

2011

# Rosie D. Community Services Review- Boston/Metro Boston Regional Report

Report of Findings of the Community Services Review  
of Boston conducted January 24-February 1, 2011

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## ***Executive Summary***

This report presents findings of the Community Services Review (CSR) conducted in the Boston/Metro Boston region in January and February 2011. The CSR is a case-based monitoring methodology that reviews how *Rosie D.* class members are doing across key indicators of status and progress as a way to determine how services and practices are being performed. Intensive reviews were conducted of forty-five 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 Boston/Metro Boston 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. At the time of the Boston/Metro Boston Community Services Review (CSR) the *Rosie D.* Remedy Services, with the exception of Crisis Stabilization services, had been in place for just over a year and a half. Since the start of the Remedial Plan, agencies have been providing the new services through a practice model that requires team-based work and fully integrates family voice and choice. Services are required to be delivered through a coordinated approach consistent with System of Care and Wrap-Around principles.

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

***Characteristics of Youth Reviewed.*** Data that describe the population of youth that were reviewed in Boston/Metro Boston are presented in this report. The largest number of youth (sixteen or 35%) was in the 14-17 year old age group. There were two youth in the 18-21 year old range, and none in the 0-4 range. At the time of the review the majority of youth reviewed (87%) were living with their biological parents or in an adoptive home. Twenty-seven percent (27%) had a change in living or school placement within the past year. The largest ethnicity represented among the youth in the sample was European-American (33%) followed by African-American (29%), and Latino (27%). English was the primary language spoken at home for the majority of the youth (80%). Over half of the youth (51%) were attending school in part-time or full-time special education settings. Fifty-six percent (56%) had special education services (some youth were in a full inclusion regular education setting). Two youth were not in school because they were graduated or dropped out (4%).

Youth in the sample were involved with a variety of other agencies with the highest frequency being Special Education (56%) and the Department of Children and Families (DCF) (47%). The youth were referred to ICC or IHT services in the largest numbers by DCF (27%), and then by their families (22%). Nine percent (9%) were referred by outpatient therapists, and 7% each were referred by their primary care physician, a hospital or an intensive in-home service.

The review also collected information related to behavioral health and physical conditions, including co-occurring conditions, with the highest condition prevalence being mood disorders (49%), followed by ADD/ADHD (40%) and anxiety disorders (36%). Thirty-three percent (33%) of the youth had a co-occurring medical problem, with a high prevalence in the sample of youth with asthma (20%). Current mental health assessments were found for 87% of the youth reviewed. Fifty-six percent (56%) of the youth were on one or more psychotropic medications, with 17% on three or more medications. Most of the youth in the sample (93%) had not used any crisis services in the 30 days prior to the review.

Caregivers of the youth were facing challenges that included adverse effects of poverty (49%), extraordinary care burdens (38%), and their own serious mental illness (31%).

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

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

*Youth Status.* A number of youth in the sample were experiencing some problems in being in a stable situation free of disruption with 76% having favorable stability status at home, and 79% at school. Consistency and permanency with their families or caregivers was favorable for 87% of the youth. Overall, most of the youth were safe in their homes (92%), at school (93%), and in their communities (91%). Most had favorable physical health status and had their health needs addressed (82%). The sub-indicator for educational status, academic program, was a concern with only 71% of youth with favorable status. School attendance was favorable for 80% of the youth, and 86% had favorable behavioral supports in school. Living arrangements were favorable for 80% of the sample.

Behavioral risk to self was favorable for 80% of the youth and 84% had favorable behavioral risk toward others. However, only 47% of the youth had favorable emotional status.

Across the indicators of youth status, 80% of the youth reviewed had an overall favorable status with 29% with “good” status and 51% with “fair” status. The remaining 20% of youth had unfavorable status with 13% with “marginal” status, and 7% with “poor” status. Please see Appendix 2 on Page 62 for descriptions of a youth in each status category.

*Family/Caregiver status.* Status of families and caregivers are comprised of a constellation of indicators that measure well-being and satisfaction. The data for the Boston/Metro Boston CSR reflect families experiencing considerable challenges, among the most prevalent being adverse effects of poverty, extraordinary care burdens, and parental mental illness. Only fifty-eight percent (58%) of mothers and 47% of fathers had a favorable level of challenge. The data show that voice and choice of caregivers as well as the youth are being heard in service delivery processes. Family/caregiver and youth satisfaction with services and participation was overall favorable. *Youth progress.* These indicators measure the progress patterns of youth over the six months preceding the review. Youth progress showed variable results across the indicators and only 73% of youth were making overall favorable

progress. Eighty-two percent (82%) were making favorable progress in reducing symptoms, 50% in reducing substance use (N=2), 71% in improving coping/self-management, and 100% (N=2) in work progress. School progress was an area of concern where only 65% of the youth were making favorable progress. Progress was favorable in most areas of building relationships except for in peer relationships where only 64% were making progress.

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

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

The Boston/Metro Boston CSR found very strong practices in Engagement with Families/Youth and Cultural Responsiveness with acceptable ratings all at 96% or better across these indicators. These data show that generally, families reviewed were acceptably engaged and participating, and the cultural contexts of families were being addressed.

Teamwork, which focuses on the structure and performance of the youth and family care planning teams, is comprised of two sub-indicators: Team Formation and Team Functioning. Team Formation was acceptable for 76% of the youth, which indicates a level of improvement is needed in order for families to be able to depend on teams with the right composition and continued development of the team. Team Functioning was acceptable for 78%. The overall finding for these indicators is that practice improvements are needed in roughly a quarter of teams in order to assure the consistent bringing together of the “right people” on care planning teams, and that they work together to understand, plan and implement interventions and strategies at a level that will impact progress and status of youth.

The Assessment and Understanding indicator reviewed how well teams and interveners gather all relevant information forming the basis for determining which interventions, supports and/or services will most likely result meeting youth’s and families’ objectives. There was acceptable understanding for 78% of the youth, and for 82% of families. Some improvement in these practices would assure teams consistently understand youths’ and families’ core issues and situations, a foundation for building effective plans.

The Planning Intervention indicators include six sub-indicators. Results for acceptability of care/treatment plans and planning processes show improvements can be made in the planning domains. Planning for symptom/substance abuse reduction was acceptable for 79% of youth, for behavior changes for 80%, for social connections 79%, and for risk and safety planning 80%. Planning for effective recovery and relapse prevention was applicable to three youth and acceptable for two (67% acceptable). Planning for supporting transitions continues to be an area for concerted improvements with only 61% of youth having acceptable planning in this indicator.

The indicator for identifying and articulating clear Outcomes and Goals for the youth and family indicate a fair performance with 80% of youth rated as having acceptable practice performance. The indicator for measuring Matching Interventions to Needs, which measure practices in assuring services and supports form a cohesive sensible pattern and address the identified needs of the youth and family, needs more attention with 76% of practices reviewed having acceptable performance.

Care coordination for the youth reviewed was acceptable for 78% of the youth reviewed, indicating some strengthening in practices are needed in order to assure consistently acceptable care coordination is provided. Service implementation was acceptable for 89% of youth, demonstrating strong performance in implementing the services and supports indicated as needed in care plans. Availability of Resources to implement services and supports had excellent results for the youth reviewed with 87% acceptable. The practice of Adapting and Adjusting plans and services was acceptable for 84% of youth, indicating this practice was in place consistently for most youth in the sample.

Planning, staging and implementing practices for successful Transitions and Life Adjustments was an area that could use some improvement with only 60% of youth having acceptable performance. Responding to Crises and Risk/Safety Plans was acceptable for 81% of youth who experienced a crisis over the previous ninety days.

Overall, 76% of youth were found to have acceptable system/practice performance.

The data indicate that the strongest areas of practice for the sample as a whole (there is variability in performance results for individual youth) were Engagement with the Youth and Family; Cultural Responsiveness; Service Implementation; and Availability and Access to Resources.

Indicators that showed an overall fair performance but at a less consistent or robust level of implementation were Teamwork (Functioning); Assessment & Understanding of Youth and Family; Planning Interventions for Symptom or Substance Reduction; Planning Interventions for Behavior Changes; Planning Interventions for Social Connections; Planning Interventions for Risk and Safety Planning; Outcomes and Goals; Coordinating Care; Adapting and Adjustment; and Responding to Crises and Risk & Safety Planning.

Areas of system/practice performance that need some level of improvement in order to assure consistency, diligence and/or quality of efforts are Teamwork (Formation); and Matching Interventions to Needs.

Review results indicate weak performance was found in the following system/practice domains: Planning Interventions for Recovery or Relapse; Planning Interventions for Transitions; and Transitions & Life Adjustments.

Overall, the findings of the CSR showed that for Boston/Metro-Boston services, key system of care practice such as engagement of families, and cultural responsiveness were strong. Resources were available for most youth, and services identified in youth's plans were being implemented in a timely manner.

A number of other system practices need a degree of improvement to assure all system practices are dependable, consistent and reliable. Teams for about a quarter of the youth needed to improve their ability to be formed with the right people that can bring together



collective skills and knowledge necessary to develop care plans and interventions that address youth and family needs. Teams are functioning at a fair level, including using assessment information and having an understanding of the youth and family. Planning functions that were measured need some level of improvement, particularly in the recovery/relapse and transition planning domains.

These findings suggest that a number of foundational service system practices in Boston/Metro Boston are occurring well and moving toward achieving dependable functional teams and well-coordinated care. Quality training, support and oversight is likely needed to assure all teams are working in concert to consistently understand the strengths and needs of the youth and family, establishing agreed upon goals, and identify and implement strategies that work.

***Findings: Strengths.*** The CSR found teams in general value family voice and are listening to family choices and preferences. There were a number of examples of excellent work with families by care coordinators, teams and other interveners. Notable were Family Partners and Therapeutic mentors providing services that were impacting positive change for youth and families.

***Findings: Challenges.*** Challenges identified through the CSR include a need for more consistency in teams fully assessing youth and families, and using the multiple perspectives of team members to develop a broad-based understanding of youth and family strengths, functioning and needs. Plans were often not individualized or detailed in their description of strategies or achievable goals. There was a large percentage of youth with developmental and autism spectrum disorders and most of the teams working with these youth needed more knowledge about their unique needs and strategies that work with this population. At a broader level, the review did not observe strong supervision structures or practices routinely building the knowledge, skills and abilities of staff.

***Recommendations.*** The Recommendations starting on Page 58 reflect the findings of the CSR and are provided as suggestions for further assuring the consistency and quality of behavioral health practices and service delivery for *Rosie D.* class members in the Boston/Metro Boston region. Recommendations revolve around the need for stronger individualized planning, supervision practices, coordination, and clarification of the scope of crisis services.

## **The Rosie D. Community Services Review**

### **Regional Report for Boston/Metro Boston**

#### ***For the Review Conducted in January 2011***

### **Introduction**

#### ***Overview of Rosie D. Requirements and Services***

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

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

More 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, 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 that reflects the identification and use of strengths, identification of needs, is culturally competent and responsive, multi-system and results in a unique set of services, therapeutic interventions and natural supports that are individualized for each child and family to achieve a positive set of outcomes. ICC services are intended for Medicaid eligible children with Social Emotional Disturbance (SED), who have or need the involvement of other state agency services and/or receiving multiple services, and need a care planning team. It is expected that the staff of the involved agencies and providers are included on the care team.

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

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

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

***Purpose of monitoring***

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 area.

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

The CSR process 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 are 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 24, it will be helpful to refer to Appendix 2 in understanding the ratings and findings.

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

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

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

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

### **The Boston/Metro Boston CSR (January-February 2011)**

#### ***Description of the Region***

The Boston Region consists of two sub-areas, with neighborhoods that combine to make up the Greater Boston area. Boston is a city of much history, sits on Boston Harbor, the Charles River winds its way through the city, there are parks and green space, many interesting and diverse neighborhoods linked by public transportation, is a “walking” city, and attracts many visitors. It is known for its North End eateries, high end shopping in Back Bay and well known and accomplished educational and medical facilities. Each neighborhood has a history, character and culture that define it. For example, some neighborhoods have a wonderful mix of urban hub and density mixed with green space, such as Hyde Park, Fenway, and Brookline. Dorchester and Jamaica Plain are known for

their diversity, East Boston as a home to many and diverse immigrants, Beacon Hill as an historic section of the city with cobblestone streets, row houses, Boston Common, the state house and many historical sites. Cambridge is home to Harvard Square, many universities and has a strong cultural and social diversity. Brighton, Charlestown and Allston have diverse but significant histories of industrial, shipping and agricultural activity and have evolved into neighborhoods of families, young professionals, students with a variety of shops, restaurants and street vendors. Arlington is about 6 miles outside of Boston and as part of Metro Boston has excellent access to Downtown Boston, has a diverse population, attracts families and has many parks and recreation areas. Quincy has an industrial history, known for the granite mined from the area, located on Quincy Harbor, just south of Boston. Again as part of Metro Boston, there is good access to Downtown Boston, Logan airport and the city neighborhoods. Historically it was part of Dorchester, and is now separated from that area by a major north/south highway.

### ***Community Service Agencies (CSAs) and In Home Services***

The Greater Boston region is divided into two sub-areas: Boston and Boston Metro. Community Service Agencies (CSA) are the designated agencies across the Commonwealth for the provision of Intensive Care Coordination. CSAs also provide Family Support and Training Services (commonly called Family Partners). There are 5 CSAs, provided by 4 human service agencies, in the Boston sub-area of the Greater Boston region. There are 3 CSAs, provided by 2 human service agencies, in the Boston Metro sub-area of the Greater Boston region. There is a specialty statewide CSA that provides CSA services to deaf and hearing impaired youth/families in the Greater Boston region.

The Boston CSAs are located and provide services in various areas of the city of Boston. Children's Services of Roxbury is located in Roxbury, The Home for Little Wanderers (The Home) has 2 CSAs, one in the Park Street area of Boston and the other in Hyde Park. Massachusetts Society for Prevention of Cruelty to Children (MSPCC) is located in Jamaica Plain. North Suffolk Mental Health Association is in Chelsea. Each of the CSAs provides services to the areas surrounding their CSA office location.

