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.

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Purpose and Scope of the Review

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

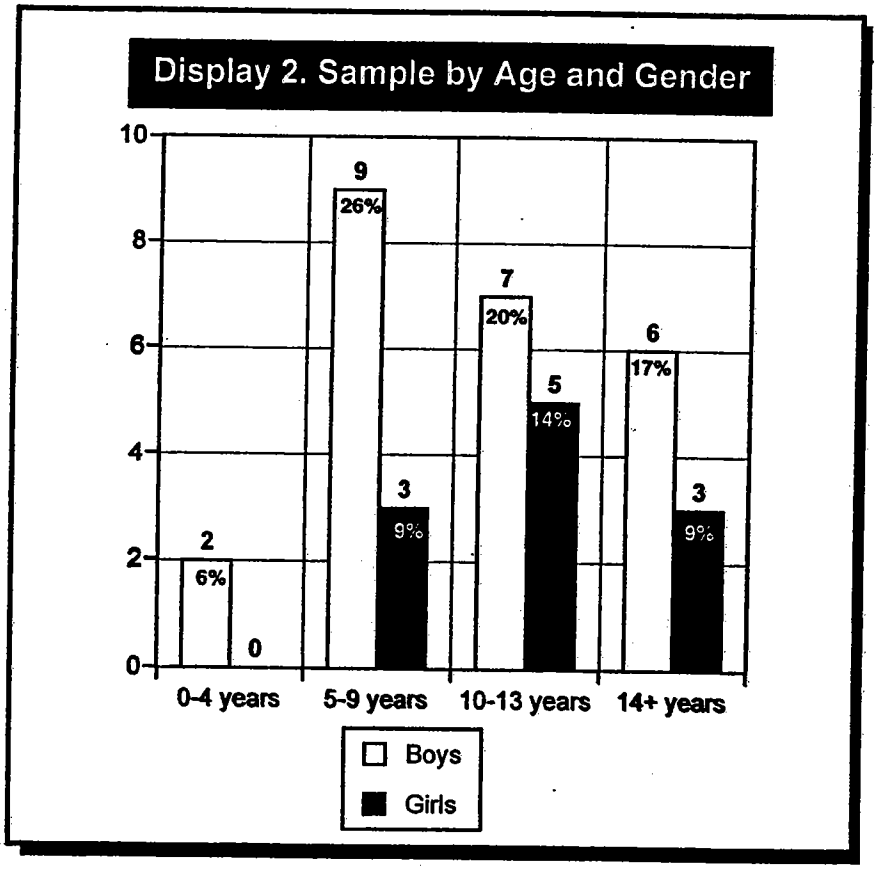
In summary, there were various difficulties encountered during the course of setting up the March 2003 review of services provided to Dixon class members who were children and youth. Lessons learned from this experience should be applied by DMH, the core agencies, and the Dixon Court Monitor in planning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

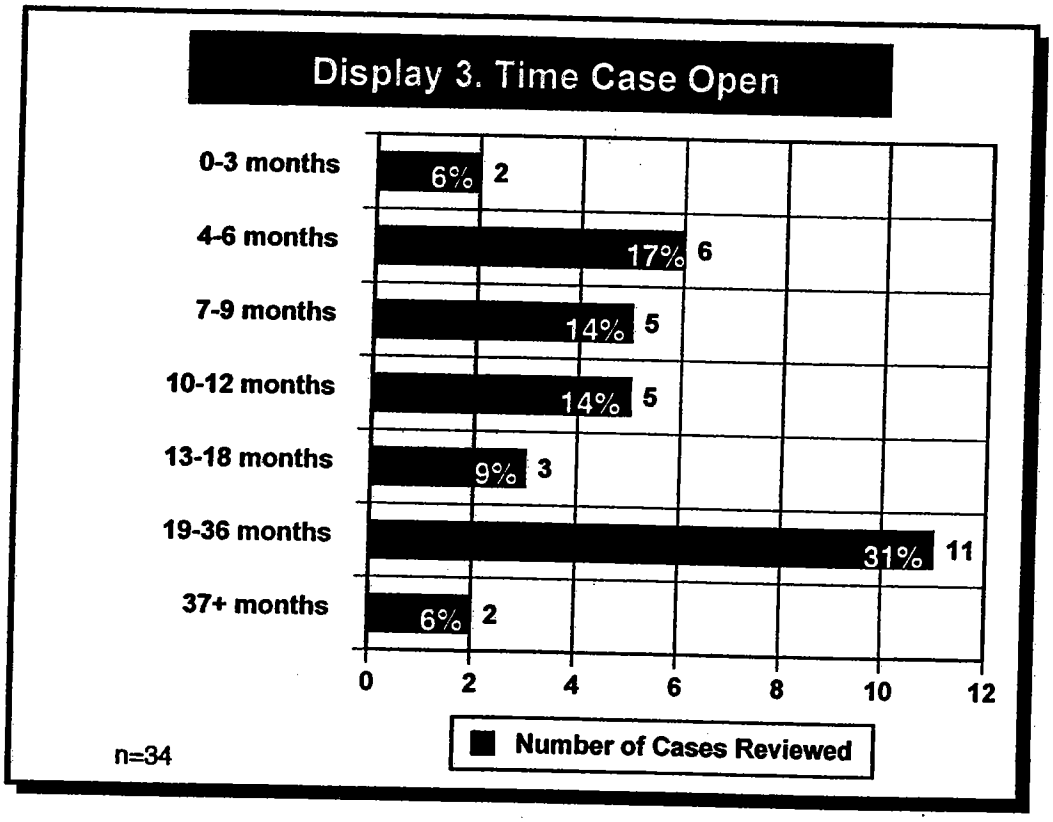
The review sample was composed of boys and girls drawn across the age spectrum served by the Department of Mental Health. **Display 2** presents the sample of 35 children and youth distributed by age and gender. As shown in this display, boys comprised 69% of the sample while girls comprised 31%. By 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

