

Report of Findings of the
Community Services Review of
Western Massachusetts
September 2011

Fiscal Year 2011-2012 Reviews

Rosie D.
Community
Services Review-
Western
Massachusetts
Regional Report

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Rosie D. Court Monitor

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Executive Summary

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

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

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

Highlights of Findings from the 2011 Western Massachusetts CSR

Status and Progress Indicators. In the CSR, Youth Status, Youth Progress, and Family Status are reviewed as a way to understand the performance of behavioral health services and practices.

Youth Status. A number of youth were experiencing stability issues in both home and school. Overall, youth were living in permanent situations and were safe in their homes, schools and communities. Most of the youth had favorable physical health. Youth were attending school regularly, however academic status and adequacy of behavioral supports in schools was a concern for many of the youth. Youth were generally not posing behavioral risk toward others. Additional supports to strengthen families' capacity to provide a favorable living situation were warranted for a quarter of those reviewed.

The two largest areas of concern were youths' risk to self and youths' emotional/behavioral well-being. For these indicators only 58% of youth had favorable behavioral self-risk, and only 38% favorable emotional-behavioral well-being. Because of the importance of these indicators for youth to achieve positive functioning, reviews by teams to determine ways to increase their understanding so that they can better address risk and emotional well-being is recommended.

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

Mothers in the Western Massachusetts CSR were found to have substantial challenges in their lives, far more than the fathers reviewed. Support for youth was negatively impacted more for mothers than fathers. The substitute caregivers reviewed were unable to provide favorable support and had considerable challenges. Family voice and choice was strong for mothers and fathers, but youth in the 12-17 age range had less of a voice and choice in service processes. Mothers and fathers expressed high satisfaction in having their needs understood, with services, and with their level of participation. Youth were generally satisfied with their needs understood and services, and less satisfied with their participation.

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

Overall, only 52% of the youth, just over half of the youth reviewed, were making favorable progress (Fair, Good or Optimal Progress). The data for Youth Progress indicates that with the exception of the indicator for Improved Relationships with Families/Caregivers and Other Adults, youth progress was extremely weak. There is a clear need for teams to address barrier and help youth make greater rates of progress across domains.

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

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

For the youth reviewed, only 54% were found to have acceptable system/practice performance. This indicates overall weak system performance and practices for youth in Western Massachusetts. It means for roughly half of the youth, the system is not providing dependable, quality services. It is a decline in performance as compared to last year's CSR when 60% of the sample has acceptable findings.

The data indicate that the strongest areas of practice for youth in Western Massachusetts were Engagement with the Family; Cultural Responsiveness to the Youth; Planning Interventions for Risk and Safety; and Responding to Crises. Findings in engagement with family and cultural competency with youth were roughly the same as last year, however there were marked improvements in both planning and responding to youth crises. Indicators that showed an overall fair performance but at a less consistent or robust level of implementation were Engagement with the Youth; and Cultural Responsiveness to the Family.

Areas of system/practice performance that need improvement in order to assure consistency, diligence and/or quality of efforts are Teamwork (Formation); Assessment & Understanding of the Family; Planning Interventions for Symptom or Substance Reduction; Coordinating Care; and Availability and Access to Resources.

Review results indicate weak performance in the following system/practice domains: Teamwork (Functioning); Assessment & Understanding of Youth; Planning Interventions for Behavior Changes; Planning Interventions for Social Connections; Planning Interventions for Recovery and Relapse; Planning Interventions for Transitions; Outcomes and Goals; Matching Interventions to Needs; Service Implementation; Adapting & Adjustment; and Transitions & Life Adjustments.

The system of services and behavioral health practices in Western Massachusetts cannot be considered to be performing with consistency or quality because of the number of foundational system of care practices that were found to need improvement or are weak. Nearly 30% of teams were not adequately formed with the right people to address youth and family needs. Over half of teams were functioning in a limited manner, were splintered or inconsistent in their planning and evaluating results, and were not engaged in collaborative problem-solving at a level necessary to impact positive change for youth and families. Only half of the teams were adequately using clinical and related information to increase the teams' understanding of the youth's issues at a scope and depth needed to design the right set of interventions and supports. Outside of risk and safety planning, planning interventions across the domains measured lacked the specificity and accountability to help enough youth in Western Massachusetts make progress in achieving their goals. Weak planning was found in reducing mental health symptoms, impacting behavioral changes, increasing youth's social connections, addressing substance abuse recovery or relapse and assuring successful transitions. Focused work to assure these practices occur at a higher level of quality and effectiveness is necessary.

Matching the right interventions to address youth and family needs was weak for nearly half of the youth reviewed as was identifying clear outcomes and goals. For 25% of the youth, care coordination required stronger leadership, including facilitating teams to monitor results to adjust care plans and address transitions. Also weak was implementing services, adapting and adjusting plans and services as needed, and managing youth's transitions. Necessary services and supports were not accessible or available for nearly 30% of the youth.

Overall system/practice performance for the youth reviewed in Western Massachusetts was very weak and will need considerable improvement in order to assure youth and families can dependably rely on service to work well and achieve results.

The Rosie D. Community Services Review

Regional Report for Western Massachusetts

For the Review Conducted in September 2011

Introduction

Overview of Rosie D. Requirements and Services

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

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

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

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

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

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

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

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

Purpose of monitoring

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

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

Overview of the CSR methodology

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

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

The CSR process involves a cadre of trained reviewers who interview those involved with providing services and supports for the youth, along with parents and/or caregivers, and the youth if appropriate. Also interviewed are members of the care team which may include teachers, child welfare workers, probation officers, psychiatrists and others. Reviewers also read ICC and/or IHT case records. Through using a structured protocol, reviewers make determinations about youth status/progress (favorable or unfavorable) and system/practice performance (acceptable or unacceptable) through a six-point scale. Refer to Appendix 2 on Page 59 for a full description of how each of the terms is defined. The six-point ratings are overlaid with “zones” of improvement, refinement, or maintenance. This overlay is provided to help care planning teams focus on youth concerns and/or system practices that may need attention. When reviewing the status and performance indicators that start on Page 33, it will be helpful to refer to Appendix 2 in understanding the ratings and findings.

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

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

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

- Once a youth is enrolled in ICC and or IHT, are services being implemented in a timely manner?

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

The Western Massachusetts CSR

Community Service Agencies (CSAs) and In Home Service Agencies

There continues to be five Community Service Agencies (CSA) providing care in the Western Region of Massachusetts. In the “Berkshires”, the most western part of the Western Region and the state, the CSA is the Brien Center. Pittsfield is home to the Brien administrative offices, and services span north to North Adams and surrounding towns and south to Great Barrington and the surrounding towns. In the north, central part of the Western Region, Clinical Support Options (CSO) is the CSA. The service area encompasses the greater Greenfield, Athol and Northampton areas. The Carson Center is the CSA for the Greater Westfield area, which is east of the Berkshires and west of Greater Springfield. Behavioral Health Network (BHN) is the CSA for the Greater Springfield area and extends up to Holyoke and to the surrounding towns to the west of Springfield, with a contracted site in Ware. Gandara is a “specialty” CSA and provides linguistically and culturally responsive services to Latino families in the Greater Holyoke and Springfield areas.

There are In Home Therapy Services (IHT) throughout the Western District, with IHT services being provided by the five CSA agencies and nine other private providers, for a total of thirteen IHT providers. The Community Services Review included IHT services provided by the agencies listed below in Table 3.

Review Participants

Altogether, over 300 people participated either in the youth-specific reviews or were interviewed in stakeholder focus groups in the Western Massachusetts CSR. Table 1 displays data related to the youth-specific reviews where a total of 153 interviews were conducted. As can be seen, the average number of interviews was 6.7 with a maximum of 9 and a minimum of 3 interviews conducted.

Child Status and Performance Profile - Number of Interviews

Number of cases: 24 MA Western Review Sept 2011

Number of Interviews

Total number of interviews	153
Average number of interviews	6.7
Minimum number of interviews	3
Maximum number of interviews	9

Table 1

How the sample was selected

The sample for the Western Massachusetts CSR was drawn primarily from the population of all children who received Intensive Care Coordination (ICC). A smaller portion of the sample was drawn from In-Home Therapy (IHT), but only includes IHT youth who were not also receiving ICC services at the time the lists were drawn. The sample includes ICC and IHT youth ranging in age from birth to twenty-one years old who are covered by Medicaid. The CSR sample included 16 ICC youth and 8 IHT youth who were not also currently receiving ICC.

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

ICC Selections. For ICC, a random sample of youth was drawn from the open caseload list. The number of youth selected from each agency was determined based on the number of youth enrolled since July 1, 2010 and the number of enrolled youth at the time of selection.

IHT Selection. For IHT, the open caseload list was further sorted to create a list of youth who were receiving IHT but not currently also receiving ICC. There were thirteen agencies actively providing IHT in Western Massachusetts at the time the lists were submitted. Some of these agencies were providing IHT in only one location, but some were serving multiple areas of the Western Massachusetts region. Of the thirteen agencies, two were serving too few to be included in the sample, and were dropped from the selection process. Of the 8 youth selected from IHT lists, 4 were drawn from programs which operated as part of CSAs. There were 5 CSAs providing IHT, so four were randomly selected from the remaining IHT

agencies which were not also CSA providers. In total, there were 8 IHT youth included in the sample.

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

The second column of Table 2 displays the number of the unduplicated youth enrolled in ICC since July 1, 2010. The third column displays the total number of youth by agency, who were being served within open cases at the time the agencies submitted lists. The number of youth to be included from each agency was then determined by comparing the number of youth being served by that agency to the total number of youth being served in the Western Massachusetts region. Behavioral Health Network (BHN), which had served the largest number of youth since July 1, 2010, had 6 youth in the sample including 5 from their Springfield CSA and one from their Van Wart CSA. The BHN Van Wart CSA subcontracts with The Carson Center at Valley Human Services (VHS) to provide ICC, and 1 youth was drawn from the subcontracted list. Gandara Center, a specialty CSA serving Latino families, had 3 youth in the sample. Three agencies had 2 ICC youth from each of their ICC programs: The Brien Center, Clinical and Support Options (CSO), and The Carson Center for Human Services. These 16 ICC youth may have been receiving services in addition to ICC, including IHT.

Agency	Total Enrolled Since 7/1/10	Number Open at List Submittal	Number ICC Cases Selected
Behavioral Health Network (BHN) – Robert Van Wart	388	60	1
Subcontracted BHN – Carson Center at Valley Human Services	79	33	1
Behavioral Health Network (BHN) Springfield	698	132	5
Brien Center for Mental Health & Substance Abuse – Pittsfield	212	171	2
Carson Center for Human Services- Holyoke	190	79	2
Clinical & Support Options (CSO) Greenfield, Northampton, Athol	217	77	2
Gandara Center	322	118	3
Total	2106	670	16

Table 2

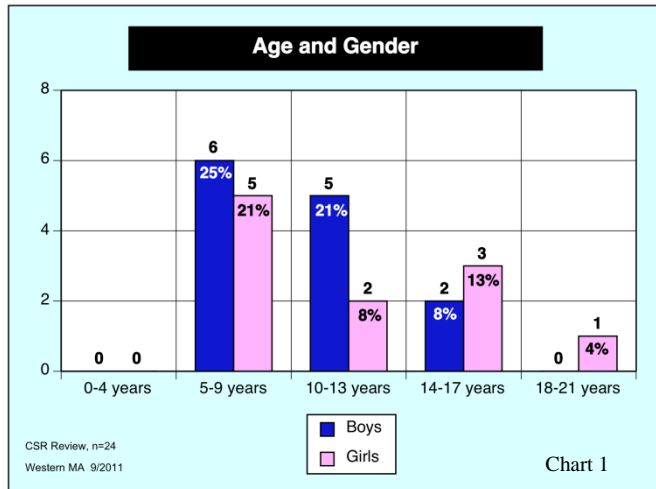
Information about the 8 IHT agencies, which were randomly selected for inclusion in the CSR sample is shown in Table 3. The second column shows the total unduplicated enrollment for youth receiving IHT by agency since July 1, 2010. The third column displays the number of youth who were included in open cases at the time the list was submitted. The fourth column displays the total number of youth who were receiving IHT without current ICC services. The last column lists by agency, the number of IHT youth who were designated for selection in the CSR.

Agency	Total Enrolled Since 7/1/10	Total Open at List Submittal	Total Open and Receiving IHT/No ICC	Number IHT Only Selected
Behavioral Health Network (BHN)	377	161	126	1
Brien Center for Mental Health & Substance Abuse Pittsfield	87	44	24	1
Carson Center for Human Services	138	74	59	1
Gandara Center	77	46	39	1
Brightside	191	68	60	1
The Key Program, Inc.	83	45	37	1
Northeast Center for Youth and Families (NCYF)	110	62	59	1
ServiceNet	280	105	101	1
Total	1343	605	505	8

Table 3

As can be seen, each of the following agencies had one youth included in the CSR: Behavioral Health Network (BHN), The Brien Center for Mental Health & Substance Abuse, Carson Center for Human Services, Gandara Center, Brightside, Key Program Inc., Northeast Center for Youth and Families, and ServiceNet.

Characteristics of the Youth Reviewed in Western Massachusetts



Age and Gender. Twenty-four (24) youth receiving services in the Western Massachusetts region were reviewed in the CSR conducted during September 2011. *Chart 1* displays the distribution of genders across the age groups in the sample. There were 13 boys and 11 girls in the sample. The proportion of boys to girls was 54% boys to 46% girls. The largest number, 11 youth or 46% of the sample, were in the 5-9 year old range. There were 7 youth, or 29% of the sample in the 10-13

year old range, and 5 youth or 23% of the sample in the 14-17 year old range. One youth, or 4% of those reviewed was in the 18-21 year old range. There were no youth in the sample 0-4 year old range.

Current placement, placement changes and permanency status. The majority of the youth in the Western Massachusetts CSR sample lived with their families (87%), either with their biological/adoptive families or in a kinship/relative home. One youth each were residing in a foster home, a therapeutic foster home and an inpatient psychiatric hospital (*Table 4*).

