Report of Findings of the
Community Services Review of
Boston/Metro-Boston,
Massachusetts
April-May 2012

Fiscal Year 2011-2012 Reviews

Rosie D. Community Services Review Boston/ Metro-Boston

Regional Report

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Executive Summary

This report presents findings of the Community Services Review (CSR) conducted in the Boston/Metro-Boston region during April-May 2012. The CSR, a case-based monitoring methodology, reviews *Rosie D.* class members across key indicators of status and progress as a way to determine how services and practices are being performed. The intensive reviews were conducted of 48 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 area.

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

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

Highlights of Findings from the April-May 2012 Boston/Metro-Boston CSR

Status and Progress Indicators. In the CSR, Youth Status, Youth Progress, and Family Status are reviewed to understand the how well behavioral health services and practices are working for youth and families. The following are the status and progress findings for youth reviewed in the Boston/Metro-Boston CSR during April-May 2012.

Youth Status. Overall youth status was favorable for 67% of the sample; a significant number of youth had overall unfavorable status. Stability of home was a concern for a number of youth reviewed, as were patterns of attendance, academic performance and behavioral supports in school. Youth were generally safe in their homes and schools; community safety was a concern for a number of youth reviewed. Youth also had generally favorable living arrangements and permanency status. Behavioral risk toward self was an area of concern for many of the youth, and emotional status was unfavorable for 42% of those reviewed. More attention by teams in understanding and building effective supports and treatments for improving youths' home stability, behavioral risk to self and emotional well-being is warranted.

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

Fathers and mothers in the Boston/Metro-Boston CSR had high levels of challenge in their lives; support for youth was negatively impacted for both parents. Support for youth who were in substitute and group caregiving was positive. Family voice and choice was fairly strong for mothers and substitute caregivers, but weaker for fathers and youth, especially for those aged 18-21. Satisfaction was favorable among mothers and fathers in the understanding of their needs and with services; but less favorable for their level of participation. Youth were satisfied with services, but less satisfied with their needs understood and their participation. Substitute caregivers were satisfied with all domains measured.

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

Only 63% of the youth in the Boston/Metro-Boston CSR were making favorable progress (Fair, Good or Optimal Progress). This indicates that overall, youth were making weak progress in key life areas. Of particular concern was weak progress for youth in reducing substance use, and improving coping and self-management skills. As well, youth were making weak progress in school, in their peer relations and in their overall well-being and quality of life. Youth were making fair progress in improved family relationships, and relationships with other adults.

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

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

For the youth reviewed, only 54% were found to have acceptable system/practice performance. This indicates system performance and practices for youth in Boston/Metro-Boston are weak. For 46% of youth, the system needs to improve its performance in providing dependable, quality services. This represents a decline in performance compared to the previous CSR for Boston/Metro-Boston when 76% of the sample had acceptable findings. All but one of the system/practice indicators saw declines since the previous CSR results; most of the indicators were performing well below acceptable levels.

The data indicate that the strongest area of practice for youth in Boston/Metro-Boston was Cultural Responsiveness to Youth.

There were three areas of practice with overall fair performance: Engagement with the Family; Engagement with Youth; and Cultural Responsiveness to the Family.

One system/practice performance indicator needs improvement in order to be considered to have adequate consistency, intensity and/or quality of efforts: Availability and Access to Resources.

All of the remaining system/practice domains demonstrated weak performance including: Team Formation and Team Functioning; Assessment & Understanding of Youth and Family; all Planning Indicators (Planning Interventions for Symptom Reduction Planning Interventions for Behavior Changes; Planning for Social Connections; Planning Interventions for Risk and Safety; Planning Interventions for Recovery and Relapse; Planning Interventions for Transitions); Outcomes and Goals; Matching Interventions to Needs; Care Coordination; Service Implementation; Adapting & Adjustment; Managing Transitions & Life Adjustments; and Responding to Crises.

No system practices showed improvement over the previous CSR; all indicators declined in performance with the exception of Managing Transitions, which stayed the same and continued to have weak performance. Cultural Responsiveness to Youth was the only system practice that remained at a strong level.

Overall practice was very weak (54%). Based on the review of youth, the system of services in Boston/Metro-Boston has declined in performance and lacks capacity to provide consistently reliable services at the quality needed to help youth make progress, achieve desired outcomes or maintain recent gains. Nearly all areas of practice need concerted improvement in order to be considered adequately working for youth and families.

There is considerable concern about the system of services for youth in Boston/Metro-Boston. Almost twice as many youth as in the previous CSR were found to have unacceptable system performance. Teams were not adequately formed for half (50%) of youth, and nearly half (48%) of teams were functioning in a limited manner, were splintered or inconsistent in their planning and evaluating results, and were not engaged in collaborative problem-solving in ways that could impact positive change for youth and families. Half of youth (50%) and 44% of families were not well-assessed or understood, which is a foundation for providing effective supports and services for youth and families. Further, 46% of youth did not have a current mental health assessment in their files. The planning indicators overall were found to be extremely weak and, for a significant number of youth, did not reflect effective planning processes or plans that were well-reasoned or clear in addressing strengths and needs for enough youth. Planning transitions for youth was unacceptable for almost 47% of youth, and transitions were not managed well for 40%. Managing crises for youth dipped to being acceptable for only 62% of youth as compared to 81% in the previous review.

With only 54% of youth receiving acceptable system performance, focused improvements of core practice functions and concerns identified in this report will be important for the Commonwealth to address in order to be considered to providing adequate services for youth in Boston/Metro-Boston.

The Rosie D. Community Services Review
Regional Report for Boston/Metro-Boston, Massachusetts
For the Review Conducted in April-May 2012

Introduction

Overview of Rosie D. Requirements and Services

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

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

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

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

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

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

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

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

Purpose of monitoring

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

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

Overview of the CSR methodology

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

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

The CSR process involves a cadre of trained reviewers who interview those involved with providing services and supports for the youth, along with parents and/or caregivers, and the youth if appropriate. Also interviewed are members of the care team which may include teachers, child welfare workers, probation officers, psychiatrists and others. Reviewers also read ICC and/or IHT case records. Through using a structured protocol, reviewers make determinations about youth status/progress (favorable or unfavorable) and system/practice performance (acceptable or unacceptable) through a six-point scale. Refer to Appendix 2 on Page 60 for a full description of how each of the terms is defined. The six-point ratings are overlaid with "zones" of improvement, refinement, or maintenance. This overlay is provided to help care planning teams focus on youth concerns and/or system practices that may need attention. When reviewing the status and performance indicators that start on Page 20, it will be helpful to refer to Appendix 2 in understanding the ratings and findings.

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

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

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

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

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

The Boston/Metro-Boston CSR

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

CSAs are the designated agencies across the Commonwealth for the provision of Intensive Care Coordination. There are eight Community Service Agencies (CSAs) provided by human service agencies across the Boston/Metro-Boston region. In addition to Intensive Care Coordination, the CSAs also provide Family Support and Training Services, more commonly called Family Partners.

In the Boston/Metro-Boston region, the CSAs serve the towns in which they are located and the surrounding areas. The CSAs are Bay State Community Services (Quincy, Coastal), Children's Services of Roxbury (Roxbury, Boston), The Home for Little Wanderers (Park Street, Boston), The Home for Little Wanderers (Hyde Park, Boston), MSPCC (Dimock Street, Boston), North Suffolk Mental Health Association (Chelsea, Harbor Area), Riverside Community Care (Arlington), and The Guidance Center (Cambridge).

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

Review Participants

Altogether, approximately 575 individuals participated either in the youth-specific reviews or were interviewed in stakeholder focus groups in the Boston/Metro-Boston CSR. Table 1 displays data related to the youth-specific reviews where a total of 276 interviews were conducted. As can be seen, the average number of interviews was 5.8 per youth with a maximum of 9 and a minimum of 3 interviews conducted.

Child Status and Performance Profile - Number of Interviews

Number of cases: 48 MA Boston/Metro Review April 2012

Number of Interviews

Total number of interviews	276
Average number of interviews	5.8
Minimum number of interviews	3
Maximum number of interviews	9

Table 1

How the sample was selected

The sample for the Boston/Metro Boston CSR was drawn primarily from the population of all children who received Intensive Care Coordination (ICC). A smaller portion of the sample was drawn from In-Home Therapy (IHT), but only includes IHT youth who were not also receiving ICC services at the time the lists were drawn. The sample includes ICC and IHT youth ranging in age from birth to twenty-one years old who are covered by Medicaid. The CSR sample drawn for the Boston/Metro-Boston CSR consisted of 48 youth, including 26 ICC youth and 22 IHT youth.

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

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

IHT Selection. For IHT, the open caseload list was further sorted to create a list of youth who were receiving IHT but not currently also receiving ICC. There were 30 agencies actively providing IHT in Boston/ Metro Boston region at the time the lists were submitted. Some of these agencies were providing IHT in only one location, while others were serving multiple areas of the Boston/Metro-Boston region. Of the 22 youth selected from IHT lists, 8 were drawn from agencies which operated a CSA service as well as an IHT

service. The 8 youth were drawn randomly from 4 of the 6 CSA's providing IHT. The other 2 CSA's providing IHT were serving too few youth to be included in the sample. The final 14 youth in the sample were selected from the remaining IHT agencies. There were 5 IHT providers which were serving larger numbers of youth, and 10 youth were randomly chosen from these agencies. The final 2 youth were randomly selected from the remaining IHT providers. Each of the IHT youth were receiving IHT but not also receiving ICC. In total, there were 22 IHT youth included in the sample.

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

Agency	Total Enrolled Since 7/1/10	Number Open at List Submittal	Number ICC Cases Selected
Bay State Coastal	262	58	2
Children's Services of Roxbury	502	215	7
Riverside Cambridge	195	81	3
The Home Park Street	231	109	4
The Home Hyde Park	156	84	3
MSPCC	136	62	2
North Suffolk Mental Health Association	299	98	3
Riverside Arlington	288	81	2
Total	**2069**	**788**	**26**

Table 2

The second column of Table 2 displays the number of the youth enrolled in ICC since July 1, 2010. The third column displays the total number of youth by agency 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 Boston region. Children's Services of Roxbury actively served the largest number of youth, and had 7 youth in the sample. The sample also included 4 youth from The Home Park Street. There were 3 youth drawn from Riverside Cambridge, The Home Hyde Park, and North Suffolk Mental Health Association. There were 2 youth from each of the following agencies: Bay State Coastal, MSPCC, and Riverside Arlington. These 26 ICC youth may have been receiving services in addition to ICC, including IHT.

Agency	Total Served since 7/1/10	Total Open	Total Receiving IHT/ No ICC	Number IHT only selected
Academic & Behavioral Clinic (ABAC)	*	*	*	*
Arbour Counseling Services	510	120	106	2
Bay State Community Services	*	*	*	*
Boston Partners in Mentoring	196	41	41	1
Brookline Community Mental Health Center	*	*	*	*
Children's Services of Roxbury	127	44	27	1
Edinburg Center	*	*	*	*
Family and Community Solutions	203	71	45	1
The Family Center	*	*	*	*
Family Service of Greater Boston	227	56	44	1
Germaine Lawrence	*	*	*	*
Home for Little Wanderers	473	172	150	3
Institute for Family Centered Services	*	*	*	*
Justice Resource Institute (JRI)	*	*	*	*
Key Program Children's Charter	*	*	*	*
Lamour By Design	*	*	*	*
Latin American Health Institute	*	*	*	*
MSPCC	*	*	*	*
North American Family Institute	*	*	*	*
North Suffolk Mental Health Association, Inc.	324	86	72	2
Osiris Family Institute	219	87	73	2
Priority Professional Care	230	120	100	2
Pyramid Builders Associates	*	*	*	*
Riverside Community Care	223	135	105	2
Roxbury Multi-Service Center, Inc	*	*	*	*
Somerville Mental Health Association	71	43	37	1
South Bay Mental Health	*	*	*	*
South End Community Health Center	*	*	*	*
South Shore Mental Health	277	222	169	3
Wayside Youth & Family Support Network	179	68	58	1
TOTAL	3259	1265	1027	22

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

Table 3

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

As can be seen in the table, each of the following IHT programs had 1 youth included in the CSR: Boston Partners in Mentoring, Children's Services of Roxbury, Family and Community Solutions, Family Service of Greater Boston, Somerville Mental Health Association, and Wayside Youth and Family Support Network. In the sample, 5 IHT programs had 2 youth included from each of their programs: Arbour Counseling Services, North Suffolk Mental Health Association, Inc., Osiris Family Institute, Priority Professional Care, and Riverside Community Care. There were 2 agencies, which served the largest numbers of youth in Boston/Metro-Boston region. Each of these agencies had 3 youth included in the sample: Home for Little Wanderers and South Shore Mental Health.

Characteristics of the Youth Reviewed in Boston/Metro-Boston

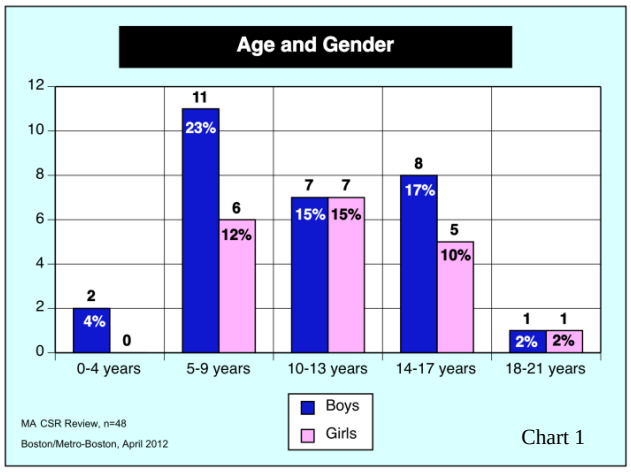


Chart 1

Age and Gender. Forty-eight (48) youth receiving services in the Boston/Metro-Boston region were reviewed in the CSR conducted during April and May 2012. *Chart 1* displays the distribution of genders across the age groups in the sample. There were 29 boys and 19 girls in the sample. The proportion of boys to girls was 60% boys to 40% girls. There were 2 youth reviewed in the 0-4 year old range, 17 youth in the 5-9 range, 14 youth in the 10-13 range, 13 youth in the 14-17 range, and 2 youth in the 18-21 range.

Cur*rent placement*. Ninety-one percent (92%) of the youth in the Boston/Metro-Boston Massachusetts CSR sample lived with their families, either with their biological/adoptive families or in a kinship/relative home (*Table 4*). Three youth or 6% were in a hospital at the time of the review, and one (2%) was in a residential treatment facility.

