2013 Report on Children and Youth

Served by the
District of Columbia
Department of Mental Health

June 2013

Presented to the District of Columbia Department of Mental Health

by
Human Systems and Outcomes, Inc.

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Executive Summary

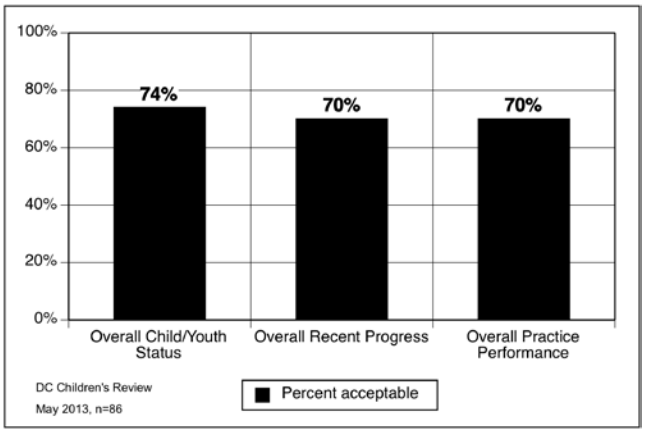
The Human Systems and Outcomes, Inc. review of 2013 services for a randomly selected sample of youth receiving services in the District of Columbia public mental health system was conducted using a qualitative review process: Community Services Review (CSR). The CSR is based heavily on the face-to-face interviewing of all service providers and persons involved with a child or youth receiving services. Those interviewed include the youth, parents/caregiver, and family members, as well as team members, such as a community support worker, therapist, psychiatrist, teachers and school personnel, probation officer, child welfare worker, group home workers, behavioral specialist, etc. There were 606 people interviewed as part of the CSR this year, with an average of seven interviews occurring per youth reviewed. Reviews were completed over a three-week period of time between May 6 and May 24, 2013, and included 86 youth receiving mental health services. After reviewing records and conducting interviews, reviewers then rated child status, progress, and the quality and consistency of system practice using a protocol with specific indicators in accordance with a 6-point rating scale. Simultaneous to the reviews, focus group and stakeholder interviews were conducted with persons involved with, providing, or impacted by services, such as core service agency (CSA) staff, Child and Family Services Administration (CFSA), and Department of Mental Health (DMH) leadership and staff.

Overall Summary of Findings

Overall, the findings (as shown in the graph below) from the 2013 review of 86 youth showed that 74% of them had favorable status, 70% were making adequate progress, and 70% were receiving at least minimally acceptable services. Sixty-one percent (52 youth) had acceptable status and acceptable services. These are good results that meet the requirements of the

Settlement Agreement; however, there continues to be variability in the consistency and quality of services provided among the CSAs.

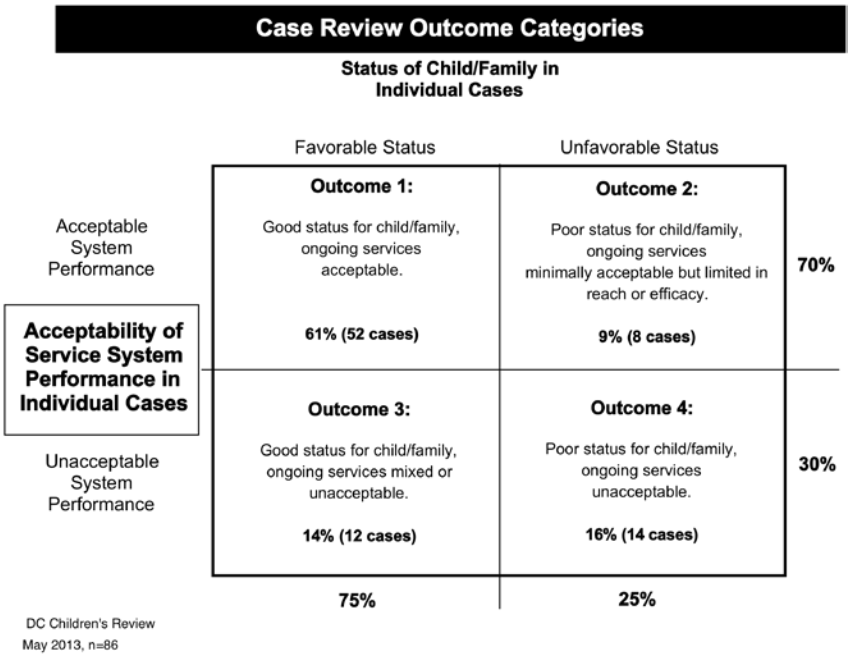
2013 Overall Review Results



It should be noted that these findings are constrained by the review sample composed of youth and families who are currently receiving services and who are willing to consent to participation in the review.

The overall results of this review were sorted into one of four categories based on the overall score for child status and practice performance (see the following graph). The youth can be classified and assigned to one of four categories that summarize the review outcomes. For the 2013 review, 61% of the 86 youth reviewed had an acceptable child status rating and an acceptable practice performance rating, placing them in outcome category 1. This is a 5% increase in outcome 1 from the 2012 review. There were eight youth (9%) in outcome category 2, consistent with the 2012 review data. This category represents children whose needs are so great or complex that despite the diligent practice performance of the service system, the overall status of the child or youth is still unacceptable. Fourteen percent or 12 children and youth were in outcome category 3, also consistent with 15% in 2012. Outcome 3 contains those review sample members whose status was acceptable at the time of the review, but reviewers could not see evidence that the system was performing consistently and current practice performance is limited, inconsistent, or inadequate at this time. Fourteen youth or 16% of the review sample were in outcome category 4, which is the least favorable combination as the child's status is

unfavorable and practice performance is inadequate. There were 4% less youth in this category than in the 2012 review.



Strengths and Conclusions

The review process this year continued to show improvement at the system level and identified many strengths in the District's system for children's mental health services. These include the following:

- Youth are doing well and making progress, with 74% having acceptable status and 70% showing at least a minimally acceptable pattern of progress. The overall system performance rating for acceptable practice is 70%, an increase of 5% from 2012 (65% overall acceptable practice) and an increase of 11% from 2011 (59%).
- The development and functioning of teams has improved significantly, compared to 2012. Team functioning improved with a 15% increase in acceptable practice in this area (from 43% in 2012 to 58% acceptable in 2013) and a 13% increase in youth in the maintenance zone with a score of 5-good or 6-optimal.

- Functional assessment showed the largest increase during the 2013 review of 28%, with an overall score of 74% acceptable.
- The indicator for planning also improved significantly with an 18% improvement in 2013 from 48% to 66% acceptable practice in this area.
- There is increased partnership and commitment between DMH and CFSA in taking joint ownership in providing quality services to youth. Each agency has a review process, as well as a combined Quality Service Review (QSR)/CSR protocol and regular process for reviewing children and youth who are involved in both systems.
- The Children's unit is using data to monitor and support system improvement through the learning collaborative and to determine service expansion efforts. Additionally, the Children's team have provided technical assistance and expanded the use of evidence-based practice to improve service delivery.
- CSA leadership and staff are committed to providing quality services and are struggling to align this commitment with viable business practices. CSWs, therapists, supervisors, administrators, and psychiatrists are working hard to improve the lives of children, youth, and families, in spite of frontline challenges, productivity requirements, increasing paperwork and regulatory constraints, and increasing complexity of persons accessing services.

DMH has accomplished a great deal in improving the quality and consistency of services provided to children. It is now faced with the challenge of continuing the upward trend of positive results while simultaneously working to sustain the positive growth and accommodate ongoing federal and District-level priorities. It will take full collaborative efforts on the part of the DMH team and its partners at the CSAs, CFSA, DYRS, education, developmental disabilities, substance abuse, neighborhood collaboratives, and community resources to continue the positive trend in providing quality services.

Recommendations

Much progress has been made; however, the complex challenges of children in the context of their families and as well as their own needs, combined with the number of child-serving

agencies involved in these children and families' lives, require continued effort to improve the communication around the provision of services to each and every child and family.

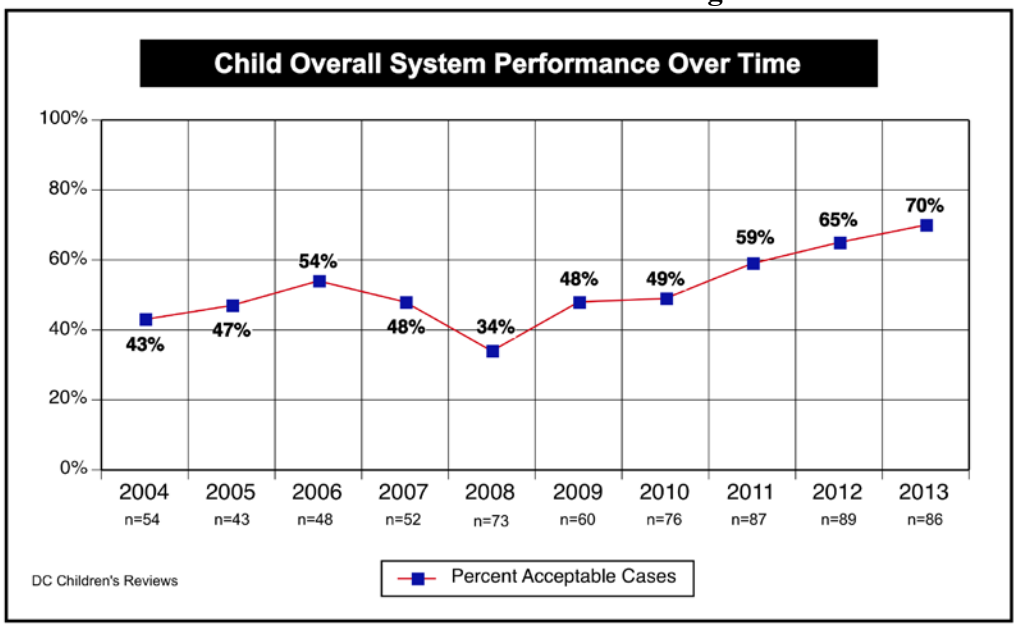
It is recommended that the highest priority continue to be given to identifying and implementing strategies that support and promote the highest quality of practice across all frontline providers of services. The most pressing question to consider is: What are the immediate steps DMH and CSAs can take that will support and improve current clinical performance and lead to better outcomes for children and families regardless of where they enter the system and their level of need.

- Specifically, there need to be strategies implemented to better reach and connect those people that attempt to get services but end up not actually receiving the services. Examples include first appointment "no shows" or persons with significant change in engagement with services and persons who are homeless or in major transition. It is recommended that more effort be devoted to outreach and mobile interventions that can target and engage these individuals.
- The bi-modal performance data show that there are providers demonstrating good consistent performance of clinical practice and there are those that are not. There is clearly a difference between providers/CSAs. Some providers are responsive and highly engaged and others are non-responsive, aloof, and lack supervision, execution, and follow through of clinical practice. These are clearly important differences that matter to parents and to children who are trying to engage with providers and receive individualized services. There must continue to be multiple strategies implemented across DMH to reduce this variance in provider performance. It is important that strategies to address this issue be coordinated across programs, quality improvement, and contracts to have maximum impact on improving performance.
- As recommended last year, DMH needs to ensure that the CSR unit is able to support the ongoing use of CSR in the CSAs and the unit needs to begin to conduct small targeted CSR reviews on a regular and timely basis. These reviews should be done in coordination with the Office of Quality Improvement and program areas. It is recommended that a specific schedule of reviews be set and performance expectations for CSR reviews be set across program, CSR unit, and Office of Quality Improvement that can be tracked and monitored by senior management on a quarterly basis. Expectations for staff participation in CSR reviews should be

made transparent. If these recommendations are not followed, then it is predictable that CSR reviews will not continue on a meaningful basis.

- DMH needs to formally complete and widely disseminate the children's mental health plan that is in the working stage at the earliest opportunity and work with Medicaid, managed care organizations (MCOs), and other child-serving agencies to ensure that there is a coherent overall approach to a mental health system for children that provides timely and responsive services, including primary care services, regardless of each child's specific context and presentation of need.

Overall Child Practice Performance Ratings 2004-2013



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Background and History

The Final Court-Ordered Plan for Dixon, et al v. Gray, et al [March 28, 2001] required that performance measures be developed and used for measuring practice performance. The court-ordered Exit Criteria and Method [September 21, 2001] set forth further detail for measurement requirements pertaining to consumers, including children and youth:

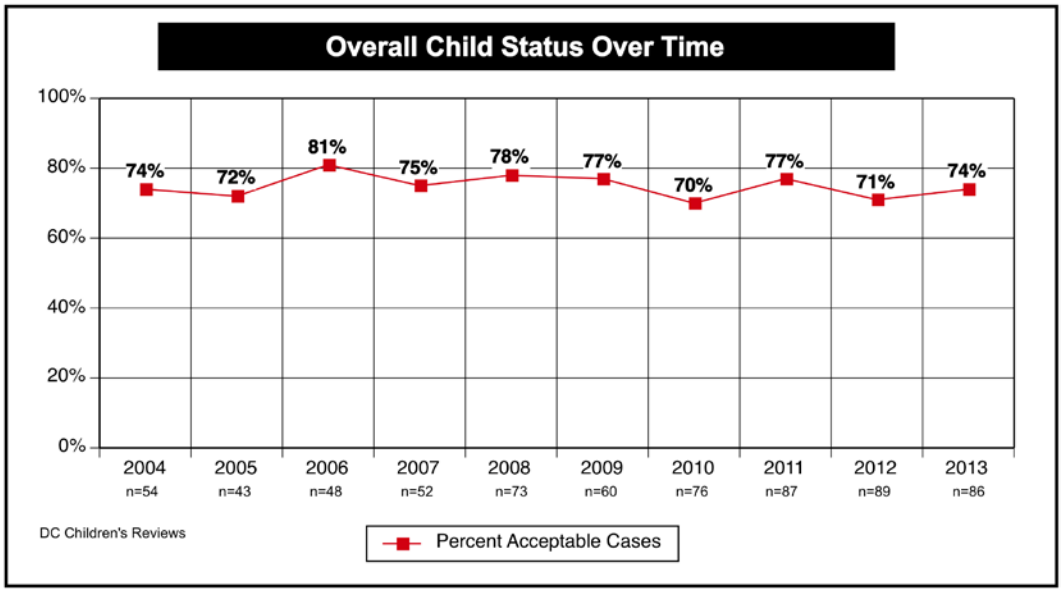
- Consumer service reviews will be conducted using stratified samples.
- Annual reviews will be conducted by independent teams.
- Annual data collection on individuals will include consumer and family interviews, record reviews, staff interviews, caregiver interviews, and analysis of data.
- The independent teams will cover key areas of review for each consumer. For children and youth, these key areas include home and school activities, life skills, health and development, treatment planning, treatment, family supports, specialized services, coordination of care, and emergent/urgent response to needs.

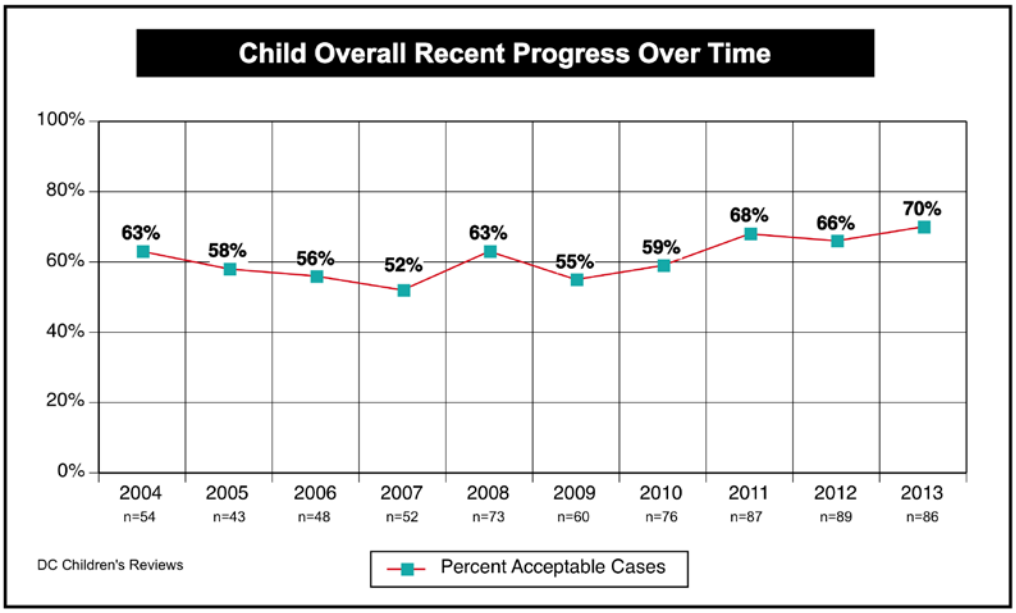
In 2012, the District of Columbia and the Department of Mental Health (DMH) entered into a Settlement Agreement that ended the 37-year-old *Dixon* class-action lawsuit. During the last ten years of the lawsuit, the District and DMH were required to satisfy certain criteria; two of those criteria were designed to measure the public mental health system's performance on an annual basis. The Community Services Review or CSR protocols were developed by Human Systems and Outcomes, Inc. (HSO) as a measuring tool and used to assess performance for the adult and child system since 2003. Based upon data from prior reviews, as well as satisfactory completion of other exit criteria, the District was able to substantially meet the requirements for adult services prior to the end of the lawsuit; however, it was determined that the child/youth system was in need of additional system improvement. As part of the Settlement Agreement, the District

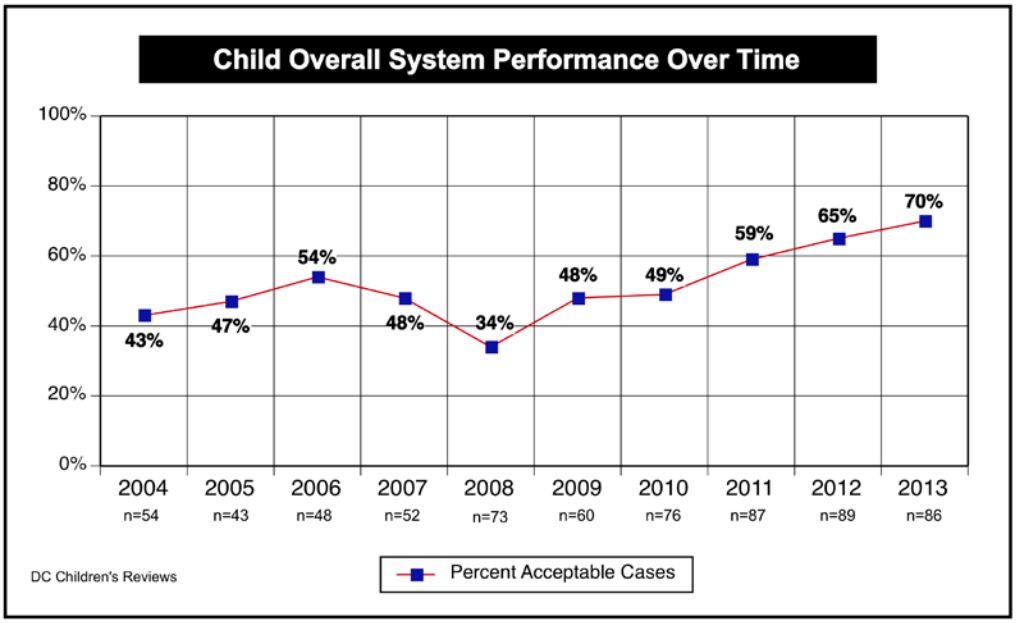
agreed to contract with HSO for the next two years for continued support to conduct the children and youth CSRs, and for consultation for targeted interventions with the providers and with DMH as it moves to more frequent, provider-specific CSRs. The 2013 review is set to be the last year of reviews affiliated with the Dixon lawsuit.

The initial CSR was completed during March 2003, with reviews occurring every year since. Multi-year data comparison shows consistent overall child status ratings in the low 70% to low 80% range, as illustrated in the graph below. Multi-year comparison for practice shows overall system performance hovering around 47% until 2010. There was an outlier year in 2008 when the sample size was increased to n=73 and overall system performance rated as 34%. In 2011, scores started to trend upward with an overall system performance score of 59%, 65% in 2012, and finally, 70% in 2013.

The following graphs display the child status, child progress, and practice performance ratings over ten years—2004 through 2013.







2013 Children's Review

The design of the 2013 sampling process, selection of the sample, training of reviewers, supervision of data collection, and analysis of data were conducted by HSO, an organization with extensive experience in qualitative child service review processes used in monitoring services in class action litigation in numerous states across the country. HSO initially was contracted by the

Dixon Court Monitor, and then in 2012, by DMH. Logistical preparation and organization of the on-site case review activities was completed in 2013 by the Department of Mental Health CSR unit. The CSR unit, along with the Child and Family Services Administration (CFSA), the Center for the Study of Social Policy (CSSP), and HSO, worked with core service agencies (CSAs) to guide and assist in the building of review schedules. HSO expresses its deep thanks to all involved in setting up the large number of individual child reviews.

Context for the 2013 Review

A major system change process has been occurring in the District of Columbia for children's mental health services since 2006. The goal of the change process is to develop a system that will collaborate with children and families and the other child-serving agencies to deliver individually identified, appropriately matched, and well-coordinated services to each child and family consistent with an Individualized Resiliency Plan (IRP) (commonly referred to within the District of Columbia as an Individualized Plan of Care-IPC, or a mental health treatment plan). The expectation is that there will be a consistent level of high quality performance across CSAs, providers, community partners, and other child-serving agencies, and that each child and family served receives services according to the practice principles of an integrated System of Care.

Over the last seven years, leadership at DMH focused on a number of system change initiatives: defining and supporting teaming, contracting and coaching of CSAs, identification of a wraparound provider, development of crisis mobile outreach, large transition of consumers from the public provider DCCSA to community-based CSAs, addition of the CSR unit to DMH, introduction of several evidence-based practices to include family functional therapy, trauma-focused community-based treatment, and high fidelity wraparound, targeted practice-improvement and integration consultation to CSAs, development of DMH practice principles, juvenile diversion program, and development of a combined CSR/QSR (Quality Service Review) protocol with CFSA.

Overview of the Child Service Review Process

The review of services for children, youth, and families is conducted through an individual review process. This process yields both qualitative and quantitative data on identified indicators of child status and system functioning. The review process is a case-based inquiry of services received by individual children, youth, and families that is based heavily on the face-to-face interviewing of all service providers and persons involved with a youth, such as the child, parents or guardian, and key team members, such as a CFSA social worker or case manager, community support worker (CSW), therapist, psychiatrist, wrap-worker, teachers, juvenile justice, advocates, Individualized Education Plan (IEP) coordinator, group home staff, and foster parents. Other adults who have a significant role, or who provide support to the youth or family, may also be interviewed. These adults can include other family members, community members, coaches, pastor and church members, and babysitters or respite/caregivers.

For 2013, 86 reviews were completed over a three-week period. Reviewers trained to standard by HSO trainers completed the child reviews. HSO-affiliated personnel conducted 34 reviews (40%) and DMH staff completed 52 reviews (60%). The majority of the reviews conducted included a second "shadow" reviewer who participated in the review process either for training purposes or as an observer.

Changes to the Review Process

There were no fundamental changes to the review process during the 2013 review; however, 26 of the 30 youth also in the care or custody of CFSA were co-reviewed by experienced reviewers from CFSA or CSSP using another protocol (QSR) that has been developed for CFSA and DMH as a joint protocol by HSO. Data were collected using both the QSR and the CSR protocols for these youth.

Families were again offered a $25 gift card at the conclusion of the review in order to show appreciation for their time and participation in the review.

Feedback on individual cases was scheduled and logistical preparation, specific training of reviewers, and preparation of staff and CSAs to receive the input were accomplished prior to the review weeks. Feedback sessions are an opportunity for dialogue with the service providers and practitioners about the individual practice issues pertaining specifically to the youth being reviewed. Feedback includes the sharing of information, suggestions for next steps, and problem solving around barriers and challenges. Feedback sessions do not serve as directives from DMH regarding how teams should proceed. Positive response to the feedback process has been consistently received. Follow-up from DMH occurs in rare instances that require a mandatory report due to safety or threat of harm or as requested by the team leader. Feedback is generally provided to staff and team members working directly with the youth and families, and includes supervisors as deemed appropriate by the CSA. For the 2013 reviews, 94% of the reviews included feedback to the CSA team. Seventy-one percent (71%) of the feedback sessions included a supervisor, clinical director, and/or a program manager, in addition to the CSW and/or therapist.

The Sample for Children and Youth

The targeted number of children and youth to review was determined to be 86. A stratified random sample of 94 youth (84 youth plus roughly a 10% oversampling) and replacement names were drawn from the DMH eCURA data system for youth receiving services between October 1, 2012 and January 31, 2013. The stratified random sample of 94 was used to account for sampling attrition that occurs during scheduling and the review weeks (e.g., if a youth reviewed had not been receiving services during the designated timeframe).

Sixty-seven youth were replaced in the original sample in order to make up the final number of 86 scheduled reviews; this is an increase of 23 persons replaced when compared to last year. Many replacements this year were due to refusals and youth no longer being served at the CSA. Youth selected for the review received at least one form of billable mental health service from a provider agency during the noted timeframe. The total unduplicated population served during this time period was reported to be 2,333 children, an increase of 125 youth from 2012.

Core Service Agencies

According to the information supplied to HSO by the DMH eCURA system, there were a total of 2,333 children who received a billed-for service between October 1, 2012 and January 31, 2013, from 15 different provider agencies. These provider agencies differ substantially in the total number of children they serve. The number of children reviewed from each agency varied slightly from the number originally selected due to sampling and review attrition factors, such as refusal to participate, placement or relocation out of the District of Columbia and immediate area, or youth discontinuing services and not receiving services from another CSA. Some agencies were not represented in the review sample as they showed a low number of children in the population (low percentage of the population). Agencies with less than 37 consumers were combined and a sample was randomly selected from that group. The following table illustrates the breakdown of the population, random sample, and youth reviewed by agency.

Display 1
Number of Children Receiving a Billed Service
Between October 1, 2012 to January 31, 2013
According to the eCURA Data System

Core Service Agency	# In Population	# In Sample	# Reviewed
1. First Home Care Corporation	768	28	22
2. Community Connections, Inc.	306	13	12
3. Hillcrest Children's Center	305	13	11
4. Universal Health Care Management	237	11	11
5. Life Enhancement	174	7	7
6. MD/DC Family Resource Center	127	5	5
7. Inner City Family Services	107	4	4
8. PSI	87	3	3
9. Family Matters	70	3	3
10. Life Stride, Inc./ Affordable Behavioral Consultants	60	2	3
11. Mental Health Services Division	39	2	2
12. Fihankra Place, Inc.	37	2	2
13. Mary's Center	9	2	1
14. Latin American Youth Center	4	0	0
15. Youth Villages	1	1	0
16. Miscellaneous/Other	2	0	0
Totals	2,333	96*	86

*Includes the oversample of ten youth.

Age and Gender of Youth

When selecting the sample for the 2013 review, the total sample was stratified by age and gender. **Display 2** shows the distribution of the eCURA population, random sample, and review sample by age and gender. Some youth had no information in the age or gender field in eCURA.

Display 2
Age and Gender of Youth in the Population, Random Sample, and Review Sample in 2013

Age of Youth	# In Population	% Of Population	# In Sample	% In Sample	# In Review	% In Review
Birth to 4 years	1	0	0	0	0	0
5-9 years	539	23%	22	23%	21	24%
10-13	835	36%	35	36%	33	38%
14+	958	41%	39	41%	32	37%
Totals	2333	100%	96	100%	86	99%

Note: Total percentages may not equal 100% due to rounding. This applies to all displays.

Gender	# In Population	% Of Population	# In Sample	% In Sample	# In Review	% In Review
Female	918	40%	38	40%	37	43%
Male	1414	60%	58	60%	49	57%
Totals	2332*	100%	96	100%	86	100%

*One was listed as "unidentified."

Children and Families Included in the Review

The target number of reviews was met this year as data were gathered for 86 youth; therefore, the review findings yielded results that are believed to be reflective of District-wide trends in the children's mental health system. The qualitative and quantitative data collected are sufficiently representative to make system-wide generalizations regarding the quality and consistency of practice across the District's mental health system. Agency-by-agency comparison should be interpreted with caution, since review sample sizes for some of the provider agencies are extremely small. For the 2013 review, 67 youth replacements were made for a variety of reasons; most declined to participate (28 youth) or were no longer receiving services (26 youth). There is a sharp increase in the number of youth refusing to participate (up from 17 in 2012). The sampling timeframe used to select children and families for the review can impact the number of replacements made to the original sample, as well as the new responsibilities and approach to the logistics. **Display 3** shows the general reasons for replacement and the number of youth replaced.

Display 3
Reason for Youth Replacement in Review Sample

Reason for Replacement	# of Youth Replaced
Declined to participate	28
Discharged from services/inactive	26
Difficulty locating authorized signature	12
Total Replacements *One was incarcerated	67

Description of the Children and Youth in the Review Sample

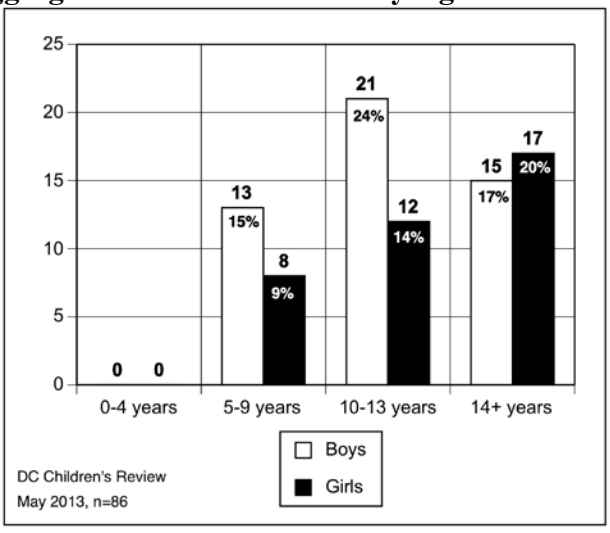
A total of 86 child and family reviews were completed during May 2013. Presented in this section are displays that detail the characteristics of the children and youth in the review sample this year.

