Baseline Report on Children and Youth

Served by the
District of Columbia
Department of Mental Health

March 2003

Presented to the Dixon Court Monitor

by
Human Systems and Outcomes, Inc.

Table of Contents

Baseline Report on Children and Youth

Served by the District of Columbia Department of Mental Health

March 2003

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 consumers, including children and youth:

- Consumer service reviews will be conducted using stratified samples.
- Annual reviews will be conducted by independent teams.
- Annual data collection on individuals will include consumer and family interviews, record reviews, staff interviews, caregiver interviews, and analysis of data.
- The independent teams will cover key areas of review for each consumer. For children and youth, these key areas include community living, life skills, health and development, treatment planning, treatment, family supports, 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 March 24-28, 2003, using measurements taken on a sample of 35 children and youth 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 Children and Youth

A stratified random sample of 36 cases was drawn for establishing a baseline measurement of the quality and consistency of children's 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 were that the case is currently active and receiving a minimum of one type of service (i.e., case management, counseling, medication management, etc.). Three variables were identified as differentiating points for a stratified random sample that was drawn the week of February 13, 2003: (1) provider agency, (2) age of child, and (3) child's level of need.

Provider Agency

According to the information that was supplied to HSO by DMH, there are a total of 999 children receiving services from four different provider agencies. These four provider agencies differ substantially in the total number of children that they serve: Community Connections, Inc.; Hillcrest Children's Center; Public Core Service Agency; and the Center for Mental Health, Inc.

Age of Child

The number of children receiving services at each site varies by the ages of the children. At this time, the computerized DMH Management Information Systems (MIS) track the ages of children receiving services according to three possible ranges (0-9, 10-13, 14+). There is a fairly proportionate number of children within each of the three specified age ranges, however, a majority of the children in the 0-9 range are ages five and older.

Child's Level of Need

The child's level of need was separated into three categories (low, medium, high). At that time, there were no means to determine the child's level of need utilizing only the identifying information for children receiving services previously provided to HSO by DMH. As a result, some additional information that could provide insight into the child's current level of need had to be obtained. There was some discussion with each of the four provider agencies to determine the proportion of children in varying placement types. This discussion was facilitated by HSO. There was a brief survey to be completed by the provider agency for each of the children included in the random sample. This survey was used to collect information such as the child's current level of service (type of service or Global Assessment of Functioning Scale (GAF) score). The breakdown for level of need is as follows:

Low Need:	Basic outpatient services: GAF > 7
Medium Need:	Intensive outpatient or wraparound services: GAF 6-7
High Need:	Residential or partial hospitalization placement: GAF < 6

Although the intent of the baseline sample was to include only 36 cases, there was a randomly drawn double sample (n=72) in order to produce a sample replacement list that can account for both a proportional draw of children according to level of need and sample attrition. **Displays 1A** and **1B** define the total population distribution and sampling frames planned for the review.

Display 1A
A Breakdown of Provider Agency and Age for all Children Being Served

	Ages 0-9	Ages 10-13	Ages 14+	Total
Community Connections	11	12	20	43
Hillcrest Children's Center	11	48	39	98
Public Core Service Agency	143	171	134	448
Center for Mental Health, Inc.	175	145	90	410
Total	340	376	283	Σ=999

Display 1B
Stratified Random Sampling Distribution for the DC Children's Review

	Ages 0-9	Ages 10-13	Ages 14+	Total
Community Connections		2	2	4
Hillcrest Children's Center		4	4	8
Public Core Service Agency	12	10	10	32
Center for Mental Health, Inc.	12	8	8	28
Total	24	24	24	Σ=72

The intent of the proposed sampling methodology was to collect a random sample of children that is proportional to the actual age, level of need, and breakdown of children receiving services in each provider agency. The sample size was determined using a binomial distribution sampling table that would yield 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 similar case review methodologies as a measure for monitoring consent decree compliance. It is anticipated that subsequent monitor's reviews using this method will need to include larger sample sizes in order to more precisely measure the children's mental

health system level of performance following a period of improvement. Case reviews were actually completed for a total of 35 children and youth.

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

Logistical Problems Encountered

The process of setting up and conducting the baseline data collection for the review of services provided to children and youth proved more daunting than expected by those involved in the effort. During the course of setting up the children's baseline review for the D.C. Department of Mental Health, the very process of determining the sample and arranging the child and family reviews revealed some of the organizational and developmental issues that will need to be addressed in order to create a smoothly operating system of care for children.

- There are significant discrepancies between the automated data systems of DMH and provider enrollment files.

- Children who are placed in residential programs are discharged, never enrolled, or at least not care coordinated by the core agencies.

- Consumers who were not engaged and seen regularly were not likely to end up in the sample. As a result, the sample reflected service provision to the most engaged and served children.

- Middle managers and frontline practitioners are not clear on practice and performance expectations that are to be met in order to serve children most efficiently and effectively and also comply with the consent order. There does not appear to be a general understanding of the priority given to meeting agreed-on Dixon requirements.

- Middle managers and frontline practitioners are not sufficiently aware of the mandatory obligations and priority of the monitoring process that is used to measure system performance and determine compliance with the consent order of the court.

- There is a lack of clearly defined/understood case management and coordination expectations on the part of frontline practitioners.

- The overall result was lack of follow through in setting up reviews of children and significant difficulties in achieving a full sample.

It should be noted that exactly one week prior to the review, two of 36 cases had been fully completed. At the agreed-upon deadlines for completion three days prior to the onset of the review, the breakdown of completed preparation is as follows:

Core Service Agencies:	6 of 16 cases
Hillcrest:	1 of 4 cases (with set up completed directly by HSO staff)
Center for Mental Health:	9 of 14 cases
Community Connections:	2 of 2 cases (with set up completed directly by HSO staff)

Additional efforts after the set deadlines resulted in 35 of 36 cases being sufficiently prepared for review.

Problems of Sampling Children Placed into Residential Treatment Centers

During the initial meetings with providers' children's directors, program managers, or others appointed responsible for being the on-site contact, it became apparent that no children initially identified in the double sample were residing in residential treatment centers (RTCs). This violated a methodological expectation of including children residing in RTCs in the baseline sample. Upon inquiry regarding children in RTCs, each provider stated that their respective agencies do not include a residential component (the two primary local residential providers are Devereaux and Riverside Hospital) and that when children enter residential programs they are not involved in case management.

Additional inquiry from HSO resulted in partial lists of children placed into RTCs, and these lists were provided by related human services providers (child welfare, juvenile justice, special

education, etc.). It should be noted that a substantial majority of these children are residing in residential treatment facilities outside the District of Columbia, with many of these children residing several hundred miles from their home of origin. A cross reference was completed between the list of currently active cases and those children in RTCs, resulting in zero noted matches.

In order to meet the expectation of the baseline review to include high need/utilization cases, a review of children diverted through the MAPT process was provided, so that children in the sample could be cross referenced to that list. Through random selection, three RTC-diverted children were included in the sample.

Lack of Clearly Defined Case Management/Care Coordination

There does not appear to be the practice expectation of a single point of case coordination operating within the provider agencies included in the review. This leads to repeated difficulty in identifying basic information, such as the child's current school placement, special educational status, involvement in child welfare, receiving substance abuse services, or experiencing legal difficulties.

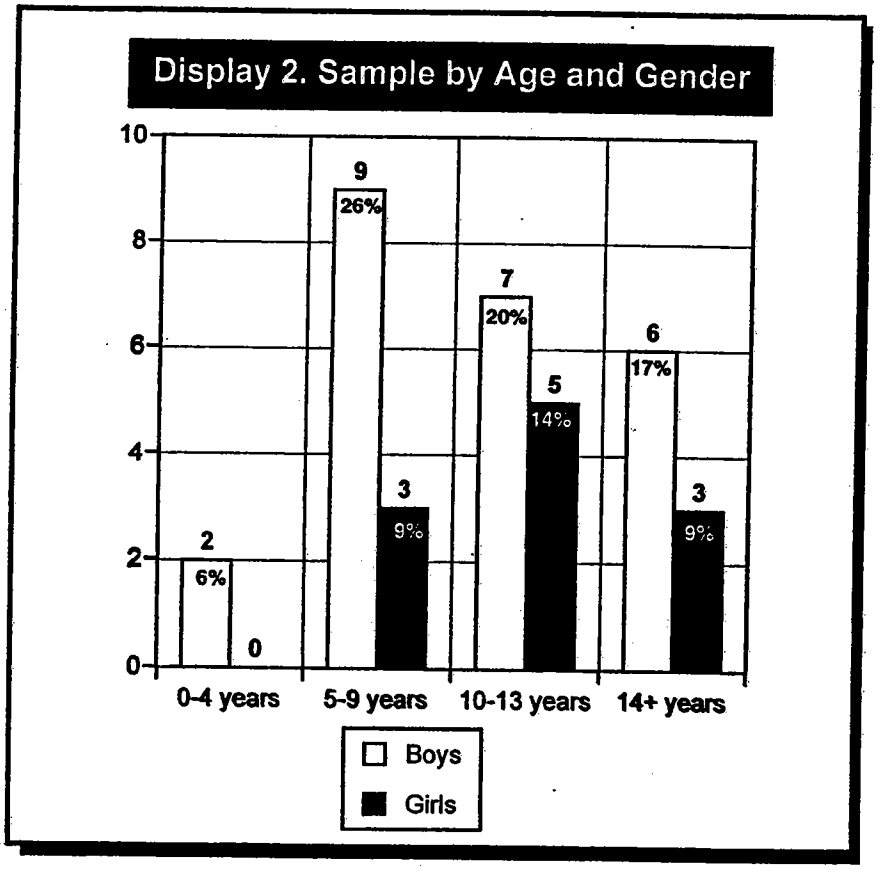
In summary, there were various difficulties encountered during the course of setting up the March 2003 review of services provided to Dixon class members who were children and youth. Lessons learned from this experience should be applied by DMH, the core agencies, and the Dixon Court Monitor in planning both the next-step efforts in system development and future monitoring activities.

Description of the Children and Youth in the Baseline Sample

Case reviews were conducted for 35 children and youth during the week of March 24-28, 2003. Presented in this section are displays that detail the characteristics of the 35 children and youth in the baseline sample.

Age and Gender

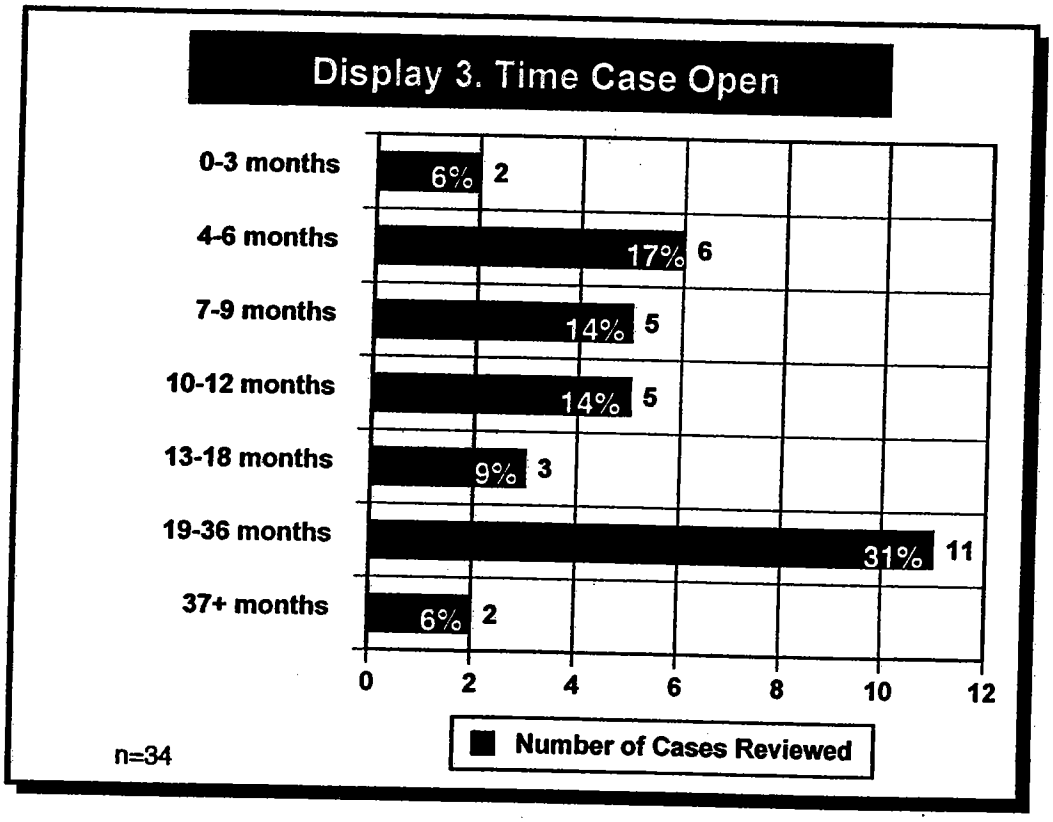
The review sample was composed of boys and girls drawn across the age spectrum served by the Department of Mental Health. **Display 2** presents the sample of 35 children and youth distributed by age and gender. As shown in this display, boys comprised 69% of the sample while girls comprised 31%. By experience, many systems of care report a majority of boys within the active service population. The sample had two children under age five and another 12 in the 5-9 year age range. Children under age ten comprised 40% of the sample while children and youth age ten and older comprised 60%.



Length of Mental Health Services

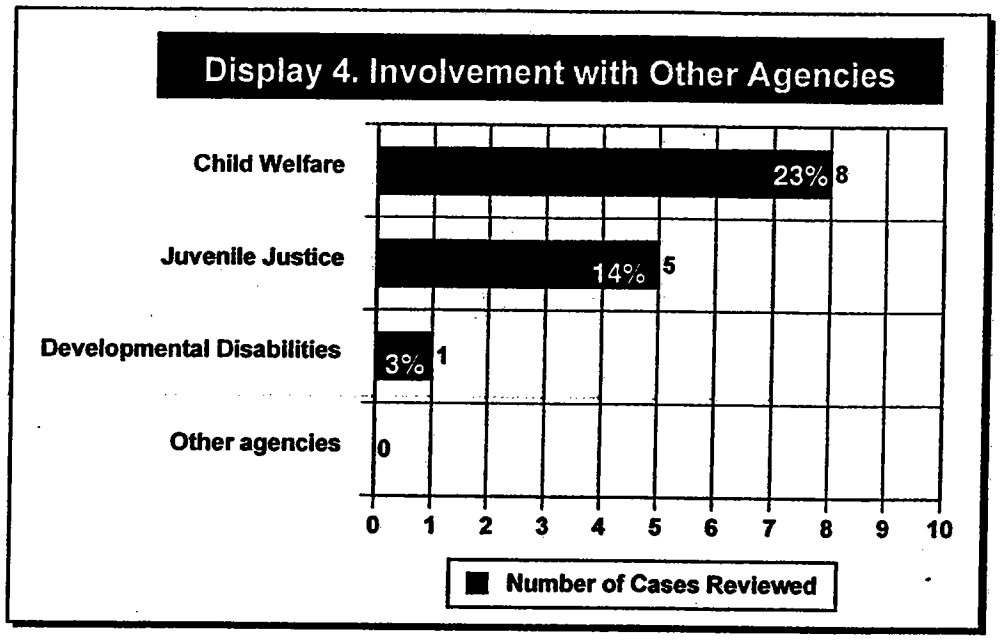
All children in the review sample were served by the Department of Mental Health. **Display 3** presents, for the sample of 35 children and youth reviewed, the amount of time their cases had been open with DMH during their current, most recent admission for services. As can be seen in

this display, 51% of the sample had cases open for 12 months or less, 40% were open for 13 to 36 months, and 6% were open for more than three years. One case in the 35-member sample was not classified.



