ROSIE D. COMMUNITY SERVICES REVIEW- ANNUAL REPORT

Report of Statewide Findings- FY2011-2012

Findings of reviews of service system functions and practices conducted during Fiscal Year 2011-2012

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July 2012

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Executive Summary

The *Rosie D.* Court Monitor receives and reviews information from a variety of sources to monitor compliance and progress with the requirements of the *Rosie D.* Remedial Plan. The Community Services Review was selected in consultation with the Parties to assist the Court Monitor as one way to receive and review information about the status and progress of services and requirements of *Rosie D.* This Second Annual Report of Statewide Findings of the CSRs provides information about how well behavioral health services and the integrated system of coordinated care for youth with Serious Emotional Disturbances (SED) and their families committed through the *Rosie D.* Remedy Plan are performing for class members. The Remedy Plan commits the Commonwealth to providing services through a practice model that requires team-based work and fully integrates family voice and choice. Services are required to be delivered through a coordinated approach consistent with System of Care and Wrap-Around principles.

Between September 2011 and May 2012, five regional Community Services Reviews (CSR) were conducted in the Western, Northeastern, Southeastern, Central and Boston/Metro-Boston areas. In total, 142 youth and families receiving Intensive Care Coordination (ICC) and/or In-home Therapy (IHT) services through Community Service Agencies (CSAs) and provider agencies were reviewed.

Data in this report are presented at the statewide aggregate level. As well, comparative data of the five regional CSRs are displayed for the System/Practice Performance indicators. Reports were published throughout the year for each of the five regional CSRs.

Statewide Community Services Review Findings Summary

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

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

Youth Status. Overall youth status was favorable for 70% of the youth in the statewide sample. Youth were in permanent situations and safe across home, school and community settings. The youth reviewed were generally attending school regularly, and a significant number had favorable physical health status. Stability both at home and school was an issue for a substantial number of youth, as was academic status. A primary issue was the level of behavioral risk to self, which impacted risk status for 30% of the youth. Most concerning was the emotional status of youth; 49% of those reviewed were found to have unfavorable emotional well-being.

Across the indicators of youth status, 70% of the youth reviewed had an overall favorable status with no youth found to have "optimal" status, 25% with "good" status and 44% with "fair" status. The remaining 30% of youth had unfavorable status with 21% with "marginal" status, 8% with "poor" status, and 1% with "adverse" status. Please see Appendix 2 on Page 73 for descriptions of each status category.

Family/Caregiver status. Status of families and caregivers are comprised of a constellation of indicators that measure well-being and satisfaction. Fathers and mothers in the statewide CSR sample had high levels of challenge in their lives; support for youth was negatively impacted for both parents. Support for youth who were in substitute and group caregiving was positive. Family voice and choice was fairly strong for mothers and substitute caregivers, but weaker for fathers and youth. Satisfaction was favorable among mothers and fathers in the understanding of their needs and with services; fathers were less satisfied with their level of participation. Youth were satisfied with services, but less satisfied with their needs understood and their participation. Substitute caregivers were satisfied with all domains measured.

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. Only 63% of the youth statewide were making favorable progress (Fair, Good or Optimal Progress). This indicates that overall, youth were making weak progress in key life areas. Of particular concern was weak progress for youth in reducing psychiatric/behavioral symptoms, reducing substance use, and improving coping and self-management skills. As well, youth were not making progress in school and work, in their peer relations and in their overall well-being and quality of life at overall favorable levels. Youth were making fair progress in improved family relationships, and relationships with other adults.

System/Practice Functions.
Determinations of performance in key indicators of system and practice functions are made to evaluate how well services and service processes provide the conditions that lead to desired changes for youth and families. The CSR rates thirteen core system/practice functions. System practices, as reflected in the knowledge, skills and actions of staff and teams working in concert with youth and their families, support the achievement of sustainable results. The patterns of interactions and interconnections help explain what is working and not working at the practice points in the service system. The overall goal is system and practices to perform at consistently acceptable level for youth.

For the youth reviewed statewide, only 60% were found to have acceptable system/practice performance. This indicates overall system performance and practices for youth are weak. For 40% of youth, the system needs to improve its performance in providing dependable, quality services. This represents a decline in performance compared to the fiscal year 2010-2011 CSR when 66% of the sample had acceptable findings. Engagement with Families and Cultural Responsiveness remained strong system practices. Most of the other indicators were performing well below acceptable levels.

As stated above, the FY 2011-2012 CSR found strong practices at the statewide level in Engagement with Families with 88% of families experiencing acceptable performance on this indicator. Engagement with Youth was acceptable for fewer youth, with 80% experiencing acceptable engagement. Cultural Responsiveness reflected strong performance for both youth and families with respective 90% and 85% acceptable performance ratings for those the indicator applied to.

The two indicators for Teamwork focus on the structure and performance of youth and family care planning teams. Team Formation was acceptable for only 64% of the youth, indicating improvements are needed in order for families to be able to reliably depend on teams with the right composition and practices to plan and implement services and supports with them. Team Functioning was performing even less well with only 57% of teams functioning acceptably well. Both Teamwork indicators declined since last year's CSR. The statewide data indicate focused work is needed to help teams across the state to consistently form and work together to achieve common goals for youth and families.

The Assessment and Understanding indicators for youth and families reviewed how well teams and interveners gather all relevant information forming the basis for determining which interventions, supports and/or services will most likely result in meeting youth's and families' objectives. There was acceptable understanding for only 55% of youth, and 66% of families statewide. Assessment and Understanding performance declined since last year. These data indicate improvements are needed in practices that assure better understanding of the key determinants of the youth's emotional and behavioral issues, and the foundations for building effective plans.

Planning Intervention encompasses six sub-indicators. Results for acceptability of care/treatment plans and planning processes showed improvements are needed across all of the indicators of planning in order to achieve consistently effective plans. Planning for symptom/substance abuse reduction was acceptable for only 69% of youth, for behavior changes for 68%, and for social connections 61%. Planning for effective recovery and/or relapse prevention applied to 14 youth and was acceptable for only 43% of them. Planning for supporting transitions was acceptable for 49% of the 107 youth the indictor was applicable for. Risk and safety planning was acceptable for only 69% of the youth, and did not see the same gains made over the course of last year. All Planning Intervention indicators declined since last year.

The indicator for identifying and articulating clear Outcomes and Goals for the youth and family was rated as acceptable for 68% of the youth reviewed statewide, indicating room for improvement in this system practice. Performance for the Outcomes and Goals indicator remained the same as last year. The indicator for Matching Interventions to Needs, which measures practices in assuring services and supports form a cohesive sensible pattern and address the identified needs of the youth and family, showed 57% of those reviewed with acceptable performance, which was a significant decline since last year.

Care coordination for the youth reviewed was acceptable for 67% of the youth reviewed, indicating a need for improvement in this core system function. Care Coordination declined since in performance since last year's CSR. Service implementation was acceptable for 70% of youth, and also declined in performance. There was acceptable Availability and Access of Resources for 75% of the youth reviewed statewide. Improvements are needed to assure access necessary supports and services in a timely manner. Performance declined in this indictor since last year.

The practice of Adapting and Adjusting plans and services was acceptable for 66% of youth, representing a decline since last year, and indicating concerted improvements are needed in making changes to plans and interventions as needed. Planning, staging and implementing

practices for successful Transitions and Life Adjustments was an area where practices continue to need considerable work, with only 59% of the youth for which the indicator applied experiencing adequate transitions. This was comparable to last year when 57% of youth experienced acceptable transition management. Seventy-two (72%) of youth who experienced a crisis over the ninety days previous to their review were found to acceptable crisis management as reflected in the indicator for Responding to Crises and Risk/Safety Plans. This was comparable to last year, when 73% of youth reviewed had acceptable management of their crises. Improvements are indicated in this crucial system practice.

Summary of Findings

Overall across the CSRs, 60% of youth were found to have acceptable system/practice performance. The need for focused efforts to improve many system/practice areas are indicated by the data.

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

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

Areas of system/practice performance that <u>need substantial improvement</u> in order to be considered to have adequate consistency, intensity and/or quality of efforts are:
- Planning Interventions for Symptom or Substance Reduction;
- Planning Interventions for Behavioral Changes;
- Planning Interventions for Risk and Safety;
- Outcomes and Goals;
- Service Implementation;
- Availability and Access to Resources; and
- Responding to Crisis & Risk and Safety Planning.

Review results indicate <u>weak</u> performance for the following system/practice domains:
- Team Functioning;
- Team Formation;
- Assessment & Understanding of the Youth;
- Assessment & Understanding of the Family;
- Planning Interventions for Social Connections;
- Planning Intervention for Recovery/Relapse;
- Planning Interventions for Transitions,
- Matching Interventions to Needs;
- Coordinating Care;
- Adapting and Adjusting; and
- Transitions & Life Adjustments.

Overall, statewide results indicate that several system of care practices including engagement with families and cultural responsiveness to youth and families continued to have the same strong performance as in the FY 2010-2011 CSR. The remaining system practices are not considered to be performing in a dependable, consistent or effective manner. Three system indicators had the same results as in the previous year's CSR (Outcomes & Goals, Transitions & Life Adjustments, and Crisis Response). The remaining saw declines in performance.

The Rosie D. Remedy has identified the development of care planning teams, care plans and care coordination as core functions in the practice model, and that youth and families should expect these functions to be in place and working for them. The statewide findings for this year's CSR found that teams for well over a third of the youth (36%) were not being formed consistently and for 43%, were not functioning at an adequate level, were splintered or inconsistent in planning and evaluating results, and were not engaged in collaborative problem-solving. With the number of teams with weak functioning, concerted development is clearly indicated to strengthen the ability of teams to plan together, collaboratively problem-solve and unify their implementation efforts. Planning interventions across all indicators needed strengthening particularly in the areas of strengthening youths' social connections, recovery/relapse and assuring successful transitions. Care coordination was not at an acceptable level of practice for a third of youth (33%).

A challenge for 45% of teams was using information, including in existing assessments and information that is held by other providers, schools, etc., to increase team-based understanding of youths' strengths and needs at a scope and depth necessary to develop the right set of interventions and supports. Information gathered to inform planning and interventions should include observations, information from parents during in-home assessments and both formal and informal assessment to understand strengths and needs across domains. Understanding and assessment is an ongoing, dynamic process that changes as youth and families' needs, gains, and circumstances change, and as teams identify and incorporate the learning that comes with providing interventions and continuous discussion and engagement with the youth, family and other team members. It is a fundamental part of teamwork and the therapeutic process. Of concern is that 42% of youth statewide did not have a current mental health assessment, and only 25% of parents had received their child's mental health assessment. Moreover, far fewer youth reviewed this year than last had a current mental health assessment; last year, 22% of youth did not have a current mental health assessment.

The system practice that continues to need priority attention is assuring adequate supports for managing youths' transitions. Transitions are key events in youths' lives that need to be anticipated, planned for and supported by teams in ways that result in successful adjustment for the youth to significant events, changes in treatment, school, or living situations, the next developmental stage or a new set of services. A key finding in a number of the CSRs was that there were pressures from both internal and external administration to "speed up" processes due to admission demands and waitlists resulting in unsupported transitions for youth. Transitions were not systematically considered by teams through well-planned individualized approaches, and are not yet consistently part of supervisory reviews or oversight despite the fact that the management of transitions has been identified as a system

weakness in virtually every review over the last two years. Sixty-one percent (61%) of youth this year were found to have an unacceptable level management of their transitions.

Overall, 40% of youth reviewed statewide did not receive an acceptable level of system/practice performance. These results indicate focused improvements are needed in most areas of practice before the system of services can be considered to be consistently performing well for youth, and so that families can reliably depend on services to help their children progress, achieve desired outcomes and/or maintain gains.

Findings: Strengths. Statewide, family engagement and cultural responsiveness continued to be strong system practices, and families in general are very appreciative of the services they are receiving. System of Care Committees in many areas are continuing to be venues for intersystem and community partnerships, and active problem-solving. Two regions (Northeast and Southeast) experienced improvements in a number of practice indicators and in overall system performance, and there were notable strengths in both areas. In these regions, there were many examples of well-functioning teams with community-based orientations

Findings: Challenges. The CSRs identified concerns with the quality and consistency of care coordination in regions across the state. Care coordination and teaming practices are expected to be provided by the ICC, IHT, or outpatient "hub," and may be more or less intensive depending on the level of intensity of coordination and teaming needed by the family to successfully integrate the care planning, interventions and continued learning of state agencies, schools, and treatment providers in supporting the goals and objectives for the youth and family. In many of the reviews, care coordinators were noted to lack clarity about their role expectations, or care coordination functions required by "hubs" were not well-implemented. Often there was a lack of discernment or objective assessment when a youth and family should have been referred to a different "hub" that would better address their planning and coordination needs. As well, care coordinators in a number of reviews were noted to be inexperienced and not adequately trained to take on their roles. Workforce stability and preparation for the role are key issues. These issues often resulted in fragmented and ineffective care for youth. This year, the CSRs continued to observe a lack of consistent capacity of teams to uniformly use assessments, clinical/behavioral data and other relevant information to inform care plans. Intervention planning and teamwork was found to need strengthening in all areas of the state, and care plans and interventions often lacked the specificity, depth and unity of effort needed to help youth progress.

Outpatient providers continued to lack integration into the work of ICC teams, and a number of systemic barriers to moving outpatient services into a more effective role in the system of care were noted. Families continue to be frustrated with key aspects of service delivery, with outpatient services, access to certain service and crisis services the most frequently noted issues. As well, families and agency staff are increasingly concerned about what they perceive to be limits to services and premature discharges of youth from services.

Recommendations. The Recommendations starting on Page 71 reflect the themes and patterns of the CSRs statewide and are provided as suggestions for further assuring the consistency and quality of behavioral health practices and service delivery for *Rosie D.* class members. Recommendations relate to core system functions that include skills and delivery

of care coordination, the need for development of a "big picture understanding" of the child and family's strengths and needs through informal and formal assessment, the development of effective plans, strengthening of the formation and functioning of teams, and better management of youth transitions. Systems level recommendations include addressing how outpatient services function in the system of care, access to services, role clarification, and assurances for key system requirements such as quality comprehensive mental health assessments, appropriate discharges based on assessment of youth progress, and assuring the system of services performs the key practice functions that will help youth to benefit from services.

The Rosie D. Community Services Review
Annual Report
For Reviews Conducted during Fiscal Year 2011-2012

Introduction

This report presents findings for the five Community Service Reviews (CSR) conducted throughout Massachusetts between September 2011 and May 2012. Reports for each of the regional reviews (Western Massachusetts, Northeastern Massachusetts, Southeastern Massachusetts, Central Massachusetts and Boston and Metro-Boston) were published throughout the year. Aggregate demographic data for the 142 youth reviewed are presented, as well as overall CSR findings and selected comparative data of system performance. The purpose of this report is to present findings regarding youth status and system/practice performance of the system of care for youth and families during the second full fiscal year of implementation of the array of Rosie D. Remedial Services.

Overview of Rosie D. Requirements and Services

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

Initially all services were to become available on June 30, 2009. New timelines were established by the Court, whereupon Intensive Care Coordination (ICC), Family Training and Support Services (commonly called Family Partners), and Mobile Crisis Intervention began on July 1, 2009. In-home Behavioral Services and Therapeutic Mentoring began on October 1, 2009 and In-home Therapy Services (IHT) started on November 1, 2009. Crisis stabilization services were to begin on December 1, 2009, but have not been approved by the Centers for Medicare and Medicaid Services (CMS) as part of the Massachusetts Medicaid state plan. The in-home component of Crisis Stabilization is being implemented through the Mobile Crisis Intervention Service; Community Based Acute Treatment is an existing service that meets some of the needs that would have been met by out of home Crisis Stabilization.

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

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

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

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

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

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

Purpose of monitoring

The Court Monitor monitors compliance and progress with the requirements of the Judgment. The Court Monitor receives and independently reviews information about how youth with SED and their families are accessing, using and benefiting from changes in the service delivery system, and how well core service system functions (examples: identification

and screening; assessment of need; care/treatment planning; coordination of care; management of transitions) are working for them. In order to make such determinations, the Community Services Review (CSR) methodology was selected in consultation with the Parties. The CSR uses a framework that yields descriptions and judgments about child status and system performance in a systematic manner across service settings. In combination with performance data provided by the Commonwealth and other facts gathered by the Court Monitor, information from the CSRs will be used to assess the overall status of implementation.

Overview of the CSR methodology

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

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

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

Through using a structured protocol, reviewers make determinations about youth status/progress (favorable or unfavorable) and system/practice performance (acceptable or unacceptable) through a six-point scale. Refer to Appendix 2 on Page 73 for a full description of how each of the terms is defined. The six-point ratings are overlaid with "zones" of improvement, refinement, or maintenance. This overlay is provided to help care planning teams focus on youth concerns and/or system practices that may need attention. When reviewing the status and performance indicators that start on Page 16, it will be helpful to refer to Appendix 2 in understanding the ratings and findings.

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

The CSR provides focused feedback for use by system managers, practitioners and system stakeholders about the performance of behavioral health services, practices and key service system functions. Included in this feedback are areas for improvements at the service delivery and system level, in practice level patterns, and at the individual youth/family level.

It also identifies which practices/service delivery are consistently and reliably being performed as the well-being of youth depends on services being delivered in a consistent and reliable manner. The CSR provides quantitative and qualitative data that allows for the tracking of performance of behavioral health service delivery for youth across the Commonwealth over time.

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

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

Rosie D. CSRs Conducted During Fiscal Year 2011-2012

Review Participants

Approximately 2000 people throughout Massachusetts participated in the five regional CSRs in either the youth-specific reviews or in the stakeholder focus groups. Table 1 displays data related to the youth-specific reviews where a total of 931 interviews were conducted for the 142 youth reviewed. As can be seen, the average number of interviews was 6.6 with a maximum of 13 and a minimum of 2 interviews conducted.