Age, Gender, and Ethnicity of Youth

The review sample was composed of youth, both males and females, drawn across the age spectrum served by DMH. The following display **(Display 4)** presents the aggregate review sample of 86 children and youth distributed by both age and gender. As shown in this display, boys made up 57% of the youth reviewed and girls made up 43% of the youth reviewed. These percentages are similar to last year's percentages, with 4% more boys reviewed in 2013 (2012 males=53%, females=46%). The display below shows the aggregate of youth reviewed by both age and gender. Children under age ten comprised 24% of those reviewed (21 youth). This is a 2% increase from 2012.

Thirty-three children (38%) were in the 10-13-year-old age group and 32 youth (37%) were in the 14+-year-old age group. Comparatively, in 2012, 29 children (32%) were in the 10-13-year-old age group, and 45% (40 youth) were in the 14+-year-old age group. Ninety-seven percent of the youth reviewed were of African-American ethnicity. The other ethnicities represented are as follows: Asian/Indian-3 youth, Caucasian-6 youth, Hispanic-40 youth, and Unspecified-21 youth.

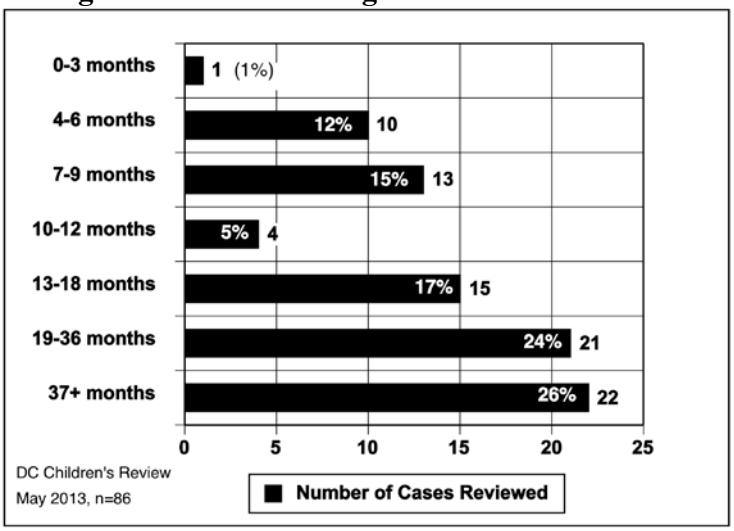
Display 4
Aggregate of Reviewed Cases by Age and Gender



Length of Mental Health Services

Display 5 presents the amount of time the children's cases had been open during their current, or most recent, admission for services. As described below, 50% or 43 of the youth had been receiving services for 19 months or longer, which is 8% more than the youth in the 2012 review where 42% had been receiving services for this length of time. Twenty-eight youth (33%) had been receiving services for 12 months or less, which is consistent with youth reviewed in 2012.

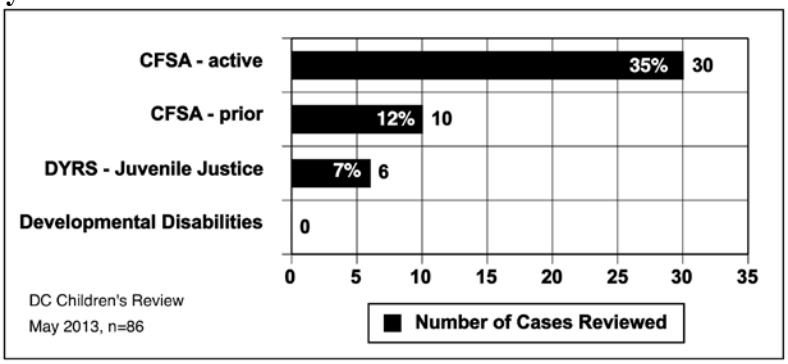
Display 5
Length of Time Receiving Mental Health Services



Other Agency Involvement

Some children and youth in the review sample were also receiving services from other major child-serving agencies, such as CFSA and the Department of Youth Rehabilitation Services (DYRS). **Display 6** presents the number of youth identified as being served by these other key agencies. Of the 36 youth currently served by one or more of these agencies, 30 were actively involved with CFSA, representing 35% of the youth reviewed and comparable to 33% in 2012. Ten youth or 12% had prior involvement with CFSA (oversight discontinued or closed). This year, six youth (7%) in the review were involved with DYRS, also comparable to the 2012 youth review. Again this year, there were no youth reviewed that were involved with developmental disabilities.

Display 6
Other Agency Providers Involved With Children and Youth in the Review Sample



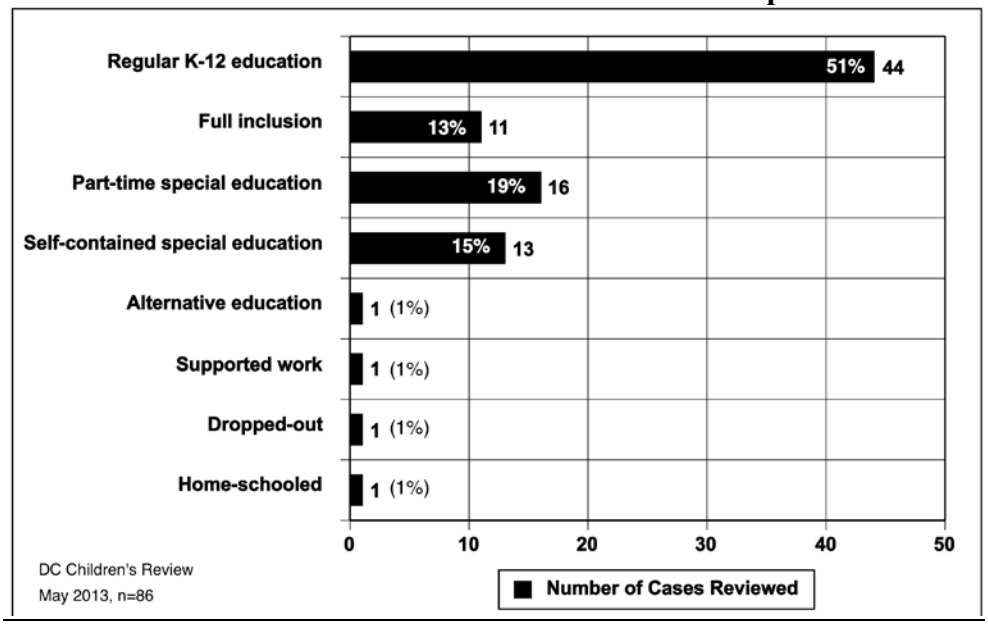
Educational Program Placement

Reviewers look to see that the educational setting of a youth meets instructional and behavioral needs and provides an environment that is conducive for learning. Reviewers learn about social interactions and peer relationships, a student's ability to manage stress and frustration and transition processes, in addition to information regarding learning style, academic levels, processing, and academic achievement. **Display 7** below illustrates the educational status/placement for the children and youth in the review sample. The categories are not mutually exclusive; more than one educational placement may be reported for a single child.

Forty-four youth (51%) were in regular K-12 educational settings. Forty youth (47%) were receiving some type of special educational service, either full inclusion (11 youth; 13%), part-

time special education services (16 youth; 19%), or in a self-contained special education setting (13 youth; 15%). The largest difference from 2012 is in youth in self-contained special education settings, with half as many youth in this educational setting and comparable to the 2011 review having 14 youth in this setting. The 2012 review data indicate the following comparison: 37 youth (42%) in regular K-12 educational settings, 51 youth (57%) receiving some type of special educational service---full inclusion (8 youth; 9%), part-time special education services (15 youth; 17%), self-contained special education setting (28 youth; 31%).

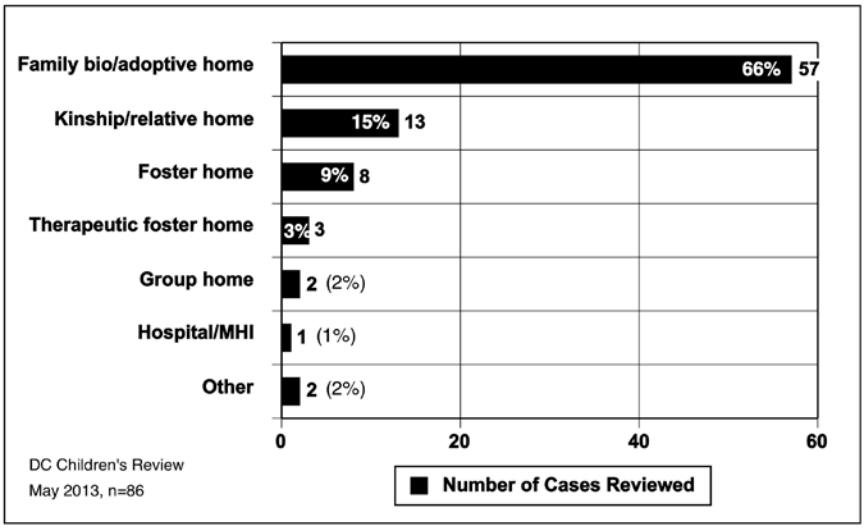
Display 7
Types of Educational Services/Placements or Educational Status for Children and Youth in the Review Sample



Living Setting

Children and youth in the review sample were found to be living in a number of different home settings. **Display 8** shows the distribution of review sample members according to their residences at the time of the review. Similar to prior years, the majority of the youth reviewed were living with biological or adoptive family (57 youth; 66%), with an additional 13 youth (15%) living with relatives or in kinship placement. The remaining youth were living outside of the family/kinship home with eight (9%) living in a foster home, three (3%) living in a therapeutic foster home, two were in a group home, one was hospitalized at the time of review, and two were living in a shelter.

Display 8
Current Placements/Places of Residence for Children and Youth in the Review Sample



Placement Changes

The following table lists the total number of placement changes youth in the review have experienced over their lifetime, based on information learned during the review. The placement change history was assessed through review of records and/or through interview findings and is across the life of the child. Placement changes are defined as a change in the primary caregiver for the child as a result of agency intervention (including child welfare involvement). Forty-five youth (52%) in the 2013 review had no placement changes in their lifetime, and that finding is the same as 2012. Twenty-two youth (26%) had one placement. Eleven youth (13%) had 3-5 different placements, six youth (7%) had 6-9 placements, and two (2%) youth had 10 or more lifetime placements. Data are mostly consistent with 2012, with a slight decrease in 2013 in the percentage of youth having 3-5 placement changes and a corresponding increase in the percentage of youth having 6-9 placement changes.

Display 9
Total Number of Placement Changes for Children and Youth in the Review Sample

Placement Changes	Frequency in Review	% of Review
No placement changes	45	52%
1-2 placement changes	22	26%
3-5 placement changes	11	13%
6-9 placement changes	6	7%
10 or more placement changes	2	2%
Totals	86	100%

Functional Status and Level of Need

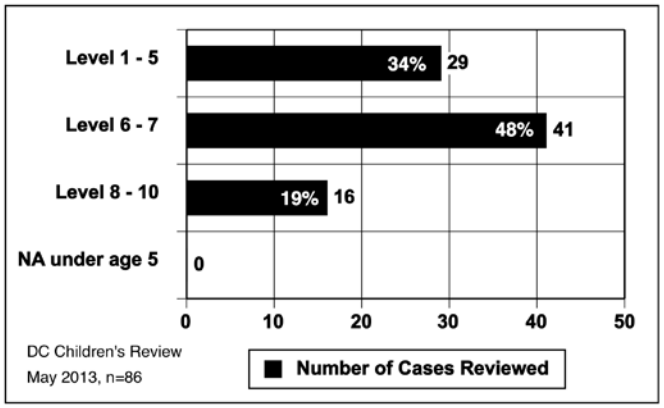
Functional Status

Display 10 provides the distribution of the review sample across functioning levels for the 86 children and youth age five and older. (Level of functioning data are gathered only for children age five and older.) These are general level of functioning ranges assigned by the reviewer at the time of review. Reviewers use information gathered from case records, past assessments and evaluations, interviews, and specific criteria in the CSR protocol to determine youth level of functioning. The scale is based on and similar to the Child Global Assessment of Functioning Scale (CGAF). On this scale, a child or youth in the low 1-5 range would be experiencing

substantial problems in daily functioning in normal settings, and usually requiring a high level of support through intensive in-home or wraparound services. Often, children receiving scores from 1-5 on the functional status scale may be receiving services in a temporary treatment or alternative setting (or recently received services in one of these settings). A child receiving scores of 6-7 would have some difficulties or symptoms in several areas and would often be receiving intensive outpatient or other in-home supports in most settings. A child or youth receiving scores of 8-10 would have no more than a slight impairment of functioning but could be functioning well in normal daily settings, with only a minimal amount of supports.

Twenty-nine youth (34%) in the review had level of functioning scores in the lowest range, or higher severity and need. This range captures youth requiring many supports and, oftentimes, involving multiple agencies. The majority of the youth in the 2013 review were in the mid-level range, with 41 youth (48%) in this range. The remaining youth currently had less severe impairment in functioning and required minimal support; 16 youth or 19%). There is a 6% shift from the mid-level range to the higher-need range (from 6-7 level to 1-5 level) when compared to 2012.

Display 10
Functional Status of Children and Youth in the Review Sample



Display 11 separates level of functioning ratings by age range. Level of functioning is typically collected for youth age five and older and there were no youth in the review this year under the age of five. The majority of the youth, for all age groups, were in the 6-7 level range—having some difficulties and likely receiving intensive outpatient or similar supports. There was an increase in 2013 in the number and percent of youth 10-13 years old in the Moderate Level of Functioning (6-7 range) from 14 youth (16%) to 18 youth (21%), and a decrease in the number and percent in youth ages 14 and older from 20 youth (22%) to 14 youth (16%).

Display 11
Level of Functioning Ratings for Children and Youth in the 2013 Review Sample Compared to the 2012 Review Sample

Age Ranges	Low Level of Function 2012 (1-5)	Low Level of Function 2013 (1-5)	Moderate Level of Function 2012 (6-7)	Moderate Level of Function 2013 (6-7)	High Level of Function 2012 (8-10)	High Level of Function 2013 (8-10)	Total in the 2012 Review	Total in the 2013 Review
5-9 Yrs Old	2 (2%)	6 (7%)	13 (15%)	9 (10%)	5 (6%)	6 (7%)	20	21
10-13 Yrs Old	10 (11%)	9 (10%)	14 (16%)	18 (21%)	5 (6%)	6 (7%)	29	33
14 Yrs or Older	13 (15%)	14 (16%)	20 (22%)	14 (16%)	7 (8%)	4 (5%)	40	32
Totals	25(27%)	29 (34%)	47 (53%)	41 (48%)	17 (20%)	16 (19%)	89	86

Child's Level of Need

The child's level of need was separated into three categories—low, medium, and high. The survey completed by the provider agencies was used to collect specific information, such as the current array of services a youth was receiving. Other level of care indicators, such as the current CGAF score and the Child and Adolescent Level of Care System (CALOCUS) score, were also gathered when possible. The breakdown for level of need is as follows:

Low Need: Basic outpatient services (CGAF 8 or higher)
Medium Need: Intensive outpatient or wraparound services (CGAF 6-7)
High Need: Residential or partial hospitalization placement (CGAF 5 or less)

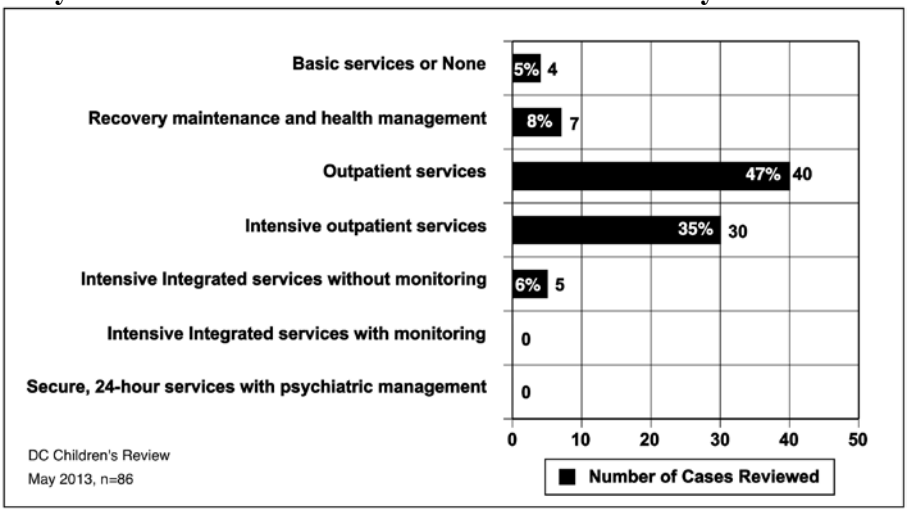
Forty-eight percent (48%) of the 86 children and youth reviewed were receiving services in the medium level of need range.

Level of Care

The CALOCUS scale was used to identify the level of mental health care the child should be receiving according to evaluative criteria in the CALOCUS decision matrix. This scale provides seven different levels of care ranging from basic or preventive-level services to secure, 24-hour care with psychiatric management. Reviewers provided a CALOCUS rating based on their understanding of the mix of services children were receiving at the time of the review using the decision matrix in the CALOCUS instrument. Reviewers were not intending to use the CALOCUS rating to specify whether a child should be receiving a different level of care other than what services were currently in place. The intent of using the CALOCUS was measuring what array of service levels children were receiving at the point in time they were reviewed.

Display 12 represents the distribution of children according to their level of care. The CALOCUS rating was reported for all 86 of the youth reviewed. Reviewers rely first on CALOCUS scores that are present in case records, and then use their best judgment to estimate service level based on current information when actual CALOCUS scores are not present. CALOCUS scores for the 2013 review showed 47% of the youth receiving outpatient-level services and 35% receiving intensive outpatient services. CALOCUS ratings for 2012 are similar with 49% receiving outpatient services and 35% receiving intensive outpatient.

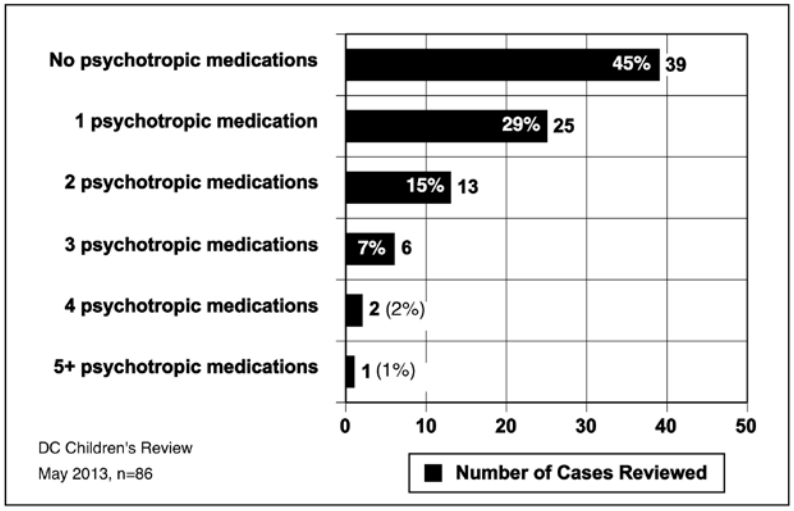
Display 12
CALOCUS for Range of Services Received
by Children and Youth in the Review Assessed by Reviewers



Medications

The number of psychotropic medications prescribed for children and youth in the 2013 review were counted and reported by reviewers. Forty-seven youth were prescribed psychotropic medications (**Display 13)**. Of those 47, 29% percent (25 youth) were prescribed one medication, 15% (13 youth) two medications, 7% (six youth) three psychotropic medications, 2% (two youth) four medications, and one youth was prescribed five or more medications. Compared to the youth who were prescribed medications in 2012, there was an 8% increase in youth prescribed only one psychotropic medication and a 7% decrease in the percentage of youth prescribed two medications. In 2012, there were no youth prescribed five or more medications.

Display 13
Number of Psychotropic Medications Prescribed for Children and Youth at the Time of the Review

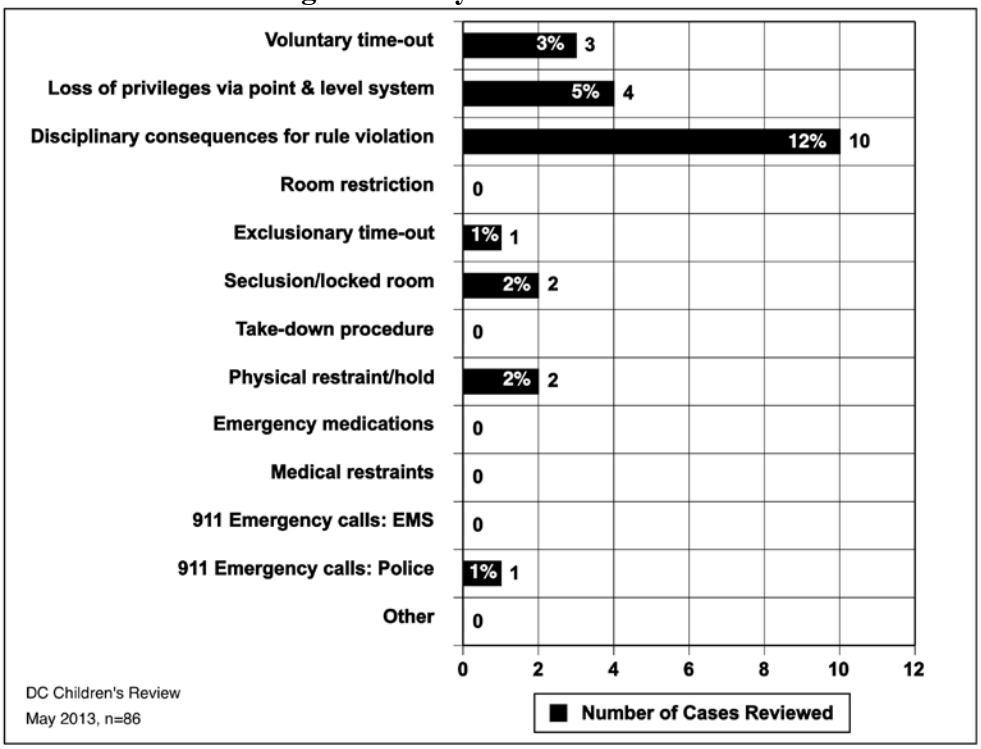


Special Procedures

Special procedures are used in certain situations to prevent harm but are not a form of therapy or treatment intervention. **Display 14** shows the number of youth reviewed who experienced at least one of ten types of special procedures used within the 30-day period preceding the review. It should be noted that a majority of these special procedures recorded are attributed to a relatively small number of children. This year, 65 occurrences of a special procedure were noted in the 30 days prior to the review, compared to 40 occurrences in 2012. Oftentimes, youth experiencing this type of intervention have more than one special procedure used in order to prevent harm.

The highest occurrence of a special procedure is that of consequences for rule violations (ten youth or 12%), with loss of privilege via point or level system being next with four or 5%. No youth experienced a take-down procedure, although there were two instances each of seclusion and physical restraint. This is a 4% decrease in physical restraint, compared to 2012.

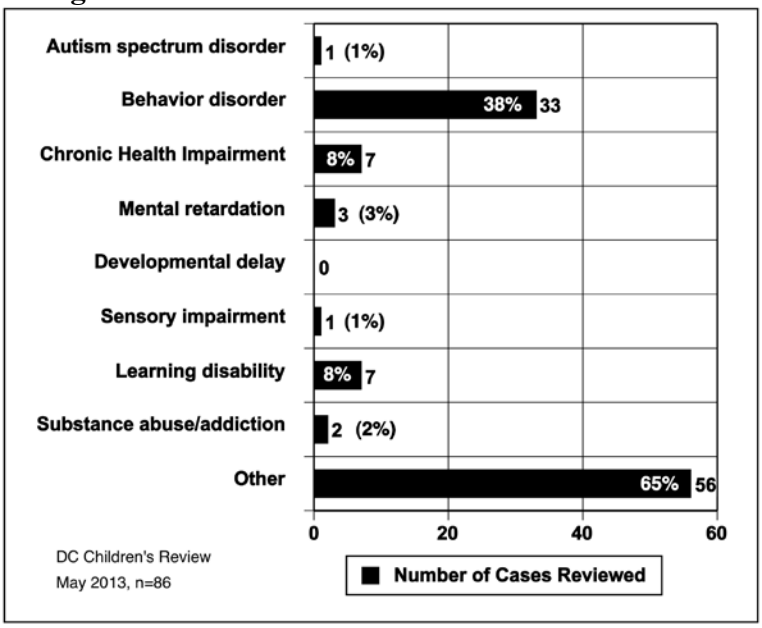
Display 14
Special Procedures Experienced by Children and Youth in the Review Sample During the 30 Days Prior to the Review



Co-Occurring Conditions

As noted in **Display 15** for co-occurring conditions, one-third of the youth reviewed were diagnosed with a behavior disorder (of a serious nature or degree). Seven youth each were noted in the health impairment and learning disability categories. Fifty-six youth were indicated in the "other" category, which consisted largely of ADHD, mood disorders, trauma, and asthma. Most youth are captured in more than one area. There were no youth indicated as developmentally delayed, and only two were marked as having substance abuse/addiction.

Display 15
Co-Occurring Conditions of Children and Youth in the Review Sample



Child Review Findings

Child reviews were conducted for 86 children and youth in May 2013 using the *Community Services Review Protocol*, a case-based review tool developed for this purpose. This tool was based on a resiliency-based service delivery model within a System of Care approach to service provision and the exit criteria for Dixon. The general review questions addressed in the protocol are summarized in **Appendix A**.

Review questions are organized into three major domains. The first domain pertains to questions concerning the current status of the child (e.g., safety or academic status). The second domain pertains to recently experienced progress or changes made (e.g., symptom reduction) as they may relate to achieving treatment goals. The third domain contains questions that focus on the performance of practice functions (e.g., engagement, teamwork, or assessment) for provided services in a System of Care practice model. For each question deemed applicable in a child's situation, the finding was rated on a 6-point 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 case review findings in the "green, yellow, or red zone." For the purposes of the Dixon exit criteria, a second interpretive requirement is applied to this 6-point rating scale; ratings of 1-3 are considered "unacceptable" and ratings of 4-6 are considered "acceptable." A more detailed description of each level in the 6-point rating scale can be found in **Appendix B**. It should be noted that the protocol provides item-appropriate details for rating each of the individual status, progress, and performance indicators. Both the three-tiered action zone and the acceptable versus unacceptable interpretive frameworks will be used for the following presentations of aggregate data.

Interviews

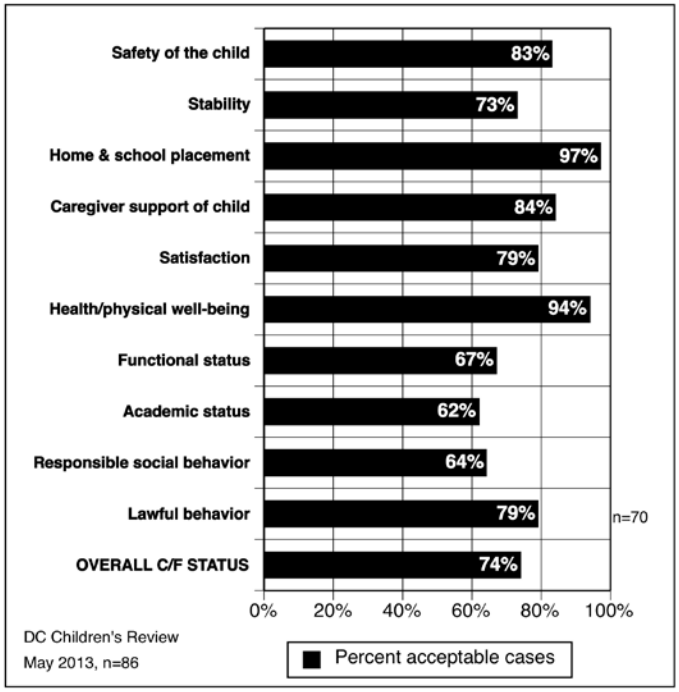
Review activities in each case included a review of plans and records as well as interviews with the child, caregiver, and others involved in providing services and supports. A total of 606

persons were interviewed for the 86 children and youth reviewed this year. The number of interviews ranged from a low of three persons in one case to a high of 16 persons in another case. The average number of interviews was seven.

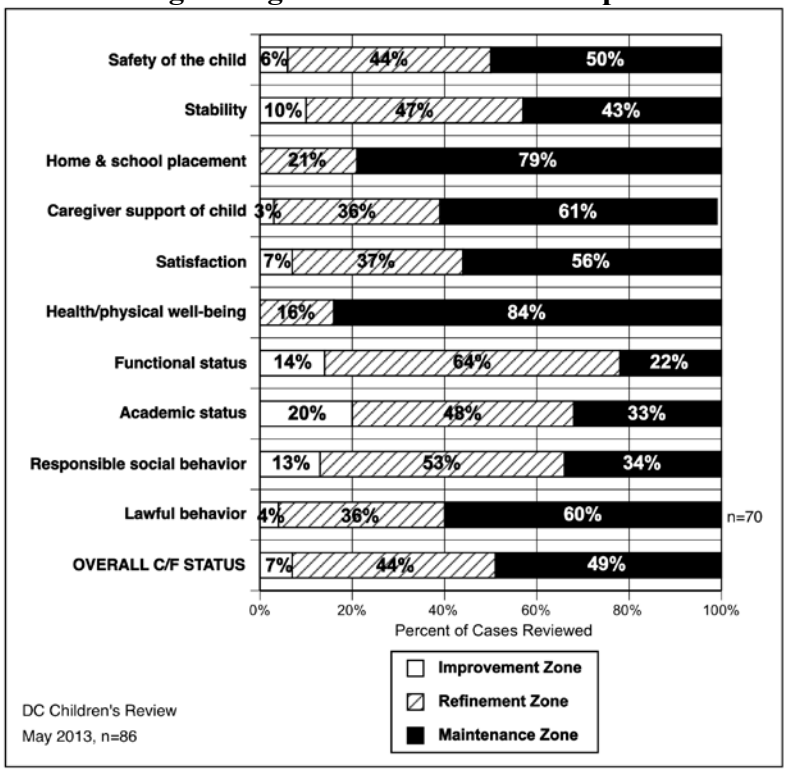
Child Status Results

Ten indicators related to the current status of the child or youth were contained in the CSR Protocol used by reviewers. Readers are directed to **Appendix A** for a detailed description of these ten areas examined by the reviewers. The next two displays present findings for each of the ten indicators. **Display 16** uses a "percent acceptable" format to report the proportion of the review sample members for whom the item was determined applicable and acceptable. **Display 17** uses the "action zone" framework that divides the 6-point rating scale into three segments corresponding to the maintenance, refinement, and improvement zones. Findings on both displays are presented concurrently below. While these two different displays are useful in presenting findings to different audiences, both displays are derived from the same data. **Display 18** uses the three-tiered action zone and the acceptable versus unacceptable interpretive frameworks to present the "overall child status ratings."

