Report of Findings of the Community Services Review of Northeastern Massachusetts October 2011

Fiscal Year 2011-2012 Reviews

Rosie D. Community Services Review- Northeastern Massachusetts Regional Report

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Rosie D. Court Monitor

Table of Contents

Executive Summary

This report presents findings of the Community Services Review (CSR) conducted in the Northeastern Massachusetts region during October 2011. The CSR, a case-based monitoring methodology, reviews *Rosie D.* class members across key indicators of status and progress as a way to determine how services and practices are being performed. The intensive reviews were conducted of 24 randomly selected youth receiving Intensive Care Coordination (ICC) and/or In-home Therapy (IHT) services through Community Service Agencies (CSAs) and provider agencies throughout the Northeastern Massachusetts region.

The *Rosie D.* Remedial Plan finalized in July 2007 commits the Commonwealth of Massachusetts to providing new behavioral health services and an integrated system of coordinated care for youth with Serious Emotional Disturbances (SED) and their families through a practice model that requires team-based work and fully integrates family voice and choice. Services are required to be delivered through a coordinated approach consistent with System of Care and Wrap-Around principles.

The role of the *Rosie D.* Court Monitor is to receive and review information from a variety of sources in order to monitor compliance and progress with the requirements of the *Rosie D.* Remedial Plan. The Community Services Review was selected in consultation with the Parties to assist the Court Monitor as one way to receive and review information about the status and progress of services and requirements of *Rosie D.*

Highlights of Findings from the 2011 Northeastern Massachusetts CSR

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. The following are the status and progress findings for youth reviewed in the Northeastern Massachusetts CSR during October 2011.

Youth Status. Youth were fairly stable in their school settings, were generally living in permanent situations, and were safe in their homes, schools and communities. Most of the youth had favorable physical health. Youth were attending school regularly and had adequate behavioral supports in school settings. Youth were generally not posing behavioral risk toward others, but self-risk was a concern for a number of youth reviewed. Additional supports to strengthen families' capacity to provide a favorable living situation were warranted for over 30% of those reviewed.

The largest areas of concern were youths' home stability - a concern for 37% of the youth reviewed, and youths' academic status – a concern of 32%. An even larger area of concern was youths' emotional-behavioral well-being - which was unfavorable for 62% of the youth. Because of the importance of these indicators for youth to achieve positive functioning, reviews by teams to determine ways better address self-risk, academic status and emotional well-being is recommended.

Family/Caregiver status. Status of families and caregivers is comprised of a constellation of indicators that measure their well-being and satisfaction.

Fathers in the Northeastern Massachusetts CSR were found to have substantial challenges in their lives, and more than the mothers reviewed. Challenges for the substitute caregivers reviewed were variable. Support for youth was negatively impacted more for fathers than mothers. Family voice and choice was strong for mothers and youth, but fathers had less of a voice and choice in service processes. Mothers, youth and substitute caregivers expressed overall satisfaction in having their needs understood, with services, and with their level of participation; fathers were less satisfied across all three domains.

Youth progress. A goal of care planning is to coordinate strategies and identify all needed treatments or supports youth need to make progress in key areas of their lives. Youth progress indicators measure the progress patterns of youth over the six months preceding the review.

Overall, only 58% of the youth in the Northeastern Massachusetts CSR were making favorable progress (Fair, Good or Optimal Progress). The data for Youth Progress indicates that with the exception of the indicator for Improved Relationships with Other Adults, youth progress needs improvement. There is a clear need for teams to address barriers and help youth make greater rates of progress across domains.

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

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

For the youth reviewed, 75% were found to have acceptable system/practice performance. This indicates system performance and practices continue to need improvement. It means for a quarter of the youth, the system needs to improve its performance in providing dependable, quality services. This represents an improvement in performance as compared to last year's CSR for Northeastern Massachusetts when 67% of the sample had acceptable findings. A number of key system/practice indicators saw improvement over last year's CSR results.

The data indicate that the strongest areas of practice for youth in Northeastern Massachusetts were Engagement with the Family; Cultural Responsiveness to the Family; Planning Interventions for Symptom or Substance Reduction; and Planning Interventions for Behavior Changes. Findings in engagement and cultural competency with families were roughly the same as last year; however there were improvements in both of the intervention planning indicators.

Indicators that showed an overall fair performance but at a less consistent or robust level of implementation were Engagement with the Youth; Cultural Responsiveness to the Youth; Teamwork (Formation); Assessment & Understanding of the Family; Outcomes and Goals; Matching Interventions to Needs; Service Implementation; Availability and Access to

Resources; Adapting & Adjustment; and Responding to Crises. There were improvements over last year's CSR in each of these indicators with the exception of engagement and cultural responsiveness to youth, and resource access/availability, each of which declined slightly.

Areas of system/practice performance that need improvement in order to assure consistency, diligence and/or quality of efforts are: Teamwork (Functioning); Assessment & Understanding of Youth; Planning Interventions for Social Connections; Planning Interventions for Risk and Safety; Coordinating Care; and Overall Practice Performance. Improvements over last year's CSR were seen in assessment of youth, risk/safety planning and overall performance. Performance for planning for social connections and care coordination was the same as last year, and these areas continue to need considerable improvement.

Review results indicate weak performance in the following system/practice domains: Planning Interventions for Recovery and Relapse; Planning Interventions for Transitions; and Transitions & Life Adjustments. Each of these indicators of system practice declined in performance since last year.

The findings of the November CSR show that for Northeastern Massachusetts services, system of care practices such as engagement of families and cultural responsiveness to families continue to be strong. As well, there was enough of an improvement in two planning indicators (Planning for Symptom Reduction and Behavior Changes) where many youth experienced good planning in these areas.

A number of system practices that had fair performance were showing improvements over last year's CSR. This trend is promising. Important foundational practices such as assessment/understanding of families, establishing clear outcomes and goals, matching interventions to needs, service implementation, resource availability, adapting/adjusting services, and crisis response all saw an improvement in performance. Continued support to assure sustainable performance in these areas is recommended.

The remaining system practices need more development, and cannot yet be considered reliable in helping youth make progress, achieve desired outcomes or maintain recent gains. At this point in time, the system is not performing well at a consistent enough level because many foundational system of care practices were found to need improvement or are weak, and not enough youth are receiving overall acceptable practices. However, given the trend toward more practice functions improving, it appears that the system is moving in the right direction and has strengthened its ability to adequately serve children and families.

There are key areas that need concerted attention. In this year's Northeastern CSR, a quarter (25%) of teams were functioning in a limited manner, were splintered or inconsistent in their planning and evaluating results, and were not engaged in collaborative problem-solving at a level necessary to impact positive change for youth and families. As well, a quarter (25%) of teams were not adequately using clinical and related information to increase their understanding of the youth's issues at a scope and depth needed to design the right set of interventions and supports. Planning for symptom reduction and behavior changes was very strong however planning interventions across the rest of the domains lacked the specificity

and accountability to help enough youth in Northeastern Massachusetts make progress in achieving their goals as reflected in how many youth were not making favorable overall progress (42%). Care coordination, a pivotal system function to guide many of the other practices youth need to realize results and improved status was not acceptable for a quarter (25%) of the youth. While many of the other system functions measured in the CSR were found to be performing at a fair level, and are demonstrating an improving trend, they will need continued focused attention to help them achieve a higher level of quality and effectiveness.

Overall system practices in Northeastern Massachusetts continue to need improvement in order for families to be able to consistently depend on receiving acceptable services.

The Rosie D. Community Services Review
Regional Report for Northeastern Massachusetts
For the Review Conducted in September 2011

Introduction
Overview of Rosie D. Requirements and Services
The *Rosie D.* Remedial Plan finalized in July 2007 sets requirements for the Commonwealth of Massachusetts to implement new behavioral health services, an integrated system of coordinated care, and the use of System of Care and Wrap-Around Principles and Practices. Through the implementation of these requirements a coordinated, child-centered, family driven care planning and services is to be created for Medicaid eligible children with behavioral health concerns and their families.

The initial timeline required all services to become available on June 30, 2009, however new timelines were established by the Court. 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.

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; and 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. Features of the plan of care are to be reflective of the identification and use of strengths, identification of needs, culturally competent and responsive, multi-system and results in a unique set of services, therapeutic interventions and natural supports that are individualized for each child and family to achieve a positive set of outcomes. ICC services are intended for Medicaid eligible children with Serious Emotional Disturbances (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 (FP) 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) in 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 is a case-review monitoring methodology that provides focused assessments of recent practice using the context of how *Rosie D.* class members are doing across key measures of status and progress, and provides point-in-time appraisals of how well specific behavioral health service system functions and practices are working for youth and their families. In a CSR, each youth/family reviewed serves as a unique "test" of the service system. Each CSR involves a small randomly drawn sample of youth in a particular region.

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 59 for a full description of how each of the terms is defined. The six-point ratings are overlaid with "zones" of improvement, refinement, or maintenance. This overlay is provided to help care planning teams focus on youth concerns and/or system practices that may need attention. When reviewing the status and performance indicators that start on Page 33, 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 Family Partners being utilized in engaging and supporting families?
- For youth in ICC, how well are teams forming and functioning; 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?
- Are there adequate and effective crisis plans and responses?
- Are services (in-home, in-home behavioral, mentoring, etc.) having a positive impact on youth progress and producing results

The Northeastern Massachusetts CSR

Community Service Agencies (CSAs) and In Home Service Agencies

There continues to be six Community Service Agencies (CSAs) provided by four human service agencies in the Northeast Region of Massachusetts. CSAs are the designated agencies across the Commonwealth for the provision of Intensive Care Coordination. The CSAs also provide Family Support and Training (more commonly called Family Partners) Services.

In the central northeast region, the CSA is Eliot Community Human Services. The CSA is located in Malden, administrative offices are located in Lexington and the CSA provides services to the surrounding communities. Children's Friend and Family has a CSA located in Lynn, 7 miles north of Boston, and a second CSA in Lawrence, with each CSA serving the surrounding communities.   The MSPCC (Massachusetts Society for the Prevention of Cruelty to Children) CSA is located in Lowell, 25 miles from Boston, and provides services for Lowell and surrounding communities. HES/NHS has two CSAs, one located in Beverly and provides CSA services to the Greater Cape Ann area. The second CSA is located in

Haverhill, which is about 15 miles south of the New Hampshire border, and provides services to Haverhill and surrounding communities.

There are In-home Therapy Services (IHT) throughout the Northeast region, with IHT services being provided by CSA agencies as well as other private agencies. The CSR included IHT services provided by the agencies listed below in Table 3.

Review Participants

Altogether, over 400 people participated either in the youth-specific reviews or were interviewed in stakeholder focus groups in the Northeastern Massachusetts CSR. Table 1 displays data related to the youth-specific reviews where a total of 176 interviews were conducted. As can be seen, the average number of interviews was 7.3 with a maximum of 12 and a minimum of 3 interviews conducted.

Child Status and Performance Profile - Number of Interviews

Number of cases: 24   MA Northeast Review Oct 2011

Number of Interviews

Total number of interviews	176
Average number of interviews	7.3
Minimum number of interviews	3
Maximum number of interviews	12

Table 1

How the sample was selected

The sample for the Northeast Massachusetts CSR was drawn primarily from the population of all children who received Intensive Care Coordination (ICC). A smaller portion of the sample was drawn from In-Home Therapy (IHT), but only includes IHT youth who were not also receiving ICC services at the time the lists were drawn. The sample includes ICC and IHT youth, ranging in age from birth to twenty-one years old who are covered by Medicaid. The CSR sample initially drawn for the Northeast CSR consisted of 24 youth, including 16 ICC youth and 8 IHT youth (who were not also currently receiving ICC). During the course of the Review, one of the youth was found to have discharged from ICC, and was receiving care coordination through IHT. Thus the final sample included 15 ICC youth and 9 IHT youth.

Each ICC provider and each IHT provider was asked to a submit list of the youth who were enrolled since July 1, 2010. The caseload enrollment list was sorted to create a list of youth who were currently enrolled within open cases.

ICC Selection. 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 enrolled since July 1, 2010 and the number 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 thirteen agencies

that were actively providing IHT in Northeast Massachusetts at the time the lists were submitted. Some of these agencies were providing IHT in only one location, but some were serving multiple areas of the Northeast Massachusetts region. Of the thirteen agencies, one was serving too few to be included in the sample, and was dropped from the selection process. Of the 8 youth selected from IHT lists, 4 were drawn from programs which operated as parts of CSA's within the same agencies. There were 4 CSA's providing IHT, so a youth was drawn from each of their programs for the sample. The final 4 youth in the sample were randomly selected from the remaining IHT agencies, which were not also CSA providers. In total, there were 8 IHT youth included in the initial sample, and 9 in the final sample due to the one youth changing designation from ICC to IHT coordination during the course of the review

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

Northeast Agency	Total Enrolled Since 7/1/10	Number Open at List Submittal	Number ICC Cases Selected
Children's Friend and Family - Lawrence	215	98	2
Children's Friend and Family - Lynn	265	129	2
Eliot Community Human Services- Malden	425	203	4
Northeast Behavioral Health- Haverhill	180	115	2
Northeast Behavioral Health- Cape Ann	399	190	4*
MSPCC - Lowell	261	106	2
Total	1745	841	16**

Table 2

*Reflects initial sample; final sample for Northeast Behavioral Cape Ann was 3.
**Reflects initial sample size for ICC; final sample size for ICC was 15 due to 1 youth moving to IHT coordination during the course of the review.

The second column of Table 2 displays the number of the youth enrolled in ICC since July 1, 2010. The third column displays the total number of youth by agency that was served within open cases at the time the agencies submitted lists. The number of youth to be included from each agency was then determined by comparing the number of youth being served by that agency to the total number of youth being served in Northeast Massachusetts. Two agencies had served the largest number of youth since July 1, 2010: Eliot Community Human Services in Malden, and Northeast Behavioral Health in Cape Ann. Both of these CSA's had 4 youth in the original sample. The youth that moved to IHT care coordination in the final sample was originally selected as part of the Northeast Behavioral Health in Cape Ann, thus this CSA had 3 ICC youth in the final sample.

Each of the remaining CSA's had 2 youth in the sample: Children's Friend and Family in Lawrence, Children's Friend and Family in Lynn, Northeast Behavioral Health in Haverhill, and MSPCC in Lowell. These 16 ICC youth may have been receiving services in addition to ICC, including IHT.

Agency	Total Enrolled Since 7/1/10	Total Open at List Submittal	Total Open and Receiving IHT/ No ICC	Number IHT Only Selected
Children's Friend and Family – Salem IHT	55	41	25	1
Eliot Community Human Services- Lynn IHT and Malden IHT	311	71	62	1
Northeast Behavioral Health– Haverhill IHT, Beverly IHT, and Lowell IHT	388	219	90	1
MSPCC	253	58	39	1
Key Program	25	17	12	1
Lowell Treatment Center	183	48	39	1
St Ann's Home	25	10	9	1
South Bay Mental Health- Lowell IHT, Salem IHT, and Lawrence IHT	274	141	107	1*
Total	1514	605	383	8**

Table 3

*Reflects initial sample; final sample for South Bay Mental Health was 2
** Reflect initial samples size for IHT; final sample size for IHT was 9 due to 1 youth moving to IHT coordination during the course of the review.

Information about the 8 IHT agencies, which were randomly selected for inclusion in the CSR sample, is shown in Table 3. The second column shows the total unduplicated enrollment for youth receiving IHT by agency since July 1, 2010. The third column displays the number of youth who were included in open cases at the time the list was submitted. The fourth column displays the total number of youth who were receiving IHT without current ICC services. The last column lists by agency, the number of IHT youth who were designated for selection in the CSR. As can be seen in the table, each of the following agencies had one youth included in the initial CSR sample: Children's Friend and Family, Eliot Community Human Services, Northeast Behavioral Health, MSPCC, the Key Program, Lowell Treatment Center, St. Ann's Home, and South Bay Mental Health. In the final sample, 2 youth were reviewed from South Bay Mental Health due to one youth's change in care coordination from ICC to IHT.

