2011

Rosie D.
Community Services Review
Central Massachusetts
Regional Report

Report of Findings of the Community Services Review
of Central Massachusetts conducted during May 2011

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Executive Summary

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

The *Rosie D.* Remedial Plan finalized in July 2007 commits the Commonwealth of Massachusetts to providing new behavioral health services and an integrated system of coordinated care for youth with Serious Emotional Disturbances (SED) and their families. At the time of the Central Massachusetts Community Services Review (CSR) the *Rosie D.* Remedy Services, with the exception of Crisis Stabilization services, had been in place for approximately a year and a half. Since the start of the Remedial Plan, agencies have been providing the new services through a practice model that requires team-based work and fully integrates family voice and choice. Services are required to be delivered through a coordinated approach consistent with System of Care and Wrap-Around principles.

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

Characteristics of Youth Reviewed. Data that describe the population of youth that were reviewed in Central Massachusetts are presented in this report. The largest number of youth (13 or 54%) was in the 10-13 year old age group. There were no youth reviewed in the 18-21 year old range or in the 0-4 range. At the time of the review, 75% were living with their biological parents or in an adoptive home; most of the remaining youth were living in crisis, detention, or residential settings. Twenty-five percent (25%) had a change in living or school placement within the past year. The largest ethnicity represented among the youth in the sample was European-American (63%) followed by Latino (33%). English was the primary language spoken at home for the majority of the youth (79%). The most frequent educational setting for the youth was in a regular educational classroom (29%), followed by part-time special education (17%), and a fully self-contained special educational classroom (13%). One youth had completed school (4%).

Youth in the sample were involved with a variety of other agencies with the highest frequency being Special Education (63%) followed by the Department of Children and Families (DCF) (46%). The youth were referred to ICC or IHT services in the largest numbers by their families (25%), followed by DCF (17%), and by outpatient providers (17%).

The review also collected information related to behavioral health and physical conditions, including co-occurring conditions, with the highest condition prevalence being mood

disorders (71%) and ADD/ADHD (71%) and anger/impulse control issues (38%). This was followed by 25% each with Anxiety disorders, PTSD/adjustment to trauma, and disruptive disorders Twenty-one percent (21%) of the youth had a co-occurring medical problem. Current mental health assessments were found for 71% of the youth reviewed.

Seventy- nine percent (79%) of youth in the sample were on one or more psychotropic medication, with 33% on three or more medications. Most of the youth in the sample (88%) had not used a crisis services in the 30 days prior to the review. Thirty-seven percent (37%) had experienced a special procedure for managing behaviors during the 30 days preceding the review.

Caregivers of the youth were facing challenges that included extraordinary care burdens (46%), adverse effects of poverty (38%), a serious physical illness or disabling condition (25%), and/or serious mental illness (25%).

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

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

Youth Status. A portion of youth in the sample were experiencing problems in being in a stable situation free of disruption, with 75% having favorable stability status at home and 74% at school. Consistency and permanency with families or caregivers was favorable for 92% of the youth. Overall, most of the youth were safe at school (96%) and home (88%), with fewer safe in in their communities (83%). Most of the youth had favorable physical health status and had their health needs addressed (88%). Living arrangements were favorable for 83% of the sample. The sub-indicators for educational status showed 91% of the youth having favorable status in their attendance, and 86% with a favorable level behavior supports in the school setting. Fewer (78%) were doing well in their academic or vocational program.

The following indicators of youth status were concerning for the youth reviewed. Behavioral risk to self and others was favorable for only 71% of the youth. Only 42% of the youth had favorable emotional status, clearly indicating the need for more focus on this domain of youth status when planning interventions and supports.

Across the indicators of youth status, 75% of the youth reviewed had an overall favorable status with no youth with "optimal" status, 33% with "good" status and 42% with "fair" status. The remaining 25% of youth had unfavorable status with 17% with "marginal" status, and 8% with "adverse" status. Please see Appendix 2 on Page 67 for descriptions of each status category.

Family/Caregiver status. Status of families and caregivers are comprised of a constellation of indicators that measure well-being and satisfaction. The data for the Central Massachusetts

CSR, as discussed previously, reflect families experiencing challenges, among the most prevalent being extraordinary care burdens, adverse effects of poverty, serious physical illnesses/disabling conditions, and their own serious mental illnesses. Seventy-nine (79%) of mothers and 64% of fathers had a favorable level of challenge. The data show that voice and choice of mothers are part of the planning and service delivery process, but far less integrated for fathers and youth aged 12-17. Family/caregiver and youth satisfaction with needs being addressed was favorable. Mothers and fathers were less satisfied than youth 12-17 with their services; and the youth were less satisfied than their parents with their participation in planning and service delivery.

Youth progress. These indicators measure the progress patterns of youth over the six months preceding the review. Overall, 79% of the youth reviewed were making favorable progress. Seventy-five percent (75%) were making favorable progress in reducing symptoms, 33% in reducing substance use (N=3), 71% in improving coping/self-management, 78% in school progress and 67% (N=3) in work progress. Progress was fair to needing improvement across the indicators of building relationships (family and peers), with the exception of making progress in relationships with other adults which was 85% favorable for the sample. Well-being/quality of life progress for youth and families needed improvement.

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

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

Review of practices in Central Massachusetts found strong practices in Engagement with Families/Youth with respective ratings of 88% and 92% acceptable performance on these indicators. Cultural Responsiveness also saw strong performance for youth and families with 89% of those the indicator applied to (n=9) experiencing practices that were culturally responsive.

Teamwork, which focuses on the structure and performance of the youth and family care planning teams, is comprised of two sub-indicators: Team Formation and Team Functioning. Team Formation was acceptable for only 63% of the youth, indicating improvements are needed in order for families to be able to depend on teams with the right composition and continued development of the team. Team Functioning was even more of a concern with only 58% of teams functioning acceptably well. The overall finding for these indicators is that a high level of practice improvements are needed in teams in Central Massachusetts in order to assure the consistent bringing together of all relevant people on care planning teams, and that they work together to understand and plan at a level that will impact progress and status of youth.

The Assessment and Understanding indicator reviewed how well teams and interveners gather all relevant information forming the basis for determining which interventions,

supports and/or services will most likely result in meeting youth's and families' objectives. There was acceptable understanding for only 63% of the youth, and for 75% of families. Concerted improvement would move teams in Central Massachusetts toward better understanding of the key determinants of the youth's emotional and behavioral disorder and condition, thus improving the practice foundation for building effective plans.

The Planning Intervention measure includes six sub-indicators. Results for acceptability of care/treatment plans and planning processes show improvements can be across a number of the indicators of planning. Planning for symptom/substance abuse reduction was acceptable for 74% of youth, for behavior changes for 63%, and for social connections 61%. Planning for effective recovery and/or relapse prevention applied to five youth and was acceptable for 80% of them. Planning for supporting transitions was acceptable for 63% of the 16 youth the indictor was applicable for. Risk and safety planning was acceptable for 88% of the youth, a strong finding.

The indicator for identifying and articulating clear Outcomes and Goals for the youth and family was rated as acceptable for 71% of the youth reviewed, indicating room for improvement in this system practice. The indicator for measuring Matching Interventions to Needs, which measures practices in assuring services and supports form a cohesive sensible pattern and address the identified needs of the youth and family, also needs considerable attention with 54% of those reviewed having acceptable performance. Results for this indicator may be reflective of considerable issues with resource availability in Central Massachusetts found during the CSR.

Care coordination for the youth reviewed was acceptable for only 67% of the youth reviewed. A need for strengthening of care coordination practices is indicated. Service implementation was acceptable for only 63% of youth, indicating far more diligence is required to assure services and supports that are needed by youth are implemented. Again, some correlation with service availability is suggested in these findings. There was Availability of Resources for 58% of the youth, reflecting that the inability to access necessary supports and services in a timely manner for a significant proportion of the youth reviewed. The practice of Adapting and Adjusting plans and services was acceptable for only 67% of youth, indicating improvements are needed in making changes to plans and interventions when indicated.

Planning, staging and implementing practices for successful Transitions and Life Adjustments was an area where practices need work, with only 65% of the youth for which the indicator applied experiencing adequate transitions. Eighty-four (84%) of youth who experienced a crisis over the previous ninety days experienced acceptable crisis management as reflected in the Responding to Crises and Risk/Safety Plans.

Overall, only 66% of youth were found to have acceptable system/practice performance.

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

Indicators that showed an overall fair performance but at a less consistent or robust level of implementation were Planning Interventions for Recovery and Relapse; and Responding to Crises and Risk & Safety Planning.

Areas of system/practice performance that need some level of improvement in order to assure consistency, diligence and/or quality of efforts are Assessment & Understanding of the Family; Planning Interventions for Symptom or Substance Reduction; and Outcomes and Goals.

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

Summary of Findings. Overall, the findings of the CSR showed that for Central Massachusetts services, key system of care practices such as engagement and cultural responsiveness to youth and families were exceptionally strong, as were risk and safety plans. Other practices were found to be operating at a fair level, including crisis response and substance abuse relapse planning.

The remaining system practices need more development. Many practices were not at strong enough levels to reliably help many youth make progress in core areas of well-being, desired outcomes or maintain the gains they have made through services. While exemplary practices were observed for some youth, practice was not consistent level of performance across teams, and certain foundational system of care practices needed considerable improvement. Teams for over a third of the youth were not formed with the right team members to bring together the collective skills and knowledge necessary to address youth and family needs. Teams not only needed to improve their ability to be formed more reliably, for over 40% of youth they were not functioning at an adequate level, were splintered or inconsistent in planning and evaluating results, and were not engaged in collaborative problem-solving. A challenge for over a third of teams was gathering of information including existing assessments, and using this information to increase team-based understanding of youth's strengths and needs at a scope and depth necessary to develop the right set of interventions and supports.

Many of the Planning interventions needed strengthening particularly in impacting behavioral changes, increasing social connections, and assuring successful transitions. Matching the right interventions to address youth and family needs was weak for nearly half of the youth reviewed. For nearly a third of youth, care coordination required stronger leadership, including facilitating teams to monitor results to adjust care plans and address transitions. A core issue was implementing needed services, which appeared to be largely impacted in Central Massachusetts by necessary services being unavailable or long wait times to access services.

Overall findings suggest a number of core system of care practices in the Central Massachusetts region will need attention in order to achieve consistently reliable and effective results.

Findings: Strengths. The CSR found examples of effective practices including skilled therapeutic mentors and care coordinators. In Home Behavioral Therapy (IHBT) was seen as an effective intervention, although there were issues in accessing the service for some families. When Mobile Crisis Intervention services were able to work with community teams and provided continued support using the 72-hour capacity, the services were seen as an asset.

Findings: Challenges. The CSR found a number of access and service availability issues marked by waiting lists and inability to provide necessary services identified as needed in care plans. Waiting lists were reported for IHT, IHBT, Therapeutic Mentoring, assessment services and psychiatry. For some youth, this resulted in regression in functioning and/or reliance on crisis services.

Other challenges were related to the provision of crisis services, and families finding services that were available previous to the CBHI are no longer available such as respite, DCF voluntary services, after school programs, and parent support groups. The review also found the need for strengthened practices that would support care coordinators and teams to provide effective planning, crafting of interventions, and dependable implementation of services.

Recommendations. The Recommendations starting on Page 51 reflect the findings of the CSR and are provided as suggestions for further assuring the consistency and quality of behavioral health practices and service delivery for *Rosie D.* class members in the Central Massachusetts region. Recommendations relate to helping teams when they are struggling to understand the needs of youth and families, and to plan effective interventions, the geographic scope of MCI services in Central Massachusetts, assuring services are delivered based on the needs and goals identified in care plans, and addressing access and availability to services.

The Rosie D. Community Services Review
Regional Report for Central Massachusetts
For the Review Conducted in March 2011

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

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

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

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

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

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

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

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

Purpose of monitoring

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

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

Overview of the CSR methodology

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

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

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

Through using a structured protocol, reviewers make determinations about youth status/progress (favorable or unfavorable) and system/practice performance (acceptable or unacceptable) through a six-point scale. Refer to Appendix 2 on Page 58 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 24, it will be helpful to refer to Appendix 2 in understanding the ratings and findings.

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

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

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

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

The Central Massachusetts CSR (March 2011)

Description of the Region

The Central Region of Massachusetts encompasses the area of the state that is East of Springfield and West of Boston, with Worcester being the Central "hub". The Massachusetts turnpike, "the Pike" traverses the state East and West with the Central region including about 60 towns north and south of "the Pike". Most of these towns are fairly rural to rural, becoming more rural as you move away from Worcester and away from "the Pike". Moving west, Framingham and the surrounding areas are populated and are more associated with greater Boston than greater Worcester. The northern boundary of the Central Region extends to the New Hampshire border and the southern boundary extends to Connecticut and Rhode Island. Route 2 is a key secondary road that traverses East and West along the

northern Massachusetts border and provides access to the small cities of Fitchburg and Leominster. The countryside is lovely, and as with many more rural towns and small cities, industry and economics have shifted and there are areas that struggle with employment and the development of new industry. For example, the town of Gardner in the north central area was home to the well-known furniture maker, Heywood Wakefield and at one point was known as the "City of Chairs" due to the large production of chairs. In large part the furniture industry has migrated to the southern states. Many of these small communities have interesting histories and still carry elements of their past. Travel distances can be extended and this area is in the "snow belt" and often in the winter receives more snow and "weather" and thus travel can be challenging.