Child Status and Performance Profile - Current Placement Frequency

Number of cases: 48 MA Boston/Metro Review April 2012

Type of Current Placement	Number	Percent
Family bio./adopt. home	40	83%
Kinship/relative home	4	8%
Hospital	3	6%
Residential treatment facility	1	2%
	48	100%

Table 4

Legal Status. The legal status of 81% of the youth reviewed was with their birth families. Two youths' (4%) permanency status was with his/her adoptive family, five (10%) were in permanent guardianship, and two youth (4%) were over 18 years old and did not have a guardian *(Table 5)*.

Child Status and Performance Profile - Legal Permanency Frequency

Number of cases: 48 MA Boston/Metro Review April 2012

Legal Permanency Status	Number	Percent
Birth family	39	81%
Adopted family	2	4%
Permanent guardianship	5	10%
Youth over 18 years old	2	4%
	48	100%

Table 5

Out of home placements. The CSR tracked placement changes over the last twelve months for each of the 48 youth reviewed (*Table 6*). Placement change refers to changes in living situation, as well as any changes in the type of program the child received educational services over the last twelve months. Among the youth in the sample, 32 or 67% had no placement changes in the last year. Ten youth or 21% experienced 1-2 changes in placement. Four youth (8%) had 3-5 placements, one (2%) had 6-9 placements and one (8%) had over 10 placements. In the 30 days preceding the review, two youth were in out-of home placements, including one that was had moved numerous times including home, hospital and CBAT placements (*Table 7*).

Child Status and Performance Profile - Placement Changes Frequency

Number of cases: 48 MA Boston/Metro Review April 2012

Placement Changes (past 12 months)	Number	Percent
None	32	67%
1-2 placements	10	21%
3-5 placements	4	8%
6-9 placements	1	2%
10+ placements	1	2%
	48	100%

Table 6

Child Status and Performance Profile - OOH Placement Past 30 Days

Number of cases: 48 MA Boston/Metro Review April 2012

OOH Placement Past 30 days	Number	Percent
Family/Adoptive Home	1	2%
Not Applicable	46	96%
Family/Adoptive Home, Hospital/Institution, CBAT	1	2%
	48	100%

Table 7

Ethnicity (Table 8). There was a wide range of ethnic diversity in the Boston/Metro-Boston CSR sample. Of the 48 youth in the sample, 5 or 10% were Euro-American, 12 (25%) were African-American, and 19 (40%) were Latino-American. There were 2 Asian-American youth (4%), and 1 (2%) a Pacific Island-American youth. Two youth in the sample were Arabic (4%), 1 (2%) was Biracial, 1 (2%) Dominican, 4 (8%) Haitian, and 1 West Indian.

Child Status and Performance Profile - Ethnicity Frequency

Number of youth: 48 MA Boston/Metro Review April 2012

Ethnicity	Number	Percent
Euro-American	5	10%
African-American	12	25%
Latino-American	19	40%
Asian-American	2	4%
Pacific Is. American	1	2%
Arabic	2	4%
Biracial	1	2%
Dominican	1	2%
Haitian	4	8%
West Indian	1	2%
	48	100%

Table 8

Primary languages (Table 9). There was also great diversity in the primary languages spoken at home among the youth. English was the primary language spoken at home for 29 youth or 60% of those reviewed, and Spanish was the primary language for 6 or 12%. English and Spanish was spoken in 5 homes or 10%. In one home each (2%) Cantonese, Cape Verde Creole, other Creole, Haitian Creole, English and Creole, and Vietnamese were spoken. English and Arabic was spoken in two homes or in 4% of homes.

Child Status and Performance Profile - Language Spoken Frequency

Number of cases: 48 MA Boston/Metro Review April 2012

Primary Language Spoken at Home	Number	Percent
English	29	60%
Spanish	6	12%
Cantonese	1	2%
Cape Verde Creole	1	2%
Creole	1	2%
Creole (Haitian)	1	2%
English & Arabic	2	4%
English & Creole	1	2%
English & Spanish	5	10%
Vietnamese	1	2%
	48	100%

Table 9

Child Status and Performance Profile - Educational Placement Frequency

Number of cases: 48 MA Boston/Metro Review April 2012

Educational Placement or Life Situation	Number	Percent
Regular K-12 Ed.	14	29%
Full inclusion	3	6%
Part-time Sp. Ed.	7	15%
Self-cont. Sp. Ed.	15	31%
Parenting teen	0	0%
Adult basic/GED	1	2%
Alternative Ed.	6	13%
Vocational Ed.	0	0%
Expelled/Suspended	0	0%
Home hospital	1	2%
Day treatment program	1	2%
Work	0	0%
Completed/graduated	0	0%
Dropped-out	1	2%
Other	4	8%

Table 10

Educational placement (Table 10). Youth reviewed were receiving educational services through a variety of educational programs. Of the sample, 29% were in a regular education program. Fifty-two percent (52%) of the youth were receiving special education services in a full inclusion (6%), part-time special education (15%) or fully self-contained special education setting (31%). Six youth (13%) were in an alternative education setting, one (1%) was receiving education through a home-hospital program, and one was in a day treatment program. These youth may have also had special education services in these settings. One youth was enrolled in a GED program (2%), and one had dropped out of school (2%). Youth in the "other" category were in pre-school programs, a collaborative school, and one had a 504 accommodation plan. .

Child Status and Performance Profile - Agencies Involved Frequency

Number of cases: 48 MA Boston/Metro Review April 2012

Agencies Involved	Number	Percent
DCF	10	21%
DMH	3	6%
Special Ed	28	58%
Early intervention	0	0%
Developmental disabilities	2	4%
DYS	0	0%
Probation	1	2%
Vocational Rehabilitation	0	0%
Substance abuse	0	0%
Other	4	8%

Table 11

Other state agency involvement (Table 11). Most of the youth in the sample were involved with other State and/or community agencies. Note that youth may be involved with more than one agency, so the overall number in Table 11 may be more than the number of youth reviewed. Youth were most frequently involved with Special Education (28 or 58%). Ten youth (21%) were involved with The Department of Children and Families (DCF). The Department of Mental Health (DMH) was involved with three youth (6%), and the Department of Developmental Services (DDS) with two youth (4%). One youth (2%) was on probation. Youth in the other category included Massachusetts Commission for the Dead and Hard of Hearing (MCDHH), Probate Court, and Boston Medical Center

Child Status and Performance Profile - Referral Source

Number of cases: 48 MA Boston/Metro Review April 2012

Referral Source	Number	Percent
DMH	1	2%
Hospital	3	6%
Crisis Services	1	2%
School	8	17%
Family	7	15%
DCF	8	17%
Outpatient	10	21%
Primary care physician	2	4%
Department of Developmental Services	1	2%
FST clinician	1	2%
ICC	1	2%
IHT	2	4%
Legal services	1	2%
Psychiatrist	1	2%
Transitional housing staff	1	2%
	48	100%

Table 12

Referral source (Table 12). Youth reviewed in Boston/Metro-Boston Massachusetts were referred to ICC and/or IHT services from a variety of sources as displayed in *Table 12*. The three largest referral sources were Outpatient (21%), DCF (17%), Schools (17%) and Family self-referrals (15%). This was followed by Hospital (6%) and Primary Care Physicians (4%) and IHT (4%).

Referring one youth each or 2% of the sample were DMH, Crisis Services, DDS, an FST clinician, and ICC.

Child Status and Performance Profile - Co-Occurring Condition Frequency

Number of cases: 48 MA Boston/Metro Review April 2012

Co-Occurring Condition	Number	Percent
Mood Disorder	18	38%
Anxiety Disorder	14	29%
PTSD/Adjustment to Trauma	12	25%
Thought Disorder/Psychosis	1	2%
ADD/ADHD	24	50%
Anger Control	13	27%
Substance Abuse/Dependence	2	4%
Learning Disorder	10	21%
Communication Disorder	0	0%
Autism	4	8%
Disruptive Behavior Disorder (CD, ODD)	9	19%
Mental Retardation	3	6%
Medical Problem	12	25%
Other Disability/Disorder	10	21%
Other	1	2%

Table 13

Behavioral health and co-occurring conditions (Table 13). Table 13 describes the conditions and/or co-occurring conditions present among the youth reviewed. Youth may have one or more than one condition. The largest percentages of youth in the Boston/Metro-Boston sample were diagnosed with attention deficit or attention deficit hyperactivity disorder (50%) followed by mood disorders (38%), anxiety disorders (29%), anger control issues (27%) and PTSD (25%). Twenty-one percent (21%) of the youth had a learning disorder, and 19% a disruptive behavior disorder. There were four youth with an autism spectrum disorder (8%), and three with an intellectual disability (6%). Two youth in the sample (4%) had a substance abuse disorder, and one (2%) had a thought disorder/psychosis.

The youth in the "Other Disability" or "Other" category had speech impairment, obsessive-compulsive disorder, Downs Syndrome, deafness, conversion disorder, and adjustment disorder. Five youth or 10% of the sample had an adjustment disorder diagnosis, which is fairly unusual for youth who are SED.

Medical problems that were experienced by 25% of the youth included obesity, myopia, mastocytosis, seizure disorder/seizure history, high cholesterol, nose hemorrhaging, esophagus/GI problems, Dandy-Walker syndrome, precocious puberty, Gilbert's syndrome and asthma.

Child Status and Performance Profile - Psy Meds Frequency

Number of cases: 48 MA Boston/Metro Review April 2012

Number of Psy Meds	Number	Percent
No psy meds	27	56%
1 psy med	6	12%
2 psy meds	8	17%
3 psy meds	5	10%
5+ psy meds	2	4%
	48	100%

Table 14

Medications (Table 14). Forty-four percent (44%) of the youth reviewed in Boston/ Metro-Boston were prescribed one or more psychotropic medications. As displayed in Table 14, six youth in the sample (12%) were prescribed one medication, eight (17%) were on two medications, and five (10%) were on three medications. Two youth (4%) were on five or more psychotropic medications. Of the youth that were prescribed medications, 71% were on two or more medications and 33% were on three or more medications.

Child Status and Performance Profile - Level of Functioning Frequency

Number of cases: 48 MA Boston/Metro Review April 2012

Level of Functioning	Number	Percent
In level 1-5	26	54%
In level 6-7	18	37%
In level 8-10	4	8%
	48	100%

Table 15

Youths' levels of functioning (Table 15). The general level of functioning of each youth in the CSR is rated using the General Level of Functioning scale, a 10-point scale displayed in Appendix 1 of this report. Twenty-six youth or 54% were rated to be functioning in the Level 1-5 range ("needs constant supervision" to "moderate degree of interference in functioning in most social areas or severe impairment of functioning in one area"). Eighteen or 37% were rated in the Level 6-7 range ("variable functioning with sporadic difficulties or symptoms in several but not all social areas" to "some difficulty in a single area, but generally functioning pretty well"). Four youth (8%) were rated in the Level 8-10 range ("no more than slight impairment in functioning at home, at school, with peers" to "superior functioning in all areas").

Use of Crisis Services (Table 16). Only one youth or 2% percent of the sample accessed some type of crisis service over the 30 days prior to the review. Mobile crisis was used by that youth.

Child Status and Performance Profile - Crisis Services Used Frequency

Number of cases: 48 MA Boston/Metro Review April 2012

Crisis Services Used Past 30 Days	Number	Percent
Mobile crisis	1	2%
911 Emergency call: EMS	0	0%
911 Emergency call: Police	0	0%
Emergency department	0	0%
Other	0	0%
None	47	98%

Table 16

Mental health assessments (Tables 17 and 18). Mental health assessments are among the information sets required for teams and practitioners to better understand the strengths, needs and conditions of youth and their families. Assessments help teams to formulate an overall picture of how the youth is doing emotionally, behaviorally and cognitively. They aid in the team's understanding of the social/familial context of a youth's behaviors and well-being. CSR reviewers determine the absence or presence of a comprehensive mental health assessment when answering this question.

Only slightly more than half (54%) of the youth reviewed in Boston/Metro-Boston had a current mental health assessment in their files. The other 46% of youth did not have a current mental health assessment available to help their teams better understand and plan for them.

Child Status and Performance Profile - Mental Health Assessment

Number of cases: 48 MA Boston/Metro Review April 2012

MH assessment performed	Number	Percent
Yes	26	54%
No	22	46%
	48	100%

Table 17

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

Child Status and Performance Profile - Received Mental Health Assessments

Number of cases: 48 MA Boston/Metro Review April 2012

Received MH Assessments	Number	Percent
Parent	11	23%
Education	3	6%
Court	0	0%
Child Welfare	0	0%
DOC	0	0%
Not applicable	22	46%
Not Distributed	15	31%
Other	0	0%

Table 18

For the 26 youth with mental health assessments, the assessment was distributed to 11 parents or 23%. An assessment was received by the schools of three youth or 6%. The assessment was not distributed for 15 of the 26 youth with assessments.

Child Status and Performance Profile - Special Procedures Frequency

Number of cases: 48 MA Boston/Metro Review April 2012

Special Procedures Used Past 30 Days	Number	Percent
Voluntary time-out	9	19%
Loss of privileges via point & level system	6	13%
Disciplinary consequences for rule violation	2	4%
Room restriction	1	2%
Exclusionary time out	2	4%
Seclusion/Locked room	1	2%
Take-down procedure	0	0%
Physical restraint (hold, 4-point, cuffs)	2	4%
Emergency medications	1	2%
Medical restraints	0	0%
None:	28	58%
Other:	6	13%

Table 19

Special Procedures

Special Procedures data presents information about interventions that were experienced by youth over the 30 days preceding the CSR (*Table 19*). Forty-two percent (42%) of the sample, or 20 youth experienced a special procedure during this time period. Among the youth, 19% had experienced a voluntary time-out, 13% a 1oss of privileges via a points and level system, 4% a disciplinary consequence for a rule violation, 4% an exclusionary time-out, and 4% a physical restraint. Two percent (2%) of youth each experienced a room restriction, seclusion in a locked room, and emergency medication. Special procedures in the "Other" category included school suspension, placement on a behavior management system and meeting with school counselors.

Child Status and Performance Profile - Caregiver Challenges Frequency

Number of cases: 48 MA Boston/Metro Review April 2012

Challenges in the Child's Birth Family or Adoptive Family	Number	Percent
Limited cognitive abilities	0	0%
Serious mental illness	11	23%
Substance abuse impairment or serious addiction w/ frequent relapses	3	6%
Domestic violence	3	6%
Serious physical illness or disabling physical condition	8	17%
Unlawful behavior or is incarcerated	1	2%
Adverse effects of poverty	19	40%
Extraordinary care burdens	12	25%
Cultural/language barriers	12	25%
Undocumented	2	4%
Teen parent	2	4%
Recent life disruption/homelessness due to a natural disaster	1	2%
Other	11	23%

Table 20

Caregiving challenges

Challenges experienced by the parents and caregivers of the youth reviewed are displayed in *Table 20*. The most frequently noted challenge of the parents or caregivers of youth in the sample was adverse effects of poverty experienced by 40%. This was followed by 25% each challenged with cultural or language barriers and/or extraordinary care burdens. Twenty-three percent (23%) of caregivers had a serious mental illness, and seventeen percent (17%) of caregivers a serious illness or disabling condition. Other challenges included 6% impaired by substance abuse, 6% by domestic violence, 4% were undocumented and 4% were teen parents. Challenges in the "Other" category included a parent with a developmental disability and family communication issues, challenges associated with parent-child language differences, age difference between the caregiver and youth, a recent death in the family, and housing issues.