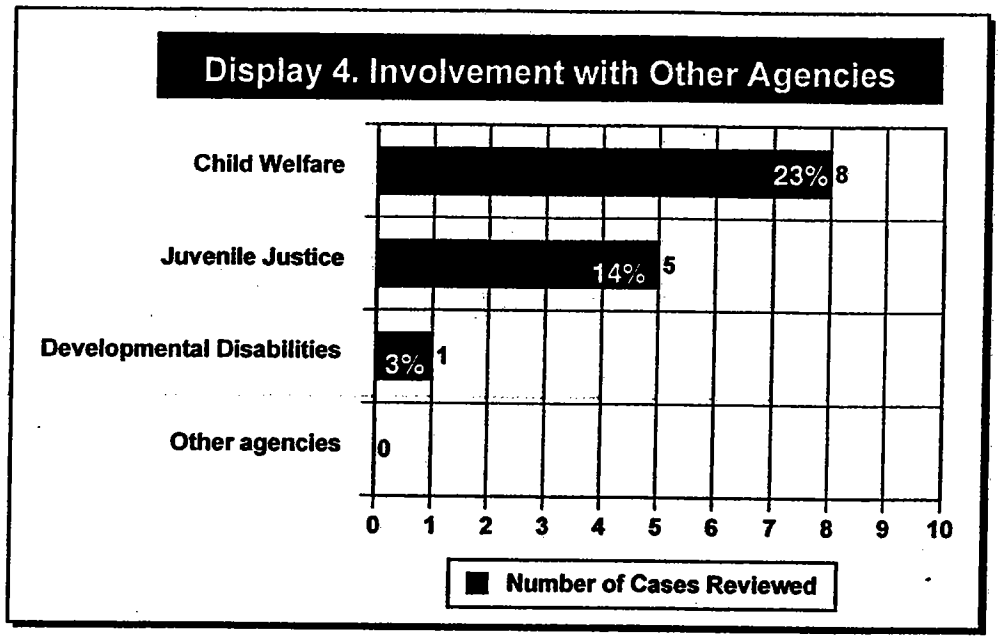
All children in the review sample were served by the Department of Mental Health. **Display 3** presents, for the sample of 35 children and youth reviewed, the amount of time their cases had been open with DMH during their current, most recent admission for services. As can be seen in