The Metro Boston CSAs provide services in the Greater metro areas of Boston. Baystate Community Services Coastal, is located in Quincy, and Riverside Community Care has 2 CSA locations, one in Cambridge (Guidance Center) and another in Arlington. Again each of these CSAs provides services to the areas surrounding their CSA office location.

The Learning Center for the Deaf, Walden School, a statewide specialty CSA, is located in Framingham, and provides CSA services to youth in the Greater Boston Region.

As with most large cities, the Greater Boston neighborhoods are varied in terms of their ethnic populations, the culture of the neighborhood, they have varied histories and have experienced significant shifts in economic conditions, cost of housing, safety, and overall community development. Boston is home to many large educational institutions, medical facilities, parks and public transportation is generally available and used.

There are In-Home Therapy (IHT) Services throughout the Greater Boston region, with IHT services being provided at CSA agencies as well as other private agencies. The

Community Service Review (CSR) included IHT services provided by Academic and Behavioral Clinic, Arbour Counseling Services, Wayside Youth and Family Support Network, Family and Community Solutions, South Shore Mental Health, Family Services of Greater Boston, Osiris Family Institute, Pyramid Builders Associates, Priority Professional Care, Germaine Lawrence, North Suffolk Mental Health Association, Riverside Community Care, and Children’s Services of Roxbury.

***Review Participants***

Altogether, over 560 people from Boston/Metro Boston participated either in the youth-specific reviews or were interviewed in stakeholder focus groups. Table 1 displays data related to the youth-specific reviews where a total of 274 interviews were conducted. As can be seen, the average number of interviews was 6.1 with a maximum of 18 and a minimum of 3 interviews conducted.

<b>Child Status and Performance Profile - Number of Interviews</b>	
<b>Number of cases:</b> 45	Boston/Metro-Boston 1/2011
<b>Number of Interviews</b>	
Total number of interviews	274
Average number of interviews	6.1
Minimum number of interviews	3
Maximum number of interviews	18

Table 1

***How the sample was selected***

The sample for the Boston/Metro Boston CSR was drawn from the population of all children who received Intensive Care Coordination (ICC) or In-Home Therapy (IHT) without currently receiving ICC service, inclusive of children from birth to twenty-one years old, who are covered by Medicaid. The original CSR sample included 26 ICC youth and 20 IHT youth who were not also currently receiving ICC.

Prior to the review, each agency was asked to submit lists of the children who were enrolled since the initiation of the service. The caseload enrollment 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 CSA was determined based on the number of youth meeting the sampling parameter against the population 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 26 agencies, which were actively providing IHT in the Boston/Metro-Boston region at the time the lists were submitted. Of the 26 agencies, 13 were serving very few youth without ICC, and were dropped from the selection process. Twenty youth were randomly selected from the remaining 13 agencies for inclusion in the CSR. One youth was randomly selected from 8 of the agencies; 2 youth were randomly selected from 4 of the agencies; and 4 youth were selected from 1 agency. The number of youth who had been served since the start of the program and the number of youth currently receiving services were taken into consideration, leading to the sampling distribution decisions.

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

The second column of Table 2 displays the number of unduplicated youth enrolled in ICC since the start of the ICC service on July 1, 2009. The third column displays the total number of youth by agency who were served within open cases at the time the agencies submitted lists. The number of youth to be included from each agency was then determined by comparing the number of youth being served by that agency to the total number of youth being served in the Boston/Metro region.

Boston/Metro Agency	Total Enrolled Since Start of ICC Opening (7/1/09)	Number Open at List Submittal	Number ICC Cases Selected
Bay State Coastal	198	85	3
Children's Services of Roxbury	509	197	4
Riverside Cambridge	164	67	3
The Home Park Street	309	114	3
The Home Hyde Park	134	50	2
MSPCC	116	90	3
North Suffolk Mental Health Association	167	77	3
Riverside Arlington	174	79	3
The Learning Center for the Deaf, Walden School	29	17	2
<b>Total</b>	<b>1800</b>	<b>776</b>	<b>26</b>

Table 2

Children's Services of Roxbury actively served the largest number of youth, and had 4 youth in the sample. The sample included 3 youth each from 6 of the ICC providers, including Bay State Coastal, Riverside Cambridge, The Home Park Street, MSPCC, North Suffolk Mental



Health Association, and Riverside Arlington. The Home Hyde Park had 2 youth in the sample. The specialty ICC, Walden School, had 2 youth in the sample. These ICC youth may have been receiving services in addition to ICC, including IHT.

In Table 3, the second column displays the total unduplicated enrollment for youth receiving IHT by agency since November 1, 2009. The third column displays the number of youth who were included in open cases at the time the list was submitted. The fourth column displays the total number of youth who were receiving IHT without current ICC services. The last column lists by agency, the number of IHT youth who were designated for selection in the CSR.

Agency	Total Enrolled Since Start of IHT (11-1-2009)	Total Open at List Submittal	Total Open and Receiving IHT/No ICC	Number IHT Only Selected
Academic & Behavioral Clinic (ABAC)	178	79	76	2
Arbour Counseling Services	318	117	81	2
Bay State Coastal	*	*	*	*
Brookline Community Mental Health Center	*	*	*	*
Children's Services of Roxbury	56	53	26	1
Dimock Community Health Center	*	*	*	*
Edinburg Center	*	*	*	*
Family and Community Solutions	99	61	39	1
The Family Center	*	*	*	*
Family Service of Greater Boston	150	49	36	1
Germaine Lawrence	43	26	16	1
Home for Little Wanderers Hyde Park	*	*	*	*
Home for Little Wanderers Park Street	*	*	*	*
Justice Resource Institute (JRI)	*	*	*	*
Key Program	*	*	*	*
Latin American Health Institute	*	*	*	*
MSPCC	*	*	*	*
North American Family Institute	*	*	*	*
North Suffolk Mental Health Association	148	82	72	2
Osiris Family Institute	42	38	25	1
Priority Professional Care	87	50	45	1
Pyramid Builders Associates	150	31	31	1
Riverside Arlington	105	61	50	1
Riverside Cambridge	126	62	50	1
Roxbury Multi-Service Center, Inc	*	*	*	*
Somerville Mental Health Association	*	*	*	*
South Shore Mental Health	244	172	147	4
Wayside Youth & Family Support Network	111	46	34	1
<b>TOTAL</b>	<b>1857</b>	<b>927</b>	<b>728</b>	<b>20</b>

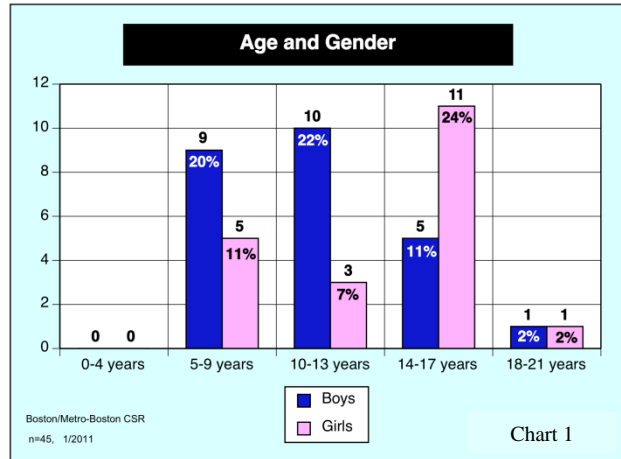
\* Of the 26 agencies providing IHT, 13 were not included in the sampling, based on small numbers of youth who were receiving IHT without ICC at the time that the lists were submitted.

Table 3

As can be seen, each of the following IHT programs had 1 youth included in the CSR: Children's Services of Roxbury, Family and Community Solutions, Family Service of Greater Boston, Germaine Lawrence, Osiris Family Institute, Priority Professional Care, Pyramid Builders Associates, Riverside Arlington, Riverside Cambridge and Wayside Youth and Family Support Network. Three IHT programs had 2 youth included from each of their programs: Academic & Behavioral Clinic (ABAC), Arbour Counseling Services and North Suffolk Mental Health Association. One agency, South Shore Mental Health, had 4 youth included in the sample. In total, the original CSR sample selection included 26 youth where ICC coordinated their care and 20 youth where IHT coordinated their care. During the course of the review, one youth was eliminated from the final sample due to the youth receiving all services outside of the Boston/Metro Boston region during the entire review period. Therefore, the final sample included 45 youth; 26 youth with care coordinated by ICC, and 19 youth with care coordinated by IHT.

**Characteristics of Youth Reviewed**

*Age and Gender.* There were 45 youth reviewed across the Boston/Metro Boston areas in the CSR conducted January 24- February 1, 2011. *Chart 1* at right shows the distribution of genders across age groups in the sample. There were 25 boys and 20 girls in the sample. This proportion of boys to girls was 56% boys to 44% girls. Two youth, one male and one female, or 4% of the sample were in the 18-21 age range. The largest number of youth (sixteen or 35%) was in the 14-17 year old age range. Of note is that there was that



69% of youth in the 14-17 age range were female. The second largest group (13 or 29%) was youth in the 5-9 year old range. Fourteen youth or 31% were in the 10-13 year old range. There were no children in the sample in the 0-4 age group.

*Current placement, placement changes and permanency status.* The largest percentage of youth (87%) in the Boston/Metro Boston CSR sample lived with their families, either their biological/adoptive families, or in a kinship/relative home. Two youth lived in group homes at the time of the review, and one each lived in a therapeutic foster home, a CBAT placement, an independent living situation, and a homeless shelter for families. (Table 4).

**Child Status and Performance Profile - Current Placement Frequency**

Number of cases: 45 Boston/Metro-Boston 1/2011

Type of Current Placement	Number	Percent
Family bio./adopt. home	36	80%
Kinship/relative home	3	7%
Therapeutic foster home	1	2%
Group home	1	2%
CBAT	1	2%
Independent living	1	2%
Family shelter homeless	1	2%
Group family home	1	2%
<b>Table 4</b>	<b>45</b>	<b>100%</b>

The legal status (Table 5) of most of the children in the sample (84%) was with their birth families. Three (7%) youth's permanency was with their adopted families, and three (7%) were in foster care. One or 2% of the sample was in permanent legal guardianship.

**Child Status and Performance Profile - Legal Permanency Frequency**

Number of cases: 45 Boston/Metro-Boston 1/2011

Legal Permanency Status	Number	Percent
Birth family	38	84%
Adopted family	3	7%
Foster care	3	7%
Permanent guardianship	1	2%
<b>Table 5</b>	<b>45</b>	<b>100%</b>

The review tracked placement changes over the last twelve months for the 45 youth reviewed (Table 6). Placement change refers to both changes in living situation, as well as changes in the type of program the child received educational services in over the last twelve months.

Achieving stability and minimizing disruptions are important factors in the lives of youth with SED. Among the sample, the

**Child Status and Performance Profile - Placement Changes Frequency**

Number of cases: 45 Boston/Metro-Boston 1/2011

Placement Changes (past 12 months)	Number	Percent
None	33	73%
1-2 placements	5	11%
3-5 placements	7	16%
	45	100%

Table 6

Of the seven youth who were in out of home placements at the time of the review, three (7%) had been in placement for less than 30 days, two (4%) for 1-3 months, one (2%) for 4-6 months, and one for 19-36 months (Table 7).

majority of youth (33 or 73%) had no placement changes in the last year, reflecting stability in their home or school setting over the last twelve months for these youth. Five of the youth or 11% had 1-2 placement changes, and seven or 16% had 3-5 changes.

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

Number of cases: 45 Boston/Metro-Boston 1/2011

Length of Stay in Current OOH Placement	Number	Percent
0-30 days	3	7%
1 - 3 mos.	2	4%
4 - 6 mos.	1	2%
19 - 36 mos.	1	2%
Not applicable	38	84%
	45	100%

Table 7

**Child Status and Performance Profile - Ethnicity Frequency**

Number of cases: 45 Boston/Metro-Boston 1/2011

Ethnicity	Number	Percent
Euro-American	15	33%
African-American	13	29%
Latino-American	12	27%
Pacific Is. American	1	2%
Bengali	1	2%
Biracial	3	7%
	45	100%

Table 8

*Ethnicity and primary languages (Table 8 and 9).* Of the 46 youth in the sample, fifteen or 33% were Euro-American, thirteen or 29% were African-American, and twelve or 27% were Latino-American. There were three youth (7%) who were Biracial, one (2%) Pacific Islander, and one (2%) who was Bengali.

**Child Status and Performance Profile - Language Spoken Frequency**

Number of cases: 45 Boston/Metro-Boston 1/2011

Primary Language Spoken at Home	Number	Percent
English	36	80%
Spanish	2	4%
Bengali	1	2%
English & ASL	1	2%
English & ASL (some)	1	2%
English & Portuguese	1	2%
English & Spanish	3	7%
	45	100%

Table 9

English was the primary language spoken at home for 36 or 80% of the youth, Spanish for two (4%), both English and Spanish for 3 (7%), English and Portuguese for 1 (2%), and Bengali for 1 (2%). English and American Sign Language were the primary languages spoken at home for two of the youth.

*Educational placement (Table 10).* Youth reviewed were receiving educational services in a variety of settings. Just over half of the youth in the sample (twenty-three or 51%) were receiving special education services either in a full-inclusion, part-time or full-time setting. Thirteen or 29% of the youth were attending school in a regular education setting. Two youth (4%) were enrolled in an alternative education program and one (2%) was in an Adult Education/GED program. Two of the youth (4%) were not enrolled in school as they had graduated or dropped out of school Youth in the “Other” category were in tutoring programs, a private special education school, an independent credit recovery program, and one was a young child who had not yet enrolled in school. Note that the total numbers and percentages in Table 10 add up to more than the total number of youth in the sample as youth may be involved in more than one educational placement or life situation.