Care Coordination

Data are routinely collected in each CSR to better understand factors that may be impacting the provision of care coordination services. Information is collected through the individual providing the care coordination function for each youth, which could have been the ICC or the IHT therapist. In the Boston/Metro-Boston Massachusetts CSR, there were 41 different individuals providing care coordination for the 48 youth reviewed. Twenty-six individual ICCs and twenty-two IHTs were interviewed.

The review tracked the length of time each of the Care Coordinators had been assigned to the youth being reviewed. As can be seen in *Table 21*, 15% of care coordinators had been assigned to the youth for 1-3 months, 31% for 4-6 months, 37% for 7-12 months, 15% for 13-24 months, and 2% for 25-36 months.

Child Status and Performance Profile - Length of Time CM Assigned

Number of cases: 48 MA Boston/Metro Review April 2012

Length of Time CM Assigned to Child/Youth	Number	Percent
1-3 months	7	15%
4-6 months	15	31%
7-12 months	18	37%
13-24 months	7	15%
25-36 months	1	2%
	48	100%

Table 21

Caseload size as reported by the care coordinator was measured along the scale in *Table 22*. Twenty-nine percent (29%) had eight or fewer cases, 24% had nine to ten cases, and 34% eleven-twelve. Twelve percent (14%) of care coordinators had thirteen to fourteen cases. Eighty-seven percent (87%) of those providing care coordination had 12 or fewer cases.

Child Status and Performance Profile - CM Current Caseload Frequency

Number of cases: 41 MA Boston/Metro Review April 2012

CM Current Caseload Size	Number	Percent
<8 cases	12	29%
9-10 cases	10	24%
11-12 cases	14	34%
13-14 cases	5	12%
	41	100%

Table 22

Child Status and Performance Profile - Barriers Affecting Case or Services

Number of cases: 48 MA Boston/Metro Review April 2012

Barriers Affecting Case Management or Services	Number	Percent
Caseload size	7	15%
Eligibility/access denied	3	6%
Inadequate parent support	10	21%
Inadequate team member participation	5	10%
Family disruptions	11	23%
Billing requirements/limits	14	29%
Case complexity	8	17%
Treatment compliance	10	21%
Team member follow-thru	7	15%
Acute care needs	4	8%
Driving time to services	6	13%
Culture/language barriers	11	23%
Refusal of treatment	5	10%
Family instability/moves	6	13%
Arrest/detention of child/youth	1	2%
Other	24	50%

Table 24

Table 22. Information about barriers impacting the provision of services was collected through interviews with the person providing care coordination for each youth. Challenges cited most often by care coordinators in Boston/Metro-Boston were billing requirements and limits cited by 29%. This was followed by cultural/language barriers and family disruptions both cited by 23% of care coordinators. Inadequate parent support, treatment compliance were each cited by 21%, followed by case complexity (17%), caseload size (15%), team member follow-through (15%), driving time to services (13%), family instability and moves (13%), and inadequate team member participation (10%). Cited by fewer care coordinators were acute care needs (8%), eligibility/access denied (6%), and arrest/detention of youth (2%).

Fifty percent (50%) of care coordinators cited "Other" barriers including resource needs, paperwork and productivity demands, insufficient Spanish speaking providers, challenges related to school systems, providers not returning calls, lack of understanding of the role, challenges in empowering families, and barriers in ICC and family partners being able to bill for coordination with each other.

Community Services Review Findings

Ratings

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

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

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

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

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

STATUS AND PROGRESS INDICATORS

Youth Status Indicators

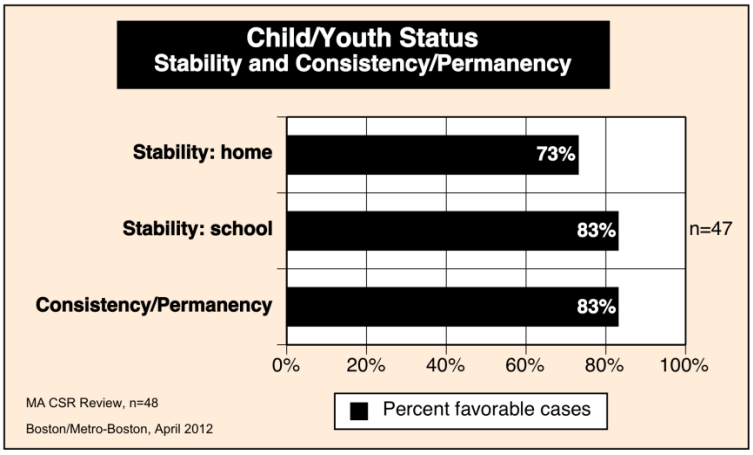
(Measures Youth Status over the last 30 days unless otherwise indicated)

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

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

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

Overall Youth Status



Community, School/Work and Living Stability

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

Home Stability. Among the 48 youth reviewed in the Boston/Metro-Boston area, 73% were found to have favorable stability at home. Fifty-eight percent (58%) had good or optimal stability with established positive relationships and well-controlled to no risks that otherwise

could jeopardize stability. A third (33%) of the youth were rated to be in the "refinement" area, which means that conditions to support stability were fair. Four youth (8%), including two with poor and two with adverse stability, need improvement.

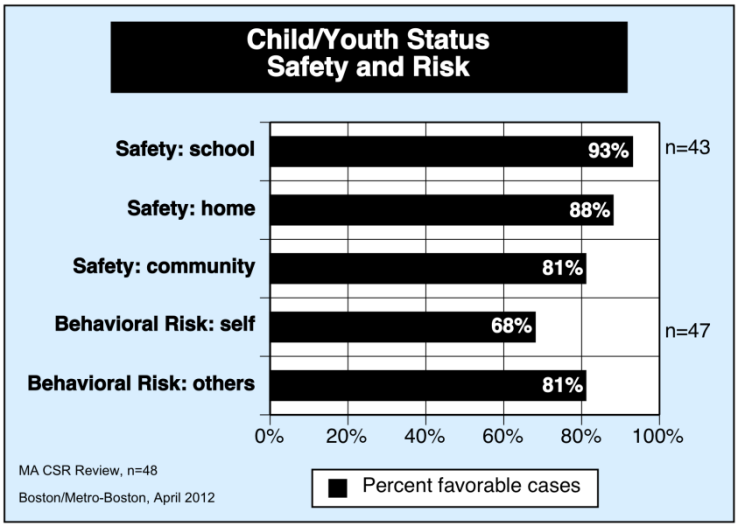
School Stability. Eighty-three percent (83%) of the 47 youth the indicator was applicable to had favorable school stability. Of these, 60% had optimal or good stability with only age appropriate or planned changes occurring in their school program. Thirty-two percent (32%) had stability issues at school that needed "refinement," with fair to marginal stability issues that were minimally to inadequately addressed. Nine percent (9%) of the youth had poor or adverse and worsening school stability.

These results indicate that teams should more carefully consider youths' home stability when planning interventions and supports.

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 Massachusetts, 40 or 83% had a favorable level of consistency and permanency in their lives. Among these, 32 or 66% had "optimal" or "good" status, meaning these youth were in enduring permanent living situations with their family of other legally permanent caregivers. Thirteen youth, or 27% were at a level of consistency and permanency situation that needed refinement in order to assure enduring relationships and consistent caregiving/living supports, and were either in a minimal to fair status, or in a marginal status with somewhat inadequate or uncertain permanence. Three youth, or 68% of the sample needed improvement and was experiencing poor status with substantial to serious and continuing problems of unresolved permanency.



Safety of the Youth

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

School safety. Ninety-three percent (93%) of youth were found to have favorable safety status at school. For the 43 youth the school safety indicator was applicable for, 31 or 72% were safe in their school programs at a "good" or "optimal" level with no risk to generally risk-free school programs. Nine youth (28%), needed refinement in terms of the school setting leaving the youth free from abuse or neglect, and were experiencing fair or marginal safety at school. There were no youth with poor or adverse school safety status.

Home safety. Eighty-eight percent (88%) of youth were safe at home. Sixty percent(60%) of the youth were found to have "good" or "optimal" safety status at home. The remaining youth (40%) were found to need refinement with a fair to minimally adequate home situation free from abuse or neglect, or marginal safety with somewhat inadequate protection posing an elevated risk of harm. There were no youth with poor or adverse home safety status.

Community safety. Eight-one percent (81%) of youth had favorable safety in the community. Twenty-five youth or 52% were experiencing "good" to "optimal" safety in their communities. Twenty-one or 44% needed refinement in their safety in the community and would benefit from their teams reviewing their safety status including any risks for intimidation or fear of harm. There was one youth (2%) with poor or one (2%) with adverse community safety status, both needing improvement in order to assure their safety in the community.

Behavioral Risk to Self and Others

The CSR determines the degree to which each youth is avoiding self-endangerment situations and refraining from using behaviors that may be placing him/herself or others at risk of harm. Behavioral risk is defined as a constellation of behaviors including self-endangerment/self-harm, suicidality, aggression, severe eating disorders, emotional dysregulation resulting in harm, severe property destruction, medical non-compliance resulting in harm and unlawful behaviors. This indicator is not applicable to children age 36 months or younger.

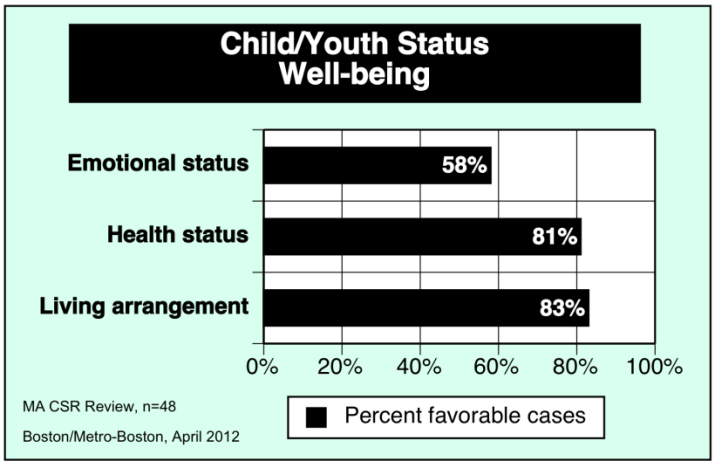
Risk to self. Behavioral risk to self was a concern for a number of youth in the sample. Only 68% of the youth had a favorable level of behavioral risk toward themselves.

Among the youth reviewed, 36% had an "optimal" or "good" level of behavioral risk. Fifty-seven perccent (57%) of the youth were found to need "refinement" in their level of behavioral risk, including both youth that are usually avoiding self-harm or self-endangerment, and those that have a risk staus that is inconsistent or concerning. Six percent of the youth had poor or serious and worsening levels of behavioral self-risk.

Risk to others. The subindictor of behavioral risk toward others was favorable for 81% of the youth in the sample.

Twenty-four youth or 50% had "good" or "optimal" levels of behavioral risk toward others. Twenty-one youth or 44% needed "refinement" and presented a fair to marginal level of risk toward others. Three youth (6%) needed "improvement" in risk to others, with poor status and a potential for harm to other people present, or serious and worsening risk for others.

Assuring risk assessment and strategies to minimize behavioral risk needs attention among teams working with youth in Boston/Metro-Boston.



Emotional and Behavioral Well-being

Youth are reviewed to determine the degree to which they are presenting age and developmentally-appropriate emotional, cognitive, and behavioral development and well-being. Factors examined include youth's levels of adjustment, attachment, coping, self-regulation and self-control as well as whether or not symptoms and manifestations of disorders are being managed and addressed. Reviewers look at emotional and behavioral

issues that may be interfering with the youth's ability to make friends, learn, participate in activities with peers in increasingly normalized settings, learn appropriate boundaries and self-management skills, regulate impulses and emotions, and other important domains of well-being. Addressing emotional and behavioral issues of youth is a core charge of mental health systems.

Emotional and behavioral well-being was favorable for only 58% youth reviewed in the Boston/Metro-Boston CSR, indicating that teams need to improve interventions and strategies to help youth achieve better emotional and behavioral status. These results indicate a large number of youth with inconsistent or poor emotional development, adjustment problems, emotional/adaptive distress, or serious behavioral problems present. Among the youth reviewed, 15% had a "good" level of emotional/behavioral status. Seventy-one percent (71%) of youth were found to need "refinement" and were functioning at a fair to marginal emotional/behavioral well-being status. These youth were demonstrating a minimally/temporarily adequate or a limited/inconsistent level of emotional status, and were doing marginally well emotionally or behaviorally. Fifteen percent (15%) of the youth had a poor or worsening emotional/behavioral status.

Support for teams in developing individualized strategies for improving youths' emotional and behavioral well-being is needed.

Health Status

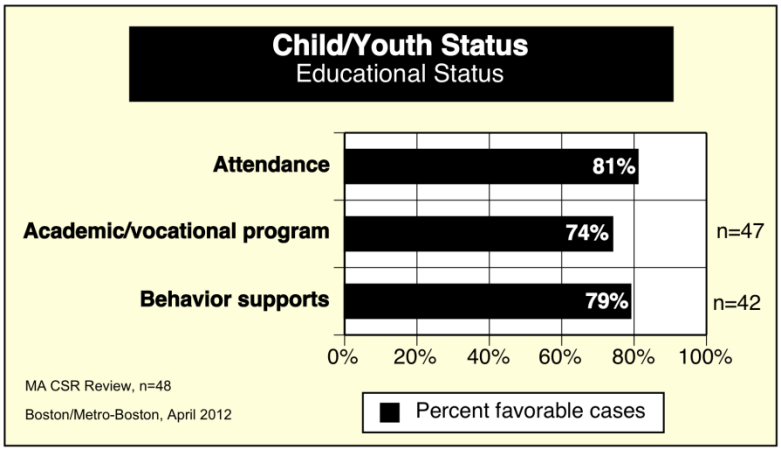
The health of the youth was reviewed to determine whether or not they were achieving and maintaining optimal health status including basic and routine healthcare maintenance. Youth's basic needs for nutrition, hygiene, immunizations, and screening for any possible development or physical problems should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

For the youth in the sample, 81% had favorable health/physical well-being status. Half of the youth (50%) had "good" or "optimal" health status. Forty-four percent 44% needed "refinement" in their health status. The remaining 6% had poor health that needed improvement.

