

Report of Findings of the
Community Services Review of
Southeastern Massachusetts
December 2011

Fiscal Year 2011-2012 Reviews

Rosie D.
Community
Services Review-
Southeastern
Massachusetts
Regional Report

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Executive Summary

This report presents findings of the Community Services Review (CSR) conducted in the Southeastern Massachusetts region during December 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 22 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 Southeastern Massachusetts region. The original sample size of 24 was reduced to 22 due to withdrawal of consent in one case, no services provided in the time frame of the review in the other (system practices are reviewed over the 90 days preceding the CSR).

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 by receiving and reviewing information about how well the Commonwealth of Massachusetts is addressing requirements of *Rosie D.* The Commonwealth is charged with creating the conditions that should lead to improvements for youth and families. The CSR examines the diligence and consistency of services and service practices in providing those conditions.

Highlights of Findings from the December 2011 Southeastern Massachusetts CSR

Status and Progress Indicators. In the CSR, Youth Status, Youth Progress, and Family Status are reviewed to understand the how well behavioral health services and practices are working for youth and families. The following are the status and progress findings for youth reviewed in the Southeastern Massachusetts CSR during December 2011.

Youth Status. Most of the youth reviewed in Southeastern Massachusetts had an overall favorable level of well-being. All youth in the sample lived with their biological or adopted families, or were in kinship or relative care. The youth were stable in their school settings, were generally living in permanent and favorable situations, and were safe in their homes, schools and communities. Most of the youth had favorable physical health. Youth were attending school regularly, had good academic status and had adequate behavioral supports in school settings. Youth were generally not posing behavioral risk toward themselves or others.

Two status indicators departed from the overall pattern of favorable status. Youths' home stability was a concern for 27% of the youth reviewed. A larger area of concern was youths' emotional-behavioral well-being, which was unfavorable for 41% of the youth. Because of

the importance of these indicators for youth to achieve positive functioning, reviews by teams to determine ways to improve youth's home stability and emotional well-being are recommended.

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

Fathers and mothers in the Southeastern Massachusetts CSR were found to have substantial challenges. Substitute caregivers reviewed had low levels of challenge. Support for youth was negatively impacted more for fathers than mothers. Family voice and choice was strong for mothers, substitute caregivers 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 the 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.

Eighty-two percent (82%) of the youth in the Southeastern Massachusetts CSR were making favorable progress (Fair, Good or Optimal Progress), a strong overall finding. Three areas where low levels of progress were found were progress in reducing psychiatric/behavioral symptoms, progress in improving relationships with peers, and progress in improving the overall well-being and quality of life for youth.

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, 78% were found to have acceptable system/practice performance. This indicates system performance and practices are fair. For 22% of youth, the system needs to improve its performance in providing dependable, quality services. This represents a considerable overall improvement in performance as compared to the previous CSR for Southeastern Massachusetts when only 55% of the sample had acceptable findings. A number of key system/practice indicators saw improvement over the previous CSR results; several indicators were performing well below acceptable levels.

The data indicate that the strongest areas of practice for youth in Southeastern Massachusetts were Engagement with the Youth and Family; Cultural Responsiveness to the

Youth; and Availability and Access to Resources. Planning Interventions for Recovery and Relapse for the one youth the indicator applied to were also good.

Indicators that showed an overall fair performance that was less consistent and minimally sufficient were Cultural Responsiveness to the Family; Teamwork (Structure/Formation); Planning Interventions for Behavior Changes; Planning Interventions for Risk and Safety; Outcomes and Goals; Service Implementation; Care Coordination; and Adapting & Adjustment.

Areas of system/practice performance that will need improvement in order to be considered adequate consistency, intensity and/or quality of efforts are: Assessment & Understanding of the Family; Planning Interventions for Symptom Reduction; Planning for Social Connections; and Matching Interventions to Needs.

Review results indicate weak performance in the following system/practice domains: Team Functioning; Assessment & Understanding of Youth; Planning Interventions for Transitions; Managing Transitions & Life Adjustments; and Responding to Crises.

A number of system practices showed improvement over the previous CSR. Of note were practices were team formation, service implementation and availability of resources, all practices that improved and were performing at a fair level. Others that improved, and with continued support could show a promising trend, are planning for behavioral change, establishing clear outcomes and goals, coordinating care, and adapting/adjusting care.

Overall practice was fair (78%) and it appears that the system of services in Southeastern Massachusetts has improved across a number of areas that were found to be weak in the last CSR. However, key system functions need more development, and cannot yet be considered reliable in helping youth make progress, achieve desired outcomes or maintain recent gains. Important practice functions need concerted attention. Of particular concern is how well teams are functioning; over 40% 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 in ways that could impact positive change for youth and families. Similarly, over 40% of youth and 32% of families were not well-assessed or understood, which is a foundation for providing effective supports and services for youth and families. Further, 32% of youth did not have a current mental health assessment in their files. Planning transitions for youth was unacceptable for over half of the youth (53%), and transitions were not managed well for 36%. Managing crises for youth dipped to being acceptable for only 64% of youth as compared to 88% in the previous review.

Focused attention on these system functions, the areas of concern identified in the summary of this report and sustaining gains made since the last CSR will be important activities for the Commonwealth to address in order for services in Southwestern Massachusetts to be considered performing in ways that are effective, consistent and reliable for youth and families.

The Rosie D. Community Services Review
Regional Report for Southeastern Massachusetts
For the Review Conducted in December 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 December 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 22 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 58 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 Southeastern Massachusetts CSR

Community Service Agencies (CSAs) and In Home Therapy Service (IHT) Agencies

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

In the Southeastern region, the CSAs serve the towns in which they are located and the surrounding areas. The CSAs are Brockton Area Multi-Services, Inc. (Brockton), Bay State Community Services (Plymouth), Child and Family Services (New Bedford), Community Counseling of Bristol County (Attleboro), Family Service Association (Fall River), and Justice Resource Institute (Cape Cod).

There are In-home Therapy Services (IHT) throughout the Southeastern region, with IHT services being provided by CSA agencies as well as other 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 Southeastern Massachusetts CSR. Table 1 displays data related to the youth-specific reviews where a total of 157 interviews were conducted. As can be seen, the average number of interviews was 7.1 with a maximum of 11 and a minimum of 2 interviews conducted.

Child Status and Performance Profile - Number of Interviews

Number of cases: 22 MA Southeast Review Dec 2011

Number of Interviews

Total number of interviews	157
Average number of interviews	7.1
Minimum number of interviews	2
Maximum number of interviews	11

Table 1

How the sample was selected

The sample for the Southeast 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 that are covered by Medicaid. The CSR sample initially drawn for the Southeast 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, the sample was reduced by two youth, one where consent was withdrawn and another who did not receive services during the period under review. The final review sample was 22 youth.

Each ICC provider and each IHT provider was asked to submit a 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 Selections. For ICC, a random sample of youth was drawn from the open caseload list. The number of youth selected from each agency was determined based on the number of youth 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 17 agencies, which were actively providing IHT in Southeast 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 Southeast Massachusetts region. Of the 8 youth selected from IHT lists, 4 were drawn from agencies which a CSA service as well as an IHT service. The 4 agencies were drawn randomly from the 6 CSA’s providing IHT. The final 4 youth in the sample were randomly selected from the remaining IHT agencies. Each of these 4 youth

were receiving IHT but not also receiving ICC. In total, there were 8 IHT youth selected in the sample.

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.

Southeast Agency	Total Enrolled Since Start of ICC Opening (7/1/10)	Number Open at List Submittal	Number ICC Cases Selected
Brockton Area Multi-Services, Inc.	361	83	2
Bay State Community Services Plymouth	397	135	3
Child and Family Services of New Bedford	391	106	2
Community Counseling of Bristol County	376	88	2
Family Service Association of Fall River	527	141	3
Justice Resource Institute	459	181	4*
Total	2511	734	16**

*Reflects initial sample; final sample for Justice Resource Institute was 3

** Reflect initial samples size for ICC; final sample size for IHT was 15 due to withdrawal of consent

Table 2

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 were served within open cases at the time the agencies submitted lists. The number of youth to be included from each agency was then determined by comparing the number of youth being served by that agency to the total number of youth being served in Southeast Massachusetts. Justice Resource Institute Cape Cod had served the largest number of youth since July 1, 2010, and 4 youth were randomly selected. Bay State Community Services Plymouth and Family Service Association Fall River each had 3 youth included in the sample.

Each of the remaining CSA’s had 2 youth in the sample: BAMSII Brockton, Child and Family Services New Bedford, and Community counseling of Bristol County Attleboro. These 16 ICC youth may have been receiving services in addition to ICC, including IHT.

Agency	Total Enrolled Since Start of IHT Opening (7-1-2010)	Total Open at List Submittal	Total Open and Receiving IHT/No ICC	Number IHT Only Selected
Arbour Fuller Hospital	113	47	42	1
Brockton Area Multi-Services Inc.	48	22	12	1
Bay State Community Services Plymouth	-	-	-	-
Child and Family Services of New Bedford	225	78	57	1
Community Care Services	-	-	-	-
Community Counseling of Bristol County	283	130	93	1*
Family Continuity Programs	168	42	32	1
Family Service Association of Fall River	-	-	-	-
Family and Children's Services of Nantucket	21	18	9	1
Justice Resource Institute	4	14	9	1
Latin American Health Institute	-	-	-	-
Martha's Vineyard Community Services	-	-	-	-
MSPCC	-	-	-	-
Pyramid Builders	-	-	-	-
South Bay Mental Health	-	-	-	-
South Shore Mental Health	-	-	-	-
Saint Vincent's Home	45	45	40	1
Total	907	396	294	8**

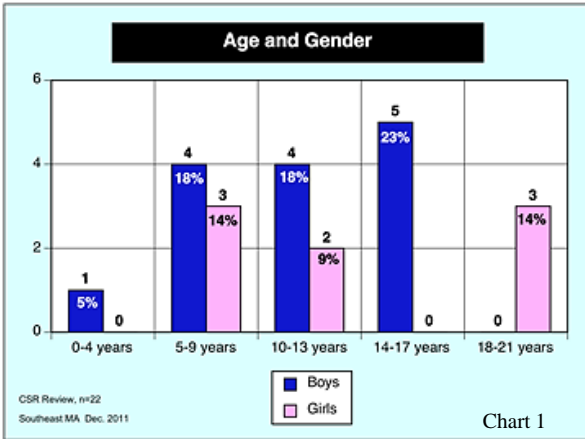
Table 3

*Reflects initial sample; final sample for Community Counseling of Bristol County was 0; of the 17 agencies providing IHT, 9 were not selected for the sample.

** Reflect initial sample size for IHT; final sample size for IHT was 7 due to 1 youth ineligible for to be considered as part of the review due to service discontinuation outside of the review period.

Information about the 8 IHT agencies that were 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: Arbour Fuller Hospital, BAMSI, Child and Family Services, Community Counseling of Bristol County, Inc., Family and Children's Services Nantucket Inc., Family Continuity Programs, Justice Resource Institute, and St. Vincent's Home. Of the 17 agencies providing IHT, 9 were not selected for the sample.

Characteristics of the Youth Reviewed in Southeastern Massachusetts



Age and Gender. Twenty-two (22) youth receiving services in the Southeastern Massachusetts region were reviewed in the CSR conducted during December 2011. *Chart 1* displays the distribution of genders across the age groups in the sample. There were 14 boys and 8 girls in the sample. The proportion of boys to girls was 64% boys to 36% girls. The largest number, 7 youth or 32% of the sample were in the 5-9 year old range. Six youth or 27% of the sample were in the 10-13 year old range. Five youth, all boys, were in the 14-17 year

old range and made up 23% of those reviewed. Three youth, all girls, were in the 18-21 year old range and made up 13% of the sample. There was one youth, or 5% of the sample, in the 0-4 year old range.