Community Service Agencies (CSAs) and In Home Services

There are five Community Service Agencies (CSAs) provided by three human service agencies in the Central Region of Massachusetts. CSAs are the designated agencies across the commonwealth for the provision of Intensive Care Coordination. At this time, the CSAs also provide Family Support and Training Services (commonly called Family Partners). Community Health Link provides CSA services in three Worcester and greater Worcester areas, Worcester North (located in Fitchburg), Worcester East and Worcester West (co-located in Worcester). The three CSAs cover a large area, including more populated as well as rural areas, and at the time of this review was serving about 75% of the youth and families receiving CSA services. Wayside Youth and Family Support Network is the CSA for the western part of the central area, and is located in Framingham, serving an area that includes a more urban, populated area that sits on the outskirts of greater Boston. Y.O.U., Inc. is located in Southbridge in the Blackstone Valley, and includes the towns of Webster and Milford, and many smaller communities. The area is quite rural, again with significant travel distances made longer by back country roads.

There are In Home Therapy Services (IHT) throughout the Central Region, with IHT being provided by the CSA agencies as well as other private agencies. There were 9 IHT agencies in the Central Region at the time of the CSR.

Review Participants

Altogether, 308 people from Central Massachusetts participated either in the youth-specific reviews or were interviewed in stakeholder focus groups. Table 1 displays data related to the youth-specific reviews where a total of 187 interviews were conducted. As can be seen, the average number of interviews was 7.8 with a maximum of 11 and a minimum of 4 interviews conducted.

Child Status and Performance Profile - Number of Interviews

Number of cases: 24 Southeastern Review 3/2011

Number of Interviews

Total number of interviews	187
Average number of interviews	7.8
Minimum number of interviews	4
Maximum number of interviews	11

Table 1

How the sample was selected

The sample for the Central Massachusetts CSR was drawn from the population of all children who received Intensive Care Coordination (ICC) or In-Home Therapy (IHT) without currently receiving ICC services, inclusive of children from birth to twenty-one years old who are covered by Medicaid. Prior to the review, each agency was asked to submit lists of the children who were enrolled since the initiation of the service. The caseload enrollment list was sorted to create a list of youth who were currently enrolled within open cases.

The original CSR sample included 16 ICC youth, and 8 IHT youth who were not also currently receiving ICC. During the course of the review, it was determined that a youth originally designated to be part of the IHT sample for Y.O.U., Inc. (Gardner) was actually receiving ICC services at the time of sample selection. The change in designation was made which increased the number in the ICC final sample to 17 and decreased the number in the IHT final sample to 7.

ICC Selections. For ICC, a random sample of youth was drawn from the open caseload list. The number of youth selected from each CSA agency was determined based on the number of youth meeting the sampling parameter against the population of enrolled youth at the time of selection.

IHT Selections. The lists of IHT youth were sorted to determine which of the youth were receiving IHT, but not currently also receiving ICC. Although it is possible that some of the youth who were selected from the ICC lists were also receiving other types of services including IHT, the IHT lists were used to identify youth who were receiving IHT but not currently also receiving ICC.

For IHT, 8 youth were randomly selected to be included in the sample. All 3 of the CSA's were also providing IHT services in a total of 5 locations. Four youth were drawn from the IHT programs which are part of the CSA's, including 2 from Wayside, 1 from You Inc Gardner, and 1 from Y.O.U., Inc. Southbridge.

There were 9 IHT providers, which were not providing ICC services in Central Massachusetts. Four IHT providers were randomly selected from this list of 9. Then, one youth was randomly selected from each of these IHT providers.

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

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

Agency	Total Enrolled Since Start of ICC (7/1/09)	Number Open at List Submittal	Number ICC Cases Selected
Community Healthlink North Central	328	205	3
Community Healthlink Worcester East	289	255	4
Community Healthlink Worcester West	222	206	3
Wayside Framingham	243	90	3
Y.O.U., Inc. Southbridge	162	90	3
Totals	**1244**	**846**	**16***

*Denotes the number chosen in the original sample. The final ICC sample was 17 as described in the text of this report.

Table 2

The sample included 3 youth from the Community Healthlink North Central CSA, 4 from the Community Healthlink Worcester East CSA, 3 from the Community Healthlink Worcester West CSA, 3 from the Wayside Framingham CSA, and 3 from the You Inc Southbridge CSA. These ICC youth may have been receiving services in addition to ICC, including IHT. As noted previously, the final number of ICC youth included in the sample changed from 16 to 17.

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

Agency	Total Enrolled Since Start of IHT Opening (11-1-2009)	Total Open at List Submittal	Total Open and Receiving IHT/No ICC	Number IHT Only Selected
Advocates	40	19	14	1
Community Healthlink Upton Center	*	*	*	*
Community Healthlink Worcester	*	*	*	*
Counseling and Assessment Clinic of Worcester	238	118	98	1
Family Continuity Program	*	*	*	*
LUK	117	68	50	1
MSPCC	417	149	129	1
Multicultural Wellness Center	*	*	*	*
Riverside Community Care	*	*	*	*
SMOC Behavioral Health Services	*	*	*	*
South Bay Mental Health	*	*	*	*
Wayside Framingham	201	78	58	2
Y.O.U., Inc. Gardner	92	34	28	1**
Y.O.U., Inc. Southbridge	40	22	13	1
Total	**1145**	**488**	**390**	**8****

* The sample did not randomly draw cases for the sample from this agency.
* *Denotes the number chosen in the original sample. The final IHT sample was 7 as described in the text of this report.

Table 3

As can be seen, each of the following IHT programs had 1 youth included in the original CSR sample: Advocates, Counseling and Assessment Clinic of Worcester, LUK, Y.O.U., Inc. Gardner, and Y.O.U., Inc. Southbridge. Two youth were drawn from the IHT program at Wayside. As noted previously, the final sample included 7 youth whose care was coordinated by IHT as the youth from Y.O.U., Inc. Gardner was determined to be an ICC youth.

Characteristics of Youth Reviewed

Age and Gender. There were 24 youth reviewed across the Central Massachusetts region in the CSR conducted during May 2011. *Chart 1* displays the distribution of genders across age groups in the sample. There were 18 boys and 6 girls in the sample. The proportion of boys to girls was 75% boys to 25% girls. Six youth (25%), were in the 14-17 age range. The largest number of youth (13 or 54%) was in the 10-13 year old age range. There were 5 youth (25%), all boys in the 5-9 year old range. There were no youth in the sample in the 0-4 or the 18-21 age ranges.

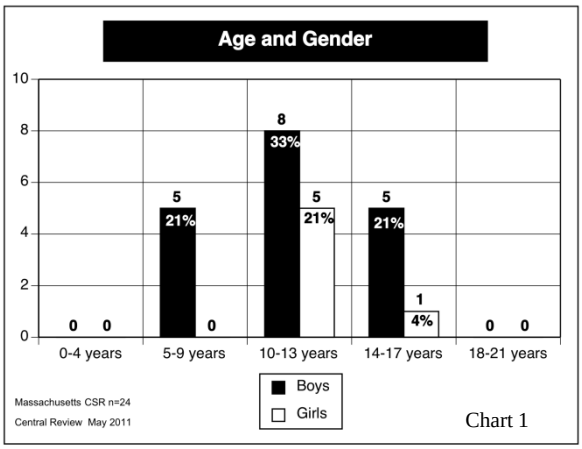


Chart 1

Current placement, placement changes and permanency status. Most of youth in the Central Massachusetts CSR sample lived with their families (75%), either their biological/adoptive families or in a kinship/relative home. Two youth or 8% were residing in a Community-Based Acute Treatment (CBAT) program at the time of the review. One youth each lived in a detention center, a residential treatment center, in kinship care, and in a substance abuse residential program (*Table 4*).

Child Status and Performance Profile - Current Placement Frequency
Number of cases: 24 MA Central Review May 2011

Type of Current Placement	Number	Percent
Family bio./adopt. home	18	75%
CBAT	2	8%
Detention	1	4%
Residential treatment facility	1	4%
Pre-Adoptive/Kinship care	1	4%
SA Residential	1	4%
	24	100%

Table 4

Child Status and Performance Profile - Legal Permanency Frequency
Number of cases: 24 MA Central Review May 2011

Legal Permanency Status	Number	Percent
Birth family	19	79%
Adopted family	4	17%
Permanent guardianship	1	4%
	24	100%

Table 5

The legal status (*Table 5*) of most of the youth in the sample was with their birth families (79%). Four youth's (17%) permanency status was with their adopted families, and one (4%) was in permanent guardianship.

The review tracked placement changes over the last twelve months for the 24 youth reviewed (*Table 6*). Placement change refers to changes in living situation, as well as changes in the type of program the child received educational services in over the last twelve months. Achieving stability and minimizing disruptions are important factors in the lives of youth with SED. Among the sample, most of the youth (18 or 75%) had no placement changes in the last year. Three youth (13%) had 1-2 placement changes, and one (4%) had 3-5 changes. There were two youth (8%) who had 6-9 placement changes.

Child Status and Performance Profile - Placement Changes Frequency
Number of cases: 24 MA Central Review May 2011

Placement Changes (past 12 months)	Number	Percent
None	18	75%
1-2 placements	3	13%
3-5 placements	1	4%
6-9 placements	2	8%
	24	100%

Table 6

Of the five youth who were in out of home placements at the time of the review, four (17%) had been in placement for 30 days or less, and one had been in placement over 37 months (*Table 7*).

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

Number of cases: 24 MA Central Review May 2011

Length of Stay in Current OOH Placement	Number	Percent
0-30 days	4	17%
37 + mos.	1	4%
Not applicable	19	79%
	24	100%

Table 7

Child Status and Performance Profile - Ethnicity Frequency

Number of cases: 24 MA Central Review May 2011

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

Table 8

Ethnicity and primary languages (Table 8 and 9). Of the 24 youth in the sample, fifteen or 63% were Euro-American, and eight or a third of the sample (33%) were Latino-American. One youth (4%) was Biracial.

Child Status and Performance Profile - Language Spoken Frequency

Number of cases: 24 MA Central Review May 2011

Primary Language Spoken at Home	Number	Percent
English	19	79%
Spanish	3	13%
English & Spanish	2	8%
	24	100%

English was the primary language spoken at home for 19 or 79% of the youth, Spanish for three (13%), and both English and Spanish for two families or 8% of those reviewed.

Educational placement (Table 10). Youth reviewed were receiving educational services in a variety of settings. Of the sample, 29% were attending school in a regular education setting. Thirty-four percent (34%) of the youth were receiving special education services in a full inclusion, part-time or fully self-contained special education setting. Four youth (17%) were in an alternative education setting, and one (4%) was in a day treatment program. These youth may have also had special education services in these settings. One youth in the sample (4%) had dropped out of school. Youth in the "Other" category included one youth in preschool, one receiving tutoring at home, and one in a collaborative school. It also reflects four youth with Section 504 plans. Note that the total numbers and percentages in Table 10 add up to more than the total number of youth in the sample as youth may be involved in more than one educational placement or life situation.

Child Status and Performance Profile - Educational Placement Frequency

Number of cases: 24 MA Central Review May 2011

Educational Placement or Life Situation	Number	Percent
Regular K-12 Ed.	7	29%
Full inclusion	1	4%
Part-time Sp. Ed.	4	17%
Self-cont. Sp. Ed.	3	13%
Parenting teen	0	0%
Adult basic/GED	0	0%
Alternative Ed.	4	17%
Vocational Ed.	0	0%
Expelled/Suspended	0	0%
Home hospital	0	0%
Day treatment program	1	4%
Work	0	0%
Completed/graduated	0	0%
Dropped-out	1	4%
Other	7	29%

Table 10

Other state agency involvement (Table 11). The majority of the youth in the sample were involved with other State and community agencies. Note that youth may be involved with more than one agency, so the overall number in Table 11 is more than the number of youth reviewed. Youth were most frequently involved with Special Education (15 or 63%). The Department of Children and Families (DCF) had involvement with 11 families or 46% of the sample. The Department of Mental Health (DMH) was involved with seven youth (29%), Probation with four youth (17%), and Department of Youth Services (DYS) with two youth (8%). The "Other" category represents a youth involved with the Autism Resource Center.

Child Status and Performance Profile - Agencies Involved Frequency

Number of cases: 24 MA Central Review May 2011

Agencies Involved	Number	Percent
DCF	11	46%
DMH	7	29%
Special Ed	15	63%
Early intervention	0	0%
Developmental disabilities	0	0%
DYS	2	8%
Probation	4	17%
Vocational Rehabilitation	0	0%
Substance abuse	1	4%
Other	1	4%

Table 11

Child Status and Performance Profile - Referral Source

Number of cases: 24 MA Central Review May 2011

Referral Source	Number	Percent
DCF	5	21%
DMH	2	8%
DYS	1	4%
School	1	4%
Family	6	25%
CBAT	1	4%
CSA	1	4%
ICC	1	4%
Other	1	4%
Outpatient	4	17%
Residential program	1	4%
	24	100%

Table 12

Referring agency (Table 12). Youth reviewed in Central Massachusetts were referred to ICC and/or IHT services from a variety of sources as reflected in Table 12. The largest referral source was families, who referred 6 youth or a quarter of the youth reviewed. The next largest referral was DCF who referred 5 youth or 21% of the sample. This was followed by outpatient providers who referred 4 youth or 17%. DMH referred 2 youth or 8%. Referring one youth (4%) each were DYS, School, CBAT, a CSA, ICC, a residential program and a community referral.