**Child Status and Performance Profile - Educational Placement Frequency**

Number of cases: 45 Boston/Metro-Boston 1/2011

Educational Placement or Life Situation	Number	Percent
Regular K-12 Ed.	13	29%
Full inclusion	7	16%
Part-time Sp. Ed.	5	11%
Self-cont. Sp. Ed.	11	24%
Parenting teen	0	0%
Adult basic/GED	1	2%
Alternative Ed.	2	4%
Vocational Ed.	0	0%
Expelled/Suspended	0	0%
Home hospital	0	0%
Day treatment program	0	0%
Work	0	0%
Completed/graduated	1	2%
Dropped-out	1	2%
Other	5	11%

Table 10

*Other state agency involvement (Table 11).* Youth in the sample were involved with a range of other agencies. Note that youth may be involved with more than one agency, so the overall number in Table 11 is more than the number of youth reviewed. Youth in the sample were most frequently involved with Special Education (25 or 56%). The Department of Children and Families (DCF) had involvement with 21 families or 47% of the sample. The Department of Mental Health (DMH) was involved with seven youth or 16%, and Developmental Disabilities had involvement with five youth or 11% of the sample. One youth (2%) was on Probation. The “Other” category represents youth involved primarily with health care providers.

**Child Status and Performance Profile - Agencies Involved Frequency**

Number of cases: 45 Boston/Metro-Boston 1/2011

Agencies Involved	Number	Percent
DCF	21	47%
DMH	7	16%
Special Ed	25	56%
Early intervention	0	0%
Developmental disabilities	5	11%
DYS	0	0%
Probation	1	2%
Vocational Rehabilitation	0	0%
Substance abuse	0	0%
Other	8	18%

Table 11

*Referring agency (Table 12).* Youth in the sample were referred to ICC and/or IHT services from a variety of sources as seen in Table 12. The largest referral source was DCF (12 or 27%), closely followed by self-referrals from Families (10 or 22%). The next largest referral source was Outpatient therapists (4 or 9%), which in one case included the parent’s therapist. Primary care physicians/pediatricians made 3 of the referrals (7%), as did Hospitals, and IHT services. Schools and FST programs made 2 referrals (4%) a piece. Other agencies and programs (afterschool programs, crisis teams, joint DCF/Hospital, Developmental Disability Services, a provider agency, and a residential treatment program) each referred one (2% each) of the children in the sample.

**Child Status and Performance Profile - Referral Source**

Number of cases: 45		
Boston/Metro-Boston 1/2011		
Referral Source	Number	Percent
DCF	12	27%
School	2	4%
Family	10	22%
Primary care physician	3	7%
Afterschool program	1	2%
Crisis Team	1	2%
DCF & Hospital	1	2%
DDS	1	2%
FST	2	4%
Hospital	3	7%
IHT	3	7%
Outpatient therapist	4	9%
Provider agency	1	2%
Residential program	1	2%
	45	100%

Table 12

*Behavioral health and co-occurring conditions (Table 13).* Table 13 displays the conditions and/or co-occurring conditions present among the youth reviewed. Youth may have one or more than one condition. The two primary diagnostic conditions were mood disorders prevalent in 22 or 49% of the youth, and attention deficit disorder/attention deficit hyperactivity disorder seen in 18 or 40%. This was followed youth diagnosed with anxiety disorders (16 or 36%).

**Child Status and Performance Profile - Co-Occurring Condition Frequency**

Number of cases: 45		
Boston/Metro-Boston 1/2011		
Co-Occurring Condition	Number	Percent
Mood Disorder	22	49%
Anxiety Disorder	16	36%
PTSD/Adjustment to Trauma	10	22%
Thought Disorder/Psychosis	2	4%
ADD/ADHD	18	40%
Anger Control	10	22%
Substance Abuse/Dependence	1	2%
Learning Disorder	8	18%
Communication Disorder	2	4%
Autism	9	20%
Disruptive Behavior Disorder (CD, ODD)	4	9%
Mental Retardation	2	4%
Medical Problem	15	33%
Other Disability/Disorder	5	11%
Other	0	0%

Table 13

Of note were the 15 or 33% of youth reviewed with a co-occurring mental health issue and medical problem. Among these were 9 youth, or 20% of the sample with asthma. Additional co-occurring medical issues among the population reviewed included obesity, hearing and visual impairments, severe gastro-intestinal problems, lead paint poisoning, and neurofibromatosis, a genetic disorder of the nervous system.

Other prevalent co-occurring issues were post-traumatic stress disorder/adjustment to trauma issues prevalent in 10 or 22% of the youth, anger control also prevalent in 10 or 22%. Nine of the youth (20%) had a co-occurring autism spectrum disorder, and two (4%) had mental retardation. Eight youth (18%) had a diagnosed learning disorder. Four youth (9%) had a diagnosed disruptive behavior disorder, two (4%) had a thought disorder/psychosis, one (2%) a substance abuse disorder and one (2%) an adjustment disorder.

**Child Status and Performance Profile - Psy Meds Frequency**

Number of cases: 45 Boston/Metro-Boston 1/2011

Number of Psy Meds	Number	Percent
No psy meds	20	44%
1 psy med	9	20%
2 psy meds	8	18%
3 psy meds	6	13%
4 psy meds	1	2%
5+ psy meds	1	2%
	45	100%

Table 14

*Youths' levels of functioning (Table 15).* The general level of functioning for the youth was rated by each reviewer. The General Level of Functioning is a 10-point scale that can be viewed in Appendix 1 of this report. Sixteen youth or 36% 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”). Twenty-six youth or 58% 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”). The remaining three youth (7%) 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”).

*Use of Crisis Services (Table 16).* The review tracked whether or not, and the form of, crisis services or crisis responses that were used by youth over the last 30 days. Crisis service/responses were used very infrequently by youth reviewed in the Boston/Metro-Boston CSR in the month preceding the review, with 93% not accessing crisis services. Among those that did, two (4%) used mobile crisis services, and one (2%) accessed crisis support through a 911 police call.

*Mental health assessments (Tables 17 and 18).* Mental health assessments are a core component of understanding youth and their families. A mental health assessment gives practitioners and teams an overall picture of how the youth is doing emotionally and cognitively, as well as the social/familial context of a

*Medications (Table 14).* The majority of the youth in the sample (56%) were prescribed at least one psychotropic medication. As seen in Table 14, nine of the youth (20%) were prescribed one medication, eight (18%) were on two medications, and six (13%) were on three medications. There was one youth on four (2%) and one (2%) on five or more medications. Eighteen percent (18%) of the youth who were prescribed psychotropic medications were prescribed three or more medications.

**Child Status and Performance Profile - Level of Functioning Frequency**

Number of cases: 45 Boston/Metro-Boston 1/2011

Level of Functioning	Number	Percent
In level 1-5	16	36%
In level 6-7	26	58%
In level 8-10	3	7%
	45	100%

Table 15

**Child Status and Performance Profile - Crisis Services Used Frequency**

Number of cases: 45 Boston/Metro-Boston 1/2011

Crisis Services Used Past 30 Days	Number	Percent
Mobile crisis	2	4%
911 Emergency call: EMS	0	0%
911 Emergency call: Police	1	2%
Emergency department	0	0%
Other	0	0%
None	42	93%

Table 16

**Child Status and Performance Profile - Mental Health Assessment**

Number of cases: 45 Boston/Metro-Boston 1/2011

MH assessment performed	Number	Percent
Yes	39	87%
No	6	13%
	45	100%

Table 17

youth’s behaviors and well-being. Eighty-seven percent (87%) of the youth had a current mental health assessment that was in their files. Six youth or 13% of the youth did not have a current mental health assessment available to help their teams better understand and plan for them.

**Child Status and Performance Profile - Received Mental Health Assessments**  
 Number of cases: 45 Boston/Metro-Boston 1/2011

Received MH Assessments	Number	Percent
Parent	18	40%
Education	4	9%
Court	2	4%
Child Welfare	4	9%
DOC	0	0%
Not applicable	6	13%
Not Distributed	18	40%
Other	9	20%

Table 18

The reviewers also examined for those that had a current mental health assessment, whether or not the assessment 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 and preferences, so these data need to be understood within this context.

Among families in the sample, 18 or 40% of parents had received their child’s assessment. Schools received a copy of the mental health assessment for 4 or 9% of the youth, the courts for 2 or 4%, and child welfare for four or 9%. Child welfare was involved with 21 or 47% of the youth in the sample so the percentage of families that were child welfare involved and had their assessments shared with DCF was actually 19%. The assessment had not been distributed for 40% of youth when it was applicable. There were a number of other people who received the Mental Health Assessment for youth which included therapists and other team members.

**Caregiving challenges**

Reviewers recorded the challenges experienced by the parents and caregivers of the youth in the sample (Table 19). Nearly half of the caregivers (49%) were experiencing adverse effects of poverty. Thirty-eight percent (38%) were challenged by extraordinary care burdens, and serious mental illness was present in 31% of the families reviewed. Substance abuse/addiction was an issue for 13% of caregivers, and domestic violence was impacting 13% of the families. Cultural/language barriers were a challenge for 9% of caregivers. Other challenges noted were limited cognitive ability, illness/physical disability, challenges associated with teen parenting, lack of parenting skills, legal difficulties, and isolation.

**Child Status and Performance Profile - Caregiver Challenges Frequency**  
 Number of cases: 45 Boston/Metro-Boston 1/2011

Challenges in the Child's Birth Family or Adoptive Family	Number	Percent
Limited cognitive abilities	1	2%
Serious mental illness	14	31%
Substance abuse impairment or serious addiction w/ frequent relapses	6	13%
Domestic violence	6	13%
Serious physical illness or disabling physical condition	2	4%
Unlawful behavior or is incarcerated	0	0%
Adverse effects of poverty	22	49%
Extraordinary care burdens	17	38%
Cultural/language barriers	4	9%
Undocumented	1	2%
Teen parent	2	4%
Recent life disruption/homelessness due to a natural disaster	0	0%
Other	5	11%

Table 19

**Care Coordination**

During the CSR, data are collected about care coordination through the person providing the care coordination function, which could have been the ICC or the IHT therapist. Among the data collected was 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 identify to be impacting their work. These data were collected to better understand factors that may be impacting the provision of care coordination services. In the Boston/Metro-Boston CSR, there were 41 individuals providing care coordination for the 45 youth reviewed (22 individual ICCs, and 19 IHTs). Several care coordinators provided coordination for more than one youth in the sample, which is why data here are provided for 41 individuals.

As can be seen in *Table 20*, most of the Care Coordinators (34%) participating in the Boston/Metro-Boston CSR had been in their positions for 13-24 months, followed by those in positions 7-12 months (27%). Twenty percent (20%) had been in the care coordinator position for 4-6 months. Seven percent (7%) of care coordinators were in the position for 25-36 months and two (5%) each in the position for 1-3 months and over 60 months.

**Child Status and Performance Profile - Length of Time CM in Position Frequency**  
 Number of cases: 41 Boston/Metro-Boston 1/2011

Length of Time CM in Position	Number	Percent
1-3 months	2	5%
4-6 months	8	20%
7-12 months	11	27%
13-24 months	14	34%
25-36 months	3	7%
37-60 months	1	2%
>60 months	2	5%
<b>Table 20</b>	<b>41</b>	<b>100%</b>

Also tracked was the length of time the Care Coordinator had been assigned to the youth being reviewed. As can be seen in *Table 21*, 33% of the care coordinators had been providing coordination for the youth for 4-6 months, and 22% for 7-12 months. Twenty percent (20%) of care coordinators had been assigned to the youth for 1-3 months, 18% for 13-24 months, 4% for less than a month, and 2% for 25-36 months.

**Child Status and Performance Profile - Length of Time CM Assigned**  
 Number of cases: 45 Boston/Metro-Boston 1/2011

Length of Time CM Assigned to Child/Youth	Number	Percent
<1 month	2	4%
1-3 months	9	20%
4-6 months	15	33%
7-12 months	10	22%
13-24 months	8	18%
25-36 months	1	2%
<b>Table 21</b>	<b>45</b>	<b>100%</b>

Caseload frequency, as reported by the care coordinator, was measured along the scale seen

**Child Status and Performance Profile - CM Current Caseload Frequency**  
 Number of cases: 41 Boston/Metro-Boston 1/2011

CM Current Caseload Size	Number	Percent
<8 cases	14	34%
9-10 cases	9	22%
11-12 cases	10	24%
13-14 cases	5	12%
15-16 cases	3	7%
<b>Table 22</b>	<b>41</b>	<b>100%</b>

in *Table 22*. Thirty-four percent (34%) of Coordinators had less than 8 cases, 22% had 9-10 cases, 24% had 11-12 cases, 12% had 13-14 cases, 7% had 15-16 cases. There were no care coordinators with more than 18 cases on their caseload.



**Child Status and Performance Profile - Barriers Affecting Case or Services**

Number of cases: 45 Boston/Metro-Boston 1/2011

<b>Barriers Affecting Case Management or Services</b>	<b>Number</b>	<b>Percent</b>
Caseload size	5	11%
Eligibility/access denied	0	0%
Inadequate parent support	6	13%
Inadequate team member participation	3	7%
Family disruptions	2	4%
Billing requirements/limits	7	16%
Case complexity	9	20%
Treatment compliance	6	13%
Team member follow-thru	2	4%
Acute care needs	1	2%
Driving time to services	6	13%
Culture/language barriers	2	4%
Refusal of treatment	0	0%
Family instability/moves	0	0%
Arrest/detention of child/youth	1	2%
Other	18	40%

Table 23

*Table 23.* Information on barriers that affect the provision of care coordination or other services was collected in the CSR. The challenges cited most often were case complexity issues (20%) and billing requirements/limits to billing (16%). Inadequate parental support, treatment compliance, and driving time to services were all cited by 13% of Care Coordinators. Caseload size was identified as a barrier by 11%.

Barriers cited less frequently were inadequate team member participation, family disruptions, team member follow-through, acute care needs, and arrest/detention of youth.

Cultural/language barriers were cited by only 4% of Care Coordinators. Barriers that were cited in the “Other” category included turnover of team members including turnover of ICCs, waiting list to access therapeutic mentors, paperwork timelines, team meeting scheduling, team communications, access to psychiatry, access to legal consultation, cancellations/”no-shows”, availability to linguistically accessible services, and team member/provider lack of understanding about the wrap-around approach.

