Report of Findings of the
Community Services Review of
Central Massachusetts
March 2012

Fiscal Year 2011-2012 Reviews

Rosie D. Community Services Review- Central 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 Central Massachusetts region during March 2012. The CSR, a case-based monitoring methodology, reviews *Rosie D.* class members across key indicators of status and progress as a way to determine how services and practices are being performed. The intensive reviews were conducted of 24 randomly selected youth receiving Intensive Care Coordination (ICC) and/or In-home Therapy (IHT) services through Community Service Agencies (CSAs) and provider agencies throughout the Central Massachusetts region.

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

The role of the *Rosie D.* Court Monitor is to receive and review information from a variety of sources in order to monitor compliance and progress with the requirements of the *Rosie D.* Remedial Plan. The Community Services Review was selected in consultation with the Parties to assist the Court Monitor by receiving and reviewing information about how well the Commonwealth of Massachusetts is addressing requirements of *Rosie D.* The Commonwealth is charged with creating the conditions that should lead to improvements for youth and families. The CSR examines the diligence and consistency of services and service practices in providing those conditions.

Highlights of Findings from the March 2012 Central Massachusetts CSR

Status and Progress Indicators. In the CSR, Youth Status, Youth Progress, and Family Status are reviewed to understand the how well behavioral health services and practices are working for youth and families. The following are the status and progress findings for youth reviewed in the Central Massachusetts CSR during March 2012.

Youth Status. Overall status was favorable for 71% of the youth reviewed indicating a significant number of youth had overall status that was unfavorable. Stability in both home and school settings was a concern for a number of youth reviewed as were youth patterns of attendance, academic performance and behavioral supports in school. However, youth were safe in their homes, schools and communities. Youth also had generally favorable health status, living arrangements and permanency. Behavioral risk toward self and others were areas of concern for many, and emotional status was unfavorable for nearly 60% of those reviewed. More attention by teams in understanding and building effective supports and treatments for improving youths' home and school stability and emotional well-being is warranted.

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

Fathers in the Central Massachusetts CSR were found to have fairly high levels of challenge in their lives; mothers also experienced challenges but at a lesser level. Support for youth was negatively impacted for both mothers and fathers. Support for youth who were in group caregiving was positive. Family voice and choice was strong for mothers, but weak for fathers and youth. Satisfaction was favorable among mothers and fathers, but less so for youth.

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

Only 63% of the youth in the Central Massachusetts CSR were making favorable progress (Fair, Good or Optimal Progress). This indicates that overall, youth were making weak progress in key life areas. Of particular concern was weak progress for youth in reducing symptoms, problem behaviors and substance use, and improving coping and self-management skills. As well, only half of the youth were making progress in school, and no youth were making progress in succeeding in employment. Youth were making weak progress in their peer relations and in their overall well-being and quality of life. Youth were making fair progress in improved family relationships, and relationships with other adults.

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 or not working at the practice points in the service system.

For the youth reviewed, only 50% were found to have acceptable system/practice performance. This indicates system performance and practices for youth in Central Massachusetts are weak. For 50% or half of youth, the system needs to improve its performance in providing dependable, quality services. This represents a decline in performance as compared to the previous CSR for Central Massachusetts when 66% of the sample had acceptable findings. Most of the system/practice indicators saw declines over the previous CSR results; most of the indicators were performing well below acceptable levels.

The data indicate that the strongest areas of practice for youth in Central Massachusetts were Engagement with the Family, and Cultural Responsiveness to the Youth and Family.
There were no areas of practice with overall fair performance.

Areas of system/practice performance that need improvement in order to be considered to have adequate consistency, intensity and/or quality of efforts are Planning Interventions for Symptom Reduction; Service Implementation: and Availability and Access to Resources.

The remaining system/practice domains demonstrated weak performance including Engagement with Youth; Team Formation and Team Functioning; Assessment & Understanding of Youth and Family; Planning Interventions for Behavior Changes; Planning for Social Connections; Planning Interventions for Risk and Safety; Planning Interventions for Recovery and Relapse; Planning Interventions for Transitions; Outcomes and Goals; Matching Interventions to Needs; Care Coordination; Adapting & Adjustment; Managing Transitions & Life Adjustments; and Responding to Crises.

A few system practices showed improvement over the previous CSR. Cultural responsiveness to families was strong last year, and strengthened to being acceptable for all families reviewed. Both service implementation and resource availability were weak in the last CSR; both areas improved but were found to need improvement.

The remaining system practices declined or stayed in the same range of performance as last year with the majority having weak performance. The one exception was planning for symptom reduction which had the same result as the last CSR, but continues to need improvement.

Overall practice was very weak (50%). Based on the review of youth, the system of services in Central Massachusetts has declined and continues to lack capacity to provide consistently reliable services at the quality needed to help youth make progress, achieve desired outcomes or maintain recent gains. Almost all areas of practice need concerted attention.

There are a number of areas of considerable concern about the services for youth in Central Massachusetts. Teams were not being adequately formed for 46% of youth, and 42% of teams were functioning in a limited manner, were splintered or inconsistent in their planning and evaluating results, and were not engaged in collaborative problem-solving in ways that could impact positive change for youth and families. Over half of youth (54%) and a third of families (33%) were not well-assessed or understood, a foundation for providing effective supports and services for youth and families. Further, half of youth (50%) did not have a current mental health assessment in their files. Almost all indicators of planning were found to be weak, and did not reflect effective planning processes or plans that were well-reasoned or clear in addressing youth and family strengths and needs. Planning transitions for youth was unacceptable for almost 60% of youth, and transitions were not managed well for 45%. Managing crises for youth dipped to being acceptable for only 59% of youth as compared to 84% in the previous review.

With only half of youth found to have received acceptable system performance, focused attention on the core practice functions and concerns identified in this report will be important for the Commonwealth to address in order to be considered to providing adequate services for youth in Central Massachusetts.

The Rosie D. Community Services Review
Regional Report for Central Massachusetts
For the Review Conducted in March 2012

Introduction
Overview of Rosie D. Requirements and Services

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

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

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

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

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

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

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

Mobile Crisis Intervention (MCI) services are provided 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 56 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 18, 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 Central Massachusetts CSR

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

CSAs are the designated agencies across the Commonwealth for the provision of Intensive Care Coordination. There are four Community Service Agencies (CSAs) provided by human service agencies across the Central Region of Massachusetts. A fifth CSA that serves a specialized population statewide was included in this CSR. In addition to Intensive Care Coordination, the CSAs also provide Family Support and Training Services, more commonly called Family Partners.

In the Central region, the CSAs serve the towns in which they are located and the surrounding areas. The CSAs are Community Healthlink (Leominster), Community Healthlink (Worcester), Wayside Youth & Family Services (Framingham), and You Inc. (Southbridge). The Learning Center for the Deaf, Walden School, is a specialized CSA. Although it is located in Waltham, The Learning Center covers this specialized population (hearing impaired) throughout Massachusetts.

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

Review Participants

Altogether, over 400 people participated either in the youth-specific reviews or were interviewed in stakeholder focus groups in the Central Massachusetts CSR. Table 1 displays data related to the youth-specific reviews where a total of 169 interviews were conducted. As can be seen, the average number of interviews was 7 with a maximum of 13 and a minimum of 4 interviews conducted.

Child Status and Performance Profile - Number of Interviews

Number of cases: 24   MA Central Review March 2012

Number of Interviews

Total number of interviews	169
Average number of interviews	7.0
Minimum number of interviews	4
Maximum number of interviews	13

Table 1

How the sample was selected

The sample for the Central 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 included IHT youth who were not also receiving ICC services at the time the lists were drawn. The sample included ICC and IHT youth ranging in age from birth to twenty-one years old that are covered by Medicaid. The CSR sample drawn for the Central CSR consisted of 24 youth, including 16 ICC youth and 8 IHT youth who were not also currently receiving ICC.

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

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

IHT Selection. For IHT, the open caseload list was further sorted to create a list of youth who were receiving IHT but not currently also receiving ICC. There were 13 agencies, which were actively providing IHT in Central 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 Central Massachusetts region. Of the 8 youth selected from IHT lists, 4 youth were drawn from 3 agencies which operated a CSA service as well as an

IHT service. The final 4 youth in the sample were randomly selected from the remaining IHT agencies. Each of these 4 youth were receiving IHT but not also receiving ICC. In total, there were 8 IHT youth included in the sample.

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

Agency	Total Enrolled Since 7/1/10	Number Open at List Submittal	Number ICC Cases Selected
Community Healthlink North Central	383	154	4
Community Healthlink Worcester East	365	129	3
Community Healthlink Worcester West	241	67	2
Wayside Framingham	155	106	3
You Inc. Southbridge	166	106	3
The Learning Center for the Deaf, Walden School	51	30	1
Totals	1361	592	16

Table 2

The second column of Table 2 displays the number of the youth enrolled in ICC since July 1, 2010. The third column displays the total number of youth by agency, which was served within open cases at the time the agencies submitted lists. The number of youth to be included from each agency was then determined by comparing the number of youth being served by that agency to the total number of youth being served in Central Massachusetts. Community Healthlink North Central served the largest number of youth since July 1, 2010, and 4 youth were randomly selected. Community Healthlink Worcester East, Wayside Framingham, and You Inc. Southbridge each had 3 youth included in the sample. Community Heathlink Worcester West had 2 youth included in the sample. The sample includes 1 youth from a specialized CSA, The Learning Center for the Deaf, Walden School. These 16 ICC youth may have been receiving services in addition to ICC, including IHT.

Agency	Total Enrolled since 7/1/10	Total Open at List Submittal	Total Open and Receiving IHT/No ICC	Number IHT Only Selected
Advocates	41	22	19	1
Community Healthlink	52	32	23	1
Counseling and Assessment Clinic of Worcester	*	*	*	*
Family Continuity Program	338	106	83	1
JRI	*	*	*	*
LUK	*	*	*	*
MSPCC	*	*	*	*
Multicultural Wellness Center	*	*	*	*
Riverside Community Care	68	36	31	1
SMOC Behavioral Health Services	*	*	*	*
South Bay Mental Health	39	24	20	1
Wayside	263	87	60	1
Y.O.U., Inc.	330	109	84	2
Total	1131	416	320	8

Table 3

 * The sample did not randomly draw cases for the sample from this agency.

Information about the 8 IHT agencies that were selected for inclusion in the CSR sample is shown in Table 3. The second column shows the total unduplicated enrollment for youth receiving IHT by agency since July 1, 2010. The third column displays the number of youth who were included in open cases at the time the list was submitted. The fourth column displays the total number of youth who were receiving IHT without current ICC services. The last column lists by agency, the number of IHT youth who were designated for selection in the CSR. As can be seen in the table, each of the following agencies had one youth included in the initial CSR sample: Advocates, Community Healthlink, Family Continuity Program, Riverside Community Care, South Bay Mental Health, and Wayside. There were 2 youth randomly drawn from the Y.O.U., Inc. IHT program.

Characteristics of the Youth Reviewed in Central Massachusetts
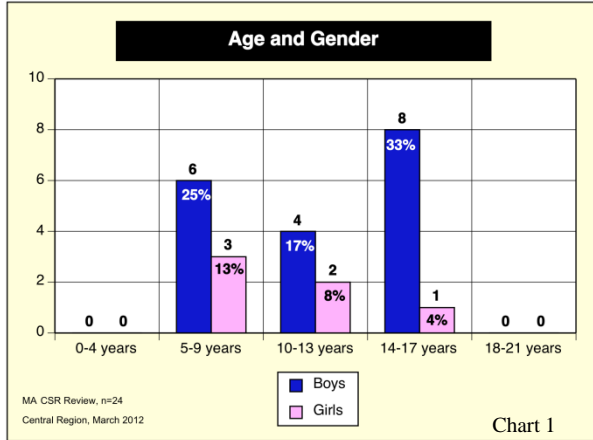
Chart 1

Age and Gender. Twenty-four (24) youth receiving services in the Central Massachusetts region were reviewed in the CSR conducted in March 2012. *Chart 1* displays the distribution of genders across the age groups in the sample. There were 18 boys and 6 girls in the sample. The proportion of boys to girls was 75% boys to 25% girls. There were 9 youth each in the 5-9 and 14-17 year old ranges, and 6 youth in the 11-13 year old range. There were no youth reviewed in the 0-4 or 18-21 year old age ranges.

Curr*ent placement.* Eighty-seven percent (87%) of the youth in the Central Massachusetts CSR sample lived with their families, either with their biological/adoptive families or in a kinship/relative home (*Table 4*). Four percent (4%) or one youth each were residing in a foster home, a CBAT, and a residential treatment facility at the time of the review.

