2004 Report on Children and Youth

Served by the District of Columbia Department of Mental Health

May 2004

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 these requirements, a child review protocol was developed, tested, revised, and then used to create a baseline for subsequent measurement of progress. The initial review was completed 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 results of the initial review were provided to the Court Monitor in a report dated March 2003. Findings from the initial review were generally mixed, with approximately 75% of the children in the sample being considered to have an overall acceptable status. The appraisal of the service system for these children was considered overall acceptable in slightly less than half of the children and families

reviewed. Due to some methodological limitations during the initial sample selection process, there was some concern on the part of the review team and the Department of Mental Health (DMH) that the actual children and families reviewed might represent only the families that were most actively engaged in the system. It was concluded that the review results likely provided a more positive status of children receiving mental health services and the overall responsiveness of the service system in addressing their needs than would be reflected in a more fully representative sample of children and families and the range of practices.

As a result, a larger sample was drawn for the second-year review and the logistical preparation was facilitated by the Dixon Court Monitor's staff with support from Human Systems and Outcomes, Inc. (HSO), as well as with major strategic support from DMH staff. Review activities for the second-year review were completed during March 2004. This review should be primarily considered an extension of the baseline review using a more refined sampling process. This report contains the results of the individual child reviews completed during the year-two review activities. Findings pertain to the final 54 children included in the review.

The design of the 2004 sampling process, training of reviewers, supervision of data collection, and analysis of data were conducted by HSO, an organization with extensive experience in qualitative child service review processes used in monitoring services in class action litigation situations. HSO was contracted by the Dixon Court Monitor and worked as staff to the monitor in conducting the review.

In reading this report, the reader must recognize that a large systemic change process is occurring in the Department of Mental Health that is going to take multiple years to bring individualized, highly coordinated services to each child and family served to a highly consistent and fully functional level of performance. To date, a tremendous amount of energy and effort has been expended to create the infrastructure and foundational capacities necessary to support a consistently performing, high quality service delivery system. In the stakeholder interviews this year, some provider agencies were just beginning to reach a stage of development in which practice issues and the barriers to good practice could be discussed. In other agencies, there is still a struggle to just get the foundational infrastructure and basic understanding in place. A

major difference from the first-year review is that core service agency staff and other providers are much more aware of the conceptual framework for the delivery of services and practice expectations. The challenges identified this year are involved with how to operationally achieve both the business model and practice model in specific actions and detail implementation for most of the consumers most of the time. From HSO's perspective, considerable progress continues to be made and the system is just now beginning to reach the point that more focus and effort can be put into the actual development and implementation of more consistent high quality practice.

The Sample for Children and Youth

A stratified random sample of 162 registered clients was drawn from the registered children on the Department of Mental Health ECURA data system. From that number, a stratified sample of 54 children was obtained from the larger sample when it was determined that the child was or had recently been an active case and the parents were willing to provide informed consent. The criteria for inclusion in the sample were that the case is currently active (as defined by receiving services within three months of the time of the review) and is 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 January 26, 2004: (1) provider agency, (2) age of child, and (3) child's level of need.

In this section, considerable detail is provided about the sampling selection and the logistical issues encountered in setting up the final sample of children and families that were ultimately reviewed. This information is provided because the challenges and issues that were encountered are instructive in regard to both the current status of infrastructure development and of the implementation of the System of Care practice model. They also reflect how complex a service delivery system is and how many details and components have to work in sync in order to achieve the best results for children and families.

Provider Agency

The DMH data system shows there are a total of 2,781 children enrolled in DMH who either requested referral for services through the Access Help-Line or received services either now or in the past from one or more of 15 different provider agencies. These provider agencies differ substantially in the total number of children they serve. Ninety-eight percent of the children enrolled in a core service agency are receiving services from one of the seven largest agencies. These agencies are: the Public Core Service Agencies; Center for Mental Health, Inc; First Home Care; Hillcrest Children's Center; Community Connections, Inc.; Optimum Care; and Universal Health Care Management. **Display 1** provides the number of children currently enrolled in all of the provider agencies, as identified through the ECURA system.

Display 1

Total Number of Children Receiving Services by Provider Agency		
Agency	Total Children	% of Children Receiving Services
1. Public Core Service Agency	1,053	38%
2. Center for Mental Health, Inc.	878	31%
3. First Home Care (First Home Care CBI-1)	327	12%
4. Hillcrest Children's Center (Hillcrest Crisis/Emergency - 1)	175	7%
5. Community Connections, Inc.	145	5%
6. Optimum Care	108	4%
7. Universal Health Care Management	60	2%
8. Fihankra Place	19	2%
9. Anchor Mental Health Association	4	<.01%
10. Washington Hospital Center	4	<.01%
11. Green Door	2	<.01%
12. Psychotherapeutic Outreach Services	2	<.01%
13. Woodley House	2	<.01%
14. Lutheran Social Services	1	<.01%
15. Psychiatric Center Chartered	1	<.01%

Age of Child

The number of children receiving services at each site varies by the ages of the children. Three pre-determined age ranges (0-9, 10-13, 14+) were specified as points to stratify the sample. There is a reasonably proportionate number of children within each of the three age ranges, with

the largest proportion of children receiving services in the 14+ age range. It should be noted that within the 0-9 age range, the majority of the children are ages five and older. **Display 2** provides the number of children being provided services in the seven largest provider agencies and the number in each of the age ranges. The sampling frame slightly over-sampled middle school and teenage children so that the final results would be most representative of the population of children receiving services.

Display 2

Number of Children Being Served Separated by Provider Agency and Age Range				
Agency	**Ages 0-9**	**Ages 10-13**	**Ages 14+**	**Total**
Public Core Service Agency	304 40%	341 38%	408 40%	1,053
Center for Mental Health, Inc.	322 42%	339 37%	217 21%	878
First Home Care	43 6%	76 8%	208 20%	327
Hillcrest Children's Center	24 3%	67 7%	83 8%	174
Community Connections, Inc.	32 4%	53 6%	60 6%	145
Optimum Care	31 4%	27 3%	50 5%	108
Total	756	903	1,026	**∑=2,685** (96.54% of 2,781)[1]
Note: There are 96 (3.46%) children being provided services in remaining provider agencies. Thus, one "at large" child is being sampled from the 96 to allow for an equal chance of being selected for inclusion in the review.				

Child's Level of Need

The child's level of need was separated into three categories (low, medium, high). There was a brief survey 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

[1] The total number of children receiving services as indicated on the master list provided by the D.C. DMH on January 5, 2004, is 2,781.

Sampling Frame

Display 3 provides the final sampling frame for the 2004 children's review. This table indicates the number of children randomly selected from each agency separated by age ranges for inclusion in the review activities. It should be noted that this table also lists the triple sample selected from the agency from which the final participants were identified. The rationale for drawing a triple sample was to allow for participants refusing to consent to be included in the review activities, to allow for sample attrition, and to ensure that there was an adequate mix of the level of need of participants.

Display 3

Target Sampling Frame Stratified by Agency and Age Ranges				
Agency	**Ages 0-9**	**Ages 10-13**	**Ages 14+**	**Total**
Public Core Service Agency	6 (18)	7 (21)	8 (24)	21 (63)
Center for Mental Health, Inc.	6 (18)	7 (21)	4 (12)	17 (51)
First Home Care	1 (3)	1 (3)	4 (12)	6 (18)
Hillcrest Children's Center	1(3)	1 (3)	2 (6)	4 (12)
Community Connections, Inc.		1 (3)	2 (6)	4 (12)
Optimum Care	1(3)	1 (3)		2 (6)
Universal Health Care Management			1 (3)	1 (3)
Total (triple sample noted in parentheses)	15 (45)	18 (54)	21 (63)	**∑=54 (162)**

The intent of the proposed sampling methodology was to collect a random sample of c that is proportional to the actual age, level of need, and breakdown of children receiving in each provider agency. The sample size was determined using a binomial distribution table that would yield an estimated range of the underlying distribution of acceptabl acceptable performance at a 95% confidence level. This strategy for determining sar has been determined to be an effective means of establishing an overall service-level l other states that use similar case review methodologies as a measure for monitori decree compliance.

Children and Families Included in the Review

Display 4 provides the distribution of child reviews completed during the year-two review. As this table indicates, there were minor variations from the sampling specification. There were slightly larger numbers of children ages 0-9 and ages 10-13 included in the review than what were originally specified. In order to include a small number of children currently receiving mental health services in more restrictive residential settings (RTCs), the active caseload for one of the two area RTCs was provided and three children were selected from the 20 currently receiving services to be included in the review.

Display 4

Final Sample of Cases Included in the Review				
Agency	**Ages 0-9**	**Ages 10-13**	**Ages 14+**	**Total**
Public Core Service Agency	5	9	4	18
Center for Mental Health, Inc.	9	5	3	17
First Home Care	1	1	4	6
Hillcrest Children's Center	1	2	1	4
Community Connections, Inc.		2	1	3
Optimum Care	2			2
Universal Health Care Management			1	1
Hurt Home		3		3
Totals	18	22	14	**54**

Issues Encountered During Review Setup

Difficulties encountered during the review preparation included: (1) multiple data management systems tracking the status of consumers; (2) inconsistent understanding or application of current discharge policies; and (3) variability in the application of the basic case management model impacting the extent to which consumers were engaged with services provided by case managers and other core service agency staff.

(1) Multiple data systems: A listing of all children receiving mental health services was taken from the ECURA system in January 2004 and provided to HSO. The triple sample of cases

was randomly selected the week of January 26, 2004, and core service agencies were provided the lists of children targeted for inclusion in the review activities on January 29, 2004. Core service agencies were initially asked to complete a basic one-page survey for selected consumers in order to verify the child's age, list the providers working with that child, and provide some indication of the child's level of need. Core service agencies also indicated if the child was unknown to the agency, had been previously discharged from services, or had never been enrolled for services. Some form of response was provided for 161 out of the 162 initial triple sample. The following is a breakdown of the 162 randomly selected names:

- Fifty-eight out of the 162 (38%) were active cases.

Of the 104 that were not receiving services at the time of selection:

- Thirty-five were unknown to the core service agency or never received any services.
- Sixty-nine were not active as of the time the cases were selected in January 2004.

Due to the fact that the target sample for the review was 54 children, each of the 58 children noted to be an active case at the time of selection became a possible candidate for inclusion in the review. However, due to both the Center for Mental Health (CMH) and the Public Core Service Agency having the greatest proportion of either non-active or unknown cases and, subsequently, exhausting all candidates from the initial triple sample from each, 18 additional children (nine from the Public Core and nine from CMH) were selected. From that list of 18, there were three included in the review. Similarly, although the intent was to define currently receiving services as of three months prior to the date of selection, this was expanded to six months, resulting in another six children becoming eligible to be included. Of these six, one was included in the review. It is important to note that adding additional names to the sample and expanding the definition of active (or recently active) cases was done in order to increase the number of possible participants so that the stratified sampling frame could be met.

(2) Inconsistent understanding of current discharge policies: Stakeholders suggested during the review activities that children may continue to be listed on the ECURA system as active cases, although the provider agency is not actively providing services to that child. This was attributed to ambiguity regarding current discharge policies, in that, there was lack of clarity regarding the timeframes when providers must list a child as active when they are no longer receiving services. It was also suggested that children and families may be referred to a core service agency after contacting the Access Help-Line, but either a family no longer wanting to receive services or limited follow-up by a provider agency results in children not being actively served, even though the child was enrolled on the ECURA system by the Access Help-Line.

(3) Inconsistent application of a basic case management model: Some providers do not appear to be consistently engaging children and families in their own homes and schools. Rather, services may be offered in more of a "drop-in" clinic setting. As it related to review preparation, in some instances, case management staff may not have been routinely engaged with children on their caseload, and despite the case being listed as open and active on the caseload information systems, providers were not, in fact, providing any direct services to the child and family. An additional effect was that in some cases, case management staff was unaware of other formal service providers working with the child and family. This also caused some difficulty in ensuring that all relevant persons were included in the list of interview participants for the case review. Similarly, in several instances with more than one provider, case management staff did not identify their personal professional role in the child and family's life as a case manager or service coordinator, rather, their professional role was defined as the child's therapist or counselor. As such, basic case management services may not have, in fact, been provided for several children and families when such services might have been deemed necessary.

Description of the Children and Youth in the Sample

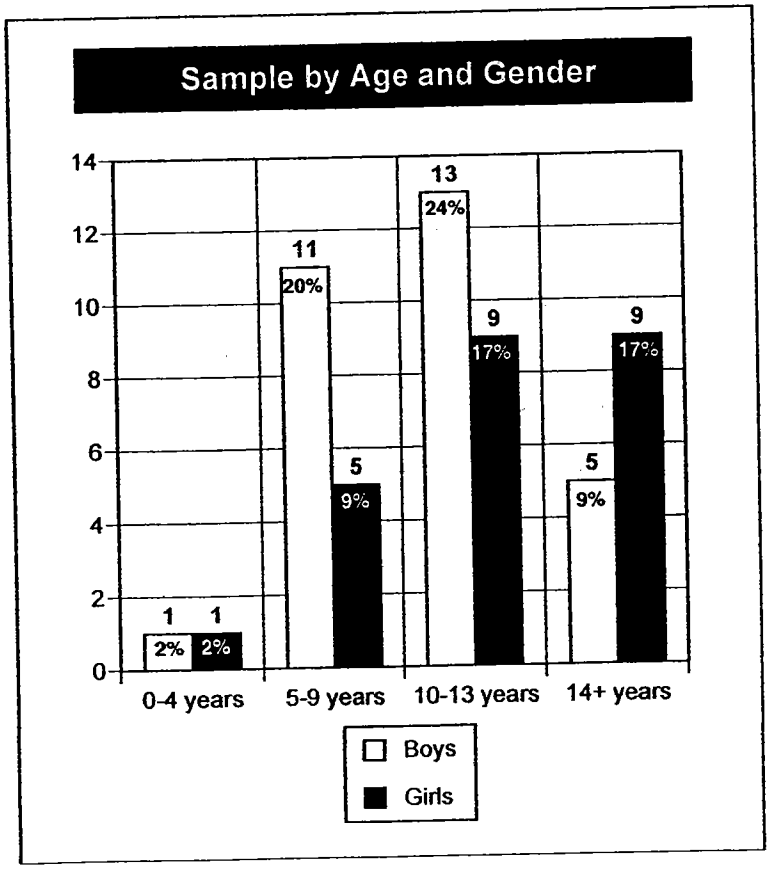
A total of 54 case reviews were completed during March 2004. These case reviews were completed over a three-week timeframe with half of the reviews completed by external reviewers

and half completed by Department of Mental Health staff trained to standard by HSO. Presented in this section are displays that detail the characteristics of the children and youth in the second-year 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 5** presents the sample of 54 children and youth distributed by age and gender. As shown in this display, boys comprised 55% of the sample while girls comprised 45%. It is not uncommon for more boys to be receiving services from a System of Care within the active population. The sample had two children age four and younger and another 16 in the 5-9-year age range. Children under age ten comprised 33% of the sample, and this is comparable to the percentage of children age ten or younger receiving services (28%).

