2011

Rosie D. Community Services Review- Southeastern Massachusetts

Regional Report

Report of Findings of the Community Services Review
of Southeastern Massachusetts conducted March 7-11, 2011

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Executive Summary

This report presents findings of the Community Services Review (CSR) conducted in the Southeastern Massachusetts region in March 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 Southeastern 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 Southeastern 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 Southeastern Massachusetts are presented in this report. The largest number of youth (ten or 42%) was in the 10-13 year old age group. There were two youth in the 18-21 year old range, and none in the 0-4 range. At the time of the review, most of the youth (83%) were living with their biological parents or in an adoptive home. Thirty-seven percent (37%) 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 (67%) followed by Latino (25%). Youth who were African-American or Haitian each were 4% of the sample. English was the primary language spoken at home for the majority of the youth (83%). The most frequent educational placement for the youth was in a fully self-contained special educational classroom (46%) followed by a regular educational setting (29%), and part-time special education (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 (67%) followed by the Department of Children and Families (DCF) (38%). The youth were referred to ICC or IHT services in the largest numbers by DCF (33%), and then in equal numbers by their families, crisis services and hospitals (13% each).

The review also collected information related to behavioral health and physical conditions, including co-occurring conditions, with the highest condition prevalence being mood disorders (58%), followed by ADD/ADHD (42%) and PTSD/adjustment to trauma (29%) and Disruptive disorders (29%). Thirteen percent (13%) of the youth had a co-occurring medical problem (asthma for all). Current mental health assessments were found for 71% of the youth reviewed.

There were a high number of youth in the sample on one or more psychotropic medication (92%), with 29% on three or more medications. Most of the youth in the sample (83%) had not used a crisis services in the 30 days prior to the review. Forty-six percent (46%) had experienced a special procedure for managing behaviors during the preceding 30 days including 29% experiencing a seclusion or restraint.

Caregivers of the youth were facing challenges that included extraordinary care burdens (33%), adverse effects of poverty (25%), and a serious physical illness or disabling condition (25%). Cultural/language barriers were a challenge for 17% and serious mental illness for 13%.

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 their families or caregivers likewise was an issue for a number of youth with only 71% having favorable status on this indicator. Overall, most of the youth were safe at school (91%), with fewer safe in their homes (83%), or in their communities (79%). Most of the youth had favorable physical health status and had their health needs addressed (92%). Living arrangements were favorable for 75% of the sample. The sub-indicators for educational status showed youth needed more supports in this area with 74% having favorable status in their attendance and academic or vocational programs, and 78% of them with favorable behavior supports in the school setting.

The following indicators of youth status were particularly concerning for the youth reviewed. Behavioral risk to self was favorable for only 58% of the youth and 71% had favorable behavioral risk toward others. Only 29% of the youth had favorable emotional status, clearly indicating the need for much more focus on this domain of youth status when planning interventions and supports.

Across the indicators of youth status, only 58% of the youth reviewed had an overall favorable status with 8% with "optimal" status, 17% with "good" status and 33% with "fair" status. The remaining 42% of youth had unfavorable status with 35% with "marginal" status,

and 4% 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 Southeastern Massachusetts CSR, as discussed previously, reflect families experiencing considerable challenges, among the most prevalent being extraordinary care burdens, adverse effects of poverty and a serious physical illnesses or disabling conditions. Only 50% of mothers and 63% of fathers had a favorable level of challenge. The data show that voice and choice of mothers, substitute caregivers and older youth are part of service delivery processes. The voice and choice of fathers and youth aged 12-17 was less of integrated into planning and service delivery processes. Family/caregiver and youth satisfaction with services and participation was generally favorable; fathers were less satisfied with their participation in planning and services.

Youth progress. These indicators measure the progress patterns of youth over the six months preceding the review. Youth progress showed poor results across the indicators, and overall only 54% of youth were making overall favorable progress. Fifty-four percent (54%) were making favorable progress in reducing symptoms, 60% in reducing substance use (N=5), 58% in improving coping/self-management, 59% in school progress and 75% (N=4) in work progress. Progress was also concerning across the indicators of building relationships and well-being/quality of life. More support in helping youth to make progress is clearly needed in Southeastern Massachusetts.

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 Southeastern Massachusetts found strong practices in Engagement with Families/Youth with respective ratings of 88% and 87% acceptable performance on these indicators. Cultural Responsiveness also saw strong performance for youth with 100% for those the indicator applied to experiencing practices that were culturally responsive. Cultural Responsiveness was less strong for families (82% acceptable).

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 71% of the youth, which indicates an improvement is needed in order for families to be able to depend on teams with the right composition and continued development of the team. Team Functioning was even more of a concern with only 50% of teams functioning acceptably well. The overall finding for these indicators is that a high level of practice improvements are needed in teams in Southeastern 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 meeting youth's and families' objectives. There was acceptable understanding for only 67% of the youth, and for only 61% of families. Concerted improvement would move teams in Southeastern Massachusetts toward better understanding of youths' and families' core issues and situations, and to improve their foundation for building effective plans.

The Planning Intervention indicators include six sub-indicators. Results for acceptability of care/treatment plans and planning processes show improvements can be across all indicators of planning. Planning for symptom/substance abuse reduction was acceptable for only 59% of youth, for behavior changes for 54%, and for social connections 67%. Planning for effective recovery and/or relapse prevention applied to seven youth and was acceptable for only 57% of them. Planning for supporting transitions was acceptable for only half (50%) of the 14 youth the indictor was applicable for. Risk and safety planning was the one exception and planning was acceptable for 83% of youth.

The indicator for identifying and articulating clear Outcomes and Goals for the youth and family indicated improvement is needed with only 63% of youth rated as having acceptable performance. 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 more attention with 75% of practices reviewed having acceptable performance.

Care coordination for the youth reviewed was acceptable for only 58% of the youth reviewed. Concerted strengthening in care coordination practices is needed for youth in Southeastern Massachusetts. Service implementation was acceptable for only 71% of youth, indicating more diligence is required to assure services and supports that are needed by youth are implemented. There was Availability of Resources for 79% of the youth. The practice of Adapting and Adjusting plans and services was acceptable for only 63% of youth, indicating improvements in making needed changes to plans are needed.

Planning, staging and implementing practices for successful Transitions and Life Adjustments, was clearly an area where practices need considerable work. Only 40% of the youth for which the indicator applied experienced adequate transitions.

Responding to Crises and Risk/Safety Plans was an area of strength, and 88% of youth who experienced a crisis over the previous ninety days experienced acceptable crisis management.

Overall, only 55% of youth were found to have acceptable system/practice performance.

The data indicate that the strongest areas of practice for the sample as a whole (there is variability in performance results for individual youth) were Engagement with the Youth and Family; Cultural Responsiveness to Youth; and Responding to Crises and Risk & Safety Planning

Indicators that showed an overall fair performance but at a less consistent or robust level of implementation were Cultural Responsiveness to Families; Planning Interventions for Risk and Safety Planning and Availability and Access to Resources.
Areas of system/practice performance that need some level of improvement in order to assure consistency, diligence and/or quality of efforts are Teamwork (Formation); Matching Interventions to Needs; and Service Implementation.

Review results indicate weak performance was found in the following system/practice domains: Teamwork (Functioning); Assessment & Understanding of Youth and Family; Planning Interventions for Symptom or Substance Reduction; Planning Interventions for Behavior Changes; Planning Interventions for Social Connections Planning Interventions for Recovery or Relapse; Planning Interventions for Transitions; Outcomes and Goals; Coordinating Care; Adapting and Adjustment and Transitions & Life Adjustments.

The findings of the CSR showed that for Southeastern Massachusetts services, certain foundational system of care practices such as engagement of youth and families, and cultural responsiveness to youth, were strong. Notable were planning for and responding to youth in crisis, which were shown to work for most of the youth who experienced a crisis. Needed resources were available for most youth.

A number of other system practices needed improvement. Teams for nearly 30% of the youth needed to improve their ability to be formed with the right people that can bring together collective skills and knowledge necessary to address youth and family needs. For about a quarter of the youth, teams needed to more consistently select the most effective strategies and assemble them into a coherent mix that can address individual youth and family goals. As well, closer tracking to assure intervention strategies are implemented with sufficient intensity and consistency were needed.

Overall, a number of important system practices reviewed in the Southeastern Massachusetts CSR were not at a level of performance that could dependably help youth make progress in achieving their goals. Concerted efforts to improve systems and practices are indicated.

Findings: Strengths. The CSR found effective family engagement and cultural competency practices. Families clearly appreciated being engaged in teams and the services they are receiving for their children. There were examples of exemplary work by skilled staff. Crisis services were viewed as an asset for a number of youth.

Findings: Challenges. The CSR found that teams need a greater depth/scope of understanding of core issues of youth and families, resulting in plans and interventions that often did not fully address the range of needs of youth and families. Service implementation for many youth reviewed lacked the level of urgency and match of strategies that resulted in behavioral or situational change needed. The necessary skills and specialized expertise particularly for youth with clinical complexity, development disorders, or transitional issues were often absent. Adequate supervision structures or practices were not uniformly building and guiding the knowledge, skills and abilities of staff.

The reviews identified a number of systems issues. For youth where IHT was the designated care coordinator, the needed level of coordination was sometimes missing, indicating a need for role-clarification and/or training. A repeated finding expressed by staff and families was an assumption that ICC and IHT services have specific time limits, with services needing to end at twelve months, versus service delivery based on needs of youth. There also appears to be the wide-spread belief that team-based decisions are secondary to external authorization controls, which often hampered the team process.

Recommendations. The Recommendations starting on Page 65 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 Southeastern Massachusetts region. Recommendations revolve around the need for stronger assessment and understanding of youth and families and individualized planning; providing clarity and training regarding the coordination role in IHT; exploring ways to provide respite and other informal supports; strengthening supervision practices; responding to the questions and concerns of families; and ongoing dissemination and coaching of best practices.

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

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

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

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

Purpose of monitoring

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

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

Overview of the CSR methodology

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

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

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

Through using a structured protocol, reviewers make determinations about youth status/progress (favorable or unfavorable) and system/practice performance (acceptable or unacceptable) through a six-point scale. Refer to Appendix 2 on Page 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 Southeastern Massachusetts CSR (March 2011)

Description of the Region

The Southeastern region of Massachusetts encompasses the areas along the coastline south of Boston and east along the RI border and includes inland southeastern cities and surrounding towns. Cape Cod and the islands of Nantucket and Martha's Vineyard are part of the Southeastern area and provide a dramatic change from metropolitan urban Boston to busy seaside towns in the summer and rural coastal towns in the winter season. It is a vacation destination for many residents and visitors. The Southeastern region has a series of small cities and towns that form the southeastern border of Massachusetts and sit along large bays of the Atlantic Ocean and abut the state of Rhode Island along the southeastern tip of Massachusetts. There are a mixture of coastal towns, and older fishing, shipping and industrial centers. The inland area of the Southeastern region is centered around a series of older small cities such as Brockton, Attleboro, Taunton, Middleboro, and Bridgewater whom have significant roots in agriculture and manufacturing.

The overall area has a mix of economic vitality and serious unemployment and economic shifting and struggle. There are significant variations in ethnic and cultural populations, including language diversity. Much of the area is linked to the sea and that is reflected in the history, activities and culture of the communities. The area has strong economic links to both Boston and Providence given the geographical boundaries of the area. It is an area with an important role in Massachusetts' history that continues to be celebrated in local communities.

Community Service Agencies (CSAs) and In Home Services

The Southeast Region has six CSAs: Justice Resources Institute (JRI), Hyannis on Cape Cod; Family Services Association (FSA), downtown Fall River; Child and Family Services of New Bedford (CFS), downtown New Bedford; Baystate Community Services (BSCS), Plymouth; Community Counseling of Bristol County (CCBC), Taunton; and Brockton Area Multi-Services Inc. (BAMSI), Brockton.

Each of the CSAs provides services to the towns surrounding their CSA office location. Southeastern Massachusetts covers a substantial area of coastal and inland towns and small cities. The areas have varied histories, and have experienced significant shifts in economic conditions and industries. The sea and waterways as well as the proximity to Boston and Providence influence the culture and activity of many areas.

Most of the Southeastern CSAs are well established organizations within their communities, though the Baystate Community Services in Plymouth and JRI in Hyannis CSAs needed to establish new locations and sites for their CSA operations and services. The JRI CSA subcontracts with the Family Continuity Program (FCP) in Hyannis to provide Family Support and Stabilization Services (Family Partners). JRI and FCP are co-located in the same building along with other human services.

In Home Therapy Services (IHT) are provided throughout the region, with IHT services being provided at the CSAs as well as being provided by other private agencies. The Community Service Review (CSR) included IHT services from 4 of the 6 CSAs and IHT services from 4 non-CSA agencies, by random selection.

Review Participants

Altogether, over 430 people from Southeastern 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 Southeast CSR was drawn from the population of all children who received Intensive Care Coordination (ICC) or In-Home Therapy (IHT) without currently receiving ICC service, inclusive of children from birth to twenty-one years old, who are covered by Medicaid. The original CSR sample included 16 ICC youth and 8 IHT youth who were not also currently receiving ICC.