Child Status and Performance Profile - Current Placement Frequency

Number of cases: 24   MA Central Review March 2012

Type of Current Placement	Number	Percent
Family bio./adopt. home	19	79%
Kinship/relative home	2	8%
Foster home	1	4%
CBAT	1	4%
Residential treatment facility	1	4%
	24	100%

Table 4

Legal Status. The legal status of 88% of the youth reviewed was with their birth families. Two youths' (8%) permanency status was with his/her adoptive family, and one was in permanent guardianship *(Table 5).*

Child Status and Performance Profile - Legal Permanency Frequency

Number of cases: 24   MA Central Review March 2012

Legal Permanency Status	Number	Percent
Birth family	21	88%
Adopted family	2	8%
Permanent guardianship	1	4%
	24	100%

Table 5

Out of home placements. The CSR tracked placement changes over the last twelve months for each of the 24 youth reviewed (*Table 6*).   Placement change refers to changes in living situation, as well as any changes in the type of program the child received educational services over the last twelve months. Among the youth in the sample, 15 or 63% had no placement changes in the last year. Six youth or 25% experienced 1-2 changes in placement. One youth (4%) had 3-5 placements, and two (8%) had 6-9 placements. Stability was an issue over the last year for 37% of the youth reviewed, however as can be seen in *Table 7*, only one youth in the sample had been in an out of home placement in the thirty days preceding the CSR, and had been placed with family member or adoptive home.

Child Status and Performance Profile - Placement Changes Frequency

Number of cases: 24   MA Central Review March 2012

Placement Changes (past 12 months)	Number	Percent
None	15	63%
1-2 placements	6	25%
3-5 placements	1	4%
6-9 placements	2	8%
	24	100%

Table 6

Child Status and Performance Profile - OOH Placement Past 30 Days

Number of cases: 24   MA Central Review March 2012

OOH Placement Past 30 days	Number	Percent
Family/Adoptive Home	1	4%
Not Applicable	23	96%
	24	100%

Table 7

Ethnicity (Table 8). Of the 24 youth in the sample, fifteen or 63% were Euro-American, one (4%) was African-American, and eight (33%) were Latino-American.

Child Status and Performance Profile - Ethnicity Frequency

Number of youth: 24   MA Central Review March 2012

Ethnicity	Number	Percent
Euro-American	15	63%
African-American	1	4%
Latino-American	8	33%
	24	100%

Table 8

Primary languages (Table 9). English was the primary language spoken at home for 19 youth or 79% of those reviewed, and Spanish was the primary language for 3 or 13%. In one home each (4%) English and Spanish; and English, Spanish, and American Sign Language were the primary languages.

Child Status and Performance Profile - Language Spoken Frequency

Number of cases: 24   MA Central Review March 2012

Primary Language Spoken at Home	Number	Percent
English	19	79%
Spanish	3	13%
English & Spanish	1	4%
English, Spanish and ASL	1	4%
	24	100%

Table 9

Child Status and Performance Profile - Educational Placement Frequency

Number of cases: 24   MA Central Review March 2012

Educational Placement or Life Situation	Number	Percent
Regular K-12 Ed.	9	38%
Full inclusion	1	4%
Part-time Sp. Ed.	6	25%
Self-cont. Sp. Ed.	3	13%
Parenting teen	0	0%
Adult basic/GED	0	0%
Alternative Ed.	4	17%
Vocational Ed.	0	0%
Expelled/Suspended	0	0%
Home hospital	1	4%
Day treatment program	0	0%
Work	0	0%
Completed/graduated	0	0%
Dropped-out	0	0%
Other	0	0%

Table 10

Educational placement (Table 10). Youth reviewed were receiving educational services through a variety of educational programs. Of the sample, 38% were in a regular education program. Forty-two percent (42%) of the youth were receiving special education services in a full inclusion (4%), part-time special education (25%) or fully self-contained special education setting (13%). Four youth (17%) were in an alternative education setting, and one (4%) was receiving education through a home-hospital program. These youth may have also had special education services in these settings.

Child Status and Performance Profile - Agencies Involved Frequency

Number of cases: 24   MA Central Review March 2012

Agencies Involved	Number	Percent
DCF	8	33%
DMH	0	0%
Special Ed	16	67%
Early intervention	0	0%
Developmental disabilities	2	8%
DYS	0	0%
Probation	3	13%
Vocational Rehabilitation	0	0%
Substance abuse	1	4%
Other	3	13%

Table 11

Other state agency involvement (Table 11). Most of the youth in the sample were involved with other State and/or community agencies. Note that youth may be involved with more than one agency, so the overall number in Table 11 may be more than the number of youth reviewed. Youth were most frequently involved with Special Education (16 or 67%). Eight youth (33%) were involved with The Department of Children and Families (DCF). The

Department of Developmental Services had involvement with two youth (8%), and one was involved with substance abuse treatment services. Youth in the other category included the YMCA, Deaf Inc. and Massachusetts Commission for the Dead and Hard of Hearing (MCDHH), and Juvenile Court.

Child Status and Performance Profile - Referral Source

Number of cases: 24   MA Central Review March 2012

Referral Source	Number	Percent
Court	1	4%
DMH	1	4%
Hospital	2	8%
Crisis Services	3	13%
School	3	13%
Family	3	13%
DCF	2	8%
Outpatient	1	4%
CBAT	1	4%
CHINS	1	4%
Deaf Inc, & MCDHH	1	4%
Family support service	1	4%
ICC for sister	1	4%
Mother's OP	1	4%
Sister's clinician	1	4%
Unknown	1	4%
	24	100%

Table 12

Referring agency (Table 12). Youth reviewed in Central Massachusetts were referred to ICC and/or IHT services from a variety of sources as displayed in *Table 12.* The three largest referral sources were Crisis Services, Schools and Family self-referrals each referring three youth or 13% of the sample. This was followed by Hospital and DCF, referring two youth or 8% each.

Referring one youth each or 4% of the sample were the courts, Department of Mental Health (DMH), an outpatient provider, CBAT, the CHINS process, Deaf Inc. and Massachusetts Commission for the Dead and Hard of Hearing (MCDHH), family support services, and providers who were working with other members of the youth's family. In one case the referral source was unknown.

Child Status and Performance Profile - Co-Occurring Condition Frequency

Number of cases: 24   MA Central Review March 2012

Co-Occurring Condition	Number	Percent
Mood Disorder	12	50%
Anxiety Disorder	7	29%
PTSD/Adjustment to Trauma	8	33%
Thought Disorder/Psychosis	0	0%
ADD/ADHD	16	67%
Anger Control	7	29%
Substance Abuse/Dependence	1	4%
Learning Disorder	6	25%
Communication Disorder	0	0%
Autism	2	8%
Disruptive Behavior Disorder (CD, ODD)	4	17%
Mental Retardation	2	8%
Medical Problem	5	21%
Other Disability/Disorder	1	4%
Other	0	0%

Table 13

Behavioral health and co-occurring conditions (Table 13). Table 13 describes the conditions and/or co-occurring conditions present among the youth reviewed. Youth may have one or more than one condition. The largest percentages of youth in the Central Massachusetts sample were diagnosed with attention deficit or attention deficit hyperactivity disorder (67%) and

mood disorders (50%), followed by PTSD (33%), anxiety disorders (29%) and anger control issues (29%). Twenty five percent (25%) of the youth had a learning disorder, and 17% a disruptive behavior disorder. There were two youth with an autism spectrum disorder (8%), and two with an intellectual disability (8%). One youth in the sample (4%) had a substance abuse disorder.

The youth in the "Other Disability" category had speech disorder.

Medical problems that were experienced by 21% of the youth included severe allergies, asthma, obesity, enuresis, and constipation.

Child Status and Performance Profile - Psy Meds Frequency

Number of cases: 24   MA Central Review March 2012

Number of Psy Meds	Number	Percent
No psy meds	6	25%
1 psy med	7	29%
2 psy meds	7	29%
3 psy meds	3	13%
4 psy meds	1	4%
	24	100%

Table 14

Medications (Table 14). Seventy-five percent (75%) of the youth reviewed in Central Massachusetts were prescribed one or more psychotropic medications. As displayed in Table 14, seven youth in the sample (29%) were prescribed one medication, seven (29%) were on two medications, and three (13%) were on three medications. One youth (4%) was on four psychotropic medications. Of the youth that were prescribed medications, 61% were on two or more medications and 22% were on three or more medications.

Youths' levels of functioning (Table 15). The general level of functioning of each youth in the CSR is rated using the General Level of Functioning scale, a 10-point scale displayed in Appendix 1 of this report. Thirteen of the youth or 54% were rated to be functioning in the Level 1-5 range ("needs constant supervision" to "moderate degree of interference in functioning in most social areas or severe impairment of functioning in one area"). Nine or 38% were rated in the Level 6-7 range ("variable functioning with sporadic difficulties or symptoms in several but not all social areas" to "some difficulty in a single area, but generally functioning pretty well"). Two youth (8%) were rated in the Level 8-10 range ("no more than slight impairment in functioning at home, at school, with peers" to "superior functioning in all areas").

Child Status and Performance Profile - Level of Functioning Frequency

Number of cases: 24   MA Central Review March 2012

Level of Functioning	Number	Percent
In level 1-5	13	54%
In level 6-7	9	38%
In level 8-10	2	8%
	24	100%

Table 15

Child Status and Performance Profile - Crisis Services Used Frequency

Number of cases: 24   MA Central Review March 2012

Crisis Services Used Past 30 Days	Number	Percent
Mobile crisis	1	4%
911 Emergency call: EMS	0	0%
911 Emergency call: Police	1	4%
Emergency department	0	0%
Other	1	4%
None	21	88%

Use of Crisis Services (Table 16). Three youth, or 12% percent of the sample accessed some type of crisis service over the 30 days prior to the review. Mobile crisis was used by one youth (4%), and a 911 emergency call for crisis for the other youth (4%). There was no crisis intervention indicated by the reviewer for the youth in the "other" category.

Mental health assessments (Tables 17 and 18). Mental health assessments are among the information sets required for teams and practitioners to better understand the strengths, needs and conditions of youth and their families. Assessments help teams to formulate an overall picture of how the youth is doing emotionally,

Child Status and Performance Profile - Mental Health Assessment

Number of cases: 24   MA Central Review March 2012

MH assessment performed	Number	Percent
Yes	12	50%
No	12	50%
	24	100%

Table 17

behaviorally and cognitively. As well, they aid in the team's understanding of the social/familial context of a youth's behaviors and well-being. CSR reviewers determine the absence or presence of a comprehensive mental health assessment when answering this question.

Only half (50%) of the youth reviewed in Central Massachusetts had a current mental health assessment in their files. The other twelve youth, or 50%, did not have a current mental health assessment available to help their teams better understand and plan for them.

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

Child Status and Performance Profile - Received Mental Health Assessments

Number of cases: 24   MA Central Review March 2012

Received MH Assessments	Number	Percent
Parent	8	33%
Education	2	8%
Court	0	0%
Child Welfare	1	4%
DOC	0	0%
Not applicable	12	50%
Not Distributed	4	17%
Other	1	4%

Table 18

For the 12 youth with mental health assessments, the assessment was distributed to 8 parents or 33% of the youth. Two schools or 9% received an assessment, as did one child welfare worker (4%).

The assessment was not distributed for 4 of the 12 youth with assessments. For the youth in the "other" category, the assessment was distributed to the IHT by the youth's ICC.

Child Status and Performance Profile - Special Procedures Frequency

Number of cases: 24   MA Central Review March 2012

Special Procedures Used Past 30 Days	Number	Percent
Voluntary time-out	3	13%
Loss of privileges via point & level system	0	0%
Disciplinary consequences for rule violation	4	17%
Room restriction	0	0%
Exclusionary time out	1	4%
Seclusion/Locked room	0	0%
Take-down procedure	1	4%
Physical restraint (hold, 4-point, cuffs)	2	8%
Emergency medications	0	0%
Medical restraints	0	0%
None:	15	63%
Other:	0	0%

Table 19

Special Procedures

Special Procedures data presents information about interventions that were experienced by youth over the 30 days preceding the CSR (*Table 19*). Thirty-seven percent (37%) of the sample, or 9 youth experienced a special procedure during this time period. Among the youth, 13% had experienced a voluntary time-out; 17% a disciplinary consequence for a rule violation. Eight percent (8%) of youth had experienced a physical restraint, 4% a "take-down" procedure, and 4% an exclusionary time out.

Caregiving challenges

Challenges experienced by the parents and caregivers of the youth reviewed are displayed in *Table 20*. The most frequently noted challenge of the parents or caregivers of youth in the sample was adverse effects of poverty experienced by 29%. This was followed by 25% each challenged with a serious illness or disabling condition and/or extraordinary care burdens. Seventeen percent (17%) of caregivers had cultural or language barriers. Eight percent (8%) of caregivers were challenged by domestic violence or were undocumented and 4% were teen parents. One parent (4%) had limited cognitive ability. Challenges in the "Other" category included a parent with a developmental disability and family communication issues. Of note is there were no parents with serious mental illness in the sample.

Child Status and Performance Profile - Caregiver Challenges Frequency

Number of cases: 24   MA Central Review March 2012

Challenges in the Child's Birth Family or Adoptive Family	Number	Percent
Limited cognitive abilities	1	4%
Serious mental illness	0	0%
Substance abuse impairment or serious addiction w/ frequent relapses	0	0%
Domestic violence	2	8%
Serious physical illness or disabling physical condition	6	25%
Unlawful behavior or is incarcerated	0	0%
Adverse effects of poverty	7	29%
Extraordinary care burdens	6	25%
Cultural/language barriers	4	17%
Undocumented	2	8%
Teen parent	1	4%
Recent life disruption/homelessness due to a natural disaster	0	0%
Other	2	8%

Table 20

Care Coordination

Data are routinely collected in each CSR to better understand factors that may be impacting the provision of care coordination services. Information is collected through the individual providing the care coordination function for each youth, which could have been the ICC or the IHT therapist. Among the data collected are information about the length of time the care coordinator was in the position (therapists may have been in the position before the start of IHT services), the current caseload size of the individual, and barriers they perceive to be impacting their work. In the Central Massachusetts CSR, there were 21 different individuals providing care coordination for the 24 youth reviewed. Thirteen individual ICCs and eight IHTs were interviewed.