Characteristics of the Youth Reviewed in Northeastern Massachusetts
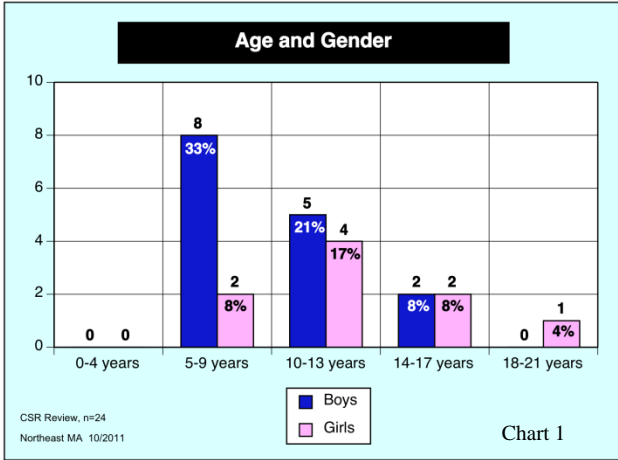
Chart 1

Age and Gender. Twenty-four (24) youth receiving services in the Northeastern Massachusetts region were reviewed in the CSR conducted during October 2011. *Chart 1* displays the distribution of genders across the age groups in the sample. There were 15 boys and 9 girls in the sample. The proportion of boys to girls was 63% boys to 37% girls. The largest number, 10 youth or 41% of the sample, were in the 5-9 year old range. There were 9 youth or 38% of the sample in the 10-13 year old range, and 4 youth or 16% of the sample in the 14-17 year old range. One youth, or 4% of those reviewed was in the 18-21 year old range. There were no youth in the sample in the 0-4 year old range.

Current placement, placement changes and permanency status. The majority of the youth in the Northeastern Massachusetts CSR sample lived with their families (87%), either with their biological/adoptive families or in a kinship/relative home. One youth each were residing in a foster home, a CBAT, and a pre-independence setting (*Table 4*).

Child Status and Performance Profile - Current Placement Frequency

Number of cases: **24**   MA Northeast Review Oct 2011

Type of Current Placement	Number	Percent
Family bio./adopt. home	19	79%
Kinship/relative home	2	8%
Foster home	1	4%
CBAT	1	4%
Pre-independent	1	4%
Table 4	24	100%

Child Status and Performance Profile - Legal Permanency Frequency

Number of cases: **24**   MA Northeast Review Oct 2011

Legal Permanency Status	Number	Percent
Birth family	19	79%
Adopted family	1	4%
Foster care	1	4%
Permanent guardianship	1	4%
Permanent guardianship split with DCF	1	4%
Self	1	4%
	24	100%

Table 5

Table 5. The legal status of 79% of the youth reviewed was with their birth families. One of the youth's (4%) permanency status were with his/her adoptive family, one (4%) with foster parents, one (4%) was in permanent guardianship, one (4%) in split guardianship with the Department of Children and Families (DCF), and one (4%) was independent.

Child Status and Performance Profile - Placement Changes Frequency

Number of cases: 24   MA Northeast Review Oct 2011

Placement Changes (past 12 months)	Number	Percent
None	14	58%
1-2 placements	6	25%
3-5 placements	4	17%
	24	100%

Table 6

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

Number of cases: 24   MA Northeast Review Oct 2011

Length of Stay in Current OOH Placement	Number	Percent
0-30 days	1	4%
4 - 6 mos.	1	4%
7 - 9 mos.	1	4%
10 - 12 mos.	1	4%
Not applicable	20	83%
	24	100%

Table 7

Out of home placements. Achieving stability and minimizing disruptions are important factors in the lives of youth with SED. The CSR tracked placement changes over the last twelve months for each of the 24 youth reviewed (*Table 6*). Placement change refers to changes in living situation, as well as any changes in the type of program the child received educational services over the last twelve months. Among the youth in the sample, 14 or 58% had no placement changes in the last year. Six youth (25%) experienced 1-2 placement changes, and four youth (17%) had 3-5 placement changes. Of the four youth who were in out of home placements at the time of the review, one (4%) had been in placement for 30 days or less, one (4%) between 4-6 months, one (4%) between 7-9 months, and one (4%) between 10-12 months (*Table 7*).

Child Status and Performance Profile - Ethnicity Frequency

Number of cases: 24   MA Northeast Review Oct 2011

Ethnicity	Number	Percent
Euro-American	14	58%
African-American	1	4%
Latino-American	6	25%
Biracial	1	4%
Haitian	2	8%
	24	100%

Table 8

Ethnicity and primary languages (Table 8 and 9). Of the 24 youth in the sample, fourteen or 58% were Euro-American, and 6 or 25% were Latino-American. One youth (4%) was African-American, one was Biracial, and two (8%) were Haitian.

English was the primary language spoken at home for 22 or 92% of the youth, English and Portuguese for one or 4%, and English and Spanish for one or (4%).

Child Status and Performance Profile - Language Spoken Frequency

Number of cases: 24   MA Northeast Review Oct 2011

Primary Language Spoken at Home	Number	Percent
English	22	92%
English & Port.	1	4%
English & Spanish	1	4%
	24	100%

Table 9

Child Status and Performance Profile - Educational Placement Frequency

Number of cases: 24   MA Northeast Review Oct 2011

Educational Placement or Life Situation	Number	Percent
Regular K-12 Ed.	5	21%
Full inclusion	2	8%
Part-time Sp. Ed.	1	4%
Self-cont. Sp. Ed.	10	42%
Parenting teen	0	0%
Adult basic/GED	1	4%
Alternative Ed.	4	17%
Vocational Ed.	0	0%
Expelled/Suspended	0	0%
Home hospital	0	0%
Day treatment program	0	0%
Work	0	0%
Completed/graduated	1	4%
Dropped-out	0	0%
Other	4	17%

Table 10

Educational placement (Table 10). Youth reviewed were receiving educational services through a variety of educational programs. Of the sample, 21% were in a regular education program. Fifty-five percent (54%) of the youth were receiving special education services in a full inclusion (8%), part-time special education (4%) or fully self-contained special education setting (42%). One youth (4%) was in a GED program. Four youth (17%) were in an alternative education setting, and one (4%) was in a day treatment program. These youth may have also had special education services in these settings. One youth in the sample (4%) had completed school. Youth in the "Other" category included youth in pre-school and community college.

Child Status and Performance Profile - Agencies Involved Frequency

Number of cases: 24   MA Northeast Review Oct 2011

Agencies Involved	Number	Percent
DCF	8	33%
DMH	1	4%
Special Ed	14	58%
Early intervention	0	0%
Developmental disabilities	1	4%
DYS	0	0%
Probation	3	13%
Vocational Rehabilitation	0	0%
Substance abuse	0	0%
Other	3	13%

Table 11

Other state agency involvement (Table 11). Many of the youth in the sample were involved with other State and/or community agencies. Note that youth may be involved with more than one agency, so the overall number in Table 11 is more than the number of youth reviewed. Youth were most frequently involved with Special Education (14 or 58%). The Department of Children and Families (DCF) had involvement with 8 families or 33% of the sample.

Three youth (13%) were on Probation. One youth each were involved with Department of Mental Health and the Department of Developmental Services. The "Other" category represents youth receiving services through Community Teamwork, Inc., housing supports, and Children's Hospital.

Referring agency (Table 12). Youth reviewed in Northeastern Massachusetts were referred to ICC and/or IHT services from a variety of sources as displayed in Table 12. The largest referral source was Outpatient providers who referred five youth or 21% of the youth reviewed. This was followed by the Department of Children and Families (DCF), and Families who each self-referred four youth or 17% of the youth reviewed each. The next largest referral source was Schools, referring three of the youth, or 13%, and Hospitals who referred two youth or 8% or the sample. Referring one youth each or 4% of the sample were Crisis Services, a CBAT, a Head Start program, ICC and an in-home therapist.

Child Status and Performance Profile - Referral Source

Number of cases: 24   MA Northeast Review Oct 2011

Referral Source	Number	Percent
Hospital	2	8%
Crisis Services	1	4%
School	3	13%
Family	4	17%
DCF	4	17%
Outpatient	5	21%
CBAT/Italian home	1	4%
CSA	1	4%
Head Start	1	4%
ICC	1	4%
In-home Therapist	1	4%
	24	100%

Child Status and Performance Profile - Co-Occurring Condition Frequency

Number of cases: 24   MA Northeast Review Oct 2011

Co-Occurring Condition	Number	Percent
Mood Disorder	15	63%
Anxiety Disorder	4	17%
PTSD/Adjustment to Trauma	8	33%
Thought Disorder/Psychosis	2	8%
ADD/ADHD	16	67%
Anger Control	16	67%
Substance Abuse/Dependence	1	4%
Learning Disorder	8	33%
Communication Disorder	5	21%
Autism	0	0%
Disruptive Behavior Disorder (CD, ODD)	4	17%
Mental Retardation	2	8%
Medical Problem	6	25%
Other Disability/Disorder	1	4%
Other	0	0%

Table 13

Behavioral health and co-occurring conditions (Table 13). Table 13 describes the conditions and/or co-occurring conditions present among the youth reviewed. Youth may have one or more than one condition. The largest percentages of youth were diagnosed with attention deficit or attention deficit hyperactivity disorder (67%), or anger control (67%). Sixty-three percent (63%) of the youth were diagnosed with a mood disorder. Following this was 33% of the

sample with PTSD, 33% with a learning disorder, and 21% a communication disorder. Seventeen percent (17%) of the youth had an anxiety disorder, and another 17% had a disruptive behavior disorder. Among the sample, 8% had a thought disorder/psychosis. Eight percent (8%) had an intellectual disability, and 4% substance abuse dependence.

The youth in the "Other Disability" category had borderline intellectual functioning. There were no youth with an autism spectrum disorder in the sample.

Medical problems were experienced by a quarter (25%) of the youth. These included youth with asthma, seizure disorder, cleft palate, and hyperhidrosis.

Child Status and Performance Profile - Psy Meds Frequency

Number of cases: 24   MA Northeast Review Oct 2011

Number of Psy Meds	Number	Percent
No psy meds	8	33%
1 psy med	4	17%
2 psy meds	5	21%
3 psy meds	4	17%
4 psy meds	3	13%
	24	100%

Table 14

Medications (Table 14). Sixty-seven percent (67%) of the youth reviewed in Northeastern Massachusetts were prescribed one or more psychotropic medications. As displayed in Table 14, four of youth in the sample (17%) were prescribed one medication, five (21%) were on two medications, and four (17%) were on three medications. There were three youth (13%) on four medications. Of the youth that were prescribed medications, 75% were on two or more medications and 43% were on three or more medications.

Youths' levels of functioning (Table 15). The general level of functioning of each youth in the CSR is rated using the General Level of Functioning scale, a 10-point scale displayed in Appendix 1 of this report. Fifteen of the youth or 63% were rated to be functioning in the Level 1-5 range ("needs constant supervision" to "moderate degree of interference in

Child Status and Performance Profile - Level of Functioning Frequency

Number of cases: 24   MA Northeast Review Oct 2011

Level of Functioning	Number	Percent
In level 1-5	15	63%
In level 6-7	7	29%
In level 8-10	2	8%
	24	100%

Table 15

functioning in most social areas or severe impairment of functioning in one area"). Seven or 29% 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"). Two youth (8%) was rated in the Level 8-10 range ("no more than slight impairment in functioning at home, at school, with peers" to "superior functioning in all areas").

Child Status and Performance Profile - Crisis Services Used Frequency

Number of cases: 24   MA Northeast Review Oct 2011

Crisis Services Used Past 30 Days	Number	Percent
Mobile crisis	2	8%
911 Emergency call: EMS	0	0%
911 Emergency call: Police	0	0%
Emergency department	1	4%
Other	0	0%
None	22	92%

Table 16

Use of Crisis Services (Table 16). Two youth, or 8% percent of the sample accessed some type of crisis service over the 30 days prior to the review. One youth used more than one crisis service. Mobile crisis was used twice by youth (8%), and used the emergency department of a hospital was used once (4%).

Mental health assessments (Tables 17 and 18). Mental health assessments are among the information sets required for teams and practitioners to better understand the strengths,

Child Status and Performance Profile - Mental Health Assessment

Number of cases: 24   MA Northeast Review Oct 2011

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

Table 17

needs and conditions of youth and their families. Assessments help teams to formulate an overall picture of how the youth is doing emotionally, behaviorally and cognitively. As well, they aid in the team's understanding of the social/familial context of a youth's behaviors and well-being.

Child Status and Performance Profile - Received Mental Health Assessments

Number of cases: 24   MA Northeast Review Oct 2011

Received MH Assessments	Number	Percent
Parent	5	21%
Education	0	0%
Court	0	0%
Child Welfare	1	4%
DOC	0	0%
Not applicable	7	29%
Not Distributed	10	42%
Other	4	17%

Table 18

Seventy-one percent (71%) of the youth reviewed in Northeastern Massachusetts had a current mental health assessment in their files. Seven youth or 29% did not have a current mental health assessment available to help their teams better understand and plan for them.

The CSR tracked for those that had a current mental health assessment, whether or not it had been distributed to team members. Team members should have a common understanding of the youth and family. Sharing assessments in the wraparound model follows the family's choices, preferences and consent so these data need to be understood within this context.

For the 17 youth with mental health assessments, the assessment was distributed to other team members for 10 of them, or 42%. Among families in the sample, only 5 or 21% had received their child's mental health assessment. The assessment was received by a child welfare worker for one youth (4%). No schools received a copy of the mental health assessment.

Special Procedures

Child Status and Performance Profile - Special Procedures Frequency

Number of cases: 24   MA Northeast Review Oct 2011

Special Procedures Used Past 30 Days	Number	Percent
Voluntary time-out	11	46%
Loss of privileges via point & level system	3	13%
Disciplinary consequences for rule violation	4	17%
Room restriction	0	0%
Exclusionary time out	1	4%
Seclusion/Locked room	0	0%
Take-down procedure	0	0%
Physical restraint (hold, 4-point, cuffs)	1	4%
Emergency medications	0	0%
Medical restraints	0	0%
None:	10	42%
Other:	2	8%

Table 19

Special Procedures data presents information about interventions that were experienced by youth over the 30 days preceding the CSR (*Table 19*). Fifty-eight percent (58%) of the sample, or 14 youth experienced a special procedure during this time period. For the 42% of youth in the sample that did, 46% had experienced a voluntary time-out; 17% a disciplinary consequence for a rule violation, and 13% loss of privileges in a points and level system. Four percent (4%) each experienced an exclusionary time out, and a physical restraint that could have been a hold or a mechanical restraint. Of the youth in the "Other" category, one experienced a "one on one" intervention, and one was asked to leave the premises.

Caregiving challenges

Challenges experienced by the parents and caregivers of the youth reviewed are displayed in *Table 20*. The most frequently noted challenge of the parents or caregivers of youth in the sample was adverse effects of poverty experienced by 50%. This was followed by serious mental illness and extraordinary care burdens each experienced by 29% of the sample. Twenty-one percent (21%) had a serious illness or disabling condition. Thirteen percent (13%) of the caregivers had limited cognitive abilities, and 13% substance abuse impairment. Eight percent (8%) were experiencing domestic violence, 4% had unlawful behavior or were incarcerated, and

Child Status and Performance Profile - Caregiver Challenges Frequency

Number of cases: 24   MA Northeast Review Oct 2011

Challenges in the Child's Birth Family or Adoptive Family	Number	Percent
Limited cognitive abilities	3	13%
Serious mental illness	7	29%
Substance abuse impairment or serious addiction w/ frequent relapses	3	13%
Domestic violence	2	8%
Serious physical illness or disabling physical condition	5	21%
Unlawful behavior or is incarcerated	1	4%
Adverse effects of poverty	12	50%
Extraordinary care burdens	7	29%
Cultural/language barriers	1	4%
Undocumented	0	0%
Teen parent	0	0%
Recent life disruption/homelessness due to a natural disaster	0	0%
Other	5	21%

Table 20

4% were challenged with cultural or language barriers. Challenges in the "Other" category included parenting skills, lack of family supports, and housing issues.

Care Coordination

Data are routinely collected in each CSR to better understand factors that may be impacting the provision of care coordination services. Information is collected through the individual providing the care coordination function for each youth, which could have been the ICC or the IHT therapist. Among the data collected are information about the length of time the care coordinator was in the position (therapists may have been in the position before the start of IHT services), the current caseload size of the individual, and barriers they perceive to be impacting their work. In the Northeastern Massachusetts CSR, there were 23 individuals providing care coordination for the 24 youth reviewed. Fourteen individual ICCs and nine IHTs were interviewed.