Current placement. All 22 youth in the Southeastern Massachusetts CSR sample lived with their families either with their biological/adoptive families or in a kinship/relative home. (*Table 4*). Eighty-two percent (82%) were in their biological or adoptive home, and 18% were living in kinship or relative care.

Child Status and Performance Profile - Current Placement Frequency

Number of cases: 22 MA Southeast Review Dec 2011

Type of Current Placement	Number	Percent
Family bio./adopt. home	18	82%
Kinship/relative home	4	18%
	22	100%

Table 4

Legal Status. The legal status of 73% of the youth reviewed was with their birth families. Two youths’ (8%) permanency status were with his/her adoptive family, three (14%) were in permanent guardianship, and one (5%) was independent. (*Table 5*).

Child Status and Performance Profile - Legal Permanency Frequency

Number of cases: 22 MA Southeast Review Dec 2011

Legal Permanency Status	Number	Percent
Birth family	16	73%
Adopted family	2	9%
Permanent guardianship	3	14%
Youth over age 18.	1	5%
	22	100%

Table 5

Out of home placements. The CSR tracked placement changes over the last twelve months for each of the 22 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 64% had no placement changes in the last year. Six youth or 27% experienced 1-2 changes in placement. One youth (5%) had 3-5 placements, and one (5%) had 6-9 placements. Stability was an issue over the last year for 36% of the youth reviewed, however as can be seen in Table 7, no youth in the sample had been in an out of home placement in the thirty days preceding the CSR.

Child Status and Performance Profile - Placement Changes Frequency

Number of cases: 22 MA Southeast Review Dec 2011

Placement Changes (past 12 months)	Number	Percent
None	14	64%
1-2 placements	6	27%
3-5 placements	1	5%
6-9 placements	1	5%
	22	100%

Table 6

Child Status and Performance Profile - OOH Placement Past 30 Days

Number of cases: 22 MA Southeast Review Dec 2011

OOH Placement Past 30 days	Number	Percent
Not Applicable	22	100%
	22	100%

Table 7

Ethnicity (Table 8). Of the 22 youth in the sample, fourteen or 64% were Euro-American, one (5%) was African-American, four (18%) were Latino, two (9%) were biracial, and one (5%) was Puerto Rican.

Child Status and Performance Profile - Ethnicity Frequency

Number of cases: 22 MA Southeast Review Dec 2011

Ethnicity	Number	Percent
Euro-American	14	64%
African-American	1	5%
Latino-American	4	18%
Biracial	2	9%
Puerto Rican	1	5%
	22	100%

Table 8

Primary languages (Table 9). English was the primary language spoken at home for 20 youth or 91% of those reviewed, and Spanish was the primary language for 2 or 9%

Child Status and Performance Profile - Language Spoken Frequency

Number of cases: 22 MA Southeast Review Dec 2011

Primary Language Spoken at Home	Number	Percent
English	20	91%
Spanish	2	9%
	22	100%

Table 9

Child Status and Performance Profile - Educational Placement Frequency

Number of cases: 22 MA Southeast Review Dec 2011

Educational Placement or Life Situation	Number	Percent
Regular K-12 Ed.	8	36%
Full inclusion	2	9%
Part-time Sp. Ed.	1	5%
Self-cont. Sp. Ed.	6	27%
Parenting teen	0	0%
Adult basic/GED	0	0%
Alternative Ed.	2	9%
Vocational Ed.	0	0%
Expelled/Suspended	0	0%
Home hospital	0	0%
Day treatment program	2	9%
Work	1	5%
Completed/graduated	2	9%
Dropped-out	0	0%
Other	2	9%

Table 10

Educational placement (Table 10). Youth reviewed were receiving educational services through a variety of educational programs. Of the sample, 36% were in a regular education program. Forty-one percent (41%) of the youth were receiving special education services in a full inclusion (9%), part-time special education (5%) or fully self-contained special education setting (27%). Two youth (9%) were in an alternative education setting, and two (9%) were in a day treatment program. These youth may have also had special education services in these settings. Two, youth in the sample (9%) had completed school, and one (5%) was working. The “Other” category included a child attending pre-school one day a week, and a youth attending community college.

Child Status and Performance Profile - Agencies Involved Frequency

Number of cases: 22 MA Southeast Review Dec 2011

Agencies Involved	Number	Percent
DCF	9	41%
DMH	1	5%
Special Ed	11	50%
Early intervention	0	0%
Developmental disabilities	0	0%
DYS	0	0%
Probation	1	5%
Vocational Rehabilitation	0	0%
Substance abuse	0	0%
Other	0	0%

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 may be more than the number of youth

reviewed. Youth were most frequently involved with Special Education (11 or 50%). A large number of families in the Southeastern sample were involved with The Department of Children and Families (DCF). DCF had involvement with 9 families or 41% of the sample. One youth (5%) was involved with Probation. No other agencies were involved with the youth at the time of the CSR.

Child Status and Performance Profile - Referral Source
 Number of cases: 22 MA Southeast Review Dec 2011

Referral Source	Number	Percent
Hospital	1	5%
Crisis Services	3	14%
School	2	9%
Family	5	23%
DCF	5	23%
Outpatient	1	5%
Daycare	1	5%
ICC	1	5%
IHT	2	9%
Police	1	5%
	22	100%

Table 12

Referring agency (Table 12). Youth reviewed in Southeastern Massachusetts were referred to ICC and/or IHT services from a variety of sources as displayed in *Table 12*. The two largest referral sources were Family self-referrals and DCF, each referring five youth or 23% of the sample. This was followed by Crisis Services, referring three youth or 14%, and Schools and IHT providers, referring 9% of the sample each.

Referring one youth each or 5% of the sample were a Hospital, an Outpatient provider, a Daycare, an ICC provider, and Police.

Child Status and Performance Profile - Co-Occurring Condition Frequency

Number of cases: 22 MA Southeast Review Dec 2011

Co-Occurring Condition	Number	Percent
Mood Disorder	15	68%
Anxiety Disorder	11	50%
PTSD/Adjustment to Trauma	7	32%
Thought Disorder/Psychosis	0	0%
ADD/ADHD	12	55%
Anger Control	8	36%
Substance Abuse/Dependence	0	0%
Learning Disorder	5	23%
Communication Disorder	1	5%
Autism	2	9%
Disruptive Behavior Disorder (CD, ODD)	5	23%
Mental Retardation	1	5%
Medical Problem	5	23%
Other Disability/Disorder	3	14%
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 in the Southeastern Massachusetts sample were diagnosed with mood disorders (68%), followed by attention deficit or attention deficit hyperactivity disorder (55%) and anxiety disorders (50%). Thirty-six percent of the youth had anger control issues (36%) and 32% were diagnosed with PTSD. Following this was 23% of the sample each with a learning disorder, disruptive behavior disorder and

medical problem. There were two youth with an autism spectrum disorder (9%), one with an intellectual disability (5%), and one with a communication disorder (5%).

Youth in the “Other Disability” category had an adjustment disorder, and selective mutism.

Medical problems that were experienced by 23% of the youth included asthma, seizure disorder, encopresis, enuresis, scoliosis, ear infections, allergies, and weight issues. Some of the youth had multiple medical problems.

Child Status and Performance Profile - Psy Meds Frequency

Number of cases: 22 MA Southeast Review Dec 2011

Number of Psy Meds	Number	Percent
No psy meds	6	27%
1 psy med	3	14%
2 psy meds	5	23%
3 psy meds	4	18%
4 psy meds	2	9%
5+ psy meds	2	9%
	22	100%

Table 14

Medications (Table 14). Seventy-three percent (73%) of the youth reviewed in Southeastern Massachusetts were prescribed one or more psychotropic medications. As displayed in Table 14, three of youth in the sample (14%) were prescribed one medication, five (23%) were on two medications, and four (18%) were on three medications. There were two youth (9%) on four medications, and two (9%) on five or more medications. Of the youth that were prescribed medications, 81% were on two or more medications and 50% 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. Nine of the youth or 41% were rated to be functioning in the Level 1-5 range (“needs constant supervision” to “moderate degree of interference in functioning in most social areas or severe impairment of functioning in one area”). Another nine or 41% 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”). Four youth (18%) were rated in the Level 8-10 range (“no more than slight impairment in functioning at home, at school, with peers” to “superior functioning in all areas”).

Child Status and Performance Profile - Level of Functioning Frequency

Number of cases: 22 MA Southeast Review Dec 2011

Level of Functioning	Number	Percent
In level 1-5	9	41%
In level 6-7	9	41%
In level 8-10	4	18%
	22	100%

Table 15

Child Status and Performance Profile - Crisis Services Used Frequency

Number of cases: 22 MA Southeast Review Dec 2011

Crisis Services Used Past 30 Days	Number	Percent
Mobile crisis	1	5%
911 Emergency call: EMS	0	0%
911 Emergency call: Police	1	5%
Emergency department	0	0%
Other	0	0%
None	20	91%

Table 16

Use of Crisis Services (Table 16). Two youth, or 10% percent of the sample accessed some type of crisis service over the 30 days prior to the review. Mobile crisis was used by one youth (5%), and there was a 911 emergency call for crisis for the other youth (5%).

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, 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.

Sixty-eight percent (68%) of the youth reviewed in Southeastern Massachusetts had a current mental health assessment in their files. Seven youth or 32% did not have a current mental health assessment available to help their teams better understand and plan for them.

Child Status and Performance Profile - Mental Health Assessment

Number of cases: 22 MA Southeast Review Dec 2011

MH assessment performed	Number	Percent
Yes	15	68%
No	7	32%
	22	100%

Table 17

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 15 youth with mental health assessments, the assessment was distributed to 9 parents or 41%. Two schools or 9% received an assessment, as did one child welfare worker. Those in the “other” category included therapeutic mentors and an in-home behavioral therapist. The assessment was not distributed for 4 of the 15 youth with assessments.

Child Status and Performance Profile - Received Mental Health Assessments

Number of cases: 22 MA Southeast Review Dec 2011

Received MH Assessments	Number	Percent
Parent	9	41%
Education	2	9%
Court	0	0%
Child Welfare	1	5%
DOC	0	0%
Not applicable	7	32%
Not Distributed	4	18%
Other	3	14%

Table 18

Child Status and Performance Profile - Special Procedures Frequency

Number of cases: 22 MA Southeast Review Dec 2011

Special Procedures Used Past 30 Days	Number	Percent
Voluntary time-out	3	14%
Loss of privileges via point & level system	1	5%
Disciplinary consequences for rule violation	2	9%
Room restriction	0	0%
Exclusionary time out	0	0%
Seclusion/Locked room	0	0%
Take-down procedure	0	0%
Physical restraint (hold, 4-point, cuffs)	0	0%
Emergency medications	0	0%
Medical restraints	0	0%
None:	15	68%
Other:	2	9%

Table 19

Special Procedures

Special Procedures data presents information about interventions that were experienced by youth over the 30 days preceding the CSR (Table 19). Forty-two percent (42%) of the sample, or 9 youth experienced a special procedure during this time period. Among the youth, 14% had experienced a voluntary time-out; 9% a disciplinary consequence for a rule violation, and 5% loss of privileges in a points and level system. Youth in the “Other” category experienced restrictions on activities.