Display 5

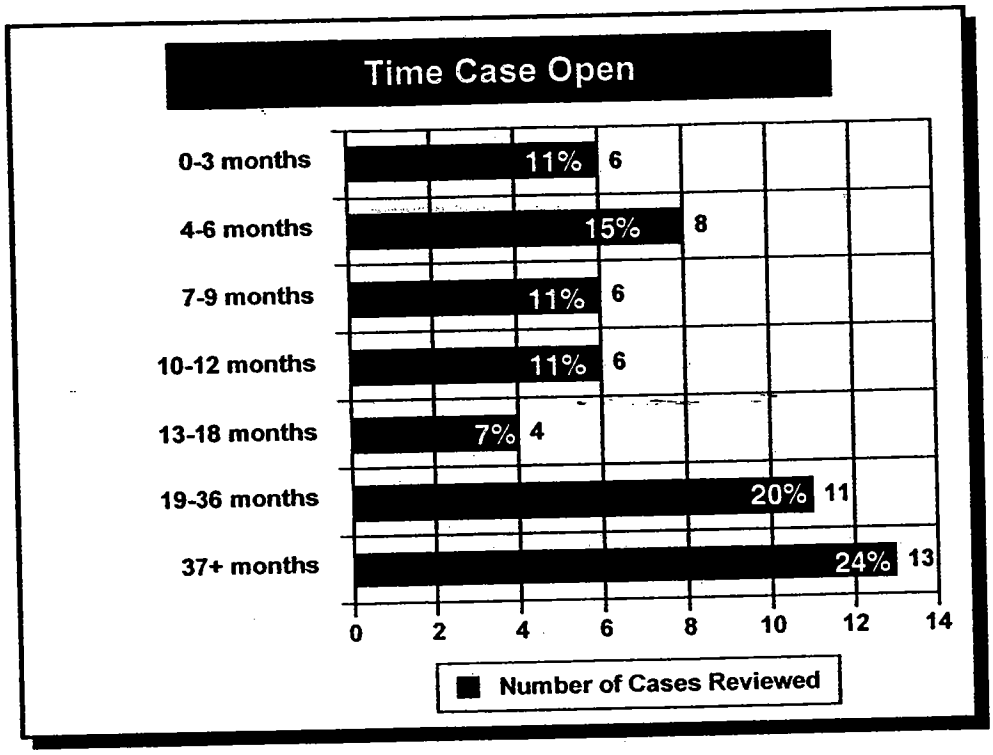


Twenty-two children (41%) ages 10-13 were included in the sample. This is somewhat greater than the total proportion of children ages 10-13 receiving mental health services (34%). Fourteen teenagers (26%) were included in the review. This is somewhat less than the total proportion of teenagers enrolled for services (38%). The lower number of teenagers in the sample is attributed to children ages 14 and older having a lesser likelihood of actively receiving services, despite their case status being listed as active on data management systems.

Length of Mental Health Services

All but one child in the review sample were receiving, or had received, services within three months of the time of review. The one additional child had received services within the previous six months. **Display 6** presents 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, 48% of the sample had cases open for 12 months or less, 27% were open for 13 to 36 months, and 24% were open for more than three years. In comparison to last year's baseline results, this year's sample had been receiving services for a more extended period of time. For example, in last year's review, there were 51% of children receiving services for less than 12 months, 40% receiving services for 13-36 months, and 6% receiving services for greater than 36 months.

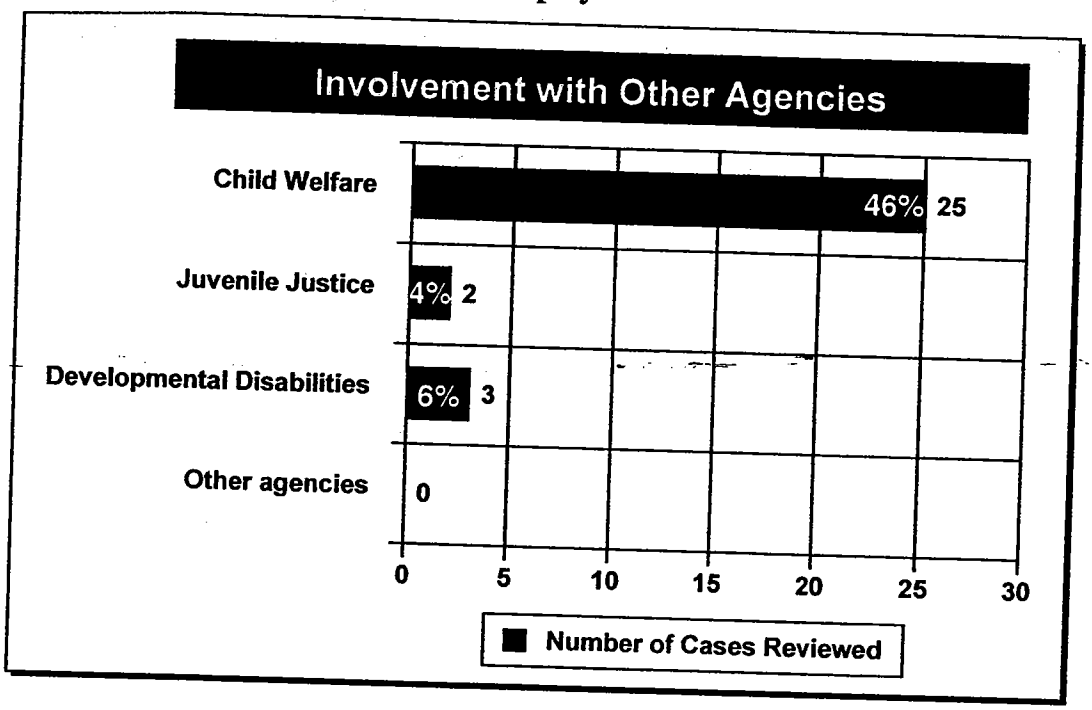
Display 6



Services by Other Agencies

Some children and youth in the review sample were also receiving services from other major agencies. **Display 7** presents the number who were identified as being served by other key agencies: child welfare, juvenile justice, and developmental disabilities. As the display indicates almost one half (46%) of the review sample of children and youth were involved with the child welfare system. This is considerably greater than the 23% receiving services from child welfare in last year's review. Only two children (4%) were noted as being involved with the juvenile justice system and three children (6%) were receiving services from developmental disabilities It is highly likely that more children in the review may, in fact, could have qualified for developmental disabilities services based on individual case review findings.

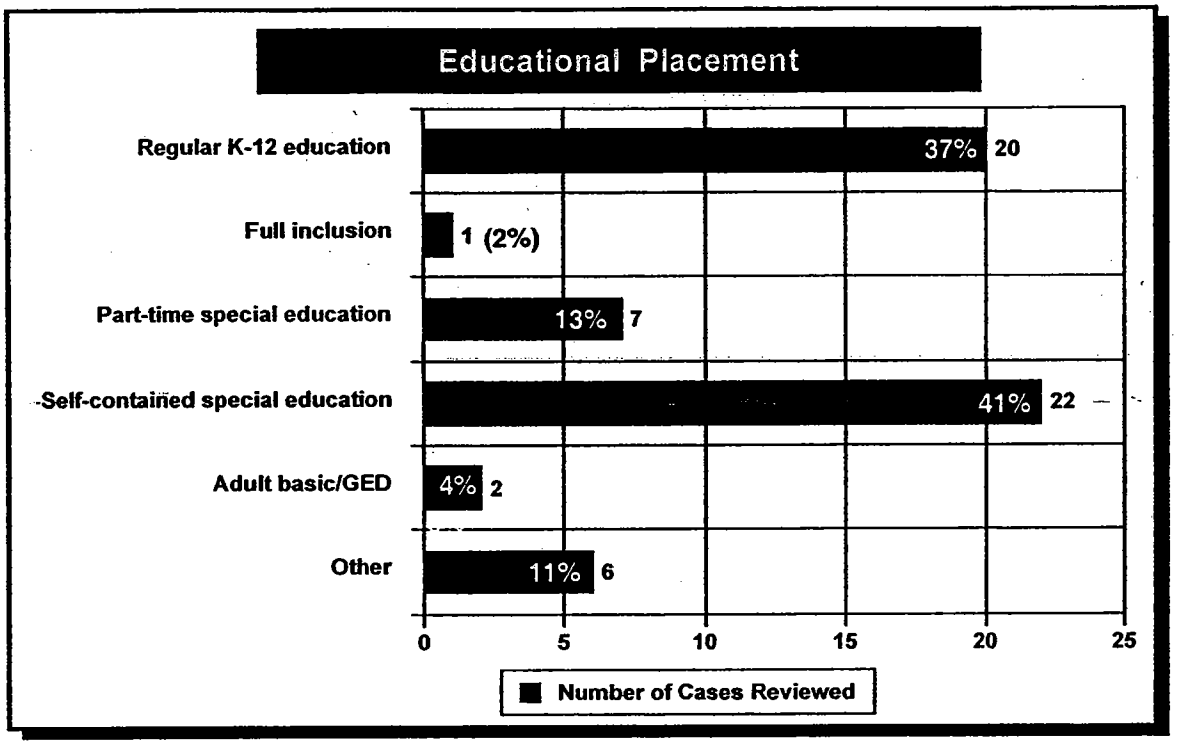
Display 7



Educational Program Placement

Getting an education and preparing for employment are major societal expectations for children and youth. **Display 8** describes the educational status/placement for the children and youth in the review sample. Less than one half (37%) were found to be participants in a regular K-12 educational program. Slightly more than half (54%) were receiving educational services from a special education program, with 2% receiving educational services in a fully self-contained program. Two teenagers were receiving adult educational/GED services, while the remaining six children classified as "other" includes children who had dropped out or were not attending school (2), were receiving homebound school services (2), were in Head Start (1), or were in college (1).

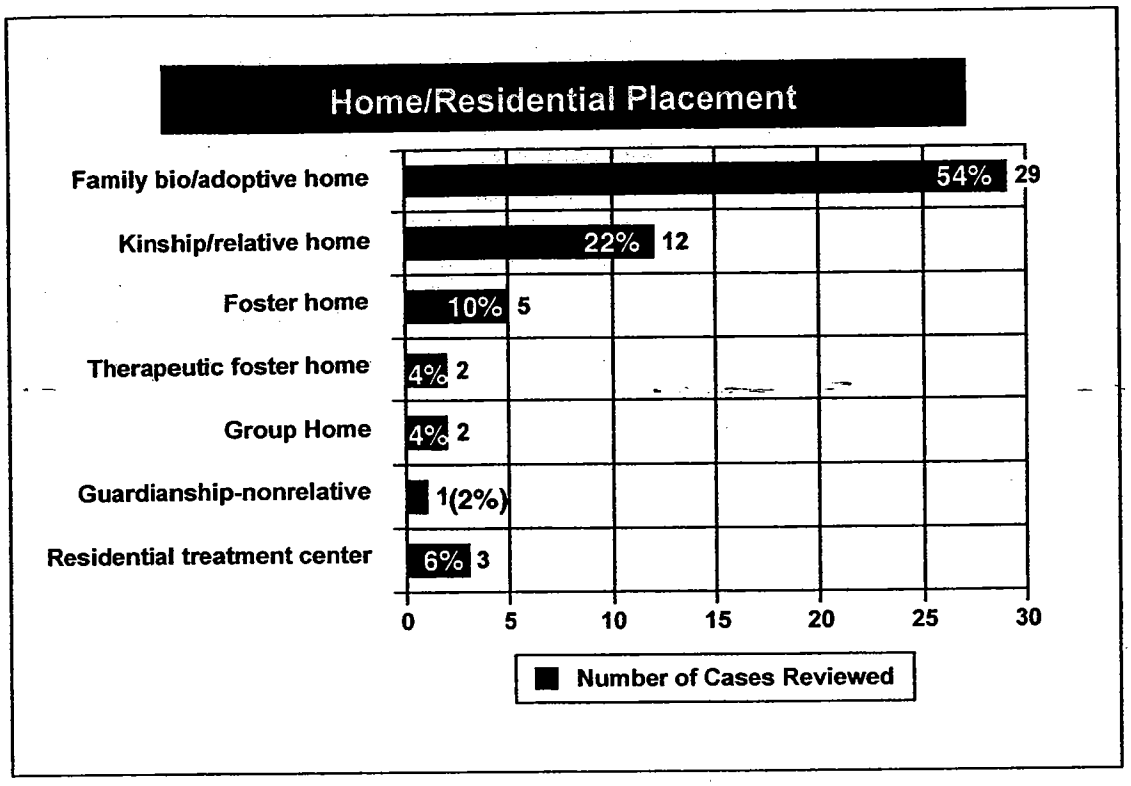
Display 8



Living Setting

Children and youth in the review sample were found to be living in six different home settings. **Display 9** shows the distribution of sample members according to their residences at the time of the review. Approximately half (54%) of sample members were living in their family homes while approximately one-fourth (22%) were living with relatives. Seven (14%) were living in foster homes or therapeutic foster homes and five children (10%) were residing in congregate settings (group homes and RTCs), however, it should be noted that three children were purposively selected from an area RTC to be included in the review. One child (2%) was residing with a non-relative (family setting).

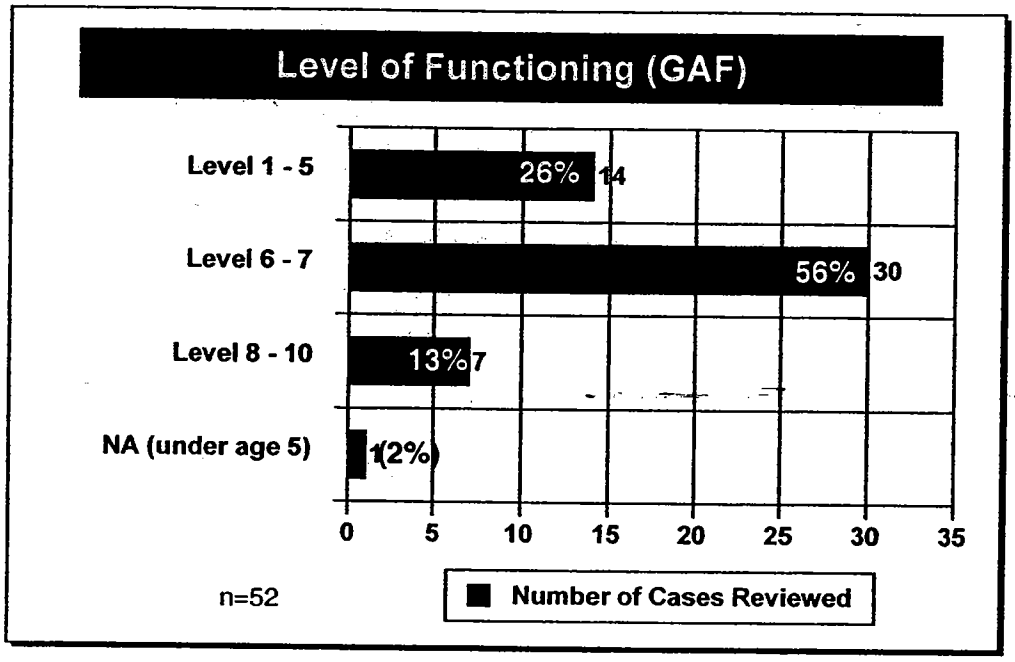
Display 9



Functional Status

The functional status of children and youth in the review sample was assessed on a 10-point scale adapted from the GAF Scale (DSM-IV, Axis V). 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 10