The review tracked the length of time each of the Care Coordinators had been assigned to the youth being reviewed. As can be seen in *Table 21*, 4% of care coordinators had been assigned to the youth less than one month, 29% for one-three months, 21% for four to six months, 21% for seven to twelve months and 21% for thirteen months to two years, and 4% for 25-26 months.

Child Status and Performance Profile - Length of Time CM Assigned

Number of cases: 24   MA Northeast Review Oct 2011

Length of Time CM Assigned to Child/Youth	Number	Percent
<1 month	1	4%
1-3 months	7	29%
4-6 months	5	21%
7-12 months	5	21%
13-24 months	5	21%
25-36 months	1	4%
	24	100%

Table 21

Caseload size as reported by the care coordinator was measured along the scale in *Table 22*. Seventeen percent (17%) of coordinators had eight or fewer cases, 22% had nine to ten cases, 13% eleven-twelve. Twenty-two percent (22%) of care coordinators had thirteen to fourteen cases, 13% had fifteen-sixteen cases, 9% had seventeen-eighteen cases and 4% had over eighteen cases. Of note is that 48% of care coordinators or nearly half had more than 12 cases on their caseload.

Child Status and Performance Profile - CM Current Caseload Frequency

Number of cases: 23   MA Northeast Review Oct 2011

CM Current Caseload Size	Number	Percent
<8 cases	4	17%
9-10 cases	5	22%
11-12 cases	3	13%
13-14 cases	5	22%
15-16 cases	3	13%
17-18 cases	2	9%
>18 cases	1	4%
	23	100%

Table 22

Child Status and Performance Profile - Barriers Affecting Case or Services

Number of cases: 24   MA Northeast Review Oct 2011

Barriers Affecting Case Management or Services	Number	Percent
Caseload size	4	17%
Eligibility/access denied	2	8%
Inadequate parent support	4	17%
Inadequate team member participation	6	25%
Family disruptions	3	13%
Billing requirements/limits	10	42%
Case complexity	7	29%
Treatment compliance	4	17%
Team member follow-thru	4	17%
Acute care needs	4	17%
Driving time to services	4	17%
Culture/language barriers	4	17%
Refusal of treatment	3	13%
Family instability/moves	7	29%
Arrest/detention of child/youth	1	4%
Other	4	17%

Table 24

Table 24. Information about barriers impacting the provision of services was collected through interviews with the person providing care coordination for each youth. Challenges cited most often by care coordinators in Northeastern Massachusetts were billing requirements and limits cited by 42%, followed by case complexity and family instability, cited by 29% for each of these barriers. A quarter (25%) of the care coordinators cited inadequate team member participation as a barrier. The following barriers to service provision were each cited by 17% of care coordinators: caseload size, inadequate parental support, treatment compliance, team member follow-through, acute care needs, and driving time to services. Thirteen percent (13%) of care coordinators cited family disruptions and treatment refusal as barriers. Eight percent (8%) identified eligibility and access denial issues as barriers, and 4% the arrest or detention of youth.

Barriers in the "Other" category included lack of specificity of tasks for team members, provider instability/turnover, productivity and waitlists for services, and "no-shows" as barriers to effective service delivery.

Community Services Review Findings

Ratings

For each question deemed applicable to 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.

For each indicator, ratings are displayed in the charts as percentage of the sample who had favorable status/progress and acceptable system/practice performance.

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 protocol used by reviewers 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.

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

STATUS AND PROGRESS INDICATORS
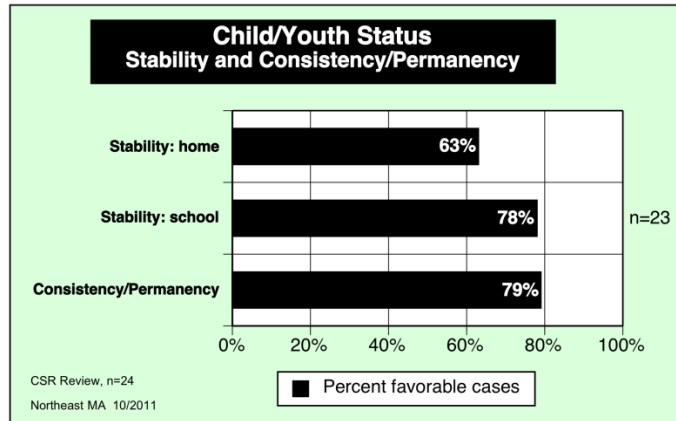
Youth Status Indicators
(Measures Youth Status over the last 30 days unless otherwise indicated)

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

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

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

Overall Youth Status

Child/Youth Status
Stability and Consistency/Permanency

Stability: home — 63%
Stability: school — 78% — n=23
Consistency/Permanency — 79%

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

CSR Review, n=24
Northeast MA 10/2011

■ Percent favorable cases

Community, School/Work and Living Stability

For the two sub-indicators of Stability, the degree of stability the youth is experiencing in their daily living and learning arrangements in terms of those settings being free from risk of unplanned disruption is determined. Noted are any emotional and behavioral conditions that may be putting the youth at risk of disruption in home or school. When reviewing for stability, disruptions over the past twelve months are tracked, and based on the current situation and pattern of overall status and practice, disruptions over the next six months are predicted

Home Stability. Among the 24 youth in the CSR sample for Northeastern Massachusetts, only 63% were found to have favorable stability at home. Sixty-two percent (42%) had good or optimal stability with established positive relationships and well-controlled to no risks that otherwise could jeopardize stability. Thirty-eight percent (38%) or nine of the youth were

rated to be in the "refinement" area, which means that conditions to support stability were fair. There were five youth (21%) who were rated to need improvement in their home stability.

School Stability. School stability applied to 23 youth. Seventy eight percent (78%) of the youth had a stable school situation. Twelve (52%) had good stability with only age appropriate or planned changes occurring in their school program. Seven youth (30%) had stability issues at school that needed "refinement," with fair to marginal stability issues that were minimally to inadequately addressed. Four youth (17%) were found to have poor stability in the school setting with uncertainty about what will happen next.

These results indicate that teams should consider ways to strengthen interventions to support stability for youth particularly to assure youth are stable in their homes and free from risk of disruptions.

Consistency/Permanency in Primary Caregivers & Community Living Arrangements
The Consistency/Permanency Indicator measures the degree to which the youth reviewed are living in a permanent situation, or if not that there is a clear strategy in place by teams to address permanency issues including identifying the conditions and supports that may be needed to assure the youth is able to have enduring relationships and consistency in their lives. Absent these conditions, there is often a direct impact on a youth's emotional well-being and behaviors.

Among the youth reviewed in Northeastern Massachusetts, 19 or 79% had a favorable level of consistency and permanency in their lives. Among these, 15 or 63% had "good" or "optimal" status, meaning these youth were in enduring permanent living situations with their family of other legally permanent caregivers. Seven youth, or 29% were at a level of consistency and permanency situation that needed refinement in order to assure enduring relationships and consistent caregiving/living supports, and were either in a minimal to fair status, or in a marginal status with somewhat inadequate or uncertain permanence.   Two youth, or 8% of the sample needed improvement on this indicator; both were experiencing poor status with substantial to serious and continuing problems of unresolved permanency.
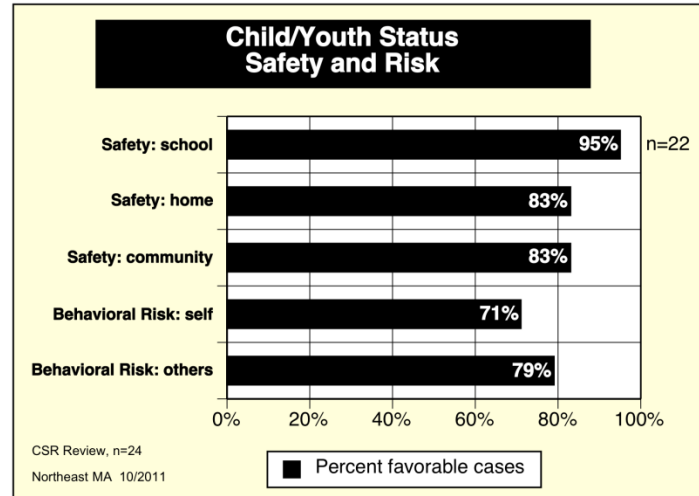
Safety of the Youth

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

School safety. Ninety-five percent of youth (95%) were found to have favorable safety status at school. For the 22 youth attending school, 16 or 73 % were safe in their school programs at a "good" or "optimal" level with no risk to generally risk-free school programs. Six youth (27%) needed refinement in terms of the school setting leaving the youth free from abuse or neglect, and were experiencing fair or marginal safety at school. There were no youth in the poor or adverse status levels on this indicator.

Home safety. Eighty-three percent (83%) of youth were safe at home. Thirteen youth (54%) were found to have "good" or "optimal" safety status at home. A third of the youth (33%) were found to need refinement with a fair to minimally adequate home situation free from abuse or neglect, or marginal safety with somewhat inadequate protection posing an elevated risk of harm. Three youth (13%) had poor safety status at home, with substantial and continuing risk of harm.

Community safety. Eighty-three percent (83%) of youth had favorable safety in the community. Twelve youth (50%) were experiencing "good" to "optimal" safety in their communities. Eleven or 46% needed refinement in their safety in the community and could benefit from their teams reviewing their safety status including any risks for intimidation or fear of harm. There was one youth (4%) with poor community safety status who was exposed to an elevated risk of harm.

Youth who have poor or adverse safety status in any of these categories should receive immediate attention from their teams and agencies.

Behavioral Risk to Self and Others

The CSR determines the degree to which each 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 disregulation resulting in harm, severe property destruction, medical non-compliance resulting in harm and unlawful behaviors.

Risk to self. Seventy-one percent (71%) of the sample had a favorable level of behavioral risk toward themselves. This finding indicates teams need to more thoroughly consider youths' behavioral risks in planning.

Among the youth reviewed, 8 or 33% had an "optimal" or "good" level of behavioral risk. Fourteen youth or 58% of those reviewed were found to need "refinement" in their level of behavioral risk, including both youth that are usually avoiding self-harm or self-endangerment, and those that have a risk staus that is inconsistent or concerning. Two youth (8%) needed "improvement" and had a poor level of behavioral risk to themselves with serious and continuing risk status.

Risk to others. The subindictor of behavioral risk toward others was favorable for 79% of the youth in the sample. Half or the youth (50%) or 12 youth had a "good" or "optimal" level of behavioral risk toward others. Eleven or 46% needed "refinement" and presented a fair to marginal level of risk toward others. One youth (4%) needed "improvement" in risk to others, with poor status and a potential for harm to other people present.
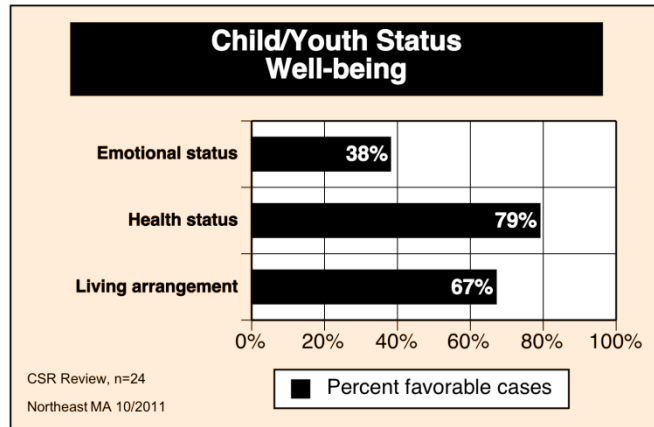
Emotional and Behavioral Well-being

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

well-being. Addressing emotional and behavioral issues of youth is a core charge of mental health systems.

Emotional and behavioral well-being was favorable for only 38% youth reviewed in the Northeastern Massachusetts CSR, indicating a need for teams to focus attention on developing interventions and strategies to address helping youth to achieve better emotional and behavioral status. These results indicate a high number of youth with inconsistent or poor emotional development, adjustment problems, emotional/adaptive distress, or serious behavioral problems present. Among the youth reviewed, there were two (8%) with a "good" level of emotional/behavioral status. Three quarters of the youth (75% or 18 youth) were found to need "refinement" and were functioning at a fair to marginal emotional/behavioral well-being status. These youth were demonstrating a minimally/ temporarily adequate or a limited/inconsistent level of emotional status, and were doing marginally well emotionally or behaviorally. Four youth (25%) were found to have poor emotional/behavioral status, and were demonstrating a consistently poor level of functioning.

Focused support for teams in developing individualized strategies for improving youth's levels of emotional and behavioral well-being is indicated.


Health Status
The health of the youth was reviewed to determine whether or not they were achieving and maintaining optimal health status including basic and routine healthcare maintenance. Youth's basic needs for nutrition, hygiene, immunizations, and screening for any possible development or physical problems should be met. Health is an important component of overall well-being. For the youth in the sample, 79% had favorable health/physical well-being status. Fourteen youth (58%) had "good" or "optimal" health status, 8 youth or 33% needed "refinement" in their health status, and 2 youth (8%) needed "improvement."

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

For the youth reviewed in the Northeastern Massachusetts CSR, 67% were found to have a favorable living arrangement. Nine youth (38%) were in living arrangements that were "good" or "optimal." Half of the youth (50%) needed "refinement" in their living arrangements. There were three youth (12%) that needed "improvement" and had poor living arrangements that were substantially inadequate, or adverse living arrangements that were inappropriate for meeting their needs.
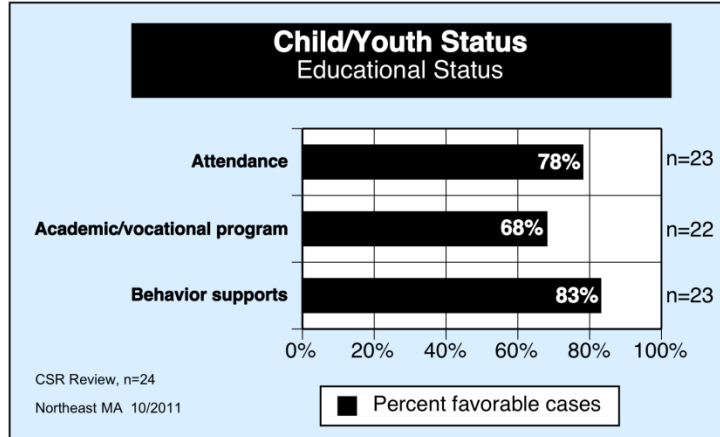
Educational Status

Three specific areas of educational status are examined to determine how well youth are doing in their educational programs across these domains. Sub-indicators may not be applicable to all youth in the sample, as youth may not be enrolled in school, or do not need specific behavioral supports during the school day in order to succeed in school.

Whether or not a youth receives special accommodations or special education services in school, the youth is expected to attend regularly, and 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. Ideally, the family with the support of the family partner, care coordinator or IHT (or others) meets and collaborates with school personal in support of educational progress and success.

Attendance. The Attendance indicator applied to 23 youth in the sample. Among the youth, 78% had a favorable pattern of attendance which was "good" to "optimal." One youth (4%) with unacceptable status needed refinement in attendance patterns. Four youth (17%) needed improvement in attendance, and had poor to adverse (chronically truant, suspended or expelled) rates of attendance

Academic or vocational program. Of the 22 youth this indicator applied to, only 68% were doing favorably well in their educational program. Twelve youth (55%) had "good" status in their academic or vocational program. Eight youth (36%) needed refinements and had minimally adequate, to marginally inadequate academic/vocational status. Two youth (9%) needed considerable improvement, and had adverse academic status.

Behavioral supports. Twenty-three of the youth in the sample required behavioral supports in their school setting. Behavioral supports were working favorably well for 83% of them. Fifteen (65%) had an "optimal" or "good" level of supports. Five of the youth (22%) could benefit from refinements in their level of supports, and had minimally adequate to marginally inadequate supports for their behaviors. Three youth or 13% had poor or adverse behavioral supports that needed improvement, and that were absent or inadequate in helping the youth do well in school.

Overall Youth Status

The overall results for Youth Status for the 24 youth reviewed in Northeastern Massachusetts are displayed below.