Services by Other Agencies

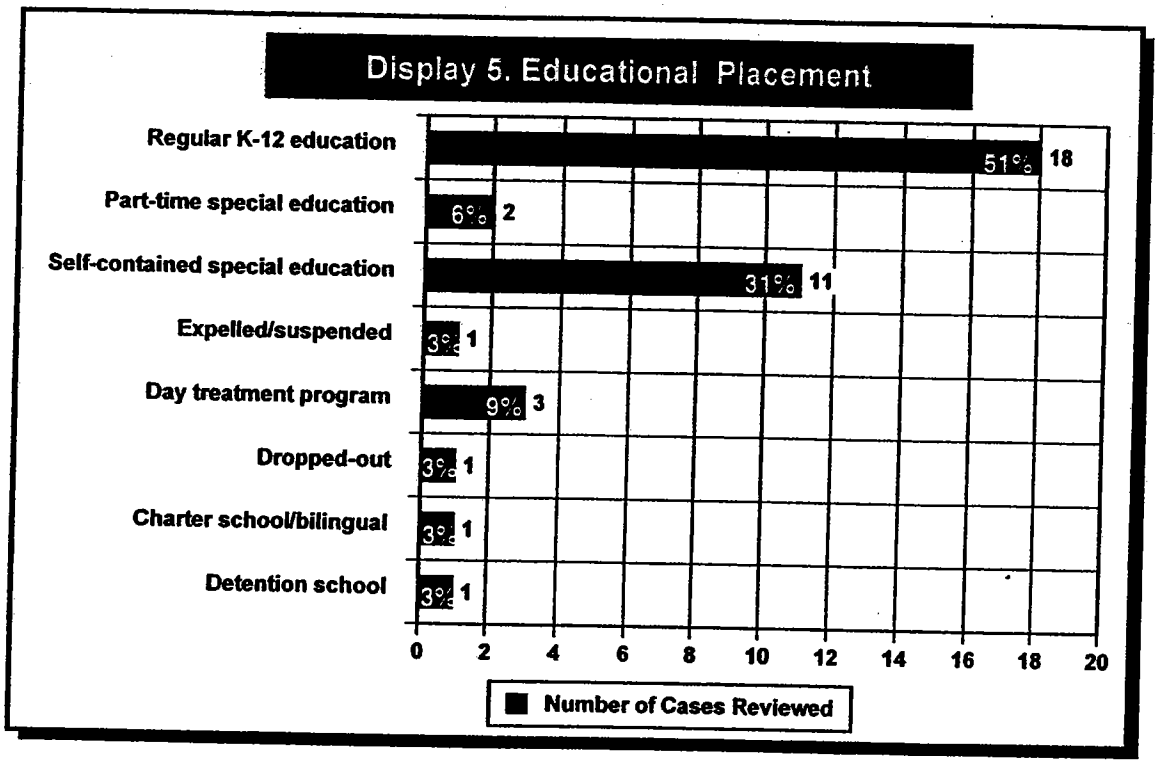
Some children and youth in the review sample were also receiving services from other major agencies. **Display 4** presents, for the sample of 35 children and youth reviewed, the number who were identified as being served by other key agencies: child welfare, juvenile justice, and developmental disabilities. Nearly a quarter (23%) of the review sample of children and youth were involved with the child welfare system. More than one in ten (14%) were involved with the juvenile justice system. One child was receiving services via developmental disabilities, although more may have qualified for services.



Educational Program Placement

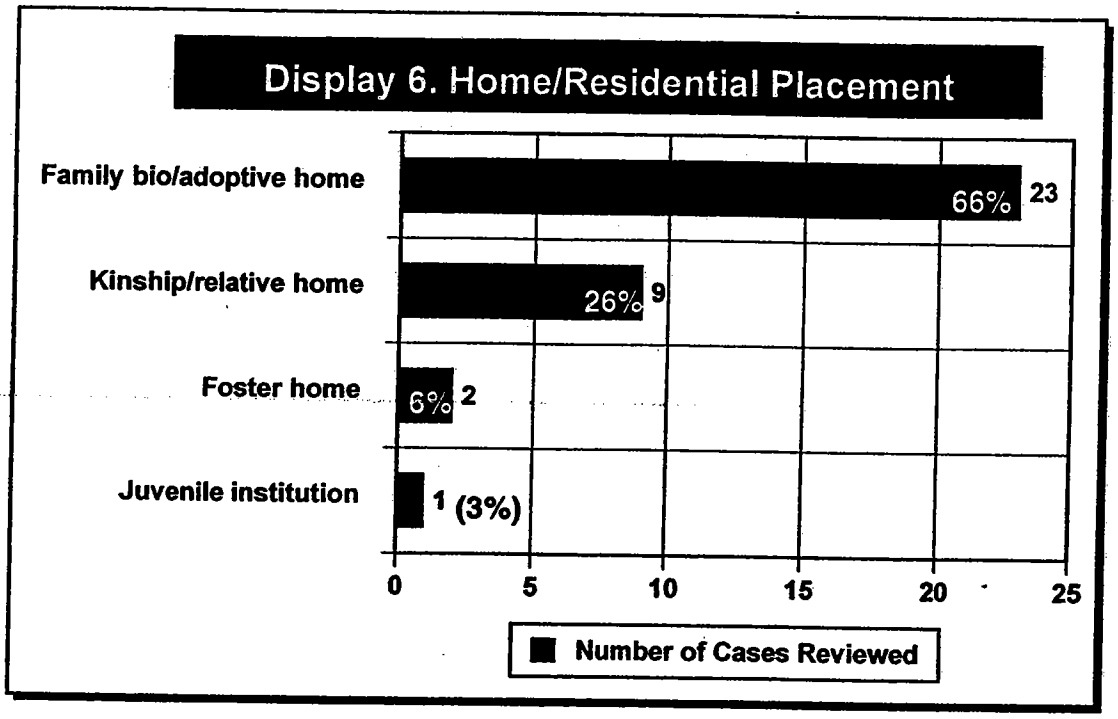
Getting an education and preparing for employment are major societal expectations for children and youth. **Display 5** describes the educational status/placement for the children and youth in the review sample. About half (51%) were found to be participants in a regular K-12 educational program. More than a third (37%) were served in a special education program, with 31% served in a self-contained program. Another 9% were served in day treatment programs. One youth was expelled and another had dropped out.

Significant absences were noted in the lack of alternative education, vocational education, and supported work participation. Youth with emotional/behavioral disabilities have the lowest school completion rate of any group of students nationally. Only about 20% of these youth ever complete a school program. Such youth need alternative ways to get successfully from school to work and to independent living. Yet, no youth in the sample was receiving such services. This fact alone is a significant finding in this review.



Living Setting

Children and youth in the review sample were found to be living in four settings. **Display 6** shows the distribution of sample members according to their residences at the time of the review. About two-thirds (66%) of sample members were living in their family homes. About another quarter (26%) were living in kinship or relative homes. Two (6%) were living in foster homes. One youth (3%) was residing in a juvenile detention center.

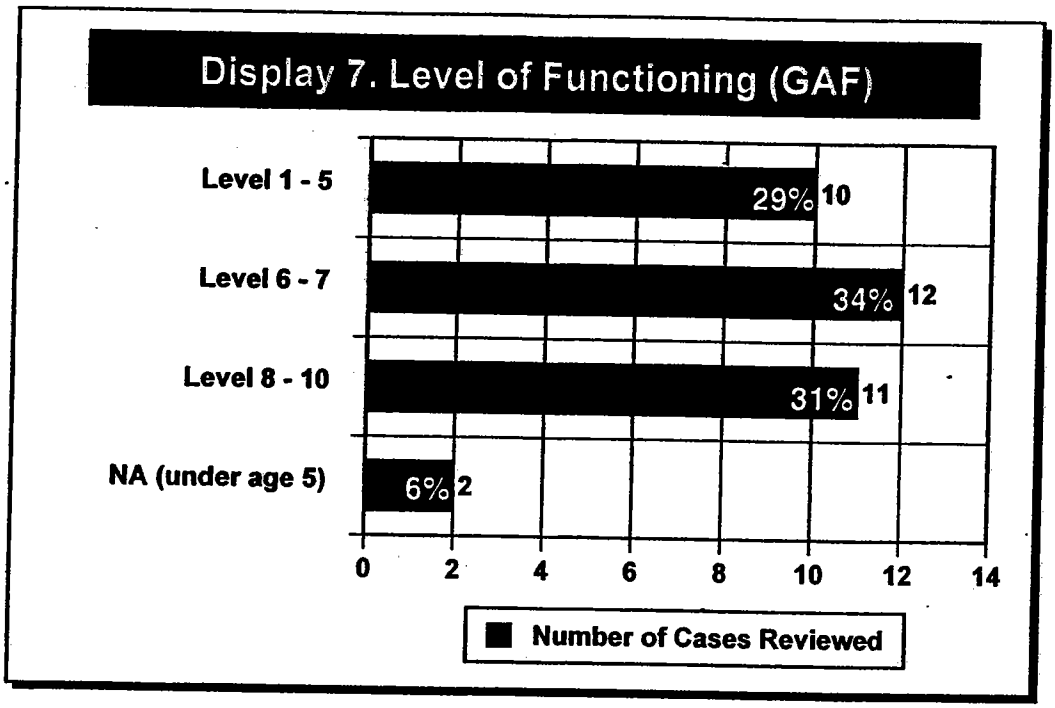


Functional Status

The functional status of children and youth in the review sample was assessed on a 10-point scale adapted from the Global Assessment of Functioning Scale (DSM-IV, Axis V), which uses a 100-point scale. On this scale, a child or youth in the low 1-5 range would be considered to be seriously emotionally disturbed (SED), having substantial problems in daily functioning in normal settings, and requiring a high level of support and/or temporary treatment in alternative settings. A child in the mid-range of 6-7 would have some difficulties or symptoms in some areas, but could get by with simple or occasional support in most settings. A child or youth in the high range of 8-10 had no more than a slight impairment of functioning but could be functioning well in normal daily settings.

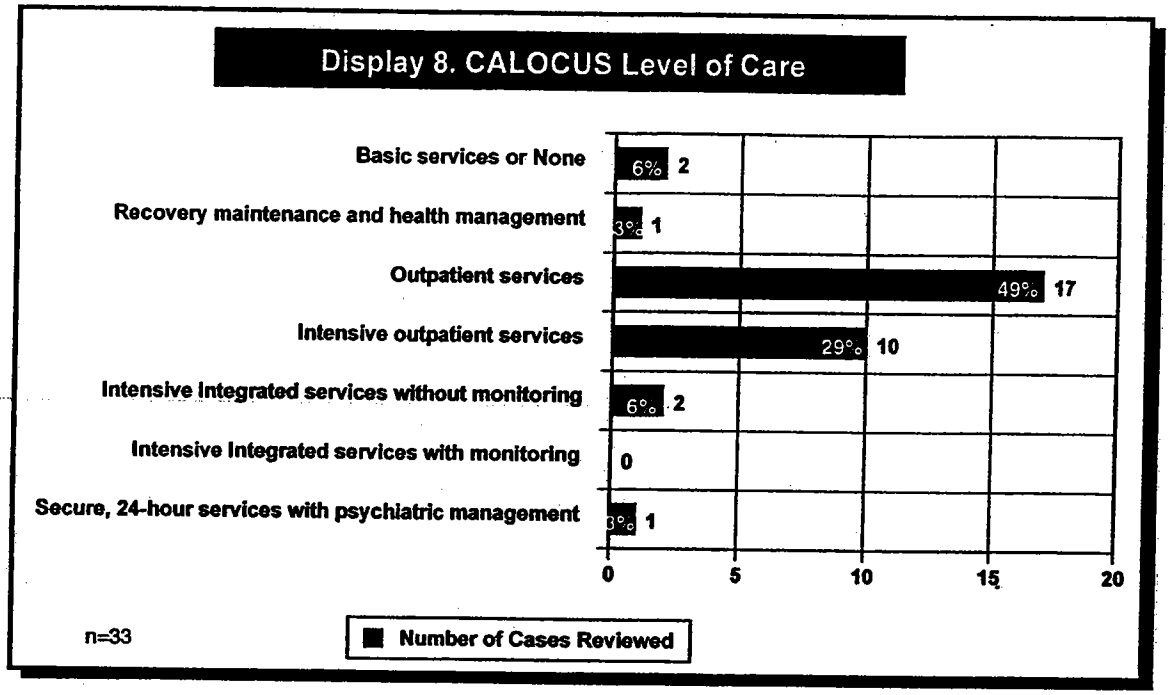
Display 7 shows the distribution of the review sample across functioning levels for the 33 children and youth age five and older. Between a quarter and a third (29%) of those in the sample were in the low range (levels 1-5), indicating that they fell within the SED range. A third (34%) were mid-range (levels 6-7). Almost a third (31%) were high range (levels 8-10). Two cases (6%) were under age five and not classified according to this scale. It should be noted that

a disproportionate share of those in the sample falling into the low functional range were youth age 14 years and older. Some 67% of the youth age 14 years and older in the sample were in the low range compared to 17% each for the 5-9 and 10-13 year age groups.