Living Arrangements

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

For the youth reviewed in the Boston/Metro-Boston CSR, 83% were found to have a favorable living arrangement. Half of the youth (50%) were in living arrangements that were "good" or "optimal," and were substantially or optimally meeting their needs. Forty-four percent (44%) needed "refinement" with living arrangements that were fair to marginal. Six percent (6%) was residing in poor living arrangements that needed improvement.



Educational Status

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

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

Attendance. Eighty-one percent (81%) of youth in the sample had a favorable pattern of school attendance. Seventy-three percent (73%) had attendance patterns that were "good" to "optimal." Seventeen percent (17%) of the youth would benefit from "refinement" in their school attendance. Ten percent (10%) of the sample had poor or adverse and worsening school attendance patterns.

Academic or vocational program. Seventy-four (74%) of the youth were doing favorably well in their educational program. Fifty-one percent (51%) had "good" or "optimal" academic or vocational status. Thirty-eight percent (38%) needed refinements and had minimally adequate, to marginally inadequate academic/vocational status. The remaining youth (11%) were doing poorly or adversely in their educational program, with academic status that needed improvement.

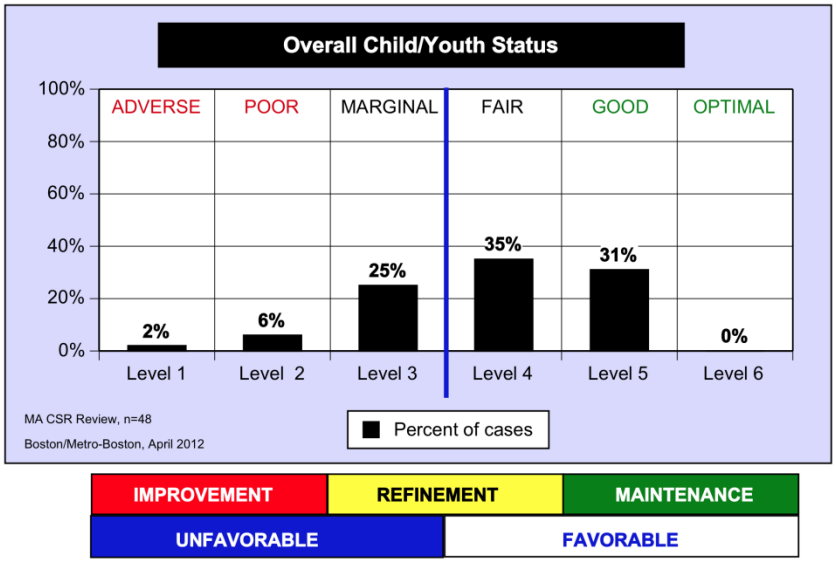
Behavioral supports. Forty-two of the youth in the sample required behavioral supports in their school setting. Behavioral supports were working favorably well for 79% of them. Sixty percent (60%) had an "optimal" or "good" level of supports. Twenty-six percent of the youth (26%) would benefit from refinements in their level of supports, and had minimally adequate to marginally inadequate supports for their behaviors. The remaining youth (14%) had poor or adverse behavioral support they were not benefitting from, or were harmful to their well-being.

Overall Youth Status

The overall results for Youth Status for the 48 youth reviewed in the Boston/Metro-Boston CSR are displayed below.

Overall, only 67% or 32 youth were found to be doing favorably well. These youth fell in Levels 4-6; youth had Fair status (35% or 15 youth), or Good status (31% or 15 youth). No youth were found to have overall Optimal status.

The remaining 16 youth (33%) had unfavorable status. They all had Marginal status (25% or 13 youth), Poor Status (6% or 3 youth), or Adverse Status (2% or 1 youth).



Overall Youth Status results are also categorized as needing Improvement, Refinement, or Maintenance. This allows for identification of youth that may need focused attention. There were four youth (8%) with status in the Improvement area, and their status was problematic or risky. Twenty-nine or 60% of the youth fell in the Refinement area which means their status was minimally favorable or marginal and potentially unstable, with further efforts likely necessary to improve their well-being. For the fifteen youth (31%) whose status was in the Maintenance area, efforts should likely be sustained and leveraged to build upon a fairly positive situation.

A number of observations can be drawn about the status of youth reviewed in Boston/Metro-Boston. A significant number of youth had overall status that was unfavorable. Stability of home was a concern for a number of youth reviewed, as were youth patterns of attendance, academic performance and behavioral supports in school. However, youth were safe in their homes and schools; community safety was a concern for a number of youth reviewed. Youth also had generally favorable living arrangements and permanency. Behavioral risk toward self was an area of concern for many of the youth, and emotional status was unfavorable for 42% of those reviewed. More attention by teams in understanding and building effective supports and treatments for improving youths' home stability, behavioral risk to self and emotional well-being is warranted.

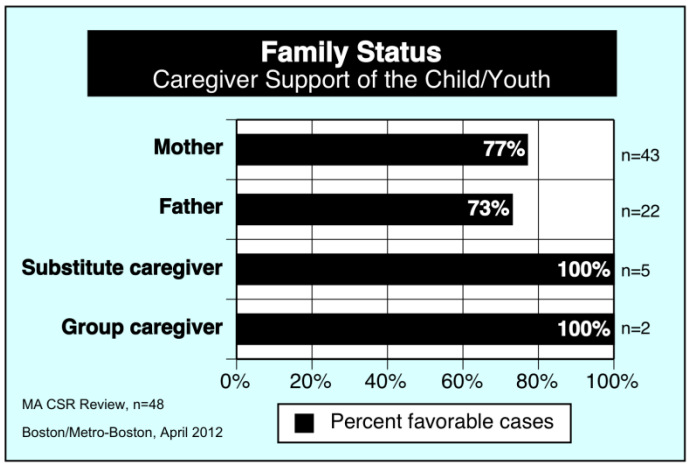
Caregiver/Family Status

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

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

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

Overall Caregiver/Family Status

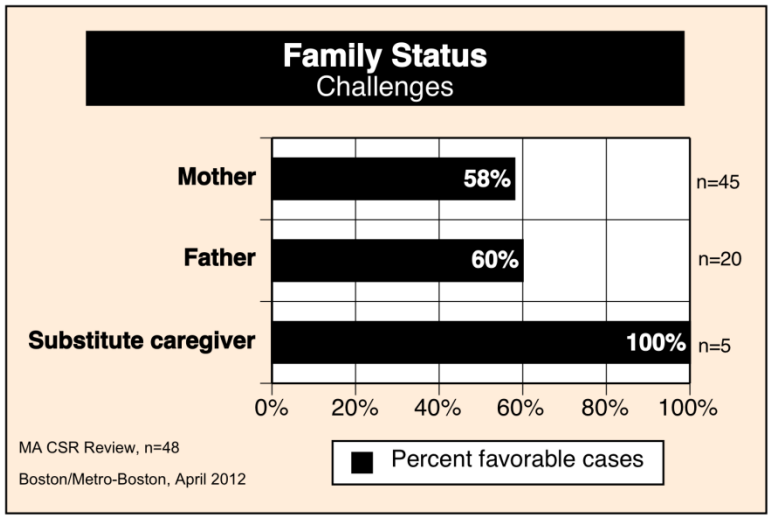


Parent/Caregiver Support of the Youth

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

For the youth reviewed in the Boston/Metro-Boston CSR, favorable support by mothers was found 77% of the time for which the indicator was applicable (N=43). Maternal support needed "refinement" or "improvement" for 21 youth (49%), including one with substantial and continuing problems with caregiving adequacy. The measure for support from fathers was applicable for 22 youth in the sample, and favorable support for youth was found for 73% of the fathers. Support from fathers needed "refinement" or "improvement" for 59% of the youth the indicator was applicable for including two fathers with substantial and

continuing problems of caregiving adequacy. Support was favorable for all of the the youth with substitute caregivers (N=5) and in group care (N=2).



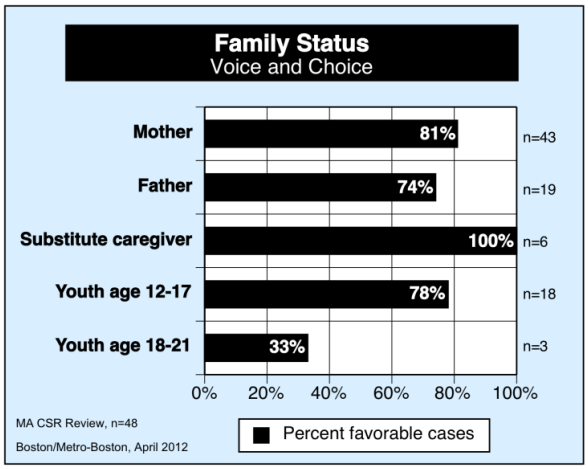
Parent/Caregiver Challenges

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

There were 25 mothers of youth reviewed in the CSR for which this indicator could be rated. Of these, 58% had favorable status related to the level of challenge they were experiencing. Eighty percent (80%) of the mothers had a level of challenge that needed to be "refined." Thirteen percent (13%) had major challenges with inadequate or missing supports, or overwhelming life challenges.

Sixty percent (60%) of the 20 fathers of youth reviewed had a favorable level of challenge. Eighty-five percent (85%) of them were experiencing levels of challenge that could benefit from "refinement" or "improvement" ranging from minor limitations with adequate supports to major life challenges with inadequate or missing supports.

For the five youth with substitute caregivers, all had a favorable level of challenge; two had some minor limitations that would benefit from refinement.



Family Voice and Choice

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

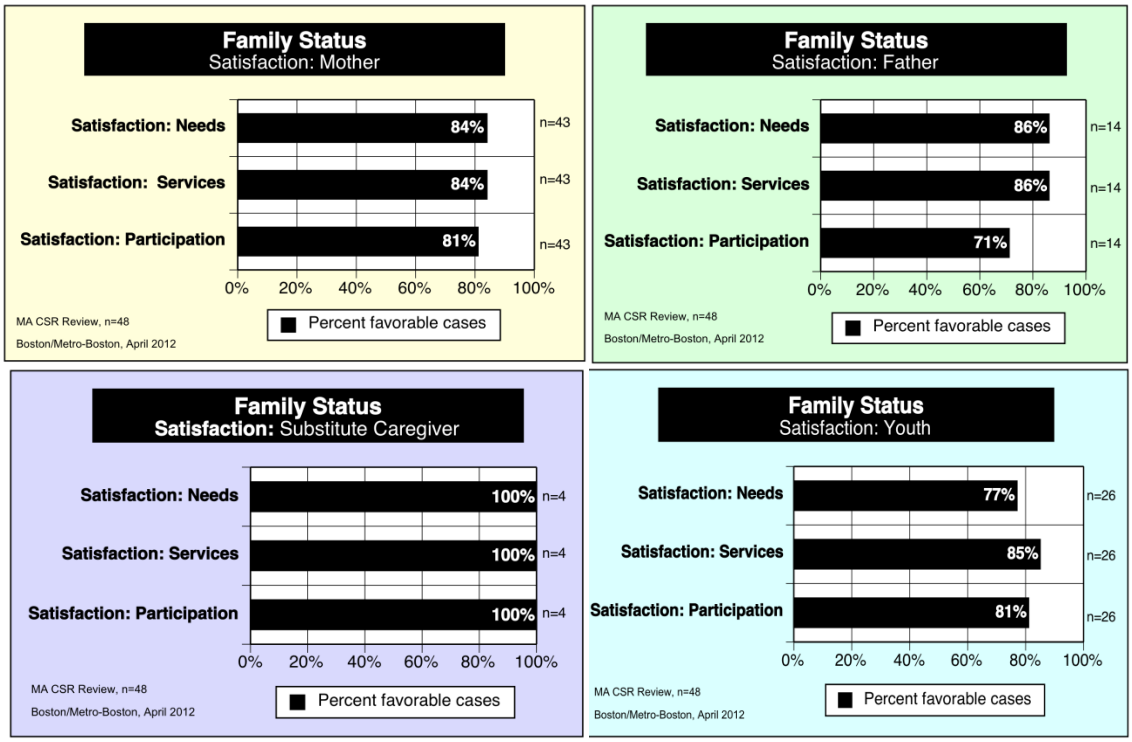
For the 43 mothers for which the indicator could be rated, 81% were experiencing favorable voice and choice in their child's assessments, planning and service delivery processes. Sixty percent of mothers (60%) had "good" to "optimal" voice and choice. Thirty-five percent (35%) of the mothers would benefit from refinement in strengthening their voice and choice, and 5% experience substantially inadequate voice

For youth whose fathers were involved and information could be gathered (N=19), 60% had favorable voice and choice in involvement with their child's service processes indicating a need for strengthening of fathers' voice and choice in planning and service delivery processes. Forty-two percent (42%) of the fathers had "good" to "optimal" voice and choice; 37% would benefit from "refinement" in the influence of their voice and choice in planning and service delivery. Four fathers (21%) fell in the range of needing improvement with substantially inadequate voice and choice.

Substitute caregivers all (100%) had a favorable voice and choice in planning and service delivery; 20% would benefit from refinement.

There were eighteen youth in the 12-17 age range in the sample; 78% of them had favorable voice and choice in their services. Twenty-two percent (22%) had "good" or "optimal" voice and choice that should be maintained; 78% had "fair" or "marginal" voice and choice that needed refinement.

For the three youth in the 18-21 age range, only one (33%) had favorable voice/choice.



Satisfaction with Services and Results

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

The charts above display the results for how satisfied each of the role groups were with having their needs understood, services and results, and participation. Eight-four percent (84%) of mothers were satisfied that their needs were understood and with services; 81% with their level of participation. For fathers, 86% were satisfied with their needs being understood and with services, 71% were satisfied with their participation. For the 26 youth that satisfaction was measured for 77% were satisfied with their needs understood, 85% with the services, and 81% with their participation. Substitute caregivers were 100% satisfied with all domains measured.

Summary: Caregiver/Family Status

Fathers and mothers in the Boston/Metro-Boston CSR had high levels of challenge in their lives; support for youth was negatively impacted for both parents. Support for youth in substitute and group caregiving was positive. Family voice and choice was fairly strong for mothers and substitute caregivers, but weaker for fathers and youth, especially for those aged 18-21. Satisfaction was favorable among mothers and fathers in the understanding of their

needs and with services; but less favorable for their level of participation. Youth were satisfied with services, but less satisfied with their needs understood and their participation. Substitute caregivers were satisfied with all domains measured.