Child Status and Performance Profile - Current Placement Frequency

Number of cases: 24 MA Western Review Sept 2011

Type of Current Placement	Number	Percent
Family bio./adopt. home	20	83%
Kinship/relative home	1	4%
Foster home	1	4%
Therapeutic foster home	1	4%
MHI	1	4%
	24	100%

Table 4

Child Status and Performance Profile - Legal Permanency Frequency

Number of cases: 24 MA Western Review Sept 2011

Legal Permanency Status	Number	Percent
Birth family	17	71%
Adopted family	4	17%
Foster care	2	8%
Permanent guardianship	1	4%
	24	100%

Table 5

Table 5. The legal status of 71% of the youth reviewed was with their birth families. Four of the youths' (17%) permanency status were with their adoptive families, two (8%) were with their foster parents and one (4%) was in permanent guardianship.

Child Status and Performance Profile - Placement Changes Frequency

Number of cases: 24 MA Western Review Sept 2011

Placement Changes (past 12 months)	Number	Percent
None	19	79%
1-2 placements	4	17%
6-9 placements	1	4%
	24	100%

Table 6

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

Number of cases: 24 MA Western Review Sept 2011

Length of Stay in Current OOH Placement	Number	Percent
0-30 days	2	8%
1 - 3 mos.	1	4%
13 - 18 mos.	1	4%
19 - 36 mos.	1	4%
Not applicable	19	79%
	24	100%

Table 7

were in out of home placements at the time of the review, two (8%) had been in placement for 30 days or less, one (4%) between 1-3 months, one (4%) between 13-18 months, and one (4%) between 19-36 months (Table 7).

Child Status and Performance Profile - Ethnicity Frequency

Number of cases: 24 MA Western Review Sept 2011

Ethnicity	Number	Percent
Euro-American	8	33%
African-American	2	8%
Latino-American	12	50%
Biracial	2	8%
	24	100%

Table 8

Child Status and Performance Profile - Language Spoken Frequency

Number of cases: 24 MA Western Review Sept 2011

Primary Language Spoken at Home	Number	Percent
English	17	71%
Spanish	6	25%
English & Spanish	1	4%
	24	100%

Table 9

Out-of-home placements. The review tracked placement changes over the last twelve months for each of the 24 youth reviewed (Table 6). Achieving stability and minimizing disruptions are important factors in the lives of youth with SED. Placement change refers to changes in living situation, as well as any changes in the type of program the child received educational services in over the last twelve months. Among the youth in the sample, 19 or 79% had no placement changes in the last year. Four youth (17%) experienced 1-2 placement changes, and one (4%) had 6-9 changes. Of the five youth who

Ethnicity and primary languages (Table 8 and 9). Of the 24 youth in the sample, eight or 33% were Euro-American, and 12 or half of the sample (33%) were Latino-American. Two (8%) of the youth reviewed were African-American and two (8%) were Biracial.

English was the primary language spoken at home for 17 or 71% of the youth, Spanish for six (25%), and both English and Spanish for one family or 4% of those reviewed.

Child Status and Performance Profile - Educational Placement Frequency

Number of cases: 24 MA Western Review Sept 2011

Educational Placement or Life Situation	Number	Percent
Regular K-12 Ed.	9	38%
Full inclusion	3	13%
Part-time Sp. Ed.	4	17%
Self-cont. Sp. Ed.	1	4%
Parenting teen	0	0%
Adult basic/GED	0	0%
Alternative Ed.	3	13%
Vocational Ed.	0	0%
Expelled/Suspended	1	4%
Home hospital	0	0%
Day treatment program	0	0%
Work	0	0%
Completed/graduated	1	4%
Dropped-out	0	0%
Other	3	13%

Table 10

Educational placement (Table 10). Youth reviewed were receiving educational services in a variety of school settings. Of the sample, 38% were in a regular education program. Thirty-four percent (34%) of the youth were receiving special education services in a full inclusion (13%), part-time (17%) or fully self-contained special education setting (4%). Three youth (13%) were in an alternative education setting, and one (4%) was in a day treatment program. These youth may have also had special education services in these settings. One youth in the sample (4%) had been expelled from school, and one (4%) had graduated. Youth in the “Other” category included one youth in a behavioral school, one in community college and one receiving educational services in a psychiatric hospital. Note that the total numbers and percentages in Table 10 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.

Child Status and Performance Profile - Agencies Involved Frequency

Number of cases: 24 MA Western Review Sept 2011

Agencies Involved	Number	Percent
DCF	11	46%
DMH	0	0%
Special Ed	12	50%
Early intervention	0	0%
Developmental disabilities	1	4%
DYS	0	0%
Probation	1	4%
Vocational Rehabilitation	1	4%
Substance abuse	0	0%
Other	7	29%

Table 11

Other state agency involvement (Table 11). The majority of the youth in the sample were involved with other State and/or community agencies. Note that youth may be involved with more than one agency, so the overall number in Table 11 is more than the number of youth reviewed. Youth were most frequently involved with Special Education (12 or 50%). The Department of Children and Families (DCF) had involvement with 11 families or 46% of

the sample. One youth each were involved with Developmental Disabilities, Probation and Vocational Rehabilitation. The “Other” category represents youth receiving outpatient services and a community college outreach and support program.

Child Status and Performance Profile - Referral Source

Number of cases: 24

Referral Source	Number	Percent
DMH	1	4%
Hospital	1	4%
Crisis Services	3	13%
Family	4	17%
DCF	5	21%
Outpatient	3	13%
Child development center preschool	1	4%
Former CSA in another area of the state	1	4%
Foster care agency	1	4%
ICC	2	8%
IHT	1	4%
Partial hospital program	1	4%
	24	100%

Table 12

Referring agency (Table 12). Youth reviewed in Western Massachusetts were referred to ICC and/or IHT services from a variety of sources as reflected in Table 12. The largest referral source was the Department of Children and Families (DCF), who referred 5 youth or 21% of the youth reviewed. The next largest referral source was Families who referred 4 youth or 17% of the sample. This was followed by Crisis Services and Outpatient providers who referred 3 youth or 13% of those reviewed each. ICC referred 2 youth or 8%. Referring one youth (4%) each were the Department of Mental Health (DMH), a Hospital, a Pre-school, the youth’s previous CSA, a Foster Care agency, an IHT provider, and a Partial Hospitalization program

Child Status and Performance Profile - Co-Occurring Condition Frequency

Number of cases: 24 MA Western Review Sept 2011

Co-Occurring Condition	Number	Percent
Mood Disorder	10	42%
Anxiety Disorder	5	21%
PTSD/Adjustment to Trauma	5	21%
Thought Disorder/Psychosis	2	8%
ADD/ADHD	17	71%
Anger Control	6	25%
Substance Abuse/Dependence	2	8%
Learning Disorder	4	17%
Communication Disorder	1	4%
Autism	3	13%
Disruptive Behavior Disorder (CD, ODD)	8	33%
Mental Retardation	1	4%
Medical Problem	9	38%
Other Disability/Disorder	3	13%
Other	1	4%

Table 13

Behavioral health and co-occurring conditions (Table 13). Table 13 describes the conditions and/or co-occurring conditions present among the youth reviewed. Youth may have one or more than one condition. The largest percentage of youth (71%) was diagnosed with attention deficit or attention deficit hyperactivity disorder. Forty-two percent (42%) of the youth were diagnosed with a mood disorder, 21% percent with an anxiety disorder, and 21% with PTSD/Trauma. Anger control issues were prevalent among 25% of the youth. Eight percent

(8%) had a substance abuse disorder, and 33% a disruptive behavior disorder. Eight percent (8%) of those reviewed had a thought disorder or psychosis.

Learning disorders were prevalent among 17% of those reviewed. Thirteen percent (13%) had an autism spectrum disorder, and 4% had an intellectual disability or a communication disorder. Youth in the “Other Disability” category included youth with pervasive developmental disorder, gender identity disorder and adjustment disorder.

Medical problems were being experienced among 38% of the youth. These included youth with asthma, enuresis, mild hearing and vision impairment, hyperthyroidism, constipation, dermatitis, hyperglycemia, and a genetic syndrome.

Medications (Table 14). Sixty-two percent (62%) of the youth reviewed in Western Massachusetts were prescribed one or more psychotropic medications. As seen in Table 14, three of youth in the sample (13%) were prescribed one medication, seven (29%) were on two medications, and three (13%) were on three medications. There were two youth (8%) on four medications. Of the youth that were prescribed medications, 80% were on two or more medications and a third (33%) were on three or more medications.

Child Status and Performance Profile - Psy Meds Frequency

Number of cases: 24 MA Western Review Sept 2011		
Number of Psy Meds	Number	Percent
No psy meds	9	38%
1 psy med	3	13%
2 psy meds	7	29%
3 psy meds	3	13%
4 psy meds	2	8%
	24	100%

Table 14

Youths’ levels of functioning (Table 15). The general level of functioning of each youth in the CSR is rated using the General Level of Functioning scale, a 10-point scale displayed in Appendix 1 of this report. Ten of the youth or 42% were rated to be functioning in the

Child Status and Performance Profile - Level of Functioning Frequency

Number of cases: 24 MA Western Review Sept 2011		
Level of Functioning	Number	Percent
In level 1-5	10	42%
In level 6-7	13	54%
In level 8-10	1	4%
	24	100%

Table 15

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”). Thirteen or 54% 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”). One youth (4%) was rated in the Level 8-10 range (“no more than slight impairment in functioning at home, at school, with peers” to “superior functioning in all areas”).

Use of Crisis Services (Table 16). The use of crisis services or crisis responses over the 30 days prior to the review was tracked for each youth. Twenty-five percent (25%) of the youth accessed some type of crisis service during that time period, which is a fairly high percentage as compared to previous reviews across the State. Among the sample, four youth (17%) used mobile crisis services, three (13%) used a 911 emergency call to the police, and two (8%) were taken to the emergency department of a hospital.

Child Status and Performance Profile - Crisis Services Used Frequency

Number of cases: 24 MA Western Review Sept 2011

Crisis Services Used Past 30 Days	Number	Percent
Mobile crisis	4	17%
911 Emergency call: EMS	0	0%
911 Emergency call: Police	3	13%
Emergency department	2	8%
Other	0	0%
None	18	75%

Table 16

Mental health assessments (Tables 17 and 18). Mental health assessments are required by teams and practitioners to help them better understand the strengths and needs of youth and their families, and to help them formulate an overall picture of how the youth is doing emotionally and cognitively. As well, they aid in the team’s understanding of the social/familial context of a youth’s behaviors and well-being.

Only 54% of the youth reviewed in Western Massachusetts had a current mental health assessment in their files. Eleven youth or 46% of the youth did not have a current mental health assessment available to help their teams better understand and plan for them.

Child Status and Performance Profile - Mental Health Assessment

Number of cases: 24 MA Western Review Sept 2011

MH assessment performed	Number	Percent
Yes	13	54%
No	11	46%
	24	100%

Table 17

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

Child Status and Performance Profile - Received Mental Health Assessments

Number of cases: 24 MA Western Review Sept 2011

Received MH Assessments	Number	Percent
Parent	2	8%
Education	1	4%
Court	0	0%
Child Welfare	0	0%
DOC	0	0%
Not applicable	11	46%
Not Distributed	6	25%
Other	5	21%

Table 18

Among families in the sample, only 2 or 8% had received their child’s mental health assessment. Schools received a copy of the mental health assessment for 1 or 4% of the youth. For the remaining six youth who had a mental health assessment, it had not been shared with team members.

Special Procedures

Special Procedures data presents information about interventions that occurred in the lives of youth over the 30 days preceding the CSR (Table 19). Fifty-eight percent (58%) of the youth did not experience a special procedure during this time period. For the 42% of youth in the sample that did, 17% had experienced a voluntary time-out; 17% loss of privileges in a points and level system, and 8% a disciplinary consequence. Four percent (4%) each had experienced a room restriction, a seclusion in a

Child Status and Performance Profile - Special Procedures Frequency

Number of cases: 24 MA Western Review Sept 2011		
Special Procedures Used Past 30 Days	Number	Percent
Voluntary time-out	4	17%
Loss of privileges via point & level system	4	17%
Disciplinary consequences for rule violation	2	8%
Room restriction	1	4%
Exclusionary time out	0	0%
Seclusion/Locked room	1	4%
Take-down procedure	0	0%
Physical restraint (hold, 4-point, cuffs)	1	4%
Emergency medications	0	0%
Medical restraints	0	0%
None:	14	58%
Other:	1	4%

Table 19

a locked room or a physical restraint that could have been a hold or a mechanical restraint. The youth in the “Other” category experienced a voluntary coping intervention. Note youth may have experienced more than one special procedure, thus the total percentage of discreet procedures is more than the overall 42% of youth who experienced a procedure.

Caregiving challenges

Challenges experienced by the parents and caregivers of the youth reviewed are displayed in Table 20. The most frequently noted challenge of the parents or caregivers of youth in the sample was serious mental illness experienced by 46%. This was followed by extraordinary care burdens experienced by 38% of caregivers, and 29% adversely impacted by poverty. Twenty-one percent (21%) of the caregivers had limited cognitive abilities, and 17% disabling physical conditions. Seventeen percent (17%) were challenged by cultural and/or language barriers. Other challenges experienced by caregivers were domestic violence (4%), and unlawful behavior/incarceration (4%).

Child Status and Performance Profile - Caregiver Challenges Frequency

Number of cases: 24 MA Western Review Sept 2011		
Challenges in the Child's Birth Family or Adoptive Family	Number	Percent
Limited cognitive abilities	5	21%
Serious mental illness	11	46%
Substance abuse impairment or serious addiction w/ frequent relapses	0	0%
Domestic violence	1	4%
Serious physical illness or disabling physical condition	4	17%
Unlawful behavior or is incarcerated	1	4%
Adverse effects of poverty	7	29%
Extraordinary care burdens	9	38%
Cultural/language barriers	4	17%
Undocumented	0	0%
Teen parent	0	0%
Recent life disruption/homelessness due to a natural disaster	1	4%
Other	5	21%

Table 20

Challenges in the “Other” category included relationship issues, frequent foster home changes of their child, infrequent communications with family supports, and challenges associated with dementia.