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

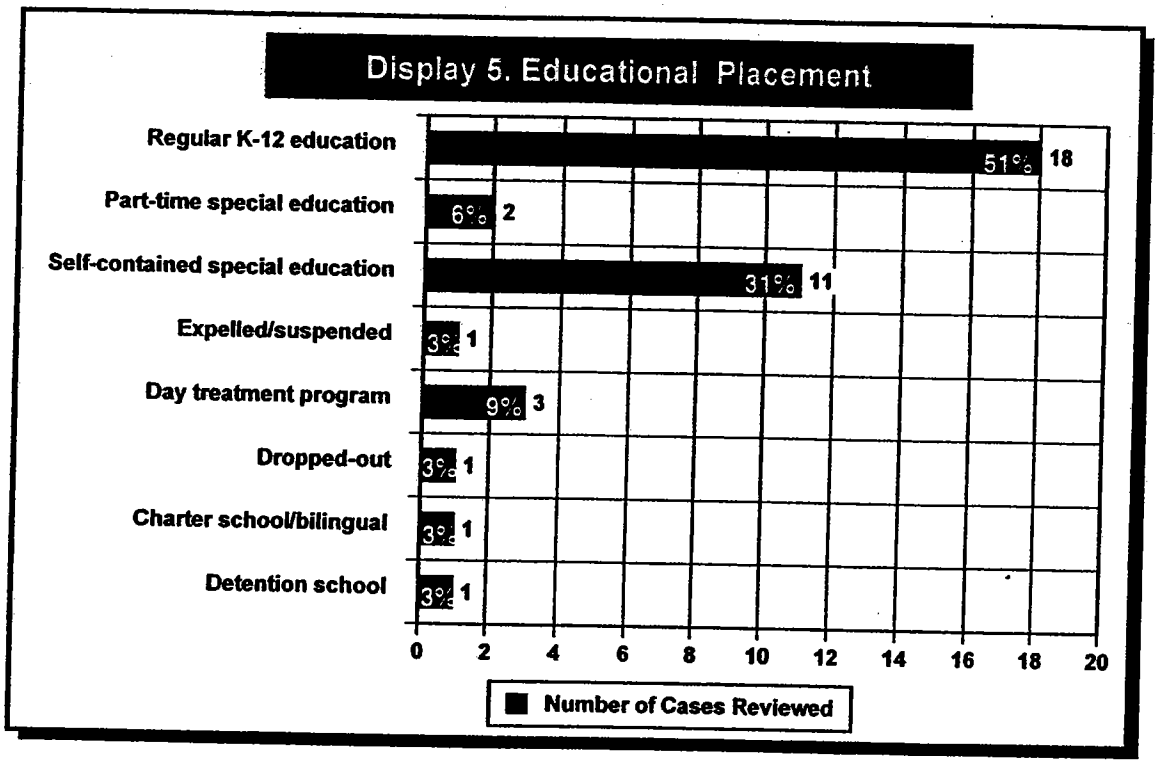
Some children and youth in the review sample were also receiving services from other major agencies. **Display 4** presents, for the sample of 35 children and youth reviewed, the number who were identified as being served by other key agencies: child welfare, juvenile justice, and developmental disabilities. 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

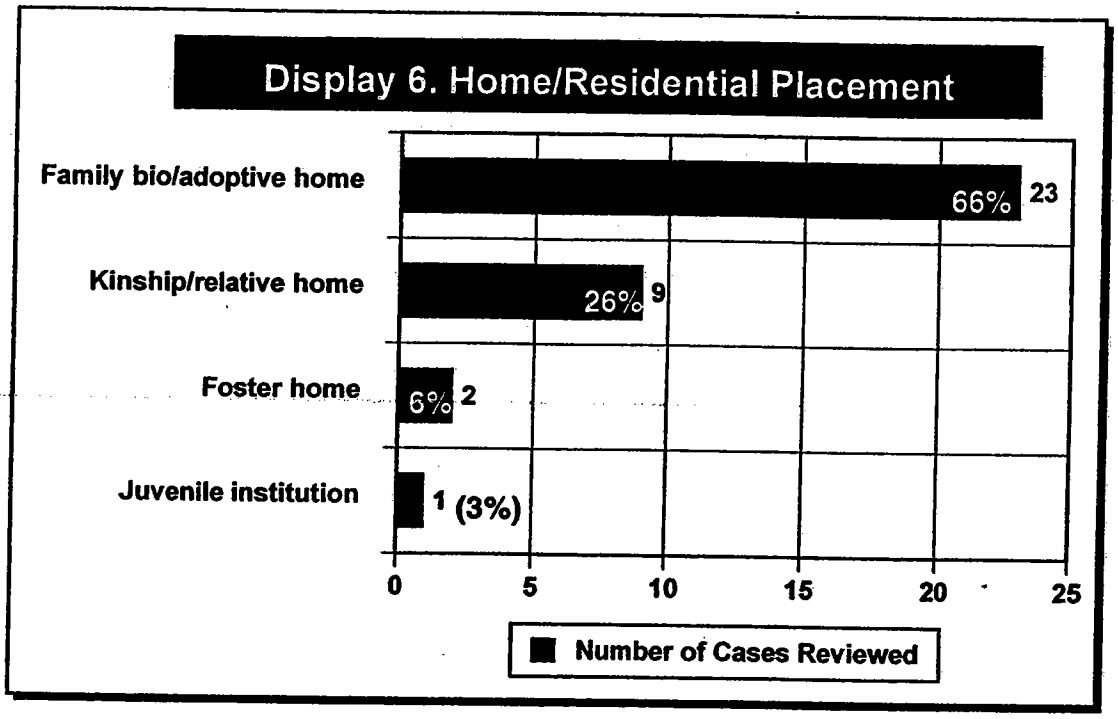
Getting an education and preparing for employment are major societal expectations for children and youth. **Display 5** describes the educational status/placement for the children and youth in the review sample. About half (51%) were found to be participants in a regular K-12 educational program. More 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.