Child Status and Performance Profile - Number of Interviews

Number of cases: 142   MA Combined 2011-2012

Number of Interviews

Total number of interviews	931
Average number of interviews	6.6
Minimum number of interviews	2
Maximum number of interviews	13

Table 1

CSR Sampling

The samples for each of the CSRs were drawn from the population of children who were enrolled at the time of sampling in Intensive Care Coordination (ICC) or In-Home Therapy (IHT) without currently receiving ICC services, inclusive of children from birth to twenty-one years old who are covered by Medicaid. Prior to the review, each agency was asked to submit lists of the children who were enrolled since the initiation of the service. The caseload enrollment lists were sorted to create a list of youth who were currently enrolled within open cases.
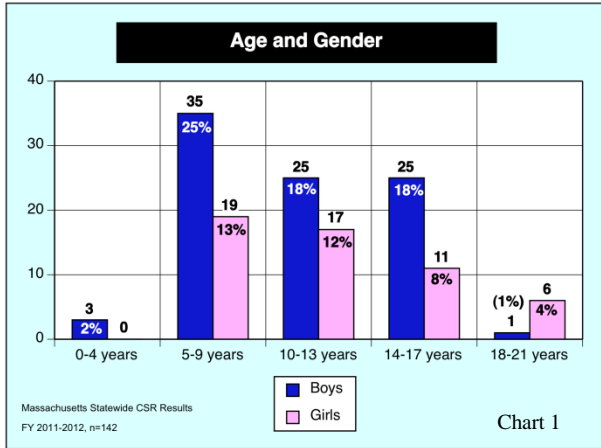
For ICC, a random sample of youth was drawn from each CSA or agency's open caseload list. The number of youth selected from each CSA was determined based on the number of youth meeting the sampling parameter against the population of enrolled youth at the time of selection. For IHT, the lists were sorted to determine which of the youth were receiving IHT, but not concurrently also receiving ICC. Although it is possible that some of the youth who were selected from the ICC lists were also receiving other types of services including IHT, the IHT lists were used to identify youth who were receiving IHT but not currently also receiving ICC. The number of youth to be included from each agency was then determined by comparing the number of youth being served by that agency to the total number of youth being served in the region.

Child Status and Performance Profile - Case Type Frequency

Number of cases: 142   MA Combined 2011-2012

Case Type	Number	Percent
ICC	88	62%
IHT	54	38%
	142	100%

Table 2

A total sample of 142 youth, which included 88 ICC youth and 54 IHT youth drawn from the 53 agencies were reviewed in the five regional CSRs conducted over the fiscal year.

Characteristics of Youth Reviewed

Age and Gender chart (Chart 1)

Massachusetts Statewide CSR Results
FY 2011-2012, n=142

Age and Gender. There were 142 youth reviewed across the five regions. *Chart 1* displays the distribution of genders across age groups in the combined samples with a total of 89 boys and 53 girls distributed among the regional samples. The proportion of boys to girls was 63% boys to 37% girls. The only age range that had more girls than boys was the 18-21 year old range, where the proportion was 14% boys to 86% girls. The largest percentage of youth was in the 5-9 year old range.

Two percent (2%) of the statewide sample was in the 0-4 age range, 38% were in the 5-9 age range, 30% were in the 10-13 age range, 26% in the 14-17 range, and 5% in the 18-21 age range.

Child Status and Performance Profile - Current Placement Frequency

Number of cases: 142   MA Combined 2011-2012

Type of Current Placement	Number	Percent
Family bio./adopt. home	116	82%
Kinship/relative home	13	9%
Foster home	3	2%
Therapeutic foster home	1	1%
CBAT	2	1%
Hospital	4	3%
Residential treatment facility	2	1%
Pre-independent	1	1%
	142	100%

Table 3

Current placement, placement changes and permanency status. The great majority of youth reviewed in the CSRs lived with their families (91%), either their biological/adoptive families (82%) or in a kinship/relative home (9%). Three percent of youth (3%) were in an impatient hospital at the time of review. Two percent (2%) resided in a foster home. One percent of the youth each were in a therapeutic foster home, a Community-Based Acute Treatment (CBAT) program, a residential treatment facility, and a pre-independence program.

The legal status (*Table 4*) of most of the youth in the sample was with their birth families (79%). Eight percent (8%) of the youths' permanency status was with their adopted families, 2% was with the foster parents, and 8% were in permanent guardianship. One youth's guardianship was split between permanent guardianship and guardianship with the Department of Children and Families (DCF). One youth was over 18 years old and did not have a guardian.

Child Status and Performance Profile - Legal Permanency Frequency

Number of cases: 142   MA Combined 2011-2012

Legal Permanency Status	Number	Percent
Birth family	112	79%
Adopted family	11	8%
Foster care	3	2%
Permanent guardianship	11	8%
Permanent guardianship split with DCF	1	1%
Youth over 18 years old	4	3%
	142	100%

Table 4

The review tracked placement changes experienced by each youth in the twelve months preceding their review. (*Table 5*). Placement change refers to changes in living situation, as well as changes in the type of program where the child received educational services. These data yields information about the youth's relative stability in the living and/or school setting. Among the youth in the statewide sample, 66% had no placement changes in year preceding the time they were reviewed. Of the 34% who experienced a change in placement, 23% had 1-2 placement changes, and 7% had 3-5 changes in placement. Four percent (4%) of the sample had experienced 6-9 placement changes, and 1% had 10 or more changes in placement.

Child Status and Performance Profile - Placement Changes Frequency

Number of cases: 142   MA Combined 2011-2012

Placement Changes (past 12 months)	Number	Percent
None	94	66%
1-2 placements	32	23%
3-5 placements	10	7%
6-9 placements	5	4%
10+ placements	1	1%
	142	100%

Table 5

Thirteen percent (13%) of the youth were in an out of home placements at the time they were reviewed. Five percent (5%) of the sample had been in the out of home placement for 30 days or less, 2% for 1-3 months. One percent each had been in the out-of-home placement for 4-6 months, 7-9 months, 10-12 months, 13-18 months, 19-36 months and 37 months or over. (*Table 6*).

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

Number of cases: 142   MA Combined 2011-2012

Length of Stay in Current OOH Placement	Number	Percent
0-30 days	7	5%
1 - 3 mos.	3	2%
4 - 6 mos.	1	1%
7 - 9 mos.	2	1%
10 - 12 mos.	1	1%
13 - 18 mos.	2	1%
19 - 36 mos.	1	1%
37 + mos.	1	1%
Not applicable	124	87%
	142	100%

Table 6

Child Status and Performance Profile - Ethnicity Frequency

Number of youth: 142   MA Combined 2011-2012

Ethnicity	Number	Percent
Euro-American	56	39%
African-American	17	12%
Latino-American	51	36%
Asian-American	2	1%
Arabic	2	1%
Biracial	6	4%
Haitian	6	4%
Pacific Island-American	1	1%
West Indian	1	1%
	142	100%

Table 7

Ethnicity and primary languages (Table 7 and 8). Of the 142 youth reviewed, 39% were Euro-American, 12% were African-American and 36% were Latino-American. Four percent (4%) of those reviewed were Biracial and 4% were Haitian. Youth reviewed of other ethnicities (1% each) were Asian-American, Arabic, Pacific Island-American, and West Indian.

Child Status and Performance Profile - Language Spoken Frequency

Number of cases: 142   MA Combined 2011-2012

Primary Language Spoken at Home	Number	Percent
English	107	75%
Spanish	17	12%
Cantonese	1	1%
Creole	3	2%
English & Arabic	2	1%
English & Creole	1	1%
English & Portuguese	1	1%
English & Spanish	8	6%
English, Spanish and ASL	1	1%
Vietnamese	1	1%
	142	100%

Table 8

English was the primary language spoken at home for 75% of the youth. Spanish was the primary language for 12% of families and both English and Spanish for 6% those reviewed. Creole was spoken in 2% of homes. Other languages spoken at home (1% each) were Cantonese, English and Arabic, English and Creole, English and Portuguese, English, Spanish and American Sign Language, and Vietnamese.

Child Status and Performance Profile - Educational Placement Frequency

Number of cases: **142**   MA Combined 2011-2012

Educational Placement or Life Situation	Number	Percent
Regular K-12 Ed.	45	32%
Full inclusion	11	8%
Part-time Sp. Ed.	19	13%
Self-cont. Sp. Ed.	35	25%
Adult basic/GED	2	1%
Alternative Ed.	19	13%
Expelled/Suspended	1	1%
Home hospital	2	1%
Day treatment program	3	2%
Work	1	1%
Completed/graduated	4	3%
Dropped-out	1	1%
Other	13	9%

Table 9

*Educational placement (Table 9). Y*outh reviewed in the CSRs were receiving their education in a variety of settings. Forty-six percent (46%) were receiving special education services in a full inclusion (8%), part-time (13%) or fully self-contained (25%) special education setting. Thirty-two percent (32%) were attending school in regular education classrooms. Thirteen percent (13%) were in alternative education settings. Others were attending school in an adult educational program (1%), and a day treatment program (2%). These youth may have also have been receiving special education services in these settings. One percent of youth (1%) were receiving education through home hospital instruction. One percent (1%) of the youth was expelled or suspended, 1% was working, 3% had completed school, and 1% had dropped out. Youth in the "Other" category included youth in a variety of settings for education including youth receiving education while in inpatient hospitalization, in pre-school, and community college. Note that the total numbers and percentages in *Table 9* add up to more than the total number of youth in the sample as youth may be involved in more than one educational placement or life situation.

Other state agency involvement (Table 10). The majority of the youth in the sample were involved with other State and community agencies. Note that youth may be involved with more than one agency, so the overall number in Table 10 is more than the number of youth reviewed. Youth were most frequently involved with Special Education (57%). The Department of Children and Families (DCF) had involvement with 32% of the families reviewed. The

Child Status and Performance Profile - Agencies Involved Frequency

Number of cases: **142**   MA Combined 2011-2012

Agencies Involved	Number	Percent
DCF	46	32%
DMH	5	4%
Special Ed	81	57%
Early intervention	0	0%
Developmental disabilities	6	4%
DYS	0	0%
Probation	9	6%
Vocational Rehabilitation	1	1%
Substance abuse	1	1%
Other	17	12%

Table 10

Department of Mental Health (DMH) was involved with 4%, Developmental Disabilities with 6%, and Probation with 6%.Vocational Rehabilitation was involved with 1% of the youth, and a Substance Abuse agency with 1%. Youth in the "Other" category were involved

with a variety of agencies including outpatient services, Massachusetts Committee for the Deaf and Hard of Hearing (MCDHH), housing support, hospitals, and foster care agencies.

Referring agency (Table 11). Youth reviewed came into ICC and/or IHT services from a variety of referral sources. The largest single referral source at the statewide level was DCF, which referred 17% of the youth reviewed. This was closely followed by families, who referred 16% of the youth. Outpatient providers referred 14% of those reviewed. Eleven percent (11%) were referred by schools (an increase over last year when 4% of youth were referred by schools. Eight percent (8%) of the youth were referred through crisis services and 6% by hospitals. ICCs and IHTs each referred 4% of youth, and DMH referred 2% of the sample. Referring 1% were Courts, primary care physicians, CBATs, and DDS. No youth were referred by DYS.

Referral sources in the "Other" category referring 1% or fewer were, pre-schools, MCDHH, family support services, CSA, and legal services.

Child Status and Performance Profile - Referral Source

Number of cases: 142   MA Combined 2011-2012

Referral Source	Number	Percent
Court	1	1%
DMH	3	2%
Hospital	9	6%
Crisis Services	11	8%
School	16	11%
Family	23	16%
DCF	24	17%
Outpatient	20	14%
Primary care physician	2	1%
CBAT	2	1%
Department of Developmental Services	1	1%
ICC	6	4%
In-home Therapist	6	4%
Other (Less than 1% each)	18	13%
	142	100%

Table 11

Child Status and Performance Profile - Co-Occurring Condition Frequency

Number of cases: 142   MA Combined 2011-2012

Co-Occurring Condition	Number	Percent
Mood Disorder	70	49%
Anxiety Disorder	41	29%
PTSD/Adjustment to Trauma	40	28%
Thought Disorder/Psychosis	5	4%
ADD/ADHD	85	60%
Anger Control	50	35%
Substance Abuse/Dependence	6	4%
Learning Disorder	33	23%
Communication Disorder	7	5%
Autism	11	8%
Disruptive Behavior Disorder (CD, ODD)	30	21%
Mental Retardation	9	6%
Medical Problem	37	26%
Other Disability/Disorder	18	13%
Other	2	1%

Table 12

Behavioral health and co-occurring conditions (Table 12). Table 12 displays the conditions and/or co-occurring conditions present among the youth reviewed. Youth may have one or more than one condition. The most prevalent diagnosis among the youth was attention deficit hyperactivity disorder (60%) followed by mood disorders (49%). Anger control was the next most prevalent condition, present among 35% of the youth, followed by anxiety disorder (29%), PTSD (28%), learning disorder (23%), and disruptive behavior disorder (21%). Eight percent (8%) of the youth were diagnosed with autism, and 6% with an intellectual disability. Other less prevalent diagnoses were communication disorder (5%), thought disorder/psychosis (4%), and substance abuse (4%).

Co-occurring medical problems were prevalent among over a quarter of the youth (26%). Of these, 38% had asthma. Other medical disorders youth were afflicted with included allergies,

seizure disorders, obesity, enuresis, encopresis, constipation, hyperthyroidism, myopia, mastocytosis, diabetes, cleft palate. diabetes and other medical conditions and syndromes. Genetic syndromes present among the youth included Downs Syndrome, DiGeorge Syndrome, Dandy-Walker Syndrome, and Gilberts Syndrome.

Youth in the "Other Disability" category included youth with pervasive developmental disorder, speech disabilities, gender identity disorder, adjustment disorder, deafness, selective mutism, and adjustment disorder. Adjustment disorder was a diagnosis for 39% of the youth in the "Other Disability" category, or 5% of the total sample.
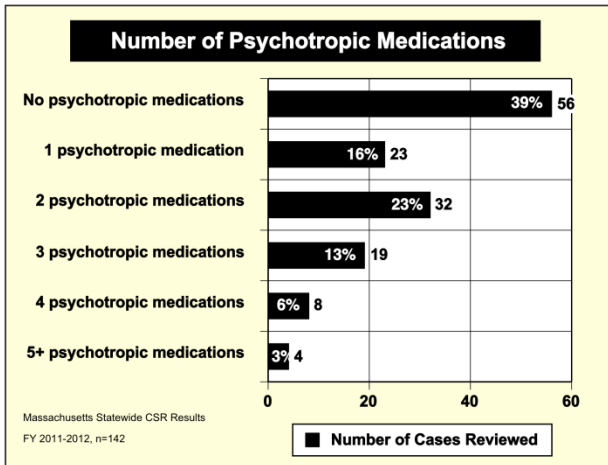

Chart 2

Medications (Chart 2). Sixty-one percent (61%) of the youth were prescribed one or more psychotropic medications at the time of the review. As seen in *Chart 2*, 16% of the sample was prescribed one medication, 23% two medications, and 13% three medications. Six percent (6%) of the youth were prescribed 4 medications, and 3% were on five or more medications. Seventy-three percent (73%) of youth prescribed psychotropic medications were prescribed two or more medications, and 36% were prescribed three or more medications.

Youths' levels of functioning (Chart 3). The functioning of each youth in the CSR is rated using the General Level of Functioning scale, a 10-point scale that can be viewed in Appendix 1 of
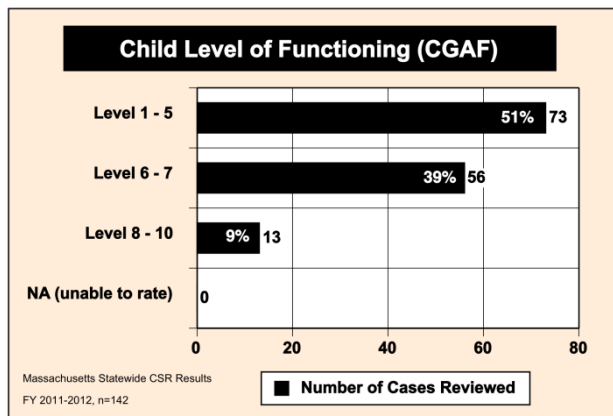

Chart 3

this report. Most of the youth in the CSR samples were functioning at a moderately to severely impaired level. Fifty-one percent (51%) 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"). Thirty-nine percent (39%) 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"). Nine percent (9%) of the sample were rated in the Level 8-10 range ("no more than slight impairment in functioning at home, at school, with peers" to "superior functioning in all areas"). Note that there were three youth in the 0-4 age range in the sample; these data reflect that the reviewers were able to rate their level of functioning despite their young age.

Use of Crisis Services (Table 13). The use of crisis services or crisis responses over the 30 days prior to the review was tracked for each youth. There was a relatively low incidence of the use of crisis services among the youth reviewed. Ninety-one percent (88%) of the youth did not access crisis service during the time period. For the 9% of youth that used crisis services 6% used mobile crisis services. Four percent (4%) accessed crisis help through a 911 call to the police. Two percent (2%) went to an emergency department of a hospital when experiencing a crisis.

Child Status and Performance Profile - Crisis Services Used Frequency

Number of cases: 142   MA Combined 2011-2012

Crisis Services Used Past 30 Days	Number	Percent
Mobile crisis	9	6%
911 Emergency call: EMS	0	0%
911 Emergency call: Police	5	4%
Emergency department	3	2%
Other	0	0%
None	129	91%

Table 13

Mental health assessments (Tables 14 and 15). CSR reviews tracked whether or not each youth had a current mental health assessment. Having a current mental health assessment is a foundational component of behavioral health practice. Assessments are part of the complement of information that helps clinicians and teams to understand the strengths, needs and context of the youth and family, and to formulate an overall picture of how the youth is doing emotionally, cognitively, behaviorally and socially. Only fifty-eight percent of youth had a current mental

Child Status and Performance Profile - Mental Health Assessment

Number of cases: 142   MA Combined 2011-2012

MH assessment performed	Number	Percent
Yes	83	58%
No	59	42%
	142	100%

Table 14

health assessment in their files. Forty-two percent (42%) of the youth did not have a current mental health assessment available. Far fewer youth this year had a current mental health assessment than last year when 78% of youth statewide had a current mental health assessment.

The CSRs also determined for those youth that had a current mental

Child Status and Performance Profile - Received Mental Health Assessments

Number of cases: 142   MA Combined 2011-2012

Received MH Assessments	Number	Percent
Parent	35	25%
Education	8	6%
Court	0	0%
Child Welfare	3	2%
DOC	0	0%
Not applicable	59	42%
Not Distributed	39	27%
Other	13	9%

Table 15

health assessment, who had received the assessment. Planning ideally includes team members developing a shared understanding about the needs, strengths, choices and preferences of the youth and family. Only a quarter of parents had received their child's assessment. Fewer parents received assessment than last year when a third (33%) had received a copy of their child's assessment. Schools received a copy of the mental health assessment for 6% of the youth reviewed, and Child Welfare for 2%. Child welfare was involved with 32% of the youth in the sample so the percentage of families reviewed that were DCF-involved and had their assessments shared with DCF was 7%. In the "other" category were assessments distributed primarily to therapists and other team members. The assessment had not been distributed for 27% of youth who had a mental health assessment.