Care Coordination

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

The review tracked the length of time each of the Care Coordinators had been assigned to the youth being reviewed. As can be seen in *Table 21*, 8% of care coordinators had been assigned to the youth less than one month, 21% for one-three months, 33% for four to six months, 29% for seven to twelve months and 8% for thirteen months to two years.

Child Status and Performance Profile - Length of Time CM Assigned

Number of cases: 24		MA Western Review Sept 2011	
Length of Time CM Assigned to Child/Youth	Number	Percent	
<1 month	2	8%	
1-3 months	5	21%	
4-6 months	8	33%	
7-12 months	7	29%	
13-24 months	2	8%	
	24	100%	

Table 21

Caseload size as reported by the care coordinator was measured along the scale seen in *Table 22*. Twenty-three percent (23%) of coordinators had eight or fewer cases, 27% had nine to ten cases, 5% eleven-twelve, and 27% had thirteen to fourteen. Fourteen percent (14%) had fifteen-sixteen cases, and 5% had seventeen-eighteen cases. No coordinators had over 18 cases. Of note is that 46% of care coordinators had more than 12 cases on their caseload.

Child Status and Performance Profile - CM Current Caseload Frequency

Number of cases: 22		MA Western Review Sept 2011	
CM Current Caseload Size	Number	Percent	
<8 cases	5	23%	
9-10 cases	6	27%	
11-12 cases	1	5%	
13-14 cases	6	27%	
15-16 cases	3	14%	
17-18 cases	1	5%	
	22	100%	

Table 22

Child Status and Performance Profile - Barriers Affecting Case or Services

Number of cases: 24 MA Western Review Sept 2011

Barriers Affecting Case Management or Services	Number	Percent
Caseload size	3	13%
Eligibility/access denied	1	4%
Inadequate parent support	4	17%
Inadequate team member participation	7	29%
Family disruptions	4	17%
Billing requirements/limits	6	25%
Case complexity	6	25%
Treatment compliance	6	25%
Team member follow-thru	5	21%
Acute care needs	4	17%
Driving time to services	4	17%
Culture/language barriers	6	25%
Refusal of treatment	8	33%
Family instability/moves	3	13%
Arrest/detention of child/youth	0	0%
Other	10	42%

Table 23

Table 23. Information about barriers impacting the provision of services was collected through interviews with the person providing care coordination for each youth. Challenges across caseloads cited most often by care coordinators in Western Massachusetts were treatment refusal (33%) and inadequate team member participation (29%). Twenty-five percent (25%) of care coordinators cited billing requirements and limits, case complexity, treatment compliance, and cultural and/or language barriers as challenges. Team member follow-through was cited by 21%, and 17% identified inadequate parent support, family disruptions, acute care needs, and driving time. Thirteen percent (13%) identified caseload size, and family instability or moves as issues. Eligibility issues or access denial was cited by 4%.

Barriers in the “Other” category included timelines for producing the CANS and other requirements, lack of support from other providers with emphasis on outpatient providers, lack of community resources, long waitlists and access for CBHI services, insurance issues and knowledge of state agency staff. Also cited were lack of resources for youth with autism spectrum disorders, or who are deaf. Coordinators also cited challenges with parental mental illness or cognitive delays, and high-risk neighborhoods as barriers.

Community Services Review Findings

Ratings

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

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

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

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

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

STATUS AND PROGRESS INDICATORS

Youth Status Indicators

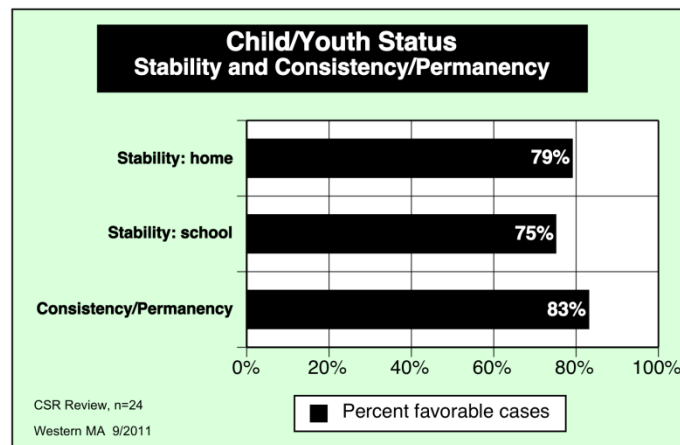
(Measures Youth Status over the last 30 days unless otherwise indicated)

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

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

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

Overall Youth Status



Community, School/Work and Living Stability

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

Among the 24 youth in the CSR sample for Western Massachusetts, 79% were found to have favorable stability at home. Sixty-two percent (62%) had good or optimal stability with established positive relationships and well-controlled to no risks that otherwise could jeopardize stability. Twenty-five percent (25%) or six of the youth, were rated to be in the

“refinement” area, which means that conditions to support stability were fair. There were three youth (13%) who were rated to need improvement in their home stability, two (8%) with poor status, and one (4%) with adverse stability and serious and worsening problems of instability at home.

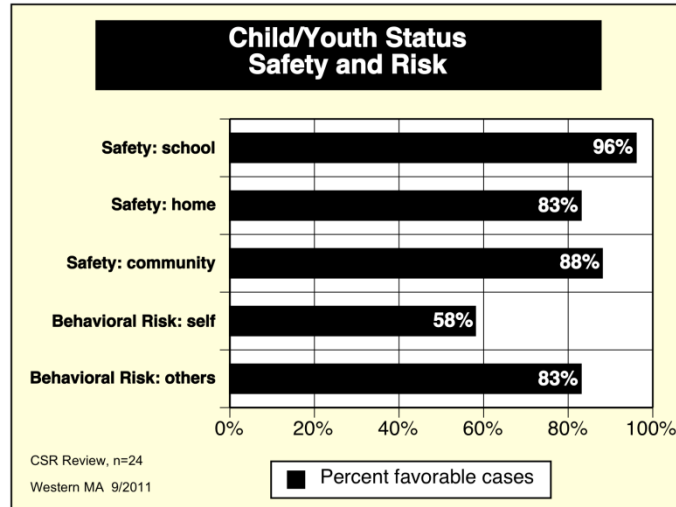
Seventy five percent (75%) of the youth had a stable school situation. Twelve (50%) had good or optimal stability with only age appropriate or planned changes occurring in their school program. Seven youth (29%) had stability issues at school that needed “refinement,” with fair to marginal stability issues that were minimally to inadequately addressed. Five youth (21%) were found to have poor stability in the school setting with uncertainty about what will happen next.

These results indicate that teams should consider ways to strengthen interventions to support stability for youth in both home and school settings. Assuring schools are consistently engaged in the team based process is an important strategy for teams to consider for each youth.

Consistency/Permanency in Primary Caregivers & Community Living Arrangements

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

Among the youth reviewed in Western Massachusetts, 20 or 83% had a favorable level of consistency and permanency in their lives. Among these, 12 or 50% had “good” or “optimal” status, meaning these youth were in enduring permanent living situations with their family or other legally permanent caregivers. Nine youth, or 38% were at a level of consistency and permanency situation that needed refinement in order to assure enduring relationships and consistent caregiving/living supports, and were either in a minimal to fair status, or in a marginal status with somewhat inadequate or uncertain permanence. Three youth, or 13% of the sample needed improvement on this indicator, and were experiencing poor or adverse status with substantial to serious and worsening problems of unresolved permanency.



Safety of the Youth

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

School safety. Ninety-six percent of youth (96%) were found to have favorable safety status at school. For the youth attending school, 16 or 66% were safe in their school programs at a “good” or “optimal” level with no risk to generally risk-free school programs. Seven youth (30%) needed refinement in terms of the school setting leaving the youth free from abuse or neglect, but all of these youth had a favorable school safety status that was minimally risk-free. One youth reviewed had “poor” school safety status, with substantial and continuing risk of harm.

Home safety. Eighty-three percent (83%) of youth were safe at home. Twelve youth (50%) were found to have “good” or “optimal” safety status at home. Ten youth (42%) 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. Two youth (8%) had poor safety status at home, with substantial and continuing risk of harm.

Community safety. Eighty-eight percent (88%) of youth had favorable safety in the community. Twelve youth (50%) were experiencing “good” to “optimal” safety in their communities. Eleven or 46% needed refinement in their safety in the community and could benefit from their teams reviewing their safety status including any risks for intimidation or fear of harm. There was one youth (4%) with poor community safety status being exposed to elevated risk of harm.

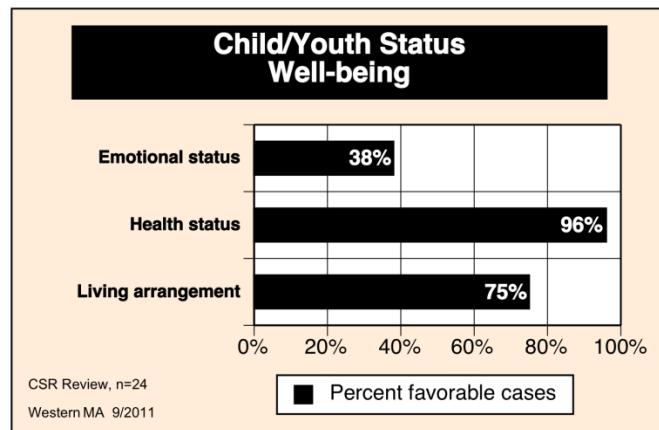
Youth who have poor or adverse safety status in any of these categories should receive focused attention from their teams and agencies.

Behavioral Risk to Self and Others

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

Risk to self. The results of the review of youth in Western Massachusetts show that only 58% of the sample had a favorable level of behavioral risk toward themselves. Among these, nine or 38% had an “optimal” or “good” level of behavioral risk. Ten youth or 47% of those reviewed were found to need “refinement” in their level of behavioral risk, including youth that are usually avoiding self-harm or self-endangerment, and those that have a risk status that is inconsistent or concerning. Five youth (21%) needed “improvement” and had a poor level of behavioral risk to themselves with serious and continuing risk status. These results indicate a need for stronger planning and support by teams to more consistently ameliorate youths’ self-risk behaviors.

Risk to others. The subindicator of behavioral risk toward others was favorable for 83% of the youth in the sample. Half or the youth (50%) or 12 youth had a “good” or “optimal” level of behavioral risk toward others. Eleven or 46% needed “refinement” and presented a fair to marginal level of risk toward others. One youth (4%) needed “improvement” in risk to others, with poor status and a potential for harm to other people present.



Emotional and Behavioral Well-being

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

Emotional and behavioral well-being was favorable for only 38% youth reviewed in the Western Massachusetts CSR, clearly indicating the need for focused attention paid to developing interventions and strategies to address helping youth to achieve better emotional and behavioral status. These results indicate a high number of youth with inconsistent or poor emotional development, adjustment problems, emotional/adaptive distress, or serious behavioral problems present. Among the youth reviewed, there were only three (13%) with a “good” level of emotional/behavioral status. Two thirds of the youth (66% or 13) were determined to need “refinement” and were functioning at a fair to marginal emotional/behavioral well-being status. Five youth (21%) were found to have poor or worsening emotional/behavioral status, and were demonstrating a consistently poor level of functioning, were not making progressing and/or were regressing.

Focused support for teams in developing individualized strategies for refining and/or improving youth’s levels of emotional and behavioral well-being is clearly indicated.

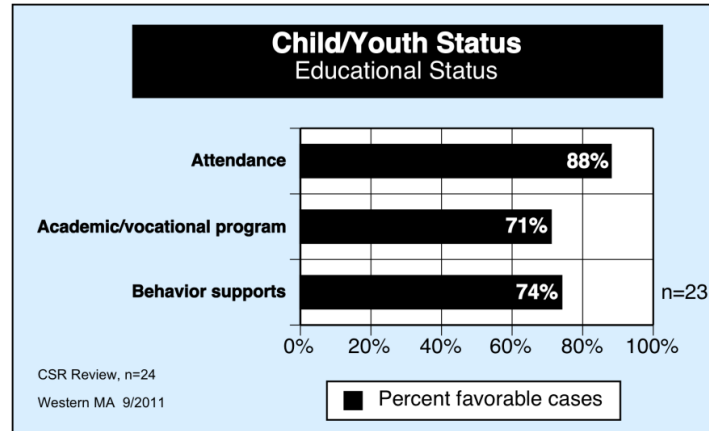
Health Status

The health of the youth was reviewed to determine whether or not they were achieving and maintaining optimal health status including basic and routine healthcare maintenance. Youth’s basic needs for nutrition, hygiene, immunizations, and screening for any possible development or physical problems should be met. Health is an important component of overall well-being. For the youth in the sample, 96% had favorable health/physical well-being status. Sixteen youth (66%) had “good” or “optimal” health status. Eight youth or 33% needed “refinement” in their health status.

Living Arrangements

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

For the youth reviewed in the Western Massachusetts CSR, 75% were found to have a favorable living arrangement. Nine youth (38%) were in living arrangements that were “good” or “optimal,” and 14 (58%) needed “refinement” in their living arrangements. There was one youth (4%) with a poor living arrangement that was substantially inadequate.



Educational Status

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

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

Attendance. In the Western Massachusetts review, 88% of the youth had favorable patterns of attendance. Eighty-three percent (83%) or twenty youth were found to have “optimal” or “good” to school attendance. One youth (4%) with favorable status would benefit from refinement in attendance patterns. Three youth (13%) needed improvement in attendance, and had poor rates of attendance including one that was expelled from school.

Academic or vocational program. Of the youth reviewed, only 71% were doing favorably well in their program. Ten of the youth (42%) who were seen as have “good” or “optimal” status in their academic or vocational program. Another ten (42%) needed refinements in how they were doing in their academic or vocational program, and two (8%) needed improvement, with one doing poorly and not meeting educational expectations, and the other in and adverse educational situation.