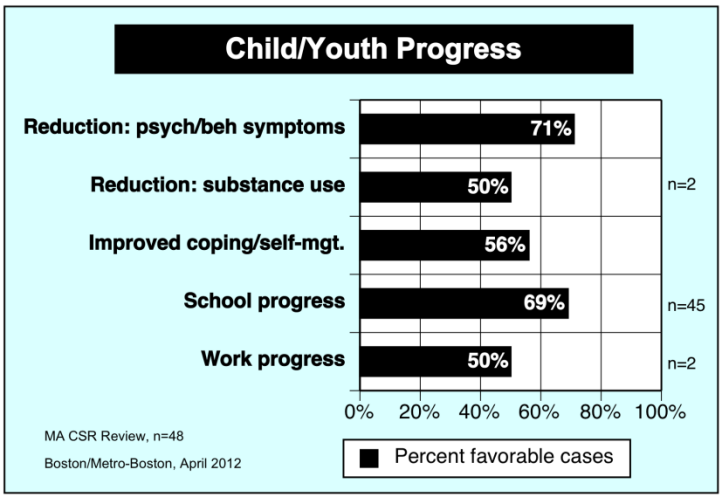
Youth Progress

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

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

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

Overall Youth Progress Patterns



Reduction of Psychiatric Symptoms and/or Substance Use

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

Reduction of Psychiatric Symptoms. Only 71% percent of the youth reviewed made favorable progress in reducing symptomatology and/or problem behaviors over the six month period previous to the CSR. Twenty-seven (27%) of the sample made "good" or "optimal" progress at a level somewhat above expectation. Sixty percent (60%) of the youth needed "refinement" in their level and rate of progress in reducing symptoms, and were making marginal to fair progress. Thirteen percent (13%) needed "improvement" and were making no progress in reducing symptoms and/or problem behaviors, or were declining with symptoms that were increasing.

Reduction of substance use. There were two youth in the sample with substance abuse issues and one of the two (59%) was making favorable rates of progress. One was making favorable progress at an "optimal" level and rate. The other was making no progress in reducing substance use.

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

Improved Coping and Self-Management

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

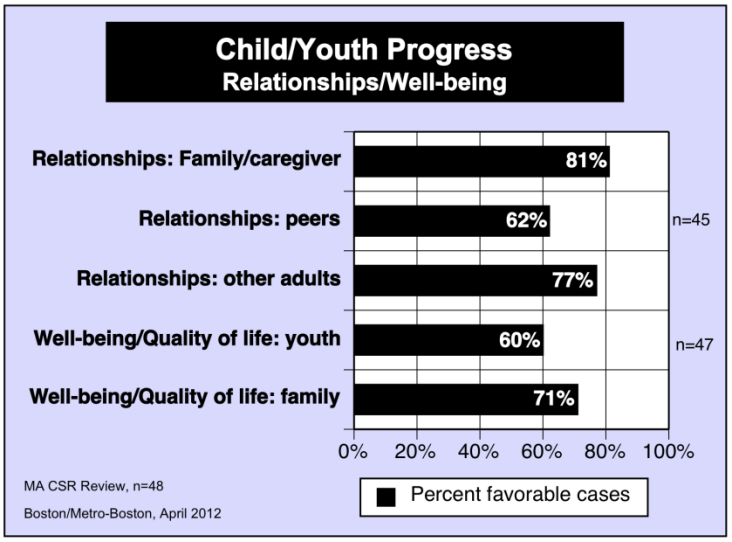
Among the youth reviewed, only 56% youth were making favorable progress in improving their coping skills and ability to self-manage their emotions and behaviors. Twenty-five percent (25%) had made "good" progress in improving their ability to cope and manage their own behaviors. Sixty-five percent of the youth (65%) needed "refinement" and had made fair to marginally inadequate progress. The remaining 10% were making poor progress in improving coping and self-management, or were regressing.

School or Work Progress

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

School progress. For the youth reviewed, 69% were making favorable progress in their educational programs. Twenty-two percent (22%) were making "good" or "optimal" progress in school reflecting consistent rates and levels of progress. Seventy-one percent (71%) were needed "refinement" and were making fair to marginally inadequate rates and levels of school progress. The remaining 6% were progressing at poor to adverse (regressing) rates, and needed improvement.

Work progress. Two youth in the sample were working; one (50%) was making favorable progress in satisfying expectations of employment. One was making marginally inadequate progress, and needed refinement.



Progress Toward Meaningful Relationships

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

For the youth reviewed, 81% were making progress in their relationships with their families or caregivers. Progress in building peer relationships was less favorable, with only 62% of youth making progress in building meaningful relationships with peers. Progress in developing relationships with positive adults (teachers, coaches, etc.) was favorable for 77%.

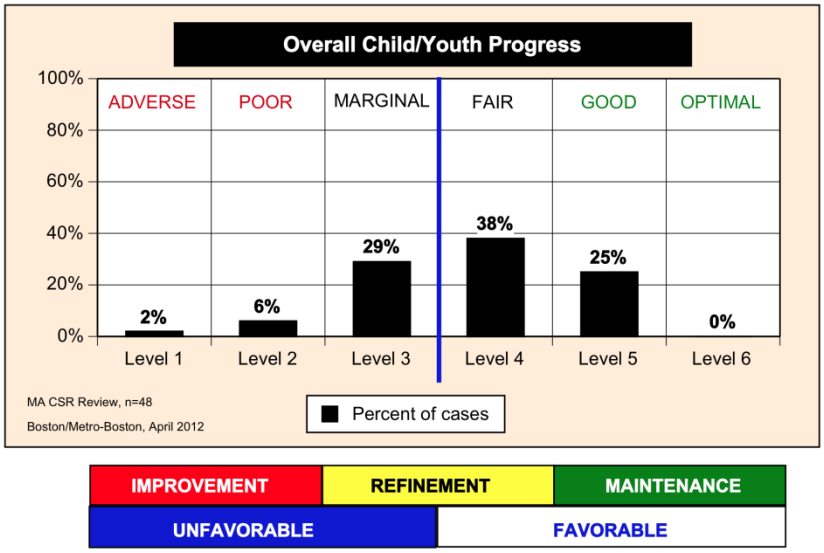
Overall Well-being and Quality of Life

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

Youth overall well-being and quality of life. For the youth reviewed in the CSR, 60% were making favorable progress in an improved overall well-being and quality of life. Twenty-three percent (23%) had made "good" progress over the last six months in developing and using personal strengths, long-term relationships, life skills, and future plans. Sixty-five percent (65%) were determined to need "refinement" indicating that teams and services need additional supports to help more youth make progress in improving their overall well-being. These youth were making fair to marginally inadequate progress in an improved quality of life. Thirteen percent (13%) needed improvement, and were making poor to no progress in their overall quality of life and had developed few to no long-term supportive relationships, life skills for problem solving, educational/work opportunities, or meaningful and achievable future plans.

Family overall well-being and quality of life. For the families and caregivers of the youth, 71% were making favorable progress in improving the overall quality of life. Among these were 17% who had made "good" progress, 79% needing "refinement," and 4% that needed "improvement."

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



Overall Youth Progress

A goal of care planning is to coordinate strategies and identify all needed treatments or supports youth need to make progress in key areas of their lives. Overall, only 63% of the youth were making favorable progress (Fair, Good or Optimal Progress).

Among the youth, 8% were determined to need improvement due to poor progress, or had made adverse progress and were regressing. Sixty-seven percent (67%) needed refinement in moving forward in the areas measured, and were making fair or marginal progress. For these youth, the right strategies at the right intensity may have been missing or underdeveloped. The remaining 25% were making good progress at a level that should be maintained and sustained. No youth were making optimal progress.

The data for Youth Progress indicates that youth reviewed in Boston/Metro-Boston were making overall weak progress in key life areas. Of particular concern was weak progress for youth in reducing symptoms, problem behaviors and substance use, and improving coping and self-management skills. As well, only half of the youth were making progress in school, and no youth were making progress in succeeding in employment. Youth were making weak progress in their peer relations and in their overall well-being and quality of life. Youth were making fair progress in improved family relationships, and relationships with other adults.

System/Practice Functions

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

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

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

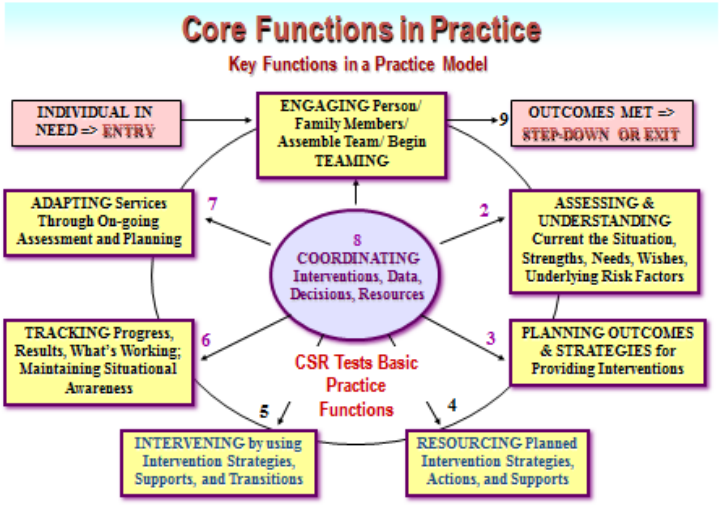
Overall System/Practice Performance

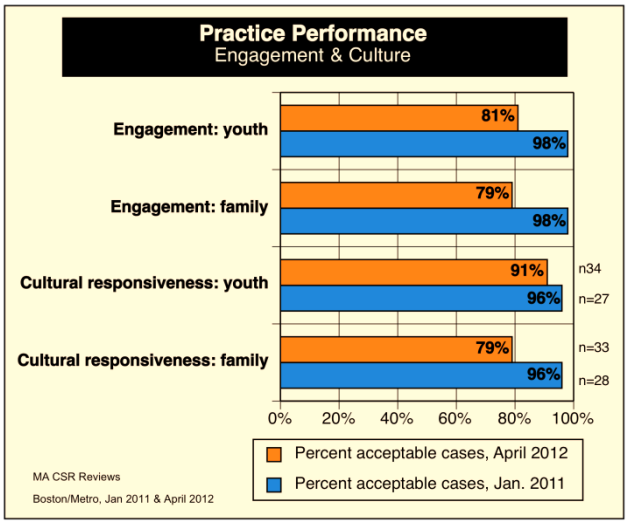
Reviewing System and Practice Performance in the CSR

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

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

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





Engagement

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

Youth engagement. For the youth reviewed, 81% experienced an acceptable level of engagement. This was a decline since last year's CSR result when 98% where found to have acceptable Youth Engagement. In this year's CSR, 52% of youth were engaged at the "good" or "optimal" level. The remaining 48% would benefit from "refinement" of engagement efforts, and their engagement was fair to marginally inadequate.

Family engagement. Families were engaged at an acceptable level 79% of the time, which was also a decline since the previous CSR. This year, 56% were engaged at a "good" or "optimal" level. Forty-two percent (42%) of the families needed "refinement" in engagement efforts, and for one family (2%), engagement was poor.

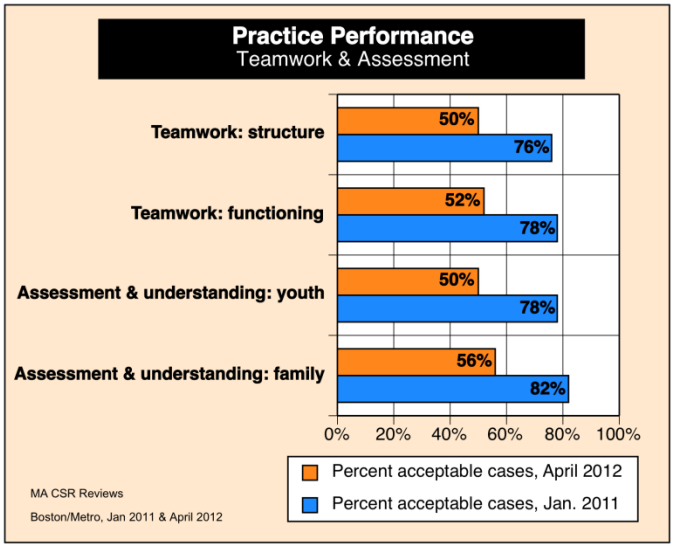
Cultural Responsiveness

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

Cultural responsiveness to youth. For the 34 youth reviewed for which the indicator applied, Cultural Responsiveness was acceptable for 91%, which was in the range but a slight decline since the last CSR.

Cultural Responsiveness in this year's CSR was found to be "optimal or "good" for 48% of youth the indicator was applicable for. The remaining 32% would benefit from "refinement" in the cultural responsiveness of services.

Cultural responsiveness to families. For the 33 families the indicator was applicable for, cultural responsiveness was acceptable for 79%. This was a marked decline from previous CSR result when 96% of families experienced acceptable cultural responsiveness. This year, cultural responsiveness was "good' or "optimal" for 58% of the families the indicator was applicable for. "Refinement" was needed for 14 families or 42% of the families; cultural responsiveness for these families was fair to marginally inadequate.



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. In the Boston/Metro-Boston CSR, team formation was acceptable for 50% of the youth. This was extremely weak performance and a marked decline since the previous CSR when 76% of youth had acceptable team formation. This means that teams are being formed with the right people who can plan to organize effective services and supports for only half of the youth.

In this year's CSR, 17 youth or 35% of the sample experienced "good" or "optimal" team formation. Twenty teams (42%) needed "refinement" in their ability to form. In these cases, team formation was minimally adequate to fair, or marginally inadequate. Eleven youth (23%) experienced team formation that was poor with teams that seldom met.

Team Functioning. Teams were functioning acceptably well for only 52% of the youth reviewed, a decline since last year when 78% of youth had teams that functioned well.

For 17 youth in the April-May 2012 CSR (35%), teams functioned at a "good" or "optimal" level. For 23 youth (48%) teams needed "refinement" and were functioning in a somewhat unified and consistent manner, or were splintered and engaged in a pattern of actions that were usually incoherent with limited problem-solving. Eight youth (17%) had poor teamwork, with individuals working in isolation.

An example of teamwork for a youth that was doing well and making progress is, "The team appears to have a comprehensive understanding of (the youth's) family system and assess (the youth's) needs in the context of the family system. Their goal is to 'break the family cycle' of (domestic violence and unaddressed mental and behavioral health needs. The transition planning to the new community and new school appears to have been effective. The ICC/FP team has continued with the family to the new community. Mother is highly satisfied with services and says she feels respected and heard."

An example where the teaming needed improvement is: "Overall practice scores were in the Refinement range, for the most part, due to the lack of a coherent team process. Even allowing for the fact that expectations for coordination of care in IHT are less than for ICC, there was not a sense that the IHT clinician thought of the work as a team effort."

Another example is: "The formation and functioning of the team was rated a 2-unfavorable, needs improvement. There was little evidence that the team met on a regular basis to review and discuss the client's needs and accomplishments. The team also worked independently of each other with very little contact. One of (the youth's) teacher's at the school, who the school had identified as a key figure in his treatment plan, did not know he was receiving services outside the school."

The capacity of Care Planning Teams to form and work together for youth and families is foundational Rosie D. requirement. Teams in Boston/Metro-Boston Massachusetts are neither forming nor functioning at an acceptable level; youth and families are unable to depend on teams to plan, communicate and work together at a consistent or reliable level.