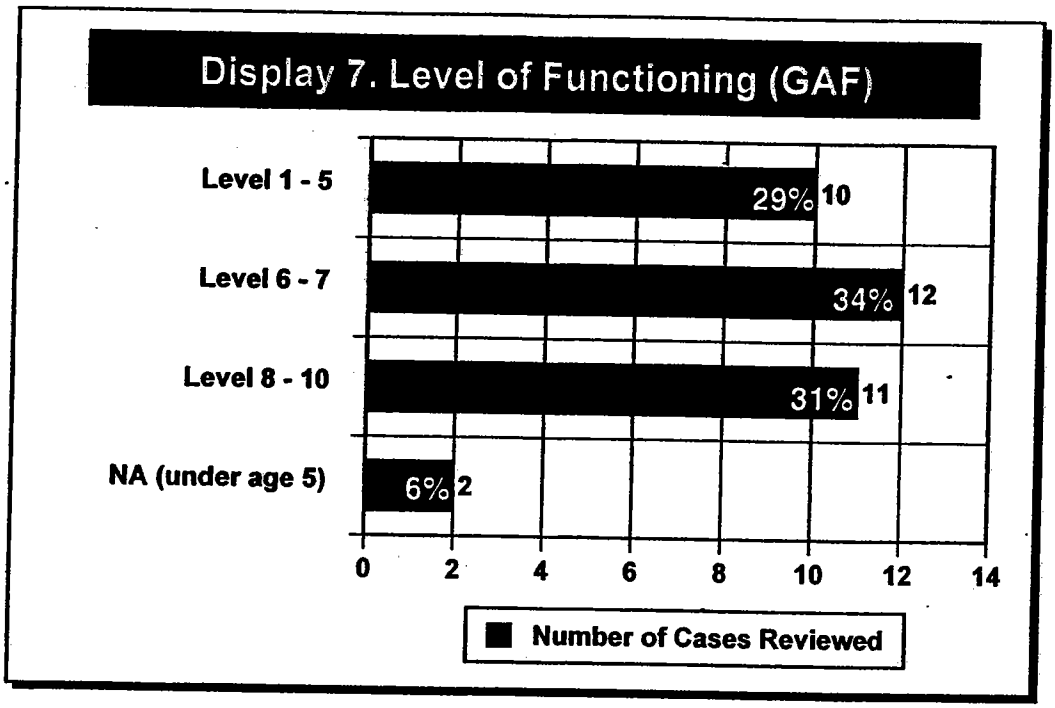


Functional Status

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.

