Baseline Report on Adult Service Consumers

Served by the District of Columbia Department of Mental Health

May 2003

Presented to the Dixon Court Monitor

by

Human Systems and Outcomes, Inc.

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Purpose and Scope of the Review

The Final Court-Ordered Plan for Dixon, et al v. Williams [March 28, 2001] required that performance measures be developed and used within a methodology for measuring service system performance. The court-ordered Exit Criteria and Method [September 21, 2001] set forth further detail for measurement requirements attendant to adult mental health service consumers:

- 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 adult service consumers, these key areas include community living, health, meaningful activity, social networks, income, assessment and planning, treatment and support services, specialized services, coordination of care, and emergent/urgent response to needs.

To begin the process of meeting the requirements of these orders, a case review protocol was developed, tested, revised, and then used to create a baseline for subsequent measurement of progress. The baseline was made during the week of May 5-9, 2003, using measurements taken on a sample of 28 adult participants randomly selected for this purpose.

The design of the protocol, sampling process, training of reviewers, supervision of data collection, and analysis of data were conducted by Human Systems and Outcomes, Inc. (HSO), an organization with extensive experience in case-based service review processes used in monitoring services in class action litigation situations. HSO was contracted by the Dixon Court Monitor and worked as staff to the monitor in conducting the baseline data collection efforts.

The Baseline Sample for Adult Service Consumers

A stratified random sample of 36 cases was drawn for establishing a baseline measurement of the quality and consistency of adult mental health services currently being provided by the District of Columbia (D.C.) Department of Mental Health (DMH). The criteria for inclusion in the baseline sample is that the consumer is actively receiving services (i.e., case management, counseling, medication management, etc.) from the D.C. Department of Mental Health or a contract provider agency. Three variables have been identified as differentiating points for a stratified random sample that was drawn on April 18th, 2003. These three variables are listed below.

1. Provider Agency
2. Age of Adult
3. Level of Need

Although the intent of the baseline sample was to include only 36 cases, a triple sample (n=108) was randomly selected in order to create a pool of possible consumers for the sample cells created by the three stratification points in the sample resulting in a proportional draw of consumers according to level of need and sample attrition. The triple sample also was used as a replacement list to provide additional consumers who could participate in the baseline review when one of the originally selected consumers was either unable or unwilling to participate.

Provider Agency

According to the information that was supplied to Human Systems and Outcomes, Inc., by the D.C. Department of Mental Health, there are a total of 5,926 adults receiving services from 13 different provider agencies. These 13 provider agencies differ substantially in the total number of adults that they serve, however, 5,368, or approximately 90%, of consumers receive services from six agencies, with 3,009, or approximately 58%, of consumers receiving services from the Public Core Service Agency. In order to assist with the completion of the logistics necessary to complete the qualitative case review process being utilized to conduct the adult services baseline review, the six largest provider agencies was the group from which 35 of the 36 sample cases were drawn. However, one additional case was randomly selected from the consumers not receiving services from the six largest agencies in order to ensure that all current consumers did have some chance of being included in the baseline review sample.

Age of Adult

According to the information provided to HSO, the age distribution for adult consumers receiving services ranges from 18 to 103. The adult baseline review stratified consumers' ages into three possible ranges. Listed, these ranges are: 18-29, with 607, or approximately 11% of consumers; 30-55, with 3,668, or approximately 68% of consumers; and 55 and greater, with 1,109, or approximately 20% of consumers. If the baseline sample of 36 cases was proportioned by age according to the percentage of consumers within each range, the distribution of cases would include four in the 18-29 range, 28 in the 30-55 range, and eight in the 55 and greater range. When utilizing this review methodology for court monitoring purposes in other locations, a minimum recommended threshold for any sample cell is eight cases. Thus, the sample size was increased for the number of consumers in both the 18-29 and the 55 and greater age ranges to eight cases. The exact sampling distribution is described in Display 1.

Level of Need

The consumer's level of need was separated into three categories (low, medium, high). There was no information available within the original list of consumers provided to HSO that would indicate the consumer's level of need. As such, additional information was obtained by HSO through a survey that was completed by provider sites' case managers/team leaders for each of the 108 consumers selected in the original triple sample. This survey collected information regarding the current type of services being provided to the consumer, his/her current placement type and its level of restrictiveness, and a Global Assessment of Functioning (GAF) score. An equal number of consumers for each level of need was selected from the original triple sample pool of 108 consumers for the baseline review. GAF scores were the primary measure to indicate the consumer's level of need, with a breakdown of score ranges as follows:

Low Need (12 consumers):	GAF $\geq$ 60
Medium Need (12 consumers):	GAF 40-59
High Need (12 consumers):	GAF < 40

Identification of the type of service being provided and current placement was included in this brief survey in case GAF scores were not known at the time of the survey's completion and was used as an additional indicator of the consumer's level of need.

Sample Stratification

Display 1-A indicates the number of consumers who are receiving services from the six largest provider agencies. As the table indicates, more than 90% of the consumers are currently receiving services from these six provider agencies. **Display 1-B** provides the distribution of cases by age and provider agency selected for the random sample. Stratification for level of need was conducted after the provider agencies completed the initial information survey, with 12 consumers selected across the provider agencies for each level of need.

Display 1-A
A Breakdown of Provider Agency and Age of Adults Being Served by the Six Largest Agencies

	Ages 18-29	Ages 30-55	Ages 55+	Total
Public Core Service Agency	347	2096	656	3009
Community Connections	87	669	216	972
Anchor Mental Health	41	333	68	442
Center for Mental Health, Inc.	91	283	23	397
The Green Door	25	159	97	281
Lutheran Social Services	16	128	49	193
Total	607	3668	656	Σ=5384 (Note: 90% of adult population is 5368)

Display 1-B
Stratified Random Sampling Distribution for D.C. Adult Baseline Review (parentheses indicate triple sample)

	Ages 18-29	Ages 30-55	Ages 55+	Total
Public Core Service Agency	2 (6)	17 (51)	1 (3)	20 (60)
Community Connections	2 (6)	3 (9)	2 (6)	7 (21)
Anchor Mental Health	2 (6)		1 (3)	3 (9)
Center for Mental Health, Inc.	2 (6)		1 (3)	3 (9)
The Green Door			1 (3)	1 (3)
Lutheran Social Services			1 (3)	1 (3)
Psychiatric Center Chartered			1 (3)	1 (3)
Total	8 (24)	20 (60)	8 (24)	36 (108)

The intent of the proposed sampling methodology was to collect a random sample of consumers that is proportional to the actual age, level of need, and breakdown of adults receiving services in each provider agency. The sample size was determined using a binomial distribution sampling table that yielded an estimated range of the underlying distribution of acceptable or non-acceptable performance at a 95% confidence level. This strategy for determining sample sizes has been determined to be an effective means of establishing an overall service-level baseline in other states that use the Quality Service Review (QSR) case review methodology as a measure for monitoring consent decree compliance. It is anticipated that subsequent monitor's reviews using the QSR will need to include larger sample sizes in order to more precisely measure the adult mental health system level of performance following a period of improvement. Case reviews were actually completed for a total of 28 consumers.

Observations Made During Set-Up Activities for the Baseline Data Collection

A variety of challenges were experienced during the logistical preparation of the adult baseline review, resulting in scheduling difficulties that decreased the total number of cases included in the final baseline study sample.

The set up of the baseline review included two stages. The first stage was the completion of the brief survey for each of the 108 consumers randomly selected in the triple sample. This was completed so that current type of service, level of need, and contact information could be obtained on each possible study candidate. Responses were provided for 99 out of the 108 in the original triple sample. Responses included completion of the one-page survey, discussion with providers regarding individual consumers, and the provision of lists indicating the type of services the consumer was receiving at that time. A breakdown of the response rate for initial information is shown below:

Public Core Service Agency	51 out of 60
Community Connections	21 out of 21
Anchor Mental Health	9 out of 9
Center for Mental Health, Inc.	9 out of 9
The Green Door	3 out of 3
Lutheran Social Services	3 out of 3
Psychiatric Center Chartered (PCC)	3 out of 3

Out of the 99 survey responses, 29 were excluded from the possible sample pool for reasons including that they had not had any contact with a mental health provider in at least the last three months (10); were unknown to the agency (4); refused to participate with any study (4); were homeless and had no known contact information (3); were incarcerated (2); were residing in St. Elizabeth's Hospital (2); had moved out of the D.C. area (2); had been transferred to an unknown provider agency (2); or was deceased (1). As a result, 36 cases were selected out of a possible candidate pool of 70 consumers receiving services.

The second stage of preparation for the adult baseline review included obtaining consent to participate in the baseline study and subsequently having consumers complete signed releases of information, and scheduling the individual qualitative case reviews. Similar difficulties were experienced once providers, and subsequently consumers, were contacted about participation. The two primary barriers encountered during the logistical preparation of the 36 cases, which ultimately led to the completion of only 28 individual case reviews in the baseline sample were:

- Despite being identified on the list of active cases, the consumer was not receiving services and had not received services for some period of time.

- When contacted, the consumer was not willing to participate in the baseline review.

During preparation, providers were supplied additional cases from the triple sample replacement list in order to have a sufficient number of cases included in the baseline study. In one instance, a provider site was provided two full triple samples due to the above-referenced difficulties. The number of actual completed cases by provider site are as follows.

Public Core Service Agency	15 out of 20
Community Connections	6 out of 7
Anchor Mental Health	3 out of 3
Center for Mental Health, Inc.	1 out of 3
The Green Door	1 out of 1
Lutheran Social Services	1 out of 1
Psychiatric Center Chartered (PCC)	1 out of 1

(Note: This case was actually receiving basic case management from the Public Core Service Agency, despite being listed on the PCC list of active cases.)

An additional logistical preparation difficulty that compounded problems encountered with the set up for the individual case reviews was either limited or miscommunication between agency administrators and the respective frontline practitioners. Case managers and team leaders were often unaware or unclear about the steps to be completed when setting up a person to be reviewed. This resulted in a flurry of set-up activity just prior to the onset of, and during, the baseline review. This occurred despite regular and ongoing communication with agency administrators, resulting in set-up materials not completed within agreed-upon timeframes. Lastly, consumers were often only contacted about participation during their previously scheduled appointments for services. These meetings may have been just prior, or during, the week of the baseline review.

In summary, the process of setting up and conducting the baseline data collection revealed several organizational issues that will need to be addressed in order to create a more smoothly operating system of care.

- There are a number of consumers who are listed as actively receiving services on the automated data systems who are, in fact, not currently involved with DMH. Furthermore, stakeholders stated that additional consumers do regularly receive services but are not enrolled in the automated data systems.

- Site managers, team leaders, and case managers do not understand the practice and performance expectations that would lead to compliance with the consent decree.

- Site managers, team leaders, and case managers are not sufficiently aware of the monitoring process that is used to measure current system performance and compliance with the consent decree.

- Consumers not regularly engaged in services were not likely to be participants in the baseline sample.

- Consumers may not have a single point of case coordination responsible for regular and on-going contact with the provider agency. Similarly, services are often provided in a drop-by, clinic-base format.

As a result of the difficulties encountered in the identification and inclusion of consumers in the baseline study, the findings should be interpreted with the consideration that this sample may well represent a best possible array of outcomes. In that, the final study sample was comprised of consumers who had regular ongoing contact with a mental health provider and were willing to participate in the study.

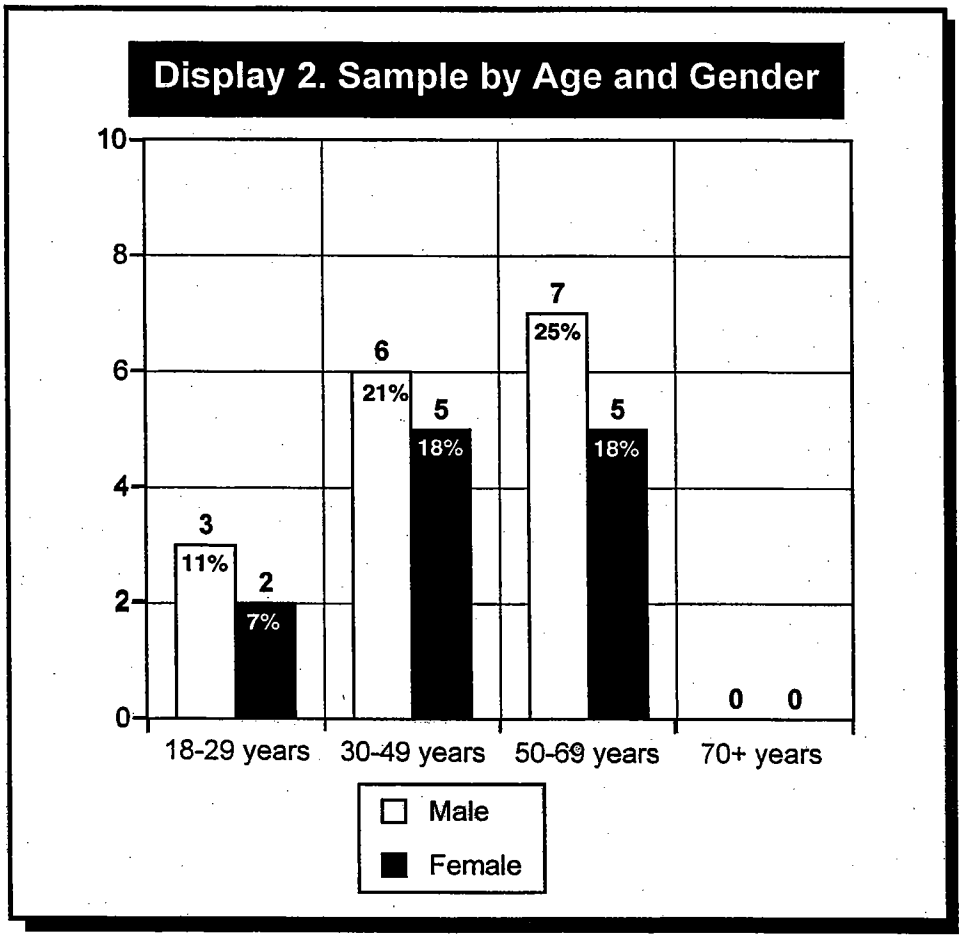
Description of the Adult Consumers in the Baseline Sample

Case reviews were conducted for 28 adult service consumers during the week of May 5-9, 2003. Presented in this section are displays that detail the characteristics of the 28 persons in the baseline sample.