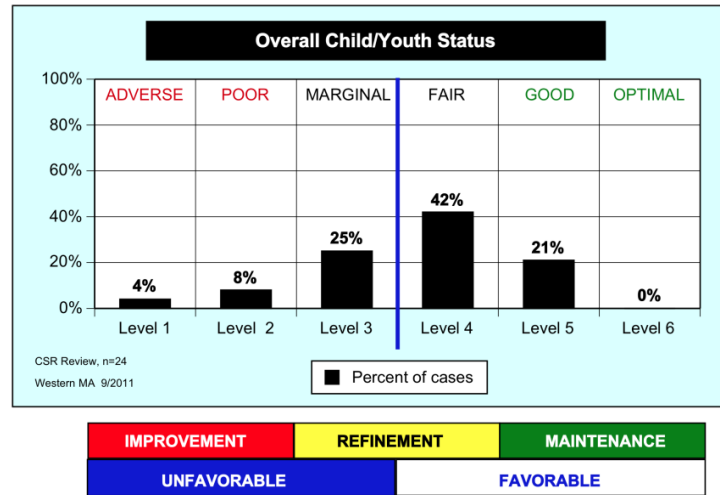
Behavioral supports. Twenty-three of the youth in the sample required behavioral supports in their school setting. Behavioral supports were working favorably well for 74% of them. Eleven (48%) had an “optimal” or “good” level of supports. Fifteen of the youth (65%) reviewed could benefit from refinements in their level of supports, and had minimally adequate to marginally inadequate supports for their behaviors. Two youth or 9% had a poor or adverse level of behavioral support that needed improvement, and were absent or not adequate to help the youth do well in school.

Overall Youth Status

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

Overall, only 63% or 15 youth were found to be doing favorably well. These youth fell in Levels 4-6; youth had Fair status (42% or 10 youth), or Good status (21% or 5 youth). No youth were found to have Optimal status.

The remaining 9 youth (37%) had unfavorable status. They had either Marginal (25% or 6 youth), Poor (8% or 2 youth), or Adverse status (4% or 1 youth).



Overall Youth Status results are also categorized as needing Improvement, Refinement, or Maintenance. This allows for identification of youth that may need focused attention. Three youth (12%) were in the Improvement area, meaning status was problematic or risky, and action should likely be taken to improve the situation for the youth. Sixteen or 67% of the youth fell in the Refinement area which is interpreted to mean their status was minimal or marginal, and potentially unstable with further efforts likely necessary to improve their well-being. For the 5 youth (21%) whose status was in the Maintenance area, efforts should likely be sustained and leveraged to build upon a fairly positive situation.

A number of observations can be drawn about the status of youth reviewed in Western Massachusetts. A number of youth were experiencing stability issues in both home and school. Overall, youth were living in permanent situations and were safe in their homes, schools and communities. Most of the youth had favorable physical health. Youth were attending school regularly, however academic status and adequacy of behavioral supports in schools was a concern for many of the youth. Youth were generally not posing behavioral risk toward others. Additional supports to strengthen families' capacity to provide a favorable living situation were warranted for a quarter of those reviewed.

The two largest areas of concern were behavioral risk to self and youths' emotional/behavioral well-being. For these indicators only 58% of youth had favorable behavioral self-risk, and only 38% favorable emotional-behavioral well-being. Because of the importance of these indicators for youth to achieve positive functioning, more attention by teams in understanding and addressing risk and emotional well-being is warranted.

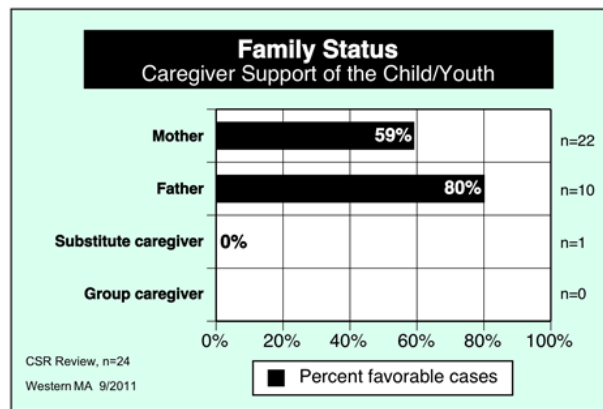
Caregiver/Family Status

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

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

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

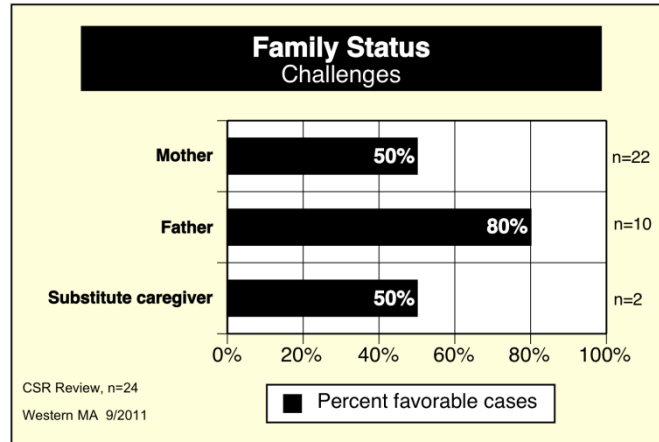
Overall Caregiver/Family Status



Parent/Caregiver Support of the Youth

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

For the youth reviewed in the Western Massachusetts CSR, favorable support by mothers was found 59% of the time for which the indicator was applicable (22 youth). Maternal support needed “refinement” or “improvement” for 14 youth or 64% of the youth. The measure for support from fathers was applicable for 10 of the 24 youth in the sample, and favorable support was found from 80% of the fathers. Support from fathers needed “refinement” or “improvement” for 40% or for youth in the sample. Support was unfavorable for the one youth with a substitute caregiver. There were no youth reviewed with a group caregiver.



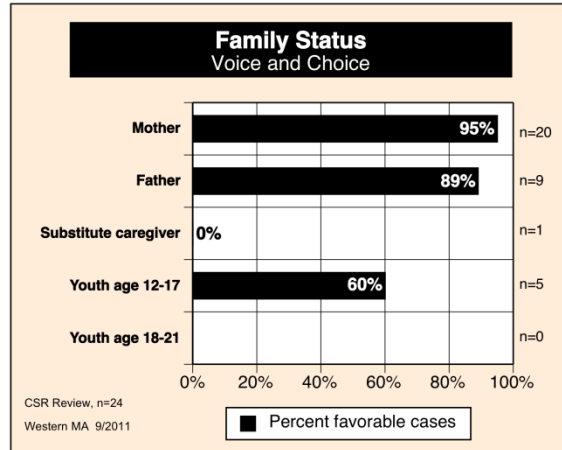
Parent/Caregiver Challenges

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

There were 22 mothers of youth reviewed in the CSR for which this indicator could be rated. Of these, 50% had favorable status in terms of the level challenge they were experiencing. Eighteen or 82% of the mothers had a level of challenge that needed to be "refined" or "improved," indicating significant challenges impacting parenting among mothers in the sample. Of these, three of the mothers (14%) were found to be have major life challenges impacting parenting capacities with inadequate or missing supports.

Eighty percent (80%) of the 10 fathers of youth reviewed had a favorable level of challenge. Five or 50% were experiencing levels of challenge that could benefit from "refinement" or "improvement" ranging from minor limitations with adequate supports to overwhelming life challenges with significant and worsening disruptions.

For the two substitute caregivers of youth reviewed, one had a favorable level of challenge (50%) and one did not. Both of them had a level of challenge that needed refinement.



Family Voice and Choice

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

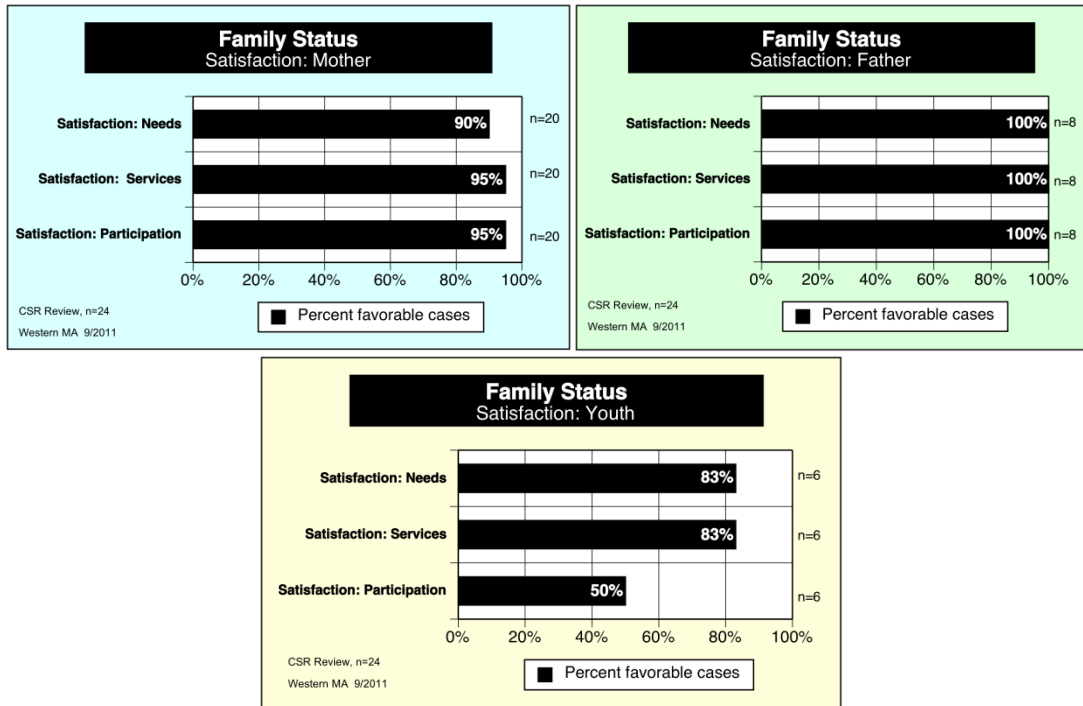
Ninety-five percent (95%) or 19 mothers for which the indicator could be rated (N=20) were experiencing favorable voice and choice in their child’s assessments, planning and service delivery processes. Thirteen mothers (65%) had “good” to “optimal” voice and choice. Seven mothers (35%) would benefit from refinement in strengthening their voice and choice.

For youth whose fathers were involved and information could be gathered (N=9), 67% or 6 fathers had favorable voice and choice in involvement with their child’s service processes indicating a need for strengthening of their voice and choice in planning and service delivery processes. Two of the fathers, or 22%, could benefit from “refinement” in the influence of their voice and choice in planning and service delivery. One of the fathers (11%) fell in the range of having no voice and choice, and had not participated in any aspect of planning or service over the last 12 months.

One substitute caregiver could be rated for this indicator, and voice and choice for the caregiver as unfavorable and substantially inadequate, with seldom participation.

There were five youth in the 12-17 age range in the sample. Of these 60% or three youth had a favorable level of voice and choice in their own services, with “refinement” or “improvement” indicated for four or 80% of youth who fell in the age range.

There was one youth in the 18-21 age range reviewed, however voice and choice was not rated for this individual.



Satisfaction with Services and Results

Satisfaction is generally measured for the Mother, Father, Youth and Substitute Caregiver. The inquiry looks at the degree to which caregivers and youth express satisfaction with current supports, services and service results. It looks at a number of aspects of satisfaction including satisfaction with the youth’s strengths and needs being understood, satisfaction with the present mix and match of services offered and provided, satisfaction with the effectiveness in getting the results they were seeking, and satisfaction with how they are able to participate in the care planning process. There were no substitute caregivers for youth in the sample.

The charts above display the results for how satisfied each of the role groups were with having their needs understood, services and results, and participation. Mothers’ satisfaction ranged from 90% satisfied with their needs being understood, to 95% satisfied with both services, and participation. For the eight fathers that satisfaction was measured for, satisfaction was 100% for all domains measured. Youth satisfaction (N=6) ranged from 50% satisfied with their participation in care planning to 83% satisfied with both their needs being understood and with the services and results being achieved.

Reviewers were unable to rate satisfaction for Substitute Caregivers.

Summary: Caregiver/Family Status

Mothers in the Western Massachusetts CSR were found to have substantial challenges in their lives, far more than the fathers reviewed. Support for youth was negatively impacted more for mothers than fathers. The substitute caregivers reviewed were unable to provide favorable support and had considerable challenges. Family voice and choice was strong for mothers and fathers, but youth in the 12-17 age range had less of a voice and choice in service processes. Mothers and fathers expressed high satisfaction in having their needs

understood, with services, and with their level of participation. Youth were generally satisfied with their needs understood and services, and less satisfied with their participation.

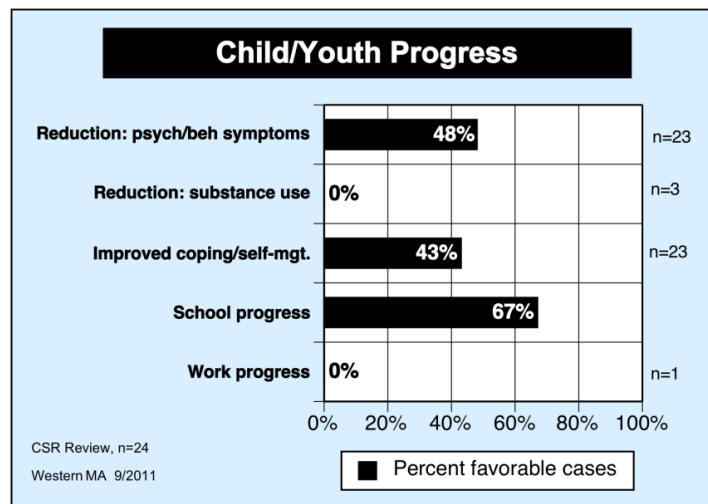
Youth Progress

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

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

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

Overall Youth Progress Patterns



Reduction of Psychiatric Symptoms and/or Substance Use

This set of indicators measure the degrees to which target symptoms, problem behaviors and/or substance use patterns causing impairment have been reduced.