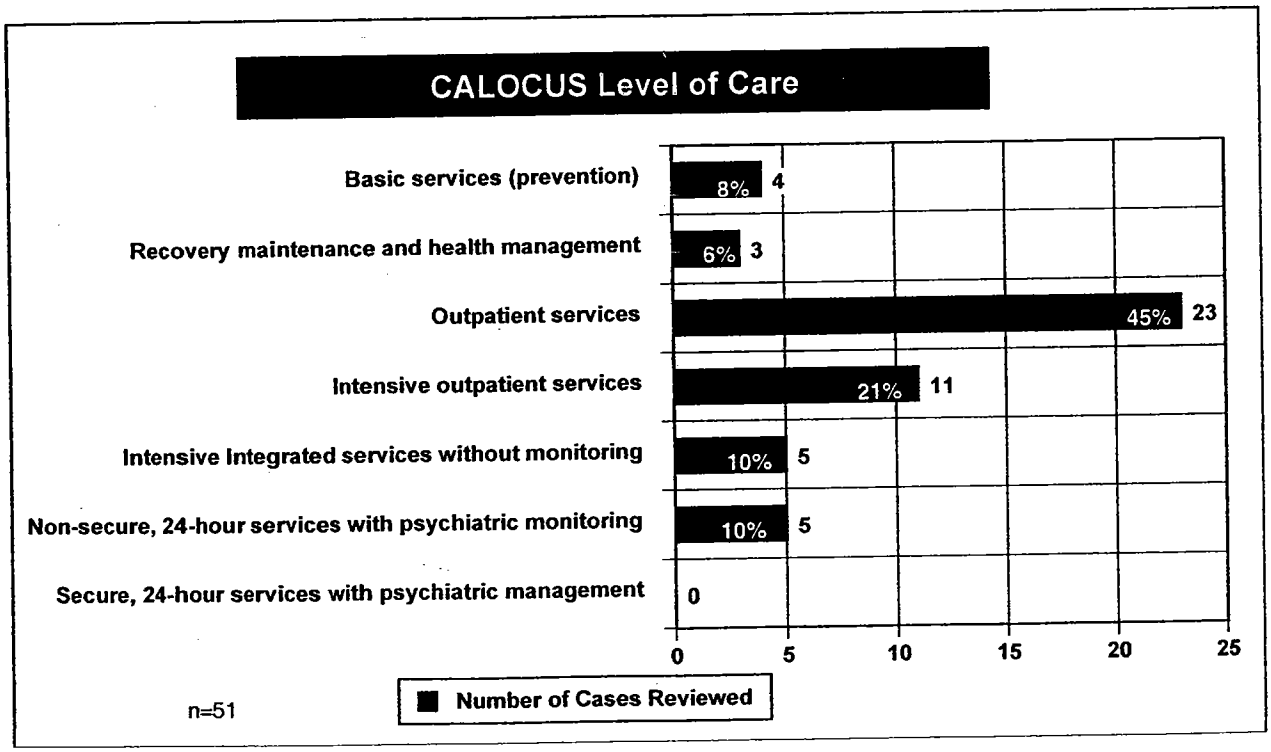
Display 10 provides the distribution of the review sample across functioning levels for the 52 children and youth age five and older. Twenty-six percent of the review sample had GAF scores in the 1-5 range, indicating these children are seriously emotionally disturbed. The majority of children reviewed (56%) had GAF scores in the 6-7 range, indicating they have impairment in one or more areas. There were seven children (13%) with GAF scores in the 8-10 range, indicating only minor functional impairment for these children. In comparison to the year-one results, in which 31% of the sample were in the level 8-10 range, there were considerably fewer children in the higher functioning range. Stakeholders reported that the level of functioning ranges captured in the second-year results are more indicative of the typical child consumers receiving services from the core service agencies. Last, 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 or children ages ten or younger.

Level of Care

The Child and Adolescent Level of Care System (CALOCUS) scale was used to identify the level of mental health care the child should be receiving according to evaluative criteria in the

CALOCUS decision matrix. This scale provides seven different levels of care ranging from basic or preventive-level services to secure, 24-hour care with psychiatric management. There were only a limited number of instances in which the child's actual level of care being received did not match the actual level of care being provided, and in instances in which it did, the level of provided care could have been increased. **Display 11** presents the distribution of children according to their level of care. Four children (8%) were receiving basic/preventive services and three children (6%) were receiving recovery maintenance and health management services. Twenty-three (45%) were receiving outpatient services and 11 (21%) were receiving intensive outpatient services. Five children (10%) were receiving intensive, integrated services without psychiatric monitoring while five children were receiving intensive, integrated services with psychiatric monitoring. Five children (10%) included in the review were considered to be needing 24-hour psychiatric monitoring, despite only three children actually residing in RTCs at the time of the review.

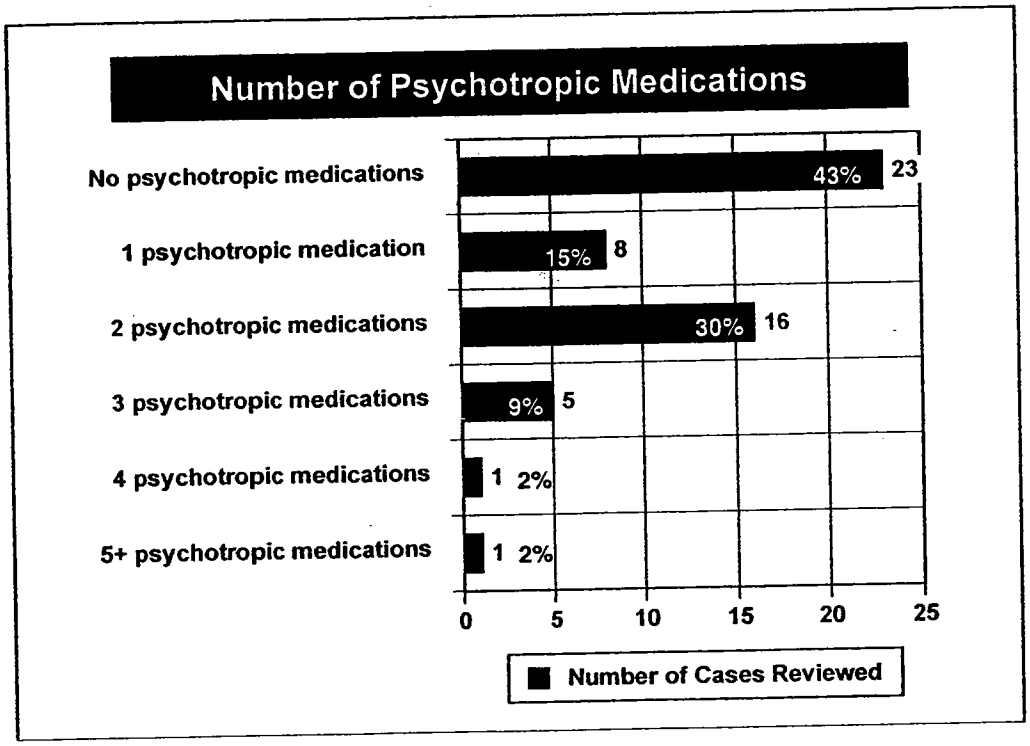
Display 11



Medications

The number of psychotropic medications taken by children and youth in the review sample were counted and reported by reviewers. **Display 12** presents the frequency count on medications taken by sample members. It is noteworthy that 43% of the children and youth in the sample were not prescribed psychotropic medications at the time of the review, and if children were receiving psychotropics, they were likely to be taking only one or two different medications. Findings from the individual child reviews suggested that medication management practices continue to be safe and appropriate, as it was often highlighted as one of the strengths in practice. This review finding is consistent with findings from the first-year review.

Display 12

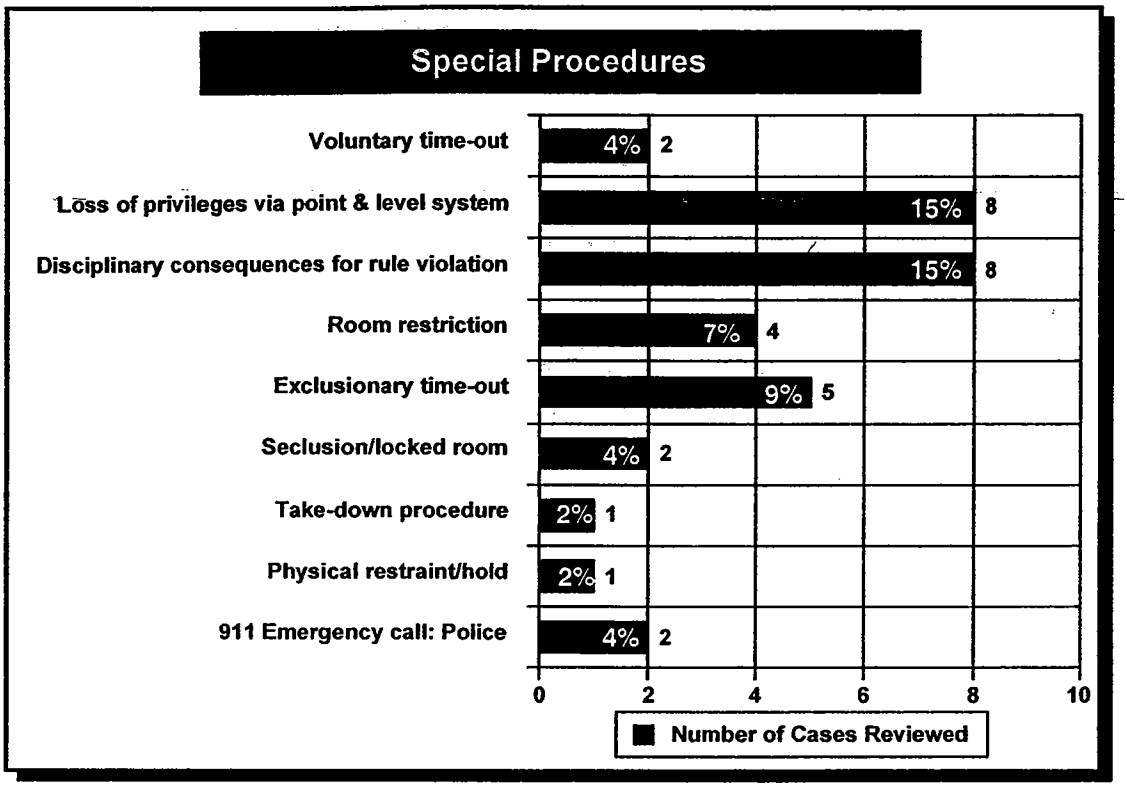


Special Procedures

Special procedures are used in extreme situations to prevent harm but are not a form of therap or treatment. **Display 13** shows the number of sample members who had one of nine types c special procedures used within the 30-day period preceding the review. It should be noted that

majority of these special procedures can be attributed to a relatively small number of children, who would often have more than one special procedure used in order to prevent harm.

Display 13



Quantitative Case Review Findings

Overview of the Case Review Process

Case reviews were conducted for 54 children and youth during the week of March 2004 using the *Community Services Review (CSR) Protocol*, 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 three major domains. The first domain pertains to questions concerning the current status of the child (e.g., safety or academic status). The second

domain pertains to recently experienced progress or changes made (e.g., symptom reduction), as they may relate toward achieving treatment goals. The third domain contained questions that focus on the performance of practice functions (e.g., engagement, teamwork, or assessment) for provided services in a recovery-oriented System of Care practice model. For each question deemed applicable in a case, the finding was rated on a 6-point scale, with a rating of 5 or 6 in the "maintenance" zone, meaning the current status or performance is at a high level and should be maintained; a rating of 3 or 4 in the "refinement" zone, meaning the status is at a more cautionary level; and a rating of 1 or 2 in the "improvement" zone, meaning the status or performance needs immediate improvement. Oftentimes, this three-tiered rating system is described as having case review findings in the "red, yellow, or green zone." A second interpretive framework can be applied to this 6-point rating scale, in that, ratings of 1-3 are considered "unacceptable" and ratings of 4-6 are considered "acceptable." A more detailed description of each level in the 6-point rating scale can be located in **Appendix B**. It should be noted that the protocol provides item-appropriate details for rating each of the individual status and progress performance indicators also. Both the three-tiered action zone and the acceptable vs. unacceptable interpretive frameworks will be used for the following presentations of aggregate data.

Interviews

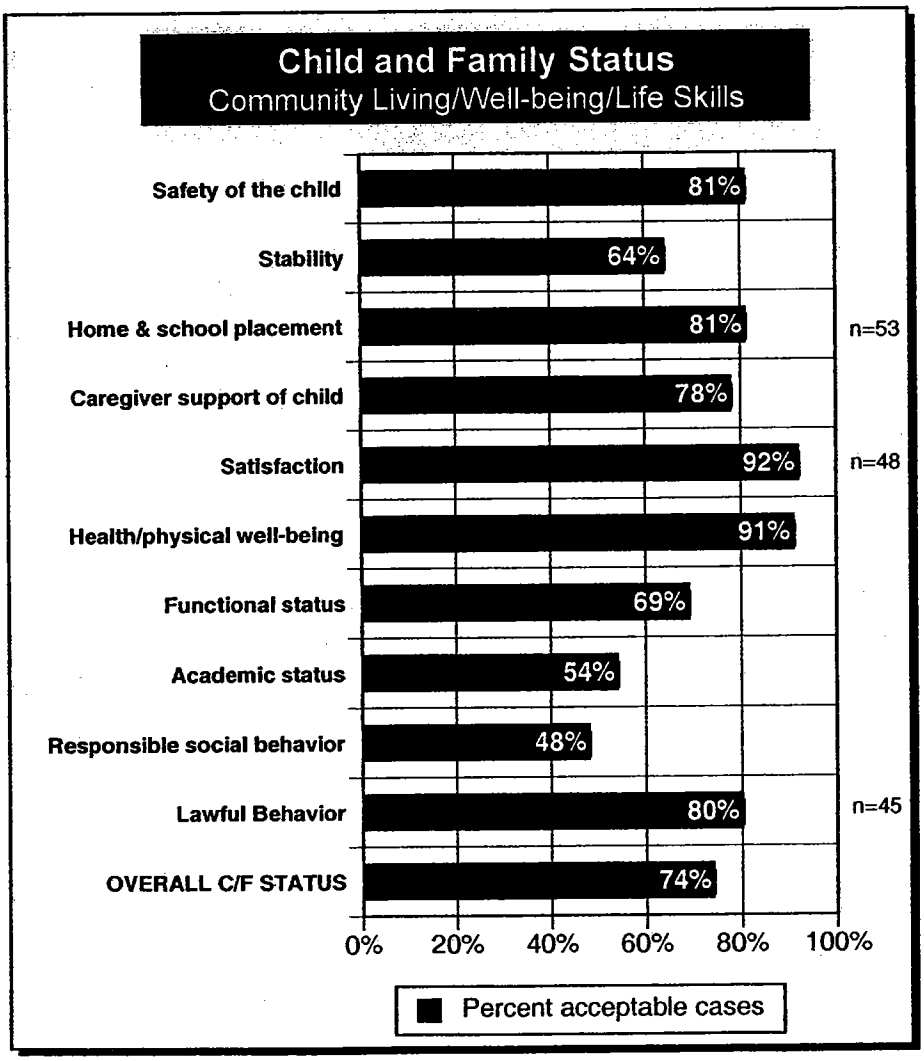
Review activities in each case included a review of plans and records as well as interviews with the child, caregiver, and others involved in providing services and supports. A total of 328 persons were interviewed for these 54 children and youth. The number of interviews ranged from a low of two persons in one case to a high of 13 persons in another case, with an average of six per case.