Age and Gender

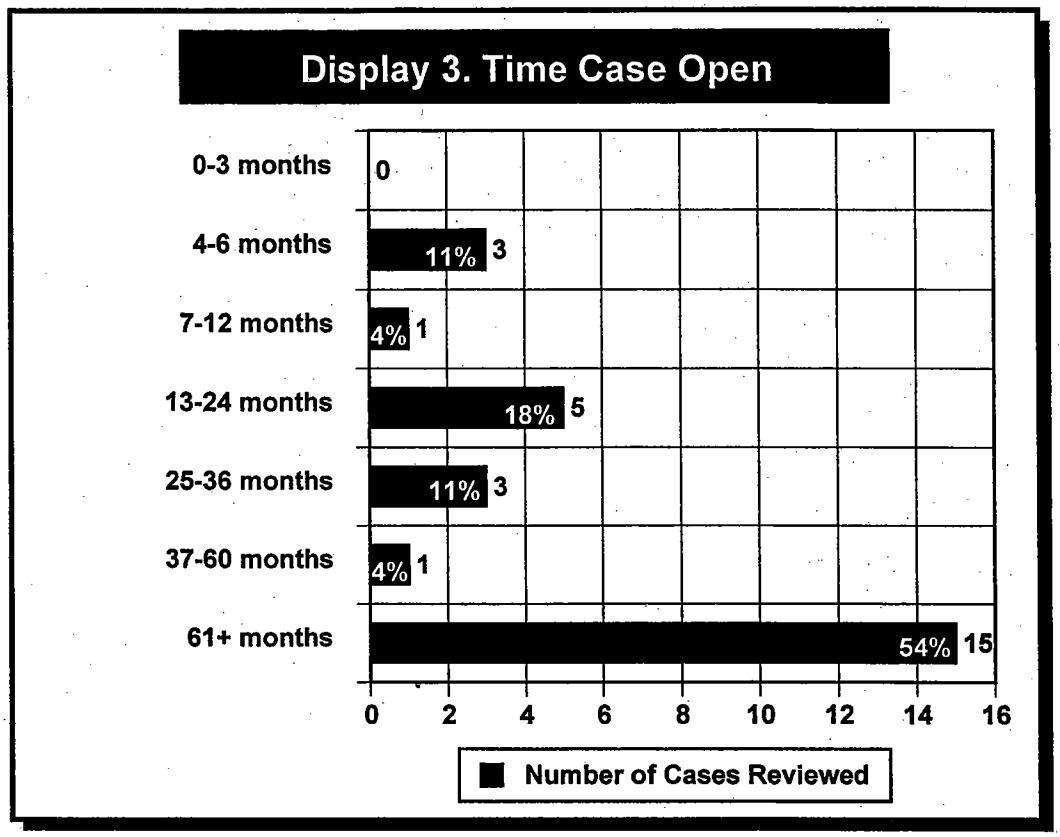
The review sample was composed of adults drawn across the age spectrum served by the Department of Mental Health. **Display 2** presents the sample of 28 adult participants distributed by age and gender. As shown in this display, men comprised 57% of the sample while women comprised 43%. By experience, many service systems report a majority of men within the active service population. Nearly one-fifth (18%) of sample members were young adults in the 18-29 year age group. More than one-third (39%) were in the 30-49 year age group. The largest age

group in the sample (43%) was composed of persons in the 50-69 year age group. None was over age 69 years.



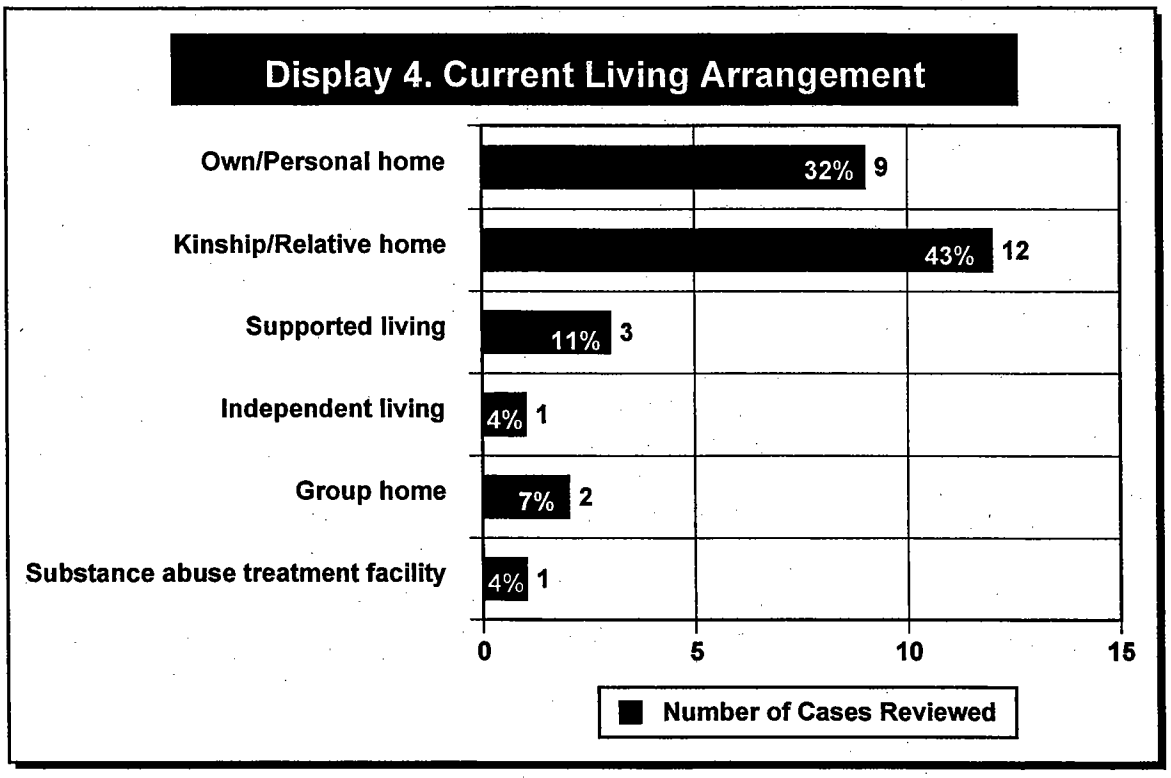
Length of Time Served during Present Admission

All adult service consumers in the review sample were presently receiving services through the Department of Mental Health. **Display 3** presents, for these 28 adults, the length of time their cases had been open with DMH during their current, most recent admission for services. As can be seen in this display, 15% of the sample had cases open for 12 months or less, 29% were open for 13 to 36 months, and 58% were open for more than three years.



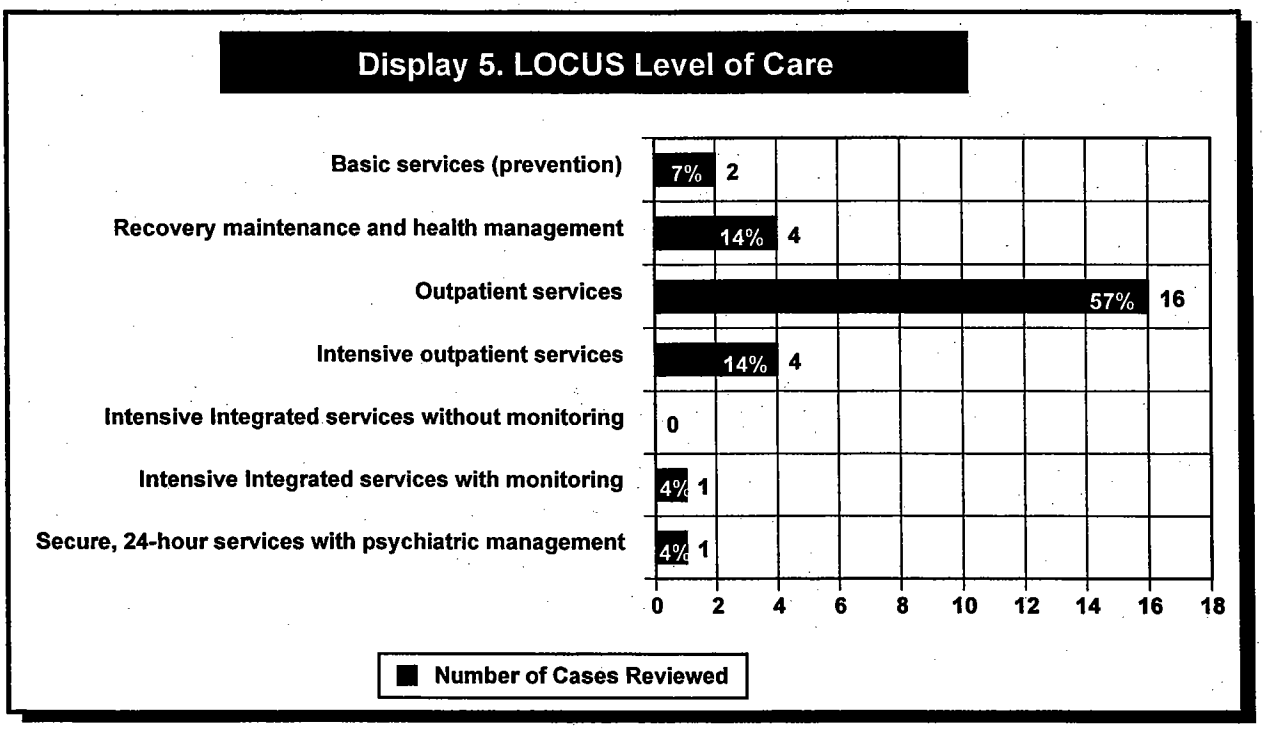
Living Settings of Sample Members

Adult service consumers in the review sample were found to be living in one of six settings. **Display 4** shows the distribution of sample members according to their residences at the time of the review. Almost a third (32%) of sample members were living in their own homes. Another 43% were living in kinship or relative homes. Three persons (11%) were in supported living arrangements. One adult (4%) was residing in an independent living program. Two adults (7%) were living in group homes. And, one person (4%) was residing in a substance abuse treatment facility.



Level of Care Provided

Persons in the sample were classified according to the level of care being received at the time of the review. The descriptive categories used were taken from the LOCUS or Level of Care Utilization System and applied by the reviewers. **Display 5** presents the distribution of the sample according to this classification scheme. Two (7%) of the sample members were determined to be receiving basic services. Another four (14%) members were receiving recovery maintenance and health management services. Sixteen (57%) of the sample members were receiving outpatient services. Another four (14%) persons were receiving intensive outpatient services. None was receiving intensive integrated services without psychiatric monitoring. One (4%) was receiving non-secure, 24-hour services with psychiatric monitoring and one other person (4%) was receiving secure, 24-hour services with psychiatric management.

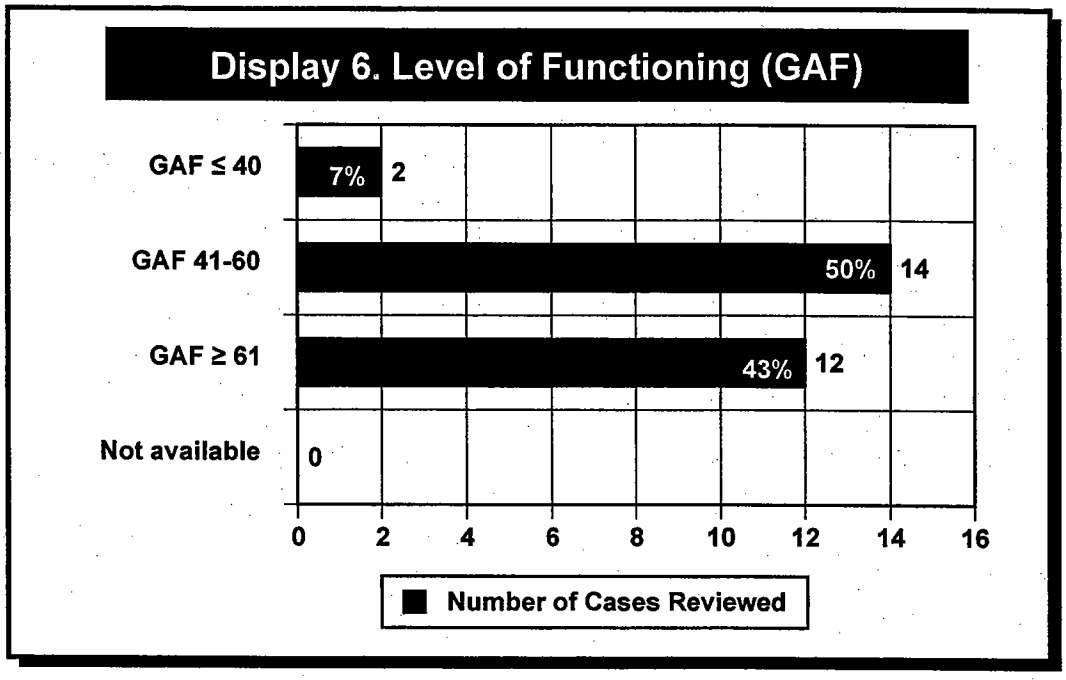


Functional Status of Sample Members

The functional status of adults in the review sample was assessed using the Global Assessment of Functioning Scale (DSM-IV, Axis V), which uses a 100-point scale. On this scale, a person in the low 1-40 range would be considered to be seriously emotionally disturbed, having substantial problems in daily functioning in normal settings, and requiring a high level of support and/or temporary treatment in alternative settings. A person in the mid-range of 41-60 would have some difficulties or symptoms in some areas but could get by with simple or occasional support in most settings. A person in the higher range of 61+ had no more than slight impairments of functioning but could be functioning well in normal daily settings.

Display 6 shows the distribution of the review sample across functioning levels for the 28 members. It should be noted that only two (7%) of those in the sample fell into the low functional range—one was in the 30-49 year age group and the other was in the 50-69 age group. Some 14 members of the sample, half (50%), were in the mid-range of functioning with 14% in the 18-29 year age group, 11% in the 30-49 year age group, and 25% in the 50-69 year age group. The remaining 12 members (43%) of the sample were in the higher functioning range

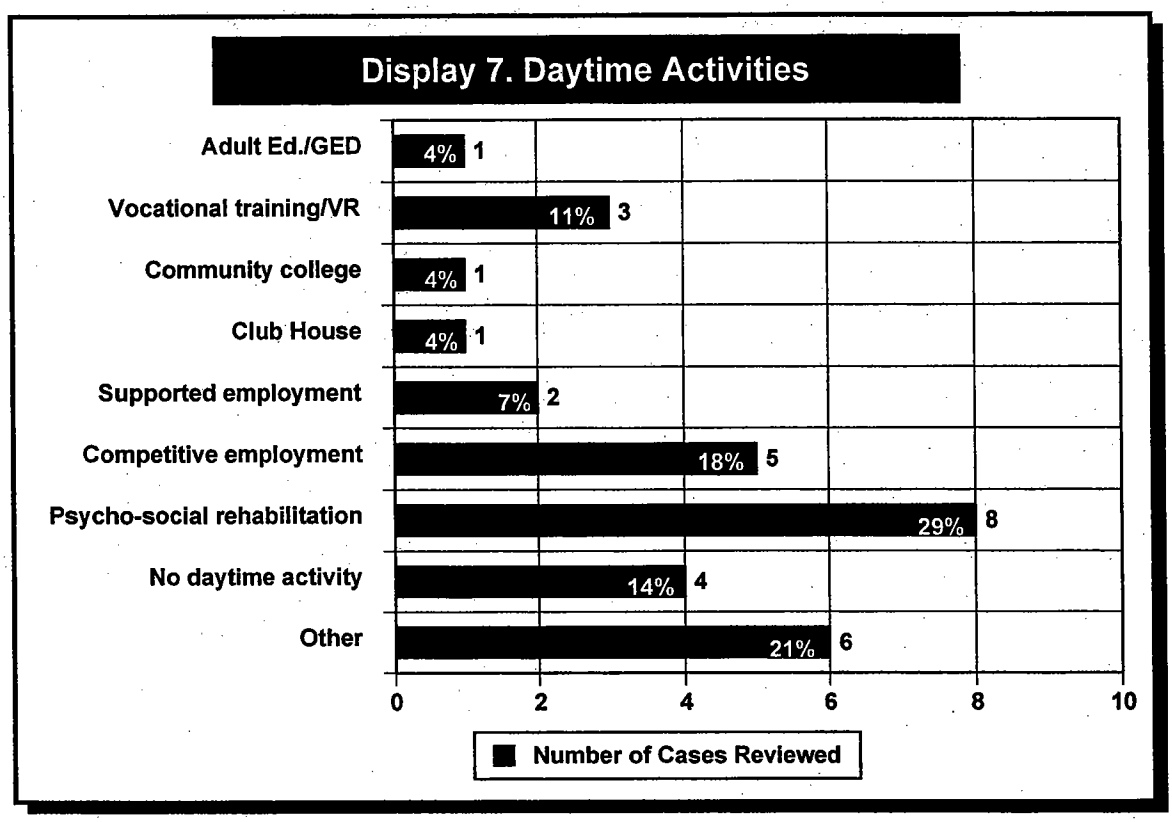
with one person (4%) in the 18-29 age group, seven (25%) in the 30-49 age group, and four (14%) in the 50-69 year age group.