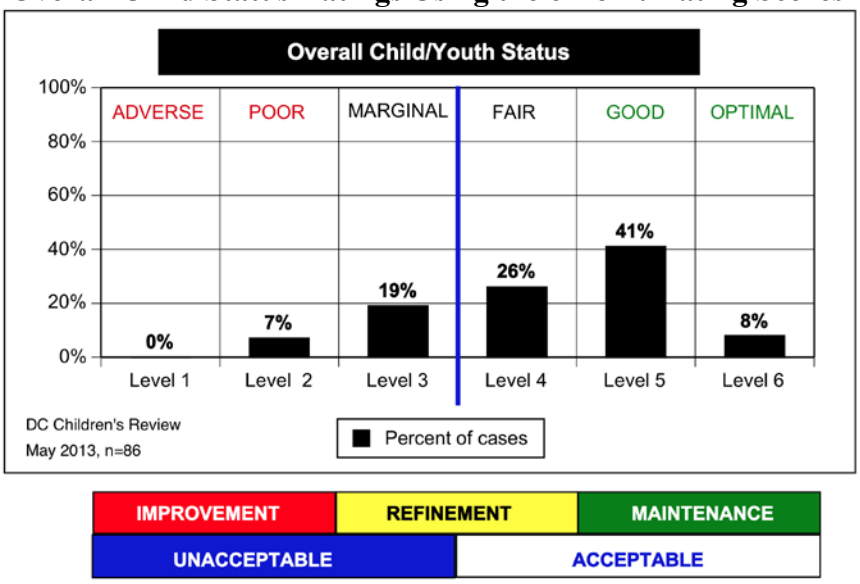
Display 16
Percentage of Acceptable Child Status Ratings



Display 17
Child Status Ratings Using the Three-Tiered Interpretive Framework



Display 18
Overall Child Status Ratings Using the 6-Point Rating Scores



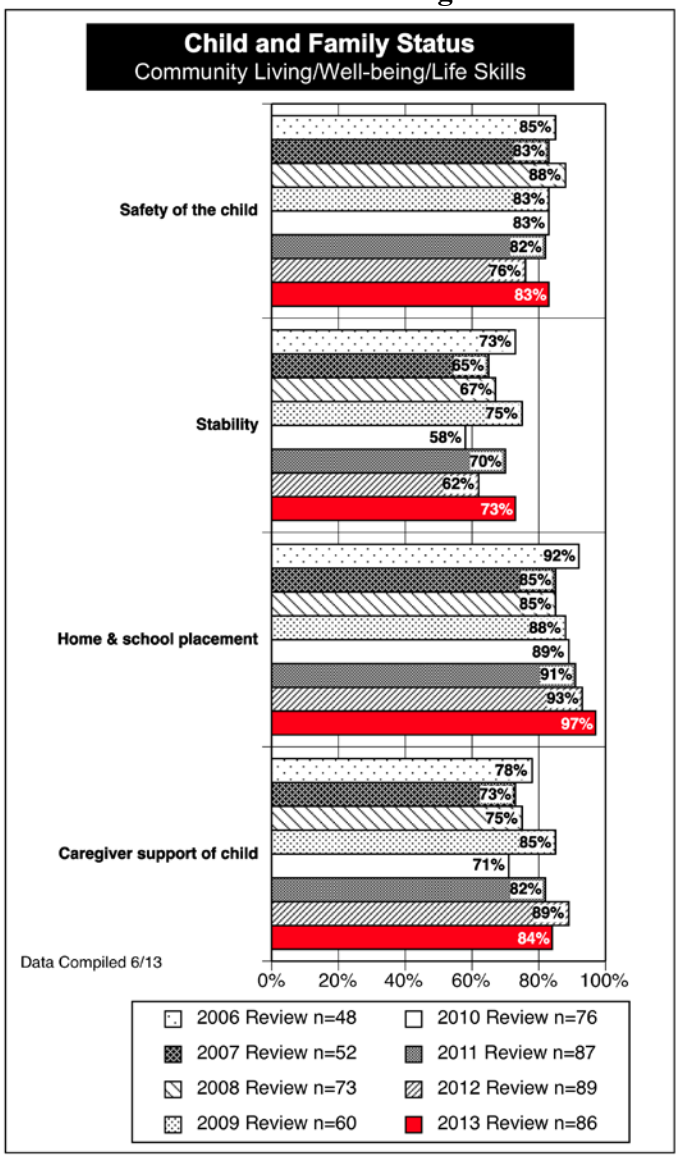
Overall Child Status. The protocol provides a scoring rubric for combining rating values across the items deemed applicable to the child or youth being reviewed to produce an "overall child status rating." Indicators are weighted, with the safety indicator being a "trump" indicator (if safety is rated a 3 or lower, in the unacceptable zone, the overall child status rating becomes the same rating as the safety rating). Of the 86 youth participating in the review, 74% were found to have acceptable overall status, a 3% increase from 2012. The overall child status scores were distributed across the zones as follows: 7% needed immediate attention and were in the improvement zone, 44% were in the refinement zone, and 49% were in the maintenance zone. When compared to overall ratings of child status for the 2012 review, the 2013 data show a 4-5% shift of youth from the improvement zone to the maintenance zone. **Display 19** shows the child status results for the reviews since 2006. Overall child status ratings have been stable, with overall scores ranging from 70% to a high of 81%, which was achieved in 2006.

There are several indicators of child well-being that rated strongly this year. Youth were found to be at least minimally safe, with 83% of the youth reviewed found acceptable in this area, a 7% improvement when compared to 2012 (76%). Youth are healthy and have regular access to medical care (94% acceptable). Ninety-seven percent of the youth reviewed were placed in

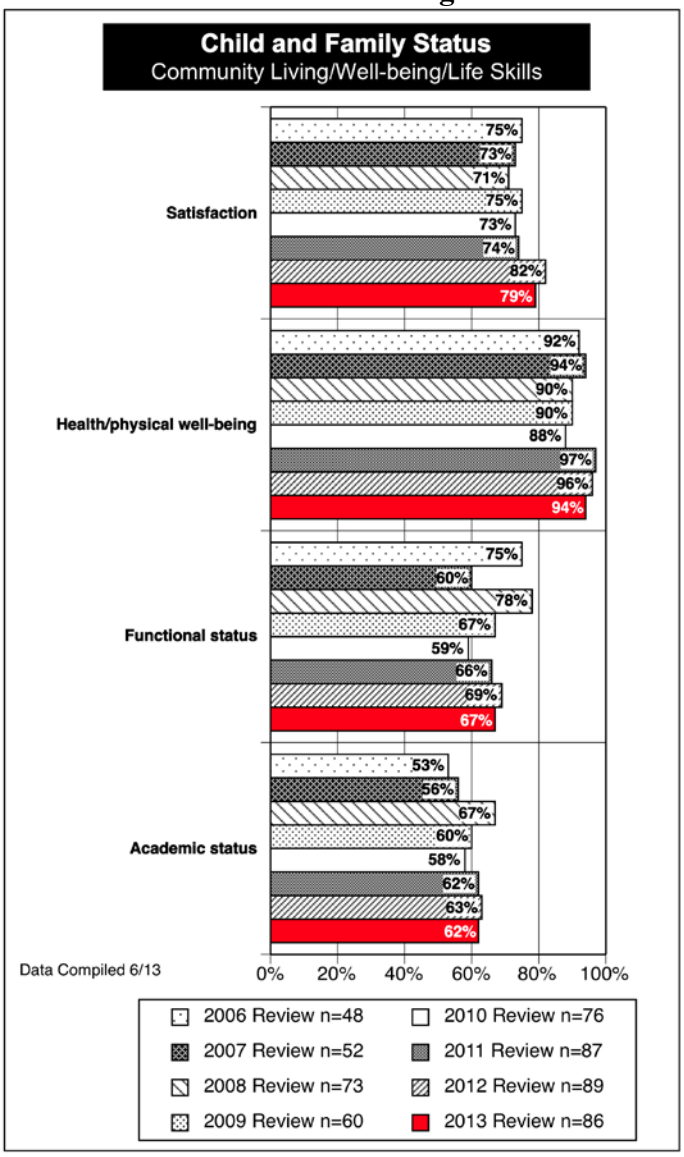
appropriate home and school settings, a 4% increase from 2012. Caregivers are supportive of youth with 84% having at least minimally acceptable ratings in this area, and parents/caregivers are satisfied with services (79%), although slightly less satisfied than in 2012 (82%). The most notable difference in 2013 is in the stability indicator, with an 11% increase in youth with acceptable stability (62% in 2012; 73% in 2013).

The lowest scoring indicators this year were identified in academic, functional, and responsible behavior status, with some scores comparable to 2012 scores in functional and academic status, and an 8% improvement in responsible behaviors. Sixty-two percent of the youth reviewed were found to have acceptable academic status, compared with 63% in 2012. The functional status indicator was rated 67%, compared to 69% last year. The responsible behavior status indicator improved, although it was still one of the lower status areas, and was rated acceptable for 64%, compared to 56% in 2012.

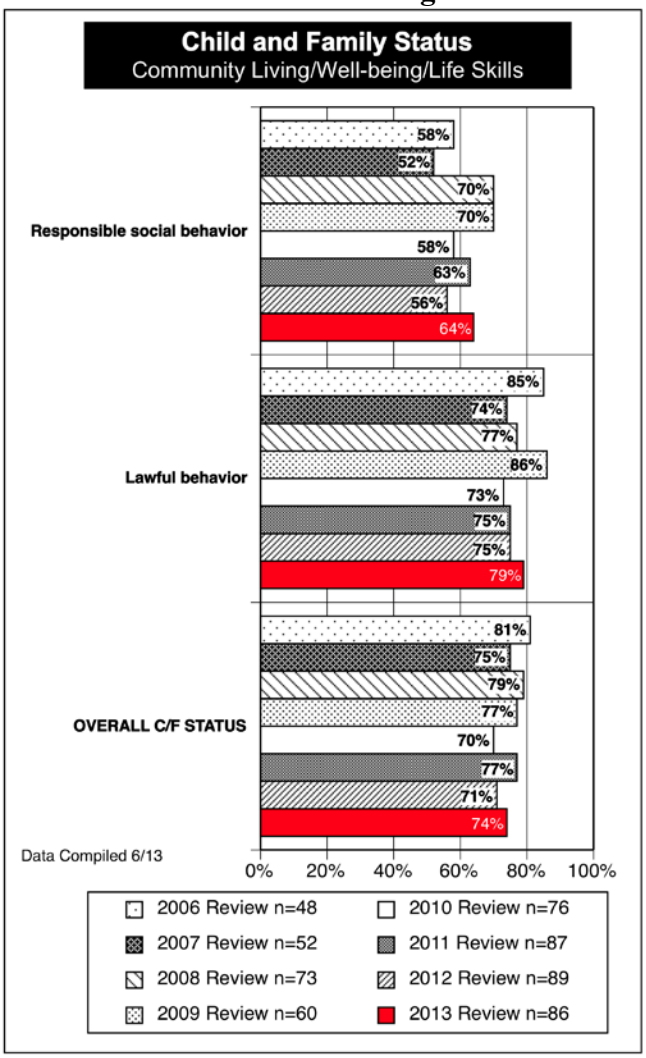
Display 19
Child Status Results for Eight Reviews



Display 19 (continued)
Child Status Results for Eight Reviews



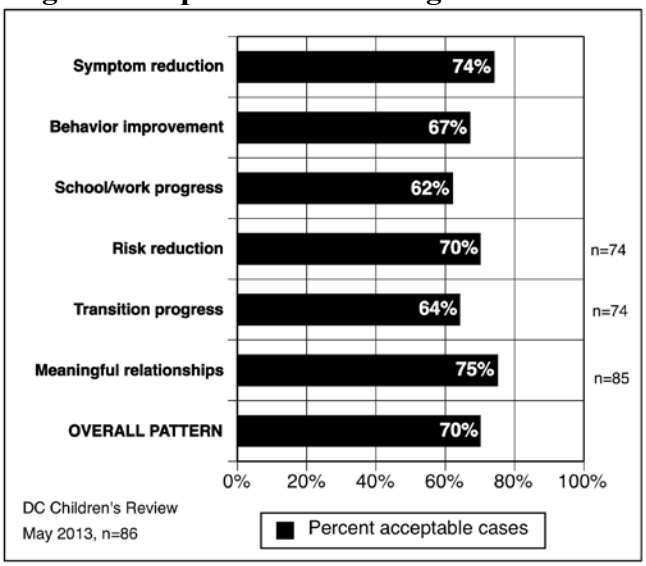
Display 19 (continued)
Child Status Results for Eight Reviews



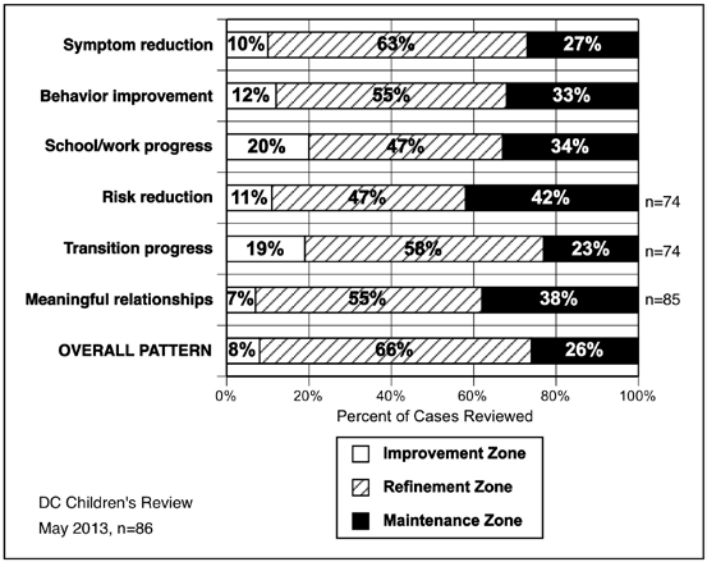
Recent Progress Patterns Showing Change Over Time

The CSR Protocol provides six indicators that enabled reviewers to examine recent progress in specific areas of treatment focus in the 2013 review. The timeframe for assessing recent progress is within the last six months, or since admission to mental health services if less than six months. Descriptions of these six indicators can be found in **Appendix A**. **Displays 20 and 21** present the findings for the progress indicators for the review sample. **Display 22** uses the three-tiered action zone and the acceptable versus unacceptable interpretive frameworks to present the overall progress pattern ratings.

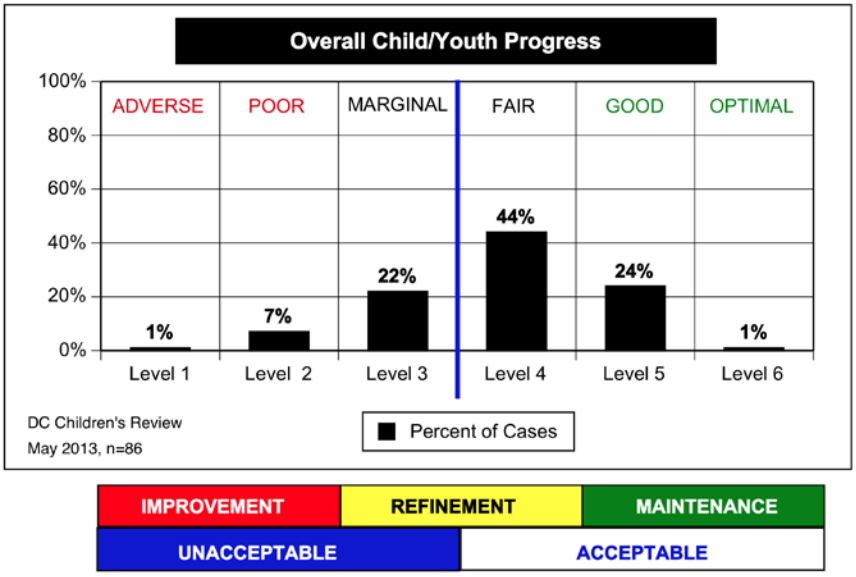
Display 20
Percentage of Acceptable Recent Progress Pattern Ratings



Display 21
Recent Progress Pattern Ratings
Using the Three-Tiered Interpretive Framework



Display 22
Overall Child Progress Ratings Using the 6-Point Rating Scores



Overall Progress Pattern. Reviewers determined an overall progress pattern for each review sample member based on an assessment of the general patterns of progress across each of the applicable indicators during the past six months. Based on this process, the overall progress pattern was acceptable for 70% of the 86 youth reviewed. This result is an improvement when

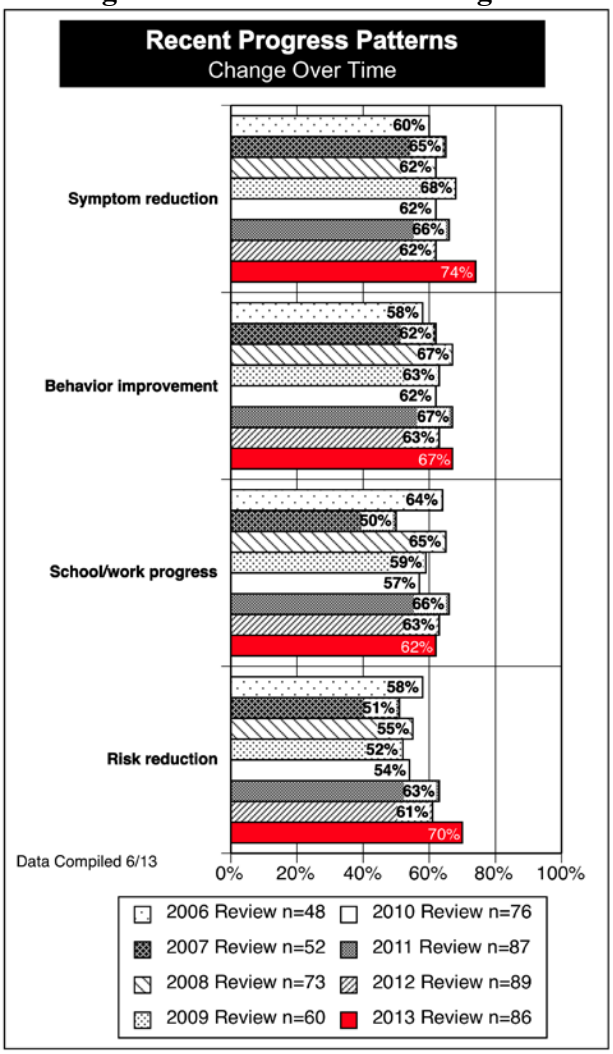
compared to the finding of 66% in 2012. Overall progress pattern ratings were distributed among the three-tiered zones as follows: 8% were found to need improvement, 66% were in the refinement zone, and 26% were in the maintenance zone. Overall, when compared to 2012, there is a positive shift with 4% less in the improvement zone (12% in 2012) and 5% more in the maintenance zone (21% in 2012).

Again this year, progress toward meaningful relationships was the indicator with the highest rating, although it is one of the only indicators with a decline from 2012. When compared to last year, all of the other indicators, with the exception of academic progress, show an increase in percentage of acceptable ratings. The two most notable percentage increases are in symptom reduction, with an increase of 12% (62% in 2012, 74% 2013) and risk reduction with an increase of 9% (61% in 2012, 70% in 2013).

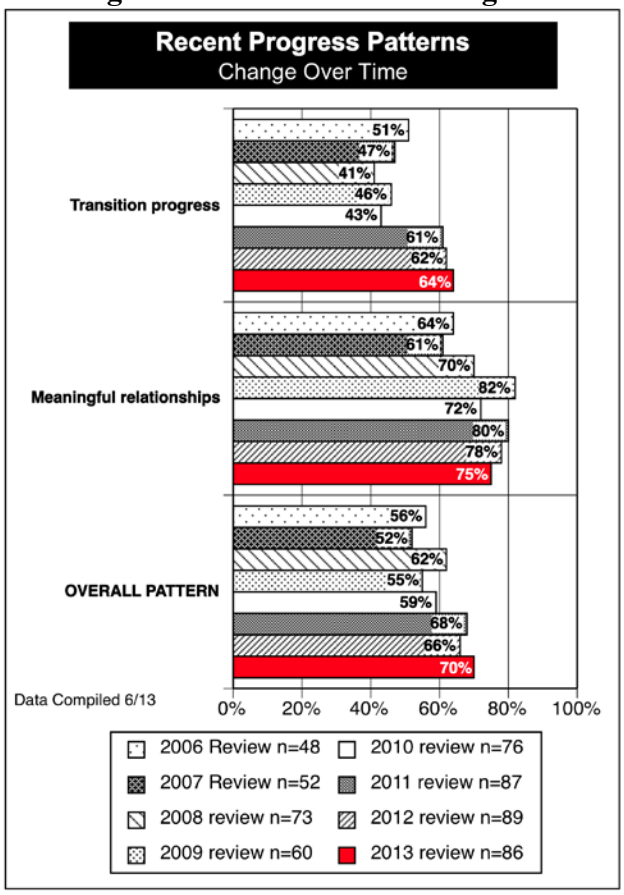
Transitions were identified as applicable for 74 of the 89 children and youth in the review sample this year, which is similar to last year. If the child had not experienced any transitions within the previous six months, or there were no known transitions in the near future, then this indicator was marked as not applicable. Progress toward smooth and successful transitions was acceptable for 64% of these 74 youth, a slight improvement from 2012 where 62% had at least minimally acceptable progress in this area.

Display 23 shows the data on progress indicators for eight reviews. Overall, the 2013 results are comparable to 2012, with the overall progress pattern of youth being highest again this year.

Display 23
Child Progress Pattern Results for Eight Reviews



Display 23 (continued)
Child Progress Pattern Results for Eight Reviews



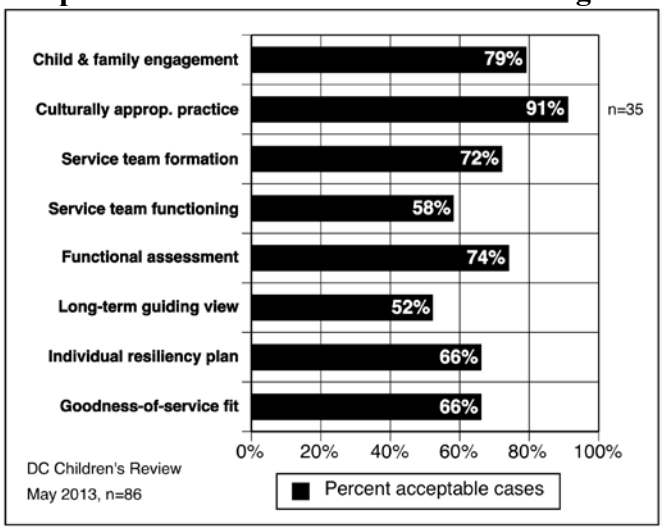
Child-Specific Performance of Practice Functions

The CSR Protocol contains 16 indicators of practice performance that are applied to the service situations observed for members of the review sample. See **Appendix A** for further information about the questions probed through these indicators. For organizational purposes, the 16 indicators are divided into two sets that are provided in the following series of displays. The first set, focusing on planning treatment, contains eight indicators. Areas of inquiry for these indicators include engaging families with appropriate cultural sensitivity, understanding or assessing the current situation, organizing a functional team, setting directions or establishing a long-term view, organizing appropriate resiliency plans, and organizing a good mix and array of services. The second set, focusing on providing and managing treatment, also contains eight indicators. Areas of inquiry for these indicators include availability of resources, implementation of plans, utilization of any special procedures and supports, coordinating services, and tracking and adjustment of services. It should be noted that the particular indicators identified as strengths or as opportunities for improvement are described in detail below, although data on all indicators are included in the graphs.

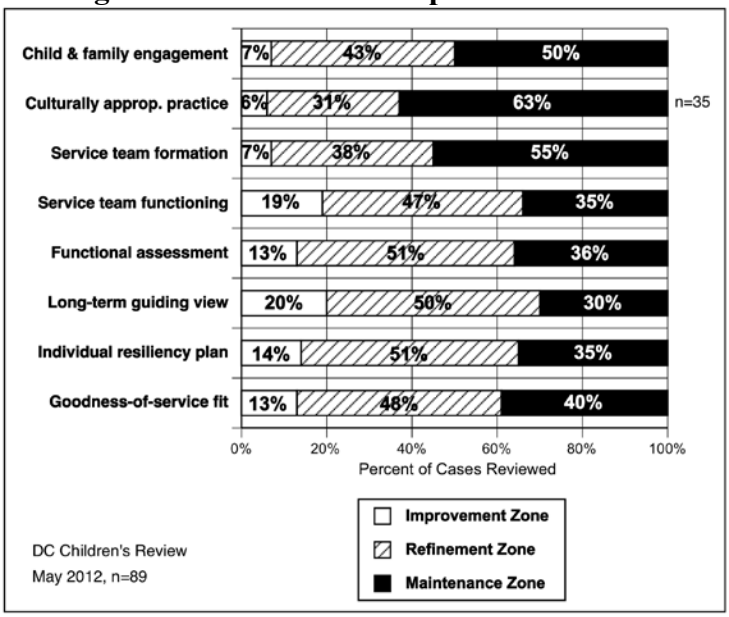
Practice Performance: Planning Treatment

Findings for the first set of indicators are presented in **Displays 24 and 25** and summarized below. It should be noted that the particular indicators identified as strengths, as opportunities for improvement, or with the greatest degree of change are described in detail below, although data on all indicators are included in the graphs. **Display 39** provides the eight-year history of practice performance ratings.

Display 24
Percentage of Acceptable Practice Performance: Planning Treatment Ratings



Display 25
Practice Performance: Planning Treatment Ratings
Using the Three-Tiered Interpretive Framework



Child and Family Engagement. Engagement of a youth and family in planning and service implementation is one of the foundations of strong practice in a System of Care and is identified as one of the essential components in effective practice. Reviewers assess the efforts of team members and the effectiveness of strategies used to engage children and families in all aspects of

treatment. Reviewers look to see if accommodations are made in order for parents and community partners to participate; if staff members are accessible, non-judgmental, and creative in their approach to facilitating active participation in treatment activities; if parents and youth are actively participating in decisions regarding treatment goals and preference of providers; and if the process is youth/family centered and driven. Engagement is a skill. Practitioners need to be supported and mentored in developing this skill, especially in situations where a parent or child may be difficult to engage.

Child and family engagement was consistent this year with the 2012 rating of 79%, although 7% more were in the maintenance zone with a 5-good or 6-optimal rating. There are also differences in the other two zones in the three-zone distribution, with a 1% decrease in the improvement zone (7% in 2013 versus 8% in 2012) and a 6% decrease in the refinement zone (43% in 2013 versus 49% in 2012). These data show an improvement in the efforts and effectiveness of engagement, although the percentage acceptable is the same as 2012.

Culturally Appropriate Practice. Cultural accommodations enable service providers to serve individuals of diverse cultural backgrounds effectively. Properly applied in practice, cultural accommodations reduce the likelihood that language, culture, custom, or belief will prevent or reduce the effectiveness of treatment efforts. Reviewers look for significant cultural issues that must be understood and accommodated in order for desired treatment results to be achieved. If cultural issues are not a potential barrier in practice or if the consumer does not identify with a particular cultural/ethnic/religious group, this indicator is marked not applicable by reviewers. This indicator was found applicable for 35 youth this year, compared to 13 youth in 2012. Ninety-one percent (91%) were found to have acceptable practice in this area, of which 63% were in the maintenance zone. There is a 6% overall improvement in this area when compared to 2012; however, there is 14% less in the maintenance zone (77% in 2012) and 6% less in the improvement zone (0% in 2012).

Service Team Formation and Functioning. The formation and functioning of the youth and family team, in coordination with all other planning, assessment, and treatment processes the child and family are involved with, is the essential component in facilitating progress toward goals. Without

all necessary personnel, such as teachers, psychiatrists, service providers, probation officers, child welfare workers, community partners, and parents, family members, and youth, communicating and working together to reach the same collectively agreed-upon goals, consistent progress for the child and family with complex needs is very difficult to achieve. The lack of a functional team means that the persons who need to be communicating about a child's participation and effectiveness of interventions, changing circumstances, and results achieved on an ongoing basis are not communicating effectively. It also negatively impacts other essential practice functions, such as assessment/understanding and planning. Acceptable team formation, meaning that all necessary personnel involved with the youth and family participate on the team at least through regular communication, was found in 72% of the 86 youth who participated in the 2013 CSR. This is an increase of 3% from last year's score of 69%. When these data are disaggregated and viewed across the three zones, there is significant difference. Fifty-five percent (55%) of the youth reviewed were rated in the maintenance zone, compared to 39% in 2012. Thirty-eight percent (38%) were in the refinement zone this year, compared to 51% in 2012, and 7% were in the improvement zone, a 3% decrease from 2012.

Strong teaming is a process, rather than a discreet event, and strong team processes include a flow of communication and information among members in a timely manner, members working together to plan and provide interventions, and a respectful and reciprocal relationship with the child and parents. Teams need to be cohesive and non-hierarchical, and able to discern which aspects of teaming to execute at particular times, such as when to meet face-to-face and how to use resources or team members strategically. Service team functioning showed a large increase of 15% when compared to 2012: 58% versus 43%. There is a positive shift also in the three-zone distribution with a 14% increase in the maintenance zone from 21% in 2012 to 35% in 2013, and a decrease in both the refinement and the improvement zones (11% and 2% respectively). This is positive trend that illustrates progress in the system.