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 serious mental illness experienced by 32%. This was followed by 27% each challenged with a serious illness or disabling condition and/or adverse effects of poverty. Fourteen percent (14%) of caregivers had extraordinary care burdens. Substance abuse impairment and domestic violence were each impacting 9% of caregivers. Impacting 5% each were caregivers with limited cognitive ability, cultural or language barriers, or being undocumented. Challenges in the “Other” category included loss of home, and relationship with extended family.

Child Status and Performance Profile - Caregiver Challenges Frequency

Number of cases: 22 MA Southeast Review Dec 2011

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

Table 20

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 Southeastern Massachusetts CSR, there were 22 different individuals providing care coordination for the 22 youth reviewed. Fifteen individual ICCs and seven 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*, 5% of care coordinators had been assigned to the youth less than one month, 5% for one-three months, 32% for four to six months, 45% for seven to twelve months and 14% for thirteen months to two years.

Child Status and Performance Profile - Length of Time CM Assigned

Number of cases: 22 MA Southeast Review Dec 2011

Length of Time CM Assigned to Child/Youth	Number	Percent
<1 month	1	5%
1-3 months	1	5%
4-6 months	7	32%
7-12 months	10	45%
13-24 months	3	14%
	22	100%

Table 21

Caseload size as reported by the care coordinator was measured along the scale in *Table 22*. Seventeen percent (14%) of coordinators had eight or fewer cases, 36% had nine to ten cases, 32% eleven-twelve. Eighteen percent (18%) of care coordinators had thirteen to fourteen cases. There were no care coordinators who had more than 14 cases, and 82% had 12 or fewer cases.

Child Status and Performance Profile - CM Current Caseload Frequency

Number of cases: 22 MA Southeast Review Dec 2011

CM Current Caseload Size	Number	Percent
<8 cases	3	14%
9-10 cases	8	36%
11-12 cases	7	32%
13-14 cases	4	18%
	22	100%

Table 22

Child Status and Performance Profile - Barriers Affecting Case or Services

Number of cases: 22 MA Southeast Review Dec 2011

Barriers Affecting Case Management or Services	Number	Percent
Caseload size	4	18%
Eligibility/access denied	2	9%
Inadequate parent support	3	14%
Inadequate team member participation	3	14%
Family disruptions	3	14%
Billing requirements/limits	6	27%
Case complexity	4	18%
Treatment compliance	4	18%
Team member follow-thru	5	23%
Acute care needs	3	14%
Driving time to services	3	14%
Culture/language barriers	3	14%
Refusal of treatment	2	9%
Family instability/moves	4	18%
Arrest/detention of child/youth	2	9%
Other	12	55%

Table 24

Table 22. 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 Southeastern Massachusetts were billing requirements and limits cited by 27%, followed by team member follow-through cited by 23%. Caseload size, case complexity, treatment compliance and family instability were each cited by 18% of coordinators. Fourteen per cent (14%) of the care coordinators cited inadequate parental support, inadequate team member participation, family disruptions, acute care needs, driving time to services and cultural/language issues as barriers. Thirteen percent (13%) of care coordinators cited treatment refusal as a barrier. Nine percent (9%) identified as barriers eligibility and access denial issues, treatment refusal and the arrest or detention of youth.

Barriers in the “Other” category included paperwork demands, sudden disruptions in services when families fall out of insurance eligibility, needs of undocumented and poor families including addressing basic needs, parental mental illness and multi-generational issues, transportation for youth and school cooperation as issues. Care coordinators identified challenges related to working on a fee-for-service versus salaried basis. Also cited as barriers were long waitlists for accessing services for youth, particularly for therapy and psychiatry.

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

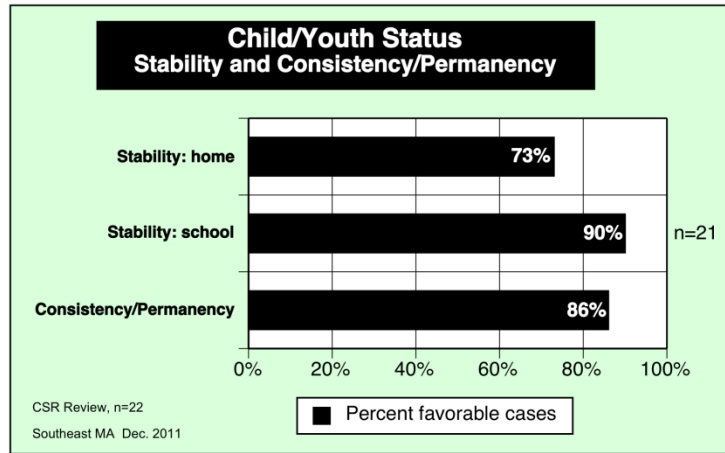
(Measures Youth Status over the last 30 days unless otherwise indicated)

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



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 22 youth in the CSR sample for Southeastern Massachusetts, 73% were found to have favorable stability at home. Sixty-four percent (64%) had good or optimal stability with established positive relationships and well-controlled to no risks that

otherwise could jeopardize stability. Thirty-six percent (36%) of the youth were rated to be in the “refinement” area, which means that conditions to support stability were fair.

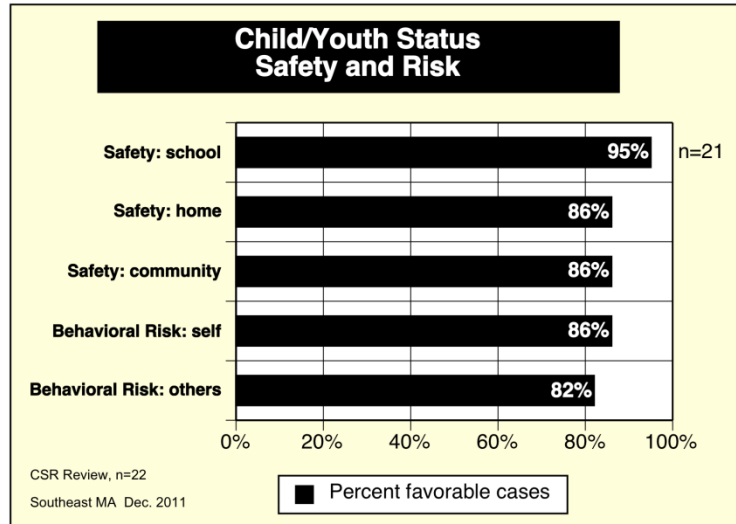
School Stability. School stability applied to 21 youth. Ninety percent (90%) of the youth had a stable school situation, a strong finding. Of these, 67% had optimal or good stability with only age appropriate or planned changes occurring in their school program. The other 33% had stability issues at school that needed “refinement,” with fair to marginal stability issues that were minimally to inadequately addressed.

These results indicate that teams should consider ways to strengthen interventions to support stability for youth in their homes to minimize risk of disruptions. The youth reviewed were stable in their school settings.

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 Southeastern Massachusetts, 19 or 86% had a favorable level of consistency and permanency in their lives. Among these, 14 or 64% had “optimal” or “good” status, meaning these youth were in enduring permanent living situations with their family or other legally permanent caregivers. Six youth, or 27% 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 9% 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 21 youth attending school, 14 or 67 % were safe in their school programs at a “good” or “optimal” level with no risk to generally risk-free school programs. Seven youth (33%) 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-six percent (86%) of youth were safe at home. Fifteen youth (68%) were found to have “good” or “optimal” safety status at home. The remaining seven youth (32%) 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. There were no youth with poor or adverse home safety status.

Community safety. Eighty-six percent (86%) of youth had favorable safety in the community. Twelve youth (54%) were experiencing “good” to “optimal” safety in their communities. Ten 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 were no youth with poor or adverse community safety status.

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

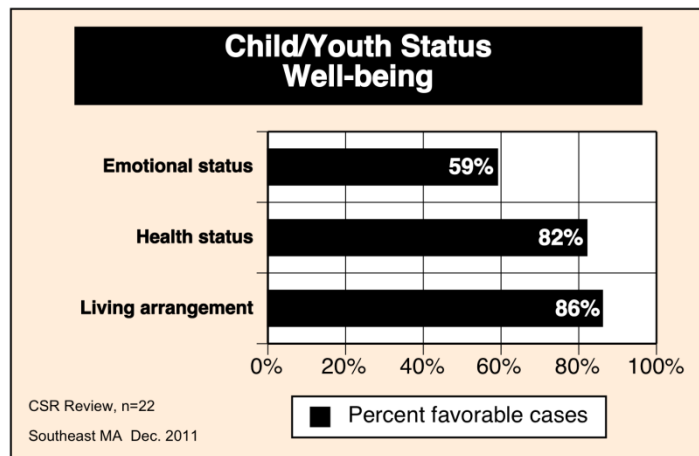
disregulation resulting in harm, severe property destruction, medical non-compliance resulting in harm and unlawful behaviors.

Risk to self. Eighty-six percent (86%) of the sample had a favorable level of behavioral risk toward themselves.

Among the youth reviewed, 7 or 32% had an “optimal” or “good” level of behavioral risk. The remaining fifteen youth or 68% 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 status that is inconsistent or concerning. There were no youth with poor or adverse levels of behavioral risk to themselves.

Risk to others. The subindicator of behavioral risk toward others was favorable for 82% of the youth in the sample.

Ten youth or 45% had “good” or “optimal” levels of behavioral risk toward others. Eleven or 50% needed “refinement” and presented a fair to marginal level of risk toward others. One youth (5%) 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 59% youth reviewed in the Southeastern 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 large 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 (10%) with a “good” level of emotional/behavioral status. Eighty-six percent (86%) or 19 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. One youth (5%) had poor emotional/behavioral status, and was demonstrating a consistently poor level of functioning.

Focused support for teams in developing individualized strategies for improving youths’ emotional and behavioral well-being is recommended.

Health Status

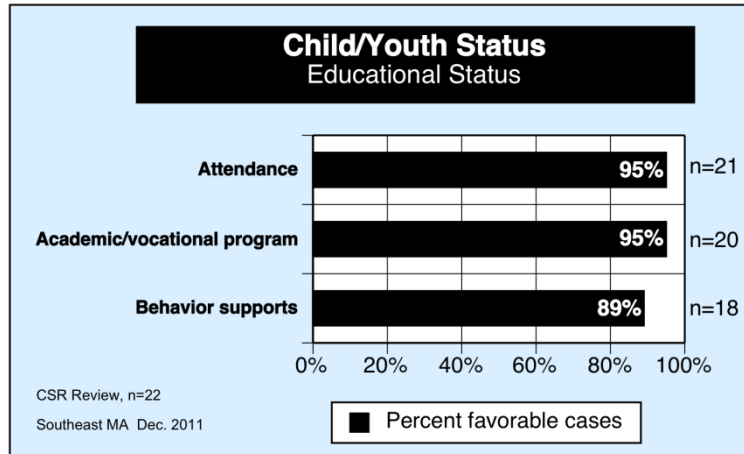
The health of the youth was reviewed to determine whether or not they were achieving and maintaining optimal health status including basic and routine healthcare maintenance. Youth’s basic needs for nutrition, hygiene, immunizations, and screening for any possible development or physical problems should be met.

For the youth in the sample, 82% had favorable health/physical well-being status. Fourteen youth (64%) had “good” or “optimal” health status; eight youth or 36% needed “refinement” in their health status.

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 Southeastern Massachusetts CSR, 86% were found to have a favorable living arrangement. Fourteen youth (64%) were in living arrangements that were “good” or “optimal,” and were substantially or optimally meeting their needs. The remaining eight youth (36%) needed “refinement” with living arrangements that were fair to marginal.



Educational Status

Three 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.

Attendance. The Attendance indicator applied to 21 youth in the sample. Among the youth, 95% had a favorable pattern of attendance. A full 86%, or 18 of the 21 youth, had attendance patterns that were “good” to “optimal.” Three youth or 14% needed “refinement” in attendance patterns; of these only one (5%) had unfavorable status.