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. Seventy-one percent (71%) of the youth were diagnosed with a mood disorder, and the same percentage (71%) was diagnosed with attention deficit or attention deficit hyperactivity disorder. Anger control issues were prevalent among 38% of the youth. Anxiety disorder, PTSD/Trauma adjustment, and disruptive disorders were each prevalent among 25% of the sample

Medical problems were being experienced among 21% of the youth. These included a serious eye disorder

Child Status and Performance Profile - Co-Occurring Condition Frequency

Number of cases: 24 MA Central Review May 2011

Co-Occurring Condition	Number	Percent
Mood Disorder	17	71%
Anxiety Disorder	6	25%
PTSD/Adjustment to Trauma	6	25%
Thought Disorder/Psychosis	2	8%
ADD/ADHD	17	71%
Anger Control	9	38%
Substance Abuse/Dependence	1	4%
Learning Disorder	4	17%
Communication Disorder	1	4%
Autism	4	17%
Disruptive Behavior Disorder (CD, ODD)	6	25%
Mental Retardation	0	0%
Medical Problem	5	21%
Other Disability/Disorder	2	8%
Other	0	0%

Table 13

causing gradual blindness, growth disorder, fetal alcohol syndrome, enuresis, encopresis, and asthma. Seventeen percent (17% or 4 youth) of the sample were youth with an autism spectrum disorder. Two youth (8%) had a thought disorder, and one each (4%) had a substance abuse disorder and a communication disorder. Youth in the "Other Disability" category included one youth with a pervasive developmental disorder, and one with partial hearing and vision loss.

Medications (Table 14). Seventy-nine percent (79%) of the youth reviewed were prescribed at least one psychotropic medication. As seen in Table 14, five of the youth (21%) were prescribed one medication, six (25%) were on two medications, and six (25%) were on three medications. There was one youth on four (4%) and one (4%) on five or more medications. Thirty-three percent (33%) of youth were prescribed three or more medications.

Child Status and Performance Profile - Psy Meds Frequency

Number of cases: 24 MA Central Review May 2011

Number of Psy Meds	Number	Percent
No psy meds	5	21%
1 psy med	5	21%
2 psy meds	6	25%
3 psy meds	6	25%
4 psy meds	1	4%
5+ psy meds	1	4%
	24	100%

Table 14

Youths' levels of functioning (Table 15). The functioning of each youth in the CSR is rated using the General Level of Functioning scale, a 10-point scale that can be viewed in Appendix 1 of this report. Most of the youth in the Central CSR sample were functioning at a fairly impaired level. Fourteen youth or 58% 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"). Ten or 42% 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"). No youth in the sample were rated in the Level 8-10 range ("no more than slight impairment in functioning at home, at school, with peers" to "superior functioning in all areas").

Child Status and Performance Profile - Level of Functioning Frequency

Number of cases: 24 MA Central Review May 2011

Level of Functioning	Number	Percent
In level 1-5	14	58%
In level 6-7	10	42%
	24	100%

Table 15

Use of Crisis Services (Table 16). The use of crisis services or crisis responses over the 30 days prior to the review was tracked for each youth. There was low incidence of the use of crisis services among the youth reviewed. Twenty-one of the 24 youth (88%) did not access crisis service during the time period. Among those that did, two (8%) used mobile crisis services. The police were called to respond via a 911 emergency call for one youth or 4% of the sample.

Child Status and Performance Profile - Crisis Services Used Frequency

Number of cases: 24 MA Central Review May 2011

Crisis Services Used Past 30 Days	Number	Percent
Mobile crisis	2	8%
911 Emergency call: EMS	0	0%
911 Emergency call: Police	1	4%
Emergency department	0	0%
Other	0	0%
None	21	88%

Table 16

Mental health assessments (Tables 17 and 18). Mental health assessments are needed by teams to help them better understand the strengths and needs of youth and their families. A mental health assessment can help practitioners and teams to formulate an overall picture of how the youth is doing emotionally and cognitively, as well as the social/familial context of a youth's behaviors and well-being. It is a foundational part of behavioral health practice. Seventy-one percent (71%) of the youth had a current mental health assessment that was in their files. Seven youth or 29% of the youth did not have a current mental health assessment available to help their teams better understand and plan for them.

Child Status and Performance Profile - Mental Health Assessment

Number of cases: 24 MA Central Review May 2011

MH assessment performed	Number	Percent
Yes	17	71%
No	7	29%
	24	100%

Table 17

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

Child Status and Performance Profile - Received Mental Health Assessments

Number of cases: 24 MA Central Review May 2011

Received MH Assessments	Number	Percent
Parent	7	29%
Education	2	8%
Court	1	4%
Child Welfare	3	13%
DOC	0	0%
Not applicable	7	29%
Not Distributed	9	38%
Other	2	8%

Table 18

Among families in the sample, only 7 or 29% of parents had received their child's assessment. Schools received a copy of the mental health assessment for 2 or 8% of the youth, the courts for 1 or 4%, and child welfare for 3 or 13% of the youth reviewed. Child welfare was involved with 11 or 46% of the youth in the sample so the percentage of families that were child welfare involved and had their assessments shared with DCF was 27% of the child-welfare involved youth. In the "other" category were assessments distributed to DMH and other team members. The assessment had not been distributed for 38% of youth who had a mental health assessment.

Special Procedures

Special Procedures data are presented for the Central Massachusetts CSR to better understand behavioral interventions occurring (*Table 19*). Sixty-three percent (63%) of the population did not experience a special procedure in the 30 days preceding the review. For the 37% of youth in the sample that did, 17% had experienced a voluntary time-out; 17% loss of privileges in a points and level system, 13% a disciplinary consequence, 8% a physical restraint that could have been a hold or a mechanical restraint; and 4% an exclusionary time out. The youth in the "Other" category experienced a school suspension. Note youth may have experienced more than one special procedure, thus the total percentage of discreet procedures is more than the overall 37% of youth who experienced a procedure.

Child Status and Performance Profile - Special Procedures Frequency

Number of cases: 24 MA Central Review May 2011

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

Table 19

Caregiving challenges

Reviewers gathered information about the challenges experienced by the parents and caregivers of the youth in the sample *(Table 20)*. The most noted challenge was extraordinary care burdens experienced by 46% of caregivers. Thirty-eight percent (38%) were impacted by effects of poverty. Twenty-five (25%) of the caregivers were challenged by serious mental illnesses and 25% by disabling physical conditions. Other challenges were cultural language barriers experienced by 8%, limited cognitive abilities by 8%, substance abuse or serious addiction by 4%, and challenges associated with being a teen parent by 4%. The challenge in the "Other" category was recent loss of a family member.

Child Status and Performance Profile - Caregiver Challenges Frequency

Number of cases: 24 MA Central Review May 2011

Challenges in the Child's Birth Family or Adoptive Family	Number	Percent
Limited cognitive abilities	2	8%
Serious mental illness	6	25%
Substance abuse impairment or serious addiction w/ frequent relapses	1	4%
Domestic violence	0	0%
Serious physical illness or disabling physical condition	6	25%
Unlawful behavior or is incarcerated	0	0%
Adverse effects of poverty	9	38%
Extraordinary care burdens	11	46%
Cultural/language barriers	2	8%
Undocumented	0	0%
Teen parent	1	4%
Recent life disruption/homelessness due to a natural disaster	0	0%
Other	1	4%

Table 20

Care Coordination

During the CSR, data are collected to better understand various factors that may be impacting the provision of care coordination services. Information is collected through the person providing the care coordination function, which could have been the ICC or the IHT therapist. Among the data collected are information about the length of time the care coordinator was in the position (therapists may have been in the position before the start of IHT services), the current caseload size of the individual, and barriers they perceive to be impacting their work. In the Central Massachusetts CSR, there were 23 individuals providing care coordination for the 24 youth reviewed (16 individual ICCs, and 7 IHTs). One ICC care coordinator provided coordination for more than one youth in the sample, which is why data here are provided for 23 individuals.

The review tracked the length of time the Care Coordinator had been assigned to the youth being reviewed. As can be seen in *Table 21*, 12% of care coordinators had been assigned to the youth being reviewed for three months or less, including one assigned for less than a month. Twenty-five percent (25%) had provided care coordination for the youth being reviewed for 4-6 months, 38% for 7-12 months, and 25% for 13-14 months.

Child Status and Performance Profile - Length of Time CM Assigned

Number of cases: 24 MA Central Review May 2011

Length of Time CM Assigned to Child/Youth	Number	Percent
<1 month	1	4%
1-3 months	2	8%
4-6 months	6	25%
7-12 months	9	38%
13-24 months	6	25%
	24	100%

Table 21

Caseload frequency as reported by the care coordinator was measured along the scale seen in *Table 22*. Twenty-six percent (26%) of coordinators had 8 or fewer cases. Four percent (4%) were in the 9-10 range. Thirty percent (30%) each were in the 11-12 and 13-14 caseload range. Nine percent (9%) had 15-16 cases. There were no care coordinators with more than 16 cases on their caseload. Of note is that 39% of care coordinators had more than 12 cases on their caseload.

Child Status and Performance Profile - CM Current Caseload Frequency

Number of cases: 23 MA Central Review May 2011

CM Current Caseload Size	Number	Percent
<8 cases	6	26%
9-10 cases	1	4%
11-12 cases	7	30%
13-14 cases	7	30%
15-16 cases	2	9%
	23	100%

Table 22

As can be seen in *Table 23*, the preponderance of care coordinators participating in the Central Massachusetts CSR had been in their positions for 13-24 months (74%), followed by those in positions 7-12 months (13%). Nine percent (9%) had been in the care coordinator position for 25-26 months. Four percent (4%) had been in their positions for 4-6 months.

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

Number of cases: 23 MA Central Review May 2011

Length of Time CM in Position	Number	Percent
4-6 months	1	4%
7-12 months	3	13%
13-24 months	17	74%
25-36 months	2	9%
	23	100%

Table 23

Table 24. Information on barriers that affect the provision of care coordination or other services was collected during the CSR. The challenges cited by care coordinators in Central Massachusetts most often were driving time to provide services cited by 25%, case complexity also cited by 25%, inadequate parent support by 21%, and inadequate team member participation by 17%. This was followed by 13% of care coordinators citing the following as barriers: caseload size, eligibility/access denial issues, billing requirements and limits, team member follow-through, and treatment refusal

Barriers cited less frequently (4% each) were acute care needs of youth, and cultural/language barriers.

Child Status and Performance Profile - Barriers Affecting Case or Services

Number of cases: 24 MA Central Review May 2011

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

Table 24

Barriers that were cited in the "Other" category included administrative requirements such as productivity, paperwork, non-billable time, duplication of meetings, and the referral/intake process needing refinement to ensure appropriate referrals. Barriers were also described regarding the "new model" that included constant changes, providers not knowing what CSAs do and which expectations can't be met, the need for more collateral understanding of wrap-around and discomfort with the strengths-based approach. One ICC cited not having an adequate level of experience for the position.

Lack of available resources, particularly therapeutic mentors and in-home behavioral therapy was cited as a barrier to effective care. Lack of resources and skills to address parental mental illness were also cited as a barrier, as was lack of telephone access to families, and more support needed in scheduling meetings.

Community Services Review Findings

Ratings

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

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

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

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

STATUS AND PROGRESS INDICATORS

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

Youth Status Indicators

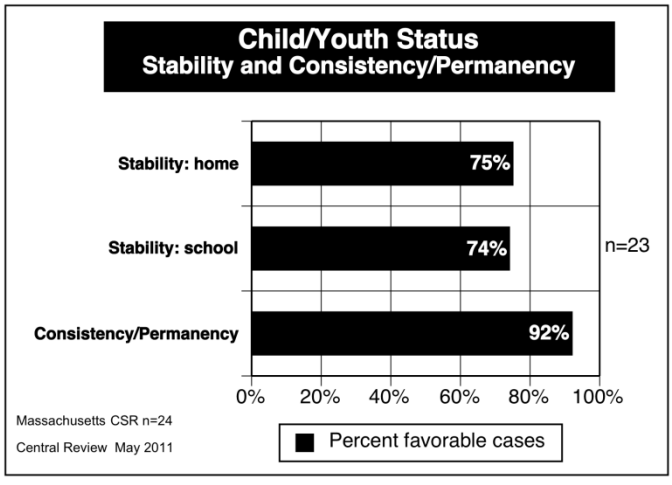
(Measures Youth Status over the last 30 days unless otherwise indicated)

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

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

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

Overall Youth Status



Community, School/Work and Living Stability

For the two sub-indicators of Stability, reviewers are asked to determine the degree of stability the youth is experiencing in their daily living and learning arrangements in terms of those settings being free from risk of unplanned disruption. Reviewers note if there are any youth's emotional and behavioral conditions that may be putting the youth at risk of

disruption in home or school. When reviewing for stability disruptions over the past twelve months are tracked, and based on the current situation and pattern of overall status and practice, disruptions over the next six months are predicted

Among the 24 youth in the CSR sample for Central Massachusetts, 75% of them had favorable stability at home. Half of the youth (50%) had good or optimal stability with established positive relationships and well-controlled to no risks that otherwise could jeopardize stability. Nine, or 38% of the youth, were rated to be in the "refinement" area, which means that conditions to support stability are fair. There were two youth (8%) who were rated to need improvement in their home stability with poor status in this indicator. One youth (4%) was experiencing adverse stability with serious and worsening problems of instability at home.

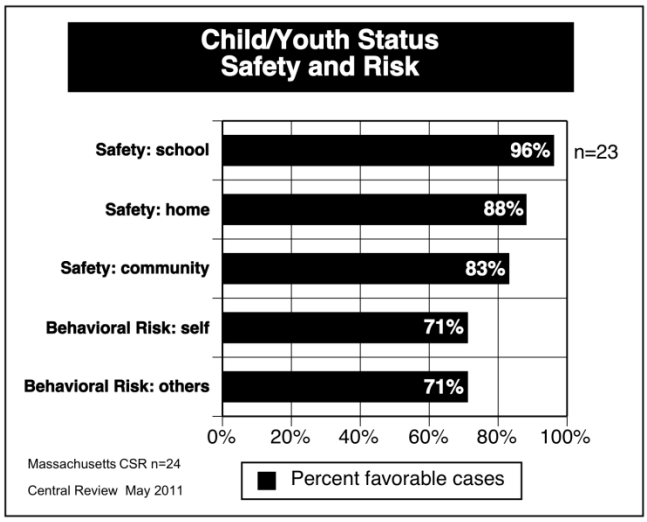
Of the 23 youth for which school stability was applicable (one youth in the sample was not in an educational program), 74% had a stable school situation. Thirteen of the youth (57%) had good or optimal stability with only age appropriate or planned changes occurring in their school program. A quarter of the youth (25%) had stability issues at school that needed "refinement," with fair to marginal stability issues that were minimally to inadequately addressed. Among the sample were three youth (13%) with poor stability in the school setting with uncertainty about what will happen next, and one youth (4%) with adverse stability at school with serious and worsening problems and no foreseeable next-step placements with the necessary level of supports.