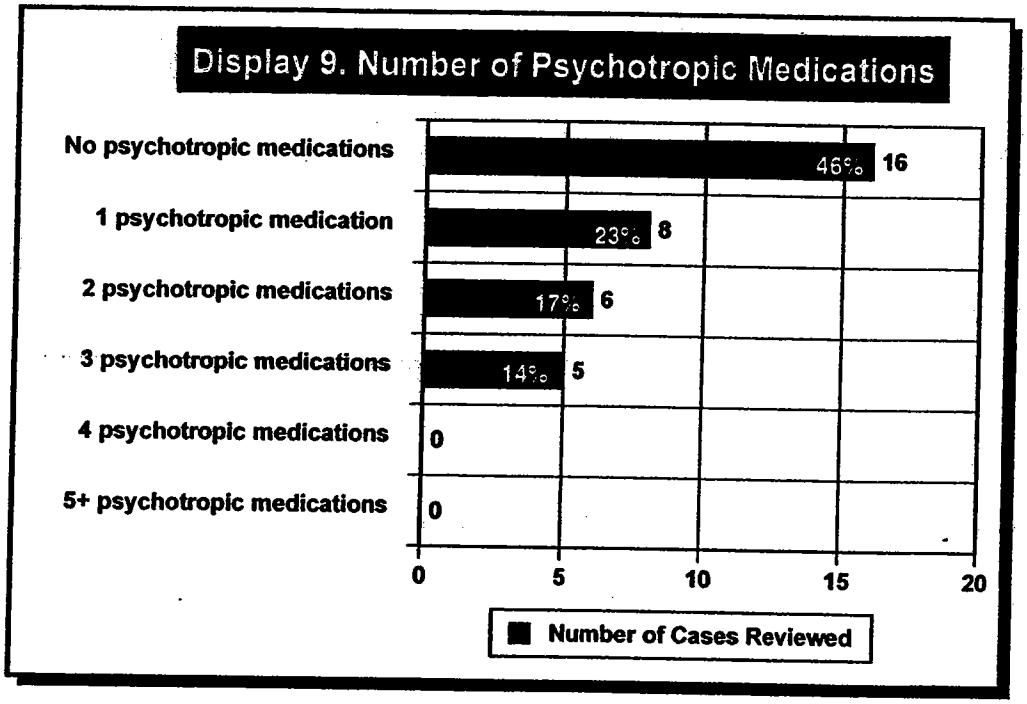
Level of Care

The Child and Adolescent Level of Care System (CALOCUS) scale was used to identify the level of mental health care presently being received by members of the sample at the time of the review. This scale provides seven different levels of care ranging from basic or preventive level services to secure, 24-hour care with psychiatric management. **Display 8** presents the distribution of sample members according to their level of care. Two sample members (6%) were receiving basic/preventive services. One member (3%) was receiving recovery maintenance and health management services. Nearly half (49%) were receiving outpatient services. Another 29% were receiving intensive outpatient services. Two persons were receiving intensive, integrated services without monitoring. One person was receiving secure, 24-hour services with psychiatric management. Two persons in the sample were not classified. Thus, about three-quarters of the children and youth in the review sample were receiving some combination of outpatient services.



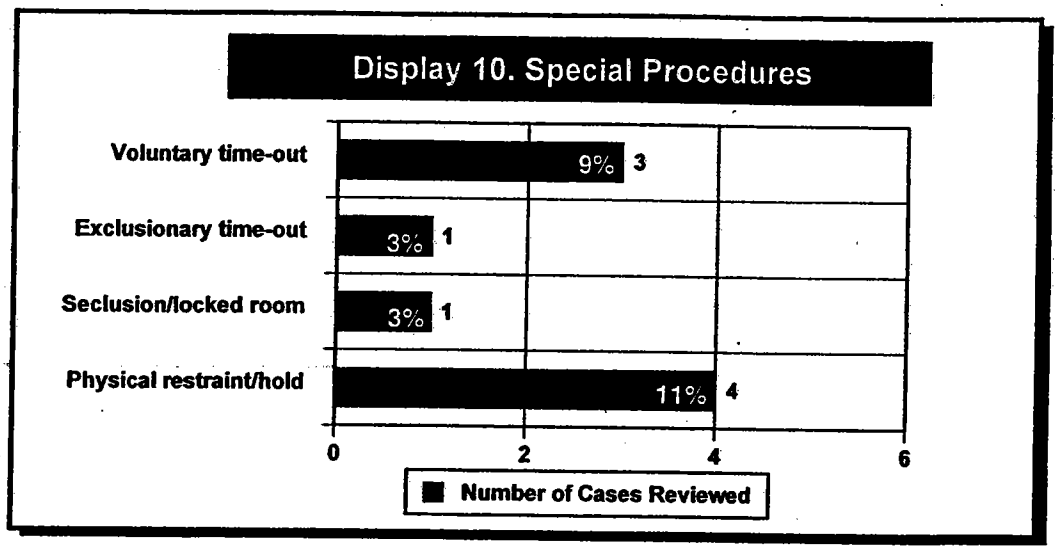
Medications

The number of pyschotropic medications taken by children and youth in the review sample were counted and reported by reviewers. **Display 9** presents the frequency count on medications taken by sample members. Remarkably, nearly half (46%) of the children and youth in the sample were not prescribed psychotropic medications at the time of the review. Nearly a quarter (23%) of the sample members were taking a single medication. Some 17% of the sample members were taking two medications. Another 14% were taking three medications. None in the sample was taking more than three medications. State-of-the art medications were noted in many cases. Medication management practices appeared to be safe and appropriate. Medications do not appear to be overused.



Special Procedures

Special procedures are used in extreme situations to prevent harm but are not a form of therapy or treatment. **Display 10** shows the number of sample members who had one of four types of special procedures used within the 30-day period preceding the review. As shown in this display, three children (9%) had voluntary time-out used, one child (3%) had exclusionary time-out used, one child (3%) had seclusion used, and four children (11%) had a hold or restraint used.



Quantitative Case Review Findings

Overview of the Case Review Process

Case reviews were conducted for 35 children and youth during the week of March 24-28, 2003, using the *Community Services Review (CSR) Protocol* [Baseline Version for Children]—a case-based review tool developed for this purpose. This tool was based on a resiliency 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 child (e.g., safety or academic status) and recent changes (e.g., symptom 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 11A** and **11B** provide an overview of the rating logic used by reviewers in determining specific rating values for an item in a case. Display 11A presents the rating scale used for child status, and Display 11B presents the scale used for rating practice performance. The protocol provided item-appropriate details for rating each question.

Display 11A. CSR Interpretative Guide for Child Status

Maintenance Zone: 5-6

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

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

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

Acceptable Range: 4-6

Refinement Zone: 3-4

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

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

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

Improvement Zone: 1-2

Status is inadequate. Quick action should be taken to improve the situation.

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

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

Unacceptable Range: 1-3

Display 11B. 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 child in this function area. This level of performance is indicative of exemplary practice and good results for the child. ["Optimal" does not imply "perfection."]

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

Acceptable Range: 4-6

Refinement Zone: 3-4

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

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

3 = **BORDERLINE PERFORMANCE.** Practice at this level is underpowered, inconsistent, or not well matched to need. Performance is insufficient for the child to meet short-term objectives. [With refinement, this case could become acceptable in the near future.]

Improvement Zone: 1-2

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

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

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

Unacceptable Range: 1-3

The above 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 range fall into the "maintenance zone," indicating that child status or practice performance is at a high level and should be maintained. Ratings in the 3 or 4 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 range fall into a seriously problematic level or "improvement zone," indicating that improvements should be undertaken promptly for this child. On the right side of Displays 11A and 11B 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 child, caregiver, and others involved in providing services and supports. A total of 206 persons were interviewed for these 35 children and youth. The number of interviews ranged from a low of two persons in one case to a high of 11 persons in another case, with an average of six per case. Presented in this section are displays detailing the aggregate quantitative review findings for the 35-member baseline sample.

Organization of Quantitative Findings

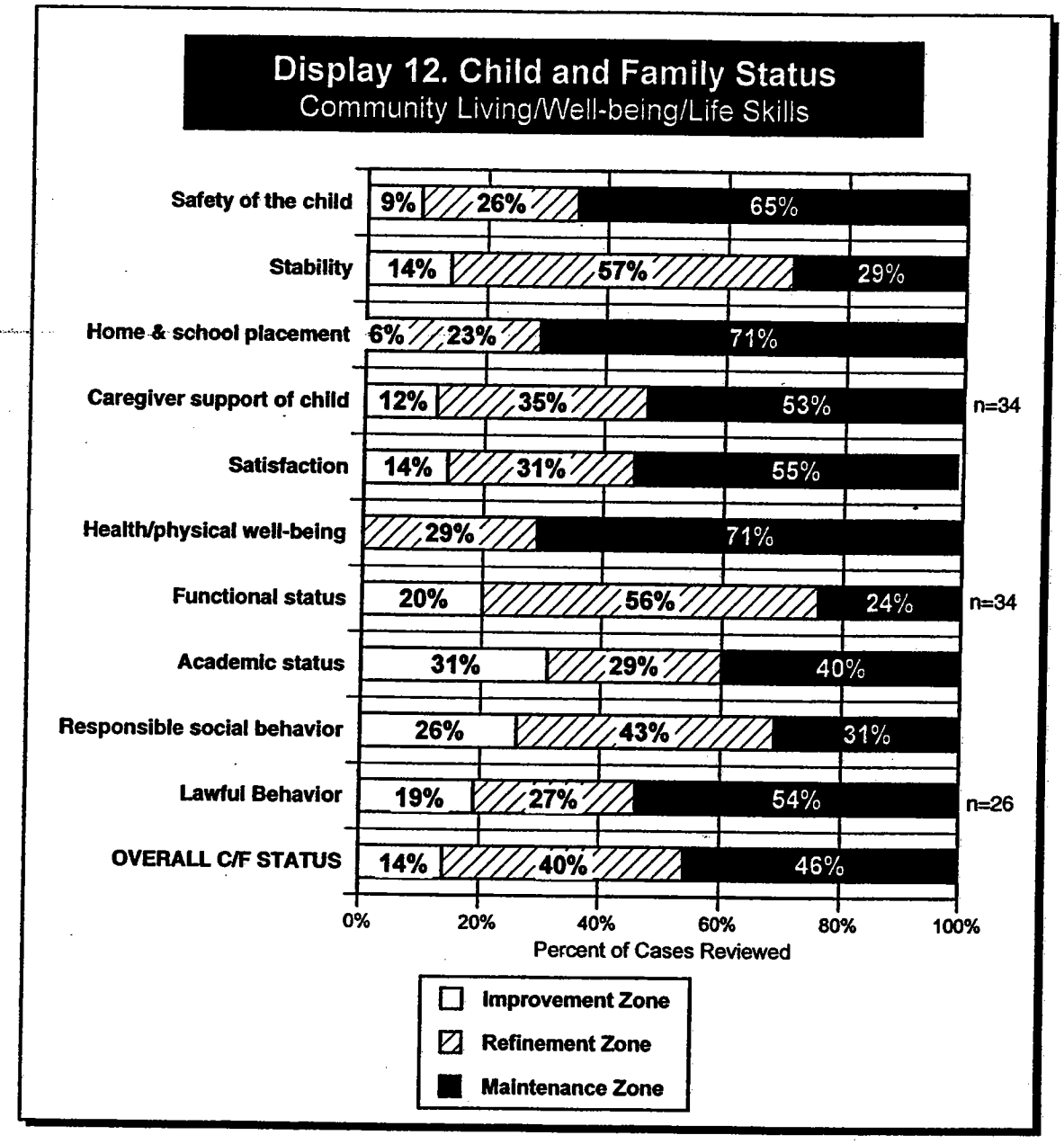
Quantitative review findings are divided into four broad sections: child status, recent changes and results, practice performance, and six-month prognosis. Findings are summarized in the sections that follow.

Child Status Results

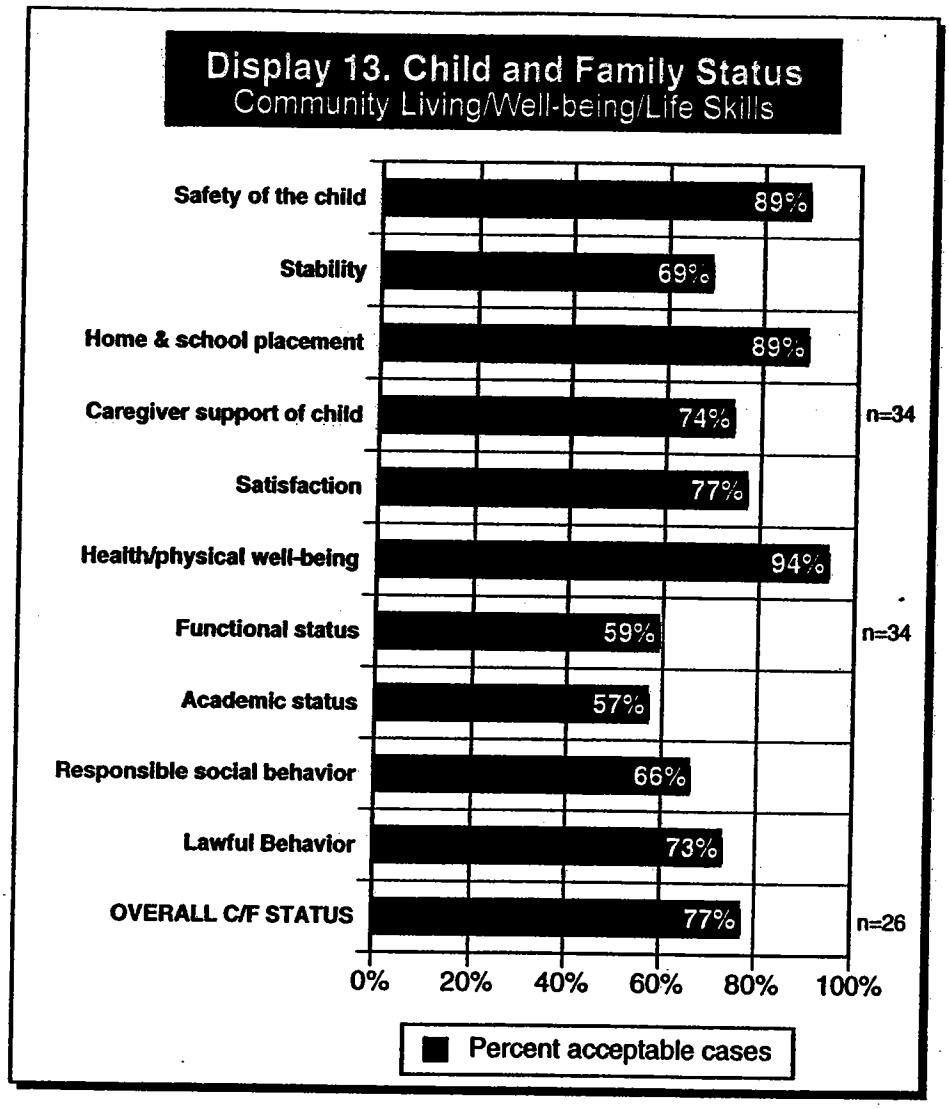
Ten indicators related to the current status of the child or youth were contained in the CSR protocol used by reviewers. Readers are directed to **Appendix A** for a detailed description of these ten areas examined by the reviewers. **Displays 12** and **13** present findings for each of the ten indicators. Display 12 uses the "action zone" framework that divides the 6-point rating scale into three segments corresponding to the maintenance, refinement, and improvement zones. Display 13 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 65% rated in the "maintenance zone." Another 9% were in the "improvement zone," indicating that three children had present circumstances that placed them at increased risk of physical harm. [Appropriate persons were alerted by the review team to take necessary follow-up actions to ensure safety in these three cases.] Some 89% of the sample members were acceptably safe at the time of the review.