Reduction of Psychiatric Symptoms. For the 23 youth the indicator was applicable for, only 48% of them had made favorable progress in reducing symptomatology and/or problem behaviors over the previous six months. Five youth, or 22% of the sample had made “good” progress at a level somewhat above expectation. Fifteen youth or 65% of the sample could benefit from “refinement” in their level and rate of progress in reducing their symptoms and were making marginal to fair progress. There were two youth (9%) who were making no progress or their disorder was at a moderate to severe level. One youth (4%) was declining, with symptoms and behaviors increasing and intensifying.

Reduction of substance use. There were three youth in the sample with substance abuse issues, and none were making favorable progress. All needed “improvement” in their level and rate of progress, with one making no progress (33%), and the other two (67%) declining.

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

Improved Coping and Self-Management

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.

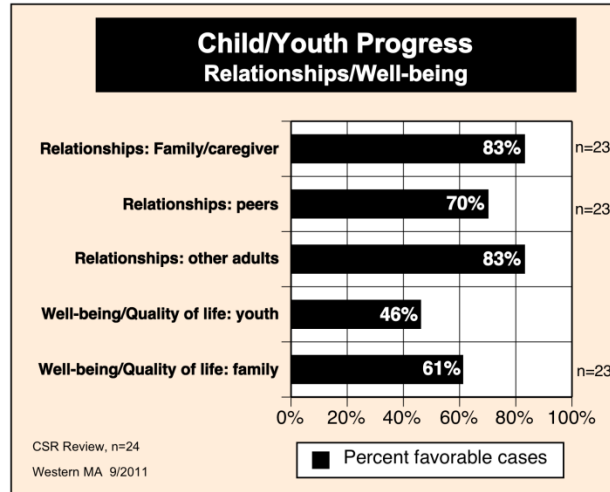
Among the youth reviewed, only 43% or ten youth had made favorable progress in improving their coping skills and ability to self-manage their emotions and behaviors, indicating room for improvement in impacting change in this domain. Six youth (25%) made had made “good” progress in improving their ability to cope and manage their own behaviors. Twelve youth (50%) could benefit from “refinement” and had made fair to marginally inadequate progress. Five youth needed “improvement” including four (17%) who were making poor progress in advancing coping and self-management at levels well-below expectations, and one (4%) who was 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. Sixteen youth or 67% of the sample were making favorable progress in their educational programs. Eight youth or 33% were making “optimal” or “good” progress in school reflecting excellent to good and consistent rates and levels of progress. Thirteen youth (54%) were determined to need “refinement” and were making fair to marginally inadequate progress. Three youth (13%) were making no progress in their educational programs.

Work progress. Progress in a work setting applied to one youth who was making unfavorable and marginally inadequate progress that was limited and inconsistent in satisfying expectations of employment,



Progress Toward Meaningful Relationships

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

For the youth reviewed and the indicator was applicable for (N=23), 19 or 83% of them were making progress in their relationships with their families or caregivers. Progress in building peer relationships was less favorable, with 70% or 16 of the 23 youth the sub-indicator was applicable for making progress in building meaningful relationships with peers. Progress in developing relationships with positive adults (teachers, coaches, etc.) applied to all the youth reviewed and was favorable for 83%.

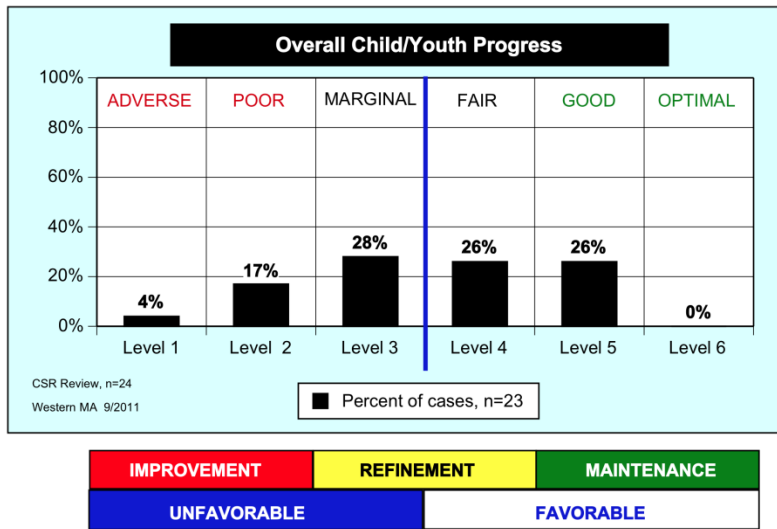
Overall Well-being and Quality of Life

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

Youth overall well-being and quality of life. For the youth reviewed in the CSR, only 46% were making favorable progress in an improved overall well-being and quality of life. Eight youth, or 33% had made "good" progress over the last six months in developing and using personal strengths, long-term relationships, life skills, and future plans. Eleven youth or 46% were determined to need "refinement" indicating that teams and services need additional supports to help more youth make progress in improving their overall well-being. These youth were making fair to marginally inadequate progress in an improved quality of life. Four youth (17%) needed improvement, including three who had made poor progress in their overall quality of life and had developed few to no long-term supportive relationships, life skills for problem solving, educational/work opportunities, or meaningful and achievable future plans. One youth had made no progress over the last six months or since beginning treatment.

Family overall well-being and quality of life. For the families and caregivers (N=23) of the youth, only 61% were making favorable progress in improving the overall quality of life. Among these were seven families (29%) who had made “good” progress, eleven (48%) needing “refinement,” and five (22%) who needed improvement and had made poor or no progress.

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



Overall Youth Progress

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

Among the youth, 21% were determined to need improvement due to poor or adverse progress across the indicators. Fifty-four percent 54% needed refinement in moving forward in the areas measured, and were making fair or marginal progress. For these youth, the right strategies at the right intensity may have been missing or underdeveloped. The remaining 26% were making good progress at a level that should be maintained and sustained. No youth were making optimal progress.

The data for Youth Progress indicates that with the exception of Improved Relationships with Families/Caregivers and Other Adults, youth progress was extremely weak. There is a clear need for teams to help youth make greater rates of progress across domains.

System/Practice Functions

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

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

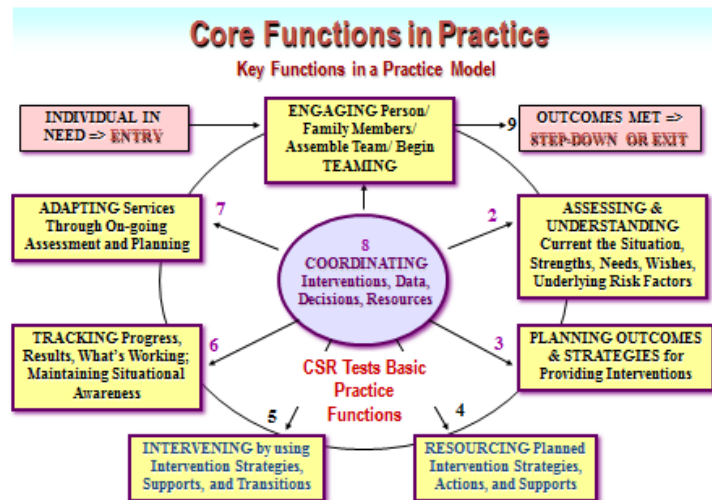
1. Engagement
 2. Cultural Responsiveness
 3. Teamwork
 - a. Formation
 - b. Functioning
 4. Assessment and Understanding
 5. Planning Interventions
 6. Outcomes and Goals
 7. Matching Interventions to Needs
 8. Coordinating Care
 9. Service Implementation
 10. Availability and Access to Resources
 11.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

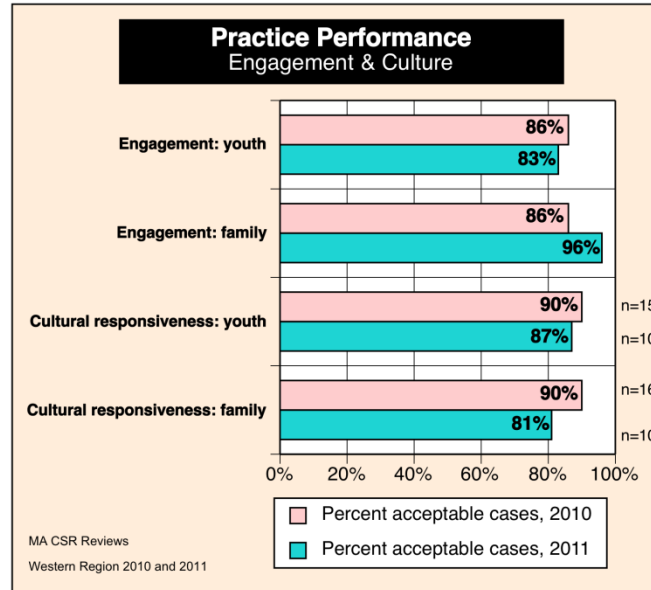
Reviewing System and Practice Performance in the CSR

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

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

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





Engagement

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

Youth engagement. For the youth reviewed, 20 or 83% experienced an acceptable level of engagement. This was in the range of performance but slightly under, last year’s CSR result for Youth Engagement (86% acceptable). In this year’s CSR, thirteen or 54% of youth were engaged at the “good” or “optimal” level. Another nine or 38% needed “refinement,” and two or 8% had poor engagement efforts that needed “improvement.”

Family engagement. Families were engaged at an acceptable level 96% of the time. This was an improvement over last year’s CSR results (86% acceptable). Fourteen families or 58% were engaged at a “good” or “optimal” level. Ten families or 42% of those reviewed may have benefitted from a “refined” level of engagement.

Cultural Responsiveness

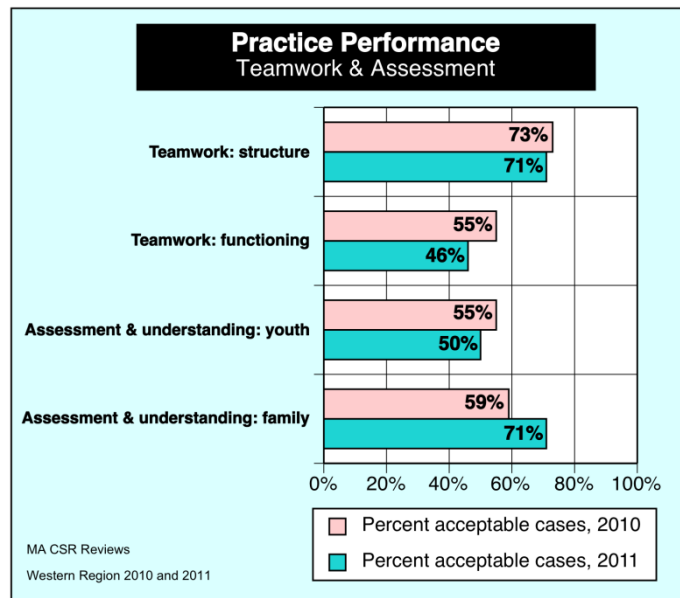
Cultural responsiveness is a practice attribute that should be integrated across all service system functions. It involves attitudes, approaches and strategies used by practitioners to reduce disparities, promote engagement, and individualize the “goodness of fit” between the youth, family and planning/intervention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

Cultural responsiveness to youth. For the fifteen youth reviewed for which the indicator applied, Cultural Responsiveness was acceptable for thirteen or 87%. This was slightly less than last year’s results of 90% acceptable. Cultural Responsiveness in this year’s was found to need “refinement” for four youth (27%) including being marginally inadequate for two youth (13%).

Cultural responsiveness to families. For the sixteen families the indicator was applicable for, cultural responsiveness was acceptable for thirteen or 81%. This was a decline from last year’s CSR results when 90% of families experienced acceptable cultural responsiveness. “Refinement” this year was determined to be needed for five families or 31%, including three families that experienced marginal cultural responsiveness.

The following provides an example of effective cultural responsiveness practices where: “The mother is grateful for the assistance and reports members come over frequently and listen to her and support her. Although mother’s ICC does not speak Spanish, there have been repeated ‘check-ins’ to be sure mother feels the communication is working.”

An example where cultural responsiveness and accommodations needed strengthening is: “(The youth’s) Mother identified challenging communication with the school based on language and this was not addressed.”



Teamwork: Team Formation and Team Functioning

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

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

Team Formation. For the 24 youth reviewed in Western Massachusetts, team formation was acceptable 71% of the time or for 17 youth, indicating improvement is needed in order for families to be able to consistently depend on teams of the right composition being formed. This was slightly under last year's performance of 73% of youth with acceptable team formation.

In this year's CSR, 8 youth or 33% of the sample experienced "good" or "optimal" team formation. Thirteen of the teams (54%) needed "refinement" in their ability to form. 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. Three youth (13%) experienced poor team formation, and had teams that seldom met, talked or planned together and did not have the capacity to organize effective services and supports.

Team Functioning. Teams were functioning acceptably well for only 46% of the youth reviewed, a concerning result. This was below last year's performance of only 55% of teams functioning well for youth.

These results indicate that for over half of the youth reviewed, teams did not have 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 these youth, there was inadequate to poor effective teamwork and collaborative problem-solving for achieving results, and weak team communications.

For 9 youth in this year's CSR sample (38%), teams functioned at a "good" or "optimal" level. For 11 youth (46%) teams needed "refinement" and were functioning in a somewhat unified and consistent manner, or were splintered and engaged in a pattern of actions that were usually incoherent with limited problem-solving. The latter was the case for 9 of the 11 or 38% of the sample. Four teams (17%) were functioning poorly, independently of the family and in isolation of other team members resulting in limited benefits for the youth and family.

An example of good team formation and functioning for a youth is, "There was evidence of regular monthly Team meetings. (The youth's mother) is running portions of her own meetings, and the agenda is clearly driven by (her) priorities and perceived needs. There is communication among the providers, and regular participation by them at the Team meetings. This Team has a very good understanding of (the mother's) needs and has worked hard to keep her engaged in the process so as to reduce the possibility of another out of home placement for the children."