## Community Services Review Findings

### *Ratings*

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

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

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

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

## STATUS AND PROGRESS INDICATORS

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

### Youth Status Indicators

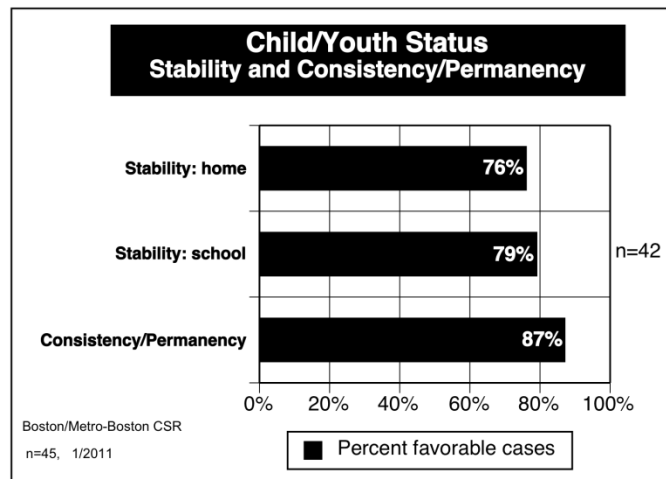
(Measures Youth Status over the last 30 days unless otherwise indicated)

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

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

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

*Overall Youth Status*



### *Community, School/Work and Living Stability*

In the sub-indicators of Stability, reviewers are asked to determine the degree of stability the youth is experiencing in their daily living and learning arrangements in terms of those settings being free from risk of unplanned disruption. Reviewers look at whether or not the

youth's emotional and behavioral conditions are addressed that may be putting the youth at risk of disruption in home or school. When reviewing for stability, reviewers track disruptions over the past twelve months and based on the current pattern of overall status and practice, predict disruptions over the next six months.

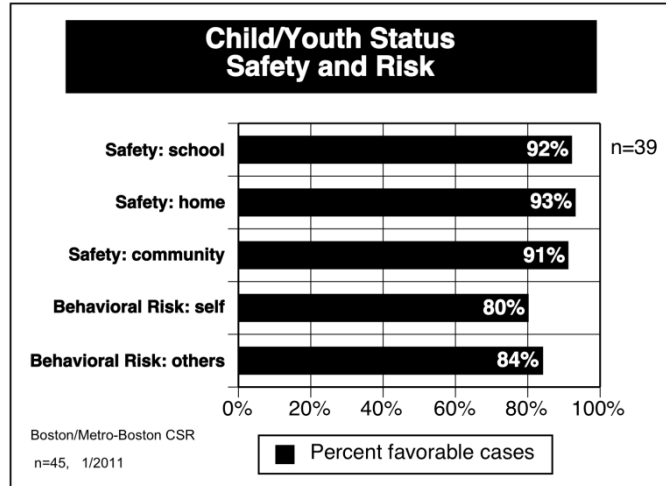
Among the 45 youth in the CSR sample in Boston/Metro Boston, 76% of them had favorable stability at home. Twenty-two of the youth (49%) had good stability with established positive relationships and well-controlled to no risks that otherwise could jeopardize stability. Five of the youth (11%) were rated to have optimal stability, with positive and enduring relationships free from any risks of disruption. Fourteen, or 31% of the youth, were rated to be in the "refinement" area, which means that conditions to support stability are fair. There were four youth (9%) who were rated to need improvement in their home stability, with poor or adverse status.

Of the 42 youth for which school stability was applicable (three of the youth in the sample were not in an educational program), 79% had a stable school situation. Half the youth (50% or 21) had issues with their school stability that needed "refinement" or "improvement." Among these were three youth (7%) with poor to adverse stability in the school setting.

***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 Boston/Metro Boston, 39 or 87% had a favorable level of consistency and permanency in their lives. Among these, 33 or 73% of the sample had "good" or "optimal" status. Ten youth (22%) had "minimal/fair" or "marginal" permanence that needed a level refinement in in order to assure enduring relationships and consistent caregiving/living supports. Two youth (4%) had "poor" permanency status with substantial and continuing problems of unresolved permanence.



### ***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.

In the sample of youth reviewed for Boston/Metro Boston, for those who were in a school program (N=39), 92% of youth were found to have favorable safety status at school. Among the entire sample, 93% were safe at home and 91% were safe in the community.

Seven of the youth in school programs (17%) needed their school safety to be “refined” or “improved”. One youth (3%) was found to have adverse safety in the school setting, with substantial and continuing risk of harm. Seventeen youth (37%) needed Refinement or Improvement in their home safety, including one (2%) that had poor safety indicating substantial and continuing risk of harm at home. Sixteen youth (35%) could benefit from their teams reviewing their safety status in their communities including one with poor status, and the one in a high safety risk situation with serious and worsening risk of of harm.

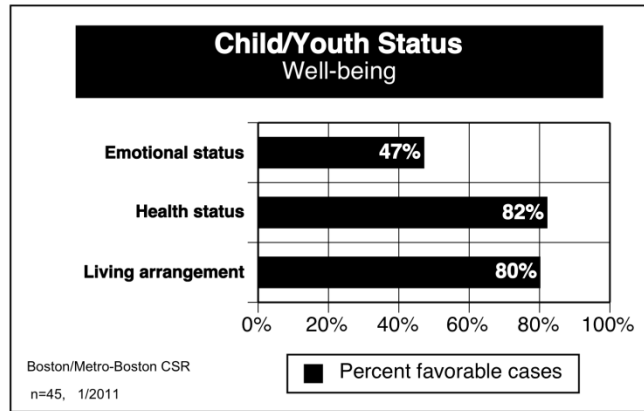
### ***Behavioral Risk to Self and Others***

Reviewers determine the degree to which the 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.

The results of the review show that 80% of youth had a favorable level of behavioral risk to themselves. Among these, 18 youth or 40% had good or optimal status on this indicator. Sixty percent (60%) of those reviewed were found to need “refinement” or “improvement” in their current status of behavioral risk to themselves indicating teams may want to evaluate strategies in youths’ plans in this area including level of risk. Among these were two youth

(4%) who had poor behavioral risk to themselves, and had behaviors that may cause self-harm. There was one youth (2%) with serious and worsening self-behavioral risk status.

The subindicator of behavioral risk toward others was favorable for 84% of the youth in the sample. Fifty-seven percent (57%) or 26 youth had a “good” or “optimal” level of behavioral risk toward others. Nineteen of the youth (42%) needed “refinement” or “improvement” in their risk to others, including two (4%) who had poor risk status, with a presence of potential of harm toward others. There were no youth with serious or worsening status on this subindicator.



***Emotional and Behavioral Well-being***

Youth are reviewed to determine to what degree 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 47% youth reviewed in the Boston/Metro Boston CSR. The other 53% were found to have unfavorable status in this indicator, indicating a high level of youth with inconsistent or poor emotional development, adjustment problems, emotional/adaptive distress, or serious behavioral problems present. Among the youth reviewed, 84% were determined to need “refinement” or “improvement” in their emotional/behavioral status. Two of the youth (4%) were found to have poor status and were not currently progressing in their emotional/behavioral well-being. Focused support for teams in developing individualized strategies for refining and/or improving youth’s levels of emotional and behavioral well-being was warranted for a large percentage of youth reviewed.

***Health Status***

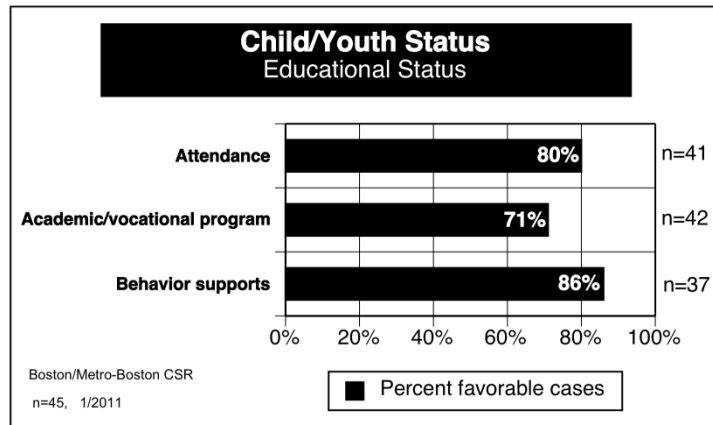
The health of the youth was reviewed to determine whether or not they were achieving and maintaining optimal health status including basic and routine healthcare maintenance.

Youth’s basic needs for nutrition, hygiene, immunizations, and screening for any possible development or physical problems should be met. Health is an important component of overall well-being. For the youth in the sample, 82% had favorable status. Forty-seven (47%) percent of the youth were noted to need “refinement” or “improvement” in their health status. One of the youth (4%) had poor health status and one had poor (4%) and worsening status. Given the high percentage of youth with co-occurring health and mental health issues in the sample, special attention by teams in coordinating closely with primary healthcare may be warranted for the population.

***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 Boston/Metro Boston CSR, 80% were found to have a favorable living arrangement. Fifty-eight percent (58%) of the sample had living arrangements that were “good” or “optimal.” Forty-two percent (42%) were indicated to need “refinement” or “improvement” in their living arrangement, including three (7%) in poor living arrangements.



***Educational Status***

This indicator looks at how youth are doing in their educational programs. Three specific areas are examined as seen in the chart above. The 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. The family with the support of the family partner, care coordinator or IHT (or others) meets and collaborates with school personal in support of youth progress and success.

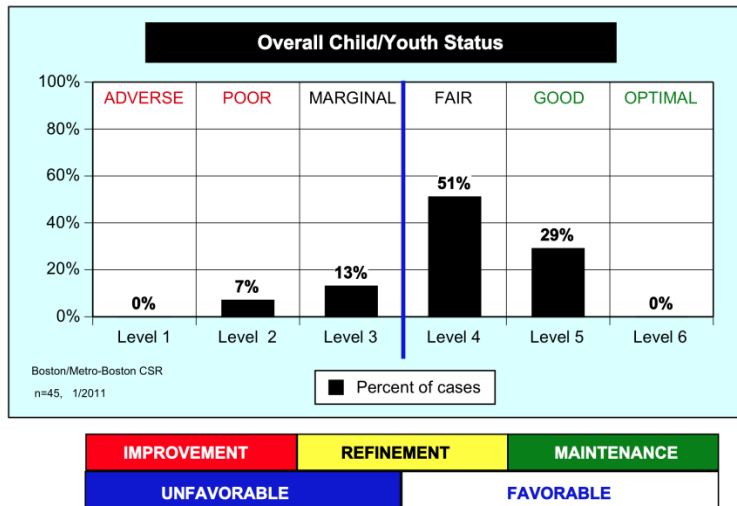
In the Boston/Metro Boston review, for the 41 youth school attendance was applicable to, a full 80% had favorable patterns of attendance. Sixty-three percent (63%) were found to have good to optimal school attendance. Thirty-seven percent (37% or 15 youth) of the sample would benefit from some refinement in their school attendance patterns. Among these, one (2%) had a poor attendance pattern due to reported chronic health issues.

For the 42 youth who were enrolled in an academic or vocational program, 71% of them were doing favorably well in their educational program, indicating improvements were needed for a fair number of youth. Twenty-five youth or 60% the youth needed their teams to look at any needed refinements in their school program.

Thirty-seven (37) youth in the sample required behavioral supports in their school setting, and supports were working favorably well for 86% of them. Nineteen, or 51% of the youth could benefit from their teams addressing the adequacy or consistency of implementation of behavioral supports.

**Overall Youth Status**

The overall results for Youth Status for the 45 youth reviewed in Boston/Metro Boston are displayed below. Overall, 80% or 36 youth were found to be doing favorably well. These youth fell in Levels 4-5, and had Fair (51% or 23 youth), or Good (29% or 13 youth) status. There were no youth in the Optimal category. The remaining nine youth had unfavorable status. They had either Marginal (13% or 6 youth) or Poor (7% or 3 youth) status. There were no youth found to have overall Adverse status.



The Youth Status Overall results are also categorized as needing Improvement, Refinement, or Maintenance. This allows for identification of youth that may need focused attention. Three youth (7%) fell into the Improvement area, meaning their status is currently problematic or risky, and action should likely be taken to improve the situation for the



youth. Nearly two-thirds of the youth fell in the Refinement area (64% or 29 youth), which is interpreted to mean their status is minimal or marginal, and are potentially unstable with further efforts likely necessary to improve their well-being. For the thirteen youth (29%) whose status should be maintained, efforts should likely be sustained and leveraged to build upon a fairly positive situation.

Several observations can be drawn about the status of youth reviewed in Boston/Metro Boston. There was a good proportion of youth that were in permanent homes, and were safe in their homes, schools and communities. However, a number of youth had factors that were impacting their stability at home and at school. Attendance issues and the adequacy of academic or vocational programs were an issue for a fair number of youth in the sample. Behavioral risk to self was a concern for 20% of the youth. Additional supports to shore up families' capacity to provide a favorable living situation were warranted for 20% of the sample. A primary concern for over half of the youth reviewed was their unfavorable emotional status.

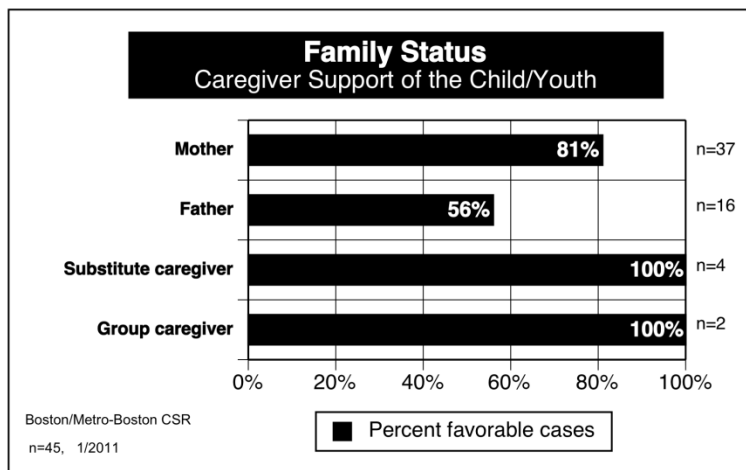
**Caregiver/Family Status**

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

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

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

*Overall Caregiver/Family Status*



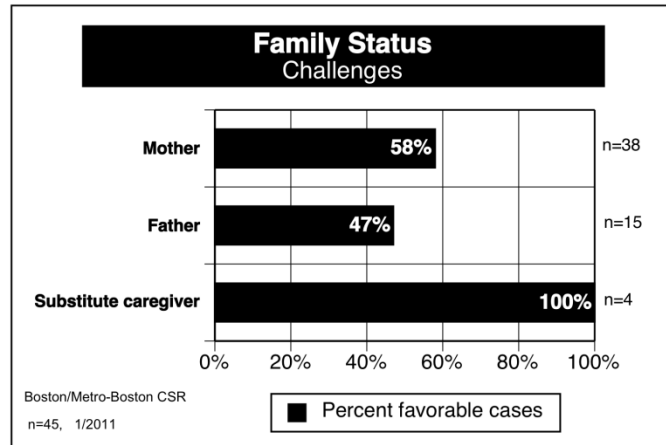
***Parent/Caregiver Support of the Youth***

This indicator measures the degree of support the person that the youth resides with is able and willing to provide for the youth in terms of giving assistance, supervision and support

necessary for daily living and development. Also considered is if supports are provided to the parent/caregiver if they need help in meeting the needs of the youth. Parent/caregiver support includes understanding any special needs and challenges the youth has, creating a secure and caring home environment, performing parenting functions adequately and consistently, and assuring the youth is attending school and doing schoolwork. It also means connecting to community resources as needed, and participating in care planning whenever possible. This domain is measured as applicable for the youth’s mother, father, substitute caregiver, and if in congregate care, for the group caregiver.