Prior to the review, each agency was asked to submit lists of the children who were enrolled since the initiation of the service. The caseload enrollment list was sorted to create a list of youth who were currently enrolled within open cases.

ICC Selections. For ICC, a random sample of youth was drawn from the open caseload list. The number of youth selected from each CSA 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. For IHT, 8 youth were randomly selected to be included in the sample. Because the number of IHT providers exceeds the number of youth who could be included in the sample, 8 IHT providers were randomly selected to be included in the CSR. In total, there were 17 IHT providers, which were actively delivering IHT services in Southeast Region at the time the lists were submitted. There were 6 IHT providers, which were also providing ICC services. And there were 11 IHT providers, which were not providing ICC services. Four providers were randomly selected from the first list and 4 agencies were randomly selected from the second list to be included in the sample. Then, one youth was randomly selected from each of the 8 randomly drawn IHT providers.

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.

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 that were served within open cases at the time the agencies submitted lists. The number of youth to be included from each agency was then determined by comparing the number of youth being served by that agency to the total number of youth being served in the Southeast region.

Southeast Agency	Total Enrolled Since Start of ICC Opening (7/1/09)	Number Open at List Submittal	Number ICC Cases Selected
Brockton Area Multi-Services Inc.	264	106	2
Bay State Community Services Plymouth	145	37	2
Child and Family Services of New Bedford	312	115	3
Community Counseling of Bristol County	246	98	2
Family Service Association of Fall River	288	182	4
Justice Resource Institute Cape Cod	221	173	3
Total	**1476**	**711**	**16**

Table 2

The sample included 4 youth from the Family Service Association of Fall River CSA; 3 from Child and Family Services of New Bedford; and 3 from the Justice Resource Institute Cape Cod. The sample included 2 youth from the each of the remaining CSA's: Brockton Area Multi-Services, Inc., Bay State Community Services Plymouth, and Community Counseling of Bristol County. These ICC youth may have been receiving services in addition to ICC, including IHT.

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

As can be seen, each of the following IHT programs had 1 youth included in the CSR: Arbour Fuller Hospital, Brockton Area Multi-Services Inc., Bay State Community Services Plymouth, Community Care Services, Community Counseling of Bristol County, Family Continuity Programs, Family Service Association of Fall River, and the Latin American Health Institute. In total, the CSR sample selection included 16 youth where ICC coordinate their care and 8 youth where IHT coordinated their care.

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
Arbour Fuller Hospital	71	41	37	1
Brockton Area Multi-Services Inc.	51	23	9	1
Bay State Community Services Plymouth	145	35	15	1
Child and Family Services of New Bedford	*	*	*	*
Community Care Services	98	28	16	1
Community Counseling of Bristol County	519	158	123	1
Family Continuity Programs	182	75	56	1
Family Service Association of Fall River	27	18	4	1
Family and Children's Services of Nantucket	*	*	*	*
Justice Resource Institute	*	*	*	*
Latin American Health Institute	14	3	3	1
Martha's Vineyard Community Services	*	*	*	*
MSPCC	*	*	*	*
Pyramid Builders	*	*	*	*
South Bay Mental Health	*	*	*	*
South Shore Mental Health	*	*	*	*
Saint Vincent's Home	*	*	*	*
Total	**1107**	**381**	**263**	**8**

* There were a total of 8 youth who were drawn from the IHT lists. Of the 17 agencies providing IHT, 9 were not randomly selected for the sample.

Table 3

Characteristics of Youth Reviewed

Age and Gender. There were 24 youth reviewed across the Southeastern Massachusetts region in the CSR conducted March 7-11, 2011. *Chart 1* displays the distribution of genders across age groups in the sample. There were 15 boys and 9 girls in the sample. This proportion of boys to girls was 62.5% boys to 37.5% girls. Two youth (8%), both boys, were in the 18-21 age range. The largest number of youth (ten or 42%) was in the 10-13 year old age range. There were six youth (25%) in the 5-9 year old range and six (25%) in the 14-17 year old range. There were no children in the sample in the 0-4 age group.

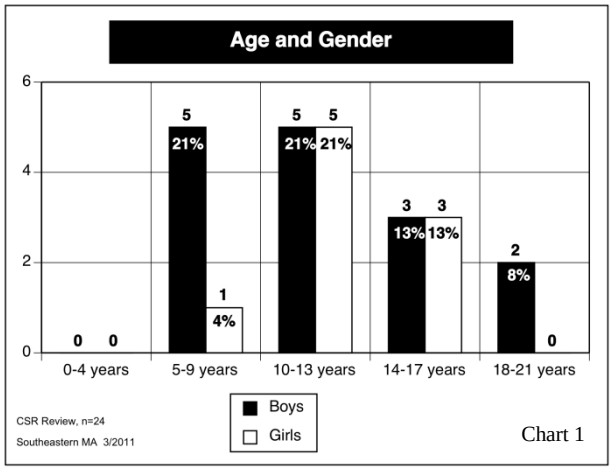


Chart 1

Child Status and Performance Profile - Current Placement Frequency

Number of cases: 24 Southeastern Review 3/2011

Type of Current Placement	Number	Percent
Family bio./adopt. home	18	75%
Kinship/relative home	2	8%
Foster home	1	4%
Therapeutic foster home	1	4%
CBAT	1	4%
MHI	1	4%
	24	100%

Table 4

Current placement, placement changes and permanency status. The largest percentage of youth (83%) in the Southeastern Massachusetts CSR sample lived with their families, either their biological/adoptive families or in a kinship/relative home. One youth each lived in a foster home, a therapeutic foster home, Community-Based Acute Treatment (CBAT), and an inpatient hospital at the time of the review(*Table 4*).

Child Status and Performance Profile - Legal Permanency Frequency

Number of cases: 24 Southeastern Review 3/2011

Legal Permanency Status	Number	Percent
Birth family	16	67%
Adopted family	2	8%
Foster care	2	8%
Permanent guardianship	2	8%
None	1	4%
Step-father	1	4%
	24	100%

Table 5

The legal status (*Table 5*) of most of the youth in the sample was with their birth families (67%). Two (8%) youth's permanency was with their adopted families, and two (8%) were in foster care. Two youth (8%) were in permanent legal guardianship, and one was in temporary legal guardianship. One youth did not have a legal guardian.

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 (15 or 63%) had no placement changes in the last year. Seven of the youth or 29% had 1-2 placement

Child Status and Performance Profile - Placement Changes Frequency

Number of cases: 24 Southeastern Review 3/2011

Placement Changes (past 12 months)	Number	Percent
None	15	63%
1-2 placements	7	29%
3-5 placements	2	8%
	24	100%

Table 6

changes, and two or 8% had 3-5 changes.

Of the five youth who were in out of home placements at the time of the review, one (4%) had been in placement for 1-3 months, one (4%) for 4-6 months, and one for 7-9 months and two for over 37 months (*Table 7*).

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

Number of cases: 24 Southeastern Review 3/2011

Length of Stay in Current OOH Placement	Number	Percent
1 - 3 mos.	1	4%
4 - 6 mos.	1	4%
7 - 9 mos.	1	4%
37 + mos.	2	8%
Not applicable	19	79%
	24	100%

Table 7

Child Status and Performance Profile - Ethnicity Frequency

Number of cases: 24 Southeastern Review 3/2011

Ethnicity	Number	Percent
Euro-American	16	67%
African-American	1	4%
Latino-American	6	25%
Haitian	1	4%
	24	100%

Table 8

Ethnicity and primary languages (Table 8 and 9). Of the 24 youth in the sample, sixteen or 67% were Euro-American, one or 4% was African-American, six or 25% were Latino-American, and one (4%) was Haitian.

Child Status and Performance Profile - Language Spoken Frequency

Number of cases: 24 Southeastern Review 3/2011

Primary Language Spoken at Home	Number	Percent
English	20	83%
Spanish	1	4%
Creole/French	1	4%
English & Spanish	2	8%
	24	100%

Table 9

English was the primary language spoken at home for 20 or 83% of the youth, Spanish for one (4%), Creole-French for one (4%) and both English and Spanish for two (8%).

Educational placement (Table 10). Youth reviewed were receiving educational services in a variety of settings. Fifty-nine percent (59%) of the youth were receiving special education services part-time or full-time setting. Twenty-nine (29%) were attending school in a regular education setting. One youth (4%) had completed their education. Youth in the "Other" category included youth receiving education in a hospital setting or an educational evaluation center. 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 Southeastern Review 3/2011

Educational Placement or Life Situation	Number	Percent
Regular K-12 Ed.	7	29%
Full inclusion	0	0%
Part-time Sp. Ed.	3	13%
Self-cont. Sp. Ed.	11	46%
Parenting teen	0	0%
Adult basic/GED	0	0%
Alternative Ed.	0	0%
Vocational Ed.	0	0%
Expelled/Suspended	0	0%
Home hospital	0	0%
Day treatment program	0	0%
Work	0	0%
Completed/graduated	1	4%
Dropped-out	0	0%
Other	3	13%

Table 10

Other state agency involvement (Table 11). Many youth in the sample were involved with other State and private 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 (16 or 67%). The Department of Children and Families (DCF) had involvement with 9 families or 38% of the sample. Developmental Disabilities had involvement with 3 youth or 13% or the sample. Vocational Rehabilitation was involved with 2 youth (8%), and DMH, DYS, and Probation each with 1 youth. The "Other" category represents youth involved with legal services and the Cerebral Palsy Association.

Child Status and Performance Profile - Agencies Involved Frequency

Number of cases: 24 Southeastern Review 3/2011

Agencies Involved	Number	Percent
DCF	9	38%
DMH	1	4%
Special Ed	16	67%
Early intervention	0	0%
Developmental disabilities	3	13%
DYS	1	4%
Probation	1	4%
Vocational Rehabilitation	2	8%
Substance abuse	0	0%
Other	2	8%

Table 11

Referring agency (Table 12). Youth in the sample were referred to ICC and/or IHT services from a variety of sources as seen in Table 12. The largest referral source was DCF who referred 8 youth or 33% of the sample. The next largest referral sources were Families, Crisis Services, and Hospitals which each referred 3 youth or 13% of the sample each. Referring one youth each were DMH, a School, a Primary Care Physician, CBAT, a joint DCA/CSA referral, Intensive Foster Care and an IHT program

Child Status and Performance Profile - Referral Source

Number of cases: 24 Southeastern Review 3/2011

Referral Source	Number	Percent
DCF	8	33%
DMH	1	4%
School	1	4%
Family	3	13%
Primary care physician	1	4%
CBAT	1	4%
Crisis Services	3	13%
DCF-CSA	1	4%
Hospital	3	13%
IFC	1	4%
IHT	1	4%
	24	100%

Table 12

Behavioral health and co-occurring conditions (Table 13). Table 13 displays the conditions and/or co-occurring conditions present among the youth reviewed. Youth may have one or more than one condition. The two primary diagnostic conditions were mood disorders prevalent with 14 or 58% of the youth, and attention deficit disorder/attention deficit hyperactivity disorder seen with 10 or 42%. This was followed youth diagnosed with anger control issues (33%). Twenty-nine percent (29%) of the youth reviewed were identified to have PTSD, and 29% had a disruptive behavior disorder. Of the sample, 21% each had an anxiety disorder, learning disorder and/or autism.

The next two prevalent disorders were mental retardation (13%) and medical problems (13%). Among the youth with

Child Status and Performance Profile - Co-Occurring Condition Frequency

Number of cases: 24 Southeastern Review 3/2011

Co-Occurring Condition	Number	Percent
Mood Disorder	14	58%
Anxiety Disorder	5	21%
PTSD/Adjustment to Trauma	7	29%
Thought Disorder/Psychosis	2	8%
ADD/ADHD	10	42%
Anger Control	8	33%
Substance Abuse/Dependence	2	8%
Learning Disorder	5	21%
Communication Disorder	1	4%
Autism	5	21%
Disruptive Behavior Disorder (CD, ODD)	7	29%
Mental Retardation	3	13%
Medical Problem	3	13%
Other Disability/Disorder	2	8%
Other	0	0%

Table 13

mental retardation, two had mild mental retardation, and one had severe mental retardation. All youth with medical problems had asthma. Eight percent (8%) of the youth had a thought disorder, and 8% had a substance abuse issue. One youth had a communication disorder. Youth in the Other Disability category included one with a visual impairment and one with an acute stress disorder.

Medications (Table 14). Ninety-two percent (92%) of the youth reviewed were prescribed at least one psychotropic medication. As seen in Table 14, nine of the youth (38%) were prescribed one medication, six (25%) were on two medications, and four (17%) were on three medications. There was one youth on four (4%) and two (8%) on five or more medications. Thirty-two percent (32%) of the youth who were prescribed psychotropic medications were prescribed three or more medications.