Child Status and Performance Profile - Special Procedures Frequency

Number of cases: 142   MA Combined 2011-2012

Special Procedures Used Past 30 Days	Number	Percent
Voluntary time-out	30	21%
Loss of privileges via point & level system	14	10%
Disciplinary consequences for rule violation	14	10%
Room restriction	2	1%
Exclusionary time out	4	3%
Seclusion/Locked room	2	1%
Take-down procedure	1	1%
Physical restraint (hold, 4-point, cuffs)	6	4%
Emergency medications	1	1%
Medical restraints	0	0%
None:	82	58%
Other:	11	8%

Special Procedures

Special Procedures data were collected in the CSRs to better understand behavioral interventions occurring (*Table 16*). Fifty-eight percent (58%) of the youth did not experience a special procedure in the 30 days preceding the review. For the 42% of youth that did, 21% had experienced a voluntary time-out; 10% loss of privileges in a points and level system, and 10% a disciplinary consequence. Five percent (5%) of the youth had experienced a recent physical restraint that could have been a hold, a "take-down", or a mechanical restraint. Three percent (3%) had experienced an exclusionary time out, and 1% seclusion in a locked room. Procedures in the "Other" category were school suspensions as a behavioral consequence, restriction of activities, meetings with school counselors, and implementation of a behavior management system.

Note youth may have experienced more than one special procedure, thus the total percentage of discr Table 16 dures is more than the overall 42% of youth who experienced a procedure.

Caregiving challenges

Challenges experienced by the parents and caregivers are identified for each of the youth reviewed *(Table 17)*. The most frequently noted challenge among parents and caregivers statewide was adverse effects of poverty impacting 36%. This was followed extraordinary care burdens experienced by 26% closely followed by 25% challenged by their own serious mental illness. Twenty-one (21%) of the caregivers were challenged by serious illness or disabling physical conditions. Other challenges were cultural language barriers experienced by 15%, domestic

Child Status and Performance Profile - Caregiver Challenges Frequency

Number of cases: 142   MA Combined 2011-2012

Challenges in the Child's Birth Family or Adoptive Family	Number	Percent
Limited cognitive abilities	10	7%
Serious mental illness	36	25%
Substance abuse impairment or serious addiction w/ frequent relapses	8	6%
Domestic violence	10	7%
Serious physical illness or disabling physical condition	30	21%
Unlawful behavior or is incarcerated	3	2%
Adverse effects of poverty	51	36%
Extraordinary care burdens	37	26%
Cultural/language barriers	22	15%
Undocumented	5	4%
Teen parent	3	2%
Recent life disruption/homelessness due to a natural disaster	2	1%
Other	25	18%

Table 17

violence by 7%, limited cognitive abilities by 7%, substance abuse or serious addiction by 6%, undocumented status by 4%, challenges associated with being a teen parent by 2%, and unlawful behavior or incarceration by 2%. Recent life disruption or homeless was a challenge for 1%. Challenges in the "Other" category included frequent changes in child's foster home placements, recent death in family, parenting skills deficits, early onset dementia of parent, language and communication issues between parent and child, custody challenges, and lack of natural supports.

Care Coordination

During the CSR, data are collected to better understand various factors that may be impacting the provision of care coordination services. Information is collected through the person providing the care coordination function, which could have been the ICC or the IHT therapist. Among the data collected are information about the length of time the care coordinator was in the position (therapists may have been in the position before the start of IHT services), the current caseload size of the individual, and barriers they perceive to be impacting their work. In the CSR conducted over the year, there were 126 individuals providing care coordination for the 142 youth reviewed.

The review tracked the length of time the Care Coordinator had been assigned to the youth being reviewed. As can be seen in *Table 18,* 3% of care coordinators had been assigned to the youth being reviewed for less than a month, and 20% for between 1-3 months. The majority of care coordinators had provided care coordination for the youth reviewed in the 4-12 month range, with 28% assigned between 4-6 months, and 32% between 7-12 months. Fourteen percent (14%) had been assigned to the youth 13-24 months, and 2% between 25-36 months.

Child Status and Performance Profile - Length of Time CM Assigned

Number of cases: 142   MA Combined 2011-2012

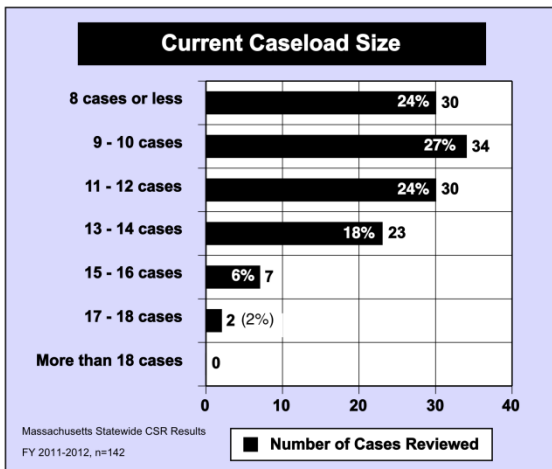| Length of Time CM Assigned to Child/Youth	Number	Percent
<1 month	4	3%
1-3 months	29	20%
4-6 months	40	28%
7-12 months	46	32%
13-24 months	20	14%
25-36 months	3	2%
	142	100%

Table 18

Chart 4

Caseload frequency as reported by the 126 care coordinators who participated in the CSR was measured along the scale seen in *Chart 4.* Twenty-four percent (24%) of coordinators had 8 or fewer cases, and 27% had 9-10 cases. Twenty-four percent (24%) of coordinators had cases in the 11-12 case range. Eighteen percent (18%) were coordinating care for 13-14 cases, and 6% for 15-16 cases. Two percent (1%) had a caseload of 17-18, and no coordinators had more than 18 cases. Just over a quarter of care coordinators (26%) had more than 12 cases on their caseload.

Table 19 presents the length of time the 126 individual care coordinators statewide had been in their positions. The majority (59%) had been in their positions between 7 months and two years with 20% in the position between 7-12 months, and 39% between 13-24 months. One percent (1%) had been in their positions for less than a month, 2% between 1-3 months, and 8% between 4-6 months. The remainder were in their positions 25-36 months (22%), 37-60 months (6%) and over 60 months (2%). Those in positions at the longer ranges were primarily therapists who started providing care coordination when this function was assigned at the advent of Rosie D. IHT services.

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

Number of cases: 126   MA Combined 2011-2012

Length of Time CM in Position	Number	Percent
<1 month	1	1%
1-3 months	2	2%
4-6 months	10	8%
7-12 months	25	20%
13-24 months	49	39%
25-36 months	28	22%
37-60 months	8	6%
>60 months	3	2%
	126	100%

Table 19

Table 20. Barriers that affect the provision of care coordination or other services is collected through interviews with care coordinators during each CSR. The challenges cited by care coordinators statewide most often were billing requirements and/or limits cited by 28%, followed by case complexity cited by 21%, and cultural/language barriers also cited by 21%. Nineteen percent (19%) of coordinators cited treatment compliance as barriers, and 17% cited inadequate parent support, team member follow-through, and driving time to services.

Child Status and Performance Profile - Barriers Affecting Case or Services

Number of cases: 126   MA Combined 2011-2012

Barriers Affecting Case Management or Services	Number	Percent
Caseload size	20	16%
Eligibility/access denied	10	8%
Inadequate parent support	22	17%
Inadequate team member participation	24	19%
Family disruptions	20	16%
Billing requirements/limits	35	28%
Case complexity	27	21%
Treatment compliance	24	19%
Team member follow-thru	21	17%
Acute care needs	15	12%
Driving time to services	21	17%
Culture/language barriers	26	21%
Refusal of treatment	19	15%
Family instability/moves	20	16%
Arrest/detention of child/youth	5	4%
Other	52	41%

Table 20

This was followed by 16% identifying caseload size, family disruptions, and family instability. Treatment refusal was cited as a barrier by 15%, followed by acute care needs (12%), eligibility/access denial (8%), and arrest or detention of youth (4%).

Barriers in the "Other" category included challenges associated working on a fee-for-service versus salaried position, waitlist for services, timeline to finish the CANS, scheduling complexities, provider instability and turnover, productivity demands, paperwork requirements, and meeting the basic needs of families. Paperwork requirements was the most frequently mentioned barrier in the "Other" category.

Community Services Review Findings

Ratings

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

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

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

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

STATUS AND PROGRESS INDICATORS

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

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

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

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

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

Overall Youth Status

Community, School/Work and Living Stability

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

Home stability. Among the 142 youth in the CSR sample statewide, 73% overall had favorable home stability. Fifty-four percent (54%) 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, meaning conditions to support their stability at home were fair to marginal. Ten percent (10%) of the youth were rated to need improvement with poor or adverse stability marked by substantial to serious and worsening problems with home stability.

School stability. School stability was applicable for 139 youth in the CSR sample. Of these, 79% were in a stable school situation. Fifty-five percent (55%) of the sample had good or optimal stability with only age appropriate or planned changes occurring in their school program. Thirty-two percent (32%) had stability issues at school that needed "refinement," with fair to marginal stability issues that were minimally to inadequately addressed. Thirteen percent (13%) needed their stability in school "improved," with uncertainty about next steps or serious and worsening problems and no foreseeable next-step placements with the necessary level of supports.

These results showed that 27% of youth reviewed were experiencing instability in their home situations, and 21% in their school settings indicating teams should more consistently consider strategies for strengthening supports to increase home and school stability for youth.
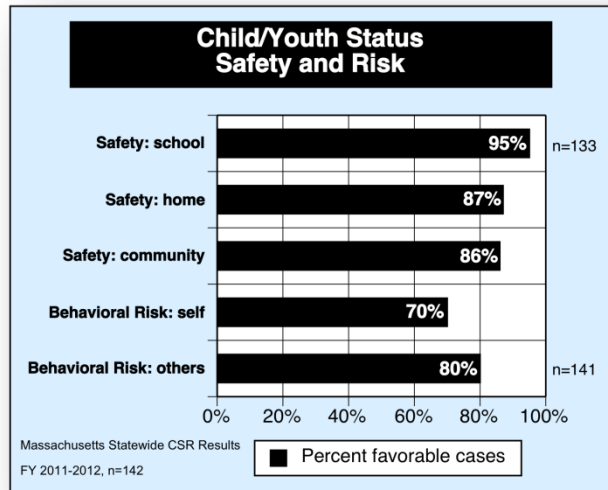
Consistency/Permanency in Primary Caregivers & Community Living Arrangements

The Consistency/Permanency Indicator measures the degree to which the youth reviewed were living in a permanent situation, or if not that there was a clear strategy in place by teams

to address permanency issues including identifying the conditions and supports that may be needed to assure the youth is able to have enduring relationships and consistency in their lives. Absent these conditions, there is often a direct impact on a youth's emotional well-being and behaviors.

Of the youth reviewed throughout Massachusetts, 84% had a favorable level of consistency and permanency in their lives. Among these, 63% of youth had "good" or "optimal" status, meaning they were in an enduring permanent living situation with their family of other legally permanent caregivers. Twenty-eight percent (28%) were at a level of consistency and permanency situation that needed "refinement" in in order to assure enduring relationships and consistent caregiving/living supports, meaning they were either in a minimal to fair status, or in a marginal status with somewhat inadequate or uncertain permanence. Eight percent (8%) of youth reviewed had poor or adverse status with substantial to serious problems of unresolved permanence.

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

Safety of the Youth

In the CSR, safety is examined to measure the degree to which each youth is free from exploitation, harassment, bullying, abuse or neglect in his or her home, community, and school. Safety includes being free from psychological harm. Reviewers also examine the extent to which caregivers, parents and others charged with the care of children provide the supports and actions necessary to assure the youth is free from known risks of harm. Freedom from harm is a basic condition for youth well-being and healthy development. Whenever there is an identified safety risk, there should be immediate response by the youth's team.

School safety. For youth receiving their education in a school setting (N=133), 95% were found to have favorable safety status at school. Of these 71% were safe at school at a "good" or "optimal" level with no risk to generally risk-free school programs. Twenty-eight percent

(28%) had a school safety status that needed "refinement" in terms of the school setting leaving the youth free from abuse or neglect. For these youth, the school setting was minimally risk-free, or had a somewhat inadequate to inconsistent level of protection. Two percent (2%) of the youth reviewed were found to have a "poor safety" status indicating a substantial risk of harm in the school setting.

Home safety. Statewide, 87% of youth were safe at home. Among the youth, 60% had "good" or "optimal" safety status in their homes. Thirty-seven percent (37%) were found to need "refinement" with a fair to minimally adequate situation free from abuse or neglect, or marginal safety with somewhat inadequate protection posing an elevated risk of harm. Four percent (4%) were found to have "poor safety" or a "high safety risk" at home with substantial risk of harm.

Community safty. Eighty-six percent (86%) of youth reviewed across the state were safe in their communities. Fifty-four percent (54%) of the youth reviewed were experiencing "good" to "optimal" safety in their communities. "Refinement" in community safety was needed for 44% of the youth who had fair to marginal safety status indicating minimally adequate to somewhat inadequate levels of protection. Threee percent (3%) of the youth were experieincing poor to high risk in the community.

For the most part, the youth reviewed had favorable safety status across settings. Because of the importance of safety in the lives of youth, teams should constantly monitor safety status including any risks for intimidation or fear of harm.
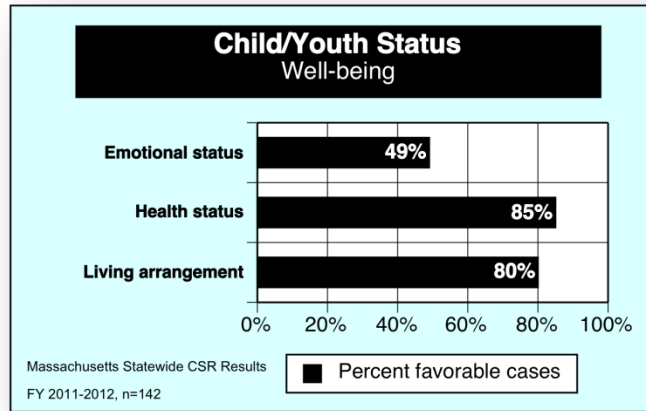
Behavioral Risk to Self and Others

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

Behavioral self-risk. Statewide results indicated that 70% of youth had a favorable level of behavioral self-risk. Among these, 35% had "good" or "optimal" status. Fifty-seven percent (57%) were found to need "refinement" in their level of behavioral risk, including youth with fair status that may occasionally present behavior that has low or mild risk of harm, and those that have a marginal risk staus that is inconsistent and concerning. Seven percent (7%) of the youth needed "improvement" and had poor or serious and continuing behavioral self-risk status.

Behavioral risk to others. The subindictor of behavioral risk toward others was favorable for 80% of the youth in the sample. Forty-nine percent (49%) of youth a "good" or "optimal" level of behavioral risk toward others. Forty-six percent (46%) needed "refinement" presenting a fair to marginal level of risk toward others. Five percent (5%) needed "improvement" in their level of risk toward others, with poor status and a potential for harm to others present.

Overall, 30% of youth had an unfavorable self-risk status, and 20% an unfavorable level of risk toward others. Stronger planning, and/or evaluation of existing strategies and supports by teams are indicated to more consistently ameliorate youths' levels of behavioral risk.

Child/Youth Status
Well-being

Emotional status	49%
Health status	85%
Living arrangement	80%

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

Massachusetts Statewide CSR Results
FY 2011-2012, n=142

■ Percent favorable cases

Emotional and Behavioral Well-being

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

Emotional and behavioral well-being was favorable for 49% of youth reviewed statewide indicating a high number of youth with emotional/behavioral issues that included inconsistent or poor emotional development, adjustment problems, emotional/adaptive distress, and/or serious behavioral problems.

Of the youth reviewed statewide, 11% had a "good" or "optimal" level of emotional/behavioral status that should be maintained. The preponderance of youth (75%) were found to need "refinement" in their emotional/behavioral well-being, and were functioning at a "fair" to "marginal" level. The remaining 14% of youth had "poor" or "worsening" levels of functioning and were not making progress.

Overall, 51% of the youth reviewed statewide were demonstrating limited to poor or worsening levels of emotional development, adjustment problems, and/or poor behavioral functioning in daily settings, and were not responding well to attempts to address these issues. Focused support for teams in developing individualized and effective strategies for refining or improving youth's emotional and behavioral well-being is recommended.

Health Status

Health of each youth was reviewed to determine whether or not they were achieving and maintaining optimal health status including basic and routine healthcare maintenance. Youth's basic needs for nutrition, hygiene, immunizations, and screening for any possible

development or physical problems should be met. Health is an important component of overall well-being.
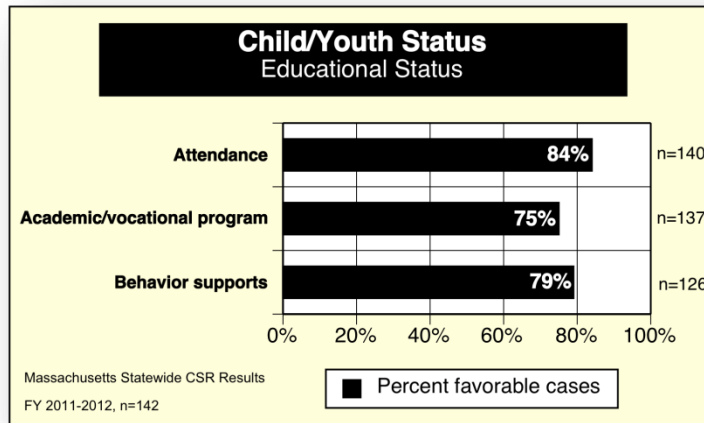
Statewide, 85% had favorable health/physical well-being status. Fifty-two percent (60%) of the youth had "good" or "optimal" health status. Forty-four percent (36%) would benefit from "refinement" in their health status. Four percent (4%) needed "improvement" with poor or worsening health status.

As seen in the demographics of youth in *Table 12* on Page 11, 26% of the youth reviewed had a co-occurring medical problem. The Health Status data indicate most of the youth were achieving their best attainable health status, for many despite a co-occurring medical condition. A number of youth may benefit from refinements in planning to address health issues.