Functional Assessment and Understanding. The functional assessment indicator assesses the team's level of understanding of the child and family's needs, goals, strengths, preferences, and underlying factors impacting behaviors and well-being. Additionally, this indicator measures a team's understanding of what dynamic factors need to change in order for youth and families to

have sustainable progress and supports that facilitate safe case closure and prevent future need for formal services. Assessment and understanding are not limited to the presence of assessments, evaluations, or diagnostic tools. This practice function has a direct impact on other aspects of practice, such as planning and the identification and implementation of treatment interventions. Teams were found to have acceptable understanding for 74% of the youth reviewed, a significant increase of 28% from the 2012 review of 46% acceptable. The three-tiered zone results also support the positive shift with a 9% decrease in youth in the improvement zone, a 2% increase in youth in the refinement zone, and an 8% increase in youth in the maintenance zone in this area.

Planning. IRPs are developed for youth receiving mental health services and supports. Plans should extend beyond the function of capturing funds and reimbursement; they should be driving interventions and strategies toward tangible, achievable short- and long-term goals. Planning processes are not limited to the achievement of goals and objectives; adequately planning to prevent and intervene during crises, strategic and step-wise planning for successful transitions, plans for building sustainable natural and community supports, contingency planning, and effective behavior plans are essential. Prior to 2010, planning had been challenged as acceptable ratings were on a downward trend; however, scores for 2010 and 2011 improved and, then in 2012, planning again declined to 48% acceptable. The 2013 data show an 18% improvement with 66% of the youth reviewed having at least minimally acceptable practice in this area. The three-tiered data show a 16% increase in youth in the maintenance zone (35% versus 19% in 2012), a 13% decrease in the refinement zone (51% versus 64% in 2012), and a 2% decrease in the improvement zone. This trend is positive; however, there continues to be difficulty with development of goals that are individualized, measurable, clearly defined, tangible, and aligned across multiple plans.

Goodness-of-Service Fit. All planned elements of therapy, special education, assistance, and support for the child and family should fit together into a sensible combination and sequence that is individualized to match the child and family's particular situation. Goodness of fit is directly related to understanding the situation and the family's opportunity and ability to participate in and benefit from services. Goodness of fit requires that programs, services, and supports are

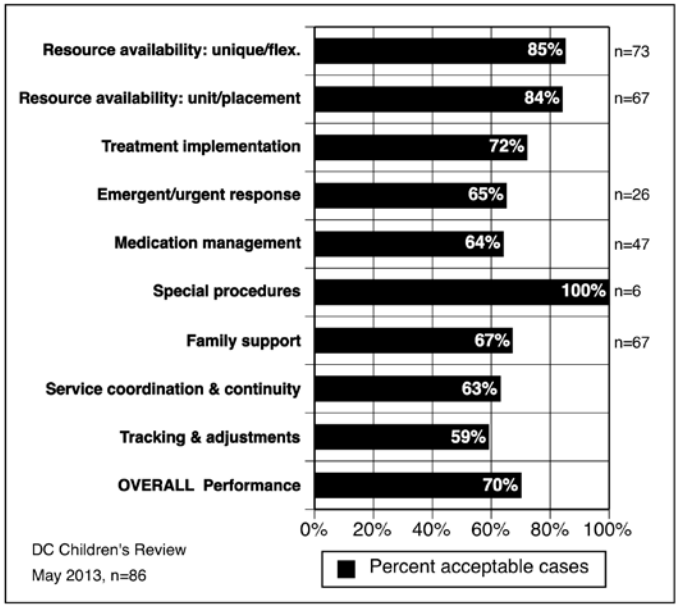
integrated and coordinated across providers and funders. Achieving a good fit optimizes the path and flow of services for maximum results. In past reviews, the combination and sequencing of supports and services was found to be acceptable for approximately half of the children and families served, with this indicator peaking in 2011 with two-thirds (66%) of the youth reviewed having acceptable practice in this area, a finding that is consistent for 2013, which is also an increase of 11% from 2012 (55% acceptable). The three-tiered analysis shows a positive trend with a 10% increase in youth in the maintenance zone and corresponding decreases in the refinement and improvement zones (6% and 3%, respectively).

Findings this year across the key indicators for *planning treatment* indicate a clear upward, positive trend toward achieving strong practice in these eight core areas of practice. There continues to be considerable variability across CSAs with some CSAs providing more consistent, stronger teaming, assessment, and planning, and others continuing to struggle to provide a meaningful and effective assessment, planning, and teaming process. There continues to be a need to work with CSAs, providers, and other child-serving agencies to insure that there is a strong commitment to developing a shared deep understanding of the needs of each child and family served, providing access to basic and specialized assessments and to communicate effectively about the changing context and situations that affect that child and family on a timely basis.

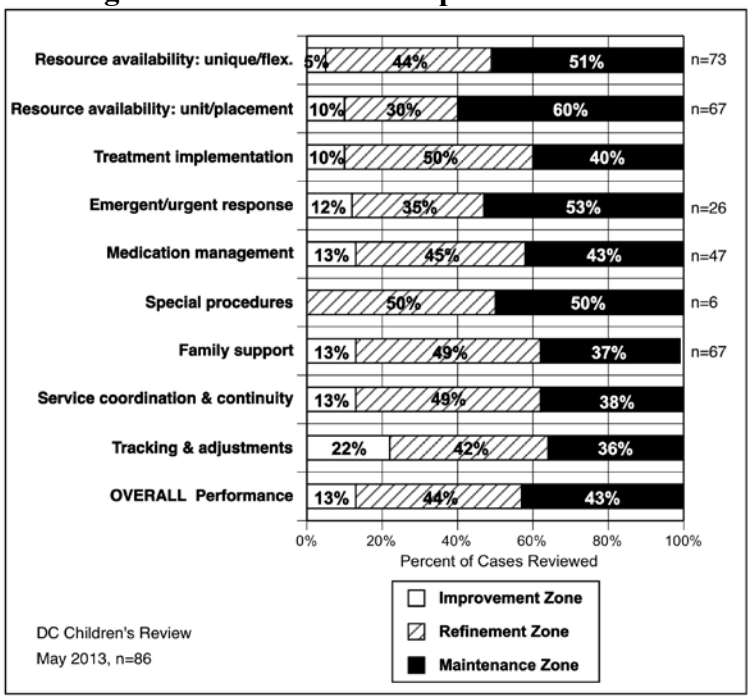
Practice Performance: Providing and Managing Treatment

The second set of performance indicators covers important functions related to the provision and management of treatment and support services to children and families. Findings for these indicators are presented in **Displays 26 and 27** and summarized below. Again, it should be noted that the particular indicators identified as strengths, as opportunities for improvement, or with the greatest degree of change are described in detail below, although data on all indicators are included in the graphs. **Display 28** uses the three-tiered action zone and the acceptable versus unacceptable interpretive frameworks to present the overall practice performance ratings. The eight-year history of the ratings for these indicators can be found in **Display 39**.

Display 26
Percentage of Acceptable Practice Performance:
Providing and Managing Treatment Ratings



Display 27
Practice Performance: Providing and Managing Treatment Ratings
Using the Three-Tiered Interpretive Framework



Resource Availability. This indicator is designed to assess the array of informal and formal supports and services necessary to fulfill requirements of a child's IRP. Resources need to be flexible, creative, easily accessed by providers, youth, and families, and should respond to individual needs. Resource availability, accessibility, and implementation should not be hindered by funding restrictions, and team members should work together to eliminate territorial issues between agencies, providers, and protective authority. Resource availability is captured in two sub-indicator ratings: resources-unique/flexible and resources-unit/placement based.

Resource availability is one of the stronger areas again in the 2013 review, with consistently high ratings in this area: flexible resources (n=73) 85% acceptable, unit-based (n=67) 84% acceptable. For both sub-indicators, the scores shifted from the improvement zone by 4-5% into the refinement and maintenance zones.

These results suggest that the availability of resources in the District continues to improve and is not a primary barrier to treatment implementation. CSWs and providers are not only more aware of resources, they are also accessing and linking families to resources more often.

Treatment Implementation. Acceptable treatment implementation includes timely, dependable, and consistent actions by service providers; supports and services delivered at the needed intensity to address priority needs; and frontline workers (e.g., therapists, CSWs, case managers) who receive the support and supervision necessary to fulfill their responsibilities. Treatment implementation in 2013 was acceptable for 72% of the youth reviewed, an increase of 7% from the 2012 score of 65% acceptable. Distribution across the three zones shifted by 5% primarily from the refinement to the improvement zone.

Emergent/Urgent Response. A child or youth who presents dangerous psychiatric symptoms, severe maladaptive behaviors (e.g., running away, fire starting), or acute episodes of chronic health problems (e.g., seizures, HIV, asthma) may require immediate and intensive services to meet the child's urgent need and to prevent harm from occurring to the child or others in the child's environment. Reviewers look to see whether children, caregivers, and service providers are aware of the plan and its contents, and if they have timely access to support services

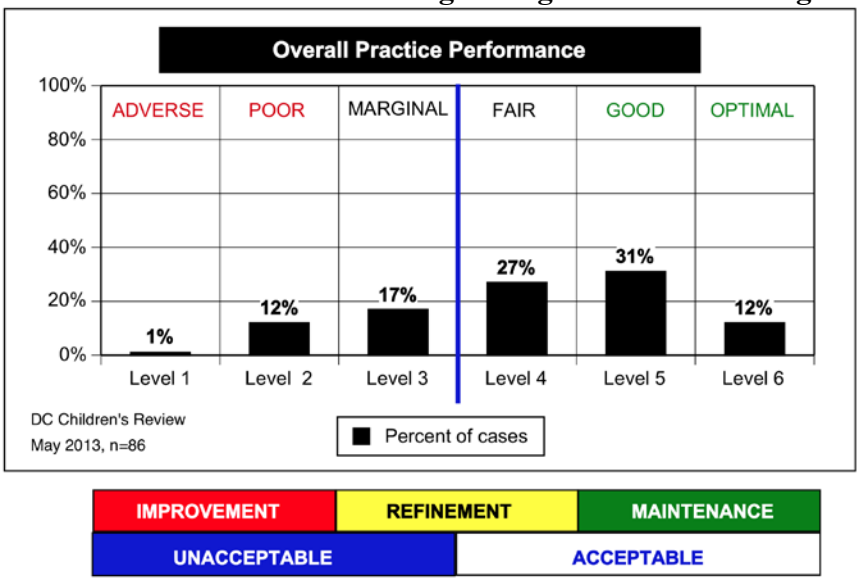
necessary to stabilize or resolve urgent problems. The urgent response indicator was rated as applicable for 26 youth this year (compared 40 in 2012), and acceptable for 65% (63% in 2012). This is only a slight improvement from 2012. The three-tiered distribution shows an 18% increase in youth in the maintenance zone (35% in 2012; 53% in 2013).

Medication Management. Use of psychotropic medications is one of many treatment modalities that may be used in treating a child with mental health problems and should be coordinated with other aspects of treatment and intervention. The effects and side effects of medication use should be assessed, tracked, and used to inform decisions regarding medication management and changes. Reviewers look to see that medications are taken as prescribed; prescriptions are current; medications are monitored regularly by a health care professional, usually a psychiatrist; and there is a correlation between each medication and a DSM-IV-R Axis I diagnosis. Historically, this indicator is an area of strength in practice; however, there is a slight decline again this year from 68% in 2012 to 64% in 2013 (n=47). Demographic data presented above show 45 youth were prescribed medications. The three-tiered analysis shows a 7% shift toward the refinement zone from the maintenance and improvement zones when compared to 2012 (improvement zone-13% in 2013 versus 17% in 2012; refinement zone-45% in 2013 versus 38% in 2012; maintenance zone-43% in 2013 versus 45% in 2012). One of the most commonly observed challenges this year is the lack of consistent teaming and communication between prescribers and other team members. Also, there continue to be some difficulties accessing prescribers due to availability. Additionally, there continue to be challenges with youth and children not taking medications as prescribed and/or parents not being supportive of medications as an intervention.

Tracking and Adjustment. The tracking, adjustment, and modification of services and supports are essential to achieving and sustaining positive gains. This process requires that a team be formed, have an adequate understanding of the youth and family, and be communicating and working with each other. Practice in this area improved by 8%, with 59% of the youth reviewed having acceptable ratings (51% in 2012). There was a 7% shift out of the refinement zone toward the improvement and maintenance zones as follows: 36% in the maintenance zone in 2013, compared to 33% in 2012; 42% in the refinement zone in 2013, compared with 49% in 2012; and 22% in the improvement zone in 2013, compared to 18% in 2012.

Overall Practice Performance. The protocol provides a scoring rubric for combining rating values across the items deemed applicable to the child or youth being reviewed to produce an "overall practice performance rating." Applying this rubric resulted in the determination that overall practice performance was rated as adequate (rating levels 4, 5, and 6) in 70% of the children and youth included in the review, a 5% increase from the 2012 results of 65% acceptable. The 2013 review shows a 12% shift of youth from the refinement zone to the maintenance zone (refinement zone-44% in 2013 versus 56% in 2012; maintenance zone-43% in 2013 versus 31% in 2012), further illustrating that practice improvement is on a steady, upward trajectory and an overall score that meets the Settlement Agreement for the Dixon Lawsuit.

Display 28
Overall Practice Performance Ratings Using the 6-Point Rating Scores

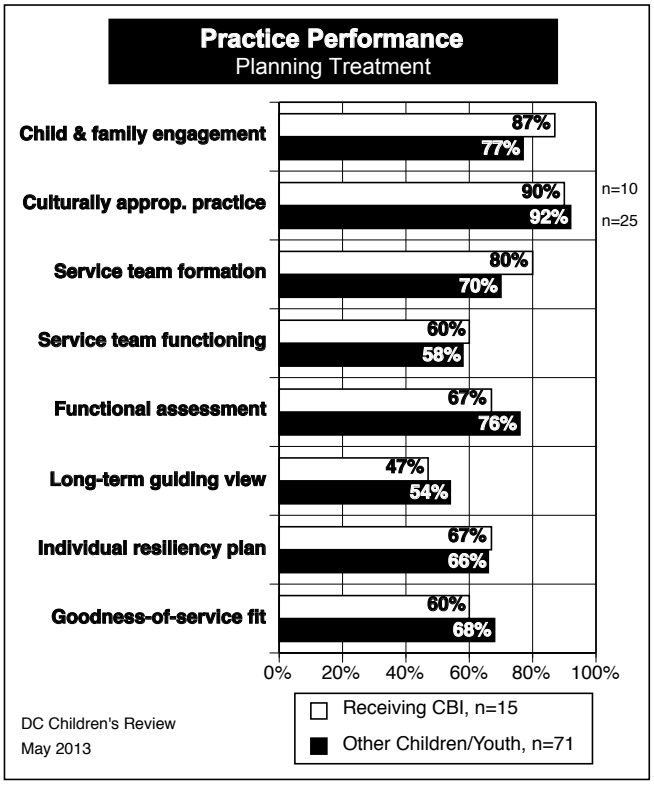


Comparison of CBI Services

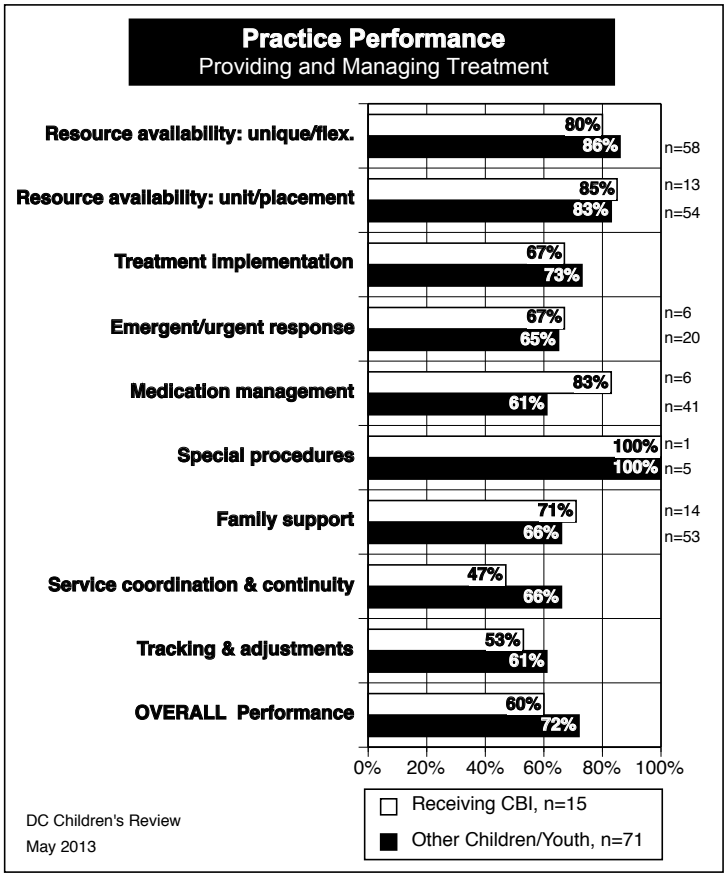
Fifteen youth were receiving community-based intervention (CBI), multi-systemic therapy (MST), or wraparound services in the 2013 CSR, six less than in the 2012 review where 21 youth were receiving these services. Two youth were receiving intensive wraparound services, both of which were also receiving CBI services and are included as CBI in the graph below. The following **Display 29** shows the practice scores for the children and youth in the 2013 review

who were receiving CBI/MST/wraparound services and compares these scores to the children and youth who were not receiving CBI services. Overall practice for the CBI children did not necessarily have better system performance or services (60%, a decrease of 7% from the 2012 data of 67%) when compared to the non-CBI children (72%). The foundational elements of practice have the most noticeable differences, as illustrated below in Display 29; the largest difference being in service coordination and continuity with 47% of CBI youth having acceptable practice in this area, compared to 66% of non-CBI youth. The other noticeable differences were in the results for functional assessment (67% CBI; 76% non-CBI), long-term guiding view (47% CBI; 54% non-CBI), treatment implementation (67% CBI; 73% non-CBI), and goodness-of-service fit (60% CBI; 68% non-CBI). The n size for each group should be noted, as there were 15 CBI youth and 71 non-CBI youth. Additionally, youth receiving CBI, MST, and wraparound services are the most challenging in the system.

Display 29
Percentage of Acceptable Practice Performance:
CBI Versus Non-CBI Children and Youth



Display 29 (continued)
Percentage of Acceptable Practice Performance:
CBI Versus Non-CBI Children and Youth

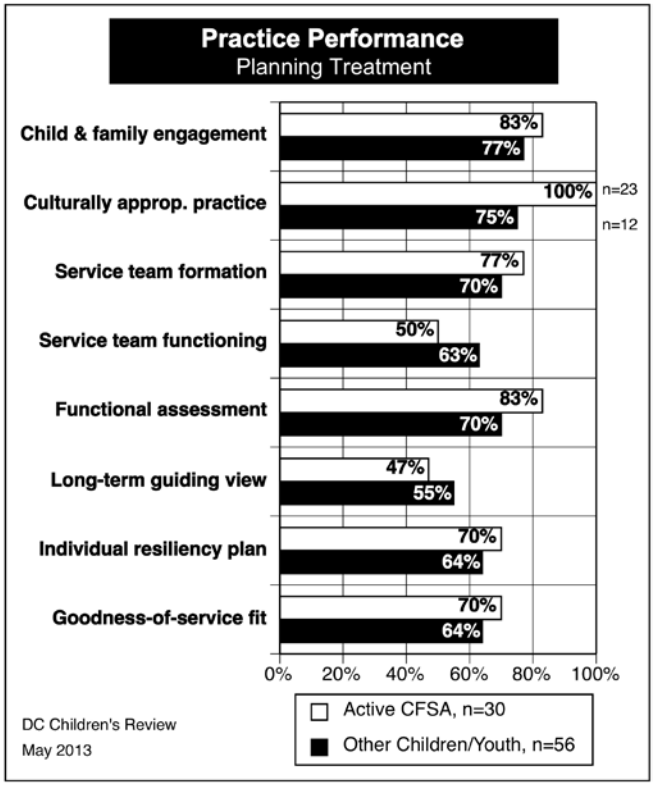


Comparison of CFSA and Non-CFSA Ratings

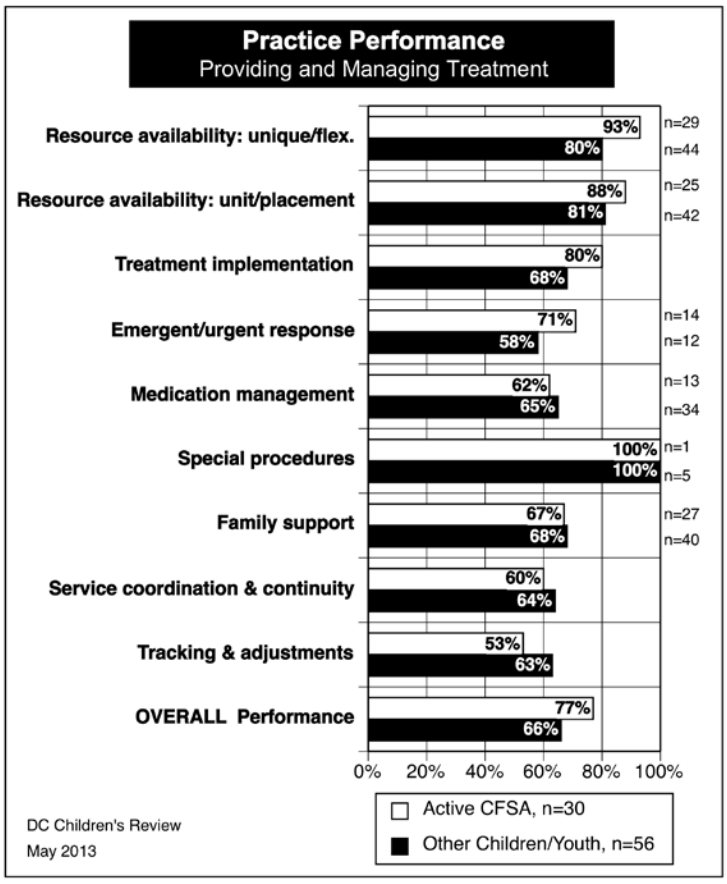
As noted earlier, 30 youth were also currently involved with CFSA during the time of the 2013 review. Overall, youth involved in CFSA scored higher on progress and system performance indicators as shown in **Display 30**. Overall status for CFSA youth was 70% acceptable, compared to 77% for youth not involved with CFSA. Overall progress pattern was rated 80% acceptable for CFSA youth also, compared with 64% acceptable for non-CFSA youth. Overall system performance was stronger for CFSA youth, with 77% having acceptable overall practice versus 66% for non-CFSA youth. It should also be noted that the majority of CFSA youth are mostly served by one or two of the largest CSAs. These CSAs have focused on improving the quality and consistency of practice by developing internal processes, strengthening the supervision of practice, and providing additional training to staff.

Specific system indicators illustrate big differences in scores as follows: team functioning- CFSA 50% versus non-CFSA 63%; functional assessment-CFSA 83% versus non-CFSA 70%; treatment implementation-CFSA 80% versus non-CFSA 68%; urgent response-CFSA 71% versus non-CFSA 58%.

Display 30
Percentage of Acceptable Practice Performance:
CFSA Versus Non-CFSA Children and Youth



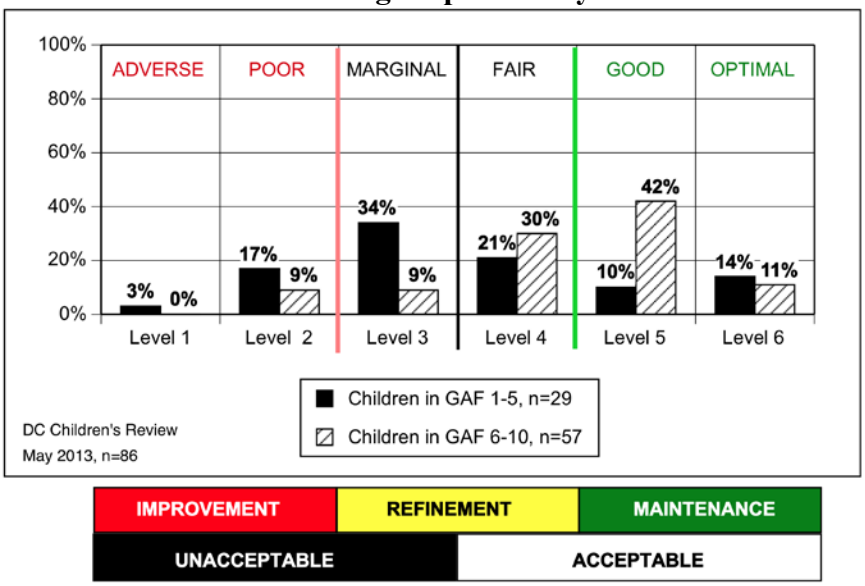
Display 30 (continued)
Percentage of Acceptable Practice Performance:
CFSA Versus Non-CFSA Children and Youth



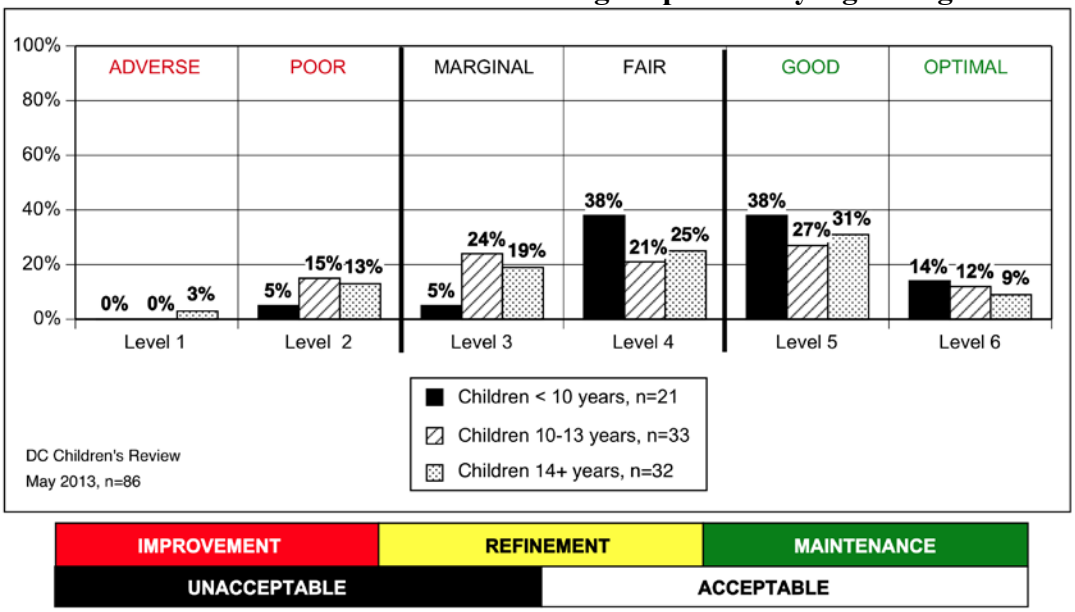
In **Appendix C** of this report are agency-by-agency results for the children and families reviewed. **This agency-by-agency comparison should be interpreted with caution, since review sample sizes for some of the provider agencies are extremely small**. **Generalizations regarding specific agency practice should not be made based on the individual case review results due to the small review sample sizes for the agency-specific findings**, rather the small review samples of children and youth are illustrative of practice performance for each of those randomly selected children from subsequent participating agencies and in the context of the larger mental health system. The combined or aggregate findings from the review can be considered indicative of trends and patterns for children, youth, and families receiving services across the District. The following two displays provide additional methods of interpreting this

year's review results. **Display 31** provides the overall practice performance ratings separated by the child's general level of functioning. **Display 32** provides the overall practice performance ratings separated by age range.

Display 31
Overall Practice Performance Ratings Separated by Level of Functioning Range



Display 32
Overall Practice Performance Ratings Separated by Age Range

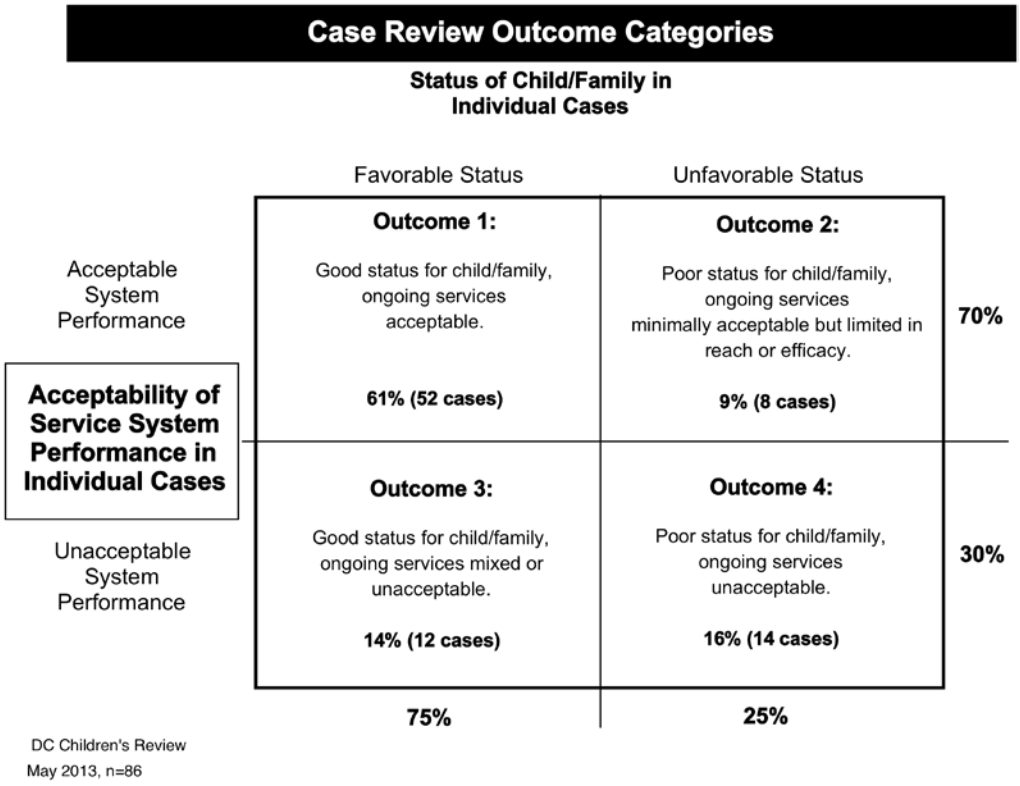


Review Outcome Categories

Children who were reviewed 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 practice 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 practice performance." These categories are used to create the following two-fold table.