These results indicate that teams should likely consider strengthening supports to ensure stability for youth when this is a factor.

Consistency/Permanency in Primary Caregivers & Community Living Arrangements

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

Among the youth reviewed in Central Massachusetts, 22 or 92% had a favorable level of consistency and permanency in their lives. Among these, 15 or 63% of the sample had "good" or "optimal" status, meaning the youth was in an enduring permanent living situation with their family of other legally permanent caregivers. Nine youth, or 38% were at a level of consistency and permanency situation that needed a refinement in 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. There were no youth with poor or adverse status on this indicator.



Safety of the Youth

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

In the sample of youth reviewed for Central Massachusetts, for those who were in a school program (N=23), 96% of youth were found to have favorable safety status at school, 88% were safe at home and 83% were safe in the community.

For the youth attending school, 15 or 65% were safe in their school programs at a "good" or "optimal" level with no risk to generally risk-free school programs. Eight youth (33%) had a school safety status that needed refinement in terms of the school setting leaving the youth free from abuse or neglect. For these youth, the school setting was minimally risk-free, or had a somewhat inadequate to inconsistent level of protection. There were no youth in the "poor" or "high safety risk" categories in the sample.

Among the youth reviewed, fifteen (63%) had "good" or "optimal" safety status at home. Eight youth (33%) were found to need refinement with a fair to minimally adequate situation free from abuse or neglect, or marginal safety with somewhat inadequate protection posing an elevated risk of harm. One youth (4%) was found to have poor safety at home, with substantial and continuing risk of harm. There were no youth with "high safety risk" at home.

Eleven youth (46%) were experiencing "good" to "optimal" safety in their communities. The remaining 13 or 54% needed refinement in their safety in the community and could benefit from their teams reviewing their safety status including any risks for intimidation or fear of harm.

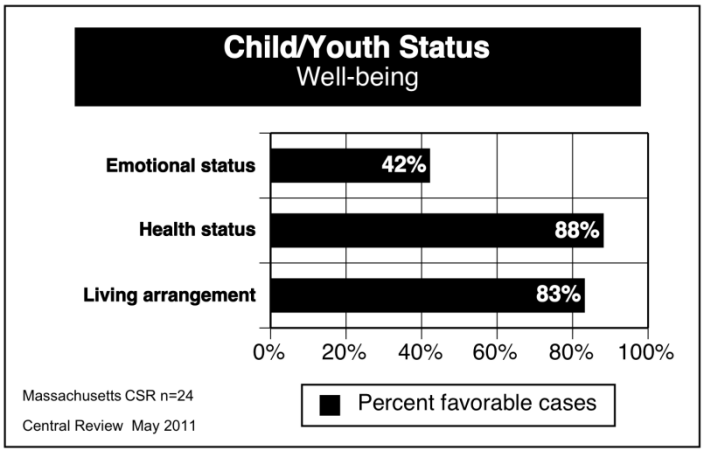
Behavioral Risk to Self and Others

Reviewers in the CSR determine 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 disregulation resulting in harm, severe property destruction, medical non-compliance resulting in harm and unlawful behaviors.

The results of the review show that 71% of youth had a favorable level of behavioral risk to themselves. Among these, a third of the sample (8 youth or 33%) had a "good" level of behavioral risk. There were no youth with "optimal" status on this indicator. Fifty-eight percent (58%) of those reviewed or 14 youth were found to need "refinement" in their level of behavioral risk, including youth that are usually avoiding self-harm or self-endangerment, and those that have a risk staus that is inconsist or concerning. Two youth (8%) needed "improvement" and had a poor level of behavioral risk to themselves with serious and continuing risk status, indicating teams should evaluate strategies in youths' plans.

The subindictor of behavioral risk toward others was favorable for only 71% of the youth in the sample. A third of the youth (33%) or 8 youth had a "good" or "optimal" level of behavioral risk toward others. Fifteen of the youth (63%) needed "refinement" and presented a fair to marginal level of risk toward others. There were two youth (8%) that needed "improvement" in their risk to others, with poor status and a potential for harm to other present.

These results indicate a need for stronger planning and support by teams to more consistently ameliorate youths' behavioral risks.



Emotional and Behavioral Well-being

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

activities with peers in increasingly normalized settings, learn appropriate boundaries and self-management skills, regulate impulses and emotions, and other important domains of well-being. Addressing emotional and behavioral issues of youth is a core charge of mental health systems.

Emotional and behavioral well-being was favorable for only 42% youth reviewed in the Central Massachusetts CSR, clearly indicating the need for focused attention paid to developing interventions and strategies to address helping youth to achieve better emotional and behavioral status. These results indicate a high number of youth with inconsistent or poor emotional development, adjustment problems, emotional/adaptive distress, or serious behavioral problems present. Among the youth reviewed, there were five (21%) with a "good" level of emotional/behavioral status. Sixty-three percent (63%) or 15 were determined to need "refinement" and were found to be functioning at a fair to marginal well-being status. Four of the youth (17%) were found to have poor emotional/behavioral status, were demonstrating a consistently poor level of functioning and were not making progressing. Focused support for teams in developing individualized strategies for refining and/or improving youth's levels of emotional and behavioral well-being is recommended.

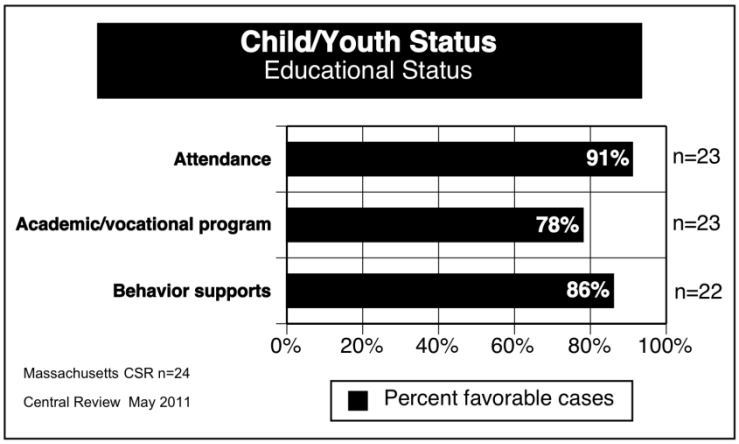
Health Status

The health of the youth was reviewed to determine whether or not they were achieving and maintaining optimal health status including basic and routine healthcare maintenance. Youth's basic needs for nutrition, hygiene, immunizations, and screening for any possible development or physical problems should be met. Health is an important component of overall well-being. For the youth in the sample, 88% had favorable health/physical well-being status. Fourteen youth (58%) had good or optimal health status. Eight youth or 33% needed "refinement" in their health status. Two or 8% need "improvement," including one that had poor status becoming more uncontrolled, and one that had worsening status with presentation of acute episodes with increasing health risk.

L***iving Arrangements***

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

For the youth reviewed in the Central Massachusetts CSR, 83% were found to have a favorable living arrangement. Ten youth (42%) had living arrangements that were "good" or "optimal," and 12 needed "refinement" in their living arrangements. There were two youth (8%) with adverse living arrangements that were inappropriate for the youth.



Educational Status

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

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

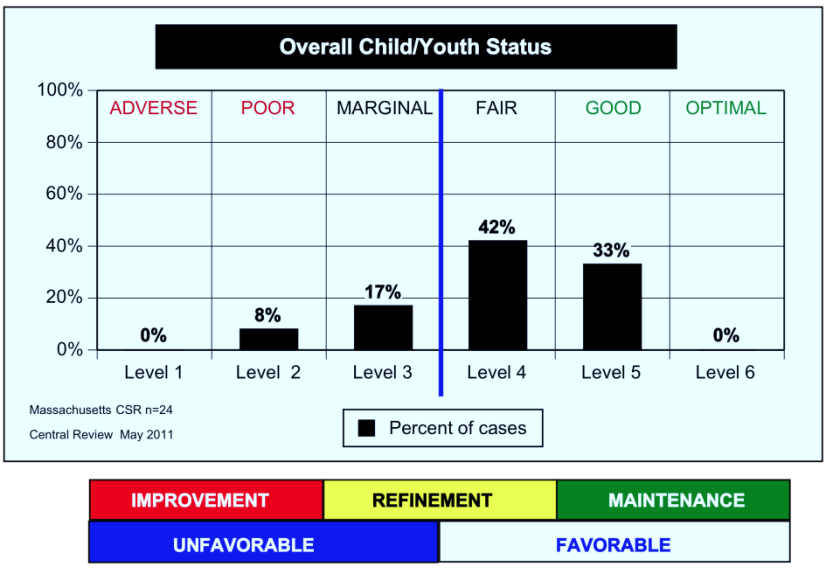
In the Central Massachusetts review, for the 23 youth school attendance was applicable to, 91% had favorable patterns of attendance. Seventy percent (70%) were found to have good to optimal school attendance. Twenty-six percent (26% or 6 youth) would benefit from refinement in their attendance patterns. One youth (4%) needed improvement and had poor rates of attendance.

For the 23 youth who were enrolled in an academic or vocational program, 78% were doing favorably well in their program. Among these were 12 youth (52%) who were seen as have "good" or "optimal" status in their academic or vocational program. Eleven of the youth (48%) needed refinements in their status in their academic or vocational program, and one (4%) needed improvement, was doing poorly and was not meeting educational expectations.

Twenty-two of the youth in the sample required behavioral supports in their school setting. Behavioral supports were working favorably well for 86% of them. Half of them (50%) had a "good" level of supports. Nine of them could benefit from refinements in their level of supports. Two youth or 9% had a poor level of behavioral support that needed improvement and supports were not adequate in helping the youth do well in school.

Overall Youth Status

The overall results for Youth Status for the 24 youth reviewed in Central Massachusetts are displayed below. Overall, 75% or 18 youth were found to be doing favorably well. These youth fell in Levels 4-6; youth had Fair status (42% or 10 youth), or Good status (33% or 8 youth). No youth were found to have Optimal status. The remaining six youth (25%) had unfavorable status. They had either Marginal (17% or 4 youth) or Poor (8% or 2 youth) status. There were no youth found to have overall Adverse status.



Overall Youth Status results are also categorized as needing Improvement, Refinement, or Maintenance. This allows for identification of youth that may need focused attention. Two youth (8%) were in the Improvement area, meaning status is currently problematic or risky, and action should likely be taken to improve the situation for the youth. Fourteen or 59% of the youth fell in the Refinement area which is interpreted to mean their status is minimal or marginal, and are potentially unstable with further efforts likely necessary to improve their well-being. For the eight youth (33%) whose status should be maintained, efforts should likely be sustained and leveraged to build upon a fairly positive situation.

Several observations can be drawn about the status of youth reviewed in Central Massachusetts. About a quarter of the youth were experiencing issues in both home and school stability. Overall, youth were in permanent situations and safe across settings. With some exceptions, youth were attending school regularly, and had an adequate level of behavioral supports in their school settings; academic status was a concern for some. Behavioral risk to self and others was a concern for 29% of the youth. Most of the youth had a favorable physical health status. Additional supports to strengthen families' capacity to provide a favorable living situation were warranted for 17% of the sample. The largest area of concern was the emotional/behavioral well-being of youth with 58% of youth with unfavorable emotional/behavioral status.

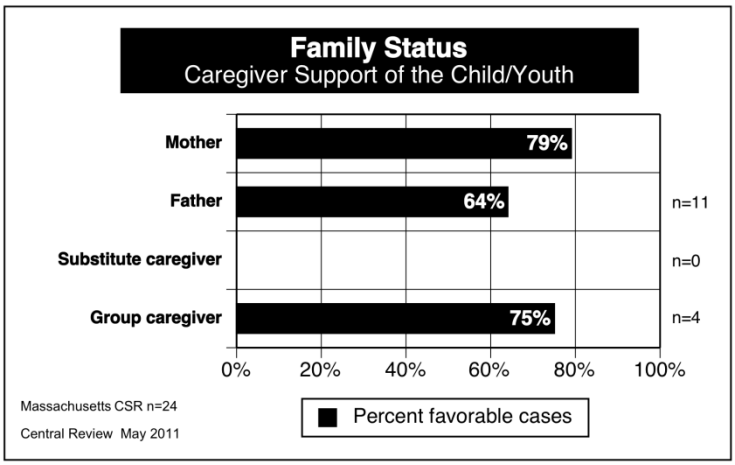
Caregiver/Family Status

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

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

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

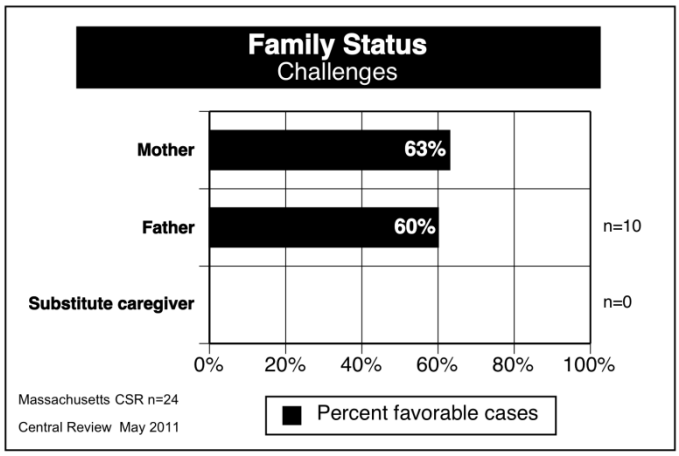
Overall Caregiver/Family Status



Parent/Caregiver Support of the Youth

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

For the youth reviewed in the Central Massachusetts CSR, favorable support by mothers was found 79% of the time (19 youth). Maternal support needed "refinement" or "improvement" for 11 youth or 46%. The measure for support from fathers was applicable for eleven of the 24 youth in the sample, and favorable support was found from 64% or seven of the fathers. Support from fathers needed "refinement" or "improvement" for 73% or for eight youth in the sample. Support was also favorable for the three of the four youth in group care. There were no youth reviewed with substitute caregiving.