An example where lack of communication and coordination among team member resulted in a confusing pattern of service delivery is: “The team is fragmented and has not functioned as a unified team. Communication is limited amongst providers. If a scheduled CPT does not occur new information and status is not readily shared. In June both the (in-home therapy) and behavioral parenting program began but there was no communication resulting in mother being given ‘parenting’ recommendations from three different sources versus coming together to share understanding, strategies and interventions towards a ‘common language.’”

Another example illustrates a need for improved communication, clarity of roles, and overall team functioning for a youth who has significant behavioral, academic, stability and safety issues: “A team does not exist and the service plan is limited. There was minimal communication between the outpatient therapist and the IHT and the IHT referenced this as an issue. The outpatient therapist did not appear to understand the benefit of regular dialogue and indicated she had 60 clients on her caseload. Although mother has had her own therapist, the IHT was not aware she could pursue her input.”

The ability of Care Planning Teams to come together to work and function well for youth and families is a foundational system requirement. Teams in Western Massachusetts continue to struggle in their ability to work in a unified manner to plan and implement needed services and supports. Part of the struggle appears to be a weak comprehension by teams of how to fully understand the needs of youth, how to problem solve with all people involved with the youth and family, and how to take responsibility and a sense of urgency for achieving results. With only 71% of teams adequately formed, and only 46% of teams functioning acceptably well, leadership for implementing improvements is clearly needed to help teams in Western Massachusetts more consistently form and work together to plan to understand the needs of the youth and family, unify efforts around common goals, communicate regularly, evaluate results, and work in alignment with system of care principles.

Assessment and Understanding

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

Assessment & Understanding of Youth. Of the 24 youth reviewed, only half (50%) were found to have an acceptable level of assessment and understanding of their core issues and situations. This was below last year’s CSR results of 55% of youth having acceptable assessments and team understanding of their situations, underlying issues and needs.

This year, 6 youth (25%) had teams that had “good” or “optimal” assessment and understanding. Fourteen youth (58%) would benefit from “refinement” of team practices in

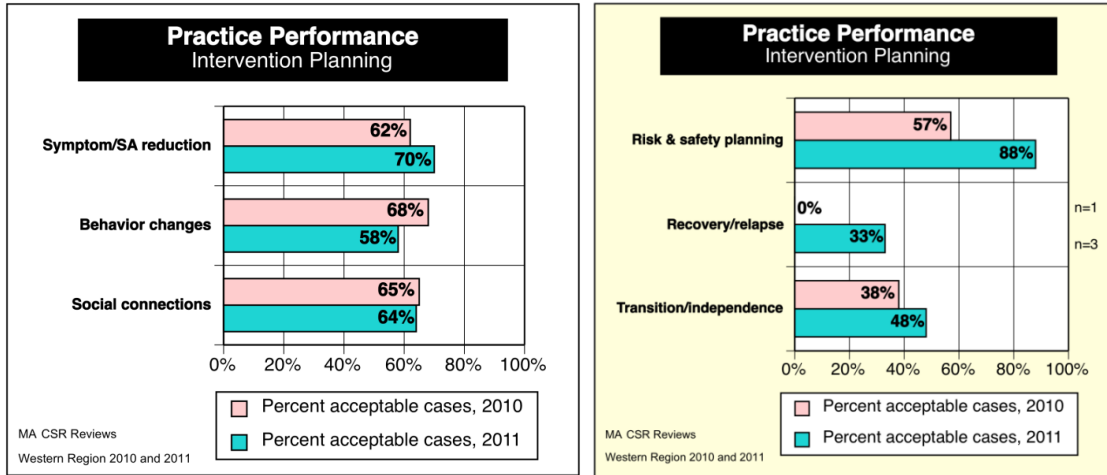
assessment and understanding and results were either fair or marginally inadequate. Thirteen percent (13%) or 4 youth had teams that had poor, incomplete or inconsistent assessment and understanding, or absent/incorrect/adverse understanding.

Assessment & Understanding of Families. Assessment and understanding of families was acceptable for 71% of the sample. This was an improvement over last year's results of 59%, but remains a system practice that needs improvement in order for teams in Western Massachusetts to be determined to consistently be able to assess and understand families' strengths and needs.

Ten families (42%) had "good" or "optimal" understanding. "Refinement" was found to be needed for another 10 families (42%) where there was fair/minimal understanding, or marginally inadequate assessment and understanding. For these families, the team needed to better understand the strengths, context, needs and vision of the family. There were four families (17%) where the team's understanding was poor, incomplete or inconsistent, or absent/adverse.

Good assessment and understanding of a youth was described by a reviewer where, "The family assessment is detailed and well written offering important historical and current information pertaining to this family... At the time of this review a neuropsychological exam was recently completed (for the youth). The ICC coordinator accompanied mother to get a verbal report and was able to help clarify and answer relevant questions and concerns and in general improve mother's understanding of the results. As soon as the written results have been (received) they will be shared with the Care planning team. There is real sharing and open communication by all team members, which includes two natural supports and this has led to a deep understanding of the family's needs and creative brainstorming concerning ways to meet them."

An example of assessment and understanding where there was poor understanding of the underlying reasons for a youth's behaviors resulting in the team's inability to address youth and family needs follows. The youth and family had received a series of intensive interventions and crisis placements for assessment, and was being considered for discharge from ICC despite limited gains made: "(The youth) continues to have behaviors that are resulting in (the youth) receiving educational services in a highly restrictive setting, is unsafe in community settings due to impulsivity, and (youth's) mother feels overwhelmed with caregiving. While (the youth) is slowly gaining skills that help (the youth) interact with adults and communicate needs, it does not appear (the youth) will have the right set of interventions and supports, including family interventions, that can help sustain progress. It appears (the youth's) team has lacked a clear understanding about the underlying reasons for (the) behaviors, as well as strategies and interventions that can help (the youth) to make sustained progress. Care coordination reported that testing had done before but that it didn't help the team to understand (the youth's) condition or behaviors. Because there was no assessment in the files, it was difficult to see how information was being used by the team."



Planning Interventions

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

Symptom or Substance Abuse Reduction. For the 23 youth the *Symptom or Substance Abuse Reduction* sub-indicator was applicable for, planning for reducing presenting psychiatric symptoms or substance abuse was acceptable for 70% or 16. This was an improvement over last year’s results of 62% of youth with acceptable planning for symptom reduction, but continues to be at a level lower than can be considered a reliable system practice.

There was “good” planning in reducing symptoms or substance abuse for 6 or 26% of the youth reviewed. Planning for these youth was generally well-reasoned. “Refinement” in planning to reduce symptoms or substance abuse was needed for 15 or 65%. In these cases planning was fair to marginally inadequate. Planning for symptom/substance abuse reduction was “poor” or “absent/misdirected” for two of the youth reviewed (9%) with poorly reasoned or missing planning processes that were generally failing to design interventions to address core issues.

Behavior Changes. Targeting *Behavior Changes* in planning was applicable to all of the youth in the sample, and was at an acceptable level for only 58%. This was a decline from last year’s performance of 68%. These results indicate that even fewer youth were benefitting from acceptable planning strategies to address behavior changes.

In this year’s CSR, 8 youth or 33%, had plans that addressed needed behavior changes that were in the “good” range. “Refinement” of behavioral supports and interventions in plans was needed for 46% of the youth. The planning for these youth was fair and somewhat

reasoned, to marginally inadequate and inconsistently aligned across interveners. For 5 youth (21%), plan components for supporting behavior changes were poorly reasoned, and failed to design interventions that could address core issues, or there was no planning in this domain.

Social Connections. Planning for increasing *Social Connections* was applicable for 22 youth in the CSR sample and acceptable for only 64%, which was comparable to last year's performance of 65% of youth with acceptable results in this planning domain. This result indicates improvement is needed to assure teams more consistently plan to strengthen youths' social connections.

Five youth (23%) had "good" strategies in their plans for improving their social connections reflecting generally well-reasoned supports. "Refinement" in planning to strengthen social connections for youth was needed for 14 or 64%. Three youth (14%) had poor planning reflecting unaligned strategies lacking in clarity and urgency to address the youths' need for social connections.

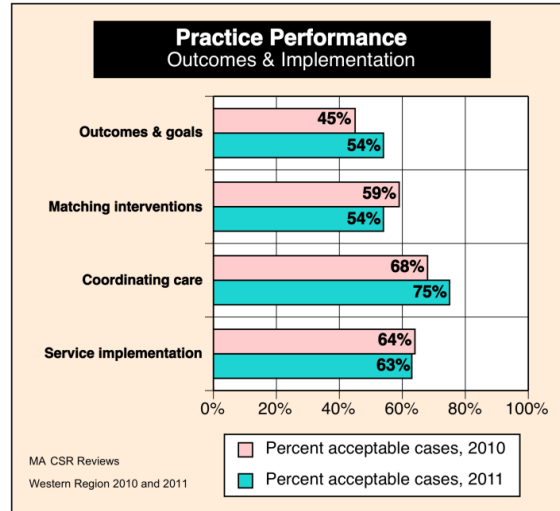
Risk/Safety Planning. Planning to address youths' risk and safety issues was acceptable for 21 or 88% of the youth, a strong finding and a significant improvement over last year's performance result of 57% acceptable. The risk/safety component of plans was "good" for or 62% of the sample. For 10 youth (48%), risk and safety planning needed refinement and was fair or marginally inadequate. One youth (5%) had poor risk/safety planning.

Recovery/Relapse Planning. Three youth in the sample needed *Recovery or Relapse* addressed in planning, and planning was acceptable for only one of the youth (33%). Two of the youth (66%) needed refinements to address fair to marginally inadequate strategies, and one youth who need interventions to support their recovery and relapse had no strategies addressed in their care plan. Last year's CSR identified one youth who needed planning in this domain, and planning was unacceptable for this youth.

Transition Planning. Review of transitions in the CSR apply to any transition occurring within the last 90 days or anticipated in the next 90 days including between placements (school and home), programs and to independence/young adulthood.

Among youth in this year's CSR sample 21 needed to have *Transitions* addressed in their planning processes, and performance was acceptable for only 10 or 48% clearly indicating improvement is needed in this planning domain. This was an improvement over last year's performance of 38% of youth having acceptable transition planning.

Transition planning was "good" for 5 of the youth or 21%, with plans that were generally well-reasoned, largely informed by the youths' and families' perspectives, and accountable. Nine of the youth (43%) would benefit from refined transition planning, and had plans that were somewhat reasoned and aligned across providers or were marginally inadequate and inconsistently aligned, with little sense of clarity or urgency. Seven youth (29%) had transition planning that was poor or absent/misdirected. Transition planning for these youth was inadequate, with poor to no use of intervention strategies to support a recent or upcoming change for the youth.



Outcomes and Goals

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

A clearly stated and understood set of goals and outcomes guiding services and strategies, and that describes what needs to happen was acceptable for only 54% of the youth. This was an improvement over last year’s CSR results of 45% acceptable specification of outcomes and goals by teams, but continues to be an area that many teams in Western Massachusetts struggle with.

A quarter of the youth (25%) had good to optimal goals specified by their teams that were well-reasoned and specific. Sixteen or two thirds (66%) of those reviewed had ending goals and outcomes that needed to be “refined,” and were fair to marginally inadequate. Two youth (8%) had poor specification of outcomes and goals which were insufficient for guiding intervention and change, or no goals specified.

Matching Interventions to Needs

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

For the youth reviewed, there was an acceptable level of matching intervention to need for only 54% (13 youth). This was a decline from last year's performance of 59% acceptable. These results indicate a clear need to improve teams' ability to assure the interventions and supports are the right interventions to help the youth and family. Matching interventions to needs are often based on the premise that the team has worked to understand the youth's and family's conditions and needs.

Seven youth (29%) had "good" or "optimal" matching of interventions to needs. Fourteen or 58% 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. Three youth (13%) had poorly matched interventions resulting in inadequate or conflicting assembly of service and supports.

Coordinating Care

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

Youth in the sample received care coordination services from both ICC (N=16) and IHT therapists (N=8). Care coordination practices were found to be at an acceptable level for 75% of the youth reviewed. This was an improvement over last year's CSR when 68% of youth received acceptable care coordination, but continues an area that needs attention in order to allow families to be able to reliably depend on acceptable care coordination practices for their children.

Care coordination in this year's review was found to be "good" or "optimal" for 42% of the youth reviewed. For 12 youth or half the sample (50%), care coordination would benefit from "refinements," and care coordination practices were deemed to be fair and minimally adequate, or marginal and limited with little leadership for service delivery and results. Two youth (8%) were found to have poor and fragmented care coordination.

Care coordination practices provided by an IHT that are working well are: "Family and youth are fully engaged and participating in after-school meetings weekly with IHT and the Therapeutic Mentor, who coordinate well together. (Three team members) are working on sensory integration and social skills with (the youth) and helping parents to manage (the youth's) anxiety. The IHT clinician has networked parents and most of the providers into a

team that communicates regularly and is generally in agreement about (the youth's) treatment; work is mostly coordinated.”

An example of care coordination that needed improvement where the youth is continuing to have serious problems in risk reduction and overall quality of life is: “Areas that need strengthening include the cohesiveness of the team, the intensity of planning and interventions that address what (the youth) needs to make progress and succeed in school and meet developmental goals, addressing the broader needs of the family, and the depth of care coordination in general. Absent was coordination with outpatient services including the psychiatrist and therapist. The outpatient therapist, if the team's plan to discharge the family from ICC moves forward, would need to pick up coordination roles, but the therapist rarely talks to team members or to the school. The current care planning team does not know what the therapist is working on, and she has never been invited to a team meeting.”