Child Status Results

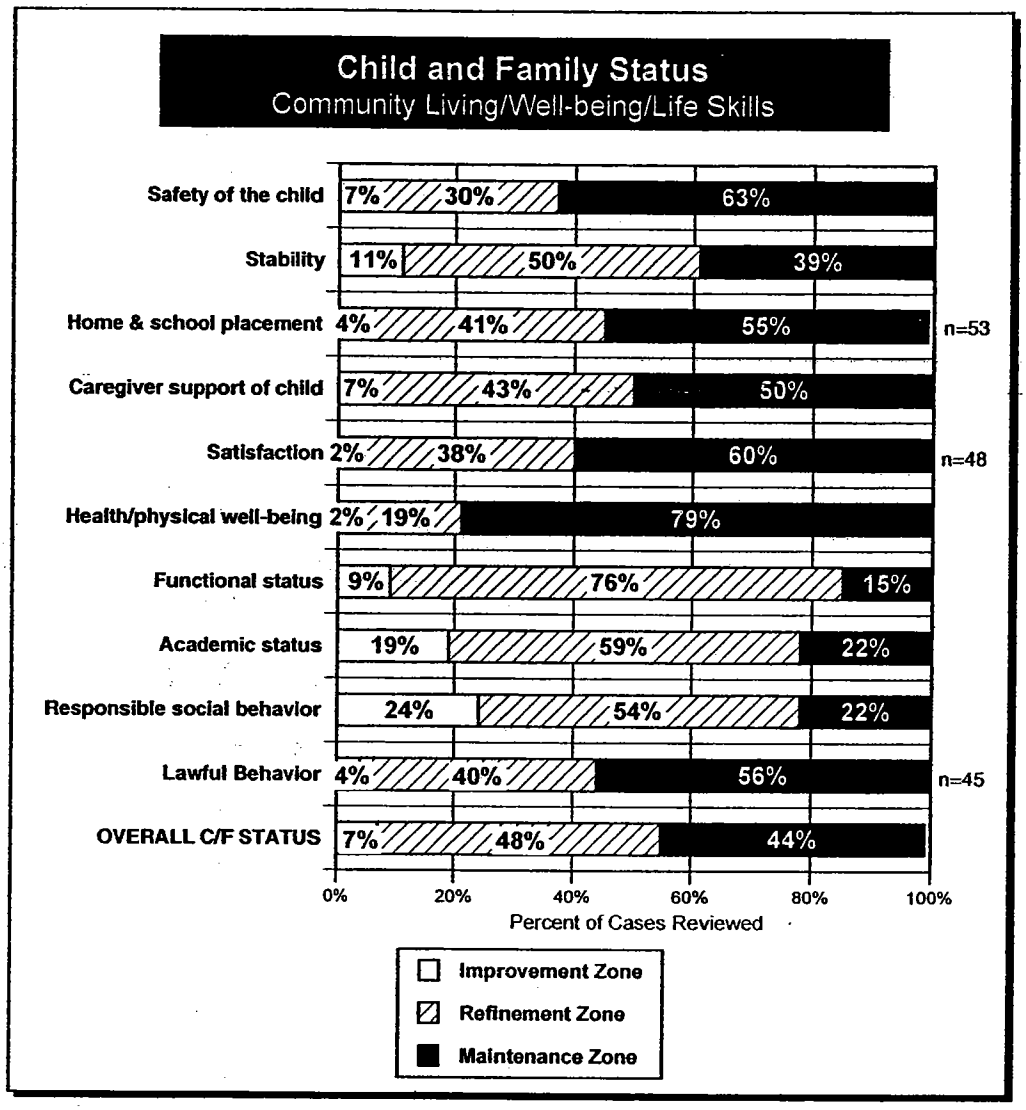
Ten indicators related to the current status of the child or youth were contained in the CSR protocol used by reviewers. Readers are directed to **Appendix A** for a detailed description of these ten areas examined by the reviewers. The next two displays present findings for each of the

ten indicators. **Display 14** uses a "percent acceptable" format to report the proportion of the sample members for whom the item was determined applicable and acceptable. **Display 15** uses the "action zone" framework that divides the 6-point rating scale into three segments corresponding to the maintenance, refinement, and improvement zones. Findings on both displays are presented concurrently below. While these two different displays are useful in presenting findings to different audiences, it should be remembered that both displays are derived from the same database of findings.

Display 14



Display 15



Safety. Sample members were generally safe from imminent risk of physical harm in their daily environment. Approximately 81% were rated as having overall acceptable physical safety at the time of the review and approximately two-thirds (63%) of the children have their safety status in the maintenance zone. However, it is important to note that ten children were considered to have an unacceptable safety status at the time of the review, and of those ten children, four had safety ratings in the area needing immediate improvement. Circumstances of these four children included: (1) a five-year-old child who is described as very aggressive, a risk to herself and her peers due to fighting, sexually acting out, as well as having the mother's new paramour recently move into the home. Although the Child and Family Services Administration (CFSA) had

investigated these circumstances during the previous year, the case is reportedly closed for services at this time; (2) a 13-year-old female who had run away for the second time within six weeks and whose whereabouts were unknown at the time of the review. The police had been notified and the mother was referred to the PINS program; (3) a ten-year-old male who is described as at risk of harming himself and others as he engages in aggressive behaviors on a daily basis, which has resulted in daily removal from the classroom and is reported to be escalating with the recent placement change in his foster care status. He also attempted to run away from his placement home within the past week and broke the front door in so doing; (4) a teenage male described as seriously emotionally disturbed living with biological family members and no longer participating in a standard educational curriculum due to ongoing behavioral problems. Last, findings for child safety were somewhat consistent with the first-year review, in that, there were a slightly smaller percentage of children considered to have overall acceptable status in 2004 versus 2003 (89% in 2003 vs. 81% in 2004).

Stability. Findings for stability were somewhat less favorable for the children included in the sample. It is important to note that review findings for stability take into account both the home and school setting. Approximately two-thirds (64%) of the sample were considered to have overall acceptable levels of stability at the time of the review, however, there were only 39% of children considered to have stability ratings in the maintenance zone. There were examples of disruption of both home and school placement due to the emotional and behavioral needs of the children included in the review sample. Half of the children included in the review had stability ratings in the refinement zone, suggesting that each of these children had experienced an unplanned move in either a classroom or home setting during the previous calendar year. Six children (11%) had overall stability needing immediate improvement, suggesting that placement changes had occurred in the recent past and that at the time of the review, additional disruptions were imminent.

Placement Appropriateness. A majority of sample members were being served in the least restrictive, most appropriate placements (including school) with 81% rated acceptable or better and 55% of those considered to be in the maintenance zone. Two children (4%) had current placements considered to need immediate improvement. In the second-year review sample, there

were only five children currently residing in non-family-like congregate settings, with three in an RTC and two residing in group homes. This includes the three children included in the review based on a selection criteria of residing in a mental health treatment setting. All other children were residing in less restrictive environments, by living with biological family members, other relatives, or foster homes.

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 for children and youth in the sample was found to be acceptable in 78% of the cases reviewed, and of those children, 50% were considered to be in the maintenance zone. Four children (7%) were found to be in the improvement zone, indicating that current caregivers were not able to consistently meet the day-to-day needs of the children, and 43% of the children in the review had support provided by their caregivers needing some refinement. In comparison to the first-year review, findings were generally consistent, in that, 53% of children were in the maintenance zone and 12% of children were in the improvement zone. In the four instances in which caregiver support was found to be needing immediate improvement, circumstances were due to: (1) a 15-year-old female described as oppositional defiant and mildly mentally retarded, who is residing with her biological mother and five siblings. The family has a history of homelessness, and the mother reportedly cannot keep her daughter's behavior under control. Other siblings are reported to be gang-involved; (2) a seriously emotionally disturbed adolescent male who also has other specific learning disabilities living with relatives; (3) a seriously emotionally disturbed teenage male living with biological family members and no longer participating in an educational curriculum (the previously described child in the safety ratings section); (4) a three-year-old female whose mother is reported as having post-traumatic stress disorder (PTSD) and major depression who had abandoned the family at the time of review. The child was residing with her two siblings and her father, who is also cognitively limited, and the family had been moving in and out of various family members' homes.

Satisfaction. In general, children and families were satisfied with the services that they were receiving. Nearly all (92%) included in the sample reported having acceptable levels of satisfaction with the services. Similarly, 60% of children and families indicated current levels of

satisfaction were in the maintenance zone, and only one child and family (2%) indicated services were as such that satisfaction needed immediate improvement. This finding is significant, in that, overall system performance was rated acceptable in 43% of the cases. As such, despite a majority of consumers being provided services that were not at least minimally acceptable, an overwhelming majority of those in the review report having a high degree of satisfaction.

Health/Physical Well-Being. Children included in the review were consistently having their physical needs met and were considered to be healthy. Reviewers found that 91% of sample members were acceptable in this area. Some 79% of the children and youth were rated in the maintenance zone, 19% were found in the refinement zone, and 2% were found in the improvement zone. These findings are similar to the first-year review findings.

Functional Status. Similar to the first-year review findings, the emotional/behavioral functioning status of sample members had considerable variability among those reviewed. Approximately two-thirds (69%) had acceptable functional status, however, the majority of these children were considered to be minimally acceptable. Eight children (15%) included in the review had emotional/behavioral status in the maintenance zone, whereas, the majority (76%) of children had functional status needing refinement. Five children (9%) had highly problematic emotional and behavioral problems currently adversely affecting their life situation, resulting in ratings of needing immediate improvement. The circumstances of these five children included: (1) a behaviorally acting out SED teenage male; (2) a fourth-grade attention deficit hyperactivity disorder (ADHD) and disruptive behavior disorder female described with currently escalating behavioral problems and in need of special educational interventions; (3) a mildly mentally retarded 15-year-old female diagnosed as having oppositional defiant disorder and a mood disorder, not otherwise specified, who is refusing to participate in a medication evaluation and is described as having escalating behavioral problems, frequently running away, and having difficulties with anger management; (4) a ten-year-old male with ADHD and a previous diagnosis of PTSD due to physical abuse who is currently described as having anger problems, low frustration tolerance, hyperactivity, and anxiety resulting in violent and aggressive behaviors; (5) a five-year-old ADHD child described as having frequent anger and behavioral outbursts as well as sexually acting-out behaviors.

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. Similar to first-year review findings, slightly more than half (54% in 2004 vs. 57% in 2003) were considered to have acceptable academic status. For the children included in this year's review, 22% were rated in the maintenance zone, indicating that they were doing substantially well in their education. However, 59% of children had academic status needing some refinement and 19% were in the improvement zone. Those children in the improvement zone were not making appropriate progress in their educational curriculum, in that, they were behind in grade level, had experienced suspension or expulsion, or had behavioral or emotional difficulties impeding active participation in an education. Interesting trends in the review findings included children ages 14 or older and ages ten or younger experiencing the most academic difficulty, with greater than half of the children in both age ranges having unacceptable academic status. In contrast, children ages 10-13 had a higher likelihood of experiencing academic success.

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. In comparison to first-year review findings, there was a notable decrease in the number of children having acceptable responsible behavior ratings (66% in 2003 vs. 48% in 2004). Furthermore, responsible behavior had the least number of children rated acceptable than any of the other child status indicators. Of the children less than ten years of age, 39% were rated acceptable, while 59% were rated acceptable in age ranges 10-13, and 43% were rated acceptable if 14 years or older. Of the 54 children included in the sample, 24% were rated needing immediate improvement, 54% were rated needing refinement, and 22% were rated in the maintenance zone. Externalizing behavioral conditions, such as behavioral outbursts, oppositional behaviors, and anger management difficulties, were the most prevalent factors noted in children and youth included in the sample considered to have unacceptable ratings. These

externalizing behavioral conditions were noted to be occurring in both the home and school settings.

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 re-offending, while developing appropriate friendship and activity patterns. It should be noted that the lawful behavior indicator applied to a smaller proportion of the general sample (n=45) due to children five years in age or less being excluded from this indicator. Of those children and youth included in the review, approximately 80% of sample members presented at least minimally acceptable lawful behavior. More than half (56%) were rated in the maintenance zone. The most prevalent unlawful behaviors noted in the review included truancy and skipping school, fighting or other inappropriate aggressive behaviors, and running away from home. Case reviews noted several children who were believed to be affiliated or socializing with known area gang members, several children who had received disciplinary action for stealing, and at least two children actively involved with the juvenile probation system.

Overall Child Status. The protocol provides a scoring rubric for combining rating values across the items deemed applicable to the child or youth being reviewed to produce an "overall child status rating." Applying this rubric resulted in the determination of approximately three-quarters (74%) of the children and youth reviewed having acceptable ratings (rating levels 4, 5, and 6), overall, in the status domain. These findings are comparable with the 77% rated as acceptable in the first-year review. Similarly, some 44% of the children and youth reviewed were rated in the maintenance zone, another 48% in the refinement zone, and 7% in the improvement zone. These findings are also similar to the first-year review. Although a considerable number of children received acceptable overall child status ratings, it is important to note that due to the protocol assessing children holistically across life domains, children and youth were often rated acceptable if they were safe, were relatively stable, were in appropriate home and school placements, and had adequate caregiver support. However, in the individual indicators that relate to the domains that mental health, special education, and other formal providers typically address, such as functional (emotional) status, academic status, and responsible behavior, case review findings had the most variability.

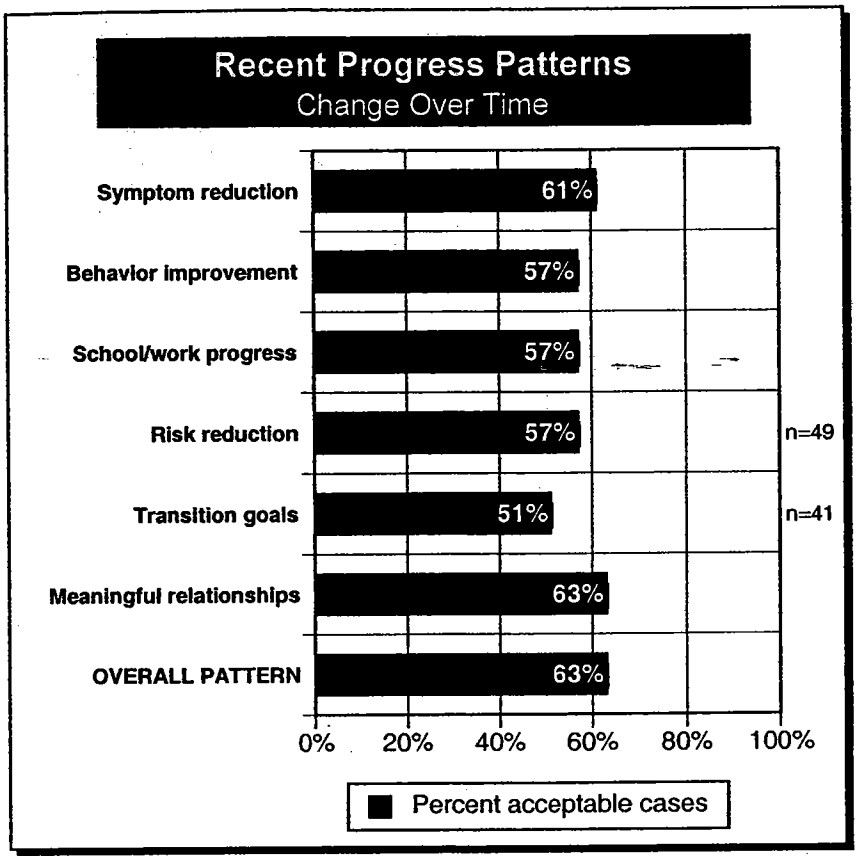
Two themes noted in the individual case findings in which progress was determined to be minimally adequate included: (1) one caregiver, such as a parent, foster parent, teacher, or mental health practitioner, routinely advocating for the child or youth's needs and working more diligently than other service team members (if a team were operating) to ensure needs were being met; (2) the child or youth demonstrating personal resiliency and overcoming life circumstances even though there are weaknesses or gaps in some components of system performance.

Recent Progress Patterns Showing Change Over Time

The CSR protocol provided six indicators that enabled reviewers to examine recent progress on specific areas of treatment focus that was noted for the sample members during the review. The timeframe for noting recent progress was within the last six months or since formal admission to mental health services. Descriptions of these six indicators can be found in **Appendix A. Displays 16 and 17** present the findings for the progress indicators for the review sample. It should be noted that indicators were deemed not applicable in a number of cases. In these instances, the applicable sample size is noted on the display. Progress findings on both displays are summarized concurrently as follows.