Daytime Activities Reported for Sample Members

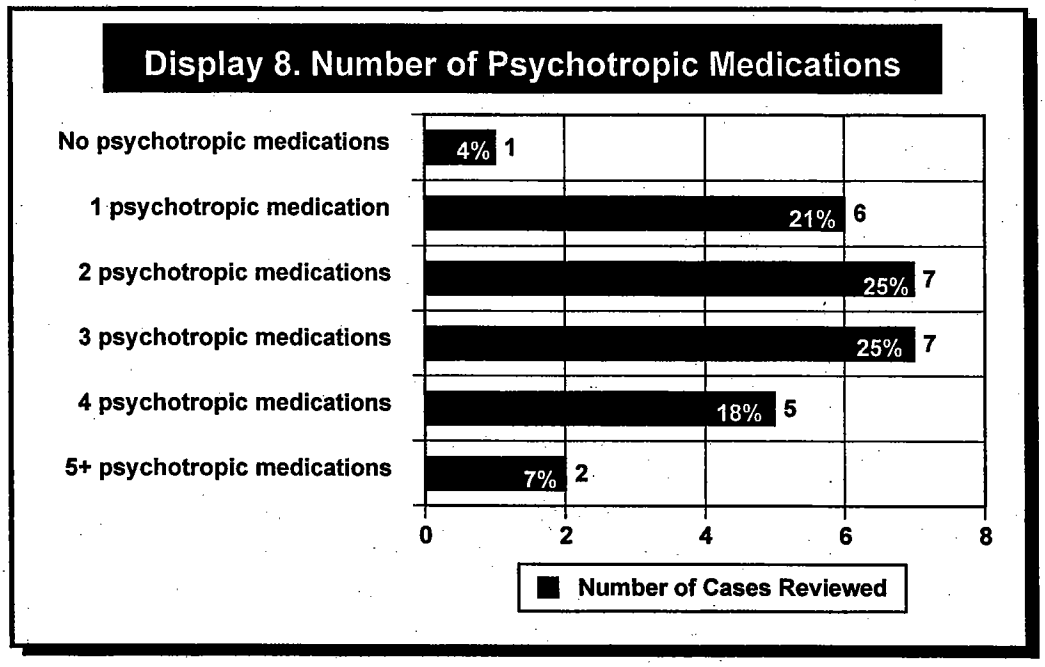
Reviewers identified the major daytime activities in which sample members were participating at the time of the review. **Display 7** presents daytime activities for members of the sample.

One member of the sample (4%) was participating in an adult education program working toward a GED (general education diploma). Three persons (11%) were participating in vocation training programs sponsored through Vocational Rehabilitation Services. Another person (4%) was taking classes at a community college. The main daytime activity for one person (4%) was visiting the Club House. Two persons (7%) were participating in supported employment programs. Five persons (18%) were working in competitive jobs. Eight members (29%) of the sample were participating in psychosocial rehabilitation programs. Two persons (7%) were engaged in job search activities. One person was on home detention. One person was a homemaker and another was taking care of her parents during the day. Four persons (14%) had no identified daytime activities.



Psychiatric Medications Reported for Sample Members

Persons with severe and persistent mental illness often take prescribed psychiatric medications to relieve symptoms. **Display 8** presents the number of psychiatric medications prescribed to members of the review sample. One person (4%) was not prescribed medications. About a fifth of the sample (21%) received one medication. A quarter (25%) received two medications. Another quarter (25%) received three medications. Nearly another fifth (18%) received four medications. Two persons (7%) received five or more medications. Thus, nearly three-quarters (75%) of the sample received three or fewer medications.



Quantitative Case Review Findings

Overview of the Case Review Process

Case reviews were conducted for 28 adult service consumers during the week of May 5-9, 2003, using the *Community Services Review (CSR) Protocol* [Baseline Version for Adults]—a case-based review tool developed for this purpose. This tool was based on a recovery philosophy, 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 were organized into major domains. One domain contained questions concerning the current status of the person (e.g., safety or economic security) and recent changes (e.g., improved self-management, risk reduction) that were related to treatment. The other domain contained questions focused on the performance of practice functions (e.g., engagement, teamwork, or assessment). For each question deemed applicable in a case, the finding was rated on a 6-point scale. **Displays 9A** and **9B** provide an overview of the rating logic used by reviewers in determining specific rating values for an item in a case. Display 9A presents the

rating scale used for adult status, and Display 9B presents the scale used for rating practice performance. The protocol provided item-appropriate details for rating each question.

These two displays show not only the 6-point rating scales but also two different interpretive frameworks for presenting review findings. On the left side of these displays are three "action zones" that provide a suggestive framework for next-step action by case practitioners for items with ratings falling into these zones. Ratings in the 5- and 6-point range fall into the "maintenance zone," indicating that adult status or practice performance is at a high level and should be maintained. Ratings in the 3- or 4-point range are at a more cautionary level, falling into the "refinement zone," indicating that refinements in service strategies or practices are necessary. Ratings in the 1- or 2-point range fall into a seriously problematic level or "improvement zone," indicating that improvements should be undertaken promptly for this person. On the right side of Displays 9A and 9B is a second interpretive framework for the rating scales and findings produced. This framework divides the 6-point scale into two segments. The segment with the upper end of the scale, containing ratings 4, 5, and 6, is deemed to be in the "acceptable range." The segment having the lower end of the scale, containing ratings 1, 2, and 3, is deemed to be in the "unacceptable range." These two interpretative frameworks are used to present quantitative findings from the case review protocol.

Interviews

Review activities in each case included a review of plans and records as well as interviews with the adult service consumer and others involved in providing services and supports to the adult service consumer. A total of 105 persons were interviewed for these 28 adult service consumers. The number of interviews ranged from a low of two persons in one case to a high of six persons in another case, with an average of 3.8 per case. Presented in this section are displays detailing the aggregate quantitative review findings for the 28-member baseline sample.

Display 9A

CSR Interpretative Guide for Adult 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 person in this area [taking age and ability into account]. The person 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 person in this area with an ongoing positive pattern. This status level is consistent with attainment of long-term goals in area. Status is "looking good" and likely to continue.

Acceptable Range: 4-6

Refinement Zone: 3-4

Status is minimum or marginal, may be unstable. Further efforts are necessary to refine the situation.

4 = **FAIR STATUS.** Status is minimally or temporarily sufficient for the person to meet short-term objectives in this area. Status is minimally acceptable at this point in time, but may be short-term due to changing circumstance, requiring change soon.

3 = **MARGINAL STATUS.** Status is marginal or mixed and not quite sufficient to meet the person's short-term objectives now in this area. Status now is not quite enough for the person to be satisfactory today or successful in the near-term. Risks are minimal.

Improvement Zone: 1-2

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

2 = **POOR STATUS.** Status continues to be poor and unacceptable. The person seems to be "stuck" or "lost" and status is not improving. Risks are mild to moderate.

1 = **ADVERSE STATUS.** The person's status in this area is poor and getting worse. Risks of harm, restriction, separation, regression, and/or other poor outcomes are substantial and increasing.

Unacceptable Range: 1-3

Display 9B

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 person in this function area. This level of performance is indicative of exemplary practice and results for the person. ["Optimum" does not imply "perfection."]

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

Acceptable Range: 4-6

Refinement Zone: 3-4

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

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

3 = **MARGINAL PERFORMANCE.** Practice at this level may be under-powered, inconsistent, or not well-matched to need. Performance is insufficient for the person to meet short-term objectives. [With refinement, this could become acceptable in the near future.]

Improvement Zone: 1-2

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

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

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

Unacceptable Range: 1-3

Organization of Quantitative Findings

Quantitative review findings are divided into four broad sections: person status, recent changes and results, practice performance, and six-month prognosis. Findings are summarized in the sections that follow.