For the youth reviewed in the Boston/Metro Boston CSR, the measure was applicable to mothers for 37 youth, and favorable support was found 81% of the time (30 youth). Maternal support needed “refinement” or “improvement” for 20 youth or 38%. The measure for support from fathers was applicable for sixteen of the 45 youth in the sample, and favorable support was found from 56% or 9 of the fathers. Support from fathers needed “refinement” or “improvement” for 81% or 13 youth in the sample. For the four youth with substitute caregiving (adoptive or kinship care), support was favorable for all of them, with one of the four needing some refinement in their support of youth

There were two youth in group care at the time of the review; support for the youth in both cases was favorable and the level of support should be “maintained.”



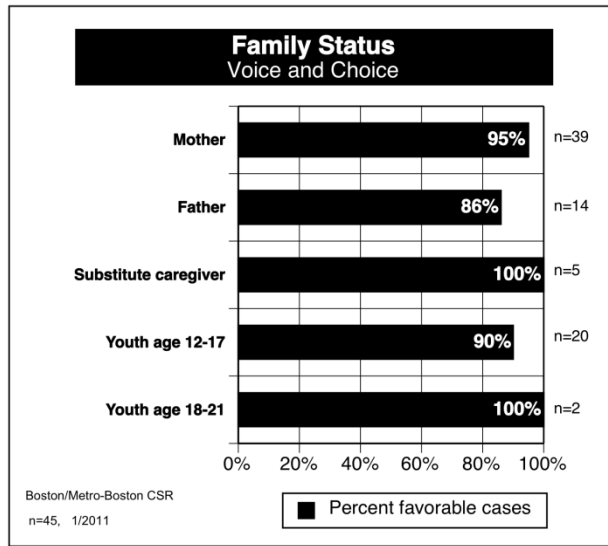
***Parent/Caregiver Challenges***

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.

In the sample, for the 38 youth for which this indicator applied, 58% or 22 mothers had favorable status in terms of the level challenge they were experiencing. Thirty-four or 89% of the mothers had a level of challenge that needs to be “refined” or “improved,” indicating a significant level of challenge and hardships impacting parenting among families in the sample. Two of the mothers (5%) were found to be experiencing major life challenges with inadequate or missing supports.

For the fifteen youth where the fathers were present, only 47% or 7 of them had a favorable level of challenge. All were experiencing levels of challenge that could benefit from “improvement” or “refinement,” ranging of challenges from minor limitations with adequate supports to major life challenges with inadequate or missing supports. Four fathers (27%) were found to have significant challenges impacting their ability to be a support to their children.

The four substitute caregivers of youth in the sample were all found to have favorable status (100%) in their level of life challenges, with few to minor limiting conditions; only one was seen to need “refinement” in lessening their level of challenge.



***Family Voice and Choice***

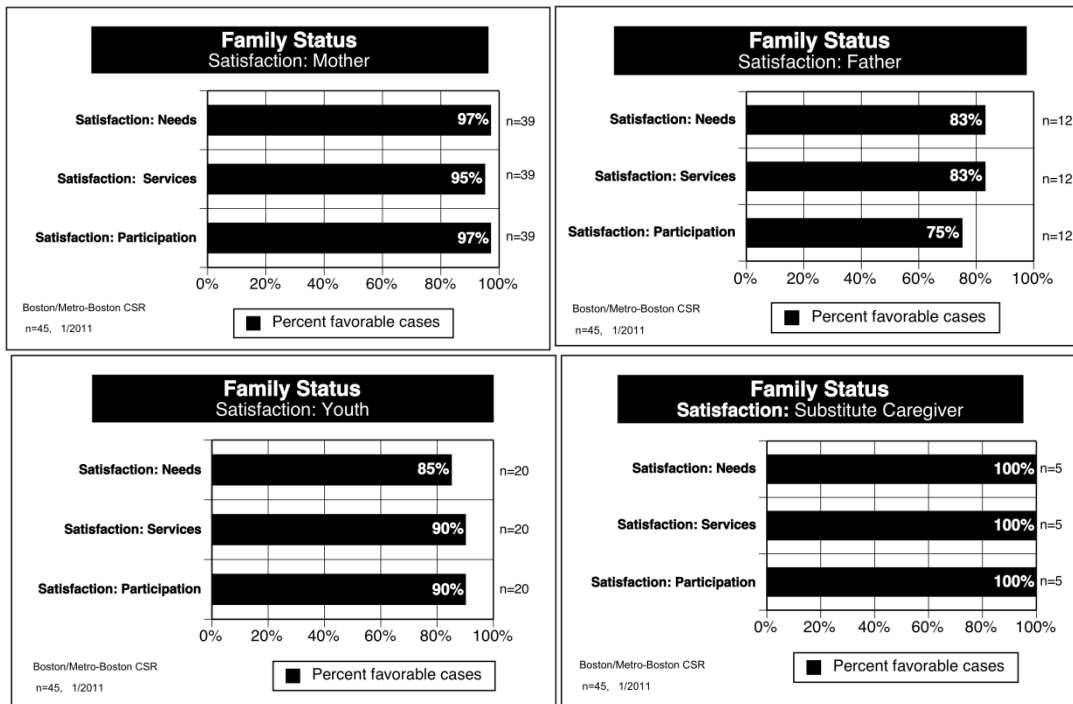
Family Voice and Choice is rated across a range of people as seen in the Caregiver Status: Family Voice and Choice chart above. For this indicator, in addition to parents/caregivers, the voice and choice of the youth is rated for youth who are over age 12. The variables that are considered when rating 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 youth reviewed where their mother was their caregiver (N=39), 95% or 37 mothers had favorable voice and choice in their child’s assessments, planning and service delivery processes. There were two mothers or 5% where there could be some refinement in strengthening their voice and choice. These data indicate that a significant percentage of mothers felt included in team processes, and the system is building a strong foundation for engagement of mothers reflective of use of system of care principles.

For youth whose fathers were involved and information could be gathered (N=14), 86% or 12 fathers had favorable voice and choice in involvement with their child’s service processes, again a favorable finding. Eight of the fathers, or 57%, could benefit from “refinement” or “improvement” in the influence of their voice and choice in planning and service delivery.

For the five youth with a substitute caregiver, all had a favorable situation in terms of their voice and choice in service processes. All were in the “maintenance” area indicating an ongoing positive pattern of inclusion of their voice and choice in service delivery processes.

There were twenty youth in the 12-17 age range in the sample. Of these 90% or eighteen youth had a favorable experience in having a voice and choice in their own services, with “refinement” indicated for eight or 40% of youth who fell in this age range. There were two youth age 18 and older, both with substantially good inclusion of their voice and choice in planning and service delivery, or 100% favorable.



**Satisfaction with Services and Results**

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

The charts above display the results for how satisfied each of the role groups were with having their needs understood, services and results, and participation. Mothers’ satisfaction was applicable for 39 families, with fairly high satisfaction (95%-97%) across the domains

measured. For the twelve fathers that satisfaction was measured for, ten (83%) were satisfied in having their child's needs addressed and with the service their child was receiving. Nine or 75% were satisfied with their ability to participate in services. The twenty youth for which satisfaction was measured were generally satisfied with the aspects of services examined (85%-90%). Satisfaction was measured for the five substitute caregiver, who were optimally satisfied across all sub-indicators.

***Summary: Caregiver/Family Status***

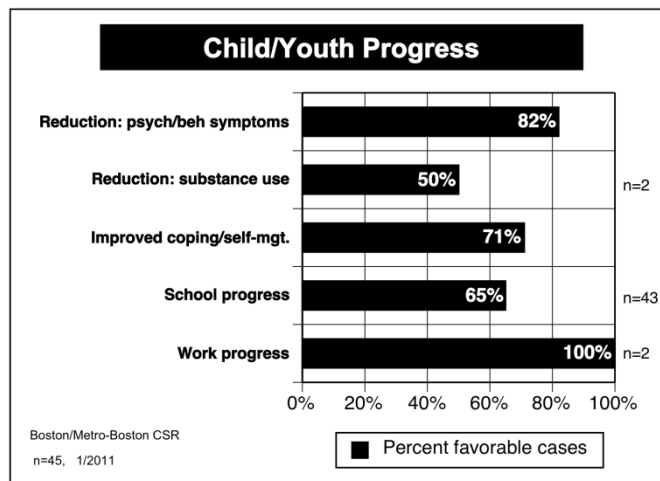
A high proportion of parents in the Boston/Metro-Boston CSR were found to be experiencing considerable challenges in their lives, often impacting their ability to provide the level of support their child required. Substitute caregivers had far fewer challenges and were providing favorable levels of support. Family voice and choice was strong across all groups. Mothers, youth, and substitute caregivers expressed satisfaction with the services; fathers were slightly less satisfied with identifying their children's needs and services; they were substantially less satisfied with their level of participation in planning and service processes.

**Youth Progress**

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

Determinations about a youth's progress serve as a context for understanding how much of an impact services and supports are having on a youth's forward movement in key areas of her/his life.

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. Change in this area is reviewed over the past six months or since the beginning of treatment if it has been less than six months. For the 45 youth reviewed, 82% of them had made favorable progress in reducing symptomatology and/or problem behaviors over the last six months which is a strong finding. Fifteen youth, or a third of the sample had made good to optimal progress. Thirty, or two thirds of the youth could benefit from “refinement” or “improvement” in reduction in the psychiatric symptoms. Three youth (7%) had made no progress, and their disorders were at moderate to severe levels with functional impairment and some risk present and increasing.

There were two youth with substance abuse issues, one had made fair progress needing refinement, and had made little to no progress and needed improvement.

***Improved Coping and Self-Management***

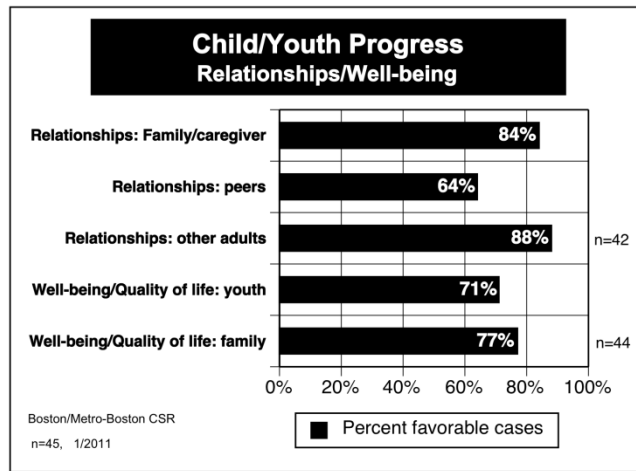
This indicator looks at the degree to which the youth has made progress in building appropriate coping skills that help her/him to manage symptoms/behaviors including preventing substance abuse relapse, gaining functional behaviors and improving self-management. Among the youth reviewed, only 32 or 71% had made favorable progress in improving their coping skills and ability to self-manage their emotions and behaviors.

Thirteen of the youth (29%) had made good or optimal progress in improving their ability to cope and manage their own behaviors. Thirty-two or 71% of the youth reviewed could benefit from “refinement” or “improvement” in their progress of improving their coping and self-management skills. Four youth (9%) were making poor progress in advancing coping and self-management at levels well-below expectations. These data indicate room for improvement in consistently helping youth to make progress in improving their coping/self-management skills.

**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. Of the 43 youth for which school progress was applicable, only 28 or 65% were making favorable progress. Eleven or 26% were making good to optimal progress in school. Thirty-two of the youth or 74% of the sample could benefit from a level of “refinement” or “improvement” in their school progress. One youth was making no progress, and three youth was regressing in key school areas. These results indicate more attention by teams in planning and implementing strategies for school success are needed for youth.

Progress in a work setting applied to two youth who were both making fair but favorable progress that needed some refinement in satisfying expectations necessary for maintaining employment.



**Progress Toward Meaningful Relationships**

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

For the 45 youth reviewed, 38 or 84% of them were making progress in their relationships with their families or caregivers, a positive finding. Progress in building peer relationships was less favorable, with only 29 of the 45 youth, or 64% making progress in building

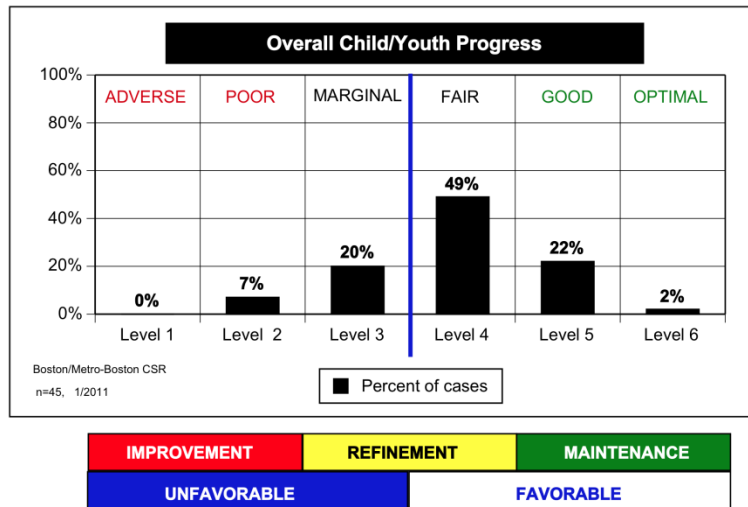
meaningful relationships with peers. Progress in developing relationships with positive supportive adults (teachers, coaches, etc.) was favorable for 88% of the youth for which the sub-indicator applied (N=42), which again was a positive finding.