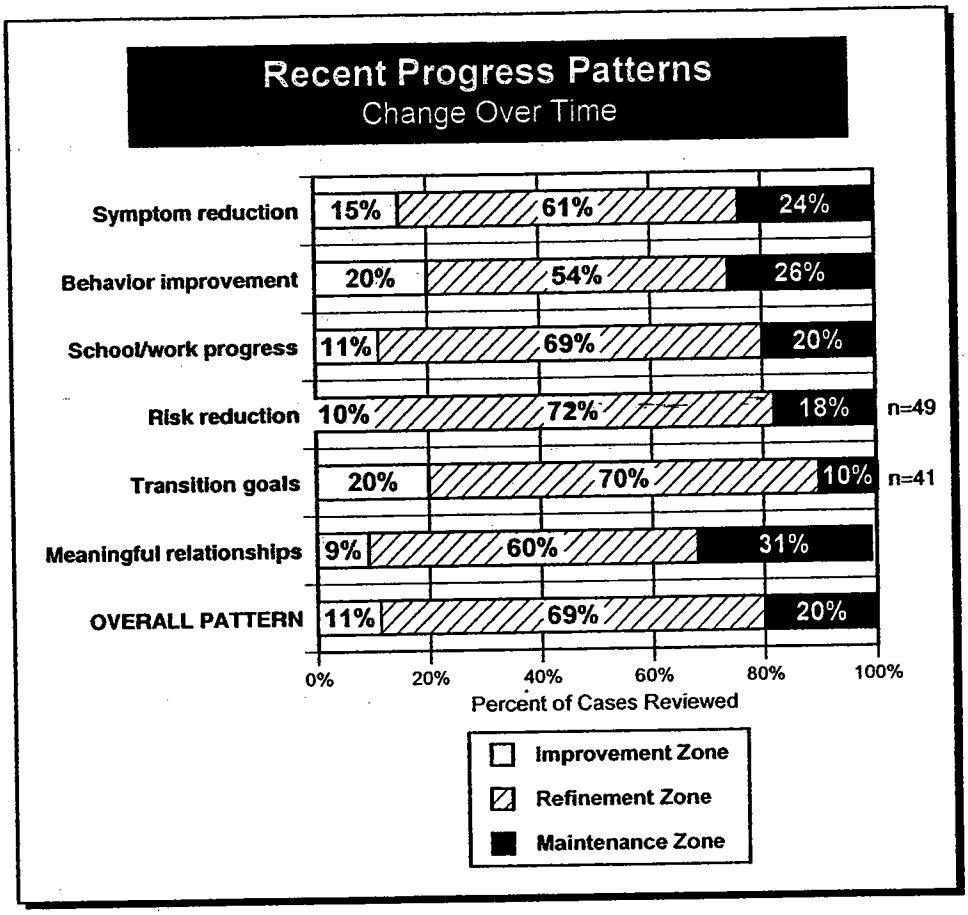
Symptom Reduction. Reducing symptoms of mental illness is usually a goal of treatment for children and youth receiving mental health services. Recent progress in symptom reduction was found to be at least minimally adequate in approximately two-thirds (61%) of the children and youth included in the sample. This is comparable to first-year results, in which 66% of the sample members were considered to be making adequate recent progress in symptom reduction. Despite the majority of cases having minimally acceptable symptom reduction, only 24% of the sample were considered in the maintenance zone and 61% of children and youth were in the refinement zone.

Display 16



Behavior Improvement. As symptoms diminish, daily functioning should improve. Specific behaviors associated with daily functioning are often targeted for improvement in the treatment process. Reviewers found that 57% of the sample members were making at least minimally acceptable behavioral improvement. This figure is somewhat lower than first-year review findings in which 71% of children and youth sampled were demonstrating behavioral improvements. Similar to findings for the other progress indicators, if a child or youth were showing progress, it was most likely considered to be minimally adequate, as 26% of the sample were considered to be in the maintenance zone and 54% in the refinement zone.

Display 17



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. Of those children and youth included in the sample, 57% were found to be making at least minimally acceptable school/work progress. However, this finding also suggests that the remaining 43% were at risk for not completing their current academic year and being promoted to the next grade level. Reviewers were able to obtain current reading levels for 39 of the children in the sample. Of those 39, 21 were reading below grade level, 15 were reading at grade level, and three were reading above grade level. If a child were reading below grade level, they were most likely reading between 1-3 full academic years behind their assigned grade. Of the 21 children reading below grade level, all but three were receiving special education services, with four classified as having mental retardation and 11 classified as having specific learning disabilities. Of those children reading on or above grade level, six were receiving special education services, with two classified as having a specific learning disability. These findings

alone have significant practice implications, in that, there is a strong probability that children and youth being provided mental health services are receiving specialized educational services and that these children are not adequately progressing in their educational curriculum.

It should be noted also that these findings are generally consistent with the first-year review findings for school progress in which less than a third (20% in 2004 vs. 30% in 2003) of the sample members were rated in the maintenance zone. Similarly, in the refinement zone, there were 69% in 2004 vs. 45% in 2003, and in the improvement zone, there were 11% in 2004 and 24% in 2003.

Progress in Risk Reduction. Forty-nine of the 54 children included in the review had identified risks that suggested increased likelihood of harm, hardship, or poor down-stream life outcomes. Generally, children omitted from this indicator were younger aged or had demonstrated significant previous improvement and had already achieved treatment goals. For those children in which risks can still be identified, 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 57% of the 49 sample members for whom this indicator was deemed applicable. Of the sample, 18% were found to have progress in risk reduction to be in the maintenance zone, 72% were rated as being in the refinement zone, and another 10% were in the improvement zone. The 10% of children in the improvement zone related to five children, in which three were also considered to have currently unacceptable safety levels. These included aforementioned behaviorally acting-out youths who, due to violent outbursts, were considered at continued risk, as well as an adolescent female runaway. One noteworthy case included a child recently returned to school following a ten-day suspension due to getting into a fight. This child had missed over 30 days during the school year as a result of placement instability, which included he and his mother recently being placed in a secret shelter due to a dispute with an extended family member that involved a gun after the child was accused of sexually molesting a younger cousin. At the time of the review, the mother and child had recently returned home due to eligibility for the secret shelter placement expiring, although the alleged perpetrator is still at large.

Progress toward Transitions Goals. Transitions may pose significant service coordination and life adjustment problems for children and youth with emotional/behavioral challenges and their caregivers. Transitions were identified for 41 of the 54 children and youth in the sample. These transitions included school and placement changes due to CFSA involvement, placement changes within a school setting, transition of key service team members, or considerable changes in treatment approach. Review findings reveal that progress toward smooth and successful transitions was determined to be at least minimally adequate for 51% of the sample members. Transition progress was rated in the maintenance zone for 10%, in the refinement zone for 70%, and in the improvement zone for 20%. These findings are somewhat lower than first-year review findings in which transition progress was rated 30%, 43%, and 27% across each rating zone, respectively.

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. Of the children and youth reviewed, 63% were found to be making adequate progress in forming and maintaining meaningful relationships. Of those children making adequate progress, 31% were in the maintenance zone. An additional 60% of sample members were in the refinement zone and 9% were in the improvement zone.

Overall Progress Pattern. Reviewers determined an overall progress pattern for each sample member based on two factors. First, the indicators deemed applicable for each sample member, and second, a general pattern of progress across each of the applicable indicators. Based on this process, the overall progress patterns for sample members were determined to be at least minimally acceptable in 63% of the cases. Similarly, of the cases reviewed, 20% were considered to be in the maintenance zone, 69% in the refinement zone, and 11% in the improvement zone. Although the overall percentage of acceptable progress in the cases reviewed is consistent with first-year findings, the distribution of cases across the three rating zones suggests that a smaller percentage of cases were in the optimal, or maintenance, zone and a larger percentage of cases were needing refinement. It is encouraging that there were fewer cases considered to be needing immediate improvement regarding overall progress achieved.

Child-Specific 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, which are provided in the following series of displays. The first set, focusing on planning treatment, contained eight indicators. Areas of inquiry for these indicators include engaging families, understanding or assessing the current situation, setting directions or establishing a long-term view, organizing appropriate recovery plans, and organizing a good mix and array of services. The second set, focusing on providing and managing treatment, also contained eight indicators. Areas of inquiry for these indicators include availability of resources, implementation of plans, utilization of any special procedures and supports, coordinating services, and tracking and adjustment of services.

Findings for the first set of indicators are presented in **Displays 18 and 19** and summarized 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 76% of the 54 sample cases reviewed. Engagement was found to be in the maintenance zone in 18 cases (33%), in the refinement zone in 27 cases (50%), and in the improvement zone in nine cases (17%). Although the percentage of cases having acceptable levels of engagement are consistent with first-year review findings, there were a notably higher percentage of cases in the refinement and improvement zones when compared to last year's findings. This may be somewhat due to sampling limitations in the first-year review, in that, case reviews were most likely completed for children that had a higher level of engagement with service providers, whereas, significant steps were taken by the monitor's office to complete case reviews on each randomly selected child, despite the level of engagement with service providers. As such, it is believed that second-year

engagement results are more indicative of the degree of engagement with children and families. Last, it is important to note that a selection criteria for inclusion in the review was that the child and family were actively receiving services, so it would be hoped that all children and families would be engaged with service providers since this is a minimum basic practice expectation. For the purpose of illustration, an example of a case in which engagement, or the establishment of trust-based working relationships with service providers, was rated in the maintenance zone included the following:

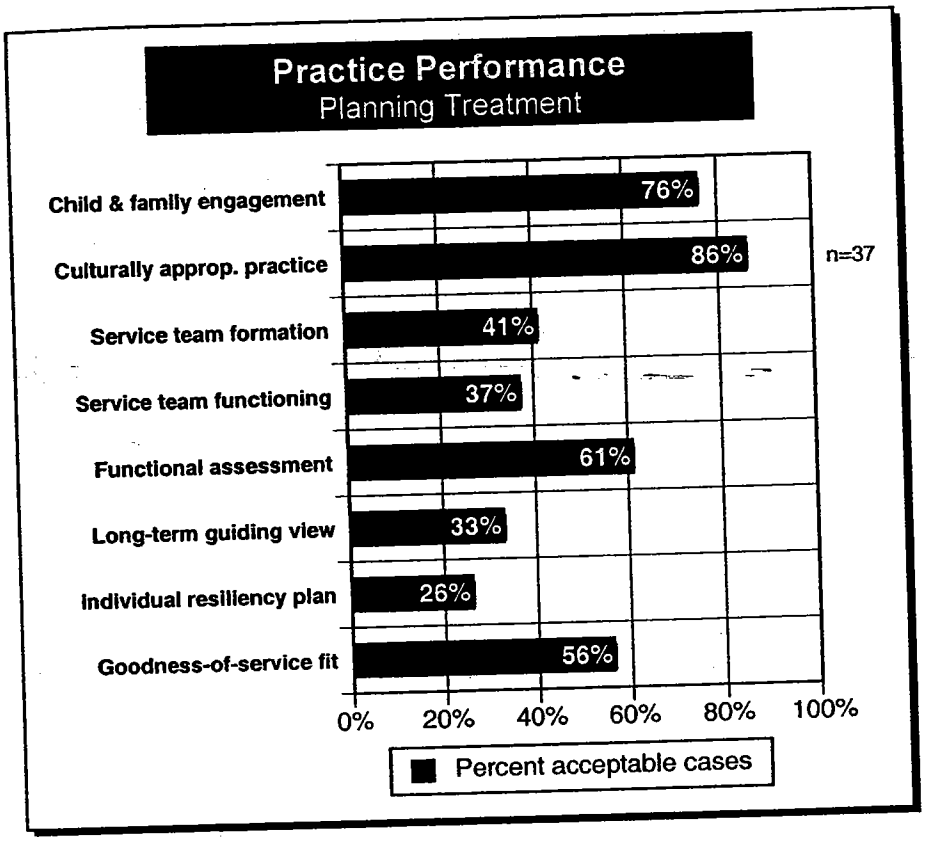
> "[The child] is in a safe and stable home and school environment. There is strong support from the center, educational advocate, and guardian ad litem. In addition, [the child] is not exhibiting any current "at-risk" behavior and appears to be in a meaningful relationship with the adults in her life.... Service coordination and tracking are good, and there is a goodness-of-fit between the family, their advocates, and their service providers."

For comparative purposes, an example in which engagement was rated as an area needing immediate improvement, due to the lack of trust-based working relationships with any service providers, included the following in a case narrative:

> "[The child's] father would benefit from consistent, skilled advocacy through case management services that would help him secure financial and health benefits for his children and help him work with the school to assure adequate educational and behavioral supports. These services are not in place. [The child] and his family could benefit from help from multiple public systems, including developmental disabilities, vocational counseling, the family court system, the educational system, mental health, and public assistance. Again, there is no one that is providing the function and coordinating the planning that would help the family to access needed services."

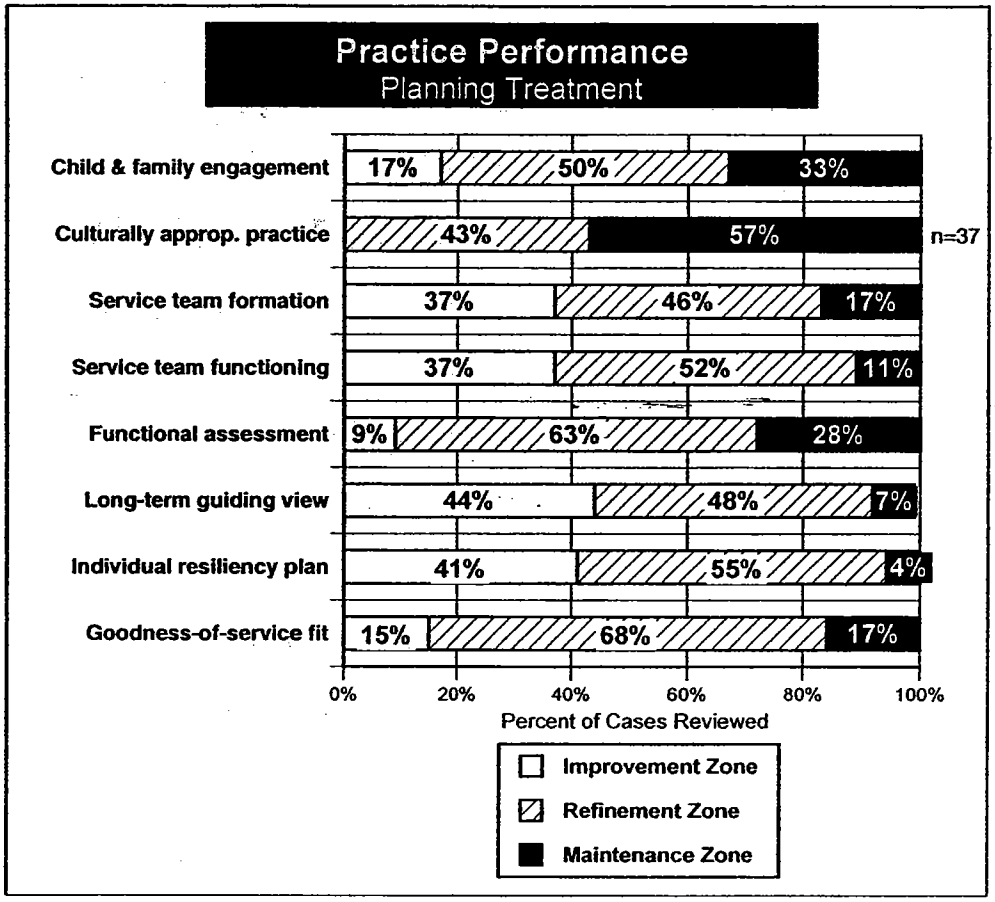
In summary, there does not appear to be consistently applied child and family engagement practices operating for all children and families receiving services from the System of Care. It is encouraging to note that while both quantitative and qualitative case review findings would suggest at least 75% of children and families have at least a minimally acceptable level of engagement with service providers, there still exists a number of children and families in which this basic practice expectation is limited in its application.