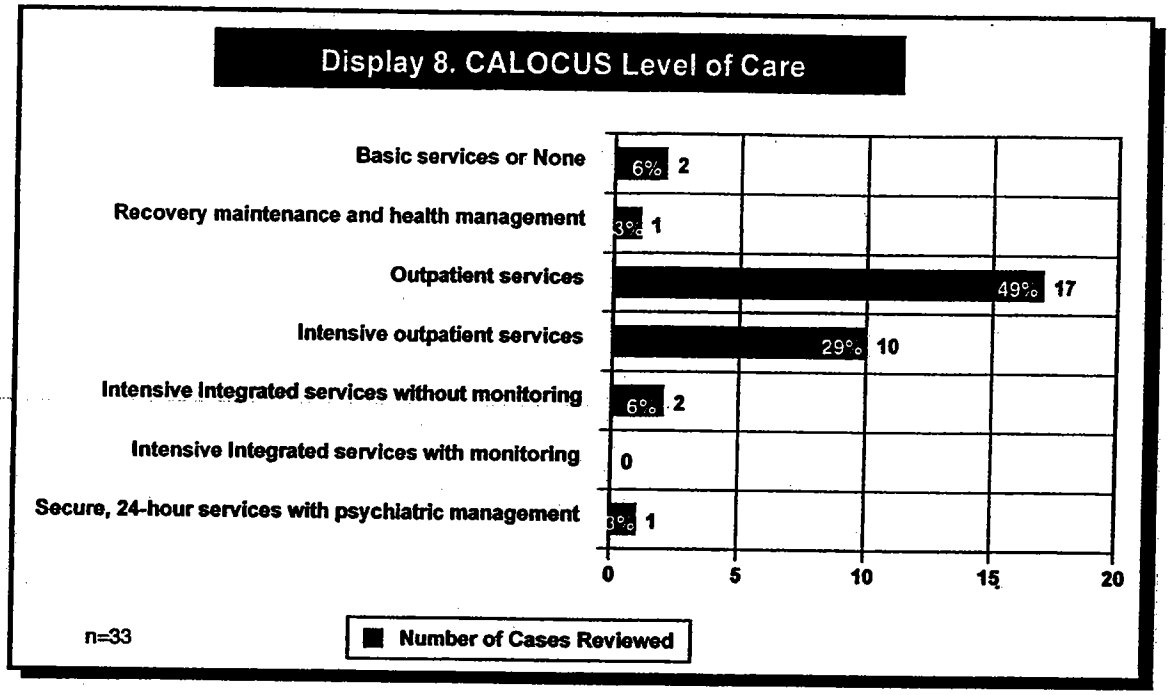
Display 7 shows the distribution of the review sample across functioning levels for the 33 children and youth age five and older. Between a quarter and a third (29%) of those in the sample were in the low range (levels 1-5), indicating that they fell within the SED range. A third (34%) were mid-range (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.



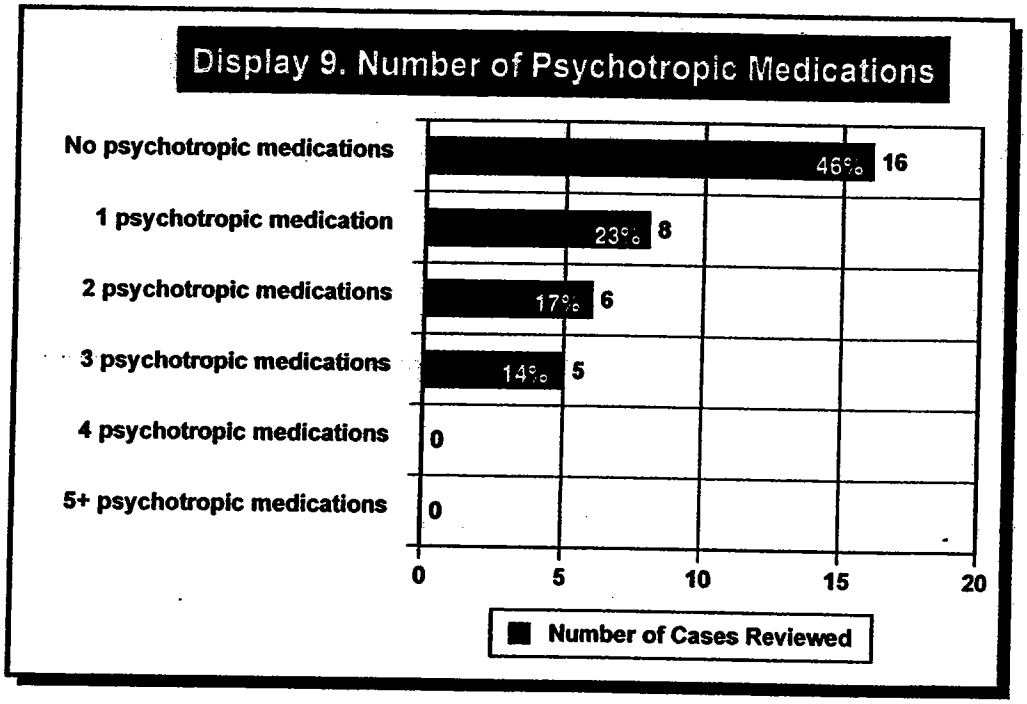
Level of Care

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.