Child Status and Performance Profile - Psy Meds Frequency

Number of cases: 24 Southeastern Review 3/2011

Number of Psy Meds	Number	Percent
No psy meds	2	8%
1 psy med	9	38%
2 psy meds	6	25%
3 psy meds	4	17%
4 psy meds	1	4%
5+ psy meds	2	8%
	24	100%

Table 14

Youths' levels of functioning (Table 15). The General Level of Functioning is a 10-point scale that can be viewed in Appendix 1 of this report. The functioning of each youth is rated during the CSR using this scale. Most of the youth in the Southeastern 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"). Nine or 38% were rated in the Level 6-7 range ("variable functioning with sporadic difficulties or symptoms in several but not all social areas" to "some difficulty in a single area, but generally functioning pretty well"). The remaining youth (4%) was rated in the Level 8-10 range ("no more than slight impairment in functioning at home, at school, with peers" to "superior functioning in all areas").

Child Status and Performance Profile - Level of Functioning Frequency

Number of cases: 24 Southeastern Review 3/2011

Level of Functioning	Number	Percent
In level 1-5	14	58%
In level 6-7	9	38%
In level 8-10	1	4%
	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. Twenty of the 24 youth (83%) did not access crisis service during that time period. Among those that did, three (13%) used mobile crisis services. One youth each used a 911 call to an emergency medical service or a police department. One youth went to an emergency department in a hospital. In the Other category was a youth whose pediatrician provided a crisis response, and one who accessed CBAT.

Child Status and Performance Profile - Crisis Services Used Frequency

Number of cases: 24 Southeastern Review 3/2011

Crisis Services Used Past 30 Days	Number	Percent
Mobile crisis	3	13%
911 Emergency call: EMS	1	4%
911 Emergency call: Police	1	4%
Emergency department	1	4%
Other	2	8%
None	20	83%

Table 16

Mental health assessments (Tables 17 and 18). Mental health assessments are a core component of understanding youth and their families. A mental health assessment helps 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 Southeastern Review 3/2011

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 Southeastern Review 3/2011

Received MH Assessments	Number	Percent
Parent	9	38%
Education	5	21%
Court	1	4%
Child Welfare	3	13%
DOC	0	0%
Not applicable	7	29%
Not Distributed	4	17%
Other	3	13%

Table 18

Among families in the sample, 9 or 38% of parents had received their child's assessment. Schools received a copy of the mental health assessment for 5 or 21% 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 9 or 38% of the youth in the sample so the percentage of families that were child welfare involved and had their assessments shared with DCF was actually 33%. The assessment had not been distributed for 17% of youth who had a mental health assessment. There were several other people who received the Mental Health Assessment for youth which included a CBAT program, a guardian ad litem, the youth, and other team members.

Special Procedures

Special Procedures data has been collected for the CSRs in other regions, but has not been previously reported, primarily because of low incidence. For the Southeastern CSR, these data are presented to better understand behavioral interventions occurring (*Table 19*). Fifty-four percent (54%) of the population did not experience a special procedure in the 30 days preceding the review. For the 46% of youth in the sample that did, 21% had experienced a voluntary time-out; 17% a physical restraint that could have been a hold or a mechanical restraint; 13% a disciplinary consequence; 8% each loss of privileges in a points and level system, room restriction or a "take-down" procedure; and 4% each an exclusionary time out or seclusion in a locked room. Note youth may have experienced more than one special procedure, thus the total percentage is more than the overall 46% of youth who experienced a procedure.

Child Status and Performance Profile - Special Procedures Frequency

Number of cases: 24 Southeastern Review 3/2011

Special Procedures Used Past 30 Days	Number	Percent
Voluntary time-out	5	21%
Loss of privileges via point & level system	2	8%
Disciplinary consequences for rule violation	3	13%
Room restriction	2	8%
Exclusionary time out	1	4%
Seclusion/Locked room	1	4%
Take-down procedure	2	8%
Physical restraint (hold, 4-point, cuffs)	4	17%
Emergency medications	0	0%
Medical restraints	0	0%
None:	13	54%
Other:	0	0%

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 33% of caregivers. A quarter (25%) of the caregivers were challenged by serious illnesses or disabling physical conditions, and a quarter (25%) adversely impacted by poverty. Other challenges were cultural language barriers experienced by 17%, serious mental illness by 13%, and 4% each by substance abuse and/or domestic violence. Challenges in the "Other" category included non-disabling health issues, termination of parental rights and economic stressors.

Child Status and Performance Profile - Caregiver Challenges Frequency

Number of cases: 24 Southeastern Review 3/2011

Challenges in the Child's Birth Family or Adoptive Family	Number	Percent
Limited cognitive abilities	0	0%
Serious mental illness	3	13%
Substance abuse impairment or serious addiction w/ frequent relapses	1	4%
Domestic violence	1	4%
Serious physical illness or disabling physical condition	6	25%
Unlawful behavior or is incarcerated	0	0%
Adverse effects of poverty	6	25%
Extraordinary care burdens	8	33%
Cultural/language barriers	4	17%
Undocumented	0	0%
Teen parent	0	0%
Recent life disruption/homelessness due to a natural disaster	0	0%
Other	5	21%

Table 20

Care Coordination

During the CSR, data are collected about care coordination through the person providing the care coordination function, which could have been the ICC or the IHT therapist. Among the data collected 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. These data were collected to better understand factors that may be impacting the provision of care coordination services. In the Southeastern Massachusetts CSR, there were 22 individuals providing care coordination for the 24 youth reviewed (14 individual ICCs, and 8 IHTs). Two ICC care coordinators provided coordination for more than one youth in the sample, which is why data here are provided for 22 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*, half of the care coordinators (50%) had been providing coordination for the youth in the 7-12 month range. Twenty-five percent (25%) of care coordinators had been assigned to the youth between 13-24 months, and 17% between 4-6 months. Eight percent (8%) had been providing coordination for 1-3 months.

Child Status and Performance Profile - Length of Time CM Assigned

Number of cases: 24 Southeastern Review 3/2011

Length of Time CM Assigned to Child/Youth	Number	Percent
1-3 months	2	8%
4-6 months	4	17%
7-12 months	12	50%
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*. Forty-five percent (45%) of Coordinators had had 11-12 cases. Eighteen percent (18%) were in the 9-10 or 13-14 caseload range. Nine percent (9%) had 15-16 cases, and 5% had less than 8 or 17-18 cases. There were no care coordinators with more than 18 cases on their caseload. Of note is that 32% of care coordinators had more than 12 cases on their caseload.

Child Status and Performance Profile - CM Current Caseload Frequency

Number of cases: 22 Southeastern Review 3/2011

CM Current Caseload Size	Number	Percent
<8 cases	1	5%
9-10 cases	4	18%
11-12 cases	10	45%
13-14 cases	4	18%
15-16 cases	2	9%
17-18 cases	1	5%
	22	100%

Table 22

As can be seen in *Table 23*, most of the Care Coordinators participating in the Southeastern Massachusetts CSR had been in their positions for 13-24 months (59%), followed by those in positions 7-12 months (23%). Nine percent (9%) had been in the care coordinator position for 37-60 months. Five percent (5%) had been in their positions for 1-3 months or 4-6 months

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

Number of cases: 22 Southeastern Review 3/2011

Length of Time CM in Position	Number	Percent
1-3 months	1	5%
4-6 months	1	5%
7-12 months	5	23%
13-24 months	13	59%
37-60 months	2	9%
	22	100%

Table 23

Table 24. Information on barriers that affect the provision of care coordination or other services was collected in the CSR. The challenges cited most often were billing requirements or limits to billing (25%). This was followed by the complexity of the case (17%) and issues with treatment compliance (17%). Eligibility and denial to access was cited by 8%, as was inadequate team member participation, team member follow-through, cultural/language barriers, treatment refusal, and family instability or moves.

Barriers cited less frequently (4% each) were caseload size, inadequate parental support, family disruptions, acute care needs, and driving time to services.

Child Status and Performance Profile - Barriers Affecting Case or Services

Number of cases: 24 Southeastern Review 3/2011

Barriers Affecting Case Management or Services	Number	Percent
Caseload size	1	4%
Eligibility/access denied	2	8%
Inadequate parent support	1	4%
Inadequate team member participation	2	8%
Family disruptions	1	4%
Billing requirements/limits	6	25%
Case complexity	4	17%
Treatment compliance	4	17%
Team member follow-thru	2	8%
Acute care needs	1	4%
Driving time to services	1	4%
Culture/language barriers	2	8%
Refusal of treatment	2	8%
Family instability/moves	2	8%
Arrest/detention of child/youth	0	0%
Other	11	46%

Table 24

Barriers that were cited in the "Other" category included issues when families lose insurance; waitlists for services and service availability including residential treatment/access to DMH services; lack of transportation for families; not being able to bill for time coordinating with Family Partners; mounting and poorly designed paperwork including timelines for families to complete paperwork; role confusion and misunderstanding of the role of ICC; MCE understanding of medical necessity; and lack of individualization of the process that is driven by the MCEs.

Community Services Review Findings

Ratings

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

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

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

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

STATUS AND PROGRESS INDICATORS

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

Youth Status Indicators

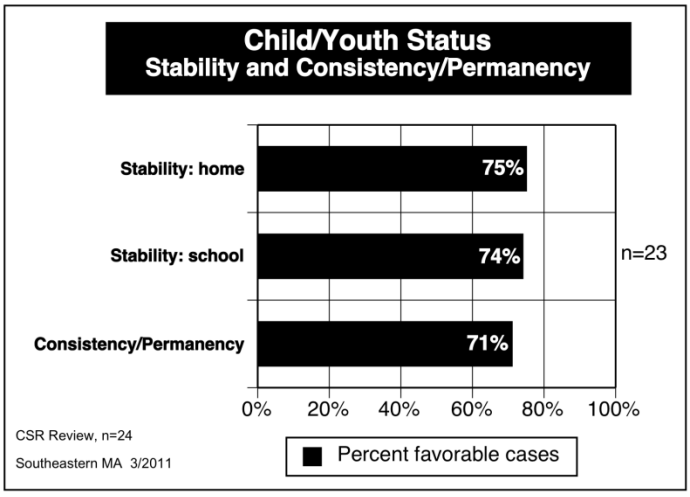
(Measures Youth Status over the last 30 days unless otherwise indicated)

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

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

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

Overall Youth Status



Community, School/Work and Living Stability

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

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

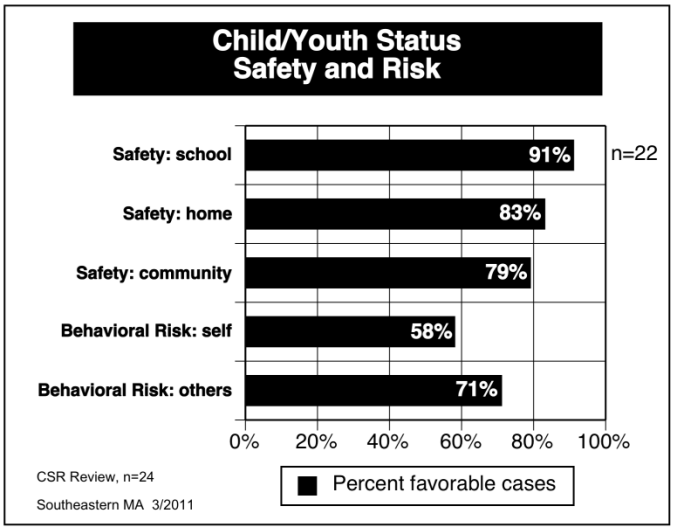
Among the 24 youth in the CSR sample in Southeastern Massachusetts, 75% of them had favorable stability at home. Six of the youth (25%) had good stability with established positive relationships and well-controlled to no risks that otherwise could jeopardize stability. Five of the youth (21%) were rated to have optimal stability, with positive and enduring relationships free from any risks of disruption. Eleven, or 46% 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.

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. Forty-two percent (42%) had issues with their school stability that needed "refinement" or "improvement," Among these were three youth (7%) with poor to adverse stability in the school setting including two youth (9%) with poor school stability. There were seven youth (30%) with good school stability, and six (26%) with optimal stability.

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 Southeastern Massachusetts, 17 or 71% had a favorable level of consistency and permanency in their lives. Among these, 14 or 58% of the sample had "good" or "optimal" status. A third of the sample (8 youth or 33%) had "minimal/fair" or "marginal" permanence that needed a level refinement in in order to assure enduring relationships and consistent caregiving/living supports. Two youth (8%) had "poor" permanency status with substantial and continuing problems of unresolved permanence.



Safety of the Youth

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

In the sample of youth reviewed for Southeastern Massachusetts, for those who were in a school program (N=22), 91% of youth were found to have favorable safety status at school. Among the sample, 83% were safe at home and 79% were safe in the community, indicating more attention by teams may be warranted for these youth in these settings.

Eight of the youth in school programs (36%) needed their school safety to be "refined." Fourteen youth (58%) needed Refinement or Improvement in their home safety, including one (4%) that had was in a high safety risk situation with serious and worsening risk of harm. Half of the youth (12 or 50%) could benefit from their teams reviewing their safety status in their communities including one with poor status, and the one in a high safety risk situation with serious and worsening risk of of harm.