The review tracked the length of time each of the Care Coordinators had been assigned to the youth being reviewed. As can be seen in *Table 21*, 38% of care coordinators had been assigned to the youth for one to three months, and 21% for four to six months. Twenty-five percent (25%) had been assigned to the youth for seven to twelve months, 13% for thirteen months to two years, and 4% for 25-36 months.

Child Status and Performance Profile - Length of Time CM Assigned

Number of cases: 24   MA Central Review March 2012

Length of Time CM Assigned to Child/Youth	Number	Percent
1-3 months	9	38%
4-6 months	5	21%
7-12 months	6	25%
13-24 months	3	13%
25-36 months	1	4%
	24	100%

Table 21

Caseload size as reported by the care coordinator was measured along the scale in *Table 22*. Twenty-nine percent (29%) had eight or fewer cases, 29% had nine to ten cases, and 24% eleven-twelve. Fourteen percent (14%) of care coordinators had thirteen to fourteen cases, and 5% had fifteen-sixteen cases. Eighty-two percent (82%) of those providing care coordination had 12 or fewer cases.

Child Status and Performance Profile - CM Current Caseload Frequency

Number of cases: 21   MA Central Review March 2012

CM Current Caseload Size	Number	Percent
<8 cases	6	29%
9-10 cases	6	29%
11-12 cases	5	24%
13-14 cases	3	14%
15-16 cases	1	5%
	21	100%

Table 22

Child Status and Performance Profile - Barriers Affecting Case or Services

Number of cases: 24   MA Central Review March 2012

Barriers Affecting Case Management or Services	Number	Percent
Caseload size	4	17%
Eligibility/access denied	4	17%
Inadequate parent support	6	25%
Inadequate team member participation	4	17%
Family disruptions	3	13%
Billing requirements/limits	3	13%
Case complexity	6	25%
Treatment compliance	5	21%
Team member follow-thru	2	8%
Acute care needs	4	17%
Driving time to services	6	25%
Culture/language barriers	8	33%
Refusal of treatment	4	17%
Family instability/moves	1	4%
Arrest/detention of child/youth	1	4%
Other	6	25%

Table 24

Table 22. Information about barriers impacting the provision of services was collected through interviews with the person providing care coordination for each youth. Challenges cited most often by care coordinators in Central Massachusetts were cultural/language barriers cited by 33%. This was followed by inadequate parent support and driving time to services, each cited by 25% of care coordinators. Seventeen percent of coordinators cited each of the following as barriers: caseload size, eligibility and access denial issues, inadequate team member participation, acute care needs, and treatment refusal. Family disruption, and billing requirements and limits, were each cited by 13%, and team member follow-through by 8%. Four percent (4%) cited family instability and youth arrest or detention as barriers.

Barriers in the "Other" category included waitlists for services, scheduling complexities, and barriers with the referral process. Also cited were lack of natural supports for families, the need for more Spanish-speaking providers, and lack of funding for community supports for youth.

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

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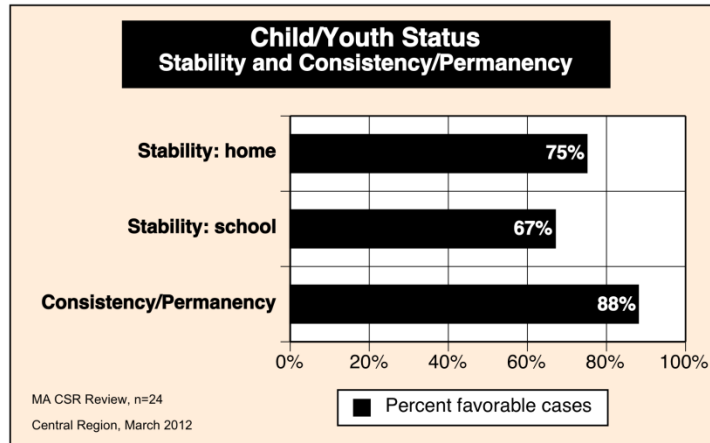
Youth Status Indicators
(Measures Youth Status over the last 30 days unless otherwise indicated)

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

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

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

Overall Youth Status

Child/Youth Status
Stability and Consistency/Permanency

Stability: home — 75%
Stability: school — 67%
Consistency/Permanency — 88%

MA CSR Review, n=24
Central Region, March 2012
■ Percent favorable cases

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

Home Stability. Among the 24 youth reviewed in Central Massachusetts, 75% were found to have favorable stability at home. Forty-two percent (42%) had good or optimal stability with established positive relationships and well-controlled to no risks that otherwise could

jeopardize stability. Fifty percent (50%) of the youth were rated to be in the "refinement" area, which means that conditions to support stability were fair. Two youth (8%), including one with poor and one with adverse stability, need improvement.
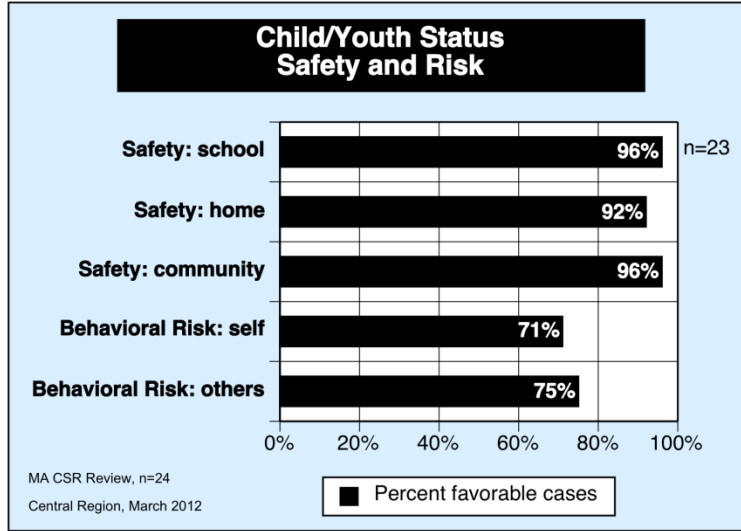
School Stability. Only 67% of the youth had a stable school situation, a concerning finding. Of these, 46% had optimal or good stability with only age appropriate or planned changes occurring in their school program. A third of the youth (33%) had stability issues at school that needed "refinement," with fair to marginal stability issues that were minimally to inadequately addressed. Twenty one percent (21%) of the youth had poor or adverse and worsening school stability.

These results indicate that teams need to strengthen interventions to support stability for youth in their homes and schools to minimize risk of disruptions

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

Among the youth reviewed in Central Massachusetts, 21 or 88% had a favorable level of consistency and permanency in their lives. Among these, 17 or 71% had "optimal" or "good" status, meaning these youth were in enduring permanent living situations with their family of other legally permanent caregivers. Five youth, or 21% were at a level of consistency and permanency situation that needed refinement in order to assure enduring relationships and consistent caregiving/living supports, and were either in a minimal to fair status, or in a marginal status with somewhat inadequate or uncertain permanence. Two youth, or 8% of the sample needed improvement on this indicator; one was experiencing poor status with substantial to serious and continuing problems of unresolved permanency, and one youth's permanency was adverse and worsening. In both these cases, behavioral health issues were impacting youths' permanency status.

**Child/Youth Status
Safety and Risk**

Safety: school	96% n=23
Safety: home	92%
Safety: community	96%
Behavioral Risk: self	71%
Behavioral Risk: others	75%

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

MA CSR Review, n=24

Central Region, March 2012

■ Percent favorable cases

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 (96%) of youth were found to have favorable safety status at school. For the 23 youth attending school, 17 or 74% were safe in their school programs at a "good" or "optimal" level with no risk to generally risk-free school programs. Five youth (23%), all with acceptable status, needed refinement in terms of the school setting leaving the youth free from abuse or neglect, and were experiencing fair or marginal safety at school. One youth had poor school safety that needed improvement.

Home safety. Ninety-two percent (92%) of youth were safe at home. Two-thirds (66%) of the youth were found to have "good" or "optimal" safety status at home. The remaining youth (33%) were found to need refinement with a fair to minimally adequate home situation free from abuse or neglect, or marginal safety with somewhat inadequate protection posing an elevated risk of harm. There were no youth with poor or adverse home safety status.

Community safety. Ninety-six percent (96%) of youth had favorable safety in the community. Fifteen youth or 63% were experiencing "good" to "optimal" safety in their communities. Nine or 38% needed refinement in their safety in the community and could benefit from their teams reviewing their safety status including any risks for intimidation or fear of harm. There were no youth with poor or adverse community safety status.

Behavioral Risk to Self and Others

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

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

Risk to self. Behavioral risk to self was a concern for a number of youth in the sample. Only 71% of the youth had a favorable level of behavioral risk toward themselves.

Among the youth reviewed, nine or 38% had an "optimal" or "good" level of behavioral risk. The remaining fifteen youth or 62% of those reviewed were found to need "refinement" in their level of behavioral risk, including both youth that are usually avoiding self-harm or self-endangerment, and those that have a risk staus that is inconsistent or concerning. There were no youth with poor or adverse levels of behavioral risk to themselves.

Risk to others. The subindictor of behavioral risk toward others was favorable for 75% of the youth in the sample.

Twelve youth or 50% had "good" or "optimal" levels 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.

Assuring risk assessment and strategies to minimize behavioral risk should be enhanced among teams working with youth in Central Massachusetts.
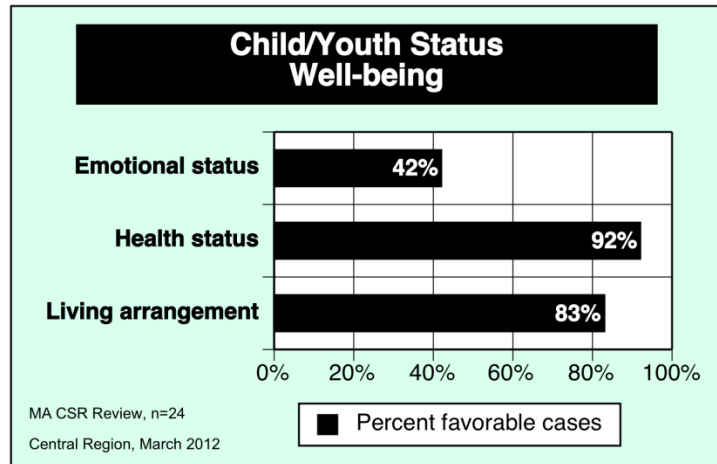
Emotional and Behavioral Well-being

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 42% youth reviewed in the Central Massachusetts CSR, clearly indicating that teams need to improve interventions and strategies to help youth achieve better emotional and behavioral status. These results indicate a large number of youth with inconsistent or poor emotional development, adjustment problems, emotional/adaptive distress, or serious behavioral problems present. Among the youth reviewed, there was only one (4%) with a "good" level of emotional/behavioral status. Eighty-three percent (83%) or 20 youth were found to need "refinement" and were functioning at a fair to marginal emotional/behavioral well-being status. These youth were demonstrating a minimally/temporarily adequate or a limited/inconsistent level of emotional status, and were doing marginally well emotionally or behaviorally. Three youth (13%) had a poor or adverse level of emotional/behavioral functioning.

Support for teams in developing individualized strategies for improving youths' emotional and behavioral well-being is needed.
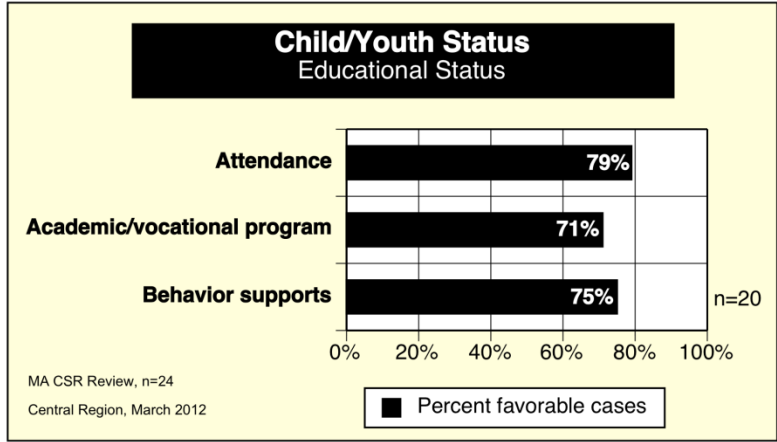
Health Status
The health of the youth was reviewed to determine whether or not they were achieving and maintaining optimal health status including basic and routine healthcare maintenance. Youth's basic needs for nutrition, hygiene, immunizations, and screening for any possible development or physical problems should be met.

For the youth in the sample, 92% had favorable health/physical well-being status. Seventeen (71%) had "good" or "optimal" health status, and six youth or 25% needed "refinement" in their health status. One youth (4%) had poor health that needed improvement.