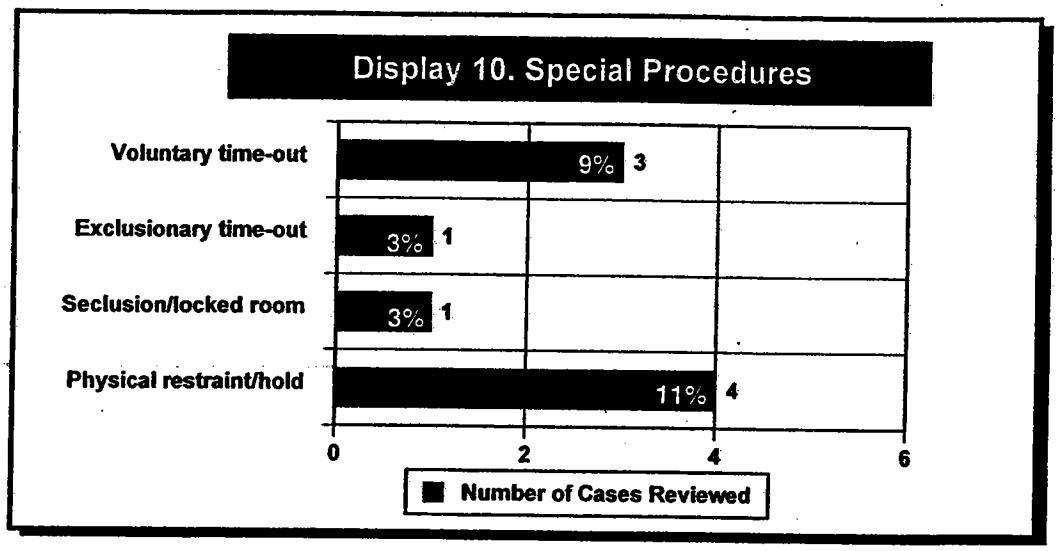
Medications

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

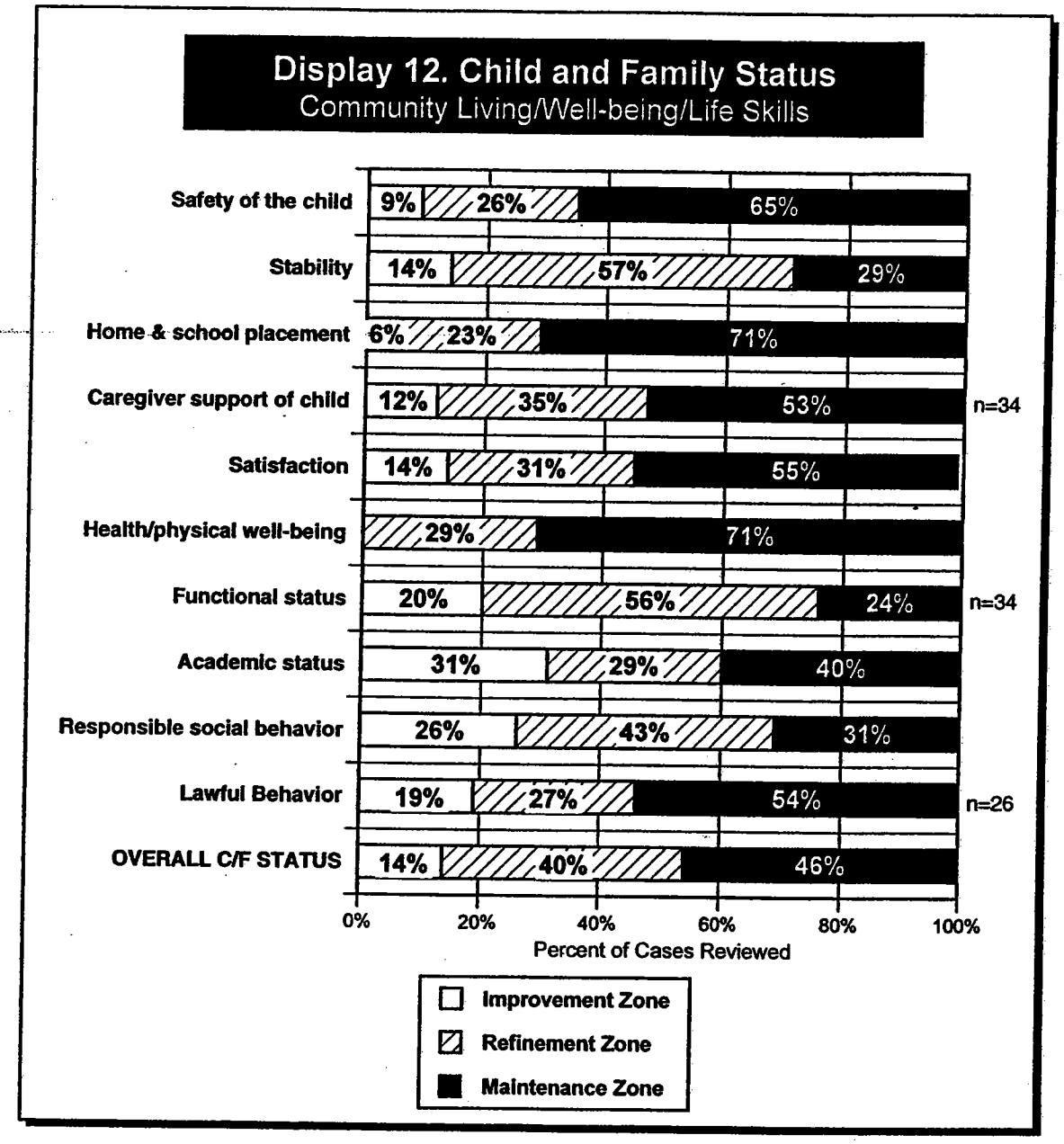
Quantitative review findings are divided into four broad sections: child status, recent changes and results, practice performance, and six-month prognosis. Findings are summarized in the sections that follow.