Overall, 75% or 18 youth were found to be doing favorably well. These youth fell in Levels 4-6; youth had Fair status (58% or 14 youth), or Good status (17% or 4 youth). No youth were found to have overall Optimal status.

The remaining 6 youth (25%) had unfavorable status. They had either Marginal (17% or 4 youth), or Poor status (8% or 2 youth). There were no youth with overall Adverse status.
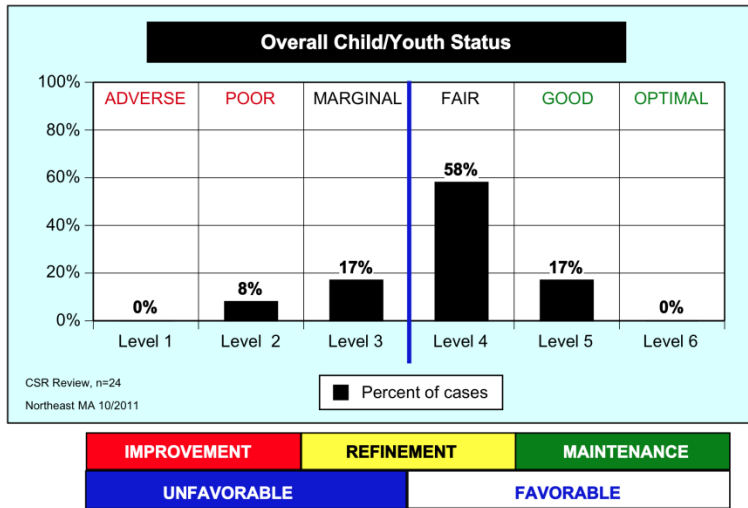
Overall Youth Status results are also categorized as needing Improvement, Refinement, or Maintenance. This allows for identification of youth that may need focused attention. Two youth (8%) were in the Improvement area, meaning status was problematic or risky, and action should likely be taken to improve the situation for the youth. Eighteen or 75% of the youth fell in the Refinement area which is interpreted to mean their status was minimal or marginal and potentially unstable, with further efforts likely necessary to improve their well-being. For the 4 youth (17%) whose status was in the Maintenance area, efforts should likely be sustained and leveraged to build upon a fairly positive situation.

A number of observations can be drawn about the status of youth reviewed in Northeastern Massachusetts. Over a third of youth were experiencing stability issues in their homes at the time of the review. School stability was fair for a large part of the sample. These stability data should also be seen in the context of the demographic data about the sample where 62% of the youth having experienced a home or school placement change in the year preceding the review, indicating considerable stability issues for the group. Overall, youth were living in fairly permanent situations. They were generally safe in their homes, schools and communities. Most of the youth had favorable physical health. Behavioral risk to self was a concern for a large part of the sample; they were generally not posing behavioral risk toward others. Youth were attending school fairly regularly and had good behavioral supports in schools; however academic status was a concern for many of the youth.

Additional supports to strengthen families' capacity to provide a favorable living situation were warranted for nearly a third of the youth reviewed.

The largest area of concern was youths' emotional/behavioral well-being. Only 38% of the youth were found to have favorable emotional-behavioral well-being. Because of the importance of this domain in youth achieving positive functioning, more attention by teams in understanding and building effective supports and treatments for improving youths' emotional well-being is warranted.

Caregiver/Family Status
(Measures the status of caregivers over the last 30 days)

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

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

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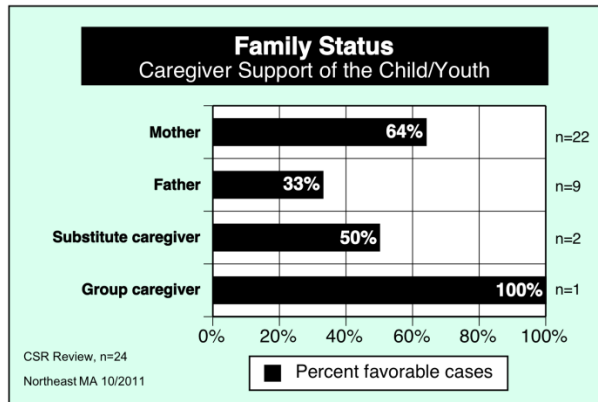
Parent/Caregiver Support of the Youth
The indicator for Parent/Caregiver Support measures the degree of support the person(s) that the youth resides with is able and willing to provide for the youth in terms of giving assistance, supervision and care necessary for daily living and development. Also considered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

For the youth reviewed in the Northeastern Massachusetts CSR, favorable support by mothers was found 64% of the time for which the indicator was applicable (22 youth). Maternal support needed "refinement" or "improvement" for 13 youth or 59% of the youth. The measure for support from fathers was applicable for 9 youth in the sample, and favorable support was found from 33% of the fathers. Support from fathers needed "refinement" or "improvement" for 89% of the youth the indicator was applicable for. Support was favorable for one of the two youth with a substitute caregiver (50%); for the other youth support was poor. One youth was in a group caregiving situation, and had good support.
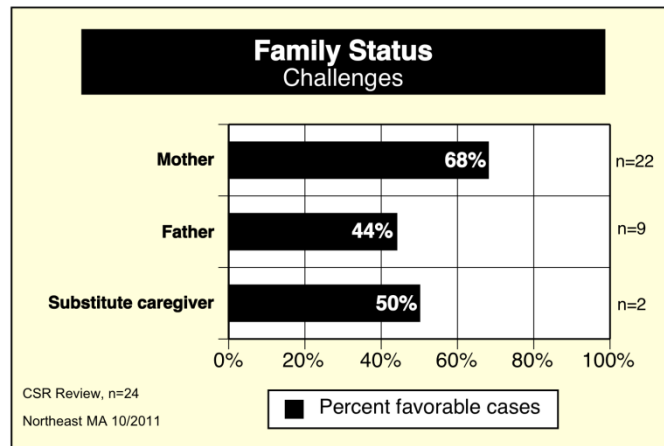

Parent/Caregiver Challenges
Parents' and caregivers' situations are reviewed to determine the degree of challenges they have that may limit or adversely impact their capacity to provide caregiving. Also considered is the degree to which challenges have been identified and reduced via recent interventions.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

There were 22 mothers of youth reviewed in the CSR for which this indicator could be rated. Of these, 68% had favorable status related to the level challenge they were experiencing. Seventeen or 71% of the mothers had a level of challenge that needed to be "refined" or "improved." Of these, 31% were found to have limiting circumstances to major life challenges impacting parenting capacities with inadequate or missing supports.

Forty-four percent (44%) of the 9 fathers of youth reviewed had a favorable level of challenge. Eight or 88% were experiencing levels of challenge that could benefit from "refinement" or "improvement" ranging from minor limitations with adequate supports to overwhelming life challenges with significant and worsening disruptions.

For the two substitute caregivers of youth reviewed, one had a favorable level of challenge (50%) and one did not. One had few challenges, and the other had major life challenges, with inadequate or missing supports.
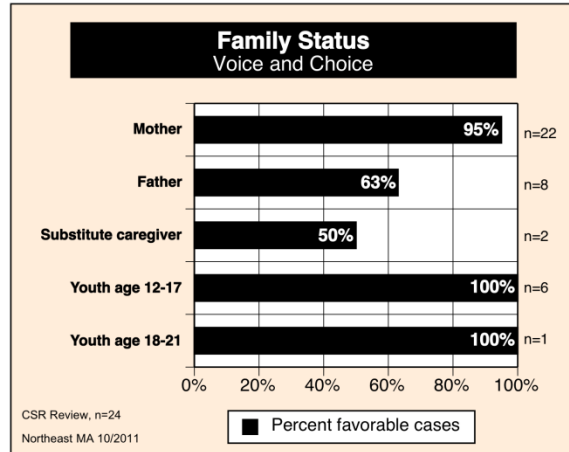
Family Voice and Choice

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

Ninety-five percent (95%) or 21 mothers for which the indicator could be rated (N=22) were experiencing favorable voice and choice in their child's assessments, planning and service delivery processes. Sixteen mothers (73%) had "good" to "optimal" voice and choice. Six mothers (28%) would benefit from refinement in strengthening their voice and choice.

For youth whose fathers were involved and information could be gathered (N=8), 63% or 5 fathers had favorable voice and choice in involvement with their child's service processes indicating a need for strengthening of their voice and choice in planning and service delivery processes. Four of the fathers, or 50%, could benefit from "refinement" in the influence of their voice and choice in planning and service delivery. One of the fathers (11%) fell in the range of needing improvement as his voice and choice was substantially inadequate.

Of the two substitute caregivers of youth in the sample, one (50%) had favorable voice and choice; the other had marginally inadequate voice and choice, with limited and inconsistent participation.

There were six youth in the 12-17 age range in the sample and 100% of them had favorable voice and choice in their services. Of these two youth, or 33% had "optimal" or "good" voice and choice, and four needed "refinement," with minimally adequate voice and choice.

There was one youth in the 18-21 age range reviewed who had "optimal" voice and choice in their services.
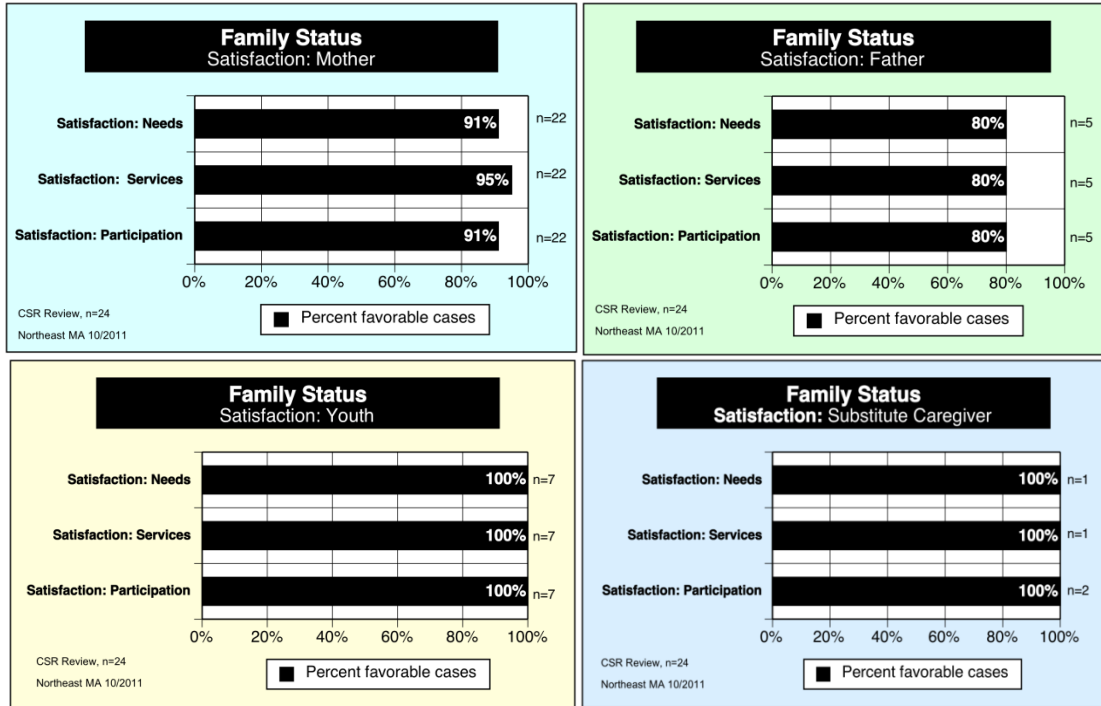
Satisfaction with Services and Results

Satisfaction is generally measured for the Mother, Father, Youth and Substitute Caregiver. The inquiry looks at the degree to which caregivers and youth express satisfaction 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. There were no substitute caregivers for youth in the sample.

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 ranged from 91% satisfied with their needs being understood and their participation, to 95% satisfied with services. For the five fathers that satisfaction was measured for, satisfaction was 80% for all domains measured. Youth satisfaction (N=7) was 100% in all domains measured, as was satisfaction of Substitute Caregivers.

Summary: Caregiver/Family Status

Both mothers and fathers in the Northeastern Massachusetts CSR were found to have considerable challenges in their lives, with fathers experiencing more challenges than mothers. Support for youth was negatively impacted far more for fathers than mothers. The substitute caregivers had variable levels of challenges and support. Family voice and choice was strong for mothers and youth, but fathers and substitute caregivers had less of a voice and choice in service processes. Satisfaction was strong among mothers, youth and substitute caregivers, and less strong for fathers.

Youth Progress
(M*easures the progress pattern of youth over the last 180 days*)

Determinations about a youth's progress serve as a context for understanding how much of an impact services and supports are having on a youth's forward movement in key areas of her/his life. Progress is measured at a level commensurate with the youth's age and abilities and is measured as positive changes over the past six months, or since the beginning of treatment if it has been less than six months.

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

Overall Youth Progress Patterns
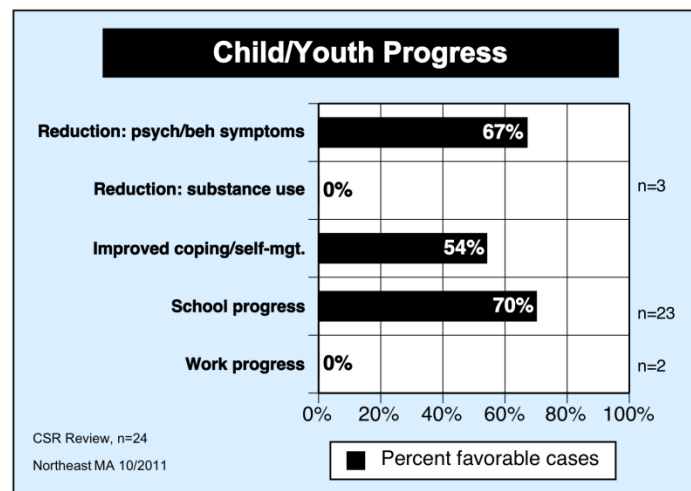
Reduction of Psychiatric Symptoms and/or Substance Use
This set of indicators measure the degrees to which target symptoms, problem behaviors and/or substance use patterns causing impairment have been reduced.

Reduction of Psychiatric Symptoms. Sixty-seven percent (67%) of the youth reviewed made favorable progress in reducing symptomatology and/or problem behaviors over the six month period previous to the CSR. Three youth, or 12% of the sample made "good" progress at a level somewhat above expectation. Twenty youth or 83% of the sample could benefit from "refinement" in their level and rate of progress in reducing symptoms, and were making marginal to fair progress. One youth (4%) was making no progress in reducing targeted symptoms and their disorder was at a moderate to severe level.

Reduction of substance use. There were three youth in the sample with substance abuse issues, and none (0%) were making favorable progress. Two (66%) were making marginal progress that was limited or inconsistent, and one (33%) was making no progress with their substance use at a moderate to severe level.

These results indicate focused support for teams is needed to help youth progress in reducing psychiatric, problem behaviors and substance use.

Improved Coping and Self-Management

The indicator measures the degree to which the youth has made progress in building appropriate coping skills that help her/him to manage symptoms/behaviors including preventing substance abuse relapse, gaining functional behaviors and improving self-management.

Among the youth reviewed, only 54% or 13 youth were making favorable progress in improving their coping skills and ability to self-manage their emotions and behaviors, indicating room for improvement in helping youth in this domain. Four youth (17%) made "good" progress in improving their ability to cope and manage their own behaviors. Eighteen youth (75%) could benefit from "refinement" and had made fair to marginally inadequate progress. Two youth (8%) needed "improvement" and were poor progress in advancing coping and self-management 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, vocational curriculum or work situation.

School progress. For the 23 youth for which the indicator applied, 16 or 70% were making favorable progress in their educational programs. Eight youth or 35% were making "good" progress in school reflecting consistent rates and levels of progress. Eleven youth (48%) were determined to need "refinement" and were making fair to marginally inadequate progress. Four youth (17%) were making no progress, including one that was regressing in their educational programs.