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

For the youth reviewed in the Central Massachusetts CSR, 83% were found to have a favorable living arrangement. Half of the youth (50%) were in living arrangements that were "good" or "optimal," and were substantially or optimally meeting their needs. Eleven youth (46%) needed "refinement" with living arrangements that were fair to marginal, and one (4%) was residing in a poor living arrangement that needed improvement.

Child/Youth Status
Educational Status

	Percent favorable cases
Attendance	79%
Academic/vocational program	71%
Behavior supports	75% n=20

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

MA CSR Review, n=24
Central Region, March 2012

■ Percent favorable cases

Educational Status

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

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

Attendance. Seventy-nine percent (79%) of youth in the sample had a favorable pattern of attendance. Sixteen youth or 66% had attendance patterns that were "good" to "optimal." Three youth (13%), all with acceptable attendance status, needed "refinement." Five youth or 21% of the sample had unacceptable school attendance, with poor or adverse and worsening status.

Academic or vocational program. Only 71% or the youth were doing favorably well in their educational program. Nine youth (38%) had "good" or "optimal" academic or vocational status Eleven youth or 46% needed refinements and had minimally adequate, to marginally inadequate academic/vocational status. The remaining four youth (17%) were doing poorly or adversely in their educational program, and had status that needed improvement.

Behavioral supports. Twenty of the youth in the sample required behavioral supports in their school setting. Behavioral supports were working favorably well for 75% of them. Eight (40%) had an "optimal" or "good" level of supports. Nine youth (38%) would benefit from refinements in their level of supports, and had minimally adequate to marginally inadequate supports for their behaviors. The remaining three youth (15%) had poor or adverse behavioral support they were not benefitting from, or were harmful to their well-being.

Educational status across the domains measured was a concern for a high percentage of the youth reviewed, and youth would benefit from stronger supports in the educational setting.

Overall Youth Status

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

Overall, only 71% or 17 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 (29% or 7 youth). No youth were found to have overall Optimal status.

The remaining 7 youth (30%) had unfavorable status. They all had Marginal status (13% or 3 youth) or Poor Status (17% or 4 youth). There were no youth with overall Adverse status.
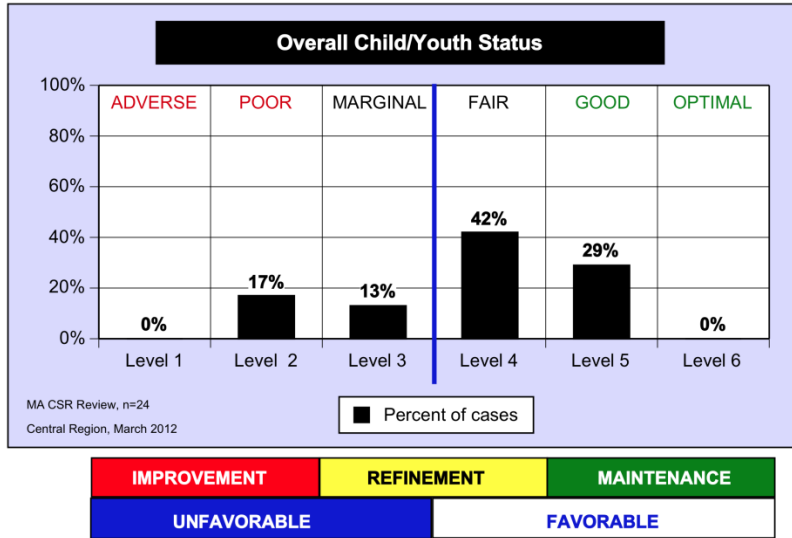
Overall Youth Status results are also categorized as needing Improvement, Refinement, or Maintenance. This allows for identification of youth that may need focused attention. There were four youth (17%) with status in the Improvement area, and their status was problematic or risky. Thirteen or 55% of 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 seven youth (29%) 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 Central Massachusetts. Stability in both home and school settings was a concern for a number of youth reviewed. As well, youth patterns of attendance, academic performance and behavioral supports in school were areas of concern. However, they were safe in their homes, schools and communities. Youth also had generally favorable health status, living arrangements and permanency. Behavioral risk toward self and others was an area of concern for many, and emotional status was unfavorable for nearly 60% of those reviewed. More attention by teams in understanding and building effective supports and treatments for improving youths' home and school stability and emotional well-being is warranted.
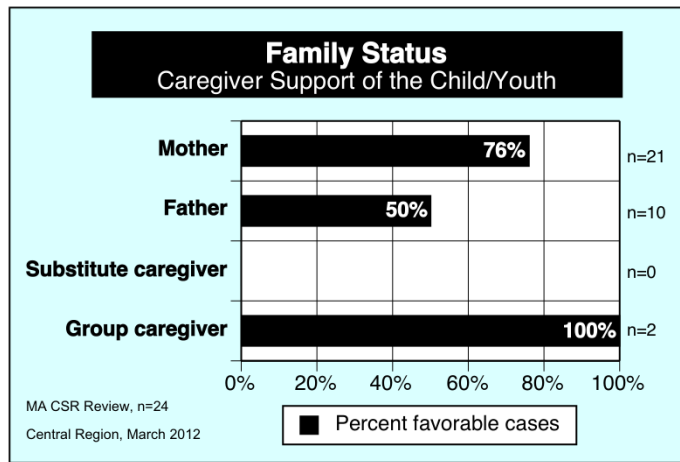
Caregiver/Family Status
(Measures the status of caregivers over the last 30 days)

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

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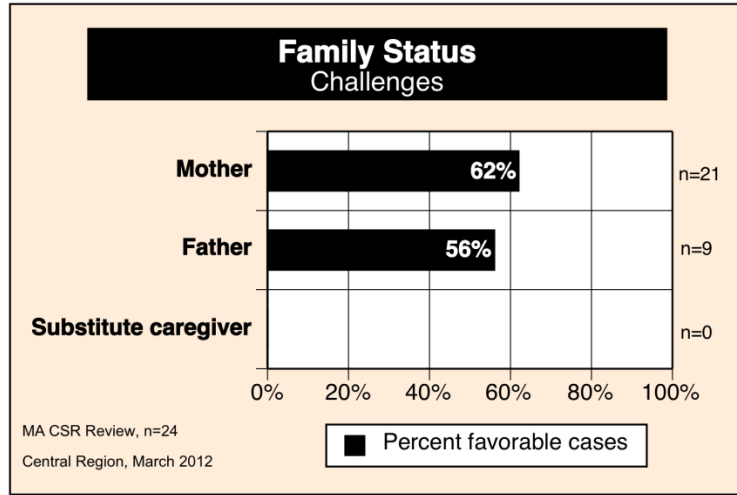
Overall Caregiver/Family Status

Family Status
Caregiver Support of the Child/Youth

Mother 76% n=21
Father 50% n=10
Substitute caregiver n=0
Group caregiver 100% n=2

MA CSR Review, n=24
Central Region, March 2012

■ Percent favorable cases

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 Central Massachusetts CSR, favorable support by mothers was found 76% of the time for which the indicator was applicable (21 youth). Maternal support needed "refinement" or "improvement" for 10 youth (24%), including one with substantial and continuing problems with caregiving adequacy. The measure for support from fathers was applicable for 10 youth in the sample, and favorable support for youth was found for half (50%) of the fathers. Support from fathers needed "refinement" or "improvement" for 50% of the youth the indicator was applicable for including one father with substantial and

continuing problems of caregiving adequacy. Support was favorable for the two youth in group care (100%).

Family Status
Challenges

Mother	62% n=21
Father	56% n=9
Substitute caregiver	n=0

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

MA CSR Review, n=24

Central Region, March 2012

■ Percent favorable cases

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 21 mothers of youth reviewed in the CSR for which this indicator could be rated. Of these, 62% had favorable status related to the level of challenge they were experiencing. Seventeen or 81% of the mothers had a level of challenge that needed to be "refined." One mother or 5% had major challenges and there were inadequate or missing supports.

Fifty-six percent (56%) of the 9 fathers of youth reviewed had a favorable level of challenge. Eight or 89% were experiencing levels of challenge that could benefit from "refinement" or "improvement" ranging from minor limitations with adequate supports to major life challenges with inadequate or missing supports.

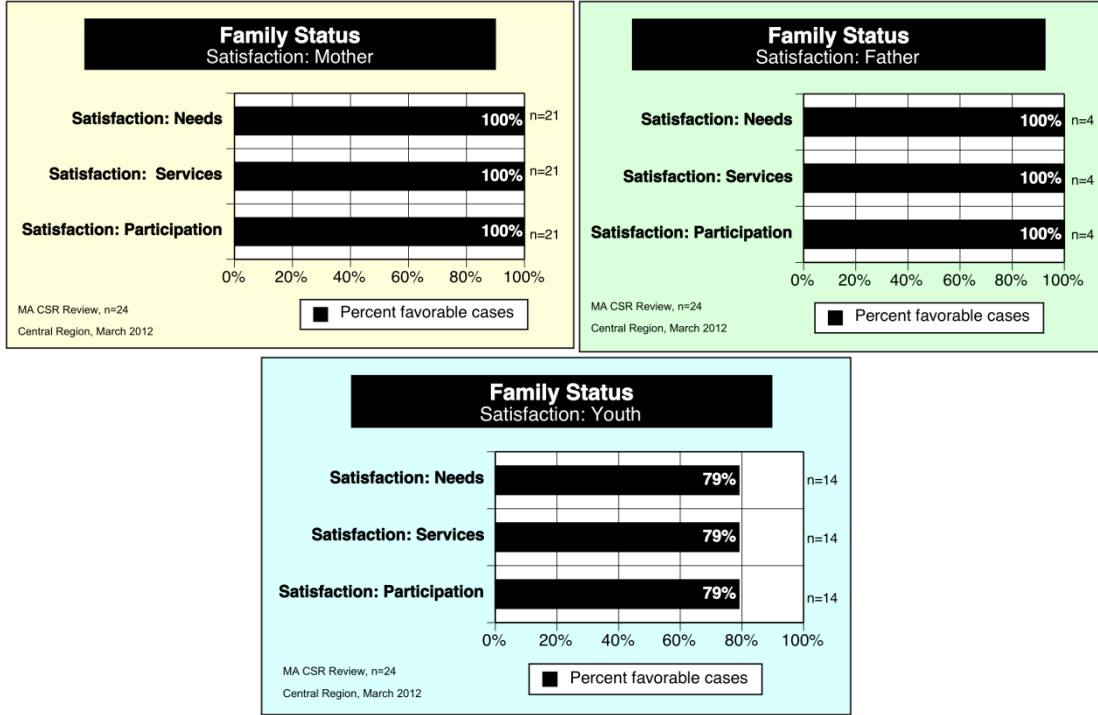There were no youth with a substitute caregiver in the sample.
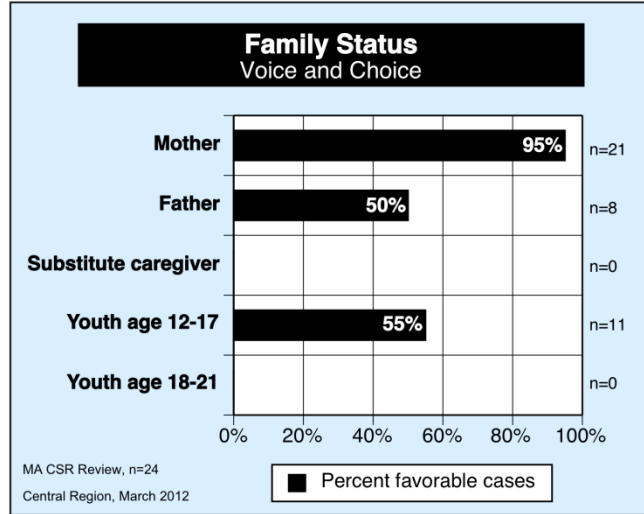
Family Voice and Choice

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.

For the 21 mothers for which the indicator could be rated, 95% were experiencing favorable voice and choice in their child's assessments, planning and service delivery processes. Sixteen mothers (76%) had "good" to "optimal" voice and choice. Five mothers (24%) would benefit from refinement in strengthening their voice and choice.

For youth whose fathers were involved and information could be gathered (N=8), 50% had favorable voice and choice in involvement with their child's service processes indicating a need for strengthening of fathers' voice and choice in planning and service delivery processes. Five of the fathers, or 50%, could benefit from "refinement" in the influence of their voice and choice in planning and service delivery. Three fathers (38%) fell in the range of needing improvement as voice and choice was substantially inadequate.

There were eleven youth in the 12-17 age range in the sample and only 55% of them had favorable voice and choice in their services. Three had "good" or "optimal" voice and choice that should be maintained, and the remaining eight had "fair" or "marginal" voice and choice that needed refinement.