As **Display 33** indicates, 61% or 52 of the 86 youth reviewed were in outcome category 1, a 5% improvement from 2012. Outcome 1 is the desired situation for all children and families receiving services because it indicates both the child/family are doing well and the system is able to provide the appropriate interventions and supports for the child/family. There were eight youth (9%) in outcome category 2, the same finding as in 2012. This category represents children whose needs are so great or complex that despite the best practice efforts and diligent practice performance of the service system, the overall status of the child or youth is still unacceptable. Fourteen percent or 12 children and youth were in outcome category 3, compared to 15% or 13 youth in 2012. Outcome 3 contains those review sample members whose status was favorable at the time of the review but who were receiving less than acceptable practice 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 practice performance is limited, inconsistent, or inadequate at this time. For many of these children, focused efforts in one area of practice likely could result in the child progressing into the outcome 1 category. This year, 14 youth or 16% of the review sample were in outcome category 4, 4% less when compared to 18 youth (20%) in the 2012 review. Outcome 4 is the most unfavorable combination as the child's status is unfavorable and practice performance is inadequate.

Display 33
Case Review Outcome Categories

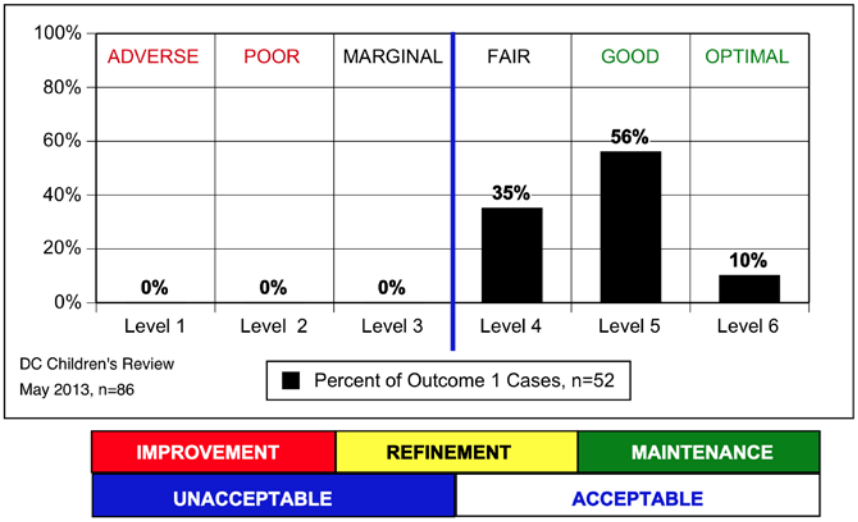


Displays 34 to 37 show the distribution of scoring on the 6-point scale for the children who were in each of the outcomes shown in Display 33. For example, for Outcome 1, the charts in Displays 34a, 34b, and 34c show the distribution of child status ratings, progress ratings, and practice performance ratings, respectively. Display 34a shows that 35% of the 52 children in Outcome 1 had overall status indicators rated 4-fair, 56% rated 5-good, and 10% rated 6-optimal. Sixty-six percent of these 52 youth had a status rating in the maintenance zone with 5-good or 6-optimal, compared to 68% in 2012. Display 34c shows that practice efforts for these youth shifted positively toward the maintenance zone when compared to the 2012 findings of 52% having overall practice ratings of 4-fair, and 48% having overall practice ratings of 5-good or 6-optimal. In 2013, 65% of the youth in this outcome category had an overall practice rating in the maintenance zone and 35% has an overall rating of 4-fair/refinement zone.

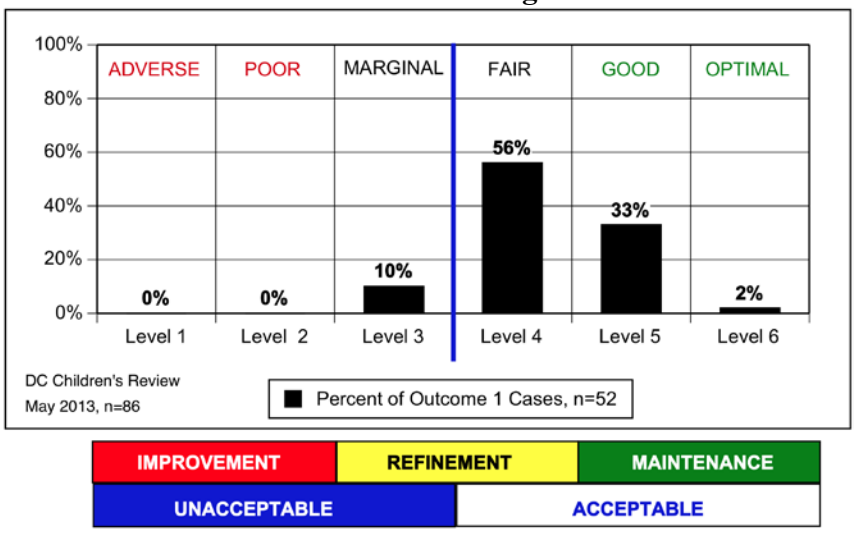
The breakdown for Outcome 4, Display 37a, shows that 21% of the 14 youth in this outcome category were rated 1-adverse/improvement zone or 2-poor/improvement zone and 79% were rated

3-marginal/refinement zone for child status. Display 37c shows 43% of the 14 youth rated in the improvement zone have a rating of 2-poor for overall practice and 57% in the refinement zone have a rating of 3-marginal (there was one youth rated 1-adverse/improvement zone). This is a 4% increase in the percentage of youth in the improvement zone when compared to 39% in 2012.

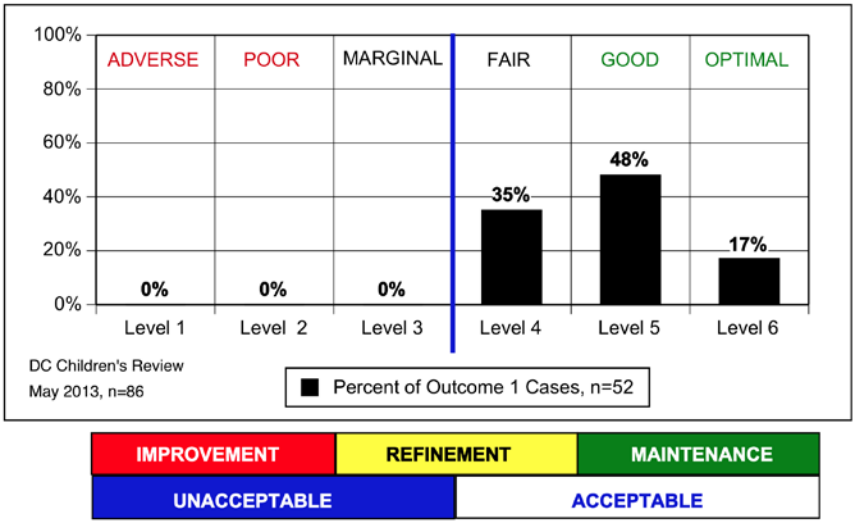
Display 34a
Outcome 1
Overall Child/Youth Status



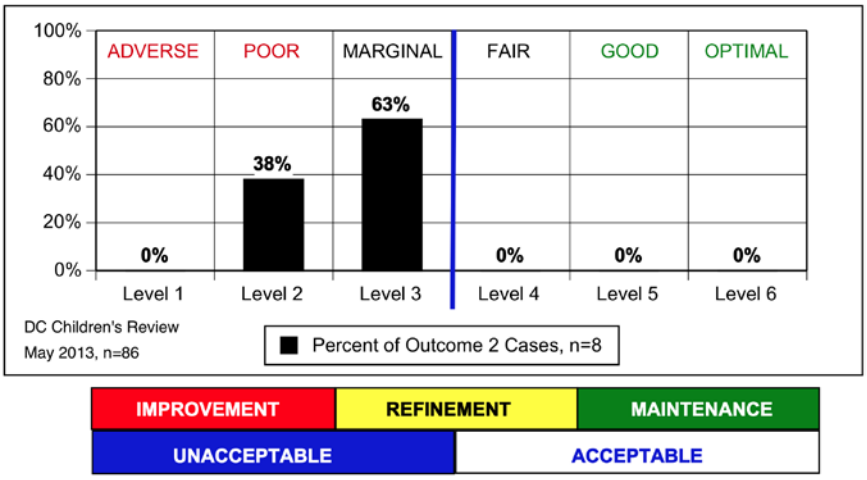
Display 34b
Outcome 1
Overall Recent Progress



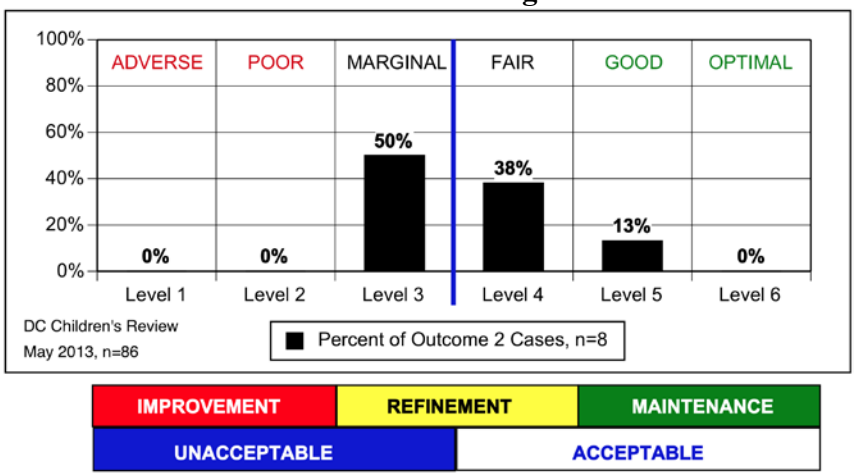
Display 34c
Outcome 1
Overall Practice Performance



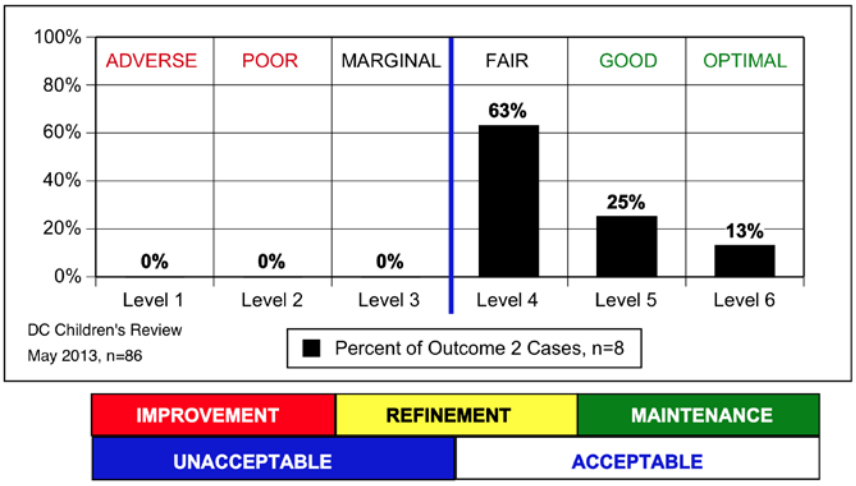
Display 35a
Outcome 2
Overall Child/Youth Status



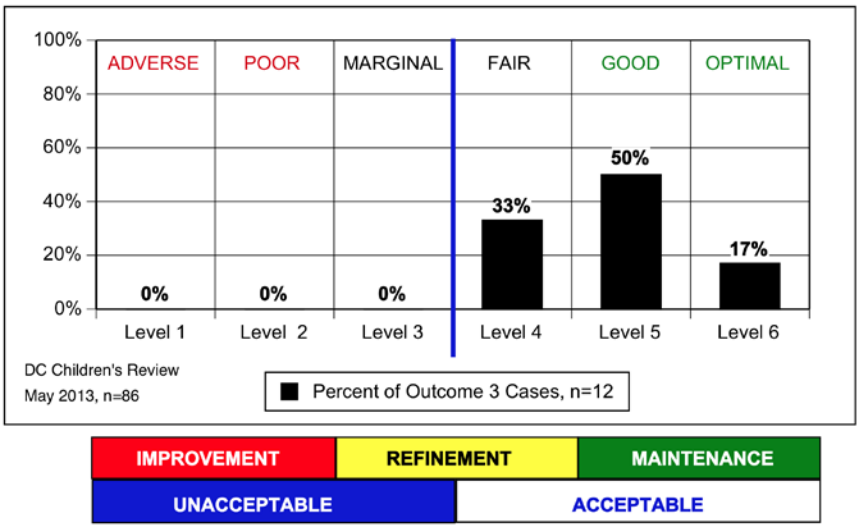
Display 35b
Outcome 2
Overall Recent Progress



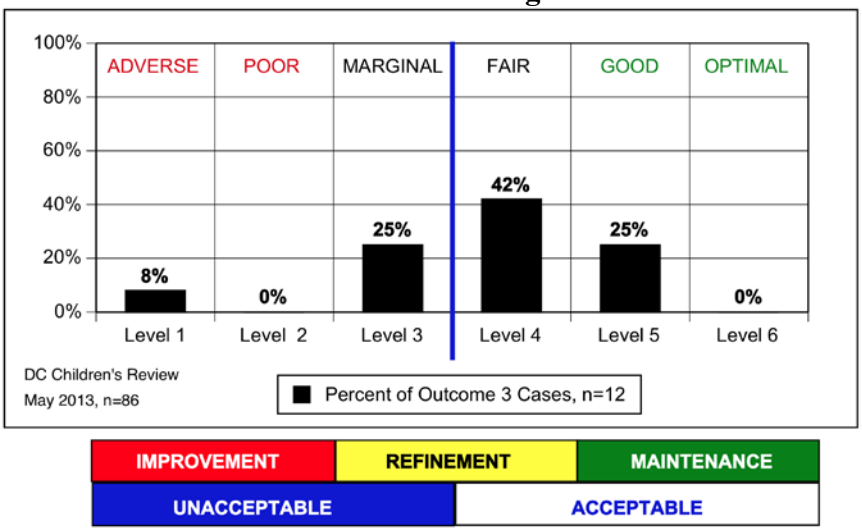
Display 35c
Outcome 2
Overall Practice Performance



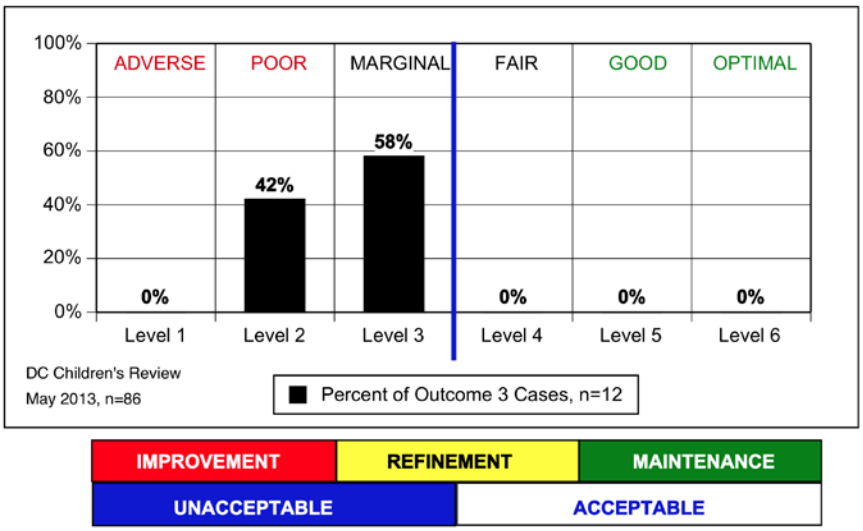
Display 36a
Outcome 3
Overall Child/Youth Status



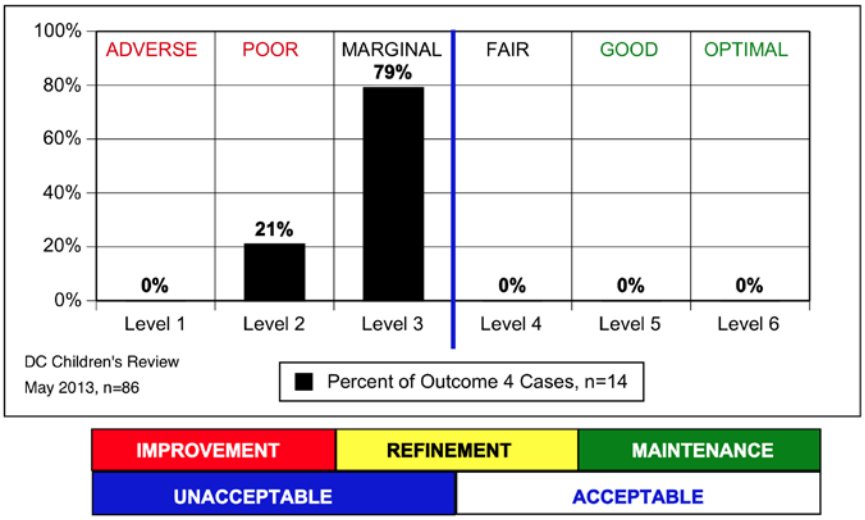
Display 36b
Outcome 3
Overall Recent Progress



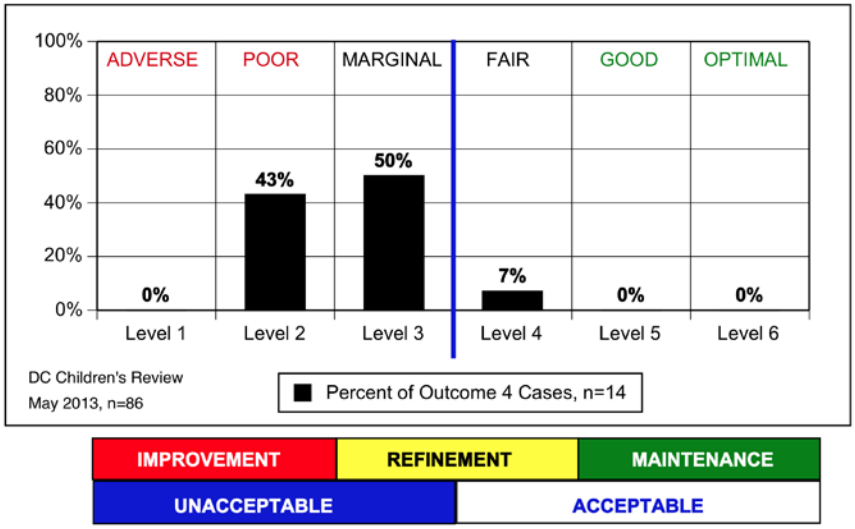
Display 36c
Outcome 3
Overall Practice Performance



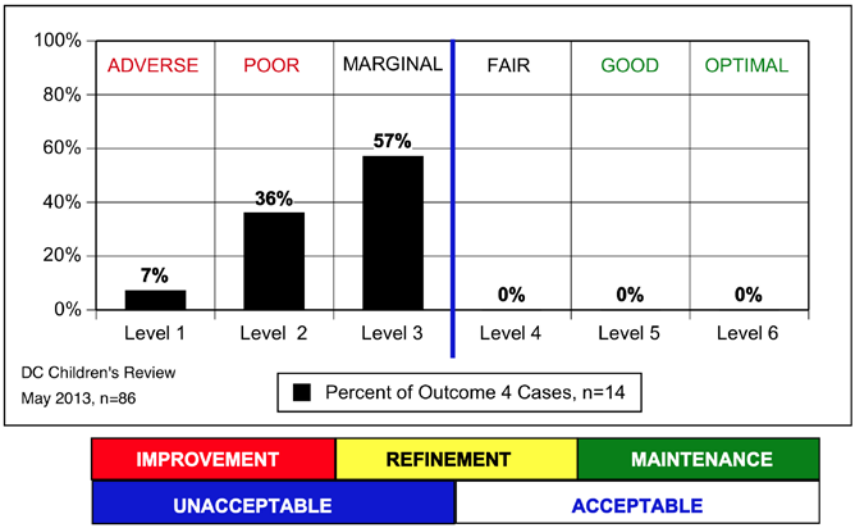
Display 37a
Outcome 4
Overall Child/Youth Status



Display 37b
Outcome 4
Overall Recent Progress



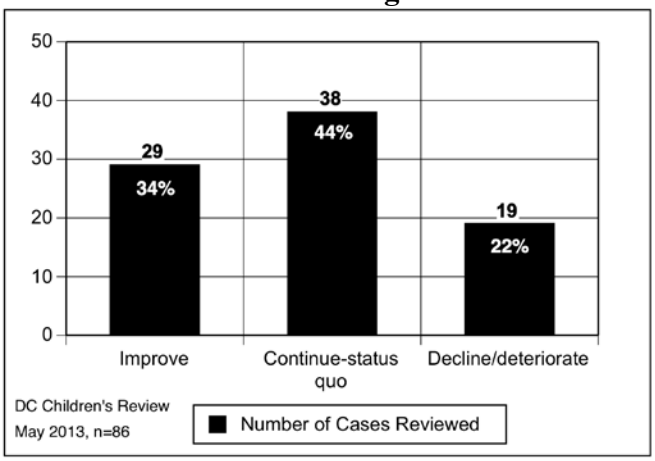
Display 37c
Outcome 4
Overall Practice Performance



Six-Month Prognosis

Reviewers provide a six-month prognosis for each member of the review sample based on an overall impression of the current status and trajectory of the child or youth, how the system is performing for that individual child or youth, and any known upcoming transitions or changes. **Display 38** presents the six-month prognosis offered by reviewers for all children and youth in the review. As the display indicates, 29 youth (34%) were expected to improve, 38 (44%) were expected to remain about the same, and 19 (22%) were expected to decline or experience deterioration of circumstances over the next six months. The prognosis for improvement increased by 8% from the 2012 review.

Display 38
Six-Month Prognosis

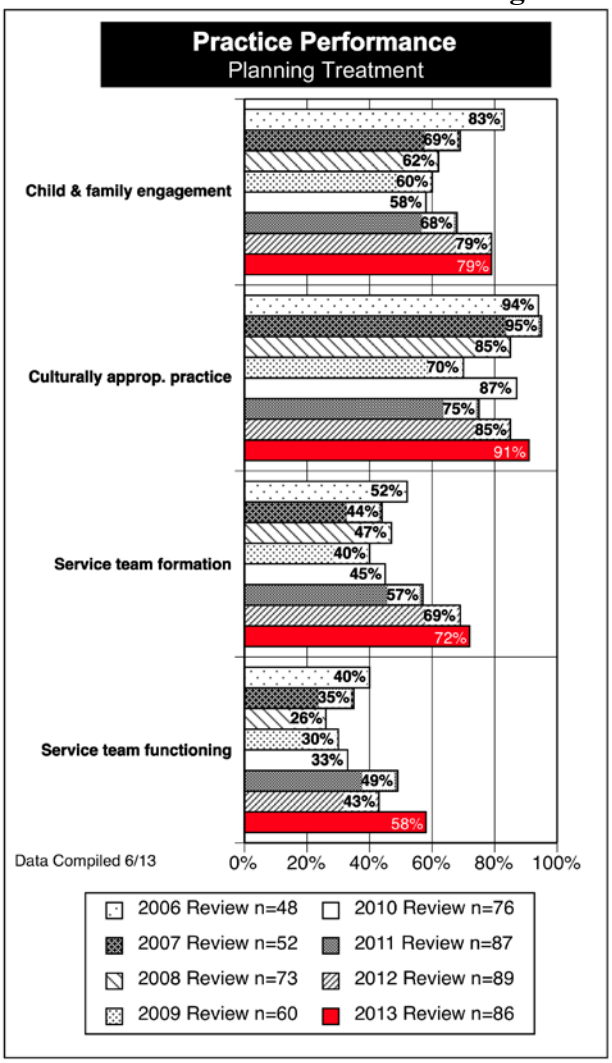


Overall, the results of the 2013 CSR data show that consistency and quality of practice continues to improve. The overall percentage of children who are provided services with the quality, coordination, consistency, and diligence necessary to achieve progress and improvements in children has improved by 5% since the 2012 review and by 36% since the lowest overall acceptable practice score of 34% in the 2008 review. There is improvement in some of the core practice functions of teaming, assessment, and planning.

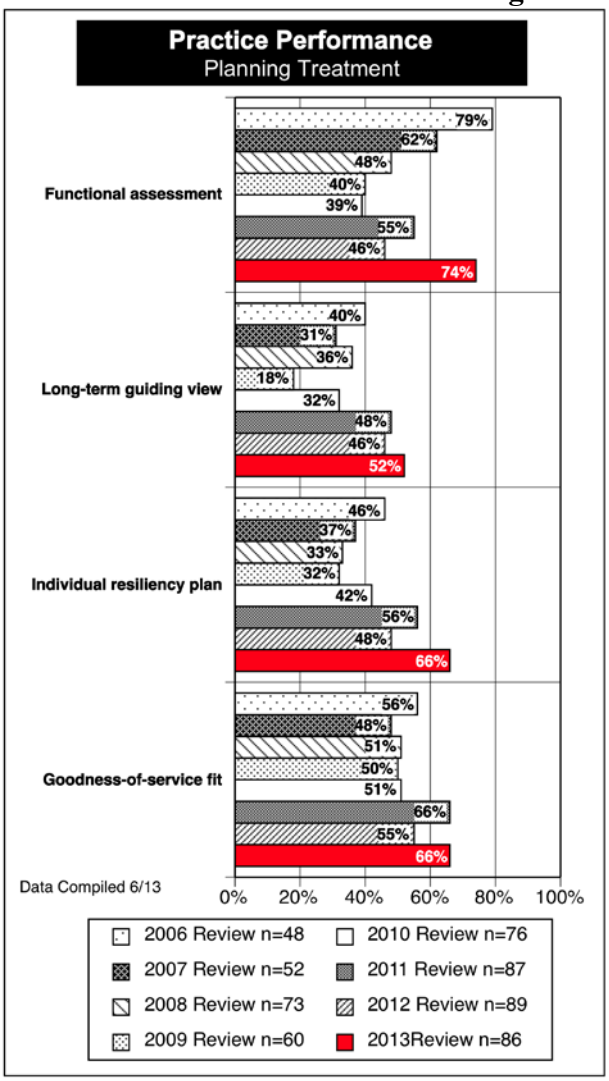
Display 39 shows the results for practice performance for the past eight years in which CSRs have been conducted. The data trends do not show real significant improvement in the consistent implementation of quality services until the 2011 review. In spite of significant improvement in

systemic issues and progress in coordination and communications across child-serving agencies, the overall quality and consistency of actual practice with children and families, as shown by a random sample of children selected across the system, had shown very little improvement in the years up to 2010. The positive trend in improvement continues this year with the overall acceptable practice score reaching 70%.