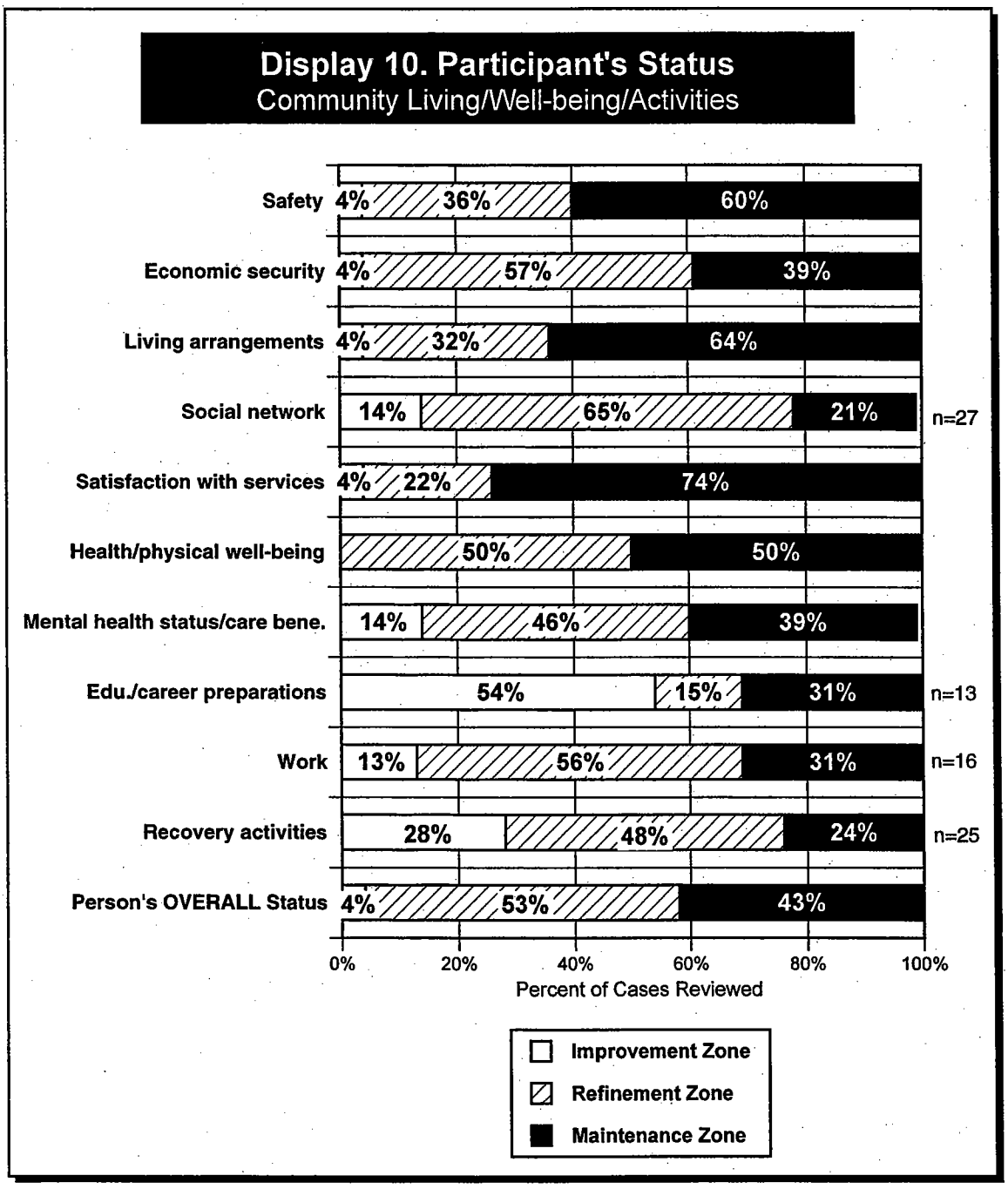
Status of the Adult Service Consumers

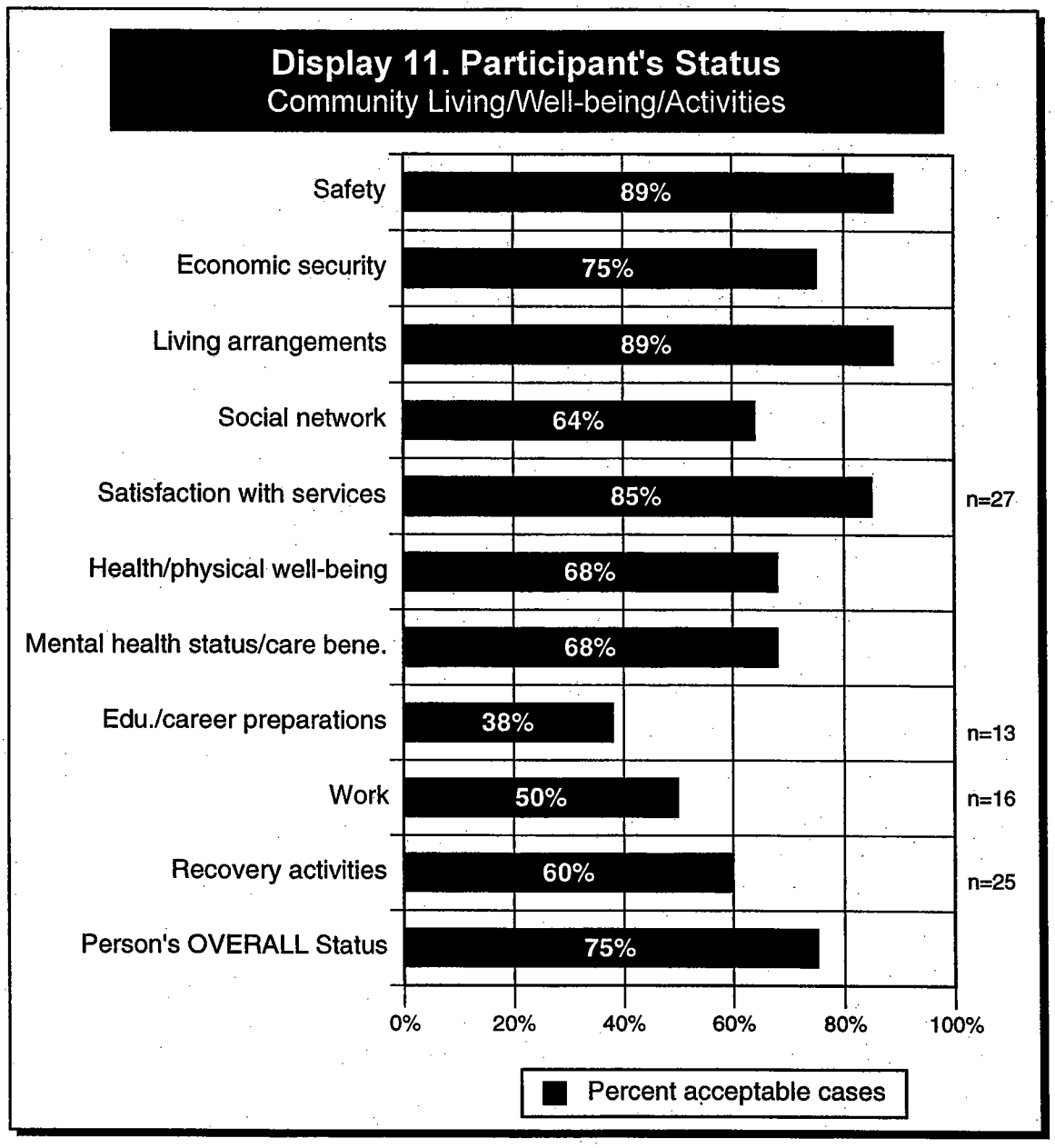
Ten indicators related to the current status of the adult service consumer were contained in the CSR protocol used by reviewers. Readers are directed to **Appendix A** for a detailed description of these ten areas examined by the reviewers. **Displays 10** and **11** present findings for each of the ten indicators. Display 10 uses the "action zone" framework that divides the 6-point rating scale into three segments corresponding to the maintenance, refinement, and improvement zones. Display 11 uses a "percent acceptable" format to report the proportion of the sample members for whom the item was determined applicable and acceptable. Findings on both displays are presented concurrently below. While these two different displays are useful in presenting findings to different audiences, it should be remembered that both displays are derived from the same database of findings.

Safety. Sample members were generally safe from imminent risk of physical harm in their daily environment, with 60% rated in the "maintenance zone" and another 36% in the "refinement zone." One person (4%) was in the "improvement zone," indicating that the person was at increased risk of physical harm. Appropriate persons were alerted to take necessary follow-up actions to ensure the safety of this person. Some 89% of the sample members were acceptably safe at the time of the review.

Economic Security. This area of review focused on: (1) whether the person is receiving entitled economic benefits; (2) whether income and economic supports are sufficient to cover basic living requirements; and (3) whether the person's economic security is sufficient for maintaining stability and effective life planning. Most persons (75%) in the sample had minimally adequate or better economic security. More than a third (39%) of those in the sample were found to have

economic security in the "maintenance zone." Another 57% were rated in the "refinement zone." Just one person (4%) was rated in the "improvement zone."





Living Arrangements. This review area probed whether the person was living in a home of choice with supports necessary and sufficient for safe and successful pursuit of recovery. Some 89% of the sample members were determined to be in living arrangements that were at least minimally appropriate and adequate for recovery or better. More than three-fifths (64%) were determined to be in the "maintenance zone," about a third (32%) in the "refinement zone," and one person (4%) in the "improvement zone."

Social Network. This examination determined whether the adult consumer was connected to a natural support network of family, friends, and peers, consistent with the person's choices. Achieving and maintaining a social network may depend on whether the person is provided peer support and community activities and whether the person has opportunities to meet people outside the service provider organization. Just more than three-fifths (64%) of the sample members were found to have minimally adequate or better social network connections. Just more than a fifth (21%) of the sample members were found to be in the "maintenance zone," about two-thirds (65%) in the "refinement zone," and 14% in the "improvement zone."

Satisfaction with Services. This involved asking the consumer the extent to which the person was satisfied with the treatment, support services, respect, and recovery progress that he/she was presently experiencing. Many (85%) of the consumers expressed minimal satisfaction with services or better. Satisfaction was rated in the "maintenance zone" for 74% of those responding, in the "refinement zone" for 22%, and in the "improvement zone" for one person (4%).

Health/Physical Well-Being. This status indicator asked whether the person was in the best attainable heath, had basic physical needs met, and had access to health care services as needed. About two-thirds (68%) of sample members were found to be healthy with physical needs met, including access to health care services. Half (50%) were determined to be in the "maintenance zone," with the other half (50%) determined to be in the "refinement zone."

Mental Health Status. Is the person's mental health status currently adequate or improving? If symptoms are present, does the person have access to mental health services that are sufficient to reduce symptoms and improve the person's daily functioning? Is the person benefiting from mental health care received? These were the questions explored in this area by reviewers. Findings indicate that mental health status among persons reviewed was determined to be minimally adequate or better for two-thirds (68%) of the sample members. Mental health status was found to be in the "maintenance zone" for 39%, in the "refinement zone" for nearly half (46%), and in the "improvement zone" for 14% of the persons reviewed.

Education/Career Preparation. Based on the person's needs and interests, is this adult actively engaged in educational activities (e.g., adult basic education/GED preparation, post-secondary education) or a vocational training program? This was the central concern in this review area. This review was deemed applicable to 13 (46%) of the 28 sample members. Among those for whom the review item was applied, some 38% were found to be receiving an adequate level of education and career preparation. Some 31% were found to be in the "maintenance zone," 15% in the "refinement zone," and 54% in the "improvement zone." The status was poor in this area for more than half of those for whom this area was deemed applicable.

Work. Based on the person's needs and interests, is the person actively engaged in employment (e.g., competitive, supported, or transitional)? If not, does the person have access to productive activities? This review area was deemed applicable for 16 (57%) of the 28 persons in the sample. Work activities and opportunities were found to be minimally acceptable or better for 50% of the sample members for whom the review area was deemed applicable. Work was found to be in the "maintenance zone" for 31%, in the "refinement zone" for 56%, and in the "improvement zone" for 13% of those applicable sample members. Clearly, education and work status are of concern for those persons participating in the review.

Recovery Activities. Consistent with the person's needs and preferences, did the person actively engage in activities necessary to improve capabilities, competencies, coping, self-management, social integration, and recovery? This review area was deemed applicable for 25 (89%) of the 28 persons in the sample. Engagement in recovery activities was found to be minimally adequate or better for 60% of the sample members for whom the review was deemed applicable. Engagement in recovery activities was rated in the "maintenance zone" for 24%, in the "refinement zone" for 48%, and in the "improvement zone" for 28% of sample members. As with education and work, the rate of acceptable participation and opportunity was found to be substantially inadequate for many persons in the sample. Thus, access to meaningful activities remains a challenge for many adults, as does provision of meaningful activities for the service system.

Overall Status of Adult Consumers. The protocol provides a scoring rubric for combining ratings values across the items deemed applicable to the adult service consumer being reviewed to

produce an "overall status rating." Applying this rubric resulted in the determination that nearly three-quarters (75%) of the adult consumers reviewed were doing acceptably well (rating levels 4, 5, and 6), overall, in the status domain. Some 43% of the adult sample members reviewed were rated in the "maintenance zone," another 53% in the "refinement zone," and 4% in the "improvement zone." This is a fair result for a baseline measurement across status indicators but should also be understood to reflect consumers who are successfully engaged with the system, are actively participating in treatment, and are satisfied with services.

Recent Progress Patterns Showing Change Over Time

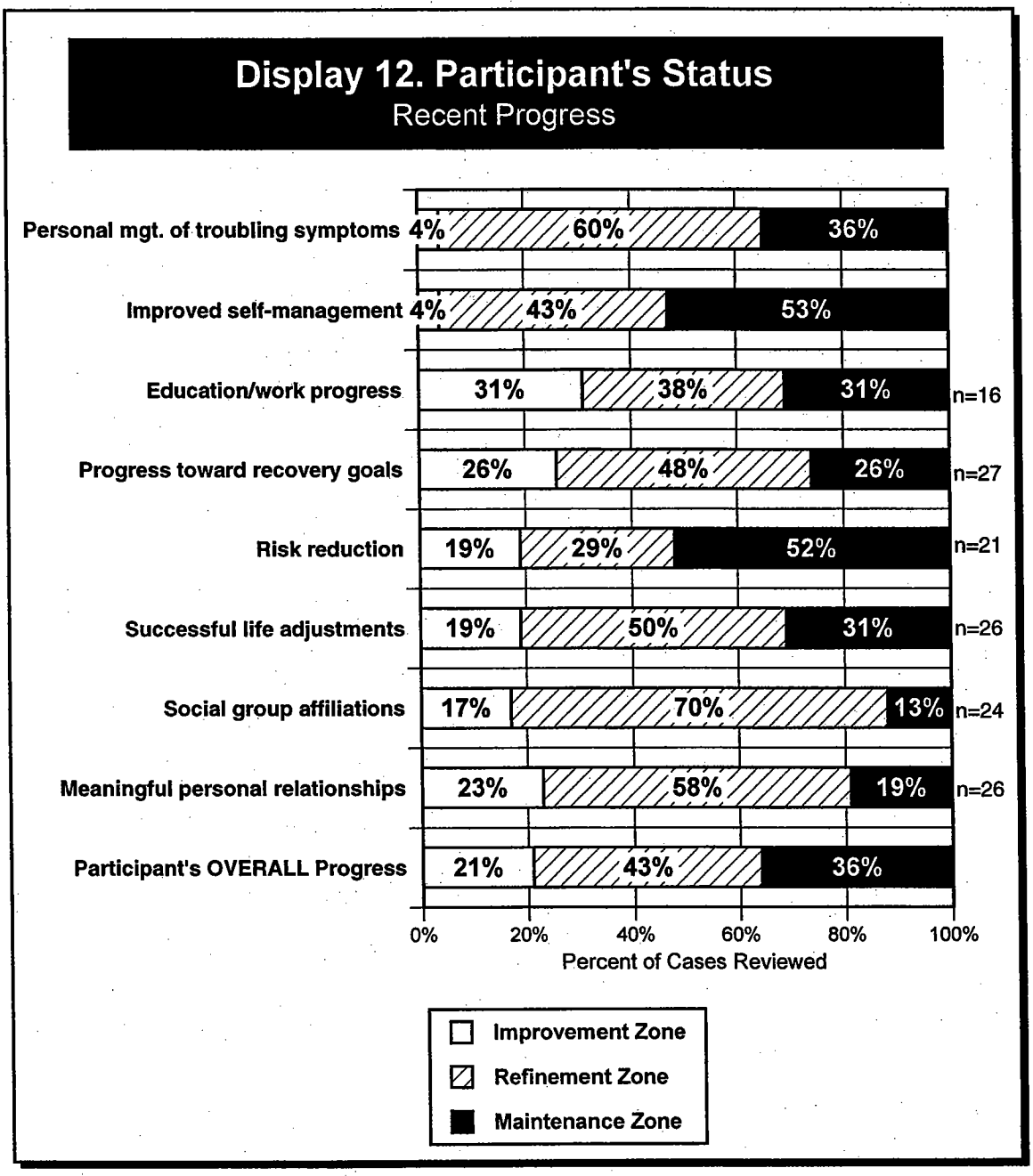
The CSR protocol provided eight indicators that enabled reviewers to examine recent progress noted for the sample members reviewed. The focus was placed on changes occurring over the past six months or since admission if less than six months. Descriptions of these eight indicators can be found in **Appendix A**.

Displays 12 and 13 present findings for the progress indicators for the review sample. It should be noted that indicators could be deemed not applicable in certain cases, based on specific case circumstances. Progress findings on both displays are summarized concurrently as follows.

Progress in Symptom Reduction and Management. The focus of this review was placed on the extent to which troublesome symptoms or mental illness were being reduced, coped with, and personally managed by the individual. Reducing symptoms of mental illness is usually a goal of treatment for adults receiving mental health services. Recent progress in symptom reduction and management was found to be at least minimally adequate for nearly two-thirds (64%) of sample members reviewed. Symptom reduction and management was determined to be in the "maintenance zone" for 36% of sample members, in the "refinement zone" for another 60%, and in the "improvement zone" for 4% of sample members.

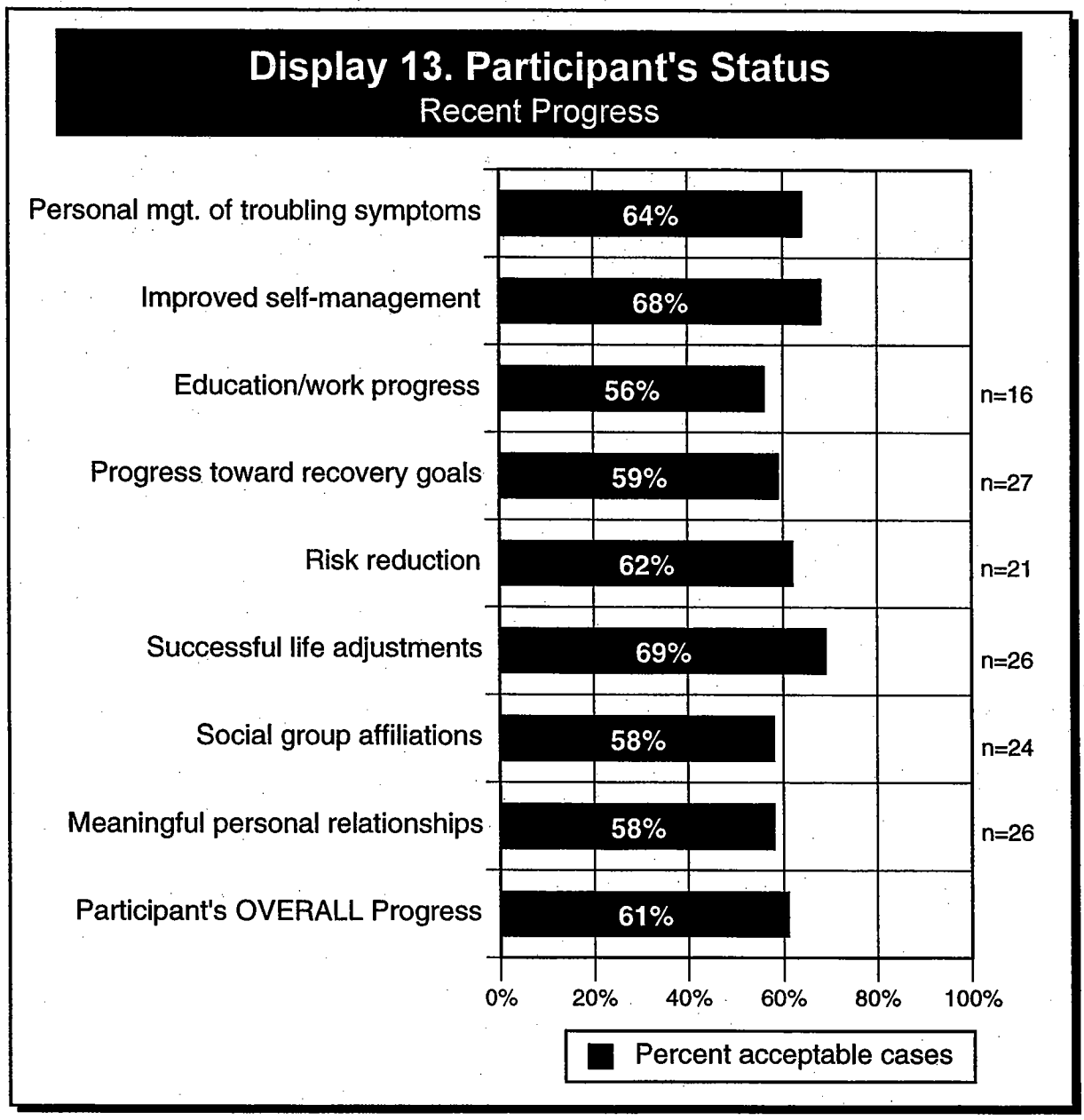
Progress in Self-Management. The extent to which a person was making progress in key life areas, including self-management in the community, was the focus of review in this indicator. Improvements in self-management were found to be minimally adequate or better in two-thirds

(68%) of the cases reviewed. About half (53%) of the cases were rated in the "maintenance zone," 43% in the "refinement zone," and 4% in the "improvement zone."