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 youth reviewed statewide, 80% were found to have a favorable living arrangement. Forty-eight percent (48%) had living arrangements that were "good" or "optimal." Forty-six percent (46%) needed "refinement" in their living arrangements with fair to marginal situations. Six percent (6%) of the youth had poor or adverse living arrangements that were inappropriate for the youth, and needed improvement.

Educational Status

Three specific areas of educational status are examined to determine how well youth are doing in their educational programs across key domains. Sub-indicators may not be

applicable to all youth in the sample, as youth may not be enrolled in school, or do not need specific behavioral supports during the school day in order to succeed in school.

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

Attendance. For the 140 youth the school attendance sub-indicator was applicable to statewide, 84% had favorable patterns of attendance. Seventy-six (76%) were found to have "good" or "optimal" school attendance. Eleven percent (11%) of the youth reviewed would benefit from "refinement" in their attendance patterns and had minimally adequate to marginally inadequate attendance. Twelve percent (12%) of the youth needed "improvement" and had poor to adverse rates of attendance, including those that were chronically truant, suspended or expelled from school.

Academic or vocational program. For the 137 youth who were enrolled in an academic or vocational program, 75% were doing favorably well in their program. Half of the statewide sample (50%) had "good" or "optimal" status in their academic or vocational program. Thirty-nine percent (39%) needed "refinement" in their status in their academic or vocational program. Eleven percent (11%) of the youth reviewed needed "improvement" in their school programs, and were not meeting educational expectations, or were losing existing skills and regressing.
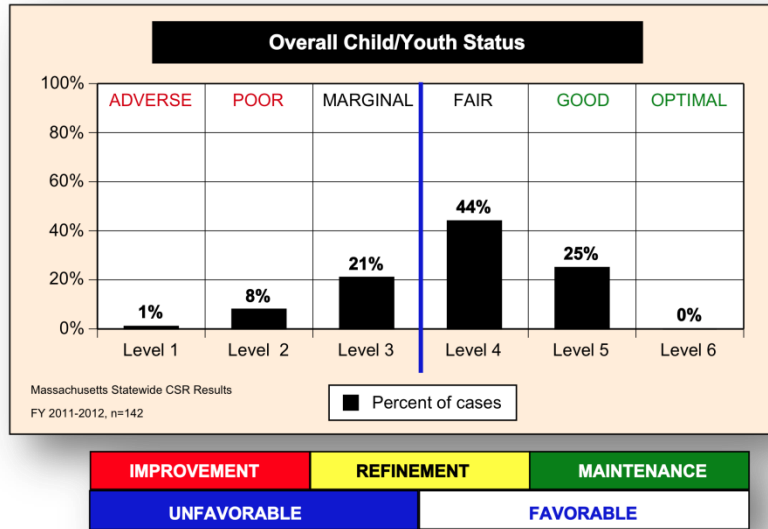
Behavioral supports in school. Statewide, 126 of the youth in the sample required behavioral supports in their school setting. Behavioral supports were working favorably well for 79% of them. Fifty-three percent (53%) had a "good" or "optimal" level of supports. Thirty-six percent (36%) would benefit from "refinement" in their level of supports. Eleven percent (11%) had poor levels of behavioral support that needed improvement, and supports were not adequate in helping the youth do well in school.

Overall, attendance status was moderately strong for youth reviewed across the state. Youth's academic/vocational status and adequacy of behavioral supports in the educational setting would benefit from improved strategies.

Overall Youth Status

The overall results for Youth Status for the 142 youth reviewed statewide during Fiscal Year 2011-2012 are displayed below. Overall, 70% of the youth were found to be doing favorably well. These youth fell in Levels 4-6; youth had Fair status (44% or 63 youth), or Good status (25% or 36 youth). No youth had overall Optimal status.

The remaining youth (30%) had unfavorable status. They had either Marginal status (21% or 30 youth), Poor status (8% or 11 youth), or Adverse status (1% or 2 youth).

Overall Youth Status results are also categorized as percentage of youth who required Improvement, Refinement, or Maintenance in status. Nine percent (9%) of youth fell into the Improvement area, meaning their status was problematic or risky. For these youth, action should likely be taken to improve their situation. The majority of the youth (65%) fell in the Refinement area. The status of these youth was minimal or marginally good, and potentially unstable with further efforts likely necessary to improve their well-being. Twenty-five percent (25%) of the youth statewide had status that should be maintained. Efforts for these should likely be sustained and leveraged to build upon a fairly positive situation.

Overall youth status was unfavorable for 30% of the youth in the statewide sample. Youth were in permanent situations and safe across home, school and community settings. The youth reviewed were generally attending school regularly, and a significant number had favorable physical health status. Stability both at home and school was an issue for a substantial number of youth, as was academic status. A primary issue was the level of behavioral risk to self, which impacted risk status for 30% of the youth. Most concerning was the emotional status of youth; 49% of those reviewed were found to have unfavorable emotional well-being.
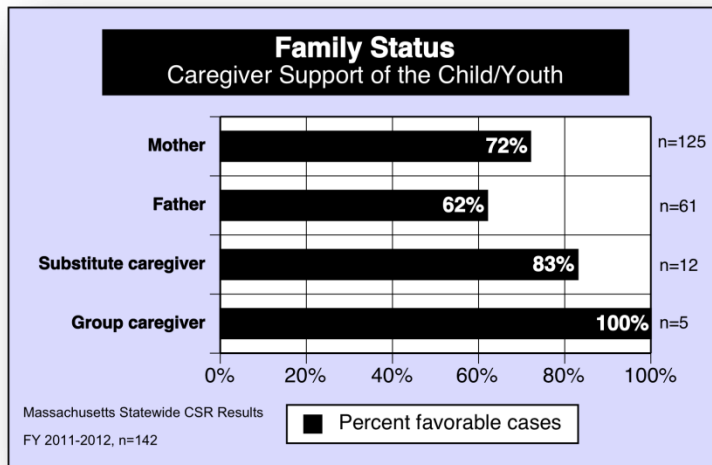
Caregiver/Family Status
(Measures the status of caregivers over the last 30 days)

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

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

Family Status
Caregiver Support of the Child/Youth

Mother	72%	n=125
Father	62%	n=61
Substitute caregiver	83%	n=12
Group caregiver	100%	n=5

Massachusetts Statewide CSR Results
FY 2011-2012, n=142

■ Percent favorable cases

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

Support from mothers. For the youth reviewed statewide, favorable support by mothers was found 72% of the time. There was "good" or "optimal" support for 49% of youth. Maternal support was fair or marginally inadequate and needed "refinement" for 45% the youth reviewed. "Improvement" was needed for 6% of the youth.

Support from fathers. The measure for support from fathers was applicable for 61 of the youth in the statewide sample. Favorable support was found from 62% of the fathers. Support from fathers was "good" or "optimal" for 38% of the youth, needed "refinement" for 39%, and "improvement" for 23%.

Support from substitute caregivers. Support was favorable for 83% of the 12 youth with a substitute caregiver. Half of the youth (50%) of the youth were determined to have a "good" or "optimal" level of support, and a third (33%) had fair support that could benefit from "refinement." Seventeen percent (17%) had poor support that needed improvement.

Support for youth in group care. For the five youth reviewed who were in group care, support of the youth was favorable for 100%, all with "optimal" or "good" levels of support.

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

Mothers' challenges. For the 127 youth the indicator was applicable for, 61% of mothers had favorable status in terms of the level challenge they were experiencing. Sixteen percent (16%) of mothers had a "good" or "optimal" level of challenge with few limitations and good supports, or no limitations. Most of the mothers (76%) needed "refinement" in their level of challenge, with minor limitations and adequate supports, or limits with inadequate or inconsistent supports. Nine percent (9%) of the mothers had a level of challenge that needed to be "improved," and were experiencing major life challenges with inadequate or missing supports.

Fathers' challenges. Sixty-two percent (62%) of fathers had a favorable level of challenge. Of these, 19% had a "good" or "optimal" challenge level (few to no challenges). The majority (66%) needed "refinement" in their level of challenge. Sixteen percent (16%) of the fathers were experiencing major to overwhelming/worsening levels of challenge with inadequate to no supports.

Substitute caregivers' challenges. For the thirteen youth with substitute caregivers, 85% were experiencing a favorable level of challenge with 54% having few to no limitations, and 46% needing "refinement" with some minor limitations, but with adequate supports, and 8% experiencing major life challenges with inadequate supports.

These results can be more fully understood within the context of the specific caregiving challenges identified in the population as reflected in Table 17 on page 14 of this report where 36% of caregivers were experiencing adverse effects of poverty, 26% extraordinary care burdens, and 25% challenged by their own mental illnesses.

Family Voice and Choice

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

Voice and choice of mothers. Ninety-one percent (91%) of mothers experienced favorable voice and choice in their child's assessments, planning and service delivery processes. Of these, 69% experienced a "good" to "optimal" level of voice and choice. Twenty-nine percent (29%) would benefit from "refinement" and strengthening of their voice and choice. Only 2% were found to have a substantially inadequate voice and choice in the service process.

Voice and choice of fathers. For youth whose fathers were involved and information could be gathered (N=53), 70% had a favorable level of voice and choice with their child's service processes. Forty-two percent (42%) had "good" or "optimal" voice and choice, and 38%
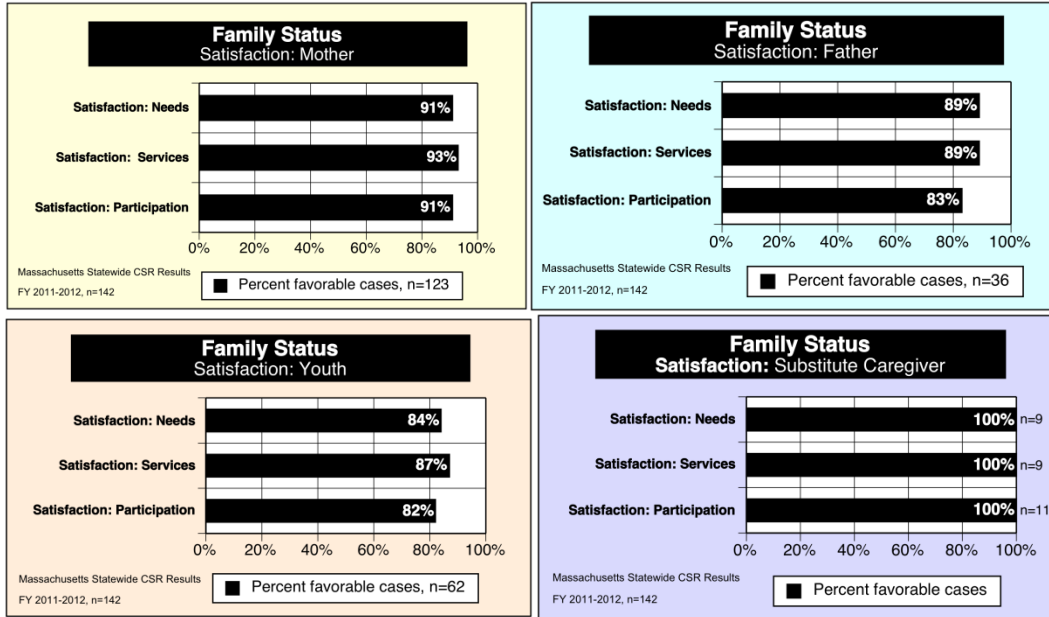
needed refinement. Twenty percent (20%) of the fathers fell in the range of having substantially inadequate to no voice and choice in planning and services, indicating a need for improvement in assuring fathers' voice and choice.

Voice and choice of substitute caregivers. Of the substitute caregivers of youth reviewed, 85% had a favorable level of voice and choice in service delivery processes. Among these, 62% had "good" or "optimal" voice and choice, and 31% with minimally adequate voice and choice that would benefit from "refinement," and 8% with substantially inadequate voice and choice.

Voice and choice of youth 12-17. Of the youth reviewed in the 12-17 age range, 76% had a favorable level of voice and choice in their own services, with a third (33%) in the "good" or "optimal" category. "Refinement" was indicated for the remaining two-thirds (66%) of youth in this age range.

Voice and choice of youth 18-21. Seventy-one percent (71%) of youth in the 18-21 age range experienced a favorable level of voice and choice in their planning and services. Forty-three percent (43%) of the youth had "good" or "optimal" voice and choice, another 43% had "minimally adequate" to "marginally inadequate" voice and choice that needed refinement. Fourteen percent (14%) had "substantially inadequate" voice and choice in planning and services.

These data indicate voice and choice is strong for mothers, and substitute caregivers. Voice and choice for fathers and youth, both in the 12-17 and the 18-21 age ranges, needs to be strengthened.

Satisfaction with Services and Results

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

The displays above show the results for how satisfied each of the role groups were with needs understood, services and results, and participation. Mothers' satisfaction overall was strong and ranged with 91% satisfied with their needs being understood and with their level of participation, to 93% satisfied with services.

Fathers' were also generally satisfied, with satisfaction ranging from 83% satisfied with their level of participation to 89% satisfied with their child and family's needs understood and with services.

Youth satisfaction was sought in the CSRs for youth age 12 and older. Eighty-four percent (84%) were satisfied with their needs being understood, 87% with services, and 82% with their participation.

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

Summary: Caregiver/Family Status

Fathers and mothers in the statewide CSR sample had high levels of challenge in their lives; support for youth was negatively impacted for both parents. Support for youth who were in substitute and group caregiving was positive. Family voice and choice was fairly strong for mothers and substitute caregivers, but weaker for fathers and youth. Satisfaction was favorable among mothers and fathers in the understanding of their needs and with services; fathers were less satisfied with their level of participation. Youth were satisfied with services, but slightly less satisfied with their needs understood and their participation. Substitute caregivers were satisfied with all domains measured.

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

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

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

Overall Youth Progress Patterns

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

Reducing psychiatric symptoms. For the youth reviewed statewide, only 65% had made favorable progress in reducing symptomatology and/or problem behaviors over the previous six months or since beginning services. Twenty-three percent (23%) of the youth had made "good" or "optimal" progress at levels above expectation. Sixty-seven percent (67%) would benefit from "refinement" in their level and rate of progress in reducing their symptoms, and were making fair progress near expectations or marginal progress somewhat below expectations. The remaining 10% had made no progress in reducing targeted symptoms and/or behavioral issues, or were declining with symptoms and behaviors increasing.

Reducing substance use. Of youth in the sample with substance abuse issues, only 25% had made favorable progress. A quarter of the youth (25%) with substance abuse issues were making "good" or "optimal" progress. Seventeen percent (17%) needed their level of progress to be "refined" and had made fair to marginal progress. The preponderance of

youth with substance abuse issues (58%) had made no progress, or they were declining with substance use patterns increasing and intensifying.

Improved Coping and Self-Management

This indicator measures the degree to which the youth has made progress in building appropriate coping skills that help her/him to manage symptoms/behaviors including preventing substance abuse relapse, gaining functional behaviors and improving self-management.
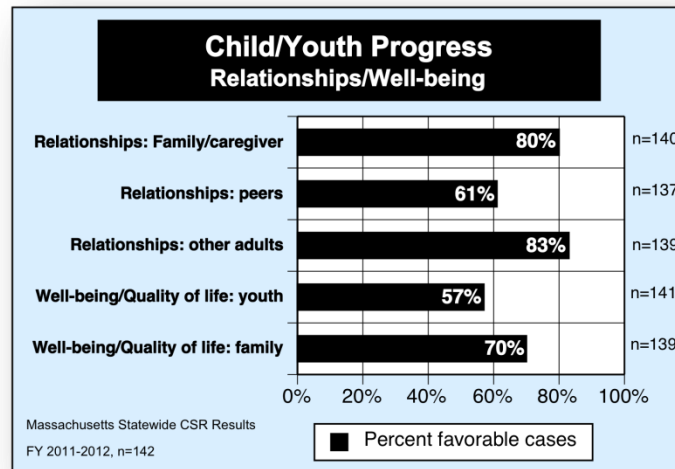
Among the youth reviewed statewide, only 59% had made favorable progress in improving their coping skills and ability to self-manage their emotions and behaviors. Twenty-three percent (23%) had made "good" or "optimal" progress in improving their ability to cope and manage their own behaviors. Sixty-five percent (65%) of the sample fell in the "refinement" area and had made fair to marginally inadequate progress in coping and self-management. Eleven percent of the youth (11%) were making poor progress in advancing coping and self-management at levels well-below expectation, or were regressing.

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. Of the youth for which school progress was applicable, 70% had made favorable progress in school. Thirty-four percent (34%) of the youth were making "good" or "optimal" progress in school. Fifty-three percent (53%) were determined to need "refinement" and had made fair to marginally inadequate progress. Twelve percent (12%) had made making no progress or and were regressing in school.

Work progress. Progress in a work setting applied to nine youth and only a third (33%) had made favorable progress in satisfying expectations necessary for maintaining employment. Two of the nine or 22% had made "good" to "optimal" progress in the work setting. Another 44% needed their level of progress with work to be "refined." Three youth (33%) were making no progress in satisfying work expectations necessary to maintain employment, or were regressing and having significant problems in satisfying work expectations.

Progress Toward Meaningful Relationships

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

For the youth reviewed statewide, 80% had made progress in their relationships with their families or caregivers. Progress in building peer relationships was less favorable, with only 61% making progress in building meaningful relationships with peers. Progress in developing relationships with positive supportive adults (teachers, coaches, etc.) was more favorable, with 83% making progress in this domain.

Overall Well-being and Quality of Life

Measured for the youth and the family, this indicator reviews to what degree is progress being made in key areas of life such as having basic needs met, having increased opportunities to develop and learn, increasing control over one's environment, developing social relationships/reducing social isolation, having good physical and emotional health, and increasing sustainable supports from one's family and community.

Youths' quality of life. For the youth reviewed in the CSR across the Commonwealth, only 57% had made favorable progress in an improved overall well-being and quality of life. Twenty-four percent (24%) had made "good" or "optimal" progress in developing and using personal strengths, long-term relationships, life skills, and future plans. Sixty-three percent (63%) were determined to need "refinement," and had made fair or marginally inadequate progress in an improved quality of life. Thirteen percent (13%) had made poor or no progress in their overall quality of life and had developed few to no long-term supportive relationships, life skills for problem solving, educational/work opportunities, or meaningful and achievable future plans.