Work progress. There were no youth that were working in the sample.
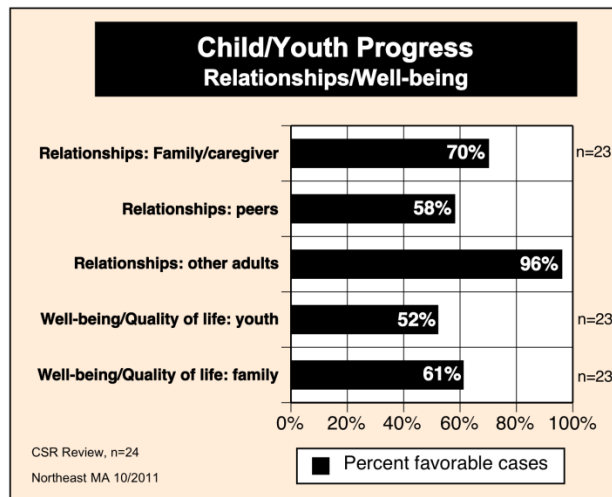
Progress Toward Meaningful Relationships

The focus of the sub-indicators for Meaningful Relationships 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 and the sub-indicator for Relationship with Families was applicable for (N=23), 16 or 70% of them were making progress in their relationships with their families or caregivers. Progress in building peer relationships was far less favorable, with 58% or 14 of the 24 youth the sub-indicator was applicable for making progress in building meaningful relationships with peers. Progress in developing relationships with positive adults (teachers, coaches, etc.) applied to all the youth reviewed and was favorable for 96%.

Overall Well-being and Quality of Life

Measured for the youth and the family, these sub-indicators determine to what degree progress is 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.

Youth overall well-being and quality of life. For the youth reviewed in the CSR, only 52% were making favorable progress in an improved overall well-being and quality of life. Three youth, or 13% had made "good" progress over the last six months in developing and using personal strengths, long-term relationships, life skills, and future plans. Eighteen youth or 78% were determined to need "refinement" indicating that teams and services need additional supports to help more youth make progress in improving their overall well-being. These youth were making fair to marginally inadequate progress in an improved quality of life. Two youth (17%) needed improvement, and were making poor progress in their overall quality of life and had developed few to no long-term supportive relationships, life skills for problem solving, educational/work opportunities, or meaningful and achievable future plans.

Family overall well-being and quality of life. For the families and caregivers (N=23) of the youth, only 61% were making favorable progress in improving the overall quality of life. Among these were four families (17%) who had made "good" progress, seventeen (74%) needing "refinement," and two (9%) who needed improvement and had made poor or no progress.

These results indicate that improving the overall well-being and quality of life for both youth and families should be a greater focus of teams.
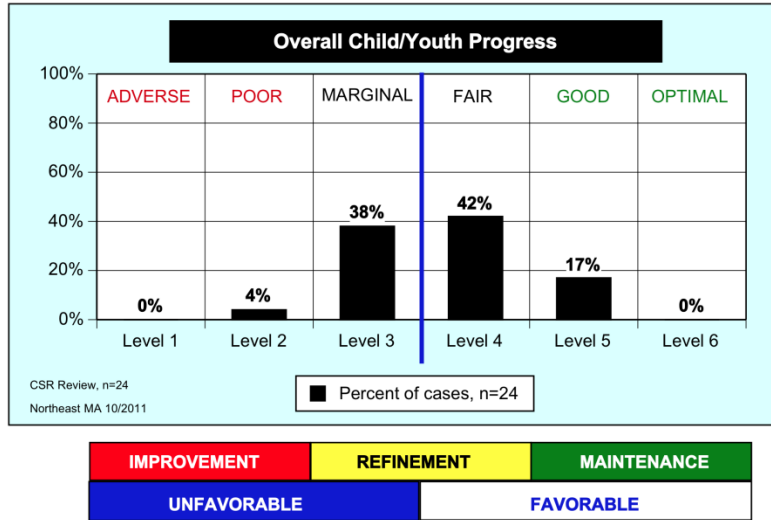
Overall Youth Progress

A goal of care planning is to coordinate strategies and identify all needed treatments or supports youth need to make progress in key areas of their lives. Overall, only 52% of the youth, or just over half of the youth reviewed, were making favorable progress (Fair, Good or Optimal Progress).

Among the youth, 4% were determined to need improvement due to poor progress across the indicators. No youth were making adverse progress, or were regressing. Eighty percent (80%) needed refinement in moving forward in the areas measured, and were making fair or marginal progress. For these youth, the right strategies at the right intensity may have been missing or underdeveloped. The remaining 17% were making good progress at a level that should be maintained and sustained. No youth were making optimal progress.

The data for Youth Progress indicates that with the exception of Improved Relationships with Other Adults, youth progress needs improvement, and was weak. Teams likely need more support in helping youth make greater rates of progress across domains.

System/Practice Functions

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

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

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

Overall System/Practice Performance

Reviewing System and Practice Performance in the CSR

The Commonwealth of Massachusetts is charged with creating the conditions that should lead to improvements for youth and families. The CSR examines the diligence of services and service practices in providing those conditions. In other words, the review of youth status and progress provides the context for understanding their services; in the CSR, system/practice indicators are rated independently of how youth are doing and progressing. The system/practice functions are rated as how they are being performed.

Practice is defined as actions taken by practitioners that help an individual and/or family move through a change process that improves functioning, well-being, and supports. Practice is best supported by using a practice model that works (example: engage, fully assess and understand youth and family, teamwork/shared decisions, choose effective change strategies, coordinate services, track/measure, learn and adjust) and having adequate local conditions that support practitioners (examples: worker craft knowledge, continuity of relationships, clear worker expectations practice supports/supervision, timely access to services/supports, dependable system of care practices and provider network). Having services is necessary but not necessarily sufficient; having services and practices that function consistently well is a key to having a dependable system that can reliably create the conditions where youth will make progress.

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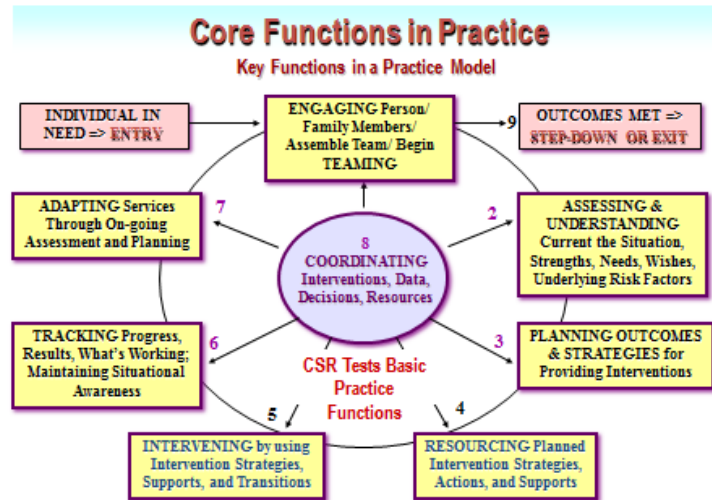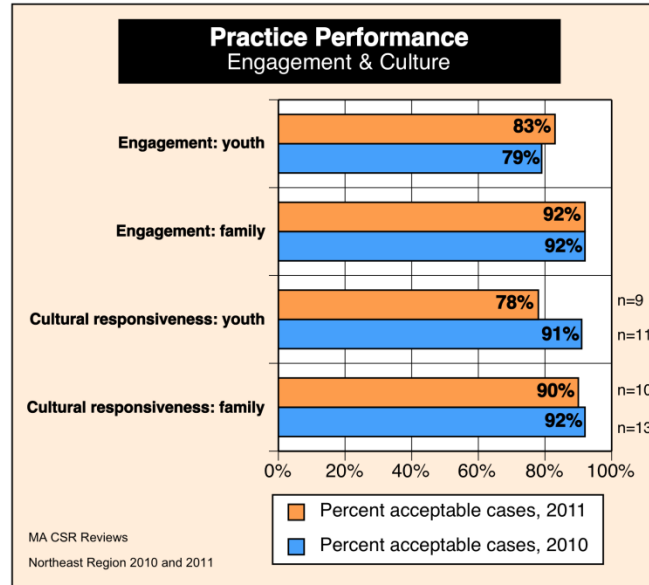
Engagement

Reviewing system practices for *Engagement* helps to determine how consistent care coordinators and care planning teams are in taking actions to engage and build meaningful rapport with youth and families, 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 supported in understanding the role of all services providers, as well as the teaming and wrap around process. 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.

Youth engagement. For the youth reviewed, 20 or 83% experienced an acceptable level of engagement. This was in the range of performance but slightly better than last year's CSR result for Youth Engagement (79% acceptable). In this year's CSR, sixteen or 66% of youth were engaged at the "good" or "optimal" level. The remaining eight youth or 33% would benefit from "refinement" of engagement efforts.

Family engagement. Families were engaged at an acceptable level 92% of the time, which were the same strong results as in last year's CSR. This year, sixteen families or 66% were engaged at a "good" or "optimal" level. Seven families or 29% of those reviewed may have benefitted from a "refined" level of engagement. There were poor engagement efforts for one family (4%), and "improvement" was needed.

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.

Cultural responsiveness to youth. For the nine youth reviewed for which the indicator applied, Cultural Responsiveness was acceptable for seven or 78%. This was a decline from last year's results of 91% acceptable. Cultural Responsiveness in this year's was found to be "optimal or "good" for seven youth. One youth (11%) would benefit from "refinement" and experienced cultural responsiveness that was marginal, and one (11%) needed "improvement" in cultural responsiveness, with poor practices.

Cultural responsiveness to families. For the ten families the indicator was applicable for, cultural responsiveness was acceptable for 90%. This was in the range of last year's CSR results when 92% of families experienced acceptable cultural responsiveness. "Refinement" this year was determined to be needed for three families or 30%, including one family that experienced marginal cultural responsiveness.

While there were no specific examples cited of favorable cultural responsiveness in the reviewers' narratives, the results generally showed a theme of strong engagement practices and understanding of families coupled with favorable cultural responsiveness.

An example where weak cultural responsiveness links to lack of teaming and understanding is: "Although information is shared by the IHT, no care planning team meetings are being held, and the information the various professionals have about this family is not being integrated into a coherent plan of care. The lack of understanding by the team of some of the cultural issues is also a barrier to their success."

Practice Performance
Teamwork & Assessment

- Teamwork: structure — 79% (2011), 75% (2010)
- Teamwork: functioning — 75% (2011), 67% (2010)
- Assessment & understanding: youth — 75% (2011), 71% (2010)
- Assessment & understanding: family — 78% (2011), 71% (2010)

MA CSR Reviews
Northeast Region 2010 and 2011

☐ Percent acceptable cases, 2011
☐ Percent acceptable cases, 2010
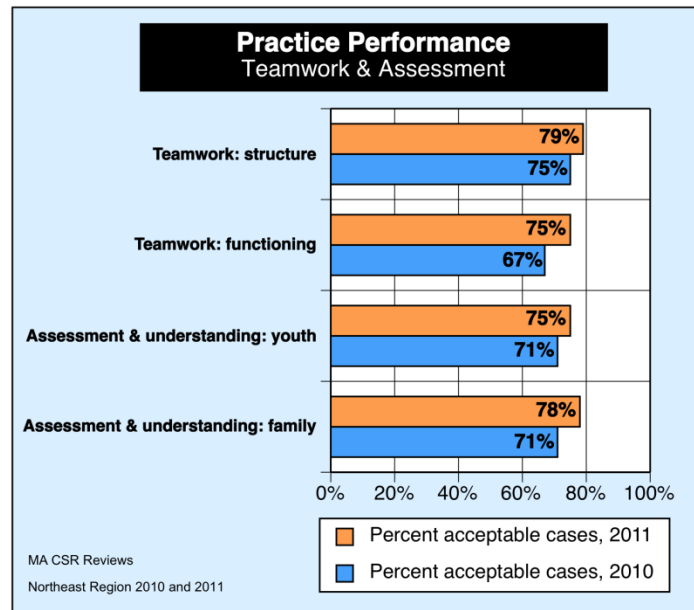
Teamwork: Team Formation and Team Functioning
Teamwork focuses on the structure and performance of the youth and family's care planning team. Team Formation considers the degree to which the care planning team is meeting, communicating, and planning together, and has the skills, family knowledge and abilities to organize and engage the family and the youth whenever appropriate. The "right people" should be part of the team including the youth, family, care coordinator, those providing behavioral health interventions, and others identified by the family. Individuals involved with

the youth and family from schools and other child-serving systems, as well as those that make up the family's natural support system should be engaged whenever possible.

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

Team Formation. For the 24 youth reviewed in Northeastern Massachusetts, team formation was acceptable 79% of the time or for 19 youth. This was an improvement over last year's performance of 75% of youth with acceptable team formation.

In this year's CSR, seventeen youth or 33% of the sample experienced "good" or "optimal" team formation. Four of the youths' teams (17%) needed "refinement" in their ability to form. In these cases, team formation was minimally adequate to fair, or marginally inadequate. Two youth (8%) experienced poor team formation, and had teams that seldom met, talked or planned together. One youth (4%) had absent or adverse team formation.

Team Functioning. Teams were functioning acceptably well for 75% of the youth reviewed. This was an improvement over last year's performance when 67% of teams functioned well for the youth reviewed.

For eleven youth in this year's CSR sample (46%), teams functioned at a "good" or "optimal" level. For ten youth (42%) teams needed "refinement" and were functioning in a somewhat unified and consistent manner, or were splintered and engaged in a pattern of actions that were usually incoherent with limited problem-solving. Two teams (8%) were functioning poorly, independently of the family and in isolation of other team members resulting in limited benefits for the youth and family. There was no evidence of a functional team for one youth (4%).

An example of good team formation and functioning for a youth is, "There is a skilled team of providers who have responded to the youth and family with the appropriate urgency and intensity. The case manager and in-home therapist work together to provide therapeutic interventions, manage the team, and link the family with supports. There has been good partnering with school personnel, who have also been responsive in providing supports in the classroom. Team members communicate frequently and are consistent in the implementation of interventions. Team members are using art and creativity based hands-on interventions with (the youth)."

An example where there is a lack of team process resulting in poor implementation across system practices is: "While the system has engaged with this family, the care coordination and team formation and functioning have been unacceptable. Although information is shared by the IHT, no care planning team meetings are being held, and the information the various professionals have about this family is not being integrated into a coherent plan of care. The lack of understanding by the team of some of the cultural issues is also a barrier to

their success… The lack of a comprehensive assessment of this youth and his family impairs planning and service delivery. The lack of coordination among providers also limits understanding and progress that could be made if all providers were working with the same understanding of this family. Since the team is not meeting and setting common goals, the goals and outcomes for each provider are not coordinated into a comprehensive plan. The team does not have a comprehensive safety plan for the youth and family."

The ability of Care Planning Teams to come together to work and function well for youth and families is a foundational system requirement. Teams in Northeastern Massachusetts would benefit from additional supports and improvement to assure their practices are consistently effective and producing results for youth.

Assessment and Understanding

The Assessment and Understanding 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 a necessary foundational practice to build cohesive care plans toward achieving positive outcomes.

Assessment & Understanding of Youth. Of the 24 youth reviewed, 75% of teams were found to have an acceptable level of assessment and understanding of the youth's core issues and situations. This was in the range of last year's CSR results of 71% of youth having acceptable assessments and team understanding of their situations, underlying issues and needs.

This year, 13 youth (54%) had teams that had "good" or "optimal" assessment and understanding. Nine youth (38%) would benefit from "refinement" of practices, and assessment and understanding was either fair or marginally inadequate. Eight percent (8%) or two youth had teams that had poor, incomplete or inconsistent assessment and understanding.

Assessment & Understanding of Families. Assessment and understanding of families was acceptable for 78% of the sample. This was an improvement over last year's results of 71% of teams having acceptable assessment and understanding of families' strengths and needs.

This year, thirteen teams (54%) had "good" or "optimal" understanding of the families reviewed. "Refinement" was found to be needed for eleven families (46%) where there was fair/minimal understanding, or marginally inadequate assessment and understanding. For these families, teams needed to better understand the strengths, context, needs and vision of the family. For one family (4%) the team's understanding was poor, incomplete and inconsistent among team members.

