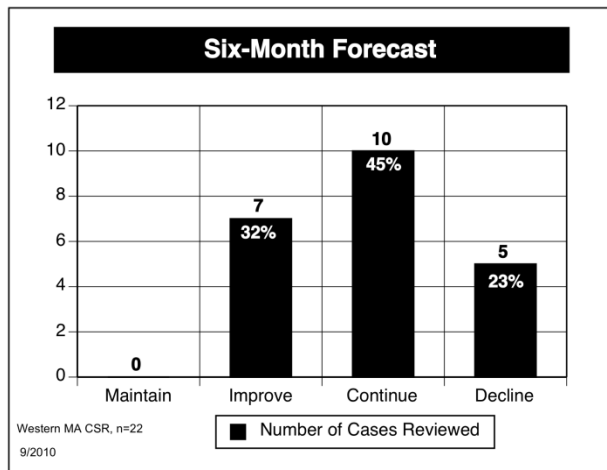
“The team is fragmented and everyone has pieces of information of what is going on with (the youth) and family. The (prescribing clinician) reported being unaware that In Home services were in place. Services are being rendered based upon a different presentation of symptoms than the In Home Services team is addressing. The planning of interventions is not likely to produce the desired outcomes as there is not a clear understanding of the individual and the family dynamics. There was not a defined role on the team to ensure that coordination and communication occurs among the team.”

Overall outcome findings

The percentages on the outside of the two-fold table represent the total percentages in each category. The percentage at outside, top right (60%) is the total percentage of youth with acceptable system/practice performance (sum of Outcomes 1 and 2). The percentage below this (41%) is the inverse- the percentage of youth with unacceptable system/practice performance. Again, these numbers reflect rounding and the total is slightly more than 100%. Likewise the number on the outside lower left is the percentage of youth that has favorable status (81%) and next to this the percentage of youth with unfavorable status (19%).

Six-month Forecast

Based on review findings, reviewers are asked if the child’s situation is likely maintain, improve, continue or decline. For 7 youth or 32% of the sample, the prediction was for improvement in situation. For 10 youth or 45%, the reviewers predicted the youth’s situation to remain the same, which could be favorable or unfavorable. For five youth or 23%, the prediction was that their situation would decline.



Summary of Findings

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

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

Strengths

Teams, Care Coordinators and Family Support Workers (Family Partners) are engaging and providing culturally-relevant supports for families.

Many of the reviews found families engaged, attending team meetings and having their voices and choices heard, a positive reflection of the training and practice expectations groundwork that has been laid over that last year. Engagement and working with families in ways that are respectful of diversity are important foundational system of care practices. Families and staff clearly felt that the “voice of families” is growing and respected more at team meetings. As a result, more people who are a part of providing services for youth are listening to families. Families expressed feeling more empowered and less isolated.

Families and staff find Family Partners to be helpful.

Family Partner supports were mentioned many times in reviews and in stakeholder meetings as being an important addition to the service array. Clearly, support for families at team meetings and other interactions with services are making a difference for many families. Most of the Family Partners appeared well-trained, well-supervised and competent. Although some families did not understand the role of their Family Partner, most Family Partners knew what their roles were and provided family support with fidelity to the model

Team-based work is occurring.

Families, behavioral health agency staff, and child-serving system partners expressed how they found the new CBHI services and the team-based and family-centered model to be an important addition to the Western Massachusetts children’s behavioral health service system. There were examples found in several youth-specific review of more use of community resources, creativity in providing services and supports, and effective teaming with schools and DCF. When Care Coordinators and management understood the practice model and roles of all team members, strong care plans were seen.

There are examples of strengthened collaboration among agencies.

System of Care Committee meetings are occurring and there are instances of their planning to address systemic issues. There is a developing “culture of learning and support,” and regular communication and working relationships between the CSAs and state agencies (primarily DCF and DMH). More joint problem-solving is happening at the youth team and system levels. There is a growing sense that stakeholders and families are building a common language about services and supports and the system of care philosophy, and are “on the same page.”

Challenges

Many teams lacked a depth of understanding of youth issues and the capacity to plan adequate interventions.

While more teams are meeting, a number of them are not consistently understanding youth’s needs, creating plans at the right level to meet needs, nor reliably implementing the right set of individualized supports and treatments that can likely impact youth’s emotional/behavioral well-being. For a large portion of the population, teams do not meet to plan and have goal-oriented discussions often enough, or planning does not occur at a level of depth needed to address core issues. While these findings need to be seen within the context of Remedy services being introduced over only the last year, it is likely that more support is needed for care coordinators and teams to adequately implement key system/practice functions at a level needed for youth to make progress.