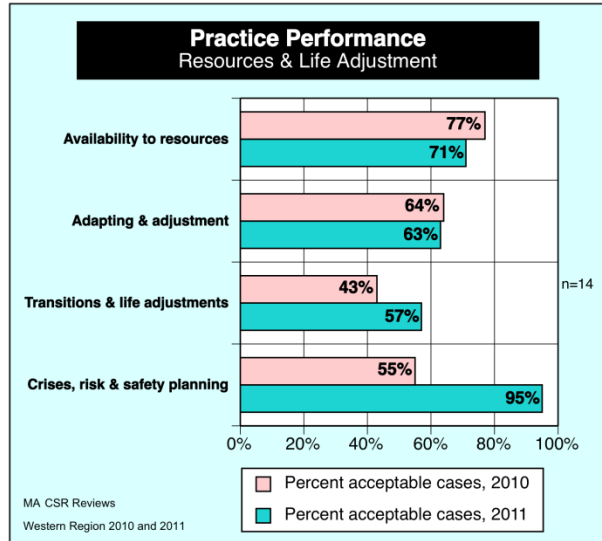
Service Implementation

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

For the youth reviewed, only 63% were found to have acceptable service implementation. This is comparable to last year's performance result of 64% acceptable, and indicates a continued need for concerted improvement to assure the services and supports identified as needed are actually implemented.

Nine youth (38%) were found to have “good” or “optimal” service implementation where services had a substantial pattern of being implemented in a timely, competent and consistent manner. For half of the youth (50%) service implementation needed “refinement” and the overall pattern of implementing needed services and supports was fair to marginal and inconsistent. Three youth (13%) had poorly implemented services with significant and continuing implementation problems. There were many comments made in interviews and stakeholder meetings about waiting lists and staffing shortages impacting the ability to provide timely services.

An example of service implementation, as well as coordination, that needs improvement is: “Although opened to the CSA in (month and year), it wasn't until a ‘crisis’ involving MCI resulting in partial hospitalization occurred 6 months later that services began. A month earlier referrals were made for IHT and IHB. The ICC was not aware that IHT had begun nor did the IHT realize it was open to ICC...While the record indicated past questions of expressive language disorder vs. ADHD and questionable need for neurological testing via the PCP it was unclear who the lead was in pursuing. There have been no CPT meetings in the last 2 months (mom has cancelled) and other methods of communication and coordination amongst team and school could be enhanced.”



Availability and Access to Resources

The indicator for *Availability and Access to Resources* measures the degree to which behavioral health and natural/informal supports and services necessary to implement the youth’s care plan are available and easily accessed. Reviewers look at the timeliness of access as planned, and any delays or interruptions to services due to lack of availability or access in the last 90 days.

Seventy-one percent (71%) of the youth reviewed were determined to have acceptable access and availability of resources. This was a decline from last year’s result of 77% acceptable. Service access and availability is clearly a concern for youth and families in Western Massachusetts as nearly 30% of youth were found to have unacceptable system performance on this indicator.

Eleven youth or 46% had “good” or “optimal” access to needed resources. Half of the youth (5%) of those reviewed had fair to marginally inadequate resource availability that indicated a need for refinement. Only one youth (4%) experienced poor resource access and availability severely limiting their ability to receive needed services.

Adapting and Adjustment

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

For youth reviewed, practices related to adapting and adjusting plans and services was acceptable for only 63% of the youth, indicating a need for improvement. This was comparable to last year’s results, when 64% of youth had acceptable practices in adapting and adjusting.

Half of the youth (50%) had “good” or “optimal” practices that were responsive to changing conditions with acceptable levels of monitoring and adjustment. A third of the youth (33%) were experiencing needed changes to their plans and services at a minimally adequate to

marginally inadequate level, with only periodic to occasional monitoring. There were four youth (17%) with poor and fragmented, or absent adapting and adjustment of services.

Transitions and Life Adjustments

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

For the 23 youth this indicator applied to, only 57% or 13 youth had acceptable transition management practices. This was an improvement over last year when only 43% of youth received acceptable transition management, but continues to be an extremely weak system practice.

In this year's CSR, 8 youth (35%) experienced "good" or "optimal" transition interventions. Ten youth (43%) could benefit from "refined" transition supports. Five youth (21%) experienced a poor transition with unaddressed transition issues, or a transition that was adverse, with no planning considerations or arrangements made.

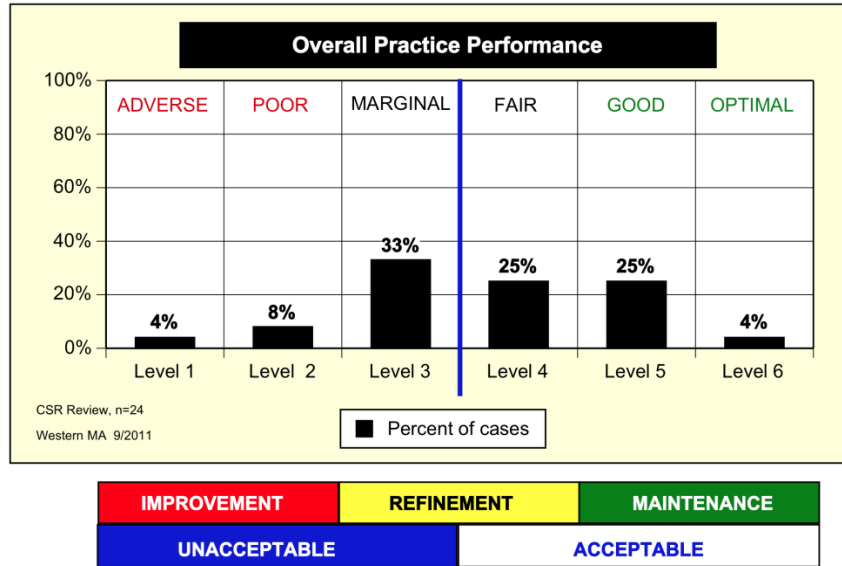
Overall, results indicate practices to improve the ability of teams to identify, plan for and implement transition supports for youth are clearly needed.

Responding to Crises and Risk/Safety Planning

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

For youth where this indicator was applicable (N=21), 95% had an acceptable crisis response and risk plan that worked acceptably well for them, reflecting practices that most of the youth and families could depend on. This was a significant improvement over last year's findings when only 55% of youth had acceptable findings on this indicator.

Thirteen youth (62%) were rated to have experienced an "optimal" or "good" response to crises and/or safety issues. Seven youth (33%) had acceptable practices, but would benefit from "refinement" in the response to their crises and risk/safety issues. There was one youth (5%) that experienced a poor response to crisis.



Overall System/Practice Performance

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

For the youth reviewed, only 54% were found to have acceptable system/practice performance. This indicates overall weak system performance and practices for youth in Western Massachusetts. It means for roughly half of the youth, the system is not providing dependable, quality services. It is a decline in performance as compared to last year’s CSR when 60% of the sample has acceptable findings.

The largest percentage of youth (58%) fell in the “Refinement” area which means that performance was limited or marginal, and further efforts are necessary to refine practices. The highest percentage of youth reviewed had practice patterns that were in the Marginal level (33%). Practice at this level is underpowered, inconsistent, not well-matched to youth needs, and is insufficient for the youth to meet short-term objectives.

Twenty-nine percent (29%) of the youth reviewed 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.

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

The data indicate that the strongest areas of practice for youth in Western Massachusetts were Engagement with the Family; Cultural Responsiveness to the Youth; Planning Interventions for Risk and Safety; and Responding to Crises. Findings in engagement with family and cultural competency with youth were roughly the same as last year, however there were marked improvements in both planning and responding to youth crises.

Indicators that showed an overall fair performance but at a less consistent or robust level of implementation were Engagement with the Youth; and Cultural Responsiveness to the Family.

Areas of system/practice performance that need improvement in order to assure consistency, diligence and/or quality of efforts are Teamwork (Formation); Assessment & Understanding of the Family; Planning Interventions for Symptom or Substance Reduction; Coordinating Care; and Availability and Access to Resources.

Review results indicate weak performance in the following system/practice domains: Teamwork (Functioning); Assessment & Understanding of Youth; Planning Interventions for Behavior Changes; Planning Interventions for Social Connections; Planning Interventions for Recovery and Relapse; Planning Interventions for Transitions; Outcomes and Goals; Matching Interventions to Needs; Service Implementation; Adapting & Adjustment; and Transitions & Life Adjustments.

The findings of the CSR showed that for Western Massachusetts services, system of care practices such as engagement of families and cultural responsiveness to youth were strong, as were risk and safety planning and responding to crises. Youth engagement and cultural responsiveness to families was fair.

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

Overall, the system cannot be considered to be performing well because of the number of foundational system of care practices that were found to need improvement or are weak. Nearly 30% of teams were not adequately formed with the right people to address youth and family needs. Over half of teams were functioning in a limited manner, were splintered or inconsistent in their planning and evaluating results, and were not engaged in collaborative problem-solving at a level necessary to impact positive change for youth and families. Only half of the teams were adequately using clinical and related information to increase the teams' understanding of the youth's issues at a scope and depth needed to design the right set of interventions and supports. Outside of risk and safety planning, planning interventions across the domains lacked the specificity and accountability to help enough youth in Western Massachusetts make progress in achieving their goals. Weak planning was found in reducing mental health symptoms, impacting behavioral changes, increasing youth's social connections, addressing substance abuse recovery or relapse and assuring successful transitions. Focused work to assure these practices occur at a higher level of quality and effectiveness is necessary.

Matching the right interventions to address youth and family needs was weak for nearly half of the youth reviewed as was identifying clear outcomes and goals. For 25% of the youth, care coordination required stronger leadership, including facilitating teams to monitor results to adjust care plans and address transitions. Also weak was implementing services, adapting and adjusting plans and services as needed, and managing youth's transitions. Necessary were not accessible or available for nearly 30 percent of the youth.

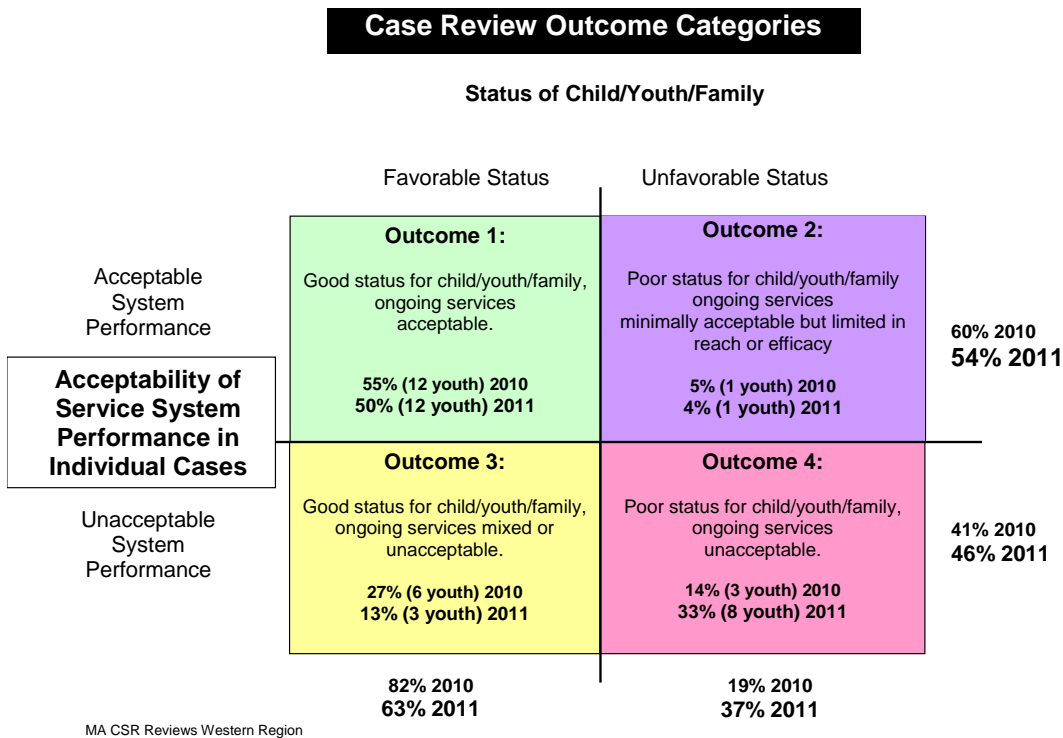
Overall system/practice performance for the youth reviewed in Western Massachusetts was very weak and will need considerable improvement in order to assure youth and families can dependably rely on service to work well and achieve results.

CSR Outcome Categories

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

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

Outcome Results: Western Massachusetts CSR (September 2011)



System/Practice Performance for youth

in the 2011 Western Massachusetts CSR was 54%.

- This means that services were working at a dependable or consistently acceptable level for only 54% of the youth reviewed.
- This was a decline in performance over last year’s CSR result of 60% of youth with acceptable system/practice performance.

Outcome 1

As the display indicates, half (50%) of the 24 youth fell into outcome category 1. Outcome 1 is the desired situation for all children and families receiving services, and represents youth who have favorable status and acceptable system/practice performance.

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

“(The youth and the youth’s mother) are well engaged with the Care Coordinator and the Family Partner. They are waiting for (the youth) to start the week of this interview with a new therapist. They have identified, referred, and have a scheduled appointment for a neuropsychological evaluation within the next month. Additionally, despite waiting for a new psychiatrist at the same location as the new therapist, the previous psychiatrist is willing to act as a bridge until the transition (is complete). The school has been very accepting of (the youth)... and have met with (the youth’s) mother and the Team to create strategies and communication plans. (The youth) is aware of this and is experiencing school differently than... last year. (The youth’s) mother reports that Intensive Care Coordination and the team meeting process are exactly what she and (the youth) needed.”

Outcome 2

One youth or 4% of the sample fell in Outcome 2. This category represents children whose needs are so great or complex that despite the best practice efforts and diligent system performance of the service system, the overall status of the child or youth is still unacceptable.

An example of a youth who fell in Outcome 2 who has safety and behavioral risk concerns is:

“The ICC began working with (the youth and) family in the early summer and the contact has been consistent since that time. There has been groundwork laid in terms of engaging (the youth and caregiver) obtaining a good assessment and understanding of (the youth) and obtaining the approval of (collateral) services. The family seems not to be in a ‘crisis’ mode repeatedly, and thus focus can be on strategies and interventions that are needed to manage and function safely and appropriately in social and interpersonal situations and to consider what skills and supports will be needed as (the youth) expects more independence.”