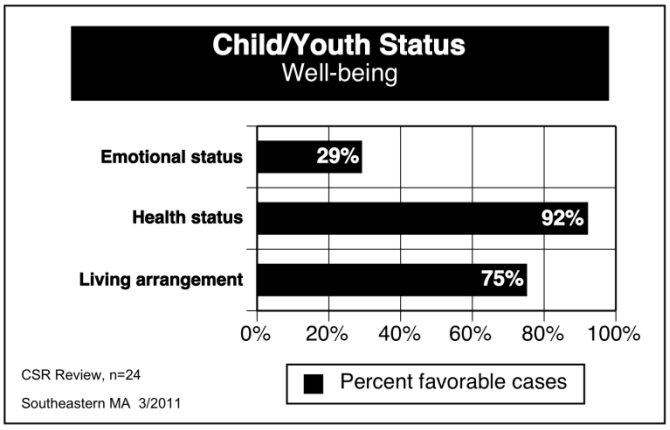
Behavioral Risk to Self and Others

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

The results of the review show that only 58% 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 or optimal level of behavioral risk. The other two thirds (66%) of those reviewed were found to need "refinement" or "improvement" in their current status of behavioral risk to themselves indicating teams may want to carefully evaluate strategies in youths' plans in this area including level of risk. Among these were two youth (8%) who had poor behavioral

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

The subindictor of behavioral risk toward others was favorable for only 71% of the youth in the sample. Forty-two percent (42%) or 10 youth had a "good" or "optimal" level of behavioral risk toward others. Fourteen of the youth (58%) needed "refinement" or "improvement" in their risk to others, including one (4%) who had poor risk status, with a presence of potential of harm torward others, and one (4%) who had serious and worsening riks behaviors toward others.



Emotional and Behavioral Well-being

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

Emotional and behavioral well-being was favorable for only 29% youth reviewed in the Southeastern Massachusetts CSR, clearly indicating the need for more attention in developing interventions and strategies to address improved status this domain. These results indicate a high level of youth with inconsistent or poor emotional development, adjustment problems, emotional/adaptive distress, or serious behavioral problems present. Among the youth reviewed, 83% were determined to need "refinement" or "improvement" in their emotional/behavioral status. Five of the youth (21%) were found to have poor emotional/behavioral status and were not currently progressing in their emotional/behavioral well-being. Focused support for teams in developing individualized strategies for refining and/or improving youth's levels of emotional and behavioral well-being is indicated.

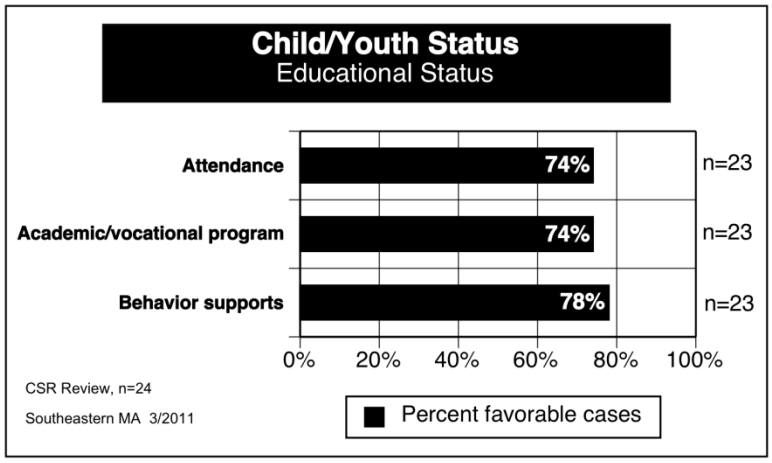
Health Status

The health of the youth was reviewed to determine whether or not they were achieving and maintaining optimal health status including basic and routine healthcare maintenance. Youth's basic needs for nutrition, hygiene, immunizations, and screening for any possible development or physical problems should be met. Health is an important component of overall well-being. For the youth in the sample, 92% had favorable health/physical well-being status. Fourteen youth (58%) had good or optimal health status. Forty-two (42%) percent of the youth were noted to need "refinement" or "improvement" in their health status. One of the youth (4%) had poor health status.

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 Southeastern Massachusetts CSR, 75% were found to have a favorable living arrangement. Half of the youth (50%) had living arrangements that were "good" or "optimal." The other half (50%) were indicated to need "refinement" or "improvement" in their living arrangement, including one (4%) that had a poor living arrangement in a substantially inadequate setting.



Educational Status

Three specific areas are examined to determine how well youth are their educational programs. 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.

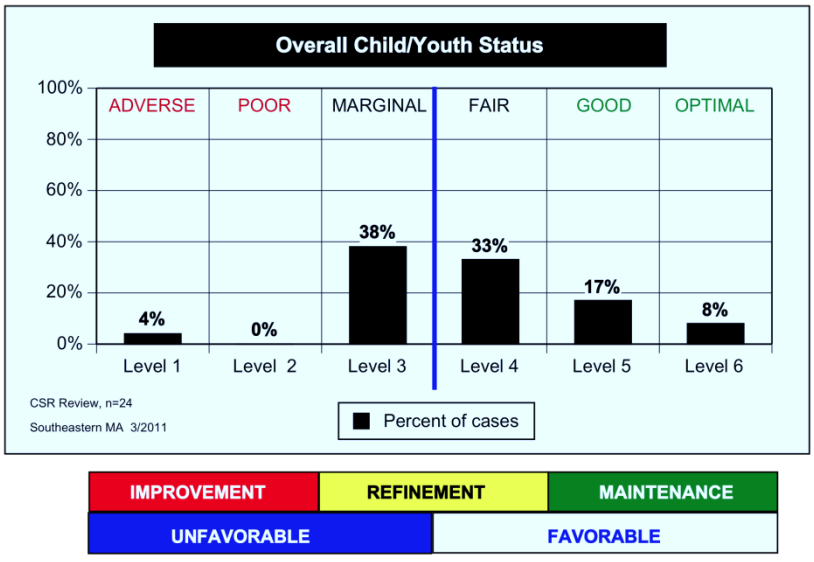
In the Southeastern Massachusetts review, for the 23 youth school attendance was applicable to, 74% had favorable patterns of attendance. Sixty-five percent (65%) were found to have good to optimal school attendance. Thirty-five percent (35% or 10 youth) would benefit from refinement or improvement in their school attendance patterns. Among these, one (4%) had a poor attendance pattern and one (4%) had adverse school attendance.

For the 23 youth who were enrolled in an academic or vocational program, 74% of them were doing favorably well in their program. Thirteen youth or 57% the youth needed their teams to look at any needed refinements in their school program, including one (4%) who had poor academic status, and whose program was not meeting educational needs.

Twenty-three (23) youth in the sample required behavioral supports in their school setting, and supports were working favorably well for 78% of them. Nine or 39% of the youth could benefit from their teams addressing the adequacy or consistency of implementation of behavioral supports.

Overall Youth Status

The overall results for Youth Status for the 24 youth reviewed in Southeastern Massachusetts are displayed below. Overall, only 58% or 14 youth were found to be doing favorably well. These youth fell in Levels 4-6; 33% or 8 youth had Fair status, 17% or 4 youth had Good status and 8% or 2 youth had Optimal status. The remaining ten youth (42%) had unfavorable status. They had either Marginal (38% or 9 youth) or Adverse (4% or 1 youth) status. There were no youth found to have overall Poor status.



The Youth Status Overall results are also categorized as needing Improvement, Refinement, or Maintenance. This allows for identification of youth that may need focused attention. One youth (4%) fell into the Improvement area, meaning status is currently problematic or risky, and action should likely be taken to improve the situation for the youth. Seventeen or 71% 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 six youth (25%) 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 Southeastern Massachusetts. About a quarter of the youth were experiencing issue with both stability and achieving permanency. Overall, youth were safe in school, but several youth had substantial safety issues at home and in the community. Attendance issues and the adequacy of academic or vocational programs were unfavorable for a fair number of youth in the sample. Behavioral risk to self was a concern for 42% of the youth and risk to others for 29%. 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 a quarter of the sample. The largest area of concern was the emotional/behavioral well-being of youth with 71% of youth with unfavorable status on this indicator.

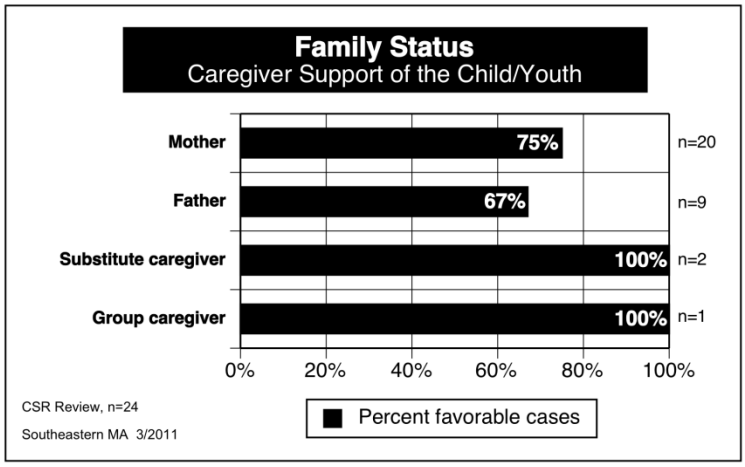
Caregiver/Family Status

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

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

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

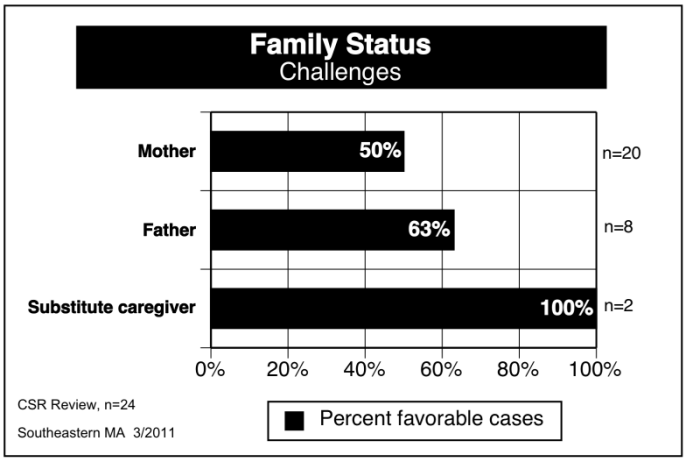
Overall Caregiver/Family Status



Parent/Caregiver Support of the Youth

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

For the youth reviewed in the Southeastern Massachusetts CSR, the measure was applicable to mothers for 20 youth, and favorable support was found 75% of the time (15 youth). Maternal support needed "refinement" or "improvement" for 12 youth or 60%. The measure for support from fathers was applicable for nine of the 24 youth in the sample, and favorable support was found from 67% or six of the fathers. Support from fathers needed "refinement" or "improvement" for 67% or for six youth in the sample. For the two youth with substitute caregiving (adoptive or kinship care), support was favorable for both of them. Support was also favorable for the one youth in group care at the time of the review.



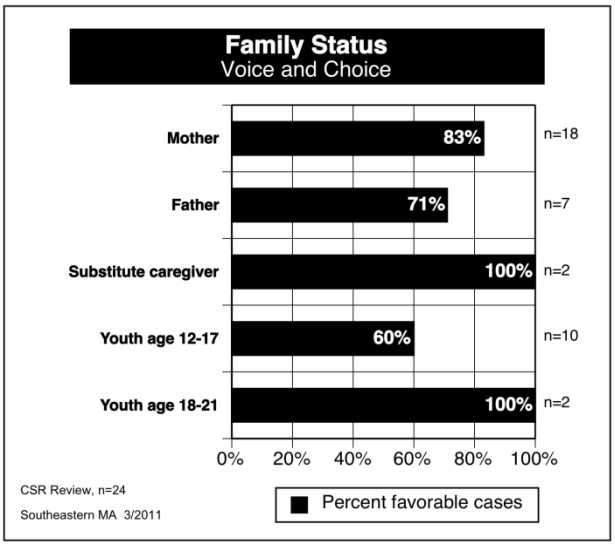
Parent/Caregiver Challenges

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

In the sample, for the 20 youth the indicator for Mother applied to, 50% or 10 mothers had favorable status in terms of the level challenge they were experiencing. Fifteen 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 (15%) were found to be experiencing major life challenges with inadequate or missing supports.

For the eight youth where the fathers were present, 63% or 5 of them had a favorable level of challenge. Five were experiencing levels of challenge that could benefit from "improvement" or "refinement," ranging from minor limitations with adequate supports to overwhelming life challenges with significant and worsening disruptions.

The two substitute caregivers of youth in the sample were found to have favorable status (100%) in their level of life challenges, with few to minor limiting conditions. One caregiver was seen to need "refinement" in lessening their level of challenge.