Education/Work Progress. The focus of this indicator was on the extent to which a person was making progress toward educational program completion or making progress in getting and keeping a job. This review was deemed applicable to 16 (57%) of the persons in the review

sample. Education or work progress was found to be minimally adequate or better in 56% of the applicable cases. Almost a third of these cases were rated in the "maintenance zone" (31%), more than a third in the "refinement zone" (38%), and about a third in the "improvement zone" (31%).



Progress Toward Recovery Goals. To what degree is the person making progress toward attainment of personally selected recovery goals in the person's individualized recovery plan (IRP)? This review indicator was deemed applicable in 27 (96%) of the 28 cases in the sample.

Recovery progress was found to be minimally adequate or better in 59% of the applicable cases. Recovery progress was rated in the "maintenance zone" in just over a quarter (26%) of the applicable cases. Progress made toward recovery goals was rated in the "refinement zone" in 48% of the cases and in the "improvement zone" in 26% of the applicable cases.

Risk Reduction. To what extent is reduction of risks of harm, addiction, or use of coercive techniques being accomplished with and for this person? This indicator was deemed applicable in 21 (75%) of the 28 cases in the review sample. Risk reduction was found to be minimally acceptable or better in 62% of the applicable cases in the sample. Risk reduction was rated in the "maintenance zone" in 52% of the case, in the "refinement zone" in 29%, and in the "improvement zone" in 19% of the applicable cases.

Successful Life Adjustments. Consistent with the person's life goals, to what extent is the person making successful transitions and life adjustments between settings, service providers, levels of care, and from dependency to personal control and direction of one's life? This review indicator was deemed applicable to 26 (93%) of the 28 cases in the sample. Successful life adjustments were found to be minimally acceptable or better in two-thirds (69%) of the applicable cases. Successful life adjustments were rated in the "maintenance zone" in 31% of the cases, in the "refinement zone" in 50%, and in the "improvement zone" in 19% of the applicable cases.

Improved Social Group Affiliation. To what degree is the person increasing his/her social affiliation among a variety of social groups (outside of his/her immediate social group), consistent with IRP goals? This indicator was deemed applicable in 24 (86%) of 28 cases. Reviewers found progress in social group affiliation minimally adequate or better in 58% of the applicable cases. Progress in social group affiliation was rated in the "maintenance zone" in 13% of the cases, in the "refinement zone" in 71%, and in the "improvement zone" in 17% of the applicable cases in the sample.

Improved Meaningful Personal Relationships. To what degree is the person improving meaningful personal relationships with peers, friends, and community members, consistent with the person's preferences? This indicator was deemed applicable in 26 (93%) of the 28 cases in

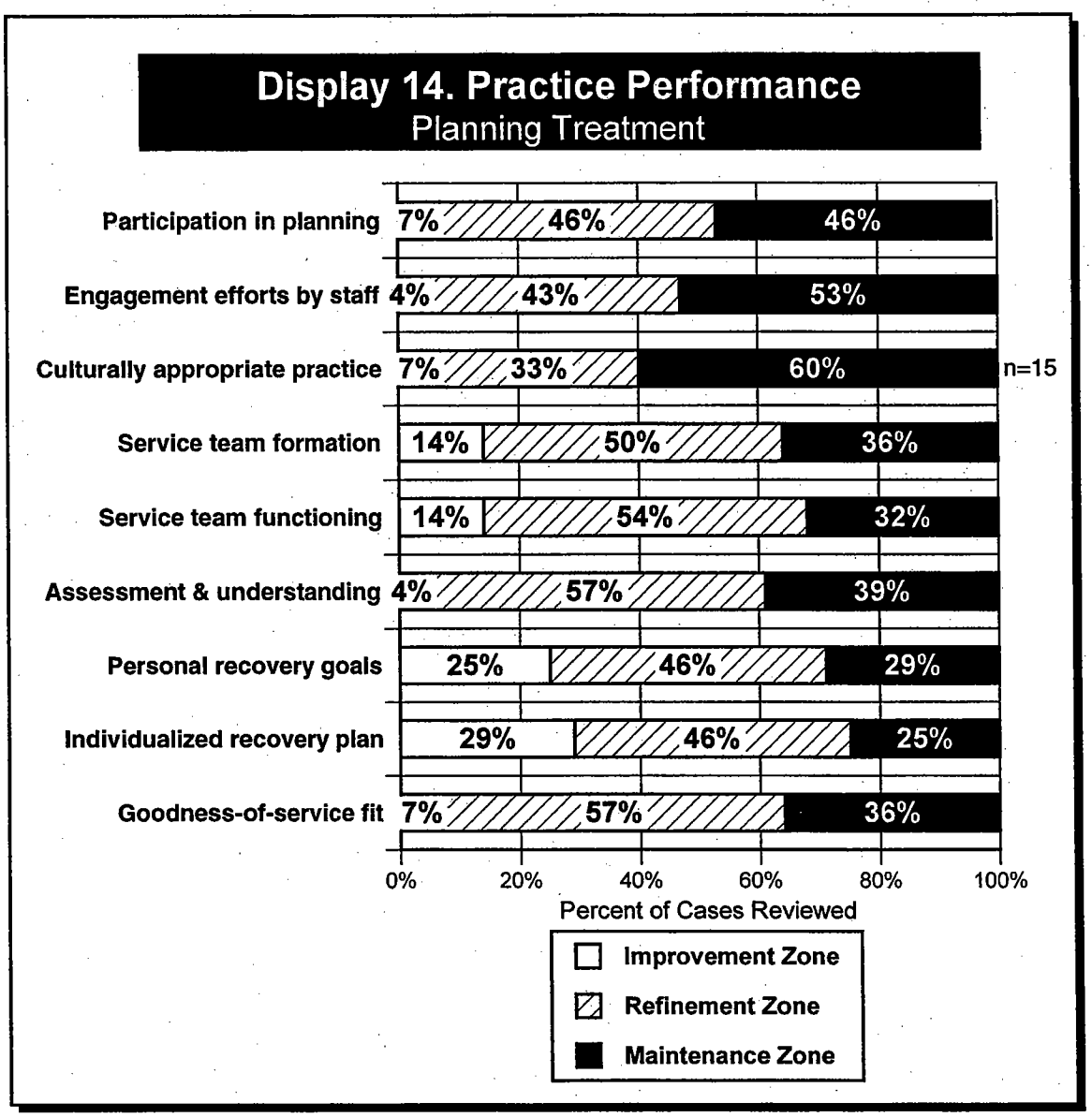
the sample. Progress toward improved meaningful relationships was found to be minimally adequate or better in 58% of the applicable cases reviewed. Progress on this indicator was rated in the "maintenance zone" in 19% of the applicable cases, in the "refinement zone" for 58%, and in the "improvement zone" for 23% of the applicable cases.

Overall Progress Pattern. To what extent are persons in the sample making overall progress on applicable indicators in their cases? Reviewers provided a holistic impression of overall progress in each case based on those progress indicators deemed applicable in the case. The overall progress pattern was found to be minimally acceptable or better in 61% of the cases in the sample. Overall progress was rated in the "maintenance zone" in about a third (36%) of the cases, in the "refinement zone" in 43%, and in the "improvement zone" for 21% of the sample members.

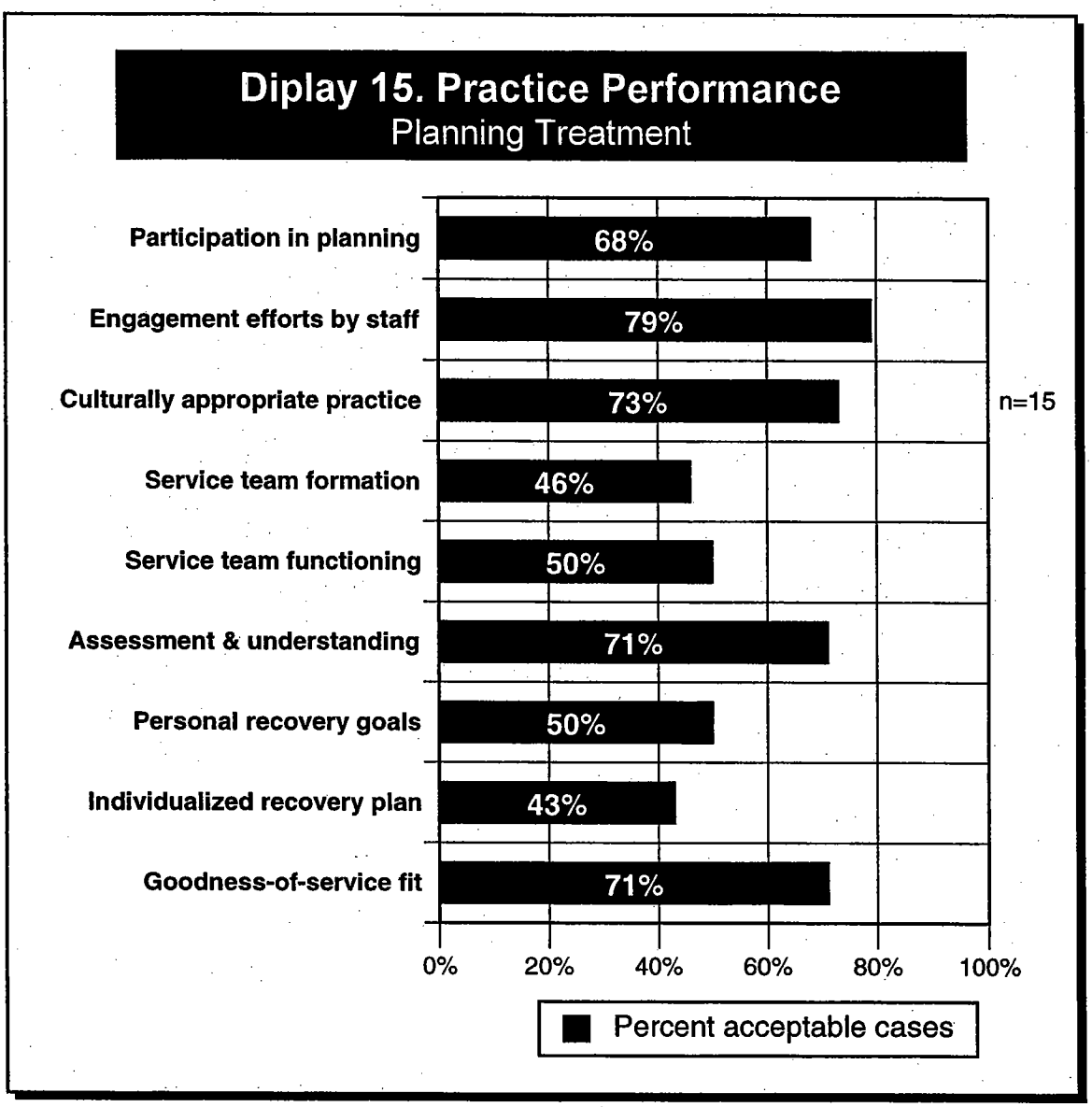
Case-Level Performance of Practice Functions

The CSR protocol contained 17 indicators of practice performance that were 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 17 indicators were divided into two sets. The first set—"planning treatment," containing nine indicators—focused on engaging families, understanding the situation, setting directions, making plans, and organizing a good mix of services. Findings for these eight indicators are presented in **Displays 14 and 15**. The second set—"providing and managing treatment," containing eight indicators—focused on resources, implementation, special procedures and supports, service coordination, and tracking and adjustment. **Displays 16 and 17** present findings for the second set of indicators.

The first set of performance indicators illuminates important functions and aspects of daily frontline practice conducted with 28 persons. Findings for these indicators are presented in the two displays and summarized concurrently below.



Engagement/Participation of the Person. The adult consumer and his/her selected supporters should be active participants in making decisions and plans about services. For more resistant persons, greater outreach and engagement efforts should be made by service staff. Achieving active participation depends on the relationships formed and sustained over the course of the treatment process. The function of engagement was determined to be working acceptably in two-thirds (68%) of the 28 sample cases reviewed. Engagement/participation was found to be in the good to optimal range ("maintenance zone") in 46% of these cases. Engagement was found to be in the "refinement zone" in 46% and in the "improvement zone" in another 7% of the cases reviewed.



Culturally Appropriate Practice. Significant cultural issues should be recognized and addressed in practice through special accommodations and supports used to adapt or augment basic functions of practice (e.g., engagement, assessment, and planning). This expectation is applicable when there are cultural differences between the persons providing and receiving services. This indicator was deemed applicable for 15 (53%) of the 28 sample members. Reviewers found that practice was culturally appropriate in 73% of the cases to which this indicator was applied. Culturally competent practice was found to be in the good to optimal range ("maintenance zone") in more than half (60%) of these cases. Culturally competent practice was found to be in

the "refinement zone" in 33% of the cases and in the "improvement zone" in another 7% of the cases.

Service Team Formation. Each adult consumer served should have a service team involving the person, informal supports, and service providers. There is no fixed formula for team composition, but the team should be the "right people" for the person and include those who are active interveners in the person's life. Such active interveners could include a parole officer, therapist, or teacher. Service team formation was found to be at least minimally adequate for 46% of the adults reviewed. Service team formation was found to be in the good to optimal range ("maintenance zone") in just over a third (36%) of these cases. Team formation was found to be in the "refinement zone" in half (50%) of the cases and in the "improvement zone" in another 14% of the cases reviewed.

Service Team Functioning. The service team should function as a unified team in planning services. The actions of the service team should reflect a coherent pattern of teamwork and collaborative problem solving that achieves results benefiting the adult service consumer. Service team functioning was found to be at least minimally adequate for half (50%) of the persons reviewed. Service team functioning was found to be in the good to optimal range ("maintenance zone") in 32% of these cases. Team functioning was found to be in the "refinement zone" in more than half (54%) of the cases and in the "improvement zone" in another 14% of the cases reviewed. Clearly, service team functioning is an area that warrants significant attention in practice development efforts undertaken by the Department of Mental Health.