**Overall Well-being and Quality of Life**

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

For the youth reviewed in the CSR, 71% or 32 youth were making favorable progress in an improved overall well-being and quality of life. Eleven youth, or 24% had made good progress over the last six months in developing and using personal strengths, long-term relationships, life skills, and future plans. The bulk of the youth, seventy-six percent (76%) or 34, could benefit from “refinement” or “improvement” in this area, indicating that teams and services may be underpowered in their ability to help youth in making more progress in improving their overall well-being. Of these, four youth (8%) had made poor progress in their overall quality of life and had developed few to no long-term supportive relationships, life skills for problem solving, educational/work opportunities, or meaningful and achievable future plans.

For the families and caregivers, 77% were making favorable progress in improving the overall quality of life.



**Overall Youth Progress**

A goal of care planning is to coordinate strategies across settings, and identify any needed treatments or supports youth need to make progress in key areas of their lives. Overall, 73% of the youth were making favorable progress (Fair, Good or Optimal Progress), which is an overall fair finding for progress. Among the youth reviewed, 7% were determined to need improvement, and 69% needed refinement in moving forward in the areas measured. For these youth, the right strategies at the right intensity may have been missing or underdeveloped. The remaining 31% were experiencing progress that should be maintained and sustained.



## **System/Practice Functions**

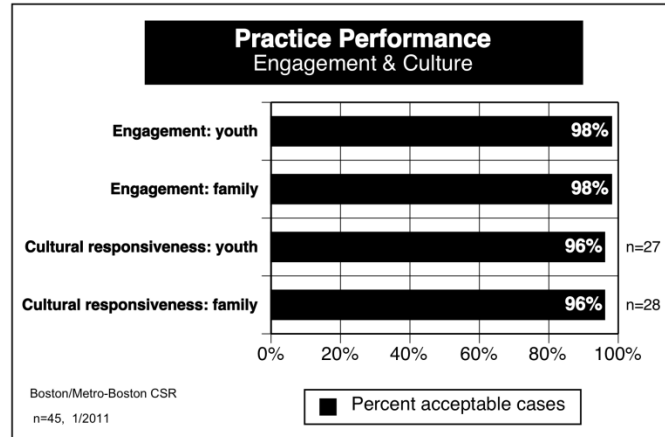
(System/Practice functions are measured as pattern of performance over the past 90 days)

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

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

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).



### ***Engagement***

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

For the youth reviewed, 44 or 98% experienced an acceptable level of engagement. Families were also engaged at an acceptable level 98% of the time. These are exceptional findings for Engagement. Eight youth (18%) and eight families (18%) in the sample may have benefitted from a strengthened level of engagement (Refine or Improve).

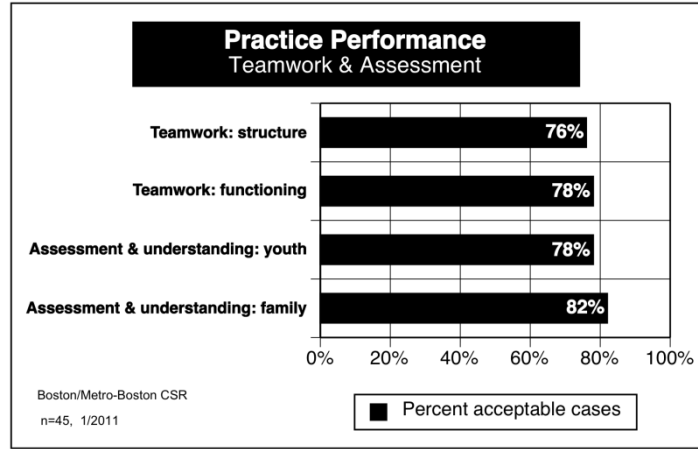
An example of Family Engagement that was successful across multiple domains of practice was found for one of the youth reviewed where, “(the) family is fully engaged in all aspects of treatment and planning and are driving treatment processes. The mother and youth both report a strong voice and choice. Cultural Responsiveness is one aspect of practice that is particularly strong for this team. The IHT and mentor are both (of the same gender as the youth) and the IHT speaks (the family's native language). (The IHT) reported that being of the same cultural background and being able to speak the mother's native language has allowed for the therapeutic bond to be strengthened and therapeutic sessions to address her underlying, core issues.”

### ***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.

For the 27 youth reviewed for which the indicator applied Cultural Responsiveness was acceptable for 96% of them, and for the 28 families where it was applicable, it was also

acceptable for 96%. These are very positive findings. Cultural Responsiveness was found to be unacceptable and poor for one youth (4%) and one family reviewed (4%).



***Teamwork: Team Formation and Team Functioning***

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

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

*Team Formation.* For the 45 youth reviewed in Boston/Metro Boston, team formation was acceptable 76% of the time or for 34 youth, indicating a level of improvement is needed in order for families to be able to consistently depend on teams of the right composition being formed. It should be noted that for 25 youth, or 56% of the sample, team formation was found to be good to optimal. Twenty of the teams (44%) needed “refinement” or “improvement” in formation through identifying the important team members, and engaging them in meeting, communicating and planning together. For three youth or 7% of the sample, team formation was considered to be poor meaning their teams met infrequently, did not include all the “right people” and did not have the skills or family knowledge necessary to organize effective services.

*Team Functioning.* Teams were functioning acceptably well for 35 or 78% of the youth reviewed. In 42% of the reviews, or for 19 youth, teams functioned at a good to optimal level and had the skills, family knowledge and abilities necessary to work in a unified manner and organize effective services and supports for the youth and families. Twenty-six of the teams (58%) needed some level of refinement or improvement to assure adequate team functioning. There was one team (2% of the sample) where the teams were functioning poorly, independently of the family and individuals were working in isolation of each other resulting in limited benefits for the youth and family.

An example of good team formation and functioning for a youth that had been expected to terminate from services is as follows. “The team maintains very good communication with one another, and is meeting regularly—which is even more impressive when one takes into account that meetings generally take much longer due to the need for an interpreter. Because the team is in good communication with one another, they have demonstrated adaptability and a clear delineation of roles and responsibilities. DCF commented in particular that the coordination of services has been a positive aspect of the work over the past several months.”

Also important to look at is an example where team functioning needed improvement. In this example, a number of core system/practice functions needed strengthening in order to better serve this youth and family. This example also highlights what has happened in this case where continuity of care has been interrupted during a transition from a residential treatment setting. “The youth has experienced turnover of all of her clinical providers at a critical time of transition for her. Due to her (residential) placement, and no firm projected date of discharge, IHT and Therapeutic Mentoring services, which have been experienced as quite helpful, will be discontinued imminently. There does not seem to be an effective team organized around the needs of this youth and family, other than those provided through the (residential) program. The alternative plan for family treatment, which will be delivered by the (residential program) on-site, is seen by (the youth and mother) as unworkable. It does not seem that her opinion has been sought relative to the development of the alternative plan.”

Teams forming and functioning well for youth and families is a foundational system function. The overall finding for this indicator is that there were many examples of well-formed teams that were achieving desired results. A level of improvement is needed in order to assure all teams consistently and diligently work together toward achieving common goals, communicates often, evaluates their results, and works in alignment with system of care principles.

### ***Assessment and Understanding***

This 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 an important foundational condition for practitioners to build cohesive teams and care plans that will result in positive outcomes.

Of the 45 youth reviewed, 35 or 78% were found to have an acceptable level of assessment and understanding of their core issues and situations. Twenty-six or 58% of the youth would benefit from “refinement” or “improvement” in the teams’ understanding of them. There were 19 youth (42%) with good to optimal assessment and understanding.

Assessment and understanding of families was acceptable for 82% of the sample. “Refinement” or “Improvement” was found to be needed for 27 families or 60% of the sample.

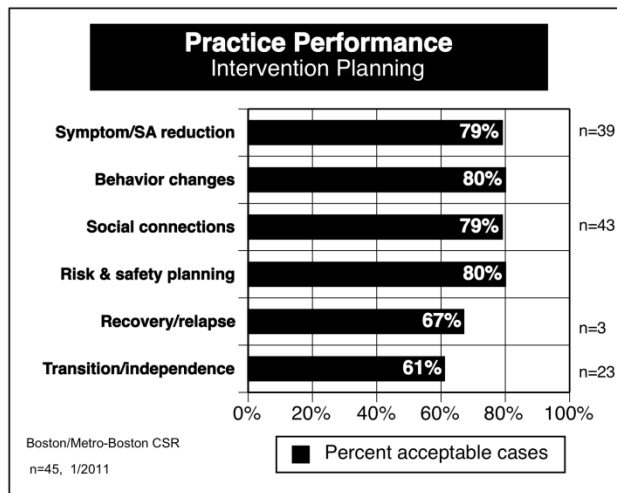
The following example highlights good assessment and understanding practices by a well-functioning team. “The ICC completed an excellent, sensitive Strengths, Needs and Culture Discovery and a fine, well understood Risk and Safety Plan that addresses the possible triggers to an angry outburst and practical steps to help deflect a crisis. The CSA has matched staff with the culture of the child and foster family. The Care Plan Team includes most of the important persons in (the youth’s) current situation, meets regularly, and communicates well. The whole team is working collectively on a clear set of mutually agreed upon goals -- trying to plan ahead for the transition to public school and help (the youth) prepare for adolescence. The individual therapist is attuned to the underlying needs that contribute to (the youth’s) negative behaviors, and consults regularly with the family.”

An example of assessment and understanding where the family’s needs were understood, but improvement was needed in achieving a shared understanding of the youth was: “Although there appears to be a good understanding of the family’s circumstances, natural supports, and needs, the youth’s (caregiver) feels that there is an incomplete understanding of (the youth’s) needs, more specifically (youth’s) cognitive abilities as well as mental health status. (The caregiver) stated that she wishes there could be a ‘full evaluation’ because she believes ‘there’s something else there.’ The IHT did a mental health assessment but there is no evidence that this was shared with others on the team, including the (caregiver). There is no evidence of any cognitive testing or in-depth neuropsychological evaluation. The IHT provider did a risk assessment, and (the youth) was assessed at low risk for harm to self and no risk to others, yet there is no evidence that the concerns expressed in the interviews about (the youth’s) continued involvement with gangs and risk of (condition) were reflected in this assessment, or that there is a shared understanding of the extent of these risks and how to address them.”

Another is: “Team members have conflicting views of the parents. The IHT staff, Individual Therapist, and Therapeutic Mentor describe the parents as ‘cognitively impaired’ with difficulties following through on recommendations, trouble reading and comprehending what is communicated to them, as ‘not wanting to do a lot to help (the youth),’ and having ‘no clue on how to parent.’ On the other hand, the principal describes the parents as having good follow through and ‘mom listens, she is good at that.’ The afterschool program director sees the parents as actively involved, giving the example of mother calling to express concerns about the youth’s anxiety ... The psychiatrist describes them as ‘very devoted parents who really love (the youth),’ indicating that they both come to appointments, provide good information, bring medication bottles with them, and express appropriate concerns about excess sedation. The PCP states the parents provide him with copies of reports and are good with follow-through. The DCF worker is not sure the parents are cognitively limited, ‘they need a lot of support, they understand everything but they get confused.’ The DCF worker does not share the protective concerns that the IHT team has

expressed. The CBAT Social Worker sees the parents as ‘limited, they take things literally’ but also states they want to learn about parenting as indicated by their participation in parenting support groups.”

“There are also differing perspectives about the child. The psychiatrist says ADHD is well founded but PTSD is not. The CBAT Social Worker sees (the youth) as limited intellectually and possibly showing signs of PDD. The IHT team sees unrealistic expectations from the school as being partly responsible for (the youth’s) hospitalization. The principal strongly disagrees, stating (the youth) ‘is playing a game, he can do his work.’ There are also different views about his prognosis, with some team members predicting improvement and some predicting a decline. All team members are hopeful that the upcoming trauma evaluation and neuropsychological evaluation will provide some clarity and direction. The individual therapist, however, disagrees with the need for a trauma evaluation and does not believe the alleged (trauma) occurred.” This example clearly shows the need for this team to “get on the same page” in order to have a clear, common understanding of the youth and family in order to develop a unity of effort and effective interventions.



### ***Planning Interventions***

In the CSR, Intervention Planning is evaluated across six sub-indicators. 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 look at planning from the perspective that plans and processes 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.

For the 39 youth the *Symptom or Substance Abuse Reduction* sub-indicator was applicable for, planning for reducing presenting psychiatric symptoms or substance abuse was acceptable for 79% or 31 of them. Refinement or improvement in planning in this area was needed for

24 or 62% of the youth. There was good or optimal planning in reducing symptoms or substance abuse for 15 or 38% of youth in the sample, hallmarked by well-reasoned strategies informed by an understanding of needs, and the youth and families' preferences and perspectives. For 2 youth (5%), planning in this area was poorly reasoned, inadequate to core issues, and lacked clarity/urgency.