Family Voice and Choice

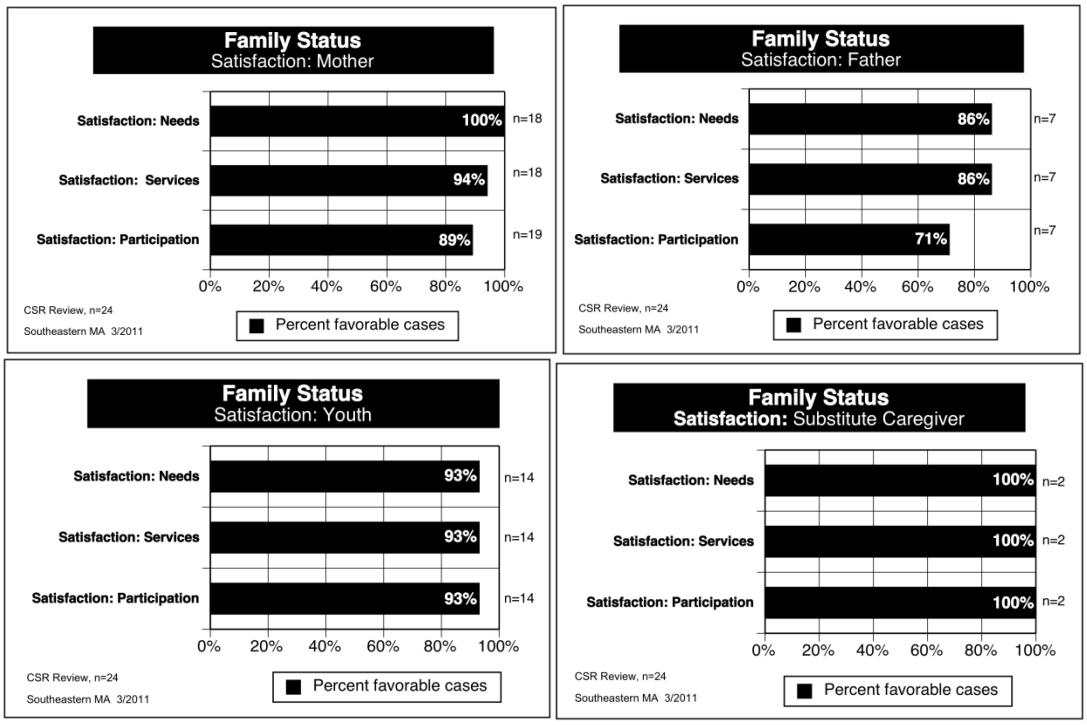
Family Voice and Choice is rated across a range of people as seen in the Caregiver Status: Family Voice and Choice chart above. For this indicator, in addition to parents/caregivers, the voice and choice of the youth is rated for youth who are over age 12. The variables that are considered when rating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

For the youth reviewed where their mother was their caregiver (N=18), 83% or 15 mothers had favorable voice and choice in their child's assessments, planning and service delivery processes. Nine mothers (50%) had substantially good to optimal voice and choice. The other half of the mothers (9 or 50%) where there could be some refinement in strengthening their voice and choice. One mother (6%) fell in the range of experiencing substantially inadequate family voice.

For youth whose fathers were involved and information could be gathered (N=7), 71% or 5 fathers had favorable voice and choice in involvement with their child's service processes indicating some room for strengthening of their voice and choice in planning and service delivery processes. Three of the fathers, or 43%, could benefit from "refinement" or "improvement" in the influence of their voice and choice in planning and service delivery. One father fell in the range of having no voice and has not participated in any aspects of planning or service delivery.

For the two youth with a substitute caregiver, both had a favorable situation in terms of their voice and choice in service processes. Both were in the optimal level and had experienced an ongoing positive pattern of inclusion of their voice and choice in service delivery processes.

There were ten youth in the 12-17 age range in the sample. Of these only 60% or six youth had a favorable experience in having a voice and choice in their own services, with "refinement" indicated for nine or 90% of youth who fell in this age range. There were two youth age 18 and older, both with substantially good inclusion of their voice and choice in planning and service delivery, or 100% favorable.



Satisfaction with Services and Results

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

The charts above display the results for how satisfied each of the role groups were with having their needs understood, services and results, and participation. Mothers' satisfaction was applicable for 18-19 families, with fairly high satisfaction (89-100%) across the domains measured. For the seven fathers that satisfaction was measured for, six (86%) were satisfied in having their child's needs addressed and with the service their child was receiving and less satisfied (71%) with their ability to participate in services. The fourteen youth for which satisfaction was measured were generally satisfied with the aspects of services examined (93% satisfied). Satisfaction was measured for the two substitute caregivers, who were optimally satisfied across all sub-indicators.

Summary: Caregiver/Family Status

Mothers and fathers in the Southeastern Massachusetts CSR were found to be experiencing considerable challenges in their lives, which for a number impacted their ability to provide the level of support their child required. Substitute caregivers had far fewer challenges and were providing favorable levels of support. Family voice and choice was stronger for substitute caregivers than mothers, and fathers had a less than adequate voice and choice in service processes. Mothers, fathers, youth, and substitute caregivers expressed satisfaction with the services; fathers were far less satisfied with their level of participation in planning and service processes.

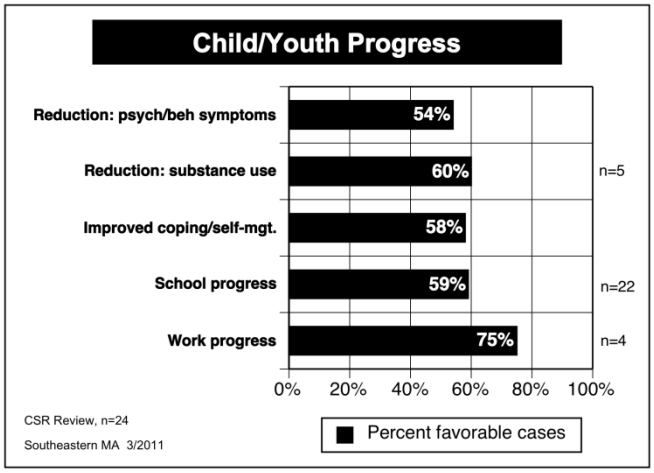
Youth Progress

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

Determinations about a youth's progress serve as a context for understanding how much of an impact services and supports are having on a youth's forward movement in key areas of her/his life. Progress is measured at a level commensurate with the youth's age and abilities.

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

Overall Youth Progress Patterns



Reduction of Psychiatric Symptoms and/or Substance Use

This set of indicators measure the degrees to which target symptoms, problem behaviors and/or substance use patterns causing impairment have been reduced. Change in this area is reviewed over the past six months or since the beginning of treatment if it has been less than six months. For the 24 youth reviewed, only 54% of them had made favorable progress in reducing symptomatology and/or problem behaviors over the last six months, indicating a need for teams to look at ways to better impact progress in this domain for youth. Five youth, or 21% of the sample had made good to optimal progress. The remaining 19 or 79% of the youth could benefit from "refinement" or "improvement" in reduction in the psychiatric symptoms. Six youth or 25% had made marginal progress which was limited and inconsistent, and five youth (21%) had made no progress with symptoms/behaviors at moderate to severe levels and increasing risk.

There were five youth with substance abuse issues, with 60% making favorable progress. Four of the five could benefit from "refinement" or "improvement" in the rate of progress; one was making marginal progress, and one was making no progress in reducing substance use patterns.

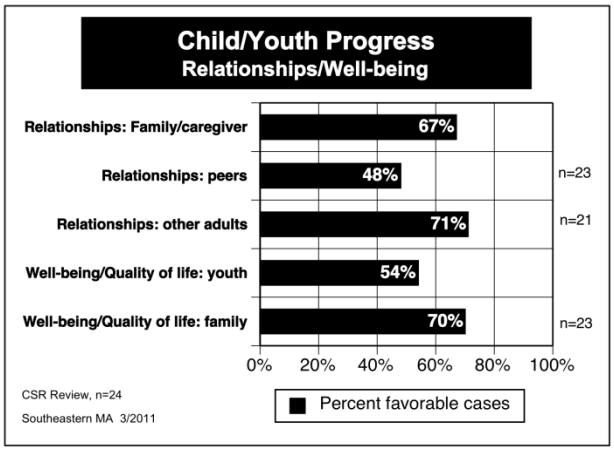
Improved Coping and Self-Management

This indicator looks at the degree to which the youth has made progress in building appropriate coping skills that help her/him to manage symptoms/behaviors including preventing substance abuse relapse, gaining functional behaviors and improving self-management. Among the youth reviewed, only 14 or 58% had made favorable progress in improving their coping skills and ability to self-manage their emotions and behaviors. Four youth made (17%) had made "good" progress in improving their ability to cope and manage their own behaviors; the remaining 20 youth (83%) could benefit from "refinement" or "improvement." Four youth (17%) were making poor progress in advancing coping and self-management at levels well-below expectations. These data indicate considerable room for improvement in helping teams to assure youth make progress in improving their coping/self-management skills.

School or Work Progress

Being able to succeed in the school or work setting for youth with SED is often dependent on their ability to make progress academically and behaviorally during the school/work day. This indicator looks at the degree of progress the youth is making consistent with age and ability in her/his assigned academic, vocational curriculum or work situation. Of the 22 youth for which school progress was applicable, only 13 or 59% were making favorable progress. Four youth or 18% were making good to optimal progress in school; the remaining 18 (82%) could benefit from a level of "refinement" or "improvement" in their school progress. Four youth (18%) were making no progress, and one was regressing. These results indicate more concerted attention by teams in planning and implementing strategies for school success are needed to help youth progress in school.

Progress in a work setting applied to four youth and three or 75% were making favorable progress in satisfying expectations necessary for maintaining employment.



Progress Toward Meaningful Relationships

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

maintaining relationships is a need for a youth, care plans should identify strategies for engaging youth in goal-directed relationship-building.

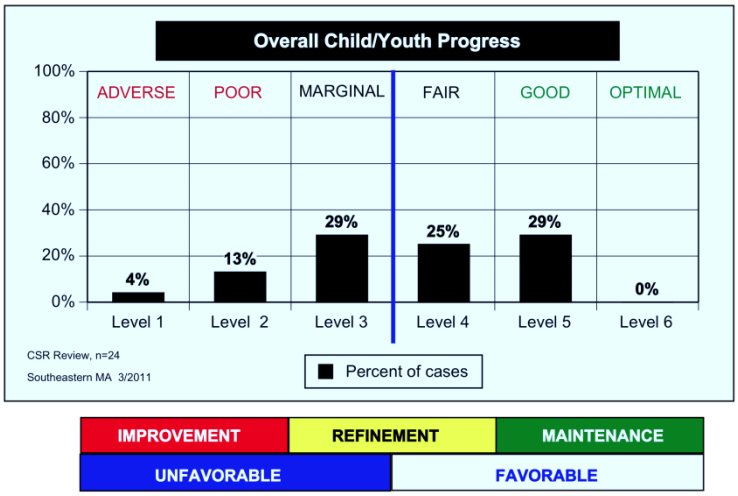
For the 24 youth reviewed, only 16 or 67% of them were making progress in their relationships with their families or caregivers, indicating an area for more focus by teams. Progress in building peer relationships was even less favorable, with only 11 of the 23 youth (48%) the sub-indicator was applicable to making progress in building meaningful relationships with peers. Progress in developing relationships with positive supportive adults (teachers, coaches, etc.) was slightly more favorable, but still a concern with only 71%, or 15 of the 21 youth of the youth for which the sub-indicator applied. Overall, making progress in building relationships was an area that needed improvement because of the number of youth that were determined to be making little to no progress or regressing.

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, only 54% or 13 youth were making favorable progress in an improved overall well-being and quality of life. Seven youth, or 30% had made good progress over the last six months in developing and using personal strengths, long-term relationships, life skills, and future plans. The bulk of the youth, seventy percent (70%) or 17 youth, could benefit from "refinement" or "improvement" in this area, indicating that teams and services may need additional supports to help more youth make progress in improving their overall well-being. Of the sample, eight youth (33%) had made poor progress in their overall quality of life and had developed few to no long-term supportive relationships, life skills for problem solving, educational/work opportunities, or meaningful and achievable future plans. One youth (4%) had made no progress in these areas.

For the families and caregivers, 70% were making favorable progress in improving the overall quality of life, a better level of progress than youth, but still concerning for a fairly large proportion of families reviewed.



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 54% of the youth reviewed were making favorable progress (Fair, Good or Optimal Progress), which indicates a need to work on improving progress for youth. Among the youth reviewed, 17% were determined to need improvement, and 54% 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 29% were making progress at a level that should be maintained and sustained.