Family Status
Satisfaction: Mother

Satisfaction: Needs	100% n=21
Satisfaction: Services	100% n=21
Satisfaction: Participation	100% n=21

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

MA CSR Review, n=24
Central Region, March 2012

■ Percent favorable cases

Family Status
Satisfaction: Father

Satisfaction: Needs	100% n=4
Satisfaction: Services	100% n=4
Satisfaction: Participation	100% n=4

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

MA CSR Review, n=24
Central Region, March 2012

■ Percent favorable cases

Family Status
Satisfaction: Youth

Satisfaction: Needs	79% n=14
Satisfaction: Services	79% n=14
Satisfaction: Participation	79% n=14

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

MA CSR Review, n=24
Central Region, March 2012

■ Percent favorable cases

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 and fathers were 100% satisfied with their needs being understood, their level of participation, and with services. For the fourteen youth that satisfaction was measured for, satisfaction was 79% for all domains measured.

Summary: Caregiver/Family Status

Fathers in the Central Massachusetts CSR were found to have fairly high levels of challenge in their lives; mothers also experienced challenges but at a lesser level. Support for youth in group caregiving was positive. Support for youth was negatively impacted for both mothers and fathers. Family voice and choice was strong for mothers, but weak for fathers and youth. Satisfaction was strong among mothers and fathers, but less strong for youth.

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

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

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

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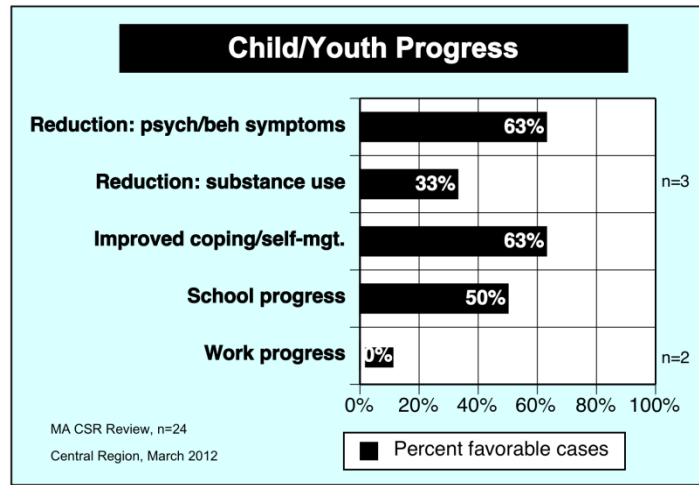
Reduction of Psychiatric Symptoms and/or Substance Use
This set of indicators measure the degrees to which target symptoms, problem behaviors and/or substance use patterns causing impairment have been reduced.

Reduction of Psychiatric Symptoms. Only sixty-three percent (63%) of the youth reviewed made favorable progress in reducing symptomatology and/or problem behaviors over the six month period previous to the CSR. Four youth, or 17% of the sample made "good" progress at a level somewhat above expectation. Sixteen youth or 67% of the sample could benefit from "refinement" in their level and rate of progress in reducing symptoms, and were making marginal to fair progress. Four youth (17%) need "improvement" and were making poor progress in reducing symptoms and/or problem behaviors.

Reduction of substance use. There were three youth in the sample with substance abuse issues and only 33% were making favorable rates of progress. One was making favorable progress at a "good" level and rate. Two youth were making poor to adverse rates of progress in reducing substance use, and needed "improvement."

These results indicate focused support for teams is needed to help youth progress in reducing psychiatric/behavioral issues and substance use.

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

Among the youth reviewed, only 63% or 15 youth were making favorable progress in improving their coping skills and ability to self-manage their emotions and behaviors. Four youth (17%) made "good" progress in improving their ability to cope and manage their own behaviors. Sixteen youth (67%) needed "refinement" and had made fair to marginally inadequate progress. The remaining four youth (17%) were making poor progress in improving coping and self-management, and needed "improvement."

School or Work Progress
Being able to succeed in the school or work setting for youth with SED is often dependent on their ability to make progress academically and behaviorally during the school/work day. This indicator looks at the degree of progress the youth is making consistent with age and ability in her/his assigned academic, vocational curriculum or work situation.

School progress. For the youth reviewed, only 50% were making favorable progress in their educational programs, a concerning finding. Nine youth or 38% were making "good" or "optimal" progress in school reflecting consistent rates and levels of progress. Eight youth (33%) were determined to need "refinement" and all were making fair to marginal progress. The remaining seven youth (29%) were progressing at poor to adverse (regressing) rates, and needed concerted improvements.

Work progress. Two youth in the sample were working, and neither (0%) were making favorable progress in satisfying expectations of employment. Both were progressing at a poor level.
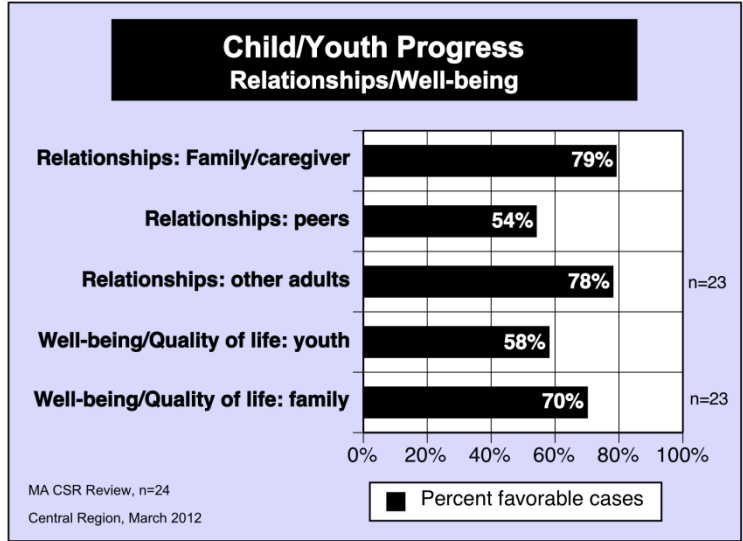
Progress Toward Meaningful Relationships

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

For the youth reviewed, 19 or 79% were making progress in their relationships with their families or caregivers. Progress in building peer relationships was far less favorable, with only 54% or 13 youth making progress in building meaningful relationships with peers. Progress in developing relationships with positive adults (teachers, coaches, etc.) applied to 23 of the youth reviewed, and was favorable for 78%.

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 58% were making favorable progress in an improved overall well-being and quality of life. Six youth, or 25% had made "good" progress over the last six months in developing and using personal strengths, long-term relationships, life skills, and future plans. Thirteen youth or 54% 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. Five youth (21%) needed improvement, and were making poor progress in their overall quality of life and had developed few to no long-term supportive relationships, life skills for problem solving, educational/work opportunities, or meaningful and achievable future plans.

Family overall well-being and quality of life. For the families and caregivers (N=23) of the youth, 16 or 70% were making favorable progress in improving the overall quality of life. Among these were five families (22%) who had made "good" progress, and seventeen (74%) needing "refinement," and one (4%) that needed "improvement."

These results indicate that improving the overall well-being and quality of life for youth and families should be a greater focus of teams.
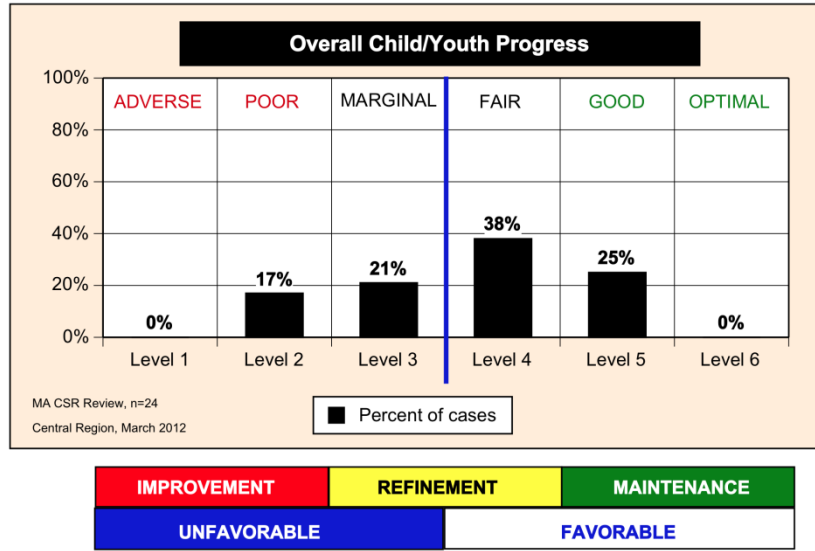
Overall Youth Progress
A goal of care planning is to coordinate strategies and identify all needed treatments or supports youth need to make progress in key areas of their lives. Overall, only 63% of the youth were making favorable progress (Fair, Good or Optimal Progress).

Among the youth, 17% were determined to need improvement due to poor progress across the indicators. No youth were making overall adverse progress, or were regressing. Fifty-nine percent (59%) 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 25% 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 youth reviewed in Central Massachusetts were making overall weak progress in key life areas. Of particular concern was weak progress for youth in reducing symptoms, problem behaviors and substance use, and improving coping and self-management skills. As well, only half of the youth were making progress in school, and no youth were making progress in succeeding in employment. Youth were making weak progress in their peer relations and in their overall well-being and quality of life. Youth were making fair progress in improved family relationships, and relationships with other adults.

System/Practice Functions

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

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

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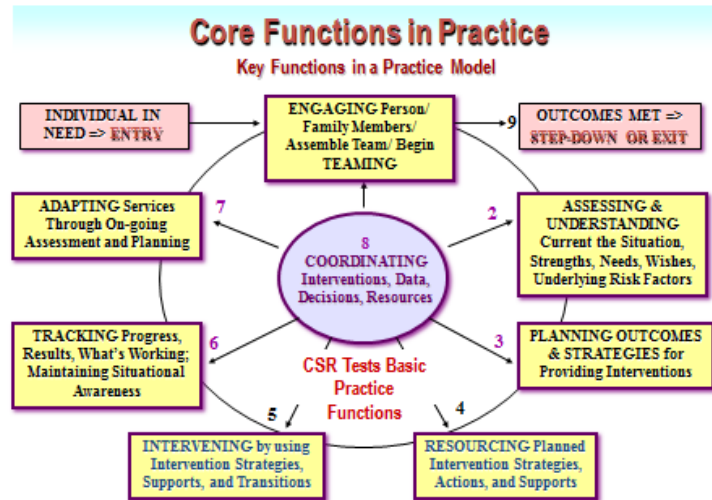
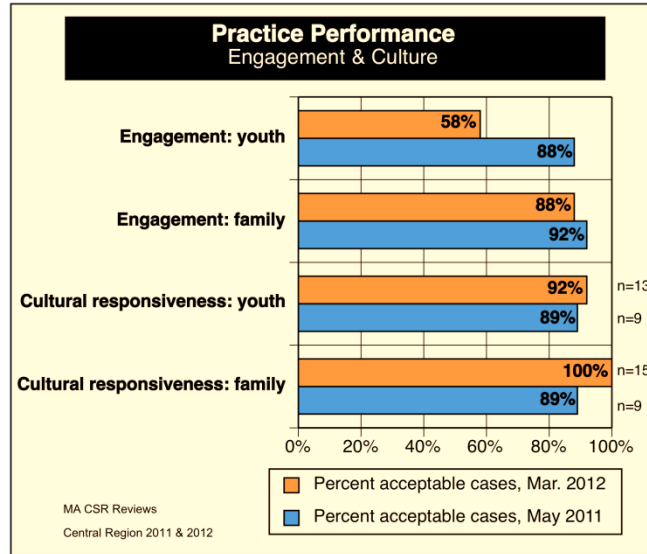*Overall System/Practice Performance*

Reviewing System and Practice Performance in the CSR

The Commonwealth of Massachusetts is charged with creating the conditions that should lead to improvements for youth and families. 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:

Practice Performance
Engagement & Culture

(Chart data)

- Engagement: youth — 58% (Percent acceptable cases, Mar. 2012); 88% (Percent acceptable cases, May 2011)
- Engagement: family — 88% (Percent acceptable cases, Mar. 2012); 92% (Percent acceptable cases, May 2011)
- Cultural responsiveness: youth — 92% (Mar. 2012) n=13; 89% (May 2011) n=9
- Cultural responsiveness: family — 100% (Mar. 2012) n=15; 89% (May 2011) n=9

MA CSR Reviews
Central Region 2011 & 2012

Legend:
- Percent acceptable cases, Mar. 2012
- Percent acceptable cases, May 2011

Engagement

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

Youth engagement. For the youth reviewed, 15 or 58% experienced an acceptable level of engagement. This was a decline since last year's CSR result when 88% where found to have acceptable Youth Engagement. In this year's CSR, five or 21% of youth were engaged at the "good" level. Thirteen youth or 54% would benefit from "refinement" of engagement efforts, and their engagement was fair to marginally inadequate. Two youth (8%) experienced poor engagement efforts.