Families'/Caregivers' quality of life. For the families and caregivers of youth, 70% had made favorable progress in improving the overall quality of life. Among these were 23% of

families or caregivers who had made "good" to "optimal" progress, 70% needing "refinement," and 7% who had made poor or no progress and needed "improvement."

Overall Youth Progress

A goal of care planning and services is to coordinate strategies and provide services across settings that will help youth to make progress in key areas of their lives.

Overall, 63% of the youth reviewed statewide were making favorable progress (Fair, Good or Optimal Progress). Of these, 24% had made "good" progress, and 39% "fair" progress. No youth in the statewide sample had made an overall "optimal" level of progress.

Thirty-seven percent (37%) of youth statewide made unfavorable rates and levels of progress. Of these, 26% made "marginal" progress, 9% "poor" progress, and 1% "adverse" levels of progress.

Twenty-four percent (24%) had a level of progress that should be "maintained", 65% that needed "refinement", and 10% progress that needed to be "improved."

The data for Youth Progress indicates that overall statewide, youth were making weak progress in key life areas. Of particular concern was weak progress for youth in reducing psychiatric/behavioral symptoms, reducing substance use, and improving coping and self-management skills. As well, youth were not making progress in school and work, in their peer relations and in their overall well-being and quality of life at overall favorable levels. Youth were making fair progress in improved family relationships, and relationships with other adults.

System/Practice Functions

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

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

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

Overall System/Practice Performance

Reviewing System and Practice Performance in the CSR

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

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

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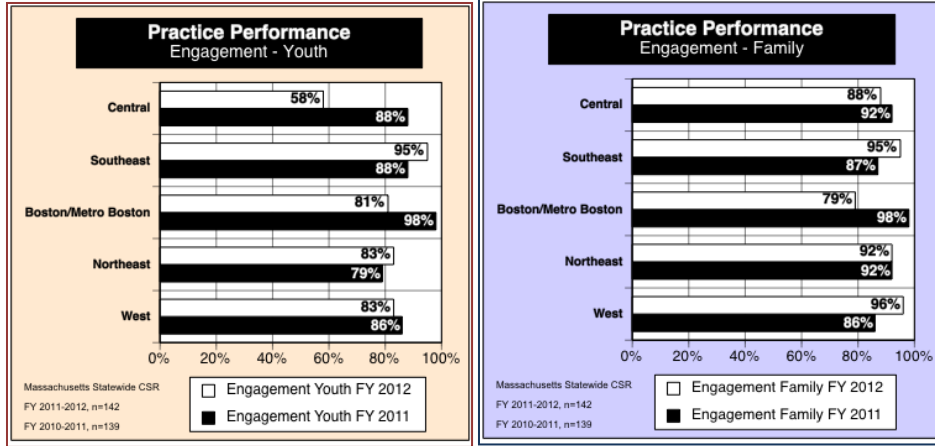
Engagement

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

Youth engagement. For the youth reviewed statewide, 80% experienced an acceptable level of engagement. This was a decline in performance since last year's statewide results of 89% of youth engaged at an acceptable level.

This year, 58% of the youth were engaged at a "good" or "optimal" level. Thirty-nine percent (39%) of youth experienced engagement that would benefit from "refinement," with minimally adequate/fair, to marginally inadequate engagement efforts. Three percent (3%) of youth experienced poor engagement that needed "improvement," or there were no engagement efforts with the youth.

Family engagement. Families were engaged at an acceptable level 88% of the time, a continued strong finding but a slight decline from fiscal year 2010-2011 when 92% of families were engaged at acceptable levels

Statewide this year, 63% of families were engaged at "good" or "optimal" levels, and 36% of engagement efforts needed "refinement." Only 1% of families experienced poor engagement efforts.

Regional results for youth and family engagement. Comparative results of Youth and Family Engagement across the five regional CSRs are presented above. As can be seen, practices for youth engagement improved in the Southeast and Northeast regions, but declined in the rest of the state, with the Central region seeing a significant dip. Family engagement remained strong in all regions with the exception of the Boston/Metro-Boston area, that saw a marked decline in performance.
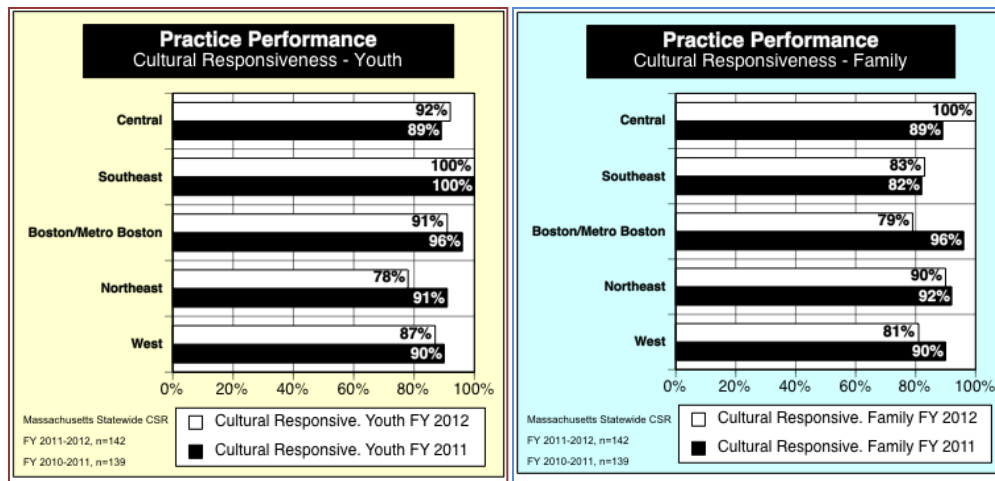
Cultural Responsiveness

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

Youth. For the youth the indicator applied for Cultural Responsiveness was strong and acceptable for 90%. This is in the range of last year's result of 94% of youth statewide with acceptable Cultural Responsiveness.
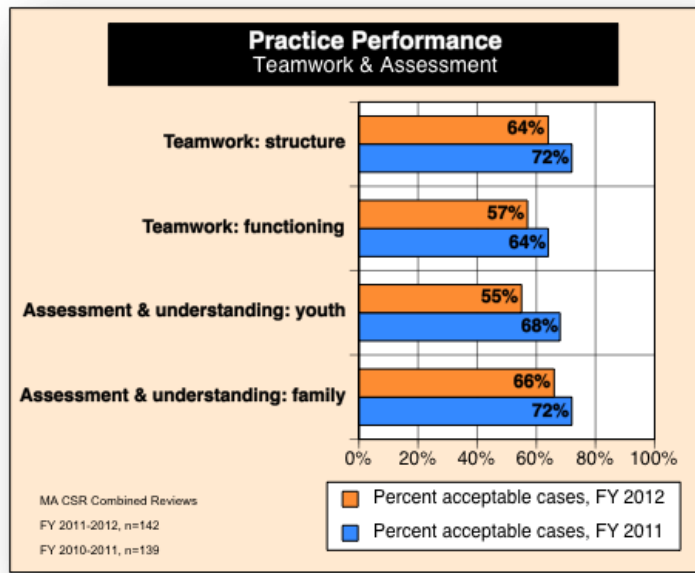
Cultural Responsiveness was at a "good" or "optimal" level for 69% of youth. For 39% of youth practices needed "refinement," and were fair to marginal. Cultural Responsiveness was found to be poor in service processes for only 1% of youth

Families. Cultural Responsiveness to families was acceptable for 85%, a strong finding but a decline from last year when 92% of families experienced acceptable practices for this indicator.

This year 63% of families experience "good" or "optimal" cultural responsiveness. The remaining 37% of practices for families would benefit from "refinement."

Regional results for cultural responsiveness. The regional CSR Cultural Responsiveness practice results are presented above. For youth, Cultural Responsiveness was consistently strong across the regions with the exception of the Northeast region, which saw a decline. For families Cultural Responsiveness was strong for families in the Central and Northeastern regions. Families in the Boston/Metro-Boston area saw a marked decline in performance.

Practice Performance
Teamwork & Assessment

Teamwork: structure — 64% / 72%
Teamwork: functioning — 57% / 64%
Assessment & understanding: youth — 55% / 68%
Assessment & understanding: family — 66% / 72%

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

MA CSR Combined Reviews
FY 2011-2012, n=142
FY 2010-2011, n=139

☐ Percent acceptable cases, FY 2012
☐ Percent acceptable cases, FY 2011

Teamwork: Team Formation and Team Functioning

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

Team Functioning further determines if the members of the team collectively function in a unified manner in understanding, planning, implementing, evaluating results, and making appropriate and timely adjustments to services and supports. Reviewers evaluate the degree to which decisions and actions reflect a coherent, sensible and effective set of interventions and strategies for the child and family that will positively impact core issues. Care coordinators should be communicating regularly with the youth, family and team members particularly when there are any changes in situation. The youth and family's preference should be reflected in any team actions. Optimally, there is a commitment by all team members to help the youth and family achieve their goals and address needs through consistent problem-solving.
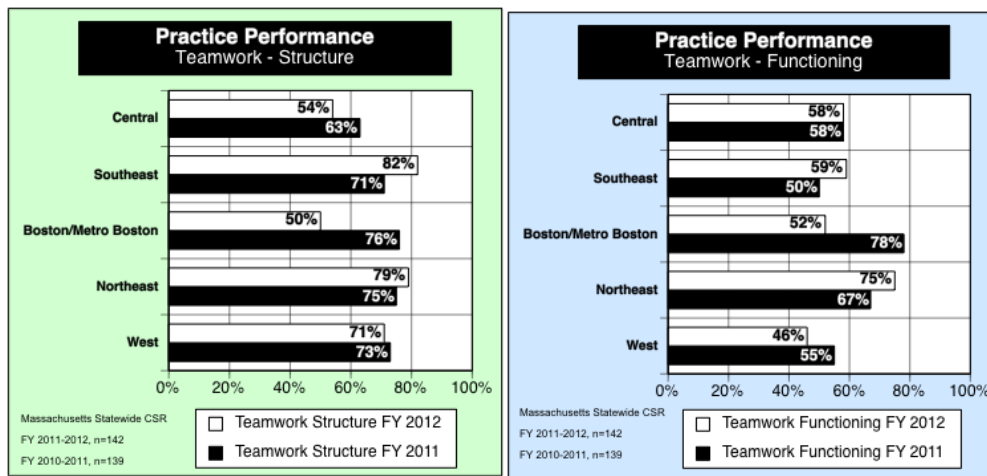
Team Formation. Statewide, team formation was acceptable for only 64% of youth, which is considered to be weak performance. This was a decline in performance since the FY2010-2011 reviews when 72% of youth experienced acceptable levels of team formation.

Teams were formed at a "good" or "optimal" level for 41% of the youth reviewed. Forty-two percent (42%) needed "refinement." In these cases, team formation was minimally adequate to fair, or marginally inadequate, meaning the care planning team met only occasionally and had few to limited skills, family knowledge, and abilities necessary to

organize effective services. Seventeen percent (17%), a significant percentage, were experiencing poor or absent/adverse team formation indicating a need for improvement.

Team Functioning. Teams were functioning acceptably well for only 57% of youth statewide, which is weak performance, and a decline since last year when only 64% of teams were functioning well.

Statewide, 35% of teams functioned at a "good" or "optimal" level with the skills, family knowledge and abilities necessary to work in a unified manner and organize effective services and supports for the youth and families. For 49% of youth, teams needed "refinement" and were functioning in a somewhat unified and consistent manner, or were splintered and engaged in a pattern of actions that was usually incoherent with limited problem-solving. Sixteen percent (16%) of teams were functioning poorly, independently of the family and in isolation of other team members resulting in limited benefits for the youth and family, or there was absent or adverse teamwork.

Regional results for Team Formation and Functioning. The chart above displays the results for Team Formation and Team Functioning for the five regional CSRs conducted during Fiscal Year 2011-2012. Team Formation improved in the Southeast and Northeast regions, but remained at levels that indicate improvement is needed. There was marked decline in performance in Boston/Metro-Boston, and decline in the Central and Western regions. Team Functioning continues to be below levels where the system function can be considered to be dependable across all areas of state, and outside of Northeastern Massachusetts, there was very weak performance. Both system practices need focused improvements across all regions.

Overall findings: Team Formation & Functioning. These results indicate that support for teams to form consistently and work well to understand, plan, implement, and making appropriate and timely adjustments to services and supports for youth and families are needed across all areas of Massachusetts. Focused work is needed statewide to help teams achieve common goals, unify efforts, communicate regularly, evaluate results, and work in alignment with system of care principles to benefit youth and families.

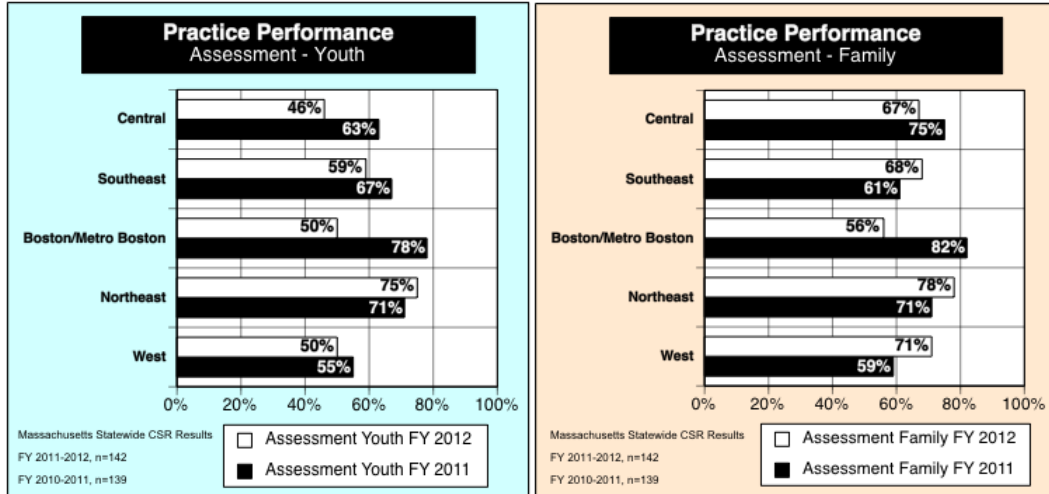### Assessment and Understanding

The Assessment and Understanding indicator reviews system processes that serve as the basis for determining the set of interventions, supports, and/or services that will be most likely to result in necessary changes for the youth and family. Reviewers assess the degree to which all relevant information has been gathered and synthesized resulting in a complete "big picture" understanding of the strengths, needs, preferences, current situation, risks and core issues of the youth and family. Also important is the ability of teams to assure that assessment and learning is an ongoing process in order to track progress and respond to the changing needs of the youth and family. Assessment and understanding of youth and families is a necessary foundational condition for practitioners to build cohesive care plans that can be implemented by teams toward achieving positive outcomes.

Assessment & Understanding of Youth. Statewide, only 55% of youth were found to have an acceptable level of assessment and understanding of their core issues and situations. This is a significant decline in performance since last year when 68% of youth experienced acceptable assessment and understanding of their strengths and needs.

This year, 35% of teams had assessment and understanding of the youth's strengths, underlying issues, needs, risks and preferences at a "good" or "optimal" level. Forty-seven percent (47%) of the youth needed "refinement" in their teams' level of understanding of them. For these youth, assessment and understanding was at a fair level with efforts made but nominal understanding of the youth's strengths and needs, or marginally inadequate with limited information that was only occasionally updated. Eighteen percent (18%) of youth had teams that had poor, incomplete or inconsistent assessment and understanding of the youth. In these cases, information necessary to understand the youth's strengths, needs and underlying issues were absent or outdated.
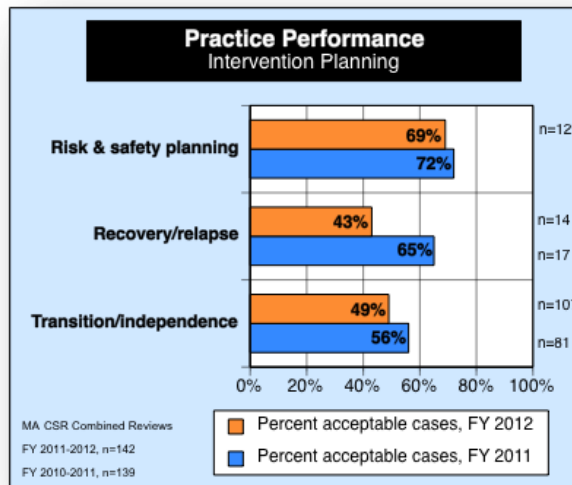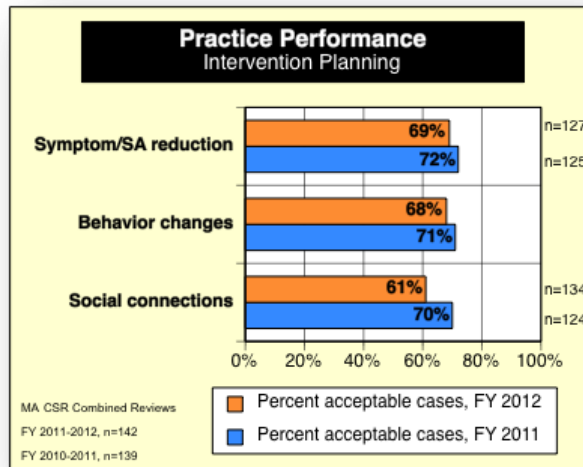
Assessment and understanding of families. This system practice was acceptable for only 66% of families statewide, a decline in performance since last year when 72% experienced acceptable assessment and understanding.

Assessment and understanding of families was found to be "good" or "optimal" for 40%. "Refinement" was needed for 49% where there was fair/minimal understanding, or marginally inadequate assessment and understanding. In these cases the team needed to better understanding the strengths, context, needs and vision of the family. Eleven percent (11%) of family had teams that had a poor level of understanding of their context and dynamics with information that was sometimes confused or contradictory.

Regional results for Assessment and Understanding. Results of the five CSRs by region for the youth and families reviewed are presented above. Assessment and understanding of youth was weak and declined in all areas, with the exception of the Northeast where there was a slight improvement. Assessment and Understanding of families ranged from 56% to 78% acceptable performance, with gains made in the Southeast, Northeast, and Western regions. However, improvements are needed across regions in order for this system practice to be considered to be at a level where the needs of youth and families are adequately understood.