Assessment and Understanding

The Assessment and Understanding indicator reviews the basis for determining the set of interventions, supports, and/or services that will be most likely to result in necessary changes for the youth and family. Reviewers assess the degree to which all relevant information has been gathered and synthesized resulting in a complete "big picture" understanding of the strengths, needs, preferences, current situation, risks and core issues of

the youth and family. Also important is the ability of teams to assure that assessment and learning is an ongoing process in order to track progress and respond to the changing needs of the youth and family.

Assessment & Understanding of Youth. Only 50% of teams were found to have an acceptable level of assessment and understanding of the youths' core issues and situations. This result demonstrates weak performance far below what is needed for forming adequate plans and services for youth. This was also a considerable decline since the last CSR when 78% of youth had acceptable assessment and team understanding of their situations, underlying issues and needs. Assessment and understanding of youth clearly needs improvement.

In this year's CSR, 29% of youth had teams that had "good" or "optimal" assessment and understanding of them. Forty-eight percent (48%) were found to need "refinement" of practices, and assessment and understanding was either fair or marginally inadequate. Twenty-three percent (23%) had teams that had poor/incomplete/inconsistent assessment and understanding, or absent/incorrect/adverse assessment and understanding.

Assessment & Understanding of Families. Assessment and understanding of families was acceptable for only 56%. This was a marked decline since the last CSR's results of 82% of teams having acceptable assessment and understanding of families' strengths and needs.

In this year's CSR, 38% of families experienced "good" or "optimal" understanding by their teams. "Refinement" was needed for a third of the families (33%) where there was fair/minimal understanding, or marginally inadequate assessment and understanding. For these families, teams needed to better understand the strengths, context, needs and vision of the family. For six families (13%) the team's understanding was poor, incomplete and inconsistent among team members.

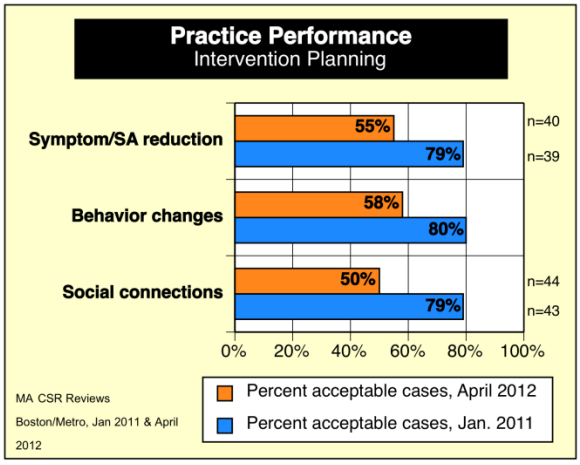
An example of a team that has strong practices and understanding of the youth and family resulting in cohesive planning is: "The team did an excellent job of engaging the family and (the youth). The team has consisted of individuals who were involved with the family and aware of the overall treatment plan. Communication has been timely and persistent. The team has a strong understanding of (the youth and) family. This understanding has driven treatment plan development. The team has heard the family and recognized their needs. A set of goals and outcomes were developed that reflected the family's needs and wishes. Needs were identified and matched to interventions."

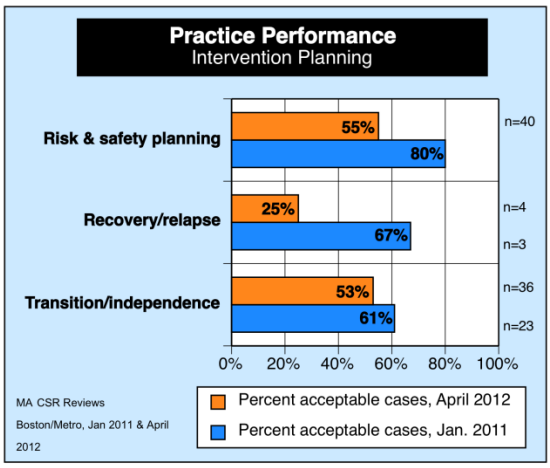
An example where clear assessment and understanding is hindered by coordination and is impacting development of an effective plan is: "The parents were asked to make arrangements for the evaluation. At the time of the review, the neuropsychological exam had not occurred. The IHT felt that he had explained the process and the procedure to the mother. However, she took (the youth) to a neurologist and reported that there were no problems. A school CORE evaluation will take place in the near future but it is uncertain when the psychological evaluation will occur… The overall lack of understanding of (the youth) and his presentation continues to hamper treatment planning and treatment implementation… Due to lack of understanding and lack of engagement, planning has been minimally acceptable and has not driven practice."

Another example is: "(The youth and) family have not been fully engaged nor has a therapeutic connection been established. There is not a clear assessment and understanding

of (the youth's) disorder and needs. There are many references to (the youth's) 'memory and organizational' issues but little understanding of their root cause – behavioral – mental health and/or learning disorder. Consequently when interventions are tried – developing a poster board schedule and reviewing – don't work, the 'team' has not attempted to understand why and plan accordingly."

Assessment and understanding of youth and families is a necessary foundational practice to build cohesive care plans toward achieving positive outcomes. For youth in Boston/Metro-Boston, this practice clearly is not at a level where teams are clearly and consistently understanding youth and family needs or mental health issues.





Planning Interventions

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

Symptom or Substance Abuse Reduction. Planning for reducing presenting psychiatric symptoms or substance abuse was applicable to 40 youth and acceptable for only 55% of them. This was a decline since last year's CSR results when 79% of youth with acceptable planning for symptom reduction, and indicates this critical area of planning needs improvement.

There was "good" or "optimal" planning in reducing symptoms or substance abuse for eleven or 28% of the youth reviewed. Planning for these youth was generally well-reasoned, informed by the youths' and families' perspectives, and addressed core issues. "Refinement" in planning to reduce symptoms or substance abuse was needed for twenty-two or 55%. In these cases planning was fair to marginally inadequate. Planning to reduce psychiatric

symptoms was found to be poor or absent for seven youth or 18% of those reviewed, with poorly reasoned and inadequate planning that failed to provide interventions to address youth's symptoms, or no plan existed to address symptomatology or substance use.

Behavior Changes. Targeting *Behavior Changes* in planning was acceptable level for only 58% of the youth. This was a marked decline since last year's performance of 80% of youth with acceptable planning to address behavioral change. Focused work to improve planning in this domain is clearly indicated.

In the April-May 2012 CSR, 38% had plans that addressed needed behavior changes that were in the "good" or "optimal" range. "Refinement" of behavioral supports and interventions in plans was needed for 52% of the youth. Planning for these youth was fair and somewhat reasoned, to marginally inadequate and inconsistently aligned across interveners. Five youth or 10% of those reviewed experienced a poorly reasoned, inadequate plan that failed to design interventions to address behavior changes, or had no planning strategies to impact needed changes in their behaviors.

Social Connections. Planning for increasing *Social Connections* was acceptable for only half (50%) of the 44 youth the indicator was applicable for. This was a decline since the last CSR's result of 79% of youth with adequate planning to address improving their social connections.

Eleven youth (25%) had "good" or "optimal" planning strategies for improving their social connections that reflected generally well-reasoned supports. "Refinement" in planning to strengthen social connections for youth was needed for twenty-nine youth or 66% of the sample. Nine percent (9%) of youth had poor or absent planning reflecting unaligned strategies lacking in the clarity and urgency necessary to address the youths' need for social connections, or no planning process was evident.

Risk/Safety Planning. Planning to address youths' risk and safety issues was applicable for 40 youth and acceptable for only 55%. This was a marked decline from last year's CSR performance of 81% of youth with acceptable risk and safety plans. This is clearly another area that has diminished in performance and needs attention.

The risk/safety component of plans was "good" or "optimal" for twelve youth or 30% of the youth. For seventeen youth (43%), risk and safety planning needed refinement and was fair or marginally inadequate. For the remaining eleven youth (28%), risk and safety planning was poor or absent.

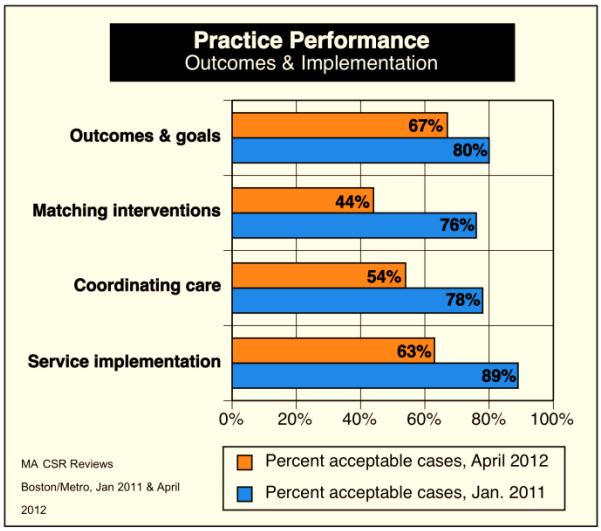
Recovery/Relapse Planning. Four youth in the sample needed *Recovery or Relapse* addressed in their care plan, and planning was acceptable for only one or 25%. In the last CSR three youth needed planning in this domain, and planning was acceptable for 67%. In the April-May 2012 CSR, one youth had good planning, two had marginally inadequate planning, and one had poor planning to address their recovery. Results indicate that better planning to address recovery and relapse supports for youth are needed.

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

Among youth in this year's CSR sample, thirty-six needed to have a transition addressed in their planning processes. Performance was acceptable for only 53% indicating concerted

improvement is needed in transition planning for youth. This was a decline over last year's performance when 61% of youth had acceptable transition planning.

Transition planning was "good" or "optimal" for nine of the youth or 25%, with plans that were generally well-reasoned, largely informed by the youths' and families' perspectives, and accountable. Eighteen of the youth (50%) would benefit from refinement in transition planning, and had plans that were somewhat reasoned and aligned across providers or were marginally inadequate and inconsistently aligned, with little sense of clarity or urgency. Nine or 25% of youth had poor transition planning that was inadequate, with no sense of clarity or urgency to achieve successful transitions, including three who had no transition planning in place to address imminent changes.



Outcomes and Goals

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

A clearly stated and understood set of goals and outcomes guiding services and strategies, and that describes what needs to happen was acceptable for only 67% of the sample. This was decline since the previous CSR results when 80% of youth had acceptable specification of outcomes and goals by teams. Assuring teams can define clear outcomes and goals to guide service implementation needs to be better addressed.

Thirteen youth or 27% had good specification of goals by their teams that were well-reasoned and specific and were considered to be "good" or "optimal." Thirty-one youth or 65% of those reviewed had ending goals and outcomes that needed to be "refined," and were fair to marginally inadequate. Four youth (8%) had poor specification of outcomes and goals which was insufficient to guide intervention and change.

Matching Interventions to Needs

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

There was an acceptable level of matching intervention to need for only 44% of the youth in the sample, a very concerning finding. This was a decline since the last CSR when 76% of the sample had acceptable results. These findings indicate that less than half of youth are receiving interventions that address their needs.

Sixteen youth (33%) had "good" or "optimal" matching of interventions to needs, meaning necessary supports and services are generally assembled in a workable fit with what the youth and family needs to progress. Twenty-six youth or 54% needed their teams to "refine" identification and assembly of services and supports that matched the youth and families' situations and needs. For these youth there was fair matching and integration that could meet short-term objectives, or marginal matching that was insufficient. Six youth or 13% had poor matching of interventions to their needs with supports and services that were poorly or adversely assembled, and were inadequate in meeting identified needs.

Coordinating Care

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

Youth in the sample received care coordination services from both ICC (N=26) and IHT therapists (N=22). Care coordination practices were found to be at an acceptable level for only 54% of the youth reviewed, a decline in performance since the last CSR, when performance was acceptable for 78% of youth.

Care coordination in the April-May 2012 review was found to be "good" or "optimal" for sixteen youth or 33% of the sample. For twenty-two youth or 46%, care coordination needed "refinement," and practices were fair and minimally adequate, or marginal and limited with little leadership for service delivery and results. Eleven youth (23%) had poor, inconsistent and fragmented care coordination that was substantially inadequate.

Care coordination practices that were working well are described in this example as: "(The youth) participates in team meetings which are held at convenient locations [school, home, (ICC) office]. Although the OP and psychiatrist don't participate in person in team meetings, the ICC is in frequent contact with the OP, less so with the psychiatrist, and both receive the care plans. The team has prioritized transition planning to adulthood … and addressing potential risk situations (such as the dangerous neighborhood)."

An example of care coordination that needed improvement is: "Communication between team members appears minimal and the team has met only twice since the original Care Plan was developed in November. The psychiatrist reported he did not receive updates on progress and would be interested in participating to ensure coordination of care and his input would provide an enhanced level of expertise. The (ICC) although invested, did not appear to have an understanding of the complexities of this family and stated the Therapeutic Mentor is doing the 'trauma work'. There is little identification of any family supports or need areas targeting mother's challenges. Specific and concrete recommendations from both CBAT placements addressed both Evidenced Based Parenting Curriculum and positive reinforcements (and) are not integrated into (the) Care Plan."

Care coordination for youth is not only a required practice of the Rosie D. agreement, it is a "lynchpin" function for most, if not all of the system practices to work well including assessment/understanding, planning, teaming, and matching interventions to needs. Without concerted improvements in how well care is coordinated for youth, other key system functions may continue to show the weak performance demonstrated in this review.

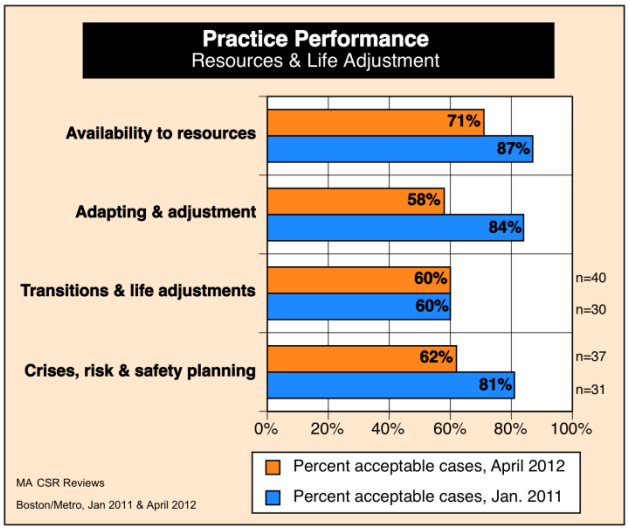
Service Implementation

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 about the adequacy of service implementation, reviewers weigh if implementation is timely and competent, if team members are accountable to each other in assuring implementation and if barriers to implementation are discussed and addressed by the team. Also examined is the degree to which any urgent needs are met in ways that they protect the youth from harm or regression.

For the youth reviewed, only 63% were determined to have acceptable service implementation. This is a large decline since last year's CSR result of 89% with acceptable implementation, and indicates necessary services and supports in care plans are not consistently implemented for a large percentage of youth.