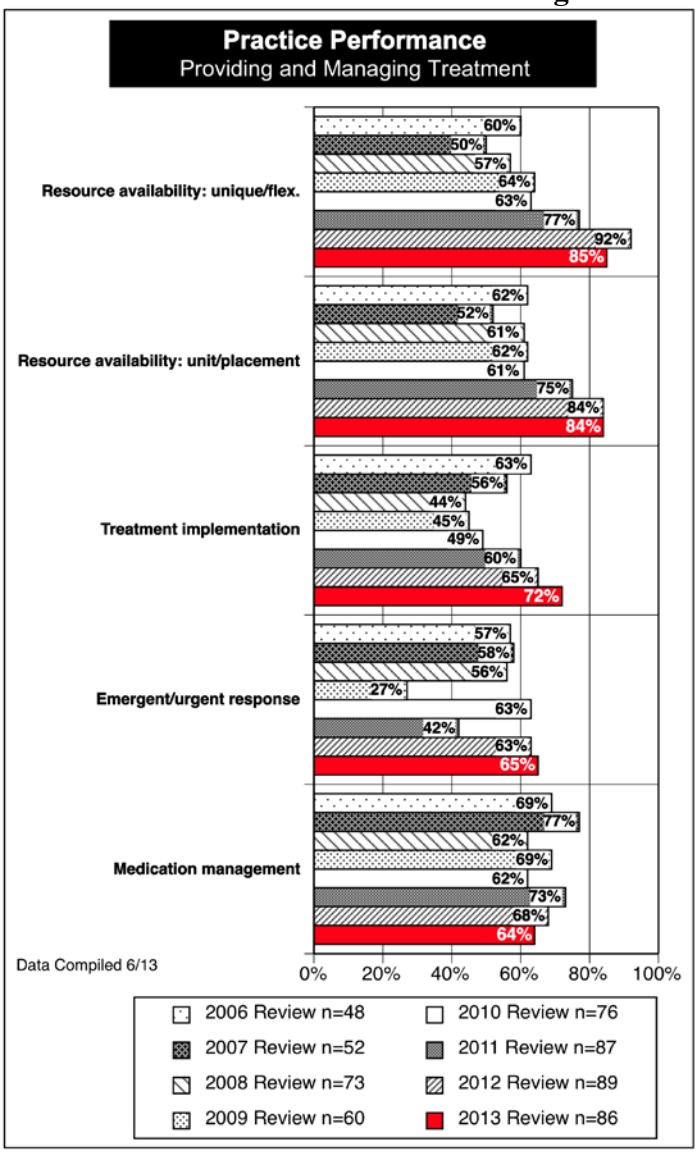
Display 39
Child Practice Performance Results for Eight Reviews



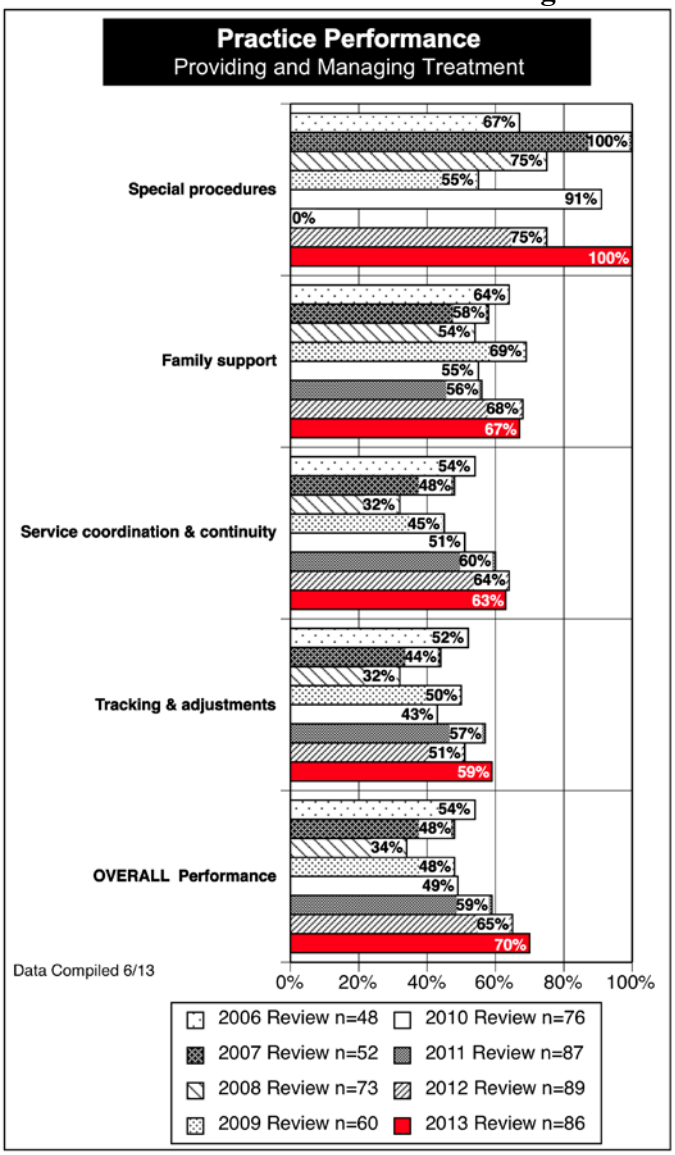
Display 39 (continued)
Child Practice Performance Results for Eight Reviews



Display 39 (continued)
Child Practice Performance Results for Eight Reviews

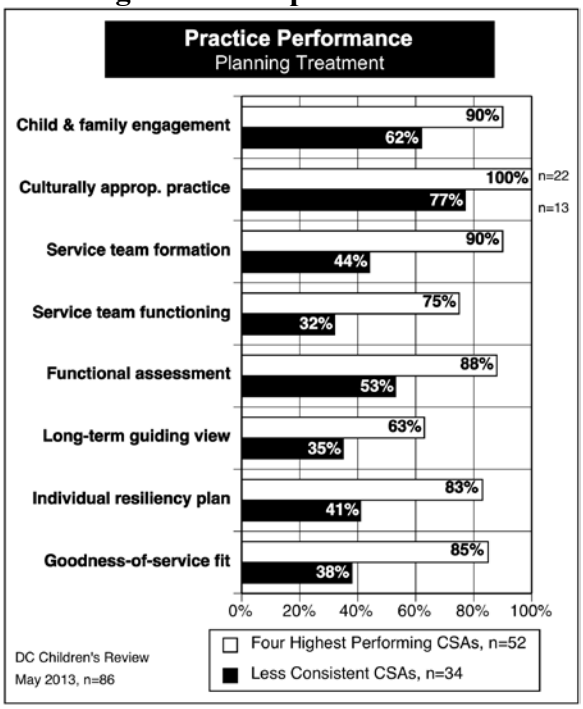


Display 39 (continued)
Child Practice Performance Results for Eight Reviews

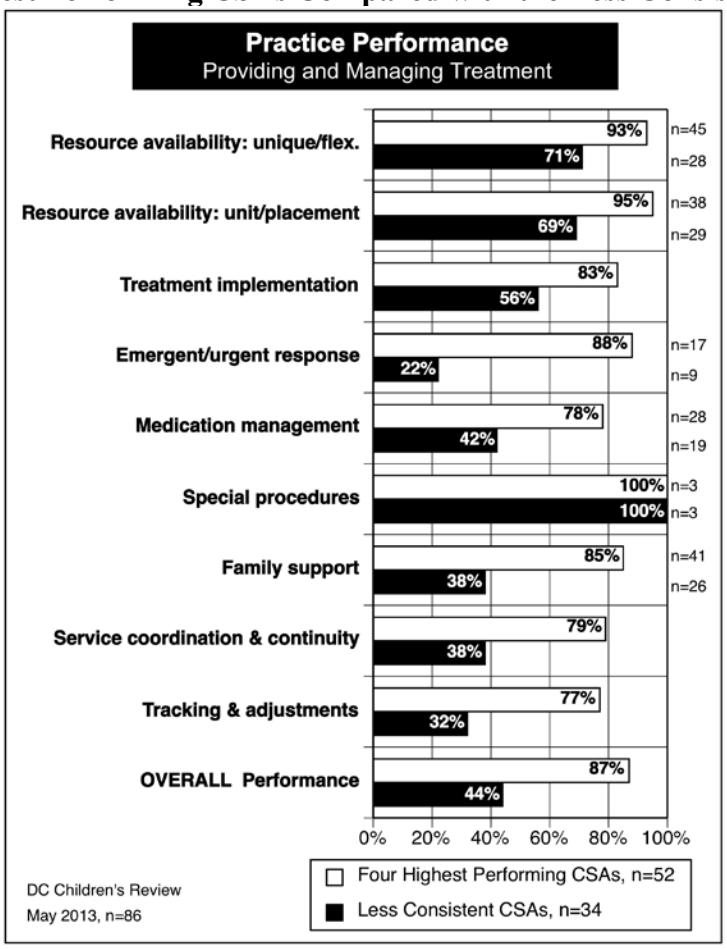


Examination of the individual CSA data shows great variability across the CSAs. Some CSAs have dramatically improved the quality and consistency of services in the past year. This year, the top performers were the large- and medium-sized providers of children's services and, specifically, include First Home Care, Community Connections, Life Enhancement Services, and Universal Health Care. Life Stride/Affordable Behavioral Consultants also did well for the three youth who were reviewed there, with all three (100%) having at least minimally acceptable practice. In 2013, there was a large increase in acceptable overall practice for Universal Health Care, from 58% in 2012 to 82%. There continues to be great variability in the consistency of delivery of high quality services among the smaller agencies. Displays 40-43 show the system performance data for the four top performers, compared to all other CSAs. (See Appendix D for the complete comparison data). Examination of the performance data at the domain level (**Displays 40 and 41**) or at the overall level (**Displays 42 and 43**) shows that there is dramatic difference in the quality and consistency of performance in some CSAs. The overall system performance level was 87% for the top four CSAs with the highest quality and consistency in practice. The remaining CSAs scored 44% for overall system performance.

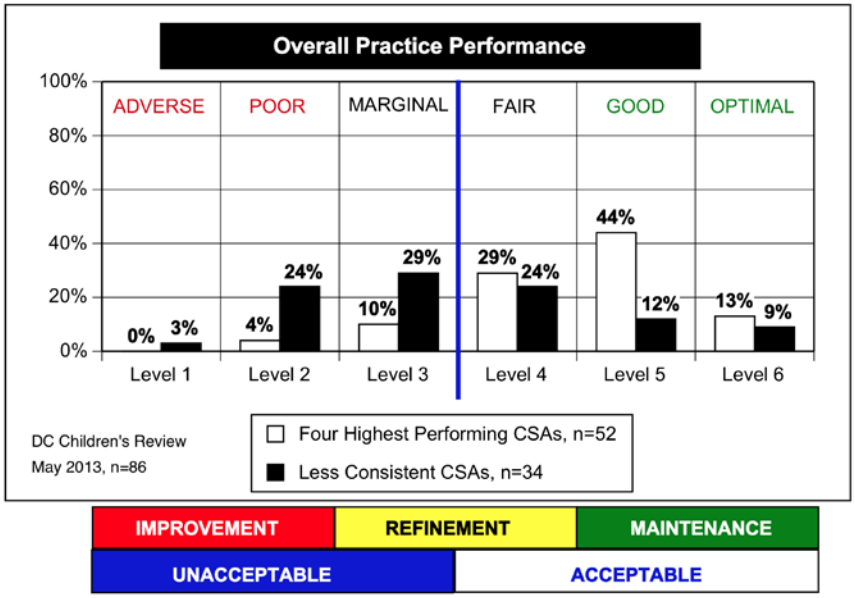
Display 40
Percentage of Acceptable Practice Performance: Planning Treatment Ratings
Four Highest Performing CSAs Compared with the Less Consistent CSAs



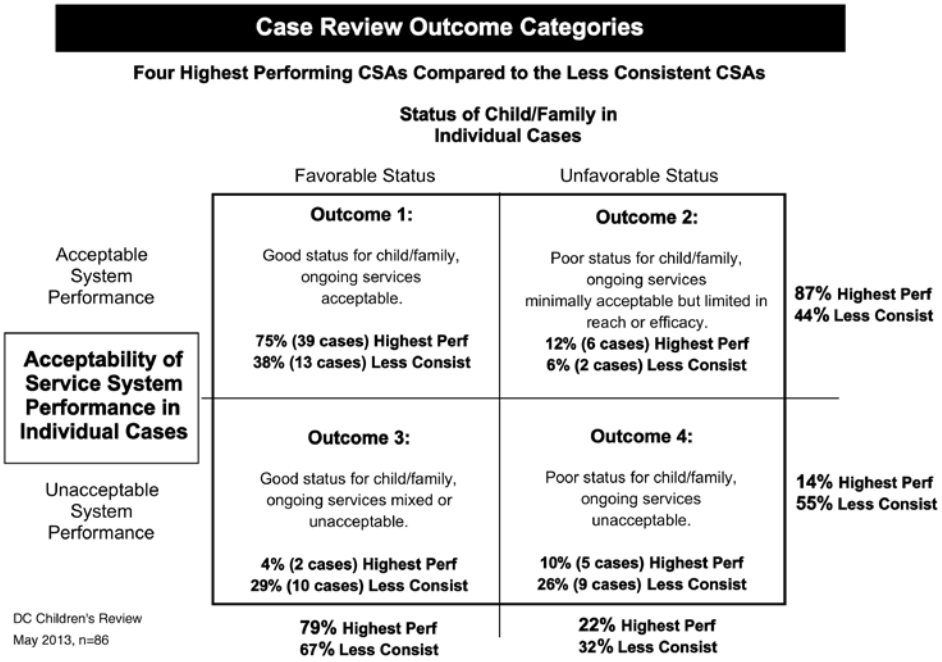
Display 41
Percentage of Acceptable Practice Performance:
Providing and Managing Treatment Ratings
Four Highest Performing CSAs Compared with the Less Consistent CSAs



Display 42
Overall Practice Performance
Four Highest Performing CSAs Compared with the Less Consistent CSAs



Display 43
Case Review Outcome Categories
Four Highest Performing CSAs Compared with the Less Consistent CSAs



Qualitative Summary of Child Review Findings: Themes and Patterns Noted in the Individual Reviews and in the Stakeholder Interviews

The findings discussed above are further reflected in the thematic issues identified in the case write-ups and debriefing of the service strengths, barriers, and patterns found for the 86 children and families who were reviewed. Further support for these themes was also found in the input received from the stakeholder focus groups. Input from the debriefing and stakeholder interviews, as well as themes, trends, and challenges and opportunities of change, is summarized below.

Individual child reviews completed during the CSR were debriefed with review team members in order to more readily recognize themes and patterns emerging out of the review sample. The following is a list and general discussion of systemic themes and patterns gathered from the 2013 review of services for children and youth. Specific areas of strengths and opportunities for improvement are described separately. In addition to the child and family reviews, stakeholder interviews and focus groups were conducted with 48 persons who are involved with children's services in the District. The information gleaned from these discussions is included in the discussion of themes and patterns. Overall, four focus groups were conducted over a two-week period of time and included CSA staff, CFSA, and DMH leadership and staff.

- A majority of the youth reviewed this year were again found to be safe from harm (by self or others) and abuse/neglect (83%, an increase from 76% in 2012), were in an appropriate home and school placement (97%, compared with 93% in 2012), and were experiencing good health (94% versus 96% in 2012).
- Youth are making progress, with 70% showing a minimally acceptable pattern, or upward trend. Prognosis for youth reviewed in 2013 showed more youth who were likely to improve in the next six months than in 2012; 34% in 2013 versus 26% in 2012.
- The overall rating for acceptable practice is 70%, an increase of 5% from 2012 (65% overall acceptable practice) and an increase of 11% from 2011 (59%).

There continues to be variability in the delivery of consistent, high quality services. Strengths and challenges were not observed consistently across the system in each of the agencies reviewed. One of the factors that contributes to this variability is how the agency is structured, with some agencies struggling with basic infrastructure, such as regular, frequent, structured clinical leadership meetings, and other agencies continuing to use contracted or part-time workers. The use of contractors presents significant challenges for supervision, accountability, and coordination of services. An additional contributing factor is the incompatibility of the business and practice models, making the delivery of quality, viable services challenging, with smaller agencies having the greatest challenges in accomplishing this. The message that quality practice is the priority and expectation should continue to be clearly stated by both DMH and individual CSA leadership, and in collaboration with CFSA and other departmental partners. The emphasis on quality practice should be promoted by DMH with fiscal support, training and technical assistance, resource development, and collaborative problem solving.

Strengths Observed During the Reviews

- Practice expectations have also been imbedded in DMH policy since late 2011, which required providers of service to adhere to these expectations. This important step by DMH illustrated the District's commitment to providing high quality services to families and youth. Reviewers noted that there is a better understanding of foundational elements, functions and expectations of practice across all CSAs, from leadership to supervisors to frontline staff. In the second half of 2012, DMH also provided technical assistance to several CSAs in order to guide, direct, and support the understanding and execution of the practice expectations.
- There continue to be strong therapeutic, trusting relationships between providers and youth and caregivers. Engagement of families, youth, and caregivers was rated acceptable for 79% of the youth reviewed.
- The development and functioning of teams has improved significantly, compared to 2012. Team functioning improved with a 15% increase in acceptable practice in this area (from 58% in 2012 to 72% acceptable in 2013) and a 14% increase in youth in the maintenance zone with a score of 5-good or 6-optimal.

- Reviewers noted that there is a better situational awareness of youth and families, with providers better at gathering needed information and identifying trauma as a key underlying factor impacting the behaviors and functioning of youth and caregivers. Functional assessment showed the largest increase during the 2013 review of 28%, with an overall score of 74% acceptable. Cultural competency was also rated strong, with 91% acceptable practice in this area for the 35 youth to which it was applied.

Challenges Observed During the Reviews

- With the strengthening of the formation and functioning of teams, there are ongoing challenges with coordinating teams, conducting regular, useful communication via in-person meetings or through virtual communication, and knowledge of how to facilitate teams and when face-to-face meetings should be held.
- There are continued opportunities for CFSA and DMH to work together to identify common goals, streamline service plans, blend resources, and work in a collaborative effort with families and youth.
- Functional assessment and understanding improved significantly this year. Reviewers found a need for strengthening diagnostic clarity and identifying appropriate diagnosis. For example, many youth had Not Otherwise Specified as part of the diagnosis and had this placeholder for long lengths of time without resolution or clarification. Additionally, although the identification of trauma was a core issue for families, reviewers indicated some teams did not know what steps to take to address and resolve trauma issues.
- The impact of unresolved permanency, multiple staff changes, and poorly anticipated and planned transitions are areas identified for further training and teaming.
- Academic performance was a concern for reviewers this year (academic status 62% acceptable), with many youth failing or not attending school. There also was a lack of urgency in planning summer activities for some youth.

Issues Pertaining to CSWs in Particular

- The past discrepancies and confusion regarding the roles and responsibilities of CSWs to coordinate care, work with youth and families to build skills, and link youth and families to community resources is beginning to diminish. Reviewers noted that there is a better understanding and execution of the comprehensive Community Support services and the CSW function.
- Debriefing discussions identified that there appears to be more clinical supervision, oversight, and support of CSWs system-wide. DMH has been and will be providing multiple trainings on evidence-based practices. Although there is improvement, there continues to be a need for strengthening in this area.
- It is clear again this year that CSWs are committed to youth and families and strive to provide quality services. Many CSWs, therapists, and service providers are doing whatever it takes in order to positively impact the lives of youth and families.

Stakeholders

CFSA continues to make progress and see improvement in collaborative efforts between the agencies. CFSA and DMH have both received federal funding to impact System of Care and promote trauma-informed systems. They have an excellent working relationship with Mrs. Morilus-Black and her staff. CFSA has applied for the IV-E waiver that will potentially redesign current prevention services and to increase the capacity of the community to develop and deliver evidence-based practices that effectively engage families and to offer customized and family-driven services to support and stabilize families. CFSA has proposed the use of the Homebuilders model, an intensive, in-home crisis intervention, counseling, and life-skills education for families who have children at imminent risk of placement in state-funded care; and Project Connect, an intensive, in-home services to high-risk families affected by parental substance abuse, mental illness, and/or domestic violence and involved in the child welfare system for this waiver. CFSA also is implementing Trauma Systems Therapy (TST) to support the development of a trauma-informed system. Additionally, further collaboration will continue to occur with the implementation of a unified functional assessment tool. To date, DMH, CFSA,

DYRS, Department of Human Services, and other city agencies have agreed to jointly use the Child and Adolescent Functional Assessment Scale (CAFAS) as a common functional assessment tool. This is further evidence of transition from collaboration to integration. DMH and CFSA continue to collaborate on training in evidence-based practices.

DMH has implemented six evidence-based services. To date in 2013, only one of the six services, MST, was identified as having a high rejection rate of referrals and the need for MST for problem sexual behaviors for sexual offenders to be widely utilized. CFSA reports that there continues to be communication issues at the individual child and family team level, these issues include communication between team members, and with the receipt of timely progress notes and information about "no shows." They also continue to struggle with getting quarterly progress reports from CSAs on individual children. Overall, CFSA sees that the collaborative efforts are much more advanced and progressing between CFSA and DMH but there is still work to do to insure that all team members and agencies are knowledgeable about the needs, progress and changes in status or context of each and every child and family served.

The CSAs continue to be quite variable in their performance and understanding of system expectations. The most advanced and high performing CSAs continue to make internal modifications to supervision and focus to give greater priority to achieving consistent high quality services for each family served.

Some CSAs report that they have increased training and mentoring of new workers in how to run team meetings, to identify underlying needs, and to better understand the practice model. In these CSA, therapists and CSWs are mentored and expected to demonstrate that they can perform in accordance with the practice model and expectations. As a result of these efforts, buy in to the practice model is perceived to be much better.

The DMH children's team continues to be highly regarded by community stakeholders. They are working on many initiatives that will benefit children from birth to 21. These include focus on early intervention with Parent-Child Interaction Therapy, keeping children in the community successfully and out of Psychiatric Residential Treatment Facilities (PRTFs), as well as training

and implementation support for multiple evidence-based practices. Each member of the children's team has assigned areas of responsibility and program development and they can give detailed and data-oriented updates on the progress they are making. One issue to work on is to clearly understand and then communicate how each of these areas of program development is connected to and contributes to the quality and effectiveness of the overall children's mental health services system. The Children's Plan is a key element in both identifying and communicating how these pieces all fit together and function synergistically to make a complete children's mental health service system.

The issues cited above are specific aspects of service delivery that need to be reviewed, with refinements made to the processes that are identified as barriers. As has been a consistent theme for the past few years, there continues to be wide variability of performance across providers. This is clearly evident in the data for individual provl.iders in Appendix C and as shown in Displays 40-43 discussed above. There are some CSAs who have employed focused and intentional efforts to improve the quality and consistency of their services, which has resulted in significant progress. Other CSAs are interested in acquiring training and guidance on how to improve services, retain staff, and be fiscally viable. If DMH is to provide high quality consistent services across the District, then they are going to have to continue to address the variability of performance at the provider level.

Conclusions and Recommendations

The review process this year continued to show excellent improvement at the system level and the level of practice performance for individual children and families. The review identified multiple strengths in the District's system for children's mental health services provided in collaboration with their child-serving partners. These included the following:

- The children's leadership in DMH and DMH senior management are providing excellent leadership and role modeling of community collaboration and integrated services. There is good recognition that improvement in practice from this point forward requires greater

knowledge of clinical issues that lead to more differentiated diagnostics and more targeted choices of differentiated therapeutic interventions.

- There is increased partnership and commitment between DMH and CFSA in taking joint ownership in providing quality services to youth. Each agency has a review process, as well as a combined QSR/CSR protocol for reviewing children and youth who are involved in both systems.
- Some CSAs continue to improve the supervision of practice and clinical knowledge at the individual CSW and therapist level and have achieved significant improvements in practice performance in their organizations. They continue to value the feedback they receive from the CSR process and implement mechanisms internally to both conduct CSRs and use it as a training and development process. Training and mentoring new workers in key practice skills, such as facilitating family team meetings and developing an in-depth understanding of the child and family's needs has definitely improved performance and the well-being of children.
- As we have found in prior reviews, there are many dedicated and committed CSWs and therapists who make every effort to improve the functioning and well-being of the children and families they serve. The CSWs and therapists overcome significant challenges to make a difference in children's lives. More effort needs to be made to ensure that the processes and requirements of the system facilitate and do not impede the efforts of these staff members to provide high quality services responsive to the needs of their clients. They continue to report that the multiple and redundant documentation requirements take inordinate time and can be a significant barrier to timely provision of services. They also report that when multiple provider agencies are involved or when specialized services like MST are provided, the communication between the team members is not of the quality and consistency that it should be to ensure that children and families receive the individualized services they need on a timely and responsive basis.
- CSA leadership and staff are committed to providing quality services and are struggling to align high quality practice with viable business practices. CSWs, therapists, supervisors, administrators, and psychiatrists are working hard to improve the lives of children, youth, and families, in spite of frontline challenges, productivity requirements, increasing

paperwork and compliance constraints, and increasing complexity of persons accessing services.

DMH has accomplished a great deal in improving the quality and consistency of services provided to children. It is now faced with the challenge of continuing the upward trend of positive results while simultaneously working to sustain the positive growth and adjust to ongoing federal and local changes. It will take full collaborative efforts on the part of the DMH team and its partners at the CSAs, CFSA, DYRS, education, developmental disabilities, substance abuse, neighborhood collaboratives, and community resources to continue the positive trend in providing quality services.

Recommendations

Much progress has been made; however, the complex challenges of children in the context of their families and as well as their own needs, combined with the number of child-serving agencies involved in these children and families' lives, require continued effort to improve the communication around the provision of services to each and every child and family.

It is recommended that the highest priority continue to be given to identifying and implementing strategies that support and promote the highest quality of practice across all frontline providers of services. The most pressing question to consider is: What are the immediate steps DMH and CSAs can take that will support and improve current clinical performance and lead to better outcomes for children and families regardless of where they enter the system and their level of need.

- Specifically, there need to be strategies implemented to better reach and connect those people that attempt to get services but end up not actually receiving the services. Examples include first appointment "no shows" or persons with significant change in engagement with services and persons who are homeless or in major transition. It is recommended that more effort be devoted to outreach and mobile interventions that can target and engage these persons.
- The bi-modal performance data show that there are providers demonstrating good consistent performance of clinical practice and there are those that are not. These data show it really

matters for children, moms and dads which CSA or provider they are served by. Some providers are responsive, highly engaged deliver appropriate services more consistently. Others CSAs/providers are non-responsive, aloof, and lack supervision, execution, and follow through of clinical practice. There must continue to be multiple strategies implemented across DMH to reduce this variance in provider performance. It is important that strategies to address this issue be coordinated across programs, quality improvement, and contracts to have maximum impact on improving performance.

- As recommended last year, DMH needs to ensure that the CSR unit is able to support the ongoing use of CSR in the CSAs and the unit needs to begin to conduct small targeted CSR reviews on a regular and timely basis. These reviews should be done in coordination with the Office of Quality Improvement and program areas. It is recommended that a specific schedule of reviews be set and performance expectations for CSR reviews be set across program, CSR unit, and Office of Quality Improvement that can be tracked and monitored by senior management on a quarterly basis. Expectations for staff participation in CSR reviews should be made totally clear. If these recommendations are not followed, then it is predictable that CSR reviews will not continue on a meaningful basis.
- DMH needs to formally complete and widely disseminate the children's mental health plan that is in the working stage at the earliest opportunity and work with Medicaid, managed care organizations (MCOs), and other child-serving agencies to ensure that there is a coherent overall approach to a mental health system for children that provides timely and responsive services, including primary care services, regardless of each child's specific context and presentation of need.

We would like to thank the DMH CSR unit staff for their full cooperation and support in conducting, organizing, and managing the logistics and operations of this review and all prior reviews. It has been a pleasure to work with the leadership of DMH and the CSAs to improve the quality and consistency of mental health practice in the District. We would also like to thank the efforts of each CSA, CFSA, and CSSP for their support and participation in completing the reviews. Thank you for allowing HSO to be a participant in this meaningful and worthwhile endeavor.

Appendix A

Community Services Review For a Child and Family

Questions to be Answered

The Community Services Review is a process for learning how well children and families served are doing and how services are working for them.

Produced for Use by the Dixon Court Monitor

by
Human Systems and Outcomes, Inc.

March 2004

Questions Concerning the Status of the Child and Family

Presented below is a set of common sense questions used to determine the current status of the child and family. Persons using this list of questions are directed to the **Community Services Review Protocol** for further explanation of these questions and matters to consider when applying these questions to a child and family receiving supports and services. Training, certification, and supervision are required for persons conducting case review activities using the Community Services Review (CSR) protocol.

Community Living

1. **SAFETY:** • Is the child safe from injury caused by him/herself or others in his/her daily living, learning, and recreational environments? • Are others safe from the child? • Is the child free of abuse, neglect, and sexual exploitation in his/her place of residence?

2. **STABILITY:** • Are the child's daily learning, living, and work arrangements stable and free from risk of disruption? • If not, are known risks being substantially reduced by services provided to achieve stability and reduce the probability of disruption?

3. **HOME AND SCHOOL PLACEMENT:** Is the child in the most appropriate residential and school placement, consistent with the child's needs, age, ability, and peer group and consistent with the child's language and culture?

4a. **PARENT SUPPORT OF THE CHILD:** • Are the parents or foster caregivers with whom the child is currently residing willing and able to provide the child with the assistance, supervision, and support necessary for daily living? • If added supports are required in the home to meet the needs of the child and assist the caregiver, are these supports meeting the needs?

4b. **GROUP CAREGIVER SUPPORT OF THE CHILD:** Are the child's primary caregivers in the group home or facility supporting the education and development of the child adequately on a consistent daily basis?

5. **SATISFACTION WITH SERVICES/RESULTS:** To what extent are the child/youth and primary caregiver satisfied with the supports, services, and service results they presently are experiencing?

Health & Well-being

6. **HEALTH/PHYSICAL WELL-BEING:** • Is the child in good health? • Are the child's basic physical needs being met? • Does the child have health care services, as needed?

7. **FUNCTIONAL STATUS:** • To what degree is the child symptom free of anxiety, mood, thought, or behavioral disorders that interfere with his/her capacity to participate in and benefit from his/her education? • What is the child's current level of functioning in the child's daily settings and activities?

Development of Life Skills

8. **ACADEMIC STATUS:** Is the child [according to age and ability]: (1) regularly attending school; (2) in a grade level consistent with age; (3) actively engaged in instructional activities; (4) reading at grade level; and (5) meeting requirements for promotion, course completion or graduation, and transition to employment or post-secondary education?

9a. **RESPONSIBLE BEHAVIOR** (age 8 and older)**:** • Does the child behave in socially responsible ways at school, at home, and/or in other daily settings (as appropriate to age and developmental level)? • Is the child/youth actively avoiding harmful activities that could lead to addiction, injury, or arrest?

9b. **RESPONSIBLE BEHAVIOR** (under age 8)**:** • Does the child engage in age-appropriate social interaction, self-regulation, i.e., calm him/herself when upset, wait a short time for something he/she wants? • Does the child follow simple directions, generally behave similarly to other children the same age in different settings such as at home, in a grocery store, in a library? • Does the child generally accept and facilitate daily routines such as eating, dressing, getting into the car (as appropriate to age and developmental delay)? • If not, is the child's pattern of interaction and behavior currently improving?

10. **LAWFUL BEHAVIOR:** • Does the child/youth behave in legally responsible ways at school, at home, and/or in daily community settings (as appropriate to age and developmental level)? • If involved with the juvenile justice system, is the child/youth complying with the court plan, avoiding reoffending, and developing appropriate friendships and activity patterns?

11. **OVERALL CHILD/FAMILY STATUS:** • Based on the Community Services Review findings determined for the Child Status Exams 1–10, how well is this child and family presently doing? Overall child and family status is considered acceptable when specified combinations and levels of examination findings are present. A special scoring procedure is used to determine Overall Child/Family Status using a six-point rating scale.

Questions Concerning Progress

Presented below is a set of questions used to determine the progress of a child or youth receiving services. A primary focus is placed on the pattern of changes recently occurring for the child. Progress should be associated with treatment goals and services provided to the child and family.

1. **SYMPTOM REDUCTION:** To what extent are the psychiatric symptoms, which resulted in diagnosis and treatment, being reduced?

2. **BEHAVIORAL IMPROVEMENT (RESILIENCY):** • To what extent is the child/youth making adequate behavioral progress, consistent with the student's age and ability, in presenting appropriate daily behavior patterns in school and home activities? • To what degree is the child/youth demonstrating increased resiliency in meeting daily life challenges?