Display 18



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 37 of the 54 sample members. Reviewers found that practice was culturally appropriate in 86% of the 37 cases to which this indicator applied. Culturally competent practice was found to be in the maintenance zone in 57% of these cases and in the refinement zone in 43% of the cases. No cases were considered to be needing improved culturally appropriate practice. These findings are consistent with the first-year review findings and should be considered one of the foundational strengths of service provision within the district.

Display 19



Service Team Formation. Each child and family served should have a service team, beginning with the child and family and including appropriate informal supports and service providers. Although there is no fixed formula for team composition, the basic practice expectation is that the child and family's individual service team should be comprised of not only those directly providing mental health services, but also others that are actively providing services for the child and family. Oftentimes, these service providers could be a child welfare worker, special educator, or juvenile court officer.

Service team formation was found to be at least minimally adequate for 41% of the children and families reviewed. Service team formation was found to be in the maintenance zone in nine cases (17%), in the refinement zone in 25 cases (46%), and in the improvement zone in 20 cases (37%). It was not uncommon to have the identified "team" be comprised of several mental health professionals within a core service agency regularly meeting to update the child's Individualized

Resiliency Plan (IRP). However, children and families were not always involved in these meetings nor do they always recognize these regularly scheduled update meetings as IRP team meetings. Similarly, participation of other service professionals, such as child welfare case managers or special education teachers/providers, was mostly lacking.

The integration of IRP objectives, goals, and services with Individualized Education Plan (IEP) objectives and goals was not common. However, ambiguity from stakeholders was noted regarding current billing policies, in which a question was raised about whether participation in an IRP team meeting or other multidisciplinary service team meeting is a billable service for more than one of the meeting participants.

Service Team Functioning. The role of a service team is to function as a unified team in planning services. The unity of effort of a functional service team is demonstrated through a coherent pattern of teamwork and collaborative problem solving that achieves the specified IRP goals and objections. Service team functioning was found to be acceptable in 37% of the children and families reviewed. Service team functioning was considered in the maintenance zone in six cases (11%), in the refinement zone in 28 cases (52%), and in the improvement zone in 20 cases (37%) reviewed. Similar to first-year review results, the construction and functioning of appropriate individualized service teams remains a challenge within the district in adhering to System of Care practice principles.

Following are excerpts from two individual case reviews that illustrate limited continuity of care across multiple service providers (special education and mental health):

> (1) "The school's IEP team did not include anyone from [the core service agency]. While the [core service agency] had a treatment team that discussed cases on occasion, there was no service team formed with the family to support the needs of the child and family.... The school was unaware of [the child's] mental health services but was eager to invite [mental health] staff to the IEP process."
>
> (2) "The mental health case manager reported that she has never met the [child welfare social worker] and does not view CFSA as the lead agency. She stated that she telephoned the CFSA social worker to introduce herself and has never attended a service planning meeting at CFSA. The mental health case manager indicated that she had no

> contact with [the child's] school. A counselor reported that she met the mental health case manager for the first time last week.... A teacher reported that she has never been contacted by anyone from another agency involved in [the child's] care. She feels that communication with other agencies would be very useful in understanding [the child's] situation and communication would facilitate planning and service delivery."

Both of these case examples illustrate incomplete service teams, however, both of these examples also illustrate the willingness of other service providers outside the auspices of mental health to partner and collaborate so that the therapeutic benefit of offered services for the child and family is maximized.

Functional Assessment. A functional assessment involves the synthesis and analysis of available information in order to gain a "big picture understanding" of the child and family's core story so that underlying problems that cause the child and family to continue to need services and supports can be sufficiently identified and subsequently addressed. Completing functional assessments is a dynamic process, in that, information is gained in an ongoing and coordinated manner so that the individualized service team is better equipped to provide a combination of supports and services that promotes progress and success for the child and family. Functional assessments were found to be acceptable in 61% of the children and youth reviewed. Functional assessments were considered in the maintenance zone in 15 cases (28%), in the refinement zone in 34 cases (63%), and in the improvement zone in five cases (9%).

Long-Term Guiding View (LTV). The LTV focuses on practitioners' ability to anticipate, plan for, and execute known transitions, as well as specify long-term goals that the child and family want to achieve. It is through the formulation of an appropriate long-term view that more short-term goals and objectives listed in IRPs are operationalized. 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 acceptable for 33% of the children and youth reviewed. The LTV was considered in the maintenance zone in four cases (7%), in the refinement zone in 26 cases (48%), and in the improvement zone in 24 cases (44%). Following is a noteworthy case that illustrates the inter-relationship between developing a functional

assessment, an appropriate long-term view, and adequate recovery planning to meet identified goals:

> "This case involves a three-year-old ADHD male receiving services in a therapeutic Head Start program. The child was previously living in an over-crowded family member's home prior to being returned to live with his 23-year-old biological mother. Upon return, the child was transitioned from a Head Start program to a therapeutic Head Start program. The service team has done a good overall assessment of this child and family and provided [the child] with the support that he needed to adjust to this setting. They have developed a treatment plan and implemented the classroom component. They plan to introduce individual play therapy within the next month. The decision was made to ensure that [the child] understood he belonged in the classroom and felt he was part of that community before removing him for individual time with an adult, which he loves. The on-site clinical Head Start team members share information. [The child's] mother clearly sees that her son has made progress and is pleased with the classroom instruction and staff as well as the classroom-based therapeutic intervention. The child's current status is expected to improve as he continues to adjust to this program and individual play therapy is implemented. The psychologist/play therapist plans to meet with the mother at least monthly to update her on [the child's] status in treatment. It is expected that the upcoming IEP meeting will serve as an opportunity to re-engage his mother in his treatment. The family's living situation continues to improve."

Individualized Resiliency Plan. The role of the IRP is to set forth intervention strategies and services that providers and the child and family will implement in order to achieve the child and family's specified objectives and goals. Effective IRPs are based upon the individual strengths of the child and family and plan the interventions and supports that will be utilized in order to assist the child succeeding at home and school. The IRP was found to be acceptable in 26% of the cases reviewed. IRPs were considered to be in the maintenance zone in two cases (4%), in the refinement zone in 30 cases (55%), and in the improvement zone in 22 cases (41%). Case review findings often highlighted that the IRP's primary role was perceived to be the authorizing payment for services and that an IRP is not the primary factor driving practice for a specific child and family. Similar to first-year review findings, the development and use of the functional IRPs require significant attention and development for service providers in core agencies.

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

assessment, an appropriate long-term view, and adequate recovery planning to meet identified goals:

> "This case involves a three-year-old ADHD male receiving services in a therapeutic Head Start program. The child was previously living in an over-crowded family member's home prior to being returned to live with his 23-year-old biological mother. Upon return, the child was transitioned from a Head Start program to a therapeutic Head Start program. The service team has done a good overall assessment of this child and family and provided [the child] with the support that he needed to adjust to this setting. They have developed a treatment plan and implemented the classroom component. They plan to introduce individual play therapy within the next month. The decision was made to ensure that [the child] understood he belonged in the classroom and felt he was part of that community before removing him for individual time with an adult, which he loves. The on-site clinical Head Start team members share information. [The child's] mother clearly sees that her son has made progress and is pleased with the classroom instruction and staff as well as the classroom-based therapeutic intervention. The child's current status is expected to improve as he continues to adjust to this program and individual play therapy is implemented. The psychologist/play therapist plans to meet with the mother at least monthly to update her on [the child's] status in treatment. It is expected that the upcoming IEP meeting will serve as an opportunity to re-engage his mother in his treatment. The family's living situation continues to improve."

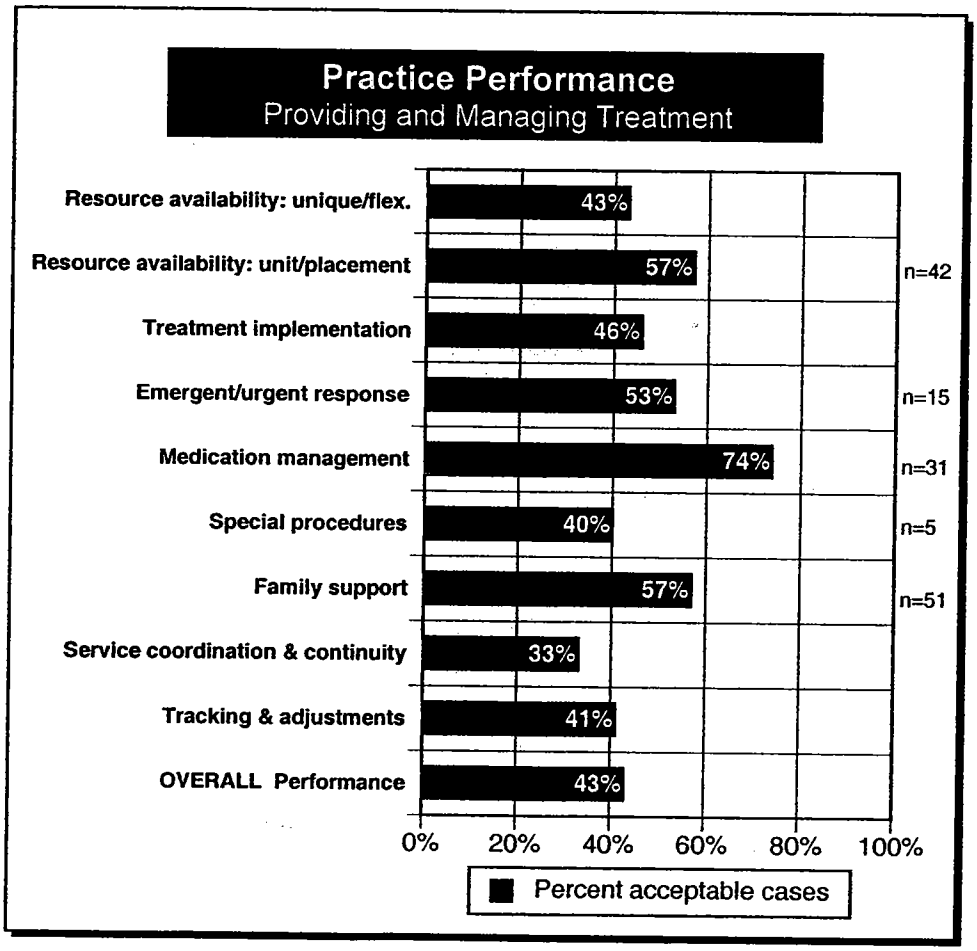
Individualized Resiliency Plan. The role of the IRP is to set forth intervention strategies and services that providers and the child and family will implement in order to achieve the child and family's specified objectives and goals. Effective IRPs are based upon the individual strengths of the child and family and plan the interventions and supports that will be utilized in order to assist the child succeeding at home and school. The IRP was found to be acceptable in 26% of the cases reviewed. IRPs were considered to be in the maintenance zone in two cases (4%), in the refinement zone in 30 cases (55%), and in the improvement zone in 22 cases (41%). Case review findings often highlighted that the IRP's primary role was perceived to be the authorizing payment for services and that an IRP is not the primary factor driving practice for a specific child and family. Similar to first-year review findings, the development and use of the functional IRPs require significant attention and development for service providers in core agencies.

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

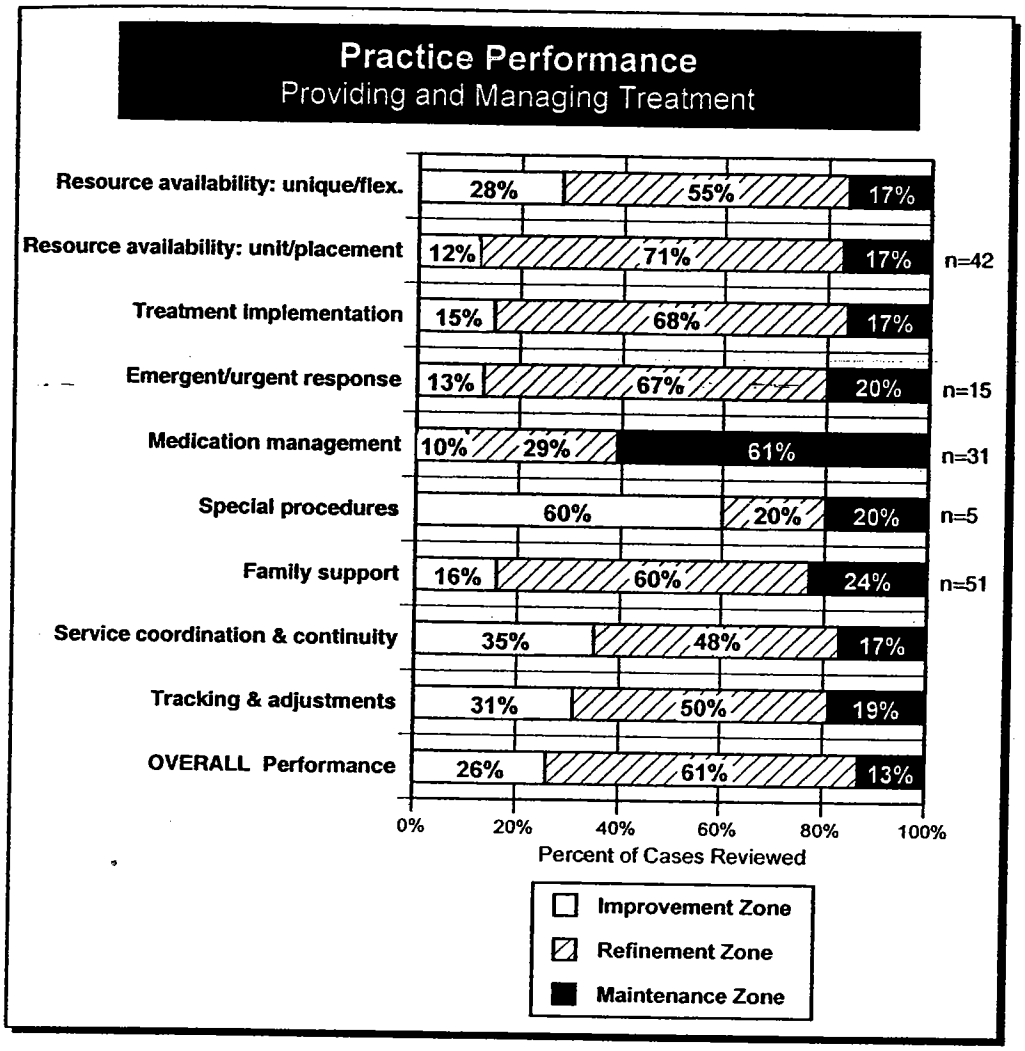
results and benefits while minimizing conflicting strategies and hardships imposed. The goodness-of-service fit was found to be adequate for 56% of the children and youth reviewed. The service fit was considered in the maintenance zone in nine (17%) of these cases, in the refinement zone in 37 (68%) of the cases, and in the improvement zone in eight (15%) of the cases.

The second set of performance indicators covers important functions related to the provision and management of treatment and support services to children and families. Findings for these indicators are presented in **Displays 20 and 21** and summarized concurrently below.