Overall findings: Assessment & Understanding. Statewide, 45% of youth and 34% of families had teams that did not have the level of assessment and understanding necessary to plan supports and interventions. Statewide data presented on Page 13 shows that 42% of youth statewide did not have a current mental health assessment, and only 25% of parents had received their child's mental health assessment. Moreover, far fewer youth reviewed this year than last had a current mental health assessment; last year, 22% of youth did not have a current mental health assessment. Overall, this foundational practice needs concerted improvement in order to assure all relevant and current information about youth and families is consistently gathered and synthesized so that teams have the full understanding needed to develop effective plans of care.
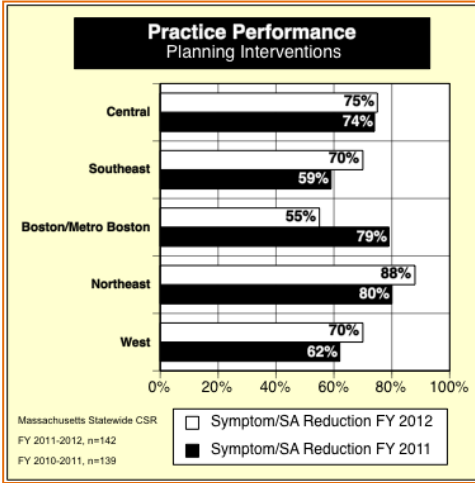
Intervention Planning

Intervention Planning was evaluated for each youth and family across six sub-indicators. Specific indicators may or may not be applicable to a particular youth/family depending on their specific needs and goals. Acceptability of intervention planning for each sub-indicator is based on an assessment of the degree to which processes are consistent with system of care and wraparound principles. Reviewers also examine plans and processes to see if they are cognizant of safety and potential crises, are well-reasoned, well-informed by all available sources of information and are likely to result in positive benefits to the child and family. Plans need to be specific, detailed, accountable and derived from a family-driven team-based planning process. Plans also need to evolve as the youth and family's situation changes or more or different information is learned.

Planning for Symptom or Substance Abuse Reduction. For the 127 youth the sub-indicator was applicable for, planning for reducing presenting psychiatric symptoms or substance abuse was acceptable for 69%. This was a decline, but in the range of last year's performance of 72% with acceptable planning on this sub-indicator.
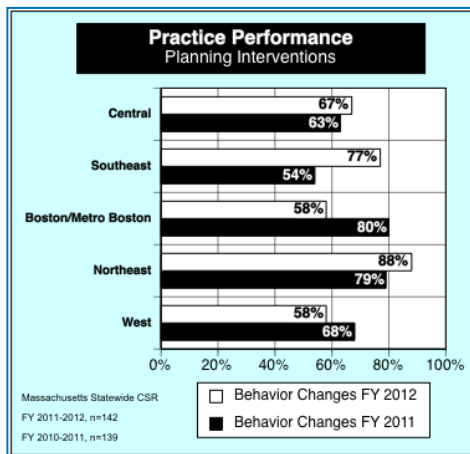
There was "good" or "optimal" planning in reducing symptoms or substance abuse for 36% of youth with well-reasoned strategies informed by an understanding of needs, and the youth and families' preferences and perspectives. "Refinement" in planning to reduce symptoms or substance abuse was identified to be needed for 53% of the sample where planning was fair to marginally inadequate. Planning for symptom/substance abuse reduction was poor or absent/misdirected for 11% of those reviewed.

Regional results for planning for Symptom/Aubstance Abuse Reduction. This chart displays the comparative results for the five regional CSRs for planning for Symptom or Substance Abuse reduction. Performance in adequately addressing symptom/substance abuse reduction in care plans ranged from 55% to 88% of planning efforts. Planning improved in four of the five regions for this sub-indicator, but continues to need improvement in all areas except for the Northeast region. Planning strategies and supports for reducing youth's presenting psychiatric symptoms and/or substance use declined significantly for youth in the Boston/Metro-Boston area.

Planning for Behavior Changes. Addressing behavior changes in the care plan was at an acceptable level for only 68%, a decline in performance since last year when 71% had acceptable planning for behavior changes.
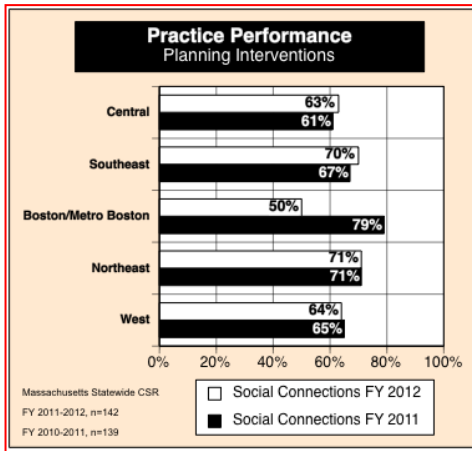
Forty-two percent (42%) had care plans that addressed needed behavior changes in the "good" or "optimal" range. These plans reflected understanding of the youth and family, and had clear interventions for addressing behaviors that created problems for the youth. "Refinement" of behavioral supports and interventions in plans was needed for 48% of the youth. For 10%, plan components for supporting behavior changes were poorly reasoned and failed to design interventions that could address core issues, or there was no plan to address presenting behaviors.

Regional results for planning for Behavior Change. Performance in addressing youth's problematic behaviors through strategies in care plans for each of the regional CSRs is displayed. Results ranged from 58% to 88% acceptable performance. Improvements were seen in the Central, Southeast, and Northeast regions. Marked declines occurred in the Boston/Metro-Boston and Western regions. Assuring behaviors are adequately addressed in planning are indicated in all areas with the exception of the Northeast region, where performance on this sub-indicator was strong

Planning for Social Connections. Planning for increasing *Social Connections* was applicable for 134 of the youth reviewed and acceptable for only 61%, a decline from last year when 70% of youth had acceptable planning on this sub-indicator.

Thirty percent (30%) of the youth had "good" or "optimal" strategies in their plans for improving social connections with well-understood and well-reasoned supports. "Refinement" was indicated in plans for 60% of youth who needed stronger social connections in order to do better emotionally or behaviorally. These youth had fair to marginal strategies reflected in their care plans that were somewhat aligned, or limited and inconsistent. Ten percent (10%) of youth who needed stronger social connections had poor planning reflecting unaligned strategies lacking in clarity and urgency to address their social connection needs, or had absent or misdirected planning.
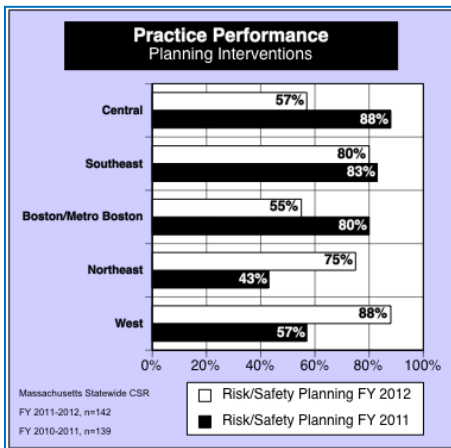

Regional results for Planning for Social Connections. Planning interventions for increased Social Connections across the five CSRs ranged from 50% to 71% of youth with acceptable performance. Strengthening of the Social Connection planning domain is indicated for all regions and all regions. All regions saw comparable performance to last year with the exception of Boston/Metro-Boston where there was a marked decline.

Risk/Safety Planning. Planning to address risk and safety was acceptable for 69% of the youth statewide, a decline in performance since the last CSR when 72% had acceptable performance.

The risk/safety component of plans was "good" or "optimal" for 47% of the sample. For 39% of the youth, risk and safety planning needed "refinement" with planning found to be fair or marginally inadequate. For 15%, risk/safety planning was poor or absent.
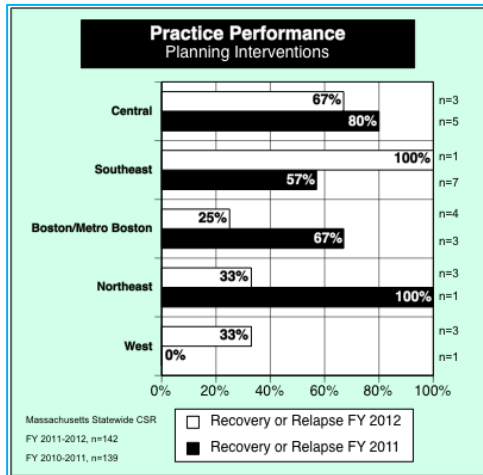

Regional results for Risk/Safety planning. Risk and safety planning improved considerably since the last CSR in the Northeast and Western regions, and was comparable to last year in the Southeast. Performance declined significantly in the Central and Boston/Metro-Boston areas. Results for these regions indicate that the results from last year were not sustained, and efforts to assure effective risk and safety planning occurs consistently needs focused work.

Recovery/Relapse planning. Fourteen youth statewide needed Recovery or Relapse issues addressed in planning. Planning to address the recovery process and prevention of relapse was acceptable for only 43% of them, a considerable decline from last year's CSR when only 65% had acceptable planning.

Fourteen percent (14%) were found to have "good" or "optimal" planning in this domain. Planning for 57% of the youth fell in the "refine" range indicating fair to marginally inadequate planning which could benefit from enhancement of efforts. Twenty-nine percent (29%) of the youth experienced poor planning to address recovery/relapse issues with a poorly reasoned, inadequate planning process.
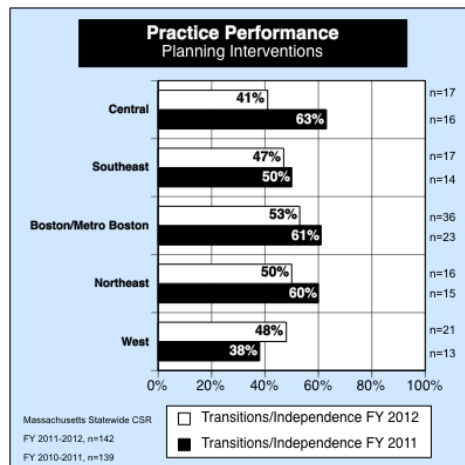

Regional results for Recovery/Relapse planning. Regional results indicating relative sample size are displayed. There were small samples for this sub-indicator. With 57% of youth with unacceptable planning in this domain, there is a clear need for improvement in assuring substance abuse issues are adequately addressed in care plans for youth needing recovery and relapse supports.
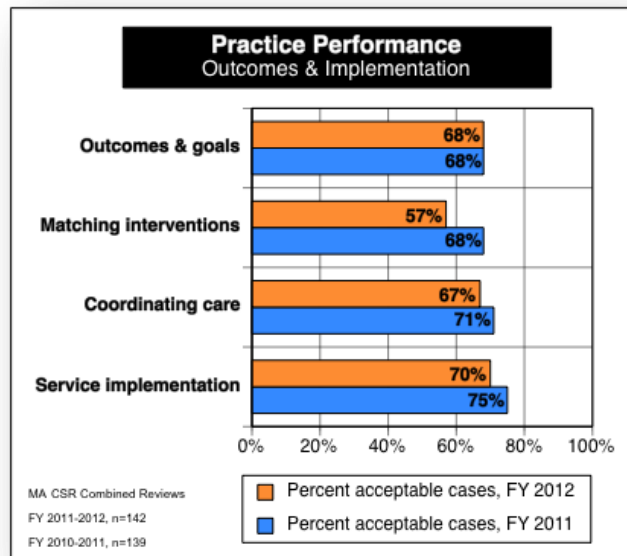
Transition planning. Review of *Transitions* in the CSR apply to any transition occurring within the last 90 days or anticipated in the next 90 days including between placements (school and home), programs and to independence/young adulthood.

One hundred and seven (107) of the 142 youth reviewed had active or imminent transitions that needed to be addressed in their planning processes. Transition planning was acceptable for only 49%, a decline since the last CSR when 56% had acceptable planning.

Twenty-three percent (23%) experienced transition planning that was "good" or "optimal." Over half (51%) of the youth needed "refinement" in planning for transitions. A quarter of youth (25%) had poor or absent planning for supporting their transitions.
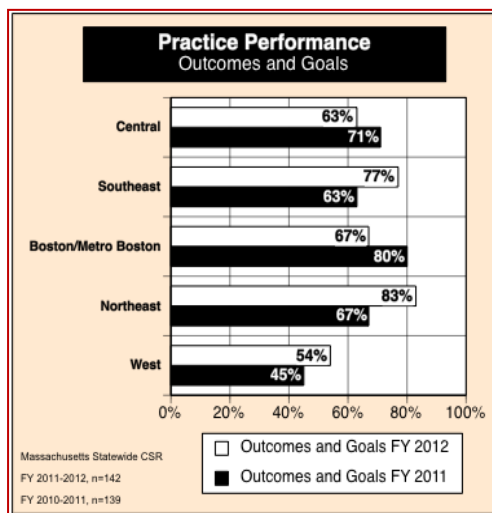

Regional results for Transition planning. Data from the regional results clearly indicate improvement is needed in identifying and planning for effective transitions statewide. Performance ranged from 41% to 53% of youth experiencing acceptable transition planning, which demonstrates extremely weak transition planning practices statewide. Performance declined in all areas of the state outside of the Western region, where transition planning continued to be weak. Implementing better practices in supporting youth's transitions are clearly indicated given the statewide results.

Practice Performance
Outcomes & Implementation

Outcomes and Goals

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

A clearly stated and understood set of goals and outcomes guiding services and strategies was acceptable for only 68% of youth statewide, which is the same result as last year, and indicates a continued need for improvement.

Thirty-two (32%) of the youth had "good" or "optimal" goals that were well-reasoned and specific. Fifty-nine percent (59%) of those reviewed had ending goals and outcomes that were fairly to marginally inadequate and needed "refinement." Eight percent (8%) had poor specification of outcomes and goals insufficient for guiding intervention and change, or absent goals.
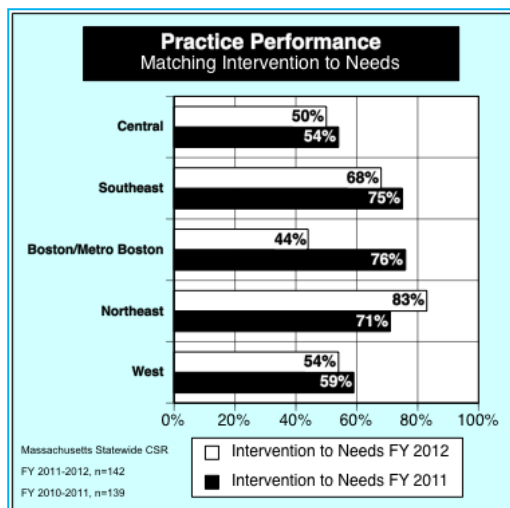
Regional results. Regional results ranged from 54% acceptable to 83% acceptable, indicating a wide range of system/practice performance. There were improvements in several regions. Strengthening the specification of outcomes and goals in youth's plans is indicated statewide.

Matching Interventions to Needs

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

There was an acceptable level of matching intervention to need for 57% of the youth reviewed statewide. This was a marked decline in performance since last year's CSR when 68% of youth had acceptable matching of their interventions to what they need.

Thirty-nine percent (39%) of youth had "good" or "optimal" matching. Forty-nine percent (49%) 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. Eleven percent (11%) experienced poorly matched interventions resulting in inadequate or conflicting assembly of service and supports, adverse matching of interventions to needs.

Regional results. Displayed are the regional CSR results for Matching Interventions to Needs, which ranged from 44% to 83% acceptable. The Northeast region saw improvement and the strongest performance. The remaining areas experienced declines, and demonstrated weak matching of interventions to what youth and families need to progress. Strengthening of teams' abilities to assure interventions match what the youth needs to make progress is indicated for those regions that are struggling in this key system practice.
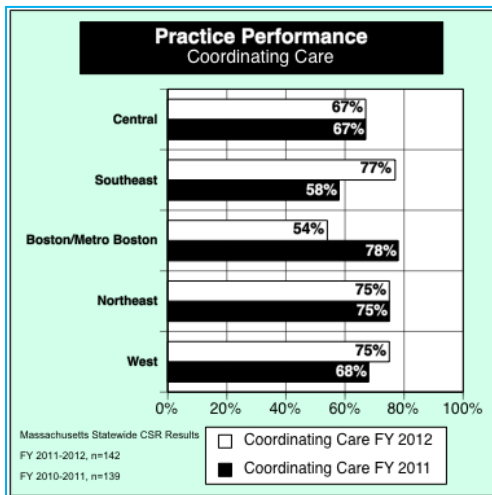
Coordinating Care

Care coordination processes and results were reviewed to determine the extent to which practices aligned with the model of providing a single point of coordination of care with the leadership necessary to convene and facilitate effective care planning. Reviewers look at care coordination processes including efforts made to ensure that all parties participate and have a common understanding of the care plan, and support the use of family strengths, voices and choices. Other core processes reviewed are the skills of the care coordinator in executing core functions, and assuring the team participates in analyzing and synthesizing assessment information, planning interventions, assembling supports and services, monitoring implementation and results, and adapting and making adjustment as necessary. Care coordinators should be able to manage the complexities presented by the youth and

family in their care, and should receive adequate clinical, supervisory and administrative support in fulfilling their role. For youth both in ICC and in-home therapy, the care coordinator should disseminate the youth's Risk and Safety Plan to all appropriate service providers as well as the family. The care coordinator's role is to facilitate ongoing communications among the entire team

Youth in the sample received care coordination services from both ICC (N=88) and IHT therapists (N=54). Care coordination practices were found to be at an acceptable level statewide for 67% of the youth reviewed.

Care coordination was found to be "good" or "optimal" for 35% of the youth hallmarked by effective and dependable coordination. For 46% of the statewide sample, care coordination needed "refinement," and practices were found to be fair and minimally adequate, or marginal and limited with little leadership for service delivery and results. Fourteen percent (14%) of youth statewide were found to have poor, fragmented/inconsistent care coordination, or absent/misdirected coordination.

Regional results. Care coordination performance across the five regional CSRs is displayed. Results ranged from 54% to 77% of youth in each area receiving acceptable coordination. Performance statewide continues to be below levels where care coordination can be considered to be a consistently dependable practice. However, performance in the Southeast and Western regions improved over last year. Results for the Central and Northeast regions were the same. The Boston/Metro-Boston area saw a significant decline in care coordination practices. Concerted improvements are needed statewide to assure youth receive quality care coordination.
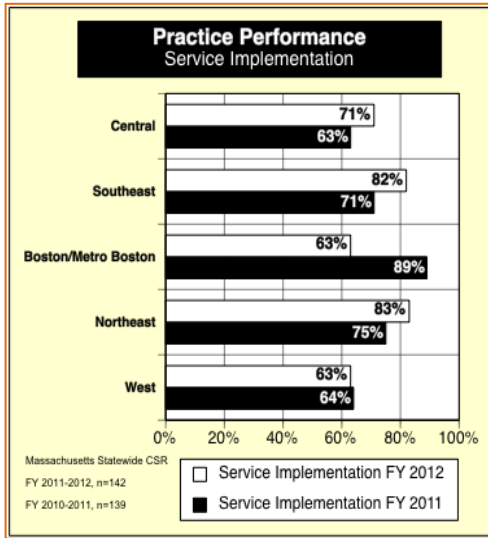
Service Implementation

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

For the youth reviewed statewide, 70% were found to have an acceptable level of service implementation, a decline since the last CSR when 75% had acceptable service implementation.