Stability. Disruptions of home and school placements due to the child's emotional or behavioral problems or due to conditions within the home were present for some sample members. Only 29% were in the "maintenance zone," meaning that their placement situations were stable and free from disruption in the recent past and not likely in the near future. Another 57% of sample members were rated in the "refinement zone," and 14% were in the "improvement zone" due to problems of instability. Some 69% of the sample members were acceptably stable at the time of the review.



Placement Appropriateness. Most sample members were being served in the least restrictive, most appropriate residential and educational placements necessary for treatment, with 71% rated in the "maintenance zone." Two cases (6%) were found in the "improvement zone." These cases involved older youth with complicated life situations. Nearly nine out of ten (89%) youth were in at least minimally acceptable placement situations.



Caregiver Support of the Child. Children and youth require adequate and consistent levels of care and supervision to grow normally and develop successfully into adults. The level of caregiver support to children and youth in the sample was found to be in the "maintenance zone" in 53% of the cases. Four children or youth (12%) were found to be in the "improvement zone," indicating that some members of the sample were experiencing difficulties in their present home and caregiver situations. It should be remembered that eight children (23%) were involved with child welfare and 12 children (34%) were living with persons other than their birth parents. Some 74% of these children were found to have at least minimally adequate or better caregiver support.

Satisfaction. Satisfaction with services was rated as minimally adequate or better by 77% of the families. Satisfaction was in the "maintenance zone" in 55% of the cases reviewed and in the

"improvement zone" by 14% of the families. This rating reflects the fact that the sample primarily involved families who were engaged at least to some degree and were receiving services.

Health/Physical Well-Being. Most of the children and youth reviewed were healthy and were having their basic physical needs being met consistently. Reviewers found that 94% of sample members were acceptable in this area. Some 71% of the children and youth were rated in the "maintenance zone," and none were found in the "improvement zone."

Functional Status. The emotional/behavioral functioning status of sample members varied substantially among those reviewed. About a quarter (24%) of the sample members were doing well, being rated in the "maintenance zone." More than half (56%) were experiencing some recurring problems functioning in daily activities, placing them in the "refinement zone." A fifth (20%) of these children and youth had highly problematic emotional and behavioral problems currently adversely affecting their life situation. Some 59% of the sample members had at least minimally acceptable functional status or better.

Academic Status. Getting an education is a primary goal of childhood and adolescence. Attending school regularly, participating in the educational process, and making progress at a level necessary for promotion and graduation are aspects of academic status that lead to an education. Only 57% of the sample members were rated as having academic status. Some 40% were rated in the "maintenance zone," indicating that they were doing substantially well in their education. But, another 31% were in the "improvement zone," meaning that they were far behind, not catching up, suspended, expelled, or had dropped out. Because success in school is a leading predictor of success in life, reviewers expressed concern about the number of children and youth who were not succeeding in school. It should be noted that nationally only about 20% of students who are described as seriously emotionally disturbed ever complete a school program.

Responsible Social Behavior. Children and youth should behave in socially appropriate ways at school, at home, and in the community, as appropriate to age and ability. This includes following

rules, getting wants and needs met in appropriate ways, communicating feelings in acceptable ways, working effectively in groups, using good problem-solving skills, and making good life decisions. Some 66% of sample members were rated as presenting at least minimally acceptable social behaviors. Less than a third (31%) of these children and youth were found in the "maintenance zone" and more than a quarter (26%) were rated in the "improvement zone." Age and level of functioning have an impact on need for and use of responsible social behaviors.

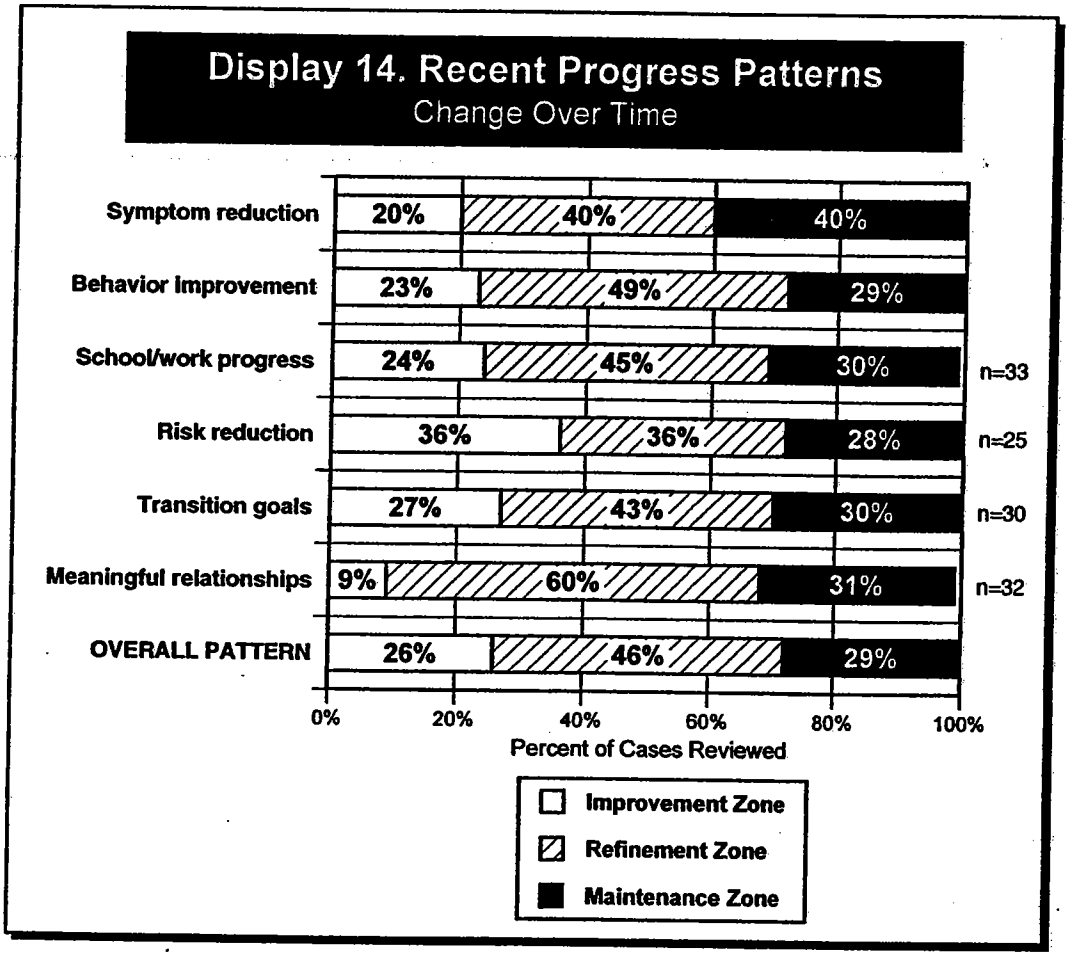
Lawful Behavior. Children and youth should behave lawfully at home, at school, and in the community. If involved with the juvenile justice system, youth should comply with the court plan, avoid reoffending, while developing appropriate friendship and activity patterns. Nearly three-quarters (73%) of sample members presented at least minimally acceptable lawful behavior. More than half (54%) were rated in the "maintenance zone." But, nearly a fifth (19%) of these youth were found to be in the "improvement zone" in lawful behavior. Adolescents are more likely to engage in illegal behaviors than are younger children.

Overall Child Status. The protocol provides a scoring rubric for combining ratings values across the items deemed applicable to the child or youth being reviewed to produce an "overall child status rating." Applying this rubric resulted in the determination that more than three-quarters (77%) of the children and youth reviewed were doing acceptably well (rating levels 4, 5, and 6), overall, in the status domain. Some 46% of the children and youth reviewed were rated in the "maintenance zone," another 40% in the "refinement zone," and 14% in the "improvement zone." This is a fair result for a baseline measurement across status indicators.

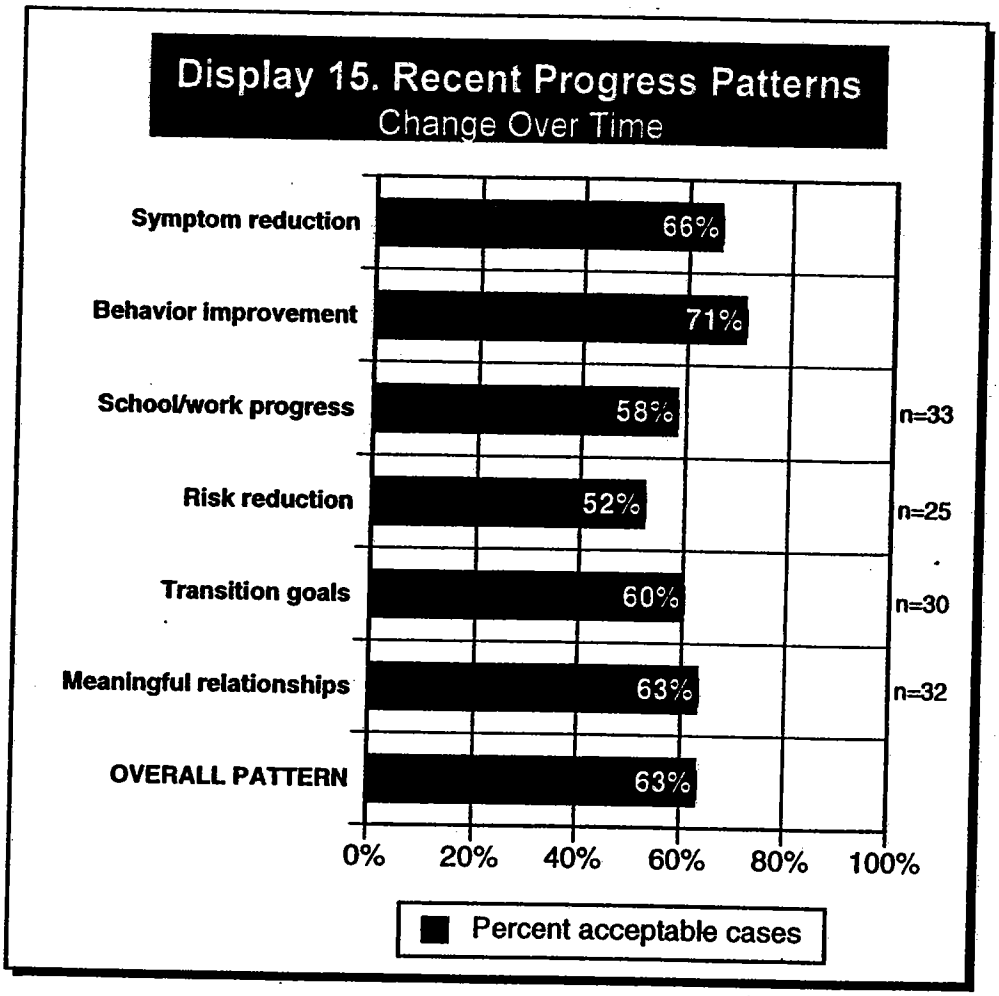
Recent Progress Patterns Showing Change Over Time

The CSR protocol provided six 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 six indicators can be found in **Appendix A**.

Displays 14 and 15 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.



Symptom Reduction. Reducing symptoms of mental illness is usually a goal of treatment for children and youth receiving mental health services. Recent progress in symptom reduction was found to be at least minimally adequate for about two-thirds (66%) of the sample members. Symptom reduction was determined to be in the "maintenance zone" for 40% of sample members, in the "refinement zone" for another 40%, and in the "improvement zone" for 20% of sample members.



Behavior Improvement. As symptoms diminish, daily functioning should improve. Specific behaviors associated with daily functioning are often targeted for improvement in the treatment process. This indicator focused on recent behavioral improvements observed for the child or youth being reviewed. Reviewers found that 71% of the sample members were making at least minimally acceptable behavioral improvement. Between a quarter and a third (29%) of the sample members had behavioral improvement rated in the "maintenance zone," nearly half (49%) in the "refinement zone," and nearly a quarter (23%) in the "improvement zone."

School/Work Progress. Children and youth are expected to be making progress along planned academic, vocational, or employment pathways. Such progress is critical to their success in life. A little more than half (58%) of the 33 sample members for whom this item was deemed applicable were found to be making at least minimally acceptable school/work progress. Less

than a third (30%) of the sample members were rated in the "maintenance zone," indicating good to excellent progress. Close to half (45%) were found to be in the "refinement zone." Nearly a quarter (24%) of sample members were rated as being in the "improvement zone." These are poor and troubling findings that foreshadow diminished life opportunities for many of these young people.

Progress in Risk Reduction. Some 25 of the 35 children and youth in the sample had risk factors present in their lives that suggested increased likelihood of harm, hardship, or poor down-stream life outcomes. Thus, steps should be taken to mitigate or diminish such risks in order to improve chances of successful lives for these children and youth. Risk reduction was determined to be acceptable for about half (52%) of the 25 sample members for whom this indicator was deemed applicable. About a quarter (28%) were found to have progress in risk reduction to be in the "maintenance zone." About a third (36%) were rated as being in the "refinement zone," and about another third (36%) in the "improvement zone." As with the school/work progress indicator, the findings for risk reduction are also poor and troubling and foreshadow problems and diminished life opportunities for some of these young people.

Progress toward Transitions Goals. Transitions may pose significant service coordination and life adjustment problems for children and youth with emotional/behavioral challenges and for their caregivers. Some 30 of the 35 children and youth in the sample had life circumstances that were in flux or required a long-term approach to planning to achieve smooth and successful results. Some may have involved returning to home and school following time spent in a treatment or detention setting. Others having special needs may be transitioning from middle to high school and may require summer programs and supervision to avoid possible rearrest for law violations. Older youth in special education may have a transition plan for getting successfully from school to work, to independent living, and to adult services, if needed. Review findings reveal that progress toward smooth and successful transitions was determined to be at least minimally adequate for 60% of the sample members. Transition progress was rated in the "maintenance zone" for 30%, in the "refinement zone" for 43%, and in the "improvement zone" for 27% of the sample members for whom this indicator was deemed applicable.