Family engagement. Families were engaged at an acceptable level 88% of the time, which was in the range, but a slight decline since the previous CSR. This year, fifteen families or 62% were engaged at a "good" or "optimal" level. Nine families or 38% of those reviewed would have benefitted from "refinement" in engagement efforts.
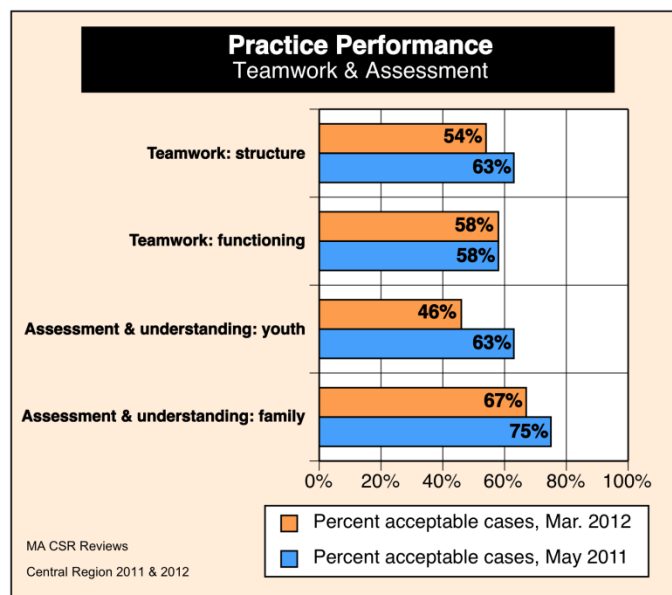
Cultural Responsiveness

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 13 youth reviewed for which the indicator applied, Cultural Responsiveness was acceptable for 92%, which was in the range but a slight improvement since the last CSR.

Cultural Responsiveness in this year's CSR was found to be "optimal or "good" for 7 youth or 54%. The remaining 6 youth (46%) would benefit from "refinement."

Cultural responsiveness to families. For the 15 families the indicator was applicable for, cultural responsiveness was acceptable for all (100%) This was an improvement over the previous CSR result when 89% of families experienced acceptable cultural responsiveness. "Refinement" this year was needed for 6 families or 40% of the families that received acceptable, but minimally adequate engagement efforts.

Practice Performance
Teamwork & Assessment

	Percent acceptable cases, Mar. 2012	Percent acceptable cases, May 2011
Teamwork: structure	54%	63%
Teamwork: functioning	58%	58%
Assessment & understanding: youth	46%	63%
Assessment & understanding: family	67%	75%

MA CSR Reviews
Central Region 2011 & 2012

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 meaningful care coordination and collaboration with a consistent focus on continuous learning, problem-solving, and adaptation of interventions and strategies.

Team Formation. For the youth reviewed in Central Massachusetts, team formation was acceptable for only 13 youth or 54%. This was extremely weak performance, and in the range but a decline since the previous CSR's performance of 63% of youth with acceptable team formation.

In this year's CSR, 8 youth or 33% of the sample experienced "good" or "optimal" team formation. Eleven teams (46%) needed "refinement" in their ability to form. In these cases, team formation was minimally adequate to fair, or marginally inadequate. Five youth (21%) experienced team formation that was either poor or absent/adverse with no evidence of a functional team.

Team Functioning. Teams were functioning acceptably well for only 58% of the youth reviewed, the same result as last year.

For 7 youth in the March 2012 CSR (27%), 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. Six youth (25%) had no evidence of a functional team, or actions and decisions made by people were inappropriate or adverse to the youth and family,

An example of team formation and functioning for a youth that was found to be acceptable but in need of refinement is, "The current ICC/FP team seems to have been very successful in engaging both (the youth and) mother. This is a marked improvement from the first time that the family received ICC. The mother reported being 'very happy' with everyone, although it appeared she had difficulty understanding the construct of 'satisfaction with services." The team has a strong understanding of the…cultural influences on the family system, and concurs on how to address them, particularly regarding (the youth's) mother. The team appears to include all relevant stakeholders in (the youth's) life, and has a shared understanding of most of the needs of the youth and the family, primarily in the areas of housing and the mother's capacity for self-efficacy and appropriate parenting."

An example where the lack of formation of a team is resulting in unaddressed issues is: "The ICC has tried to provide help and has a strong relationship with mother but there is clearly no established team working on goals and objectives outlined in the care plan and resources have been grossly inadequate to meet the significant needs of this family. The family has been on a waiting list for an in home therapist… (The youth) has been struggling at school all year and has yet to have an IEP. There has also been an inordinate delay in getting a medication evaluation for this youth. What has not worked is the development of a functional, active and focused team with a good understanding of (the youth and) family and providing services, supports based on a common set of goals and actions to support (the youth's) school attendance and success as well as his emotional and social development. He is at risk for continued school disengagement, poor social adaptation, poor emotional and self development, family conflict, and potentially family disruption and continued out of home placement….(The) FP never knew that the IHT had started and was involved with the

family. The school reported that they had limited contact with the services and had not been at a team meeting, and had no formal role in the support and plan for (the youth) as a team member. It was reported that DCF was hard to reach and had not implemented their service plan with the family. There was a limited working relationship with the probation officer. "

The ability of Care Planning Teams to form and work together for youth and families is foundational Rosie D. requirement. Teams in Central Massachusetts are neither forming nor functioning at a consistent or reliable enough level so that youth and families can depend on them to plan, communicate and work together.

Assessment and Understanding

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

Assessment & Understanding of Youth. Only 46% of teams were found to have an acceptable level of assessment and understanding of the youths' core issues and situations. This result demonstrates performance far below what is needed for forming adequate plans and services for youth. This was also a decline since the last CSR when 63% of youth had acceptable assessment and team understanding of their situations, underlying issues and needs. Assessment and understanding of youth clearly needs improvement.

In this year's CSR, 7 youth (29%) had teams that had "good" or "optimal" assessment and understanding. Eleven youth (46%) were found to need "refinement" of practices, and assessment and understanding was either fair or marginally inadequate. Nine percent (25%) had teams that had poor/incomplete/inconsistent assessment and understanding, or absent/incorrect/adverse assessment and understanding.

Assessment & Understanding of Families. Assessment and understanding of families was acceptable for 68% of the sample. This was a decline since the last CSR's results of 75% of teams having acceptable assessment and understanding of families' strengths and needs, but continues to be an area that needs improvement.

In this year's CSR, nine teams (38%) had "good" or "optimal" understanding of the families reviewed. "Refinement" was needed for twelve families (50%) where there was fair/minimal understanding, or marginally inadequate assessment and understanding. For these families, teams needed to better understand the strengths, context, needs and vision of the family. For three families (13%) the team's understanding was poor, incomplete and inconsistent among team members, or teams had absent, incorrect or adverse assessment and understanding of the family.

An example of good assessment and understanding of a youth resulting in progress is: "The youth's natural support system has a full understanding of (his/her) needs, triggers, safety issues, and positive behavioral interventions. As a result, (the youth) continues to make improvements in (his/her) ability to manage behavioral and communication challenges in the home and (to a lesser degree) community settings and make academic progress."

An example of assessment and understanding that needs improvement in order to help a youth and family with complex issues is: "The major missing piece is a good assessment and understanding of (the youth and) family. (The youth) is scheduled for a full psychological work-up in April that should help the team and (parent) plan for (the youth's) needs. Right now they are not well understood at home, at school, or by the team. The team would benefit from making an extra effort to understand (the parent)."

Another example illustrates a need for a common understanding across team members: "(The youth) has a history of severe emotional and behavioral difficulties. It does not appear, however, that DCF, the ICC or other team members have an understanding of (the youth's) trauma and the connection to (his/her) behavior and distress. Several individuals interviewed assigned diagnoses to (the youth) as a matter of fact but those comments were made without assessment or consensus…The complete lack of understanding of (the youth's) trauma and the drivers of (the youth's) behavior resulted in a placement that was severely underpowered to meet (the youth's) needs. "
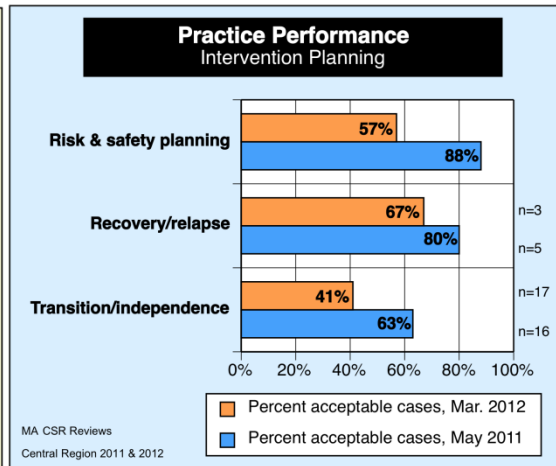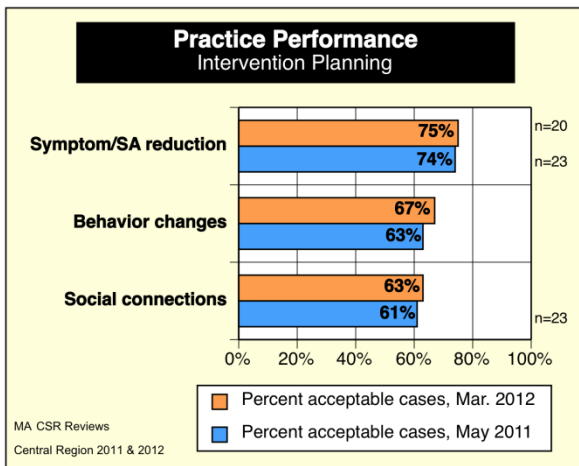
Planning Interventions

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

to evolve as the youth and family's situation changes or more or different information is learned.

Symptom or Substance Abuse Reduction. Planning for reducing presenting psychiatric symptoms or substance abuse was applicable to 20 youth and acceptable for 75% of them. This was comparable the last CSR's results of 74% of youth with acceptable planning for symptom reduction, but continues to be an area of practice the needs more focus.

There was "good" planning in reducing symptoms or substance abuse for five or 25% of the youth reviewed. Planning for these youth was generally well-reasoned, informed by the youths' and families' perspectives, and addressed core issues. "Refinement" in planning to reduce symptoms or substance abuse was needed for thirteen or 65%. In these cases planning was fair to marginally inadequate. Planning to reduce psychiatric symptoms was found to be poor for two youth or 10% of those reviewed, with poorly reasoned and inadequate planning that failed to provide interventions to address youth's symptoms.

Behavior Changes. Targeting *Behavior Changes* in planning was acceptable level for only 67% of the youth. This was in the range, but a slight improvement over last year's performance of 63% of youth with acceptable planning to address behavioral change. Focused work to improve planning in this domain is warranted.

In the March 2012 CSR, six youth or 25% had plans that addressed needed behavior changes that were in the "good" range. "Refinement" of behavioral supports and interventions in plans was needed for fifteen or 63% of the youth. Planning for these youth was fair and somewhat reasoned, to marginally inadequate and inconsistently aligned across interveners. Three youth or 13% of those reviewed experienced a poorly reasoned inadequate plan that failed to design interventions to address behavior changes.

Social Connections. Planning for increasing *Social Connections* was acceptable for only 63% of the youth reviewed. This was comparable to the last CSR's result of 61%, and improvement continues to be needed to assure teams more consistently plan to strengthen youths' social connections.

Seven youth (29%) had "good" or "optimal" planning strategies for improving their social connections that reflected generally well-reasoned supports. "Refinement" in planning to strengthen social connections for youth was needed for fourteen youth or 58% of the sample. Three youth (13%) had poor or absent planning reflecting unaligned strategies lacking in the clarity and urgency necessary to address the youths' need for social connections, or no planning process was evident.

Risk/Safety Planning. Planning to address youths' risk and safety issues was applicable for 21 youth and acceptable for twelve or only 57%. This was a marked decline from last year's CSR performance of 88% of youth with acceptable risk and safety plans. This is clearly an area that has diminished in performance and needs attention.

The risk/safety component of plans was "good" for seven youth or 33% of the youth. For nine youth (43%), risk and safety planning needed refinement and was fair or marginally inadequate. For the remaining five youth (24%), risk and safety planning was poor or absent.

Recovery/Relapse Planning. Three youth in the sample needed *Recovery or Relapse* addressed in their care plan, and planning was acceptable for two or 67%. In the last CSR five youth needed planning in this domain, and planning was acceptable for 80%. In the March 2012

CSR, one youth had good planning, one fair planning, and one had no operative plan. Results indicate that better planning to address recovery and relapse supports for youth are needed.

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

Among youth in this year's CSR sample seventeen needed to have a transition addressed in their planning processes, and performance was acceptable for only seven youth or 41%, indicating much improvement is needed in transition planning for youth. This was a decline over last year's performance when 63% of youth had acceptable transition planning.

Transition planning was "good" for three of the youth or 18%, with plans that were generally well-reasoned, largely informed by the youths' and families' perspectives, and accountable. Seven of the youth (41%) would benefit from refinement in 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 or 41% of those reviewed had poor transition planning that was inadequate, with no sense of clarity or urgency to achieve successful transitions, or had no transition planning in place to address imminent changes.
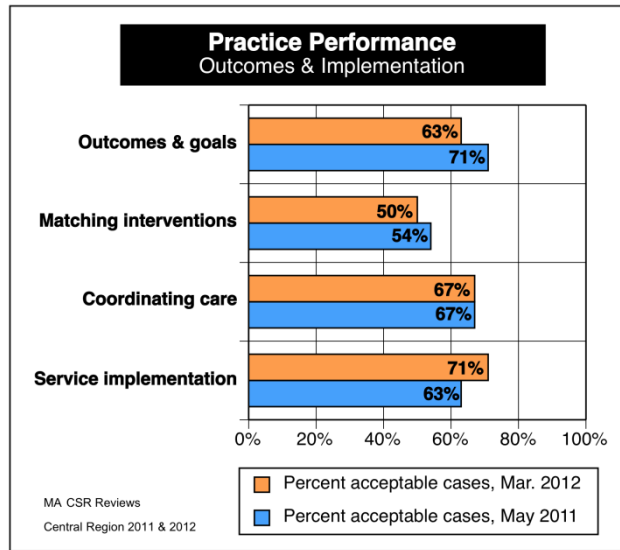
Outcomes and Goals

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 63% of the sample. This was decline since the previous CSR results when 71% of youth had acceptable specification of outcomes and goals by teams. Assuring teams can define clear outcomes and goals to guide

Six youth or 25% had good specification of goals by their teams that were well-reasoned and specific and were considered to be "good." Fifteen youth or 63% of those reviewed had ending goals and outcomes that needed to be "refined," and were fair to marginally inadequate. Three youth (13%) had poor or absent specification of outcomes and goals which was insufficient to guide intervention and change.