Display 20



Display 21



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 team members and families while increasing the use of more restrictive and costly placement resources. Unique service arrangements and flexible resources were found to be adequate for 43% of the children and youth reviewed. Availability of such resources was considered to be in the maintenance zone in nine (17%) of these cases, in the refinement zone in 30 (55%) of the cases, and in the improvement zone in 15 (28%) of the cases. These findings are somewhat lower than first-year review results, demonstrating that continued emphasis is needed

on improving the availability and strategic use of flexible resources that can be used to provide individual services based on the unique needs and context of individual children and families.

Resource Availability: Unit-Based and Placement-Based Resources. Such resources tend to be the traditional modalities through which mental health services are delivered. 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. Traditional unit-based and placement-based resources were applicable for 42 children and youth included in the review. Unit-based and placement-based resources were found to be adequate for 57% of the children and youth reviewed. Availability of such resources was considered to be in the maintenance zone in seven (17%) of the cases, in the refinement zone in 30 (71%) of the cases, and in the improvement zone in only five (12%) of the cases reviewed.

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. Likewise, necessary supports and services are to be implemented in a timely and competent manner. Treatment implementation was found to be adequate in 46% of the children and youth reviewed. Implementation was considered in the maintenance zone in nine (17%) of the cases, in the refinement zone in 37 (68%) of the cases, and in the improvement zone in eight (15%) 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. Ratings were assigned if such services were needed and/or accessed within the previous 90 days. As such, this rating applied to 15 children within the sample. For those 15 children, emergency and urgent service provision was found to be adequate for 53% of the children and youth. Emergency and urgent service provision was found to be in the maintenance zone in three (20%) of the cases, in the refinement zone in ten (67%) of the cases, and in the improvement zone in two (13%) of the cases reviewed.

Medication Management. The use of psychotropic medications is often incorporated into the treatment of mental illness. When utilized, psychotropic medications are to be provided in a safe, effective, and well-monitored manner. Oftentimes, psychotropic medications are coordinated with other treatment modalities and with treatment for any co-occurring conditions (e.g., seizures, diabetes, or asthma). Thirty-one of the 54 children in the sample were taking psychotropic medications; as such, this indicator applies to these individuals. Medication management was found to be adequate for 74% of the children and youth reviewed. Medication management was considered to be in the maintenance zone in 19 (61%) of the cases, in the refinement zone in nine (29%) of the cases, and in the improvement zone in three (10%) of the cases. These findings are consistent with the first-year results and medication management continues to be one of the strongest areas of current practice within the district.

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 five of the 54 cases in the review sample. Use of special procedures was found to be adequate in two of the five cases. Of those five cases, one was considered to be in the maintenance zone, one in the refinement zone, and three in the improvement zone.

Family Support. Based on needs and requests, caregivers in the child's home often receive practice assistance, training, and supports necessary to perform essential parenting and caregiving functions for the child. In order to be effective, the array of in-home services provided needs to be adequate in intensity, dependability, and cultural compatibility; provide the caregiver choices; and enable the caregiver to meet the challenging needs of the child while maintaining the stability of the home. Similarly, informal supports and services are oftentimes incorporated into treatment planning as deemed necessary and appropriate by the child and family. This indicator was deemed applicable in 51 of the 54 cases in the review sample. Family support was found to be adequate in 57% of the children and families reviewed. Family support was

considered in the maintenance zone in 12 (24%) of the cases, in the refinement zone in 31 (60%) of the cases, and in the improvement zone in eight (16%) of the cases reviewed. These result findings are generally consistent with the first-year review results.

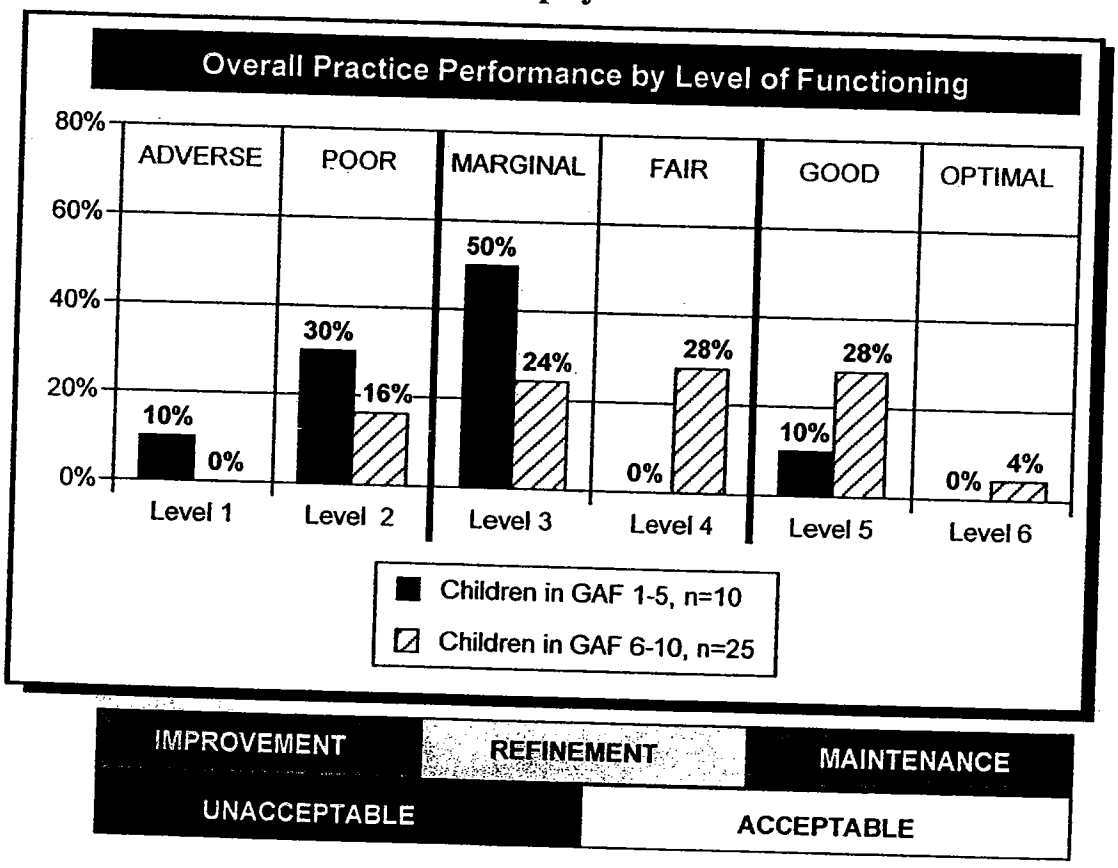
Service Coordination and Continuity. The primary role of case management is to be a single point of coordination, accountability, and continuity of services for the child and family. The intent of the IRP process is to coordinate appropriate services across settings and to ensure an adequate System of Care for this child and family. Service coordination was adequate in 33% of the children and youth reviewed. Service coordination was considered in the maintenance zone in nine (17%) of these cases, in the refinement zone in 26 (48%) of the cases, and in the improvement zone in 19 (35%) of the cases reviewed.

Tracking and Adjustments. An additional role of the service coordinator and other service team members is to monitor the child/youth's treatment progress, family stressors and supports, and results. Services and strategies should be modified 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 adequate in 41% of the children and youth reviewed. Tracking and adjustment was considered in the maintenance zone in ten (19%) of these cases, in the refinement zone in 27 (50%) of the cases, and in the improvement zone in 17 (31%) of the cases reviewed.

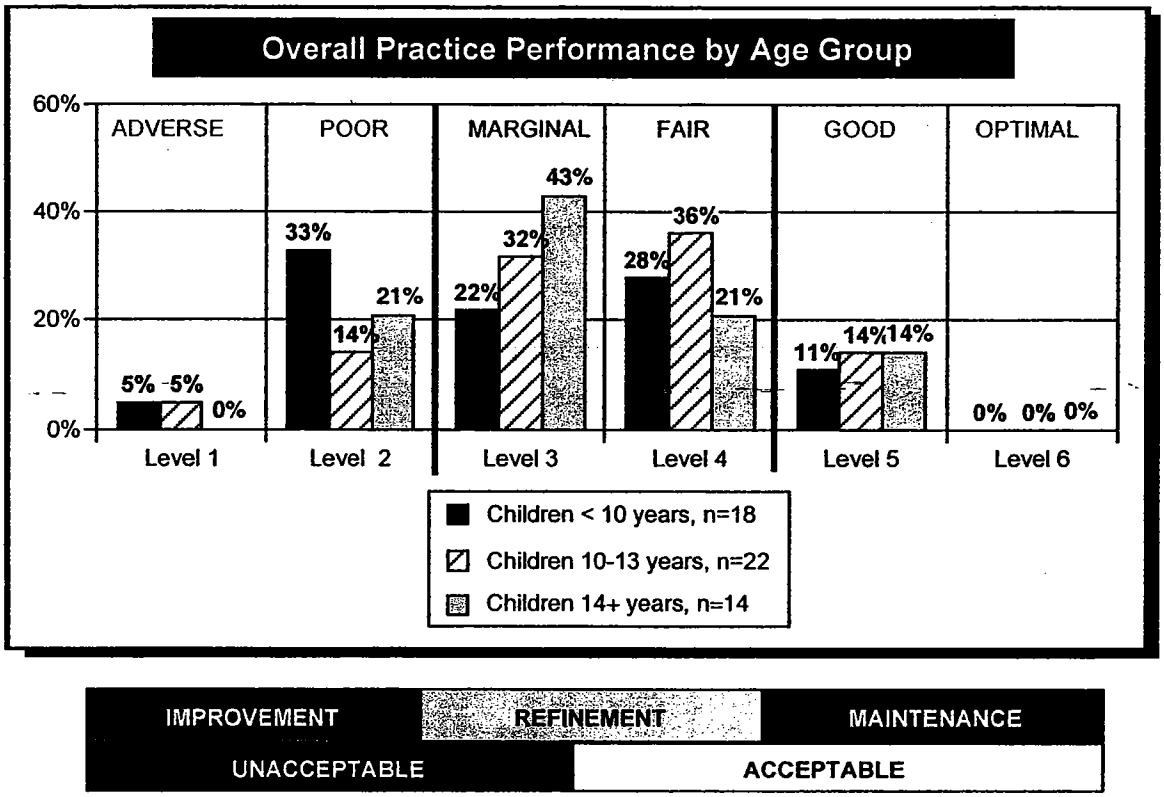
Overall Practice Performance. The protocol provides a scoring rubric for combining rating values across the items deemed applicable to the child or youth being reviewed to produce an "overall practice performance rating." Applying this rubric resulted in the determination that overall practice performance was rated as adequate (rating levels 4, 5, and 6) in 43% of the cases reviewed. Some 13% of the children and youth reviewed were rated in the maintenance zone, 61% in the refinement zone, and 26% in the improvement zone. Overall, these results combined with last year's data create a baseline measurement across practice performance indicators for children currently receiving and participating in services provided by the DMH System of Care for children and families.

The following two displays provide additional methods of interpreting the second-year review results. **Display 22** provides the overall practice and performance rating separated by the child's general level of functioning. As the display indicates, there is a higher likelihood that the system was performing adequately for children or youth with a generally higher level of functioning. In contrast, there was a lower likelihood that the system was providing adequate services for children whose needs are more complex and have a lower general level of functioning. **Display 23** provides the overall practice and performance ratings separated by age ranges. As the display indicates, children less than age ten and greater than age 14 presented the most challenge to the service system.

Display 22



Display 23



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 following two-fold table.

As **Display 24** indicates, 21 of the 54 cases (39%) fell into outcome category 1. Outcome 1 is the desired situation for all children and families receiving services. There were two children or youth in outcome category 2. This category represents children whose needs are so complex that despite the best practice efforts and diligent system performance of the service system, the overall status of the child or youth is still unacceptable. Nineteen (35%) children or youth were

in 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. Twelve cases (22%) 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 43% of the sample members, whereas the desired rate of a service system is to provide minimally adequate services for at least 85-90% of the children and families being served.

Display 24

Case Review Outcome Categories

Status of Child/Family in Individual Cases

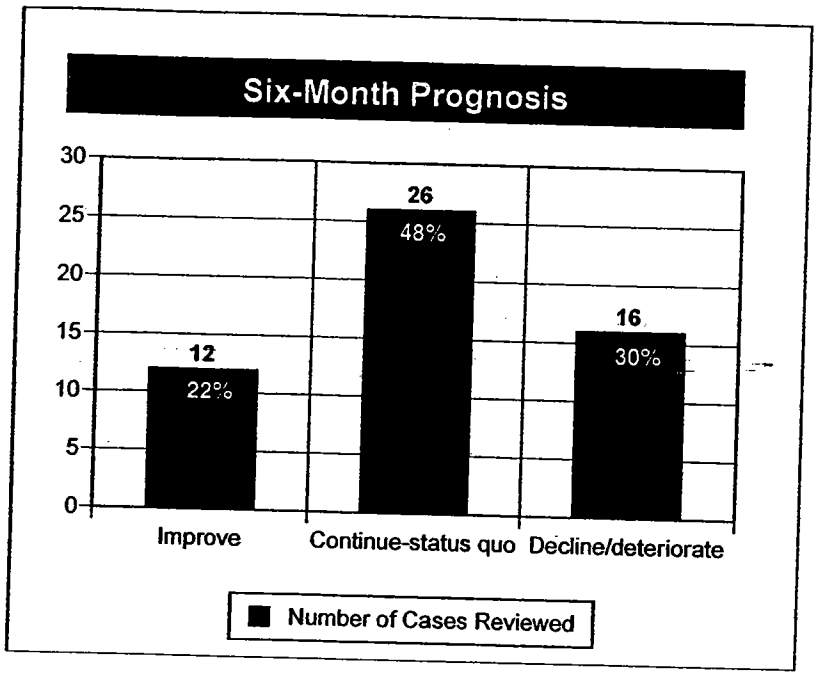
Acceptability of Service System Performance in Individual Cases	Favorable Status	Unfavorable Status	
Acceptable System Performance	**Outcome 1:** Good status for child/family, ongoing services acceptable. **39% (21 cases)**	**Outcome 2:** Poor status for child/family, ongoing services minimally acceptable but limited in reach or efficacy. **4% (2 cases)**	**43%**
Unacceptable System Performance	**Outcome 3:** Good status for child/family, ongoing services mixed or unacceptable. **35% (19 cases)**	**Outcome 4:** Poor status for child/family, ongoing services unacceptable. **22% (12 cases)**	**57%**
	74%	**26%**	

Six-Month Prognosis

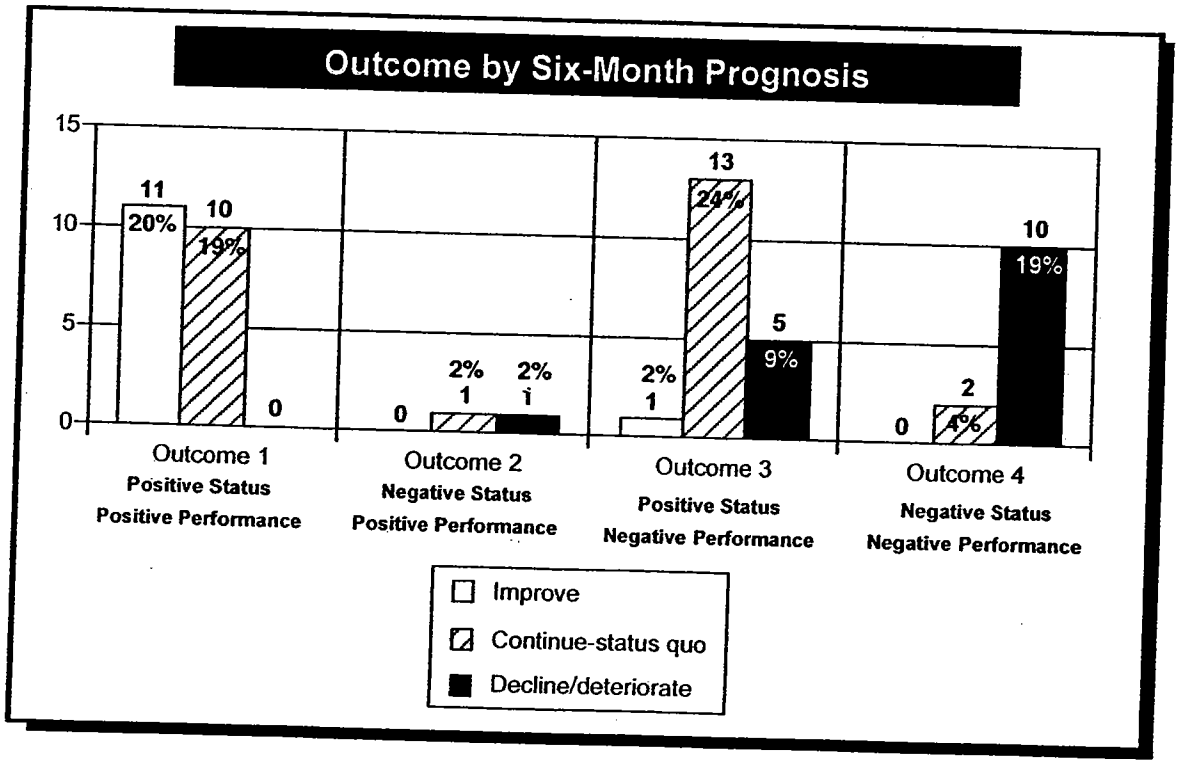
Reviewers made a six-month prognosis for each member of the sample. Formulation of the six-month prognosis was based on current overall status, known events forthcoming in the next six months, and the current overall practice performance observed in the case. The following displays present both the six-month prognosis offered by reviewers for all children or youth in the review, as well as the six-month prognosis separated by each of the previously described outcome categories. As **Display 25** indicates, 12 children or youth (22%) were expected to achieve improved status, 26 (48%) were expected to remain about the same, and 16 (30%) were expected to decline or experience deterioration of circumstances over the next six months.