Child Status Results

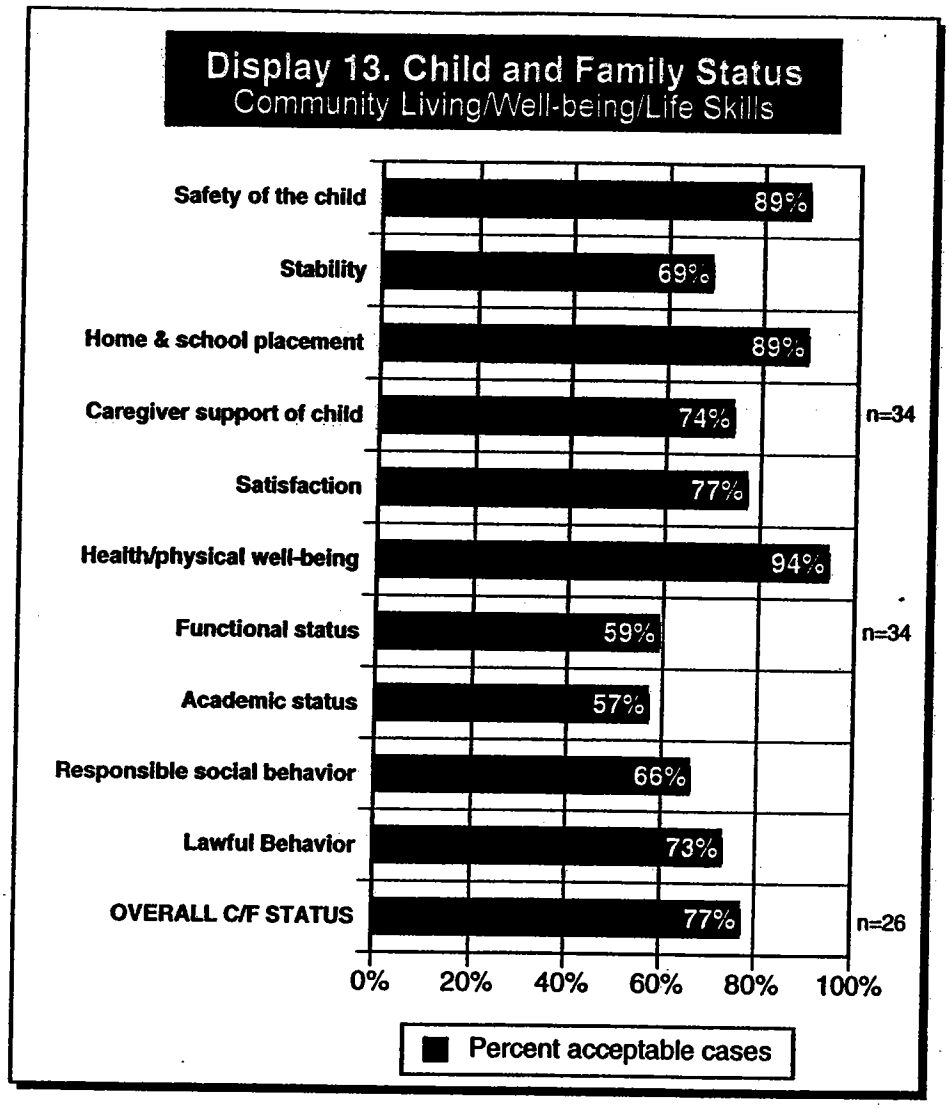
Ten indicators related to the current status of the child or youth were contained in the CSR protocol used by reviewers. Readers are directed to **Appendix A** for a detailed description of these ten areas examined by the reviewers. **Displays 12** and **13** present findings for each of the ten indicators. 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.