Fifteen youth or 31% were found to have "good" or "optimal" service implementation where services had a substantial pattern of being implemented in a timely, competent and consistent manner. For twenty-six youth or 54%, service implementation needed "refinement" and the overall pattern of implementing needed services and supports was fair to marginal and inconsistent. Seven youth or 15% had poor implementation with few

services being implemented at inadequate levels of necessary intensity, or services were not implemented.



Availability and Access to Resources

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

Seventy-one percent (71%) of the youth reviewed were found to have acceptable access. This is a decline since the previous CSR performance of 87% of youth having timely access to the services they need. The result indicates that not only did far fewer youth have access to necessary services, but that a substantial proportion of youth are having difficulty accessing the services they need.

Fifteen youth or 31% had "good" or "optimal" access to needed resources. Thirty youth or 67% had fair to marginally inadequate resource availability indicating refinement was needed. Three youth or 6% had poor availability and access, with a limited array that was generally inaccessible.

Adapting and Adjustment

The *Adapting and Adjusting* indicator examines the degree to which those charged with providing coordination, treatment and support are checking and monitoring service and support implementation, progress, changing family circumstances and results for the youth and family. Strategies, services and supports should be modified when objectives are met, strategies are not working and/or new needs arise. For youth with serious mental health issues, the provision of treatment and supports is often a process that requires many adaptations and adjustments over time as they build their knowledge and systematically implement strategies that will work.

For the youth reviewed in Boston/Metro-Boston, practices related to adapting and adjusting plans and services was acceptable for only 58%. This was marked decline since the last CSR results when 84% of youth experienced acceptable practices in adapting and adjusting.

Performance on this fundamental practice indicates a substantial number of teams are not making necessary adjustments to services and supports that youth need to progress.

Eighteen youth or 38% had "good" or "optimal" practices that were responsive to changing conditions with acceptable levels of monitoring and adjustment. Twenty-five youth or 52% were experiencing needed changes to their plans and services at a minimally adequate to marginally inadequate level, with only periodic to occasional monitoring. Five youth (10%) had a fragmented or shallow adapting and adjustment process that was not responsive to changing conditions.

Transitions and Life Adjustments

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

For the forty youth the indicator applied to, only 60% had acceptable transition management practices, the same as last year's CSR result. Transition management continues to be a weak system practice that needs improvement.

In this year's CSR, ten youth (25%) experienced "good" or "optimal" transition supports. Twenty-five youth (62%) would benefit from "refined" transition supports, and had minimally adequate to marginally inadequate transitional interventions. For the remaining seven youth (18%) transitions had poorly managed, and their transitions were not addressed.

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

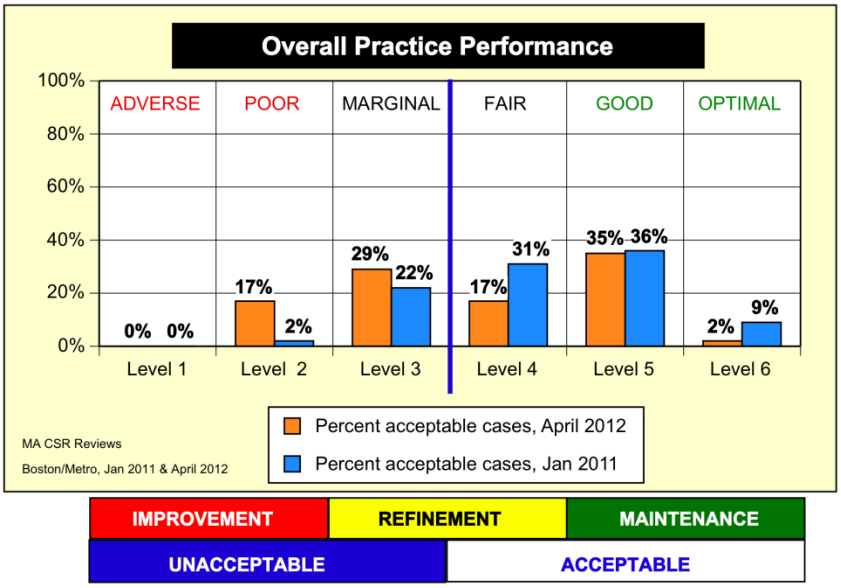
Responding to Crises and Risk/Safety Planning

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

For youth where this indicator was applicable (N=37), only 62% had experienced an acceptable crisis response. This represented a considerable decline in performance since the last CSR findings when 81% of youth had acceptable findings on this indicator.

Twelve youth (32%) were rated to have received a "good" or "optimal" management of their crises and/or safety issues. Twenty-two youth (59%) needed "refinement" in the response to their crises and risk/safety issues and experienced fair to marginally inadequate crisis responses. Six youth (16%) experienced poor or absent/adverse responses to their crises. Because of the critical importance of adequate crisis response for youth, and the weak

performance of the service system on this indicator, development of strategies to improve crisis response are warranted.



Overall System/Practice Performance

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

For the 48 youth reviewed in the April-May 2012 CSR for Boston/Metro-Boston, only 54% of youth were found to have acceptable system/practice performance. For the remaining 46% of youth, the system was not providing dependable, quality services. These findings represent a decline in overall performance as compared to the previous CSR when 76% of the sample had acceptable findings.

The largest percentage of youth (46%) fell in the "Refinement" area which means that performance was limited or marginal, and further efforts are necessary to refine practices.

Thirty-seven percent (37%) of the youth fell in the "Maintenance" area, meaning that system and practices were effective for the youth reviewed, and efforts should focus on sustaining and building upon positive practice. Two percent (2%) of youth were found to have "optimal" system practices.

Seventeen percent (17%) of youth fell in the "Improvement" area; performance for these youth was inadequate. In these cases practices were fragmented, inconsistent and lacking in intensity or were non-existent. Fifteen percent (15%) more youth fell in the "Improvement" zone than in the last CSR. Immediate action is recommended to improve practices for youth falling in this category.

The highest percentage of youth reviewed had practice patterns that were at the "Good" level (35%), meaning system practice was substantially and dependably positive. Practice for these youth was consistent with attainment of long-term goals. While the greatest percentage of youth fell at this level, the combined impact of youth that fell in the unacceptable category caused the overall performance for Boston/Metro-Boston to be weak.

The data indicate that the strongest area of practice for youth in Boston/Metro-Boston was Cultural Responsiveness to Youth.

There were three areas of practice with overall fair performance: Engagement with the Family; Engagement with Youth; and Cultural Responsiveness to the Family

One area of system/practice performance needs improvement in order to be considered to have adequate consistency, intensity and/or quality of efforts: Availability and Access to Resources.

All of the remaining system/practice domains demonstrated weak performance including: Team Formation and Team Functioning; Assessment & Understanding of Youth and Family; all Planning Indicators (Planning Interventions for Symptom Reduction Planning Interventions for Behavior Changes; Planning for Social Connections; Planning Interventions for Risk and Safety; Planning Interventions for Recovery and Relapse; Planning Interventions for Transitions); Outcomes and Goals; Matching Interventions to Needs; Care Coordination; Service Implementation; Adapting & Adjustment; Managing Transitions & Life Adjustments; and Responding to Crises.

No system practices showed improvement over the previous CSR; all indicators declined in performance with the exception of Managing Transitions, which stayed the same and continued to have weak performance. Cultural responsiveness to Youth was the only system practice that remained at a strong level.

Overall practice was very weak (54%). Based on the review of youth, the system of services in Boston/Metro-Boston Massachusetts has declined since the last review and lacks capacity to provide consistently reliable services at the quality needed to help youth make progress, achieve desired outcomes or maintain recent gains. Nearly all areas of practice need concerted improvement in order to be considered adequately working for youth and families.

There is considerable concern about the system of behavioral health services for youth in Boston/Metro-Boston. Almost twice as many youth as in the previous CSR were found to have unacceptable system performance. Teams were not adequately formed for half (50%) of youth, and nearly half (48%) of teams were functioning in a limited manner, were splintered or inconsistent in their planning and evaluating results, and were not engaged in collaborative problem-solving in ways that could impact positive change for youth and families. Half of youth (50%) and 44% of families were not well-assessed or understood, which is a foundation for providing effective supports and services for youth and families. Further, 46% of youth did not have a current mental health assessment in their files. All of planning indicators were found to be extremely weak and, for a significant number of youth, did not reflect effective planning processes or plans that were well-reasoned or clear in addressing youth and family strengths and needs. Planning transitions for youth was unacceptable for almost 53% of youth, and transitions were not managed well for 60%. Managing crises for youth dipped to being acceptable for only 62% of youth as compared to 81% in the previous review.

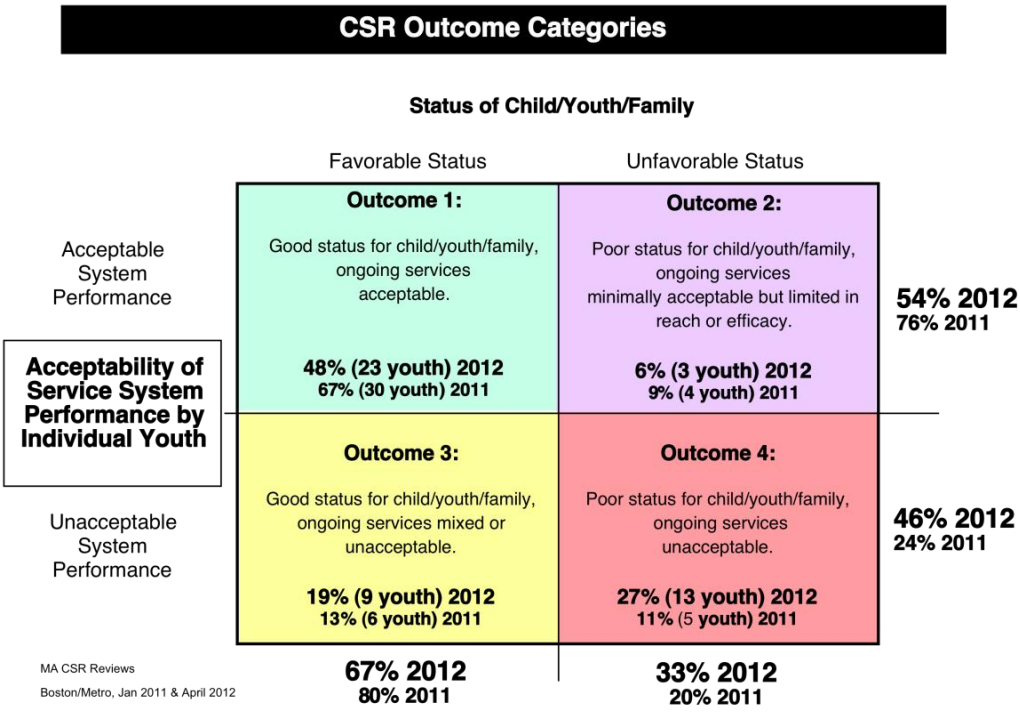
With only 54% of youth receiving acceptable system performance, focused improvements of core practice functions and concerns identified in this report will be important for the Commonwealth to address in order to be considered to providing adequate services for youth in Boston/Metro-Boston.

CSR Outcome Categories

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

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

Outcome Results: Boston/Metro-Boston CSR (April-May 2012)



System/Practice Performance for youth in the April-May2012 Boston/Metro-Boston CSR was 54%.

- This means that services were working at a dependable or consistently acceptable level for 54% of the 48 youth reviewed which is considered to be weak performance.

- This was a decline in performance since last year's CSR result of 76% of youth with acceptable system/practice performance.

Outcome 1

48% of the 48 youth fell into outcome category 1. Outcome 1 is the desired situation for all children and families receiving services, and represents youth who have favorable status and acceptable system/practice performance.

In last year's CSR, 67% of youth fell into Outcome 1; far fewer youth fell in Outcome 1 this year.

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

> *"The team of providers has effectively engaged (the youth and) mother. The team consists of individuals from different agencies and the school. They have maintained communication with each other and care coordination has been strong. The ICC assures that all providers are informed and working for the same goals. About once per month the team met to set goals and evaluate progress. Some of the services were redundant and so the individual therapist stepped back as the in-home therapist began to work with (the youth). None-the-less the individual therapist has continued to be involved with the team. The team has a good understanding of (the youth and) family dynamics and needs. Planning was predicated on the teams understanding. The team joined with (the youth and) mother to create goals and outcomes. Service implementation was effective for frequency and intensity. The team also did a good job of matching services to needs. Resources have been available to (the youth and) mother. (The youth) has had crises and the team has worked to create a crisis response and to implement that response. (The youth) is in a therapeutic school. The school has welcomed the involvement of the outside providers. Continuity of care has been strong."*

Outcome 2

Three youth or 6% of the sample fell in Outcome 2. This category represents children whose needs are so great or complex that despite the best efforts and diligent performance of the service system, the overall status of the child or youth is still unacceptable.

In the previous CSR, 9% of the sample fell in Outcome 2.

An example of youth who fell in Outcome 2 who has poor status, risk issues, and team practice that needs refinement but is overall acceptable is:

> *"Despite hard and committed work on the part of the two (agency) clinicians working with (the youth and) family, (the youth) remains tenuously connected to all efforts to help…It was clear that the IHT clinicians have done a wonderful job engaging the parents and youth. Although (the youth) expressed low levels of satisfaction, all reports indicate that he continues to allow the clinician to see him on a regular basis, which is the most success any provider has reportedly ever had with (the youth), according to his mother. (The youth's) IHT clinician has been very creative in his attempts to see (the youth) on days when (the youth) seems to be wanting to cancel appointments [e.g., offering to give him a ride to a desired activity, changing the time of the visit at the last minute to accommodate (the youth's) preferences]. (The youth) is known to the local MCI team, and he is listed on their alert list on a regular basis."*

Outcome 3

Nine youth or 19% of the sample were in outcome category 3. Outcome 3 reflects youth whose status was favorable at the time of the review, but who were receiving less than acceptable service system performance. Some children are resilient and may have excellent

naturally occurring supports provided by family, friends, school personnel, or some other key person in their life whose efforts are significantly contributing to the child's favorable status at the present time. However, current service system/practice performance is limited, inconsistent, or inadequate at this time. For these children, when teams and interveners adequately form, understand the youth and family, and work diligently and cohesively, the youth could likely progress into the outcome 1 category. Without key practice functions occurring reasonably well, status for youth in this category is often fragile, and at risk of becoming unfavorable.

In last year's CSR, 13% of the sample fell in Outcome 3.

The following is an example of a youth in Outcome 3. This youth is doing well and has minimal needs, but many services.