Academic or vocational program. Of the 20 youth this indicator applied to, 95% were doing favorably well in their educational program. Fourteen youth (70%) had “good” or “optimal” academic or vocational status. The remaining six youth (30%) needed refinements and had minimally adequate, to marginally inadequate academic/vocational status; of these only one (5%) had unfavorable academic status.

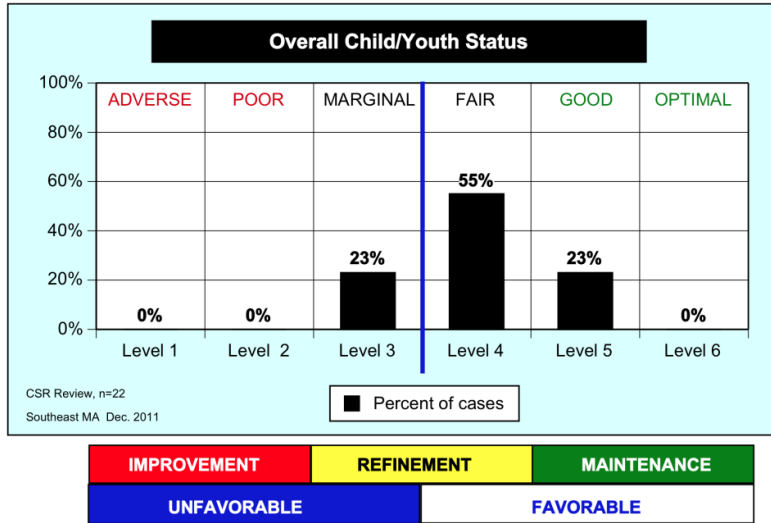
Behavioral supports. Eighteen of the youth in the sample required behavioral supports in their school setting. Behavioral supports were working favorably well for 89% of them. Eight (44%) had an “optimal” or “good” level of supports. The other youth (56%) could benefit from refinements in their level of supports, and had minimally adequate to marginally inadequate supports for their behaviors; of these two youth (11%) had unfavorable behavioral supports.

Overall Youth Status

The overall results for Youth Status for the 22 youth reviewed in Southeastern Massachusetts are displayed below.

Overall, 78% or 17 youth were found to be doing favorably well. These youth fell in Levels 4-6; youth had Fair status (55% or 12 youth), or Good status (23% or 5 youth). No youth were found to have overall Optimal status.

The remaining 5 youth (23%) had unfavorable status. They all had Marginal status (23% or 5 youth). There were no youth with overall Poor or 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. There were no youth with status in the Improvement area, which would have meant that their status was problematic or risky. Seventeen or 78% 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 five youth (23%) 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 Southeastern Massachusetts. Youth were doing well across most of the indicators of child well-being. Of note is that youth were in stable educational settings, and had strong patterns of attendance, academic performance and behavioral supports in school. They were safe in their homes, schools and communities. Youth had favorable health status, living arrangements and permanency. Behavioral risk toward self and others was generally favorable for the youth reviewed. Two areas of concerns were home stability, an issue for just over a quarter of youth, and emotional/behavioral well-being status, which was unfavorable for a full 41% of the sample. These two indicators appeared to have an impact on the overall well-being of a number of youth. Because of the importance of these domains in youth achieving positive functioning, more attention by teams in understanding and building effective supports and treatments for improving youths’ home stability and emotional well-being is warranted.

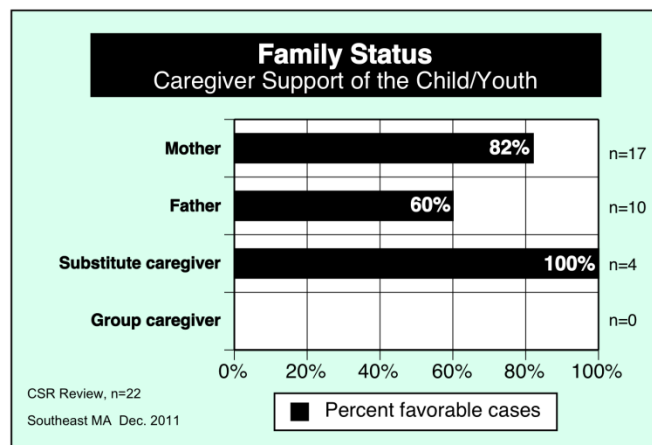
Caregiver/Family Status

(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

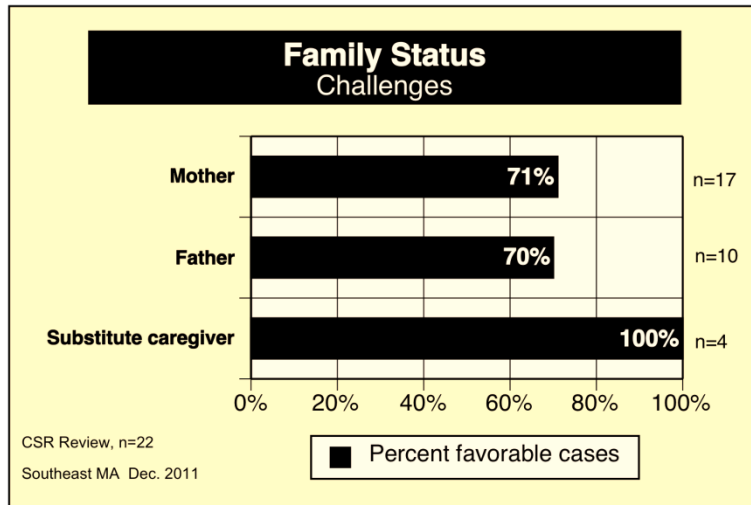


Parent/Caregiver Support of the Youth

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 Southeastern Massachusetts CSR, favorable support by mothers was found 82% of the time for which the indicator was applicable (17 youth). Maternal support needed “refinement” or “improvement” for 6 youth (35%). The measure for support from fathers was applicable for 10 youth in the sample, and favorable support for youth was found for 60% of the fathers. Support from fathers needed “refinement” or “improvement” for 60% of the youth the indicator was applicable for including 3 fathers with substantial and continuing problems of caregiving adequacy. Support was favorable for

all four of the youth with a substitute caregiver (100%). There were no youth in group caregiving.



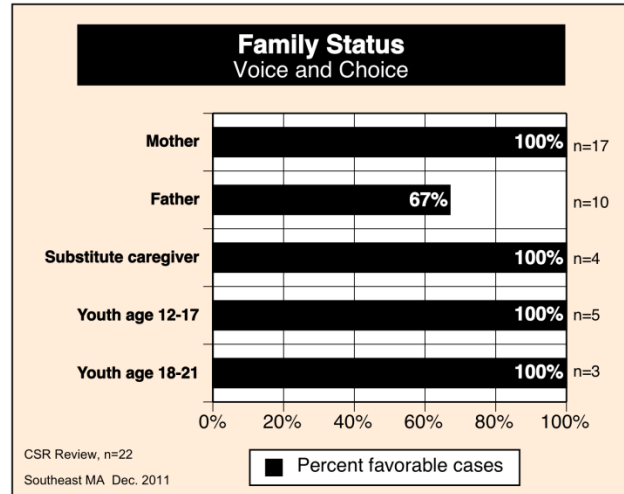
Parent/Caregiver Challenges

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 17 mothers of youth reviewed in the CSR for which this indicator could be rated. Of these, 71% had favorable status related to the level challenge they were experiencing. Twelve or 71% of the mothers had a level of challenge that needed to be “refined.” Of these, 29% were found to be having limiting circumstances impacting parenting capacities with inadequate supports.

Seventy percent (70%) of the 10 fathers of youth reviewed had a favorable level of challenge. Nine or 90% were experiencing levels of challenge that could benefit from “refinement” or “improvement” ranging from minor limitations with adequate supports to major life challenges with inadequate or missing supports.

For the four substitute caregivers of youth reviewed, all (100%) had a favorable level of challenge. One had minor limitations that would benefit from “refinement.”



Family Voice and Choice

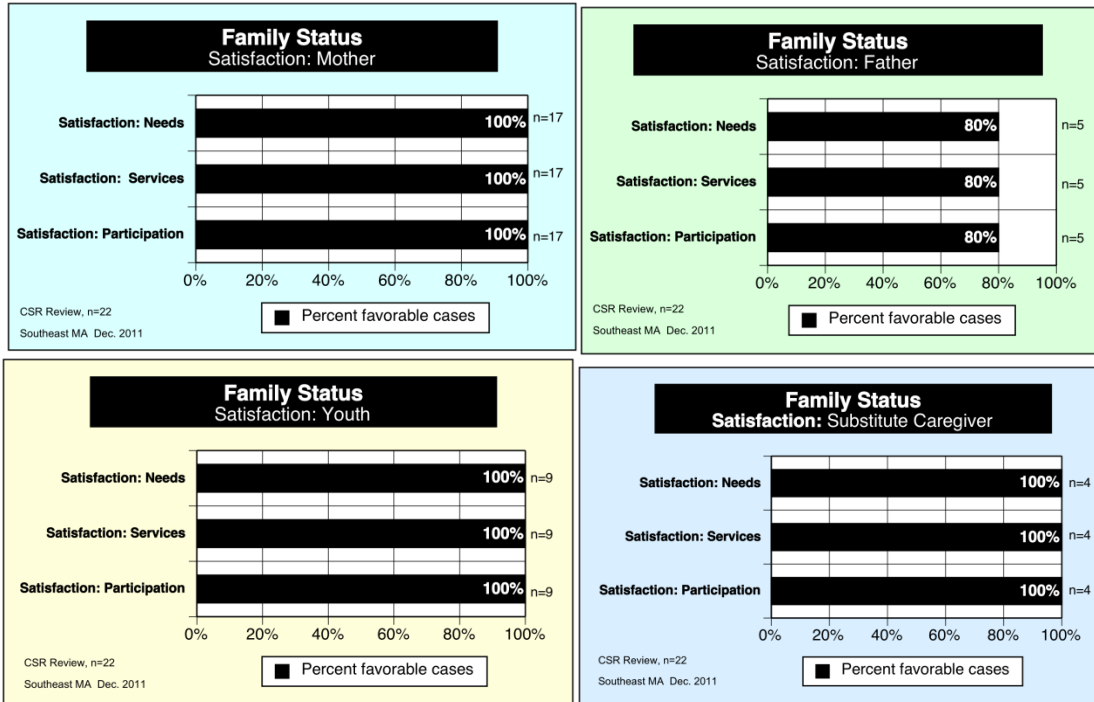
Family Voice and Choice is rated across a range of individuals as seen in the Caregiver Status: Family Voice and Choice chart above. For this indicator, in addition to parents/caregivers, the voice and choice of the youth is rated for youth who are over age 12. The variables that are considered when 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.

All 17 mothers (100%) for which the indicator could be rated were experiencing favorable voice and choice in their child's assessments, planning and service delivery processes. Fourteen mothers (82%) had "good" to "optimal" voice and choice. Three mothers (18%) would benefit from refinement in strengthening their voice and choice.

For youth whose fathers were involved and information could be gathered (N=10), 67% or 6 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. Five of the fathers, or 50%, could benefit from "refinement" in the influence of their voice and choice in planning and service delivery. Two fathers (20%) fell in the range of needing improvement as his voice and choice was substantially inadequate.

All four substitute caregivers (100%) of youth in the sample had favorable voice and choice; three had "good" voice and choice, and one had minimally adequate voice and choice that would benefit from "refinement."