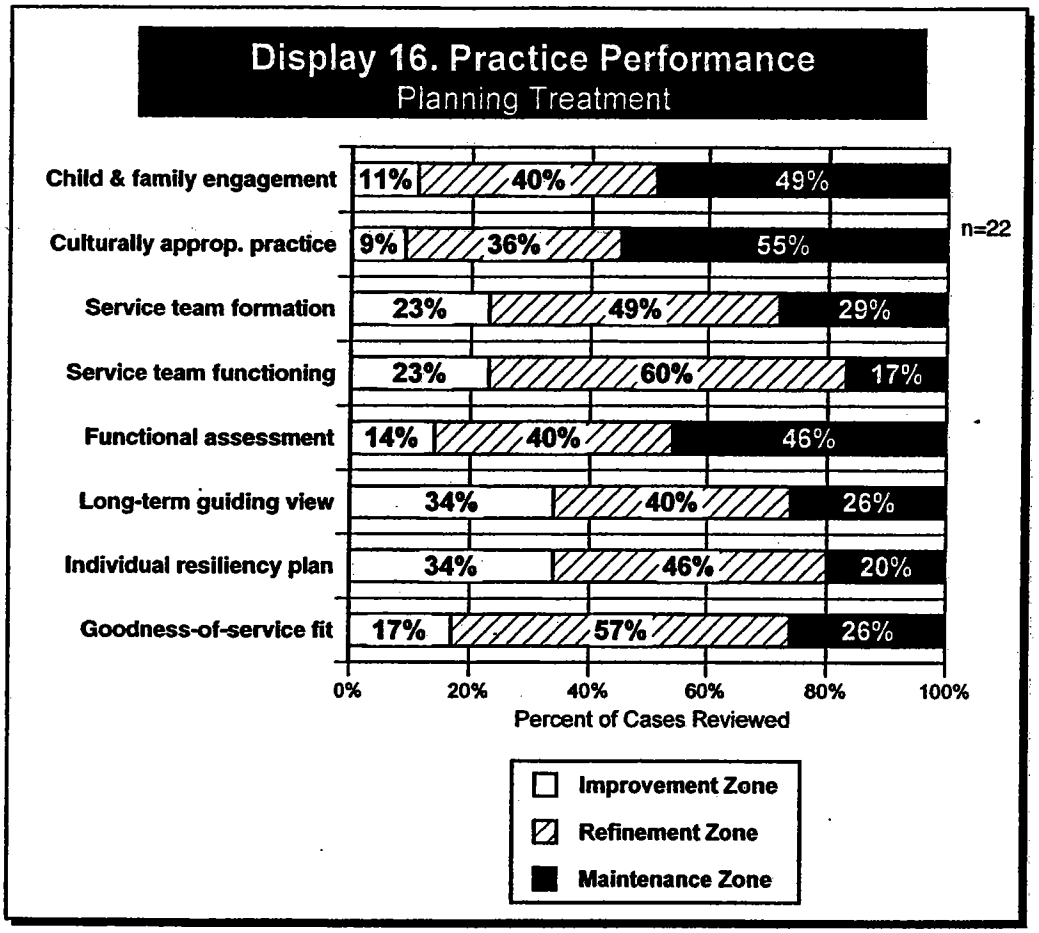
Progress in Meaningful Relationships. Children and youth with emotional/behavior disorders tend to have greater difficulties in forming and maintaining meaningful relationships with others. Therefore, developing significant and enduring relationships is often an intention or formal goal in the treatment process. This indicator was determined to be applicable for 32 of the 35 members of the review sample. Some 63% of applicable sample members were found to be making adequate progress in forming and maintaining meaningful relationships. Less than a third (31%) were making good to excellent progress ("maintenance zone"). Another 60% of sample members were making marginal to fair progress ("refinement zone"). A few (9%) were making no or poor progress ("improvement zone").

Overall Progress Pattern. Reviewers determined an "overall progress pattern" for each sample member, based on the indicators deemed applicable and the weight given to each indicator, taking into account the circumstances and trajectory of the case. Based on this process, the overall progress patterns for sample members were determined to be at least minimally acceptable in 63% of the cases. Less than a third (29%) were making good to excellent overall progress ("maintenance zone") across applicable indicators. Another 46% of sample members were making marginal to fair progress ("refinement zone"). About a quarter (26%) were making no or poor progress ("improvement zone"). This is a disappointing level of progress for the children and youth in the review sample.

Case-Level Performance of Practice Functions

The CSR protocol contained 16 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 16 indicators were divided into two sets. The first set—"planning treatment," containing eight 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 16 and 17**. The second set—"providing and managing treatment," containing eight indicators—focused on resources, implementation, special procedures and supports, service

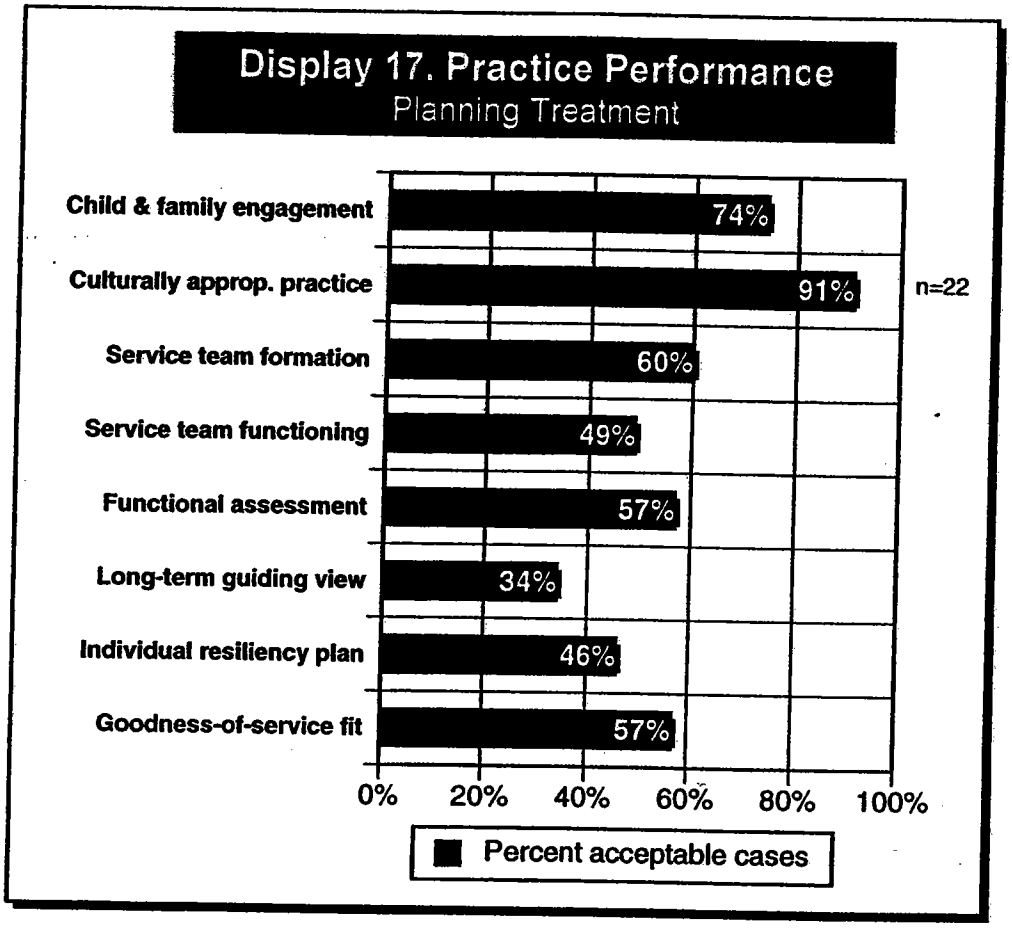
coordination, and tracking and adjustment. **Displays 18 and 19** present findings for the second set of indicators.



The first set of performance indicators illuminate important functions and aspects of daily frontline practice conducted with 35 real children, youth, and their families. Findings for these indicators are presented in the two displays and summarized concurrently below.

Child and Family Engagement. The child or youth and caregivers should be active participants in making decisions and plans about services. For more resistant family members, 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 74% of the 35 sample cases reviewed. Engagement was found to be in the good to optimal range ("maintenance zone") in

nearly half (49%) of these cases. Engagement was found to be in the "refinement zone" in 40% of the cases and in the "improvement zone" in another 11% of the cases.



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 22 of the 35 sample members. Reviewers found that practice was culturally appropriate in 91% of the 22 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 (55%) of these cases. Culturally competent practice was found to be in the "refinement zone" in 36% of the cases and in the "improvement zone" in another 9% of the cases.

Service Team Formation. Each child and family served should have a service team involving the child and family, informal supports, and service providers. There is no fixed formula for team composition but the team should be the "right people" for the child and include those who are active interveners in the life of the child and family. Such active interveners could include a child welfare worker, special educator, or juvenile court officer. Service team formation was found to be at least minimally adequate for 60% of the children and families reviewed. Service team formation was found to be in the good to optimal range ("maintenance zone") in more than a quarter (29%) of these cases. Team formation was found to be in the "refinement zone" in nearly half (49%) of the cases and in the "improvement zone" in nearly another quarter (23%) 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 child and family. Service team functioning was found to be at least minimally adequate for nearly half (49%) of the children and families reviewed. Service team functioning was found to be in the good to optimal range ("maintenance zone") in 17% of these cases. Team functioning was found to be in the "refinement zone" in more than half (60%) of the cases and in the "improvement zone" in nearly another quarter (23%) 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.

Functional Assessment. A functional assessment involves not only the collection and assembly of information about a child and family but also the development of a "big picture view" and deep understanding of their situation and circumstances. 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 child and family. Functional assessment was found to be at least minimally adequate for more than half (57%) of the children and families reviewed. Functional assessment was found to be in the good to optimal range ("maintenance zone") in 46% of these cases. Functional assessment was found to be in the

"refinement zone" in 40% of the cases and in the "improvement zone" in 14% of the cases reviewed.

Long-Term Guiding View (LTV). The LTV enables practitioners to look ahead to where they hope the child or youth will be in the next 3-5 years so that goals can be reached and transitions accomplished. The LTV takes into account the circumstances present within the child's life situation. For example, if the child has a developmental disability or a degenerative disease, the LTV would reflect that understanding and adjust the expectations and strategies used in planning services. If the child has a pattern of instability in placements (perhaps due to unresolved permanency issues in child welfare), 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 child." The long-term success of the child or youth depends on a meaningful, long-term, strategic vision that creates a pathway that guides services, enabling the child to achieve important life outcomes.

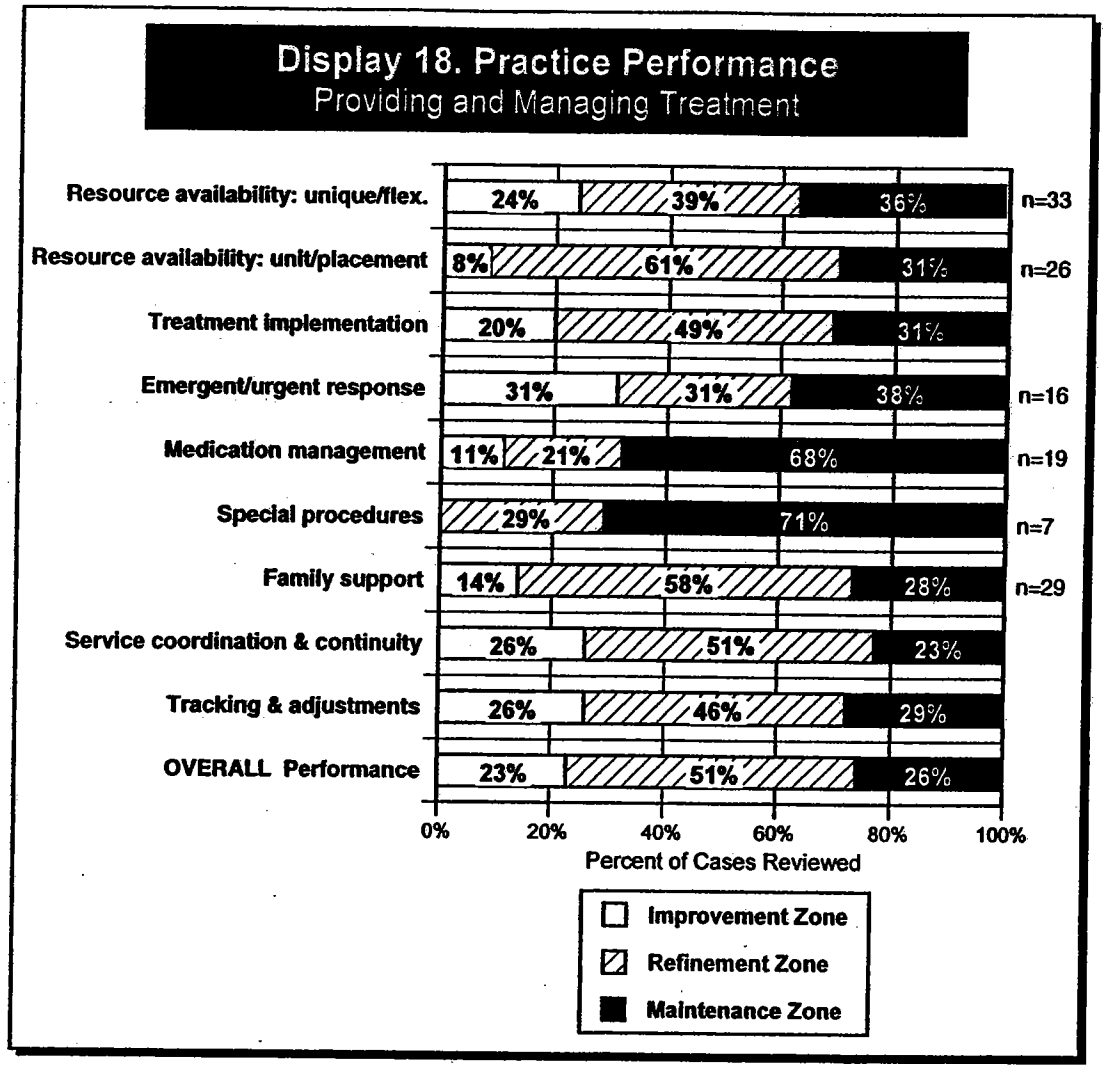
The LTV is a critical aspect of service for youth who have special needs of a long-term nature. Without an LTV to guide planning, service providers tend to focus on the present episode (reduce a behavior problem or change a placement) rather than planning and providing strategies and services for reaching critical long-term goals. The LTV was found to be at least minimally adequate for only about a third (34%) of the children and youth reviewed. The LTV was found to be in the good to optimal range ("maintenance zone") in about a quarter (26%) of these cases. The LTV was found to be in the "refinement zone" in 40% of the cases and in the "improvement zone" in another third (34%) of the cases reviewed. It does not appear that the development and use of a clear guiding vision for achieving major life goals for the child is a part of current practice.