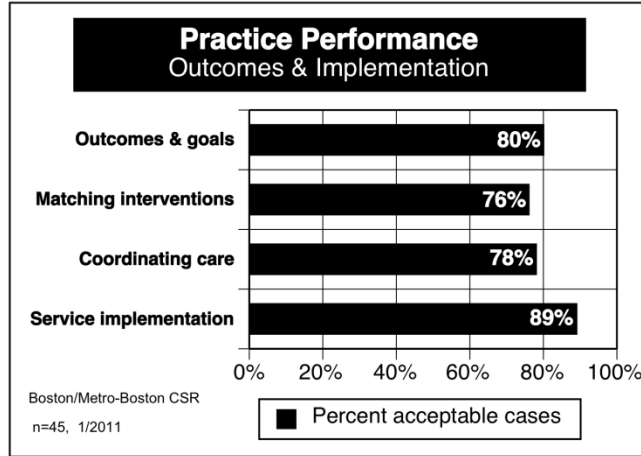
Targeting *Behavior Changes* in planning was applicable to all youth in the sample, and was at an acceptable level for 80% of them. Refinement/improvement was found to be needed 53% of the time. Twenty-one or 47% of youth had good to optimal plans that reflected understanding of the youth and family, and had clear interventions for addressing behaviors that created problems for the youth. For one youth (2%) intervention planning to address behaviors was poorly reasoned and inadequate, failing to design interventions to address needed behavioral change.

Planning for increasing *Social Connections* was applicable for 43 youth in the CSR sample and acceptable for 79% of them. Fourteen youth (33%) had good to optimal strategies in their plans for improving their social connections reflecting well-reasoned and ongoing planning processes. Refinement/improvement was needed in plans for 29 or 67% of youth who needed their social connections to be strengthened in order to do better emotionally or behaviorally. Of these, two youth (5%) had poor planning that reflected unaligned strategies that lacked clarity and urgency, and one youth (2%) had no clear planning process in place that addressed social connections.

*Risk/Safety* planning was applicable to all 45 youth in the CSR sample. Planning was acceptable for 36 or 80% of the youth. The risk/safety component of plans was good to optimal for 19 youth or 42%. Youth would benefit from refined/improved planning in 57% of the cases for which risk/safety issues were present. For three youth (7%), risk/safety planning was marginally inadequate to poor, and should be reviewed by teams to assure the likelihood that they will work if a crisis were to occur.

Three youth in the sample needed *Recovery or Relapse* addressed in planning. Planning to address the recovery process and prevention of relapse was acceptable but needed refinement for two of the youth (66%). For one (33%), intervention planning to address recovery/relapse issues was poorly reasoned and inadequate. Overall, *Recovery/Relapse* planning was acceptable for 67% of the youth this indicator was applicable for.

Among youth in the CSR sample, 23 needed to have *Transitions* addressed in their planning processes. 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. For the 23 youth experiencing transitions in their lives, planning was acceptable for 14 or 61%, indicating an area for improvement in order to assure transitions are consistently identified and planned for. Transitions are key opportunities for teams to take special care in their planning so that youth with special needs do not decompensate, regress or lose gains that have been made. While 5 youth (22%) had transition planning at a good to optimal level, 78% of the sample could benefit from refinement or improvement in planning. Five youth (22%) had transition planning that was poor and inadequate to support the youth through a transition.



***Outcomes and Goals***

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

A clearly stated and understood set of goals and outcomes guiding services and strategies that describe the “ending requirements” for the youth was acceptable for 80% of the youth. Forty-seven (47%) of the youth had good to optimal goals that were well-reasoned and were specific. Fifty-three (53%) of them had ending goals and outcomes that needed to be “refined” or “improved.” Among these, one youth or 2% of the sample had poor specification of outcomes and goals, insufficient for guiding intervention and change.

***Matching Interventions to Needs***

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

For the youth reviewed, there was an acceptable level of matching intervention to need for 76% (34 youth). Overall, 47% of teams could “refine” or “improve” the identification and assembly of services and supports into a more sensible, coherent service process that is coordinated across service providers, and will support youth in meeting their goals. One youth (2%) had poorly matched interventions, resulting in inadequate assembly of service and supports.



### ***Coordinating Care***

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

Youth in the sample received care coordination services from both ICC (N=26) and IHT therapists (N=19). Care coordination practices were found to be at an acceptable level for 78% of the youth reviewed. Care coordination was found to be "good" or "optimal" for 51% of the youth reviewed. For the other 49%, care coordination needed "refinement" and was found to be at fair or marginal levels.

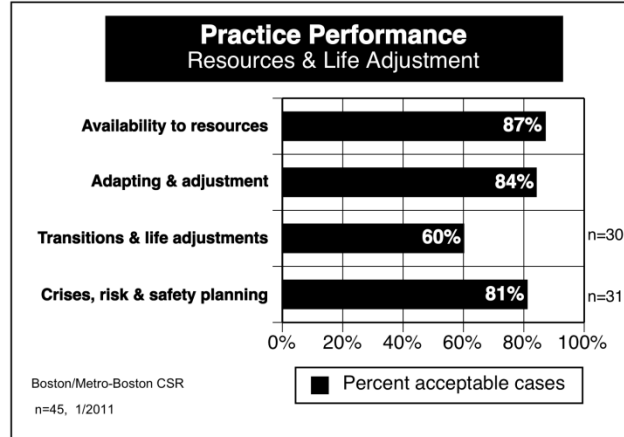
Good care coordination practices were observed where, "The ICC has a clear perspective of the family functioning and the underlying issues impacting progress, and she has done a notable job of engaging team members to participate, and in keeping them informed."

An example of coordinating care that needed improvement was, "Turnover in ICC, (there have been 3 in 6 months) has caused a lack of leadership and direction. There have been no CPT meetings in the last 2 months and most members raised lack of consistent ICC as a barrier to team functioning. The CPT can reference its past progress but future direction is unclear and the team seems to be experiencing a plateau or drift with direction." In this case, it is clear to see how care coordination is linked to team functioning.

### ***Service Implementation***

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

For the youth reviewed, 89% of them had acceptable service implementation, a strong finding. Fifty-six percent (56%) had good to optimal service implementation, while 44% needed implementation to be "refined" or "improved." One youth (2%) had poor service implementation, meaning services and supports identified in the care plan were not adequately implemented.



***Availability and Access to Resources***

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

In the CSR, 87% of youth had acceptable access to available resources, a strong finding. There was a good and substantial array of supports and services for 51% of the sample, and room for refinement, meaning fair to marginal resource availability, for the remaining 49%. Access to needed resources appears to be a strength for youth who are in ICC/IHT services in the Boston/Metro-Boston area.

***Adapting and Adjustment***

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

For youth reviewed, practices related to adapting and adjusting plans and services was acceptable for 84% of the youth, with 58% having good to optimal practices. Forty-two percent (42%) were found to need some level of “refinement” or “improvement.” There were two youth (4%) with poor and fragmented adapting and adjustment of services and interventions. Overall, adapting and adjusting services through monitoring of progress and changing interventions when needed, appears to be a strong system practice in the Boston/Metro-Boston service system.

***Transitions and Life Adjustments***

For youth who have had a recent transition, or one is anticipated, reviewers examined the degree to which the life or situation change was planned, staged and implemented to assure a timely, smooth and successful adjustment. If the youth is over age 14, a view by the team as well step-wise planning to assure success as the youth transitions into young adulthood is most often 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 thirty youth this indicator applied to, only 60% or 18 youth had acceptable transition management practices in place. Nine youth (30%) experienced good to optimal transition interventions. Twenty-one youth (70%) could benefit from “refined” or “improved”

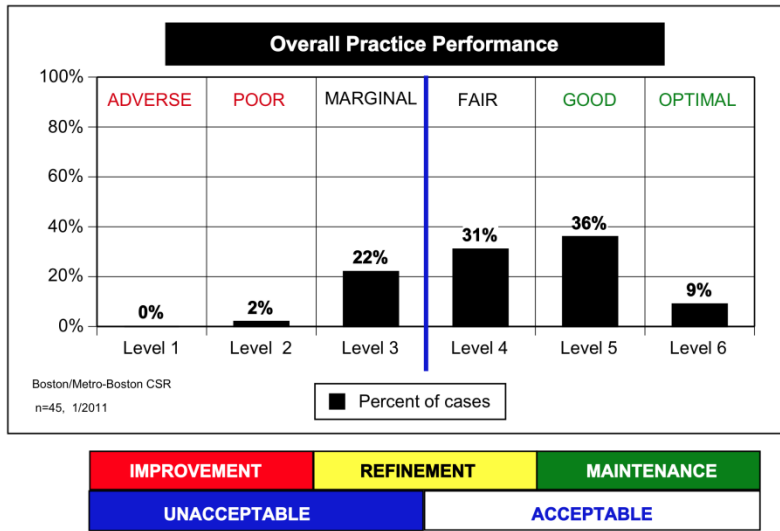
transition supports, including six youth (20%) who experienced a poor transition with unaddressed transition issues, and no transition plan for an imminent change.

Overall, improving the ability to identify, plan for and implement supporting youth in their life transitions needs improvement. Strategies such as focused training, supervision and quality management are warranted to improve transition and life adjustment management.

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

For youth where this indicator was applicable (N=31), 81% or 25 youth had an acceptable crisis response and risk plan that worked acceptably well. Fifteen of the youth (48%) were rated to have experienced a good to optimal response to crises and/or safety issues, and 52% needed “refinement” or “improvement” in crisis response and risk/safety planning. Among the youth that needed improvement in their crisis response were two (6%) who experienced a poor response, and one (3%) that had an adverse response to a crisis.



***Overall System/Practice Performance***

The chart above shows the distribution of scores for System/Practice Performance across the six point rating scale. For the youth reviewed, when rounded, 76% were found to have acceptable system/practice performance. Performance scores clustered at the good, fair and marginal levels with 89% of youth reviewed falling in this range. When interpreting results for system/practice performance, it is important to see them in the light of overall practice

patterns and how youth are doing and progressing. Youth and families come into services with the expectation that they can depend on services that will help them. In other words, the expectation is that the system and practices should be performing acceptably well for most of the youth and families services.

Forty-five percent (45%) of the youth reviewed fell in the “Maintenance” area, meaning the system and practices were effective for them, and efforts should focus on sustaining and building upon a positive practice situation.

Fifty-three percent (53%) of youth reviewed fell in the “Refinement” area which means that performance was limited or marginal, and further efforts are necessary to refine the practice situation. Practice patterns in these situations require refinement in order to impact better youth engagement, teamwork, understanding, planning, matching interventions to needs, coordinating, implementation/adjustment of services and crisis responses as described in this section.

Two percent (2%) of youth fell in the “Improvement” area meaning performance was inadequate, in this case practices were fragmented, inconsistent and lacking in intensity. Immediate action is recommended to improve practices for youth falling in this category.

The data indicate that the strongest areas of practice for the sample as a whole (there is variability in performance results for individual youth) were Engagement with the Youth and Family; Cultural Responsiveness; Service Implementation; and Availability and Access to Resources.

Indicators that showed an overall fair performance but at a less consistent or robust level of implementation were Teamwork (Functioning); Assessment & Understanding of Youth and Family; Planning Interventions for Symptom or Substance Reduction; Planning Interventions for Behavior Changes; Planning Interventions for Social Connections; Planning Interventions for Risk and Safety Planning; Outcomes and Goals; Coordinating Care; Adapting and Adjustment; and Responding to Crises and Risk & Safety Planning.

Areas of system/practice performance that need some level of improvement in order to assure consistency, diligence and/or quality of efforts are Teamwork (Formation); and Matching Interventions to Needs.

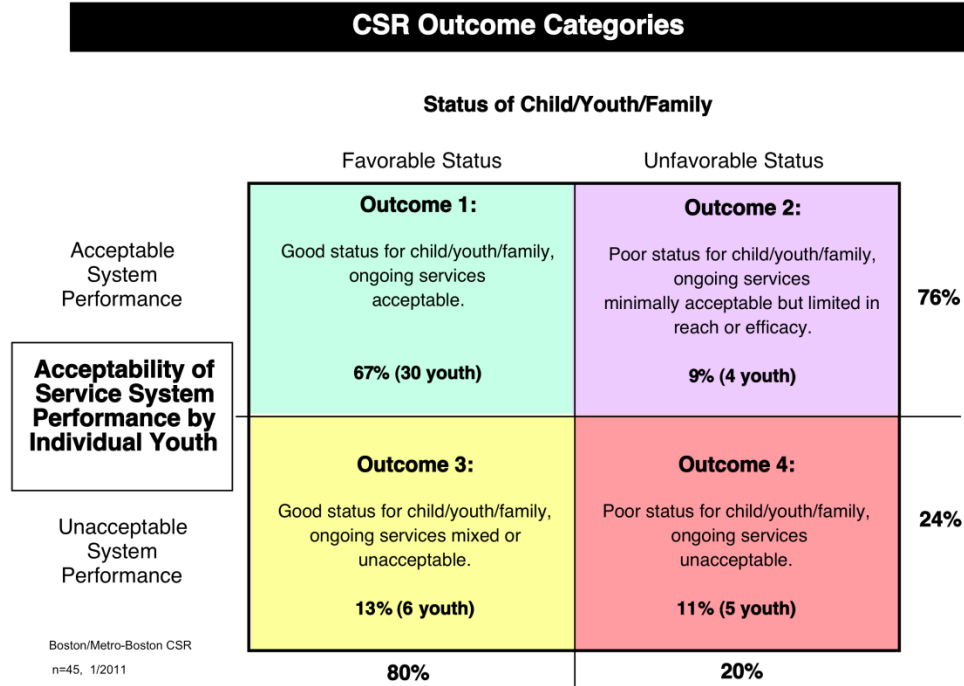
Review results indicate weak performance was found in the following system/practice domains: Planning Interventions for Recovery or Relapse; Planning Interventions for Transitions; and Transitions & Life Adjustments.

Overall, the findings of the CSR showed that for Boston/Metro-Boston services, key system of care practice such as engagement of families, and cultural responsiveness were strong. Resources were available for most youth, and services identified in youth’s plans were being implemented in a timely manner.

A number of other system practices need a degree of improvement to assure all system practices are dependable, consistent and reliable. Teams for about a quarter of the youth needed to improve their ability to be formed with the right people that can bring together collective skills and knowledge necessary to address youth and family needs. Teams are functioning at a fair level, including fully assessment information and broad understanding of the youth and family to create workable plans. Planning functions that were measured need some level of improvement, particularly in the recovery/relapse and transition planning domains, in order to assure youth have plans that address the core issues and achieve desired

results though active care coordination and systematic review and adjustment of plans and services.