There were five youth in the 12-17 age range in the sample and 100% of them had favorable voice and choice in their services that was "good." The three youth in the 18-21 age range likewise all (100%) had favorable voice and choice, one of them "good" and two needed "refinement."



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, youth and substitute caregivers were 100% satisfied with their needs being understood, their level of participation, and with services. For the five fathers that satisfaction was measured for, satisfaction was 80% for all domains measured.

Summary: Caregiver/Family Status

Both mothers and fathers in the Southeastern Massachusetts CSR were found to have fairly high levels of challenge in their lives. Support for youth was negatively impacted for fathers, and far less for mothers. The substitute caregivers did not have substantial challenges and support for youth was high. Family voice and choice was strong for mothers, youth, and substitute caregivers; fathers had less of a voice and choice in service processes. Satisfaction was strong among mothers, youth and substitute caregivers, and fairly strong for fathers.

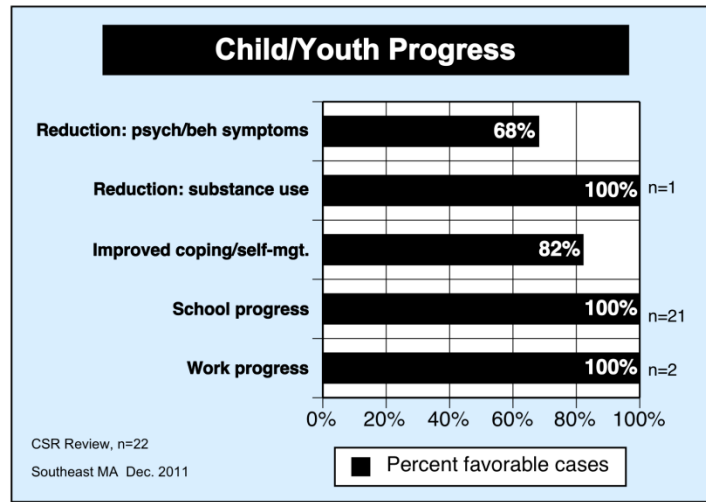
Youth Progress

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

Determinations about a youth's progress serve as a context for understanding how much of an impact services and supports are having on a youth's forward movement in key areas of her/his life. 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-eight percent (68%) of the youth reviewed made favorable progress in reducing symptomatology and/or problem behaviors over the six month period previous to the CSR. Seven youth, or 32% of the sample made “good” progress at a level somewhat above expectation. Fifteen youth or 68% of the sample could benefit from “refinement” in their level and rate of progress in reducing symptoms, and were making marginal to fair progress.

Reduction of substance use. There was one youth in the sample with substance abuse issues who was making favorable progress at a “good” level and rate.

These results indicate focused support for teams is needed to help youth progress in reducing psychiatric issues.

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.

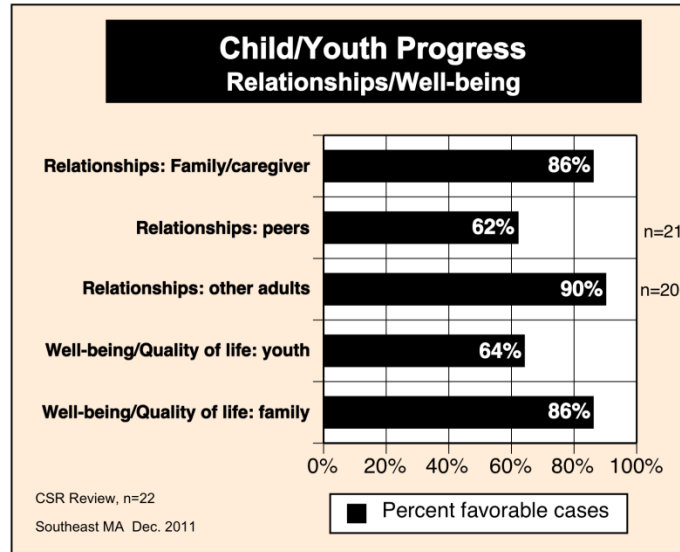
Among the youth reviewed, 82% or 18 youth were making favorable progress in improving their coping skills and ability to self-manage their emotions and behaviors. Seven youth (32%) made “good” progress in improving their ability to cope and manage their own behaviors. Fifteen youth (68%) could benefit from “refinement” and had made fair to marginally inadequate progress.

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 21 youth for which the indicator applied, 100% were making favorable progress in their educational programs, a very strong finding. Twelve youth or 57% were making “good” or “optimal” progress in school reflecting consistent rates and levels of progress. Nine youth (42%) were determined to need “refinement” and all were making fair progress.

Work progress. Two youth in the sample were working, and both (100%) were making favorable progress in satisfying expectations of employment, one at a “good” level and one that would benefit from “refinement.”



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 19 or 86% of them were making progress in their relationships with their families or caregivers. Progress in building peer relationships was far less favorable, with only 62% or 13 of the 21 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 20 of the youth reviewed, and was favorable for 90%.

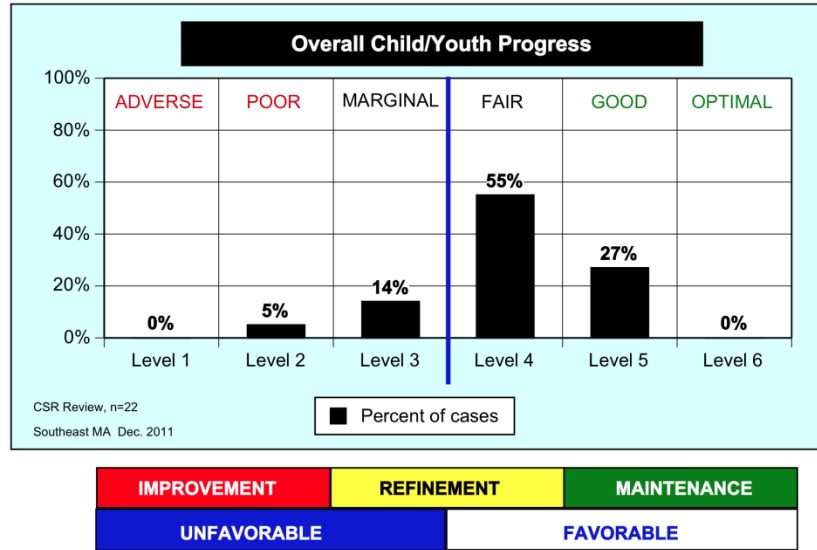
Overall Well-being and Quality of Life

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 64% were making favorable progress in an improved overall well-being and quality of life. Six youth, or 27% had made "good" or "optimal" progress over the last six months in developing and using personal strengths, long-term relationships, life skills, and future plans. Fifteen youth or 68% 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. One youth (5%) needed improvement, and was 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=22) of the youth, 19 or 86% were making favorable progress in improving the overall quality of life. Among these were eight families (36%) who had made “good” or “optimal” progress, and fourteen (64%) needing “refinement.”

These results indicate that improving the overall well-being and quality of life for youth 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 82% of the youth were making favorable progress (Fair, Good or Optimal Progress).

Among the youth, 5% was determined to need improvement due to poor progress across the indicators. No youth were making adverse progress, or were regressing. Sixty-nine percent (69%) 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 27% 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 Reduction of Psychiatric Symptoms, Peer Relations, and Well-being/Quality of Life of Youth, progress was fair to good for youth in Southeastern Massachusetts.

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.

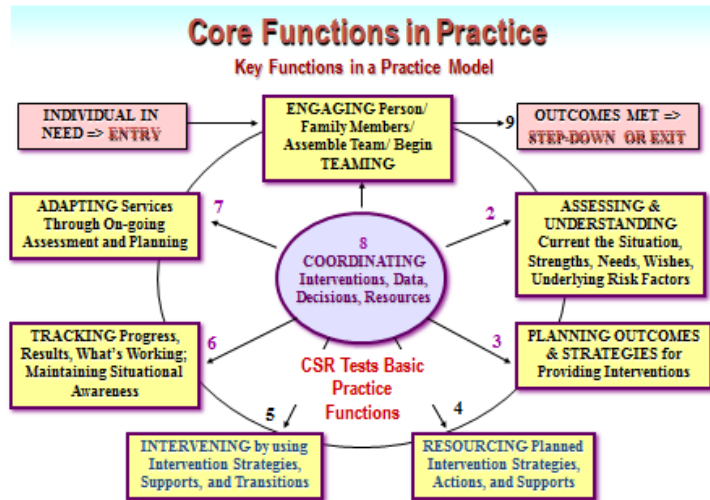
1. Engagement
 2. Cultural Responsiveness
 3. Teamwork
 - a. Formation
 - b. Functioning
 4. Assessment and Understanding
 5. Planning Interventions
 6. Outcomes and Goals
 7. Matching Interventions to Needs
 8. Coordinating Care
 9. Service Implementation
 10. Availability and Access to Resources
 11.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

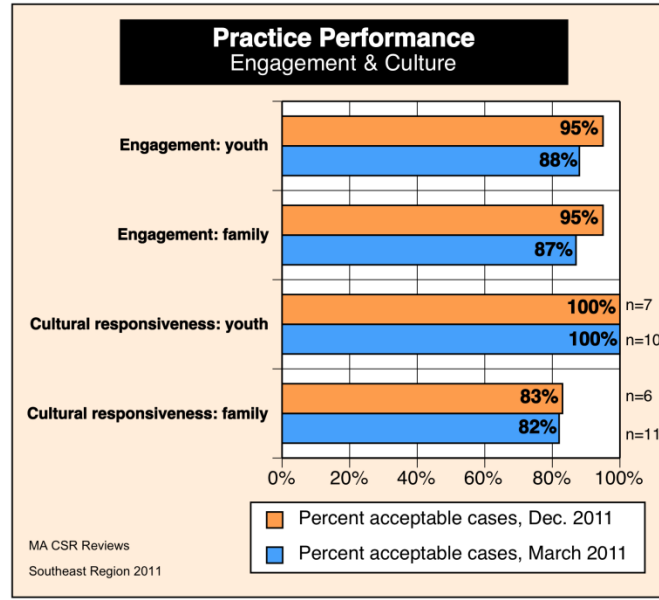
Reviewing System and Practice Performance in the CSR

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 22 youth reviewed, 21 or 95% experienced an acceptable level of engagement. This was in the range of performance but slightly better than the last CSR result for Youth Engagement (88% acceptable). In this year's CSR, sixteen or 73% of youth were engaged at the "good" or "optimal" level. The remaining six youth or 27% would benefit from "refinement" of engagement efforts.

Family engagement. Families were engaged at an acceptable level 95% of the time, which was in the range, but an improvement over the previous CSR. This year, 17 families or 77% were engaged at a "good" or "optimal" level. Seven families or 32% of those reviewed may have benefitted from a "refined" level of engagement.

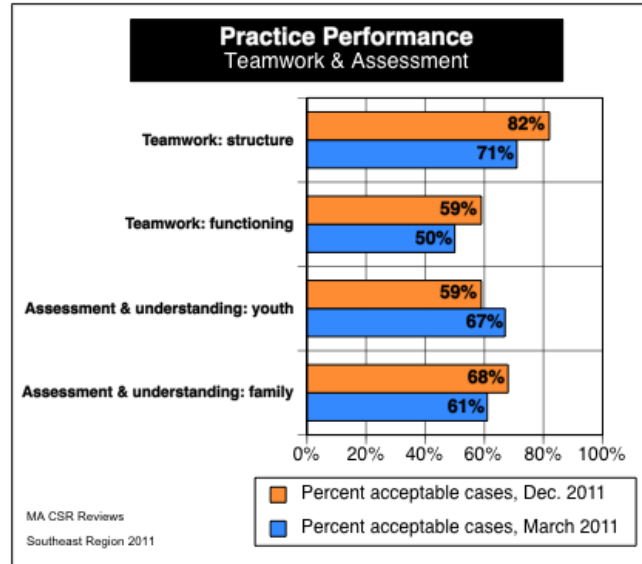
Cultural Responsiveness

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 7 youth reviewed for which the indicator applied, Cultural Responsiveness was acceptable for all of them (100%), the same result as the last CSR.