System/Practice Functions

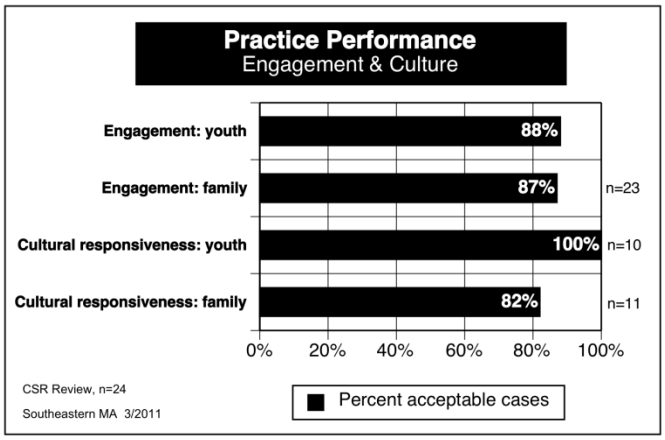
(System/Practice functions are measured as pattern of performance over the past 90 days)

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

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

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

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

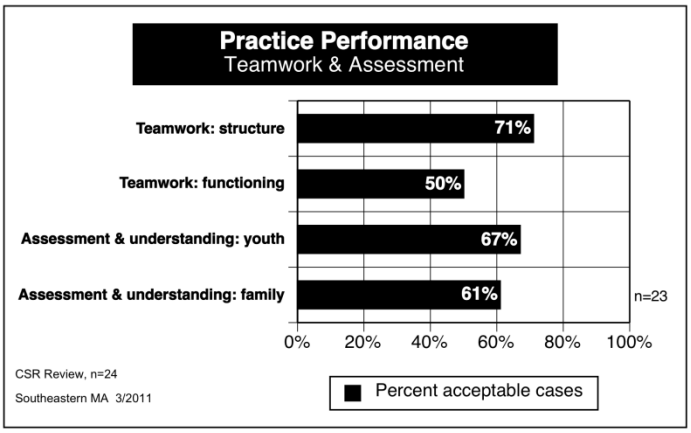
For the youth reviewed, 21 or 88% experienced an acceptable level of engagement. Families were also engaged at an acceptable level 87% of the time. Eleven youth (46%) and seven families (30%) in the sample may have benefitted from a strengthened level of engagement (Refine or Improve).

An example of Family Engagement that was successful was, "Overall the care planning team has done a solid job of engaging father and encouraging his participation. The family partner has shown patience and creativity in forming a relationship with the father and helping him focus on what he will need to get (the youth) the help that (s/he) needs."

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 10 youth reviewed for which the indicator applied, Cultural Responsiveness was acceptable for all of them (100%), and exceptional finding. For the 11 families the indicator was applicable for, it was acceptable for 9 or 82%. Cultural Responsiveness was found to be marginally inadequate two of the families reviewed (18%), and could benefit from "refinement."



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 Southeastern Massachusetts, team formation was acceptable 71% of the time or for 17 youth, indicating improvement is needed in order for families to be able to consistently depend on teams of the right composition being formed. For 9 youth, or 37% of the sample, team formation was found to be good to optimal. Fifteen of the teams (63%) needed "refinement" or "improvement" in formation through identifying the important team members, and engaging them in meeting, communicating and planning together. For two youth or 8% of the sample, team formation was considered to be poor meaning their teams met infrequently, did not include all the "right people" and did not have the skills or family knowledge necessary to organize effective services.

Team Functioning. Teams were functioning acceptably well for only half of the youth reviewed (13 or 50%). In 29% of the reviews, or for 7 youth, teams functioned at a good to optimal level and had the skills, family knowledge and abilities necessary to work in a unified manner and organize effective services and supports for the youth and families. Seventeen of the

teams (71%) needed some level of refinement or improvement to assure adequate team functioning. 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.

An example of good team formation and functioning for a youth with a very complex history is, "The Care planning team and the care being given to this (youth) is very good. The team is well functioning in all the key ways, coordinated, a common understanding of the youth, the right people are fully engaged in the team (including the OP therapist), each team member understands their role in the support of this youth. All team members communicate openly, frequently, under good leadership by the ICC. The (caregiver) is engaged and using the team, feels satisfied and empowered. She advocates for (the youth) and uses the team's ideas and contributes to the team's knowledge. Every team member demonstrates their commitment to this youth. The team is aware and involved in the visits, and is demonstrating appropriate concern and input for a planful and thoughtful process that considers (the youth and the youth's) needs, strengths and vulnerabilities."

An example where team functioning needing improvement is, "When the status of this family changed from ICC to IHT the formal team meetings stopped occurring. While there are subsets of providers who have found ways to communicate regularly with each other this family requires better coordination if a plan is to develop to ensure this child can remain safely in her home. An example, all interviewed thought the Individual Therapist was to monitor the effectiveness of the medications, but she did not have any information of what the MD had prescribed or why. Several members of the team …have lost enthusiasm for working with the family and are leaving now or very soon."

Another example illustrates a need for improved and more cohesive team functioning: "The members of the team from the same agency communicated as a team. The team members outside the agency were not as informed or part of the decision making. The natural supports were not clear on the goals for the family and they were not clear on the function of the ICC team. Initially, the school was grateful to be part of the team but they soon felt they were viewed as resistant rather than part of the solution. They felt the care plan goals regarding the school were negative and adversarial toward the school. The communication between the school and the ICC was also difficult. The communication would often occur through email, a voice mail or a letter requesting them to be at a care plan meeting, requesting them to provide information on the client or requesting them to provide transportation for the client. The school wanted to be part of the care plan meetings and was willing to host them, but they do not have the two hours of time allotted for the meetings to focus on one student. The school also felt that the goals were set with the presumption that the school did not try these recommendations…Communication is an important part of the team and the school team was not aware that the client was placed on medication. The teacher discovered that (the youth) started medication after she asked (the youth), since she had noticed such a drastic change in …study habits. The school personnel are in support of the CBHI services and have waited many years to receive the additional professional support in the community. However, at this point they feel that being part of the team is more work than trying to achieve the goals on their own."

Teams forming and functioning well for youth and families is a foundational system function. With only 71% of teams being adequately formed and only half of teams functioning acceptably well, clear improvements are needed in order to assure teams in

Southeastern Massachusetts can work together to achieving common goals, communicate regularly, evaluate results, and work in alignment with system of care principles.

Assessment and Understanding

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

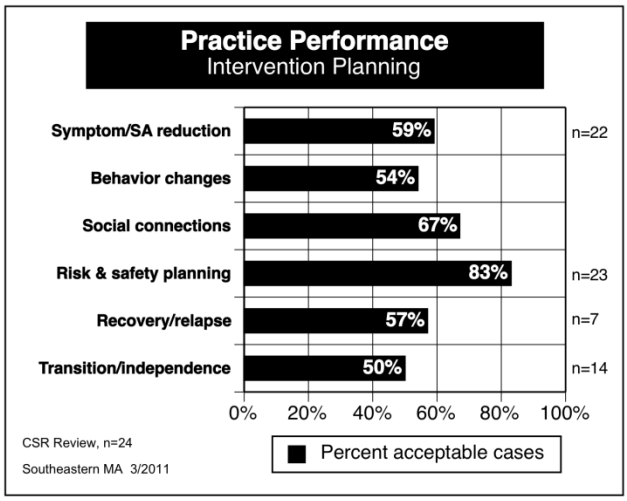
Of the 24 youth reviewed, only 16 or 67% of youth were found to have an acceptable level of assessment and understanding of their core issues and situations. There were 9 youth (38%) where teams had a good to optimal assessment and understanding. Fifteen or 63% of the youth would benefit from "refinement" or "improvement" in the teams' understanding of them. There were three youth (13%) where teams had poor, incomplete or inconsistent assessment and understanding.

Assessment and understanding of families was acceptable for only 61% of the sample. "Refinement" or "Improvement" was found to be needed for 12 families or half (50%) of the sample.

Good assessment and understanding practices by a well-functioning team was described by one reviewer as, "The plan is informed by a comprehensive assessment and diagnosis, and goals and objectives are clearly tied to assessed needs."

An example of assessment and understanding where the team was operating with a disjointed picture of what was needed was, "There is a confusing array of mental health assessments in the chart which have not been brought together into one comprehensive assessment that integrates current status into the documentation. While current treatment appears to be working well, team members had various understandings of (the youth's) academic ability, diagnosis, and medication."

Another example describes, "This is a period of fragile awareness of the seriousness of (the youth's issue). The team needs to reconvene and develop a well-integrated approach to the treatment and support of (the youth and family)…There is no clear path at this time, and thus an existing fragmented team will need to pull together and also react and intersect with evolving decisions by (another agency)."



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 22 youth the *Symptom or Substance Abuse Reduction* sub-indicator was applicable for, planning for reducing presenting psychiatric symptoms or substance abuse was acceptable for only 59% or 13 of them. Refinement or improvement in planning in this area was needed for 14 or 64% of the youth. There was good or optimal planning in reducing symptoms or substance abuse for 9 or 41% of youth in the sample, hallmarked by well-reasoned strategies informed by an understanding of needs, and the youth and families' preferences and perspectives. For 3 youth (14%), planning in this area was poorly reasoned, inadequate in addressing core issues, and lacked clarity/urgency.

Targeting *Behavior Changes* in planning was applicable to all of the youth in the sample, and was at an acceptable level for only 54% of them. Refinement/improvement was found to be needed 58% of the time. Ten youth or 42% of youth had good to optimal plans that reflected understanding of the youth and family, and had clear interventions for addressing behaviors that created problems for the youth. For two youth (8%) intervention planning to address behaviors was poorly reasoned and inadequate, failing to design interventions to address needed behavioral change.

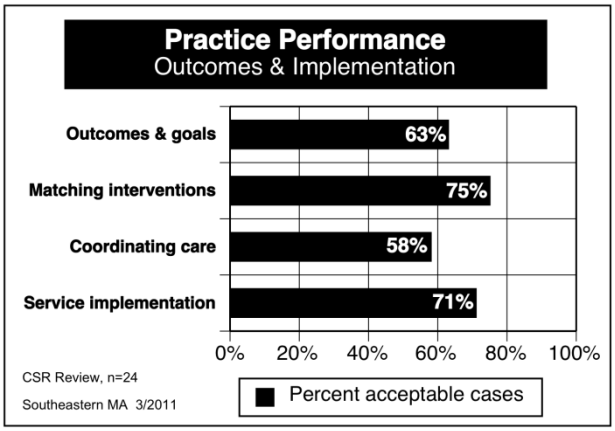
Planning for increasing *Social Connections* was applicable for all 24 youth in the CSR sample and acceptable for 67% of them. Six youth (25%) had good to optimal strategies in their plans for improving their social connections reflecting well-reasoned and ongoing planning processes. Refinement/improvement was needed in plans for the remaining 18 or 75% of youth who needed their social connections to be strengthened in order to do better

emotionally or behaviorally. Of these, two youth (8%) had poor planning that reflected unaligned strategies lacking in clarity and urgency to address the youths' need for social connections.

Risk/Safety planning was applicable to 23 of the 24 youth in the CSR sample. Planning was acceptable for 36 or 80% of the youth. The risk/safety component of plans was good to optimal for 19 or 83%, which is a fair finding. Thirteen or 57% of youth had good to optimal risk/safety plans. Youth would benefit from refined/improved planning in the other 43% of the cases for which risk/safety issues were present. For one youth (4%), risk/safety planning was poor, and should be reviewed by the team to assure crises are managed.

Seven youth in the sample needed *Recovery or Relapse* addressed in planning. Planning to address the recovery process and prevention of relapse was acceptable for only four of them (57%), a clear area that needs more work by teams. Two youth had good to optimal planning in addressing substance abuse recovery/relapse issues. Three youth (43%), intervention planning to address recovery/relapse marginally reasoned, somewhat inadequate, and could benefit from refinement efforts.

Among youth in the CSR sample, 14 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 14 youth experiencing transitions planning was acceptable for half of them (50%) indicating improvement is needed in identifying and planning for effective transitions. While 5 youth (36%) had transition planning at a good to optimal level, 64% of the sample could benefit from refinement or improvement in planning. Two youth (14%) had transition planning that was poor and inadequate to support the youth through a transition.



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 only 63% of the youth. Forty-two (42%) of the youth had good to optimal goals that were well-reasoned and were specific. Fifty-eight (58%) of them had ending goals and outcomes that needed to be "refined" or "improved." Among these were three youth or 13% of the sample had poor to absent specification of outcomes and goals, insufficient for guiding intervention and change.

Matching Interventions to Needs

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

For the youth reviewed, there was an acceptable level of matching intervention to need for 71% (17 youth) indicating room for improvement in these practices. Ten youth (42%) had good to optimal matching; the remaining 14 (58%) teams could "refine" or "improve" the identification and assembly of services and supports that better "fits" the youth and families' situations and needs. One youth (4%) had poorly matched interventions, resulting in inadequate assembly of service and supports.

Coordinating Care

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

Youth in the sample received care coordination services from both ICC (N=16) and IHT therapists (N=8). Care coordination practices were found to be at an acceptable level for only 58% of the youth reviewed. Care coordination was found to be "good" or "optimal" for 38% of the youth reviewed. For the other 62%, care coordination needed "refinement"

and was found to be at fair, marginal, or poor levels. Two youth (8%) were found to have poor and fragmented care coordination.

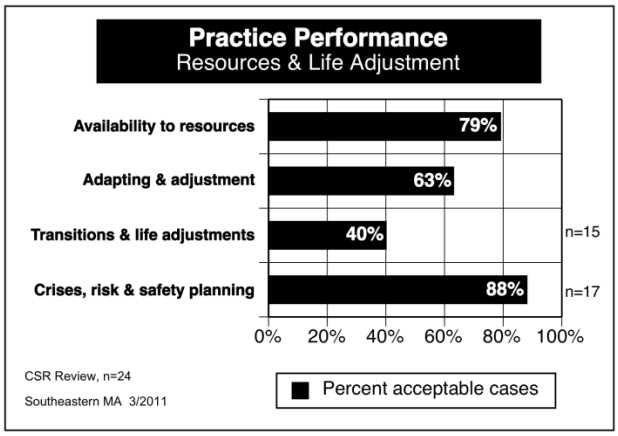
Good care coordination practices were observed where a reviewer describes that, "The team is cohesive, well- coordinated, and meets regularly and as needed to modify and/or support the plan. Although not all members attend all meetings, there is consistently good communication among team members (except for the psychiatrist) to support a cohesive plan."