> *"The case appears to be in disarray in virtually every aspect…There was no consistency in identifying (the youth's or) mother's culture…Teamwork is sketchy. While most team members have nice things to say about one another, information from team members often conflicts. For example, the teacher's description of (the youth) following directions and getting along well with others contradicts the ICC contention that (the youth) is aggressive and has no attention span. No one on the team seems to question why a child with such mild impairment needs so many services and mother seems convinced that the services are in place to help her learn patience. There have been only two Care Plan Team meetings in 5 months."*

Outcome 4

In the Boston/Metro-Boston CSR, 27% of the sample or 11 youth fell into outcome category 4. Outcome 4 is the least favorable outcome combination as the child's status is unfavorable and system performance is inadequate. For many of the youth who are in Outcome 4, a thorough understanding of the youth and family coupled with strong teamwork and planning interventions that meet the needs of the youth with oversight of implementation would move the youth into a better Outcome classification.

In last year's CSR 11% of the sample were in Outcome 4, representing a decline in overall performance.

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

> *"(The youth and) mother are marginally engaged in the treatment process. Team members have been slow in their attempts to connect with the family. Further, there is the issue of poverty and the mother's view that team members look down on her due to her circumstances. It does appear that team members may not fully understand the culture of poverty that engulfs this family. There are two teams of individuals working with the family. The intensive school based counselor has the longest relationship with this family and the most knowledge. It does not appear that the mental health team has attempted to integrate or to learn from the intensive school based counselor. The mental health team does not appear to be meeting on a regular basis and planning has been limited. A neuropsychological assessment has been ordered for (the youth). The teams do not have a good understanding of (the youth) or of the drivers of (his/her) behavior. It is also clear that the teams do not fully understand family dynamics. Intervention planning has therefore been fragmented and weak… Further, next year (the youth) will be in a new, middle school environment. Planning for*

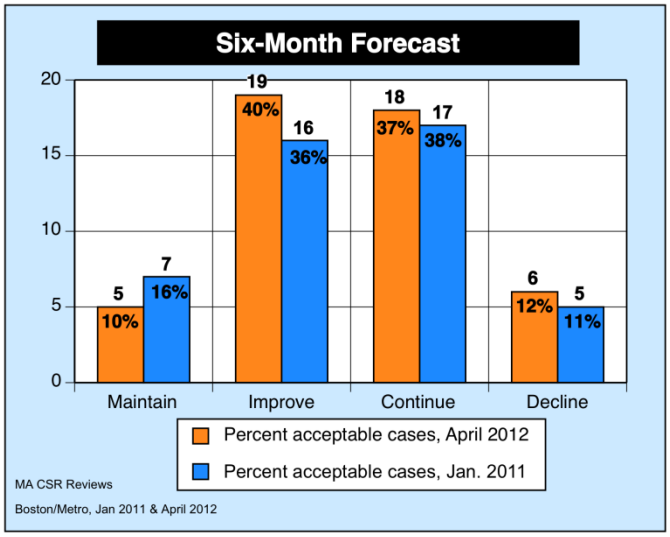
that transition or transition to independence has been poor. The mental health team has developed goals as listed above. These goals do not appear to be understood by the school. Given the general lack of understanding about (the youth and) family and inadequate planning, outcomes and goals was rated as inadequate. Implementation of services has been slow and services have not been adequately matched to needs. The ICC has increased her activity of late but the coordination of care has not been adequate. Finally, (the youth) has difficulty in the after school program or extended day program. The mental health team has not worked with the school or family to create appropriate responses to the crisis situations."

Six-month Forecast

Based on review findings, reviewers are asked if the child's status is likely to maintain at a high status level, improve to higher than the current overall status, continue at the same status level, or decline to a level lower than the current overall status.

For 5 youth or 10% of the sample, the prediction was that the youth would maintain at a high status level (youth in the "good" or "optimal" status category). For 19 youth or 40% of the sample the prediction was for improvement in status. For 18 youth or 37% (youth with "fair, marginal, poor or adverse" status) reviewers predicted the youth's status to continue at the same level. For 6 youth or 12%, the prediction was that their status would decline.

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



Summary of Findings

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

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

Strengths

Many families appreciate the services they are receiving.

Many of the families that were interviewed or participated in stakeholder meetings were very appreciative of the services and felt that people are working together and involving the whole family. Parents expressed that they are learning how to be good parents, how to be more accepting, and how to trust. Therapeutic Mentors are especially valued by families. There were examples in the reviews of strong connection between providers and families, where families felt supported, and the voice and choice of families was well-integrated into the clinical work.

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

- More services are being provided that are a cultural and linguistic match with families. There was an exemplary example of team communication where all documents were written both in Spanish and English.
- There were many instances of strong teaming with schools. Several of the SOCs have conducted trainings with schools about CBHI services.
- In-home therapy providers are consistently taking on the coordination role for families than seen in the last CSR.
- The reviews identified examples of exemplary practice and committed staff providing services resulting in positive outcomes for youth and families.

Challenges

There is considerable variability in the quality of care coordination.

When ICCs were well-trained and clearly knew their roles, practice most frequently worked well. However, many ICCs were noted to be inexperienced, were not fully engaging or communicating with families and teams, and had poor therapeutic boundaries. Some lacked the necessary level of professionalism required to carry out the functions of the position. This often resulted in fragmented and disorganized care. There is a lack of consistency in interpreting the standards of ICC, resulting in variability of implementation and quality of services. There appears to be weak oversight and supervision of care coordination practices in these cases.

There were situations where almost the entire array of services were given to families without the team fully understanding the needs of the youth or how the services fit together to form a sensible mix. Often families are confused about the purpose of the multiple providers involved.

Understanding of the CBHI model and standards is not consistent and is resulting in weak practice and poor results across services for a number of youth and families.

Some of the agencies have an insular approach and do not embrace team-based practice. This sometimes occurred even within agencies where there was a lack of coordination or teaming when youth received two different services from the same agency. Lack of a team-based approach in some cases resulted in breakdowns in communication, and sometimes not knowing that other providers are involved. There were instances of in-home providers not knowing that it was important to connect with schools to understand the full scope of youth's status across settings, resulting in unaddressed issues and even risk for youth. Agencies working with youth are sometimes not informed when services end by another agency.

MCI agencies were reportedly not consistent in adhering to service standards resulting in MCI services in some communities being undependable.

There appears to be coordination, quality and standard implementation in all three of the "hubs" for service provision that need to be addressed to ensure youth are receiving services in the way the Rosie D. Remedy intended.

There are multiple issues for youth needing inpatient and CBAT levels of care.

Youth who need assessment and intensive treatment for serious mental health problems often end up "bouncing" between different settings and services, and decompensate to levels worse than when they initially accessed treatment due to the de-stabilizing impact of the moves. Besides the issues associated with inability for some youth to receive intensive, quality treatment in a stable setting for the length of time needed, when a youth is hospitalized, community teams often to not move into a mode of planning cohesive strategies and supports for the youth upon discharge that would prevent further hospitalizations.. Often the assigned ICC or IHT care coordinator communicated with the inpatient setting when the youth was there, but did not work concurrently with the broader

community team along with the youth and family to develop a successful transition and long-term plan to assure appropriate individualized treatment and supports. What resulted was a placement-focused mode of work, versus a planning and implementing services that would help the youth achieve sustained progress.

Service intensity, access, and continuity of care issues are barriers to many youth making progress.

Many of the care plans had vague strategies coupled with intervention models that were rigid and geared to a short-termed, time-limited approach that was not conducive to addressing stabilization, needs or achievement of sustainable progress for youth. Many of the strategies designed for youth are not well-informed by understanding of the youth and family or past interventions, are clinically limited in scope and intensity, and are not impacting youth progress.

The ability of the service system to provide timely and accessible services that are appropriately responsive to the needs of youth and families of Boston/Metro-Boston was a frequently seen concern. As seen in the CSR, availability of resources was an issue for nearly 30% of youth, and services were not well-implemented for 37%. Despite there being claims of no waitlists, it appears that the data may not be reliable enough from which to base assumptions about access to services on. There were access issues for key services for youth reviewed.

Many youth have difficulty accessing child psychiatry. The requirement by outpatient clinics to have outpatient treatment through a clinic provider in order to access the psychiatrist impacts care, for example sometimes care is disrupted with current therapists, youth have to stop services with the psychiatrist when they no longer need outpatient therapy, youth and families engaged in IHT cannot access psychiatry without the assignment of an outpatient clinician which the youth may not need, or youth and families who need intensive services may be referred to outpatient treatment in order to access psychiatry, thus delaying or diverting from a more intensive community service.

Other issues impacting continuity of care for youth are:

- Families falling in and out of Medicaid eligibility impacts continuity of care for youth.
- The process for requesting additional units for needed services is increasingly challenging, and is an administrative burden for agencies that often detracts from providing direct services.
- There is a need for more access to services that have language and cultural capacities.

The overall performance of the system of services was weak and has declined in almost every area since the last review.

As described in this report, many of the key system functions were weak and not at a level of performance where youth and families can reliably depend on services to work for them. Youth and families, at this point in time, can't consistently rely on their teams to have comprehensive and in-depth understanding of their needs, teams that work well together, a

quality care plan, or services that address their needs. Outcomes and goals of care plans and service foci was vague for many, and plans were not adjusted as needed. Care coordination for a significant number of youth was fragmented and inconsistent, and necessary services were not available or implemented for many. Transitions for youth were not consistently addressed, and crisis responses were weak.

These declines in performance need to be better understood within the context of a developing service system. Many of the foundational practices for Boston/Metro-Boston in last year's CSR were seen as operating at a better level than many of the other regions of the state. This year, many of the strengths have waned, and agencies appear to be struggling in their ability to provide the components of services in a reliable manner. While there is variability in the quality of services across agencies and staff, the goal must be to assure consistent quality and results for youth needing services.

Recommendations

Provide support for of care coordination practice and continuous workforce development.

- Design and support supervision practices that can identify when youth are not progressing, and when teams may need consultation to address youth and family needs.
- Assure ICCs are fully prepared and supervised to provide coordination, facilitation of teams that develop effective plans and individualized services and supports that produce positive outcomes for youth and families. Assure have the basic skills they need to provide services and can implement their roles consistently.
- Strengthen supervision, training and supports for ICCs
- Systematically engage schools in youths' care planning.

System-level recommendations:

- Assure all youth have a current quality mental health assessment that informs team planning.
- Provide orientation to all team members to assure they fully understand their roles and what is expected of them in being part of the youth and family's care planning team.
- Work with inpatient programs, CBATs and residential programs and support care coordinators when youth enter these programs to engage in focused planning with program and community teams to support youth's stability, treatment, and long-term strategies for addressing needs beyond the immediate situation.

- Develop strategies for improving system/practice functions that are weak and need improvement with particular emphasis on :
    - ✓ team formation and functioning,
    - ✓ assessment/understanding of youth and families,
    - ✓ care planning,
    - ✓ clear outcomes and goals for services,
    - ✓ assuring youth are receiving services and supports that address their needs,
    - ✓ care coordination,
    - ✓ timeliness and quality of service implementation,
    - ✓ access and availability of services youth need,
    - ✓ adapting/adjusting plans and services as needed,
    - ✓ managing transitions, and
    - ✓ responding to youth crises.
- Help all provider agencies to understand role specifications of each CBHI service, inclusive of "hub" roles.
- Assure that there is consistency in service delivery across agencies.
- Assure management and compliance priorities of MCOs are aligned with helping youth and families achieve positive outcomes.
- Evaluate whether or not staff are closing cases prematurely when there are continued needs of youth.

Appendix 1

Child's General Level of Functioning

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

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

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

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

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

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

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

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

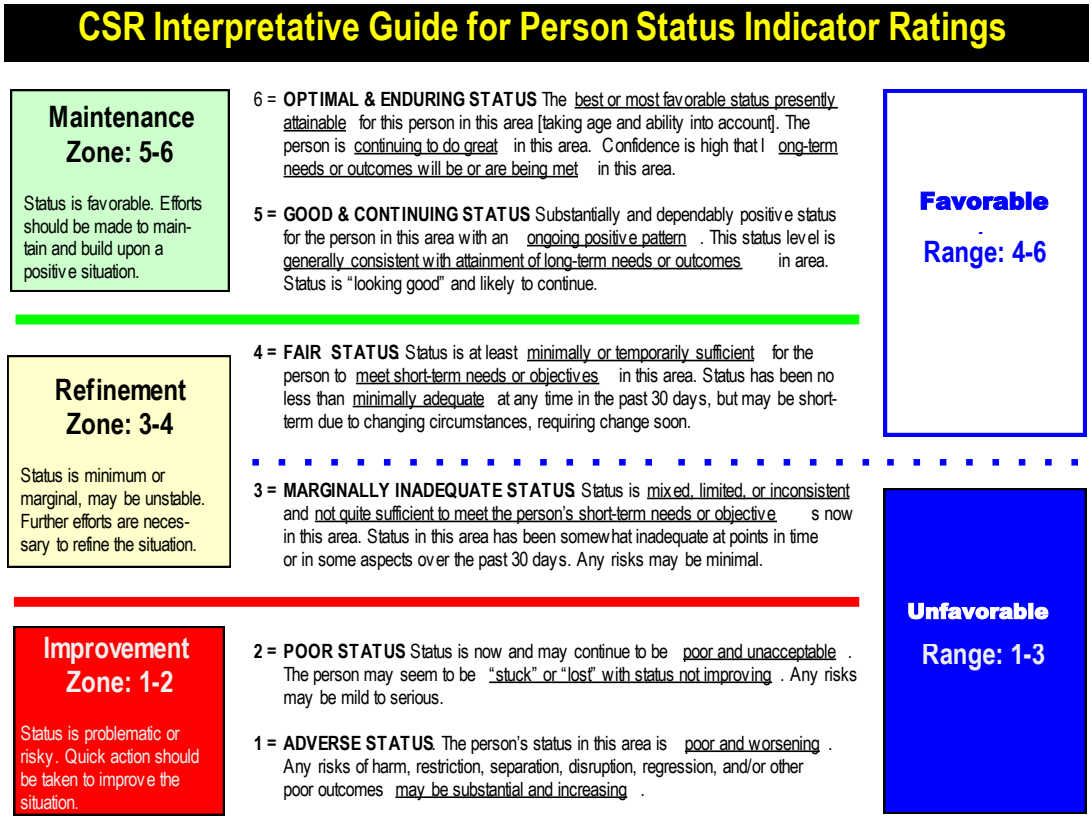
□ **3** Unable to function in almost all areas, e.g., stays at home, in a ward, or in a bed all day without taking part in social activities or severe impairment in reality testing or serious impairment in communication (e.g., sometimes incoherent or inappropriate).

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

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

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

Appendix 2


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

CSR Interpretative Guide for Practice Performance Indicator Ratings

Maintenance Zone: 5-6

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

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

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

Acceptable Range: 4-6

Refinement Zone: 3-4

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

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

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

Improvement Zone: 1-2

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

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

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

Unacceptable Range: 1-3