Cultural Responsiveness in December's CSR was found to be "optimal or "good" for 6 youth, and 1 youth (14%) would benefit from "refinement."

Cultural responsiveness to families. For the 6 families the indicator was applicable for, cultural responsiveness was acceptable for 83%. This was in the range of the previous CSR results when 82% of families experienced acceptable cultural responsiveness. "Refinement" this year was determined to be needed for 2 families or 33%, including one family that experienced marginal cultural responsiveness.



Teamwork: Team Formation and Team Functioning

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

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

Team Formation. For the 22 youth reviewed in Southeastern Massachusetts, team formation was acceptable 82% of the time or for 19 youth. This was an improvement over the previous CSR’s performance of 71% of youth with acceptable team formation.

In this year’s CSR, 9 youth or 41% of the sample experienced “good” or “optimal” team formation. Eleven teams (50%) needed “refinement” in their ability to form. In these cases, team formation was minimally adequate to fair, or marginally inadequate. Two youth (9%) experienced absent or adverse team formation that needed “improvement where there was no evidence of a functional team.

Team Functioning. Teams were functioning acceptably well for only 59% of the youth reviewed. Although this was an improvement over the last CSR’s performance when only

half (50%) of teams were functioning well, it continues to be a concerning performance level for this key system practice.

For 6 youth in December's CSR sample (27%), teams functioned at a "good" or "optimal" level. For 14 youth (64%) 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 youth (9%) had no evidence of a functional team, or actions and decisions made by people were inappropriate/adverse to the youth and family,

An example of team formation and functioning for a youth that was found to be acceptable but in need of refinement is, "The team has engaged (the youth) and mother in the ICC process and services. The team includes the appropriate members and they have a good understanding of (the youth). Team formation has been good, but is in the refine zone because the team was slow to pick up on (the youth's) steady deterioration this Fall."

An example where the team is struggling to implement an effective plan, engagement and team communications is: "Team functioning ...needs improvements. Information seems to be gathered by the Care Coordinator and she makes strong efforts to communicate with (the youth's) mother but there is poor engagement. The Therapeutic Mentor has a good connection with (the youth) and mother, but creeps into doing family work which is outside of (the) scope. The family reports to the Family Partner and Care Coordinator needing additional supports for in the home but then has struggled to understand their benefit or role when they begin the work. There seems to be a need for additional efforts to understand and engage (the youth's) mother in the process."

The ability of Care Planning Teams to function well for youth and families is a foundational system requirement. Teams in Southeastern Massachusetts appear to be forming, but would benefit from concerted supports to help them understand their roles and function effectively.

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 22 youth reviewed, only 59% of teams were found to have an acceptable level of assessment and understanding of the youth's core issues and situations. This was a decline since the last CSR when 67% of youth had acceptable assessment and team understanding of their situations, underlying issues and needs. This is an area of that clearly needs improvement.

In December's CSR, 10 youth (45%) had teams that had "good" or "optimal" assessment and understanding. Another ten youth (45%) would benefit from "refinement" of practices,

and assessment and understanding was either fair or marginally inadequate. Nine percent (9%) or two youth had teams that had poor, incomplete or inconsistent assessment and understanding.

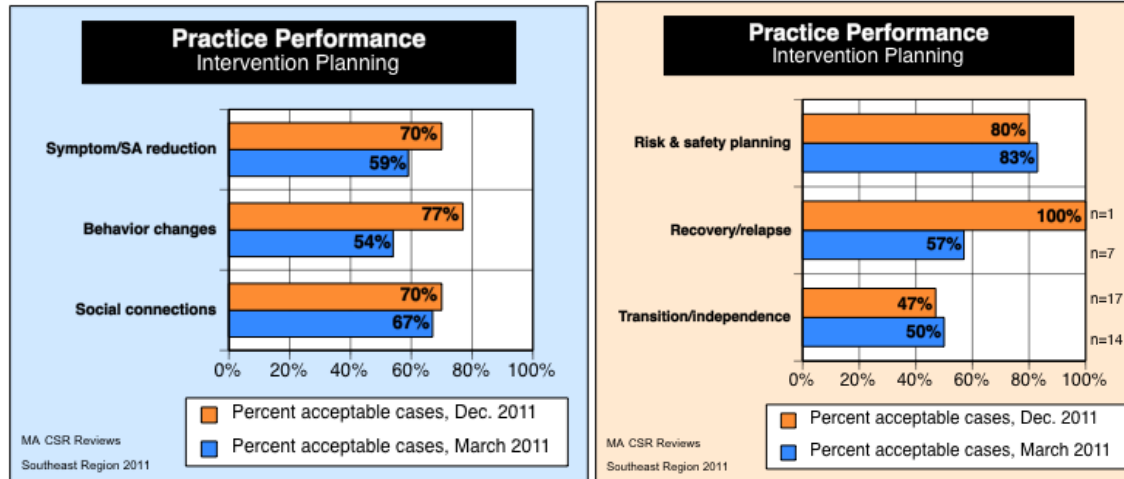
Assessment & Understanding of Families. Assessment and understanding of families was acceptable for 68% of the sample. This was an improvement over the last CSR's results of 61% of teams having acceptable assessment and understanding of families' strengths and needs, but continues to be an area that needs improvement.

In December's CSR, nine teams (41%) had "good" or "optimal" understanding of the families reviewed. "Refinement" was needed for twelve families (55%) 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 (5%) the team's understanding was poor, incomplete and inconsistent among team members.

There were no discrete examples of good assessment and understanding of youth described in the narratives by CSR reviewers, but those that were rated as acceptable generally had effective plans and teaming.

An example of assessment and understanding where the team had an incomplete understanding of the youth's risks and behaviors resulting in poor planning is: "Assessment of the child needs improvement. The initial assessment (by the first IHT clinician) references significant mental health issues... which are never followed up. The many hospitalizations and CBAT emergencies call for a fuller understanding of the emotional disturbance of this child, with a clearer grasp of how (the youth's) underlying needs may be affecting (the) behavior. Intervention planning needs improvement, especially in the area of planning ahead for potential disruptions of the very fragile home stability."

Another example illustrates the need for coordinating and gathering information across people who have provided assessment in order to come to a comprehensive well-informed understanding that can effectively inform care planning: "The psychiatrist and neurologist at (the) Hospital have not been integral members of the team, and communication with them has not been sufficient to fully inform the team of (the youth's) diagnosis, treatment plan, and ongoing psychiatric/neurological needs. The educational advocate was aware of a neuropsychological evaluation that had been done at (the) Hospital, but this information had not been incorporated into the CSA assessment or care planning process. A Mental Health Assessment that clearly describes signs and symptoms and impact on functioning is not present in the record, although the CSA assessment and CANS are present. This lack of a complete assessment limits the team's understanding of (the youth's) needs and the planning for needed interventions."



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 applicable to 20 youth and acceptable for 70% of them. This was an improvement over the last CSR's results of 59% of youth with acceptable planning for symptom reduction, but continues to be an area of practice the needs more focus.

There was "optimal" or "good" planning in reducing symptoms or substance abuse for eight or 40% 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 nine or 45%. In these cases planning was fair to marginally inadequate. Planning to reduce psychiatric symptoms was found to be poor for three youth or 15% of those reviewed, with poorly reasoned and inadequate planning that failed to provide interventions to address youth's symptoms.

Behavior Changes. Targeting *Behavior Changes* in planning was also at an acceptable level for 77% of the youth. This was an improvement over last year's performance of 54% of youth having acceptable planning to address behavioral change.

In the most recent CSR, eleven youth or 50%, 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 ten or 45% of the youth. The planning for these youth was fair and somewhat reasoned, to marginally inadequate and inconsistently aligned

across interveners. One youth or 5% of those reviewed experienced a poorly reasoned inadequate plan that failed to design interventions to address behavior changes.

Social Connections. Planning for increasing *Social Connections* was acceptable for 70% of the 20 youth the indicator was applicable for. This was comparable to the last CSR's result of 67%, and improvement continues to be needed to assure teams more consistently plan to strengthen youths' social connections.

Eight youth (40%) had "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 ten youth or 50% of the sample. Two youth (10%) had poor planning reflecting unaligned strategies lacking in the clarity and urgency necessary to address the youths' need for social connections.

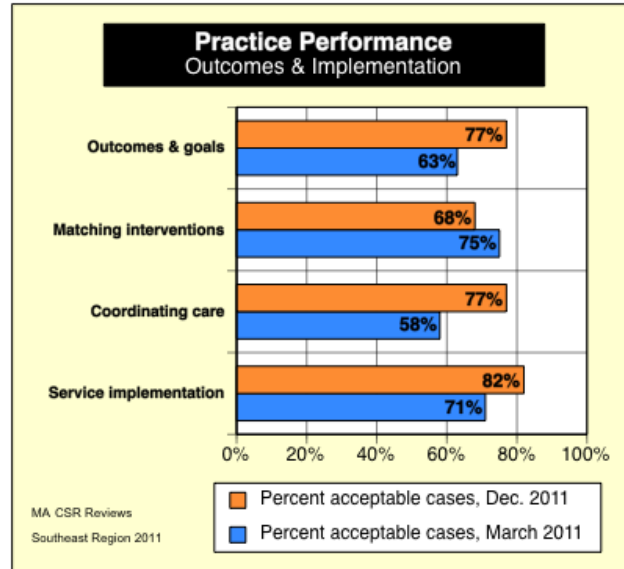
Risk/Safety Planning. Planning to address youths' risk and safety issues was applicable for 20 youth and acceptable for sixteen or 80%, a comparable result to the last CSR. The risk/safety component of plans was "optimal" or "good" for eleven youth or 55% of the sample. For four youth (20%), risk and safety planning needed refinement and was fair or marginally inadequate.

Recovery/Relapse Planning. One youth in the sample needed *Recovery or Relapse* addressed in their care plan, and planning was acceptable but would benefit from refinement. In the last CSR seven youth needed planning in this domain, and planning was acceptable for only 57%. No conclusions about improvement can be drawn due to the significant difference in the samples.

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 seventeen needed to have a transition addressed in their planning processes, and performance was acceptable for only eight youth or 47%, indicating considerable improvement is needed in transition planning for youth. This was a slight decline over last year's performance of 50% of youth having acceptable transition planning.

Transition planning was "good" for four of the youth or 24%, with plans that were generally well-reasoned, largely informed by the youths' and families' perspectives, and accountable. Nine of the youth (45%) 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. Four youth or 24% of those reviewed had poor transition planning that was inadequate, with no sense of clarity or urgency to achieve successful transitions.



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 77% of the youth. This was an improvement over the previous CSR results of 63% acceptable specification of outcomes and goals by teams.

Eleven youth or 50% had good specification of goals by their teams that were well-reasoned and specific. Ten or 45% of the youth reviewed had ending goals and outcomes that needed to be “refined,” and were fair to marginally inadequate. One youth (5%) had poor specification of outcomes and goals which was insufficient to guide 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 only 68% of the youth in the sample. This was a decline in performance since the last CSR when 75% of the sample had acceptable results. These findings indicate that assuring youth are receiving interventions that meet their needs is a system practice that needs improvement.