Assessment and Understanding. A functional assessment involves not only the collection and assembly of information about a person but also the development of a "big picture view" and deep understanding of the person's situation, circumstances, and preferences. The knowledge gained through ongoing functional assessments enables the service team to provide a combination and sequence of services and supports that promotes progress and success for the person. Assessment and understanding of the person were found to be minimally adequate or better for 71% of the adult service consumers reviewed. Functional assessment was found to be

in the good to optimal range ("maintenance zone") in 39% of these, in the "refinement zone" for 57%, and in the "improvement zone" for 4% of the cases reviewed.

Personal Recovery Goals. Do the personal recovery goals used for service planning reflect the person's life situation, interests, and career aspirations? If met, will these goals lead to the person managing successfully at home, at work, and in the community, with supports and services as necessary? Personal recovery goals of the person being served enables practitioners to look ahead to where they hope the person will be in the next 3-5 years so that goals can be reached and transitions accomplished. Personal recovery goals should take into account the circumstances present within the person's life situation. For example, if the person has a developmental disability or a degenerative disease, the goals would reflect that understanding and adjust the expectations and strategies used in planning services. If the person has a pattern of instability in home placements, then achieving stability and permanency has to be taken into account in the "grand vision" of where things are headed. This means that the service team has to know about and deal realistically with the "whole person." The long-term success of the person depends on a meaningful, long-term, strategic vision that creates a pathway that guides services, enabling the person to achieve important life outcomes.

Without personal recovery goals to guide planning, service providers tend to focus on the present episode (reduce a behavior problem or change a placement) rather than planning strategies and providing services for reaching critical long-term goals. Personal recovery goals were found to be at least minimally adequate for half (50%) of the persons reviewed. The long-term view was found to be in the good to optimal range ("maintenance zone") in about a quarter (29%) of these, in the "refinement zone" in 46%, and in the "improvement zone" in another quarter (25%) of the cases reviewed.

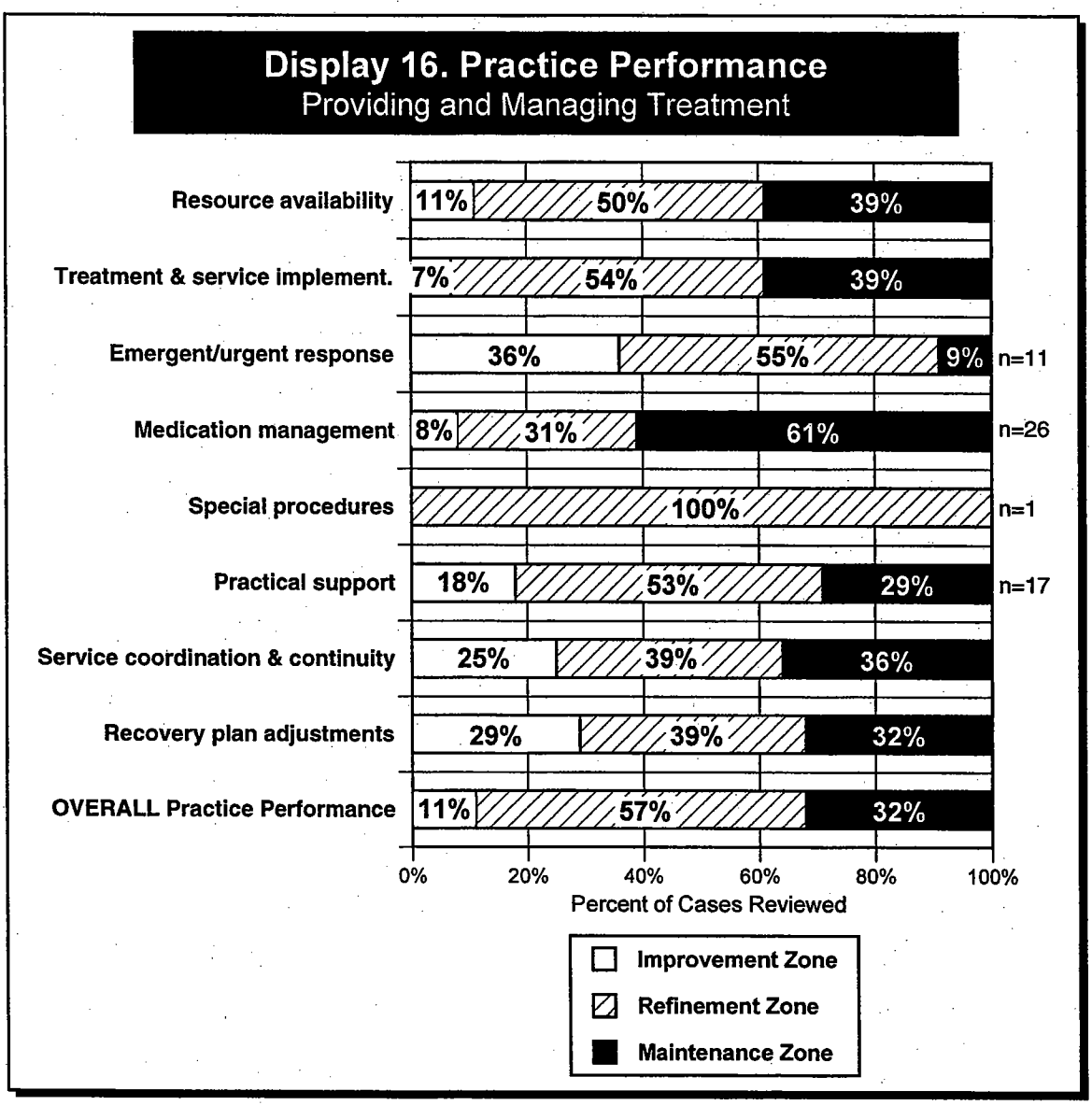
Individualized Recovery Plan. The IRP should set forth strategies and services across providers that are directed at achieving the personal recovery goals set for the person. The IRP should build on personal resiliency and strengths, providing interventions and supports that help the person succeed at home and work. More than a mere service authorization document, the IRP should actually drive practice and service provision in a case. The IRP was found to be at least

minimally adequate for 43% of the persons reviewed. The IRP was found to be in the good to optimal range ("maintenance zone") for a quarter (25%) of these cases, in the "refinement zone" for another 46%, and in the "improvement zone" for 29% of the cases reviewed. Clearly, the development and use of the IRP in actual case practice is an area that merits further attention for frontline staff.

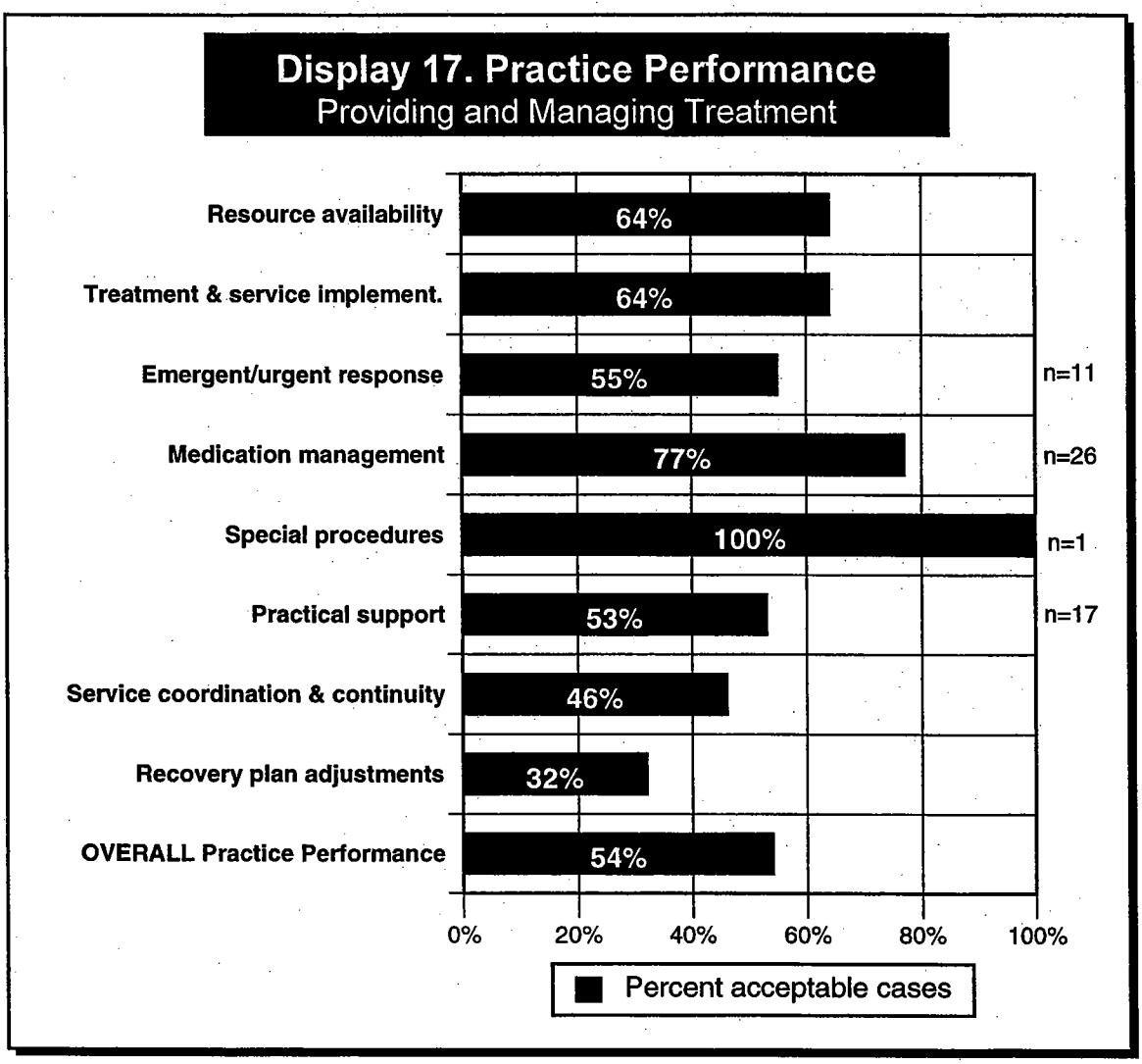
Goodness-of-Service Fit. The therapeutic, educational, and supportive services provided for a person and family should be assembled into a coherent mix and sequence of services. This combination of services should fit the person's situation so as to maximize positive results and benefits while minimizing conflicting strategies and hardships imposed. The goodness-of-service fit was found to be at least minimally adequate for 71% of the persons reviewed. The service fit was found to be in the good to optimal range ("maintenance zone") in about a third (36%) of these cases. The service fit was found to be in the "refinement zone" in 57% of the cases and in the "improvement zone" in 7% of the cases reviewed. Because the quality of service fit can either enhance or limit a person's participation and results, attention should be given to teaching techniques for improving service fit to frontline staff who plan, assemble, and coordinate services for the persons served.

The second set of performance indicators covers important functions related to the provision and management of treatment and support services to persons receiving services. Findings for these indicators are presented in the next two displays and summarized concurrently below.

Resource Availability. Are the supports, services, and resources necessary to meet the needs addressed in the IRP available for use by the person, supporter, and service team? Are any needed but unavailable resources identified by the service team with efforts being made to secure these resources? Resource availability was found to be minimally adequate or better for nearly two-thirds (64%) of sample members. Resource availability was rated as good or optimal ("maintenance zone") for 39% of the sample members. It was rated as fair or marginal ("refinement zone") for half (50%) of those in the sample. Resource availability was found to be poor or adverse ("improvement zone") for 11% of persons in the sample.



Treatment Implementation. Intervention strategies, supports, and services set forth in the person's IRP should be implemented with sufficient intensity and consistency to achieve the goals and results expected. Implementation should be timely and competent. Treatment implementation was found to be at least minimally adequate for nearly two-thirds (64%) of the sample members reviewed. Implementation was found to be in the good to optimal range ("maintenance zone") for 39% of these cases. Implementation was found to be in the "refinement zone" in more than half (54%) of the cases and in the "improvement zone" for 7% of the cases reviewed.



Emergent/Urgent Response. Persons served should have timely access to and provision of effective services to stabilize or resolve emergent or episodic problems of an urgent nature. Not all persons served need such services. Indeed, only 11 persons served within the sample of 28 needed and used these services in the recent past. Emergency and urgent service provision was found to be at least minimally adequate for about half (55%) of the persons in the sample who needed and used such services. Emergency and urgent service provision was found to be in the good to optimal range ("maintenance zone") for 9% of these cases. Emergency and urgent service provision was found to be in the "refinement zone" in 55% of the cases and in the "improvement zone" in another 36% of the cases reviewed. Findings indicate that emergency

and urgent service provision are areas in which significant improvements are needed to benefit service consumers.

Medication Management. Use of psychotropic medications should be necessary, safe, and effective, when used. The person taking such medications should be screened and treated for any side effects. Medication use should reflect state-of-the-art medications and practices. Medication use should be coordinated with other treatment modalities and with treatment for any co-occurring conditions (e.g., seizures, diabetes, or asthma). Some 26 of the 28 persons served in the sample were taking psychotropic medications. Medication management was found to be minimally adequate or better for about three-quarters (77%) of the persons in the review sample who took medications. Medication management was found to be in the good to optimal range ("maintenance zone") in 61% of these cases. Medication management was found to be in the "refinement zone" in 31% of the cases and in the "improvement zone" in only 8% of the cases reviewed. Medication management was found to be one of the strongest areas of current practice.

Special Procedures. If emergency seclusion or restraint is used for a person, each use should be: (1) done only in an emergency, (2) done after less restrictive alternatives were found insufficient or impractical, (3) ordered by a trained and authorized professional, (4) accomplished with proper techniques that were safely and respectfully performed by trained staff, (5) effective in preventing harm, and (6) properly supervised during use and evaluated afterward. This review indicator was deemed applicable in only one of the 28 cases in the review sample. Use of special procedures was found to be at least minimally adequate for the one applicable case. Use of special procedures was found to be in the "refinement zone" for this one person.

Practical Support. Is the array of in-home and community-based supports provided to the person sufficient [in design, intensity, and dependability] to meet the person's preferences and do they assist him or her achieve recovery goals? Are practical supports effective during life change adjustments and in maintaining the person in his/her home, job, and community? Where applicable, are individually assigned staff (job coach, crisis worker, skills trainer) receiving the education and supports necessary to maintain an appropriate relationship with the person? This indicator was deemed applicable in 17 of the 28 cases in the review sample. Practical support

was found to be at least minimally adequate for about half (53%) of these persons. Practical support was found to be in the good to optimal range ("maintenance zone") in about a quarter (29%) of these cases. Family support was found to be in the "refinement zone" in a little more than half (53%) of the applicable cases and in the "improvement zone" in 18% of the 17 applicable cases reviewed.