Good assessment and understanding of a youth was described by a reviewer where, "Team members have good clinical and practical knowledge of the youth and family. Underlying causes for behaviors have been attributed to youth immaturity; concerns about the mother's health and finances; missing the father; needing assistance with deconstructing situations;

mom needing parenting support and education; and the mother having high expectation and lecturing or talking too much to youth (parent-child interaction). "

An example of assessment and understanding where the team was an incomplete understanding of the underlying reasons for a youth's behaviors and have yet to identify effective strategies to help this youth with a long-standing issue that interferes in his functioning and ability to be accepted socially is: "Mother is well-meaning and willing to reach out for help, but needs concrete direction in order to do so. She was identified by at least one provider as 'the problem' and there appears to be little understanding on the part of the team of what she needs in order to successfully parent (the youth)…The team had a poor understanding of the (diagnosis) and how to develop a coordinated strategy for addressing this significant problem."
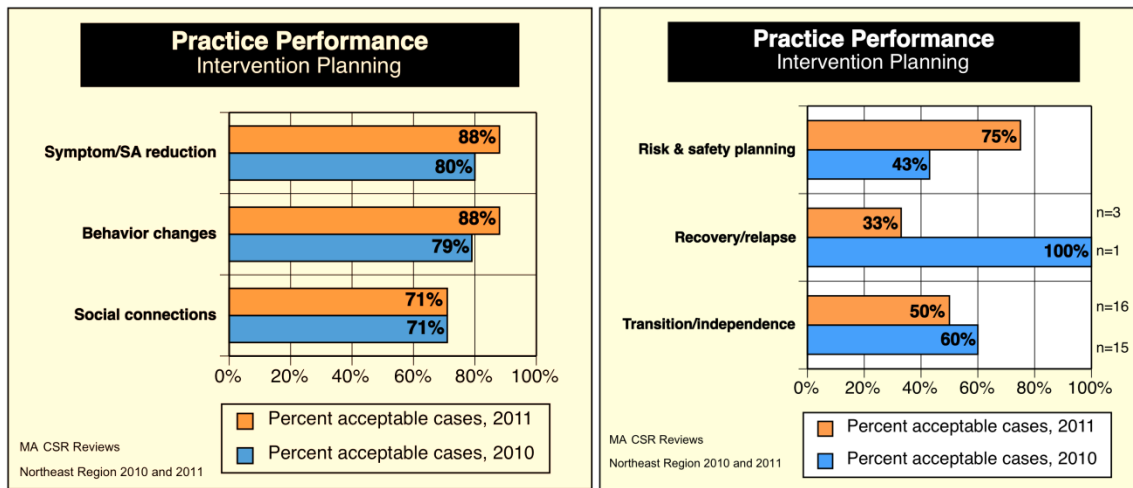
Planning Interventions

Intervention Planning was evaluated for each youth across the six sub-indicators seen above. 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 review plans and planning processes to evaluate the degree to which they are cognizant of safety and potential crises, are well-reasoned, well-informed by all available sources of information and are likely to result in positive benefits to the child and family. Plans need to be specific, detailed, accountable and derived from a family-driven team-based planning process. Plans also need to evolve as the youth and family's situation changes or more or different information is learned.

Symptom or Substance Abuse Reduction. Planning for reducing presenting psychiatric symptoms or substance abuse was acceptable for 88% or 21, a strong finding. This was an improvement over last year's results of 80% of youth with acceptable planning for symptom reduction.

There was "optimal" or "good" planning in reducing symptoms or substance abuse for sixteen or 66% of the youth reviewed. Planning for these youth was generally well-reasoned, informed by the youths' and families' perspectives, and addressed core issues. "Refinement" in planning to reduce symptoms or substance abuse was needed for eight or 33%. In these cases planning was fair to marginally inadequate.

Behavior Changes. Targeting *Behavior Changes* in planning was also at an acceptable level for 88% of the youth. This was a considerable improvement over last year's performance of 79%. These results indicate that more youth were benefitting from acceptable planning strategies to address behavior changes, and is strong performance for this planning sub-indicator.

In this year's CSR, seventeen youth or 71%, had plans that addressed needed behavior changes that were in the "optimal" or "good" range. "Refinement" of behavioral supports and interventions in plans was needed for seven or 29% of the youth. The planning for these youth was fair and somewhat reasoned, to marginally inadequate and inconsistently aligned across interveners.

Social Connections. Planning for increasing *Social Connections* was acceptable for only 71% of the sample, the same finding as in last year's CSR. This result indicates improvement is needed to assure teams more consistently plan to strengthen youths' social connections, and may be related to the Youth Progress result for peer relationships where only 58% of youth had made recent progress.

Nine youth (38%) had "optimal" or "good" strategies in their plans for improving their social connections that reflected generally well-reasoned supports. "Refinement" in planning to strengthen social connections for youth was needed for fourteen youth or 58%. One youth (4%) had poor planning reflecting unaligned strategies lacking in clarity and urgency to address the youths' need for social connections.

Risk/Safety Planning. Planning to address youths' risk and safety issues was acceptable for 18 or 75% of the youth, indicating some room for improvement. However, this was marked improvement over last year's result of only 43% of plans with acceptable risk and safety planning. The risk/safety component of plans was "optimal" or "good" for seventeen youth or 71% of the sample. For five youth (21%), risk and safety planning needed refinement and was fair or marginally inadequate. One youth (4%) had poor risk/safety planning, and one (4%) did not have a plan to mitigate risk and assure safety.

Recovery/Relapse Planning. Three youth in the sample needed *Recovery or Relapse* addressed in planning, and planning was acceptable for only one of the youth (33%). Last year's CSR identified one youth who needed planning in this domain, and planning was acceptable for this youth. Two of the youth (66%) needed refinements to address fair to marginally inadequate strategies, and one youth who needed interventions to support his or her recovery and relapse had poor strategies addressed in their care plan which needed to be "improved."

Transition Planning. 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.

Among youth in this year's CSR sample sixteen needed to have *Transitions* addressed in their planning processes, and performance was acceptable for only eight or 50%, indicating

improvement is needed in transition planning for youth. This was a decline over last year's performance of 60% of youth having acceptable transition planning.

Transition planning was "good" for 4 of the youth or 25%, with plans that were generally well-reasoned, largely informed by the youths' and families' perspectives, and accountable. Twelve of the youth (43%) would benefit from refined transition planning, and had plans that were somewhat reasoned and aligned across providers or were marginally inadequate and inconsistently aligned, with little sense of clarity or urgency.

Practice Performance
Outcomes & Implementation

Outcomes & goals	83% (2011)	67% (2010)
Matching interventions	83% (2011)	71% (2010)
Coordinating care	75% (2011)	75% (2010)
Service implementation	83% (2011)	75% (2010)

MA CSR Reviews
Northeast Region 2010 and 2011

Percent acceptable cases, 2011
Percent acceptable cases, 2010
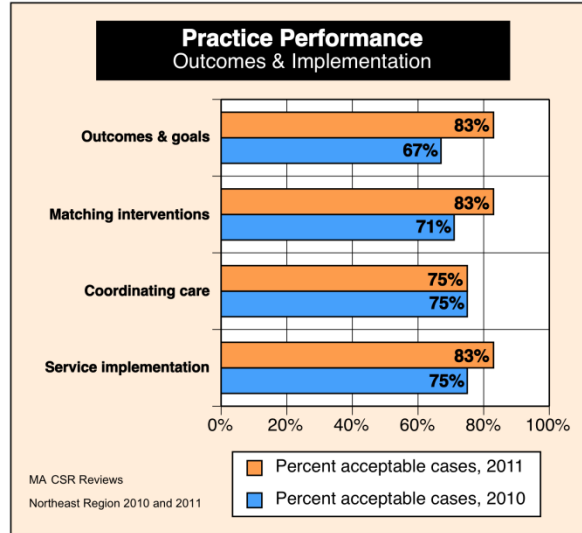
Outcomes and Goals

The focus of Outcomes and Goals is to measure the degree of specificity, clarity and use of the outcomes and goals that the youth must attain, and when applicable the family must attain, in order to succeed at home, school and the community. Outcomes and goals need to be identified and understood by the care planning team so all members can support their achievement. They ideally 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, and that describes what needs to happen was acceptable for 83% of the youth. This was considerable improvement over last year's CSR results of 67% acceptable specification of outcomes and goals by teams.

Ten youth or 42% had good specification of goals by their teams that were well-reasoned and specific. Twelve or half (50%) of the youth reviewed had ending goals and outcomes that needed to be "refined," and were fair to marginally inadequate. Two youth (8%) had poor specification of outcomes and goals which were insufficient for guiding intervention and change.

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 needs of the youth and family/goals of the care plan and interventions and if the level of intensity, duration and scope of services are at a level necessary to meet expressed goals. Also examined is the unity of effort of interveners, and whether or not there are any contradictory strategies in place. CSR Reviewers commonly refer to this as looking at the "mix, match and fit" of interventions for the youth and family.

There was an acceptable level of matching intervention to need for 83% of the youth in the sample. This was an improvement over last year's performance of 71% acceptable, and indicates that more youth are receiving interventions that meet their needs.

Fifteen youth (62%) had "good" or "optimal" matching of interventions to needs. Nine youth or 38% needed their teams to "refine" identification and assembly of services and supports that matched the youth and families' situations and needs. For these youth there was fair matching and integration that could meet short-term objectives, or marginal matching that was insufficient.

Coordinating Care

Care coordination processes and results for each youth are evaluated to determine the extent to which practices align with the practice model of providing a single point of coordination with the leadership necessary to convene and facilitate effective care planning. Reviewers examine 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 how well the care coordinator executes core functions including: assuring the team participates in analyzing and synthesizing assessment information, planning interventions, assembling supports and services, monitoring implementation and results, and adapting and making adjustments 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. A key role of the care coordinator is to facilitate ongoing communications among the entire team

Youth in the sample received care coordination services from both ICC (N=15) and IHT therapists (N=9). Care coordination practices were found to be at an acceptable level for 75% of the youth reviewed, the same result as in last year's CSR. Care coordination practices continue to need improvement.

Care coordination in this year's review was found to be "good" or "optimal" for fourteen youth or 58% of the sample. For eight youth or 33%, care coordination would benefit from "refinement," and practices were deemed to be fair and minimally adequate, or marginal and limited with little leadership for service delivery and results. Two youth (8%) were found to have poor and fragmented care coordination.

Care coordination practices that are working well are described in this example as: "Services are family-centered and the mother has a clear voice in the determination and course of services. There is also a well-formed, competent, cohesive team working with this family, despite turnover in the ICC and therapeutic mentor in the past 4 months. Communication and coordination is generated by an ICC, who is the clear point person for this team… The team communicates frequently and meets face-to-face regularly. Communication includes problem solving, support for the mother, adjustment to interventions for (the youth) -at home, in the community, and at school- and updates on the transition to the new school."

An example of care coordination that needed improvement where the youth is continuing to have serious problems with risk factors and overall quality of life is: "The lack of communication and follow through actions in getting (the youth) completely enrolled and started in school is an issue for this team. The role of care coordination is not clear, and is lacking presence and a sense of urgency. There has been a gap in providing all of the supports all the way and teaming processes have not been responsive enough to (the youth's) drift away from services. "

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. Also examined is the degree to which any urgent needs are met in ways that they protect the youth from harm or regression.

For the youth reviewed, 83% were determined to have acceptable service implementation. This is an improvement over last year's performance result of 75% acceptable, and indicates more youth are having the services and supports in their plans consistently implemented.

Twelve youth or 50% were found to have "good" or "optimal" service implementation where services had a substantial pattern of being implemented in a timely, competent and consistent manner. For the other half of the youth (50%) service implementation needed "refinement" and the overall pattern of implementing needed services and supports was fair to marginal and inconsistent.
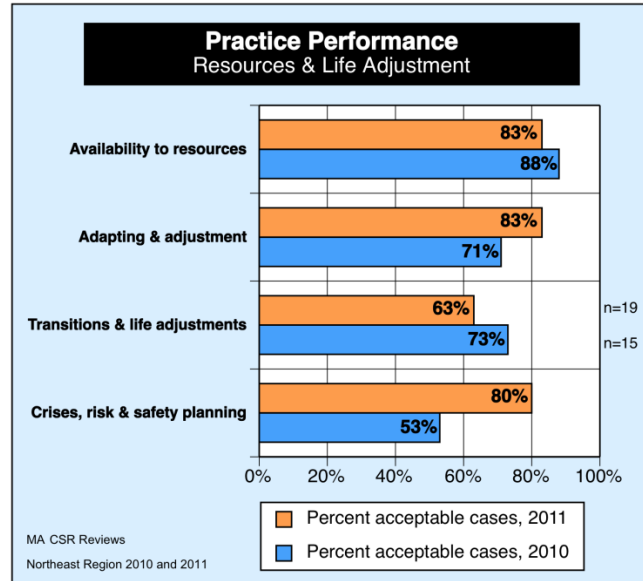
Availability and Access to Resources

The indicator for *Availability and Access to Resources* measures the degree to which behavioral health and natural/informal supports and services necessary to implement the youth's care plan are available and easily accessed. 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.

Eighty-three percent (83%) of the youth reviewed were found to have acceptable access and availability of resources, a slight decline since last year's performance of 88%. Fifteen youth or 62% had "good" or "optimal" access to needed resources. Nine youth or 38% of those reviewed had fair to marginally inadequate resource availability that indicated a need for refinement.

Adapting and Adjustment

The *Adapting and Adjusting* indicator examines the degree to which those charged with providing coordination, treatment and support are checking and monitoring service and support implementation, progress, changing family circumstances and results for the youth and family. Strategies, services and supports should be modified when objectives are met, strategies are not working and/or new needs arise.

For youth reviewed, practices related to adapting and adjusting plans and services was acceptable 83% of the youth… This was an improvement over last year's results when 71% of youth were experiencing acceptable practices in adapting and adjusting.

Thirteen youth or 54% had "good" or "optimal" practices that were responsive to changing conditions with acceptable levels of monitoring and adjustment. The remaining eleven youth (46%) were experiencing needed changes to their plans and services at a minimally adequate to marginally inadequate level, with only periodic to occasional monitoring.

Transitions and Life Adjustments

For youth who had a recent transition, or a transition is anticipated, reviewers examined the degree to which the life or situation change was planned for, staged and implemented to support a timely, smooth and successful adjustment. If the youth is over age 14, a long-term view by the team as well step-wise planning to assure success as the youth transitions into young adulthood is 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 nineteen youth this indicator applied to, only 63% or twelve youth had acceptable transition management practices. This was decline compared to last year when 73% of youth received acceptable transition management. Transition management continues to be a weak system practice that needs improvement.

In this year's CSR, 8 youth (42%) experienced "good" or "optimal" transition interventions. Eleven youth (58%) could benefit from "refined" transition supports, and had minimally adequate to marginally inadequate transitional interventions.

Overall, results indicate practices to improve the ability of teams to identify, plan for and implement transition supports for youth are needed.

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. Access to reliable mobile crisis services is needed for many youth with SED, and is a requirement of the *Rosie D.* Remedy.

For youth where this indicator was applicable (N=20), 80% had an acceptable crisis response and risk plan that worked acceptably well for them. This represented a significant improvement over last year's findings when only 53% of youth had acceptable findings on this indicator.

Thirteen youth (65%) were rated to have experienced an "optimal" or "good" response to crises and/or safety issues. Five youth (33%) would benefit from "refinement" in the response to their crises and risk/safety issues and experienced fair to marginally inadequate crisis responses. Two youth (10%) experienced poor responses to their crises.
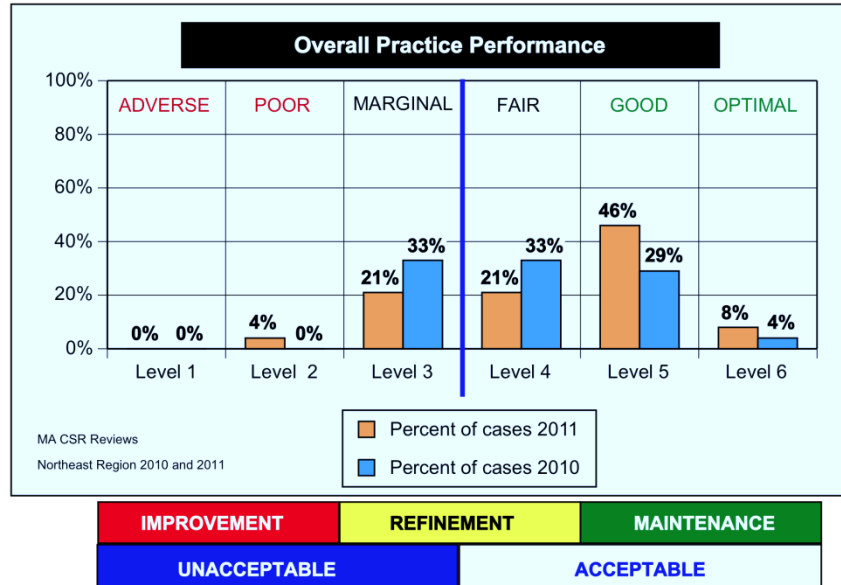
Overall System/Practice Performance

The chart above displays the distribution of scores for System/Practice Performance across the six point rating scale.