An example of coordinating care that needed improvement is, "There has not been a coordinated functioning team working with this family. Services have been fragmented and there is little evidence of planning and implementing needed services and supports and evaluating results. ICC is phasing out for this family and a new outpatient therapist has been recently been assigned for (the youth). Services have not been well coordinated and seem to have been operationalized in a piecemeal fashion. There was a waiting list for in home behavioral services and a considerable delay in the therapeutic mentor's engagement has led to fragmented service delivery." In this case, it is clear to see how care coordination is linked to team fully understanding the youth and family, team functioning, and service implementation.

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, 71% of them had acceptable service implementation, indicating improvement is needed to achieve consistently implemented services. Forty-two percent (42%) had good to optimal service implementation, while 58% needed implementation to be "refined" or "improved." Two youth (8%) had poor service implementation, meaning services and supports identified in the care plan were not adequately implemented.



Availability and Access to Resources

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

In the CSR, 79% of youth had acceptable access to available resources, which is a fair finding. There was a good and substantial array of supports and services for half of the sample (50%) of the, and room for refinement or improvement for the other 50%. One youth (4%) experienced absent or adverse service implementation.

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 only 63% of the youth. Half (50%) had good to optimal practices. The other half were found to need some level of "refinement" or "improvement." There were three youth (13%) with poor and fragmented adapting and adjustment of services and interventions.

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.

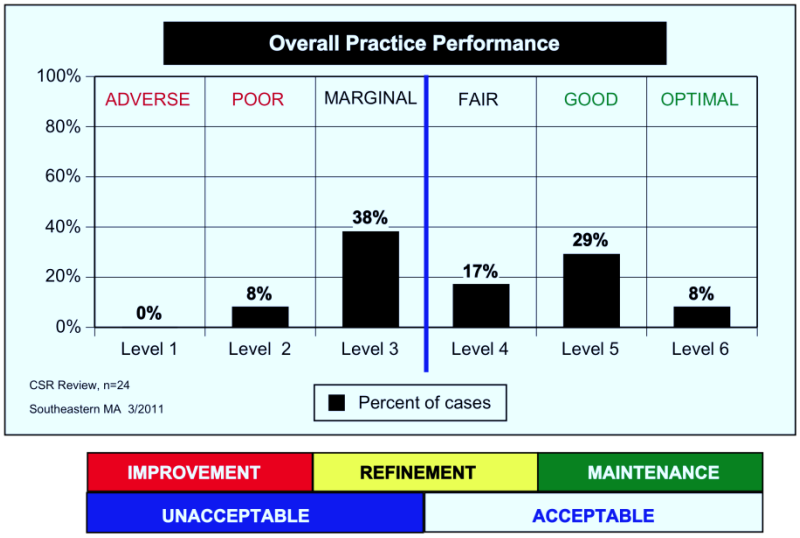
For the fifteen youth this indicator applied to, only 40% or six youth had acceptable transition management practices in place. Four youth (27%) experienced good to optimal transition interventions. Eight youth (73%) could benefit from "refined" or "improved" transition supports, including three youth (20%) who experienced a poor transition with unaddressed transition issues, and no transition plan for an imminent change. Overall,

practices to improve the ability of teams to identify, plan for and implement supports for youth in their life transitions needs considerable improvement. Strategies such as focused training, supervision and quality management are warranted to improve transition and life adjustment management.

Responding to Crises and Risk/Safety Planning

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

For youth where this indicator was applicable (N=17), 88% or 15 youth had an acceptable crisis response and risk plan that worked acceptably well for them, which are strong findings. Nine youth (53%) were rated to have experienced a good to optimal response to crises and/or safety issues. The remaining eight youth (47%) needed "refinement" in crisis response and risk/safety planning, and no youth were found to have poor or adverse planning. Crisis planning and response is a clear strength for youth in Southeastern Massachusetts.



Overall System/Practice Performance

The chart above shows the distribution of scores for System/Practice Performance across the six point rating scale. For the youth reviewed, when rounded, 55% were found to have acceptable system/practice performance. The largest percentage of youth fell in the marginal performance level (38%). Performance scores clustered at the good, fair and marginal levels with 84% of youth reviewed falling in this range. When interpreting results for system/practice performance, it is important to see them in the light of overall practice patterns and how youth are doing and progressing. Youth and families come into services with the expectation that they can depend on services that will help them. In other words, the expectation is that the system and practices should be performing acceptably well for most of the youth and families services.

Thirty-seven percent (37%) of the youth reviewed fell in the "Maintenance" area, meaning the system and practices were effective for them, and efforts should focus on sustaining and building upon a positive practice situation.

Fifty-five percent (55%) of youth reviewed fell in the "Refinement" area which means that performance was limited or marginal, and further efforts are necessary to refine the practice situation. Practice patterns in these situations require refinement in order to impact better youth engagement, teamwork, understanding, planning, matching interventions to needs, coordinating, implementation/adjustment of services and crisis responses as described in this section.

Eight percent (8%) of youth fell in the "Improvement" area meaning performance was inadequate, in this case practices were fragmented, inconsistent and lacking in intensity. Immediate action is recommended to improve practices for youth falling in this category.

The data indicate that the strongest areas of practice for the sample as a whole were Engagement with the Youth and Family; Cultural Responsiveness to Youth; and Responding to Crises and Risk & Safety Planning

Indicators that showed an overall fair performance but at a less consistent or robust level of implementation for the sample as a whole were Cultural Responsiveness to Families;

Planning Interventions for Risk and Safety Planning and Availability and Access to Resources.

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

Review results indicate weak performance was found in the following system/practice domains: Teamwork (Functioning); Assessment & Understanding of Youth and Family; Planning Interventions for Symptom or Substance Reduction; Planning Interventions for Behavior Changes; Planning Interventions for Social Connections Planning Interventions for Recovery or Relapse; Planning Interventions for Transitions; Outcomes and Goals; Coordinating Care; Adapting and Adjustment and Transitions & Life Adjustments.

Overall, the findings of the CSR showed that for Southeastern Massachusetts services, key foundational system of care practice such as engagement of youth and families and cultural responsiveness to youth were strong. Notable were the systems for responding to youth in crisis, which were shown to work for most of the youth who experienced them. As well, the system of care was assuring consistent cultural responsiveness to youth, and adequate planning for managing risk/safety issues for the majority of youth. Needed resources were available for most youth.

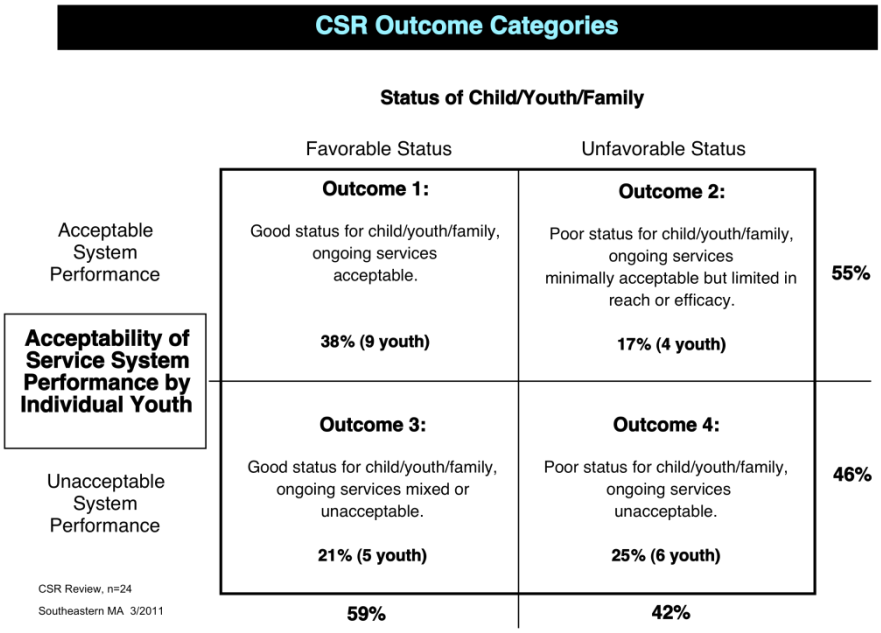
A number of other system practices needed improvement to assure all system practices are dependable, consistent and reliable. Teams for nearly 30% of the youth needed to improve their ability to be formed with the right people that can bring together the collective skills and knowledge necessary to address youth and family needs. For about a quarter of the youth, teams needed to more consistently select the most effective strategies and assemble them into a coherent mix that can address individual youth and family goals. As well, closer tracking to assure intervention strategies are implemented with sufficient intensity and consistency were needed.

Many core system practices reviewed in the Southeastern Massachusetts CSR were not at a level of practice that could dependably help youth make progress in achieving their goals. While there were examples of strong work, practice was inconsistent across teams. Teams not only needed to improve their ability to be formed more reliably, for half the 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. For some, this process was occurring independently of the family or in isolation of other team members resulting in limited benefit to the youth and family. A fundamental challenge was the need for better gathering of information including existing assessments, and using this information to increase team-based understanding of youth's and families' strengths and needs at a scope and depth necessary to develop the right set of interventions and supports.

Likely as a result of weak team formation/functioning and diffuse understanding of youth and family issues, care plans tended to be inadequate in their ability to design interventions and supports that could address core issues for more youth. The exception was the risk and safety component of plans which was adequate for 83% of the youth. However, the remaining planning processes reviewed did not adequately address needs such as reducing symptoms/behaviors or substance use, increasing social connection, recovery/relapse supports, or strategies for managing transitions. Transitions were marginally to poorly managed for 60% of the youth. Planning did not consistently identify outcomes and goals

for interventions, and plans were not adjusted when needed at a level that youth and families could depend on the practice to occur. For over 40% of youth, care coordination needed stronger leadership for service delivery and results and assurances of cohesive, timely, and effective delivery of services.

These findings suggest that in a number of foundational system of care practices in the Southeastern Massachusetts region need improvement in order to achieve dependable, functional teams and well-coordinated care. Strategies that can help assure teams are working in concert to consistently understand the strengths and needs of the youth and family, establish agreed upon goals, and identify, implement and track strategies that work need to be developed. As will be discussed in the next section, only 55% of the youth were found to have overall acceptable system practices, suggesting a level of focused, strategic, and sustained improvements in practice will likely be needed to improve system performance.



CSR Outcome Categories Defined

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

CSR Results

Outcome 1

As the display indicates, 38% (9 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 family has been involved for 16 months with the (agency), and the combined efforts of the team over that time have produced strong outcomes for (the youth and caregiver) with excellent planning for (youth's) transition to adulthood. (The) family is fully engaged. (The youth's) school supports are very strong, and everyone is working toward the same goals with agreed upon interventions and supports. The ICC is beginning to transition out of the picture, with planning for (the other providers) to continue. (The caregiver) will continue to take an active role in coordinating services. A referral is being made for (other) services in the event that (the youth's) status declines in future.*

Outcome 2

Four youth or 17% of the sample fell in Outcome 2. This category represents children whose needs are so great or complex that despite the best practice efforts and diligent system performance of the service system, the overall status of the child or youth is still unacceptable.

An example of a youth who fell in Outcome 2 is as follows.

> *"This team works at a very high level of functioning in almost every way. (The youth) is as fully engaged with the team members as possible for his age and level of functioning. (The youth_ reports liking (the) Mentor and therapist especially. The team has included every stakeholder in (the youth's) life…The team communicates fully with each other, keeps the Mobile Crisis team alerted to potential crises, and shares the same concerns and goals. The whole team is working to maintain (the youth) in (the) school through June and to keep some contact with (current providers). Several members of the team have stepped up on non-work hours to facilitate meetings … The team shares a common vision for (the youth's) future and believes that the coming months in (placement) will be the safest place for him to tackle past trauma in the hopes that (the youth) can emerge with enough stability to be able to live in a family environment."*

Outcome 3

Thirteen percent (21%) or 5 youth were in outcome category 3. Outcome 3 reflects youth whose status was favorable at the time of the review, but who were receiving less than acceptable service system performance. Some children are resilient and may have excellent naturally occurring supports provided by family, friends, school personnel, or some other key person in their life whose efforts are significantly contributing to the child's favorable status at the present time. However, current service system/practice performance is limited, inconsistent, or inadequate at this time. For these children, when teams and interveners adequately form, understand the youth and family, and function well, the youth could likely progress into the outcome 1 category.

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

> *"Not all team members are present or fully participating in the treatment team.…There are multiple diagnoses for (the youth), with several team members having differing diagnoses and other team members, such as school, reporting an absence of symptoms and behaviors. There is an unclear and inconsistent understanding of (the youth)…as well as a surface understanding of what skills the mother needs to acquire in order to sustain progress long term and without (or with minimal) system supports. Plans and goals were primarily task oriented, such as exploring activities in the community. Plans and goals also lacked direction and specifics regarding ending points or description of achievement of goals, thus creating an unclear understanding of when this youth and family will no longer need services. The team also has not planned for the (youth's transition) to intermediate school, out of special education services, and has an under-developed plan for changes in services."*

Outcome 4

In the Southeastern Massachusetts CSR, 25% of the sample or 6 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.