Service Coordination and Continuity. There should be a single point of coordination, accountability, and continuity of services for the person. IRP-specified treatment and support services should be well coordinated across service settings, providers, funding agencies, and levels of care for this person. Service coordination was found to be at least minimally adequate for just less than half (46%) of the persons reviewed. Service coordination was found to be in the good to optimal range ("maintenance zone") in about a third (36%) of these cases. Service coordination was found to be in the "refinement zone" in 39% of the cases and in the "improvement zone" in a quarter (25%) of the cases reviewed.

Recovery Plan Adjustments. Is the service coordinator using monitoring activities to follow the person's progress, changing conditions, consistency and effectiveness of supports, and results achieved? The service coordinator and team should be tracking the person's treatment progress, stressors and supports, and results. The team should communicate frequently to discuss treatment fidelity, barriers, and progress. IRP services and strategies should be adjusted in response to progress made, changing needs, problems solved, and experience gained to create a self-correcting treatment process for the person. Tracking and adjustment was found to be at least minimally adequate for just less than a third (32%) of the persons reviewed. Tracking and adjustment was found to be in the good to optimal range ("maintenance zone") in 32% of these cases. Tracking and adjustment was found to be in the "refinement zone" in 39% and in the "improvement zone" in 29% of the cases reviewed.

Overall Practice Performance. The protocol provides a scoring rubric for combining ratings values across the items deemed applicable to the person 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 just more than half

(54%) of the cases reviewed. Some 32% of the persons served and reviewed were rated in the "maintenance zone," about half (57%) in the "refinement zone," and 11% in the "improvement zone." Overall, these results create a baseline measurement across practice performance indicators for persons served currently receiving and participating in services and who generally can be served at the outpatient level.

Case Review Outcome Categories

Members of the case review sample can be classified and assigned to one of four categories that summarize review outcomes. Sample members having overall status ratings in the 4, 5, and 6 levels are considered to have a "favorable status." Likewise, those having overall practice performance ratings of 4, 5, and 6 are considered to have "acceptable system performance" at the time of the review. Those having overall status ratings less than 4 had "unfavorable status" and those having overall practice performance ratings less than 4 had "unacceptable system performance." These categories are used to create the two-fold table shown in **Display 18.**

Display 18 reveals that 15 of the 28 cases (54%) fell into outcome category 1. Outcome 1 is the desired situation for all adults receiving services. None of the members of the sample fell into outcome category 2. Six cases (21%) fell into outcome category 3. Outcome 3 contains those sample members whose status was favorable but experienced less than acceptable service system performance. Some persons are resilient and may have excellent supports provided by family, friends, or others whose efforts are contributing to the person's favorable status. But, current service system performance may be limited, inconsistent, or seriously inadequate at this time. Seven cases (25%) fell into review outcome category 4. Outcome 4 is the most unfavorable combination because the person's status is unfavorable and system performance is inadequate. This display shows that service system performance was acceptable for 54% of the sample members. This is about half the desired rate of 90% and greater.

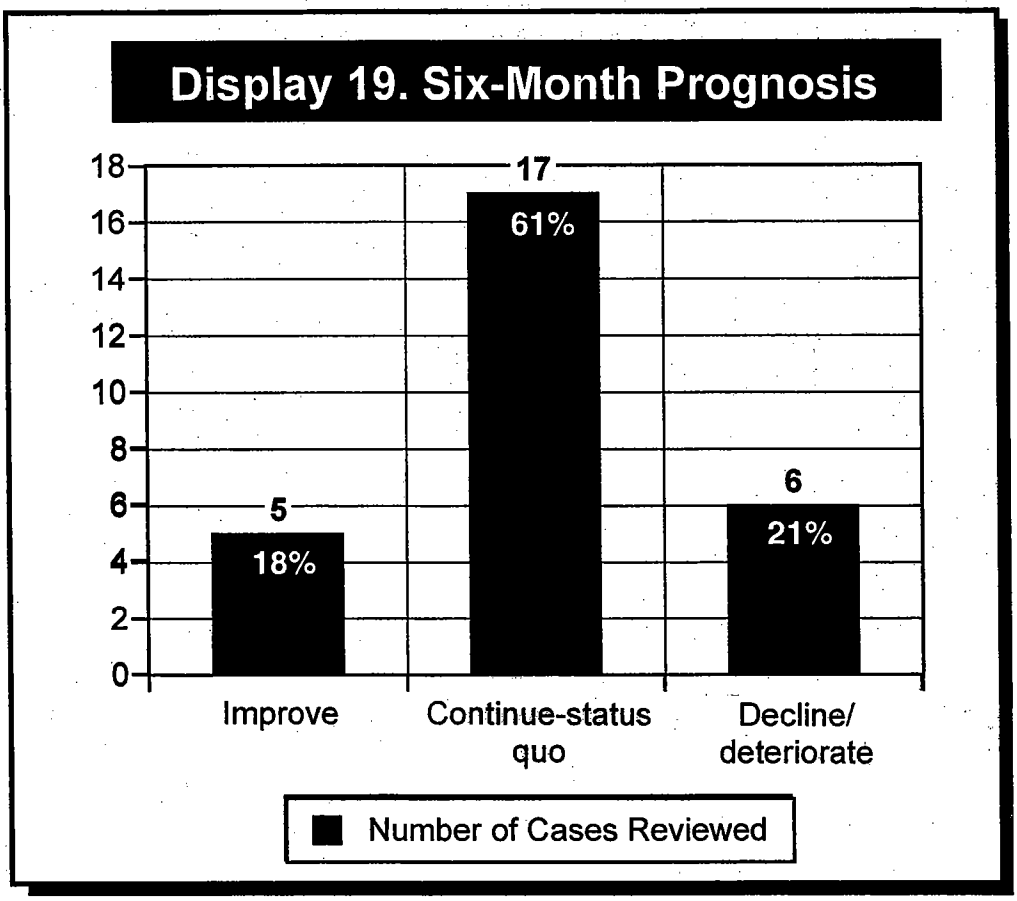
Display 18. Case Review Outcome Categories

Status of the Participant in Individual Cases

Acceptability of Service System Performance in Individual Cases	Favorable Status	Unfavorable Status	
Acceptable System Performance	**Outcome 1:** Good status for the participant, ongoing services acceptable. **54% (15 cases)**	**Outcome 2:** Poor status for the participant, ongoing services minimally acceptable but limited in reach or efficacy. **0% (0 cases)**	**54%**
Unacceptable System Performance	**Outcome 3:** Good status for the participant, ongoing services mixed or unacceptable. **21% (6 cases)**	**Outcome 4:** Poor status for the participant, ongoing services unacceptable. **25% (7 cases)**	**46%**
	75%	**25%**	

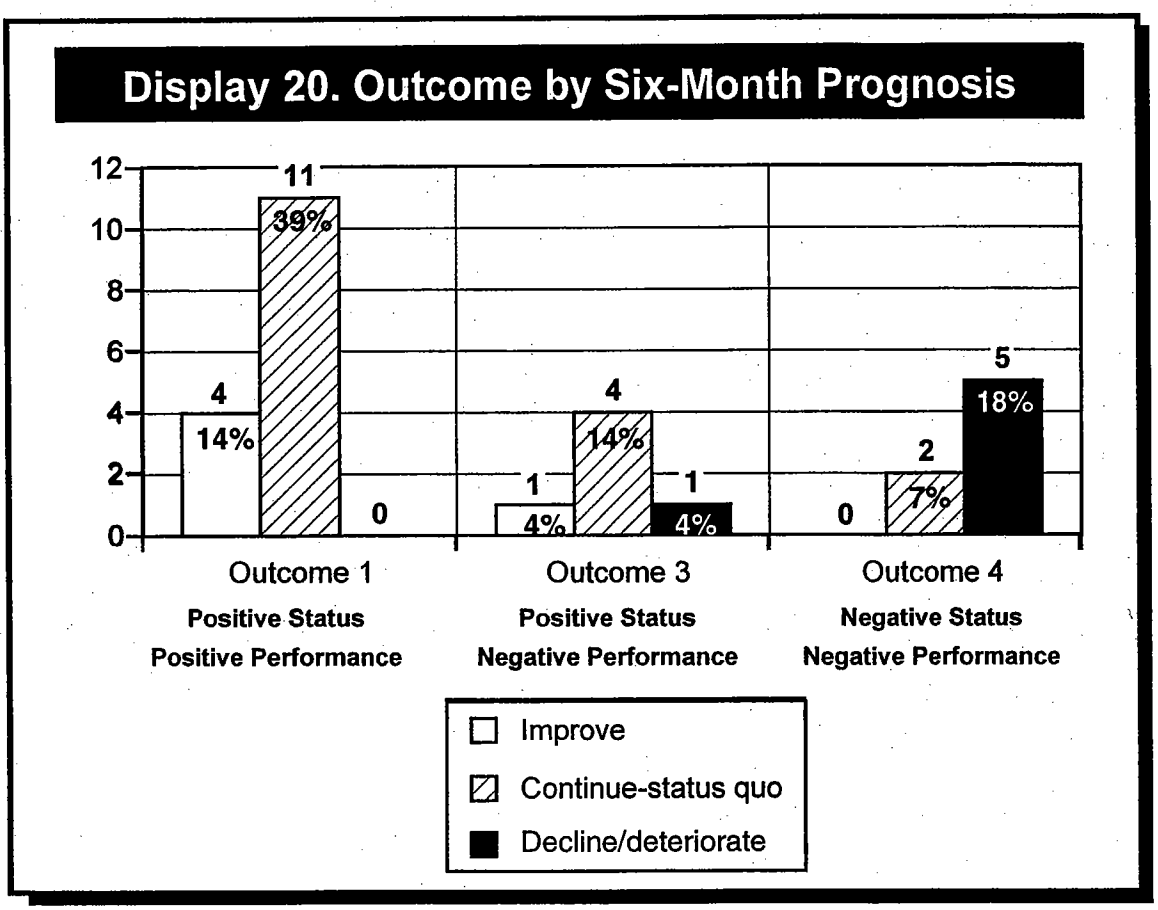
Six-Month Prognosis

Reviewers made a six-month prognosis for each member of the sample. Formulation of the six-month prognosis was based on current overall status, known events forthcoming in the next six months, and the current overall practice performance observed in the case. **Display 19** presents the six-month prognoses offered by reviewers. Nearly a fifth (18%) of those in the sample were expected to achieve improved status, more than half (61%) were expected to remain about the same, and another fifth (21%) were expected to decline or experience deterioration of circumstances over the next six months.



Review Outcome and Prognosis

For members of the review sample, Display 20 reveals the relationship between the person's outcome category and the person's six-month prognosis. All persons categorized in review outcome 1 (i.e., favorable status and acceptable system performance) were predicted to continue status quo (39%) or to improve status (14%). Mixed prognoses were found for those sample members in outcome 3 (i.e., favorable status but unacceptable system performance). One person (4%) in outcome 3 was expected to improve, another four persons (14%) were predicted to remain about the same, and one other person (4%) was expected to decline over the next six months. Persons found in outcome 4 (i.e., unfavorable status and unacceptable service system performance) tended to have poor near-term predictions. Two persons (7%) in outcome 4 were predicted to be about the same in six months and five persons (18%) were predicted to get worse.



Conclusions from Quantitative Data Patterns

Summarized below are general conclusions formed from the baseline data collection experience and from patterns observed in the quantitative data.

- The logistical set-up requirements for conducting case-based practice reviews are challenging given the current stage of organizational development and the status of the developing data management systems. Even extra efforts undertaken prior to and during the on-site case review process were insufficient to produce a full sample of 36 cases. The current data systems and disconnected case coordination make selection of sample cases difficult. "Easy-to-get" cases may not be fully representative of all cases in the system. It is recommended that new strategies be used for sampling, contacting prospective sample members, and scheduling appointments for selected cases in the next measurement cycle.

- Overall service system performance was found to be "acceptable" (rating levels 4, 5, and 6) for only 54% of the members in the sample. If the performance bar is set at 90%, then current service system performance is about half of what is reasonably expected. The system of care has not yet developed so that it can perform consistently for more complicated or challenging cases. To be effective, a service system should work most of the time for most of the people seeking/receiving services.

This was the level of service system performance for adult service consumers in May 2003.

Qualitative Summary of Case Review Findings

Presented in this section is a summary of recurrent themes and patterns noted among and across cases in the baseline sample. These themes are organized in categories of common attributes.

Noted Strengths and Accomplishments

- A number of positive remarks were provided regarding the quality of casework in the cases reviewed from both the Multicultural Center and The Green Door.

- Several examples of effective and creative casework were noted in cases reviewed, however, such levels of services were not being provided with sufficient consistency.

- Community support workers stated throughout the review a desire to provide services in a more community-based and consumer collaborative format.

- A majority of the consumers in the baseline review were residing in stable living environments.

- Consumers in the review often had supportive family members upon whom the consumers relied for assistance.

- Many consumers demonstrated a high degree of personal resiliency.
- There were a large number of shelter beds (approximately 6,000) available within D.C.
- Most consumers were receiving consistent medication management.
- Many consumers in the review were living independently.
- Nearly all of the consumers in the review were considered to be safe.
- Consumers report being satisfied with their community support workers and stated that they enjoy working with them.
- Available resources were generally sufficient to meet the needs of the consumers in the review.

Noted Areas Needing Improvement

- The dynamic process of practice using a recovery-based model does not appear to be consistently implemented across the frontline, nor does it appear that there is a consistent expectation to provide services according to such a model.
- Consumers were often socially isolated and were not being linked to peers or other social support groups.
- Services did not appear to be consistently coordinated across service providers, resulting in breakdowns in communication that either delayed or diminished the implementation of services.
- Many workers report having high caseloads that are acting as a barrier to providing services with the quality and consistency needed for an effective recovery-based model.

- A number of consumers suffered from obesity and were not receiving adequate medical attention for this physical health issue. Furthermore, several consumers in the review were taking psychotropic medications having side effects that would negatively impact their physical health.

- A variety of difficulties were encountered with the data management system in current use.

- Modeling, mentoring, coaching, and other activities of effective supervision were not being consistently provided on the frontline.

- Casework practice does not appear to be built on the readily identified strengths of consumer family involvement and consumer resiliency.

- Service planning was reported to be crisis responsive, or episodically driven, and not with the sufficient long-term view needed to ensure a higher likelihood of positive outcomes.

- Consumers did not appear to be well educated regarding what can be expected of the mental health service system. Consumers often stated that the "system isn't listening yet" to their expressed desires and needs.

- Services appear to be focused primarily on mental health needs and are not focused on improving activities of daily living. Many consumers were reliant upon family support and benefits for economic security rather than on independent employment.

- There is a continued need for housing and employment opportunities.

Recurring Patterns in the Service System

Just as a number of recurrent patterns were noted by the review team for adults receiving services, other patterns were noted for the service system. Among the prominent patterns noted were the following:

- Individualized recovery plans tend to be episode driven. Plans lacked a comprehensive and thoughtful analysis of what it would take to assist the consumer to live independently.

- There were virtually no examples of interagency teams and coordination across the treatment setting, home setting, and job setting or with supported living coaches, job trainers, supported employment, employers, or probation offices operating as a team. Engaged relatives who were actively supporting a consumer were not involved in the IRP or intervention planning process.