Nine youth (41%) had “good” or “optimal” matching of interventions to needs. Twelve youth or 55% 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. One youth (5%) had poor matching of interventions to needs with supports and services that were poorly assembled and were inadequate in meeting identified needs.

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=7). Care coordination practices were found to be at an acceptable level for 77% of the youth reviewed, an improvement over the last CSR when 58% of youth had acceptable care coordination

Care coordination in December 2011 review was found to be “good” or “optimal” for nine youth or 41% of the sample. For twelve youth or 55%, care coordination would benefit from “refinement,” and practices were fair and minimally adequate, or marginal and limited with little leadership for service delivery and results. One youth (5%) had poor and fragmented care coordination.

Care coordination practices that are working well are described in this example as: “(The Care Coordinator appears to do a good job of communicating with various team members regarding plans. Communication at the level of coordinating activities seems good. (The Therapeutic Mentor), for example, communicates with (the) “hub” (the CSA) weekly.”

An example of care coordination that needed improvement is: “The IHT clinician, by comparison, seemed less involved and not clear on (his/her) role, not as involved with the team or with (the youth)....This raised the question of whether the appropriate CBHI service would be ICC, since the team is large and participants change with (the youth’s)

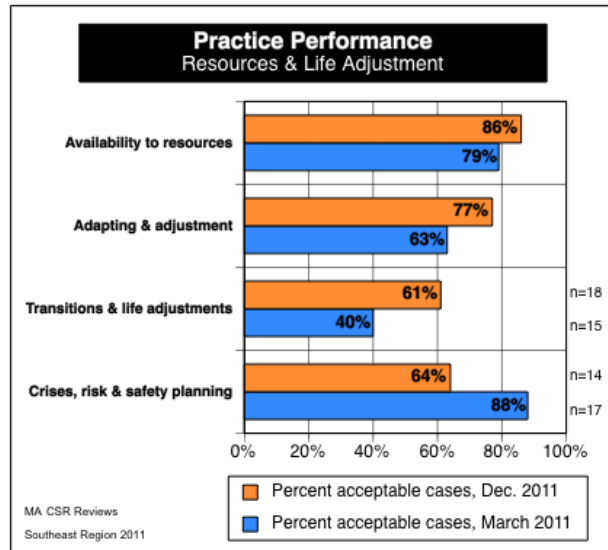
moves. ...There are major decisions looming... which will require coordinated, high-level teamwork.”

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, 86% were determined to have acceptable service implementation. This is an improvement over the previous CSR result of 71% acceptable, and indicates more youth are having the services and supports in their plans consistently implemented.

Twelve youth or 55% 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 nine or 41%, service implementation needed “refinement” and the overall pattern of implementing needed services and supports was fair to marginal and inconsistent. One youth or 5% had poor implementation with few services being implemented at inadequate levels of necessary intensity.



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-six percent (86%) of the youth reviewed were found to have acceptable access, an improvement over the previous CSR performance of 79%. Eleven youth or 50% had “good” or “optimal” access to needed resources. The remaining eleven youth or 50% 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 the youth reviewed, practices related to adapting and adjusting plans and services was acceptable for 77%. This was an improvement over the last CSR results when only 63% of youth experienced acceptable practices in adapting and adjusting.

Nine youth or 41% had “good” or “optimal” practices that were responsive to changing conditions with acceptable levels of monitoring and adjustment. Twelve youth (55%) were experiencing needed changes to their plans and services at a minimally adequate to marginally inadequate level, with only periodic to occasional monitoring. One youth (5%) had a fragmented or shallow adapting and adjustment process that was not responsive to changing conditions.

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 eighteen youth this indicator applied to, only 61% or eleven youth had acceptable transition management practices. This was decline compared to last year when only 40% of youth received acceptable transition management. Transition management continues to be a weak system practice that needs improvement.

In the most recent CSR, three youth (17%) experienced “good” transition interventions. Fourteen youth (78%) could benefit from “refined” transition supports, and had minimally adequate to marginally inadequate transitional interventions. One youth’s (6%) next transition had not been addressed.

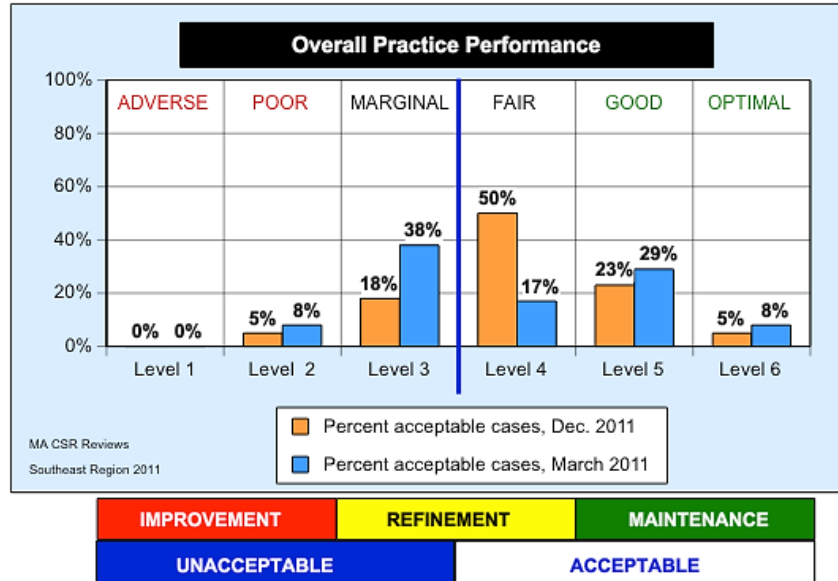
Overall, results indicate improvement in practices to identify, plan for and implement transition supports for youth are needed.

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=14), only 64% had an acceptable crisis response that worked acceptably well for them. This represented a considerable decline in performance since the last CSR findings when 88% youth had acceptable findings on this indicator.

Seven youth (50%) were rated to have experienced an “optimal” or “good” response to crises and/or safety issues. Six youth (43%) would benefit from “refinement” in the response to their crises and risk/safety issues and experienced fair to marginally inadequate crisis responses. One youth (7%) experienced an absent/adverse response to crises.



Overall System/Practice Performance

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

For the 22 youth reviewed in the December 2011 CSR for Southeastern Massachusetts, 78% were found to have acceptable system/practice performance. For 22% of youth, the system was not providing dependable, quality services. These findings represent an improvement in overall performance as compared to the previous CSR when only 55% of the sample had acceptable findings.

The largest percentage of youth (68%) fell in the “Refinement” area which means that performance was limited or marginal, and further efforts are necessary to refine practices.

Twenty-eight percent (28%) of the youth fell in the “Maintenance” area, meaning that system and practices were effective for the youth reviewed, and efforts should focus on sustaining and building upon positive practice.

Practice for more youth fell in the “Refinement” area and fewer in the “Maintenance” area than in the March 2011 CSR. In that CSR, 37% of youth had performance that needed to be maintained, and 55% that needed to be refined.

Five percent (5%) 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 “Fair” level (50%), meaning system practice was minimally or temporarily sufficient to meet temporary needs. Performance for these youth was minimally adequate but short-termed in nature with changes in practice likely required.

The data indicate that the strongest areas of practice for youth in Southeastern Massachusetts were Engagement with the Youth and Family; Cultural Responsiveness to the

Youth; and Availability and Access to Resources. Planning Interventions for Recovery and Relapse for the one youth the indicator applied to were also good.

Indicators that showed an overall fair performance that was less consistent and minimally sufficient were Cultural Responsiveness to the Family; Teamwork (Structure/Formation); Planning Interventions for Behavior Changes; Planning Interventions for Risk and Safety; Outcomes and Goals; Service Implementation; Care Coordination; and Adapting & Adjustment.

Areas of system/practice performance that will need improvement in order to be considered adequate consistency, intensity and/or quality of efforts are: Assessment & Understanding of the Family; Planning Interventions for Symptom Reduction; Planning for Social Connections; and Matching Interventions to Needs.

Review results indicate weak performance in the following system/practice domains: Team Functioning; Assessment & Understanding of Youth; Planning Interventions for Transitions; Managing Transitions & Life Adjustments; and Responding to Crises.

A number of system practices showed improvement over the previous CSR. Of note were practices were team formation, service implementation and availability of resources, all practices that improved and were performing at a fair level. Others that improved, and with continued support could show a promising trend, are planning for behavioral change, establishing clear outcomes and goals, coordinating care, and adapting/adjusting care.

Overall practice was fair (78%) and it appears that the system of services in Southeastern Massachusetts has improved across a number of areas that were found to be weak in the last CSR. However, key system functions need more development, and cannot yet be considered reliable in helping youth make progress, achieve desired outcomes or maintain recent gains. Important practice functions need concerted attention. Of particular concern is how well teams are functioning; over 40% 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 in ways that could impact positive change for youth and families. Similarly, over 40% of youth and 32% of families were not well-assessed or understood, which is a foundation for providing effective supports and services for youth and families. Further, 32% of youth did not have a current mental health assessment in their files. Planning transitions for youth was unacceptable for over half of the youth (53%), and transitions were not managed well for 36%. Managing crises for youth dipped to being acceptable for only 64% of youth as compared to 88% in the previous review.

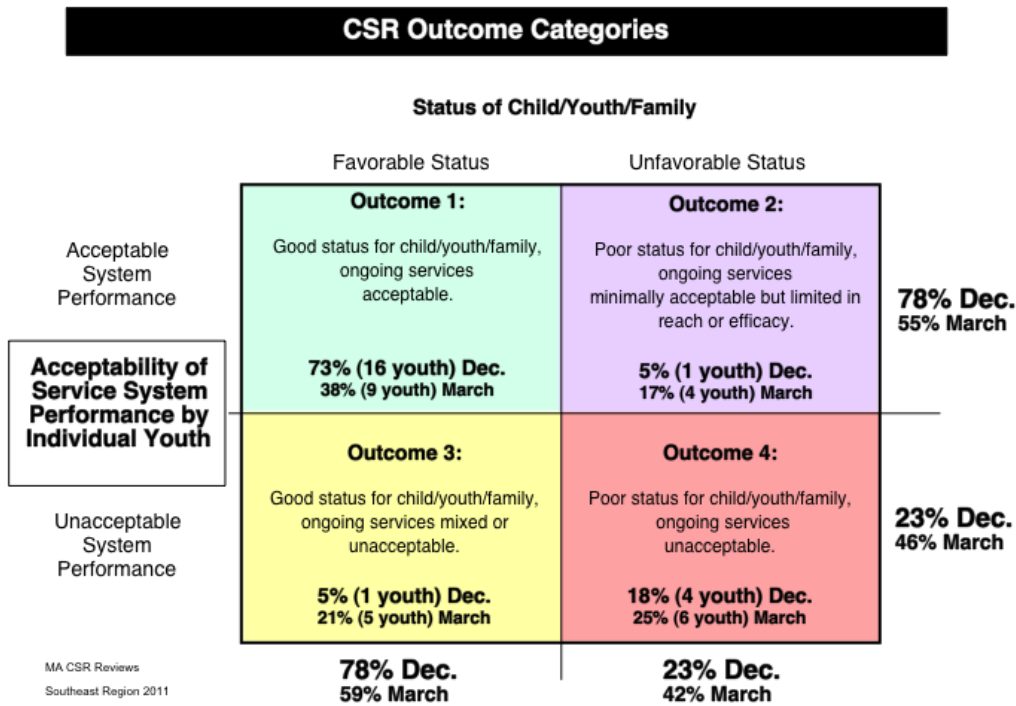
Focused attention on these system functions, the areas of concern identified in the summary of this report and sustaining gains made since the last CSR will be important activities for the Commonwealth to address in order for services in Southwestern Massachusetts to be considered performing in ways that are effective, consistent and reliable for youth and families.