Twenty-five percent (25%) experienced "good" or "optimal" service implementation reflecting a substantial pattern of service implementation that was timely competent and consistent. Just over half of youth (51%) experienced service implementation that needed

"refinement" with an overall pattern of implementing needed services and supports that was fair to marginal/ inconsistent. Nine percent (9%) of the youth had poorly implemented services with continuing significant implementation problems, or no needed services implemented.

Regional results. Service Implementation patterns across the five regional CSRs are presented. Results ranged from 63% to 82% acceptable implementation practices. Performance in implementing services youth need improved in the Central, Southeast, and Northeast areas; the Western region saw comparable performance to last year. For the Southeast and Northeast regions, service implementation was fairly strong. Performance for youth reviewed in the Boston/Metro-Boston fell significantly since last year when there had been strong performance. Assuring more consistent and effective service implementation is needed to assure services and supports youth need to progress are implemented.
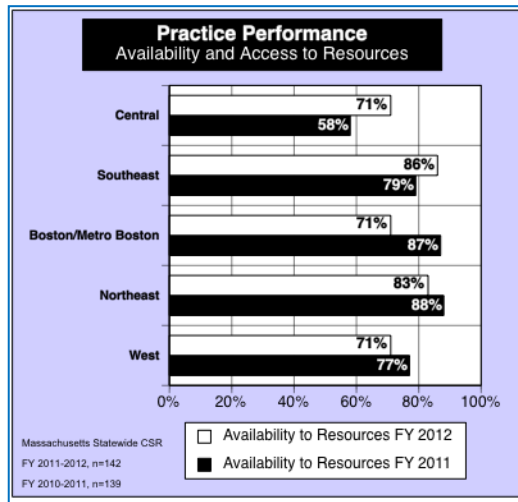

Availability and Access to Resources

The Availability and Access to Resources indicator measures the degree to which behavioral health and natural/informal supports and services necessary to implement the youth's care plan are available and easily accessed. Factors reviewed include the timeliness of access as

planned and any delays or interruptions to services due to lack of availability or access over the 90 days preceding the review.

Statewide, 70% of youth were found to have acceptable access to available resources. This was a decline in performance since last year's CSR when 79% of youth had acceptable access/availability to services.

Thirty-nine percent (39%) had a "good" or "optimal" access to needed resources, with a good to excellent array of supports and services available. Fifty-five percent (55%) had fair to marginally inadequate resource availability that reflected a need for "refinement." Six percent (6%) of the statewide sample experienced poor to absent resource access and availability severely limiting their ability to receive needed services.
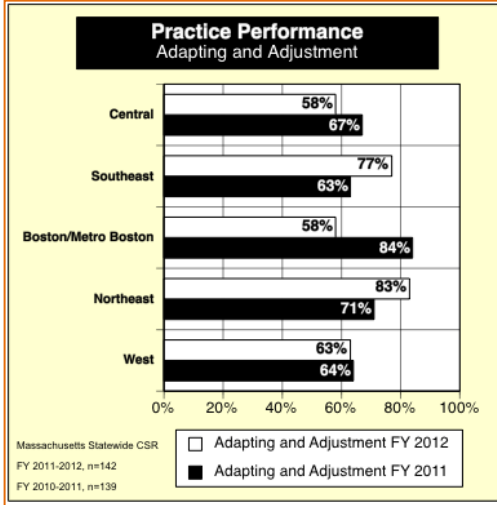

Regional results. Regional Availability and Access to Resources system/performance results are displayed. The Southeast region had strong, improved performance over last year's CSRs. Improvements were seen in the Central area, although continued work is needed in the region to assure youth consistently have access to needed services. Declines in performance were experienced in the Western, Northeast and Boston/Metro-Boston CSRs.

Adapting and Adjustment

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

For youth reviewed statewide, practices related to adapting and adjusting plans and services was acceptable for 66% of youth, a decline since last year when 72% experienced acceptable practices in adapting and adjusting.

Forty-four percent (44%) of the youth experienced "good" or "optimal" practices that were responsive to changing conditions, with acceptable levels of monitoring and adjustment. Forty-six percent (46%) of youth were experiencing necessary changes to plans and services at a minimally adequate to marginally inadequate level, with only periodic to occasional monitoring. Ten percent (10%) of the youth had poor and fragmented adapting and adjustment of services and interventions, or absent or non-operative adapting and adjustment processes.
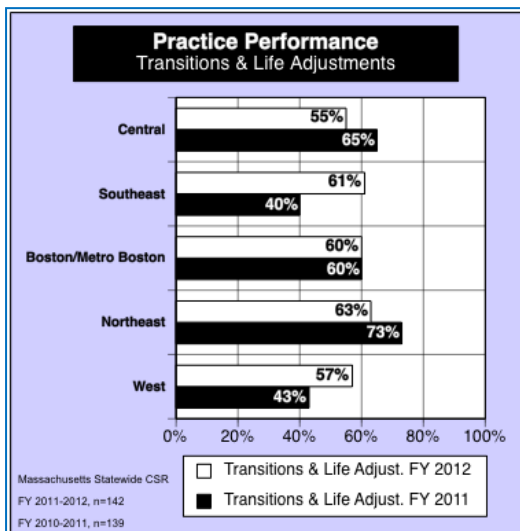
Practice Performance
Adapting and Adjustment

Central 58% / 67%
Southeast 77% / 63%
Boston/Metro Boston 58% / 84%
Northeast 83% / 71%
West 63% / 64%

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

Massachusetts Statewide CSR
FY 2011-2012, n=142
FY 2010-2011, n=139

☐ Adapting and Adjustment FY 2012
■ Adapting and Adjustment FY 2011

Regional results. System/practice performance results for each regional CSR are displayed above. Performance ranged from 58% to 83% acceptable. Performance in the Northeast and Southeast regions improved. Western region results were comparable to the last CSR. Performance in the Central and Boston/Metro-Boston areas declined and was weak; focused efforts to assure consistent practices in adapting and adjusting strategies in youth's service plans are indicated statewide.

Transitions and Life Adjustments

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

For the 122 youth this indicator applied to across the state, only 59% were found to have acceptable transition management practices evident, which is comparable to the last CSR when 57% of youth had acceptable transitions. Of these, 28% had "good" or "optimal" transition intervention practices working for them. Fifty-seven percent (57%) of youth the indicator was applicable for needed "refined" transition supports. Transition practices for these youth were fair/minimally adequate or marginally inadequate. Sixteen percent (16%) of youth statewide experienced a poor or adverse transition with unaddressed transition issues, or no transition plan for an imminent change.

Practice Performance
Transitions & Life Adjustments

Central 55% / 65%
Southeast 61% / 40%
Boston/Metro Boston 60% / 60%
Northeast 63% / 73%
West 57% / 43%

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

Massachusetts Statewide CSR
FY 2011-2012, n=142
FY 2010-2011, n=139

☐ Transitions & Life Adjust. FY 2012
■ Transitions & Life Adjust. FY 2011

Regional results. Performance was weak in all areas however, there were improvements in the Southeast and Western regions as compared to last year's CSR. Boston/Metro-Boston had the same performance as the last CSR. There were declines in the Central and Northeast regions.
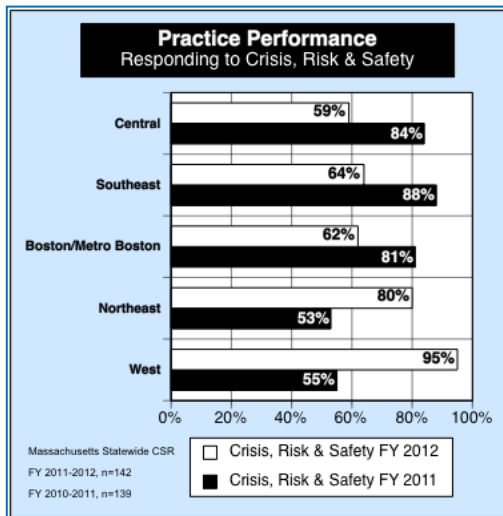
These results indicate practices to improve the ability of teams to identify, plan and implement supports for youth in their life transitions need focused improvement statewide.
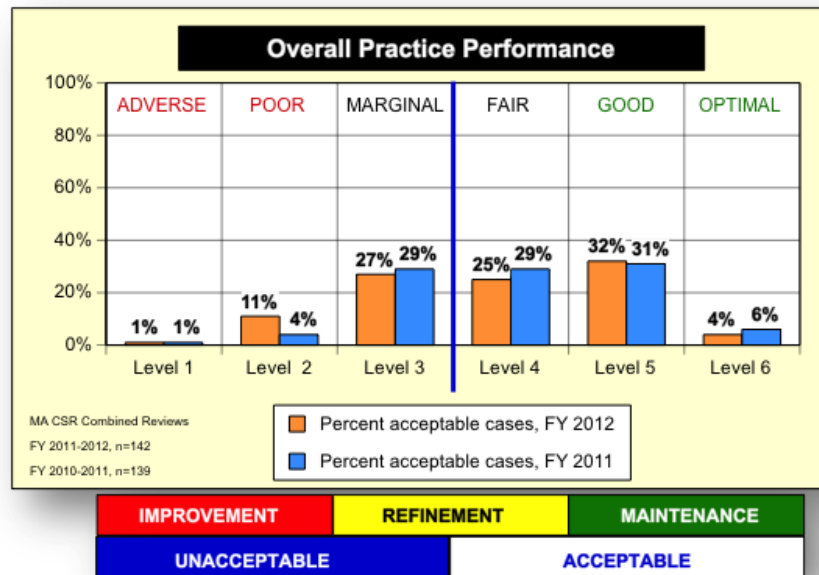
Responding to Crises and Risk/Safety Planning

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

Seventy-two percent (72%) of youth the indicator was applicable for (N=109) experienced an acceptable crisis response and risk plan that worked for them in a crisis. This was a comparable result to last year's CSR when 73% of youth had an acceptable crisis response, and indicates a need for continued improvement.

Forty-eight percent (48%) of youth were found to have a "good" or optimal response. Another 39% had a fair to marginally inadequate response and plan that was in need of "refinement." The remaining 13% of youth were found to have a poor to adverse response in need of "improvement."

Practice Performance
Responding to Crisis, Risk & Safety

Region	Crisis, Risk & Safety FY 2012	Crisis, Risk & Safety FY 2011
Central	59%	84%
Southeast	64%	88%
Boston/Metro Boston	62%	81%
Northeast	80%	53%
West	95%	55%

Massachusetts Statewide CSR
FY 2011-2012, n=142
FY 2010-2011, n=139

Regional results. This chart displays the performance of each of the regional CSRs in Responding to Crisis, Risk and Safety Planning. Performance improved greatly for the Northeast and Western regions; performance in the Western region demonstrates that the youth reviewed received strong crisis responses. Crisis response in the Central, Southeast and Boston/Metro-Boston regions declined substantially, and will require focused efforts to assure there is an acceptable level of crisis response to assure youth safety and manage risk.

Overall System/Practice Performance

The chart above shows the distribution of scores for System/Practice Performance statewide across the six point rating scale, as well as the scores this year relative to last year's CSR. For the youth reviewed in the five regional CSRs, 60% were found to have acceptable system/practice performance (25% "Fair", 32% "Good", and 4% "Optimal") and 40% had unacceptable system/practice performance (1% "Adverse", 11% "Poor", and 27% "Marginal"). Performance scores clustered at the good, fair and marginal levels with 84% of youth reviewed falling in this range.

Thirty-six percent (36%) of the youth reviewed statewide fell in the "*Maintenance*" area, meaning the system and practices were **effective** for them, and efforts should focus on **sustaining and building** upon positive practice. Last year, 37% of youth fell in the *Maintenance* area.

Fifty-two percent (52%) of the youth fell in the *"Refinement"* area which means that performance was **limited or marginal**, and **further efforts are necessary** to refine practices. Practice patterns in these situations **require refinement**. Last year, 58% of youth fell in the *Refinement* area.

Twelve percent (12%) of the youth fell in the *"Improvement"* area meaning performance was **inadequate**. In these cases practices were **fragmented, inconsistent and lacking** in intensity or non-existent. **Immediate action is recommended** to improve practices for youth falling in this category. In last year's CSR, 5% of youth fell in the *Improvement* area.

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

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

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

- Engagement with the Youth

Areas of system/practice performance that <u>need substantial improvement</u> in order to be considered to have adequate consistency, intensity and/or quality of efforts are:

- Planning Interventions for Symptom or Substance Reduction;
- Planning Interventions for Behavioral Changes;
- Planning Interventions for Risk and Safety;
- Outcomes and Goals;
- Service Implementation;
- Availability and Access to Resources; and
- Responding to Crisis & Risk and Safety Planning.

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

- Team Functioning;
- Team Formation;
- Assessment & Understanding of the Youth;
- Assessment & Understanding of the Family;
- Planning Interventions for Social Connections;
- Planning Intervention for Recovery/Relapse;
- Planning Interventions for Transitions,
- Matching Interventions to Needs;
- Coordinating Care;
- Adapting and Adjusting; and
- Transitions & Life Adjustments.

Overall, statewide results indicate that several system of care practices including engagement with families and cultural responsiveness to youth and families continued to have the same strong performance as in the FY 2010-2011 CSR. The remaining system practices are not considered to be performing in a dependable, consistent and effective manner. Three system indicators had the same results as in the previous year's CSR (Outcomes & Goals, Transitions & Life Adjustments, and Crisis Response). The remaining saw declines in performance.

The Rosie D. Remedy has identified the development of care planning teams, care plans and care coordination as core functions in the practice model, and that youth and families should expect these functions to be in place and working for them. The statewide findings for this year's CSR found that teams for well over a third of the youth (36%) were not being formed consistently and for 43%, were not functioning at an adequate level, were splintered or inconsistent in planning and evaluating results, and were not engaged in collaborative problem-solving. With the number of teams with weak functioning, concerted development is clearly indicated to strengthen the ability of teams to plan together, collaboratively problem-solve and unify their implementation efforts. Planning interventions across all indicators needed strengthening particularly in the areas of strengthening youths' social

connections, recovery/relapse and assuring successful transitions. Care coordination was not at an acceptable level of practice for a third of youth (33%).

A challenge for 45% of teams was using information, including in existing assessments and information that is held by other providers, schools, etc., to increase team-based understanding of youths' strengths and needs at a scope and depth necessary to develop the right set of interventions and supports. Of concern is that 42% of youth statewide did not have a current mental health assessment, and only 25% of parents had received their child's mental health assessment. Moreover, far fewer youth reviewed this year than last had a current mental health assessment; last year, 22% of youth did not have a current mental health assessment.

The system practice that continues to need priority attention is assuring adequate supports for managing youths' transitions. Sixty-one percent (61%) of youth were found to have an unacceptable of level management of their transitions.

Overall, 40% of youth reviewed statewide did not receive an acceptable level of system/practice performance. These results indicate focused improvements are needed in most areas of practice before the system of services can be considered to be consistently performing well for youth, and so that families can reliably depend on services to help their children progress, achieve desired outcomes and/or maintain gains.

CSR Outcome Categories

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

Overall CSR Outcomes FY2011-2012

The percentages on the outside of the two-fold table above represent the total percentages in each category. The percentage at outside, top right (60%) is the total percentage of youth with acceptable system/practice performance (sum of Outcomes 1 and 2). A smaller percentage of youth this year than last year had acceptable system/practice performance.

The percentage below this (39%) is the inverse- the percentage of youth with unacceptable system/practice performance. Likewise the number on the outside lower left is the percentage of youth that had favorable status (69%) and under the next block the percentage of youth with unfavorable status (30%).

System/Practice Performance for youth statewide in FY2011-2012 was 60%.

- This means that services were working at a dependable or consistently acceptable level for only 60% of the 142 youth reviewed, which is weak performance.

-This was a decline in performance since last year's CSR result of 66% of youth with acceptable system/practice performance.

CSR Results by Outcomes

Outcome 1
As the indicated in the display, 54% of the youth reviewed fell into outcome category 1. Outcome 1 is the desired situation for all children and families receiving services. It means that youth had favorable status, and services were performing well for them.

This was a decline in performance since the last CSR when 58% of youth were in Outcome 1.

Outcome 2
Six percent (6%) of the statewide sample fell in Outcome 2. This category represents children whose needs are so great or complex that despite the best practice efforts and diligent system performance of the service system, the overall status of the child or youth remains unacceptable.

Eight percent (8%) of the youth statewide were in Outcome 2 in the previous CSR.

Outcome 3
Fifteen percent (15%) of the youth were in outcome category 3. Outcome 3 reflects youth whose status was favorable at the time of the review, but who were receiving less than acceptable service system performance. Some children are resilient and may have excellent naturally occurring supports provided by family, friends, school personnel, or some other key person in their life whose efforts are significantly contributing to the child's favorable status at the present time. However, current service system/practice performance is limited, inconsistent, or inadequate at this time. For these children, when teams and interveners adequately form, understand the youth and family, and function well, the youth could likely progress into the Outcome 1 category. Without key practice functions occurring reasonably well, status for youth in this category is often fragile, and at risk of becoming unfavorable.

Seventeen percent (17%) of youth were in Outcome 3 in last fiscal year's CSR.

Outcome 4
Twenty-four percent (24%) of the sample fell into outcome category 4. Outcome 4 is the most unfavorable outcome combination as the child's status is unfavorable and system performance is inadequate. For many of the youth who are in Outcome 4, a better understanding of the youth and family coupled with stronger teamwork and planning interventions that meet the needs of the youth with strong oversight of implementation would move the youth into a better Outcome classification.

A larger percentage of youth fell in Outcome 4 this year than last; last year 17% were in Outcome 4.