Display 26 presents the six-month prognosis for sample members according to the outcome categories to which they were assigned. As the display indicates, if children or youth were in outcome 1, they were likely to either continue improving or remain status quo at the acceptable levels. Whereas, children in either outcome 2 or outcome 3 were not likely to improve, rather, their prognosis was to remain status quo. Last, children or youth in outcome 4 were most likely to decline or deteriorate. Children or youth for whom the service system was not performing adequately (outcome categories 3 or 4) did not have favorable prognoses.

Display 25



Display 26



Qualitative Summary of Case Review Findings

Stakeholder Interview Comments

The Dixon court monitoring review team facilitated a series of stakeholder interviews and focus groups. Groups were composed of senior management of the core service agency, program coordinators and other site supervisors, and frontline practitioners. Additional group meetings were held with the executive management team for the Department of Mental Health and also a meeting was held with parents and other consumer advocates. Participation was somewhat limited from core service agencies, with only a few of the core service agencies represented at the focus group interviews.

Overall, stakeholders acknowledged that progress in system development was being made. It was recognized that DMH was still working on building the infrastructure and capacity to support highly consistent practice for each child and family. The stakeholders were knowledgeable about the "big picture" conceptual understanding of the system goals and objectives and about the practice expectations. Stakeholders were either still working on very basic change in staff awareness and buy-in as in the public core agency or working to figure out how to make the reimbursement framework support the delivery of services in accordance with the practice expectations and values. For the children's providers, the implementation of Community-Based Interventions (CBIs) was proving to be very difficult to make workable financially. Stakeholders expressed the desire to continue to work with the department as a valued partner and to be allowed to help participate in the problem solving necessary to continue to develop and refine the System of Care.

Strengths Inherent in the System

- The multi-agency placement (MAP) process has been effective in creating more generalized understanding and knowledge across the service system.

- Mobile Crisis Services and Community-Based Interventions are perceived as strengths within the system, however, there are questions regarding how to increase access to such services when the presenting circumstances of the child and family require this level of intensity of intervention and how to make the financial components support implementation.

- Discussions of developing a more effective System of Care for children continue and the Department of Mental Health and the core service agencies are dedicated to achieving the task.

- The number of children being provided services in the community is increasing while the number of children provided services in more restrictive residential treatment settings is decreasing. Structures and supports continue to be developed to monitor the status of children placed into RTCs, regardless of the placing agency.

- The Department of Mental Health is pursuing additional System of Care grant funding through the Substance Abuse and Mental Health Services Administration (SAMHSA) and are also exploring the utilization of Multisystemic Therapy within the district.

- Core service agencies are being seen by the community as more family friendly than before and as having more success in partnering and engaging with family members in the treatment process.

- Excitement exists that the mental health system is at the beginning stages of implementing a significant system change process.

Challenges to the Service System

The following are comments that were offered by the focus group participants as challenges to the service system:

- Leadership and staff of core service agencies conceptually understand System of Care practice principles, but the specifics of application are more ambiguous. There is a perception that the provider role in service delivery is not always clearly understood.

- The skill set of the staff does not always match the needs of the circumstances and the direction the agencies want to take, and there is insufficient access to training on evidence-based practices in working with the specific needs of the target population.

- Despite emphasis of recent training on billing appropriately, providers are still not clear on what services can be reimbursed and are fearful that they may provide services that will not be paid for under the current Medicaid billing structure. Furthermore, a conflict may exist between the practice expectation and the emphasis on reimbursable hours.

- Core service agencies report that staff is unclear on how best to partner with other agencies (both mental health and other human service providers) and that team meetings are not reimbursable activities for most participants.

- Access to flexible funding to pay for such services as respite, transportation, "wrap" services, tutoring, or other in-home assistance is limited and treatment emphasis is often placed on the child, when the needs of the child and family may require family supports and interventions.

- There is a perception that the processes and procedures of DMH were developed to support adult services and not specifically shaped to support children's System of Care services.

- There still exists additional opportunities to better partner with juvenile justice and child welfare providers at both the frontline and higher systemic levels.

Recurring Patterns in the Service System and Recommendations

Individual child reviews completed during the review were debriefed with other review team members in order to more readily recognize themes and patterns emerging out of the sample of

children and families that were reviewed. Following are a list and general discussion of systemic themes and patterns noted from the cases.

- Inconsistent mastery of the basic craft knowledge necessary to provide mental health services in a System of Care. Factors to which this was attributed include ongoing turnover of staff at core service agencies other than the public core and inconsistent and, oftentimes, limited supervision of practice for experienced and licensed clinicians. Although the Department of Mental Health and subsequent core service agencies have recently completed several training initiatives, review team participants and stakeholders suggested that providing ongoing coaching, mentoring, and modeling of basic System of Care practice at the micro (or frontline) level may be a more effective strategy. One suggestion included using the Community Services Review in a small scale and targeted manner for ongoing training purposes. This may include developing reviewers at the core service agency level and providing regular opportunities to shadow CSRs. Also suggested was to begin providing direct feedback to clinicians and supervisors regarding the individual cases completed during the CSR.

- Current emphasis on producing billable hours and Medicaid billing codes determining allowable billable hours may be impeding the utilization of multidisciplinary individualized service teams. Review participants and stakeholders indicated that although the practice expectations specify that the utilization of individualized service teams is to be the basis of Individualized Resiliency Planning, emphasis is primarily placed on generating sufficient billable hours. Furthermore, policies may discourage the use of a team meeting format as review participants and stakeholders indicated only one team meeting participant may actually claim available dollars for this service. Similarly, frontline practitioners often perceive community support services as "talk therapy" and may not be claiming basic case management activities as community support services.

- The Individualized Resiliency Plan is used more as a mechanism to authorize payment for services and is not perceived to be the basis for practice activities. Child review findings show the inconsistent utilization of child- and family-centered IRP teams. Teams are often

lacking in needed composition and typically do not include practitioners beyond the core service agency. In some instances, individuals adhered to a more clinical team meeting and medical model approach, in that, participants included clinical supervisors and other practitioners not actively providing services to the child and family. Although IRPs are typically updated in 90-day intervals according to current policy and standards, these updates are not regularly utilized as an opportunity to reconvene the child and family's individual team, and there were limited examples of the team convening on an as-needed basis outside the expectation of the regularly held IRP updates.

- Child service teams are often limited in composition and frequently do not function according to System of Care principles. Some examples of adequately constructed and appropriately functioning IRP teams were seen in the child review findings, but as the quantitative findings indicate, this is occurring for less than half of the children reviewed. Oftentimes, the provision of services and other practice activities occurred more in response to crises rather than as a function of an appropriately crafted IRP through a functional individualized service team. There is little multi-agency participation in child teams. It is a significant finding that approximately half of the children included in the review were receiving services from CFSA and that approximately half of the children in the review were also receiving specialized educational services.

- Additional opportunities are needed to increase the craft knowledge of frontline practitioners as it pertains to ensuring that the educational needs of children are adequately addressed through education. Similarly, specialized training and instruction may be necessary regarding the educational planning process (Individualized Education Plans) strategies for integrating mental health services with IEPs and advocating for appropriate school-based services to address the emotional, behavioral, and educational needs of this population.

- Assessments were often limited in scope and were not regularly identifying the actual underlying needs of the child and family. Critical information, such as educational plans, child welfare involvement, and the role of the juvenile court, were often not thoroughly understood and sometimes overlooked.

- Limited service array for teenagers continues to challenge practitioners working with this age group. The prevalence of effective working relationships with the Division of Youth Services (juvenile probation) was described as inconsistent.

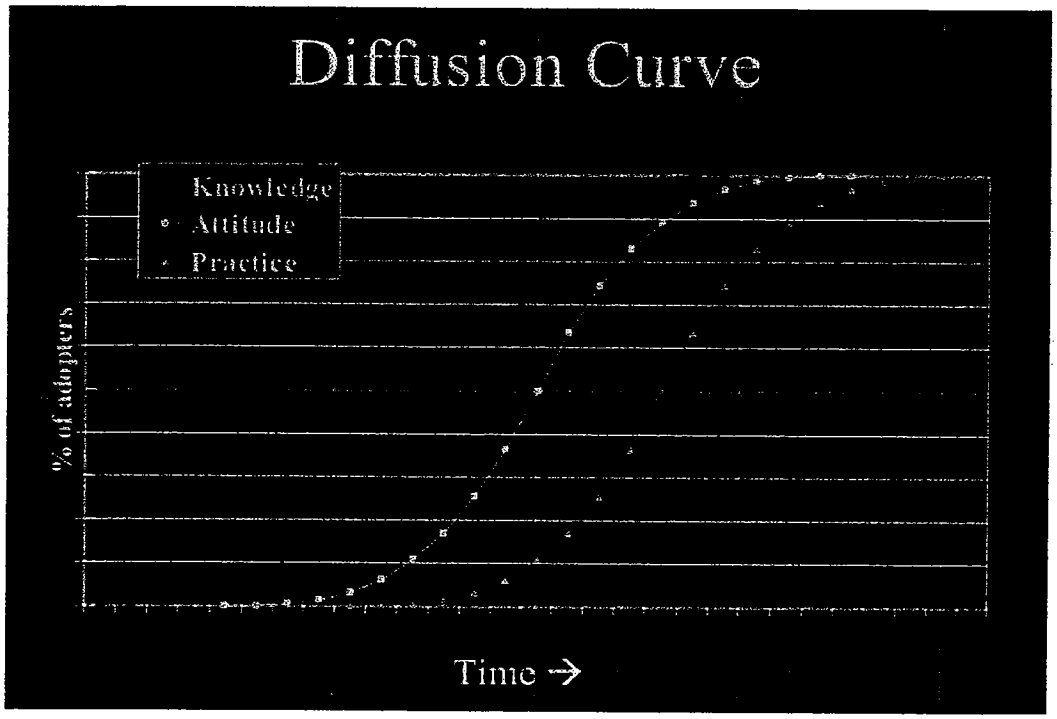
Conclusions and Recommendations

The Department of Mental Health continues to make progress in developing a high quality System of Care for children and families. The stakeholder interviews were revealing in that they show that the understanding of the performance expectations for core service agencies are better understood and that providers are just getting to the developmental stage that will allow them to place more emphasis on the quality and consistency of practice. Examples of strong quality practice provided in accordance with the System of Care principles were observed in some of the children and families that were reviewed.

When one considers the developmental milestones that a system must achieve to create the basic structure and foundation to support high quality consistent delivery of services to children, DMH is about on schedule for this stage of system reform.

The focus of effort now needs to include more coaching, mentoring, and training of practitioners. It also needs to continue to engage and refine practices with the practice partners of education, child welfare, juvenile justice, and core agencies.

Display 27



Display 27 shows the stages of organizational development and the dissemination of new practices. Many of the core service agencies have moved through the knowledge and attitude stages and are beginning to actually improve practice.

One exception to this progress is the public core service agency. Due to its size, history, and manpower challenges, it needs increased supports and interventions to assist it to make the necessary changes. It also provides services in some of the most challenging communities in the district and needs additional support to effectively perform in these complex and complicated service delivery arenas. There are still some significant attitudinal issues within the public core agency and also some very real challenges regarding the location and adequate support of the service delivery by the public core. It is generally perceived in the public core that the change process needs more attention and development to help the workforce make the necessary transition. The public core agency is a critical component because it services the largest proportion of clients in the district.

Recommendations

DMH must be acknowledged for the progress that has been made and encouraged to work with its community partners to continue to refine the particulars of the service delivery system in order to make the system work most efficiently and effectively.

DMH needs to continue to work on completing the infrastructure build out and to troubleshoot and refine some of the remaining problem areas. At this point, DMH and core service agencies should work together to develop strategies to address the areas identified as possible barriers to implementing the full practice model described by the System of Care principles.

A specific plan of mentoring, coaching, and training should be developed in conjunction with providers to place priority and emphasis on the provision of high quality services consistently in accordance with the System of Care principles as specified in the Dixon exit criteria.

Consideration should be given to modifying the monitor's reviews for the next year or two to get more training and development benefits from the review process. This might include small-scale reviews in core service agencies for the purposes of training and practice development. Data from these reviews could still be aggregated to show the status of child practice.

Appendix A

Community Services Review For a Child and Family

Questions to be Answered

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

Produced for Use by the Dixon Court Monitor

by
Human Systems and Outcomes, Inc.

March 2004

Questions Concerning the Status of the Child and Family

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

Community Living

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

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

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

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

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

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

Health & Well-being

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

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

Development of Life Skills

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

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

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

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

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

Questions Concerning Progress

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

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

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

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

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

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

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

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

Questions Concerning Performance of Key Service Delivery Systems

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

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 child? (4) Accomplished with proper techniques that were safely and respectfully performed by qualified staff? (5) Effective in preventing harm? and (6) Properly supervised during use and evaluated afterwards?

14. **FAMILY SUPPORT:** • Are the caregivers in the child's home receiving the training, assistance, and supports necessary for them tc 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 anc support services well coordinated across providers, funding agencies, and levels of care for this child and family?

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

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

Appendix B

CSR Interpretative Guide for Child Status

Maintenance Zone: 5-6

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

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

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

Acceptable Range: 4-6

Refinement Zone: 3-4

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

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

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

Improvement Zone: 1-2

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

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

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

Unacceptable Range: 1-3

CSR Interpretative Guide for Practice Performance

Maintenance Zone: 5-6

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

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

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

Acceptable Range: 4-6

Refinement Zone: 3-4

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

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

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

Unacceptable Range: 1-3

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.