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: Southeastern Massachusetts CSR (December 2011)



System/Practice Performance for youth

in the December 2011 Southeastern Massachusetts CSR was 78%.

- This means that services were working at a dependable or consistently acceptable level for 78% of the 22 youth reviewed, which is considered to be fair performance.
- This was an improvement in performance over last year’s CSR result of 55% of youth with acceptable system/practice performance.

Outcome 1

As the display indicates, 73% of the 22 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.

In the previous CSR, 38% of youth fell into Outcome 1.

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

“There has been good engagement with both the youth and...parents. The team that has been active has functioned well, with good communication and coordination efforts. All members of the team report a positive, productive planning process with frequent monitoring of progress in school and in peer relationships. Intervention planning in the area of social connections has been good, and (the youth) has developed one friendship that has transferred from school to the community with supervision. The Family Partner has been instrumental in identifying appropriate resources in the community for both (the youth and parents).”

Outcome 2

One youth or 5% 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.

In the previous CSR, 17% of the sample fell in Outcome 2.

An example of a youth who fell in Outcome 2 who had been progressing, but has had a recent crisis impacting his/her emotional well-being is as follows. The youth's team is very active and well-connected:

“(The youth's) mother is clearly connected to all of her providers. She was able to discuss each service, what the goals were for that service, and how she felt the service was working or not. The Team also clearly knows their roles. Each providers' goals and outcomes were complementary to the others, with very little of the overlap or duplication that one often sees with so many services involved. The IHT program was focusing primarily on improving relationships among (the youth and) siblings; the IHBT Team was working primarily with (the youth's) mother around her reactions to her children's behavior and successful management of their challenging behaviors; the Therapeutic Mentor and DMH Respite worker were focused primarily on (the youth's) social skills in the community with other adults and peers; the individual therapist is focused primarily on the (youth's) issues; the Family Partner has been working with (the youth's) mother around obtaining benefits for the family to help sustain them financially, and helping connect (the youth's) mother to community supports. The Care Plan was written very well, with clarity about Goals, and how progress towards the objectives would be monitored and tracked. Safety plans were also sent to the MCI team...”

Outcome 3

One youth or 5% of the sample 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.

In the March 2011 CSR, 21% of the sample fell in Outcome 3

The following is an example of a youth in Outcome 3. This youth is doing minimally well in school, but struggles with emotions, and has ongoing permanency and stability concerns. The team has been apprehensive, and as a result has not been able to address concerns in the home.

“The team does not have a comprehensive understanding of the many factors at play in (the youth)’s life. Without a well-rounded understanding of what (the youth) has experienced in...life and how those experiences have been processed through (the youth’s) mental health challenges, (the team) is not able to come up with interventions that address (the youth’s) needs in a comprehensive way.”

Outcome 4

In the Southeastern Massachusetts CSR, 14% of the sample or 3 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 an 11% improvement this year in the number of youth in Outcome 4 over the last CSR when 25% of the sample was in Outcome 4.

An example of a youth who fell in Outcome 4 is as follows. The youth had marginal status, there was no effective team in place, planning was weak and service delivery has been inconsistent:

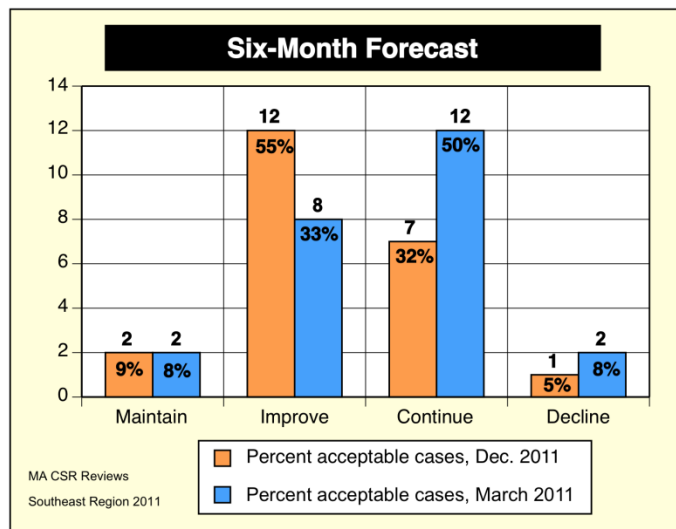
“There is no team working with (the youth) so care and understanding is somewhat fragmented. There is no comprehensive assessment in the chart, and the care plan consists of fairly generic interventions that are not tailored to this child and (the) unique needs. Intervention planning does not adequately address any areas, although there is a safety plan in place. Outcomes and goals are stated, but relate only to improving (the youth’s) behavior to mother’s standards at home. There is minimal care coordination, although IHT will attend a school meeting in the future. The interventions do not address all of (the youth’s) and the family’s needs in a way that will effect positive, long-lasting change. The family has been enrolled in IHT since July 2011 and there have been two periods of at least a month that IHT had no contact with the family for different reasons. This has certainly affected the consistency in treatment and planning, as well as the IHT ability to make appropriate adaptations to the intervention plan based on real time changes in (the youth’s) life.”

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 9%, the prediction was that the youth would maintain at a high status level (youth in the “good” or “optimal” status category). For 12 youth or 55% of the sample the prediction was for improvement in status. For 7 youth or 32% (youth with “fair, marginal, poor or adverse” status) reviewers predicted the youth’s status to continue at the same level. For 1 youth or 5%, the prediction was that their status would decline.

These results are an improvement over the last CSR’s Six-month Forecast results as a larger percentage of youth were predicted to improve in their status.



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 Southeastern 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

Many of the staff providing services were skilled and providing beneficial services.

The training, supervision, background and quality of Therapeutic Mentors were evident; many were using effective strategies in their work with youth. Stakeholders commented that Therapeutic Mentors were evolving into a “service of choice” of many families as well as other child-serving agency staff because of their ability to connect with youth and positively impact their therapeutic progress.

As well, Family Partners in general were observed to be experienced and skilled. There were a number of bi-lingual Family partners, which was helpful to families.

As compared to the last CSR, more care coordinators and direct service staff could describe interventions with greater specificity. More teams had a better overall understanding of strengths and needs of youth and families. There was noticeable advocacy for the youth by care coordinators and teams. New staff in many of the agencies were oriented to the requirements of their positions, and were prepared for their work with teams and families.

Of note is many parents expressed that their children were benefiting from services. A frequently expressed sentiment of families was that the care planning process was overly protracted, but once they began receiving services, the services they needed were readily available.

Teams were forming to respond to the needs of youth and families.

Teams were observed to have “community-based” orientations, connecting youth to community resources. School staff for many of the youth were invested and involved in teams, and team meetings were often occurring at schools.

Challenges

Parents felt that key aspects of services were not responsive to their children’s and families’ needs.

A theme in discussions with parents was their frustration with what they see as a slow response of services when their children need help. Parents expressed that they came into services expecting help, and felt too much time was spent on planning; they would rather have quicker access to services that could help stabilize their situations. A number felt that the service teams had difficulty in recognizing what needed to be done in order to help their children. Parents felt understanding and addressing their children’s underlying issues came slowly. Many expressed frustration with the team planning process and felt they were “starting over” at every meeting, versus receiving the services that could help their children with their mental health concerns.

Parents identified that what would help them the most are social and support groups for families, funding for basic needs, education for providers, adoption supports, and providing timely services.

Aspects of outpatient service delivery are incongruent with the system of care approach.

Outpatient providers were reported to be reluctant to fulfill the role of being a “hub” for services. There appears to be systemic disincentives to outpatient providers to coordinating care, or providing services at the intensity and modality needed.

Outpatient therapy is generally disconnected from the team-based family-driven model. Services such as Family Partners are rarely connected to outpatient hubs, which often hampers ICC or IHT teams from transitioning youth to outpatient services while offering continuity of support through Family Partners. A concern for many youth is lack of goal continuity when youth transition to outpatient services.

Access to psychiatric services through the outpatient clinic model continues to be extremely problematic. Youth are known to wait for months for a medication evaluation. Further hampering access are agencies that require a “trial” of outpatient therapy of four-six sessions before access to the psychiatrist is allowed.

Discharge from services is frequently driven by time limitations versus youth needs and completion of treatment goals.

IHT in particular is seen as a “6-month service” and rarely goes beyond 8 months. Some youth are being discharged from services before goals are met, and there are reports of teams and schools not being informed when services end. Many youth are reportedly returning to services as a result of continued needs being unaddressed.

Other challenges identified were:

- Therapeutic mentors are often the preferred service for youth, but are difficult to access. Many youth would rather have a mentor than a therapist. This challenge may relate to limitations of outpatient therapy or IHT.
- Some of the CSAs reported that the requirement to have a consulting psychiatrist has been “dropped.”
- Engaging the medical community is difficult but important, especially in assessing and treating medical issues which may be underlying children’s problems. PCPs need more education about CBHI.
- Youth’s transitions need more concrete proactive planning and active support.
- More younger children need services; services for young children are difficult to access.
- The role of residential services in the system of care needs development to assure it is congruent with the broader system, especially in the area of engagement of parents, schools and teams.
- A significant number of youth and families experience service disruptions due to insurance issues.
- Youth with intellectual disabilities and co-occurring mental health issues have difficulty accessing services.

Recommendations

Supporting practice of care coordinators and teams:

- Strengthen supervision and supports for teams that need help in better understanding the reasons for youth’s challenging behaviors, or when youth are not progressing.
- Consider current progress and improvements when assessing if youth should be discharged from any service.
- Strengthen the skills of care coordinators and their supervisors so the work consistently moves beyond a “service brokerage” model, and is helping teams to craft strategies that work and respond at the depth needed by youth and families.
- Assure all youth have a current quality mental health assessment that informs team planning.
- Assure youth that are receiving multiple medications, off-label prescriptions, medications for behavioral control or more than one medication for a single diagnosis are carefully monitored and reviewed.
- Improve meaningful coordination with psychiatrists and medical providers.

Strengthen support for youth, parents and community partnerships:

- Consider ways to provide support groups and social events for youth and families.

- Provide opportunities for youth leadership, and support youth participation in System of Care Committees or other venues where their voice can collectively help improve services.

System-level recommendations:

- Address ways to improve the role of outpatient services, continuity of care, outpatient “hub” functions and access to psychiatry.
- Identify structural and systemic solutions to improve outpatient providers’ capacity to perform the functions that support a child and family to continue to make gains and progress previously achieved in more intensive services.
- Consider that some youth may need quicker access to direct services that may need to be provided concurrent to the assessment and planning process.
- Explore modalities of IHT and outpatient service provision that families and youth find beneficial and that youth are receptive to.
- Provide education to community physicians and schools about children’s mental health and CBHI services.
- Develop strategies for improving system/practice functions that were found to be weak or needing improvement with particular emphasis on: Team Functioning, Assessment and Understanding of Youth and Families, Planning and Managing Transitions, and Responding to Crises.

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 (22-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.

Refinement Zone: 3-4
 Status is minimum or marginal, may be unstable. Further efforts are necessary to refine the situation.

Improvement Zone: 1-2
 Status is problematic or risky. Quick action should be taken to improve the 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

- 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

- 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.

Refinement Zone: 3-4
 Performance is minimal or marginal and may be changing. Further efforts are necessary to refine the practice situation.

Improvement Zone: 1-2
 Performance is inadequate. Quick action should be taken to improve practice now.

- 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

- 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

- 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.