It is not insignificant that foundational practices are being introduced and many parents and guardians are adequately engaged. However, planning to address youths’ core mental health concerns (symptoms, substance abuse including relapse and recovery, behavioral change, risk/safety planning, transitional supports) was not consistently at the depth of detail or scope needed to impact emotions and behaviors. Many teams appear to lack the ability to gather information to help them understand youths’ issues, as well as the ability to plan interventions and strategies that would work best with the population they are serving. Ideally functional assessments that afford a depth and scope of understanding should be used to select and use effective change strategies. Additionally, full support is needed for assuring the family and youth’s voice and information is listened to, working in concert with the important role of the team in providing families with options for interventions and support in making their choices about services, supports and interventions. Absent this, what results for a number of youth is almost a superficial understanding of needs, and plans that miss the mark in terms of being the right mix of interventions delivered with adequate power, consistency and beneficial effect. This was especially the case for crisis and safety planning. Because a large portion of the population being served have serious and complex mental health issues coupled with family challenges, a higher-level of “craft” and clinical knowledge and support for teams is warranted.

Several observations were made that may also be exacerbating team functioning. Few comprehensive clinical assessments were evident that would better inform treatment and care plans when youth had complex mental health issues. Prescribers of psychotropic (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 from planning for youth and families. There were a number of situations

where parents had mental health challenges with few teams referring and coordinating with adult services. Engagement with schools was missing in some cases, although this issue appears to be “on the radar” for a number of agencies and System of Care Committees.

Provider agencies are struggling in a number of areas.

Agencies that provide direct services are having difficulty retaining qualified staff which in some instances are reported to be impacting their ability to provide access to services and continuity of care. A number of agencies described their challenges in assuring the sustainability of services such as Family Partners and IHT within the business model. They describe having difficulty balancing implementing “unsupported” requirements such as supervision, training, retraining, and travel for providers. Many direct service staff describe chasing “productivity goals” within the current business model at the cost of compromised quality of care. Teams identify good strategies that may require “flexible funds;” many stakeholders identified the need for respite support. MassHealth may want to explore how relatively low-cost supports such as respite, transportation, parent support groups and flexible funds could be built to assist families and youth in achieving success. This also may be a viable agenda for System of Care Committees.

Families and providers have concerns about accessing services.

A number of families reported experiencing continuity of care disruptions when their MassHealth plans change or when there are untimely service authorizations. A number of providers, state agency staff, and families reported confusion on how to access services. Access to mobile crisis services was also identified as an issue both in the youth-specific reviews and stakeholder focus groups (see below).

Outpatient providers seem isolated from the system of care;

It was reported that many outpatient providers of therapy service are not referring youth who may need ICC and IHT in order to do well, and/or are not participating in team meetings when youth are involved with ICC. Management and staff describe outpatient therapists as perhaps distrustful or not understanding of the Remedy services, and that there may be barriers to their participation. It is also sometimes difficult for teams to coordinate and/or integrate the outpatient therapy modalities into the youth’s overall treatment, with challenges in working at cross-purposes in approach.

Crisis services are undependable in communities.

As noted throughout this report, when a number of youth experienced a mental health crisis, crisis mobile services were not available, or did not adequately support the youth during the crisis to the point where many parents do not feel they can depend on the service to help. This experience was also reported by parents and staff in the stakeholder interviews across the region. The actual reliability of the service was compounded with weak safety planning as reflected in the ratings of the review where only 55% of youth had an acceptable response/safety plan.

Based on the data of the CSR, monitoring and strengthening crisis response capacity as well as assuring functional risk and safety plans is a critical area that needs immediate attention.

Recommendations

Strengthen Team, Planning and Care Coordination practices.

- Evaluate if assessments and continued information gathering are at an adequate quality and level of depth to functionally inform the planning process in terms of highlighting underlying issues and providing a big picture understanding of the youth's history and family, current circumstances, reflective of family input and what works or doesn't work for the youth and family. Also look at the assessment and understanding process to see if it is at a level that can help teams to be clear about outcomes and goals, reflect the voices and choices of families and youth, and select interventions and supports that will help the youth to do better and stay better. This evaluation should be conducted through a functional approach, that is, is the assessment and understanding process working to help teams create plans that work for youth, and why or why not.
- Assure plans/interventions are at the depth/scope needed to address needs and achieve results.
- Develop strategies to assure care coordinators and teams have the necessary levels of expertise and access to consultation and supervision when a youth/family has complex clinical or specialized needs.
- Assure all team members understand the role and goals of all other team members, with a special focus on the role of the Family Partner.
- Staff have had basic training in wrap-around and other important concepts; they would likely benefit from continued modeling, mentoring, coaching and supervision in order to build their practice skills.
- Improve the ability of teams to identify and plan for supporting youth transitions, and functional risk and safety plans.
- Engage schools and out-patient providers in team-based planning; provide more education for these role-groups as well as physicians, other agencies and the community at-large.

Timely access to services

- Assure youth have timely access to services and continuity of ongoing services.
- Make the "front-door" to services less confusing for parents and communities. Consider providing clear and frequent information to parents.

Mobile Crisis Services

- Take a focused look at mobile crisis services to assure timely/therapeutic response to crises is consistently provided.

Appendix 1

Child's General Level of Functioning

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

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

Appendix 2

CSR Interpretative Guide for Person Status Indicator Ratings

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

CSR Interpretative Guide for Practice Performance Indicator Ratings

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