Individualized Resiliency Plan (IRP). The IRP should set forth strategies and services across providers that are directed at achieving the strategic goals for the child or youth that are envisioned via the LTV. The IRP should build on child resiliency and family strengths, providing interventions and supports that help the child succeed at home and school. 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 nearly half (46%) of the children and youth reviewed. The IRP was found to be in the good to optimal range ("maintenance zone") in about a fifth (20%) of these cases. The IRP was found to be in the "refinement zone" in 46% of the cases and in the "improvement zone" in another third (34%) 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.

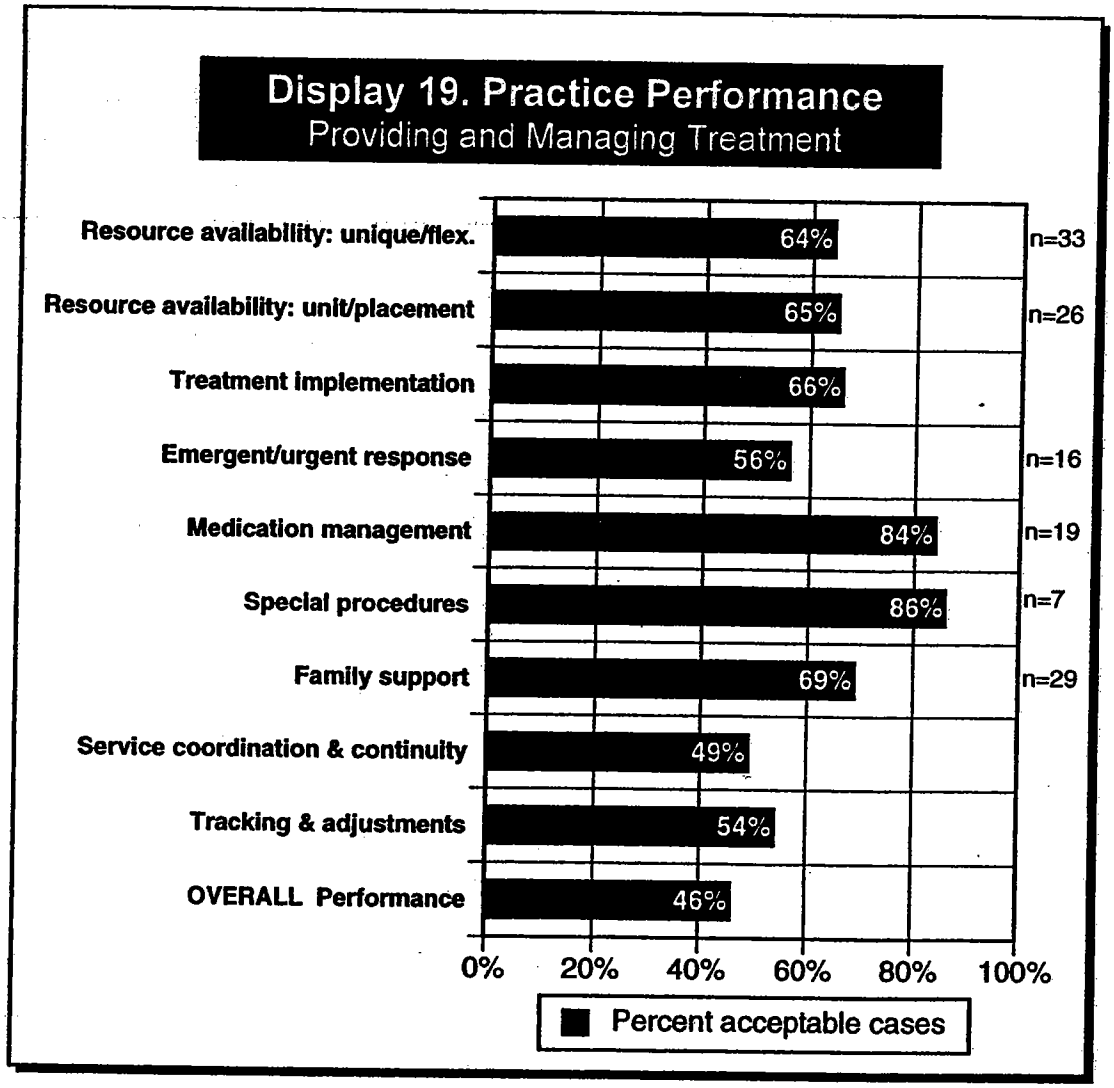
Goodness-of-Service Fit. The therapeutic, educational, and supportive services provided for a child and family should be assembled into a coherent mix and sequence of services. This combination of services should fit the child and family situation so as to maximize positive results and benefits while minimizing conflicting strategies and hardships imposed. The goodness-of-service fit was found to be at least minimally adequate for more than half (57%) of the children and youth reviewed. The service fit was found to be in the good to optimal range ("maintenance zone") in about a quarter (26%) 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 17% of the cases reviewed. Because the quality of service fit can either enhance or limit family participation and results, attention should be given to teaching techniques for improving service fit to frontline staff who plan, assemble, and coordinate services for children and families.

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



Resource Availability: Unique Arrangements and Flexible Resources. Flexible supports and unique service arrangements [sometimes referred to as "wraparound services"] may be necessary to meet the needs of the child without the child having to change homes or schools to get services. Absence of unique arrangements and flexible resources tends to limit problem-solving options for frontline staff and families while increasing the use of placement-based resources. Unique service arrangements and flexible resources were found to be at least minimally adequate for nearly two-thirds (64%) of the children and youth reviewed. Availability of such resources was found to be in the good to optimal range ("maintenance zone") in about a third (36%) of these cases. Availability was found to be in the "refinement zone" in 39% of the cases and in the "improvement zone" in 24% of the cases reviewed. Because the quality of service fit may be dependent on the use of unique service arrangements and flexible resources, improving the

availability and strategic use of such resources should be a priority in service development and training efforts.



Resource Availability: Unit-Based and Placement-Based Resources. Such resources tend to be the traditional modes through which resources in mental health are delivered as services. These tend to be the "on-hand" resource options that are dispensed as "service units" or used as "placement slots" to move a child to a center-based service situation necessary for increasing the variety and/or intensity of services provided to a child or youth. It takes less creativity and precision to deliver these traditional resources than it does to create unique service arrangements using flexible resources. These traditional resources should be available as appropriate to case circumstances to meet needs and achieve IRP goals. Traditional unit-based and placement-based

resources were found to be at least minimally adequate for nearly two-thirds (65%) of the children and youth reviewed. Availability of such resources was found to be in the good to optimal range ("maintenance zone") in less than a third (31%) of the cases reviewed. Availability was found to be in the "refinement zone" in 61% of the cases and in the "improvement zone" in only 8% of the cases reviewed. These findings suggest that resource availability is presently a limiting factor in the selection of intervention and treatment strategies planned and used by frontline staff at the time of the review.

Treatment Implementation. Intervention strategies, supports, and services set forth in the child'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 about two-thirds (66%) of the children and youth reviewed. Implementation was found to be in the good to optimal range ("maintenance zone") in about a third (31%) of these cases. Implementation was found to be in the "refinement zone" in nearly half (49%) of the cases and in the "improvement zone" in a fifth (20%) of the cases reviewed.

Emergent/Urgent Response. Children and families should have timely access to and provision of effective services to stabilize or resolve emergent or episodic problems of an urgent nature. Not all children need such services. Indeed, only 16 children within the sample of 35 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 (56%) of the children and youth who needed and used such services. Emergency and urgent service provision was found to be in the good to optimal range ("maintenance zone") for more than a third (38%) of these cases. Emergency and urgent service provision was found to be in the "refinement zone" in 31% of the cases and in the "improvement zone" in another 31% of the cases reviewed.

Medication Management. Use of psychotropic medications should be necessary, safe, and effective, when used. The child 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 19 of the 35 children in the sample were taking psychotropic medications. Medication management was found to be at least minimally adequate for more than four-fifths (84%) of the children and youth reviewed. Medication management was found to be in the good to optimal range ("maintenance zone") in two-thirds (68%) of these cases. Medication management was found to be in the "refinement zone" in about a fifth (21%) of the cases and in the "improvement zone" in about a tenth (11%) 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 child, 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 seven of the 35 cases in the review sample. Use of special procedures was found to be at least minimally adequate for more than four-fifths (86%) of the children and youth reviewed in which the indicator was applicable. Use of special procedures was found to be in the good to optimal range ("maintenance zone") in more than two-thirds (71%) of these cases. Use of special procedures was found to be in the "refinement zone" in about more than a quarter (29%) of the cases and in the "improvement zone" in none (0%) of the applicable cases reviewed.

Family Support. Based on needs and requests, caregivers in the child's home should be receiving the training, practice assistance, and supports necessary to perform essential parenting and caregiving functions for the child. The array of in-home services provided should be adequate in intensity, dependability, and cultural compatibility to provide the caregiver choices and enable the caregiver to meet the challenging needs of the child while maintaining the stability of the home. This indicator was deemed applicable in 29 of the 35 cases in the review sample. Family support was found to be at least minimally adequate for more than two-thirds (69%) of the children and families reviewed. Family support was found to be in the good to optimal range ("maintenance zone") in about a quarter (28%) of these cases. Family support was found to be in

the "refinement zone" in a little more than half (58%) of the applicable cases and in the "improvement zone" in 14% of the 29 cases reviewed.

Service Coordination and Continuity. There should be a single point of coordination, accountability, and continuity of services for the child and family. IRP-specified treatment and support services should be well coordinated across service settings, providers, funding agencies, and levels of care for this child and family. Service coordination was found to be at least minimally adequate for just less than half (49%) of the children and youth reviewed. Service coordination was found to be in the good to optimal range ("maintenance zone") in almost a quarter (23%) of these cases. Service coordination was found to be in the "refinement zone" in about half (51%) of the cases and in the "improvement zone" in about a quarter (26%) of the cases reviewed.

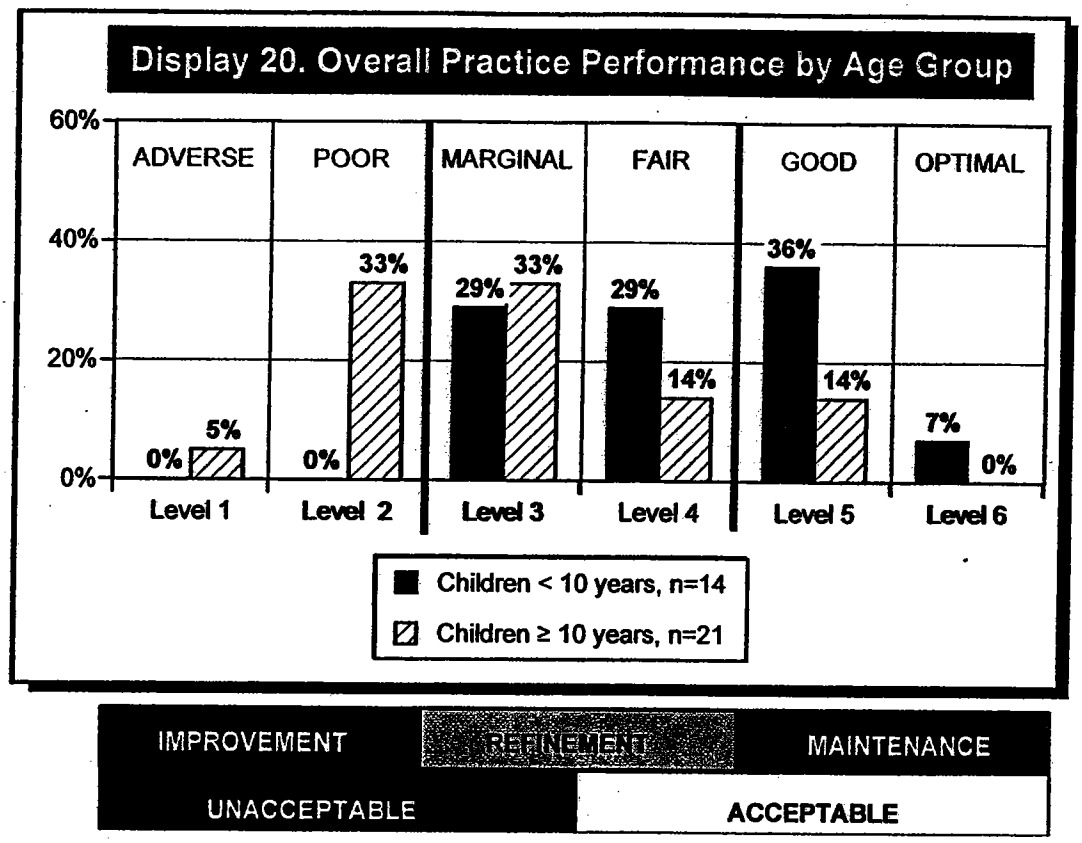
Tracking and Adjustments. The service coordinator and team should be tracking the child's treatment progress, family stressors and supports, and results. The team should communicate frequently to discuss treatment fidelity, barriers, and progress. IRP services and strategies should be adjusted in response to progress made, changing needs, problems solved, and experience gained to create a self-correcting treatment process for the child and family. Tracking and adjustment was found to be at least minimally adequate for just more than half (54%) of the children and youth reviewed. Tracking and adjustment was found to be in the good to optimal range ("maintenance zone") in more than a quarter (29%) of these cases. Tracking and adjustment was found to be in the "refinement zone" in almost half (46%) of the cases and in the "improvement zone" in about a quarter (26%) of the cases reviewed.

Overall Practice Performance. The protocol provides a scoring rubric for combining ratings values across the items deemed applicable to the child or youth being reviewed to produce an "overall practice performance rating." Applying this rubric resulted in the determination that overall practice performance was rated as adequate (rating levels 4, 5, and 6) in less than half (46%) of the cases reviewed. Some 26% of the children and youth reviewed were rated in the "maintenance zone," about half (51%) in the "refinement zone," and nearly a quarter (23%) in the "improvement zone." Overall, these results create a baseline measurement across practice

performance indicators for children currently receiving and participating in services and who generally can be served at the outpatient level.