3. **SCHOOL/WORK PROGRESS:** To what extent is the child/youth presently making adequate progress, consistent with the child's age and ability, in his/her assigned academic or vocational curriculum or work situation?

4. **RISK REDUCTION:** To what extent is adequate progress, consistent with the child/youth's life circumstances and functional abilities, being made in reduction of specific risks identified for this child/youth?

5. **TRANSITION PROGRESS:** To what extent is the child/youth presently making adequate progress, consistent with an appropriate timeline, toward achievement of transition goals in the IRP, IEP, and/or other long-term transition goals?

6. **MEANINGFUL RELATIONSHIPS:** To what degree is this child/youth making progress in developing meaningful relationships with family members, non-disabled age peers, and adults [at home, school, and in the community]?

7. **OVERALL PROGRESS PATTERN:** Taking into account the relative degree of progress observed for the child on the above six progress indicators, what is the overall pattern of progress for this child: optimal, good, fair, marginal, poor, or adverse? Overall progress is considered acceptable when the overall pattern is deemed to be fair or better.

Questions Concerning Performance of Key Service Delivery Systems

Presented below is a set of questions used to determine the performance of essential system functions for the child in a Community Services Review. These questions focus on support and service functions rather than formal service system procedures.

<u>Planning Treatment & Support</u>

1. **CHILD AND FAMILY ENGAGEMENT:** • Are family members (parents, grandparents, step-parents) or substitute caregivers active participants in the process by which service decisions are made about the child and family? • Are parents/caregivers partners in planning, providing, and monitoring supports and services for the child? • Is the child actively participating in decisions made about his/her future? • If family members are resistant to participation, are reasonable efforts being made to engage them and to support their participation?

2. **CULTURAL ACCOMMODATIONS:** • Are any significant cultural issues of the child and family being identified and addressed in practice? • Are the behavioral health services provided being made culturally appropriate via special accommodations in the family engagement, assessment, planning, and service delivery processes being used with this child and family?

3. **SERVICE TEAM FORMATION:** • Do the persons who compose the service team of the child and family collectively possess the technical skills, knowledge of the family, authority, and access to the resources necessary to organize effective services for a child and family of this complexity and cultural background?

4. **SERVICE TEAM FUNCTIONING:** • Do members of the service team for this child and family collectively function as a unified team in planning services and evaluating results? • Do the actions of the service team reflect a coherent pattern of effective teamwork and collaborative problem solving that benefits the child and family in a manner consistent with the guiding system of care principles?

5. **FUNCTIONAL ASSESSMENT:** • Are the child's current symptoms and diagnoses known by key interveners? • Is the relationship between treatment diagnoses and the child's bio/psycho/social functioning in daily activities understood? • Does the team have a working understanding of family strengths/needs and underlying issues that must change for the child to function in normal daily settings and for the family to support the child successfully at home?

6. **LONG-TERM VIEW:** Is there a guiding view for service planning that includes strategic goals for this child that will lead to his/her functioning successfully in his/her home, school, and community including the child's next major developmental or expected placement transition?

7. **INDIVIDUALIZED RESILIENCY PLAN (IRP):** • Is there an IRP for the child and family that integrates strategies and services across providers and funders? • Is the IRP built on identified strengths, needs, and preferences of the child and family? • Is the IRP coherent in the assembly of strategies, supports, and services? • Does the IRP specify interventions and supports necessary for the child's primary caregiver(s) and teacher(s)? • If properly implemented, will the IRP help the child to function adequately at home and school?

8. **GOODNESS-OF-SERVICE FIT:** • Are therapeutic, educational, and support services assembled into a holistic and coherent mix of services uniquely matched to the child/family's situation and preferences? • Does the combination of supports and services fit the child and family situation so as to maximize potential results and benefits while minimizing conflicting strategies and inconveniences?

Providing Treatment & Support

9. **RESOURCE AVAILABILITY:** • Are the supports, services, and resources (both informal and formal) necessary to meet the identified needs in the IRP available for use by the child and family? • Are the flexible supports and unique service arrangements (both informal and formal) necessary to meet individual needs in the child's plans available for use by the child and family on a timely, adequate, and convenient local basis? • Are the unit-based and placement-based resources necessary to meet goals in the child's plans available for use by the child and family on a timely and adequate basis? • Are any unavailable but necessary resources identified?

10. **TREATMENT IMPLEMENTATION:** • Are the intervention strategies, techniques, and supports specified in the child's planned treatment services (IRP) being implemented with sufficient intensity and consistency to achieve expected results? • Is implementation timely and competent? • Are treatment providers receiving the support and supervision necessary for adequate role performance?

11. **EMERGENT/URGENT RESPONSE CAPABILITY:** Is there timely access to and provision of effective services to stabilize or resolve emergent or episodic problems of an urgent nature?

12. **MEDICATION MANAGEMENT:** • Is the use of psychotropic medications for this child necessary, safe, and effective? • Does the person have a voice in medication decisions and management? • Is the child routinely screened for medication side effects and treated when side effects are detected? • Have new atypical/current generation drugs been tried, used, and/or appropriately ruled out? • Is the use of medication coordinated with other treatment modalities and with any treatment for any co-occurring conditions (e.g., seizures, diabetes, asthma, HIV)?

13. **SPECIAL PROCEDURES:** • If emergency seclusionor restraint has been used for this child, was each use: (1) Done only in an emergency? (2) Done after less restrictive alternatives were found insufficient or impractical? (3) Ordered by a trained, authorized child? (4) Accomplished with proper techniques that were safely and respectfully performed by qualified staff? (5) Effective in preventing harm? and (6) Properly supervised during use and evaluated afterwards?

14. **FAMILY SUPPORT:** • Are the caregivers in the child's home receiving the training, assistance, and supports necessary for them to perform essential parenting or caregiving functions reliably for this child? • Is the array of in-home supports provided adequate in variety, intensity, dependability, and cultural compatibility to provide for caregiver choices and to enable caregivers to meet the challenging needs of the child while maintaining the stability of the home?

Managing Treatment & Support

15. **SERVICE COORDINATION AND CONTINUITY:** • Is there a single point of coordination, accountability, and continuity in the organization, delivery, and results of treatment and support services for this child and family? • Are IRP-specified treatment and support services well coordinated across providers, funding agencies, and levels of care for this child and family?

16. **TRACKING AND ADJUSTMENTS:** • Is the service coordinator and service team tracking the child's treatment progress, family conditions and supports, and results for the child and family? • Does the team meet frequently to discuss treatment fidelity, barriers, and progress? • Are services adjusted in response to progress made, changing needs, and knowledge gained to create a self-correcting treatment process?

17. **OVERALL PRACTICE PERFORMANCE:** Based on the Community Services Review findings determined for Practice Performance exams 1-16, how well is the service system functioning for this child and family now? Overall system performance is considered acceptable when specified combinations and levels of examination findings are present. A special scoring procedure is used to determine Overall Practice Performance for a child.

Appendix B

CSR Interpretative Guide for Child Status

Maintenance Zone: 5-6

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

6 = **OPTIMAL STATUS**. The best or most favorable status presently attainable for this child in this area [taking age and ability into account]. The child is doing great! Confidence is high that long-term goals or expectations will be met in this area.

5 = **GOOD STATUS**. Substantially and dependably positive status for the child in this area, with an ongoing positive pattern. This status level is consistent with attainment of long-term goals in this area. Child status is "looking good" and likely to continue.

Acceptable Range: 4-6

Refinement Zone: 3-4

Status is minimal or marginal, maybe unstable. Further efforts are necessary to refine the situation.

4 = **FAIR STATUS**. Status is minimally or temporarily adequate for the child to meet short-term objectives in this area. Status is minimally acceptable at this point in time, but due to changing circumstances, may be temporary or unstable.

3 = **BORDERLINE STATUS**. Status is marginal/mixed, not quite adequate to meet the child's short-term objectives now in this area. Not quite enough for the child to be successful. Risks may be uncertain.

Improvement Zone: 1-2

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

2 = **POOR STATUS**. Status has been and continues to be poor and unacceptable. The child seems to be "stuck" or "lost" and is not improving. Risks may be mild to moderate.

1 = **ADVERSE STATUS**. Child status in this area is poor and getting worse. Risks of harm, restriction, exclusion, regression, and/or other adverse outcomes may be substantial and increasing.

Unacceptable Range: 1-3

CSR Interpretative Guide for Practice Performance

Maintenance Zone: 5-6

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

6 = **OPTIMAL PERFORMANCE**. Excellent, consistent, effective practice for this student in this function area. This level of performance is indicative of exemplary practice and good results for the child. ["Optimal" does not imply "perfection."]

5 = **GOOD PERFORMANCE**. At this level of performance, system practice is working dependably for this child, under changing conditions and over time. Effectiveness level is consistent with meeting long-term goals for the child. [Keep this going for good results.]

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**. This level of performance is minimally or temporarily sufficient for the child to meet short-term objectives. Performance may be time limited or require adjustment soon due to changing or uncertain circumstances. [Some refinement is indicated.]

3 = **BORDERLINE PERFORMANCE**. Practice at this level is underpowered, inconsistent, or not well matched to need. Performance is insufficient for the child to meet short-term objectives. [With refinement, this case 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 in intensity, or off target. Elements of practice may be noted, but are incomplete/not operative on a consistent basis.

1 = **ADVERSE PERFORMANCE**. Practice is either absent or wrong and possibly harmful. Performance may be missing (not done). Or, practices being used may be inappropriate, contraindicated, performed inappropriately, or harmfully.

Unacceptable Range: 1-3

Appendix C

Appendix C

This agency-by-agency comparison should be interpreted with caution, since sample sizes for some of the provider agencies are extremely small. **Generalizations regarding specific agency practice should not be made based on the individual case review results due to the small sample sizes for the agency-specific findings**, rather the small samples of children and youth are illustrative of system performance for each of those randomly selected children from subsequent participating agencies.

*Note: Blanks on the following pages denote items that are not applicable.

CSR/Child Status and Performance Profile

Community Connections n= 12 DC Child Review May 2013

Child & Family Status	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Safety of the child	12	92%	0%	50%	50%
Stability	12	83%	0%	42%	58%
Home & school placement	12	100%	0%	0%	100%
Caregiver support of child	12	92%	0%	33%	67%
Satisfaction	12	83%	0%	25%	75%
Health/Phy well-being	12	92%	0%	33%	67%
Functional status	12	67%	8%	67%	25%
Academic status	12	67%	8%	75%	17%
Responsible social behavior	12	75%	8%	50%	42%
Lawful behavior	11	82%	0%	45%	55%
Overall C & F Status	12	83%	0%	50%	50%

Recent Progress	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Symptom reduction	12	83%	0%	67%	33%
Behavior improvement	12	75%	8%	42%	50%
School/work progress	12	67%	8%	67%	25%
Risk reduction	12	92%	0%	42%	58%
Transition progress	11	73%	9%	64%	27%
Meaningful relationships	12	83%	0%	75%	25%
Overall Progress	12	83%	0%	67%	33%

CSR/Child Status and Performance Profile

Community Connections n= 12 DC Child Review May 2013

Current Practice Performance	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Child & family engagement	12	92%	0%	25%	75%
Culturally appropriate practice	4	100%	0%	25%	75%
Service team formation	12	92%	0%	17%	83%
Service team functioning	12	83%	0%	33%	67%
Functional assessment	12	100%	0%	42%	58%
Long-term guiding view	12	75%	0%	33%	67%
IRP	12	83%	0%	33%	67%
Goodness-of-service fit	12	92%	0%	33%	67%
Resource avail.: unique/flex.	10	100%	0%	10%	90%
Resource availability: unit/place.	8	100%	0%	0%	100%
Treatment implementation	12	92%	0%	8%	92%
Emergent/urgent response	3	100%	0%	0%	100%
Medication management	9	100%	0%	22%	78%
Special procedures	1	100%	0%	0%	100%
Familty support	11	91%	0%	27%	73%
Service coord. & continuity	12	83%	0%	33%	67%
Tracking & adjustment	12	92%	0%	25%	75%
Overall Practice Performance	12	92%	0%	25%	75%

CSR/Child Status and Performance Profile

Family Matters n= 3 DC Child Review May 2013

Child & Family Status	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Safety of the child	3	67%	33%	0%	67%
Stability	3	67%	0%	33%	67%
Home & school placement	3	100%	0%	0%	100%
Caregiver support of child	3	100%	0%	33%	67%
Satisfaction	3	67%	0%	67%	33%
Health/Phy well-being	3	100%	0%	0%	100%
Functional status	3	33%	33%	33%	33%
Academic status	3	67%	33%	33%	33%
Responsible social behavior	3	67%	33%	0%	67%
Lawful behavior	3	67%	0%	33%	67%
Overall C & F Status	3	67%	33%	0%	67%

Recent Progress	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Symptom reduction	3	33%	33%	33%	33%
Behavior improvement	3	33%	33%	33%	33%
School/work progress	3	67%	33%	33%	33%
Risk reduction	2	50%	0%	50%	50%
Transition progress	3	67%	0%	67%	33%
Meaningful relationships	3	33%	0%	67%	33%
Overall Progress	3	67%	0%	67%	33%

CSR/Child Status and Performance Profile

Family Matters n= 3 DC Child Review May 2013

Current Practice Performance	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Child & family engagement	3	67%	33%	67%	0%
Culturally appropriate practice	1	100%	0%	100%	0%
Service team formation	3	33%	33%	67%	0%
Service team functioning	3	33%	33%	67%	0%
Functional assessment	3	0%	0%	100%	0%
Long-term guiding view	3	0%	67%	33%	0%
IRP	3	0%	33%	67%	0%
Goodness-of-service fit	3	0%	33%	67%	0%
Resource avail.: unique/flex.	2	50%	0%	100%	0%
Resource availability: unit/place.	3	67%	0%	67%	33%
Treatment implementation	3	67%	33%	33%	33%
Emergent/urgent response					
Medication management	1	0%	0%	100%	0%
Special procedures					
Familty support	3	67%	0%	100%	0%
Service coord. & continuity	3	33%	33%	67%	0%
Tracking & adjustment	3	33%	33%	67%	0%
Overall Practice Performance	3	0%	33%	67%	0%

CSR/Child Status and Performance Profile

Fihankra Place n= 2 DC Child Review May 2013

Child & Family Status	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Safety of the child	2	100%	0%	50%	50%
Stability	2	100%	0%	100%	0%
Home & school placement	2	100%	0%	0%	100%
Caregiver support of child	2	100%	0%	50%	50%
Satisfaction	2	50%	0%	100%	0%
Health/Phy well-being	2	100%	0%	0%	100%
Functional status	2	50%	0%	100%	0%
Academic status	2	0%	50%	50%	0%
Responsible social behavior	2	50%	50%	0%	50%
Lawful behavior	2	50%	0%	50%	50%
Overall C & F Status	2	50%	0%	50%	50%

Recent Progress	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Symptom reduction	2	50%	0%	100%	0%
Behavior improvement	2	50%	50%	50%	0%
School/work progress	2	0%	50%	50%	0%
Risk reduction	2	50%	50%	50%	0%
Transition progress	2	50%	50%	50%	0%
Meaningful relationships	2	100%	0%	50%	50%
Overall Progress	2	50%	50%	50%	0%

CSR/Child Status and Performance Profile

Fihankra Place n= 2 DC Child Review May 2013

Current Practice Performance	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Child & family engagement	2	0%	100%	0%	0%
Culturally appropriate practice	1	0%	100%	0%	0%
Service team formation	2	0%	50%	50%	0%
Service team functioning	2	0%	100%	0%	0%
Functional assessment	2	0%	50%	50%	0%
Long-term guiding view	2	0%	0%	100%	0%
IRP	2	0%	50%	50%	0%
Goodness-of-service fit	2	0%	50%	50%	0%
Resource avail.: unique/flex.	2	100%	0%	0%	100%
Resource availability: unit/place.	2	100%	0%	0%	100%
Treatment implementation	2	0%	100%	0%	0%
Emergent/urgent response					
Medication management	1	100%	0%	100%	0%
Special procedures					
Familty support	1	0%	0%	100%	0%
Service coord. & continuity	2	0%	50%	50%	0%
Tracking & adjustment	2	0%	100%	0%	0%
Overall Practice Performance	2	0%	100%	0%	0%

CSR/Child Status and Performance Profile

First Home Care n= 22 DC Child Review May 2013

Child & Family Status	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Safety of the child	22	82%	9%	36%	55%
Stability	22	64%	5%	64%	32%
Home & school placement	22	95%	0%	14%	86%
Caregiver support of child	22	86%	5%	32%	64%
Satisfaction	22	95%	0%	18%	82%
Health/Phy well-being	22	95%	0%	14%	86%
Functional status	22	73%	9%	64%	27%
Academic status	22	68%	18%	50%	32%
Responsible social behavior	22	64%	14%	59%	27%
Lawful behavior	21	81%	5%	33%	62%
Overall C & F Status	22	68%	9%	36%	55%

Recent Progress	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Symptom reduction	22	73%	9%	68%	23%
Behavior improvement	22	73%	14%	50%	36%
School/work progress	22	64%	23%	45%	32%
Risk reduction	19	74%	11%	37%	53%
Transition progress	20	55%	20%	50%	30%
Meaningful relationships	22	82%	5%	50%	45%
Overall Progress	22	64%	0%	68%	32%

CSR/Child Status and Performance Profile

First Home Care n= 22 DC Child Review May 2013

Current Practice Performance	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Child & family engagement	22	100%	0%	36%	64%
Culturally appropriate practice	10	100%	0%	40%	60%
Service team formation	22	100%	0%	18%	82%
Service team functioning	22	77%	9%	45%	45%
Functional assessment	22	86%	9%	45%	45%
Long-term guiding view	22	50%	14%	64%	23%
IRP	22	91%	9%	59%	32%
Goodness-of-service fit	22	82%	5%	55%	41%
Resource avail.: unique/flex.	20	90%	0%	45%	55%
Resource availability: unit/place.	18	100%	0%	33%	67%
Treatment implementation	22	82%	0%	55%	45%
Emergent/urgent response	7	86%	0%	43%	57%
Medication management	8	75%	13%	25%	63%
Special procedures					
Familty support	16	88%	6%	50%	44%
Service coord. & continuity	22	82%	5%	50%	45%
Tracking & adjustment	22	68%	14%	45%	41%
Overall Practice Performance	22	86%	0%	41%	59%

CSR/Child Status and Performance Profile

Hillcrest Children's Center n= 11 DC Child Review May 2013

Child & Family Status	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Safety of the child	11	73%	9%	45%	45%
Stability	11	73%	9%	55%	36%
Home & school placement	11	100%	0%	36%	64%
Caregiver support of child	11	64%	9%	45%	45%
Satisfaction	11	73%	18%	18%	64%
Health/Phy well-being	11	91%	0%	27%	73%
Functional status	11	73%	18%	73%	9%
Academic status	11	36%	36%	36%	27%
Responsible social behavior	11	45%	9%	64%	27%
Lawful behavior	8	63%	13%	25%	63%
Overall C & F Status	11	64%	9%	45%	45%

Recent Progress	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Symptom reduction	11	82%	9%	55%	36%
Behavior improvement	11	73%	9%	55%	36%
School/work progress	11	27%	36%	45%	18%
Risk reduction	9	44%	22%	44%	33%
Transition progress	7	57%	14%	43%	43%
Meaningful relationships	11	73%	9%	55%	36%
Overall Progress	11	73%	18%	55%	27%

CSR/Child Status and Performance Profile

Hillcrest Children's Center n= 11 DC Child Review May 2013

Current Practice Performance	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Child & family engagement	11	64%	9%	45%	45%
Culturally appropriate practice	2	100%	0%	0%	100%
Service team formation	11	55%	0%	55%	45%
Service team functioning	11	45%	27%	27%	45%
Functional assessment	11	64%	27%	36%	36%
Long-term guiding view	11	45%	36%	27%	36%
IRP	11	64%	9%	45%	45%
Goodness-of-service fit	11	55%	9%	45%	45%
Resource avail.: unique/flex.	8	63%	13%	50%	38%
Resource availability: unit/place.	10	70%	30%	10%	60%
Treatment implementation	11	64%	0%	64%	36%
Emergent/urgent response	6	33%	17%	67%	17%
Medication management	8	50%	25%	50%	25%
Special procedures	1	100%	0%	100%	0%
Familty support	7	29%	43%	43%	14%
Service coord. & continuity	11	64%	9%	45%	45%
Tracking & adjustment	11	55%	27%	27%	45%
Overall Practice Performance	11	55%	18%	36%	45%

CSR/Child Status and Performance Profile

Inner City Family Services n= 4 DC Child Review May 2013

Child & Family Status	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Safety of the child	4	50%	25%	75%	0%
Stability	4	75%	25%	0%	75%
Home & school placement	4	100%	0%	25%	75%
Caregiver support of child	4	50%	0%	50%	50%
Satisfaction	4	0%	75%	25%	0%
Health/Phy well-being	4	75%	0%	25%	75%
Functional status	4	25%	50%	50%	0%
Academic status	4	50%	0%	75%	25%
Responsible social behavior	4	50%	25%	75%	0%
Lawful behavior	4	75%	25%	25%	50%
Overall C & F Status	4	50%	25%	25%	50%

Recent Progress	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Symptom reduction	4	0%	25%	75%	0%
Behavior improvement	4	25%	25%	75%	0%
School/work progress	4	50%	50%	25%	25%
Risk reduction	4	25%	25%	75%	0%
Transition progress	3	33%	33%	67%	0%
Meaningful relationships	4	25%	50%	25%	25%
Overall Progress	4	25%	25%	75%	0%

CSR/Child Status and Performance Profile

Inner City Family Services n= 4 DC Child Review May 2013

Current Practice Performance	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Child & family engagement	4	25%	25%	75%	0%
Culturally appropriate practice					
Service team formation	4	0%	50%	50%	0%
Service team functioning	4	25%	25%	75%	0%
Functional assessment	4	25%	50%	50%	0%
Long-term guiding view	4	0%	75%	25%	0%
IRP	4	25%	50%	50%	0%
Goodness-of-service fit	4	0%	75%	25%	0%
Resource avail.: unique/flex.	4	50%	25%	50%	25%
Resource availability: unit/place.	4	50%	25%	50%	25%
Treatment implementation	4	0%	100%	0%	0%
Emergent/urgent response	1	0%	0%	100%	0%
Medication management	2	0%	50%	50%	0%
Special procedures					
Familty support	3	0%	100%	0%	0%
Service coord. & continuity	4	0%	75%	25%	0%
Tracking & adjustment	4	0%	75%	25%	0%
Overall Practice Performance	4	0%	75%	25%	0%

CSR/Child Status and Performance Profile

Life Enhancement Services n= 7 DC Child Review May 2013

Child & Family Status	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Safety of the child	7	86%	0%	57%	43%
Stability	7	100%	0%	71%	29%
Home & school placement	7	100%	0%	14%	86%
Caregiver support of child	7	100%	0%	14%	86%
Satisfaction	7	100%	0%	29%	71%
Health/Phy well-being	7	100%	0%	0%	100%
Functional status	7	86%	14%	57%	29%
Academic status	7	57%	14%	57%	29%
Responsible social behavior	7	57%	0%	71%	29%
Lawful behavior	6	83%	0%	33%	67%
Overall C & F Status	7	86%	0%	57%	43%

Recent Progress	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Symptom reduction	7	86%	14%	57%	29%
Behavior improvement	7	86%	0%	57%	43%
School/work progress	7	86%	14%	29%	57%
Risk reduction	7	71%	14%	29%	57%
Transition progress	7	86%	14%	71%	14%
Meaningful relationships	7	100%	0%	71%	29%
Overall Progress	7	86%	14%	71%	14%

CSR/Child Status and Performance Profile

Life Enhancement Services n= 7 DC Child Review May 2013

Current Practice Performance	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Child & family engagement	7	100%	0%	14%	86%
Culturally appropriate practice	2	100%	0%	0%	100%
Service team formation	7	100%	0%	14%	86%
Service team functioning	7	86%	14%	29%	57%
Functional assessment	7	86%	14%	43%	43%
Long-term guiding view	7	86%	14%	43%	43%
IRP	7	71%	14%	29%	57%
Goodness-of-service fit	7	86%	14%	29%	57%
Resource avail.: unique/flex.	7	86%	14%	14%	71%
Resource availability: unit/place.	7	86%	14%	0%	86%
Treatment implementation	7	86%	0%	43%	57%
Emergent/urgent response	2	100%	0%	0%	100%
Medication management	3	100%	0%	0%	100%
Special procedures	1	100%	0%	0%	100%
Familty support	7	86%	0%	29%	71%
Service coord. & continuity	7	100%	0%	29%	71%
Tracking & adjustment	7	86%	14%	29%	57%
Overall Practice Performance	7	86%	14%	0%	86%

CSR/Child Status and Performance Profile

Lifestride n= 3 DC Child Review May 2013

Child & Family Status	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Safety of the child	3	67%	0%	67%	33%
Stability	3	67%	33%	0%	67%
Home & school placement	3	67%	0%	33%	67%
Caregiver support of child	3	67%	33%	33%	33%
Satisfaction	3	67%	33%	33%	33%
Health/Phy well-being	3	100%	0%	0%	100%
Functional status	3	67%	33%	33%	33%
Academic status	3	100%	0%	0%	100%
Responsible social behavior	3	67%	33%	33%	33%
Lawful behavior	2	50%	0%	100%	0%
Overall C & F Status	3	67%	33%	33%	33%

Recent Progress	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Symptom reduction	3	67%	33%	33%	33%
Behavior improvement	3	67%	33%	33%	33%
School/work progress	3	100%	0%	0%	100%
Risk reduction	2	50%	0%	100%	0%
Transition progress	2	50%	50%	50%	0%
Meaningful relationships	3	67%	0%	67%	33%
Overall Progress	3	67%	0%	67%	33%

CSR/Child Status and Performance Profile

Lifestride n= 3 DC Child Review May 2013

Current Practice Performance	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Child & family engagement	3	67%	0%	67%	33%
Culturally appropriate practice	1	100%	0%	0%	100%
Service team formation	3	100%	0%	0%	100%
Service team functioning	3	33%	0%	67%	33%
Functional assessment	3	100%	0%	0%	100%
Long-term guiding view	3	67%	0%	67%	33%
IRP	3	33%	0%	67%	33%
Goodness-of-service fit	3	67%	0%	67%	33%
Resource avail.: unique/flex.	2	100%	0%	50%	50%
Resource availability: unit/place.	2	50%	0%	50%	50%
Treatment implementation	3	100%	0%	67%	33%
Emergent/urgent response					
Medication management	2	50%	0%	100%	0%
Special procedures					
Familty support	2	0%	50%	50%	0%
Service coord. & continuity	3	100%	0%	67%	33%
Tracking & adjustment	3	33%	0%	67%	33%
Overall Practice Performance	3	100%	0%	67%	33%

CSR/Child Status and Performance Profile

Mary's Center n= 1 DC Child Review May 2013

Child & Family Status	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Safety of the child	1	100%	0%	100%	0%
Stability	1	100%	0%	0%	100%
Home & school placement	1	100%	0%	0%	100%
Caregiver support of child	1	100%	0%	100%	0%
Satisfaction	1	100%	0%	100%	0%
Health/Phy well-being	1	100%	0%	0%	100%
Functional status	1	0%	100%	0%	0%
Academic status	1	0%	100%	0%	0%
Responsible social behavior	1	0%	100%	0%	0%
Lawful behavior	1	100%	0%	0%	100%
Overall C & F Status	1	100%	0%	100%	0%

Recent Progress	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Symptom reduction	1	100%	0%	100%	0%
Behavior improvement	1	100%	0%	100%	0%
School/work progress	1	0%	0%	100%	0%
Risk reduction	1	100%	0%	100%	0%
Transition progress	1	0%	100%	0%	0%
Meaningful relationships	1	0%	0%	100%	0%
Overall Progress	1	0%	0%	100%	0%

CSR/Child Status and Performance Profile

Mary's Center n= 1 DC Child Review May 2013

Current Practice Performance	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Child & family engagement	1	100%	0%	0%	100%
Culturally appropriate practice	1	0%	0%	100%	0%
Service team formation	1	0%	100%	0%	0%
Service team functioning	1	0%	100%	0%	0%
Functional assessment	1	0%	100%	0%	0%
Long-term guiding view	1	0%	100%	0%	0%
IRP	1	0%	100%	0%	0%
Goodness-of-service fit	1	0%	0%	100%	0%
Resource avail.: unique/flex.	1	100%	0%	100%	0%
Resource availability: unit/place.	1	100%	0%	100%	0%
Treatment implementation	1	100%	0%	100%	0%
Emergent/urgent response	1	0%	0%	100%	0%
Medication management	1	100%	0%	100%	0%
Special procedures	1	100%	0%	100%	0%
Familty support	1	100%	0%	100%	0%
Service coord. & continuity	1	0%	0%	100%	0%
Tracking & adjustment	1	0%	0%	100%	0%
Overall Practice Performance	1	0%	0%	100%	0%

CSR/Child Status and Performance Profile

MD/DC Family Resources n= 5 DC Child Review May 2013

Child & Family Status	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Safety of the child	5	100%	0%	40%	60%
Stability	5	60%	40%	0%	60%
Home & school placement	5	100%	0%	40%	60%
Caregiver support of child	5	100%	0%	60%	40%
Satisfaction	5	60%	0%	60%	40%
Health/Phy well-being	5	100%	0%	20%	80%
Functional status	5	60%	0%	60%	40%
Academic status	5	100%	0%	20%	80%
Responsible social behavior	5	80%	0%	40%	60%
Lawful behavior	4	100%	0%	50%	50%
Overall C & F Status	5	100%	0%	40%	60%

Recent Progress	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Symptom reduction	5	100%	0%	100%	0%
Behavior improvement	5	80%	0%	80%	20%
School/work progress	5	100%	0%	40%	60%
Risk reduction	5	60%	20%	60%	20%
Transition progress	5	60%	20%	60%	20%
Meaningful relationships	5	60%	20%	40%	40%
Overall Progress	5	80%	0%	80%	20%