Overall outcome findings and year to year changes by region

Region	Acceptable System Performance FY 2011-2012	Acceptable System Performance FY 2010-2011	Year to Year Change
Western Massachusetts	**54%**	60%	Decline
Northeastern Massachusetts	**75%**	67%	Improve
Southeastern Massachusetts	**78%**	55%	Improve
Central Massachusetts	**50%**	66%	Decline
Boston/Metro-Boston	**54%**	76%	Decline

Results ranged from 50% of youth in Central Massachusetts to 78% of youth in Southeastern Massachusetts experiencing acceptable system/practice performance. Two regions saw improvement since last year's CSR. Northeastern Massachusetts improved from 67% acceptable system performance to acceptable system performance for 75%. Southeastern Massachusetts had considerable improvement in system performance with an improvement to 78% of youth with acceptable performance from 55% last fiscal year.

The remaining areas saw declines in performance. Western Massachusetts declined to 54% from 60% of youth with acceptable system performance. Central Massachusetts declined to only half of youth (50%) with acceptable overall performance. The Boston/Metro-Boston area saw the largest decline in performance with only 54% of youth this fiscal year having acceptable system performance as compared to 76% in last year's CSR.

These data indicate region to region variability. While there are potentially promising trends in Northeastern and Southeastern Massachusetts, none of the regions are yet performing at a level where youth and families can reliably depend on services working well for them.

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.
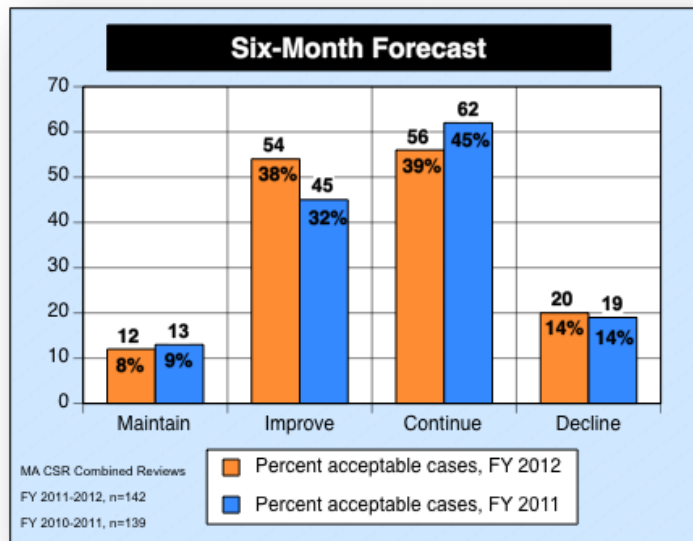
For 8%, the prediction was that the youth would maintain at a high status level (youth in the "good" or "optimal" status category).

For 38% of the sample the prediction was for improvement in status.

For 39% it was predicted the youth's status will continue at the same level ("fair", "marginal", "poor" or "adverse"). *Note:* These are youth <u>not</u> currently at a "good" or "optimal" level, which indicates that a more intensive or sustained level of services may be indicated to help the youth make progress.

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

The results for six-month forecast are comparable to the last fiscal year's CSR.

Summary of Findings

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

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

Strengths

Two regions (Northeast and Southeast) saw improvements in a number of practice indicators and overall system performance.

Both the Northeast and Southeast regions improved in performance in this fiscal year's CSR as compared to last year; the Northeast improved from 67% acceptable system performance in last year's CSR to 75% this year, and the Southeast improved from 55% acceptable system performance last year to 78% this year. Although both regions have practices and system issues that need continued improvement, there were noticeable strengths in both areas. Of note is that many of the staff providing services were skilled and providing beneficial services.

The CSR for the Northeast identified examples of well-functioning teams and care coordination achieving results for youth/families including IHT teams in their coordination role that helped families work with the various services they were receiving, and helped them to have a voice in the process. Teams in the region were generally aware of the need for integration of psychiatry and other treatments, although actually being able to integrate these services was not always achieved. It was noted that coordination was especially helpful for families of children with intellectual disabilities.

In the Southeast region 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. 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. 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. 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. Also in the Southeast, the training, supervision, background and quality of Therapeutic Mentors was evident. Therapeutic Mentors were noted to use effective strategies in their work, connected well with youth and were positively impacting youths' therapeutic progress.

Family engagement and cultural responsiveness continue to be strong system of care practices across all of the regions. Many families appreciate the services they are receiving.

Many of the families that were interviewed or participated in stakeholder meetings were very appreciative of services, and felt that people were working together and involving the whole family. There were examples in the reviews of strong connection between providers and families, where families felt supported, and the voice and choice of families was well-integrated into the clinical work.

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 for youth in ICC, often resulting in what parents expressed as not "feeling heard" and their child and family not being "helped right away." However, many parents and providers felt services in general are helping more youth, and many value the team-based approach. Parents describe having the most confidence when there are the "right" people on their teams, and when actions are tied to purpose, are individualized, and when they are learning skills to help their children.

There was notable strengthened capacity since the last review in key areas:

- There are increased opportunities to provide services that are a cultural and linguistic match with families.
- There were more instances of teaming with schools. Several of the SOCs have conducted trainings with schools about CBHI services.
- In-home therapy providers are assuming care coordination for families with increased frequency than seen in the last CSR. More clarification for IHT providers on when to refer youth to ICC is needed as well as guidelines and service process expectations for addressing the referral and integration process from existing IHT services to ICC to achieve successful transition so families don't feel like they are "starting over."
- Reviews across the state identified examples of exemplary practice and committed staff providing services resulting in positive outcomes for youth and families.

System of Care Committees continue to be venues in many communities for increasing partnerships and active problem-solving.

Many System of Care Committees are developing local partnerships and identifying opportunities for strengthening services Communications and linkages between agencies are improving in many areas as a result, and agencies are engaging in proactive problem-solving. Involving more families and young adults may be helpful.

Challenges

The quality and consistency of care coordination is variable; care coordination is a weak system practice for many.

While care coordination issues were identified in both ICC and IHT, the quality of ICC services in a number of areas was problematic. When ICCs were well-trained and clearly knew their roles, practice most frequently worked well. However, in a number of the reviews, ICCs were noted to be inexperienced, and were not fully engaging or communicating with families and teams. Many care coordinators appeared to be under-prepared to take on their roles, and did not have a clear view of their job functions. This often resulted in fragmented and disorganized care. There appeared to be weak oversight and supervision of care coordination practices in these cases. Systematic consultation with CSA psychiatrists on complex cases was not observed as a system practice.

The skill level of care coordinators is understandably variable in work forces. However, the goal is to assure care coordinators are adequately supported to provide the service through training and supervision. In a number of the CSRs, care coordinators had difficulty in synthesizing information, or were confused about how to use assessment information to inform planning. Clinical assessments and other relevant knowledge were often not current or available, or were lacking information important to building effective plans of care. Moreover, many youth did not have comprehensive psychosocial assessments of the quality needed to fully understand the youth and family. A number of care coordinators for youth reviewed were not adequately preparing for team meetings. Weak engagement of team members for some youth was observed where invitations were sent out to critical team participants late, and did not allow enough notice to ensure their involvement.

In several of the regional CSRs, the quality of care coordination in agencies was compounded by frequent staff turnover, productivity demands, unclear understanding of roles and weak training and supervision to prepare and adequately support care coordination practices.

Understanding and implementation of the CBHI model and standards is not consistent across IHT agencies.

Some of the agencies providing IHT services did not engage in team-based practices, could not articulate the practice model and worked in isolation of other agencies that were involved with the youth and family. Lack of a team-based approach in some cases resulted in breakdowns in communication, and sometimes not knowing that other providers were involved. In-home therapists sometimes did not coordinate or communicate with schools to understand the full scope of youth's status across settings, resulting in unaddressed issues and even risk for youth. Agencies working with youth were sometimes not informed when services end by another agency. An issue noted in a number of reviews and from feedback by stakeholders is that IHTs did not always know when to, or were not willing to, refer youth to ICC who were multi-agency involved and might benefit from ICC services.

Care plans and interventions often were ineffective in helping youth make progress.

While families continued to be engaged in planning meetings, many of the care plans of youth had vague strategies that were not well-informed by understanding of the youth and family or past interventions, were clinically limited in scope and intensity, and were not helping youth to make progress. Intervention for many youth was geared to short-termed, time-limited contacts that did not address stabilization, needs of youth and families or how sustainable progress would be achieved. This was the case in both ICC and IHT care plans.

Contextual to the lack of depth of plans is the continued issue of teams not uniformly using assessments, clinical/behavioral data and other relevant information to initially and systematically inform planning and interventions. The gathering of information and assessment of youth and families that is functional, well-formulated, continuous, identifies unmet needs and reasons for behaviors, and uses all available/relevant information continues to be an issue. Often all the individuals who should be on teams to assist in planning and implementation of interventions through a unified approach were not included. As a result, teams often operated on a superficial understanding of youth's needs and clinical issues, and plans often did not identify the right mix, integration or intensity of interventions that were delivered with consistency and beneficial effect. It can't be stressed enough that a full 42% of youth did not have a current mental health assessment, and many assessments were not at the quality needed to fully understand the youth and family.

Families expressed that key aspects of services were not responsive to their children's needs.

A theme in discussions with parents in a number of areas was their frustration with what they see as a slow response of ICC services when their children need help. Parents expressed that they came into services expecting help, and felt too much time was spent on planning and process; 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 and that understanding and connecting their child's experiences, competencies, needs and the clinical interventions, 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 in a number of the reviews did not understand all the services they were receiving, and were overwhelmed with keeping up with meeting with providers while also managing their everyday lives.

Many families also expressed dissatisfaction with their experiences with outpatient services. Families described long-term involvement with outpatient therapists that had little impact on their children improving. A primary frustration expressed by parents as well as ICC/IHT staff is the requirement by many agencies to see an outpatient therapist in order to access psychiatric services, whether or not the child needs outpatient therapy.

The inconsistent quality of mobile crisis services continued to be a frustration for many of the families that were interviewed (see below for a further discussion of crisis services).

Aspects of outpatient service delivery continues to lack integration with the system of care approach and is impacting continuity of care for youth.

Outpatient participation in team processes was limited and inconsistent, and outpatient therapy is generally disconnected from the team-based family-driven model. Outpatient providers were reported to be reluctant to fulfill the role of being a "hub" for services, and there were delays in access to services such as Therapeutic Mentoring when they were the "hub" for youth. Outpatient providers serving in the role of the "hub" for youth were reported to provide inadequate to no care coordination, with a number of systemic issues impacting the coordination and team participation roles. Issues cited included the disincentives in the fee for service and billing model, limiting factor because of outpatient caseloads and lack of flexibility in scheduling, and misunderstandings of the coordination and team participation roles.

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. Unless resolved this issue will impact the ability of Family Partner services to support the integration of information, efforts and continued support needs of families. For youth transitioning to outpatient services from ICC, outpatient providers were often not involved in transition planning which resulted in fragmented care and missed opportunities for information sharing and family engagement.

A concern for many youth is lack of continuity of the youth and family's service goals, as well as ties to prior treatment focus and achievements when youth transition to outpatient services. In a number of the regional CSRs, it was reported that outpatient providers may not refer youth who may need ICC and IHT, and/or are not consistently participating in team meetings when youth are involved with ICC. It was often difficult for teams to coordinate and/or integrate the outpatient therapy modalities into the youth's overall treatment, and sometimes teams and outpatient providers were at cross-purposes in their approaches. Engaging psychiatrists and physicians in team-based work was a continuing unmet collaboration need and challenge for many care coordinators.

Youth and families do not have timely reliable access to all services they need.

Staff and families statewide cited waitlists to access services such as specialized assessments, psychiatric services, therapeutic mentors and in-home behavioral services. In the Western region, there were protracted wait times for ICC services. Although agencies report that there are not many youth on official waitlists, it appears that the waitlist data may not be reliable enough from which to base assumptions about access to services on as there was such widespread reporting of waits for services. Many of the youth reviewed experienced significant delays between intake at an agency and their first receipt of services. Youth and families in some regions often waited months before their first team meeting was convened. In more than one case, this resulted in regression for the youth. There needs to be further understanding of the pathways to care in terms of assuring access to services is clear, timely and barrier-free, and "processes" do not create delays.

Access to psychiatric services through the outpatient clinic model continues to be very 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. Youth were reported to be waiting to see

an outpatient provider in the 4-12 week range, and in some areas the wait was reported as averaging 4-6 months. Access to psychiatry was especially impacting youth recently discharged from residential or inpatient treatment who often are not systematically connected to community-based services before discharge.

It was reported across the state the youth who need psychiatric evaluations or medication management must use outpatient therapy whether it is needed or not, even when it is the same agency providing ICC or IHT, resulting in further wait times to access care. This requirement is problematic for many youth on multiple levels including disrupting care with youths' current therapists, youth having to stop services with the psychiatrist when they no longer need outpatient therapy, youth and families engaged in IHT not being able to access psychiatry without the assignment of an outpatient clinician which the youth may not need, or youth and families who need intensive services being referred to outpatient treatment in order to access psychiatry, thus delaying or diverting from a more intensive community service the youth may need.

The dependability and quality of crisis services continues to be variable.

There is a continued need for improvements in the mobile crisis service intervention delivery in many communities. As mentioned previously, the reliability of mobile crisis services was noted in a number of areas; both families and other child-serving agency staff cited issues with the service being undependable and selective about calls they would respond to. It should be noted that mobile crisis managers appeared well-aware of the issues with the service, and are reportedly training staff to systematically respond to crises versus screening out any signs of youth aggression.

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

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

Families and teams expressed that services are sometimes terminated prematurely. There were observations of cases being closed before there was evidence of sustained progress. IHT in particular is seen in many communities as a "3-month service" or 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.

A number of agencies reported experiencing pressure to "close cases." The process for requesting additional units for needed services is increasingly challenging for agencies, and is an administrative burden for agencies that often detracts from providing direct services.

Recommendations

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

Staff/agency training and support for assuring quality CBHI services:

- Assure consistency of knowledge and oversight so that ICC care coordinators have the basic skills they need to provide services and are able to consistently provide the role expectations of their jobs. This includes being fully prepared and supervised to provide coordination, facilitation of teams that develop effective plans and implement individualized services and supports that produce positive outcomes for youth and families.

- Revisit how training is being implemented and evaluate if there are assurances that skills and practices for assessment, planning, team functioning, coordination, timely implementation of services, adjusting services as needed, managing transitions and crises and assuring key elements of the practice model are being implemented with fidelity for each youth and family.

- Assure ICC teams, IHT and OP "hubs" use comprehensive information to develop a broad and deep understanding of youth and family strengths and needs. Assure teams gather and synthesize all available information about the youth and family in order to inform functional, well-formulated plans.

- Assure ICC teams, IHT and OP "hubs" have the right composition of people and agencies, and work together in a unified manner to produce results with the youth and family in ways that are not overwhelming, but make sense to families.

- Strengthen practices for supporting staff and teams through systematic supervision, oversight, and/or other specialized consultations or processes. Design and support supervision practices that can identify when youth are not progressing, and when teams may need consultation to address youth and family needs. Explore supervision modalities that provide modeling and field-based observations and coaching of staff.

- Better integrate outpatient and other clinical providers into teams, teamwork and the CBHI processes. Provide training for outpatient providers on the role of team members on Care Teams.

- Assure each youth has a current comprehensive assessment that helps to guide service planning and delivery.

- Improve identification of transitions, comprehensive transition planning, and provision of effective transition supports.

- Provide clarification for IHT providers on when to refer youth to ICC inclusive of guidelines and service process expectations for addressing the referral and integration

process from existing IHT services to ICC to achieve successful transition so families don't feel like they are "starting over" in the transition.

- Develop capacity and skills of staff to understand the needs of, and support parents with serious mental illnesses or other important physical or emotional factors, including any challenges that parents may have in implementing strategies they are assigned in their child's care plan.

- Better utilize the CSA psychiatrist for direct consultation to ICC teams particularly when teams are struggling to understand or plan interventions, youth are not progressing, are in crisis, when there are questions such as mental status concerns, potentially complicating medical conditions, a need for medications to assist in treatment and achieving outcomes or other consultation needs.

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

System-level recommendations:

- Address ways to improve the role of outpatient services, continuity of care, care coordination and expected outpatient "hub" functions and access to psychiatry. Identify systemic solutions to improve outpatient providers' capacity to perform the functions that support a child and family to make gains.

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

- Assure all provider agencies understand specifications of each CBHI service.

- Improve and monitor crisis services.

- Consider that some youth may need quicker access to direct services that may need to be provided concurrent to and integrated with the assessment and planning process.

- Assure all youth in ICC and IHT have a current quality mental health assessment that informs treatment planning, interventions, and overall care.

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

- Understand and address issues that may be preventing referrals to ICC when youth have intensive coordination needs. There were a number of IHT providers who were reluctant to refer youth to ICC, and were providing a level of coordination that was potentially impacting time that should have been spent on providing clinical interventions.

- Assure discharges for services are based on clear determinations of assessment of progress, youth status, any remaining goals and objectives, identification of needed services and supports to achieve remaining goals, and assessment of less intensive services capacity to address remaining goals and objective.

- Develop strategies for improving system/practice functions that are weak and need improvement with particular emphasis on :

    ➢ team formation and functioning,

    ➢ assessment/understanding of youth and families,

    ➢ care planning,

    ➢ clear outcomes and goals for services,

    ➢ assuring youth are receiving services and supports that address their needs,

    ➢ care coordination,

    ➢ timeliness and quality of service implementation,

    ➢ access and availability of services youth need,

    ➢ adapting/adjusting plans and services as needed,

    ➢ managing transitions, and

    ➢ responding to youth crises.

- Evaluate the business model to assure it supports the infrastructure to provide effective services and promotes best practices..

- Explore pathways to care and administrative barriers as well as pathway practices that could explain the experience of "waits" by families and referral sources, and "network access"

Appendix 1
Child's General Level of Functioning

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

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

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

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

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

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

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

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

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

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

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

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

Appendix 2

CSR Interpretative Guide for Person Status Indicator Ratings

Maintenance Zone: 5-6

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

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

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

Favorable - Range: 4-6

Refinement Zone: 3-4

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

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

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

Improvement Zone: 1-2

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

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

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

Unfavorable Range: 1-3

CSR Interpretative Guide for Practice Performance Indicator Ratings

Maintenance Zone: 5-6

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

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

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

Acceptable Range: 4-6

Refinement Zone: 3-4

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

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

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

Unacceptable Range: 1-3

Improvement Zone: 1-2

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

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

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