These findings suggest that in a number of foundational system of care practices Boston/Metro Boston region are occurring well and moving toward achieving dependable functional teams and well-coordinated care. Quality training, support and oversight is likely needed to assure all teams are working in concert to consistently understand the strengths and needs of the youth and family, establishing agreed upon goals, and identify and implement strategies that work. As will be discussed in the next section, 76% of the youth were found to have overall acceptable system practices, suggesting a level of focused, strategic, and sustained improvements in practice will likely continue to enhance system performance.



**CSR Outcome Categories Defined**

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

**CSR Results**

**Outcome 1**

As this display indicates, 67% (30 youth) of the 45 youth fell into outcome category 1. Outcome 1 is the desired situation for all children and families receiving services.

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

*“Most excellent...is the level of assessment and understanding that underlies the team’s work. The ICC has done an outstanding job of bringing together a clinical picture of (the youth) that all parties fully understand and agree with, incorporating the CANS, and sharing the comprehensive assessment with the team. The ICP follows clearly from the assessment and contains specific, measurable goals. Each team member is clear on his or her role. Communication among team members is full, up-to-date, and collaborative...The CPT is working together to prepare mother for self-sufficiency in the future. The Family Partner is building natural supports through connections to other parents in CSA services, neighborhood groups, and encouragement of help from the children’s godmother. Mother is beginning to facilitate her own CPT meetings.”*

## **Outcome 2**

Four youth or 9% of the sample fell in Outcome 2. This category represents children whose needs are so great or complex that despite the best practice efforts and diligent system performance of the service system, the overall status of the child or youth is still unacceptable.

An example of a youth who fell in Outcome 2 is as follows. This is a youth who was in an out-of-home treatment setting at the time of the review, and whose serious mental health concerns had not been well-understood by those providing services in the past.

*“The Care Planning Team has done a wonderful job engaging parents who for years have been both culturally and linguistically isolated from their community. They are successfully overcoming years of fear and mistrust of professional helpers, and are now working with the parents to develop plans for (the youth’s) transition home. The Team has made a good effort to understand the family’s culture, and how this might impact the implementation of the Care Plan and IHT Treatment Plan. (The youth’s) most recent C-BAT admission occurred as the result of the parents initiating a successful Mobile Crisis evaluation, which reportedly would have been unheard of just a few months ago. As mentioned above, the parents have both now accepted that (the youth) has special needs, and that they must learn new skills to more effectively help him. Both parents reported high levels of trust with this group of providers, and felt that the past few months have been very positive.”*

## **Outcome 3**

Thirteen percent (13%) or 6 youth were in outcome category 3. Outcome 3 reflects youth whose status was favorable at the time of the review, but who were receiving less than acceptable service system performance. Some children are resilient and may have excellent naturally occurring supports provided by family, friends, school personnel, or some other key person in their life whose efforts are significantly contributing to the child’s favorable status at the present time. However, current service system/practice performance is limited, inconsistent, or inadequate at this time. For these children, when teams and interveners adequately form, understand the youth and family, and function well, the youth could likely progress into the outcome 1 category.

The following is an example of a youth in Outcome 3.

*“While (the youth) has made gains in the community and with his social interaction, there continues to be issues at home and school. His service plan is limited with broad goals that aren’t measurable and do not fully address key areas of concern. Turnover in ICC, (there have been 3 in 6 months) has caused a lack of leadership and direction. There have been no (Care Planning Team) meetings in the last two months and most members raised lack of consistent ICC as a barrier to team functioning. The Care Planning Team can reference its past progress but future direction is unclear and the team seems to be experiencing a plateau or drift with direction.”*

## **Outcome 4**

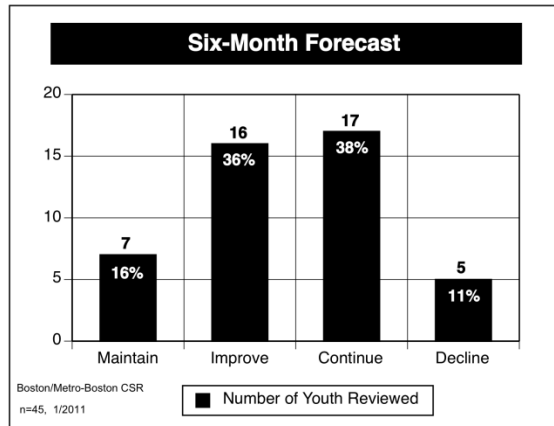
In the Boston/Metro Boston CSR, 11% of the sample or 5 youth fell into outcome category 4. Outcome 4 is the most unfavorable outcome combination as the child’s status is unfavorable and system performance is inadequate. For many of the youth who are in Outcome 4, a better understanding of the youth and family coupled with stronger teamwork and planning interventions that meet the needs of the youth with strong oversight of implementation would move the youth into a better Outcome classification.

An example of a youth who fell in Outcome 4 is as follows. There are a number of significant challenges for this youth and family, including cognitive disability of the parent impacting the ability to provide effective caregiving, housing issues threatening stability for the family, and a sibling with a disability. The youth has co-occurring serious health issues, had recent suicidal ideation, and DCF has become involved. Risk does not appear to be acknowledged, and there is not a unified effort by the team at the level needed to address the youth and family’s challenges.

*“Although the team consists of many of the appropriate team members, the family would benefit by receiving ICC services and a family partner to give additional support to address (their) struggles. The team struggles in communicating and meeting on a regular basis. The team focused many of its efforts on the mother’s functioning and less time assessing the client’s immediate emotional needs. The communication between the team members did not occur on a regular basis. There were no up to date risk assessments in the file. The safety planning was completed verbally with the family. At the time the IHT didn’t see behaviors that were considered at-risk.”*

**Overall outcome findings**

The percentages on the outside of the two-fold table on Page 50 represent the total percentages in each category. The percentage at outside, top right (76%) is the total percentage of youth with acceptable system/practice performance (sum of Outcomes 1 and 2). The percentage below this (24%) is the inverse- the percentage of youth with unacceptable system/practice performance. Again, these numbers reflect rounding and the total is slightly more than 100%. Likewise the number on the outside lower left is the percentage of youth that has favorable status (80%) and under the next block the percentage of youth with unfavorable status (20%).



**Six-month Forecast**

Based on review findings, reviewers are asked if the child’s situation is likely maintain, improve, continue or decline. For 7 youth or 16%, the prediction is that the youth would maintain their current status. For 16 youth or 36% of the sample, the prediction was for improvement in situation. For 17 youth or 38%, the reviewers predicted the youth’s situation to remain the same, which could be favorable or unfavorable. For 5 youth or 11%, the prediction was that their situation would decline.



## Summary of Findings

Data, Findings and Recommendations in this report are presented through the perspective of examination of the consistency and quality of service provision and practices in meeting requirements of the *Rosie D.* Remedy. These include requirements for services provided consistent with System of Care Principles, and wraparound principles and phases. Eligible youth are also required to be provided timely access to necessary services through effective screening, assessment, coordination, treatment planning, pathways to care and mobile crisis intervention when needed. In addition, services and practices need to support youth and families to participate in teams, have teams with the involved people that work together to solve problems, and understand the changing needs and strengths of youth and families across settings. As well, it requires well-executed care coordination that results in care consistent with the CASSP principles; and is strength-based, individualized, child-centered, family-focused, community-based, multi-system and culturally competent. The Remedy requires 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

#### ***Respect for family voice is growing as a system of care value.***

Most of the teams reviewed clearly embraced the importance of family voice/choice and family engagement in their work. Many families expressed appreciation for services and felt supported by their care planning teams. The value of family voice in the service process was also acknowledged by staff from other child-serving systems such as DCF; many were excited about the emerging practice model afforded through the CBHI.

#### ***There were many examples of excellent work.***

The CSR review team identified exemplary practices including in care coordination, teamwork and integration of efforts with other agencies. Care Coordinators, in general, had built strong engagement with families and youth. Notable was the coordination by an ICC for youth who are hearing-impaired. Teams were seen to have increasingly more ownership for outcomes. Reviewers reported on a functional working relationship created with a family previously seen by interveners as “difficult to work with,” resulting in a better understanding of the youth and family. The review team also observed many Family Partners and Therapeutic Mentors whose interventions and supports were therapeutic and supportive of family and youth progress, and IHT clinicians who were skilled and going the “extra mile” in their work. There were staff from diverse ethnicities among the providers, although bilingual staff appear overburdened because of the demand for their services.

#### ***Teams are implementing key foundational system practices.***

There was evidence to support the conclusion that most of the teams are aware of wraparound principles and practices, are engaging and listening to the expressed goals of families and youth, and understand the strengths and needs of families. Teams are approaching their work in culturally responsive ways. Care coordinators are assuring services are implemented in a timely manner.

***System of Care Committees are meeting and offering a viable forum for stakeholder problem solving.***

System of Care (SOC) Committees are providing opportunities for joint problem-solving and have the potential to become an important asset for the local systems of care in Boston/Metro-Boston communities.

**Challenges**

***Staff and teams do not consistently know how to use assessments and other relevant information needed to develop effective plans of care.***

Although it was reported that 87% of youth had a current assessment in their file, it was less apparent that teams consistently used information that helped them to better understand youth's functioning and behaviors and to identify unmet needs. Information from multiple perspectives and domains (example: education, health, etc.) were not consistently integrated into the team's discussions, formulation of strengths and needs, and planning efforts for services and interventions.

Absent broader and in-depth understanding, "underpowered" plans and interventions often ensued which lacked the capacity to fully address behaviors and needs. Plans were often formulaic and stopped at itemizing a set of services from the array; they were not individualized, detailed or accountable at the level needed to impact a youth's progress or status in important areas of their lives.

***For youth with specialized needs, teams lacked the knowledge, capacity and resources to develop plans and services***

Twenty percent (20%) of the youth reviewed had an autism spectrum disorder. Teams for these youth often lacked knowledge about the unique needs and strategies that work for the population. They were challenged in their ability to develop useful plans, and did not consistently consider in-home behavioral services.

Specialized therapeutic and community resources were difficult to find or non-existent for youth who are hearing-impaired.

***Supervision structures that support the practice model, develop staff skills, and assure effective results were not consistently evident.***

Supervision structures and systematic supervisory practices that consistently support staff to address challenges in their work and acquire the skills, knowledge and abilities to implement the practice model can be a pivotal component to service systems. It was not clear in the CSR that care coordinators and other staff were receiving the level of support or supervision that may help address key system challenges. These included:

- Developing comprehensive individualized plans that truly reflect an understanding of the needs of the youth and family.
- Under-identification and use of natural supports to address youth and family needs.
- Planning and supporting youth transitions
- Effectively addressing recovery/relapse issues of youth
- Understanding the coordination role of IHT including when to refer to ICC.
- Role of the team in implementing strategies and the work and teaming that needs to occur in between meetings.

- Therapeutic mentors were seen to be a clear asset however there was little support, specialized training, or strategic use of the TM's beyond broad goals (e.g.: “work on socialization skills.”).
- When teams and coordinators are unable to address “system issues,” that are impacting the well-being of youth; teams are not aware of pathways to raise interagency issues to senior management.

***Coordination with some role groups remains a challenge.***

Although reportedly improving, reviewers observed continued challenges of achieving real collaboration with certain role groups that are critical for team processes. Staff from other child serving agencies (schools, DCF, DYS, etc.) are not consistently included in teams. Outpatient providers often provide services through a “private practice” model and do not join with teams. Inpatient treatment often does not work closely with teams and community providers creating issues with medication changes, recommendations that do not reflect the ongoing process with youth and family and less than effective transitions. Many of the youth in the sample had serious health issues impacting their status; in a number of the reviews, there were weak linkages to healthcare.

***Mobile crisis teams don't uniformly respond to a crisis when a child is aggressive.***

***Business practices often challenge staff in their work.***

While there is recognition by stakeholders that the system is still emerging and adapting, and there has been a tremendous amount of good will among them, challenges to implementing the practice model have been identified. Key among the expressed challenges is that productivity and billing demands sometimes drive decision-making instead of the best planning of the team. Documentation requirements are cited as being onerous. Team and care coordinator turnovers resulted in disruption in relationships and/or service delivery causing youth and families to lose ground.

There were issues identified regarding the definition of a “billable service” and the crosswalk with mandates for providers that are impacting coordination efforts. For example, there is a need for ICC care coordinators and Family Partners to collaborate, but that collaboration time is not billable. Another example is ICC care coordinators have to meet with inpatient or CBAT staff if a youth is admitted to those service with admissions occurring all over the state, but travel time is not billable, which impacts the ability to coordinate at critical times for the youth. There is also the example of supervision being expected and needed, but the rate provides for only a minimal amount of supervision and training.

## **Recommendations**

### ***Assure plans/interventions are individualized and at the intensity/scope needed to address needs and achieve results.***

- Provide greater emphasis in care plans for short-term achievable goals versus only 3-6 month goals.
- Help teams to achieve functional status results and progress for youth in areas such as improved stability, behavioral risk, emotional/behavioral status, academic achievement/school progress, family challenges, substance use, and social connections with peers.
- Address transition planning and substance abuse recovery/relapse.
- Consider ways to build these practices into the quality assurance and improvement systems of agencies.

### ***Strengthen supervision to fully support the practice model.***

- Assure staff have a way to obtain support, information and/or direction from senior management when interagency challenges threaten to impact child well-being and/or progress.
- Consider effective strategies for ongoing wraparound and practice training and coaching
- Provide support through supervisory practices for in-home therapists to assess when a youth and family may need ICC. Assure all in-home therapists understand their role in providing care coordination.
- Coach facilitation skills of care coordinators for engaging all relevant people who should be part of teams.

### ***Develop an inter-system protocol for systematic coordination with:***

- Primary care when a youth has medical issues impacting their overall well-being
- Psychiatrists
- Inpatient and residential providers

### ***Clarify Scope of Crisis Services***

- Clarify the role of MCI in responding to a crisis where a child is reported as aggressive. While by no means do all crises involve aggressive behaviors, there are times when they do. It is recommended that practice guidelines for crisis response are well-understood by all responders and stakeholders.

## Appendix 1

### Child's General Level of Functioning

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

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

Appendix 2

**CSR Interpretative Guide for Person Status Indicator Ratings**

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

**CSR Interpretative Guide for Practice Performance Indicator Ratings**

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