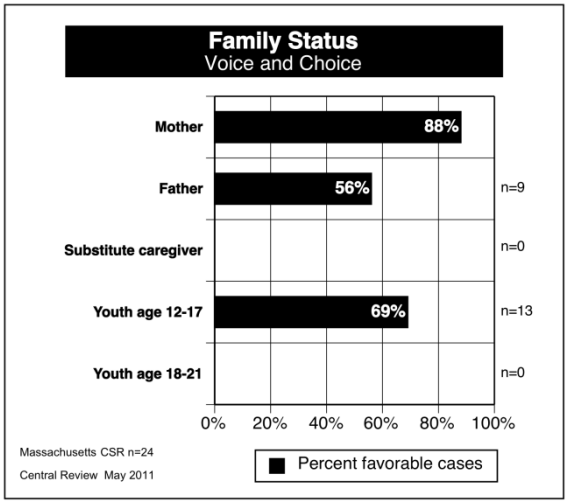
Parent/Caregiver Challenges

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

In the sample, 63% or 15 mothers had favorable status in terms of the level challenge they were experiencing. Seventeen or 75% of the mothers had a level of challenge that needs to be "refined" or "improved," indicating a significant level of challenge and hardships impacting parenting among mothers in the sample. Three of the mothers (13%) were found to be have major life challenges with inadequate or missing supports.

Sixty percent (60%) or 6 fathers had a favorable level of challenge. Eight or 80% were experiencing levels of challenge that could benefit from "refinement" or "improvement" ranging from minor limitations with adequate supports to overwhelming life challenges with significant and worsening disruptions.

There were no substitute caregivers for youth in the Central Massachusetts CSR.



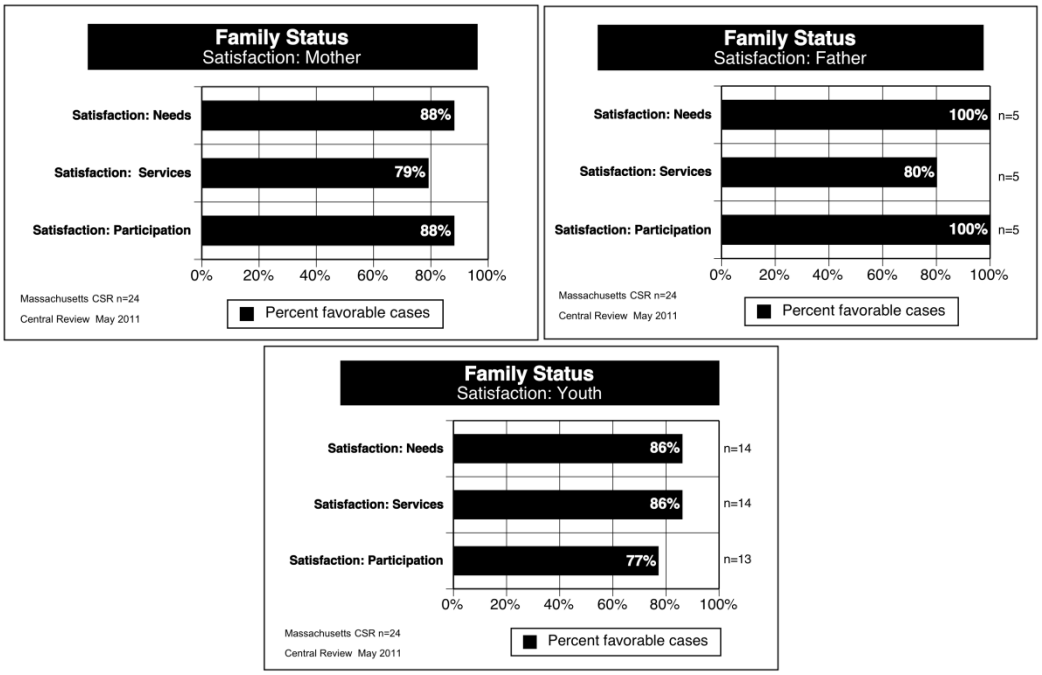
Family Voice and Choice

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.

Eighty-eight percent (88%) or 21 mothers were experiencing favorable voice and choice in their child's assessments, planning and service delivery processes. Twenty mothers (83%) had "good" to "optimal" voice and choice. Three mothers (13%) would benefit from refinement in strengthening their voice and choice. One mother (4%) had no voice and choice and had not participated in any aspects of assessment, planning or evaluation of results.

For youth whose fathers were involved and information could be gathered (N=9), 56% or 5 fathers had favorable voice and choice in involvement with their child's service processes indicating a need for strengthening of their voice and choice in planning and service delivery processes. Eight of the fathers, or 89%, could benefit from "refinement" or "improvement" in the influence of their voice and choice in planning and service delivery. Three fathers (33%) fell in the range of having substantially inadequate voice and choice in planning and services.

There were thirteen youth in the 12-17 age range in the sample. Of these 69% or nine youth had a favorable level of voice and choice in their own services, with "refinement" or "improvement" indicated for seven or 78% of youth who fell in this age range. There were no youth in the 18-21 age range.



Satisfaction with Services and Results

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

The charts above display the results for how satisfied each of the role groups were with having their needs understood, services and results, and participation. Mothers' satisfaction ranged from 79% satisfied with services, to 88% satisfied with both needs being understood, and participation. For the five fathers that satisfaction was measured for, satisfaction ranged from 80% satisfied with services, to 100% satisfied with needs being understood, and their level of participation. Youth satisfaction ranged from 77% satisfied with their participation in care planning to 86% satisfied with both their needs being understood and with the services and results being achieved.

Summary: Caregiver/Family Status

Mothers and fathers in the Central Massachusetts CSR were found to be experiencing substantial challenges in their lives. Support for youth was negatively impacted more for fathers than mothers. Support for youth in group caregiving situations was favorable for 75%. Family voice and choice was strong for mothers; fathers and youth in the 12-17 age range had far less adequate voice and choice in service processes. Mothers, fathers and youth expressed high satisfaction in having their needs understood. Mothers and fathers were highly satisfied with their participation. Youth were more satisfied than their parents with services, and less satisfied with their participation in planning.

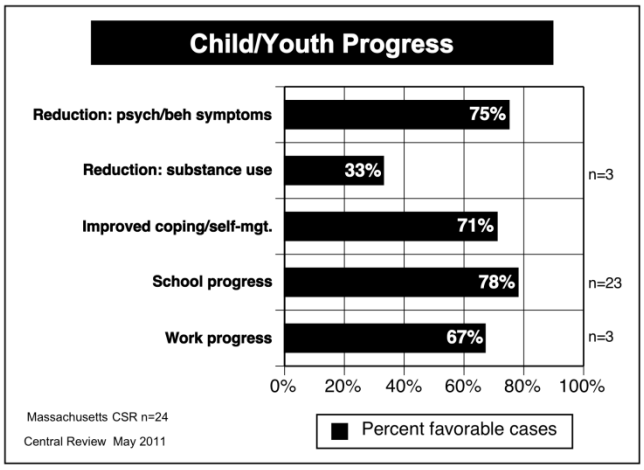
Youth Progress

(*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. For the 24 youth reviewed, 75% of them had made favorable progress in reducing symptomatology and/or problem behaviors over the last six months. Four youth, or 17% of the sample had made "good" or "optimal" progress. Sixteen youth or 71% of the sample could benefit from "refinement" in their level and rate of progress in reducing their symptoms. There were three youth (13%) who were making no progress, and one youth (4%) that was declining, with symptoms and behaviors increasing.

There were three youth in the sample with substance abuse issues, with 33% or one making favorable progress. This youth and one other (66% of sample) could benefit from refinements in their level and rate of progress in reducing substance use. The other youth (33%) was making no progress.

Improved Coping and Self-Management

This indicator measures the degree to which the youth has made progress in building appropriate coping skills that help her/him to manage symptoms/behaviors including

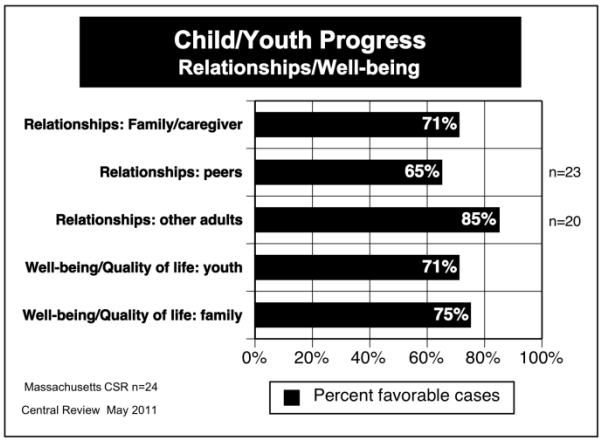
preventing substance abuse relapse, gaining functional behaviors and improving self-management. Among the youth reviewed, 17 or 71% had made favorable progress in improving their coping skills and ability to self-manage their emotions and behaviors, indicating room for improvement in impacting change in this domain. Five youth made (21%) had made "good" or "optimal" progress in improving their ability to cope and manage their own behaviors. Sixteen youth (67%) could benefit from "refinement" and had made fair to marginally inadequate progress. Three youth (13%) were making poor progress in advancing coping and self-management at levels well-below expectations and needed improvement.

School or Work Progress

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

Of the 23 youth for which school progress was applicable, 17 or 74% were making favorable progress. Ten youth were making "good" progress in school reflecting consistent rates and levels of progress. Eleven youth (48%) were determined to need "refinement" and were making fair to marginally inadequate progress. One youth (4%) was making no progress, and one was regressing in school.

Progress in a work setting applied to three youth; two (67%) were making favorable progress in satisfying expectations necessary for maintaining employment, with one needing "refinement." One youth (33%) was making no progress in satisfying work expectations necessary to maintain employment.



Progress Toward Meaningful Relationships

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

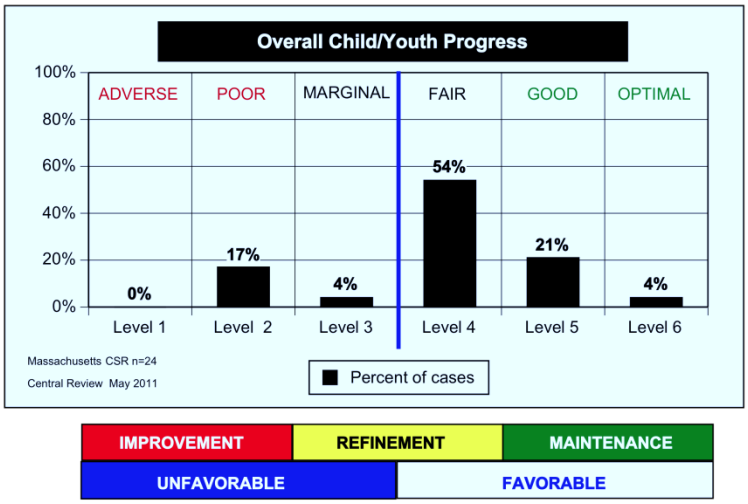
For the 24 youth reviewed, 17 or 71% of them were making progress in their relationships with their families or caregivers, indicating an area for more focus by teams. Progress in building peer relationships was less favorable, with only 65%, or 15 of the 23 youth the sub-indicator was applicable, to making progress in building meaningful relationships with peers. Progress in developing relationships with positive supportive adults (teachers, coaches, etc.) was more favorable, with 85%, or 17 of the 20 youth the sub-indicator applied to making progress, Assuring youth make progress in building relationships with families and peers is an area that needs attention by teams.

Overall Well-being and Quality of Life

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

For the youth reviewed in the CSR, 71% or 17 youth were making favorable progress in an improved overall well-being and quality of life. Three youth, or 13% had made "good" or "optimal" progress over the last six months in developing and using personal strengths, long-term relationships, life skills, and future plans. The bulk of the youth, 71% or 17 youth, were determined to need "refinement" indicating that teams and services may need additional supports to help more youth make progress in improving their overall well-being. Of the sample, four youth (17%) had made poor progress in their overall quality of life and had developed few to no long-term supportive relationships, life skills for problem solving, educational/work opportunities, or meaningful and achievable future plans.

For the families and caregivers, 75% were making favorable progress in improving the overall quality of life. Among these were 8 families (33%) who had made "good" to "optimal" progress, 14 (58%) needing "refinement," and 2 (8%) who had made no progress.



Overall Youth Progress

A goal of care planning is to coordinate strategies across settings, and identify any needed treatments or supports youth need to make progress in key areas of their lives. Overall, only 79% of the youth reviewed were making favorable progress (Fair, Good or Optimal Progress). Among the youth, 17% were determined to need improvement, and 58% needed refinement in moving forward in the areas measured. For these youth, the right strategies at the right intensity may have been missing or underdeveloped. The remaining 25% were making progress at a level that should be maintained and sustained.

The data for Youth Progress indicates that with the exception of Improved Relationships with Other Adults, there is a need for teams to look at ways to help youth make greater rates of progress across domains.