For the youth reviewed, 75% were found to have acceptable system/practice performance. This means for 75% of the youth services were acceptable, but for a quarter of youth the system was not providing dependable, quality services. It represents an improvement in performance as compared to last year's CSR when only 67% of the sample has acceptable findings.

The largest percentage of youth (54%) fell in the "Maintenance" area, which is also an improvement over last year's CSR when 33% of the youth fell in this area. Results in the "Maintenance" area mean that system and practices were effective for the youth reviewed, and efforts should focus on sustaining and building upon positive practice.

Forty-two percent (42%) of the youth fell in the "Refinement" area, which means that performance was limited or marginal, and further efforts are necessary to refine practices.

Four percent (4%) of youth fell in the "Improvement" area meaning performance was inadequate. In these cases, practices were fragmented, inconsistent and lacking in intensity or were non-existent. Immediate action is recommended to improve practices for youth falling in this category.

The highest percentage of youth reviewed had practice patterns that were at the "Good" level (46%), meaning system practice was working for the youth, and the effectiveness level was consistent with meeting their long-term goals.

The data indicate that the strongest areas of practice for youth in Northeastern Massachusetts were Engagement with the Family; Cultural Responsiveness to the Family; Planning Interventions for Symptom or Substance Reduction; and Planning Interventions for Behavior Changes. Findings in engagement and cultural competency with families were roughly the same as last year; however there were improvements in both of the intervention planning indicators.

Indicators that showed an overall fair performance but at a less consistent or robust level of implementation were Engagement with the Youth; Cultural Responsiveness to the Youth; Teamwork (Formation); Assessment & Understanding of the Family; Outcomes and Goals; Matching Interventions to Needs; Service Implementation; Availability and Access to Resources; Adapting & Adjustment; and Responding to Crises. There were improvements over last year's CSR in each of these indicators with the exception of engagement and cultural responsiveness to youth, and resource access/availability, each of which declined slightly.

Areas of system/practice performance that need improvement in order to assure consistency, diligence and/or quality of efforts are: Teamwork (Functioning); Assessment & Understanding of Youth; Planning Interventions for Social Connections; Planning Interventions for Risk and Safety; Coordinating Care; and Overall Practice Performance. Improvements over last year's CSR were seen in assessment of youth, risk/safety planning and overall performance. Performance for planning for social connections and care coordination was the same as last year, and these areas continue to need considerable improvement.

Review results indicate weak performance in the following system/practice domains: Planning Interventions for Recovery and Relapse; Planning Interventions for Transitions; and Transitions & Life Adjustments. Each of these indicators of system practice declined in performance since last year.

The findings of the November CSR show that for Northeastern Massachusetts services, system of care practices such as engagement of families and cultural responsiveness to families continue to be strong. As well, there was enough of an improvement in two planning indicators (Planning for Symptom Reduction and Behavior Changes) where many youth experienced good planning in these areas.

A number of system practices that had fair performance were showing improvements over last year's CSR. This trend is promising. Important foundational practices such as assessment/understanding of families, establishing clear outcomes and goals, matching interventions to needs, service implementation, resource availability, adapting/adjusting services, and crisis response all saw an improvement in performance. Continued support to assure sustainable performance in these areas is recommended.

The remaining system practices need more development, and cannot yet be considered reliable in helping youth make progress, achieve desired outcomes or maintain recent gains.

At this point in time, the system is not performing well at a consistent enough level because many foundational system of care practices were found to need improvement or are weak, and not enough youth are receiving overall acceptable practices. However, given the trend toward more practice functions improving, it appears that the system is moving in the right direction and has strengthened its ability to adequately serve children and families.

There are key areas that need concerted attention. In this year's Northeastern CSR, a quarter (25%) of teams were functioning in a limited manner, were splintered or inconsistent in their planning and evaluating results, and were not engaged in collaborative problem-solving at a level necessary to impact positive change for youth and families. As well, a quarter (25%) of teams were not adequately using clinical and related information to increase their understanding of the youth's issues at a scope and depth needed to design the right set of

interventions and supports. Planning for symptom reduction and behavior changes was very strong however planning interventions across the rest of the domains lacked the specificity and accountability to help enough youth in Northeastern Massachusetts make progress in achieving their goals as reflected in how many youth were not making favorable overall progress (42%). Care coordination, a pivotal system function to guide many of the other practices youth need to realize results and improved status was not acceptable for a quarter (25%) of the youth. While many of the other system functions measured in the CSR were found to be performing at a fair level, and are demonstrating an improving trend, they will need continued focused attention to help them achieve a higher level of quality and effectiveness.
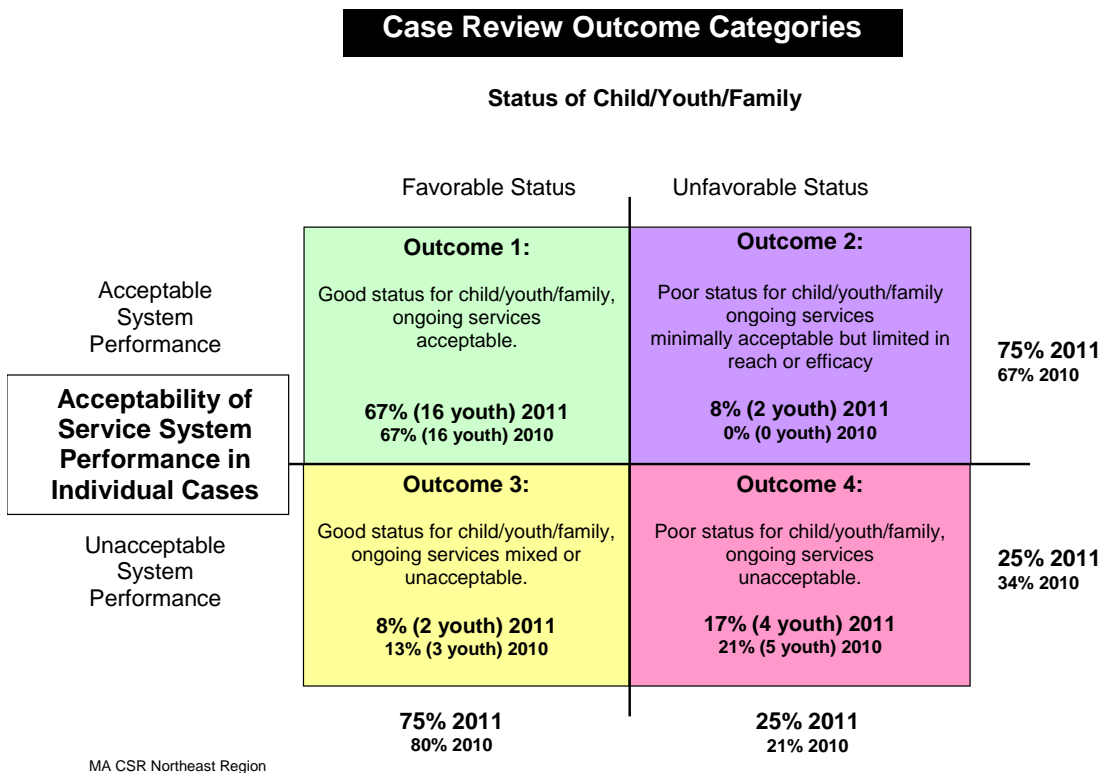
Overall system practices in Northeastern Massachusetts continue to need improvement in order for families to be able to consistently depend on receiving acceptable services.

CSR Outcome Categories

Youth in the CSR sample can be classified and assigned to one of four categories that summarize their 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 two-fold table displayed below. Please note that numbers are rounded and overall totals may add up to slightly more than 100%.

The percentages on the outside of the two-fold table below represent the total percentages in each category. The percentage on the outside, top right is the total percentage of youth with acceptable System/Practice Performance (sum of Outcomes 1 and 2). The percentage below this is the inverse- the percentage of youth with unacceptable system/practice performance. The number on the outside lower left is the percentage of youth that has favorable status and under the right block, the percentage of youth with unfavorable status. Also displayed are last year's CSR results.

Outcome Results: Northeastern Massachusetts CSR (October 2011)

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Case Review Outcome Categories

Status of Child/Youth/Family

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	Favorable Status	Unfavorable Status	
Acceptable System Performance	**Outcome 1:** Good status for child/youth/family, ongoing services acceptable. **67% (16 youth) 2011** **67% (16 youth) 2010**	**Outcome 2:** Poor status for child/youth/family ongoing services minimally acceptable but limited in reach or efficacy **8% (2 youth) 2011** **0% (0 youth) 2010**	**75% 2011** **67% 2010**
Unacceptable System Performance	**Outcome 3:** Good status for child/youth/family, ongoing services mixed or unacceptable. **8% (2 youth) 2011** **13% (3 youth) 2010**	**Outcome 4:** Poor status for child/youth/family, ongoing services unacceptable. **17% (4 youth) 2011** **21% (5 youth) 2010**	**25% 2011** **34% 2010**
	75% 2011 **80% 2010**	**25% 2011** **21% 2010**	

Acceptability of Service System Performance in Individual Cases

MA CSR Northeast Region

**System/Practice Performance for youth
in the 2011 Northeastern Massachusetts CSR was 75%.**
*- This means that services were working at a dependable or consistently acceptable level for 75% of the youth reviewed which is considered to be fair performance.
- This was an improvement in performance over last year's CSR result of 67% of youth with acceptable system/practice performance.*

Outcome 1

As the display indicates, 67% of the 24 youth fell into outcome category 1. Outcome 1 is the desired situation for all children and families receiving services, and represents youth who have favorable status and acceptable system/practice performance.

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

> *"There is optimal service implementation with this family and their care planning team. There is an updated and revised…Strengths, Needs and Culture Discovery, that is comprehensive, well written and provides a wealth of information concerning the family. Exemplary care planning team meetings are being held regularly, are well attended and have clearly articulated tasks, persons responsible and target dates for completion. It is obvious that significant planning and preparation with an active agenda are in place for every meeting.*
>
> *The family assessment is detailed and well written offering important historical and current information pertaining to this family. There is a comprehensive risk/safety plan that is current and updated. In one section there are 19 strategies listed for mother to employ when trying to de-escalate and calm her son.*
>
> *The care plan team is well coordinated, focused and creative, planned strategies and supports are implemented in timely, competent and consistent manner. There is a strong sense of optimism and genuine concern and warm regard that is palpable and bodes well for continued success."*

Outcome 2

Two youth or 8% of the sample fell in Outcome 2. This category represents children whose needs are so great or complex that despite the best practice efforts and diligent system performance of the service system, the overall status of the child or youth is still unacceptable.

An example of a youth who fell in Outcome 2 who has multiple challenges and has experienced many life disruptions is:

> *"Despite the discouraging current status for (the youth),…practice with this family (was found) to be very good. There were many elements that were being implemented faithfully and with a high level of skill (including) consistent participation of natural supports and community members on the Care Planning Team…Likewise, the Care Coordinator had also managed to keep the key professional providers engaged as well, despite the challenging nature of the work with this family. The Care Plans over the past two years have clearly attempted to be flexible and responsive to (the youth's) needs, and have tried to address the core issues. Services have been implemented consistently. Care was very well coordinated. All Team members credited the Care Coordinator with very good communication and helping to keep the whole process moving."*

Outcome 3

Eight percent (8%) or 2 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 work diligently and cohesively, the youth could likely progress into the outcome 1 category. Without key practice functions occurring reasonably well, status for youth in this category is often fragile, and at risk of becoming unfavorable.

The following is an example of a youth in Outcome 3. This youth is doing minimally well in a special education school, and continues to struggle with mental health issues impacting daily functioning.

> *"The system has minimally engaged with this family, and because of the family's long history of significant engagement with the service system, they expect to be working with them in the future. Interventions have not been adequate to meet the family's or (the youth's) needs and yet ICC will end as soon as (the youth) has a therapeutic mentor assigned…Team has not coordinated care with (the youth's) medical providers and has not been able to provide mom with the supports she needs to learn how to work consistently on addressing the encopresis at home.*
>
> *Care coordination has been lacking especially around engagement of the medical providers at the (specialized) clinic. The goals for (the youth and) family are unclear. The care plan was not dynamic – goals remained the same throughout, progress was not tracked, and the bulk of the activity/action was relegated to the family and family partner. The team had a poor understanding of the (youth's diagnosis) and how to develop a coordinated strategy for addressing this significant problem."*

Outcome 4

In the Northeastern Massachusetts CSR, 17% of the sample or 4 youth fell into outcome category 4. Outcome 4 is the least favorable 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 thorough understanding of the youth and family coupled with strong teamwork and planning interventions that meet the needs of the youth with oversight of implementation would move the youth into a better Outcome classification.

There was a 9% improvement (1 less youth) this year in the number of youth in Outcome 4 over last year's CSR results.

An example of a youth who fell in Outcome 4 is as follows. The youth has marginal status, and there are risk factors present in multiple life areas:

> *"There is not a fully formed and functioning team operating for this youth. There have only been two Care Plan team meetings since July (the last four months) and the person who holds the most history and knowledge of (the youth) was not at either. The ICC has not reached out to (the youth's) two former foster families to invite them to participate in a care planning team. There are no natural supports participating in this process and (the youth) needs considerable and tangible support for (the youth) does not have a safety net…There is not a comprehensive assessment in the file. There is no risk/safety plan…"*

Six-month Forecast

Based on review findings, reviewers are asked if the child's status is likely to maintain at a high status level, improve to higher than the current overall status, continue at the same status level, or decline to a level lower than the current overall status. For 2 youth or 8%, the prediction was that the youth would maintain at a high status level (youth in the "good" or "optimal" status category). For 8 youth or 33% of the sample the prediction was for improvement in status. For 11 youth or 46% (youth with "fair, marginal, poor or adverse" status) reviewers predicted the youth's status to continue at the same level. For 3 youth or 13%, the prediction was that their status would decline.

These results are comparable to last year's CSR Six-month Forecast results for Northeastern Massachusetts.
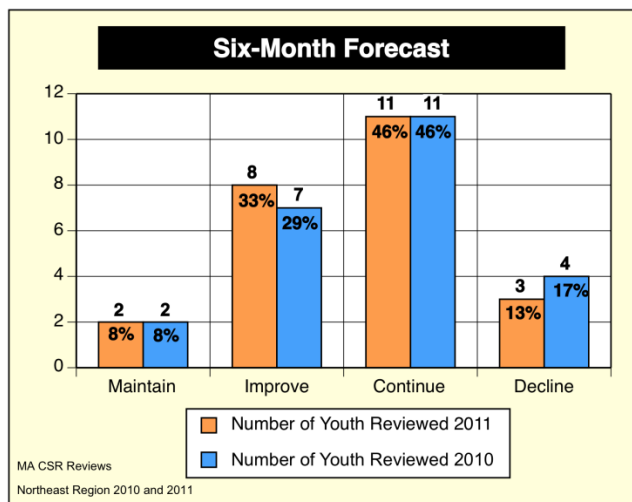
Summary of Findings

Data, Findings and Recommendations in this report reflect the CSR's examination of the consistency and quality of service provision and practices in Northeastern Massachusetts as they relate to meeting the requirements of the *Rosie D.* Remedy. These include requirements for services provided consistent with System of Care and Wraparound principles and phases of Wraparound practice. Eligible youth are also required to have timely access to necessary services through effective screening, assessment, coordination, treatment planning, pathways to care and mobile crisis intervention when needed. In addition, services and practices need to support youth and families participation in teams, and have teams that work together to solve problems and understand the changing needs and strengths of youth and families across settings. The *Rosie D.* Remedy also 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

The CSR identified examples of well-functioning teams and care coordination achieving results for youth/families including:

- IHT teams that helped families organize around the various services they were receiving, and helped them to have a voice in the process.
- Teams aware of the need for integration of psychiatry and other treatments.
- Coordination that was especially helpful for families of children with intellectual disabilities.
- A Family Partner (FP) who played a key role in successful outcomes for a family where the FP worked with the mother to meet basic needs for the family and to advocate for her children, as the other team members worked on treatment issues.
- Coordination by a Therapeutic Mentor who met with the parent and the youth to make sure they were "on the same page."
- An agency that also provides adult services that is able to provide concurrent services to parents, or transition them to adult services when the youth is discharged from CBHI services.