Outcome 3

Seventeen percent (13%) or 3 youth were in outcome category 3. Outcome 3 reflects youth whose status was favorable at the time of the review, but who were receiving less than acceptable service system performance. Some children are resilient and may have excellent naturally occurring supports provided by family, friends, school personnel, or some other key person in their life whose efforts are significantly contributing to the child's favorable status at the present time. However, current service system/practice performance is limited, inconsistent, or inadequate at this time. For these children, when teams and interveners adequately form, understand the youth and family, and work diligently and cohesively, the youth could likely progress into the outcome 1 category. Without key practice functions occurring reasonably well, status for youth in this category is often fragile, and at risk of becoming unfavorable.

The following is an example of a youth in Outcome 3. This youth is resilient and current status is fair, however there are multiple family stressors and caregiving issues with concerns in the areas of stability, safety and permanency for the youth.

“The team has not been functioning. There is not yet a comprehensive understanding of the challenges and root causes to the difficulties reported. The only diagnosis is depression, but there is little evidence to support. For the last 3 months diagnostic clarity was identified as a need but what interventions are in place to meet this need are unclear. The service plan is limited and does not address support and service needs for the family. Critical life events ... have not been addressed. The plans provided to address goals, although stated,, do not provide detailed action steps, person responsible for implementing and how measured. No additional resources accessed besides outpatient although (the) original Individual Care Plan referenced a need for a Therapeutic Mentor... No other natural supports have been developed.”

Outcome 4

In the Western Massachusetts CSR, 33% of the sample or 8 youth fell into outcome category 4. Outcome 4 is the most unfavorable outcome combination as the child’s status is unfavorable and system performance is inadequate. For many of the youth who are in Outcome 4, a thorough understanding of the youth and family coupled with strong teamwork and planning interventions that meet the needs of the youth with oversight of implementation would move the youth into a better Outcome classification. There was a 20% increase (5 more youth) this year in the number of youth in Outcome 4 over last year’s CSR results.

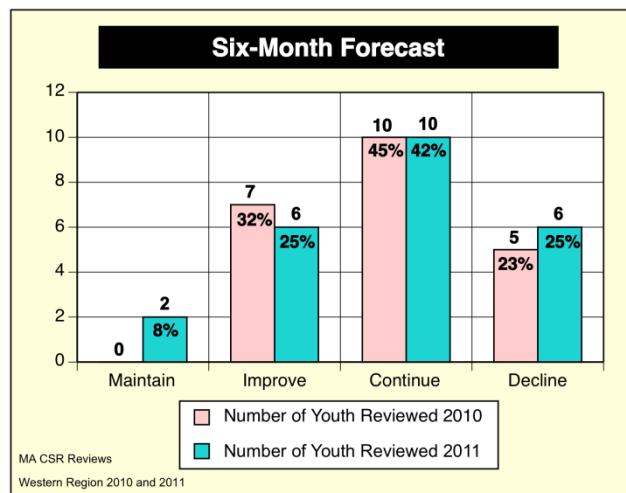
An example of a youth who fell in Outcome 4 is as follows. The youth is extremely emotionally unstable, with risk factors present across status indicators

“The record contains no clinical assessment; (Youth’s) diagnosis is based on a ‘report’ from (the youth’s guardian) of a prior diagnosis with no previous assessment to support it. The record contains one evaluation by the Mobile Crisis team with a different diagnosis and no records from (the youth’s) stay in hospital or STARR (Stabilization, Assessment, and Rapid Reintegration) placements. The record showed no grasp of (the youth’s) history of trauma over the last 3 years. The Individual Action Plan is underpowered, out of date, and extremely basic. For example, a goal for all the children in the aunt’s home to develop coping skills listed tasks for the ICC team to ‘investigate wait lists’ and ‘refer to treatment.’ There is little or no evidence of teamwork. Engagement with the child and family was limited even while (the youth) lived with (the youth’s guardian), with many ‘no shows’ for home visits noted. The record indicates only 1 school meeting, despite the significant problems that (the youth) was having in school. While there was communication between the FP and the school social worker, this was not used to leverage teamwork with teachers, treatment providers, or family. The few Care Plan Team meetings were sparsely attended, with 0 input from (the youth’s) therapist; contact with DCF was so sporadic that there is no record of the foster home changes that (the youth) experienced. Interviews suggested that the ICC/FP team had no idea what to do next and were casting around for people to work with.”

Six-month Forecast

Based on review findings, reviewers are asked if the child’s status is likely to maintain at a high status level, improve to higher than the current overall status, continue at the same status level, or decline to a level lower than the current overall status. For 2 youth or 8%, the prediction was that the youth would maintain at a high status level (youth in the “good” or “optimal” status category). For 6 youth or 25% of the sample the prediction was for improvement in status. For 10 youth or 42%, reviewers predicted the youth’s status to continue at the same level. For 6 youth or 25%, the prediction was that their status would decline, which is a concern as a quarter of youth receiving services are expected to do worse than they are doing now.

These results are comparable to last year’s CSR Six-month Forecast results for Western Massachusetts.



Summary of Findings

Data, Findings and Recommendations in this report reflect the CSR’s examination of the consistency and quality of service provision and practices in Western Massachusetts as they relate to meeting the requirements of the *Rosie D. Remedy*. These include requirements for services provided consistent with System of Care and Wraparound principles and phases of Wraparound practice. Eligible youth are also required to have timely access to necessary services through effective screening, assessment, coordination, treatment planning, pathways to care and mobile crisis intervention when needed. In addition, services and practices need to support youth and families participation in teams, and have teams that work together to solve problems and understand the changing needs and strengths of youth and families across settings. The *Rosie D. Remedy* also requires well-executed care coordination that results in care consistent with the CASSP principles, and is strength-based, individualized, child-centered, family-focused, community-based, multi-system and culturally competent. It requires individualized care plan to be updated as needed, addressing transition and discharge planning specific to child needs.

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

Strengths

The CSR identified examples of notable work including:

- Teams engaging with schools in planning and implementing supports
- A program that was sharing building space with other providers, including clinical and medical services, which facilitated collaboration and team building for a population with a high degree of need.

Most of the parents and youth reviewed felt their care planning team respected them and was their “ally.”

Family and youth engagement by care planning teams was happening consistently for the majority of youth reviewed. Family Partners in particular were successfully engaging families and developing trusting relationships. A recommendation would be to leverage this foundational system of care practice to strengthen understanding of youth and family needs, planning with families, and assuring the interventions that are implemented are helping youth to progress.

As compared to last year’s CSR of Western Massachusetts, many more youth have safety and risk management plans as a component of their care plans.

Almost all of the youth reviewed had a safety and risk management plan in their files. For the youth reviewed that had experienced a recent crisis, crisis response was adequate.

A number of System of Care committees in the region are successfully approaching problem-solving through a community-building approach.

Many of the System of Care (SOC) committees throughout the region have built productive working relationships and strategic approaches to building more responsive, collaborative system responses for youth with special needs. There is wide representation from community agencies and civic groups on several of the SOC committees, and many are

engaged in community-building approaches that are invigorating local efforts toward creative problem-solving.

Challenges

The inability of staff and teams to fully understand clinical issues of youth and strengths and challenges of families was a core practice issue for teams in Western Massachusetts.

Nearly half of the youth reviewed did not have a comprehensive mental health assessment in their files. Further, many care coordinators and teams did not appear to know how to use assessment information to guide planning. For many, the CANS alone were being used in lieu of also securing a comprehensive mental health assessment for each youth. Formulation and selection of services and strategies were often misaligned due to lack of full understanding by teams including the integration of accurate, comprehensive clinical/mental status of clients. As a result individualized goal-setting was often simplistic and superficial given the issues of many of the youth. Services were often not adjusted when youth were not making progress or were regressing, and teams did not try to seek underlying reasons for lack of progress.

A number of youth were noted to be accessing emergency departments or crisis services as a way to receive clinical evaluations. Further, it was noted that the level of evaluations obtained through MCI, CBATs and EDs were often not helpful in understanding the clinical, functional or medical needs of youth. Assessments conducted in these settings tended to focus more on assessment of need for inpatient hospitalization.

For assessments in general, medical understanding was often not integrated into the overall diagnostic picture of the youth, further hampering some youth from receiving the right treatment for their conditions. This was especially true for youth with co-occurring PDD, serious cognitive impairments, neurological dysfunctions or medical/genetic conditions that may have been impacting behaviors and/or symptoms.

It was noted that Therapeutic Training and Support (TTS) staff on some of the IHT teams of youth reviewed had weak understanding of youth's mental health issues, and also lacked skills in therapeutic interventions. Assuring understanding of youth and family needs by all team members, particularly those providing clinical interventions, is a vital system practice.

Team functioning was weak for over half of the youth reviewed.

Effective teaming is a foundational system function for youth with SED. Youth and families need their teams to work with them to understand their needs, to plan services and supports and work in a unified manner, to make adjustments as needed, and to work closely with them to achieve results.

The ability for teams to work together to coordinate implementation of services was exceptionally weak for most of the youth reviewed in Western Massachusetts. Only 46%, less than half of the youth reviewed, had an acceptable level of team functioning, and performance declined as compared to last year's CSR. Missing for a number of youth was the team and/or care coordinator's sense of urgency to act or have "ownership" for working

to achieve results. Effective team planning and managing of transitions was a key area of concern and weak performance.

Staff need help to better grasp the link between teams' conducting clear and thorough assessments, understanding the strengths and needs of youth and families, and working collaboratively to impact change. Many of the teams in Western Massachusetts appeared to lack an understanding of the practice model for teaming, and their role in impacting change. Further guidance and supervision for these core system practices appeared weak and/or inconsistent across agencies.

A number of teams seemed to lack clarity about when to consider using IHT services. In at least one case, it was stated that IHT services needed to be tried first before IHT could be used, which is not the case.

Service delays were experienced by many of the youth reviewed.

A number of youth experienced significant delays between intake at an agency and their first receipt of services. Youth and families too often waited months before their first team meeting was convened. In more than one case, this resulted in regression for the youth. Waitlists for services were cited for many of the youth reviewed, including excessive wait times for ICC services, therapeutic mentoring and outpatient services. In particular, psychiatric services are difficult to access, with four to six months cited by many as an average wait time. Staff turnover in a number of agencies appears to be limiting team building capacity and impacting continuity of care.

Families expressed feeling that services for their children were sometimes reduced too quickly and that staff are pressured into doing less.

A number of families were concerned that children were being moved to discharge quickly despite lack of progress on goals, or continued serious clinical or behavioral issues present. Some of the staff interviewed also expressed a concern about pressures to discharge youth, although others felt that their discharges and reductions of services were generally clinically supported.

Outpatient providers were not consistently well-integrated into team based processes.

In general, outpatient providers providing services for youth did not attend team meetings, and were not part of team-based planning and care processes. For youth transitioning to outpatient services from ICC, outpatient providers were not involved in transition planning which resulted in fragmented care and missed opportunities for information sharing and family engagement.

Families expressed concern about a requirement to receive outpatient therapy, even when it was not part of the care plan, in order to receive psychiatric services through mental health clinics. Many parents interviewed did not feel their children were benefitting from outpatient therapy, and preferred services that addressed the whole family, including children other than the child registered for services.

Recommendations

Staff/agency training for assuring quality services:

- Revisit training foci to improve skills and practices for assessment, team planning, team functioning, coordination, adjusting services as needed and assuring key elements of the practice model are being implemented with fidelity for each youth and family.
- Provide ongoing/recurrent education/training relative to the appropriate use of data to increase teams' understanding including a comprehensive mental health assessment, psychosocial information about the child and family, review of records, information from other agencies that are/have been involved with the youth, and other information that will help the team to develop a broad and in-depth understanding in order to build effective plans of care.
- Assure each child has a current comprehensive assessment and that the team understands and uses the information in combination with the CANS and the SNCD to inform their planning with the family. Assure mental health assessments are reviewed with families, and they receive a copy of their child's assessments.
- Train TTS staff on IHT teams to better understand and recognize signs and symptoms of various childhood psychiatric disorders as well as concrete tools to utilize on common issues like setting limits and promoting follow through for parents.
- Assure CSA and IHT team meetings include as many providers and natural supports as possible as opposed to including only agency staff for both
- Better integrate outpatient and other clinical providers into teams and the CBHI processes. Assure when youth transition from ICC or IHT to outpatient therapists that there is adequate joint planning and transfer of information, and that the outpatient therapist is able to provide the services (youth and family), school and other agency collaborative work and any "hub" coordination that is needed.
- When youth transition between services, joint transition planning:
 - Should consider care coordination and specific transition needs of the youth and family ;
 - Have concrete, individualized and specific strategies that are agreed upon by the team;
 - Assure the family is a part of the planning and understands the transition plan, any changes in services, and what the frequency of contact will be.
- Improve documentation to better ensure that client records reflect the depth and breadth of service provision and collaboration of team and providers.
- Assure youths' psychiatrists or others prescribing psychotropic medications are included in team processes including understanding, planning, implementation and monitoring of services, especially given the number of youth that are on multiple medications.

- Develop capacity and skills of staff to understand the needs of, and support parents with serious mental illnesses, including any limitations that parents may have in implementing strategies they are assigned in their child’s care plan
- Address areas identified in the findings of the CSR with emphasis on youth self-risk, planning and managing transitions, and assuring service delivery is timely.

Consultation and supervision for teams:

- Better utilize the CSA psychiatrist for direct consultation to teams particularly when teams are struggling to understand or plan interventions, or youth are not progressing or are in crisis.
- Strengthen practices for supporting staff and teams through systematic supervision, oversight, and/or other specialized consultations or processes.

System issues:

- Performance across agencies is variable. Assure there is consistency of quality practices across CSAs and agencies.
- Review the adequacy of access and availability to services.
- Assess the impact of higher caseloads in the ability of staff to effectively provide key service functions such as bringing a comprehensive and in-depth assessment and understanding to teams, receiving an adequate level of supervision consultation and continuous training, developing quality plans that will work, preparing team members and the family for team meetings, and facilitating adjustments to plans and services as needed.

Appendix 1

Child's General Level of Functioning

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

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

Appendix 2

CSR Interpretative Guide for Person Status Indicator Ratings

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

CSR Interpretative Guide for Practice Performance Indicator Ratings

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