System/Practice Functions

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

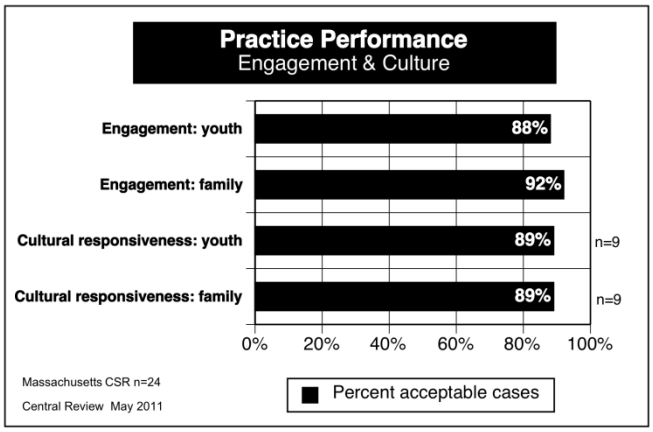
Determining how well the key elements of practice are being performed allow for discernment of which practice functions need to be maintained, refined or improved/developed.

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

Overall System/Practice Performance

The Commonwealth of Massachusetts is charged with creating the conditions that should lead to improvements for youth and families, and the CSR examines the diligence of services and service practices in providing those conditions. In other words, the review of youth status and progress provides the context for understanding their services; in the CSR, system/practice indicators are rated independently of how youth are doing and progressing. The system/practice functions are rated as how they are being performed. Having services is necessary but not necessarily sufficient; having services and practices that function consistently well is a key to having a dependable system that can reliably create the conditions where youth will make progress.

Practice is defined as actions taken by practitioners that help an individual and/or family move through a change process that improves functioning, well-being, and supports. Practice is best supported by using a practice model that works (example: engage, fully assess and understand youth and family, teamwork/shared decisions, choose effective change strategies, coordinate services, track/measure, learn and adjust) and having adequate local conditions that support practitioners (examples: worker craft knowledge, continuity of relationships, clear worker expectations practice supports/supervision, timely access to services/supports, dependable system of care practices and provider network).



Engagement

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

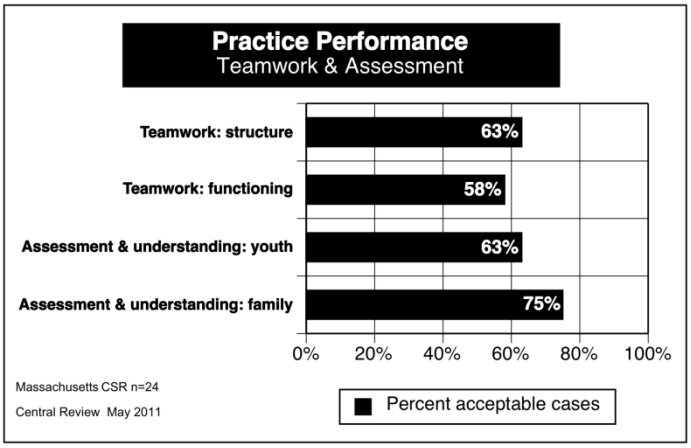
For the youth reviewed, 21 or 88% experienced an acceptable level of engagement. Families were engaged at an acceptable level 92% of the time. Six youth (25%) and five families (21%) reviewed may have benefitted from a "refined" level of engagement; two youth (8%) and one family (4%) needed "improvement," and engagement efforts were 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.

For the 9 youth reviewed for which the indicator applied, Cultural Responsiveness was acceptable for 8 or 89%. Likewise, for the 9 families the indicator was applicable for, it was acceptable for 8 or 89%. Cultural Responsiveness was found to be marginally inadequate for one of the youth (11%), and poor for one family (11%).

The following provides an example of strong cultural responsiveness practices: "The ICC facilitated a strong engagement with the youth and the mother that was culturally responsive. An interpreter was used when needed. There was evidence of cultural and religious values being respected throughout the work. The mother selected the persons to be on the family team, all of whom were providers working closely with her child."



Teamwork: Team Formation and Team Functioning

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

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

Team Formation. For the 24 youth reviewed in Central Massachusetts, team formation was acceptable only 63% of the time or for 15 youth, indicating improvement is needed in order for families to be able to consistently depend on teams of the right composition being formed. For 11 youth, or 46% of the sample, team formation was found to be "good" or "optimal." Eleven of the teams (46%) needed "refinement." In these cases, team formation was minimally adequate to fair, or marginally inadequate, meaning the care planning team met only occasionally and had few to limited skills, family knowledge, and abilities necessary to organize effective services. One youth (4%) was experiencing poor team formation, and one (4%) had absent/adverse team formation.

Team Functioning. Teams were functioning acceptably well for only 58% of the youth reviewed. For 9 youth (38%), teams functioned at a "good" or "optimal" level and had the skills, family knowledge and abilities necessary to work in a unified manner and organize effective services and supports for the youth and families. For 11 youth (46%) teams needed "refinement" and were functioning in a somewhat unified and consistent manner, or were

splintered and engaged in a pattern of actions that were usually incoherent with limited problem-solving. Three teams (13%) were functioning poorly, independently of the family and in isolation of other team members resulting in limited benefits for the youth and family. For one youth (4%), there was no evidence of a functional team.

An example of good team formation and functioning for a youth moving toward discharge from intensive services is, "The team not only meets monthly, but also communicates in some manner daily. There is a continuous process of problem solving and adjusting interventions to meet the needs of (the youth), mother, and other siblings. Outcomes and goals are specific and consistent amongst team members. Additionally, all team members were able to describe that when the youth is engaged in/transitioned to an educational or vocational program and the parent has consistently displayed skills for parenting and coping with (all their children) with behavior disorders, the team will feel confident about then transitioning to discontinue services if appropriate. This long-term view is shared by all team members, including the mother and youth."

An example where team functioning needed improvement is, "This care team is unclear about who the team consists of and the members of the team have changed frequently due to staff turnover and requests for changes in providers from the family. As a result of the inconsistent team and missing team members, this team has not been able to work together. Care team members communicated that they have their own ideas and tasks that need to be accomplished for this family, resulting in an infrequent and rare pattern of team work and collaborative problem solving."

Another example illustrates a need for improved and more goal-driven team functioning for a youth who has been experiencing crises and educational issues: "The team meetings focus on mom's updates about events and concerns since the last meeting, but seem to have stepped away from a clear focus on goals, interventions, progress, and meaningful discussion and brainstorming between all team members; some team members expressed feeling like they are observers rather than members. It is a critical time for the team to be working closely and with the full focus. Not only is the youth not in school, (but) has had a recent crisis team visit, has expressed increased self-harm and some threats to (others)… The team may be getting caught in the series of crisis, events, and changes and following the events and adding more services and interventions which may not allow for the focus and understanding needed to prioritize actions and to be consistent in the focus and objectives."

Care planning teams forming and functioning well for youth and families is a foundational system requirement. With only 63% of teams being adequately formed and only 58% of teams functioning acceptably well, clear and focused improvements are needed in order to help teams in Central Massachusetts form and work together to plan to achieve common goals, unify efforts, communicate regularly, evaluate results, and work in alignment with system of care principles.

Assessment and Understanding

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

learning is an ongoing process in order to track progress and respond to the changing needs of the youth and family. Assessment and understanding of youth and families is necessary foundational condition for practitioners to build cohesive care plans that can be implemented by teams toward achieving positive outcomes.

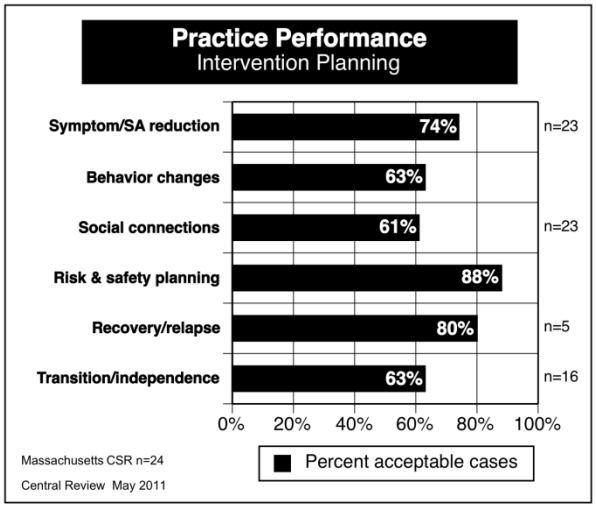
Of the 24 youth reviewed, only 15 or 63% of youth were found to have an acceptable level of assessment and understanding of their core issues and situations. There were 9 youth (38%) where teams had a "good" or "optimal" assessment and understanding. Another 9 (38%) would benefit from "refinement" or in the teams' practices in understanding them. A quarter of the youth (25% or 6 youth) had teams that had poor, incomplete or inconsistent assessment and understanding of the youth. In these cases, information necessary to understand the youth's strengths, needs and underlying issues were absent or outdated.

Assessment and understanding of families was acceptable for 75% of the sample. "Refinement" was found to be needed for 11 families or 46% where there was fair/minimal understanding, or marginally inadequate assessment and understanding. In these cases the team needed to better understanding the strengths, context, needs and vision of the family.

Good assessment and understanding of a youth was described by one reviewer where, "The team supported new testing to inform practice techniques which has provided crucial information about (the youth's) processing and learning abilities to be implemented across all life domains."

An example of assessment and understanding where there was poor understanding of the reasons for a youth's behaviors was, "(The youth) has experienced several out of home placements due to behaviors and mental health needs in the past 6 months. There is not a shared understanding of this youth's needs and behaviors by the members of (the) team. The record did not contain a mental health assessment and the team members speculated regarding the reasons or causes of this youth's disruptive and dangerous behaviors."

Another example describes a mother's struggle to have her child's behaviors better understood where, "(The mother) has wanted to have her (child) 'tested' and the waits are over a year, she was on a waitlist for a year at (two agencies) and when she called once to say her needs were more urgent as she was concerned her (child) might want to harm (his/herself), she was told the only resource was MCI. They couldn't understand that there was not a 'crisis' at that moment but her child was doing worse and she was worried and needed ongoing help not a crisis team…what would the crisis team do?"



Planning Interventions

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

For the 23 youth the *Symptom or Substance Abuse Reduction* sub-indicator was applicable for, planning for reducing presenting psychiatric symptoms or substance abuse was acceptable for 74% or 17. There was "good" or "optimal" planning in reducing symptoms or substance abuse for 7 or 30% of youth in the sample, hallmarked by well-reasoned strategies informed by an understanding of needs, and the youth and families' preferences and perspectives. "Refinement" in planning to reduce symptoms or substance abuse was identified to be needed for eleven or 48% of those reviewed. In these cases planning was fair to marginally inadequate. Planning for symptom/substance abuse reduction was poor for four of the youth reviewed (17%) with poorly reasoned planning processes that were generally failing to design interventions to address core issues. For one youth (4%), there was no planning process in place.

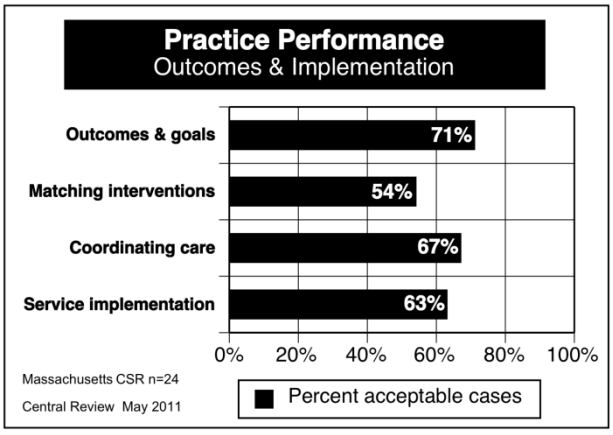
Targeting *Behavior Changes* in planning was applicable to all of the youth in the sample, and was at an acceptable level for only 63% of them. Seven youth or 29%, had plans that good addressed needed behavior changes in the "good" or "optimal" range. These plans reflected understanding of the youth and family, and had clear interventions for addressing behaviors that created problems for the youth. "Refinement" of behavioral supports and interventions in plans was needed for 54% of the youth. For three youth (13%), plan components for supporting behavior changes were poorly reasoned, and failed to design interventions that could address core issues. For one youth (4%), there was no plan to address needed changes in behaviors.

Planning for increasing *Social Connections* was applicable for 23 youth in the CSR sample and acceptable for only 61% of them. Six youth (26%) had "good" or "optimal" strategies in their plans for improving their social connections reflecting well-understood and well-reasoned supports. Refinement was needed in plans for 13 or 57% of youth who needed their social connections to be strengthened in order to do better emotionally or behaviorally. Two youth (9%) had poor planning reflecting unaligned strategies lacking in clarity and urgency to address the youths' need for social connections. Two youth (9%) had absent or misdirected planning in this domain.

Risk/Safety planning was acceptable for 21 or 88% of the youth, a very strong finding for this important indicator. The risk/safety component of plans was "good" or "optimal" for 11 or 46% of the sample. For 10 of the youth (41%), risk and safety planning needed refinement, but were still in the acceptable range. For two youth (8%), risk/safety planning was poor, and for one the practice was absent; youth with these results should be reviewed by their teams to assure crises are anticipated and managed.

Five youth in the sample needed *Recovery or Relapse* addressed in planning. Planning to address the recovery process and prevention of relapse was acceptable for four of them (80%). Planning for all five youth fell in the "refine" range indicating fair to marginally inadequate planning which could benefit from enhancement efforts.

Among youth in the CSR sample, 16 needed to have *Transitions* addressed in their planning processes. Review of transitions in the CSR apply to any transition occurring within the last 90 days or anticipated in the next 90 days including between placements (school and home), programs and to independence/young adulthood. For the 16 youth experiencing transitions planning was acceptable for only 63% indicating improvement is needed in identifying and planning for effective transitions. Four youth (25%) had transition planning that was "good" or "optimal." Nine of the youth (56%) would benefit from refined transition plans. Two youth's (13%) transition plans were poor, and one youth (6%) who needed transition planning had no plans in this area.