- Lack of a long-term view in individualized recovery plans. Services seem to be driven by the present episode rather than being aimed at achieving important longer-term results. The long-term view concept, as expressed through personal recovery goals, seemed to be a limited element in current service planning. Most services are office-based counseling and therapy that are provided on a schedule that the consumer may or may not follow. Assertive community treatment was not significantly observed in the sample of consumers who were reviewed.

- Engagement of adults into the service process seems weak in some cases (only center-based contact is offered in many cases). Active strategies of engagement and outreach to consumers and their families did not appear to be assertively implemented or coordinated with other settings where many consumers might be living. An example would be the consumers living in homeless shelters. The quality of relationships formed between service consumers and providers creates the trust, understanding, and willingness necessary to move forward in treatment to meet important life goals. Developing such relationships often requires time spent in the home and other informal settings getting to know and understand people in their daily environments. Relationship building requires outreach, engagement, and continuity. The quality of engagement was limited in some cases, resulting in limited assessments and IRPs.

- Individualized recovery plans function as service authorization documents but don't drive case practice. The IRPs developed for providing services to adult consumers presently are

functioning as devices for authorizing services and are not functional tools to support the necessary communication, coordination, and delivery of services necessary to address the underlying issues. The IRP should be designed and used by the team, service coordinator, and providers to actually drive practice. But, in the absence of functional service teams, useful assessments, a guiding long-term view, and an expectation that IRPs drive practice, the necessary conditions of practice have not yet been set for this accomplishment.

- Confusion or resistance between "therapist" and "case manager" roles. System changes often lead to confusion and resistance. Changing the traditional roles of therapists who are now expected to be support coordinators with certain case management responsibilities is moving slowly, partly due to resistance and partly due to a lack of practice skills and craft knowledge.

- Uncertain expectations. In both setting up the consumer reviews and in conducting the individual reviews, one did not perceive that either the practice community or consumers were clear about the expectations created by the consent decree nor were the practices changing in many provider settings to reflect the current thinking in recovery and supports for persons with serious mental illness.

- Lack of effective linkages with the faith community and in connecting people with natural supports. It is easier to purchase services through a provider than it is to actively assist in connecting adult consumers to natural supports in the community, including organizations within the faith community. Making such connections was not part of the traditional role of "therapists," but it is consistent with the role of "support workers." Therefore, a part of practice development will be training and supervising frontline staff in these important aspects of role performance.

Recommendations

After presenting and discussing the 28 cases in the sample and the perspectives gained during the review process, the review team considered areas of practice development and organizational

development that may be helpful to the Dixon Court Monitor and DMH leadership in moving the system forward. The following suggestions are offered in the spirit of improvement, recognizing that decisions and actions are the province of managers, not reviewers. Recommendations for consideration by leadership are offered below.

- Improve the consistency of performance of core practice functions and all that entails through increased communication of expectations, training, practice coaching and mentoring, and systemic measurement of the fidelity/implementation of practice. This would include many of the following activities:

  - articulating a clear practice model for conducting key practice functions and providing supports and therapeutic interventions based on system of care principles and the recovery model;
  - setting expectations of performance of a recovery-based model in daily practice;
  - training frontline practitioners and supervisors on practice expectations, functions, and assessing results achieved;
  - promoting and supporting a more assertive implementation of ACT and other efforts to support consumers where they live or are temporarily residing;
  - creating and using individualized recovery plans that really organize, communicate, and drive practice activities between all service providers;
  - providing practice supervision and support;
  - offering clinical support and technical assistance for the most challenging and difficult adult service consumers;
  - promoting a stronger sense of urgency and ownership/obligation to engage consumers in a means that promotes more self-support and community integration;
  - improving the capacity and skills to engage the hard-to-engage and resistant adult consumers;
  - evaluating practice, performance, and outcomes for results;
  - providing constructive, individualized feedback about actual adult consumers who are experiencing the practice of the system;
  - rewarding good practice and results achieved for adult service consumers.

- Build a supervisor corps that is focused on practice (rather than focused primarily on administrative concerns) and that is provided the time and support to supervise and assess the adequacy of practice.

- Expand capacities for developing, providing, and managing unique, flexible, supportive, non-traditional services provided in the home, work setting, and community settings.

- Develop and use an electronic performance support system (data management system) that actively supports efficient practice while providing necessary documentation for meeting financial and system management obligations.

- Create a sense of urgency in getting things done! In a person's life, down time or waiting for services can result in a rapid increase in problems, loss of functioning, and long-term failure.

- Give attention to the importance of actual execution of practice, because good results won't be achieved without timely, adequate execution (due diligence).

Appendix A

Community Services Review for Adult Mental Health

Questions to be Answered

The Community Services Review is a process for learning how well an adult participant served is doing and how well services are working for the person.

Baseline Version

Produced for Use by the Dixon Court Monitor

by
Human Systems and Outcomes, Inc.

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Questions Concerning the Status of the Adult Service Consumer

Presented below is a set of common sense questions used to determine the current status of the person/service consumer. Persons using this list of questions are directed to the **Dixon Community Services Review Protocol** for further explanation of these questions and matters to consider when applying these questions to a person receiving mental health services. Training on review concepts, methods, and protocols is recommended for anyone wishing to apply these questions in actual case review activities.

Community Living

1. **SAFETY:** • Is this person safe from manageable risks of harm caused by him/herself or others in living, learning, working, and recreational environments? • Are others in the person's environments safe from this person and is the person safe from retribution of others? • Is this person free of abuse, neglect, or exploitation in his/her home or current living arrangement? • Is substance use creating harm or significant risk?

2. **ECONOMIC SECURITY:** • Is this person accessing, receiving, and controlling the economic benefits to which he/she is entitled? • Are his/her income and economic supports sufficient to cover basic living requirements (i.e., shelter, food, clothing, transportation, health care/medicine, leisure, child care)? • Does the person have economic security sufficient for maintaining stability and for effective future life planning?

3. **LIVING ARRANGEMENTS:** • Is this person living in a home that he/she chose, with supports that are necessary and sufficient for safe and successful pursuit of recovery? • If not, is this person residing in a community living arrangement that is necessary to meet the person's therapeutic and recovery needs? • Are the person's culture, language, and living and housemate preferences addressed in an appropriate and supportive manner, consistent with his/her recovery goals?

4. **SOCIAL NETWORK:** • Is this adult connected to a natural support network of family, friends, and peers, consistent with his/her choices and preferences? • Is this adult provided access to peer support and community activities? • Does this adult have opportunities to meet people outside of the service provider organization and to spend time with them?

5. **SATISFACTION WITH SERVICES:** To what extent is the person satisfied with the treatment, support services, respect, and recovery progress that he/she is presently experiencing?

Physical/Emotional Status & Access to Care

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

7. **MENTAL HEALTH STATUS/CARE BENEFIT:** • Is the adult's mental health status currently adequate or improving? • If symptoms of mental illness are present, does the adult have access to mental health care, necessary and sufficient, to reduce symptoms and improve daily functioning? • Is the person benefiting from continuity of care provided across mental health and health care providers?

Meaningful Life Activities

8. **EDUCATION/CAREER PREPARATION:** • Is this adult actively engaged in educational activities (e.g., adult basic education, GED course work, or post-secondary education) or vocational training programs? • Is the person receiving information about work benefits, loss of financial benefits, access to work supports, rights, responsibilities, and advocacy? • If not, does this person have access to such opportunities, subject to the person's needs and preferences?

9. **WORK:** • Is this person actively engaged in employment (competitive, supported, transitional) or in an individual placement with support in a productive situation? • If not, does this person have access to productive opportunities (e.g., consumer-operated services, community center, or library)?

10. **RECOVERY ACTIVITIES:** • Is this person actively engaged in activities necessary to improve capabilities, competencies, coping, self-management, social integration, and recovery? • If not, does this person have access to recovery and relapse prevention opportunities, subject to his/her needs, life ambitions, and personal preferences?

11. **OVERALL STATUS OF THE PERSON:** • Based on the review findings determined for Status Reviews 1–10 above, how well is this person presently doing? [Person's overall status is considered acceptable when specified combinations and levels of review findings are present. A special scoring rubric is used to determine Overall Status using a 6-point rating scale.]

Questions Concerning the Person's Progress

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

1. **SYMPTOM MANAGEMENT:** To what extent are troublesome symptoms of mental illness being reduced, coped with, and personally managed by this individual?

2. **IMPROVED FUNCTIONING/SELF-MANAGEMENT:** • To what extent is the person making progress in key life areas, including self-management in the community, where appropriate?

3. **EDUCATION/WORK PROGRESS:** To what extent is this person presently making progress toward educational course completion - OR - making progress toward getting and keeping a job?

4. **PROGRESS TOWARD RECOVERY GOALS:** To what degree is the person making progress toward attainment of personally selected recovery goals in the individualized recovery plan (IRP)?

5. **RISK REDUCTION:** To what extent is reduction of risks of harm, use of chemical substances, and/or utilization of coercive techniques being accomplished with and for this person?

6. **SUCCESSFUL LIFE ADJUSTMENTS:** Consistent with this person's needs and goals, to what extent is the person making successful transitions and life adjustments between living settings, service providers, levels of care, and from dependency to personal control and direction?

7. **IMPROVEMENT IN SOCIAL GROUP AFFILIATIONS:** • To what degree is this person increasing his/her social affiliation among a variety of social groups (outside of his/her immediate social group) in the community, consistent with IRP goals? • Does the person access services and participate in social group activities available to all citizens? • Does this person affiliate with community groups, with special accommodations and supports, consistent with the person's desires? • Is the person benefiting from social group affiliation in the community?

8. **IMPROVED MEANINGFUL PERSONAL RELATIONSHIPS:** • To what degree is the person improving meaningful personal relationships with peers, friends, and family members, consistent with the person's preferences?

9. **OVERALL PROGRESS PATTERN:** Taking into account the relative degree of progress observed for the person on the above eight progress indicators, what is the overall pattern of progress made by this person: 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 Practice Performance

Presented below is a set of questions used to determine the performance of practice (essential system functions) for the person in a review. These questions focus on treatment and support functions rather than formal service system procedures.

Planning Treatment & Support

1. **PARTICIPATION/ENGAGEMENT:** • Is this person actively engaged in service decisions? • Does participation enable the person to express to the service team: (1) preferences about where and with whom to live and where to work, (2) choice of daily routines, (3) wishes about how to spend his/her time and money, (4) choice of service providers, and (5) satisfaction/dissatisfaction with services? • If the person is resistant to participation, are reasonable efforts being made to engage him/her and to support his/her participation?

2. **CULTURALLY APPROPRIATE PRACTICE:** • Are any significant cultural issues for the person being identified and addressed in practice? • Are the behavioral health services provided being made culturally appropriate via special accommodations in the person's engagement, assessment, planning, and service delivery processes?

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

4. **SERVICE TEAM FUNCTIONING:** • Do members of the person's service team collectively function as a unified team in planning services and evaluating results? • Do actions of the service team reflect a pattern of effective teamwork and collaborative problem solving that benefits the person in a manner consistent with the person's choices and personal life goals? • Is there a shared philosophy among team members about the importance of recovery to the person?

5. **ASSESSMENT & UNDERSTANDING:** • Are the diagnoses used for the person's treatment consistent with current understandings among providers? • Is the relationship between the diagnosis and the person's bio/psycho/social functioning in daily activities well established? • Does the service team have a working understanding of the person's strengths and needs in the context of the person's recovery goals as well as underlying issues that must change for the person to have a safe and satisfying life and to fulfill desired adult roles? • Are any co-occurring conditions identified, including substance abuse? • Does the team understand the person's aspirations for personal power and control in his/her life?

6. **PERSONAL RECOVERY GOALS (PRGs):** • Are there personal recovery goals used for service planning that reflect the person's life and career aspirations? • If met, will these goals lead to the person managing successfully at home, at work, and in the community, with supports and services as necessary, to achieve ongoing recovery?

7. **INDIVIDUALIZED RECOVERY PLAN:** • Is there an IRP for this person that integrates treatment, support strategies, and services across providers and funders? • Is the IRP designed to meet personal recovery goals? • Does the IRP reflect small steps in the right direction toward recovery? • Is the IRP coherent in the assembly of strategies, supports, and services? • Does the IRP state what the person wants in his/her own words?

8. **GOODNESS-OF-SERVICE FIT:** • Are treatment, rehabilitation, and support services assembled into a holistic and coherent mix of services uniquely matched to the person's particular situation and personal recovery goals? • Does the combination and intensity of supports and services fit the person's situation so as to increase recovery results and benefits while limiting any 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 person, family supporter, and service team? • Are any unavailable but necessary resources or supports identified by the person, team, or plan? • Are reasonable efforts being undertaken by the team to secure or develop any needed but unavailable supports, services, or resources?

10. **TREATMENT AND SERVICE IMPLEMENTATION:** • Are the planned therapies, services, and supports being implemented with adequate intensity and consistency to achieve stated goals? • Is implementation timely and competent? • Are recovery strategies assigned to the person and the team being implemented? • Is team problem solving any implementation problems that could lead to a failure of efforts to achieve the person's recovery goals?

11. **EMERGENT/URGENT RESPONSE CAPABILITY:** • Is there timely access to and provision of effective services to stabilize or resolve emergent or episodic problems, as needed by this person? • Are crisis services accessed and delivered in a manner that respects and does not demean the person?

12. **MEDICATION MANAGEMENT:** • Is the use of psychotropic medications for this person necessary, safe, and effective? • Does the person have a voice in medication decisions and management? • Is the person 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 seclusion or restraint has been used for this person, 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 person? (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. **PRACTICAL SUPPORTS:** • Is the array of in-home and community-based supports provided to this person sufficient [in design, intensity, and dependability] to meet the person's preferences and assist him/her to achieve recovery goals? • Are supports effective during life change adjustments and in maintaining the person within the home, job, and community? • Where applicable, is individually assigned staff (job coach, respite/crisis worker, skills trainer) receiving the education and supports necessary to maintain an appropriate relationship and support arrangement for the person?

Managing Treatment & Support

15. **SERVICE COORDINATION & CONTINUITY:** • Is there a single point of coordination, accountability, and continuity in the organization, delivery, and results of treatment, supports, and services for this person? • Are IRP-specified services well coordinated across providers, funding agencies, and service settings for this person, especially when entering and leaving intensive service settings?

16. **RECOVERY PLAN ADJUSTMENT:** • Is the service coordinator using monitoring activities to follow this person's progress, changing conditions, consistency and effectiveness of supports, and results achieved? • Does the service coordinator keep all providers informed and discuss IRP implementation fidelity, barriers encountered, and progress being made? • Are services adjusted in response to problems encountered, progress made, changing needs, and knowledge gained to create a process that supports recovery?

17. **OVERALL PRACTICE PERFORMANCE:** Based on the review findings determined for Service Reviews 1-16, how well is the service system functioning for this person now? [Overall practice performance is considered acceptable when specified combinations and levels of review findings are present. A special scoring rubric is used to determine Overall Practice Performance for a person in this review process.]