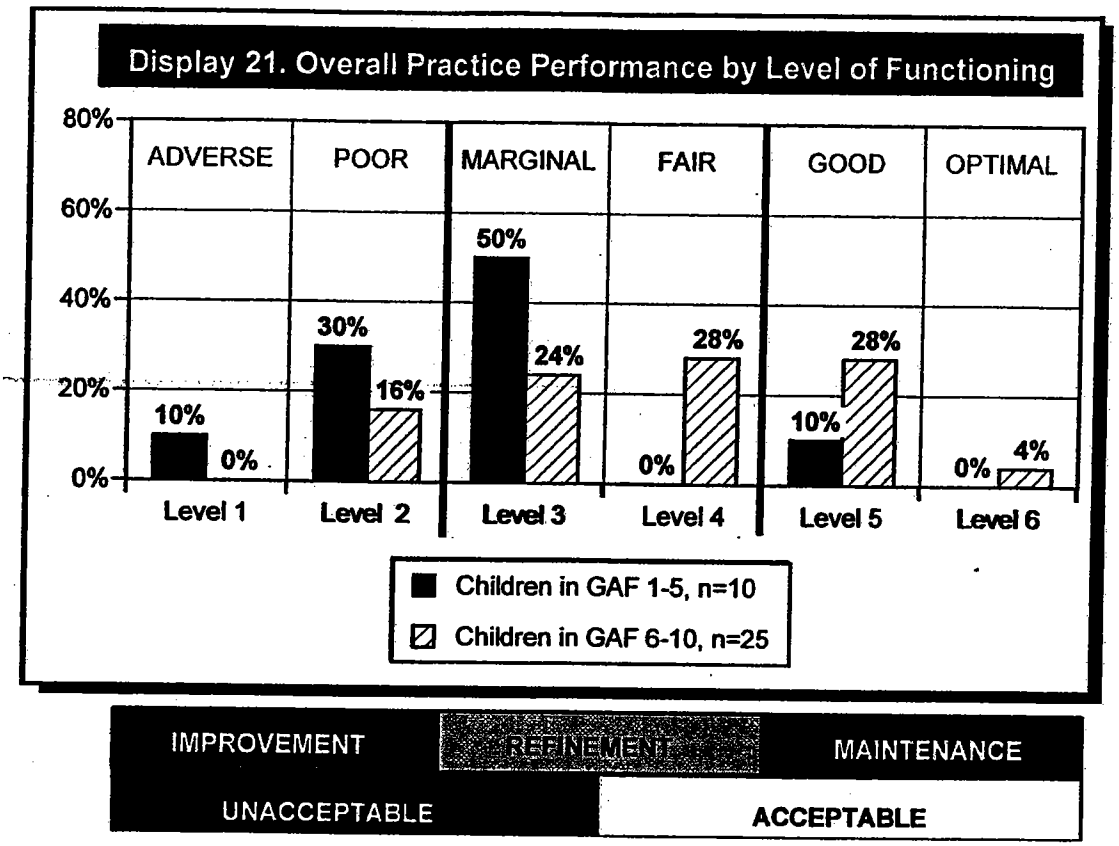
Child's Age and Level of Practice Performance

Overall practice performance was observed to vary by the age of the child or youth receiving services. **Display 20** shows the distribution of the proportions of children under age ten years and age ten years and older across the 6-point rating scale used in the CSR protocol for the 35 members of the review sample. The distribution patterns reveal a trend favoring younger children receiving services. That is, children under age ten are far more likely to have overall practice performance rated as fair, good, or optimal than children and youth age ten and older. Similarly, older children and youth are more likely to have overall practice performance rated as adverse, poor, or marginal than are children under age ten. Older children and youth tend to have more complicated lives, rely more on self-direction and control in exercising a wider array of daily choices, and tend to have more extensive histories of difficult life circumstances than do younger children. Thus, older children and youth are more likely to challenge and to defeat the strategies and resources currently available to frontline staff.



Child's Functioning and Level of Practice Performance

Overall practice performance was observed to vary by the functioning level of the child or youth receiving services. **Display 21** shows the distribution of the proportions of children and youth with lower functioning (SED range) and higher functioning across the 6-point rating scale used in the CSR protocol for the 35 members of the review sample. The distribution patterns reveal a trend favoring higher functioning children and youth receiving services. As shown in the display, higher functioning children are more likely to have overall practice performance ratings in the fair, good, and optimal ranges than are lower functioning children. Similarly, lower functioning children and youth are far more likely to have overall practice performance ratings in the adverse, poor, and marginal ranges. Thus, lower functioning children and youth are more likely to challenge the strategies and resources currently available to frontline staff. These children are also the ones who need the interagency coordinated flexible and uniquely individualized services including wraparound, intensive in-home, or multi-systemic therapy.



Case Review Outcome Categories

Members of the case review sample can be classified and assigned to one of four categories that summarize review outcomes. Children and youth having overall status ratings in the 4, 5, and 6 levels are considered to have 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 22.**

Display 22 reveals that 16 of the 35 cases (46%) fell into outcome category 1. Outcome 1 is the desired situation for all children and families receiving services. None of the members of the sample fell into outcome category 2. Eleven cases (31%) fell into outcome category 3. Outcome 3 contains those sample members whose status was favorable but experienced less than acceptable service system performance. Some children are resilient and may have excellent

supports provided by family, friends, or school personnel whose efforts are contributing to the child's favorable status. But, current service system performance may be limited, inconsistent, or seriously inadequate at this time. Eight cases (23%) fell into review outcome category 4. Outcome 4 is the most unfavorable combination because the child's status is unfavorable and system performance is inadequate. This display shows that service system performance was acceptable for 46% of the sample members. This is about half the desired rate of 90%.

Display 22. Case Review Outcome Categories - Overall

Status of Child/Family in Individual Cases

Acceptability of Service System Performance in Individual Cases	Favorable Status	Unfavorable Status	
Acceptable System Performance	**Outcome 1:** Good status for child/family, ongoing services acceptable. **46% (16 cases)**	**Outcome 2:** Poor status for child/family, ongoing services minimally acceptable but limited in reach or efficacy. **0% (0 cases)**	**46%**
Unacceptable System Performance	**Outcome 3:** Good status for child/family, ongoing services mixed or unacceptable. **31% (11 cases)**	**Outcome 4:** Poor status for child/family, ongoing services unacceptable. **23% (8 cases)**	**54%**
	77%	**23%**	

Displays 20 and 21 revealed trends in overall practice performance based on the age and functioning level of the children and youth reviewed. This effect is demonstrated again in **Displays 23 and 24**. Display 23 presents the sample members distributed by age level in the two-fold table. As shown in Display 23, of the 16 members in Outcome 1, ten are children under age ten while six are children and youth age ten years and older. Conversely, in Outcome 4, only one child is under age ten while the other seven are age ten or older.

Display 23. Case Review Outcome Categories - Age

Status of Child/Family in Individual Cases

Acceptability of Service System Performance in Individual Cases

	Favorable Status	Unfavorable Status	
Acceptable System Performance	**Outcome 1:** Good status for child/family, ongoing services acceptable. **71% (10 cases) Children < 10 years** **29% (6 cases) Children ≥ 10 years**	**Outcome 2:** Poor status for child/family, ongoing services minimally acceptable but limited in reach or efficacy. **0% (0 cases) Children < 10 years** **0% (0 cases) Children ≥ 10 years**	**71% <10** **29% ≥ 10**
Unacceptable System Performance	**Outcome 3:** Good status for child/family, ongoing services mixed or unacceptable. **21% (3 cases) Children < 10 years** **38% (8 cases) Children ≥ 10 years**	**Outcome 4:** Poor status for child/family, ongoing services unacceptable. **7% (1 cases) Children < 10 years** **33% (7 cases) Children ≥ 10 years**	**28% <10** **71% ≥ 10**
	92% <10 **67% ≥ 10**	**7% <10** **33% ≥ 10**	

The effect of the child's functioning level on classification is illustrated in **Display 24**. In Outcome 1, 15 of the sample members are higher functioning while only one case is lower functioning. Conversely, in Outcome 4, seven of the members are lower functioning while only one member is higher functioning. Once again, the current capacity of the service system to meet the needs of older and of lower functioning youth is revealed as exceedingly limited, both for service consumers and frontline practitioners.

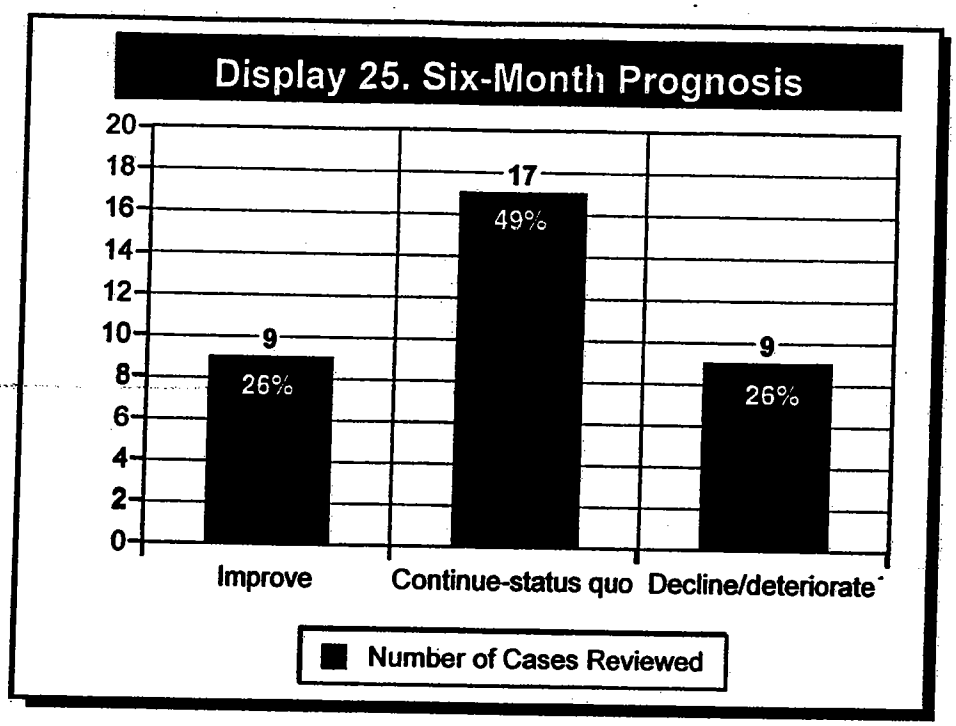
Display 24. Case Review Outcome Categories - Level of Functioning

Status of Child/Family in Individual Cases

Acceptability of Service System Performance in Individual Cases	Favorable Status	Unfavorable Status	
Acceptable System Performance	**Outcome 1:** Good status for child/family, ongoing services acceptable. **10% (1 cases) in GAF 1-5 60% (15 cases) in GAF 6-10**	**Outcome 2:** Poor status for child/family, ongoing services minimally acceptable but limited in reach or efficacy. **0% (0 cases) in GAF 1-5 0% (0 cases) in GAF 6-10**	**10%GAF 1-5 60% GAF 6-10**
Unacceptable System Performance	**Outcome 3:** Good status for child/family, ongoing services mixed or unacceptable. **20% (2 cases) in GAF 1-5 36% (9 cases) in GAF 6-10**	**Outcome 4:** Poor status for child/family, ongoing services unacceptable. **70% (7 cases) in GAF 1-5 4% (1 cases) in GAF 6-10**	**90% GAF 1-5 40% GAF 6-10**
	30% GAF 1-5 96% GAF 6-10	**70% GAF 1-5 4% GAF 6-10**	

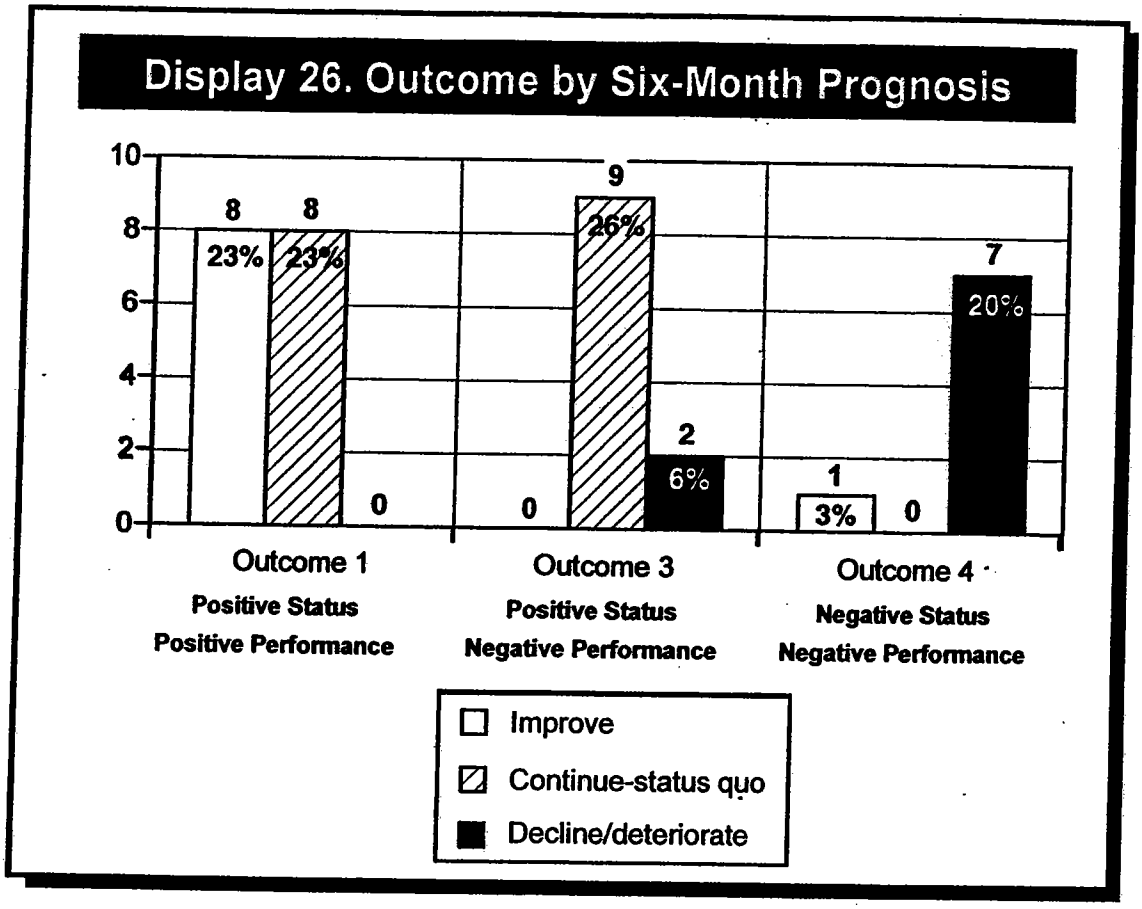
Six-Month Prognosis

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 25** presents the six-month prognoses offered by reviewers. About a quarter (26%) were expected to achieve improved status, about half (49%) were expected to remain about the same, and another quarter (26%) were expected to decline or experience deterioration of circumstances over the next six months.