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 should

be identified and understood by the care planning team so all members can support their achievement. They should reflect a "long-term guiding view" that will help move the youth and family from where they are now, to where they want/need to be in the long-term, as well represent the family's vision of success for the youth. This indicator is measured as goals and outcomes guiding interventions over the past 90 days.

A clearly stated and understood set of goals and outcomes guiding services and strategies that describes what needs to happen order for the youth to be deemed to no longer receive services was acceptable for 71% of the youth. Thirty-eight (38%) of the youth had good to optimal goals that were well-reasoned and were specific. Twelve or half of those reviewed had ending goals and outcomes that needed to be "refined." Two youth (8%) had poor specification of outcomes and goals, insufficient for guiding intervention and change. One (4%) had absent goals (no plan).

Matching Interventions to Needs

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

For the youth reviewed, there was an acceptable level of matching intervention to need for only 54% (16 youth). This indicates a clear need to improve teams' ability to assure the interventions and supports can actually address what the youth and family needs. Nine youth (38%) had "good" or "optimal" matching. Twelve or half of the youth 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. Two youth (8%) had poorly matched interventions resulting in inadequate or conflicting assembly of service and supports, and one youth (4%) was experiencing adverse matching of interventions to needs.

Coordinating Care

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

coordinator should disseminate the youth's Risk and Safety Plan to all appropriate service providers as well as the family. The care coordinator's role is to facilitate ongoing communications among the entire team

Youth in the sample received care coordination services from both ICC (N=17) and IHT therapists (N=7). Care coordination practices were found to be at an acceptable level for only 67% of the youth reviewed. Care coordination was found to be "good" or "optimal" for 47% of the youth reviewed. For 12 youth or half the sample, care coordination would benefit from "refinements," and care coordination practices were deemed to be fair and minimally adequate, or marginal and limited with little leadership for service delivery and results. Two youth (8%) were found to have poor and fragmented care coordination, and one youth (4%) had no care coordination.

A well-functioning team driven by good care coordination practices was observed where, "The team is comprised of all providers in (the youth's) life. They all report being invested in the care planning process and that communication among all members is good. They appear well-grounded in a strength-and-need, wrap-around approach. The planning process is dynamically driven by the SNCD (Strengths, Needs, and Culture Discovery) which is used as part of weekly reviews of (the youth and) family's circumstances. The team uses this review to set the agenda for team meetings and develop the care plan. All members are consistent in reporting a high level of participation and input to the planning process, including (the youth and) mother, and that they are all 'on the same page'."

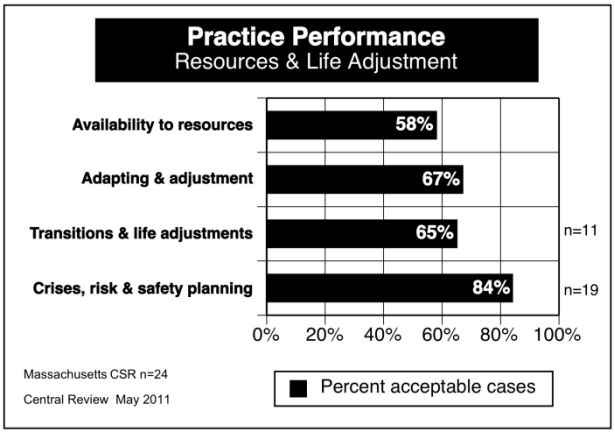
An example of coordinating care that needed improvement across practice domains follows. The youth is currently declining emotionally and behaviorally, and at-risk for a number of negative outcomes. "(The youth and) family were not able to establish a working relationship with the IHT clinician, resulting in the closure of services after 2 months. This lack of engagement also impacted the IHT's ability to form a team of current providers and natural supports to support this youth and family in their attempts to reach their goals. Although the IHT clinician had some historical information regarding this youth's past behaviors and current mental health concerns, it appears that the IHT clinician did not have a clear understanding of the family system and their needs. As a result of a lack of initial engagement and assessment, this IHT was not able to provide this family with the planning and interventions that were necessary to begin to address symptom reduction, behavior changes, as well as risk management and safety planning. This youth was able to make social connections through (the) local church community however this connection was not identified as an intervention or support to be incorporated into the planning process."

Service Implementation

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

For the youth reviewed, only 63% of them had acceptable service implementation, indicating concerted improvement is needed to assure services identified as needed are actually

implemented. Ten youth (42%) had "good" or "optimal" service implementation meaning services had a substantial pattern of service implemented in a timely competent and consistent manner. For 11 youth (46%), service implementation needed "refinement" and the overall pattern of implementing needed services and supports was fair to marginal/ inconsistent. Two youth (8%) had poorly implemented services with continuing significant implementation problems. One youth (4%) had no needed services implemented.



Availability and Access to Resources

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

Availability and access to needed resources was a significant issue for youth reviewed in the Central CSR. Only 58% of youth had acceptable access to available resources. Thirty percent (30%) of the youth, or 7 of them, had "good" access to needed resources. Fifty-eight percent (58%) of those reviewed, or 14 youth, had fair to marginally inadequate resource availability that indicated a need for refinement. Three youth, or 13% of the sample experienced poor resource access and availability severely limiting their ability to receive needed services.

Adapting and Adjustment

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

For youth reviewed, practices related to adapting and adjusting plans and services was acceptable for 67% of the youth. Eleven youth (46%) had "good" to "optimal" practices that were generally to highly responsive to changing conditions, with acceptable levels of monitoring and adjustment. Nine youth (38%) were experiencing necessary changes to plans and services at a minimally adequate to marginally inadequate level, with only periodic to occasional monitoring. There were three youth (13%) with poor and fragmented adapting and adjustment of services and interventions, and one (4%) with an absent or non-operative adapting and adjustment process.

Transitions and Life Adjustments

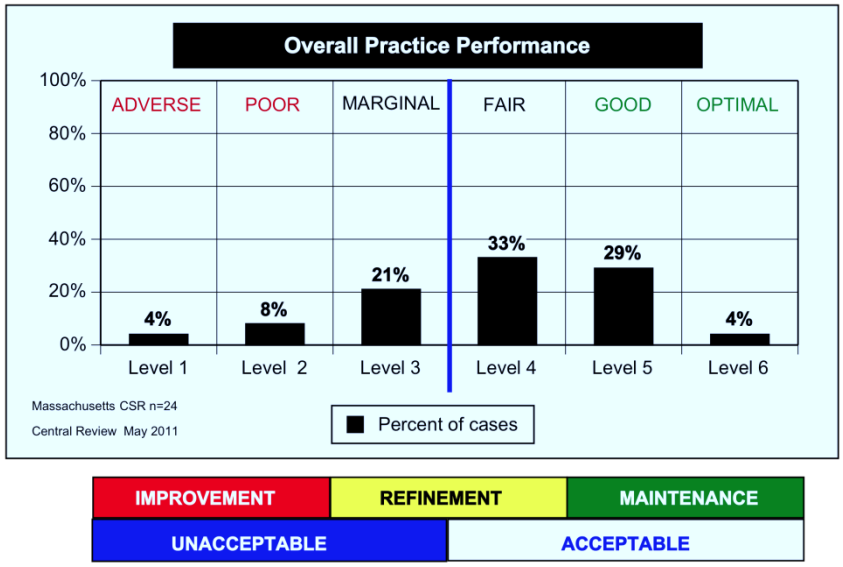
For youth who have had a recent transition, or one is anticipated, reviewers examined the degree to which the life or situation change was planned, staged and implemented to assure a timely, smooth and successful adjustment. If the youth is over age 14, a view by the team as well step-wise planning to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

For the seventeen youth this indicator applied to, 65% or 11 youth had acceptable transition management practices in place. Five youth (29%) experienced "good" or "optimal" transition interventions. Eight youth (47%) could benefit from "refined" transition supports. Three (18%) experienced a poor transition with unaddressed transition issues, and no transition plan for an imminent change. One youth (6%) had a transition that was adverse, with no planning considerations or arrangements made. Overall, results indicate practices to improve the ability of teams to identify, plan for and implement supports for youth in their life transitions are warranted.

Responding to Crises and Risk/Safety Planning

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

For youth where this indicator was applicable (N=19), 84% or 16 youth had an acceptable crisis response and risk plan that worked acceptably well for them, reflecting good practices that most of the youth and families could depend on. Twelve youth (63%) were rated to have experienced a "good" response to crises and/or safety issues. Six youth (47%) would benefit from "refinement" in the response to their crises and risk/safety issues. There was one youth (5%) that experienced a poor response to crisis.



Overall System/Practice Performance

The chart above shows the distribution of scores for System/Practice Performance across the six point rating scale. For the youth reviewed, 66% were found to have acceptable system/practice performance. The largest percentage of youth fell in the fair performance level (33%). Performance scores clustered at the good, fair and marginal levels with 83% of youth reviewed falling in this range. When interpreting results for system/practice performance, it is important to see them in the light of overall practice patterns and how youth are doing and progressing. Youth and families come into services with the expectation that they can depend on services that will help them. In other words, the expectation is that the system and practices should be performing acceptably well for the largest numbers of youth and families receiving services

Thirty-three percent (33%) of the youth reviewed fell in the "Maintenance" area, meaning the system and practices were effective for them, and efforts should focus on sustaining and building upon positive practice.

Fifty-four percent (54%) of youth reviewed fell in the "Refinement" area which means that performance was limited or marginal, and further efforts are necessary to refine practices. Practice patterns in these situations require refinement.

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

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

Indicators that showed an overall fair performance but at a less consistent or robust level of implementation were Planning Interventions for Recovery and Relapse; and Responding to Crises and Risk & Safety Planning.

Areas of system/practice performance that need a level of improvement in order to assure consistency, diligence and/or quality of efforts are Assessment & Understanding of the Family; Planning Interventions for Symptom or Substance Reduction; and Outcomes and Goals.

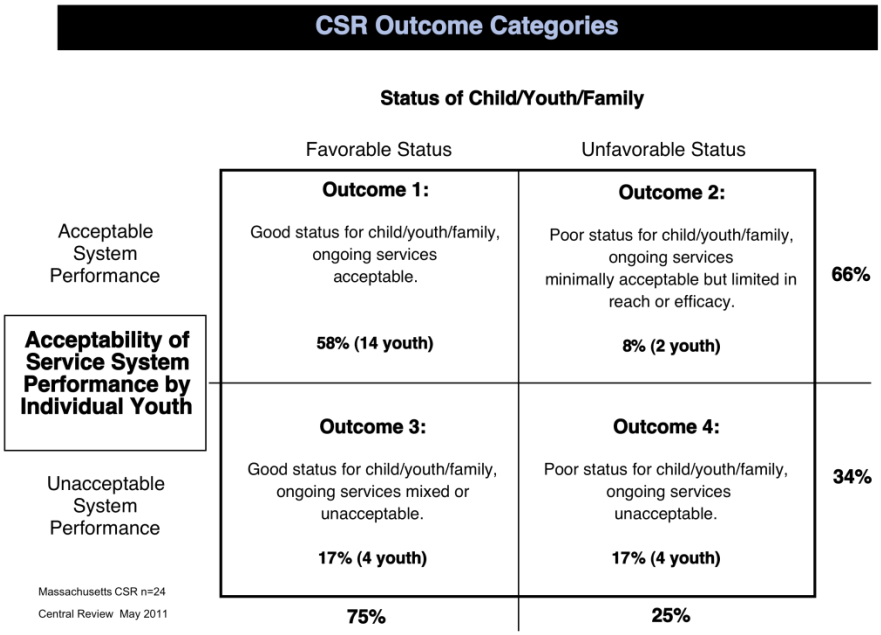
Review results indicate weak performance in the following system/practice domains: Teamwork (Formation and Functioning); Assessment & Understanding of Youth; Planning Interventions for Behavior Changes; Planning Interventions for Social Connections; Planning Interventions for Transitions; Matching Interventions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

Overall, the findings of the CSR showed that for Central Massachusetts services, key system of care practices such as engagement and cultural responsiveness to youth and families were exceptionally strong, as were risk and safety plans. Other practices were found to be operating at a fair level, including crisis response, and substance abuse relapse planning.

The remaining system practices need more development. Many practices were not at strong enough level to reliably help many youth make progress in core areas of well-being, desired outcomes or maintain the gains they have made through services. While exemplary practices were observed for some youth, work was not consistent level of performance across teams, and foundational system of care practices need considerable improvement. Teams for over a third of the youth were not formed with the right people to bring together the collective skills and knowledge necessary to address youth and family needs. Teams not only needed to improve their ability to be formed more reliably, for over 40% of youth they were not functioning at an adequate level, were splintered or inconsistent in planning and evaluating results, and were not engaged in collaborative and problem-solving. A challenge for over a third of teams was using information, including in existing assessments and information that is held by other providers, schools, etc., to increase team-based understanding of youths' and families' strengths and needs at a scope and depth necessary to develop the right set of interventions and supports.

Many of the Planning interventions needed strengthening particularly in impacting behavioral changes, increasing social connections, and assuring successful transitions. Matching the right interventions to address youth and family needs was weak for nearly half of the youth reviewed. For nearly a third of youth, care coordination required stronger leadership, including facilitating teams to monitor results to adjust care plans and address transitions. A core issue was implementing needed services, which appeared to be impacted in Central Massachusetts by several factors. One factor likely impacting implementation was the inadequate teamwork and coordination for a number of youth, including weaknesses in tracking and monitoring implementation. The other key factors were the lack of availability of certain necessary services, and long wait times to access services.

Overall findings suggest a number of core system of care practices in the Central Massachusetts region will require attention in order to achieve consistently reliable and effective results.



CSR Outcome Categories Defined

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

CSR Results

Outcome 1

As the display indicates, 58% (14 youth) of the 24 youth fell into outcome category 1. Outcome 1 is the desired situation for all children and families receiving services.