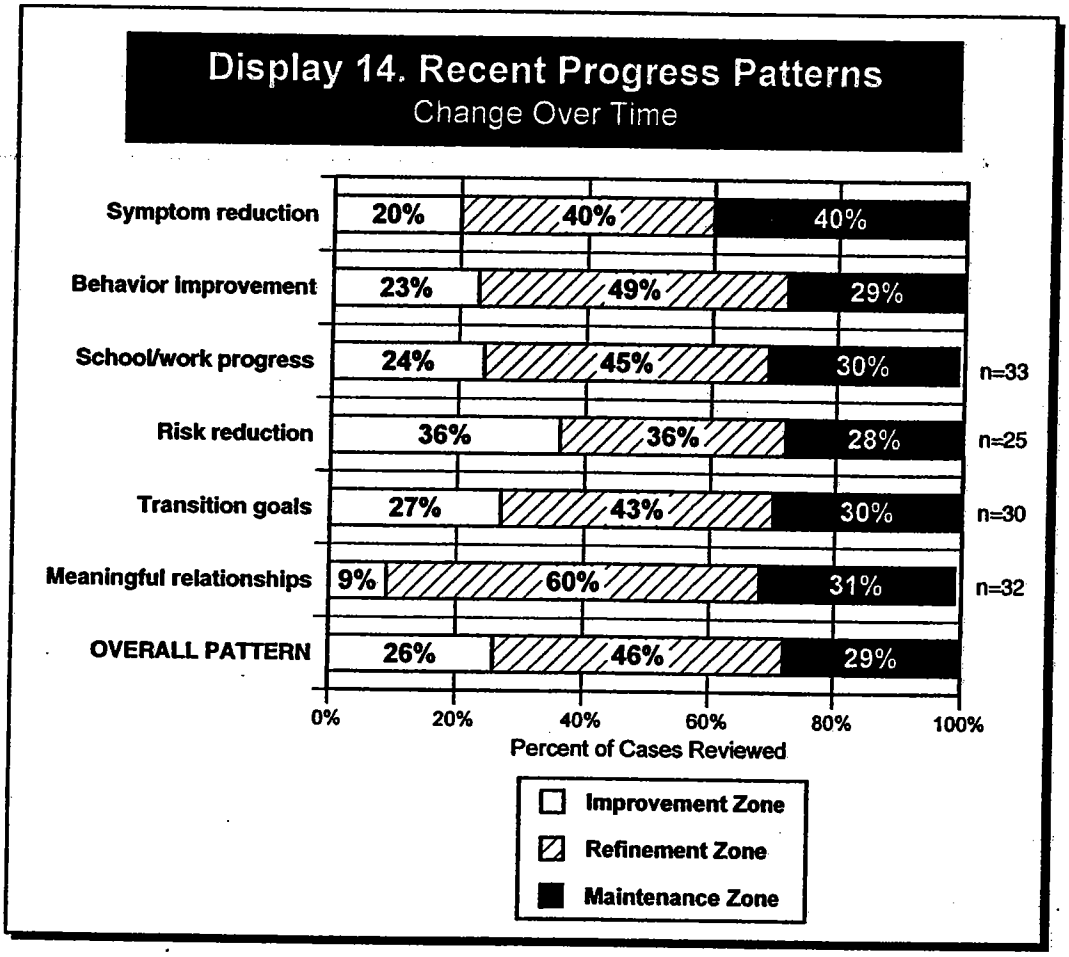
Lawful Behavior. Children and youth should behave lawfully at home, at school, and in the community. If involved with the juvenile justice system, youth should comply with the court plan, avoid reoffending, while developing appropriate friendship and activity patterns. Nearly three-quarters (73%) of 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.