Crisis planning and crisis response has been a focus of system improvements.

Over the year between the CSRs, there appears to have been a concerted effort in the Northeastern region to heighten focus on improving crisis services. More youth than in last year's CSR had risk management/safety plans as components of their care plans (75% this year versus 43% last year), although continued improvements are needed to assure that every youth has a functional crisis plan. An exemplary practice was noted for one youth where the team developed a comprehensive risk management safety plan that was updated at every

meeting, and reflected comprehensive knowledge about family dynamics and an array of strategies to de-escalate behaviors.

Agencies providing MCI services were noted to be providing training and proactive outreach to schools and other community partners. Stakeholders value MCI services and the model, although many saw performance of the MCI teams as variable across the region. Having crisis staff attend care planning meetings and connecting families with the crisis team Family Partner were activities that were cited as working well.

See further discussion about MCI services in the *Challenges* section below.

System of Care Committees are collaborating and problem-solving to strengthen services.

Many of the System of Care (SOC) committees in the region have built productive working relationships and strategic approaches to building more responsive, collaborative system responses for youth with special needs. There is wide representation from community agencies and civic groups on the SOC committees. There is a greater sense of teaming and better team communications at both the system level and the individual youth level.

Challenges

Care coordination and teamwork functions for many youth need strengthening

Assuring teams are engaged and come together to adequately plan and implement services for youth are functions directly related to care coordination performance. For a quarter of youth reviewed, care coordination was not at a level where families could reliably depend on their care being well-coordinated in terms of their teams having the leadership needed to convene and facilitate teams' understanding of strengths and needs of youth/families, effective care planning, assembly of services and supports, and unity and integration of efforts/interventions across team members.

Specific practices of note that were identified include:

- A number of care coordinators for youth reviewed were not preparing adequately for team meetings. Weak engagement of team members for some youth was observed where invitations were sent out to critical team participants in a non-planful manner, which did not allow enough notice to ensure their involvement.

  Of note is 25% of care coordinators cited inadequate team participation as a barrier to their work, indicating many care coordinators are struggling with engaging individuals who have been identified as being important to participating on youths' teams. Often schools were not engaged in team-based processes. With 48% of care coordinators interviewed in the Northeastern Massachusetts CSR having more than 12 youth on their caseload, challenges associated with high caseloads may be a factor in the ability to provide effective coordination for some youth.

- Identifying and involving natural supports on care planning teams is an important practice for building sustainable supports for youth and families. Engagement of natural supports appeared to be a challenge for many care coordinators for a variety of reasons. Often families are isolated, busy with involvement with services, and identifying natural supports may not be a priority for the teams and family until the family achieves a greater sense of stability. Continued efforts to promote engagement of natural supports in team-based processes are needed.

- Inconsistent implementation of the role of the IHT in coordinating care continues including managing transitions and determining when youth may need ICC.

- Care coordinators need to assure each youth has a current mental health assessment that is informing teams' understanding of the youth, while providing another source of information to use in the team planning of services and the selection of interventions that are targeted to meet the youth and family goals.

- As well, care coordinators need to assure each youth has a current/functional risk and safety plan. While planning for risk and safety issues was improved over last year's CSR, 25% of youth reviewed this year did not have an adequate risk and safety plan.

- Families are expressing there is a lot of time spent in meetings before they can get the help they need. Many feel the meetings are "rote" and held to meet a required process, and what they want is quicker access to services. A number of families expressed being confused by the number of services, and "who is doing what."

  Assuring the care plan development process does not overwhelm families, is a "sensible" process that families understand and can see results from, and can respond to any urgent need for services is an important function of care coordination. When done well, families feel they are having their voice heard, getting useful services, and understanding the role and function of each provider.

- Facilitating well-planned transitions that include supports for sustainable progress need strengthening.

- Assuring discharges for services are based on clear determinations of assessment of progress, youth status, any remaining goals and objectives, identification of needed services and supports to achieve remaining goals, and assessment of less intensive services capacity to address remaining goals and objectives is an important function of coordination that needs to be better supported.

- Tracking progress for youth and convening teams to consider any needed changes in intensity and type of services and supports that are offered to families is a key coordination function. With only 58% of youth reviewed making overall progress in key areas of their lives, this is an especially important function. A key are of tracking by teams is assuring the right strategies in care plans for helping youth achieve positive emotional and behavioral well-being.

Teams continue to be challenged in their ability to fully formulate comprehensive understanding of the strengths and needs of youth and their families.

Understanding the strengths and needs of youth and families though gathering and synthesizing all available information, both formally and informally, is an underpinning for teams to be able to craft the strategies and supports to bring about necessary changes for the youth and family. This includes achieving the vision, goals and objectives of the care plan; to support the youth's progress; and to build stronger parental knowledge and family relationships strategies and reliable supports that can sustain positive gains and positive development. Although improving, a large number of teams were found to have a minimal to inadequate understanding of the youth and family necessary to develop effective care plans. Nearly 30% of youth did not have comprehensive clinical assessment in their files. Collecting information from agencies youth previously received services from, and learning the history of interventions that were tried and worked or didn't work, was not systematically conducted for many youth.

As a result for a number of youth reviewed, assessment and understanding was incomplete or not available, or teams failed to fully understand the problems of youth and families. Ensuing care plans and interventions often lacked focus. Assessment in some cases was not seen as a continuing process, and the understanding and planning of teams did not reflect the evolving nature of the knowledge, understanding and/or needs youth and family as their situations changed, or when there was no progress being made. Team members did not systematically share agency assessments or their knowledge to form a comprehensive understanding that helped to identify youth and family needs across domains.

Outpatient services were not systematically available or integrated into youths' care in ways that were beneficial to youth and families.

Access to outpatient services and psychiatric services, was an issue for many youth. Youth were reported to be waiting to see an outpatient provider in the 4-12 week range. This especially was impacting youth recently discharged from residential or inpatient treatment who often are not systematically connected to community-based services upon discharge. Youth that need psychiatric evaluations or medication management must use outpatient therapy whether it is needed or not, even when it is the same agency providing ICC or IHT, resulting in further wait times to access care.

Outpatient participation in team processes was limited and inconsistent. Outpatient providers serving in the role of the "Hub" for youth were reported to provide inadequate care coordination and with many systemic issues impacting the coordination and team participation roles. Issues cited included the disincentives in the fee for service and billing model, the number of cases outpatient providers maintain being a limiting factor, the lack of flexibility in schedules, misunderstandings of the coordination and team participation roles, and other issues.

Outpatient services as the clinical service for youth discharging from IHT is often not a service that meets the needs of the youth and family. The model is most often office-based, focuses on individual therapy with the youth, and family treatment is often not continued. If the youth does have a crisis, the outpatient therapist is often not available, and/or the amount of time needed to address youth and family treatment needs is not available and at

the intensity needed. The Outpatient coordination role when serving as youths' Hub by definition requires adequate engagement with youth and families; often ongoing collaboration with other services and supports; assuring there are the "right" strategies, treatments, and services in place at the right level of intensity and coordination for youth with serious emotional disorders and often complex life situations; and tracking progress and making adjustments to services and supports as needed. This role is not being consistently implemented by outpatient providers when they are the hub for youth.

There is a continued need for improvements in mobile crisis service delivery.

While some families are experiencing good responses, others continue to feel they can't rely on MCI to provide outreach to them. They are experiencing long wait times, or are asked to come to the MCI centers or to meet staff at the hospital, where they often can wait for an extended period of time for the Behavioral Health Crisis Services or other needed attention. Many youth continue to use the Emergency Room as their alternative to a mobile response because of lack of availability of the service, or because youth are deemed to be too aggressive. Adequacy of staffing in the current MCI model appears to be a continuing issue in some parts of the region. With the MCI teams taking on the responsibility of providing in-home crisis stabilization later this Spring, this challenge may be a compounding factor in service delivery and should be closely tracked.

Practice and service concerns were identified.

Parents and providers felt services in general are helping more youth, and many value the team-based approach. Parents describe having the most confidence when there are the "right" people on their teams, and when actions are tied to purpose, are individualized, and when they are learning skills to help their children.

However, reliability and quality of certain services were expressed as issues by many people interviewed. A number of parents felt that outpatient services, despite years of involvement, were not effective, and they are concerned about having to receive the service when not needed or wanted in order to access psychiatric services. Many expressed a difficulty in bringing outpatient providers into the team-based process, even with meeting location and other accommodations offered.   Cited were issues with outpatient providers not understanding the process, and being difficult to engage, even when they have the role as the "hub" for a family. When Therapeutic Mentoring is tied to an outpatient hub, it was observed that there is little coordination or communication, which can be problematic for families. TM's are sometimes isolated in their role, and their work is not adequately developed and integrated with the skill-building or other service strategies and interventions that the youth is receiving. Families also identified lack of sufficient and ongoing medication monitoring and evaluation of effectiveness by psychiatrists.

Also cited were:
- Long wait times for Therapeutic Mentors, IHT and IHBT services.
- Fragmented services, relationships and a need for strengthened unity of effort when ICC and IHT are involved.
- IHT hubs not seeing the value of family partners, and not using family partners even when the supports could benefit a family.

- Variability in practices and quality among ICCs and CSAs.

Families expressed feeling that services for their child were sometimes closed prematurely.

There were observations of cases being closed before there was evidence of sustained progress. In one particular case, the family had just begun to make progress when the IHT terminated before an IEP was set up and without notifying the other members of the team that termination was occurring. The family was still overwhelmed with the cognitive issues of their son as well as working with the school on their own.

Transportation to clinics is an issue for families in the area, as is the need for more capacity for providers who speak different languages.

Recommendations

Practice recommendations:

- Assure each youth has a current, quality comprehensive clinical assessment that informs team planning and services.

- Use assessment data to inform care and treatment planning which includes the establishment of goals and outcomes as well as a process for assessing progress.

- Consider ways to have more team meetings with and at schools.

- Better integrate outpatient and other clinical providers into teams.

- Assure youths' psychiatrists or others prescribing psychotropic medications are included in team processes including understanding, planning, implementation, and monitoring of services, especially given the number of youth that are on multiple medications.

- Help teams that are struggling to engage key team members and natural supports.

- Provide supervision that is focused on the provision of care and achieving results.

- Assure IHT is fully implementing the level of care coordination and teaming the youth and family needs when they are the "hub" and no ICC is involved.

- When a youth/family is discharged from services, assure that the discharge is warranted, is based on youth meeting care planning and treatment goals, and all team members are part of the decision. Strengthen discharge planning practices to support sustainability of gains made, and have clear strategies for addressing any continued needs.

- Strengthen supervision, consultation, training and other identified supports for teams that need help in better understanding the reasons for youth's challenging behaviors, or when youth are not progressing.

- Assure care plans and goals reflect the evolving nature of youth's needs and including strategies to help youth make progress, develop the skills they need to succeed, and have successful transitions.

- Help teams to systematically develop and train team members on risk management and safety plans that can help families, schools and others to be able to effectively support the youth in the event of a crisis. Assure plans are reviewed often and updated as needed. Include any transportation issues when developing the plans.

- Provide supports to care coordinators that will assure all youth transitions are identified and adequately planned for.

System recommendations:

- Assure there is consistency of quality practices across CSAs and agencies. Identify common practices that could benefit from discussion and learning. Work with supervisors to identify areas of the work that need strengthening, and identify the best methods to support quality work.

- Review the adequacy of access and availability to services, particularly psychiatric services, MCI, therapeutic mentors, IHT and IHBT services.

- Reassess and strengthen the role of outpatient services in the system of care including team-based planning, and role in coordinating care when the outpatient provider is the "hub" for services for the family.

- Address areas identified in the findings of the CSR with emphasis on youth progress; emotional and behavioral well-being; team functioning; assessment and understanding of youth; planning and managing social connections, risk/safety issues, recovery, and transitions; care coordination and managing transitions.

Appendix 1

Child's General Level of Functioning

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

☐ **10** Superior functioning in all areas (at home, at school, with peers, in the community); involved in a wide range of activities and has many interests (e.g., has hobbies, participates in extracurricular activities, belongs to an organized group such as the Scouts); likable, confident; "everyday" worries never get out of hand; doing well in school; getting along with others; behaving appropriately; no symptoms.

☐ **9** Good functioning in all areas: secure in family, in school, and with peers; there may be transient difficulties but "everyday" worries never get out of hand (e.g., mild anxiety about an important exam; occasional "blow-ups" with siblings, parents, or peers).

☐ **8** No more than slight impairment in functioning at home, at school, with peers, and in the community; some disturbance of behavior or emotional distress may be present in response to life stresses (e.g., parental separation, death, birth of a sibling), but these are brief and interference with functioning is transient; such youth are only minimally disturbing to others and are not considered deviant by those who know them.

☐ **7** Some difficulty in a single area, but generally functioning pretty well (e.g., sporadic or isolated antisocial acts, such as occasionally playing hooky or committing petty theft; consistent minor difficulties with school work; mood changes of brief duration; fears and anxieties that do not lead to gross avoidance behavior; self-doubts); has some meaningful interpersonal relationships; most people who do not know the youth well would not consider him/her deviant but those who know him/her well might express concern.

☐ **6** Variable functioning with sporadic difficulties or symptoms in several but not all social areas; disturbance would be apparent to those who encounter the child in a dysfunctional setting or time but not to those who see the youth in other settings.

☐ **5** Moderate degree of interference in functioning in most social areas or severe impairment of functioning in one area, such as might result from, for example, suicidal preoccupations and ruminations, school refusal and other forms of anxiety, obsessive rituals, major conversion symptoms, frequent anxiety attacks, poor or inappropriate social skills, frequent episodes of aggressive or other antisocial behavior with some preservation of meaningful social relationships.

☐ **4** Major impairment in functioning in several areas and unable to function in one of these areas; i.e., disturbed at home, at school, with peers, or in society at large; e.g., persistent aggression without clear instigation, markedly withdrawn and isolated behavior due to either thought or mood disturbance, suicidal attempts with clear lethal intent; such youth are likely to require special schooling and/or hospitalization (but this alone is not a sufficient criterion for inclusion in this category).

☐ **3** Unable to function in almost all areas, e.g., stays at home, in a ward, or in a bed all day without taking part in social activities or severe impairment in reality testing or serious impairment in communication (e.g., sometimes incoherent or inappropriate).

☐ **2** Needs considerable supervision to prevent hurting self or others (e.g., frequently violent, repeated suicide attempts) or to maintain personal hygiene or gross impairment in all forms of communication (e.g., severe abnormalities in verbal and gestural communication, marked social aloofness, stupor).

☐ **1** Needs constant supervision (24-hour care) due to severely aggressive or self-destructive behavior or gross impairment in reality testing, communication, cognition, affect, or personal hygiene.

☐ **0** Not available or not applicable due to young age of the child.

Appendix 2

CSR Interpretative Guide for Person Status Indicator Ratings

Maintenance Zone: 5-6

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

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

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

Favorable
Range: 4-6

Refinement Zone: 3-4

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

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

3 = MARGINALLY INADEQUATE STATUS Status is mixed, limited, or inconsistent and not quite sufficient to meet the person's short-term needs or objectives now in this area. Status in this area has been somewhat inadequate at points in time or in some aspects over the past 30 days. Any risks may be minimal.

Unfavorable
Range: 1-3

Improvement Zone: 1-2

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

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

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

CSR Interpretative Guide for Practice Performance Indicator Ratings

Maintenance Zone: 5-6

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

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

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

Acceptable
Range: 4-6

Refinement Zone: 3-4

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

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

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

Unacceptable
Range: 1-3

Improvement Zone: 1-2

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

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

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