CSR/Child Status and Performance Profile

MD/DC Family Resources n= 5 DC Child Review May 2013

Current Practice Performance	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Child & family engagement	5	80%	0%	80%	20%
Culturally appropriate practice	5	100%	0%	60%	40%
Service team formation	5	80%	0%	60%	40%
Service team functioning	5	60%	20%	80%	0%
Functional assessment	5	60%	0%	100%	0%
Long-term guiding view	5	60%	20%	40%	40%
IRP	5	60%	0%	80%	20%
Goodness-of-service fit	5	60%	20%	40%	40%
Resource avail:uniqe/flex	5	80%	0%	60%	40%
Resource availability:unit/place.	4	75%	0%	50%	50%
Treatment implementation	5	60%	20%	80%	0%
Emergent/urgent response					
Medication management					
Special procedures					
Familty support	5	60%	0%	100%	0%
Service coord.& continuity	5	40%	20%	60%	20%
Tracking & adjustment	5	40%	40%	60%	0%
Overall Practice Performance	5	60%	0%	80%	20%

CSR/Child Status and Performance Profile

MHSD n= 2 DC Child Review May 2013

Child & Family Status	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Safety of the child	2	50%	0%	100%	0%
Stability	2	50%	0%	100%	0%
Home & school placement	2	100%	0%	50%	50%
Caregiver support of child	2	50%	0%	50%	50%
Satisfaction	2	50%	0%	100%	0%
Health/Phy well-being	2	100%	0%	50%	50%
Functional status	2	50%	0%	100%	0%
Academic status	2	100%	0%	100%	0%
Responsible social behavior	2	50%	0%	100%	0%
Lawful behavior					
Overall C & F Status	2	50%	0%	100%	0%

Recent Progress	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Symptom reduction	2	50%	50%	0%	50%
Behavior improvement	2	50%	0%	100%	0%
School/work progress	2	100%	0%	100%	0%
Risk reduction	2	50%	0%	100%	0%
Transition progress	1	0%	100%	0%	0%
Meaningful relationships	2	50%	50%	50%	0%
Overall Progress	2	50%	50%	50%	0%

CSR/Child Status and Performance Profile

MHSD n= 2 DC Child Review May 2013

Current Practice Performance	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Child & family engagement	2	50%	50%	50%	0%
Culturally appropriate practice	1	0%	100%	0%	0%
Service team formation	2	0%	50%	50%	0%
Service team functioning	2	0%	50%	50%	0%
Functional assessment	2	50%	0%	100%	0%
Long-term guiding view	2	50%	50%	50%	0%
IRP	2	0%	50%	50%	0%
Goodness-of-service fit	2	50%	50%	50%	0%
Resource avail.: unique/flex.	2	50%	50%	50%	0%
Resource availability: unit/place.					
Treatment implementation	2	50%	0%	50%	50%
Emergent/urgent response	1	0%	100%	0%	0%
Medication management	2	50%	0%	50%	50%
Special procedures	1	100%	0%	100%	0%
Familty support	2	50%	50%	50%	0%
Service coord. & continuity	2	0%	50%	50%	0%
Tracking & adjustment	2	0%	50%	50%	0%
Overall Practice Performance	2	50%	50%	50%	0%

CSR/Child Status and Performance Profile

PSI Services n= 3 DC Child Review May 2013

Child & Family Status	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Safety of the child	3	67%	0%	33%	67%
Stability	3	100%	0%	67%	33%
Home & school placement	3	100%	0%	67%	33%
Caregiver support of child	3	67%	0%	33%	67%
Satisfaction	3	67%	0%	100%	0%
Health/Phy well-being	3	100%	0%	0%	100%
Functional status	3	67%	33%	67%	0%
Academic status	3	33%	33%	33%	33%
Responsible social behavior	3	67%	0%	67%	33%
Lawful behavior	3	67%	0%	33%	67%
Overall C & F Status	3	67%	0%	67%	33%

Recent Progress	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Symptom reduction	3	67%	33%	33%	33%
Behavior improvement	3	67%	33%	33%	33%
School/work progress	3	67%	33%	33%	33%
Risk reduction	2	100%	0%	50%	50%
Transition progress	3	67%	33%	67%	0%
Meaningful relationships	3	100%	0%	67%	33%
Overall Progress	3	67%	33%	33%	33%

CSR/Child Status and Performance Profile

PSI Services n= 3 DC Child Review May 2013

Current Practice Performance	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Child & family engagement	3	100%	0%	67%	33%
Culturally appropriate practice	1	100%	0%	0%	100%
Service team formation	3	33%	0%	100%	0%
Service team functioning	3	0%	33%	67%	0%
Functional assessment	3	100%	0%	100%	0%
Long-term guiding view	3	33%	33%	67%	0%
IRP	3	67%	0%	100%	0%
Goodness-of-service fit	3	33%	0%	100%	0%
Resource avail.: unique/flex.	2	100%	0%	50%	50%
Resource availability: unit/place.	3	67%	33%	67%	0%
Treatment implementation	3	67%	0%	100%	0%
Emergent/urgent response					
Medication management	2	0%	50%	50%	0%
Special procedures					
Familty support	2	50%	0%	100%	0%
Service coord. & continuity	3	0%	0%	100%	0%
Tracking & adjustment	3	33%	33%	67%	0%
Overall Practice Performance	3	67%	0%	100%	0%

CSR/Child Status and Performance Profile

Universal Health Care n= 11 DC Child Review May 2013

Child & Family Status	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Safety of the child	11	100%	0%	27%	73%
Stability	11	64%	27%	27%	45%
Home & school placement	11	91%	0%	27%	73%
Caregiver support of child	11	91%	0%	27%	73%
Satisfaction	11	91%	0%	55%	45%
Health/Phy well-being	11	91%	0%	9%	91%
Functional status	11	82%	0%	73%	27%
Academic status	11	64%	27%	36%	36%
Responsible social behavior	11	82%	9%	45%	45%
Lawful behavior	5	100%	0%	20%	80%
Overall C & F Status	11	91%	0%	45%	55%

Recent Progress	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Symptom reduction	11	91%	0%	64%	36%
Behavior improvement	11	55%	0%	73%	27%
School/work progress	11	55%	9%	55%	36%
Risk reduction	7	100%	0%	43%	57%
Transition progress	9	89%	0%	78%	22%
Meaningful relationships	10	80%	0%	40%	60%
Overall Progress	11	82%	0%	73%	27%

CSR/Child Status and Performance Profile

Universal Health Care n= 11 DC Child Review May 2013

Current Practice Performance	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Child & family engagement	11	64%	0%	55%	45%
Culturally appropriate practice	6	100%	0%	17%	83%
Service team formation	11	64%	0%	73%	27%
Service team functioning	11	55%	18%	64%	18%
Functional assessment	11	82%	9%	55%	36%
Long-term guiding view	11	64%	0%	73%	27%
IRP	11	73%	18%	45%	36%
Goodness-of-service fit	11	82%	9%	45%	45%
Resource avail.: unique/flex.	8	100%	0%	75%	25%
Resource availability: unit/place.	5	80%	20%	60%	20%
Treatment implementation	11	73%	9%	73%	18%
Emergent/urgent response	5	80%	20%	0%	80%
Medication management	8	50%	13%	63%	25%
Special procedures	1	100%	0%	0%	100%
Familty support	7	71%	0%	43%	57%
Service coord. & continuity	11	55%	18%	55%	27%
Tracking & adjustment	11	73%	18%	55%	27%
Overall Practice Performance	11	82%	9%	73%	18%

Appendix D

Aggregated Performance of the Four Highest Performing CSAs on Child Status, Child Progress, and System Performance Compared with the Aggregated Ratings Across the Less Consistent CSAs

Four Highest Performing CSAs (with 5 or more cases) = 52 Cases or 60% of the total child/youth reviewed

Less Consistent CSAs = 34 Cases or 40% of the total child/youth reviewed

Overall Status and Practice
Four Highest Performing CSAs (with 5 or more cases)

CSR/Child Status and Performance Profile - Provider Frequency

# of children/youth **12** — DC Child Review May 2013

Provider	Overall Status	Overall Practice	Number
Community Connections	83%	92%	12

CSR/Child Status and Performance Profile - Provider Frequency

# of children/youth **22** — DC Child Review May 2013

Provider	Overall Status	Overall Practice	Number
First Home Care	68%	86%	22

CSR/Child Status and Performance Profile - Provider Frequency

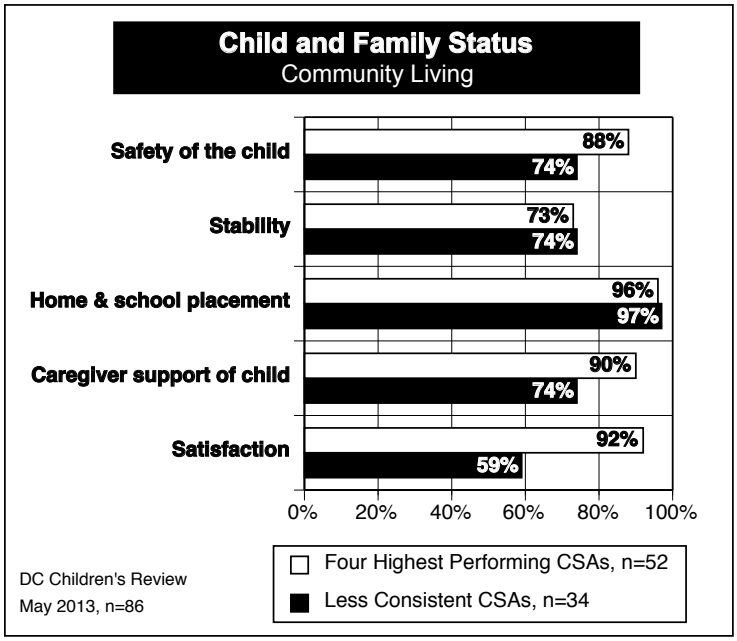
# of children/youth **7** — DC Child Review May 2013

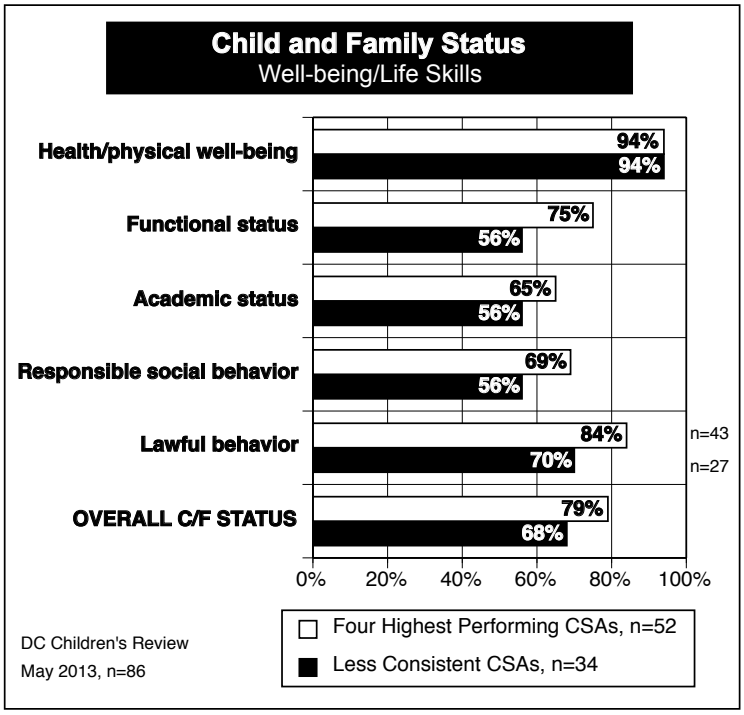
Provider	Overall Status	Overall Practice	Number
Life Enhancement Services	86%	86%	7

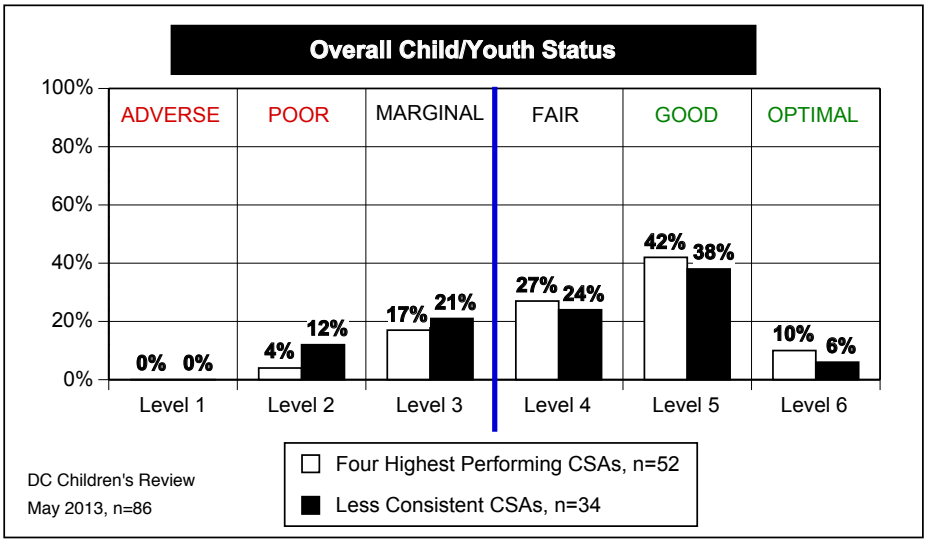
CSR/Child Status and Performance Profile - Provider Frequency

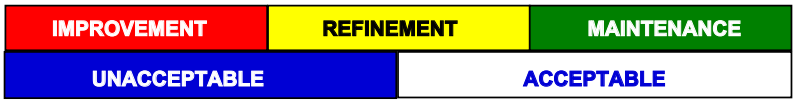
# of children/youth **11** — DC Child Review May 2013

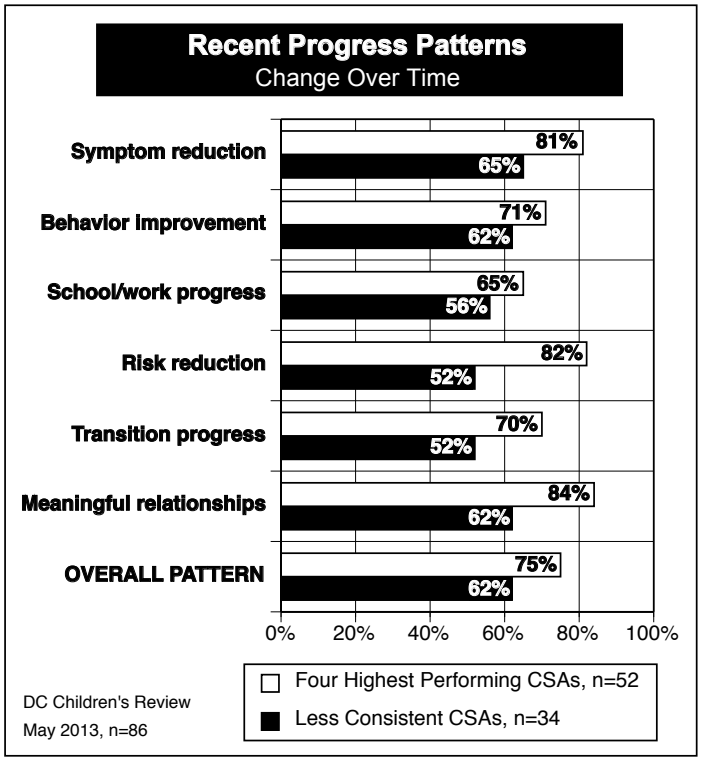
Provider	Overall Status	Overall Practice	Number
Universal Health Care	91%	82%	11

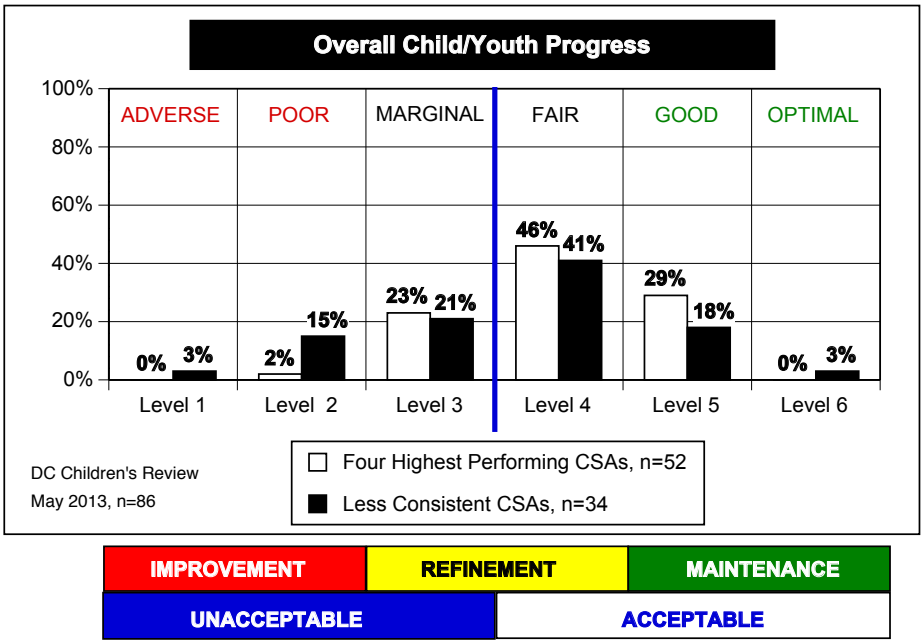

Child and Family Status
Community Living
Safety of the child
88%
74%
Stability
73%
74%
Home & school placement
96%
97%
Caregiver support of child
90%
74%
Satisfaction
92%
59%
0%
20%
40%
60%
80%
100%
DC Children's Review
May 2013, n=86
Four Highest Performing CSAs, n=52
Less Consistent CSAs, n=34

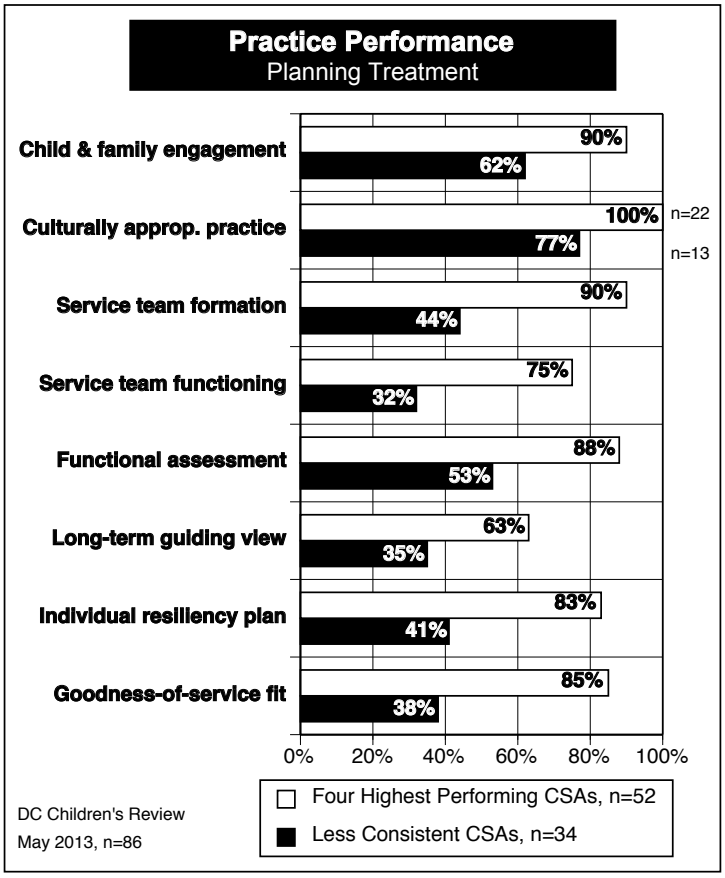

Child and Family Status
Well-being/Life Skills
Health/physical well-being
94%
94%
Functional status
75%
56%
Academic status
65%
56%
Responsible social behavior
69%
56%
Lawful behavior
84%
70%
OVERALL C/F STATUS
79%
68%
n=43
n=27
0%
20%
40%
60%
80%
100%
DC Children's Review
May 2013, n=86
Four Highest Performing CSAs, n=52
Less Consistent CSAs, n=34

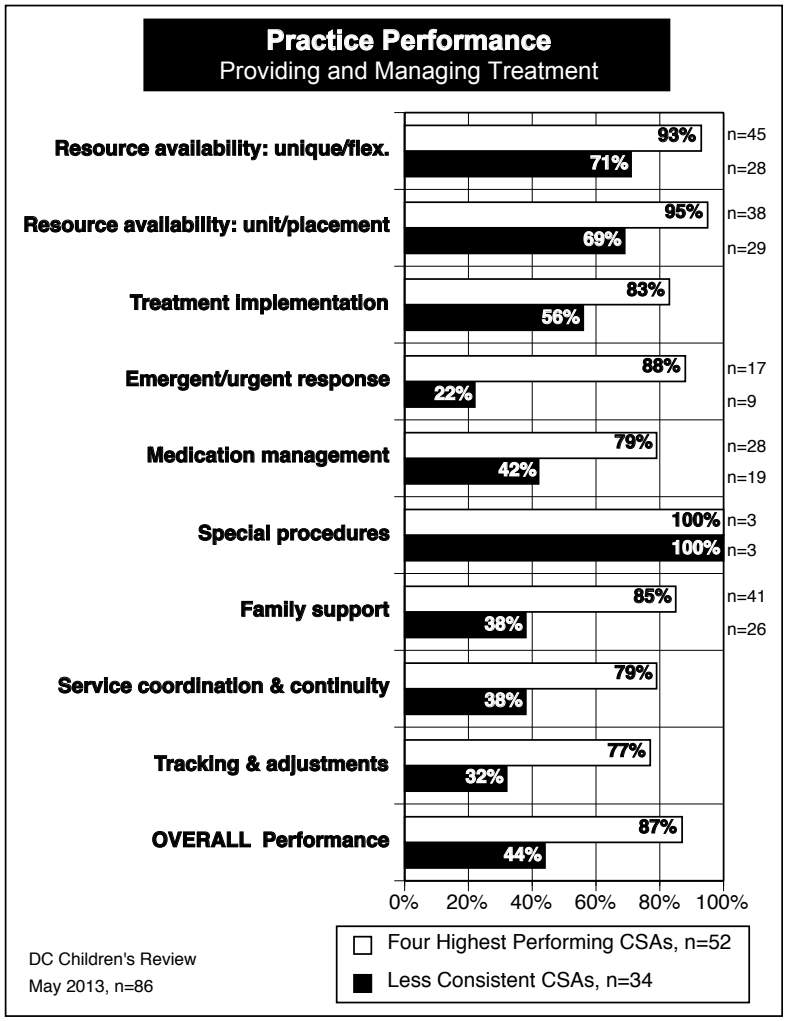

Overall Child/Youth Status
100%
80%
60%
40%
20%
0%
ADVERSE
POOR
MARGINAL
FAIR
GOOD
OPTIMAL
0% 0%
4% 12%
17% 21%
27% 24%
42% 38%
10% 6%
Level 1
Level 2
Level 3
Level 4
Level 5
Level 6
DC Children's Review
May 2013, n=86
Four Highest Performing CSAs, n=52
Less Consistent CSAs, n=34

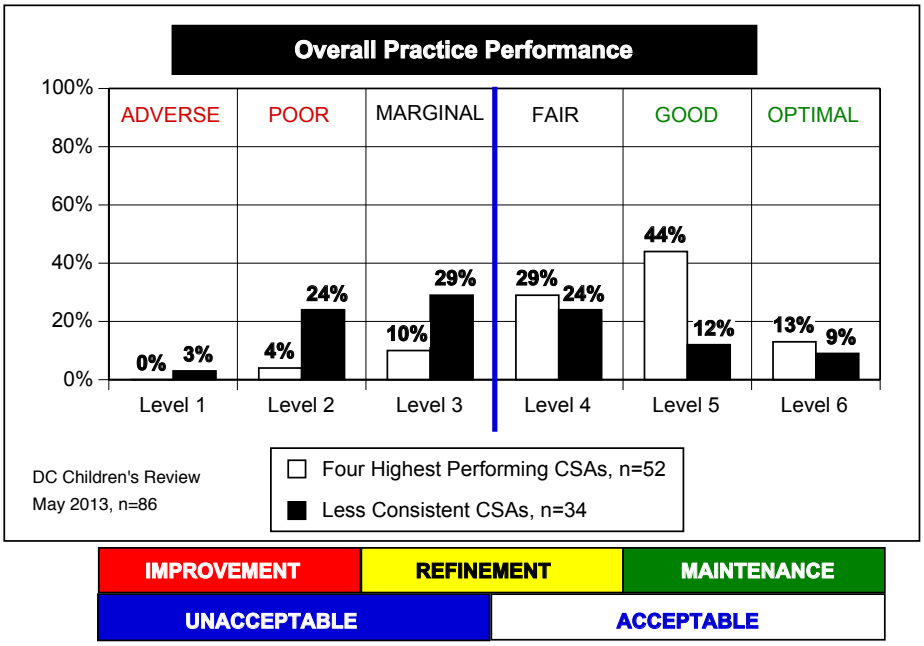

IMPROVEMENT
REFINEMENT
MAINTENANCE
UNACCEPTABLE
ACCEPTABLE


Recent Progress Patterns
Change Over Time
Symptom reduction
81%
65%
Behavior Improvement
71%
62%
School/work progress
65%
56%
Risk reduction
82%
52%
Transition progress
70%
52%
Meaningful relationships
84%
62%
OVERALL PATTERN
75%
62%
0%
20%
40%
60%
80%
100%
DC Children's Review
May 2013, n=86
Four Highest Performing CSAs, n=52
Less Consistent CSAs, n=34


Overall Child/Youth Progress
100%
80%
60%
40%
20%
0%
ADVERSE
POOR
MARGINAL
FAIR
GOOD
OPTIMAL
0%
3%
2%
15%
23%
21%
46%
41%
29%
18%
0%
3%
Level 1
Level 2
Level 3
Level 4
Level 5
Level 6
DC Children's Review
May 2013, n=86
Four Highest Performing CSAs, n=52
Less Consistent CSAs, n=34
IMPROVEMENT
REFINEMENT
MAINTENANCE
UNACCEPTABLE
ACCEPTABLE


Practice Performance
Planning Treatment
Child & family engagement
90%
62%
Culturally approp. practice
100%
77%
n=22
n=13
Service team formation
90%
44%
Service team functioning
75%
32%
Functional assessment
88%
53%
Long-term guiding view
63%
35%
Individual resiliency plan
83%
41%
Goodness-of-service fit
85%
38%
0%
20%
40%
60%
80%
100%
DC Children's Review
May 2013, n=86
Four Highest Performing CSAs, n=52
Less Consistent CSAs, n=34


Practice Performance
Providing and Managing Treatment
Resource availability: unique/flex.
93%
71%
n=45
n=28
Resource availability: unit/placement
95%
69%
n=38
n=29
Treatment implementation
83%
56%
Emergent/urgent response
88%
22%
n=17
n=9
Medication management
79%
42%
n=28
n=19
Special procedures
100%
100%
n=3
n=3
Family support
85%
38%
n=41
n=26
Service coordination & continuity
79%
38%
Tracking & adjustments
77%
32%
OVERALL Performance
87%
44%
0%
20%
40%
60%
80%
100%
Four Highest Performing CSAs, n=52
Less Consistent CSAs, n=34
DC Children's Review
May 2013, n=86



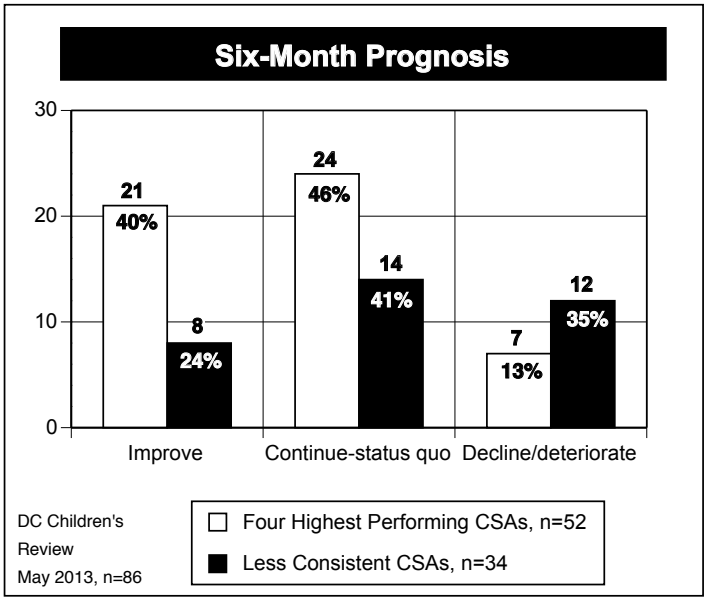
Case Review Outcome Categories

Four Highest Performing CSAs Compared to the Less Consistent CSAs

Status of Child/Family in Individual Cases

Acceptability of Service System Performance in Individual Cases	Favorable Status	Unfavorable Status	
Acceptable System Performance	**Outcome 1:** Good status for child/family, ongoing services acceptable. **75% (39 cases) Highest Perf** **38% (13 cases) Less Consist**	**Outcome 2:** Poor status for child/family, ongoing services minimally acceptable but limited in reach or efficacy. **12% (6 cases) Highest Perf** **6% (2 cases) Less Consist**	**87% Highest Perf** **44% Less Consist**
Unacceptable System Performance	**Outcome 3:** Good status for child/family, ongoing services mixed or unacceptable. **4% (2 cases) Highest Perf** **29% (10 cases) Less Consist**	**Outcome 4:** Poor status for child/family, ongoing services unacceptable. **10% (5 cases) Highest Perf** **26% (9 cases) Less Consist**	**14% Highest Perf** **55% Less Consist**
	79% Highest Perf **67% Less Consist**	**22% Highest Perf** **32% Less Consist**	

DC Children's Review
May 2013, n=86


Six-Month Prognosis
30
20
10
0
21
40%
8
24%
24
46%
14
41%
7
13%
12
35%
Improve
Continue-status quo
Decline/deteriorate
DC Children's Review
May 2013, n=86
Four Highest Performing CSAs, n=52
Less Consistent CSAs, n=34