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

There was an acceptable level of matching intervention to need for only half (50%) of the youth in the sample. This was comparable to the last CSR when 54% of the sample had acceptable results, showing that no improvement has been made in this foundational practice. These findings indicate that only half of youth are receiving interventions that meet their needs.

Nine youth (41%) had "good" matching of interventions to needs, meaning necessary supports and services are generally assembled in a workable fit with what the youth and family needs to progress. Nine youth or 38% needed their teams to "refine" identification and assembly of services and supports that matched the youth and families' situations and needs. For these youth there was fair matching and integration that could meet short-term objectives, or marginal matching that was insufficient. Six youth or 25% had poor matching of interventions to needs with supports and services that were poorly or adversely assembled and were inadequate in meeting identified needs.

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

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

Youth in the sample received care coordination services from both ICC (N=16) and IHT therapists (N=8). Care coordination practices were found to be at an acceptable level for only 67% of the youth reviewed, the same result as the last CSR.

Care coordination in the March 2012 review was found to be "good" or "optimal" for seven youth or 41% of the sample. For thirteen youth or 54%, care coordination needed "refinement," and practices were fair and minimally adequate, or marginal and limited with little leadership for service delivery and results. Four youth (17%) had poor and fragmented care coordination that was substantially inadequate.

Care coordination practices that were working well are described in this example as: "There is a strong well-coordinated and comprehensive team assembled for this family. The ICC has done a solid job of planning and updating the many team members who are actively collaborating to meet the challenges of this family. There is a solid understanding of the needs and strengths of this family and what must change for the youth and family to function more effectively. There is a broad array of services and providers working in concert to enable this youth and family to grow and achieve a higher level of functioning. The ICC has done an exemplary job of organizing care plan team meetings and keeping all members informed as to progress and next steps and objectives."

An example of care coordination that needed improvement is: "The ICC has tried to provide help and has a strong relationship with mother but there is clearly no established team working on goals and objectives outlined in the care plan and resources have been grossly inadequate to meet the significant needs of this family. The family has been on a waiting list for an in home therapist and one has been identified and is scheduled to begin."
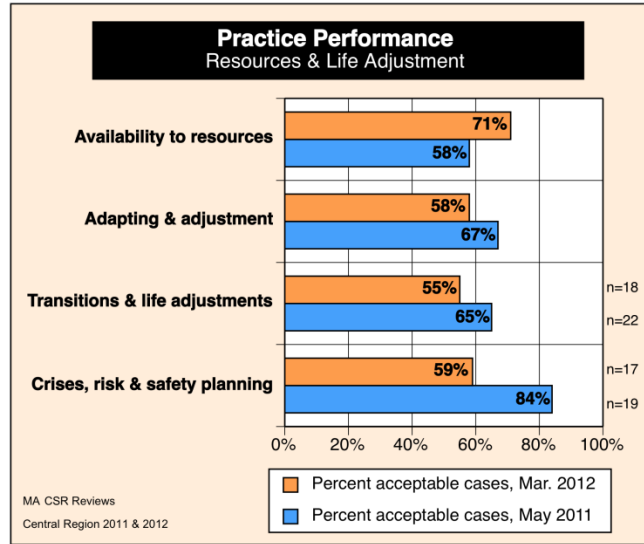
Service Implementation
The Service Implementation indicator measures the degree to which intervention services, strategies, techniques, and supports as specified in the youth's Individualized Care Plan (ICP) are implemented at the level of intensity and consistency needed to achieve desired results. 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, 71% were determined to have acceptable service implementation. This is an improvement over the previous CSR result of 63% acceptable, but indicates continued work needs to occur to assure services and supports in care plans are consistently implemented.

Nine youth or 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 thirteen or 54%, service implementation needed "refinement" and the overall pattern of implementing needed services and supports was fair to marginal and

inconsistent. Two youth or 8% had poor implementation with few services being implemented at inadequate levels of necessary intensity, or no services were implemented.

Practice Performance
Resources & Life Adjustment

- Availability to resources: 71% (Mar. 2012), 58% (May 2011)
- Adapting & adjustment: 58% (Mar. 2012), 67% (May 2011) — n=18
- Transitions & life adjustments: 55% (Mar. 2012), 65% (May 2011) — n=22, n=17
- Crises, risk & safety planning: 59% (Mar. 2012), 84% (May 2011) — n=19

Percent acceptable cases, Mar. 2012
Percent acceptable cases, May 2011

MA CSR Reviews
Central Region 2011 & 2012

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 over the last 90 days.

Seventy-one percent (71%) of the youth reviewed were found to have acceptable access, an improvement over the previous CSR performance of 58%, but a result that indicates that a substantial proportion of youth continue to have difficulty accessing the services they need.

Only four youth or 16% had "good" access to needed resources. Sixteen youth or 67% had fair to marginally inadequate resource availability that indicated refinement was needed. Four youth or 16% had poor availability and access, with a limited array that was generally inaccessible, or absent resources, with few if any need resources available.

Adapting and Adjustment

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

For the youth reviewed, practices related to adapting and adjusting plans and services was acceptable for only 58%. This was decline since the last CSR results when 67% of youth experienced acceptable practices in adapting and adjusting. Performance on this fundamental practice indicates a substantial number of teams are not making necessary adjustments to services and supports youth that youth need to progress.

Eleven youth or 46% had "good" practices that were responsive to changing conditions with acceptable levels of monitoring and adjustment. Nine youth (38%) were experiencing needed changes to their plans and services at a minimally adequate to marginally inadequate level, with only periodic to occasional monitoring. Four youth (17%) had a fragmented or shallow adapting and adjustment process that was not responsive to changing conditions, or there was an absent or misdirected adapting and adjustment process.

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 twenty-two youth the indicator applied to, only 55% had acceptable transition management practices. This was a decline in performance compared to last year when only 65% of youth received acceptable transition management. Transition management continues to be a very weak system practice that needs improvement.

In the most recent CSR, five youth (21%) experienced "good" transition interventions. Eleven youth (46%) could benefit from "refined" transition supports, and had minimally adequate to marginally inadequate transitional interventions. For the remaining six youth (25%) transitions had not been addressed, or were adversely managed.

Results indicate concerted improvements are needed in practices to identify, plan for and implement transition supports for youth.

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=17), only 59% had an acceptable crisis response. This represented a considerable decline in performance since the last CSR findings when 84% youth had acceptable findings on this indicator.

Seven of the youth (41%) were rated to have received a "good" management of their crises and/or safety issues. Six youth (35%) needed "refinement" in the response to their crises and risk/safety issues and experienced fair to marginally inadequate crisis responses. Four youth (24%) experienced poor or absent/adverse responses to their crises.

Because of the critical importance of adequate crisis response for youth, and the weak performance of the service system on this indicator, development of strategies to improve crisis response are warranted.
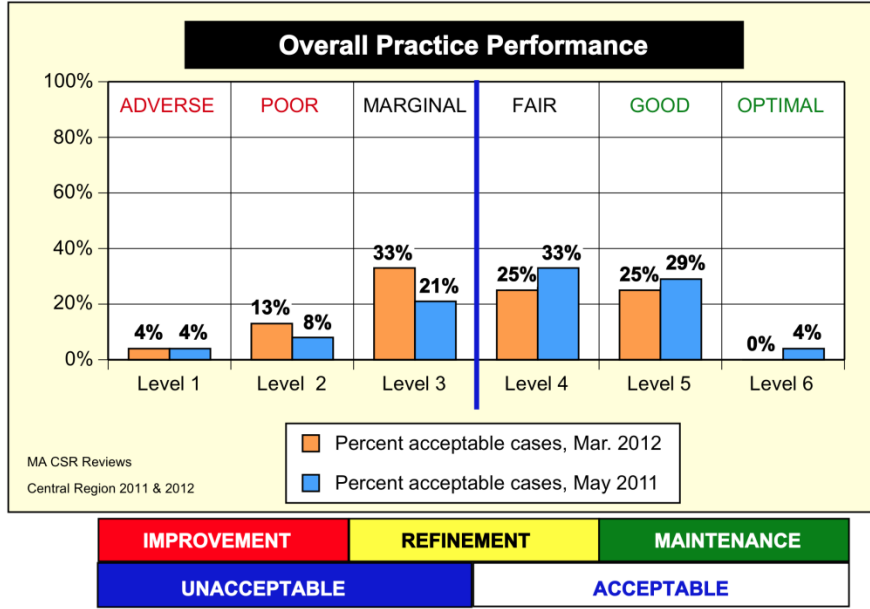
Overall System/Practice Performance

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

For the 24 youth reviewed in the March 2012 CSR for Central Massachusetts, only 50% of youth were found to have acceptable system/practice performance. For the remaining 50% of youth, the system was not providing dependable, quality services. These findings represent a decline in overall performance as compared to the previous CSR when only 66% of the sample had 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.

Twenty-five percent (25%) of the youth fell in the "Maintenance" area, meaning that system and practices were effective for the youth reviewed, and efforts should focus on sustaining and building upon positive practice. No youth were found to have "optimal" system practices.

Practice for more youth fell in the "Refinement" area and fewer in the "Maintenance" area than in the May 2011 CSR. In that CSR, 34% of youth had performance that needed to be maintained, and 54% that needed to be refined.

Seventeen percent (17%) of youth fell in the "Improvement" area and performance for them was inadequate. In these cases, practices were fragmented, inconsistent and lacking in intensity or were non-existent. Immediate action is recommended to improve practices for youth falling in this category.

The highest percentage of youth reviewed had practice patterns that were at the "Marginal" level (33%), meaning system practice was minimally or temporarily sufficient to meet temporary needs. Practice for these youth was underpowered, inconsistent or not well-matched to needs. Performance in these cases was insufficient for the youth to meet short-term objectives.

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

There were no areas of practice with overall fair performance.

Areas of system/practice performance that need improvement in order to be considered to have adequate consistency, intensity and/or quality of efforts are Planning Interventions for Symptom Reduction; Service Implementation, and Availability and Access to Resources.

The remaining system/practice domains demonstrated weak performance including Engagement with Youth; Team Formation and Team Functioning; Assessment & Understanding of Youth and Family; Planning Interventions for Behavior Changes; Planning for Social Connections; Planning Interventions for Risk and Safety; Planning Interventions for Recovery and Relapse; Planning Interventions for Transitions; Outcomes and Goals; Matching Interventions to Needs; Care Coordination; Adapting & Adjustment; Managing Transitions & Life Adjustments; and Responding to Crises.

A few system practices showed improvement over the previous CSR. Cultural responsiveness to families was strong last year, and strengthened to being acceptable for all families reviewed. Both service implementation and resource availability were weak in the last CSR; both areas improved but were found to need improvement.

The remaining system practices declined or stayed in the same range of performance as last year with the majority having weak performance. The one exception was planning for symptom reduction which had the same result as the last CSR, but continues to need improvement.

Overall practice was very weak (50%). Based on the review of youth, the system of services in Central Massachusetts has declined and continues to lack capacity to provide consistently reliable services at the quality needed to help youth make progress, achieve desired outcomes or maintain recent gains. Almost all areas of practice need concerted attention.

There are a number of areas of considerable concern about the services for youth in Central Massachusetts. Teams were not being adequately formed for 46% of youth, and 42% of teams were functioning in a limited manner, were splintered or inconsistent in their planning and evaluating results, and were not engaged in collaborative problem-solving in ways that could impact positive change for youth and families. Over half of youth (54%) and a third of families (33%) were not well-assessed or understood, a foundation for providing effective supports and services for youth and families. Further, half of youth (50%) did not have a current mental health assessment in their files. Almost all indicators of planning were found to be weak, and did not reflect effective planning processes or plans that were well-reasoned or clear in addressing youth and family strengths and needs. Planning transitions for youth was unacceptable for almost 60% of youth, and transitions were not managed well for 45%. Managing crises for youth dipped to being acceptable for only 59% of youth as compared to 84% in the previous review.

With only half of youth found to have received acceptable system performance, focused attention on the core practice functions and concerns identified in this report will be important for the Commonwealth to address in order to be considered to providing adequate services for youth in Central Massachusetts.

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: Central Massachusetts CSR (March 2012)

System/Practice Performance for youth
in the March 2012 Central Massachusetts CSR was 50%.
- This means that services were working at a dependable or consistently acceptable level
for only half of the 24 youth reviewed, which is considered to be weak performance.
- This was a decline in performance since last year's CSR result of 66% of youth
with acceptable system/practice performance.