Display 26 presents the six-month prognoses for sample members according to the outcome categories to which they were assigned. Display 26 shows that members in Outcome 1 were equally likely to remain about the same or improve. Most persons (26%) in Outcome 3 were more likely to remain about the same, while a few (6%) were expected to decline. Most persons (20%) in Outcome 4 were expected to decline while only one person in eight (3%) was expected to improve. Thus, those persons whose review outcomes were the worst were also those persons whose status was most likely to decline.

Who were these inadequately served persons? There were nine persons who were in Outcomes 3 and 4 (inadequate system performance) who also had a six-month prognosis of "decline." Of these nine persons, eight were lower functioning and seven were age 14 or older. Furthermore, eight of these nine were involved with child welfare, five with juvenile justice, and one with developmental disabilities services. Thus, older youth who are lower functioning and involved with other major agencies are those most likely to challenge and defeat current strategies and resources available to frontline practitioners.



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.

- While the overall status of sample members was found to be "favorable" (rating levels 4, 5, and 6) for 77%, overall favorable status was 67% for those age ten and older and just 30% for those who were lower functioning.

- Overall service system performance was found to be "acceptable" (rating levels 4, 5, and 6) for 46% 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. Furthermore, service system performance varied widely across sample members. Overall service system performance was found to be acceptable for 71% of children under age ten but for only 29% of older children and youth. Likewise, overall service system performance was found to be acceptable for 60% of the higher functioning and only 10% of the lower functioning sample members. Thus, the service system tends to work more frequently for children and families whose needs can be met with medications and outpatient services and for whom there is caregiver follow through. The system of care has not yet developed so that it can perform consistently for more complicated or complex children and families. To be effective, a service system should work most of the time for most of the people receiving services. The current service system works sometimes for the lower need children and less often for those whose needs and life circumstances require more intensive services, more interagency coordination, and more individualized treatment programs. These are the children who are most in need of receiving services, according to the principles of the system of care, and these are the children who are currently not receiving them.

This was the level of service system performance for children and youth in March 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.

Case Strengths: Patterns Recurring in Two or More Cases

- Resilient children able to cope with difficult life circumstances. Numerous children and youth within the sample were observed to demonstrate resilience and protective circumstances that enabled them to succeed even when the service system performance was less than acceptable.

- Strong faith expressed by family members seen as a source of support. Some of the families whose children were receiving services were well supported by members of the faith community to which they belonged. Their spiritual faith and support seemed to carry them through difficult times and circumstances.

- Extended family available to assist parents who may have life problems. In some cases, extended family members were providing valuable and practical support to birth parents in helping with the child or youth experiencing emotional or behavioral difficulties.

- Good use of kinship care arrangements. Kinship caregivers were providing homes for children and youth whose birth parents were unable to provide a home. About a quarter (26%) of the children and youth in the review sample were living in kinship care arrangements with relatives at the time of the review.

- Examples of excellent service coordinators as caring and capable problem solvers. Reviewers reported some specific persons who were providing a high level of responsive, consistent care coordination for members of the sample. Their diligence in problem-solving efforts for some children and youth were seen as exemplary.

- Examples of psychiatrists who know cases and do good problem solving. Reviewers noted several psychiatrists who had excellent knowledge of specific cases, participated in problem-solving activities with other practitioners, and were doing excellent medication management practice with the child or youth being reviewed. This is a positive role for psychiatrists, different from ones working in other systems as simple dispensers of medications operating

in 15-minute appointment units. The varied roles and problem-solving contributions of the example psychiatrists were seen as strengths within the system.

- Medications don't seem to be overused. Psychotropic medications were being used with about half (54%) of the sample members. No child or youth was taking more than three medications. State-of-the-art medications were being used and appeared to be well managed.

- Children can remain in DMH services until their 22nd birthday. Youth are not automatically dismissed from the system on their 18th or 21st birthdays. This provides flexibility in planning and accomplishing smooth and successful transitions from school to work, to independent living, and to adult services.

- Mental health center staff providing stability and security for families. Reviewers noted examples of staff at the mental health centers providing practical supports to and functioning as support networks for families who regularly use their services. This helps in building trusted relationships and achieving continuity in care coordination for children and their caregivers.

- Excellent examples of culturally competent practice at the multi-cultural center. Repeated examples were offered by reviewers of excellence in culturally-competent practice provided by the multi-cultural center. Staff at this center were seen as going far above and beyond usual practice expectations by helping consumers and families from other countries and cultures understand and cope with urban life in this country. Providing on-site medical services is a major aspect of support for consumers and families because some are undocumented aliens who have no other access to health care services. Assistance with housing, economic supports, and other essential services are being provided to persons of many nationalities who speak many different languages.

As seen through the eyes of reviewers as beneficial to children and families, the above list identifies many service system strengths that can be used to build upon in expanding the capabilities and improving the performance of the system.

Case Challenges: Patterns Recurring in Two or More Cases

In the course of conducting and reporting the 35 case reviews, reviewers observed a variety of recurring factors present in cases that posed difficult challenges for the frontline staff of the service system. Presented below are major patterns noted by the review team.

- Domestic violence as a significant stressor in families. Domestic violence occurring in the home with children present or children involved was an often-repeated pattern among cases reviewed. Continuing episodes were noted in some and historic in others. Continuing episodes pose safety risks and increase the likelihood of child removal or runaway. Children and youth with a history of domestic violence tend to be aggressive toward others more often and may perpetuate family patterns of domestic violence in future generations. Addressing domestic violence in therapeutic practice requires more than anger management classes. Despite the incidence of domestic violence observed within the service population, few specific strategies and therapies were found to be addressing this problem.

- Substance abuse/addiction affecting caregivers and children. Substance abuse problems appeared to be a co-occurring problem in a subset of the cases reviewed. Often, substance abuse and domestic violence were found occurring together within some cases. Accessing timely, convenient, and effective substance abuse treatment services seem to be difficult for youth and for caregivers in some of the cases reviewed.

- Parental incarceration resulting in loss of parents. The incidence of parental incarceration among the cases reviewed seemed high to the review team, based on experiences in other communities. The effect is that children lose parents for a portion of their childhood, must live with others while the parent is away, and may experience difficulties reunifying with the parent following parole. The problem may be compounded when the parent returns to substance use or criminal activities.

- Terminal illness resulting in loss of parents or other family members. In several cases reviewed, a parent or other close family member was either in the end-stage of a terminal

illness or recently lost to illness. Loss of a parent or close member of the family is a significant life stressor that, in combination with other emotional or behavioral problems experienced by the child, may result in the intensification of symptoms and new requirements for treatment and support.

- Grief and loss for children having lost a parent or significant others. The loss of a parent or significant other in a child's life can produce an immediate crisis and then a long-term process of recovering from grief and loss. In addition to the losses of parents or loved ones due to incarceration or illness, some children and youth have witnessed the violent death of close friends. These life events require adjustment and support through a period of healing. Such events have important implications for frontline mental health practitioners working in the system.

- Needs for mentors or other adults for forming relationships. Some of the children and youth reviewed seemed detached from the normal family and friendship patterns experienced and enjoyed by others. Too many of these children lacked a significant, enduring, and appropriate relationship with a caring adult who serves as a committed supporter and life guide. This gap left these children bereft and adrift at critical points in their development. Many of these children and youth need mentors and supportive relationships with adults who can help them grow up to be caring and contributing citizens.

- Children with behavior problems losing their educational opportunities. A frequently observed pattern among the youth in the sample was that of educational failure. The interaction of poor academic skills and disruptive classroom behavior had resulted in many of the older children and youth: (1) reading far below grade placement, (2) falling far behind in school, (3) refusing to attend school or roaming the halls at school rather than attending classes, (4) being suspended or expelled, and/or (5) dropping out. Some of these youth had never been evaluated for special education services. Others lacked positive behavior supports and tutoring necessary for them to catch up and succeed in school. As a result, many youth were failing academically with educational advocacy or support.

- Variability in the quality of school climate and support for students. Attention and support for special learning and behavior problems varied among schools. School climate was accepting and support for children with special needs was found at some schools and found missing at others.

- Attention deficit hyperactivity disorder (ADHD) and conduct disorders. Children and youth presenting ADHD symptoms and conduct disorders were prevalent within the review sample. The extent to which these patterns are present within this service population suggests that addressing the needs of children presenting this combination should be a high priority in practice. Because these children are seen and served by educators, child welfare workers, and juvenile court officers, a joint effort targeted at this group of children and youth would serve the interests of all child-serving agencies.

- Some of the older youth reviewed appeared to be lost within the larger system of care. These youth were often truant from school, abusing drugs, engaging in petty crime, teen parents, and lacking any clear, positive future pathway to self-sufficiency and independence. They were known to child-serving agencies that seemed to have given up on them. Educational advocates no longer assisted in getting kids into school or even responded to calls made in their behalf by mental health or child welfare workers. Juvenile court officers no longer enforced their court plans even though the youth were in clear violation of the court's orders. Required substance abuse treatment was not attended. Urine analyses were either avoided or returned positive without response by the system of care. Intervention efforts had simply ceased in their cases.

- Family systems temporarily stable but fragile. A frequent pattern noted in some cases involved family situations in which the caregiver and children were at a temporarily stable point but the present situation was tenuous and seemed likely to unravel in the not-too-distant future. Instability of families is a major stressor for children, especially those with emotional disorders and behavioral problems.

Recurring Patterns in the Service System

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

- Assessments were limited in terms of their usefulness in planning responsive supports and services. Among problems noted with assessments were:

  - Narrow scope or shallow depth of information produced. Underlying needs and co-occurring conditions were poorly addressed, if at all.
  - Used more for diagnosis than for understanding what to do. Assessment was used more as a justification for service authorization than as a learning process used to develop a course of action intended to produce valued results.
  - Used as a substitute for action. In some instances, referrals for further assessment or evaluation seem to be used as a substitute for present action even though enough was known to conduct an appropriate course of action without further assessment.

- Service planning tends to be episode driven. Services seemed to be directed and driven by the present episode and immediate next step, often without regard to where those steps were leading for the child or youth.

- There were not many examples of interagency teams and coordination across the treatment setting, home setting, and school setting or with child welfare caseworkers or juvenile court workers operating as a team. It is the children with problems across multiple settings who require strong team coordination and intensive services in order to change the direction from one of residential treatment, school drop-out, unemployment, and prison that is experienced by so many children with emotional problems who are not able to stay in school and acquire the necessary skills to be able to support themselves as adults.

- Lack of a long-term view in service planning. Services seem to be driven by the present episode rather than being aimed at achieving important longer-term results. The long-term view concept seemed to be a missing element in current service planning.

- Engagement of children and families served seems weak in some cases (only center-based contact is offered in many cases). 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 school 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 service plans.

- Courts making clinical decisions in some cases (contrary to mental health and child welfare assessments and treatment recommendations). In some cases reviewed, frontline staff reported that the courts were making decisions of a clinical nature about children's needs and services. In at least one case reviewed, the court had made decisions directly opposed to the recommendations made by child welfare and mental health workers.

- Lack of timely, adequate access to unique, flexible, or supportive services (respite, intensive in-home, mobile crisis, mentors, tutors, multi-systemic therapy, etc.). Being able to access the right services at the right time is often critical to success in a case. Reviewers reported numerous instances in which access to unique, flexible services arrangements was not possible. Getting prompt respite care, intensive in-home services, mobile crisis services, mentors, tutors, and multi-systemic therapy seems to be impossible, even though widespread needs exist for these services.

- Individualized Resiliency Plans function as service authorization documents but don't drive case practice. The IRPs developed for providing services to children and youth 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 slowing, partly due to resistance and partly due to a lack of practice skills and craft knowledge. This problem was evident among several of the cases reviewed.

- 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 children and families 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 35 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. This would include many of the following activities:

- articulating a clear practice model for conducting key practice functions and providing supports and therapeutic interventions;
- setting expectations/ethics of role performance in child and family practice;
- training frontline practitioners and supervisors on practice expectations, functions, and assessing results achieved;
- creating and using Individualized Resiliency Plans that really organize, communicate, and drive practice activities between all interveners;
- providing case practice supervision and support;
- offering clinical support and technical assistance for the most challenging and difficult children and families;
- improving the capacity and skills to engage the hard-to-engage and resistant child and family;
- evaluating practice, performance, and outcomes for results;
- providing constructive, individualized feedback about actual children who are experiencing the practice of the system;
- rewarding good practice and results achieved for children and families.

♦ Build a supervisor corps that is focused on daily case practice (rather than focused primarily on administrative concerns) and that is provided the time and support to supervise practice.

♦ Expand capacities for developing, providing, and managing unique, flexible, supportive, non-traditional services provided in the home, school, 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.

♦ Educate frontline staff on the theory and practices used in the new SAMHSA project, including multi-agency planning teams, service integration, multi-agency service coordination, and related system of care strategies and resources.

- Focus attention on the importance of proactive efforts in case practice rather than waiting to see what others do. For example, take a competent plan to the judge for court action rather than waiting to see what the judge orders in the next hearing in the absence of sensible therapeutic options.

- Create a sense of urgency in getting things done! In a child's life, down time, missed school, 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).

- Improve advocacy for children and youth who are missing school or are behind in school.

Appendix A

Community Services Review For a Child and Family

Questions to be Answered

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

Produced for Use by the Dixon Court Monitor

by
Human Systems and Outcomes, Inc.

March 2003

Questions Concerning the Status of the Child and Family

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

Community Living

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

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

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

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

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

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

Health & Well-being

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

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

Development of Life Skills

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

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

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

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

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

Questions Concerning Progress

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

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

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

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

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

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

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

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

Questions Concerning Performance of Key Service Delivery Systems

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

Planning Treatment & Support

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

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

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

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

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

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

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

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

Providing Treatment & Support

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

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

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

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

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

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

Managing Treatment & Support

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

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

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