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

> *"The Functional Behavioral Assessment added to the overall assessment of the youth by looking at what was driving behaviors and the function of the behaviors. All team and family members were consistent in the implementation of the behavior plan. The mother was persistent in her follow through and taught the father and the brother how to use the behavior plan. In addition, the Therapeutic Mentor had a clear agenda with specific objectives in his activities with (the youth). These objectives were clearly communicated with the youth at every visit. For example, "today we are going to practice not getting something every time we go to a store" or "today we are going to practice taking turns." The Therapeutic Mentor coordinated his activities with the overall behavior plan developed by the IHB team. Overall, there was a shared understanding of this child's needs with defined interventions to meet specific needs with clear, measurable outcomes defined. The two key factors contributing to Favorable Status were 1) the right interventions in the right amount by the*

right people were implemented, and 2) the mother had strong participation in all aspects of the Care Plan."

Outcome 2

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

An example of a youth who fell in Outcome 2 is as follows. In this example, the youth is doing poorly and not attending school. However, services are in place, and there is an active team.

> *(The youth and) family are very engaged with the providers on their team. There are regular team meetings. Services are being provided, and contact is regular… The (therapeutic mentor) wants to really focus on knowing and using (the youth's) ideas and direction. The ICC and FP are also talking with (the mother) about her own needs and supporting her access to treatment ...There is satisfaction by mom with the services and the team, feels supported by the Family Partner."*

Outcome 3

Seventeen percent (17%) or 4 youth were in outcome category 3. Outcome 3 reflects youth whose status was favorable at the time of the review, but who were receiving less than acceptable service system performance. Some children are resilient and may have excellent naturally occurring supports provided by family, friends, school personnel, or some other key person in their life whose efforts are significantly contributing to the child's favorable status at the present time. However, current service system/practice performance is limited, inconsistent, or inadequate at this time. For these children, when teams and interveners adequately form, understand the youth and family, and function well, the youth could likely progress into the outcome 1 category. Without key practice functions occurring reasonably well, status for youth in this category is often fragile, and at risk of becoming unfavorable.

The following is an example of a youth in Outcome 3. This youth had been doing well, but is losing ground and it is expected that he will begin to decline as key supports are slipping.

> *"There is not a strong functioning team working to support this family. In spite of mother's repeated requests to obtain a psychological assessment for her (child), this has not been done. (The youth) has several 'rule out' diagnoses that require further clarification, and there is a history of trauma. Mother also does not have an ongoing therapist due to miscommunication and follow through. There is not a single point of coordination and necessary leadership for convening and facilitating effective care planning and service decision processes for this family. Meetings are not well attended and are not achieving desired results, resulting in frustration and lack of progress. Mother is feeling frustrated and not listened to and she does not have an individual therapist or the support that could potentially be provided by a parent support group. Her repeated request for a psychological assessment for her son has not been provided. Her description of the care planning team is that 'people write a bunch of things down, but nothing really happens or changes'."*

Outcome 4

In the Central Massachusetts CSR, 17% of the sample or 4 youth fell into outcome category 4. Outcome 4 is the most unfavorable outcome combination as the child's status is unfavorable and system performance is inadequate. For many of the youth who are in

Outcome 4, a better understanding of the youth and family coupled with stronger teamwork and planning interventions that meet the needs of the youth with strong oversight of implementation would move the youth into a better Outcome classification.

An example of a youth who fell in Outcome 4 is as follows. The youth is currently doing poorly emotionally and functionally, with risk factors present across most of the status domains.

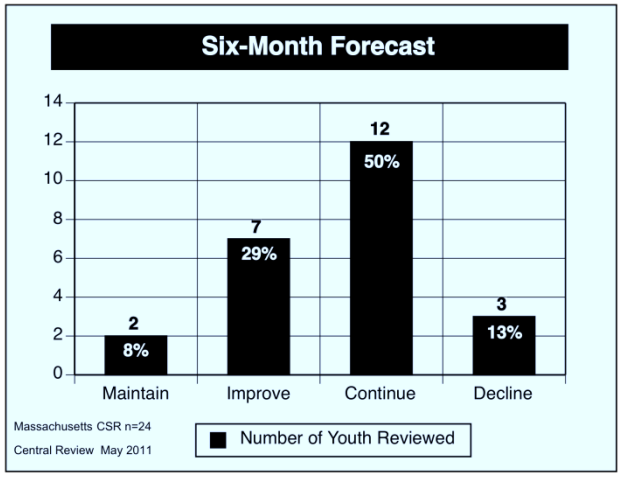
> *"(The youth) and mother have been minimally engaged in the care coordination service…the youth does not attend the care planning meetings…. (The youth's)mother indicated that she has felt left out and does not have much knowledge about the care planning process…This care team is unclear about who the team consists of and the members of the team have changed frequently due to staff turnover and requests for changes in providers from the family. As a result of the inconsistent team and missing team members, this team has not been able to work together. Care team members communicated that they have their own ideas and tasks that need to be accomplished for this family, resulting in an infrequent and rare pattern of team work and collaborative problem solving. At this time, (the youth's) care team does not have an adequate understanding knowledge of his functioning to understand his strengths, needs, and underlying issues. The care team's understanding of (the youth's and) family dynamics and family context are also inadequate to identify what is needed to effect change in behavior and present conditions. Consequently, the lack of understanding and assessment for this youth and his family has resulted in poorly reasoned, inadequate planning and use of intervention strategies, actions, timelines, and accountability for the team members. (The youth) has experienced minimal symptom reduction, behavior changes within the home and community, and minimal focus on transitions. The care team's current plan for this youth and family is lacking in goals and desired outcomes to direct the work of the providers with the family and insufficient to guide the interventions and desired change for (the youth). In addition to the lack of planning , the services that have been implemented with this family have been mismatched and inadequate to bring about the desired changes for (the youth) The youth's mother reports that there has been no change in their situation and providers shared that they are providing their services with little understanding of collaboration with the other services involved with the family. The care coordinator working with (the youth and family was unsure of the actual clinical services working with the family and was unable to identify the goals and tasks of other members of the care team.*

Overall outcome findings

The percentages on the outside of the two-fold table on Page 45 represent the total percentages in each category. The percentage at outside, top right (66%) is the total percentage of youth with acceptable system/practice performance (sum of Outcomes 1 and 2). The percentage below this (34%) is the inverse- the percentage of youth with unacceptable system/practice performance. Likewise the number on the outside lower left is the percentage of youth that has favorable status (75%) and under the next block the percentage of youth with unfavorable status (25%).

Six-month Forecast

Based on review findings, reviewers are asked if the child's status is likely to maintain at a high status level, improve to higher than the current overall status, continue at the same status level, or decline to a level lower than the current overall status. For 2 youth or 8%, the prediction was that the youth would maintain at a high status level (youth in the "good" or "optimal" status category). For 7 youth or 29% of the sample the prediction was for improvement in status. For 12 youth or 50% reviewers predicted the youth's status to continue at the same level. For 3 youth or 13%, the prediction was that their status would decline.



Summary of Findings

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

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

Strengths

The CSR identified examples of exemplary work including:

- Skilled staff, including Therapeutic Mentors that were using therapeutic approaches that were well-integrated with other services and reflected the needs identified in care plans.
- A primary care physician who was providing interim medication management appropriate use of MCI when a youth in the office was experiencing a mental health crisis, and active engagement in and support for the screening process. The physician used the Massachusetts Child Psychiatry Access Project (MCPAP) resources to support medical decisions.
- Agencies worked to ensure Family Partner continuity when families come back into services, which was appreciated by families.
- A Care Coordinator who shared information about factors that were influencing a youth's behaviors with a prescriber, which helped to inform prescribing practices.
- There were a number of examples of strong collaboration with schools including around transition planning.
- Stakeholders and reviewers identified engagement with youth who are homeless, as well as other traditionally hard to reach populations as a strength.
- Families in Central Massachusetts see DCF as helpful, and a strong support for their families.

In Home Behavioral Therapy has been an effective intervention for those youth and families that have had access to this service.

Especially for youth where other interventions have been less than effective, in-home behavioral services, including functional behavioral assessments and behavioral support plans has been effective. With the numbers of youth with developmental issues impacting their behaviors, this has been a service that is in demand. For youth and

families who have had access to IHBT, and especially when the interventions are integrated across home and school, results have been positive. Families noted that they needed to ensure there was a "good fit" between the staff and their family, as the skills and approach are critical for positive impact.

For many families, mobile crisis interventions were seen as an asset

When staff joined with teams to provide consultation for continuing care, there were examples of positive results. Families were particularly positive when MCI services assisted them both during and after the crisis to ensure youth and family stability, communication with other team members, and used the 72-hour capacity for continued support.

System of Care (SOC) Committees are starting to be a venue for active problem solving

The reception from schools to the SOC in some areas has been positive and teaming with DCF was reported be many as improving. SOC are learning how to work together and the meetings are gaining focus.

Challenges

Access issues were impacting care.

- ***Waiting lists for IHT, IHBT, Therapeutic Mentors, assessment services, and psychiatry were reported by many.***
- ***A number of youth reviewed were waiting to receive services identified as in their plans of care as being necessary***

The ability to access needed services on a timely basis appeared to be one of the core challenges impacting overall system performance for Central Massachusetts.

Recruitment and retention problems resulting in frequent turnover of providers, compounded by business constraints, were impacting both initial receipt of services and continuity of care. Solvency for provider agencies often means services being volume sensitive; agencies are cautious about growth and appear to be building waitlists into their business approaches. Particularly in rural areas, this means youth and families can wait for long periods of time to receive necessary services, which for some of the youth reviewed resulted in further functional regression, or reliance on crisis services.

Comprehensive psycho-social and other assessment resources were also difficult to access for a number of families and teams, often resulting in an incomplete understanding of the youth which is necessary to build successful plans of care. Access to services for families after receiving Emergency Services also was identified as problematic, leaving families discouraged.

Access to, and coordination with, psychiatric services was a significant issue identified in the youth specific reviews, and also reported widely by stakeholders. Youth were reported to be prescribed psychotropic medications, in some cases many different medications, without integration of treatment to provide a full view of progress, side effects, and impact.

Issues with crisis services remain unresolved.
Issues identified regarding crisis services include:

- No face to face contact with psychiatry for MCI teams when needed.
- When there are multiple MCI visits usually have different staff and teams.
- Need for Crisis Stabilization Beds, which would help youth remain in their homes and enhance treatment.

With the advent of CBHI services, other important services are no longer available.
As other state services have been defunded, CBHI services have been seen as the "catch-all" solution, despite the fact that there are certain services that CBHI does not provide. Services such as DMH respite, DCF voluntary services, after school programs, parent support groups and other non-medical services which previously provided important supports for youth and families are no longer available. It is a common assertion that with the CBHI service access issues, CHINS and courts become an option to access necessary services.

Support for teams and staff need strengthening.

- Care coordinators often did not know how to use assessments to identify needs and inform planning, and sometimes did not know how to obtain assessment services.
- More work is needed to bring natural supports into the team as families are ready and have identified or developed supports.
- Clarification is needed regarding service "rules" such as which services can be authorized simultaneously, and no time limits when services are necessary.
- Teams often needed specialized skills and knowledge to provide consultation, assist with the development of care plans and to provide interventions for youth and families with complex clinical issues
- More support was needed for teams to achieve diagnostic clarity to understand youth's needs, identify any learning or sensory processing disorders, and understand more fully what interventions might be most successful for the youth.
- Care coordinators needed help in supporting parents to access adult mental health services, including how to broach the discussion of mental health service needs with parents.
- IHT services needed clarity in their role in coordinating care and knowing when to refer to ICC

Recommendations

Provide direct and systematic support for teams.

- Assure training and coaching supports are continual.
- Provide more training to IHT agencies about their role in coordinating care.
- Assure teams gather and synthesize all available information about the youth and family in order to inform functional, well-formulated plans.
- Provide supports to staff for assisting parent's in seeking mental health services when they need them.
- Strengthen transition planning.
- Assure staff know how to access evaluations when they are needed, and effectively use all information to:
    - help teams develop a common understand of the youth and family

- determine the supports and interventions that are most likely to meet needs
- support outcomes identified in care plans
- determine when more focused or specialized information is needed

Establish agency "triggers" for internal case reviews when services are not available, youth have complex clinical/family situations, a child it not making progress, there are questions about safety, etc.

Evaluate whether or not MCI services have capacity to provide a broad enough geographical reach so that response is timely.

Assure youth are connected to services following a crisis or acute care episode and consider options for engagement (during the crisis and stabilization service/follow up activities) by the community provider (example: Family Partner, IHT, Care Coordinator).

Continue to share the practice model across stakeholders including schools, DCF and families to build awareness, understanding and partnerships.

Assure decisions are based on what the child needs and team decisions. Help providers to build skills and approaches that adequately demonstrate "medical necessity" of the services so that both MCE's utilization review and providers play a role in ensuring that services are provided based on need and continue when needed.

Address factors impacting access and availability to services.

Appendix 1

Child's General Level of Functioning

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

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

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

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

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

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

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

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

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

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

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

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

Appendix 2

CSR Interpretative Guide for Person Status Indicator Ratings

Maintenance Zone: 5-6

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

6 = **OPTIMAL & ENDURING STATUS** The best or most favorable status presently attainable for this person in this area [taking age and ability into account]. The person is continuing to do great in this area. Confidence is high that 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.

Improvement Zone: 1-2

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

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

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

Unfavorable Range: 1-3

CSR Interpretative Guide for Practice Performance Indicator Ratings

Maintenance Zone: 5-6

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

6 = **OPTIMAL & ENDURING PERFORMANCE**. Excellent, consistent, effective 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 may be changing. Further efforts are necessary to refine the practice situation.

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

3 = **MARGINALLY INADEQUATE PERFORMANCE**. Practice at this level may be under-powered, inconsistent or not well-matched to need . Performance is 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