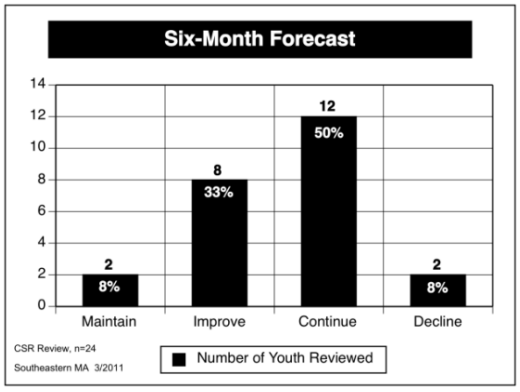
An example of a youth who fell in Outcome 4 is as follows. The youth is currently not doing well in school, and has risk factors present.

> *"The (ICC) process has been in place for 3 months, but there has been only one formal Wrap Team meeting. Mother acknowledged that part of the reason for this was due to missed or cancelled appointments by her, but the overall impression we had was of a process that may be a bit too 'leisurely' or lacking in some intensity given the current status of this (youth). The school, for example, seemed only now beginning to be aware of the existence of a team process, and had not yet attended any meetings. In addition, they were a bit confused as to the roles of the ICC, Family Partner, IHT clinician, and the IHT TT&S workers. Overall, the Team had the feel of a parallel process, where the IHT team had their plan and goals, and the CSA had their plan and goals. While it was clear that the two teams were complementary in their efforts, it did not seem truly integrated.*
>
> *It is interesting to note that during the Care Coordinator interview, the Care Coordinator indicated that her impulse or instinct was to work more intensively with this family, but felt that the "model" needed to followed (referring to the general guideline that the Team should only start with one or two goals in the wraparound process). When asked what she would add to the plan if it were "up to her", she described goals that, in this reviewer's opinion, would have been very welcome additions to the Care Plan and would have improved it considerably."*

Overall outcome findings

The percentages on the outside of the two-fold table on Page 55 represent the total percentages in each category. The percentage at outside, top right (55%) is the total percentage of youth with acceptable system/practice performance (sum of Outcomes 1 and 2). The percentage below this (46%) is the inverse- the percentage of youth with unacceptable system/practice performance. Again, these numbers reflect rounding and the total is slightly more that 100%. Likewise the number on the outside lower left is the percentage of youth that has favorable status (59%) and under the next block the percentage of youth with unfavorable status (42%).

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 is that the youth would maintain their current high status. For 8 youth or 33% of the sample, the prediction was for improvement in status. For 12 youth or 50%, the reviewers predicted the youth's status to remain the same, which could be favorable or unfavorable. For 2 youth or 8%, 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 phases. Eligible youth are also required to be provided timely access to necessary services through effective screening, assessment, coordination, treatment planning, pathways to care and mobile crisis intervention when needed. In addition, services and practices need to support youth and families to participate in teams, have teams with the involved people that work together to solve problems, and understand the changing needs and strengths of youth and families across settings. As well, it requires well-executed care coordination that results in care consistent with the CASSP principles; and is strength-based, individualized, child-centered, family-focused, community-based, multi-system and culturally competent. The Remedy requires individualized care plan to be updated as needed, addressing transition and discharge planning specific to child needs.

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

Strengths

Engagement was meaningful to families and family satisfaction was strong.

There were many examples of effective family engagement and strong cultural competency practices. Reviewers noted good support for families in need of cultural supports and interpretive services. Staff seemed especially enthusiastic and committed to implementing these components of the practice model. Families clearly appreciated being engaged in teams, and liked the services they were receiving.

Staff are increasingly making a shift from a more expert-driven, top down process to one that genuinely works collaboratively with families. This represents a large shift in practice and provides the foundation upon which practices can continue to build. CBHI providers are developing common family-centered values which are reflected in their work.

There were examples of exemplary work.

As well as evidence of strong engagement, the review team observed Care Coordinators bringing in natural supports to team meetings. Also notable was an example of dynamic teaming that resulted in thoughtful trauma-informed fully-integrated services that were profoundly impacting youth progress. There were multiple observations of Family Partners and Therapeutic Mentors who were very skilled and using therapeutic approaches that were linked to Care Plans. An exceptional practice was seen in In-home Behavioral services by a Board Certified Behavior Analyst who developed an effective Functional Behavioral Assessment and behavioral plan.

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

A number of System of Care (SOC) Committees are providing opportunities for joint problem-solving and information-sharing, and at least one included youth on their committee. Some SOC Committees were observed to be well-developed, well-attended and

have clear objectives for system development. Others are less developed and would benefit from stronger leadership and more focus.

Crisis services were viewed as an asset in many situations

Mobile Crisis Intervention staff were noted to be joining with teams and staying involved with youth post-crisis, and connecting families with services. There were examples of the inclusion of a mobile crisis team in a Care Planning meeting to address risk and safety issues.

There is growing DCF involvement on teams.

DCF refers many youth to CBHI services, and DCF workers are developing a better understanding of how to refer. Many DCF social workers are working with teams, and are having an increased understanding of the wraparound process and philosophy. Earlier referrals and anticipation of support needs of foster and adoptive parents are areas to look at improving.

Challenges

A greater depth/scope of understanding of core issues of youth and families was needed.

Teams did not systematically gather and interpret information about the youth and families that could help them to better understand youth's functioning, behaviors and identification of unmet needs. As well, there were few current comprehensive psychosocial assessments available that offered a good understanding, formulation or information that would be valuable in developing plans. Absent these foundational practices, plans and interventions sometimes did not fully address the range of needs or the types of strategies and supports that youth and families needed to make changes. In a number of cases, there was a tendency for diagnostic acceptance without verification through an adequate assessment that could promote teams' understanding of youths' core issues and behaviors. There was lack of involvement from the ICC consulting psychiatrists to resolve diagnostic conflicts and provide input to care planning teams.

A number of youth experienced a planning and service implementation process that was weak and lacked timely implementation.

For a number of youth reviewed, the timeliness, effort, and diligence applied to planning and implementing interventions and supports did not fully address what the youth needed and/or respond at the level of urgency that the situation required. Often, the frequency and intensity of services was inadequate to change behaviors or treat core issues. Plans and interventions frequently lacked individualization and were not coordinated across settings such as home, school, and the community. True teaming that involved dynamic planning and tracking of effectiveness of strategies and results was less frequent than using team meetings to merely go over the plan, or give updates. Teams that were the most effective had grasped an appropriate sense of urgency about implementing interventions, were constantly working to understand and make adjustments to their strategies, and had moved from collaboration to true integration of services and supports.

Practice was variable, without consistent quality practice across teams.

Ideally, youth and families should be able to depend on services being delivered with quality and consistency across the service system. The findings of the CSR showed variability in

practice, and key service functions (teams assembling and functioning well, assessments gathered/completed and used by the team to inform care plans, plans that are well-reasoned and address core issues, clearly understood expected outcomes, interventions matched to needs, well-coordinated care, services implemented, adjustments made as necessary, and transitions addressed) not being performed at a level of practice that resulted in positive outcomes and progress for the youth.

It was not clear if there was consistent and sufficient depth of understanding of the practice model, developed skill set among staff, conditions for effective practice, or coordination in order to make the practice model work. For example, agencies did not uniformly have a developed supervision structure that supports the practice model. Outpatient therapists in general are not incentivized or are not familiar with the new practice model, and do not generally participate in teams. Weak integration and teaming was observed with schools and psychiatry. While it is clear that much of this work is developmental and practices need to be built over time, examination of how to improve practices and results are needed.

There are many youth who have clinical complexity, developmental disorders or transitional concerns with a lack of skills and knowledge in the system to address their needs.

Teams for youth with autism, developmental disorders or complex clinical issues often lacked knowledge about the unique needs and strategies that work for the population. For youth with specialized needs or multiple disabilities, teams often lacked the knowledge, capacity and resources to develop plans and services.

For young adults and youth experiencing transitions in their lives, there was a clear lack of awareness, skills or programming to address their needs. Only half of teams adequately addressed transitions in their planning, and only 40% of youth experienced transitions that were effectively managed. Particularly challenging for staff was coordinating transitions and promoting detailed planning when a youth was being transitioned back to communities, schools and families from residential programs. These issues are often compounded by the lack of residential resources in areas such as the Cape.

Stronger integration, engagement, and articulation are needed with key system partners.

In order for youth and families to achieve progress and positive results, stronger engagement on teams is needed with schools, substance abuse treatment, probation, adult mental health services and outpatient providers including psychiatrists.

Many youth that are at-risk of entering the juvenile justice system or are being seen at court clinics have not realized success in community-based services including those that have been in services repeatedly. Many of these youth have co-occurring mental health issues, learning disabilities, school performance issues, and/or a history of DCF involvement. Teams often do not understand or design interventions well when there is this level of complexity in the youth's situation.

In Home Therapy staff often lacked clarity about their role in coordinating care for youth not involved in ICC.
IHT would benefit from training and role-clarification around the care coordination expectations of the program, and to understand the definition of what it means to be a "hub" as an IHT provider. A number of youth reviewed in IHT needed much stronger coordination of care in order to benefit from services.

Families and staff are under the assumption that ICC/IHT has specific time limits.
Many staff and families are under the impression that both ICC and IHT are time-limited services. A number of families felt they were being moved to discharge when they had not seen improvements in their child's behaviors. There is emphasis in many teams on ending services at "12 months" with a waning family voice during the time when staff are attempting to move toward discharging a youth including when there may be a continued need for services.

Service authorization protocols, distance productivity/billing demands sometimes drive decision-making rather than the team process.
Aspects of the CBHI "business model" are seen as a barrier to providing care. Productivity requirements to produce "billable" units each week tend to interfere with the amount of additional training and coaching staff could be receiving to improve the overall level of practice. Agencies are experiencing threats to their sustainability and have had to reduce staff benefits, and are having difficulty offsetting training and supervision with revenue-generating activities.

At the service-implementation level, agencies report that MCEs will not approve the recommendation for service units at the beginning of care, only a standard number of units. The agency is then questioned when the units originally recommended are requested later. This process adds burden to administrative time, and has the potential to compromise needed services.

Being able to take all referrals regardless of distance is a challenge for many providers due the travel time costs absorbed by agencies.

Given 32% of care coordinators had over 13 youth on their caseload, in the context of the review findings, caseload sizes may be impacting care coordinators' ability to coordinate quality care planning meetings and other functions of their positions.

Recommendations

Assure teams gather and synthesize all available information about the youth and family in order to inform functional, well-formulated plans.

Assure care plans/treatment plans/interventions are individualized, clear, have achievable goals and are at the intensity and scope needed to address needs and achieve results.

Provide clarity and training to IHT providers about their role in coordinating care.

Explore ways to provide low-cost, high-impact supports including:

- Respite services for parents.
- Opportunities for families and youth to connect with each other and build a "sense of community"
- Informal interventions and supports

Provide coaching and support for supervisors so they are able to play a pivotal role in assuring the practice model is implemented at a consistently quality level. Particular areas of practice that might be strengthened though focused supervision include:

- Formation and functioning of teams: assuring teams are built of the right composition, and work together in a unified manner to produce results with the youth and family.
- Assessing and understanding youth and families at level adequate to build effective plans of care.
- Planning interventions and supports that are individualized, reflect family and youth voice and participation, are targeted to meet the needs of the youth and family, and plan for and manage transition.
- Assuring clear and attainable outcomes and goals.
- Effective care coordination
- Assuring services and supports are implemented in an effective and timely manner, and match the level of urgency needed.
- Adapting and adjusting plans and service implementation as needed to address changing circumstances or new information.

Clarify issues that are misunderstood by families and staff. Provide clear and ongoing information when there are questions about services for families and staff, including:

- User-friendly information about how to access CBHI services for families and other community members
- Information about insurance including:
    - How to apply for MassHealth and CommonHealth.
    - How to access printed information and letters in the language of the person. served, and ready access to translation services.
    - Who will help when there are barriers or questions about insurance.
- Provide a clear and well-communicated process for families to obtain assistance from MassHealth when they need help accessing services, or want to express concerns about quality of care or other issues.
- Clarify that outpatient consultation can be approved for payment for time needed to attend care planning meetings.
- The use of Family Partners with other Hubs.
- How services can continue after a youth turns 18.
- How services are based on what the youth needs, and any continuing needs (medical necessity) and do not have specific time-limits.

Work with all stakeholders to create opportunities for "cross-fertilization" and dissemination of best practices.

In the CSR, it was observed that many staff and families are implementing the CBHI practice model in a way that are helping youth to make progress and realize positive outcomes. These important resources in the Southeastern Massachusetts could be maximized by supporting discussions, training and coaching across agencies and sectors. Providers would benefit from receiving feedback that is results-oriented and would assist them in making data driven decisions.

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