Outcome 1

As the display indicates, 42% 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.

In last year's CSR, 58% of youth fell into Outcome 1; fewer youth fell in Outcome 1 this year.

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

> *"The team has worked well with (the youth)…(the youth and mother) were engaged in the process and with each member of the team. The team has consisted of most of the right individuals needed to facilitate change in the family dynamic. Each member of the team appeared to have an understanding of (the youth) and the mother. This understanding informed planning and practice. The IHT and the team monitored (the youth's) progress, and adjustments and changes were made to the plan as necessary. It is also clear that the team listened to (the youth and) mother and adopted the treatment goals of the family. The IHT along with the other team members has worked well with the family to implement realistic goals and employ strategies that have resulted in an overall improvement in (the youth's) and the family's functioning."*

Outcome 2

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

In the previous CSR, 8% of the sample fell in Outcome 2.

There were no clear examples in the narratives of youth who fell in Outcome 2.

Outcome 3

Seven youth or 29% of the sample were in outcome category 3. Outcome 3 reflects youth whose status was favorable at the time of the review, but who were receiving less than acceptable service system performance. Some children are resilient and may have excellent naturally occurring supports provided by family, friends, school personnel, or some other key person in their life whose efforts are significantly contributing to the child's favorable status at the present time. However, current service system/practice performance is limited, inconsistent, or inadequate at this time. For these children, when teams and interveners adequately form, understand the youth and family, and work diligently and cohesively, the youth could likely progress into the outcome 1 category. Without key practice functions occurring reasonably well, status for youth in this category is often fragile, and at risk of becoming unfavorable.

In last year's CSR, 17% of the sample fell in Outcome 3.

The following is an example of a youth in Outcome 3. This youth is stable in a residential setting after a history of many out-of-home placements.

> *"There are a few individuals involved with (the youth), but a team does not exist and there is poor communication between those individuals working with him. Because there is really no assessed understanding of (the youth), appropriate intervention planning has been lacking. This is a (youth)*

who has experienced one failed placement after another and yet the system continues to offer the same approach to (his/her) care. The providers in this case do not have common goals or projected outcomes. Coordination of care was inadequate in the situation. The ICC deferred to DCF and communication between the agencies was lacking. Service implementation was not timely or effective…The complete lack of understanding of (the youth's) trauma and the drivers of (his/her) behavior resulted in a placement that was severely underpowered to meet (his/her) needs. (The youth) saw an individual therapist five times and those contacts were too few, far between and underpowered. (The youth's) contact with a prescriber was also inconsistent…The system has failed to form a comprehensive understanding of (the youth). The system has failed to form a team by bringing the necessary people to the table to plan, resolve interagency roadblocks and develop a treatment package that is effective for frequency of service and intensity."

Outcome 4

In the Central Massachusetts CSR, 21% of the sample or 5 youth fell into outcome category 4. Outcome 4 is the least favorable outcome combination as the child's status is unfavorable and system performance is inadequate. For many of the youth who are in Outcome 4, a thorough understanding of the youth and family coupled with strong teamwork and planning interventions that meet the needs of the youth with oversight of implementation would move the youth into a better Outcome classification.

In last year's CSR 17% of the sample were in Outcome 4, which represents a decline in overall performance.

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

"Although the family has been open for 3 months a team does not exist. Up until the day prior to the review only IHT and Psychiatry Services had been implemented. Mother had been struggling for years to get help that worked for her family. (The youth) was in outpatient for two years but never engaged and mom reports the clinic would not let her (child) access another therapist. There is a significant question around assessment and understanding the underlying issues driving the problem behaviors…Crisis/Safety planning needs development. MCI has not been utilized and the police were contacted to intervene during a home visit by IHT. There needs to be a specific plan of action for when (the youth's) behavior escalates."

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 1 youth or 4%, the prediction was that the youth would maintain at a high status level (youth in the "good" or "optimal" status category). For 9 youth or 38% of the sample the prediction was for improvement in status. For 10 youth or 42% (youth with "fair, marginal, poor or adverse" status) reviewers predicted the youth's status to continue at the same level. For 4 youth or 17%, the prediction was that their status would decline.

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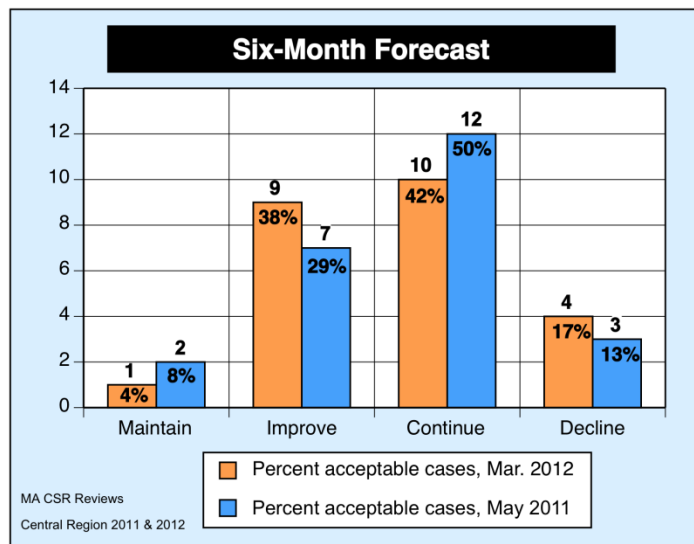
Summary of Findings

Data, Findings and Recommendations in this report reflect the CSR's examination of the consistency and quality of service provision and practices in Central 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 required to have timely access to necessary services through effective screening, assessment, coordination, treatment planning, pathways to care and mobile crisis intervention when needed. 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 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 expanded array of services and service models offered through CBHI are welcomed by families and providers.

Families and providers find value in the expanded array of CBHI services and the service-delivery models that allow teams to respond to the individualized needs of youth and families. The wrap-around model appears to be embraced by most of the agencies, and it is facilitating engagement and collaboration with families.

Many of the IHT providers like the IHT model noting that they are able to help families stabilize and youth progress more quickly than in their previous work through outpatient services. IHT is valued by many families because of its ability to provide a direct clinical service and impact changes. A number of IHT provider agencies are building their capacities to provide a range of clinical interventions including trauma-focused therapy, domestic violence interventions, addressing attachment issues, and family system treatments.

Therapeutic Mentors were noted to be an important resource for youth providing support through therapeutic relationships and communications.

Cultural responsiveness to families was strong in the last CSR, and strengthened to being acceptable to all of the families reviewed.

Cultural responsiveness, an underpinning for family engagement and understanding families, was again found to be a strong system practice among coordinators and teams in Central Massachusetts.

Challenges

Youth and families are experiencing delays in accessing necessary services and continuity of care issues and

The ability of the service system to provide timely and accessible services that are appropriately responsive to the needs of youth and families of Central Massachusetts is problematic. A number of the youth reviewed waited an extended period of time between their initial intake and receiving services. For many the wait was months long.

Delays in accessing necessary services due to waiting lists were noted for many. The average waiting time for neurological testing was noted to be at least six months. Many youth experienced delays in receiving medication evaluations. As well, crisis teams were not consistently available when needed. One reviewer described a youth and family with serious needs and waiting months for neurological testing, medication evaluation and a bi-lingual provider as, "It seems that they are on a waiting list for nearly every service that they desperately need."

For many youth coming into care with pressing needs, the urgency of response of practitioners and teams often did not match the fact that many youth have urgent needs that need immediate attention. This resulted in further decompensation for a number of youth. While many youth had well-coordinated teams, as evidenced in the data, many had non-functioning or no teams. There were multiple examples of teams meeting infrequently, or not at all. Compounding this, many schools were not engaged with teams, and a number had adversarial relationships with teams and families. Because many of the youth needed school-based supports in order to progress, this lack of engagement was problematic for many youth. Delays in educational evaluations, and the need for school-based services caused a number of youth reviewed to regress from previous gains made.

Continuity of care for a number of youth reviewed was problematic. This occurred when multiple agencies were involved, when care was outsourced by CSAs to other provider agency with little oversight or monitoring of youth progress, or when providers suddenly left agencies resulting in gaps in care.

Two systemic issues impacting continuity of care were noted by agencies. One is related to the families that fall in and out of Medicaid eligibility impacting the continuity of care for their children. This reportedly includes those that are inadvertently "dropped" from services because the eligibility data may not be current.

The other issue that was noted to impact service continuity and appropriate intensity of services is perceived challenges in securing continued authorized units from MCOs due to requests for increased information and justification for medical necessity. Agencies describe "limits" to services and feel they are constantly being asked for more and more information to provide necessary services. They describe spending an inordinate amount of administrative time justifying needs of youth. Agencies also express experiencing a lack of uniformity in authorization practices across the MCOs. These issues need to be better understood to determine if they are in fact a barrier to service continuity and access to necessary services.

The strength and quality of implementation of planning, teaming and coordination for youth was inconsistent resulting in many youth receiving inadequate care.

Review of care planning teams for youth found that many were not consistently meeting, communicating, or developing accountable strategies necessary to impact youths' progress and well-being. Goals for many youth lacked the depth needed to impact long-term changes. Schools were not engaged in many of the teams. Reviews also found that ICC communications and effectiveness across agencies was inconsistent, which impacts how well teams form and plan to address youth needs. Communicating and coordinating with outpatient services was especially a challenge for ICCs and teams. Often families did not understand the purpose of ICC or Family Partner services, and had difficulty understanding and communicating with multiple providers. Teams were observed to end services prematurely due to lack of understanding of youth and family needs, narrow view of goals, and services not implemented at the intensity needed.

As a result of weak teaming and coordination, most of the core system functions for youth with the exception of family engagement and cultural responsiveness, were found to be weak and needing improvement. Families in Central Massachusetts cannot consistently depend on services to help their children with emotional or behavioral challenges make progress.

Other challenges identified:

- Many youth would benefit from stronger and more effective collaboration with schools and special education services.

- Providers are struggling to address travel and training requirements.

- There is a need for more interpreters and providers that know the languages and cultures for the range of ethnic groups that live in Central Massachusetts.

- There is a lack of providers and services that work with sexually-aggressive youth, transition-aged youth, and youth of different cultural backgrounds.

Recommendations

Provide stronger support for care coordination practice and teaming"

- Strengthen supervision and supports for ICCs so that they can implement their roles consistently and in ways that families can understand.

- The role of the Family Partners has great potential for providing family support. However, more training and supervision is needed to assure therapeutic boundaries, promote communications with teams, and align supports with care and treatment plans.

- Assure all ICC and IHT teams have the skills needed or can access consultation to <u>understand and address</u> the needs of youth and families with complex clinical needs and life situations.

- Improve basic team functioning: Assure Care Plan Teams are scheduled regularly and the right levels of efforts are made to include team member attendance, input, improved communication and task assignments with proposed completion dates.

- Provide adequate supervision that can systematically identify when youth are not progressing, and when teams may need consultation to address youth and family needs.

Strengthen coordination with outpatient providers, schools and other community entities:

- Provide more outreach and training to state agencies and schools about CBHI services, how to make referrals, and MassHealth requirements.

System-level recommendations:

- Consider that some youth may need quicker access to direct services through ICC, and depending on the urgency of need, that services may need to be provided concurrent to the assessment and planning process.

- Assure each youth has a current comprehensive mental health assessment that informs team planning.

- Assure youth that are receiving multiple medications, off-label prescriptions and medications for behavioral control, or more than one medication for a single diagnosis are carefully monitored.

- Evaluate to assure the business model supports the infrastructure to provide effective services and promotes best practices. Balance compliance priorities with practices that will help youth and families to achieve positive results.

- Help all agencies that provide services to understand role specifications of each CBHI services.

- Design solutions to provide diverse staff that can provide services and supports for families and youth of different ethnicities and cultural backgrounds.

- Develop strategies for improving system/practice functions that are weak and need improvement with particular emphasis on :
  - ✓ team formation and functioning,
  - ✓ assessment and understanding of youth and families,
  - ✓ planning across all domains,
  - ✓ developing clear and measurable outcomes and goals,
  - ✓ matching youth and family interventions to their needs,
  - ✓ coordinating care,
  - ✓ adapting and adjusting services as needed,
  - ✓ managing and supporting youth transitions, and
  - ✓ responding effectively to crises.

Appendix 1

Child's General Level of Functioning

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

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

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

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

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

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

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

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

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

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

☐ **1** Needs constant supervision (22-hour care) due to severely aggressive or self-destructive behavior or gross impairment in reality testing, communication, cognition, affect, or personal hygiene.

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

Appendix 2

CSR Interpretative Guide for Person Status Indicator Ratings

Maintenance Zone: 5-6

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

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

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

Favorable
Range: 4-6

Refinement Zone: 3-4

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

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

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

Unfavorable
Range: 1-3

Improvement Zone: 1-2

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

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

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

CSR Interpretative Guide for Practice Performance Indicator Ratings

Maintenance Zone: 5-6

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

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

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

Acceptable Range: 4-6

Refinement Zone: 3-4

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

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

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

Improvement Zone: 1-2

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

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

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

Unacceptable Range: 1-3